

RCEM Acute Insight Series: Mental Health Emergency Care



Executive Summary

This instalment of RCEM's Acute Insight Series summarises key issues in mental health emergency care and provides recommendations for policymakers, NHS England, Integrated Care Systems, and Trusts to enable patients to access emergency mental healthcare in a safe, efficient, and timely manner. Unless otherwise stated, this report focuses on mental health emergency care in England.

Over the last five years, the overall recorded prevalence of patients experiencing mental health needs has dramatically increased. Although these patients account for a small proportion of attendances to Emergency Departments (EDs), the mismatch between capacity and demand, cuts to dedicated mental health hospital beds, and poor patient flow through the hospital means the proportion of patients with mental health needs who endure long waits in the ED has accelerated in recent months. People with mental health needs are currently twice as likely to spend 12 hours or more in EDs from their time of arrival as other patients.

Child and adolescent mental health needs have increased more rapidly than those of adults in recent years, especially during the pandemic. The severity of illness amongst children and young people that present to the ED is much greater than before; as such, there is an urgent need to expand the provision of community and hospital Children and Adolescent Mental Health Services to ensure there is enough capacity to meet growing population needs.

There has been some progress in the provision of mental health crisis care. For example, the improved availability of crisis lines which are now open 24 hours a day, seven days a week, and the expansion of Liaison Psychiatry Services in the ED which provide patients with parallel assessment for their mental and medical healthcare needs.

The treatment of the most unwell patients detained or due for assessment under the Mental Health Act is a cause for concern. At present, these patients experience unacceptable delays for their assessment and care. The Mental Health Bill currently making its way through Parliament presents an opportunity to introduce national standards, reporting, and scrutiny of the quality and access to care of these patients.

Patients waiting to be admitted into a mental health bed, children and young people in crisis, and patients detained under an Emergency Section of the Mental Health Act, are often the most unwell and vulnerable of patient with mental health needs. Yet these patients wait the longest in our EDs in busy environments with limited specialist care. Some patients unfortunately deteriorate as they wait, leading to increased distress. For these reasons the Royal College of Emergency Medicine advocates for a better provision of care. It is essential that EDs can provide these patients with timely, effective, and compassionate care for both their mental and physical health needs.

An effective mental healthcare system requires balance between adequately funded community-based services and hospital provision. Integrated Care Systems must play a role in ensuring mental health services are integrated more systematically into the wider healthcare system and to give better, more coordinated care to people with mental illness. There must also be significant investment and expansion of mental health community care and preventative services in order to ensure patients get the support they need. While not all mental health crises can be avoided, these services will go some way in preventing some patients from experiencing the distress of reaching crisis point.

We would like to thank the Royal College of Psychiatrists for their expertise and guidance throughout the process of producing this report.

Recommendations

To improve the experiences and outcomes of patients with mental health needs in accessing urgent and emergency care (UEC), change needs to be instigated at three distinct levels of policy and decision making: by the UK Government, NHS England, and by Integrated Care Systems.

For the UK Government and devolved administrations:

- Significantly increase adult, children, and young people Mental Health bed capacity in NHS Trusts.
- Provide funding to expand the provision of Children and Adolescent Mental Health services, ensuring they are available 24 hours a day, seven days a week to assess or at least triage children and young people presenting to the ED in crisis.
- Workforce planning should be in place to train professionals for these services, to ensure they are staffed overnight and at weekends, enabling the units to accept emergency admissions out of hours.
- Continue to invest in Liaison Psychiatry services, to honour the commitment to provide not just minimum Core 24 services but to deliver enhanced and comprehensive services in bigger trusts.
- Provide funding for preventative and community mental health services, especially eating disorder services, to keep up with growing demand.
- Amend the Mental Health Bill in order to introduce standards, national reporting and scrutiny of the quality and access to care provided to patients detained or due for assessment for possible detention under Emergency Mental Health legislation.

For NHS England:

- Publish, on a regular basis, the number of patients presenting with Mental Health symptoms experiencing stays over 12 hours from their time of arrival to when they leave the department to be admitted, transferred, or discharged.
- Introduce the one-hour standard to be seen by a mental health professional from referral from ED, for all ages, as recommended in the Clinical Review of Standards.
- Introduce standards for hospital security teams and mandatory training in Mental Health, so all teams can provide safe restraint when there is no other option and is absolutely necessary.
- Review and improve how Section 12 (2) doctors are commissioned and paid in order to ensure timely assessments for patients detained under the Mental Health Act.
- Carry out a national review of the numbers of Approved Mental Health Professionals to ensure patients detained under the Mental Health Act have timely access to assessment.

For Integrated Care Systems (ICS):

- Ensure universal coverage of crisis response services in every community. These include ambulance – mental health joint response cars, 24/7 phone lines and crisis cafes.
- Prioritise early intervention multidisciplinary services to address the underlying unmet need in High Intensity Use. There should be robust evaluation of services to see which models work best.
- Hold Mental Health and Acute Trusts jointly accountable for patients with mental health needs enduring delays of 12 hours or more in EDs from their time of arrival to when they leave the department to be admitted, transferred, or discharged.
- Support Mental Health trusts and Emergency Departments to develop acute assessment spaces with Mental Health Professionals to care for patients.

Introduction

This report focuses on mental health emergency care patients. Although mental illness comprises the largest single cause of disability in the UK,¹ mental health presentations account for a relatively low proportion of all Emergency Department (ED) attendances.² The care needs of these patients are often complex: they may reach the ED in a state of crisis and with emergency physical healthcare needs. It is essential that EDs are able to provide these patients with timely, effective, and compassionate care for both their mental and physical health needs.

To aid system-wide integration of physical and mental healthcare the Mental Health Taskforce was established in 2015 to improve care for patients with mental health needs including providing 24/7 mental health liaison services for all people of all ages by 2020/21.^{3 4} At the start of the pandemic, more than half of Mental Health Trusts did not have a public-facing 24/7 mental health helpline for people to access urgent mental health support. At present, all mental health providers have now set up 24/7 all-age mental health crisis lines and all acute hospitals now have adult Liaison Psychiatry teams available. In addition, 24/7 comprehensive crisis support for children and young people has grown from 26% to 67% across the country during this time.⁵

Despite this, the experience of patients with mental health needs within ED settings is extremely varied. The aim of this report is to highlight the disproportionately high number of long waits, and the most pressing needs within this population of patients.

