A survey of Children and Adolescent Mental Health (CAMH) Services in the Emergency Department

Summary

Introduction

Mental Health services for children and young people (CYP) in crisis in the Emergency Department (ED) have long been a concern for staff, patients, and carers. Children, young people, and their carers often have few alternatives than to come to the ED when in crisis, even those already being cared for by CAMH services. RCEM conducted a survey of availability of services for this group of patients in UK Emergency departments in 2018, this repeat survey is to assess progress since then.

Methods

An online survey was distributed to all UK ED Clinical and Mental Health leads (covering 240 EDs) asking about services for CYP presenting to the ED with Mental Health problems.

Results

There was a total of 56 (23% of 240 EDs) responses compared to 93 (39%) in the 2018 report.

54% of respondents reported that CAMH services for the ED were generally poor or awful. This was the same as in 2018 (53%). However, there was a mixed picture as 23% rated their CAMH service as good or excellent compared to 9% in 2018. Overall, 23% reported an improvement, 37% unchanged and 40% worsened service quality over the last 3 years.

62% of responders reported the availability of a local specialist CAMH phone service.

20% of respondents reported availability of Specialist CAMH services with 24/7 coverage (up from 8% in 2018,) but 64% of respondents reported no service after 1700.

Half of participants indicated wait times of 12-24 hours for a decision to admit or discharge for a CYP presenting to the ED between the hours of 3pm and 7pm.

65% reported deviation from NICE guidelines recommending admitting CYP who are awaiting a psychosocial assessment by specialist services.

70% reported that their paediatric ED's lacked specific areas to assess or observe children in crisis.

Two thirds of respondents reported waiting times of over 24 hours for a tier 4 bed, with free text comments indicating that some patients have waited 5 days.

Conclusions

This survey shows slight improvements in hours of coverage for CYP in crisis, but still large numbers of patients who cannot be seen by a specialist after 1700. There are still unacceptably long waits for assessment in many departments and shockingly long waits for mental health beds. RCEM acknowledges that more funding has been assigned to CAMH services and in many cases the rate limiting step to improving services has been the difficulty recruiting specialists. Add to this the increasing numbers of CYP with mental health problems during the pandemic, more needs to be done to meet this group's needs.

Recommendations

- Government bodies should continue to release more funding for community and CAMH services and ensure that workforce planning, and training is aiming to meet future demand.
- Emergency Departments should focus on training all staff in helpful approaches to supporting CYP with mental health problems and consider providing safe quieter areas for patients.
- Services should work collaboratively to provide alternatives to the ED as this will benefit patients who do not need medical care.
- Alternatives to long waits in the ED such as telephone triage and discharge for next day assessment need proper evaluation
- More beds and more flexibility of admission for CAMH patients are needed to prevent long waits in acute hospitals.

