

**The Royal College of  
Emergency Medicine**

**RCEM National Survey on  
Mental Health services for  
Children and Young People  
(CYP) in the Emergency  
Department (ED)**

**June  
2018**

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## Summary

- An online survey was conducted asking EDs about services for CYP presenting to the ED with Mental Health problems in their department. There were 93 respondents out of a possible 240 UK hospitals with Emergency Departments.
- Overall services for Children and Young People (CYP) coming to the ED with an acute MH problem were rated as poor by 53% of respondents, good by 8% and awful (i.e. concerns about safety) by 12%
- 62% respondents said they had specialist CAMH services available in working hours but for less than 8 hours per day and 31% had services in the evening. At weekends 27% said they had specialist services available during the day and 15% in the evenings.
- When asked how long a CYP would wait to be seen by any Mental Health decision maker if they presented between 3pm and 7pm, 48% estimated the CYP would wait 12-24 hours and 22% thought they would be seen by 4 hours.
- When asked if their ED followed NICE guidance to normally admit every CYP for MH assessment the next day: 9% said they admitted every CYP presenting with MH problems and felt it was helpful, 26% said they admitted every CYP but did not think it was always helpful, 65% said they did not always admit a CYP.
- Very few respondents said their ED had specific facilities or expertise for adolescents.
- When asked how long a patient might wait for a Psychiatric bed in their hospital 41% estimated that it would take more than 48 hours, 20% said less than 12 hours.
- Occasional departments with good practice were identified such as having the ability to refer direct from triage to CAMH to get an assessment.
- Suggestions were made as to how to improve services, such as training up Adult Liaison Psychiatry Services or on call Psychiatrists to assess CYP with rapid follow up from CAMH in the community where appropriate.

## Introduction

Mental Health services for patients coming in crisis to the Emergency Department (ED) have always been stretched. Services for adults are starting to improve with initiatives to provide Core 24 services to the ED. Patients who are under 17 needing mental health assessment are a huge concern for any Emergency Physician. This has prompted RCEM to survey its members on the services and quality of care these patients receive.

## Methods

An online survey was distributed to all ED clinical leads, all known ED Mental Health departmental leads and was available at a recent RCEM conference. There were 93 respondents out of a total of 240 EDs that treat children and young people (CYP).

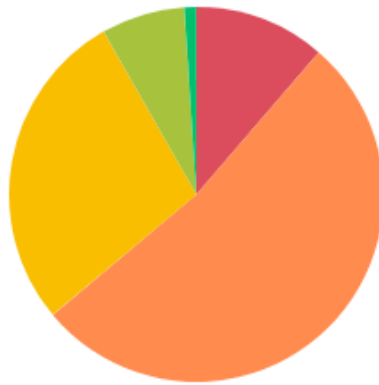
## Results

### Overall service quality

Overall 53% of respondents felt the services for CYP coming to the ED with an acute MH problem were poor, 12% said services were awful and they had concerns about safety and only 8% said they had good services.

Overall how would you rate the services for children and young people (CYP) coming to the ED with an acute Mental Health problem?

Answered: 97 Skipped: 1



■ Awful (e.g. you have concerns about patient safety)
 ■ Poor
 ■ OK
 ■ Good
 ■ Excellent

	AWFUL (E.G. YOU HAVE CONCERNS ABOUT PATIENT SAFETY)	POOR	OK	GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	11.34% 11	52.58% 51	27.84% 27	7.22% 7	1.03% 1	97	2.34

24% said their services had improved in the last year and 16% felt services had deteriorated. 59% had not changed.

## Availability of services and waiting times

Availability of services was very variable, during the week 62% (50 of 81) respondents said they had specialist CAMH services available in working hours but for less than 8 hours per day and 31% (24 of 81) had services available in the evening.

At weekends 27% (22/81) said they had specialist services available during the day and 15% (12/81) had services available in the evenings.

Comments respondents made were equally variable:



Will see patients if referred before 1pm.



There is patchy cover at weekends, for short time, depending on post code. Majority stay whole weekend.



Significant time to being seen. Often many many hours. No "pull" only push.