Mental health presentations to EDs

Social and demographic changes in the population have been reflected in the increase in people presenting in EDs with drug and alcohol problems, a rise in homelessness, an increase in acute mental illness, and rising dementia rates.⁶ With an ever-growing population living with complex, long-term health conditions and needs, co-provision of mental and physical health services is integral to good population wellbeing.⁷ Adults with mental health needs are three times more likely to attend an ED and are five times more likely to have an emergency admission to a general hospital.⁸ As the prevalence of mental ill health increases, so too does the pressure on inpatient and outpatient mental health services. The impact of this is delayed patient care, and increased pressure on clinical staff, services, and resources to deliver.⁹ National data from two subsets of Hospital Episode Statistics (HES) suggests a marked increase in ED attendances relating to mental health presentations between 2009/10 and 2017/18 (Graph 1), with little evidence of change thereafter (Graph 2).

¹ Department of Health (2013) Annual Report of the Chief Medical Officer 2013 - Public Mental Health Priorities: Investing in the Evidence. Available [here](#).

² EMJ Supp. Mental Health in the Emergency Department: skills, challenges and services. Catherine Hayhurst, 2019.

³ NHS England (2016) The Five Year Way Forward for Mental Health. Available [here](#).

⁴ NHS England (2016) The Five Year Way Forward for Mental Health – We are One Year On. Available [here](#).

⁵ NHS England (2022) Mental Health Clinically-Led Review of Standards. Available [here](#).

⁶ Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

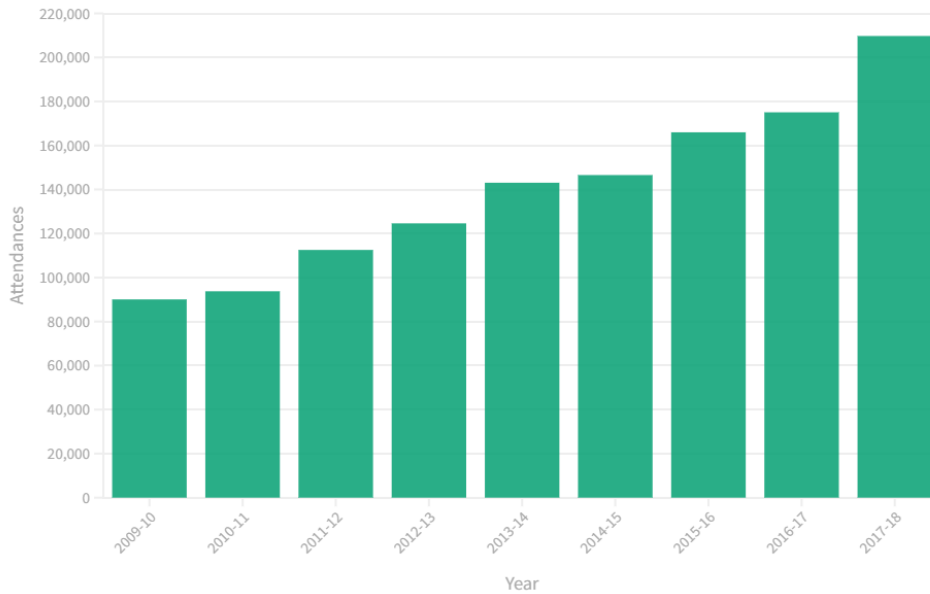
⁷ Ivbijaro, G.O., Enum, Y., Khan, A.A. et al. Collaborative Care: Models for Treatment of Patients with Complex Medical-Psychiatric Conditions. *Curr Psychiatry Rep* 16, 506 (2014). <https://doi.org/10.1007/s11920-014-0506-4>

⁸ NICE and NHS England (2016) Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance. Available [here](#).

⁹ Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

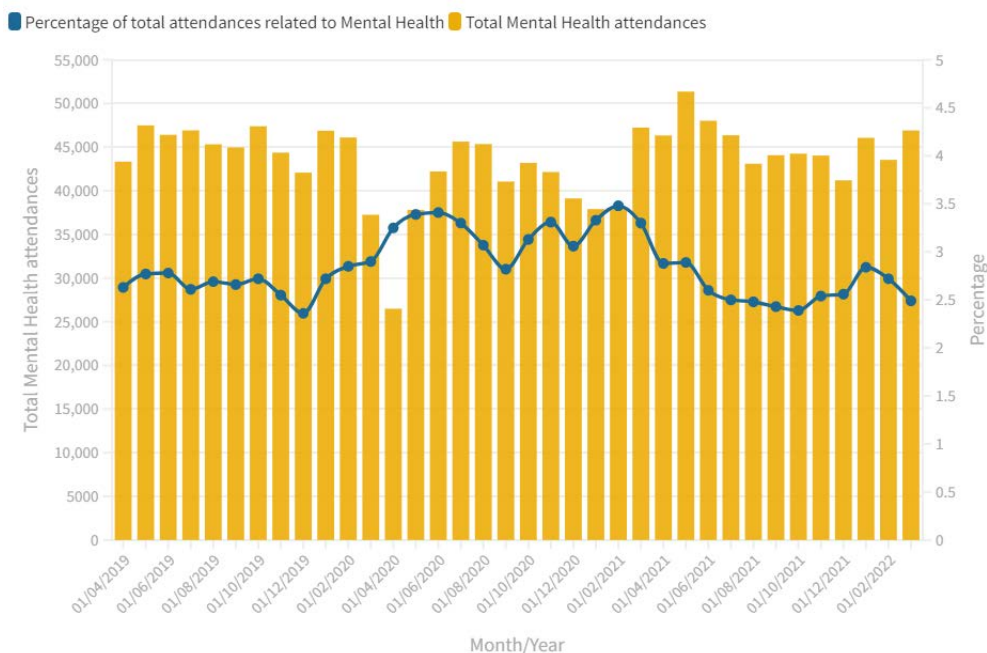
Graph 1 shows all mental health attendances to the ED identified in HES data increased by 133% between 2009/10 and 2018/19. Some of this increase may be attributable to improvements in clinical coding, and improvements in recording information about patient journeys. In 2009/10, 6.9% of all mental health ED attendances were children and young people under the age of 18 (6,192 individuals). In 2018/19, 10% of all ED mental health attendances were under 18s. This means that in 2018/19, 26,582 children and young people experienced a mental health emergency so severe that it resulted in them needing to attend an ED.

