Checklist

Improving the management of patients with mental ill health in emergency care settings

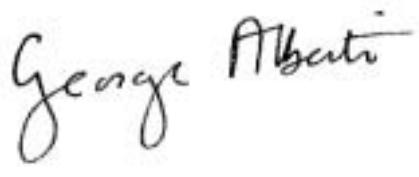
NHS

Welcome

This checklist offers practical support and guidance to help you improve the care of patients with mental ill health who access emergency care services. It outlines areas for action and includes examples of the ways in which some services are addressing some of these challenges.

The checklist is intended for anyone involved in providing care for these patients, including mental health practitioners and staff working for ambulance trusts and in emergency departments. We hope it will help you to provide faster, better treatment for mental health patients in a crisis and to improve their experience of services.

This is not intended to be a definitive list of suggestions, as many of these suggestions will already have been adopted by some trusts and different approaches taken by others. We will be updating the list regularly, so further ideas will be welcomed.



Professor Sir George Alberti
National Clinical Director for Emergency Access

Professor Louis Appleby
National Clinical Director for Mental Health

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USING the checklist

Using this checklist

This checklist has been produced in PDF format. It is designed to be used on screen where you can click between the different sections and use the live links to access other relevant information and resources on the web.

The checklist is organised into eight main sections displayed down the side of the page. Just click on a tab to go to the related suggestions and information.

Viewing tip: Go to 'view' at the top of your Acrobat Reader page and select 'full screen' or 'fit in window' from the drop-down menu to see the checklist more clearly.

Printing tip: PDFs are printer-friendly and can be easily printed out for off-line reference.

If you have any feedback about this checklist email us at:
emergencycare@doh.gsi.gov.uk

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Checklist CONTEXT

Context

It is estimated that up to 5% of those attending emergency department have a primary diagnosis of mental ill health, of which substance misuse and deliberate self-harm (DSH) are the largest groups. A further 20-30% of attendees have co-existing physical and psychological problems, with much of the latter remaining undetected. It is estimated that 35% of emergency departments attendances are related to alcohol including violent assaults, road traffic accidents, mental health emergencies and deliberate self-harm.

In January 2004 a Department of Health audit suggested that up to 10% of emergency departments' four hour breaches involved patients with mental ill health. In addition, a third of patients with mental ill health wait longer than four hours, compared to 10% of all patients.

Understanding the causes of such delay is essential to being able to achieve improvements.

These issues can only be addressed through genuine local partnerships between all agencies. Most of the actions suggested in this checklist cannot be taken by acute trusts alone. The first step must be for all the relevant parties to agree how to work together. Local emergency care networks are an ideal forum for this. Emergency care leads should ensure that their network has engaged all key parties and has appropriate representation from local mental health trusts.

The role and functioning of emergency mental health care must be considered in relation to how the remainder of the local emergency care system and crisis mental health care functions, so as to exploit local strengths and avoid unnecessary duplication of resources. This is particularly true for relationships between those providing crisis services (e.g. crisis intervention teams, gateway workers, liaison psychiatry teams, approved social worker services). Major re-design will also need to engage other health/ social care providers as well as the police.

The Department of Health recently asked mental health and acute NHS trusts to submit plans to their strategic health authority setting out how trusts are going to improve emergency access to treatment for patients. Where emergency departments have identified this as a problem, acute trust plans will need to cover how they will improve the response to mental health emergencies.The actions in this checklist

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General advice

There are some over-arching principles that will help you better manage the care of patients with mental ill health:

Involve and inform patients

- Involve patients in the development of services. Consider the whole patient journey from the viewpoint of the patient.
  A change in one component of care often affects other aspects of the patient journey.

- Develop clear information on available services for patients and for staff to use in sign-posting and referring patients.

Work with other service providers

- Develop partnerships between local mental health services, primary care, ambulance services and emergency departments. Mental health trusts should be actively involved in their emergency care network.

- Local implementation teams should include crisis access to mental health care as part of their remit.

- Develop interagency information sharing protocols to ensure that information on mental health patients at risk of violence to others or significant harm to themselves can be shared with all relevant agencies, including emergency departments and ambulance services.

General advice

Understand local needs

Analysing data effectively and assessing local needs and issues, will help you prioritise where local action should be targeted. Methodologies such as process mapping may be helpful. Consider:

- What resources are available locally?
- Who uses your emergency care services, and when?
- How appropriate is this use?
- What other services are available to patients with mental ill-health?
- What delays and blockages are there? Why do they occur?

