The College of
Emergency Medicine

Mental Health in Emergency Departments

A toolkit for improving care

The Core Principle of Mental Health in the Emergency Department:

A patient presenting to ED with either a physical or mental health need should have access to ED staff that understand and can address their condition, and access to appropriate specialist services, regardless of their postcode, GP or time of arrival.

Introduction

For many years I have worked to improve mental health services for patients within the ED. This has been largely built out of frustration that, ironically, for the sickest patients it can be extremely challenging to access mental health services. This drains resource from the ED and causes operational pressures…but most importantly for the patient it can result in significant delays and time spent in a non-therapeutic environment. Some departments have managed to provide excellent services that are liked by patients, and they feel well provided for, but this is not always the case.

Service provision for patients with mental health issues can be very challenging to resolve. Frequently ED and mental health are provided by discrete organisations, and offering a seamless service to the patient can seem impossible. Much of the commissioning structure for mental health is based around different geographical and logistical domains when compared to acute services. This often results in suboptimal or absent services to patients attending the ED with mental health needs.

It is apparent that many people, in diverse locations, are having the same discussions with colleagues, managers and commissioners. I hope that within this document are some useful points, guides and resources that will inform service development.

I look forward to receiving more examples of good practice, and hard-won learning that can be shared with others.

If the availability of mental health services at your department is poor, and you find it a constant irritation….who better to fight for improvements in service…..there will be no one else who feels the lack in service so keenly as you and your patients.

Does the education and clinical knowledge of your staff in mental health match that for major trauma, cardiac arrest, etc.?

Anne Hicks
On Behalf of the Clinical Effectiveness Committee
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1. Department strategies

Many of the key areas for quality are included in the PLAN standards (see resources).

Objective	*Description*	*Resources*
Pro-forma	Trying to meet national standards of documentation is a real challenge without a pro-forma. Mental health clerking detail is commonly poor in ED notes, and without a prompt it is unlikely that doctors will record the key findings that inform risk. It is always difficult to arrive at consensus for a pro-forma, and some examples are collated here for your consideration (see right).	Example - pro-forma (Addenbrooke's Hospital): http://secure.collemergencymed.ac.uk/code/document.asp?ID=6848 Example - risk assessment matrix (Bristol Royal Infirmary): http://secure.collemergencymed.ac.uk/code/document.asp?ID=6855 Example - 4 areas approach for assessing AED patients following self-harm: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6870
Information at Triage	"*Feeling on the Edge*" is a leaflet currently produced by the RCPsych, with approval of multiple colleges, including our own, to give to self-harm patients at triage. It explains the process and gives information about services. This leaflet is likely to reduce the proportion of "did not wait" patients, and is highly rated by staff and patients.	"*Feeling on the Edge*" patient leaflet: www.rcpsych.ac.uk/mentalhealthinfo/problems/feelingontheedge.aspx
Junior Induction	Mental health is a high risk area of our practice, and as such should feature specifically within junior doctor induction. This is particularly important because the provision and style of mental health services varies so dramatically across the country/county/city.	
Staff Education	Nursing staff should have access to training in mental health so that they are able to assess risk and contribute in a positive way to the patient's condition. It is a key element of liaison teams that they should also engage in education of ED staff (see the PLAN standards). A package of on-line teaching will be developed to ensure that suitable educational resources are available.	PLAN: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx

2. Collate risk, incident forms, 4 hour breaches, complaints

Description	Resources
Identified risk within your organisation can be a real driver for resource and change. Collecting all mental health risk, in the above format, works as a convincing driver to commissioners when discussing the style of liaison psychiatry provision. Following change, ongoing surveillance of these events will continue to inform improvement and innovation. Frequently mental health services are structured around geographical boundaries: the acute trust should be the focus for all of these reports, otherwise the true picture is lost.	Example of risk analysis: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6849

