

Psychiatric services to accident and emergency departments

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Executive summary

This report supersedes the previous joint report (Council Report CR43) from the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine. Since the publication of the original report, new demands have been placed on both mental health services and A&E departments. The requirement that 90% of patients must have been discharged from A&E departments within 4 hours of arrival (Department of Health, 2001) will have a major impact on the interaction between mental health services and A&E departments.

The main report examines the common mental health scenarios that occur in the A&E department, issues affecting patients from ethnic minorities, specific problems in the A&E department, personnel issues and the organisation of services.

Summary of recommendations

- There is a joint responsibility for commissioners, mental health service managers, and acute service managers to ensure that the input of mental health services to A&E departments is not overlooked in negotiations.
- A consultant psychiatrist should be named as the senior member of staff in the local mental health services responsible for liaison with the A&E department.
- A&E department personnel should have adequate knowledge of mental health issues, and feel confident in making an initial assessment of people with mental health problems.
- A&E department staff training should include the recognition of common mental health problems, and the appropriate responses to that recognition.
- Mental health staff training should include training from A&E department staff regarding what is helpful. Equally, A&E department staff require training from mental health staff about what is practicable.
- Common training initiatives involving both staff groups not only address training issues, but also can lead to major operational benefits.
- Local policies should be agreed regarding common mental health problems that arise in the A&E department.
- The A&E department should include facilities and resources for the assessment of patients with mental health problems. This should include an interview room with adequate safety features.
- Staff training should include safety issues.
- A Liaison Group, with representatives from the A&E department and from mental health services, should review issues of joint working between the two services, and ensure that the recommendations contained within this report are considered and implemented.

Introduction

Background to this report

The Council Report 'Psychiatric services to accident and emergency departments' (Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine, 1996) provided a template for accident and emergency (A&E) departments and mental health services to develop joint working guidelines. Anecdotal reports suggest that the section on facilities has been particularly useful in providing guidance on the provision of resources.

In early 2000, the College received advice that the report required major revision. After discussion with the BAEM, it was decided that the production of a new report was appropriate. An important report from the Scottish Executive Health Department (1998) had already provided a significant contribution.

More recently, the findings in two reports published in 2001 will have a considerable impact on the way that psychiatric services are delivered to A&E departments. The Audit Commission (2001) report *Review of National Findings for Accident and Emergency* highlights longer waiting times, under-use of nurse practitioners, and the continued lack of modern information systems in some departments. The Department of Health (2001a) report *Reforming Emergency Care* states an explicit intent to end long waiting times in A&E, and sets a standard that 90% of patients must not wait longer than 4 hours from the time of entering the department to the time of departure from the department. This standard will have an immediate impact on the delivery of psychiatric services, and poses particular challenges and questions regarding the practicability of delivering an effective, efficient and safe service within the 4-hour deadline.

This report is therefore of a different format to its predecessor. The intent is to examine the different clinical and organisational scenarios that occur in the A&E department, identify principles of good practice and develop recommendations from these principles.

Process involved in writing this report

This report was developed by a small steering group of three people, one from the BAEM and two from the Royal College of Psychiatrists. This group met on several occasions during 2000 and 2001. It had responsibility for the overall format of the report, editorial control, and for considerable parts of the text.

The group invited contributions from acknowledged experts in the field, and organised a day when contributions were critically examined by a wider group. This day took place at the Royal College of Surgeons in 2001. Further advice was

sought from individuals, and from the annual conference of the Liaison Psychiatry Section of the College.

The names of those involved appear in the acknowledgements section at the beginning of this report.

1. Current context

Accident and emergency departments

Accident and emergency (A&E) departments are involved with the resuscitation, assessment and treatment of acute illness and injury suffered by patients of all ages by appropriately trained and experienced staff. Included in this are patients with acute change in mental status, patients with alteration of consciousness and patients with acute confusional states.

Most A&E departments see in the region of 50 000 new patients each year, the range being from 30 000 for smaller departments to over 100 000 for the largest departments. The majority are staffed by two or three consultants, one or more staff grade doctors or specialist registrars and about eight senior house officers. Some smaller units are known as minor injury units or urgent treatment centres, and many of them are staffed by nurses. The incidence of patients presenting with mental health problems is about 5% of total attendances.

Accident and emergency departments may review patients for the reassessment and follow-up of defined conditions. For patients with mental health problems, this might include those who have suffered self-inflicted injuries of a soft tissue nature. The management of patients presenting with acute mental health problems is increasingly being identified as a key performance indicator for A&E departments.

Many A&E departments have short-stay ward facilities. Such wards have facilities for the temporary observation of patients who have taken minor toxic overdoses, where more thorough mental health evaluation can be carried out following recovery from intoxication or after the effects of a minor overdose have worn off.

Increasingly, A&E departments provide a multi-professional approach to the management of patients with mental health problems presenting to them. The use of psychiatric liaison nurses and liaison psychiatrists is becoming increasingly common. Social services also have a major role to play in the management of many patients presenting with deliberate self-harm.

Many departments use risk-assessment tools, such as proformas or scoring systems, to help risk-stratify patients. These proformas can be used as adjuncts in making an evaluation of patients with mental health problems. Many departments produce management plans in conjunction with the patient and other stakeholders for managing frequently attending patients or for patients who attend frequently over a short period when in crisis.

Medical and nursing staff in A&E departments receive teaching at induction courses and by way of continuing medical education. Senior emergency and psychiatric liaison staff deliver lectures on psychiatric emergencies and the management of deliberate-self-harm.

Audit is an important part of any emergency department. Most departments audit their performance in the management of a wide variety of illnesses. Emergency mental health care is suitable for audit against a number of recognised standards and should be a part of an emergency department's audit programme. Likewise, many departments are involved with research into suicide prevention and the management of deliberate self-harm, and this is best carried out at a multi-professional level.

Mental health services

Mental health services in the UK and Republic of Ireland have responsibility for the provision of specialist psychiatric assessment and treatment of patients with mental disorders. There is an increasing emphasis on patients with severe and enduring problems, and the continued specialist care of this group.

On occasions, patients will require detention under mental health legislation. The exact procedures vary depending on the country, but all systems allow for the compulsory detention of severely ill patients under strictly delineated conditions. Appendix 1 to this report gives more details of the mental health legislation in operation in Britain and Ireland.

For the past two decades, there has been a trend to deliver support and treatment to people with severe and enduring mental health problems in community settings. There have been fears that this will lead to an increased demand on A&E departments, although there is currently no objective evidence that this is occurring. There has been considerable effort over recent years to try and improve the standards of community care through initiatives such as the care programme approach (CPA). This requires that the care of people with severe and enduring mental health problems is coordinated, and that the patient and the professionals know the care plan (the plan for the management of the patient's illness drawn up by, and agreed with, the patient, the professionals and the carers). There should also be a crisis plan, which should be circulated and may often be placed in the A&E department. A care coordinator (usually a member of the community mental health team) is appointed for each patient, and will be named in the care plan.

Relationships between A&E departments and their local mental health services vary dramatically. A considerable number of districts have services based on separated sites, which may be many miles apart. Very few districts with an A&E department and no on-site mental health services have a liaison psychiatrist, and there is often little clarity as to the responsibility for liaison with A&E services. This is reflected in varying arrangements within mental health services regarding their relationship with A&E departments. Different models include an identified responsible consultant, a rota for responsibility between different consultants, sharing responsibility depending on the sector of the patient's residence, and a hybrid combination of these approaches. Experience suggests that the more mental health teams that are involved, the more difficult it is to develop practicable links between services.

Emergency assessment arrangements for people with mental health problems are therefore extremely variable. This also applies to referral and follow-up arrangements.

Over recent years, mental health services have been required to develop better links with community services, and frequently this has led to services being sited away from the local A&E department. This has often led to difficulties in developing, or maintaining, an effective collaboration with A&E services. If mental health services are sited away from A&E departments, there is frequently a problem in responding to requests for help within a reasonable time, with the risk that patients may leave the A&E department before being seen by mental health services.

Another potential problem involves the 'place of safety', which is a feature of some mental health legislation. The police may be required to convey individuals who might have a mental health problem to a designated 'place of safety'. In the absence of locally agreed protocols, there is potential for misunderstanding, conflict and the development of dangerous situations. Local arrangements need to be clear and unambiguous in order to avoid the possibility of conflict.

Different legislatures may also have different provisions relating to patients in the community, their treatment and their accommodation. When decisions are made to utilise such provision, it is important to ensure that services, such as A&E departments, are able to gain access to such information when appropriate.

Primary care

General practice is responsible for providing first-line medical care, on a 24-hour basis, for the general population. All citizens have the right to be registered with a general practitioner. If someone is away from their home, they may obtain temporary registration with a local general practitioner.

General practitioners are responsible for keeping the patient's primary care record, which is likely to contain information about the patient's medical history, and current and past medication. This is potentially vital information, but it is likely to be available only during surgery hours. It is important that this information is not under-utilised by A&E departments and secondary care services.

Social work

Social work departments have a statutory responsibility with regards to mental health legislation. Appropriately trained social workers have a key role in the implementation of mental health law in most jurisdictions. Social work departments also have a responsibility for the support and aftercare of patients and dealing with social problems, such as accommodation difficulties. Because the development of A&E departments does not necessarily reflect the distribution of local government boundaries, the social services departments might have to

develop links with more than one A&E department, and vice versa. The trend in recent years to concentrate expertise in large A&E departments means that it is more likely that one department will have to liaise with several social services departments. Confusion can easily arise if there is no clear link between social services departments and A&E. The identification of a designated social worker can reduce confusion considerably. Where there is no clear liaison responsibility, A&E departments have to utilise whatever emergency duty arrangements have been made by the social services department.

2. Clinical problems in the accident and emergency department

This chapter is devoted to examining the different presentations of people with mental health problems in the accident and emergency department, and the various clinical situations that should be highlighted. There are some principles common to all situations, however:

- The importance of gaining information from the patient, any informants, case notes and other professionals.
- This information must then be used to inform the decision-making process regarding the patient's management. This may appear to be an obvious statement, but many clinical mistakes occur through failure to make use of information that is available.
- It is bad practice to leave a patient for prolonged periods in the A&E department. In some parts of the UK, standards are being set making 4 hours the maximum permissible time that a patient may remain in A&E.
- Despite these standards, it is more important that the correct decisions are made. Sometimes a delay is unavoidable, for instance if information about a patient is awaited from another area, and in these circumstances it is more important that the correct care is given rather than quick care.

Deliberate self-harm

Introduction

Deliberate self-harm is one of the most common reasons for presentation to A&E departments. The care pathway for such patients will vary from department to department, depending upon such factors as the presence or absence of an observation ward within the department. The basic principles regarding management remain the same. For detailed guidance about the standards for clinical procedures, training and facilities in relation to self-harm, the Royal College of Psychiatrists has a separate Council Report, 'Clinical practice guidelines and their development' (Royal College of Psychiatrists, 1994a), which is currently being updated. A separate report, 'Managing deliberate self-harm in young people', (Royal College of Psychiatrists, 1998), addresses the issues of self-harm in young people and is also being updated.

Principles of management

For all people attending following an episode of deliberate self-harm, the following steps should be taken (Royal College of Psychiatrists, 1994b):

1. prompt assessment of the patient's physical condition;
2. effective treatment of the patient's physical condition in order to minimise risk of death and disability;
3. detection of immediate suicide risk and severe mental illness;
4. provision of a psychosocial assessment in order to identify those who have a psychiatric illness, those with high suicide risk, those with alcohol and drug problems and those in social crisis.

If a child or adolescent presents with self-harm, admission is deemed mandatory, whatever the medical condition.

Steps 1–3 should be undertaken by A&E staff. Patients with self-harm include some who are in urgent physical danger and some who may leave the hospital precipitately owing to an abnormal mental state. Therefore, when the presenting complaint is self-harm, a member of the emergency department staff (usually the triage nurse) should answer three questions immediately after the patient's arrival at the department and prior to any consultation:

1. Is the person physically fit to wait?
2. Is the patient in obvious severe distress?
3. Is he/she likely to wait until seen by the emergency department doctor?
(If the patient is a child or adolescent, the triage nurse must confirm who holds parental authority.)

Evidence of this triage process should be documented.

Step 4, a detailed psychosocial assessment, can be carried out by A&E staff provided there is suitable training and supervision. In most centres, however, specialist mental health staff or the on-call psychiatrist will undertake it. If a patient requires admission to a medical bed for observation or treatment, the psychosocial assessment can usually be carried out the following day or whenever the patient is fit enough to be interviewed. If the assessment can be delayed until the following day, this usually facilitates a better assessment and better communication with other professionals.

When the patient is neither admitted under the care of another doctor nor assessed by a specialist in the A&E department, the A&E staff should make a detailed record of contact. Within 24 hours, a member of the A&E staff should pass on this information to the patient's general practitioner (usually by fax). Written communication should be forwarded to the GP within 3 days. If a mental health specialist sees the patient, it is that person's responsibility to liaise with the GP, within a similar time frame.

Many A&E departments use a structured proforma to guide history taking and assessment for self-harm. This improves the quality of the assessment and record keeping.

The Royal College of Psychiatrists recommends that each major hospital should have a self-harm services planning group. The make-up of this group and its functions are detailed in 'Clinical practice guidelines and their development' (Royal College of Psychiatrists, 1994). This group may well have similar personnel

to the liaison group described in 'Organisation of services' (Chapter 7), and the responsibilities of the two groups may be combined. In smaller centres, one person may take on the responsibilities of this group and liaise with relevant stakeholders. The primary purpose of the group/coordinator is to ensure that the standards for the delivery of a self-harm service are being met, according to local needs and policy.

Service delivery

The planning group or coordinator should:

- promote high standards for the assessment and management of self-harm;
- set out a policy on whether non-psychiatric staff may undertake psychosocial assessment and management of self-harm patients;
- provide guidance and training about risk assessment;
- consider whether certain groups should be subject to routine specialist referral, for example patients under 18 years or over 65 years, patients with a learning disability, and patients under the care of a surgical or other non-medical team. There should be a specific protocol for the management of young people;
- set up training (and specify its duration and content) for newly appointed staff within their first week in post if they are going to undertake psychosocial assessments;
- specify a policy for the supervision of any staff who have been trained to carry out self-harm assessments;
- provide written guidance about clinical responsibility for discharge arrangements, specifying: first, the extent to which a specialist is providing advice to a medical or Emergency department team or acting autonomously in making management decisions; and second, the lines of responsibility within a specialist service;
- ensure that the service is subject to continuous review and audit. Ideally, the review of the subsequent death of anyone who has attended in the previous 6 months with an episode of deliberate self-harm would be of enormous benefit in the assessment of the effectiveness of services;
- ensure that there are clear arrangements for the follow-up of people who are deemed to require further input following assessment. These arrangements will require regular review.

Further points and recommendations

- Staff should be aware of covert self-harm. Unexplained coma or people with chronic disorders becoming de-stabilised are examples.
- Self-neglect may be a method of deliberate self-harm.
- There is an association between self-harm and violence to others of which staff should be aware.

- The medical seriousness of the self-harm is not necessarily indicative of the seriousness of the suicide risk. This is particularly likely when young people or old people harm themselves.
- The choice of method may be associated with the seriousness of suicide risk. Hanging, shooting and 'railway' attempts carry particular risks, as does the use of more than one method at the same time.
- Always be aware that a second method of self-harm may have been used and may not be immediately evident.
- There is a paucity of evidence regarding the efficacy of interventions in reducing the risk of subsequent self-harm, though major studies are underway at present.

Alcohol

Introduction

Alcohol misuse places a considerable burden on health services. It is responsible for about 10% of unselected attendances at A&E, and a higher percentage of attendances with trauma (Royal College of Physicians, 2001). In addition to those whose hazardous drinking has contributed directly or indirectly to the cause of their attendance, coincidental hazardous drinking is common in people presenting with non-alcohol related problems. Deliberate self-harm is common in this population, and alcohol is often consumed with an overdose.

Screening

Attendance at the A&E department is an important opportunity to detect problem drinking and provide basic education. Because of time pressures, clerking in the A&E department tends to focus on the patient's presenting problem. However, considering the high level of problem drinking in in-patients attending A&E and the effectiveness of brief interventions in these patients, there is a strong case for incorporating screening into routine care (see assessment tools section in Chapter 7: Organisation of services). Where appropriate, a more detailed assessment can be made. There should be agreed management guidelines once problem drinking has been detected.

Intoxication

Patients who present to A&E departments in an intoxicated state can cause major management problems for staff. Patients may be uncooperative with assessment, or violent towards property, staff, or other patients and those accompanying them. There may be concern about the premature discharge of intoxicated patients from the A&E department, especially if comorbid physical or mental health problems are suspected.

Deliberate self-harm is often associated with alcohol consumed shortly before or during the episode. In addition, alcohol dependency is associated with an increased risk of suicide. If A&E staff are concerned about a patient's ongoing risk of self-harm or suicide, it is not appropriate for mental health staff to refuse to make an assessment because the patient is intoxicated. However, in other cases, a mental health assessment is preferable when the patient is sober. Allowing patients to remain in an A&E department until they are sober enough to cooperate with physical or mental health assessments has repercussions for waiting time standards.

Patients with alcohol dependency often present to A&E departments in an intoxicated state, requesting help and alcohol detoxification. There should be locally agreed protocols for the management of patients with alcohol dependency, which will depend upon available services and resources.

Alcohol withdrawal syndromes

Features of alcohol withdrawal range from mild discomfort to life-threatening states.

- *Early withdrawal*
Symptoms occur up to 12 hours after last drink. These include tremor, sweating, nausea, insomnia and anxiety.
- *Moderate withdrawal*
The signs are more marked. There may also be transient auditory hallucinations in clear consciousness.
- *Withdrawal fits*
These can occur from 12 to 48 hours after the last drink. They are more likely if there is a previous history of withdrawal fits or epilepsy.
- *Severe withdrawal / delirium tremens (DTs)*
This usually develops 72 hours after the last drink, and carries an increased mortality and morbidity. Clinical features include tremor, confusion, agitation, restlessness, fearfulness, hallucinations, autonomic disturbances, sweating, pyrexia and dehydration.

Risk factors for DTs include a severe or prolonged history of alcohol dependency, a past history of DTs and concomitant acute illness.

The medical management of severe alcohol withdrawal includes:

1. close observation and monitoring of vital signs;
2. correction of dehydration and electrolyte imbalance, and treatment of concomitant illness;
3. benzodiazepine withdrawal schedule.