We have instituted recently a pathway for direct referral from triage to CAMHS which has dramatically reduced waiting times (children's ED)



CAHMS don't assess CYP in ED. They all have to be admitted to get an assessment. We don't even have the option of discharge home and follow up with CAHMS in the community.



We have recently had funding as a pilot for 3 months which has been incredibly successful and we are working on this being commissioned. We would also like this service at the weekends. It has been successful on all levels. Great and rapid service for young people. Massive reduction on admissions, removal of time wasted from clinicians trying to get hold of CAMHS, reduction in breaches. Really amazing service.



In some cases, non-specialist MH services see and assess CYP in the ED. This is a model which is acceptable in some areas. We asked the question whether ED adult Liaison Psychiatry / crisis services would assess CYP. 30% (27/91) of respondents said their adult services saw patients who were 16 and over, 8(9%) said their adult team saw CYP who were 14 or over.

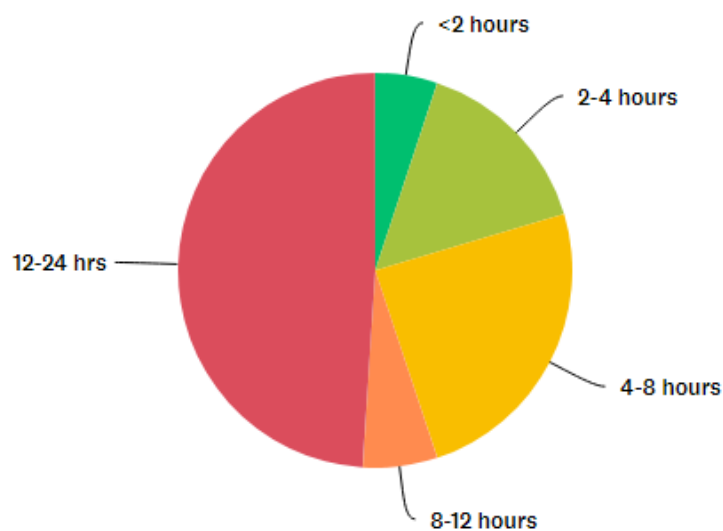
Respondents were asked whether their on-call Psychiatrists would see CYP in the ED, 42% (39/93) said they did but comments showed that this was inconsistent and some had caveats such as they would only see if the patient was not already known to CAMH services or if the CAMH consultant on call requested it.

It is known that the majority of presentations for Children and Young People to the ED with Mental Health problems are in the afternoon or evening. We asked how long a patient might wait to be seen by any Mental Health decision maker if the patient presented between 3pm and 7pm.

Our respondents estimated that 48% (45/93) would wait 12-24 hours and that only 22% (20/93) would be seen within 4 hours.

If CYP were to present to the ED between 3pm and 7pm (a common time of presentation), how long (roughly) would they wait to be seen by a service that could make a decision about admission or discharge?

Answered: 98 Skipped: 0



ANSWER CHOICES	RESPONSES	
<2 hours	5.10%	5
2-4 hours	15.31%	15
4-8 hours	24.49%	24
8-12 hours	6.12%	6
12-24 hrs	48.98%	48
<b>TOTAL</b>		<b>98</b>

Comments revealed that in some places there was conflict about where a CYP would wait to be seen by Mental Health Services.



There is great pressure on trusts to avoid 12-hour ED breaches. This has led to conflict and concerns regarding where to accommodate CYPs with MH problems whilst they await assessment, decision making, bed allocation by CAMHS. Sometimes the paediatric team decline to admit these patients to the ward and the ED has been put under pressure to accommodate the CYP on the adult only CDU.

CAMHS are currently only commissioned to review children on the paed ward, the child cannot go to the ward for review until an RMN is available. This leads to long delays in ED for the child. This is being looked at, a risk assessment has been agreed so some children go without an RMN



We have looked at as part of Observation ward audit. Average LOS 12 hours longer than any other pt group.