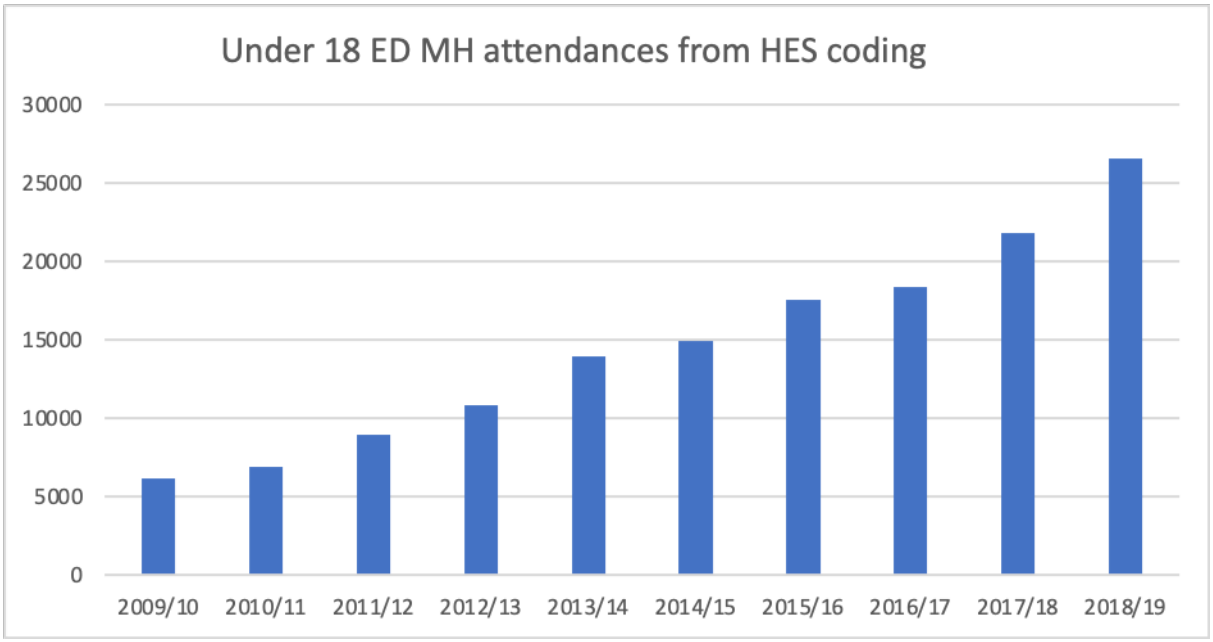
Acknowledgements

We thank everyone who contributed to the survey

Introduction

Mental health problems in children and young people are unfortunately a growing concern and stretched services nationally impact on the Emergency Department.

The following graph shows English Hospital Episode Statistic data for patients under 18 presenting to the Emergency Department with a primary mental health problem.



RCEM performed a survey of UK EDs in 2018 to provide evidence of the type of specialist mental health care available then. The results were sobering. Since 2015 then NHSE reports that they have spent £1.25 million on children and young people's mental health services, allowing 70,000 more patients access to treatment each year (a 16% increase). In 2021 this was reported to be 39.6% of CYP with a diagnosable mental health problem. More investment is promised to 345,000 more CYP via NHS funded services and schools and colleges [1]. Scotland has provided local authorities £12 million in 2019/20 and £16 million in each of the three financial years 2020/21, 2021/22 and 2022/23.

Some of this investment has been slow to take effect due to a lack of trained staff to fill new roles.

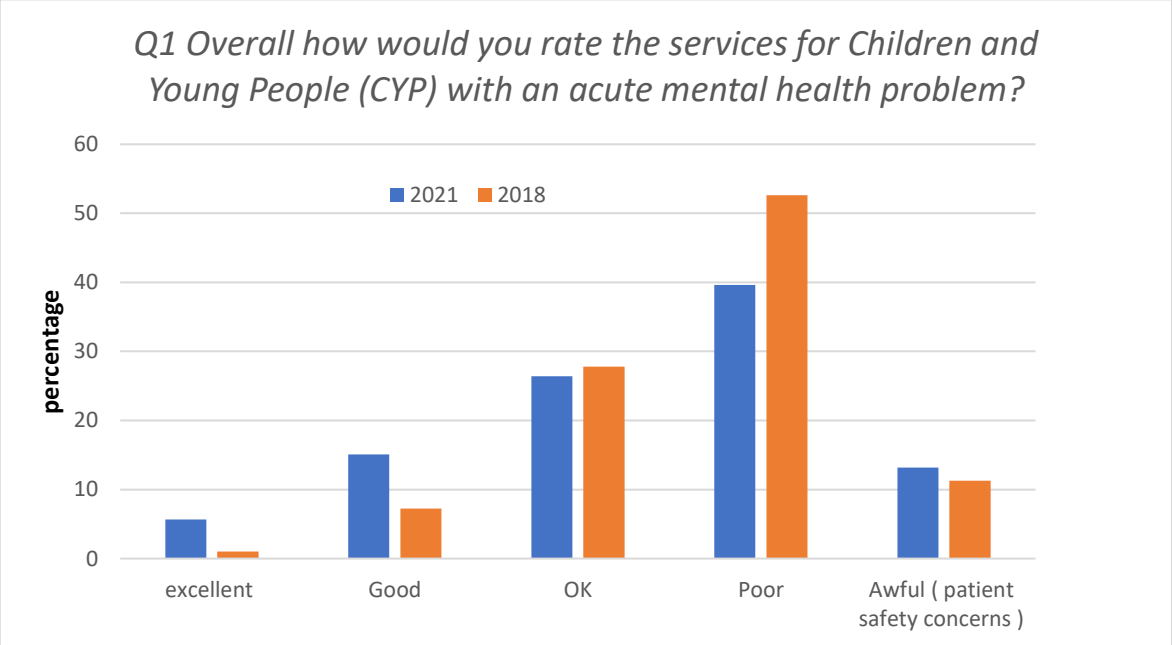
RCEM has repeated this survey to determine how much impact spending and expansion of services has had in our EDs.