Alcohol detoxification requires appropriate supervision. It should not be initiated in those patients discharged from A&E unless such support has been arranged. If resources for immediate detoxification are not available, then motivated patients should be advised to continue drinking and to gradually cut

down their intake in order to avoid potentially dangerous withdrawal symptoms. In the meanwhile, appropriate follow-up should be arranged.

Wernicke's encephalopathy

Wernicke's encephalopathy is an acute neurological complication of chronic alcohol misuse. Incipient Wernicke's encephalopathy requires parenteral thiamine supplementation (Pabrinex) to minimise irreversible brain damage. The classical triad of confusion, ataxia and ophthalmoplegia is rarely present, and the syndrome is much more common than is widely believed. A presumptive diagnosis of Wernicke's encephalopathy should therefore be made in any patient undergoing detoxification who experiences signs suggestive of the disorder (Royal College of Physicians, 2001).

Liaison psychiatry

A liaison psychiatry service or a specialist alcohol service covering the A&E department can advise on the management of alcohol withdrawal syndromes, assist in the assessment of complex cases and liaise with community alcohol services. They can also deliver brief interventions for problem drinking. Examples of good practice are contained in the Royal College of Physicians (2001) report.

Recommendations

- Screening for problem drinking should be included in routine assessment of patients in A&E.
- There should be guidelines for the management of detected problem drinking in A&E.
- Severe alcohol withdrawal (DTs) and Wernicke's encephalopathy are both medical emergencies, and should be managed accordingly.
- A named mental health worker should liaise between A&E and mental health services.
- There should be local policies regarding the management of intoxication.
- Any child or adolescent who is intoxicated should be admitted to hospital.

Substance misuse

Introduction

People who misuse substances, especially those who inject, have a high level of medical morbidity and mortality (Hulse *et al*, 1999), and as such are regularly seen in the A&E department. These patients can cause particular management difficulties for medical and nursing staff and may receive inadequate treatment (e.g. because of premature self-discharge, etc.). The space available precludes a

comprehensive discussion on the effects of individual drugs of misuse, and the interested reader is directed elsewhere (Ghodse & Tregenza, 1996). Here, we offer general guidelines for the management of people presenting with substance misuse (especially those addicted to opiates) in the A&E department, while at the same time trying to highlight some of the more commonly encountered problems.

Reasons for attendance

Substance misuse patients usually present to A&E departments with medical complications associated with their substance misuse. These complications tend to arise as a result of:

- The direct pharmacological action of the drug itself (e.g. accidental overdose is a frequent reason for attendance and is the most common cause of death among intravenous opiate users (Hulse *et al*, 1999)).
- The hazards related to the method and route of drug administration (e.g. unsterile injecting practices may give rise to abscesses, superficial thrombophlebitis, arterial occlusion, hepatitis, etc.).
- The patient's general lifestyle (e.g. poor social and dietary conditions, self-neglect, exposure to violence, etc.).
- Some A&E departments are the site of needle exchange schemes. In these areas this may be a reason for regular attendance.
- Remember that children and adolescents might present with drug intoxication.

In addition to these medical complications, patients may have other concurrent psychosocial difficulties including:

- a likelihood of poly-drug misuse/dependence;
- an increased risk of psychiatric morbidity (dual diagnosis);
- an increased risk of non-accidental overdose/suicide;
- social difficulties with poor or non-existent accommodation;
- poor access to, or engagement with, primary health care;
- a chaotic peripatetic lifestyle;
- presenting to services only when in crisis;
- often being regarded as demanding, difficult and unpopular with medical and nursing staff;
- a child presenting with intoxication of a drug (e.g. methadone) that has been prescribed for an adult.

Drug-seeking presentations

Less commonly, people who misuse substances without any obvious medical needs may access A&E departments solely in an attempt to obtain controlled drugs. Such patients often present claiming withdrawal and requesting

prescriptions for drugs (e.g. dihydrocodiene or benzodiazepines). They may claim to have lost or have had their prescribed drugs stolen. Classically, they present 'out of hours', when it is difficult to confirm their story. At times, they may demand opiates for treatment of atypical painful conditions.

To prescribe or not to prescribe?

For many individuals who misuse substances, the A&E department may be the only point of contact with health services. It is therefore important, whenever possible, to engage the drug user, assess and treat immediate medical problems and facilitate referral to appropriate substance misuse services. However, it is by no means necessary, or indeed good practice, to prescribe controlled drugs in the majority of cases. The risks of doing so include accidental overdose in a drug-naïve/non-dependent user and the likelihood that the department will very soon become flooded by people with drug addiction with similar requests. Indeed, Department of Health clinical guidelines suggest (aside from notable exceptions – see below) that 'It should not be necessary to prescribe opiates or other controlled drugs for the management of addiction to a drug misuser in the accident and emergency department' (Department of Health, 1999). Instances where controlled drugs may be indicated include:

- opiate withdrawal in a pregnant woman, as this is associated with increased risk of early miscarriage and later precipitant delivery; pregnancy is one of the situations where careful prescribing of a substitute opiate may be appropriate;
- their use as analgesics (e.g. for the treatment of abscesses, trauma, etc.), when they should not be withheld just because the patient is an addict;
- their use in patients who are to be delayed in the A&E department, perhaps because of ongoing investigations/treatment, or in those awaiting admission to the hospital, who should not be left in opiate withdrawal.

Prescribing controlled drugs

Many A&E departments have policies that forbid the prescribing of opiates to drug misusing patients, except for the indications above. In departments that do not proscribe such prescriptions, it is important that the clinician follows the local policy exactly. The policy should be drawn up jointly by:

- senior A&E staff
- substance misuse service staff
- pharmacy department staff.

Poly-drug dependence

Opiate dependent misusers commonly use other substances, including benzodiazepines and alcohol. Although opiate withdrawal is in itself not life

threatening, the same is not true for withdrawal from benzodiazepines. Sedative-hypnotic withdrawal may include confusion, delirium and seizures. For this reason, in patients showing signs of withdrawal, judicious use of a benzodiazepine in the short-term so the patient can be linked in with appropriate treatment services or their general practitioner is practical. In most cases, doses should be divided over 24 hours, and in general 40–60 mg of diazepam daily is likely to prevent severe withdrawal in the short-term (Williams *et al*, 1996).

Acute psychiatric complications

Many substances of misuse (both in intoxication and in withdrawal) can give rise to acute psychiatric complications (e.g. stimulant-induced psychosis, panic reaction following the use of hallucinogens or dance drugs, delirium). Often the clinical picture may be complicated by the use of a number of different drugs simultaneously (Williams *et al*, 1998). Management is therefore aimed at treating specific symptoms/syndromes rather than being drug specific (Ghodse, 1995; Department of Health, 1999). The following principles apply.

- It is probably best to let the drug effect wear off; however, at times it may be necessary to control symptoms caused by the addition of medication.
- Advice regarding the use of psychotropic medication in the A&E department can be found elsewhere in this report.
- General principles of care involve the patient being (where possible) nursed in quiet, secluded, safe, and well-lit surroundings. He/she will need to be reassured that the drug effects will wear off in time and be orientated as to their present whereabouts, etc. Any procedures should be explained and a calm, confident and unhurried approach by a clinician is valuable. The state of hydration and vital signs should be monitored.
- It should be noted that drug addicts have an increased risk of death from suicide (Hulse *et al*, 1999), and complaints of suicidal thoughts, etc. should always be taken seriously and carefully assessed.
- Although unlikely to influence the immediate management (owing to the time delay), a urine specimen for subsequent drug testing should be obtained.
- It must be remembered that drug users also may have comorbid disorders that are not associated with the drug misuse.

Conclusions

The A&E department provides a front-line response in acute management of the medical and psychiatric sequelae of drug misuse. It can also play a wider role in health promotion, secondary prevention and the monitoring of patterns of substance misuse. Importantly, attendance at the A&E department may present a window of opportunity to put the drug user in touch with other services (Department of Health, 1999). In order to facilitate appropriate and speedy onward

referral, A&E staff need access to, and knowledge of, local advice and treatment agencies (Ghodse & Tregenza, 1996). Locally established liaison services and referral procedures might further improve service delivery.

Another extremely important issue to address is that the presentation of a drug user to A&E might highlight the fact that they have responsibility for a child. Any concerns about a dependant child should be reported to the local child protection team.

Delirium and toxic states

Introduction

Delirium (acute confusional state) is a common presenting complaint in A&E departments. It is a syndrome (see Glossary) which may be due to a number of causes (Box 1). In each case, appropriate assessment should be carried out to identify and then treat the underlying cause. The syndrome of delirium includes behavioural and emotional disturbance, which might be exacerbated by impairments of cognition and perception. Mental health services may be asked to advise on the management of such problems.

Information about the toxic patient

Because information from the patient is likely to be impaired, it is more important than usual to obtain information from other sources:

- Ambulance crews who bring a patient to the A&E department should give a thorough hand-over to the receiving nursing or medical staff.
- Crews should also leave written details, with contact names and telephone numbers of relatives or friends.
- All attempts should be made to seek information from family members, carers and friends. Young people may present in delirium, and school friends can then be a very useful source of information.

Box 1 Causes of delirium

- Drug and alcohol related: including acute effects of both illicit and prescribed drugs, and the effects of drug and alcohol withdrawal
- Intracranial: including head injury, infections, epilepsy and post-ictal states, strokes and space-occupying lesions
- Metabolic and endocrine: including consequences of organ failure, endocrinopathies, fluid and electrolyte imbalance, hypoxia and hypoglycaemia
- Systemic infections
- Postoperative states

- Every attempt should be made to collect appropriate information from relevant healthcare providers, including previous medical records, a patient's general practitioner and mental health services, where appropriate.

Management of toxic patients

- Accident and emergency departments should have facilities for interviewing relatives or friends in a private area.
- Departments should have the resources to physically or pharmacologically restrain individuals who are a danger to themselves, other patients or staff.
- Appropriate laboratory facilities should be available to help investigate cases of delirium, and access to toxicology should be available if indicated.
- Accident & emergency departments should have appropriate facilities for nursing such patients in a high-dependency area where they can be observed for any change in their level of consciousness or any change in their physiological status. Such areas need to be specifically designed to exclude mobile or breakable equipment.
- Departments should have access to security staff who can be called upon to safeguard other individuals within the department if required.

N.B. Patients with dementia are vulnerable to delirium from an acute infective or metabolic cause. This may be indicated by an acute deterioration in mental state. Failure to detect and diagnose an underlying medical problem may result in significant and unnecessary morbidity and mortality.

Acute psychosis

Introduction

Acute psychosis (see Glossary) often presents to A&E departments. It may result from functional or organic disorders. Possible causes include acute organic reactions, schizophrenia and manic depression (bipolar disorder). Too often, functional causes of psychosis are presumed and organic causes neglected. Where a functional cause is established, patients' first experiences of treatment, such as side-effects of antipsychotic medication, can have lasting ramifications for future treatment compliance.

Organic causes of acute psychosis presenting to A&E departments include prescribed drugs (e.g. steroids, anti-cholinergics), drug misuse (e.g. cocaine, amphetamine, cannabis, ecstasy, alcohol), drug withdrawal (e.g. alcohol, benzodiazepines) or underlying systemic disease. The latter encompasses a huge range of possibilities, including cardiac, renal, hepatic or respiratory failure, a local cerebral lesion such as meningitis or a tumour, head injury, epilepsy, hypoglycaemia and cryptic infection.

Guardianship

The first priority in management is guardianship of the patient and staff. This may necessitate restraint, and always demands a safe, quiet physical environment. Try talking to the patient, using a calm, non-threatening and reassuring approach. Procedures should be explained and the patient allowed to express any fears or anxieties they might have, remembering that most agitated patients are very frightened.

Assessment

Management will depend on identifying the cause. This commences with as comprehensive a physical assessment as the situation permits, including a neurological examination. The aim of this initial assessment is to identify any treatable organic cause of agitation, such as hypoglycaemia. Physical assessment may be challenging in a behaviourally disturbed patient, but easily rectified organic causes of psychosis should not be neglected. Restraint may be necessary to conduct a physical assessment, but should be seen as a last resort.

Early referral for psychiatric assessment is desirable when physical investigations have been completed. Again, assessment of mental state is one of the most challenging tasks in a behaviourally disturbed patient and should specifically consider the possibility of delirium and other organic brain syndromes, functional psychotic disorders, personality disorders, and alcohol/drug intoxication or withdrawal. Collateral history and information about previous presentations is essential.

Sedation

As a last resort, sedation of the acutely psychotic patient may be required. Contact psychiatric staff when possible. A clear record of mental state, including level of consciousness, should be made. If a patient is tranquillised without valid consent, document reasons for invoking common law. If necessary, call the police to render the situation safe.

The following section of this report gives advice regarding sedation in the A&E department.

Aftermath

A patient with a functional psychotic disorder such as schizophrenia or manic depression (bipolar disorder) should be managed within psychiatric services. A patient with a primary organic psychosis should be managed within the medical service relevant to its aetiology. In the latter instance, input of liaison psychiatry services may be useful. Occasionally, diagnostic uncertainty may persist, in which case a close working relationship between physicians and psychiatrists is invaluable.

Recommendations

- Management of acute psychosis in the A&E department should focus on:
 1. guardianship – patient and staff
 2. assessment – physical and psychiatric
 3. sedation – final resort.
- Treatment will depend on cause: organic causes should always be considered and treated but, once excluded, psychiatric evaluation should swiftly follow. Accident and emergency is not an appropriate setting for the management of functional psychoses, and diversion to the safer environment offered by psychiatric services should be rapid. This may depend on the level of confidence in those services that organic factors have indeed been comprehensively excluded.
- A patient's first experiences of the management of their psychosis will influence long-term treatment compliance. Accident and emergency staff training should facilitate early detection of psychosis, awareness of organic differential diagnoses and management of acute behavioural disturbance.

Sedation

Introduction

Disturbed patients in the A&E department may be a danger to themselves, to other patients, and to staff members. Sedation may therefore be required. Before resorting to sedation, a number of principles should be observed by the clinician:

- Can the patient be managed without resorting to sedation? Removal to a low-stimulation environment, accompanied by family or friends, can often lead to a marked reduction in disturbance.
- A careful history from the patient (in safe conditions) will often indicate the reason for the disturbance, which can often be addressed without using sedation.
- Try and obtain a history from other informants (family, friends, ambulance crew, other professionals) for the same reason.
- If an examination under mental health law is indicated, bear in mind that such an examination is likely to be impossible if the patient is drowsy or unrousable.
- The decision to sedate should ideally be taken by as senior a member of staff as possible.
- In the case of a minor, consent for sedation should be given by the parent or guardian.
- The only reason to use sedatives in the A&E department is for behavioural control – treatment of mental disorders should take place elsewhere.
- Once the decision to sedate has been made, it should be acted on immediately: delay will only lead to greater risk for all involved.

Medication to use for behavioural control

- Prior to formal diagnosis, lorazepam is the preferred choice where there is any uncertainty about previous medical history, including history of cardiovascular disease, uncertainty regarding current medication or possibility of current illicit drug/alcohol intoxication.
- Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol is a frequently used alternative. Recently, however, its use has been called into question (McAllister-Williams & Ferrier, 2002).
- Zuclopenthixol acetate (Clopixol Acuphase) injection is not quick-acting and should be avoided in A&E.
- Oral lorazepam 1–2 mg is the sedative of choice in most circumstances. Haloperidol 5 mg may be appropriate, but its potential for cardiotoxicity must be kept in mind.
- Intra-muscular (IM) or intra-venous (IV) medication may be required, if the situation demands rapid tranquilisation and the expertise is available to support vital functions (e.g. airway management, flumazenil injection).
- Once a patient has been sedated, mental state and vital physical signs must be monitored regularly.
- It is strongly advised that a local policy is written, by A&E staff, mental health staff, and pharmacy staff.

An example of a sedation policy for a busy A&E department is included as Appendix 2 to this report.

Side-effects

- Acute dystonic or Parkinsonian reactions to haloperidol are not uncommon and, if not properly treated, can lead to long-term problems of compliance with antipsychotic medication. First experiences of tranquillisation may therefore set the scene for future management difficulties. Therefore, procyclidine injection should be obtainable for acute dystonia, given IV (5 mg) or IM (5–10 mg), though it is not required routinely.
- All standard antipsychotics have the potential to be cardiotoxic. Haloperidol has the reputation of being safer than the rest, but is still associated with serious side-effects (McAllister-Williams & Ferrier, 2002), which must be borne in mind when the decision to prescribe is made.

Other psychotropic medication

There should be little call to use other psychotropic medication in the A&E department:

- Antidepressants should not normally be prescribed in the A&E department: they act slowly and should only be prescribed as part of a continuing treatment plan.

- Antipsychotics should only be prescribed in the A&E department *de novo* for the indications above.
- Patients already taking long-term psychotropic medication (antipsychotics, antidepressants and mood stabilisers) should only have this medication changed for compelling medical reasons, unless the psychiatrist responsible for the patient's care is contacted and consulted. Should urgent changes be indicated, the psychiatrist should be informed without delay.
- Patients taking lithium are at risk from dehydration, lithium toxicity, renal damage and hypothyroidism. Anyone taking lithium attending A&E should have their lithium, urea and electrolyte levels taken. Thyroid function tests should be considered, depending on clinical findings. All hospital biochemistry laboratories should have the facility to run an urgent lithium assay, and it is important to stress the urgency if there is any suspicion of toxicity.
- Monoamine oxidase inhibitors (MAOIs) are now rarely used, but if a patient is taking an MAOI, advice from the pharmacy department about drug interactions should be sought as a matter of urgency.

Factitious disorders

Introduction

Patients with factitious disorders often attend A&E departments. Identification of such patients in the A&E department is critical, because staff have the potential to instigate early appropriate management, alert other key medical and surgical staff, prevent unnecessary admission and, in certain circumstances when factitious disorder has implications for future employment, to inform hospital medico-legal services.

Factitious disorders (also known as 'Munchausen's syndrome' and 'hospital hopper syndrome') involve the intentional production or feigning of symptoms or disabilities, either physical or psychological. The patient is aware of the deception, but has little insight into the underlying motivation for the problem. Motivation is usually obscure and presumably internal, such as a need to be cared for. This is in comparison to malingering, where symptoms or disability become exaggerated owing to *external* incentives, such as the possibility of financial compensation.