3. Suitable environment

Description	Resources
There is no question that the middle of an ED, whether busy or quiet, can be a very stressful environment for any patient. However, if a person is feeling paranoid, psychotic, distraught or suicidal, the environment can be clearly detrimental, and potentially escalate symptoms. Any assessment area needs to be safe for staff, and conducive to valid mental health assessment. Standards for these areas are described in PLAN and CR118 (soon to be updated). Importantly, the assessment room must be safe for both the patient and staff. Therefore there should be no ligature points, and nothing that can be used as a missile. The room should have an alarm system and two doors (that open both ways). It is not acceptable to use a room that doubles as an office. This is the requirement that most often prevents a liaison service from achieving full accreditation, even though it is a core element of providing a therapeutic and safe environment to this patient group.	PLAN: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx

4. Liaison service

Description	*Resources*
There is plenty of evidence that a Liaison service is of huge benefit to patients, staff and the acute trust. Often services developed just for an ED are too small, and the staff risk becoming burnt out, or the service unsustainable. If the service is commissioned for the whole acute trust, then all patients benefit, staff are less likely to burn out, and the response to mental health within the trust becomes timely and consistent. Any service based outside an acute trust usually struggles to provide a timely response, and tends to have responsibilities elsewhere. Psychiatrists in liaison are specifically trained to deal with patients in this field, and will add more to the patients and hospital Trust than a general trained psychiatrist. It is not appropriate to cover an acute trust service with a general consultant psychiatrist: one wouldn't ask a consultant cardiologist to cover the work of a consultant rheumatologist. The composition of a Liaison team is detailed in many documents, and further quantified in a document published by the Centre for Mental Health Ideally the service should provide an ageless response, i.e. it has the capacity to deal with patients of all ages. The business case for older person liaison is probably the strongest due to the high percentage of older patients in hospital and the dramatic reduction in bed stays that follows the introduction of an effective service in this patient group. However, an adult liaison service deals with the majority of self-harm presentations, personality disorders and medically unexplained symptoms. This not only encompasses the most common presentations, but also positively contributes to the cohort of patients that represent the high frequency repeat attenders to the ED. A dedicated children's service on site will rarely be an efficient use of staff. But it is important that links with the community are strong, and that the community team are able to respond quickly, get to know the hospital team, and feel part of the liaison service. This is particularly important for managing the transition stage from children's services to adult. There are options to have an adolescent service, or for the adult team to be competent to see 16 to 18 year olds. This is a contentious area, but intervention in the young really reaps rewards. It is likely that the response of health services to this group has a profound effect on how those individuals respond to services in the future.	Centre for Mental Health: http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf PLAN: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx

5. Multidisciplinary service

Description	Resources
Mental health patients in the acute trust have a high rate of co-morbidities with alcohol, substance or vulnerabilities. Close links with safeguarding also promote good holistic care. Therefore, to provide a patient-centred service there needs to be a multidisciplinary team that can deliver joint assessments in a timely fashion. This also provides an environment within the team that offers peer support and supervision. All practitioners working in this field are, by definition, working with a high risk population, and so the provision of a large team with which to share practice/concerns and learning promotes a sustainable working environment. This counteracts some historical services where a single practitioner has been funded to work in one area, and functions as a lone provider without peer support. The multidisciplinary approach has added benefits because the referrer does not need to appreciate the variations in responsibilities of the individual specialities within the liaison team, and can complete one referral to the team safe in the knowledge that all areas will be addressed. The ideal team should consist of specialists in Learning Disabilities, Alcohol, Substance and Child and Adult Safeguarding. This will enable joint assessments of patients, reducing the need for multiple assessments and interviews with different practitioners on different occasions.	Example - adult liaison team poster: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6850 Article - Salford alcohol assertive outreach service: http://fg.bmj.com/content/early/2013/01/22/flgastro-2012-100260.full.pdf CEM Best Practice guidance- safeguarding children: https://secure.collemergencymed.ac.uk/asp/document.asp?ID=4729 CEM position statement – alcohol related harm: https://secure.collemergencymed.ac.uk/code/document.asp?ID=5616