Methods

An online survey was distributed to all UK ED Clinical and Mental Health leads (covering 240 EDs) asking about services for CYP presenting to the ED with Mental Health problems. This was distributed via email and whattsapp groups. Participants were given a month to complete the survey.

Full Results

There were 56 (23% of 240 EDs) responses compared with 93 (39%) in the 2018 report. This was made up of 8 teaching hospitals and the rest DGH, the majority of those indicating their place of work were in England.



Almost half of respondents rated CYP services positively (48%; rated as excellent, good, or ok) in 2021. Although there was an increase in the proportions of responses indicating excellent and good services it is striking to see that over 52% felt the service was poor or awful.

Q2 In The last year, have MH services for CYP improved?

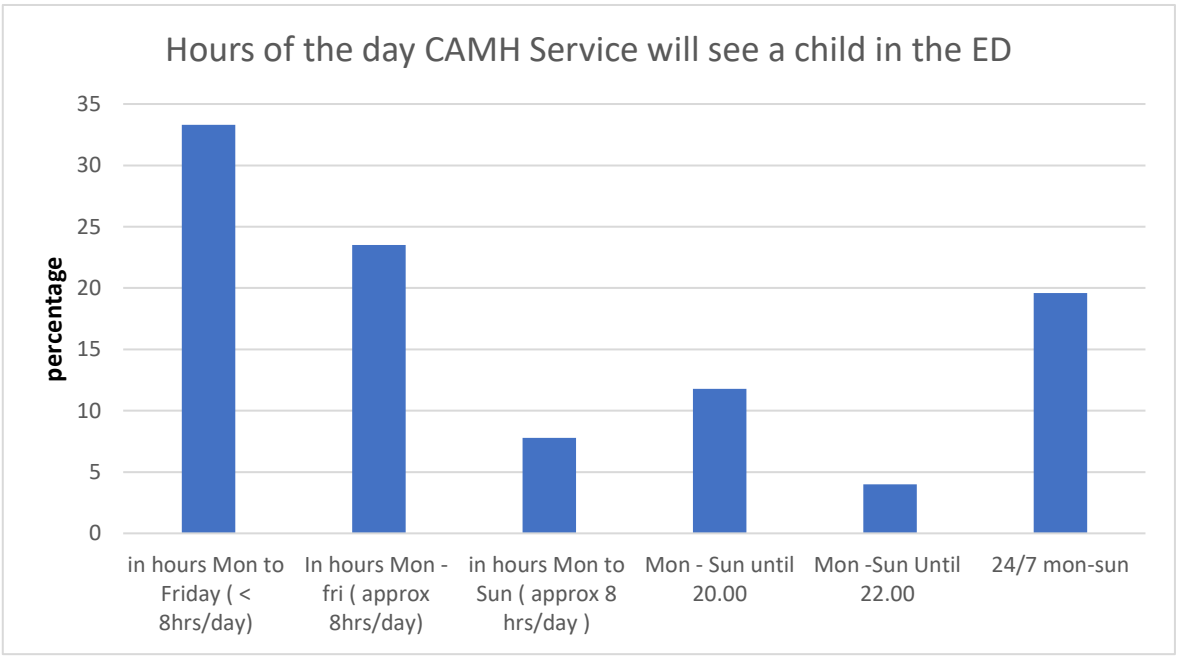
23.1% (12/52) felt that the services for MH CYP who attend the ED have improved. 36.5% (19/52) respondents felt that the service had stayed the same, but sadly 40.4% (21/52) felt that services had worsened. This may reflect the growing numbers and complexity of CYP with mental health problems overall.

> Demand a lot higher and service provision hasn't followed suit. CYP MH services generally under resourced and they are having big issues finding staff. Improvements seen in structure of provision.

Q3 Do your patients have access to telephone support line with CAMH expertise in your area?