Graph 1: All ED Attendances with a Mental Health as Primary Diagnosis from HES coding



Graph 2 displays data from the Emergency Care Dataset (ECDS) available from NHS Digital. It reveals that, for the past few years, mental health ED attendances have not increased at the rate previously illustrated by Hospital Episode Statistics. Since April 2021, mental health attendances have accounted for less than 3% of total attendances to EDs.

Graph 2: Total and percentage of Mental Health attendances



The total number of mental health ED attendances has remained stable over the past three years, except during the first national COVID-19 lockdown when all attendances to EDs declined. This pattern is also consistent with data published by the UK Health Security Agency (UKSA) examining mental health attendances over the past few months.¹⁰

However, this consistent pattern of attendances is in stark contrast to the increasing prevalence of mental health disorders in the community, which has been exacerbated by the pandemic and longstanding barriers to timely and effective early intervention.^{11 12} It is likely that these recent ED and crisis service developments are helping to meet some of the growing demand for mental health care, but that the severity and complexity of illness that presents in the ED is now greater, particularly among children and young people.¹³

Liaison Psychiatry

Liaison psychiatry is a specialty that provides a range of mental health services in physical health settings including mental health care to people with urgent needs arriving to EDs. Working alongside clinicians in EDs, Liaison Psychiatry provides quality of access, clarity of communication and concurrent care, supporting vulnerable patients with their mental health needs in acute settings.¹⁴ Core 24 provision describes a service that is available 24 hours a day, seven days of the week. There have been great improvements in the scaling up of this provision in England in recent years: in 2016, only 12% of provided Core 24 provision in England, data from 2022 reveals that now 64% of hospitals provide this service.¹⁵

The NHS Long Term Plan outlined a commitment to ensuring 70% of Mental Health Liaison services in acute hospitals met the 'Core 24' standard for adults by 2023/24, working towards 100% coverage thereafter. Core 24 was designed to be the minimum service with larger hospitals requiring enhanced services and tertiary referral centres providing comprehensive services. Patients with dual diagnosis of mental health and alcohol and drug use are frequently seen in the ED. Enhanced and Comprehensive Services provide more consultant care and specialised drug and alcohol services.

The Clinically-Led Review of NHS access standards focused on measuring what is meaningful to patients and clinically relevant. NHS England's Interim Report of the Clinical Review of Standards (CRS), published in March 2019, proposed the one-hour referral metric, whereby "patients referred from an ED should have a face-to-face assessment by mental health liaison, or children and young people equivalent service commence within 1 hour."¹⁶ This has yet to be introduced despite being consistently welcomed by every organisation as its use would promote equality and transparency of provision.

Recommendations

- The UK Government should continue to invest in Liaison Psychiatry services, to honour the commitment to provide not just minimum Core 24 services but provide enhanced and comprehensive services in bigger NHS Trusts.
- NHS England should introduce the one-hour standard to be seen by a Mental Health Professional from referral from ED, for all ages, as recommended in the Clinical Review of Standards.

¹⁰ UKSA (2022) Emergency Department: weekly bulletins for 2022. Available [here](#).

¹¹ NHS Confederation (2022) We cannot continue to neglect mental health funding. Available [here](#).

¹² Exploring Mental Health Inpatient Capacity 2019, p11

¹³ RCPsych (2020) Two-fifths of patients waiting for mental health treatment forced to resort to emergency or crisis services. Available [here](#).

¹⁴ RCEM, RCPsych, RCN, RCP (2020) Side by side: A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals. Available [here](#).

¹⁵ NHS England (2016) Report of the 3rd Annual Survey of Liaison Psychiatry in England. Available [here](#).

¹⁶ NHS England (2021) Mental Health Clinically-Led Review of Standards. Available [here](#).

Alternatives to ED attendance

The NHS Long Term Plan outlined a commitment to delivering a range of alternative crisis services by 2023/24. Patients that do not require physical health care could be better cared for in a setting that is not the ED. This may be in the form of a crisis phone line, crisis cafes and in some cases mental health emergency units. Many of these alternative settings were rapidly set up during the pandemic and were found to have mixed results.¹⁷ Providing physical health care for patients in the ED and then transferring them to a separate mental health ED risks adding delays, increasing stigma and undoing the integration of physical and mental healthcare. These units should be evaluated in the longer term, with the aim of examining the patient experience and outcomes, waiting times, transfers between units and multiple handovers of care.

Mobile crisis response services have also been introduced, combining mental health professionals with paramedics. In London, the Mental Health Joint Response Car launched in November 2018 had a significant positive impact in reducing conveyance rates i.e., the decision to transport a patient to a healthcare facility, with a conveyance rate of only 18% compared to the usual rate of 52%.¹⁸ Integrated Care Systems have the power to play an important coordinating role in providing crisis response services.

Recommendation

- Integrated Care Systems must ensure universal coverage of crisis response services in every community. These include ambulance – mental health joint response cars, 24/7 phone lines and crisis cafes.

High Intensity Use (HIU)

A patient is classed as a high intensity user (HIU) if they present to the ED five times or more within a year. Of the patients who meet this definition, 71% have a diagnosable mental health problem.¹⁹ Unpublished data from a UK teaching hospital showed 3.7% of all attendances in 2003 were by patients who came five times or more that year. In 2021, this had risen to 9.8%, and 1,592 patients accounted for 11,831 attendances. The Red Cross reported 16% of ED attendances nationally were by patients attending five times or more in 2020²⁰, illustrating a large and increasing group of patients with unmet needs. An ED attendance can meet a patient's immediate UEC needs but cannot make much impact on the overlapping mental health, drug, alcohol, social and chronic physical health problems which need longer term support.