6. Commissioning blocks

Description	*Resources*
There are several unintentional, but significant, blocks to Liaison Service commissioning: 1. If an acute trust doesn't already have a liaison service, there will be no one campaigning for it. General psychiatrists will not necessarily advocates for the development of a service that will compete financially with theirs, and most people in the acute trust don't see it as their job. Commissioners will not be looking for services on which to spend money. 2. A well-run Liaison service will save bed days for both the acute trust and mental health. However it can be a challenge to demonstrate a strong business case to one service line or budget bottom line. A new document from the Centre for Mental Health may assist in this regard, since the financial argument for the trust and health community at large is substantial. However there needs to be acceptance at commissioner level that there is benefit across the health community from a properly established and sustainable Liaison service. It may be that an attendance to the acute trust, either as a result of a mental health crisis or as an incidental finding, may give a unique opportunity for assessment, intervention and engagement that results in real therapeutic gains. 3. Not infrequently the geographical footprint of mental health services differs to the acute trust footprint, which leads to different service provision for patients from different areas attending the same acute hospital. This can promote inequality of access to services, and frequently contributes to significant delays in patient assessment and disposition. 4. Liaison services are often a small proportion of mental health service provision, and so with universal spending constraints it is a real challenge to ensure that these services remain a priority and ring-fenced from short-term, but ultimately damaging, cost reduction programmes.	Centre for Mental Health: http://www.centreformentalhealth.org.uk/pdfs/liaison_psychiatry_in_the_modern_NHS_2012.pdf Royal College of Psychiatrists: http://www.rcpsych.ac.uk/pdf/PIG2.pdf Example – liaison service business case: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6851 Example – business case summary: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6852

7. Strategic presence in the acute trust

Description	*Resources*
There will never be a time when liaison psychiatry is a priority for funding within a Community Mental Health Trust (CMHT). Therefore the acute trust must push consistently for an appropriate and effective liaison service. There needs to be a liaison strategic hub within the acute trust for the following reasons: a. Trust risk register: identify the risk to patients with unmet liaison needs b. Compliance with national guidelines (this should be evidenced) c. Most benefits are trust-wide, or realised across the wider healthcare community d. Identification of acute trust service provision needs and gaps in service. e. Enables disparate commissioning groups to agree joint working /shared resourcing f. Transparent communication links with community services g. Clinical governance framework. This is a key area for patient safety and quality. Many complaints or errors affect both trusts. Patients or relatives normally receive responses from both trusts, which often emphasises the gap in service provision, rather than addressing the need for change. It is essential that this is formally addressed with shared and cooperative governance arrangements.	Example of risk analysis: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6849

8. Care plan management

Description	Resources
There are several patient groups within substance and mental health that benefit from a consistent response. To reduce "frequent attendees" to the ED, the development of an agreed care plan can help to alter behaviours and contribute more constructively to the patient's needs. For example, some patients who are well known to services may benefit from a low key response from the ED, without formal review by liaison staff, but a timely alert to their community team. In other cases strategies to avoid admission may benefit the patient. These care plans need to be actively managed and archived. They should be composed using all appropriate clinicians from the acute trust, mental health, primary care and community services. This is an important element of a liaison service, since a key commissioning objective will be to reduce repeat attendees, and most ED's have a small number of high frequency attendees that may have their attendance pattern influenced by robust care planning. An example care plan can be found on the right.	Example – frequent attendee care plan: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6856 Example – frequent attenders letter: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6853 Example – strategy plan for frequent attenders: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6857

9. Service user involvement

Description	Resources
Throughout mental health, service users have informed the development and delivery of services. This has been useful for both commissioners and providers, and it is highly recommended that service users provide input to commissioning and healthcare staff. Allowing a service user to talk directly to staff about their experience of being in the ED can be a very powerful tool for change.	

10. Strong links with Community Mental Health Teams

Description	Resources
There should be regular meetings between the acute trust/ED and your main provider of liaison psychiatry, so that you can increase links and understand each other. Involvement in each other's induction programme really helps to improve response times and flow of service. For the pure psychiatry trainees or staff grades, they may have no knowledge of the ED's clinical standards, or time requirements. Equally, we need to understand the competing pressures that exist in mental health.	