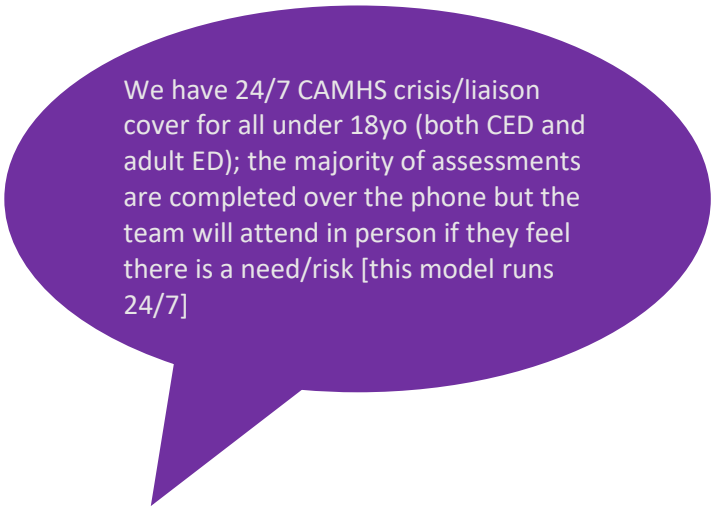
62% of responders reported a CAHM phone service. Although this was not recorded in 2018, this is a definite improvement as only 2 areas had a comprehensive phone crisis service in 2018. It is likely to have been driven by the Covid pandemic.

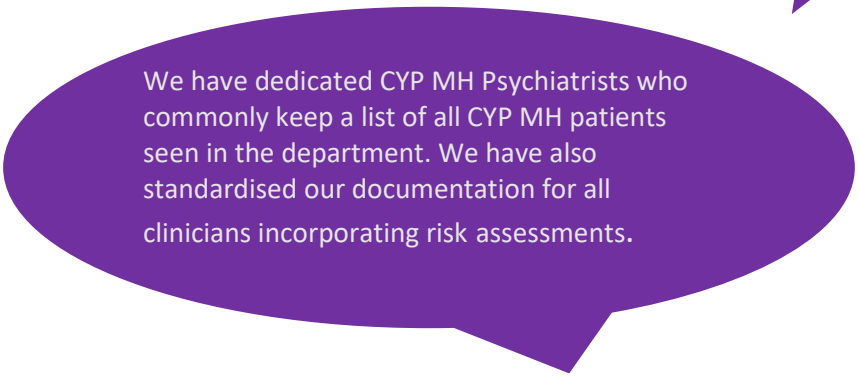
Q4 During which hours of the day will specialist CAMH services see and assess CYP in your ED? (Pick the closest model)



ANSWER	RESPONSES 2021
In Hours Mon – Fri (< 8hrs/day)	33%
In Hours (8 hrs/day)	24%
In Hours Mon-Fri + approx. 8hrs/day at weekends no evening cover	8%
Every day until 2000	12%
Every day until 2200	4%
Every day until midnight	0%
24/7	20%

20% of respondents reported that Specialist CAMH services were available with 24/7 coverage, this was 8% in 2018. Services into the evening seven days a week were reported by a further 16% in 2021 compared to 13% in 2018. 64% of trusts had no provision after 5pm leading to possible unnecessary admissions to paediatric wards, or long waits in the ED. Furthermore, there is a mismatch between the hours when CYP most frequently present in crisis (late afternoon or early evening) and the core hours in which services are available. These hours of provision contrast sharply with adult mental health services, where 24/7 coverage is available in most EDs. Free text comments (outlined below) indicate that some services have improved through offering extended hours for CAMH services, including phone support.