## Need for Admission

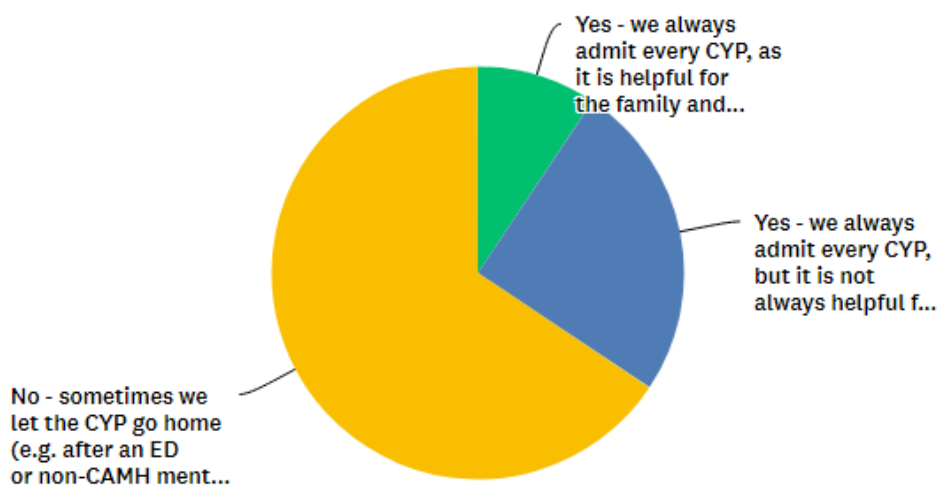
Whilst some CYP coming to the ED need admission for medical reasons such as treatment of overdose, this is much less common than for adults. It is also recognised that a proportion of young people attend ED in crisis where it is unsafe for the patient to go home due to safeguarding or social concerns. NICE guidance CG16 published in 2004 "Self-harm in over 8s: short term management and prevention of recurrence" states that CYP who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day.

In many cases, admission to a children's ward is unhelpful for the child or young person, they would prefer to be at home and are safe to be discharged. Admission to a ward can take away any urgency for the CYP to be assessed by Mental Health Services and may take up a bed for a day.

We asked our respondents whether they adhere to NICE guidance for admission. 9% (8/91) said they admitted every CYP presenting with MH problems and felt it was helpful. 26% (24/91) said they admitted every CYP but did not think it was always helpful. 65% (59/91) said they did not always admit a CYP.

NICE guideline advises that all CYP presenting with MH problems are admitted pending a comprehensive Psycho-social assessment the next day. Does your ED always admit a child / young person?

Answered: 96 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes - we always admit every CYP, as it is helpful for the family and patient	9.38%	9
Yes - we always admit every CYP, but it is not always helpful for the family and patient	25.00%	24
No - sometimes we let the CYP go home (e.g. after an ED or non-CAMH mental health practitioner has seen the patient and have discussed the patient with CAMH who are on call for advice)	65.63%	63
<b>TOTAL</b>		<b>96</b>

Comments showed a frustration with the process:



I understand the reasons for this but have to say that the whole 'period of reflection' is often used as a stick with which to make us admit YP. When the patient has self-harmed three days ago or has an ongoing problem for which they really should have been slotted into an OP slot, I do not think this is a good use of beds or good for the patient themselves.

Assuming safeguards and appropriate level of support at home - older children unlikely to be able to access suitable bed there discharge preferred option. The NICE guidance and psych guidance on this are used by mental health to default to not making out of hours assessments. Not in the young person's interests. Paeds also no longer see or admit 16+ and when these patients need admission we have nowhere suitable for them. Evidence to develop for this group urgently required.



Now you (we) have the CAMHS experts on tap up to 90 percent of admissions can be avoided. This is very helpful for patients.

CAMHS will sometimes speak to the child and main carer to have a plan if sending home, usually will be seen in community within a few days or the next day.

