

MANAGING URGENT MENTAL HEALTH NEEDS IN THE ACUTE TRUST:

A guide by practitioners, for managers
and commissioners in England and Wales



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FOREWORD

It is a matter of shame that this document is needed, but needed it most certainly is. We witness mental distress and mental illness daily, in people of all ages and in many different circumstances. Yet in our society they command less priority than do physical problems. Whatever the reasons, and the judgements and prejudices that still surround mental problems, they cannot ever warrant the relative neglect that people experience and report in the circumstances described in this document.

In few places is this relative neglect more common or more evident than in the emergency departments and the medical and surgical inpatient wards of acute hospitals. Many people are brought to Emergency Departments in acute distress, often in despair some having harmed themselves deliberately; many are seriously disturbed or made ill by substance misuse, many are distressed as a consequence of the illness or injury that has brought them to hospital. And among people with a physical illness or injury serious enough to require admission, a high proportion of them have a mental health problem, frequently masked or overlooked. We are reminded that 60% of acute hospital inpatients over 65 years of age will have a mental health problem.

It is right that College of Emergency Medicine, the Royal College of Psychiatrists and the Royal College of Nursing have led together in the preparation of this document. But the concerns they identify and address are for everyone with responsibilities in acute medical and surgical care, in the Emergency Department or in the wards, whether they are healthcare professionals, managers or commissioners of acute services. Neither, of course, are acute mental health problems limited to the acute hospital. They arise in the community, are common in primary care, and they often persist when patients leave hospital.

Mental illness and mental problems, including those of people with learning difficulties, occur in patients of all ages and of different racial, religious and cultural backgrounds. Their problems take many different forms, and different patients bring a variety of specialised needs. Often these needs are clinical and medical, but almost always they reach into family, social or working life. It is usually very difficult to have every specialised element to hand even in large acute hospitals, or for non-specialist staff to be in a position to call in the appropriate specialist help. That is why Acute Psychiatric Liaison Services are an essential part of a whole acute service, ready to respond at any time, to draw in the specialist expertise appropriate to the problem and to arrange the necessary collaboration within, between, and beyond hospitals.

This document describes the characteristics of a good acute mental health service. It sets out clearly and firmly the principles and standards that we expect to be applied to any acute medical and surgical service. These should be essential features of the psychiatric specialty service that supports the Emergency Department and the medical, paediatric and surgical wards. The input of mental health services to Emergency Departments and to acute hospitals is a vital element of the delivery of a modern, responsive and integrated service to patients.

The same standard of urgent assessment, diagnosis and intervention should be provided for mental health care as is expected for physical health care. This requires an extension of current standards to cover practice in these acute services, commissioning of services and assessment of performance. Successful implementation of these developments will require enhanced training opportunities for staff working in the Emergency Department, and in medical, paediatric and surgical wards. There must also be clear understanding of clinical responsibilities across the specialties.

The Academy hopes that this document will serve to give a strengthened impetus to the improvement of these services through commissioning, training and practice, with much needed and sustained improvement in the experience of affected patients and their families.



Professor Dame Carol Black
Chair
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The report was endorsed by the Academy of Medical Royal Colleges.

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EXECUTIVE SUMMARY

The current provision of mental health services to people attending the Emergency Department of General hospitals or those admitted to medical and surgical wards are extremely variable across the country. Yet, these departments have high levels of activity and encounter some of the most seriously ill people at greatest risk. This situation is unacceptable.

There has been no incentive to commission or develop services in these areas as it does not feature on the 'must do' agenda for mental health or acute services. On the contrary, and for the same reason, the services that do exist have been under considerable threat during times of recent change in the NHS. This situation must be addressed as it is not in the best interests of an NHS ambitious to be more effective and efficient.

Good management of mental health problems can make a significant contribution to the effectiveness and efficiency of acute hospitals and improve the outcome for patients.