Various initiatives such as "HIU Right care"²¹, community prescribers and multi-agency working have indicated that tailored care can tackle the underlying mental, physical and social challenges this population face. Unfortunately, evaluation of these interventions has relied on before and after measures rather than a control group. There is a need for robust evaluation of these interventions to better understand their effect.

Recommendation

- Integrated Care Systems must prioritise early intervention multidisciplinary services to address the underlying unmet need in High Intensity Use. There should be robust evaluation of services to see which models work best.

¹⁷ RCPsych & The Faculty of Liaison Psychiatry (2022). Alternatives to emergency departments for mental health assessments during the COVID-19 pandemic. Available [here](#).

¹⁸ AACE (2020) Mental Health Joint Response Car. Available [here](#).

¹⁹ Designing services for frequent attenders to the Emergency Department: a characterisation of this population to inform service design. Morris et al, Clinical Medicine 2016; 16 (4) 325-9.

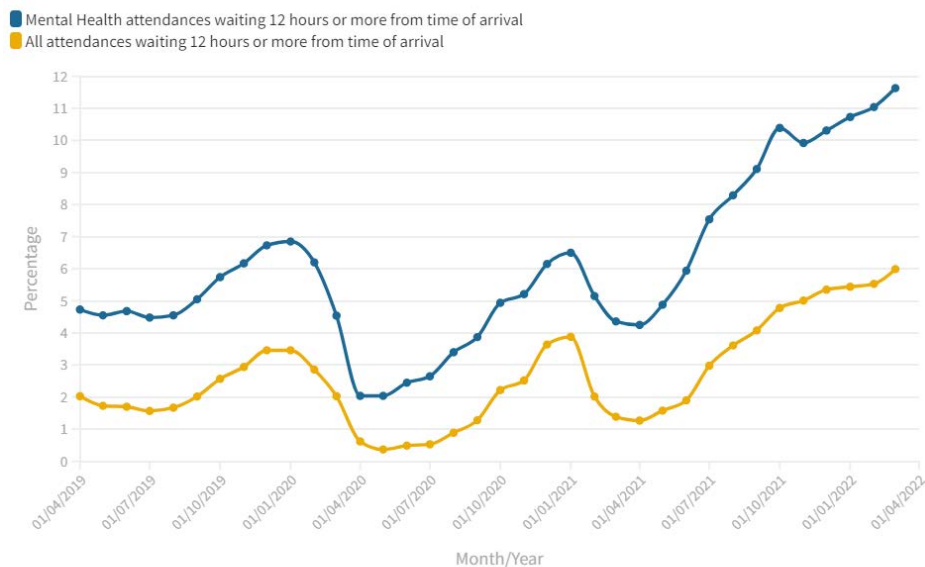
²⁰ British Red Cross (2021) Nowhere else to turn. Exploring high intensity use of A&E services. Available [here](#).

²¹ <https://www.england.nhs.uk/high-intensity-use-programme/>

Patients with mental health needs and crowding in EDs

Graph 3 shows data from HES ECDS (NHS Digital). It reveals that nearly 12% of all patients with mental health needs spend more than 12 hours in an ED from their time of arrival. They are twice as likely to spend 12 hours in the ED when compared to all attendances. It is also important to note that the numbers of these patients experiencing a 12-hour length of stay appears to follow the pattern of overall numbers of patients who are waiting 12 hours or more. This suggests that one of the biggest indicators of long delays to treatment for these patients is whether all other patients are experiencing 12-hour waits.

Graph 3: Percentage of patients waiting 12 hours or more from time of arrival



Source: ECDS, NHS Digital

RCEM has long argued that the rise in 12 hour waits from time of arrival is a symptom of poor patient flow through hospitals and a mismatch between demand and capacity in the UEC system, which seems to be worse for patients with mental health needs. Unfortunately, these patients are likely to endure waits beyond 12 hours. In a RCEM Snap Survey, 39% of Clinical Leads reporting mental health related stays in their ED of 72 hours or more. Additionally, one respondent recounted a stay of 15 days whilst another reported a patient a staggering wait of over 20 days for a bed.²² Such long waits are usually due to waiting for CAMH assessment, for a Mental Health Act assessment, or for a mental health bed to become available. Crisis resolution and Home Treatment services provide alternatives to admission, with NHS England reporting 98% of regions have a 24/7 crisis service able to visit patients at home.

²² RCEM (2022) Data and Statistics. Available here.

Recommendations

- NHS England must publish, on a regular basis, the number of patients presenting with Mental Health symptoms experiencing stays over 12 hours from their time of arrival to when they leave the department to be admitted, transferred, or discharged.
- Integrated Care Systems must hold Mental Health and Acute Trusts jointly accountable for patients with mental health needs enduring delays of 12 hours or more in EDs from their time of arrival to when they leave the department to be admitted, transferred, or discharged.

The pressure cooker effect of long waits

In our RCEM CARES campaign²³ we asserted that different patients experience care offered in EDs in different ways. Patients who suffer a mental health crisis often report having a poor experience, with long waits in an environment that is stressful and stigmatising. Studies have also shown that some patients can feel physically and psychologically unsafe in ED settings.²⁴ High levels of operational strain on the UEC system can lead to poor communication about the process and waiting times, contributing to distress.²⁵ Although this can be a stressful environment for any patient, it can be particularly detrimental to patients who experience poor mental health.²⁶ A recent study has shown that patients with mental health needs with a longer length of stay in an ED are more likely to receive an antipsychotic or sedative drug during their stay²⁷, indicating that a longer length of stay contributes to stress and agitation.

Whilst most EDs have a designated safe, quiet room for assessment²⁸, very few have designated quiet areas for patients to be cared for whilst being treated or waiting for assessment or onward care. Our SNAP survey of ED clinical leads found 66% of respondents reported caring for patients with mental health needs in unsuitable areas every day in the week before the survey. A few Trusts have successfully staffed separate areas with Mental Health Nurses or support workers. However, it is challenging for Trusts to create such areas due to the huge pressures on space due to crowding.