Objective	Description	Resources
Share learning from Serious Untoward Incidents	In most areas the SUI arrangements for acute trusts and mental health trusts are entirely separate, however there are usually a significant number of cases that affect both trusts. These should be handled contemporaneously to allow learning to be maximised. This is also more constructive when dealing with complaints. This approach may also provide useful evidence for the commissioning process.	CEM Safer Care resources: http://www.collemergencymed.ac.uk/Shop-Floor/Safer Care/
Regular case/4 hour breach review	By meeting to share information about what factors contribute to delays and poor care for patients in the ED, it is easier to understand the services that are required. Unless these issues are considered jointly with the mental health providers, they are unlikely to understand our priorities and concerns, and it may prove difficult for them to realistically prioritise our needs when compared to other competing demands.	Example of risk analysis: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6849
Transfer policy	Inevitably there is a regular flow of patients to and from the acute trust and mental health inpatient unit. It is helpful to meet and produce a shared policy to guide this process to ensure that clear lines of communication and responsibility are established. This includes some basic logistics, but should focus on the sharing of appropriate information and handover of care. Whilst some of this centres around MHA legislative requirements, there are also guidelines to ensure good transfer of clinical data.	CEM Informatics guidance: http://www.collemergencymed.ac.uk/Shop-Floor/Informatics/default.asp

11. Section 136 arrangements, local policy

Description	Resources
All areas in England will have a multi-agency policy for section 136 patients. There should be an appendix relating to the use of emergency departments. It is prudent to ensure that this is appropriate for your local service, and that the ED is only used for 136 patients who have an acute healthcare need. Otherwise mental health services should provide an assessment suite, or where necessary the patient should be taken into police custody. The policy should also include a strategy to ensure that acceptable time frames for a mental health act (MHA) assessment are established, with provision for police to remain with the patient if they are managed in the ED. The police should stay until a MHA assessment has been completed.	Standards on the use of Section 136 of the Mental Health Act 1983 (2007) - (version for England): https://secure.collemergencymed.ac.uk/code/document.asp?ID=4572

12. National representation

Description	Resources
• NICE. The college has members sitting on the guideline development groups and expert reference groups where the outputs are relevant to the ED, e.g. self-harm, delirium and alcohol. • PLAN (Psychiatric Liaison Accreditation Network). The accreditation committee for this is only quorate with representation from CEM. • Close working relationship with the Faculty of Liaison Psychiatry are in place to ensure collaborative working in all areas, but particularly on preventing suicide and the management of self-harm. CEM is also involved in the current rewrite of CR118: Psychiatry in Accident and Emergency Departments. • *Preventing Suicide in England* - National Suicide Prevention Strategy 2012. The College was consulted on several areas of this document.	NICE: http://www.nice.org.uk/ PLAN: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/liaisonpsychiatry/plan.aspx Faculty of Liaison Psychiatry: http://www.rcpsych.ac.uk/college/faculties/liaison.aspx Strategy: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