Consider new roles and teams when planning services

- Develop gateway worker posts - these are designed to help improve access to mental health services for patients, and improve the interface between specialist mental health and other services. It will be important that their role and that of any existing liaison and specialist mental health services are co-ordinated to ensure integration of effort and to prevent isolation.
- Mental Health trusts should nominate an appropriate member of staff to act as a liaison person with emergency departments, such as a gateway worker or a member of the local crisis resolution team. Similarly, emergency departments should have a person nominated for liaison with mental health services, such as a member of the liaison psychiatry service or an appropriate person from the emergency department itself.
- There are a variety of ways of organising appropriate mental health input to emergency departments. Models include liaison psychiatry services, which also provide valuable support to general hospital patients, dedicated mental health nurses or dedicated input from specialist mental health services.

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Positive practice – *understanding reasons for delay*

An analysis tool for emergency department data is being developed by the Department of Health and the Modernisation Agency. The purpose of this core analysis is to provide a structure for clinicians and operational managers to identify the particular causes of performance problems and therefore focus improvement effort in the places where it will have the most benefit. Use of this analysis is entirely voluntary.

The analysis tool will be available from 7th May. For future information or to request the analysis tool please email emergencycare@doh.gsi.gov.uk

Link-up

For information on service improvemtn programs and methadologies see the National Institute for Mental Health in England or the Emergency Services Collabarotive websites at www.nimhe.org.uk **or** www.modern.nhs.uk/scripts/default.asp?site_id=35

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Positive practice – *sharing patient information between service providers*

In the control room at London Ambulance Service NHS trust, a pilot scheme to reduce serious incidents involving people with severe mental illness through timely information sharing is underway. This service is open 24 hours a day and is staffed by a team of mental health professionals. The team maintains a database of risk information provided by staff in community mental health teams, after they have carried out a formal risk assessment with individual service users, about individuals judged to be a risk either to themselves or to others. Kirsty Jarvie, project manager, said: "The team have been trained to disclose information within a legal framework. Therefore, ambulance crews, mental health staff based in A&E departments and community mental health professionals, amongst others, are all able to request information from this service. The service also acts as a gateway for mental health staff to access information held by the Metropolitan Police and London Probation Area".

Link-up

For further information contact: kirsty.jarvie@londondevelopmentcentre.org
or see www.londondevelopmentcentre.org

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Training

It is vital to ensure that emergency care clinicians have the correct skills to provide appropriate care for patients with mental ill health.

- Every first contact practitioner, including ambulance and emergency department staff, should have training in basic mental health issues and risk assessment. First contact practitioners should feel confident in making an initial assessment of people with mental ill health. Further training such as the management of bereavement or substance misuse interventions should also be considered.
- Continuing training and development for emergency care staff with an interest in mental health, or experience in the field should be considered. This could take the form of learning sets within a local area.
- Common training initiatives involving both mental health and emergency care staff not only addresses mutual training issues, but can also lead to major operational benefits.

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Positive practice – *training for emergency department nurses*

St George's Hospital NHS trust runs a one day training programme for emergency department nurses. It provides them with:

- a broad understanding of mental ill health and possible causes of behaviours and symptoms;
- an opportunity to explore attitudes towards people with mental ill health;
- skills to conduct a triage assessment;
- skills to manage distressed and / or disturbed patients in an emergency department environment.

An emergency department nurse said: "I am more confident about working with patients who have mental health problems and feel better equipped to assess these patients".

Link-up

For further information email
chart@hscs.sghms.ac.uk

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Positive practice – *training for walk-in centre staff*

A training pilot was carried out in 8 walk-in centres (WICs). Its aim was to develop the capacity and capabilities of WIC staff to identify, assess, and manage patients attending WICs with mental ill health. SCAN (Screen, Care, Advice, Next steps) is a focused skills-driven assessment process used across NHS Direct. Nurses were given 3 days of SCAN and risk management training. Elaine Egan-Morriss, project manager, said: "We developed a CD-ROM called 'Directly about mental health – primary care' and issued it to all staff. This incorporated learning on mental health problems and examples of face to face consultations that were typical of the kind of patients that would present in primary care. Referral pathways were also developed. The programme improved the service for patients with an identified mental health need, ensured referrals were appropriate and helped sign-post patients to other services."