Management in the A&E department

The management of these patients depends not only on time and resources, but also on the awareness of A&E staff of factitious disorder as a possible diagnosis and on the availability of psychiatric services. When factitious disorder is suspected, the most likely clues are:

- no ascertainable organic cause for the symptoms
- symptoms and signs suggestive of simulation, e.g. evidence of a ligature around the thigh

- the patient providing no verifiable information, i.e. no address, nearest relative, telephone number or GP

The patient should be informed that simulated illness is a possibility and asked if a psychiatric assessment would be acceptable. Some patients will decline such an arrangement, and may self-discharge after a non-hostile and supportive confrontation.

The optimum plan of management involves discussion of the patient's history and symptoms with a psychiatrist, followed by joint consultation with the patient. This interview should be supportive rather than adversarial and accusatory, and the patient encouraged to acknowledge that he/she has emotional difficulties for which further help and support may be required.

Factitious disorder in health care workers

If the patient is a health care worker and the A&E doctor suspects factitious illness as a likely diagnosis, then certain actions are advised. The Clothier Report (Department of Health, 1994), published after the Allitt scandal, recommended that patients with severe personality disorder (by inference synonymous with factitious disorder) should be prevented from working in health-related disciplines. The detection of factitious disorder in medical or nursing personnel therefore has important implications for that person's occupation. There are also potentially serious implications if the person has dependant children. After discussion of the diagnosis with the patient, general practitioner and psychiatrist (if available), it is advisable to convene a multidisciplinary meeting involving a senior member of the A&E staff, a member of the hospital medico-legal department, a psychiatrist and the patient's GP.

Recommendations

- A & E staff would benefit from training to assist them in the recognition and management of patients with factitious disorder.
- It is important to identify and confront such patients in a non-hostile manner. The doctor's attitude has been known to have a bearing on the outcome of such an interview. Whenever possible, psychiatric referral should be sought (Meek *et al*, 1996).
- The diagnosis should be written in the medical notes and the GP (if available) informed in writing.
- All computerised A&E departments should transfer the records of patients with factitious disorder onto computer so that staff are alerted automatically when such patients register (Bretz & Richards, 2000).
- In some circumstances, hospitals in the area should be informed of the diagnosis.
- The creation of predetermined management plans for repeat attenders is worthy of consideration.

- If the patient with factitious disorder is a health care worker, then the A&E doctor is advised to discuss this with a consultant colleague and seek an urgent psychiatric opinion. If this is not feasible, then advice from the hospital medico-legal team should be sought. In certain circumstances, it may be necessary to breach patient confidentiality, i.e. if the professional poses a risk to patients as a consequence of simulated illness.

Medically unexplained symptoms

Introduction

In both primary and secondary care, a large proportion of patients present with physical symptoms that have no specific organic cause. This phenomenon has been complicated by variable and confusing terminology (e.g. somatisation, psychosomatic, functional). 'Medically unexplained symptoms' can be used as an umbrella term and makes no assumptions about the cause of the symptoms.

Common medically unexplained symptoms include chest, abdominal or back pain, tiredness, dizziness, headaches, ankle swelling, shortness of breath, insomnia and numbness (Kroenke & Mangelsdorff, 1989). Patients with medically unexplained symptoms should be differentiated from those with factitious disorders (see above), but overlap can occur. It is important to note that these patients may also be consulting frequently for physical symptoms in both primary care and medical/surgical out-patient clinics, and as a result may accumulate 'fat folders' (Williams & House, 1994).

Management in the A&E department

Management of patients with medically unexplained symptoms in the A&E department depends in part on the doctors' knowledge of the patient's previous medical history. Exploration of the patient's medical history might reveal previous consultation for similar complaints, and enquiries should be made about any other out-patient clinic(s) that the patient may be attending. For example, a subset of female patients with chronic pelvic pain may be attending both gynaecology and gastroenterology out-patient departments (Bass *et al*, 2001).

If the patient is already known to the medical/surgical services, the symptoms are known to be unrelated to organic disease, and there is evidence of psychological distress, e.g. panic attacks, then in certain circumstances it may be appropriate not to perform further medical investigations. The reason for adopting such a conservative, non-interventionist approach is that further tests in such a patient may have iatrogenic potential. For example, the ECG in the patient with non-cardiac chest pain might inadvertently increase that patient's anxiety and lead to further unnecessary consultations (the patient may think 'the doctor wouldn't have done the ECG if he didn't think there was something wrong').

For this reason, it is appropriate for the A&E doctor to attempt to provide a satisfactory alternative explanation for the symptoms in these patients, e.g. hyperventilation or oesophageal reflux in patients with non-cardiac chest pain. Many patients will be reassured by such an explanation, particularly if they feel that they have been listened to and understood by the assessing doctor.

Recommendations

- The management of patients with medically unexplained symptoms depends to a large extent on the A&E doctor's knowledge of the patient's past medical and psychiatric history.
- Where available, the use of computerised hospital records would allow A&E staff to identify patients with a previous history of medically unexplained symptoms, especially if they are also attending other out-patient departments in the general hospital.
- If the patient's medical complaints are known to be unexplained (or part of a psychiatric illness), then further investigations may be inappropriate.
- The potential to cause iatrogenic harm in these patients should not be underestimated.
- These patients should therefore be investigated judiciously, and the indications for use of further investigations carefully considered.
- If such patients are also in current psychiatric care, then the A&E doctor should communicate with the GP and medical/surgical staff.

Older people

Introduction

Rooting out age discrimination in health and social care is a principle that has recently been adopted as public policy in England and Wales (National Service Framework for Older People; Department of Health, 2001*b*) and is accepted as the norm in other legislatures. This principle needs careful consideration when designing and delivering health and social care, since older people often present with a different and more complex picture from adults of working age, and have different care needs.

There are particular factors to be considered when assessing and managing older people with mental health problems in A&E departments. These can be summarised as follows:

- Mental health problems may present differently in older people. For example, depression may present with pronounced physical symptoms such as pain.
- Difficulties in obtaining high-quality information in the presence of cognitive impairment due to delirium or dementia, both commonly encountered in A&E departments.

- Differentiation between delirium, dementia, and comorbid delirium and dementia. These two syndromes have different aetiologies and management strategies, with the presence of delirium pointing towards an underlying physical cause.
- The high levels of cognitive impairment, with associated behaviour such as wandering, may be problematic in a busy A&E department.
- The greater impact of a changing environment on those with cognitive impairment or sensory impairment.
- The frequent presence of comorbid physical and psychiatric illness. It may be difficult to distinguish the relative importance of symptoms, such as weight loss or apathy, when two or more processes may be occurring simultaneously and presentations can represent a wide variety of different types of pathology. Older people who present with memory problems, lack of concentration, anxiety, and apparent disorientation could have had a recent myocardial infarction, a urinary tract infection or a severe depressive illness.
- The frequent presence of multiple physical illnesses, which may limit treatment options because of drug interactions or contraindications.
- Communication problems when an individual has sensory impairment.
- The effects of prescribed and over-the-counter medications, particularly with polypharmacy.
- The different social supports and social networks that older people have.
- The different psychiatric services provided for working age adult and older people.

The assessment of older people in A&E departments presents particular challenges. Assessment should be completed within 4 hours, and yet for older people with multiple pathologies and problems, including physical and psychiatric comorbidity, this may not be sufficient time to collate all the information required without specialist services to provide rapid assessment. Older people tend to wait longer in A&E departments.

The following will improve the quality of assessment in older people:

- Good history taking from the patient and also from collateral source, particularly when cognitive impairment is suspected.
- Determination of the time course of symptoms. This is particularly helpful in differentiating delirium from dementia, both of which produce similar pictures of cognitive impairment, and a range of psychiatric and behavioural symptoms.
- Attention to sensory impairment: the use of devices such as portable amplifiers can improve the quality of histories and clarify whether cognitive impairment is present or absent.
- Careful examination of both the physical and mental state. Particular attention should be paid to cognitive function, with the use of a brief screening instrument such as the Abbreviated Mental Test Score both to

detect the presence of cognitive impairment and to provide a baseline score for future use.

- Access to previous health and social care records, including mental health records if they are held separately.
- Judicious use of investigations indicated by history and examination, and guided by findings of previous investigations where available.
- Consideration of the possibility of more than one diagnosis to explain the presentation, since multiple pathology is common. The presence of one condition may mask another: for instance, an older people patient with diabetes presenting in a withdrawn state should have their glycaemic status checked, but it is important that their depression (and possible recent suicide attempt) is not ignored.
- Consideration of the impact of department layout and staffing strategies on older people with cognitive impairment. A quiet reassuring environment with constancy of staff will result in less behavioural disturbance than a noisy department where several different staff deal with patients.
- The use of multi-disciplinary teams to provide rapid assessment of older people in A&E departments. Dedicated staff for older people can improve both the quality and speed of assessment, and can help to build up the core skills necessary to deal with the complex problems that older people can present with.
- The development of specialist old age liaison psychiatry services should be considered. The increased community focus of old age psychiatry services means that rapid specialist psychiatric assessment and triage in A&E may not be available unless specific arrangements are made.

It is vital that clinicians work together in the interests of the patient. This principle is also of importance when decisions are made as to where the patient should go on leaving the A&E department.

Some areas deserve further discussion:

Communication problems

It is of vital importance to define the nature of the communication problem as accurately as possible:

- Is there a hearing problem?
- Is there a language difficulty?
- Is it the clinician that does not understand the patient and is therefore making assumptions about their cognitive state?
- Does the patient understand the clinician's questions?
- If so, what type of question is understood, and what type is not understood?
- Is there a problem with concentration?

- Is there a problem with registration?
- Is there a problem with memory?
- Is the patient orientated?
- Is there a dyspraxia?
- Are there any problems with speech, and if so, of what type?
- Is there any perseveration?

Effects of medication

Both prescribed and non-prescribed medication can have a profound effect on a patient's presentation, either at therapeutic or toxic doses. This is particularly pronounced in older people. A significant population of older people has been taking benzodiazepines for many years. There should be a high index of suspicion about the effects of medication whenever an older person presents with:

- drowsiness
- disorientation
- registration and memory problems
- sudden onset of apathy, anxiety or social withdrawal.

If there is a possibility that medication may play a part in the patient's presentation, various steps should be taken:

- Enquire of the person who brought the patient to A&E as to what medication was apparent in the patient's house. It is standard practice for ambulance staff to bring any medication to A&E if the patient has come from home.
- Obtain a full list of prescribed medication from the GP as soon as possible.
- Request that a relative/friend seek out any medication still at home and bring it in. Always state that it is as important to bring in over the counter preparations and 'herbal' medicines.
- History and examination may indicate that other investigations are appropriate, such as paracetamol, salicylate or tricyclic levels; ECG may also be important.

Presentation of mental health problems in older people

Common mental health problems often present in the same way in older people as they do in any other age group. There is, however, a higher likelihood of differing presentations in old age. Some of the more frequently experienced presentations include:

- depression, which may present with apparent cognitive deficit (pseudodementia);
- dementia, which, conversely, in the early stages may present with depressive symptoms or anxiety;
- chronic conditions, such as diabetes, which may present with a loss of control of the condition as a presenting feature of depression or dementia;

- depressive symptoms, which may be the presenting feature of physical states, such as hypothyroidism;
- delirium, which may present with any psychiatric symptom, and the acute onset of symptoms may suggest an underlying physical problem producing the delirium.
- alcohol problems, which do occur in older people, and may present as physical illnesses, depression, anxiety, or apparent (or real) cognitive impairment.

Recommendations

- Ageism has no place in clinical practice: it is important that the clinician makes decisions in the light of the patient's needs and not in the light of the patient's age.
- The assessment process includes a careful history, physical and mental state examination, and getting information from as many sources as possible.
- Because of the different presentations of elderly people, it is vital that there should be good liaison between A&E departments and the local old-age psychiatry services
- Consideration should be given to the development of specialist old-age liaison psychiatry services that are able to provide a rapid response to A&E departments.

Children and adolescents in adult accident and emergency departments

The management of children in A&E departments is beyond the remit of this report.

Issues relating specifically to the management of deliberate self-harm in young people are addressed in Council Report CR64 ('Managing deliberate self-harm in young people'), published by the Royal College of Psychiatrists in 1998, and currently being updated. It is anticipated that a revised report will be published in 2004.

There is ongoing work being undertaken by the College's Child and Adolescent Psychiatry Faculty on the wider issue of children attending A&E departments.

People with learning disability in the accident and emergency department

Introduction

Approximately 3% of the general population have a learning disability defined as an IQ < 70. People with all levels of learning disability live in the community, in their family homes and in supported accommodation. Many now lead independent lives in their own accommodation.

They develop similar physical and mental health problems to non-learning disabled people (Lindsey, 1998). However, their presentations may not be typical

because of difficulties in communication, such as aggression because of physical pain or self-injury as part of a mood disorder. The prevalence of epilepsy and head injury is higher in this group, which may complicate clinical management.

Communication

Hearing and speech difficulties are more common and may be a barrier to effective communication between the clinician and the patient, especially when compounded by pain.

Common presentations

- Physical injuries and medical illnesses, e.g. epileptic seizures
- Mental illnesses manifesting as a change in the person's usual pattern of behaviour
- Deliberate self-harm
- Alcohol misuse.

Management

- Always believe what the person tells you in the absence of contrary evidence.
- Offer appropriate treatment for the presenting problem as required.
- Consider the issue of consent to treatment and facilitate the person in providing valid consent. Use simple language, pictures and diagrams, such as that used in the 'Books Beyond Words' series (Hollins *et al*, 1998).
- With the person's consent, involve the social network, e.g. family member or the carer from the community home.

Recommendations

- Assess for physical illness. Treat on clinical need without discrimination. Consult and involve the person in the care you intend to provide.
- Use simple language when taking a history, and when explaining investigations and treatment. Seek the person's consent for investigations.
- Consider the role of carers/supporters in assisting the person to give a history. Carers can facilitate understanding of your care plan.
- Avoid medication to control aggressive behaviour. Make use of a low-stimulation environment.
- Where concern for the person's mental health is present, liaise with the local community mental health team for people with learning disability.
- If abuse or exploitation of the person is suspected, refer to the local Social Services Department and their policy on vulnerable adults.
- Ensure follow-up through liaison with the general practitioner.

Patients presenting with chronic physical disorders to A&E departments

Introduction

People with chronic physical disorders frequently attend A&E departments. Because they have a clearly identifiable physical problem, coexisting mental health problems may go unnoticed.

Physical disorders and mental health

In all age groups, chronic physical disorders are associated with a markedly increased risk of depression (Royal College of Physicians & Royal College of Psychiatrists, 1995). Depression in chronic physical disorders is a predictor for subsequent suicidal behaviour (De Leo *et al*, 1999). Depression in physically ill people often goes unrecognised (Royal College of Physicians & Royal College of Psychiatrists, 1995). Depressed people utilise non-mental health services at a considerably increased rate. Suicidal ideas are more common in people with chronic physical illnesses, and are often unrecognised as medical attention is understandably focused on the physical disorder.

Chronic physical illness may also be associated with other psychiatric problems, such as anxiety and cognitive impairment.

Recognition

The diagnosis of depression in physically ill people poses some problems. 'Biological' symptoms of depression may be unhelpful because they occur as a result of the physical illness (e.g. sleep disturbance, appetite change and loss of libido). There is also a tendency to view any mood change as 'understandable' because of patients' physical problems, and therefore not pathological.

'Cognitive' symptoms of depression can help to diagnose depression in the physically ill. These include symptoms such as anhedonia and loss of sense of humour, as well as changes in the patient's view of themselves, the world and the future.

Treatment

There is evidence that the use of antidepressants in people who have both depression and physical illness is associated with a clinically significant improvement in depressive symptoms (Gill & Hatcher, 1999). Intuitively, treating depression in this group is likely to reduce the suicide risk, although there is no direct evidence for this.

Recommendations

- Staff should be made aware of the increased risk of mental health problems in patients with chronic physical illnesses.

- There should be improved training of staff in the recognition of mental disorders in physically ill people.
- A suspicion of a mental health problem should be conveyed to the relevant primary or secondary care staff.
- The frequent attendance of someone with a physical illness should alert staff to the possibility of an associated mental health problem.

Emotional response to trauma

Introduction

Emotional responses to traumatic experiences are common. Immediately after a traumatic event, typical responses include shock, disbelief, fear, horror, sadness and anger. Over the next few days or weeks, individuals often find themselves re-experiencing aspects of the trauma, avoiding reminders of it, having difficulty sleeping and feeling more on edge than normal. In the majority of individuals, these feelings gradually reduce and are no longer problematic. In some individuals they develop into symptoms of depression, anxiety, acute stress reaction (see Glossary) and post-traumatic stress disorder (PTSD; see Glossary).

Individuals who develop more long-term psychiatric responses following a traumatic event may present to the A&E department at a later date. Common forms of presentation are as a direct result of the psychiatric symptoms they are experiencing or as a result of associated conditions such as substance misuse/dependence and medically unexplained somatic symptoms.

Intervention

There have been considerable attempts in recent years to identify effective means of reducing initial distress and preventing the development of PTSD and other psychiatric disorders in individuals involved in traumatic events. No convincing evidence has been found that one-off interventions such as psychological debriefing reduce psychological symptoms.

There is growing evidence that multiple session early interventions using cognitive-behavioural techniques can reduce symptoms in those who are symptomatic within one month of a traumatic event, and it is therefore important to try to identify such individuals. There is no good evidence that medication is beneficial or harmful, and it can be used cautiously for problematic symptoms such as severe anxiety or insomnia soon after a traumatic event.

With the current evidence base, it is believed that the most appropriate immediate response following a traumatic event is to offer individuals involved empathic support and information. Ideally, this should be verbal and written regarding typical symptoms and the normality of experiencing a psychological response following a traumatic event. It should promote resiliency factors, but should not over-normalise symptoms that may develop. There should be guidance as to when and how to obtain help and suggestions regarding successful coping.

It is helpful to provide contact numbers for potential sources of help (e.g. victim support and a general practitioner).

Major incident planning

It is important that all A&E departments have a major incident plan that includes guidance on how to deal with psychological sequelae. A named local mental health professional should be a member of the planning group. The plan should include:

1. elements concerning education and training of potential service providers
2. the nature of the planned response
3. plans for longer-term support.

In the immediate aftermath of a major incident, the major requirement for most individuals is likely to be basic emotional support while physical injuries and practical requirements such as food, money and accommodation are dealt with. The plan should include the creation of an accurate database of those involved, and basic written information such as leaflets describing typical reactions and how to deal with them, for example 'Coping with Crisis' from the British Red Cross.

There is no requirement for mental health professionals to be present in the A&E department immediately after a major incident, but they should be easily accessible and familiar with the plan. Ideally, this service would be provided by the liaison psychiatry service, but it may also involve the on-call psychiatrist. It is well recognised that some individuals may develop psychological reactions that do require immediate assistance, such as acute anxiety states and psychotic reactions. The main role of mental health professionals is more likely to occur later, however, and they should continue to liaise proactively with the A&E department.