Recommendations

- Integrated care systems should support Mental Health trusts and Emergency Departments to develop acute assessment spaces with Mental Health Professionals to care for patients.

Restraint

Patients experiencing mental health crises can sometimes become fearful or anxious. They may have concomitant drug or alcohol intoxication, pain, or cognitive problems. These coupled with long waits in a stressful environment may cause agitation and violence.

Violence and aggression may arise for many reasons, not just mental health triggers. RCEM's National Survey on Security and Restraint in the Emergency Department (2020) revealed a

²³ RCEM (2021) The RCEM CARES Campaign. Available [here](#).

²⁴ Quinlivan LM, Gorman L, Littlewood DL, et al (2021) 'Relieved to be seen'—patient and carer experiences of psychosocial assessment in the emergency department following self-harm. *BMJ Open*;11:e044434.

²⁵ Quinlivan LM, Gorman L, Littlewood DL, et al (2021) 'Relieved to be seen'—patient and carer experiences of psychosocial assessment in the emergency department following self-harm. *BMJ Open*;11:e044434.

²⁶ RCEM (2021) Mental Health Toolkit. Available [here](#).

²⁷ Lane DJ, Roberts L, Currie S, et al (2022) Association of emergency department boarding times on hospital length of stay for patients with psychiatric illness. *Emergency Medicine Journal* 2022;39:494-500.

²⁸ <https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/psychiatric-liaison-accreditation-network-plan/plan-standards>

striking lack of consistency and standards for managing agitated patients across trusts with ED staff and patients being subjected to frequent potential harm.²⁹ Many trusts reported inadequate security provision and that they had to resort to phoning the police if a patient was aggressive towards others or left the department with a risk of self-harm. Whilst it is appropriate for police to be involved to protect staff and other patients, it does not seem appropriate for police to be involved to prevent self-harm. Early detection and de-escalation of aggression by ED staff is vital and security teams are needed which can respond quickly and help de-escalate when appropriate.

There are times when a patient is so unwell and agitated that despite attempts to de-escalate the situation, the safest option is to restrain and sedate them. In such situations, this allows clinicians to safely assess and treat the patient, consistent with NICE guidelines. Trained teams involving security and clinicians working together have shown a reduction in restraint use.³⁰

RCEM's Survey on Security and Restraint highlighted that ED staff were unclear if security services have received any training in mental health. Ensuring that security staff are adequately trained in engaging patients with mental health needs could provide a better outcome for patients and clinical staff.

Recommendation

- NHS England should introduce standards for hospital security teams and mandatory training in Mental Health so all teams can provide safe restraint when there is no other option and is absolutely necessary.

Child and Adolescent Mental Health Services (CAMHS)

Children and Young People's (CYP) mental health needs have increased more rapidly than those of adults in recent years, especially during the pandemic. The provision of CAMHS supporting emergency care is unevenly distributed across England. The results are long waits and poor care for this group in UEC settings.

NHS England's Children and Adolescent Mental Health GIRFT report found that in 2020, one in six children aged five to 16 had a 'probable mental disorder', a marked increase from 2017's proportion of one in nine children.³¹ According to the Royal College of Psychiatrists (RCPsych), there has been a 96% increase in referrals to CAMH services between April and June 2021 compared to the same period in 2019.³² Between April 2021 and December 2021, almost 10,000 CYP started treatment for an eating disorder.³³ In March 2022, the NHS reported that more people than ever before are receiving treatment for eating disorders, particularly among CYP.

As discussed previously, all mental health attendances to the ED identified in Hospital Episode Statistics rose by 133% between 2009/10 and 2018/19. Graph 4 above reveals that for under 18s this figure rose by 341%. Some of this increase may be due to an improvement in coding, but this increase aligns with RCEM members experience and accounts during this time.

²⁹ RCEM (2020) National Survey on Security and Restraint in the ED. Available [here](#).

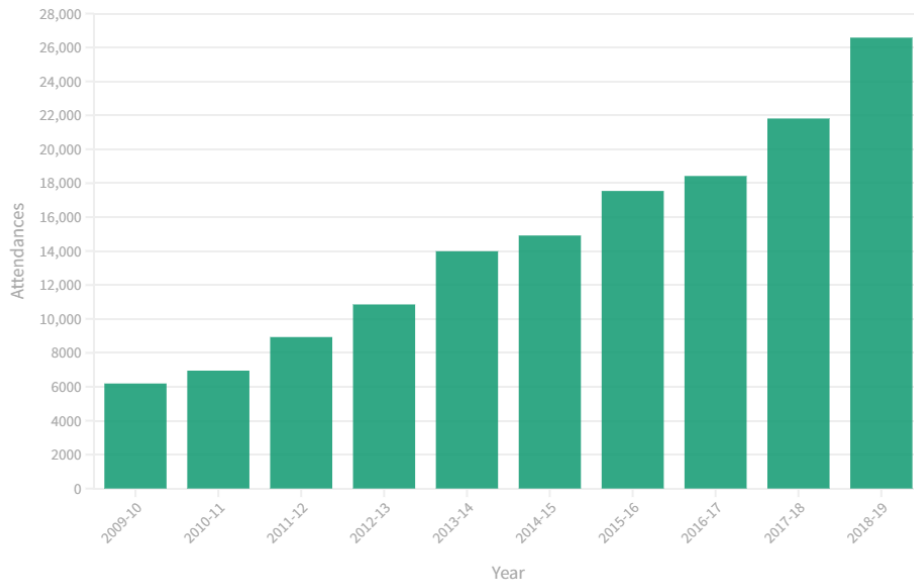
³⁰ [https://www.annemergmed.com/article/S0196-0644\(21\)01381-0/pdf](https://www.annemergmed.com/article/S0196-0644(21)01381-0/pdf)

³¹ Dr Guy Northover (2022) Children and Young People's Mental Health Services Getting it Right First Time Report.

³² RCPsych (2021) Record number of children and young people referred to mental health services as pandemic takes its toll. Available [here](#).

³³ NHS England (2022) NHS treating record number of young people for eating disorders. Available [here](#).