Link-up

For further information email
elaine.eganmorriss@alwpct.nhs.uk

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Ambulance services

Ambulance staff, including control room staff and ambulance crews, are often the first contact for many patients with mental ill health in a crisis. There are a number of actions for ambulance trusts to help improve the management of patients with mental ill health.These include:

- Training to ensure ambulance staff can understand and recognise basic mental ill health and undertake basic assessment, including assessment of risk.
- Working with out of hours GP services to ensure rapid response to referrals from the ambulance service, and to agree appropriate response times.
- Agreeing local standards of response (comparable to those for emergency departments – see section on assessment) when mental health teams are required at a person's home.
- Ensuring that ambulance crews have access to advice about mental ill health in general and, when appropriate, access to advice about individual patients.
- Working with other organisations to agree appropriate care and treatment for patients already known to the service. This could include patients being taken directly by ambulance to mental health units or patients being referred direct to primary care, crisis intervention teams or to social services.

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Positive practice – *developing alternatives to emergency departments for patients with mental ill health*

Staffordshire NHS ambulance trust have taken steps to improve the care given to patients with mental ill health by developing alternatives to emergency departments.

Paramedics link to the admitting doctor at the psychiatric unit via the tele-medicine desk at the ambulance control room. Where the patient is already known to the unit, a decision on next steps can be taken based on:

- psychiatric history including medication, self-harm attempts and admissions
- paramedic assessment of social circumstances and risk of violence
- standard medical assessment to broadly exclude any organic pathology
- immediate presentation

Where the patient requires further psychiatric assessment and / or treatment, arrangements are then made for their admission to the psychiatric unit. If the patient is not willing to go to the unit voluntarily and needs further assessment (with a view to sectioning) the crisis intervention team will be deployed to the scene.

Patients who are intoxicated or have acutely overdosed are taken to the emergency department. Patients who are not known to the psychiatric services are assessed in conjunction with the crisis intervention team.

Link-up

For further information contact anton.vandellen@physiol.ox.ac.uk **(Medical Adviser, Staffordshire, Ambulance Trust)**

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Assessment

Waiting for assessment in the emergency department is the single biggest cause of delays for patients with mental ill health. There are a number of actions that you may want to consider to improve this stage of the patient journey:

- Appropriate facilities for the assessment of patients with mental ill health is vital to ensure that patients are treated with privacy and dignity and also to ensure the safety of both patients and staff. This should include an interview room with adequate safety features and appropriate staffing to ensure staff/patient safety.
- All available information should be used in making initial assessments. This may mean it is necessary to contact the patients' GP, community psychiatric nurse or other relevant service provider.
- Have appropriate psychiatric assessment available 24/7. Staffing levels should reflect assessed hourly workload. There should be senior psychiatric staff input as soon as possible – even before medical assessment in certain cases.
- Agree protocols for initial assessment by emergency department staff and for referral for mental health assessment.
  Assessment checklists, risk matrices or a pro-forma for telephone referrals from the emergency department to mental health teams can be helpful.

Link-up

Further information about assessment facilities is available at www.nhsestates.gov.uk/download/publications_guidance/A&E.pdf **or the Royal College of Psychiatrists and BAEM's 'Psychiatric Services to Accident and Emergency' report can be found at** www.rcpsych.ac.uk/publications/cr/cr118.htm

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Assessment

- Agree response times locally for referrals for mental health assessment. These should be no greater than the response times recommended by the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine (BAEM).

These are:

	Urban areas	Rural areas
First line attendance	30 minutes from the time of referral	90 minutes from the time of referral
Section 12-approved doctor attendance	60 minutes from the time of referral	120 minutes from the time of referral

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Positive practice – *rapid access to psychiatric assessment*

Newcastle mental health NHS trust have a crisis resolution and home treatment service, available 24/7. This means that patients who attend the emergency department have rapid access to psychiatric assessment and treatment.

Stephen Niemiec, a nurse consultant with the crisis assessment and treatment service, said: "We have developed an assessment pro-forma for use in the emergency department. When used appropriately, it ensures that all patients experiencing a psychiatric crisis can be seen quickly. Currently, 80% of patients are seen within two hours of referral and 98% spend no more than 4 hours in A&E. Regular liaison meetings between ourselves and the A&E team has improved communication and helps resolve clinical pathway issues between the two services".