There is an urgent need to develop national standards that inform the commissioning of services, thereby guaranteeing that people in need receive prompt assessment and management by appropriately trained professionals. These professionals will need dedicated time to fulfil these responsibilities and will have expertise working in General hospitals. The existing specialty of liaison psychiatry is best placed to form the basis of this development.

SUMMARY OF RECOMMENDATIONS

- 1 Patients with mental health problems should receive the same priority as patients with physical problems. There should not be any discrimination against an individual because of mental health problems.
 - Patients in the acute hospital should have the same level of access to the opinion of a consultant psychiatrists as they would have from a consultant specialising in physical health problems. Ideally, liaison services and multi-disciplinary services should be developed across the country so that a consultant liaison psychiatrist is available.
 - The quality of care offered must be the same, whatever the patient's racial, religious or cultural background.
 - The quality of care offered must be the same, whatever the patient's age.
 - Rapid access to effective interpreting services, trained in the needs of people with mental health problems, must be available.
 - Particular attention should be given to the needs of people with learning disabilities.
- 2 Acute Trusts should be commissioned to ensure provision of Acute Psychiatric Liaison Services.
- 3 Liaison services should co-ordinate the front line response for psychiatric support to the Emergency Department and acute wards. This may mean working with other psychiatric services to provide a 24/7 service.
- 4 These services should be subject to the quality standards expected of other medical specialties supporting the Emergency Departments:
 - Response times to Emergency Departments.
 - Response times to medical (including Acute Medical Units) and surgical wards.
 - Level of expertise of the clinicians involved.
 - Assessment, referral and aftercare.
 - Service organisation and joint working (inter-agency and multi-agency).
 - Quality of the environment for people with mental health problems.
 - Mechanisms for obtaining feedback from service users.
- 5 The Medical Royal Colleges and the Royal College of Nursing should work together to provide training opportunities in psychiatric assessment and management. This needs to be for all grades of staff.
 - Staff in the Emergency Department, an in medical, maternity, paediatric and surgical wards, require further training in mental health issues, including assessment and appropriate response.
 - This should be included in the relevant curricula.
 - Mental health staff should have an explicit responsibility for delivering that training.
 - It is also essential that a system of clinical supervision is in place to enable staff, who have undergone training, to put that training to efficient use.
 - Training in the needs mental health needs of people from diverse racial, religious and cultural backgrounds is also required.
- 6 Liaison staff should have specific training in the needs of the hospital service, the needs of patients who also have a physical illness, the care of young people, older adults and people with learning disabilities.
- 7 Overall clinical responsibility for patients in the Emergency Department and in acute hospital beds lies with the responsible Consultant. Specialities providing input to the Emergency Department also hold responsibility and hence the responsibilities of mental health staff should be analogous to those of other specialities.
- 8 A brief intervention service is required for patients with alcohol related attendance.
- 9 A dedicated Approved Social Worker* with responsibility to those services providing input to the Emergency Department and acute hospital wards, should be explicitly commissioned and funded.

*Approved Mental Health Worker will be the appropriate term from 2008/9

- 10 Services need to be explicitly commissioned against agreed specific service standards.
- Where different services are working together, they need to share the same objectives.
 - Funding mechanisms need to include structures to ensure that these services are funded.
- 11 Standards should be monitored, and linked to a quality improvement programme. A system of accreditation of services should be available and should preferably be obligatory.
- 12 The development of services should be overseen by local Urgent Care Boards, in England & Wales. In Scotland, service developments would be overseen by the Mental Health Division, Scottish Government and Local Health Boards with standards set by NHS Quality Improvement Scotland. A separate report will be prepared in relation to services in Scotland.

POTENTIAL BENEFITS OF THESE RECOMMENDATIONS

- Improved patient care
Managing someone's physical and mental health needs in parallel optimises their outcomes.
- Reduced bed days
Patients with mental health problems have longer inpatient stays in acute hospitals. There is increasing evidence that focussed liaison mental health input can reduce bed stays, reduce admission rates, and reduce re-admission rates.
- Reduction of risk
Patients with mental health problems can often pose a risk to themselves, through self harm, neglect, or failure to understand the implications of a problem, such as a physical health problem.