Summary

- Emotional responses following trauma are common.
- Most will resolve with time and general support.
- Some individuals will develop problematic psychological difficulty.
- Brief early psychological interventions can reduce later sequelae.
- Medication can be used with caution.
- Major incident planning should include mental health issues.

Stigma

Stigma is an attribute, such as mental illness, that marks an individual out as being different from 'normal' and elicits some form of sanction. For those with mental health problems, stigma is the largest single obstacle to improving their quality of life. In the health service, stigmatising beliefs by health professionals may result in discrimination against such patients.

Stigma may adversely influence the provision and delivery of services to groups of patients with particular disorders or problems. It may also detrimentally affect individual patient care. Hostility and moral judgement may lead to poor clinical decision-making.

Recommendations

- The influence of stigma on the provision and delivery of services for patients with mental health problems should be recognised at an organisational level.
- Mental health problems and issues of stigmatisation should be included in training programmes for all A&E staff.
- Staff should be made aware of how emotional responses aroused by patients can influence their professional practice.

3. Ethnic minorities

Background

Concerns regarding the involvement of various ethnic minorities with mental health services include the over-representation of some groups in psychiatric in-patient services, and the under-representation of other groups in mental health services overall.

Not all the reasons for this are well understood, but they include different expectations of services, language problems, an expectation of difficulties in accessing services, suspicion of statutory services and a belief that services will not be sensitive to cultural needs.

Cultural sensitivity

Services must be sensitive to the needs of people from different cultures. Sensitivity encompasses many issues, including culture, religion, language and experiences of racism.

Ignorance about cultural issues leads to non-intentional insensitivity and can lead to great offence being caused. News of such incidents will rapidly travel through a community, leading to great reluctance to try and access services in the future. Should staff have knowledge of the traditions in the local minority communities, there is a much-reduced risk of causing offence.

Language

Communication is vital in order to make a mental health assessment. This is problematical when a patient does not speak English with confidence. The following hierarchy is suggested in order to address the communication problems with a patient who is unable to communicate in English:

1. The ideal approach is to arrange for the assessment to be made by a competent mental health professional who is also proficient in the patient's language. This is unfortunately rarely feasible in an emergency situation.
2. The alternative option of another health professional that speaks the language working with the mental health professional is preferable to using the services of an interpreter.
3. In the absence of a competent health professional proficient in the patient's language and aware of the cultural sensitivities of the case, the use of a well-trained interpreter is vital. Should interpreters be used, it is

very important that they have had prior training in mental health issues; otherwise there is a tendency for interpreters to be reluctant to translate speech seen as 'rubbish', 'nonsense', 'rude', or worse. This is, however, the speech that is often crucial in making a mental health assessment.

4. It is never good practice to rely on a family member to interpret and interpretation by family members and non-health professionals should not be encouraged. Children should also not be used as interpreters.

Religion

A common mistake that is made is that an individual follows the main religious practices of their community. It is important to establish which religion, if any, the patient observes. Ignorance about religion is another potential source of offence being caused.

All major religions have days of particular significance: it is important that health professionals are aware of the significance of certain dates. Patients should never be asked to return for a follow-up appointment on a major festival day. Multi-faith calendars are widely available, and these have important religious dates, which will help in planning appointments.

An awareness of what is, and what is not, acceptable in the patient's religion is of great assistance in the assessment of mental state. Some religions have specific expectations and requirements that need to be observed. Failure to do so would prevent an effective assessment from taking place.

Recommendations

- Accident and emergency and mental health staff should have an awareness of the different communities living in the locality.
- This awareness should encompass the main traditions, religions and languages in the communities. It is a professional responsibility to learn about the minority communities in a locality, and clinicians should also have an awareness of the limitations of their knowledge.
- There should be an easily-accessible register of the languages spoken by staff members. It is expected that professional staff will be willing to put their language skills to use for the benefit of patients.
- An agreed policy should be established regarding patients speaking other languages, using the hierarchy detailed above. The languages spoken most commonly in the local community can be predicted to be the ones that occur most often in A&E.
- A clearly accessible interpreter service with a register of interpreters speaking different languages, their availability and contact numbers is essential for the smooth running of any A&E department. Information about this must be made easily available so that care is not compromised.

- A calendar with the main religious festivals should be in a prominent place in the department. It should be updated frequently. In addition, hospital databases should be programmed to alert staff to such festivals.
- Every effort should be made to recruit and train staff from the local minority communities.
- Staff should have race and culture training on a regular basis. It is suggested that the frequency should be annual.

4. Specific issues in the emergency department

Violence and abusive behaviour

Introduction

Accident and emergency departments can be violent places. The staff of some departments, particularly inner-city departments that have a high volume of drug- and alcohol-related attendances, face an unacceptable amount of psychological and physical violence in the workplace.

Some health authorities have laid down a policy and issued their own guidelines on the management of violence in the workplace. Where these are in existence, they should be freely available and the procedures made known to all staff in the A&E department, including new staff on taking up appointment in the department.

There are a number of circumstances where violence is more likely to occur in the A&E department:

- misuse of alcohol and drugs
- long waiting times
- an apparently uncaring attitude on the part of staff to patients
- rowdy or over-anxious groups of people who accompany patients
- medical conditions that lead to a confusional state.

Safeguards

A number of possible safeguards may reduce or prevent the occurrence of violent incidents. These include:

- Adequate staffing.
- Contact between staff and patients/relatives. A designated member of staff who has a liaison/reception/controlling responsibility in the department and who can advise patients about waiting times, and the reason for long periods of waiting, may be an appropriate proactive step. This person should be able to monitor the general feeling in the waiting room and, therefore, identify and endeavour to allay the anxiety that may precede a violent outburst.
- Security personnel. The presence of security personnel may often be sufficient to prevent an incident. In areas where violence presents a considerable problem, the employment of security personnel on a full-time basis may be made, provided that there is careful screening prior to appointment. Alternatively, such security personnel may be employed on a part-time basis to cover the times when violence most frequently occurs,

such as late evening or weekends. In other areas, it may be sufficient for an arrangement to be made with the local police, whereby a constable calls into the department as part of his regular 'beat'.

- Identification of potentially violent patients at the triage stage. Information from previous records is important, as is the patient's current condition.
- Prompt attention for potentially violent patients. Such attention may prevent a minor incident becoming more serious, increasing tension and/or spreading among others in the waiting area.
- Segregation of visitors. Violence in A&E departments often results not from the patient, but from those who accompany him/her, and removing them from the patient waiting area and, if necessary, from the department, can prevent a violent incident.
- Segregation of patients. An empty room may be set aside in the department for the exclusion of a violent patient for a short period, but adequate supervision should be maintained.

When an incident occurs

If a violent incident occurs, no member of staff should attempt to tackle a violent patient alone. Assistance should be summoned immediately. An alarm system should be readily available in all areas where patients are treated or where they wait. Such a system should be easily accessible and, ideally, should be of a type that can be carried on the person. The alarm should be clearly audible in all areas of the department and should also be connected to the hospital switchboard so that an emergency (999) call can be made to the police. Alternatively, there could be a direct line to the police station from the A&E department.

There are a number of principles regarding addressing violent incidents:

- Angry and violent people tend to induce angry feelings in others. Responding to an incident in an angry way will only serve to escalate tension. Staff should have training and support in resisting their instinct to respond angrily, and to respond in a calm and detached manner.
- Safety must take paramount importance. Staff, patients and the public should be kept safe: maintaining the safety of equipment has to take a lower priority.
- Within the bounds of safety, establishing a dialogue with the perpetrator, and listening to them, generally serves to reduce the tension.
- Do not make any promises to the perpetrator unless you intend to fulfil them: unfulfilled promises markedly increase the risk of further violence.
- Always ensure that there is plenty of help at hand: it is preferable to have more help than is needed, rather than not enough.
- The Royal College of Psychiatrists' council report 'Safety for trainees in psychiatry' (2000) is a useful reference.

Recording

After a violent incident, it is important that a full record is kept, both for future reference within the department and for possible litigation purposes. This record should include:

- the date and time of the incident;
- the patient's name, sex and age;
- whether the perpetrator was attending as a patient or accompanying a patient;
- whether he/she was previously known to staff;
- a brief statement describing the incident;
- details of any restraint necessary;
- an assessment of the perpetrator's medical condition;
- subsequent action taken regarding the perpetrator, e.g. discharged home, taken into police custody, admitted into 'X' ward, referred to psychiatrist, etc.

Clinical staff will sometimes feel reluctant to record incidents fully. It must be stressed that such recording is absolutely essential, not only for legal reasons, but also to improve the safety of staff in the future. It is therefore a responsibility that efforts are made to try and ensure that staff in future are forewarned about the violent potential of an individual, usually by placing a warning in their records.

Recommendations

- Identifying potentially violent situations and defusing them before any violence occurs is preferable to responding to violence. All departments should therefore have agreed procedures to identify potentially violent situations, and how to respond to them.
- All departments should regularly review safety, warning and response procedures.
- All staff should have regular training in responding to violence, de-escalation techniques, and breakaway techniques.
- Recording procedures should be kept under regular review.
- Targeted dissemination of records of violent incidents is vital in order to reduce future risks: there is no point in recording incidents if the records are never read.
- There should be opportunities for staff to have support, supervision and debriefing after a violent incident.

Domestic violence

Domestic violence encompasses a wide range of physical, sexual and emotional abuse. Although it can occur within any intimate relationship, the majority of

such violence is perpetrated by men against women and their children (Department of Health, 2000). Domestic violence is rarely a one-off incident; more often there is a pattern of escalation.

People subject to domestic violence might seek help in the A&E department for both the physical and psychological consequences. Psychiatric problems such as depression, anxiety and deliberate self-harm are more common among those who have been abused compared with those who have not (Department of Health, 2000).

Victims of domestic violence are often embarrassed by what is happening, unsure of where to seek help and fearful of doing anything that will make the situation worse. Contact with health services provides an important opportunity for health professionals to respond to people experiencing domestic violence (Mezey, 2001).

All healthcare professionals who have contact with patients need to be aware of the risks of all forms of domestic violence. In situations of limited contact, such as A&E, it is especially important that warning signs are identified. The Department of Health for England and Wales has provided a synthesis of previous guidelines for the management of domestic violence (Henwood, 2000).

Recommendations

- Staff should receive training on the identification, assessment, and response to domestic violence.
- Local services should develop protocols where there is suspicion of domestic violence.
- There should be a local multi-agency response to domestic violence, with appropriate referral channels.
- Staff who encounter domestic violence should receive appropriate support.
- Most police forces have a domestic violence unit. The contact number should be available in the A&E department.

Frequent attenders

Introduction

There are a small number of patients who repeatedly attend the A&E department; they generate a disproportionate workload (Williams *et al*, 2001). Their problems are often perceived to be minor and non-urgent, and hence their attendance is seen as inappropriate (Padgett & Brodsky, 1992). As a result, they may become stigmatised and their problems, particularly physical problems, may be overlooked. Many of the patients who attend large numbers of times each year have profound physical problems, which contrasts with other parts of the hospital where this behaviour may be associated with somatisation (Williams *et al*, 2001). The presenting problem may be dealt with, but other more intractable problems that may motivate re-attendance remain unresolved.

Characteristics of frequent attenders

Frequent attendance is not a diagnosis, but a pattern of behaviour reflecting underlying difficulties. Patients who attend frequently are high users of health care services in general. They tend to have multiple complex problems, including physical and psychiatric illness, cognitive impairment, psychosocial difficulties, and alcohol and substance misuse (Williams *et al*, 2001). It is likely that some people may also suffer personality disorders, although there is little evidence to back this assertion. Often these problems go undiagnosed and untreated. The vulnerability of such patients may be increased by homelessness and social isolation and some patients may not be engaged with primary care or social services.

Problems of frequent attendance

Patients who frequently attend increase departmental workload and waiting times. They may leave staff feeling frustrated by their return visits. However it must be remembered that this group has an excess mortality, one third of which is accounted for by 'unnatural' causes, including suicide and drug and alcohol misuse (Hansagi *et al*, 1990). Comorbidity contributes to diagnostic confusion and may lead to significant health problems being overlooked. Repeated use of A&E by a patient with chronic health problems often results in inconsistent and fragmented care.

Reasons for frequent attendance

Attendance is driven by physical and psychological need, which must not be overlooked. The decision to attend A&E depends not only on a patient's symptoms, but also individual coping resources and the perceived availability and accessibility of services. Hence, the patient's perceived urgency of their problem may differ from that of staff. Attendance at A&E may compensate for a lack of social support, or have an important stabilising influence, for isolated and vulnerable individuals (Andren & Rosenquist, 1985; Ellison *et al*, 1989).

Solutions

Formally identifying frequent attenders is the first step in comprehensive treatment planning. A locally agreed definition of frequent attendance (e.g. seven or more attendances per annum) should take into account the resources available to deal with the problem. General hospital and mental health databases can be cross-referenced to generate information. Information can be supplemented from hospital notes and by discussion with A&E staff, GPs and neighbouring A&E departments.

The aim is to generate a care plan taking an active approach so that the opportunity for intervention is maximised when patients make contact with emergency services, such as encouraging registration with a GP (Bolton *et al*, 2001). Problems are varied and require planning case by case at a senior level. Review of the A&E notes to identify the problems and staff already involved

with the patient is fundamental. Individual patients should be invited for multidisciplinary review with staff possibly from A&E, psychiatry, general practice and the general hospital. The patient may not attend for such a meeting; in their absence the meeting should generate recommendations to guide future management. Individual guidelines for future attendance should include past medical and psychiatric history, social history and suggestions for future care. Most importantly, perhaps, the contact details of professionals involved should be clearly stated. If there are severe psychiatric problems, the care programme approach may be invoked. Even if repeated attendance continues, the availability of background information can produce more appropriate interventions.

Recommendations

- Frequent attendance can be considered an explicit clinical problem.
- Patients who frequently attend should be identified and background information obtained from other healthcare providers.
- Multi-disciplinary review of the patient and/or the available information can guide appropriate management.
- Individual guidelines for future attendance should include typical presentation, past medical and psychiatric history, social history, suggestions for future care and contact details of the professionals involved in care.
- Patients should be encouraged to register with a GP.
- Accident and emergency staff need training to assist in the recognition of somatisation, psychiatric comorbidity and substance misuse.
- Staff should be trained to deal with patients who present with challenging behaviours. This includes the recognition of the feelings invoked by such patients.

Patients who do not wait to be seen

Patients who do not wait to be seen or who discharge themselves against medical advice make up about 3–5% of A&E attendances. A great number of these are alcohol-related presentations. Many A&E departments choose to audit the numbers of patients who do not wait to be seen, and view this as a performance indicator for the department. A significant proportion of these patients will have harmed themselves, and will be at further risk of self-harm or suicide.

Many A&E departments operate a mental health triage system alongside the standard triage system. This can frequently identify those who appear to be at high risk of leaving without being seen, and they can be prioritised accordingly. If the risk assessment indicates that the individual is at risk of harming him/herself or others, then duty of care indicates that all efforts should be made to prevent self-discharge, pending further assessment.

Proactive steps should be taken with every patient who presents with a mental health problem. The first health care professional who comes into contact with

the patient should record a description of the patient, including a description of the clothes the patient is wearing in case he or she leaves the department before a comprehensive evaluation can be carried out. Patients who are believed to be at risk of further self-harm and who are believed to be at risk of leaving the department should be monitored closely in an appropriate area within the department. If necessary, they should be allocated one-to-one supervision by an appropriate member of staff.

Patients who attend with psychiatric problems or deliberate self-harm and who do not wait to be seen may have a serious mental health problem or may be suffering from a potentially serious episode of deliberate self-harm (Bolton & Zolese, 2000). Every effort should be made to contact the patient and ask him or her to return for a proper evaluation. Hospital security staff should be alerted, as many patients spend some time in the grounds of a hospital after leaving the A&E department. If it has not been possible to make a risk assessment of the patient, then next of kin should be contacted if the patient could be deemed to be at risk. Alternatively, the police may need to be informed and asked to call to the patient's house with a view to escorting him back. The patient's general practitioner and psychiatrist, if known, should be alerted about the event.

Issues of consent in accident and emergency

Introduction

There are a number of reasons why patients attending an A&E department may actively refuse consent for an intervention that a doctor thinks advisable. The reasons for refusing consent include:

- disorientation;
- intoxication;
- too angry to think straight;
- a state of panic or despair;
- numb with shock or pain;
- limited insight into their illness;
- not fully grasped what it is the doctor has advised;
- patient is in their right mind but disagrees with advice given,
- religious or cultural values that preclude the treatment advised.

Psychiatrists may be able to assist where mental disorder or possible mental disorder, however transient, interferes with an individual's decision-making ability to give meaningful consent or, as is more often the problem, make a valid refusal.

The concept of capacity

Before involving a psychiatrist about an issue of consent or refusal, it is important to check first that the patient has been given all necessary information to make an informed choice about the risks and benefits of the intervention. It

is also important that you have assessed whether or not he/she has correctly understood this information, and held it in their mind for long enough to make their own decision free from the pressure of others (including yourself). If you have done this, then you will have made an assessment of what lawyers term 'capacity' (Box 2). If a patient has full capacity, it is of no consequence whether or not you agree with their decision, and whatever their reasons, you must respect their wishes.

Capacity to give meaningful consent or make a valid refusal is a legal concept and not a medical one. It is independent of diagnosis. The Law presupposes that all registered medical practitioners are qualified to make an assessment of capacity. In England and Wales, there is a prior assumption in Law that adults have capacity to consent or refuse unless proven otherwise, whereas people under the age of majority (18 years) do not have the same rights. It is capacity, rather than chronological age, that determines whether a child or young person can legally give valid consent to medical interventions. In England and Wales, mentally competent 16- and 17-year-olds can give consent in their own right without reference to their parents or legal guardian, but their refusal can be overridden in law by their parents, legal guardian or the High Court.

Non-consenting deliberate self-harm patients

Very commonly, A&E departments are faced with patients who have intentionally harmed themselves and then refuse consent to either stay in hospital or have essential treatment. All such patients will warrant assessment for possible mental disorder that may be interfering with their capacity and a psychiatrist should be called to assist in an emergency assessment of capacity. The only exceptions to this rule might be patients who are so well known to the unit that there is a unit policy agreed with the psychiatric service on how to manage them when they present in a characteristic way.