Graph 4: Under 18 ED attendances with Mental Health as primary diagnosis from HES coding



In 2021, RCEM conducted a follow up survey of UK ED Clinical and Mental Health leads examining CAMH services for the ED.³⁴ The survey found that 48% of respondents rated CYP services in the ED positively, while 52% felt the service was poor or awful. The survey found that 20% of EDs had a 24/7 service, an increase from 8% of EDs in 2018. Furthermore, 64% had no service after 5 p.m. despite the fact CYP typically present with a mental health crisis in the afternoon and evening; as a result, many patients and families wait overnight for an assessment the following day. The Clinically Led Review of Standards for Mental Health recommends an hour from referral to review by a mental health professional in the ED.³⁵ Whilst this is possible in many EDs for adults, very few CAMH services achieve this. Half of respondents in RCEM’s survey reported that the time to see a CAMH specialist in ED was between 12 and 24 hours. CAMHS patients are often made to wait in environments that are not age appropriate. For example, a 16-year-old CAMHS patient could be cared for in an adult ED.

If a CYP needs admission to a mental health bed, our survey estimated that 46% will wait more than 48 hours in the ED for a bed. Two respondents reported an astonishing five day wait in the ED. Some hospitals will admit children to acute wards. While this may represent a more clinically appropriate setting than an ED, it puts further pressure on an already stretched inpatient system and leads to longer waits for other children in EDs.

It is not uncommon for patients’ mental health to deteriorate whilst waiting for a bed, sometimes resulting in self harm or increased distress. Despite increases in demand, the NHS Confederation found that the number of commissioned mental health beds for CYP has fallen by 20% over the last five years.³⁶ A survey of trust leaders from 30 NHS mental health trusts – representing 58% of all trusts providing CAMH services – found that 72% did not think they had enough staff and of the right mix to provide quality mental health care to CYP.³⁷ Additionally, 61% felt that they did not have sufficient local CAMH beds compared with 25% who felt they did.³⁸ This is particularly concerning as all beds required by CYP fall under

³⁴ RCEM (2021) A survey of Children and Adolescent Mental Health Services in the ED. Available [here](#).

³⁵ NHS England (2022) Mental Health Clinically-Led Review of Standards. Available [here](#).

³⁶ NHS Confederation (2022) We cannot continue to neglect mental health funding. Available [here](#).

³⁷ NHS Providers (2021) Children and young people’s mental health survey. Available [here](#)

³⁸ NHS Providers (2021) Children and young people’s mental health survey. Available [here](#)

section 140 of the Mental Health Act (MHA) with Trusts obliged by law to provide these with special urgency. The reason for delays to admission is partly down to a lack of beds but the issue is further impacted by the way that beds are organised, with the majority commissioned nationally. Locally managed CAMH beds (as in the 'new care models') have been reported anecdotally to work better, encouraging collaboration and accountability whilst also reducing out-of-area placements. Another factor is that many units will not admit a child or young person at the weekend or in the evenings due to lack of trained staff.

RCEM's survey also reported 62% of respondents as having access to a CAMH telephone support line. This is a welcome improvement attributed to the Covid-19 pandemic and can provide an alternative to the ED for many. Such telephone lines are an opportunity for telephone triage within the ED, which can allow patients and families to go home and return to be assessed in person the following day. It is also reported by NHS England that CYP 24/7 comprehensive crisis support have grown, rising from 26% to 67% over the last 2 years.³⁹ These services prevent admissions and crisis attendances to ED for CYP under their care, but are mostly unavailable to patients until they have been assessed by CAMH. Workforce has been a particular challenge for these new services and in many regions. While funding is often available trained staff frequently cannot be recruited. Health Education England reported a 10.6% average vacancy rate amongst all NHS CYP mental health workforce⁴⁰ – a rise of 50% since 2016.

Recommendations

- The UK Government must provide funding to expand the provision of Children and Adolescent Mental Health services, ensuring they are available 24 hours a day, seven days a week to assess or at least triage children and young people presenting to the ED in crisis.
- Workforce planning should be in place to train professionals for these services, to ensure they are staffed overnight and at weekends, enabling the units to accept emergency admissions out of hours.
- The UK Government and NHS England must provide funding for preventative and community mental health services, especially eating disorder services, to keep up with growing demand.

³⁹ NHS England (2022) Mental Health Clinically-Led Review of Standards. Available [here](#).

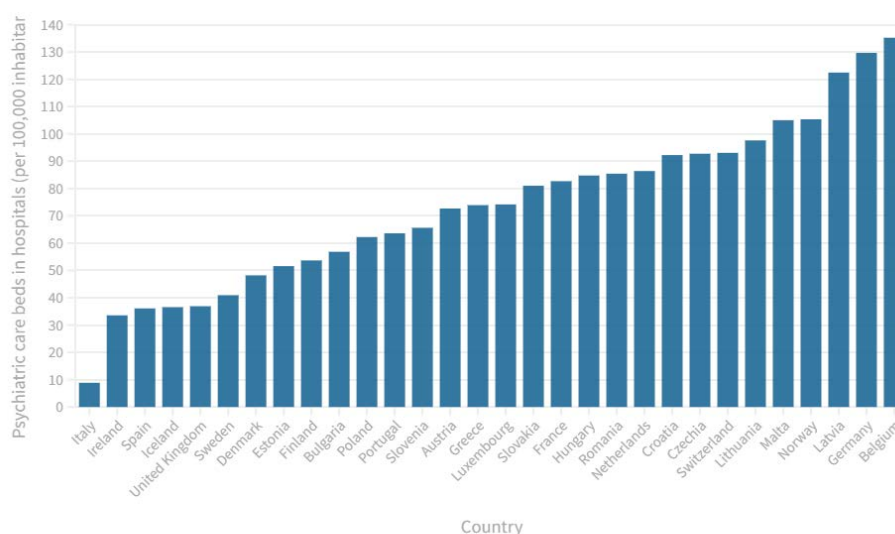
⁴⁰NHS Benchmarking Network (2021). Children and Young People's Mental Health Services Workforce Report for Health Education England. Available [here](#).