In addition, people with mental health problems are significantly more at risk, than other members of the population, of threats, violence, exploitation and extortion.

More rarely, people with mental health problems pose a risk to others.

- Reduction of discrimination
These recommendations should have considerable impact in reducing the difference in the lowered levels of service experienced by patients when they have a mental health problem.
- Patient centred service
The sum of these proposals should produce a responsive, patient centred service.

1. INTRODUCTION

The Royal College of Psychiatrists, the College of Emergency Medicine and the Royal College of Nursing are committed to improving the care of patients with acute mental health problems who attend the Emergency Department and who may require admission to an acute hospital. These patients often have complex assessment needs resulting in longer stays. Delays in service provision can further increase the time spent leading to a disproportionate number of breaches of the 4 hour target. People with mental health problems are more likely to leave the Emergency Department before being seen, are associated with a higher number of serious incidents, and are more likely to report their experience of the emergency department as negative.

Self-harm is one of the top five reasons for admission to hospital for emergency medical treatment, accounting for up to 170,000 admissions in the UK each year (NICE, 2004). Self-poisoning, mainly through overdose, accounts for some 80% of hospital admissions following self-harm; 20% have injured themselves by, for example, cutting, burning, asphyxiation or jumping from a height (Hawton, et al, 2003).

Over a quarter of the 682 adult service users surveyed in the Royal College of Psychiatrists' 'Self-Harm' project (2006/07) rated staff poorly in terms of their attitude and understanding. For some this can lead to non-engagement with services and/or further self-harm or attempted suicide.

Mental health is also a major issue for acute hospital inpatients, for example 60% of patients over 65 years of age will have a mental health problem and such patients have higher levels of physical morbidity and longer lengths of stay. (Who Cares Wins, RCPsych, 2005)

Good patient care and efficiency of the urgent and emergency health care system depends on access to high standards of assessment and management of mental health problems.

The same standard of urgent assessment, diagnosis and intervention should be provided for mental health care as is expected for physical health care.

Provision of services is challenging. Patients of all age groups present across the whole spectrum of mental health problems. Communication can be difficult either due to the effects of mental illnesses, learning disabilities or patients who may not have English as their first language.

In an RCPsych audit of 378 patients presenting with self-harm across seven trusts (2007) there were delays to discharge from the Emergency Department in 29% of cases. The single most common reason for delay was 'patient not fit for assessment' (50%), followed by lack of out-of-hours provision in 22% of cases, and a lack of provision 'within hours' for 11% of patients. A similar number reported delayed discharge due to 'waiting for blood level results'. This situation does not represent best practice, hence the need for this report.

2. REMIT AND TERMS OF REFERENCE OF THE WORKING GROUP

A working group was established under the joint chairmanship of Professor Sir George Alberti and Professor Sheila Hollins to produce a statement about the present situation regarding the input of mental health services to emergency departments, and those admitted through emergency departments to acute hospital wards and to make recommendations regarding potential solutions to the current situation. A more comprehensive background paper (2008) has been prepared by the same working group and is available as a web document at www.aomrc.org.uk

3. CURRENT PROVISION AND BACKGROUND

The current situation is complex, and a variety of factors make a significant contribution. These include:

- Local configuration of services
- Services to children and young people aged 16 and 17
- Services for older adults
- Place of safety issues
- Availability of Emergency Department observation wards/ clinical decision units
- Commissioning and funding of services
- Funding of services
- Potentially conflicting targets
- Involvement of primary care

For more information, consult the background paper at www.aomrc.org.uk (2008)

3.1 Local Configuration of Services

The input of mental health services to Emergency Departments and to acute hospitals is a vital element of the delivery of a modern, responsive and integrated service to patients. This area may be seen as of low priority by some commissioners.

At present different teams working in the Emergency Department may be subject to various and conflicting targets and standards (e.g. response times, psycho-social assessments for people who have self-harmed) and there is the continuing potential for serious problems to develop as a result. The patchy nature of service provision across the NHS is a matter of grave concern, and has the potential to jeopardise the improvements in general service provision that have been achieved in recent years.