Accident and emergency staff have a duty of care to detain, and, if necessary, restrain, the patient in order to allow a psychiatric assessment to take place. Unless the patient has been transferred under statutory Mental Health Act 1983 powers, the only immediate legal authority to detain will be from the Common Law (as derived from legal precedent).

In an extreme emergency, where time does not allow for the attendance of a psychiatrist to assist in this task, the A&E doctor's own assessment of capacity would have to suffice. Treatment may proceed where there are reasonable grounds to doubt capacity, if it is an urgent necessity, the treatment is in the patient's best interests, and the staff are acting in good faith, in line with a responsible body of medical opinion. Keep a careful written record of either why you considered that the patient was lacking in capacity to give a valid refusal, or why you concluded that they had full capacity to make a decision of grave consequence. Hospital staff have a duty of care to assist an incapacitous patient in their best interests, and could be found negligent for failing to do so.

Non-consent to assessment and treatment of mental disorder *per se* is within the remit of statutory Mental Health law.

If a young person is not consenting, it is advisable to seek advice from the childrens' services staff regarding Gillick competence. For further information, readers are directed to the British Medical Association and Law Society (1995) publication.

Box 2 To demonstrate capacity to consent or refuse medical treatment individuals should be able to:

- Understand in simple language what the medical treatment is, its purpose and nature, and why it is being proposed
- Understand its principle benefits, risks, and alternatives
- Understand in broad terms what will be the consequences of not receiving the proposed treatment
- Believe the information
- Retain the information for long enough to make an effective decision
- Make a free choice (free from pressure)

5. Personnel issues

Communication between accident and emergency department staff and mental health staff

In order to provide an effective service to patients, there must be effective communication between staff working in the two departments. There are various levels that should be addressed in order to promote good communication:

Initial contact

At an organisational level, there should be clear and explicit arrangements regarding initial contact. A single phone number is ideal, but in many districts is difficult to achieve. Many A&E departments report high levels of frustration in making the initial contact: phoning one number, being informed that it is another sector that is responsible, phoning another number and being told someone else is responsible, and so on. Such a scenario is unacceptable, and mental health services must ensure that there is an agreed procedure, which is in writing and available throughout both the A&E department and the mental health services. The referrer should only need to make one phone call.

Attendance

The mental health services should develop an operational policy regarding attendance in the A&E department. This should be developed in consultation with senior staff in the A&E department, and should be agreed by all parties. The policy should include:

- guidance about response times;
- agreement about clinical responsibilities;
- guidance about the level of seniority of mental health staff attending in different situations;
- guidance about access to information about patients already receiving input from the mental health services;
- guidance about patients with both mental health and physical health needs.

Joint working

The way in which staff from the two departments interact has an enormous bearing on the delivery of a quality service to the patient. It is not unusual for a

‘them and us’ culture to develop, with both sides feeling that they have legitimate cause for grievance against the other. In the interests of patients, it is vital that a culture of joint working is fostered. This is best characterised by the notion of clinicians from both sides looking to see how they can assist each other in managing clinical situations in the department. There is a clear responsibility for senior clinicians to be involved in developing and maintaining this culture.

Consultant sessions

A named consultant psychiatrist should have responsibility for liaising with the A&E department and for having overall responsibility for the service offered by the mental health department. The previous report advised that, for a medium-sized A&E department in a district general hospital (DGH), there should be a minimum of five consultant sessions available, to provide a service to the DGH, including the A&E department. There is no reason to alter this advice.

Liaison groups

A liaison group, consisting of senior medical and nursing staff in the two departments, as well as representatives from social services, primary care trusts, and user groups, should take responsibility for developing and reviewing the joint service. This group is described more fully in Chapter 7 of this report (‘Organisation of Services’).

Making a referral

Making a referral from the A&E department, and the way in which it is done, can set the scene as to whether the process is antagonistic or cooperative. Following the advice below will improve the chances of the process being cooperative:

- Introduce yourself by name and establish to whom you are speaking. Make a note of the name of the person.
- Establish the nature of the help you are requesting: is it advice over the phone, help in the behavioural management of a difficult patient with physical difficulties, help regarding capacity for consent, or the assessment of someone whose primary problem appears to be psychiatric.
- Give a succinct account of your findings so far. This should include an assessment of the patient’s mental state. Referrers often tell mental health staff members that the mental health assessment is the latter’s job: although this is true, it does not negate the referrer’s responsibility to have made an initial assessment. A referral to a chest physician would not take place without an attempt to examine the patient’s chest: this is an analogous situation.

- You also have a responsibility to have made an initial risk assessment. Your findings should be conveyed to your colleague.
- Establish the likely time-scale before attendance in the department is possible: it may be appropriate to receive initial advice over the phone prior to the psychiatrist attending.
- Establish what other information the psychiatrist may require, such as an account from a relative, old notes, etc.
- Remember to be polite and respectful: saying 'it's A&E, we want you down here', is a depressingly common form of referral and immediately sets the wrong tone. A good working relationship with colleagues will invariably benefit the patient.

Accepting a referral

Similar principles operate in respect of accepting a referral:

- Always make it clear who you are and your role. Establish to whom you are speaking and note their name.
- Establish what your colleague in A&E is requesting. If the patient is drunk, do not immediately refuse to attend on the grounds that a mental health assessment would be difficult. Find out why your assistance is being requested?
- Referrals from A&E often arrive in what seem to be inopportune moments. Do not sound reluctant on the phone: this will just cause problems later.
- If the referral has come to you in error, and is the responsibility of another colleague in psychiatry, offer to contact the colleague yourself rather than ask the referrer to make another phone call. They may have already been on the phone for a while before they have got through to you, and such a gesture promotes a cooperative approach.
- Inform the referrer how long you anticipate it will be before you attend. Enquire whether they want any advice regarding management during the period before you attend.
- Ask whether the referrer will be available for discussion after you have made the assessment. If they are going off shift, ask that they brief a colleague and inform you who they have briefed.
- Remember to be polite and respectful: establish a positive working relationship at an early stage.

The effect of psychiatric patients on A&E department staff

It is important to acknowledge that mental health patients may have a variety of effects on the feelings of A&E department staff. Being unaware of the feelings that a patient induces can be potentially dangerous, because the staff member

may make decisions about the patient that are determined by those feelings. The following principles apply.

- Self-harming patients frequently induce angry feelings: it is important to ensure that this anger does not interfere with the management of the patient.
- In other situations, patients may induce a feeling of fear. There may be good reason for this fear, but steps must be taken to ensure that a proper assessment is undertaken, in conditions that are as safe as possible.
- Manipulative patients may induce different feelings in different members of staff: anger in some, pity in others. This is a situation that may lead to splits in the staff group. It is important to be alert to the possibility of this occurring.
- In order to achieve effective working practices, it is important to monitor attitudes towards patients with mental health problems and to address any difficulties as they arise.
- The more confidence that A&E staff have in the support available from mental health services, the more likely that they will develop confidence in their own assessments of patients with mental health difficulties. This, in turn, will tend to have a positive effect on attitudes towards patients.

6. Working with other agencies

Social services departments

Social services departments play a pivotal role in the management of a wide variety of problems presenting to accident and emergency departments. They have specific responsibilities in a number of areas:

- Training and deploying social workers for approved social worker (ASW) duties, or the equivalent in other legislatures.
- Child protection duties.
- In many localities, social services are involved in provision of rapid-response services for elderly people who attend A&E departments, but who do not require hospital admission.
- Joint responsibility, with the health services, for managing and staffing multi-disciplinary community mental health teams, for children, adolescents, adults, and older adults.
- The provision of services for people with learning disabilities.
- The provision of, or the right of access to, residential facilities for people with enduring mental health problems, older adults, and people with learning disabilities. Such facilities may be able to offer respite care, and sometimes short-term crisis care.
- The provision of day services for people with mental health problems.
- For patients subject to the care programme approach, social services staff may frequently fulfil the role of care coordinator.
- In an increasing number of districts in Britain, social services mental health teams and health service mental health teams are being amalgamated.
- Social services will maintain their own database about their clients. Although health service staff have no direct access to these databases, social workers on call will have access to them.

Social services staff provide a round-the-clock service. In many districts, the out-of-hours service is generic, but increasingly the out-of-hours services are beginning to become more specialised, with child care teams and mental health teams in particular being identified as separate entities.

It is vital that A&E departments have a clear line of contact with the local social services department(s):

- There should be a clear, written policy about contacting the ASW. Locally, this may be the responsibility of the mental health services, but this needs to be made clear.

- The process for contacting the child protection team must be readily available and comprehensible.
- A member of social services staff should be on the liaison group (see Chapter 7, 'Organisation of services').

The role of the police

Place of safety

The Mental Health Act 1983 in England and Wales places a responsibility on health authorities and police forces to identify local places of safety. Equivalent legislation in other parts of Britain, and Ireland makes similar provision. The place of safety is not defined, and the assumption is made that the definition will be agreed locally.

The role of the A&E department will depend on the local arrangements for provision of a 'place of safety'. In some areas this is the police station, in others a hospital department, either in a psychiatric unit or an A&E department.

Failure to agree on a local definition of a place of safety leads to misunderstandings, conflict between agencies and potential risk to patients, staff and the public (Royal College of Psychiatrists, 1997)

Use of the place of safety

Constables may remove from a public place to a place of safety a person who appears to be suffering from a mental disorder, and in immediate need of care and control. They must be satisfied that it is in that person's interests to do so, or that it is necessary to do so to protect others.

They may not detain a person from their own home or any place that is not public.

Generally, the use of a place of safety is avoided where drunkenness is thought to be the cause for disturbed behaviour. Consideration is given to arrest for 'breach of the peace' or a similar offence in these circumstances. Where suicidal behaviour is present, then place of safety detention may be used and the person assessed for mental illness when sober.

The police will take straight to A&E a person who is believed to have taken an overdose.

If the police station is the place of safety

At the police station, the custody sergeant books the person in for detention in the usual way. The person is searched for weapons and drugs. Items that could be used for self-harm are removed, for example belts and shoelaces. The person's possessions are put in a labelled sealed bag and locked away. The person is told their rights. In the same way as those under arrest, they have rights such as to make a phone call, to have someone told about their detention and the right to

speak to a solicitor. If suicidal, they are put in a cell with closed-circuit television (CCTV). The person is looked up on the Police National Computer and if they have been detained on a previous occasion there will be a record with basic marker information about them relevant to custody care, 'dangerous', 'substance misuse', 'suicide' or 'mental illness'. They are put into a cell, where they will be visited regularly and offered food and drink.

A social worker is informed of the detention. In some areas, a social worker comes to the police station first and calls out doctors as necessary.

Alternatively (e.g. in Brighton) the Forensic Medical Examiner (FME) is called to make an initial assessment. This is to exclude irrational behaviour due to drink, street drugs or medical causes such as diabetes or head injury. A physical examination for fitness to be detained in a cell is also done if the person is able to cooperate. The FME tries to establish the person's date of birth and address. A psychiatric history is taken if possible or observations of the person's behaviour noted. If mental illness is the likely cause of the behaviour, the local psychiatric services or any psychiatric hospital that the person has mentioned are phoned to see if the person is known and to get any relevant history. A relative is also phoned if possible.

The social worker is informed of the result of this assessment. If it has become apparent that alcohol or drugs are involved, then a suitable time gap is agreed for a second FME assessment. If the assessment has revealed no significant mental illness, then it is possible for an agreement to be made to cancel the detention and release the person.

If the detention is to continue, the social worker usually makes arrangements to attend. A psychiatrist is also phoned, and told the reason for the detention and the outcome of the FME assessment and other enquiries. Sometimes, an urgent out-patient appointment (only for a patient already known to the psychiatrist) or informal admission are offered by the psychiatrist. These offers are relayed to the patient and may result in transfer to the psychiatric hospital, the social worker accompanying the patient for an admission. In more serious cases, the psychiatrist comes to the police station to make a psychiatric assessment, the social worker also assessing the patient with a view to a decision about a formal admission under the relevant section of the Mental Health Act 1983.

Other places of safety

Where the place of safety is an A&E department, an overdose is suspected or an injury requiring treatment is present, the person will be taken to the A&E department. A similar process to the above should occur to ensure the person's safety and to allow a medical assessment. Local agreements should include statements about the continued presence of police officers until the assessment is completed.

If the place of safety is situated in the psychiatric unit, there should be agreed arrangements with the A&E department regarding the physical care of any patients in the place of safety, in particular if the patient should prove to have an organic condition.

The local agreement should specify when the place of safety should be used and when the patient should be conveyed to the police station. For instance, many local agreements state that the place of safety can be used in all instances except when there is violence or when there is evidence of a serious offence having been committed. Local agreements should also be clear about the response to drunkenness.

Other roles of the police

The police, like any emergency service, have a role in providing information that may be of assistance in the assessment of the patient. This might include:

- where the patient was found;
- what the patient was doing;
- what else was found, e.g. empty packets of tablets, a knife;
- what the patient said.

Other roles for the police include providing assistance should there be a violent incident. The intervention of the police at such incidents may be at three different levels:

1. providing a presence to support staff in making an assessment of a violent individual;
2. conveying an individual, or individuals, off the premises;
3. making an arrest.

Staff are often dismayed at how infrequently the police make an arrest if there has been an incident in A&E; however, the police require proof that a significant offence has taken place. This usually means that sufficient numbers of staff have witnessed the incident, and are prepared to make statements and give evidence. In practice, staff are often reluctant to make statements to the police. Common reasons cited for this include the time needed to make a statement, fear of reprisals from the patient or others, and fear of breaching confidentiality.

Recommendations

The following are suggestions that should be taken into consideration when agreeing local plans for a place of safety:

- The plans need to be agreed between the mental health services, the police, the local A&E department and social services. It is good practice also to involve local patient groups.
- If the agreed place of safety is not a police station, agreement must be reached regarding the response if there is a threat of, or actual, aggression or violence, and also when there is reason to believe that a serious offence may have been committed. In these circumstances, it is common for the police station to be used as the place of safety.

- Taking someone who appears to have a mental health problem to the local psychiatric ward is about as appropriate as taking anyone with chest pain direct to the coronary care unit. The use of the local psychiatric facility as a place of safety should only be given serious consideration if a properly staffed assessment unit is available.
- A proportion of people detained under place of safety orders will prove to be suffering from physical disorders (e.g. hypoglycaemia, confusional states). The ability to recognise such states, and to respond to them appropriately, must be available in the agreed place of safety.
- Wherever the place of safety is situated, there must be contingency plans to ensure the safety of staff and patient.
- Police forces generally cover a much wider area compared with local mental health services, or indeed A&E departments. Individual officers are often moved from district to district within their force area. If different place of safety policies exist in different districts within a force area, there is considerable scope for confusion and misunderstandings. If possible, common policies across the area covered by a police force are preferable.
- Any local agreement should include clear statements about the responsibilities of the different participants. Where the place of safety is not a police station, this should include an agreement that the police must remain in attendance until decisions have been reached regarding what should happen to the patient.

Liaison with the ambulance service

The ambulance service necessarily has a close working relationship with the A&E department. Paramedics and ambulance crew are frequently an invaluable source of information about the patient, and the circumstances in which he/she was found. Sometimes overlooked is the need to rely on the ambulance service once the mental health team has assessed the patient. If the decision has been taken to admit the patient to a mental health in-patient unit, the ambulance service may be requested to provide transport. Such a request is often accorded low priority, leading to potential problems in the A&E department. In addition, the ambulance service may, reasonably, request that the patient has an escort, which is often difficult to provide.

Recommendations

- A local agreement regarding the provision of ambulance services from A&E to other local facilities is recommended.
- The liaison group should endeavour to develop a policy for the provision of escorts in ambulances.

Liaison with the coroner

A&E departments should have clearly defined links with the Coroner's Office (or equivalent). One per cent of patients who deliberately harm themselves will go on to commit suicide within a year. Many patients who commit suicide will have a history of deliberate self-harm, and may have attended their local A&E department in the weeks or months before their death. As part of a coroner's investigation he/she may wish to piece together the health care of an individual in the months leading up to a suicide. Information about previous A&E attendances may be important in this regard.

In order to provide this information, A&E departments should have an Information Technology system in place that allows retrieval of patient information.

There should be a clearly defined route for informing the coroner about deaths that have occurred in the department as a result of suspicious circumstances or where deliberate self-harm is suspected. In some cases, this may be by direct contact with the coroner's office, while in others the reporting may be done by a hospital registrar's office.

In the event of an inquest being held, advance notice needs to be given to A&E staff, who will need to ensure that departmental rosters are altered accordingly and suitable cover is in place for the department for the duration of the inquest. The role of the inquest is to establish the cause of death. It is therefore important that the role of witness is approached with the idea of assisting the court, rather than in a defensive manner.

On occasions, particularly after a critical incident with adverse consequences, a coroner may make suggestions that something needs to be done to prevent a recurrence of an event. This may have implications for the A&E department, either directly or indirectly. The coroner can draw attention to this publicly, and will usually write to someone in authority about it, for example the council, a Government department or the hospital trust. Senior staff in A&E departments and hospital management need to be aware of any recommendations made by a coroner so that appropriate action can be taken. Accident and emergency staff may on occasions need to work closely with their hospital press office to prepare an appropriate response.

7. Organisation of services

Introduction

How services are organised will depend greatly on local conditions, local need, and the configuration of other agencies and other departments in the area. Many principles regarding the delivery of services are, however, common to all departments, and it is the intention in this section of the report to discuss these principles.

Personnel requirements

Accident and emergency personnel

- A&E department personnel should have adequate knowledge of mental health issues, and feel confident in making an initial assessment of people with mental health problems.
- Triage nurses should have training, and continued supervision, in the assessment of people with mental health difficulties.
- A&E doctors should have had sufficient training so that they feel confident in making a mental health assessment and in making a referral.
- A&E staff may at times resent people with mental health problems attending the department. Frequently this resentment arises because of uncertainty about how to manage such patients: a good working relationship with the mental health service staff is therefore essential. However this resentment arises, it is important that it is recognised and the underlying causes addressed. Continued resentment may lead to this vulnerable group of patients being subject to subconscious discrimination.
- Many departments find that it useful to identify nursing and medical staff who take a lead in the initial management of mental health patients and who liaise particularly closely with mental health staff.

Mental health personnel

- A consultant psychiatrist should be named as the senior member of staff in the local mental health services responsible for liaison with the A&E department.
- The first point of contact from the mental health services might either be an experienced mental health nurse or a junior doctor.