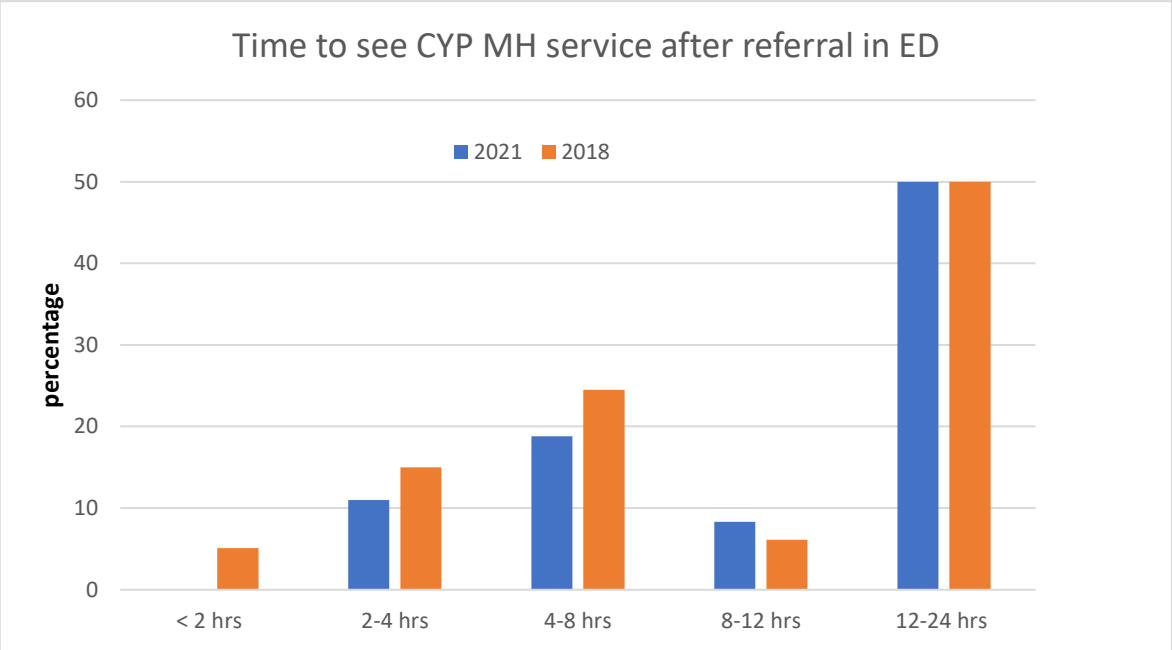


Q5 Does your Liaison Psychiatry / Crisis team assess young people?

ANSWER	RESPONSES 2021	Responses 2018
14 years old and over	10%	9%
16 years old and over	25%	30%
Adults only (> 18)	65%	61%

Similar to the 2018 survey, only a minority (34.6%) of Liaison Psychiatry or Crisis teams will assess young people. Furthermore (Q6), 77% (37) of respondent's report that their duty psychiatrist will not routinely see CYP; 10.2% will assess only those aged 14+ years and 24.5% will assess only those aged 16+ years.

Q7 If a CYP were to present to the ED between 3pm and 7pm (a common time of presentation), how long would they wait to be seen by a service that could decide about admission and discharge?



ANSWER	RESPONSES 2021	RESPONSES 2018
<2 hrs	0%	5%
2-4 hrs	23%	15%
4-8 hrs	19%	25%
8-12 hrs	8%	6%
12-24 hrs	50%	49%

No respondents reported waiting times of less than 2 hours for CYP in 2021 and half indicated wait times of 12-24 hours. The overall picture of waiting times is similar to 2018.

Q8 NICE guideline advises that all CYP presenting with MH problems are admitted pending a comprehensive Psycho-social assessment the next day. Does your ED ever NOT admit a child / young person?

ANSWER	RESPONSES 2021	Responses 2018
No, we always admit every child as it is helpful for the family and patient	16%	9%
No, we always admit every child, but it is not always helpful for the family and patient	18%	25%
Yes, sometimes we let the child / young person go home after ED or non CAMH mental health practitioner has seen the patient and have discussed the patient with CAMH who are on call for advice.	67%	66%

NICE currently recommends that children should be admitted overnight if they attend that ED with self-harm or deliberate ingestion. There will be situations where admission is essential due to safeguarding concerns, but an admission to a busy paediatric ward may not be therapeutic for some patients.

We asked respondents whether they adhere to the NICE guidelines. 67% report they sometimes discharge children rather than admit to await assessment by specialist services. Free text comments indicate the role that physical health conditions may make in influencing the decisions to admit, and the challenges of risk ownership for decisions not to admit.

No child without physical health problems is admitted. Children may wait in ED for several days if a complex social situation is difficult to resolve. On the plus side, we have vastly reduced harm to children on wards from the distressing behaviour of psychiatric patients, and also prevented children with mental illness being stranded on acute wards for weeks.

We usually admit. The CAMHS line occasionally gives advice but the risk is ours (if we discharge) ('as they haven't seen them')

Q9 (Training and environment).