13. Useful documents & web resources

Description	Links
The current version of CR118 is now too old to provide credible evidence for commissioning. However it is currently being re-written, with the working title "Mental Health in Acute Hospitals"	Due late 2013
No Health without Mental Health. The ALERT summary report, July 2009	http://www.serene.me.uk/helpers/mus-positive-practice.pdf
Mental health and the Productivity Challenge: Improving quality and value for money. The Kings Fund, Dec 2010	http://www.kingsfund.org.uk/publications/mental-health-and-productivity-challenge
Managing Urgent Mental Health Needs in the Acute Trust: A guide by practitioners, for managers and commissioners in England and Wales. Academy of Medical Royal Colleges, 2008	http://www.aomrc.org.uk/publications/reports-a-guidance/doc_details/54-managing-urgent-mental-needs-in-the-acute-trust-report.html
Who Cares Wins. Royal College of Psychiatrists, 2005	http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf
Healthy mind, healthy body: How liaison psychiatry services can transform quality and productivity in acute settings. Mental Health Network, April 2009; issue 179	http://www.nhsconfed.org/Publications/Documents/Briefing_179_Healthy_mind_healthy_body_MHN.pdf
Economic evaluation of a liaison psychiatry service, Centre for Mental Health, 2011	http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf
Feeling overwhelmed – *helping you stay safe* is a patient advice leaflet published by the Royal College of Psychiatrists in July 2012 aimed at is aimed at people who feel like they have no control over their life and who may be thinking of harming themselves. The leaflet also explains clearly and simply how to make a 'safety plan', to help organise people organise their thoughts and get the right support at the times they need it	http://www.rcpsych.ac.uk/expertadvice/problems/feelingoverwhelmed.aspx
U Can Cope film 22min film *- focuses on three people for whom life had become unbearable but who, after seeking help, are now leading happy lives. The film promotes 3 main messages: Anyone can experience suicidal thoughts, there is always hope, there is always help*	U can Cope Film and all resources available: http://www.connectingwithpeople.org/
U Can Cope also highlights the new Royal College of Psychiatrists' resources: • ***Feeling on the edge helping you get through it*** - for people in distress attending the Emergency Department following self-harm or with suicidal thoughts • ***Feeling overwhelmed and staying safe*** - for anyone struggling to cope when bad things happen in their life. Explains clearly and simply how to make a 'safety plan' • ***U Can Cope*** - designed to help young people develop resilience and cope with any current/future difficulties in their life. Just as helpful for adults	Developed by Connecting with People and collaborators have on behalf of the RCPsych http://www.connectingwithpeople.org/ www.rcpsych.ac.uk Leaflets can be ordered for a small fee from leaflets@rcpsych.ac.uk
Connecting with People Emotional Resilience and Suicide Awareness training comprises a series of peer reviewed and independently evaluated 2 hour modules, ideally suited to CPD and in-house training sessions. Participants will be able to develop a compassionate approach suitable for a demanding and time-pressured environment. At the end of the modules participants will be able to use the clinical resources to enhance their assessment and response to a suicidal patient. They will be able to undertake a safe triage and referral if appropriate, reduce their patients' distress, and collaboratively create a safety *plan to increase their patients' resilience to suicidal thoughts*	http://www.connectingwithpeople.org/

14. Accreditation

Description	*Resources*
The RCPsych runs PLAN (Psychiatric Liaison Accreditation Network). Liaison services pay to sign up to gain accreditation. The cycle involves the submission of a self-audit, a visit by a peer review team who conduct an external review, and then all the information is considered at an accreditation panel. The process is wide in its remit, and may consider all sizes of service. It looks at the personnel within the service and also the environment, education of ED staff, patient and carer feedback, etc. Where a service is accredited by PLAN, this offers assurance and benchmarking, which can provide a defence against future resource constraints. However, if the service does not meet the standard for accreditation the feedback is thorough, and where necessary involves communication at board level to demonstrate deficiencies in services and routes for improvement. This can be a significant driver for resource allocation and change. The PLAN standards are regularly reviewed, and the accreditation panel consists of representatives from the RCPsych, RCP, CEM, RCN, MIND and service users.	PLAN: www.rcpsych.ac.uk/quality/qualityandaccreditation/liaisonpsychiatry/plan

15. CEM standards for mental health

Description	*Resources*
1. Patients who have self-harmed should have a risk assessment in the ED 2. Previous mental health issues should be documented in the patient's clinical record 3. A Mental State Examination (MSE) should be recorded in the patient's clinical record 4. The provisional diagnosis should be documented in the patient's clinical record 5. Details of any referral or follow-up arrangements should be documented in the patient's clinical record 6. From the time of referral, a member of the mental health team will see the patient within 1 hour 7. An appropriate facility is available for the assessment of mental health patients in the ED	Example risk assessment matrix: http://secure.collemergencymed.ac.uk/code/document.asp?ID=6855 Example - 4 areas approach for assessing AED patients following self-harm: https://secure.collemergencymed.ac.uk/code/document.asp?ID=6870

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