Mental Health Beds

Inpatient beds

The number of hospital beds in a healthcare system determines the capacity of specialist health care professional teams and resources, to provide effective inpatient treatment. The number of hospital beds that are available should be based on population health care needs, taking regional and demographic variation into consideration. Graph 5 shows the number of acute psychiatric beds in the UK is significantly below the OECD (Organization for Economic Co-operation and Development) average. In 2018, the number of psychiatric beds in the UK was 37 per 100,000 population, compared with the OECD average of 71 per 100,000 and 68 per 100,000 within EU countries.^{41 42}

Graph 5: Psychiatric care beds across Europe hospitals per 100,000 population, 2018



Source: EuroStats



Between 1987-88, and 2018-19, the number of NHS mental health beds in England was cut from around 67,000 to 18,400 with the shift towards care in the community.⁴³ Since 2010/11, the number of mental health beds in England continued to decline from 23,500 to 18,200, a reduction greater than 23%.⁴⁴ At the beginning of the pandemic, the NHS saw its bed stock reduced by just under 10,500 beds, and although a significant proportion of those beds have since been reintroduced to the system, over 2,000 remain unavailable.⁴⁵ Graph 6 shows how the number of psychiatric care beds in the UK has continued to fall at a faster rate than other OECD nations with a similar population, despite already being significantly below the OECD average.

The reduction in the number of acute psychiatric beds has contributed to high bed occupancy levels, which are an important indicator of pressure in all parts of the system. The RCPsych recommends a maximum bed occupancy of 85%.⁴⁶ From April 2017 – March 2020, bed occupancy across mental health trusts did not once meet this target and the average level of bed occupancy during this period was 89.2%.⁴⁷

⁴¹ Eurostat (2021) Hospital beds by type of care. Available [here](#).

⁴² ACEM (2021) Nowhere else to go: why Australia's health system results in people with mental illness getting stuck in EDs. Available [here](#).

⁴³ NHS England (2022) Bed availability and occupancy data – overnight. Available [here](#).

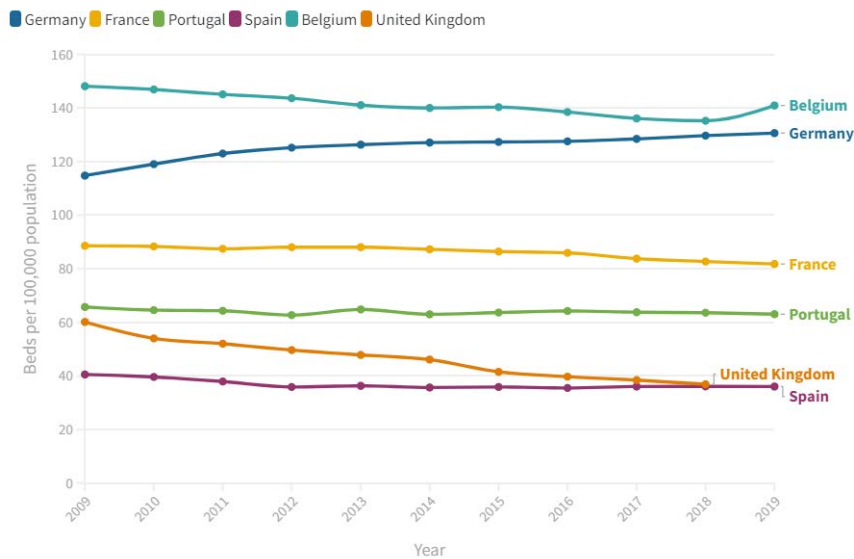
⁴⁴ RCEM (2021) Acute Insight Series: Crowding and its Consequences. Available [here](#).

⁴⁵ RCEM (2021) Acute Insight Series: Crowding and its Consequences. Available [here](#).

⁴⁶ RCPsych (2022) Bed occupancy across mental health trusts. Available [here](#).

⁴⁷ RCPsych (2022) Bed occupancy across mental health trusts. Available [here](#).

Graph 6: Annual number of psychiatric care beds in OECD nations from 2009 to 2019



Community care

The mental health policy line adopted across most of the OECD nations has been that of deinstitutionalisation, which pushes towards care for individuals within their community, rather than in hospitals.⁴⁸ Community care can benefit individuals by limiting the negative effects associated with social and familial isolation but requires intensive resources to care for patients who would previously be cared for in hospitals. Research in the EU suggests that deinstitutionalisation has had some unintended consequences. When hospitals have not been replaced by accessible and affordable community services, it has in some cases led to a rise in the frequency of admissions to hospital and even homelessness for people with severe mental illness.⁴⁹ The OECD has emphasised that an effective mental health system requires a balance between adequately funded community-based services and inpatient services.⁵⁰ RCPsych recently echoed the recommendations of the 2016 Government commissioned Crisp report that investment was still needed in community services to increase capability and capacity.⁵¹

Impact on Hospital Beds

Research from 2019 found that despite the number of admissions to mental health beds declining in the last two decades, the number of admissions of patients with primary mental health diagnoses to acute hospital beds has increased.⁵² Between 2015/16 and 2018/19, the number of patients with mental health needs admitted to a general hospital bed exceeded admissions to mental health beds.⁵³ This may in part be due to improvements in coding, and identification of patients with dementia in acute beds, but it also highlights that patients are being admitted to acute beds, increasing the pressure on an already stretched system.

Insufficient numbers of hospital-based mental health beds create problems for people with severe mental illness, as they may face extended ED waits, higher thresholds for admission to an acute bed, and short revolving-door stays with increased rates of rehospitalisation.

⁴⁸ Shen G & Snowden L (2014) Institutionalization of deinstitutionalization: a cross-national analysis of mental health system reform, *International Journal of Mental Health Systems*.

⁴⁹ OECD (2014) Focus on making mental health count. Available [here](#).

⁵⁰ Organisation for Economic Cooperation and Development (2015) OECD Health Statistics 2015. Available [here](#).