- It is advised that, where possible, mental health nurses should provide a first point of contact from mental health services. Where such professionals are employed they generally develop a close working relationship with the A&E department, and have a role in training and staff support. It is the experience in most districts that the system works more smoothly if the nurses remain part of the mental health services.
- Psychiatrists, who must be available to provide input when requested, must back up such a service.
- Whether mental health nurses are available or not, there should be clear and unambiguous arrangements regarding support and input from junior and senior psychiatric staff.
- There must also be clear arrangements for the support and supervision of mental health staff attending the A&E department.
- There must be clear and unambiguous arrangements regarding how to contact mental health staff. These arrangements should be followed, and any changes in the arrangements should only be implemented following full consultation. Staff members should be fully informed prior to any changes in contact arrangements.
- All the arrangements detailed above should be contained in a written policy agreed by both A&E and mental health staff.
- There should also be agreed arrangements regarding the assistance from local childrens' services.
- There should be locally agreed standards regarding the attendance times of mental health staff, for both initial attendance and the attendance of senior staff. The attendance arrangements regarding the assessment of patients for possible detention should also be clear.

When setting agreed targets for attendance times in A&E departments, various factors should be taken into account:

- The requirement that 90% of patients should be discharged from an A&E department within 4 hours.
- What is practicable?
- What is unacceptable?
- What is desirable?
- Is the A&E department designated as a place of safety?
- Our advice is that districts should work towards ideal response times, although it is accepted that these can not be achieved immediately in many areas:

	Urban areas	Rural areas
First-line attendance	30 minutes from being called	90 minutes from being called
Section 12-Approved doctor attendance	60 minutes from being called	120 minutes from being called

- If the A&E department is designated a place of safety, the attendance of a senior psychiatrist, who is able to conduct an assessment under the Mental Health Act 1983, should be guaranteed within a reasonable time. It is suggested that this should be no greater than 60 minutes. This is an important consideration in deciding whether the A&E department should be designated as a place of safety.
- The closer the working relationship between the two services, the broader the scope of the input of the mental health services is likely to be. Demand on staff must therefore be kept under review.

Personnel from other services

- Social services staff are a key group involved in providing services to people with mental health problems.
- There should be clear and unambiguous arrangements regarding the attendance of social workers in A&E departments. If possible, agreed standards should be in place regarding maximum attendance times, particularly when assessments for detention are required. This is particularly true in situations where the A&E department is the agreed 'place of safety'.
- In areas where there are mental health workers in primary care, it may be important to develop agreed practises with this group.
- Other groups of workers who may play a significant role include paramedics, general practitioners, probation officers, prison staff, the police and staff at local colleges.

Commissioning of services

- The optimum cooperation between A&E services and mental health services will require additional resources in most districts.
- There is a tendency for this important aspect of service delivery to be overlooked in negotiations with service commissioners: acute services and mental health services tend to concentrate on other aspects of service delivery, and there is a tendency to assume that 'someone else' will address this issue (and also provide the funds).
- There is a joint responsibility for commissioners, mental health service managers and acute service managers to ensure that the input of mental health services to A&E departments is not overlooked in negotiations.
- There is a potential role for the liaison group (see below) to take a lead in these issues.

Other resources

- Locally agreed systems should be developed in order to identify at-risk patients.

- Once patients have been identified, agreed systems to alert clinicians in A&E and other emergency settings should be in place.
- Inter-trust and inter-agency communication is an often neglected area, but is vital in situations where A&E departments must be able to work effectively with other teams. It is therefore essential that this area have adequate resources, in terms of personnel time and materials. It may be that two or more institutions have to come to a mutual agreement regarding their responsibilities in allocating resources.

Medical records, databases and information technology

- Rapid access to a patient's medical records is essential in order to provide a safe and effective service.
- In districts served by more than one secondary care trust, it is advised that arrangements be established to allow the access of information from a patient's notes.
- Mental health and acute trusts often have different electronic databases. Access to both of these should be available in the A&E department.
- Now that most trusts have an electronic database with patient information, it is important to establish local procedures concerning the access of this information from the A&E department. These arrangements will have to comply with the Data Protection Act 1998 or equivalent legislation.
- Databases should be set up in order to facilitate collection of data for audit.

Training

- The establishment of ongoing training programmes for both A&E department and mental health staff is essential.
- These programmes have to take into account both predictable changes in staff (e.g. junior doctors' rotations) and less predictable changes in staff (e.g. the steady turnover of nursing staff).
- Mental health problems should form part of the training of staff involved in triage.
- Mental health staff training should include training from A&E department staff regarding what is helpful. Conversely, A&E department staff require training from the mental health staff about what is practicable.
- A&E department staff training should include the recognition of common mental health problems and the appropriate responses to that recognition.
- Common training initiatives involving both staff groups not only address training issues, but can also lead to major operational benefits.
- In districts where there are A&E liaison nurses, attention must be paid to the need for psychiatrists in training to gain experience in A&E departments. There can be a tendency for psychiatrists in training to miss

a vital component of their training. The presence of experienced nursing staff offers the opportunity for useful training experiences, including joint assessment. Arrangements should therefore be in place to allow joint working between the psychiatrists in training and the liaison nurses.

- A clear supervision structure should be in place for all mental health staff involved in liaison work with A&E departments. This should have two components: regular supervision sessions, and the ability to discuss cases urgently. Access to senior staff is vital, and there should be the facility for senior staff to attend when necessary. A service without reliable backup from senior staff does not constitute a valid training experience.
- Staff should be given training in accessing and using databases and should have access to IT support.

Care pathways

- The development of local agreements regarding care pathways is a very useful device in order to establish an understanding of available services.
- Agreed care pathways reduce the potential for misunderstanding between services.
- Local care pathways must be known, utilised, and understood by clinicians in order for them to be effective.

Care plans

- Many patients under the care of community mental health teams (CMHTs; see Glossary) might be identified as being likely to present to the local A&E department. In these circumstances the agreed care plan should be made available in the A&E department.
- Local arrangements should therefore be in place to remind CMHT members to inform A&E departments, involve A&E staff in care planning meetings where appropriate, and to ensure easy access to a copy of the care plan whenever this is needed.
- Consideration should be given for the development of a care plan for certain frequent attenders. Many of these patients may well not be under the care of local mental health services.

Safety

- The design of the A&E department must ensure that staff and patient safety is a prime consideration.
- Interview rooms should allow for privacy to be maintained, but should also include standard safety features (panic button, two exit routes, furniture and fittings that cannot be used as offensive weapons).
- Staff training should include safety issues.

- Training should involve breakaway techniques. Breakaway courses should be attended at least every 3 years.
- Although all patients have a right to services, staff members also have a right not to be assaulted. It is therefore a sensible precaution for staff to have prior warning about patients known to pose a risk of violence, in order to ensure that the patient is attended in conditions that keep the risk to staff at a minimum.
- Swift access to case records therefore becomes an important safety issue, as does the practice of recording warnings about propensity for violence in prominent places in the case notes.
- A further safety issue for staff is the rise in the number of allegations about staff behaviour, which subsequently prove to be unfounded. Such allegations may arise as a result of a psychotic state, in association with a confusional state, or as a result of malice. Awareness of the possibility of such problems should be included in training, and in the writing of local policies.
- Staff safety is likely to be compromised if individuals, and departments, are overworked.
- Although technology (such as CCTV) can be of assistance in improving safety, it should only be employed in association with the implementation of good practice. It should never be seen as a substitute for safe practices.
- A jointly agreed and understood protocol for the reporting of untoward incidents should be in place. This will only work if the culture allows staff to feel comfortable about reporting incidents without prejudice.
- Reporting incidents should be linked to a structure that allows learning to take place, and adaptation of practices as a result of incidents.
- Every A&E department should have an interview room for psychiatric consultations. Larger A&E departments should have two rooms because of the frequent need to house more than one patient at a time. If a patient is undergoing an assessment for statutory detention, he or she may need to be in the room for some considerable time, hence the need for a 'reserve' room.
- Each patient should be interviewed in a setting that accords with privacy, confidentiality and respect.
- The room should be close to or part of the main A&E receiving area. It should not be isolated. It should be well lit, preferably by daylight, and be decorated in calming colours. There should be adequate space for up to six people to sit and move about (in departments with a second room, this room may be smaller: room for 4 people would be sufficient). NHS Estates guidance stipulates that the room should have a minimum floor area of 12 m². It is desirable to keep the atmosphere informal, with comfortable easy chairs upholstered in washable fabric. The traditional desk might be replaced by a coffee table. Ideally there should be a sofa,

or similar, in the room. This offers an opportunity to help settle an agitated patient, as being able to lie down may have a calming effect.

- The cooperation of disturbed patients is sometimes only possible if they are allowed to smoke.
- For the safety of staff, the room should have two doors, and the doors to the room should open outwards and not be lockable from the inside. The room should have an observation window. There should be a telephone with access to an outside line and a 'panic button', with connection to staff nearby or another suitable security system.
- Furniture and fittings should be selected so that they are not likely to be used as weapons (i.e. not able to be thrown or used as clubs). A closed-circuit television (CCTV) security system is an additional safeguard. The temptation to use the room as a store for equipment should be actively discouraged.
- Staff interviewing a patient in this room should *always* inform a senior member of the A&E nursing staff before commencing the interview.
- There should be agreed procedures regarding chaperones: the presence of a chaperone should be regarded as the norm, and interviews without chaperones should only proceed after discussion with relevant staff. It should be a conscious and a consensus decision.
- Department procedures should also include guidance on regular checks via the observation window while the interview is taking place (e.g. every 5 minutes).
- In some centres, the recent provision of a 'detoxification room' in A&E has enabled people intoxicated by drugs to be treated and nursed in a safe, secure environment over a short period of time.

Liaison with other services

The proper assessment of a patient with mental health problems in the A&E department may require the cooperation of many different agencies. Within the health service, various services may already be involved in the care of the patient, and may be able to provide valuable information:

- primary care
- sector mental health teams
- assertive outreach teams
- in-patient psychiatric wards
- psychiatric rehabilitation teams
- chronic illness or disability teams, if the patient has a physical condition as well as a mental health problem
- other A&E departments.

Other services outside the health service may also be involved:

- social services' mental health teams
- other social service teams

- the ambulance service
- the police
- the probation service
- non-statutory organisations (e.g. voluntary bodies).

The assessment may require information from any of these organisations. In liaising with these other services, a number of principles should be applied:

- Make it explicit what level of assistance is being requested. Is it information only, advice about immediate management, advice about 'disposal', assistance with management?
- Take note of any specific advice from anyone who knows the patient well: it is likely to be pertinent.
- Always remember to whom you are speaking: do not breach confidentiality by discussing privileged information to anyone who should not be party to that information.

Staff stress and staff support

- Stress prevention and management plans should be part of the operational policy for the department. Clerical staff also have direct patient contact, and should not be forgotten when these plans are drawn up.
- 'Burn out' is a significant factor in the management of both A&E staff and mental health teams, and active policies should be developed to prevent it occurring.
- Psychological effects experienced by staff should be a component of all major incident plans.

Assessment tools

- Psychiatric screening questionnaires and rating scales may be used in the accident and emergency department to detect psychiatric disorder or to assess the severity of a condition. Examples are shown in Box 3.
- Evidence indicates that the routine use of such scales does not influence clinicians' subsequent management (Gilbody *et al*, 2001). However, they can form part of an interview, providing prompts for further questioning. Undue reliance should not be placed on individual scores. Instead they should be interpreted in the light of further enquiry that places the findings in a wider context. For example, the Suicidal Intent Scale can supplement the assessment of deliberate self-harm, including mental state examination and a psychosocial history.
- Staff should receive education in the administration and interpretation of scales used. This should include guidelines for the referral of detected problems that require specialist assessment.

Box 3 Psychiatric instruments that may be used in the accident and emergency department

- CAGE Questionnaire (Mayfield *et al*, 1974):
a screening questionnaire for alcohol problems.
- alcohol Use Disorders Identification Test (AUDIT) (Saunders *et al*, 1993):
a screening questionnaire for alcohol problems.
- Mini-Mental State (Folstein *et al*, 1975):
a screening questionnaire for cognitive impairment.
- Suicidal Intent Scale (Hawton, 1989):
assessment of suicide risk following deliberate self-harm.
- Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983):
a rating scale for measuring symptoms of anxiety and depression in the general hospital.

Liaison group

- The establishment of a liaison group is highly recommended.
- The remit of this would be to ensure that the above guidance is implemented. The group should include: consultant emergency physician, consultant psychiatrist, A&E nursing staff, mental health nursing staff, Social Services staff, user representation, primary care representation.
- Responsibilities should include: the monitoring of operational policies; the establishment of training policies; the audit of standards; and the identification of, and response to, problems.
- The personnel in this group may well be very similar to the personnel in the group responsible for the deliberate self-harm service. There may therefore be compelling arguments to amalgamate these groups; this would be reasonable provided that all responsibilities could be fulfilled by the group.
- The responsibilities of this group should be recognised by the relevant trust boards.
- The group may also be required to take responsibility for the development and monitoring of local policies for places of safety.
- The group should meet on a regular basis. A minimum frequency of three times a year is recommended, though in practice such groups tend to find that there is sufficient reason to meet more frequently.
- The trusts participating in the running of the group should ensure that there is a recognised link between the liaison group and the commissioners of services.
- Maintaining and improving resources is likely to be a major concern of this group. Dialogue with primary care will therefore be a priority; particularly in the health care systems in which commissioning of services is increasingly being devolved to primary care.

8. Summary of recommendations

Clinical

- Local policies should be agreed regarding the following clinical situations in A&E:
 - management of deliberate self-harm;
 - management of delirium tremens;
 - management of substance misusers;
 - sedation guidelines;
 - prescription of psychotropic medication;
 - management of patients with factitious disorders;
 - management of older people;
 - management of children and adolescents, and agreed procedures in getting expert advice;
 - management of frequent attenders.
- Local policies should include procedures to enable rapid access to patient information: if case notes cannot be made available, access to databases should have high priority.
- There should be agreed procedures regarding the access to the care plan of people subject to enhanced CPA.

Ethnic minorities

- There should be local policies regarding communication with people who have problems communicating in English. These policies must include the easy access to interpreting services. Interpreters should have training regarding the needs of both patients and staff during the interview process.
- It is not good practice to rely on a family member to interpret.
- An awareness about the customs and beliefs of the main minority communities in a district is a professional responsibility.
- A calendar showing the main religious festivals should be displayed in a prominent position in the A&E department.

Accident and emergency personnel

- A&E department personnel should have adequate knowledge of mental health issues, and feel confident in making an initial assessment of people with mental health problems.

- Triage nurses should have training, and continued supervision, in the assessment of people with mental health difficulties.
- A&E doctors should have had sufficient training so that they feel confident in making a mental health assessment and in making a referral.

Mental health personnel

- A consultant psychiatrist should be named as the senior member of staff in the local mental health services responsible for liaison with the A&E department.
- The first point of contact from the mental health services may be either an experienced mental health nurse, or a junior doctor.
- Whether mental health nurses are available or not, there should be clear and unambiguous arrangements regarding the support and input from junior and senior psychiatric staff.
- There should be an agreed policy regarding the attendance of mental health staff in the A&E department.
- There should be locally agreed standards regarding the attendance times of mental health staff, for both initial attendance and the attendance of senior staff. The attendance arrangements regarding the assessment of patients for possible detention should also be clear.
- Suggested target times for attendance:

	Urban areas	Rural areas
First-line attendance	30 minutes from being called	90 minutes from being called
Section 12-Approved doctor attendance	60 minutes from being called	120 minutes from being called

- If the A&E department is designated a place of safety, the attendance of a senior psychiatrist, who is able to conduct an assessment under the Mental Health Act 1983, and an approved social worker, should be guaranteed within a reasonable time. It is suggested that this should be no longer than 60 minutes. This is an important consideration in deciding whether the A&E department should be designated as a place of safety.

Personnel from other services

- There should be clear and unambiguous arrangements regarding the attendance of social workers in A&E departments. If possible, agreed standards should be in place regarding maximum attendance times, particularly when assessments for detention are required. This is

particularly true in situations where the A&E department is the agreed 'place of safety'.

Commissioning of services

- There is a joint responsibility for commissioners, mental health service managers and acute service managers to ensure that the input of mental health services to A&E departments is not overlooked in negotiations.

Medical records

- Rapid access to a patient's medical records is essential in order to provide a safe and effective service.
- In districts served by more than one secondary care trust, it is advised that arrangements be established to allow the access of information from a patient's notes.

Training

- Mental health problems should form part of the training of staff involved in triage.
- Mental health staff training should include training from A&E department staff regarding what is helpful. Conversely, A&E department staff require training from the mental health staff about what is practicable.
- A&E department staff training should include the recognition of common mental health problems, and the appropriate responses to that recognition.
- Common training initiatives involving both staff groups address not only training issues, but also can lead to major operational benefits.
- In districts where there are A&E liaison nurses, attention must be paid to the need for psychiatrists in training to gain experience in A&E departments. There can be a tendency for psychiatrists in training to miss a vital component of their training. The presence of experienced nursing staff offers the opportunity for useful training experiences, including joint assessment. Arrangements should therefore be in place to allow joint working between the psychiatrists in training and the liaison nurses.
- A clear supervision structure should be in place for all mental health staff involved in liaison work with A&E departments. This should have two components: regular supervision sessions, and the ability to discuss cases urgently. Access to senior staff is vital, and there should be the facility for senior staff to attend when necessary. A service without reliable backup from senior staff does not constitute a valid training experience.

Care plans

- Many patients under the care of community mental health teams might be identified as being likely to present to the local A&E department. In these circumstances the agreed care plan should be made available in the A&E department.
- Local arrangements should therefore be in place to remind CMHT members to inform A&E departments, involve A&E staff in care planning meetings where appropriate, and to ensure easy access to a copy of the care plan whenever this is needed.
- Consideration should be given to the development of a care plan for certain frequent attenders. Many of these patients may well not be under the care of local mental health services.