Do you have a specific area for assessing or observing patients with MH problems in your paediatric ED?

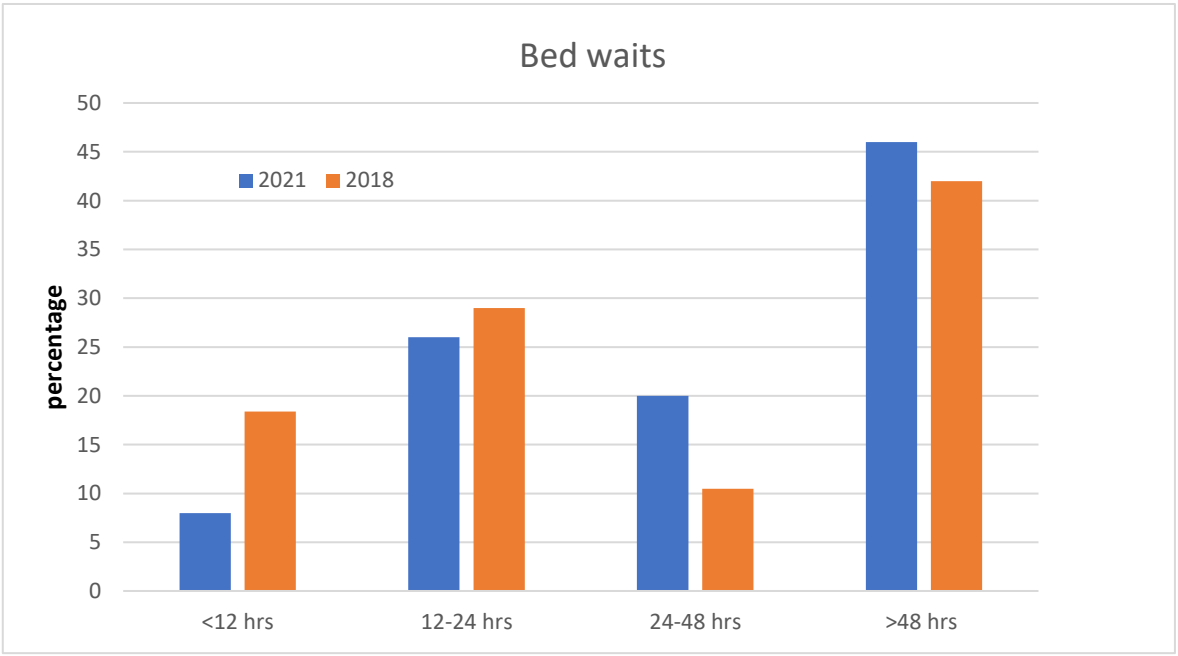
Have your paediatric ED nurses had any training in CYP mental health?

Have your adult nurses had any training in CYP mental health?

70% of responders report that their ED's have no specific areas to assess or observe children in crisis, which may result in CYP being managed in inappropriate environments, such as adult designated mental health rooms. 59% of Paediatric ED Nurses have some CYP Mental health training (which is better than the 18% of adult ED Nurses reported as receiving CYP MH training)

> If a CYP is particularly high risk (exhibiting very challenging behaviour) they are managed in our adult MH rooms. This environment is poor and not tailored to children but we do not have a safe space within Paeds ED or children's ward. Decisions are often made around tier 4 admissions but long delays in identifying beds meaning long delays held in ED

Q10 If a child or Adolescent needs admission to a Psychiatric bed, how long do they wait for a bed (rough estimate)?



BED WAIT		
	2021	2018
<12hrs	8%	18%
12-24hrs	26%	29%
28-48hrs	20%	11%
>48hrs	46%	42%

We asked about waiting times for a tier 4 MH bed. This group of children are, the sickest in terms of their mental health and most vulnerable. Rather than being in a therapeutic environment staffed with Mental health specialists they must wait in paediatric wards or worse, remain in the Emergency Department while a bed is found.

Approximately two thirds of respondents reported tier 4 wait times of over 24 hours, with free text comments indicating wait times of five days for some children. This wait has increased rather than improved since the previous survey.

Free comments indicated an increase in crisis/ home treatment teams in some areas as an alternative to admission.