This situation does not lead to the most efficient use of health care resources. In addition, people with mental health problems often do not receive the same level of care compared with people with physical health problems. This duality is discriminatory, and has no place in the modern NHS.

CURRENT SERVICE MODELS FOR PSYCHIATRIC SUPPORT TO THE EMERGENCY DEPARTMENT

SERVICE	ADVANTAGES	DISADVANTAGES
EMERGENCY DEPARTMENT STAFF	Always available. Psychiatric assessment part of Emergency Department training.	Large part of service still provided by junior doctors with limited experience. Time pressures, especially out-of-hours, may mean experienced staff do not have time for full psychiatric assessment. Some Emergency Department staff may still not regard the management of psychiatric illness as a priority.
GENERAL PSYCHIATRIC TEAMS	Might know patient. Follow-up care easier.	Often not on site, slow response times Contacting right person can be difficult Difficult to build team relations with Emergency Department staff often a very junior psychiatrist attends. Large area of on-call: priorities to community.
CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES	Very specialised assessment and treatment.	Few areas can provide 24/7 response. 24/7 cover may not be cost effective.
PAEDIATRIC STAFF	Usually available. Recent improvements in training.	Relative lack of experience in this area. Lack of therapeutic options
CRISIS TEAMS	Service widely available. Usually 24/7 service.	May see assessment of patients in community as primary objective. May not see older patients and children Response may be delayed.
LIAISON TEAMS	Service geared to needs of acute hospital patients. Main role is response to Emergency Department and acute wards- good team building. Focused training for Emergency Department staff. Pro-active management of frequent attendees. Management of up to 90% of patients with no further home management. Early input for admitted patients, reduce length of stay. Liaison nurses: key component.	Very patchy provision. Often do not provide 24/7 cover. May not see older patients and children.

SERVICE	ADVANTAGES	DISADVANTAGES
REGISTERED MENTAL NURSES IN THE EMERGENCY DEPARTMENT.	Available in the Emergency Department.	May be professionally isolated. High burn-out and turnover rates. May not have the breadth of experience across the physical/age spectrum.
OLDER PEOPLES' SERVICES	Trained to address the complex needs of older patients. Links to social care to expedite assessment and management. Specific skills in self-harm in the elderly.	Usually not available 24/7 Response times very variable. Demand for services can out strip supply.

3.2 Recommended response times

The Royal College of Psychiatrists, and the British Association for Emergency Medicine, have recommended specific response times for mental health services providing a service to Emergency departments (CR118, 2004).

	URBAN AREAS	RURAL AREAS
FIRST LINE ATTENDANCE	30 minutes from being called	90 minutes
SECTION 12 APPROVED DOCTOR ATTENDANCE	60 minutes from being called	120 minutes

These recommendations were published in 2004 and should be viewed as maximum time to response. However, many health communities have problems in meeting even these standards. This results in patients waiting longer with inevitable loss of satisfaction and potential risk. Persistent delay in response will make it difficult to comply with the 4 hour access standard, response times need to be quicker.

Implementation of mental health legislation in the Emergency Department can slow the progress of a patient through the Emergency Department considerably: awaiting the completion of two medical recommendations (one from a doctor approved under Mental Health legislation), the completion of the application by an Approved Social Worker, organising a suitable facility for the patient's further care, and arranging subsequent transfer to that facility is often extremely time consuming.

3.3 Place of Safety Issues

The Mental Health Act, 1983 (and 2007), requires that every locality has a designated Place of Safety, agreed between the health service and the police, under Section 136 of the Act. In different places this may be a police station, an emergency department, or a designated unit within the mental health services. Under Section 136, the police are empowered to remove someone from a public place, if they appear to be suffering from a mental disorder, and take them to the designated place of safety. A place of safety must therefore expect to receive people who may be acutely disturbed. It is essential that skilled and experienced staff are available to care for and to assess these people's needs. As most centres only receive a small number of people in these circumstances, it is generally unlikely that staff will be dedicated to this responsibility alone.