Link-up

For further information email
Stephen.Niemiec@nmht.nhs.uk.

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Positive practice - *assessment templates to assist with triage*

At St George's Hospital NHS trust, an assessment template has been developed to assist nurses in undertaking simple, rapid assessments at triage for people with mental ill health problems and / or people who have self-harmed. An initial assessment about the patient's level of risk is made, resulting in a risk score ranging from low to very high risk. Referral to senior clinicians within the emergency department or to the liaison psychiatry team, as appropriate, and using agreed protocols, can then be made.

Link-up

For further information contact Chart@hscs.sghms.ac.uk **(Nurse consultant, liaison psychiatry team, St George's Hospital)**

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Positive practice – *improving the appropriateness and timeliness of referrals to psychiatry*

At the Queen's Medical Centre NHS trust, an agreed referral pro-forma for use by emergency department staff has been developed as a result of collaborative working between the emergency department and the Department for Psychological Medicine, Nottinghamshire Healthcare NHS trust. It helps staff to ask pertinent questions, gather important information and prioritise. It also improves documentation and information gathering.

There is also an ongoing programme of training for emergency department staff on suicide awareness and risk assessment.

Mo Kontny, East Sector Manager in the Adult Mental Health Directorate at the Nottinghamshire Healthcare NHS Trust said "We now have improved referral information and prioritisation by the emergency department, which means shorter waits and an improved experience for patients. We feel that the proforma helps to reduce stigma for mental health clients".

Link-up

For further information please contact mo.kontny@nottshc.nhs.uk

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Positive practice – *nurse referral to the liaison psychiatry team*

South Tyneside District Hospital undertook a retrospective audit of A&E cards of patients presenting with mental ill health problems who did not require medical treatment. The results revealed lengthy waiting times for these patients. To address this issue, triage nurses were given training on mental health issues and on how to exclude physical illness or injury. A mental health triage checklist was also developed.

Jean Stores, clinical nurse lead in the A&E mental health liaison team said: "After using the checklist to exclude physical illness, the triage nurse now directly refers the patient to the mental health liaison team. In agreement with A&E consultants, the mental health team can now refer patients back to A&E doctors if they are concerned about the patient's physical state. This has resulted in faster treatment for patients. The mean waiting time for patients from arrival at A&E to being seen by a mental health liaison nurse or duty psychiatrist has fallen from over 3 hours to around 20 minutes".

Link-up

For further information contact Jean.Stores@sthct.nhs.uk

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Management

Admissions
Patients can often be delayed waiting to be admitted onto a ward. There are a number of actions that help address these issues:

- Area-wide bed management plans and systems to link acute and mental health trust resources.
- Reduction in duplication of assessment and paperwork by the admitting team.
- Make available appropriate short-stay facilities for extended assessment of patients; for example patients who are intoxicated, or who have deliberately harmed themselves. This could be a dedicated unit or a general observation / assessment ward attached to the emergency department.
- Put in place good links between wards and community mental health team to deal proactively with potential delays in discharging patients from short-stay units.

Management

Positive practice examples 1

Positive practice - *Short-term admission for further assessment*

Manchester Mental Health and Social Care Trust have a service called "Swift Assessment for the Intensive Resolution of Emergencies" (SAFIRE). This is a nurse-led multidisciplinary service that provides further assessment for patients presenting in a crisis at the emergency department and for whom, at the point of initial assessment, there does not appear to be any alternative to inpatient admission.

Within the maximum length of stay of 48 hours, SAFIRE aims to identify and fully assess the patient's needs, and the most appropriate package of care. In some instances, this will be transfer to the in-patient mental health unit. In other cases alternatives will be appropriate. Damien Longson, consultant psychiatrist, said: "SAFIRE has significantly reduced waits for a bed for psychiatric patients admitted from A&E. Furthermore, about 50% of patients transferred to SAFIRE recover sufficiently within 48 hours to no longer require in-patient care".

Link-up

For further information email dlongson@man.ac.uk **or** graham.jones@mail.nmanhc-tr.nwest.nhs.uk

Management

Mental Health Act

- The Royal College of Psychiatrists and BAEM recommend that doctors able to carry out Mental Health Act assessments (section12 approved) should respond to referrals within 60 minutes in urban areas, and 120 minutes in rural areas. This is an important consideration in deciding whether an emergency department should be designated as a place of safety.