The initial assessment is usually ok - it is what happens afterwards if home is not an option that causes most of the problems. Very few IP beds, no real pro-active approach from social services. We have had some children spend FIVE DAYS, yes, not a typing error, FIVE DAYS in ED waiting for a solution after

Often takes 24-48 hours, sometimes longer (five days is our record) about 1 time in 5 it will be less than 24 hours, but only if the child comes at teatime - they almost all spend the night in the ED whenever they present

Our local MH Trust now has a CAMHS home treatment team who can provide tier 4 level care in the community / home environment - this has markedly reduced the number of local young people waiting for tier 4 admission.

Particularly long waits for more specialist beds- eating disorders and psych high dependency. Less wait for "normal" CAMHS bed.

Two other positive initiatives are reported below – use of a CYP observation unit and an improvement in ED assessment and plans for better joint working with CAMHS.

We opened a co-located children and young person's observation unit in Feb 2021 which will admit those requiring a cooling off period / further MDT input.

The move to 24/7 CAMHS access and removing the reflex admission has definitely made things better. We currently have an SOP that means all CAMHS patients have an ED assessment, even if there is no physical health or toxicology issue, to cover safeguarding components of care; we are exploring if we can have our CAMHS team pick this up and then adopt a "fast-track" model, like we have for general adult psych liaison, where patients can be directly assessed by the liaison team and discharged

Discussion

Key findings

The key findings of this survey are that over half of respondents reported CAMH services as poor or awful, that waiting times for assessment by a specialist often greatly exceeding the one-hour standard recommended by RCPsych, and that waiting times for mental health beds are dire.

However, there is also evidence of increased out of hours service provision, and an indication that these extended hours translate into improved services and care. Telephone crisis lines for this age group are now widespread, thanks to Covid-19, indicating an alternative to the ED. There are also reports of more crisis teams providing an alternative to admission.

A limitation of this RCEM CYP MH survey is the relatively low response rate (23% vs 39% in 2018), which is likely to be affected by Coronavirus 19 Pandemic. For the first survey, face-to-face large RCEM events were used to advertise the survey but unfortunately these were not happening at the time of the 2021 survey. However, responses in 2021 indicate relatively few areas of change over time.

Demand and access

The past decade has seen disproportionate increases in mental health-associated ED use and an escalation of mental health needs among young people following the pandemic.[2,3] The rate of probable mental illness in 6-16 year olds England has increased from 11.6% in 2017 to 17.4% in 2021, with a significant proportion (6%-39%) of adolescents experiencing a deterioration in their mental health.[4–6] At the same time, the pandemic resulted in missed or delayed mental health contacts spanning primary care, CAMH and inpatient settings, particularly early in the pandemic.[7–10] The pandemic exacerbated the challenges to vulnerable young people and unfortunately social care services have also struggled to meet these challenges. These deficits in care have been followed by steep rises in emergency referrals to crisis-care teams and urgent referrals for under 18s, which increased by 62% and 58%, respectively, in March 2021 relative to the previous year.[11]. When these crises become very acute, due to a breakdown in care, family difficulties or acute behavioural crises, young people often find themselves in the Emergency Department.

A sharp rise in referrals for eating disorders is of particular concern[12]. Spill over effects are evident from the 6% of acute ward beds occupied by a child admitted due to a mental health problem in September 2019,[13] and high proportions of paediatric admissions attributable to mental health in April 2021.[14] Furthermore, many services for young people have had to operate at lower efficiency reflecting additional infection control measures, staff sickness and reduced face-to-face contacts at times.[15]

It should be considered also that some patients presenting to the ED with complex physical problems such as epilepsy, diabetes and sickle cell disease may also have concurrent mental health needs. ED and paediatric staff need to be able to address these needs and liaise with supporting mental health services.

Assessment

Given the challenges with timely access to services for mental health in community settings, the ED becomes the default option for vulnerable young people seeking help in a crisis. Assessment by specialist CAMH teams is a critical rate-limiting step in accessing care. The survey results provide evidence of a slight increase in the availability of overnight CAMH services and also a slight increase in the number of services rated good or excellent. Free text responses from survey participants indicated that extended hours of specialist provision translated into improvements in more timely assessments. However, overall, this report highlights the persistent lack of provision of specialist CAMH services for the child or young person who attends the ED in crisis. In other areas of healthcare, children's services are usually easier to access than adults. This is not true for mental health where current CAMH hours of availability fall well short of the 24/7 standard for adult services. It is important to acknowledge that there is a significant chronic work force shortage in CYP MH services which takes time to address with training and recruitment. Liaison Psychiatry may help provide more timely assessment of older CYP, but our survey indicates that only a minority of Liaison Services offer this.