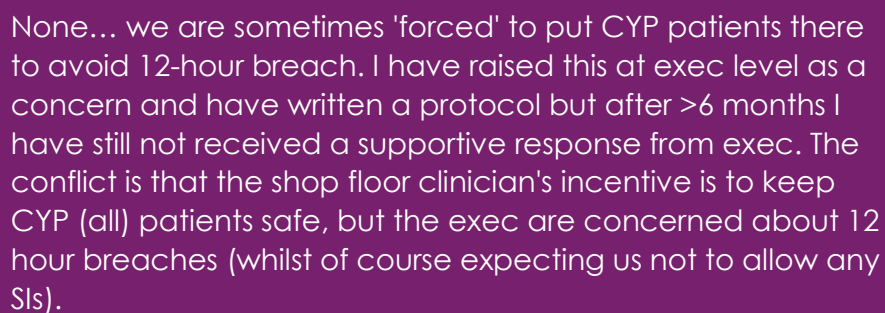


## Facilities and Expertise with ED / CDU for CYP with Mental Health presentations


We asked respondents what kind of facilities and expertise they had for CYP presenting to ED with MH problems. Most respondents said they had no facilities in their ED, 19% (16/86) of respondents said they had a dedicated adolescent room. 13% (11/86) said they had some expertise in their ED - either specific individuals with training or just those that had taken an interest.

Many departments admit over 16s with Mental Health problems to their CDU, some only 17-year olds and over. We asked the same question, did their CDU / observation ward have any facilities or expertise to look after this patient group? Most stated they did not or did not use CDU for CYP.

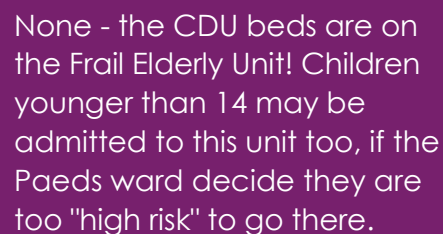
Comments included:



None... we are sometimes 'forced' to put CYP patients there to avoid 12-hour breach. I have raised this at exec level as a concern and have written a protocol but after >6 months I have still not received a supportive response from exec. The conflict is that the shop floor clinician's incentive is to keep CYP (all) patients safe, but the exec are concerned about 12 hour breaches (whilst of course expecting us not to allow any SIs).



For 16 up, the staff have developed good skills.



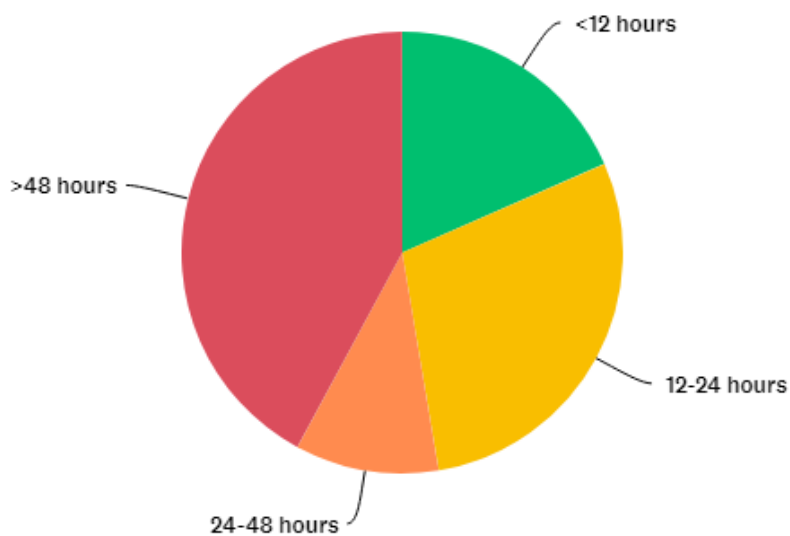
None - the CDU beds are on the Frail Elderly Unit! Children younger than 14 may be admitted to this unit too, if the Paeds ward decide they are too "high risk" to go there.

## Onward admission to Psychiatric bed

We asked respondents to estimate how long a child or adolescent would wait for a psychiatric bed in their hospital. 41% (29/71) estimated that it would take more than 48 hours, 20% (14/72) said less than 12 hours.

If a child or adolescent needs admission to a Psychiatric bed, how long do they wait for a bed (rough estimate)?