⁵¹ Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

⁵² Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

⁵³ Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

Additionally, limited access to inpatient mental health treatment has been associated with higher suicide risk, premature mortality, homelessness, violent crime, and incarceration.⁵⁴

A lack of local bed management has led to an increase in out of area placements (OAP). An OAP occurs when a person with acute mental health needs who requires inpatient care is admitted to a facility away from their local area, an environment that is unfamiliar and potentially far away from family and friends. An OAP is classed as inappropriate if the reason is non-availability of a local bed.

Some patients are treated hundreds of miles away from their homes due to insufficient mental health beds in their area. The Royal College of Psychiatrists has calculated that in 2019 those patients travelled a total of approximately 550,000 miles.⁵⁵ Mental Health Trusts struggling with high bed occupancy and inappropriate OAPs levels must be funded to provide additional beds which would improve standards of care and patient experience.

For OAP patients, discharge back to community services becomes more difficult to co-ordinate and handovers may be less effective. Despite the government's pledge to end all inappropriate adult OAP for acutely ill patients by 2021, this has not been the case. Data from NHS Digital shows that by September 2021, there were 715 active OAPs in England, 90% of which were deemed 'inappropriate'.

Recommendation

- The UK Government must significantly increase adult, children, and young people Mental Health bed capacity in NHS Trusts.

The ED and the Mental Health Act (1983)

The Mental Health Act (MHA) was introduced in 1983 and significantly amended in 2007. It applies to England and Wales and sets out the circumstances in which patients can be detained in hospitals. A small proportion of people with mental health presentations to the ED are brought under Section 136 of the MHA or the equivalent in Scotland and Northern Ireland by the police.⁵⁶ These patients are conveyed to EDs because they also have concurrent physical health problems, or because the local place of safety is full. Other patients may arrive at the ED in crisis and are so unwell that they need assessment under the MHA. In an average, medium-sized ED, there may only be a few patients per week, but patients awaiting an MHA assessment are likely to wait for several hours before they are assessed.

Data from three separate teaching hospitals, showed that patients under Section 136 experienced a mean wait of 11.18 hours, 10 hours, and 8.26 hours respectively from referral to MHA assessment. This shows that the patients experiencing the most severe psychiatric symptoms endure the longest waits. There is currently no national standard for a waiting time for assessment and no nationally collected data, contributing to the lack of voice for this patient group.

For some patients being detained under Section 136 or the equivalent in Scotland and Northern Ireland, may add to their distress, and a busy ED environment may make this worse. It is not uncommon for patients to become more agitated and be given sedation to reduce their agitation. Patients are likely to wait overnight to be seen the next day, leading to sleep deprivation which may impact on their assessment the following day. Patients are also often transferred from one place of safety to another to facilitate assessment, which is disruptive

⁵⁴ Allison, S., Bastiampillai, T., Licinio, J. et al. (2018) When should governments increase the supply of psychiatric beds?. *Mol Psychiatry* 23, 796–800.

⁵⁵ Strategy Unit (2019) Exploring Mental Health Inpatient Capacity. Available [here](#).

⁵⁶ This is referred to as Section 136 in England and Wales, Section 297/8 in Scotland, and Article 130 in Northern Ireland.

and may involve transport in a police van. Patients often report feeling like a burden to the system as a result. In England and Wales, assessment is carried out by an approved mental health professional (AMHP) and two doctors, one of whom must be approved by the Secretary of State for Health and Social Care under Section 12(2) of the Mental Health Act (1983), where they are described as having "special experience in the diagnosis or treatment of mental disorder". In most places, the Local Authority commissions this service. Accessing these doctors can be difficult as most services depend on an on-call AMHP contacting the relevant doctors, who may or may not be available.

There is a general lack of availability of these doctors and AMHPs are often stretched, as they cover safeguarding emergencies for a large area. A recent study found that there were 9,907 Section 12(2) doctors on the approvals register in England and Wales, but only 36% of these (3,478) made themselves available for a fee-paying assessment.⁵⁷ Section 12(2) doctors report that the fee paid per assessment is not enough incentive for them to work out of hours. Both of these factors lead to delays in assessment. As well as a need to improve the timeliness of assessment for patients under the MHA, there is also a need to prevent patients being detained by earlier and improve mental health intervention.

There is also a need to prevent patients getting to the point of being detained under the Mental Health Act. Joint mental health and ambulance response cars provide rapid mental health advice to police may reduce the use of the Mental Health Act. There must be robust evaluations of these services to determine whether they reduce the use of the Mental Health Act.

Recommendations

- The UK government should amend the Mental Health Bill in order to introduce standards, national reporting and scrutiny of the quality and access to care provided to patients detained or due for assessment for possible detention under Emergency Mental Health legislation.
- NHS England should review and improve how Section 12 (2) doctors are commissioned and paid in order to ensure timely assessment for patients detained under the Mental Health Act.
- NHS England should carry out a national review of the numbers of Approved Mental Health Professionals to ensure patients detained under the Mental Health Act have timely access to assessment.

Conclusion

The NHS Constitution for England pledges to provide convenient and easy access to healthcare services for every patient. This instalment of our Acute Insight Series reveals that at present, the NHS is failing to meet this pledge for patients with mental health needs who require emergency care. Patients needing admission, children and young people, and patients waiting for assessment under the Mental Health Act are particularly let down. These groups of patients will continue to fall through the gaps in the system unless meaningful action is taken by the government, NHS England, and ICSs.

To support the healthcare system to provide safe, timely, and efficient emergency mental healthcare to all patients, we urge policymakers to tackle long waits for assessment and admission endured by these patients. This can be achieved through expanding staffed mental health bed capacity across the NHS and ensuring CAMHS are available overnight and during

⁵⁷ Stevens, M., Martineau, S., Steils, N., & Manthorpe, J. (2022). The availability of section 12 doctors for Mental Health Act assessments: Interview perceptions and analysis of the national MHA Approvals Register Database. NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

the weekends. ICSs can play an important role in ensuring mental health provision meets local population needs through providing novel and integrated crisis response services. NHS England can additionally support these efforts through the introduction of access standards for these patients and appropriately trained hospital security teams and ensuring adequate numbers of mental health professionals are available to provide patients efficient access to assessment and treatment.