Environment

The majority of ED's and Paediatric wards often do not offer safe places that are designated for children in crisis to wait, such as quiet / low stimulus rooms or adolescent friendly spaces. Our departments are often crowded and noisy and this can lead to a pressure cooker effect leading to distress for some patients. The acute crowding currently means it is even more challenging to create such places as space is at such a premium and needs to be multifunctional. When timely assessment is not possible, NICE guidance currently states that the young person should be admitted to an acute bed after overdose or self-harm, however not all hospitals do this. NICE guidance for self-harm is currently being revised. Where a CYP is discharged without specialist assessment, RCEM recommends that discharge should occur after assessment by another mental health professional contracted to provide services to young people, or by assessment by a senior ED clinician with telephone advice from CAMH, or by phone triage by CAMH trained clinician.

NICE guidance on admission for assessment was based on expert opinion and there is a need to evaluate the safety of alternatives such as telephone triage and discharge for next day assessment.

If a CYP is unwell and needs a mental health admission, lack of suitable mental health beds often results in long waits in the ED or admission to a paediatric ward. Not only is there a shortage of specialist mental health beds for young people, but they are also often not able to take admissions over a weekend, due to lack of staff support out of hours. This leads to further delays. This may exacerbate anxiety and stress for the young person and their family and is more costly to the hospital.[2] Our survey shows it can be several days before the sickest of patients have access to specialist mental health care.

Models of care

Better resourcing of community services is likely to help intervene with young people earlier in their illness, preventing some crises. When a crisis occurs, there need to be alternatives to the Emergency Department available outside working hours. [16] The growth of crisis teams is welcome, but it is recognised that a dearth of trained professionals has slowed these developments down.

RCEM recognises that even if there are alternatives to ED and improved services, there will always be times when these patients need to come to the ED. Alternative staffing and care models, including the use of social workers or counsellors (under the supervision of a psychiatrist) to deliver brief interventions in the ED, may increase efficiency.[17,18] Promising results have been reported for family approaches, typically comprising brief intervention in the ED with the young person and parents, discharge with a safety plan, followed by longer-term therapy as an outpatient.[18] Where family approaches are not appropriate (e.g. those in care) motivational interviewing in the ED may offer an alternative.[18] However, these approaches have not been evaluated at scale, or in a UK setting.

Patient priorities

Relatively little scientific literature describes the experiences and needs of young people presenting to the ED in crisis. One study of young people with experience of presenting to the ED with self-harm describes viewing ED attendance as a last resort that was associated with feelings of shame and self-loathing.[19] These feelings were compounded by negative perceptions of treatment and care in the ED, ultimately contributing to a cycle of avoiding help-seeking until crisis point.[19,20] Similarly young people and their parents identified reducing stigma, increasing consistency and clarity about when the threshold for crisis has been met, as well as continuity in community and hospital care as priorities for care.[16] Although changing staff perceptions and attitudes to mental health is complex, there is evidence that it is amenable to change.[21] It is therefore encouraging that over half of nurses have had some training in CYP mental health, but this needs to extend to adult nurses, health care assistants and all doctors. It should be acknowledged that caring for CYP in crisis may be more complex than for adults - Information sharing can be a barrier to effective and person-centred care.[22] Although young people generally support parental involvement in care - especially in times of crisis - they also report that this can be intrusive and may increase reluctance to open up about their experiences. Conversely, parents felt isolated if they were not given detailed information about care.[22] Training and a careful approach may help reframe this challenge in ED settings.

Recommendations

- Government bodies should continue to release more funding for community and CAMH services and ensure that workforce planning, and training is aiming to meet future demand.
- Emergency Departments should focus on training all staff in helpful approaches to supporting CYP with mental health problems and consider providing safe quieter areas for patients.
- Services should work collaboratively to provide alternatives to the ED as this will benefit some patients who do not need medical care.
- Alternatives to long waits in the ED such as telephone triage and discharge for next day assessment need proper evaluation
- More beds and more flexibility of admission for CAMH patients are needed to prevent long waits in acute hospitals.

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