Safety

- Interview rooms should allow for privacy to be maintained, but should also include standard safety features (panic button, two exit routes, furniture and fittings that cannot be used as offensive weapons).
- Staff training should include safety issues.
- Training should involve breakaway techniques. Breakaway courses should be attended at least every 3 years.
- Although all patients have a right to services, staff members also have a right not to be assaulted. It is therefore a sensible precaution for staff to have prior warning about patients known to pose a risk of violence, in order to ensure that such patients are attended in conditions that keep the risk to staff at a minimum.
- Swift access to case records therefore becomes an important safety issue, as does the practice of recording warnings about propensity for violence in prominent places in the casenotes.
- Staff safety is likely to be compromised if individuals, and departments, are overworked.
- Although technology (such as CCTV) can be of assistance in improving safety, it should only be employed in association with the implementation of good practice. It should never be seen as a substitute for safe practices.
- A jointly agreed and understood protocol for the reporting of untoward incidents should be in place. This will only work if the culture allows staff to feel comfortable about reporting incidents without prejudice.
- Reporting incidents should be linked to a structure that allows learning to take place, and adaptation of practices as a result of incidents.
- Every A&E department should have an interview room for psychiatric consultations. Larger A&E departments should have two rooms, because of the frequent need to house more than one patient at a time. If a patient

is undergoing an assessment for statutory detention, he or she may need to be in the room for some considerable time, hence the need for a 'reserve' room.

- Each patient should be interviewed in a setting that accords with privacy, confidentiality and respect.
- The room should be close to or part of the main A&E receiving area. It should not be isolated. It should be well lit, preferably by daylight, and be decorated in calming colours. There should be adequate space for up to six people to sit and move about (in departments with a second room, this room may be smaller: room for 4 people would be sufficient). NHS Estates guidance stipulates that the room should have a minimum floor area of 12m². It is desirable to keep the atmosphere informal, with comfortable easy chairs upholstered in washable fabric. The traditional desk might be replaced by a coffee table. Ideally there should be a sofa, or similar, in the room. This offers an opportunity to help settle an agitated patient, as being able to lie down may have a calming effect.
- The cooperation of disturbed patients is sometimes only possible if they are allowed to smoke.
- For the safety of staff, the room should have two doors, and the doors to the room should open outwards and not be lockable from the inside. The room should have an observation window. There should be a telephone with access to an outside line, and a 'panic button', with connection to staff nearby or another suitable security system.
- Furniture and fittings should be selected so that they are not likely to be used as weapons (i.e. not able to be thrown or used as clubs). A CCTV security system is an additional safeguard. The temptation to use the room as a store for equipment should be actively discouraged.
- Staff interviewing a patient in this room should always inform a senior member of the A&E nursing staff before commencing the interview.
- There should be agreed procedures regarding chaperones: the presence of a chaperone should be regarded as the norm, and interviews without chaperones should only proceed after discussion with relevant staff. It should be a conscious and a consensus decision.
- Department procedures should also include guidance on regular checks via the observation window while the interview is taking place (e.g. every 5 minutes).
- In some centres the recent provision of a 'detoxification room' in A&E has enabled people intoxicated by drugs to be treated and nursed in a safe, secure environment, over a short period of time.

Staff stress and staff support

- Stress prevention and management plans should be part of the operational policy for the department. Clerical staff also have direct

patient contact, and should not be forgotten when these plans are drawn up.

- 'Burn-out' is a significant factor in the management of both A&E staff and mental health teams, and active policies should be developed to prevent it occurring.
- Psychological effects experienced by staff should be a component of all major incident plans.

Liaison group

- The remit of this group would be to ensure that the above guidance is implemented. The group should include: consultant emergency physician, consultant psychiatrist, A&E nursing staff, mental health nursing staff, Social Services staff, user representation, primary care representation.
- Responsibilities should include the monitoring of operational policies; establishment of training policies; audit of standards; identification of, and response to, problems.
- The personnel in this group may well be very similar to the personnel in the group responsible for the deliberate self-harm service. There may, therefore, be compelling arguments to amalgamate these groups; this would be reasonable provided that all responsibilities can be fulfilled by the group.
- The responsibilities of this group should be recognised by the relevant trust boards.
- The group may also be required to take responsibility for the development and monitoring of local policies for places of safety.
- The group should meet on a regular basis. A minimum frequency of three times a year is recommended, though in practice such groups tend to find that there is sufficient reason to meet more frequently.
- The trusts participating in the running of the group should ensure that there is a recognised link between the liaison group and the commissioners of services.
- Maintaining and improving resources is likely to be a major concern of this group. Dialogue with primary care will therefore be a priority, particularly in the health care systems in which commissioning of services is increasingly being devolved to primary care.

Appendix 1. Mental health legislation

The Mental Health Act 1983 (England and Wales)

[Extract from: *The Psychological Care of Medical Patients. A practical guide*. Report of a joint working party of the Royal College of Physicians and the Royal College of Psychiatrists, 2nd edn, 2003]

The remit of the Act

The Mental Health Act 1983 (MHA) allows for the legal detention and treatment of persons with mental illness, mental impairment and psychopathic disorder where admission is considered necessary in the interest of their health or safety, or for the protection of others, and where they are unable or unwilling to consent to such admission. The MHA does not apply to the detention and treatment of patients for physical illness, for which they must give informed consent, or be treated under common law. In legal terms it is an 'enabling' Act, which means it need not be used in all possible instances of the above, but its use provides certain legal safeguards for patients and for staff responsible for the patients subject to the MHA. Although any mental disorder can fall within the remit of the MHA, in practice there are common circumstances where restraint and treatment are applied without recourse to the Act. In these situations, the actions performed (if carried out without the real consent of the patient) can only be defended if within the scope of the common law.

In Section 1 of the MHA, mental disorder is defined very broadly: s1 (2) states:

'mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and 'mentally disordered' shall be construed accordingly...

and hence this may include temporary states of mental disturbance such as delirium and intoxication (subject to exclusion under s1 (3) of the Act – see below), as well as more prolonged conditions such as dementia and brain damage. Use of the MHA would be unusual in these conditions in general acute psychiatric practice with the exception of drug-induced psychosis, whereas in general hospital psychiatric practice the MHA is more likely to be temporarily applied to patients with organic brain disorders in circumstances of risk to self or others. It should be noted in particular that someone who is intoxicated with alcohol or drugs may legitimately be subject to the MHA provided there are grounds for intervention other than alcohol or drug addiction alone. (s1 (3) states that the Act cannot be applied to persons by 'reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs').

The use of the Act enables patients to be detained in hospital and to be treated, against their will, only for their mental disorder. It does not sanction treatment for physical disorders unconnected to the mental disorder, even where the patient is unable or unwilling to give consent. In such cases, practitioners would have to look to other authorities such as common law or a declaration by the courts, and the Trust would normally be expected to take legal advice (Mental Health Act Commission, Guidance Note GN1, 2001).

Use of the medical holding order

Section 5(2) of the Mental Health Act 1983 contains a short-term holding order for 72 hours that may be used to detain an existing hospital in-patient. However, it may not be used in an accident and emergency (A&E) department, which is regarded as an out-patient setting. Someone who is not already a hospital in-patient may only be detained under MHA Sections 2, 3 or 4. Where an A&E department has an associated ward, MHA Section 5(2) may be applied to patients who have already been admitted to it.

Unlike patients detained under MHA Sections 2, 3 or 4, those held under MHA section 5(2) may not be transferred to another hospital using the authority of the MHA (in a real medical emergency transfer could still be done under the authority of the common law) and there are no powers to treat without consent. A 6-hour holding order is available under MHA Section 5(4), but it may only be used by a registered mental nurse in the case of a patient already admitted for the treatment of mental disorder, so it is unlikely to be used in a general hospital.

The MHA Section 5(2) power may be used by the registered medical practitioner (RMP) in charge of the patients' care. Once a psychiatrist is involved in a patient's care, it is desirable that he/she becomes the RMP for the purposes of the MHA. Once the patient is detained on a Section 2 or 3, the consultant has the title 'responsible medical officer' ('RMO'), and is the consultant in charge of the patient.

In general hospitals, the initials 'RMO' are frequently applied to the resident medical officer, who is usually only of senior house officer grade. It is therefore very important to be clear that, where the term 'RMO' is used in connection with the MHA, it always denotes the consultant with medical responsibility for the case.

The MHA permits the RMO to nominate a deputy, who must be a registered medical practitioner (and not, therefore, a pre-registration house officer). Therefore, a consultant physician or surgeon may nominate his/her own junior as a deputy for the purposes of the MHA Section 5(2). However, it is not a good practice for junior physicians or surgeons to be left to invoke the powers of Section 5(2) when they and their seniors are unclear about the precise nature and scope of the powers. An audit carried out at Leeds demonstrated various failings in the use of Section 5(2) when it was left to physicians to invoke the power (Buller *et al*, 1996).

The Code of Practice on the use of the MHA (Department of Health and Welsh Office, 1999) states that an RMO who is not a psychiatrist should make immediate contact with a psychiatrist when he/she has made use of his/her MHA Section 5(2) power.

The Mental Health Act Commission has issued further guidance on this point for general hospitals as follows:

It is good practice for general hospitals to have a service level agreement in place which allows the care and treatment for the mental disorder to be given under the direction of a consultant psychiatrist from a psychiatric unit. Where such good practice is adhered to, the consultant psychiatrist who takes responsibility for the treatment of the mental disorder that has led to detention should be considered to be RMO for the purposes of the Act.

If a non-psychiatrist does assume responsibility as RMO, he or she should ensure that all relevant staff are aware of the implications of s5 of the Act, which deals with consent to treatment.

Guidance can be found in Chapters 15 and 16 of the Code of Practice (Mental Health Act Commission Guidance, Note GN1/2001, September 2001).

Assessment and treatment orders

A patient in an A&E department who needs to be detained under the MHA would generally be placed under a Section 2 (28-day order) or Section 3 (6-months treatment order). Both require two medical recommendations, one of which must be from an approved psychiatrist, and an approved social worker to make the application. The emergency order for 72 hours (s4), which needs only one registered medical practitioner to make the recommendation, still requires the approved social worker and may take as long to complete as a Section 2, though this may not be the case in rural areas. Completing all formalities may take several hours and the patient is detained under common law powers until such time as the managers have received the papers. Patients can be conveyed to other hospitals on Sections 2, 3 and 4.

The use of the place of safety order and the role of the police

Section 136 of the MHA empowers a police constable to detain and take to a place of safety someone found in a public place who appears to be suffering from a mental disorder. It may not be used as an emergency admission section. Its purpose is to enable someone to be assessed in safety for possible admission under the MHA. There are no statutory documents covering the MHA, Section 136 power, but many NHS trusts and police forces have developed their own forms to record its use.

A person should only be brought to hospital under MHA Section 136 if the hospital has been designated for that purpose. In fact, in many areas it is the police station or a special area in a psychiatric unit that is a designated place of safety. Accident and Emergency departments are often ill equipped for use as a

place of safety. They may be unsuited to receive people with severe mental disturbance, and their use for that purpose may put others at great risk. In any locality, the places of safety that may be used under MHA Section 136 should be agreed between NHS trusts responsible for general non-psychiatric hospitals, those that provide psychiatric services, and the police. In addition, the police should be invited to state in what circumstances they would assist in the removal of dangerous persons, and what they would do to assist hospital staff in circumstances where they have brought a dangerous person to a general hospital for medical assessment and/or care that is not possible elsewhere. Police should use the A&E department for the patient if they believe this is necessary for medical reasons (e.g. the patient is bleeding profusely).

Managerial arrangements for the Mental Health Act 1983

Where an NHS trust does not normally provide in-patient psychiatric services, it may wish to make arrangements for any MHA functions to be performed on its behalf by an NHS trust that does provide in-patient psychiatric services. This will be particularly so for the receipt, scrutiny and, if necessary, rectification of the admission papers, and where the two NHS trusts share the same hospital site. However, even where one NHS trust delegates its functions in this way, it will remain responsible for their performance.

Where staff of a non-psychiatric NHS trust may need to perform some MHA functions, it is important that they receive specialist training in that regard and that their performance of those functions is subject to regular, specialist review.

Non-psychiatric NHS trusts should consider issuing guidance to their clinical and security staff about the measures that may be taken, and those that are prohibited, in respect of patients who are incapable of consenting to medical treatment. Guidance will need regular review to keep abreast of changes in the law. To ensure its application, trusts should provide appropriate training for staff. For further information, readers are referred to the Mental Health Act Commission (2001) Guidance Note GN1.

Use of the Mental Treatment Act 1945 in the accident & emergency department in Ireland

The involuntary detention of a person for psychiatric care and treatment is governed by the Mental Treatment Act 1945. This Act is due to be superseded by the new Mental Health Act, although this is not yet in effect.

At present, a person can be detained in hospital if he/she is suffering from a mental illness, is believed to require not more than 6 months suitable treatment for his recovery and is unfit on account of his/her mental state for treatment as a voluntary patient (defined under the 1945 Act as a person who submits voluntarily for treatment). In addition, the 1945 Act allows for the involuntary detention of a

person who is an addict and is believed to require at least 6 months preventive and curative treatment for recovery.

In practice, involuntary detention occurs if the person has a mental illness and is an immediate danger to himself/herself or others and is not willing or not capable of making the decision to enter hospital voluntarily. The Act is not used for the treatment of alcohol abuse, drug abuse, dementia, learning disability or personality disorder unless mental illness is suspected.

A person may also be detained in hospital as a person of unsound mind. The Act defines this as a person who is in need of care and treatment and is unlikely to recover within 6 months, who is not under proper care or is neglected or cruelly treated, or who for public safety or the safety of the person himself/herself, it is necessary to place under care and control.

In practice, a person is rarely admitted from an A&E department as a person of unsound mind.

The Act sets out in detail the procedure that must be followed in the involuntary detention of a patient in hospital. A specific form has to be completed which consists of three parts, namely:

1. the application
2. the medical practitioner's recommendation/certification
3. the order for reception and detention.

The application is generally made by the next of kin or another blood relative. However, often in the A&E department there is no relative or next of kin available. In this situation, a concerned person such as a senior A&E nursing staff member may make the application. However, the applicant, who must be over 21 years of age, has to state their connection with the named person (i.e. not a relative) and the circumstances in which the application is being made. The usual circumstances are that admission is required on an emergency basis and that no relative is available to make the application. In practice, the concerned person usually communicates by phone with the person's next of kin or family.

The applicant also has a duty to inform the person of the intention to admit them to hospital, of the nature of the certification and of the fact that they can request a second medical examination.

A registered medical practitioner conducts the medical examination. The registered medical practitioner is usually the person's GP. However, if the GP is unavailable, then any registered medical practitioner (i.e. casualty officer) can make the medical recommendation. The casualty officer must not be related to the patient and must not have a connection with the psychiatric hospital (approved centre) to which the person is being admitted.

For patients being transferred to a private psychiatric hospital, the medical recommendation has to be made by two registered medical practitioners. This anomaly will be eradicated when the New Mental Health Act comes into force.

The transfer of the patient to the psychiatric unit or hospital (approved centre) is the responsibility of the applicant. In practice, the Gardai are requested to

assist in the transfer of the patient if the person is deemed to be a risk to either themselves or others.

There are current practical difficulties regarding the exact role of the psychiatric nursing staff, ambulance service and Gardai. These may be clarified with the introduction of the new Act.

Once the patient has been admitted to the approved centre, the Order for Reception and Detention is completed, usually by the responsible consultant psychiatrist within 12 hours of the person's arrival. The completion of the form allows the person to be detained for up to 6 months.

People under 16 years of age, can be admitted to a psychiatric hospital can only be on a voluntary basis. Their parents must sign the consent form on their behalf.

The Mental Health Act 2001 (Ireland)

New mental health legislation has been signed into law and is being implemented on a phased basis. The Mental Health Commission, which was established under the Act, is responsible for drawing up protocols and forms, etc. for applications for detention. Essentially the new Act will have two different procedures for the admission of people under and over the age of 18 years.

The Act specifically excludes the involuntary admission of persons solely on the grounds that they have a personality disorder, social deviance or addiction to drugs or intoxicants. An application may be made for involuntary detention where a person is suffering from a mental disorder and is unlikely to receive the treatment he/she needs if not involuntarily detained. The Garda Siochana will also have the power to take persons into custody if they believe them to be suffering from a mental disorder and if it is likely, because of that, that they may cause immediate and serious harm to themselves or others. The Gardai may take the person into custody and/or may enter the person's dwelling by force if necessary.

In relation to the patient, the applicant may be:

- a spouse, cohabitee of more than 3 years (not a spouse who is absent by separation or divorce) or another relative of the person;
- an authorised officer of the Health Board (to be defined in the future by the Mental Health Commission);
- a member of the Garda Siochana;
- any other person.

The applicant must have observed the patient not more than 48 hours before making the application. Persons disqualified from making an application would be persons under the age of 18 years, a Garda who is a relative or spouse of the person, a member of staff of the hospital of the approved centre, any person who is likely to gain financially from the persons admission to the centre, a registered medical practitioner who provides a medical service to the centre or a relative who qualifies for any the aforementioned. Technically speaking, a member of staff of

the A&E department could make an application in an emergency situation to have the person involuntarily detained. However, when the applicant is a person under the 'other' category, they must show that all reasonable efforts have been made to contact the person's family and a written statement must be provided as to the reason why this person has undertaken the position of applicant.

The Act requires that an examination of the patient must take place within 24 hours of the receipt of the application. This is usually performed by the person's GP; however, in the A&E situation, the casualty officer could be the examining medical officer, provided that he/she is not a relative of the patient, is not employed by the patient or likely to benefit from the patient's admission to the approved centre, and is not the applicant. The recommendation that the person be admitted is sent to the clinical director of the approved centre and a copy of the recommendation is given to the applicant. The recommendation remains in force for 7 days from the date of its making and expires if the patient is not admitted. When the recommendation is received by the approved clinical director or consultant psychiatrist of the approved centre, the patient must be seen within 24 hours by a consultant psychiatrist from the approved centre, who may then make an admission order, which will be valid for 21 days. This can then be further renewed for a period of 3 months.

A big difference between the new Mental Health Act and the Mental Treatment Act 1945 is that all decisions to involuntarily detain a patient will be referred to a Mental Health Tribunal for review. Where there is a difficulty with removal of the person to an approved centre, the onus is placed on the clinical director or the consultant psychiatrist of the receiving approved centre to arrange an escort with the staff of the centre. Where necessary, there is also a provision that the Gardai shall comply with the request to escort staff from the approved centre. Further clarification of the mechanisms here will hopefully be drawn up by the Mental Health Commission.

Following the decision to make an admission order, the patient must be notified in writing of the fact that they are to be detained, that they are entitled to legal representation and a written treatment plan, that they will have their detention reviewed by a tribunal, that they can communicate with the Inspector of Mental Hospitals, that they can appeal to the Circuit Court and that they may have their status changed to that of a voluntary patient if they so wish. All decisions to admit are sent to the Mental Health Commission, which will refer the matter to a tribunal, assign a legal representative and organise an independent review within 21 days.

There will be a difference procedure for children under 18 years of age. They cannot be involuntarily detained under this Act unless their parents are missing or are refusing consent.