- Section 12 doctor rotas should be accessible to emergency care staff. These could be available from the hospital switchboard. Access through NHS Direct could also be considered.

- Local inter-agency protocols should be agreed for patients brought in by the police under section136. This should cover designated places of safety, who stays with the patient, who is responsible for transport etc.

- Consider developing alternative places of safety to the emergency department, for patients brought in by the police under section 136 of the Mental Health Act, who do not need medical treatment.

Management

Positive practice examples 1

Positive practice – *alternatives to emergency departments for patients sectioned by the police*

In Lambeth, South London, patients who are brought in by the police under section136 of the Mental Health Act are taken to Lambeth Hospital 136 suite. London Ambulance Service will be involved in the transfer. If the patient requires urgent medical assessment, usually because of self-harm or overdose, they are brought to the emergency department.

On average, the 136 suite unit undertakes four to five such assessments per month. Only one person in the last six months has required treatment in the emergency department.

The 136 suite provide a secure setting for the assessment to take place. It has its own toilet facilities and access to refreshments. On arrival the person is assessed by a psychiatrist and approved social worker. After assessment most patients are transferred on a further section of the Mental Health Act to the acute wards based at Lambeth Hospital. A number of patients agree to informal admission and others are discharged for community follow-up.

Link-up

For further information please contact Tunji Adeyemi, Eden Ward Manager at Lambeth Hospital on tunji.adeyemi@slam.nhs.uk

Transport

Responsibilities and response times for transport e.g. between the emergency department and the mental health unit should be agreed. This is particularly important when patients attend emergency departments outside their "home" mental health trust catchment area and need to be transported back in order to be admitted to a bed.

Specific conditions

Frequent attenders | Alcohol

We will be developing recommendations on other specific conditions including deliberate self-harm and care of children and teenagers with mental ill health.

Frequent attenders

It can be helpful for emergency departments to keep care plans for patients who regularly attend emergency departments and who are known to mental health services. This could include background information about the patients' condition, details of appropriate interventions / referrals and the name and contact details of the lead mental health clinician for that patient. If appropriate, care plans could be shared with other healthcare professionals including ambulance staff and those in primary care.

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Positive practice – *use of care plans to improve the response to frequent attenders*

St George's Hospital NHS trust have compiled structured care plans that enable the causes of repeat attendances to be identified and possible solutions considered. These care plans are kept in the emergency department, and the existence of a plan is automatically printed on the front of the attendance card when the patient attends the emergency department.

Jim Bolton, a psychiatrist in the liaison psychiatry team said: "The introduction of these care plans was followed by a reduction in attendance rates. The availability of background information has led to patients spending less time in A&E. Staff also felt better equipped to manage this common clinical problem with less frustration and a more satisfactory conclusion".

Link-up

For further information contact Jim Bolton on jgbolton@ sghms.ac.uk'**.**

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Specific conditions

Frequent attenders | Alcohol

Alcohol

- Introduce simple screening strategy for harmful and hazardous drinkers
- Assess dependence of severity using appropriately trained staff
- Provide brief interventions for hazardous drinkers
- Develop management protocols for specific situations, e.g. alcohol withdrawal, prevention of Wernicke's encephalopathy; and appropriate referral for on-going support

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Positive practice – *use of screening and brief interventions with hazardous or dependent drinkers*

- St Mary's Hospital, London found that using the Paddington Alcohol Test (PAT) in the emergency department to screen for harmful or hazardous drinking resulted in a 10-fold increase in referrals to an alcohol health worker (AHW) for counselling, generating 27 hours of work per week. Brief interventions by the AHW resulted in a reduction of 43% in alcohol consumption from 30 to 17 units per day. For every 2 referrals accepted by the AHW, there was one less re-attendance within the next 12 months.
- St Thomas' Hospital, London established a team of psychiatric liaison nurses who made it part of their role to assist in the detection, assessment and management of alcohol dependent patients. Emphasis is placed on risk management and on interim care planning in the department. They also advise on detoxification regimes and appropriate referral. Some patients are directed to local specialist alcohol services, while those presenting with self-harm, severe withdrawal or confusional states are admitted to the emergency department observation ward or a medical bed.

Link-up

Click here to contact Professor Touquet, **A&E consultant at St Mary's Hospital.**
For further information please contact Andrew Hodgkiss, Consultant in liaison psychiatry, St Thomas' Hospital at andrew.hodgkiss@slam.nhs.uk

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