3.4 Funding of Services

These services are usually provided by the local mental health trust and the funding is absorbed within the overall budget. Some liaison services are provided by acute trusts and in other cases the acute trust provides a degree of funding for the service. Without explicit commissioning, all these services are potentially under threat when there are financial constraints.

3.5 Involvement of Primary Care

Primary care still provides a great deal of the management of patients with mental illness. Communication and improved referral practices for follow-up of patients need to be improved.

The management of patients with complex co-morbidity, or who attend the Emergency Department on a frequent basis, requires a close working relationship with primary care. Although there are some excellent examples of such a relationship, generally the co-ordination of the management of complex patients between primary care, and the differing elements of secondary care, is often over-reliant on individuals who make an additional effort to address issues faced.

4. THE IDEAL SERVICE

4.1 Guiding Principles

The following principles should underpin service delivery and commissioning:

- The quality of care given to people with mental health problems should be the same as the care given to people with physical health problems.
- The quality of care offered must be the same, whatever the patient's racial, religious or cultural background.
- Particular attention should be given to the needs of people with a learning disability.
- Emergency Department staff should be trained to carry out initial mental health assessments and an initial risk assessment.
- Emergency Departments should receive timely support from mental health services, led and co-ordinated by liaison psychiatry teams.
- Patients in the acute hospital should have the same level of access to the opinion of a consultant psychiatrist as they would have from a consultant specialising in physical health problems.
- There should be good referral pathways and communications with primary care.

4.2 Specific mental health services needed

- First response support by generalist service is best provided by a liaison team and supported by crisis teams.
- Access to more specialist psychiatric services for children and older people.
- Rapid access to effective interpreting services.
- A brief intervention service for patients with alcohol related attendance.
- A team approach to handling acutely disturbed patients and Place of Safety issues. This will involve the police, local psychiatric services, primary care, liaison services and the Emergency Department. Place of Safety procedures need to be planned at a local level.

4.3 Service roles and responsibilities

- Initial clinical responsibility for patients in the Emergency Department rests with the Emergency Department staff. They are responsible for the reception, triage and initial assessment and initial management of patients.
- Just as with other acute specialties, optimum patient care is dependent on timely and effective response by mental health staff.
- Mental health Services supporting Emergency Departments and acute hospitals, need to be subject to standards that include response times, the ability to respond to the needs of the acute hospital, appropriate training and linkages with mental health services.
- There needs to be rapid and reliable access to senior competent first mental health assessments.
- Services need to be explicitly commissioned. Commissioners will require access to agreed specific service standards.
- Where different services are working together, they need to share the same objectives.
- Approved Social Worker services with responsibility to the Emergency Department and acute hospital wards should be explicitly commissioned and funded.
- Standards should be monitored, and linked to a quality improvement programme. A system of accreditation of services should be available and should preferably be obligatory.
- The development of services should be overseen by local Urgent Care Boards.

5. SERVICE STANDARDS

There are already nationally agreed service standards.

- Response times in Emergency Departments are included in the joint report, from the RCPsych and BAEM, CR118.
- The NICE guideline of patients who self-harm.
- The Royal College of Psychiatrists Child and Adolescent Faculty has produced a document, “CAMH Problems in the ED” which gives guidance on services for younger people.

Further standards need to be produced to include the attendance of, the assessment of, and the management of inpatients with mental health problems in the acute wards.

Performance against these standards could be measured and improved by a national quality improvement programme, such as the ‘Better Services for People who Self-Harm’ project, run by the Royal College of Psychiatrists’ Research Unit.

Specifically, standards should include:

- Times to assessment by Emergency Department staff (by triage category)
- Response times to Emergency Departments.
- Response times to medical and surgical wards.
- Level of expertise of the clinicians involved.
- Training (see section below)
- Assessment, referral, intervention, and aftercare.
- Service organisation and joint working (inter-agency and multi-agency)
- Quality of the environment for people with mental health problems.
- Access to appropriately qualified interpreting services.
- Mechanisms for obtaining feedback from service users.