Representation may be made to a Circuit Court by a 'Health Board'. The Act does not specify who this may be. If the court is so satisfied, it will make an order that the child is examined by a consultant psychiatrist, who must then give evidence on the child's mental state and the need for admission. The court will then make an order as to the child's admission. For children under 18 years who

have a psychiatric disorder and whose parents are present and consent to admission, the child may be admitted to a psychiatric hospital. Consent is assumed on the basis of the parents' consent.

The operation of procedures for under-18s are very unclear and hopefully will be clarified in regulations set out by the Mental Health Commission. It is the view of the profession that it would be preferable to invoke the Child Care Act 1991 where a child's parents are either missing or refusing consent, in order that the child would be in the care of the Health Board before an application for their admission to a psychiatric approved centre is made.

Scotland (Mental Health Scotland Act 1984)

The current mental health legislation applicable in Scotland for the emergency detention of patients with a mental disorder is the Mental Health (Scotland) Act 1984. Note, however, that the recently passed Mental Health (Care and Treatment) (Scotland) Act 2003 is likely to come into effect in Spring 2005.

The Adults with Incapacity Act (Scotland) 2000 is now applicable for the physical treatment of patients who lack capacity. However, it is considered that in an emergency situation, a doctor would be able to treat a patient under the doctrine of necessity.

Emergency detention would require application of the Mental Health (Scotland) Act 1984: Section 24 covers the emergency detention of a patient who is not already in hospital. Section 25 covers the emergency detention of a patient who is already in hospital and is roughly equivalent to Section 5/2 of the Mental Health Act 1983 for England and Wales. The same ethical principles apply as above.

Section 118 of the 1984 Act provides powers for a police constable to remove from a public place to a place of safety a patient who appears to be suffering from a mental disorder, and to be in immediate need of care or control. This authority allows detention for a period at the place of safety not exceeding 72 hours, for the purpose of enabling a medical practitioner to make an examination.

Mental Health (Northern Ireland) Order 1986

The Mental Health (Northern Ireland) Order 1986 follows on and has many similarities with the Mental Health Act 1983 for England and Wales. Mental disorder in the Northern Ireland Order means mental illness, learning disability and any other disorder or disability of mind. In particular, psychopathic disorder is excluded from the definition of mental disorder. The remit of the Northern Ireland Order is, however, similar to the Mental Health Act 1983 in England and Wales.

The use of Holding Orders

Articles 7 and 7A are the emergency medical holding orders for those that are already voluntary in-patients and as with the English Mental Health Act 1983

(MHA) Section 5(2) would not apply to patients in an A&E department, as that is regarded as an out-patient setting, but would be applicable to patients admitted to a medical or observation ward. As with the MHA Section 5 (2), patients cannot be transferred to another hospital under these articles.

Under the Northern Ireland Order, the consultant in charge of the patient's care is the responsible medical officer (RMO), and is a Part II consultant psychiatrist (substantive or locum) appointed by the Mental Health Commission for Northern Ireland.

Assessment and Treatment Orders

Under the Mental Health (Northern Ireland) Order 1986, patients are initially admitted to hospital for assessment for a maximum period of 14 days under Part II of the Order. A patient in an A&E department who requires to be admitted for assessment would initially be seen for a medical recommendation under Article 6 of the Order, preferably by his general practitioner (subject to the exclusions mentioned in s1), any fully registered medical practitioner can deputise, and by the patient's nearest relative, as defined in Article 32 of the Order. If the nearest relative does not wish to be involved or is not available, an approved social worker can act as an alternate. When the forms have been completed, the patient is deemed to be in legal custody (Article 131(1)) and can be conveyed to the approved hospital.

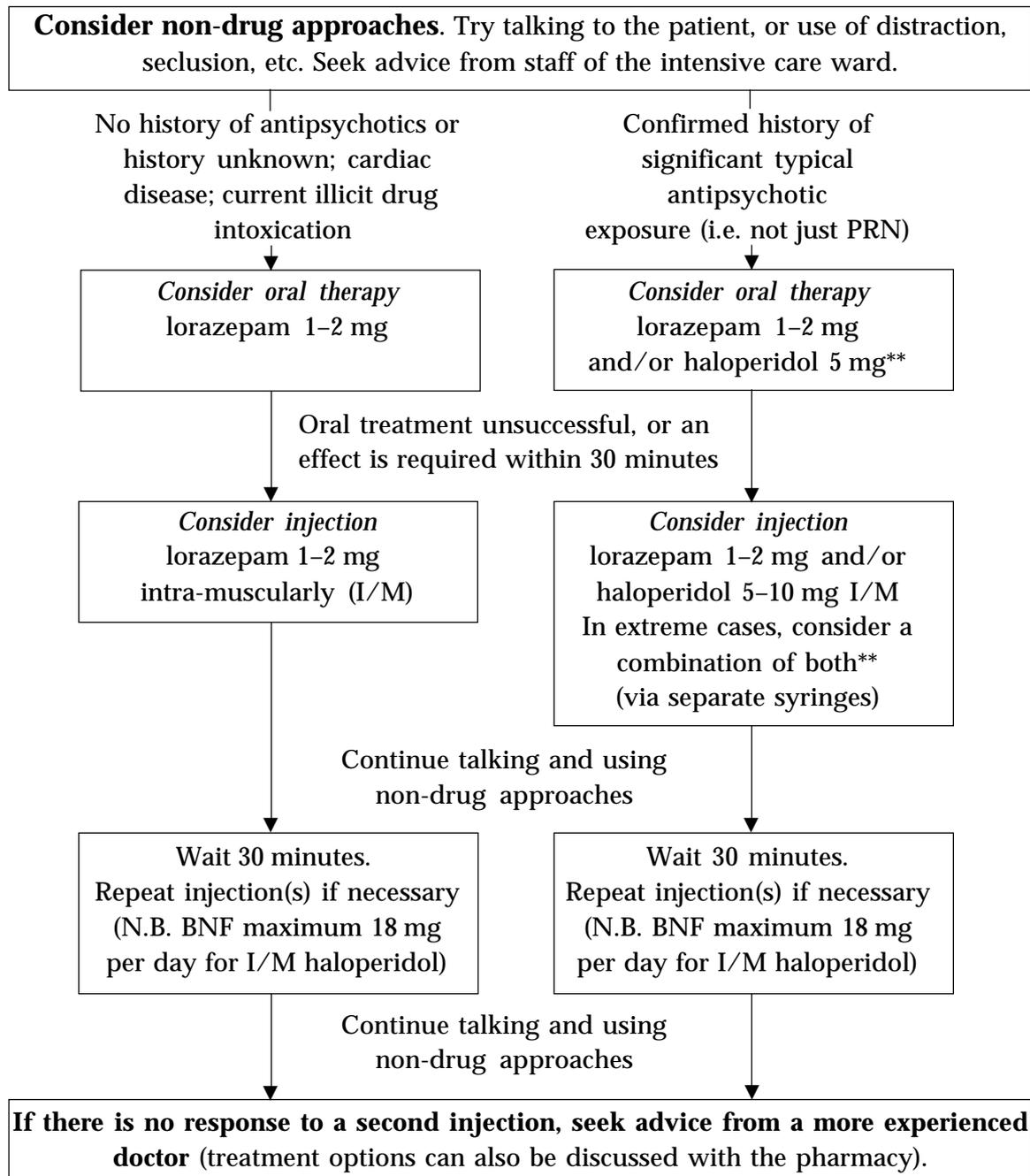
Use of the Place of Safety Order and the role of the police

As with the Mental Health Act 1983, the Northern Ireland Order allows any constable who finds someone in a public place whom he/she feels to have a mental disorder and to be in immediate need of care or control to convey such a person to a place of safety. This is defined in the Order as any hospital willing to temporarily receive such a person, any police station or any other suitable place. The person is deemed to be in legal custody for a period not exceeding 48 hours until he/she can be examined by a medical practitioner and interviewed by a social worker. As noted earlier, the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine (1996) have commented on the inadvisability of making hospitals a place of safety.

Appendix 2. An example of sedation guidelines for accident and emergency departments

Adults

This is given as an example of a sedation guideline for adults only, and it should not be used for young people.



Notes

** Combination treatment may be considered on the basis of either previous knowledge of the patient that predicts poor response to a single agent, or if the level of arousal of the patient is such that forced restraint is required and will be very difficult to repeat in 30 minutes' time.

Emergency resuscitation equipment, procyclidine injection and flumazenil injection must be available before treatment.

Monitoring of the patient must be performed and recorded according to the guidelines overleaf after any injection is given.

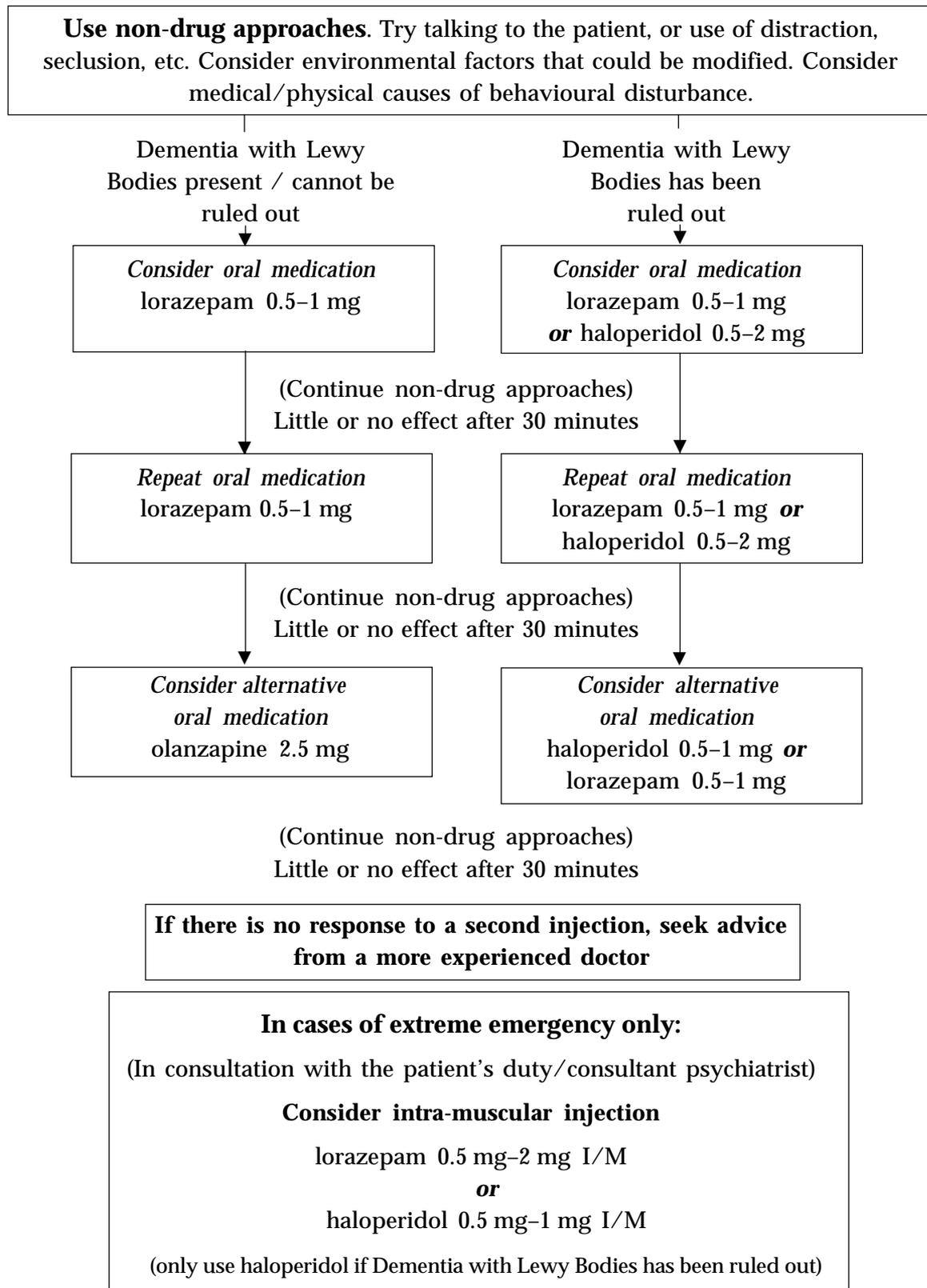
Procyclidine injection 5–10 mg can be given IV or IM for acute dystonic or parkinsonian reactions.

Flumazenil (a benzodiazepine antagonist) must be given if the respiration rate falls to <10 breaths/minute after lorazepam has been used (see panel below).

Give flumazenil 200 microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100 microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1mg (1000 microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level.

N.B. The effect of flumazenil may wear off and respiratory depression can return – monitoring must therefore continue beyond initial recovery of respiratory function.

Older adults



These guidelines apply where a frail patient over 65 years of age is behaving in a disturbed or violent manner that is unusual for him/her and that cannot be modified by interventions already in their care-plan. For physically fit patients and those currently/ previously treated with higher doses of antipsychotics, the protocol for younger adults may be more appropriate. Details of the clinical situation and all interventions must be recorded in the patient's medical notes.

Emergency resuscitation equipment, procyclidine injection and flumazenil injection must be available before treatment

Medication should be the last resort in older people. If required, medication must be used cautiously and only by the oral route (except in very extreme emergencies – see lower panel **). (Note the Mental Health Act 1983 status of the patient.)

Monitoring of the patient must be performed and recorded according to the guidelines overleaf after any injection is given.

Procyclidine injection 2.5–5 mg can be given IV or IM for acute dystonic or parkinsonian reactions.

Flumazenil (a benzodiazepine antagonist) must be given if the respiration rate falls to <10 breaths/minute after lorazepam has been used (see panel below).

Give flumazenil 200 microgram IV over 15 seconds. If desired level of consciousness is not obtained within 60 seconds, a further 100 microgram can be injected and repeated at 60 second intervals to a maximum total dose of 1 mg (1000 microgram) in 24 hours (initial + 8 additional doses). Monitor respiration rate continuously until it returns to baseline level.
N.B. The effect of flumazenil may wear-off & respiratory depression return – monitoring must continue beyond initial recovery of respiration.

Example of a monitoring schedule

After injections, this monitoring schedule must be followed, unless there are compelling reasons for doing otherwise, & must be recorded in all cases:

- Pulse & respiration as soon as possible after injection, then every 5 minutes for 1 hour
- Temperature (using Tempadots) as soon as possible after injection as a baseline, then at 5, 10, 15 and 60 minutes
- Blood pressure at 30 and 60 minutes after injection
- Monitor for signs of neurological reactions (e.g. acute dystonia, acute parkinsonism).

If not followed, the 'responsible nurse' (below) must document the reasons why.

Responsibilities

1. The qualified nurse in charge of the ward is responsible for delegating responsibility for managing the incident to another registered nurse, or managing and coordinating the incident her/himself.
2. The nurse who manages and coordinates the incident (the responsible nurse) is responsible for:
 - (a) deciding whether a doctor needs to be informed, and then liaising with him/her as appropriate. This will include any deterioration in the patient's mental or physical state, when the duty senior nurse must also be informed;
 - (b) ensuring that all decisions and actions are fully documented in the patient's nursing record. This will include decisions to deviate from the standard monitoring schedule (above) and reasons for these decisions. It will also include any/all conversations with the doctor;
 - (c) ensuring a registered nurse, or a suitably competent health care assistant (HCA), performs the patient monitoring, as detailed above, after injections have been administered;
 - (d) deciding, in consultation with the doctor if necessary, whether the next dose of regular medication should be omitted, in the light of the response to rapid tranquillisation (4a below);
 - (e) deciding after 60 minutes, in consultation with a doctor if required, the appropriate level of observations to be subsequently followed. This will depend on the degree of agitation of the patient.
3. The nurse or HCA delegated to perform the monitoring by the responsible nurse is responsible for monitoring strictly according to this protocol, or as advised by the responsible nurse. Any untoward signs/symptoms (e.g. weakening pulse, decreased respiratory rate, etc.), or any other causes for concern, must be reported promptly to the responsible nurse, who will make a more detailed assessment.
4.
 - (a) The doctor (ward or duty doctor) who prescribes the medication must indicate in the medical record any monitoring required in addition to the standard monitoring as detailed above and any subsequent action to be taken by the nursing staff with regard to the subsequent administration of any regularly prescribed medication, etc.
 - (b) If a doctor, whether ward or duty doctor, is contacted by the responsible nurse, he/she must respond promptly. If requested to attend, he/she must do so within an agreed time frame, which will be documented by the responsible nurse. If required to attend, the doctor then assumes lead responsibility for the clinical management of the patient until it is formally passed back to the responsible nurse.

Glossary

Acute stress reaction

A transient disorder, which develops in an individual in response to an exceptional stress. Not everyone exposed to exceptional stress will develop this disorder, which indicates that individual vulnerability and coping resources play a role in its occurrence and severity. Symptoms are variable, and may include a feeling of being 'dazed', agitation, and overactivity. Symptoms associated with autonomic arousal are usually present, such as sweating, tremor and palpitations. The symptoms usually subside over hours or days.

Community mental health team (CMHT)

Adult mental health services are usually delivered by multi-disciplinary teams, which cover a defined geographical area or are linked to particular primary care services. A typical CMHT will include a consultant psychiatrist, junior doctors in psychiatry, community psychiatric nurses and team members from other disciplines including social services, psychology and occupational therapy. As well as providing a community-based mental health service, the team will also have access to in-patient psychiatric beds.

Delirium

An organic syndrome, with a global effect on cerebral functioning. Symptoms include disturbances of consciousness, attention and concentration, perception, thinking, emotion, behaviour, and the sleep-wake cycle. Delirium is transient and of fluctuating course. It is aetiologically non-specific and can be due to a variety of causes (see main text).

Post-traumatic stress disorder (PTSD)

Arises as a response to an exceptionally stressful event or situation of a threatening or catastrophic nature. Typical symptoms include repeated reliving of the trauma in intrusive memories ('flashbacks') or dreams, a background sense of emotional detachment or 'numbing', avoidance of activities or situations reminiscent of the trauma, and a state of autonomic hyperarousal and hypervigilance. The onset follows the trauma with a latency period of up to 6 months. The course is protracted and fluctuating, but recovery can be expected in the majority of cases.

Psychosis

Psychosis refers to disorders of thinking and perception that are so extreme as to result in divorce from reality and, often, loss of insight. Patients may display abnormal, unshakeable beliefs (delusions) and hallucinations in any sensory modality. The term 'acute psychosis' refers to the development of psychotic symptoms usually over a matter of days.

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