Answered: 76 Skipped: 22



ANSWER CHOICES	RESPONSES
<12 hours	18.42% 14
12-24 hours	28.95% 22
24-48 hours	10.53% 8
>48 hours	42.11% 32
<b>TOTAL</b>	<b>76</b>

Comments were as follows:



On one occasion, we have had a patient sleeping on a mattress on the floor for over 50hrs awaiting an in-patient bed

It's measured in days, not hours-longest wait in ED was 7 days.



If appropriate, will be admitted to the ward with a RMN to wait for a psych bed. Total wait 24-48hrs on average

## General Comments

We asked respondents for any other comments they would like to make about CYP and Mental Health services for the ED. Comments revealed a strength of feeling:



Incredible that this unmet need, and provision gap is getting bigger.



There is no parity of esteem between adult psych and CAHMS services. Children and adolescents get a raw deal in comparison. This places significant risk to the CYP/ their families and the ED staff that are left to try and manage what can be very challenging situations.



It is so appalling that it has reduced our staff to tears and to the resignation of a senior ED nurse. ED is not the place for an acutely disturbed or distressed CYP to be, there is no appropriate room to accommodate them, they wait hours for CAMHS assessment (although the ED doctors, nurses and the on-site adult MH liaison team are attentive and caring).

Other respondents put forward suggestions for improvement:



Needs a really good shake up. We are not trained sufficiently to always deal with this and feel a few emergency slots in an OP clinic per day could help prevent many of our attendances. I often really feel for the YP and their parents/carers."

Way forward is an ageless MHL service which operates 24/7. Increased CAMHs provision for EDs unlikely to be achievable."



Camhs. Called HYMS in Stockport. Delivered by Pennine Mental Health trust. Has a fixed 1400 pm slot every day for ED. Have telephone triage and advice. In working hours

There is a lack of being able to come and do a brief assessment. It seems there is comprehensive assessment involving 2 1/2 hours with everyone only. At times ED Drs do a much briefer assessment to establish that the patient is safe to go home and then defer a full assessment with CAMH to the next day."



## Discussion

This survey provides further powerful evidence of just how little provision of specialist CAMH services there is for CYP coming to the ED. CYP and their families wait in a busy EDs which rarely have facilities for adolescents. They and their families may be feeling anxious, distressed or low. CYP may be admitted, when arguably there is no real need for admission. Most CYP wait a long time to see a MH professional and even longer for a bed if they need a Mental Health admission.

There has been much talk of improving Mental Health provision both in crisis and in crisis prevention. Our results show that there are a few green shoots of improvement in a handful of places but that the general picture is very poor for this age group.

EDs need to look at their own facilities and training and start to provide a better environment for adolescents. RCEM proposes to add specific adolescent competences to the curriculum for Emergency medicine trainees.

CYP presenting to the ED with Mental Health problems, although increasing, do not present in large numbers, which makes it all the more difficult for every ED to have an acute service in hours and out of hours. Pragmatic guidance is needed for when it is helpful to assess a young person with a Mental Health problem, for example for most adolescents can be assessed into mid evening but after 9-10pm, they may be too tired for an assessment to be representative and admission may be unavoidable. Referral from triage to services for patients that are fit for assessment would reduce waiting times and allow some patients to be assessed earlier in the evening.

In the short term it is unlikely that specialist CAMH services are likely to be extended to become as responsive as they need to be and to work weekends and evenings. Consideration should be given to training up Adult Liaison Psychiatry services and Psychiatric trainees to be able to assess CYP with additional support from CAMH on call consultants. Adult services need to be resourced to do this, as will CAMH services to provide the support and access to rapid follow up clinics.

The trend in Mental Health Funding is that no funding is given unless savings can be demonstrated from the improved service. For this patient group there will be savings for having shorter times in ED, less admissions etc, but these savings are unlikely to be able to fund a specialist service. There is however a moral and ethical need to improve services for this group of patients. The impetus should be on providing services that are shown to be effective and not always cost saving.

## Conclusion

This survey provides further evidence of a huge gap in service provision for a complex group of patients who are currently getting a raw deal if they come to an ED with a Mental Health Crisis. RCEM hopes that this evidence will be acted on by those with the ability to improve services for CYP.