6. CHARACTERISTICS OF A GOOD ACUTE MENTAL HEALTH SERVICE

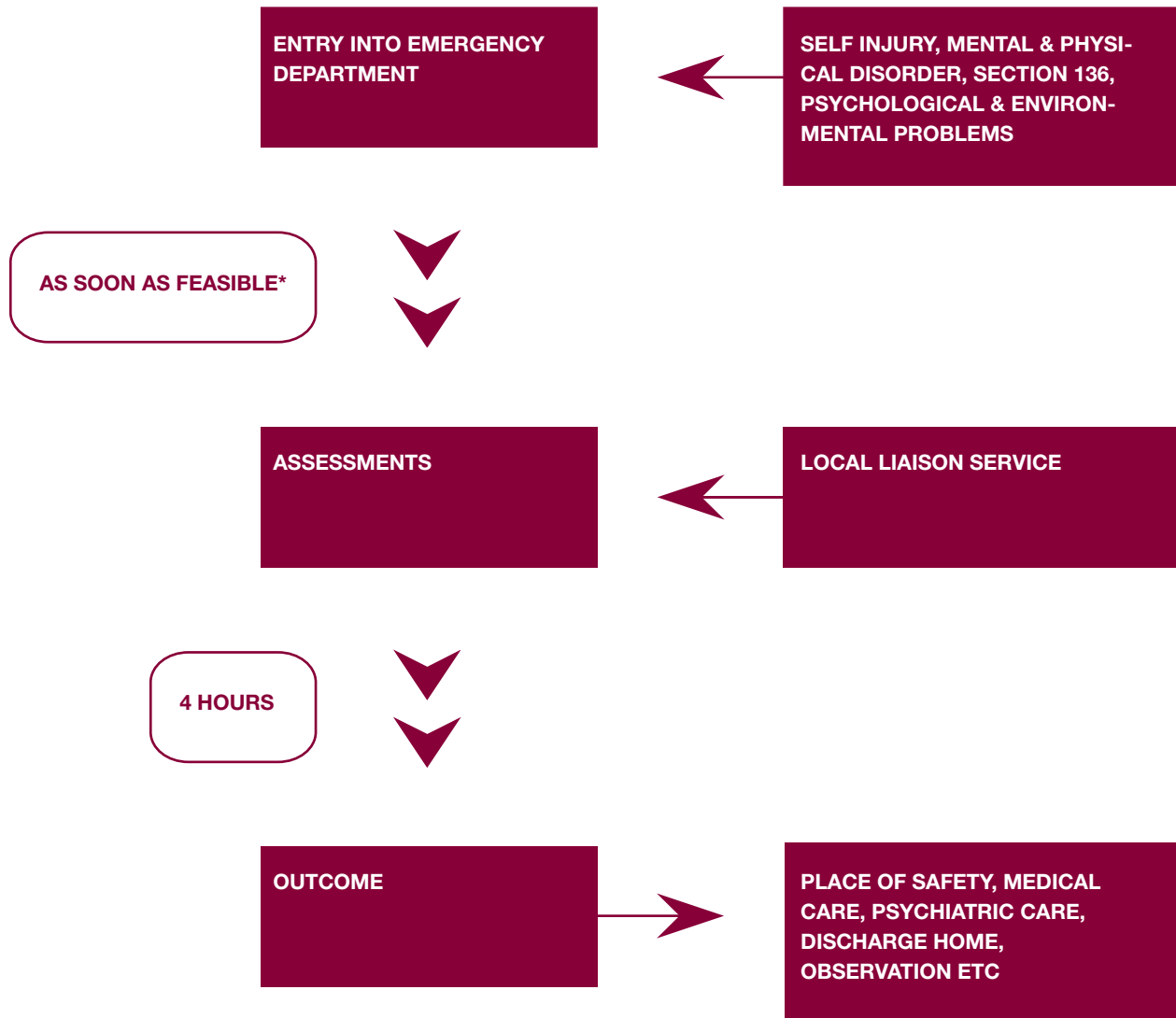
- Clear single call access for Emergency Department staff for appropriate mental health referral 24/7.
- A dedicated service that works closely with the Emergency Department and acute inpatient teams on a daily basis, most likely to be delivered by Liaison teams working in partnership with Crisis teams.
- Response within the current time standards.
- Pathways of care for some common conditions where specific groups of patients may need more specialist input (e. g. older people, children, young people, pregnant women and people with learning disabilities).
- Work with Emergency Department staff and other services to provide pro-active management plans for frequent attenders.
- Provision of some 'same day' or 'next day' services, such as an alcohol support worker, who may then initiate brief interventions.
- Early referral to appropriate community or specialist teams for those patients requiring ongoing care.
- Pathways for ensuring response within 30 minutes for very disturbed patients or patients requiring compulsory admission.
- Pathways for ensuring prompt attendance of an Approved Social Worker.
- Discussion between referrer and liaison team, for inpatients with mental health problems, to agree rapidity of response.

Second line mental health:

- Specialist assessment within an agreed time frame between referrer and the liaison team. This will usually be within 24 hours of the patient's referral via the Emergency Department or inpatient teams.
- Develop pathways of care for common presentations where a fast specialist response may prevent admission.
- Make available early clinic appointments.

The services fulfilling these roles will vary between health communities. However, the RCPsych, the RCN and the CEM agree that a Liaison Mental Health Team based in the Acute Trust, working with Crisis teams, is likely to provide the best and most sustainable solution for first line response. For children and young people under 18 the recommendation is for a CAMHS liaison team for working hours referrals, and a rota of suitably trained CAMHS professionals on call out of hours.

PATHWAYS TO MENTAL HEALTH CARE THROUGH THE EMERGENCY DEPARTMENT



* For the service to run efficiently and effectively, this assessment needs to be accomplished rapidly. The current resource situation in many localities means that this is often not achieved.

7. TRAINING AND EDUCATION

Training and education and proper supervision of staff, is essential:

- Staff in the Emergency Department, in medical and surgical wards, as well as paediatric staff, paramedics and GPs, require further training in mental health issues, including assessment and appropriate response.
 - o This should be included in the relevant curricula.
- Mental health staff should have an explicit responsibility in delivering that training, in collaboration with acute hospital staff for that age group.
- Mental health staff providing input to the acute hospital services also require training, which should include:
 - o The needs of the acute hospital service.
 - o The needs of people who are physically unwell.
 - o The needs of young people.
 - o The needs of older adults.
 - o The needs of people with learning disabilities.
- To enable staff, who have undergone training, to ensure that training is used efficiently, it is also essential that a system of clinical supervision is in place.
- The Department of Health has recently emphasised the importance of risk management in health services, particularly in emergency settings (DH, 2007). The Royal College of Psychiatrists 'Risk Management Working Group' (Morgan, 2007) has welcomed this emphasis, but feels that structured risk assessment questionnaires should be designed to enhance rather than replace clinical risk assessments carried out by well-trained experts in the field, and particularly in emergency settings, as considered in this report. Thus training and resources are essential to deliver on risk management in emergency settings.

8. COMMISSIONING STANDARDS

Clearer standards would help in making explicit the responsibilities of commissioners in ensuring service delivery. At present there is no clarity regarding how these services should be commissioned. Should they be commissioned via acute services, or mental health services?

We recommend that that national guidance, alongside national standards, is issued to commissioners.

Our recommendation is that commissioning via acute services would emphasise the joint responsibility to this group of patients owned by both acute services and mental health services.

It is important that these arrangements are overseen by local Urgent Care Boards.

9. CONCLUSION

There is an urgent need to develop multi-disciplinary psychiatry services in all acute hospitals, working in collaboration with mental health crisis teams. Liaison psychiatry teams are best placed to provide these services.

For further information, consult the background paper at www.aomrc.org.uk (2008)

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