Care of patients with Mental Health Problems in the Emergency Department

Authors
Mark Buchanan | Adrian Boyle

Introduction

This chapter should be read in conjunction with the estate standards for people with mental health problems in the emergency department.

Standards

1. Each Department must have a Mental Health Lead with dedicated time. The role of the Lead includes engaging with the mental health liaison team, police and social care promoting best care for patients attending with a Mental Health presentation.

2. Patients must have mental health triage by ED nurses on arrival to briefly gauge their risk of self-harm, suicide, and risk of leaving the dept before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED.

3. Patients at medium or high risk of self-harm or suicide must be searched for objects or medication that may be used to self-harm.

4. Patients at medium or high risk of suicide or of leaving before assessment and treatment are complete must be observed closely whilst in the ED. There should be documented evidence of either continuous observation or intermittent checks (recommended every 15 minutes), whichever is most appropriate.

5. If a patient states that they want to leave or decline treatment, then there must be documentation of the assessment of that patient's capacity to make that particular decision at that time, based on a face-to-face conversation and not rely on records from previous attendances.

Standards

1. When an ED doctor reviews a patient presenting with self-harm or a primary mental health problem, they must conduct a brief risk assessment of suicide and further self-harm.

2. Previous psychiatric history must be documented in the patient's ED clinical record. This must include previous self-harm or suicide attempts, previous admissions and current treatment.

3. A Mental State Examination (MSE) must be recorded in the patient's ED clinical record.

4. From the time of referral, a member of the mental health team must see the patient face to-face and offer appropriate assistance to both patient and referrer within one hour. Full assessment may be delayed if the patient is not yet fit for assessment.

5. Parallel assessment must be seen as the default approach. This means that patients are assessed concurrently, not consecutively, for both physical and mental health problems. This requires the patient to be well enough to undergo a psychiatric assessment.

6. People who have attended the ED for help with self-harm must receive a comprehensive biopsychosocial assessment with appropriate safety or care planning at every attendance, unless a joint ED/Psychiatric written management plan states that this is not necessary or unhelpful.

7. Details of any referral or follow-up arrangements should be documented in the patient's ED notes

Recommendations

1. Emergency Departments should have a search policy which clearly states when a patient can and can't be searched

2. Departments should have a trust's policy for restrictive intervention and should follow guidance for Rapid Tranquilisation (NICE or their own guideline). At all times this must be in the patient's best interest.

3. EDs should have a policy for patients under the relevant policing and mental health legislation - including section 297 (Scotland), section 130 (Northern Ireland) or section 136 (England and Wales) to ensure safety, dignity, and timely management.

4. Patients awaiting Mental Health Beds should have daily Mental Health reviews. These should be including assessing whether an admission is still the least restrictive option, advice on management of agitation and medication changes.

5. An appropriate programme should be in place to train ED nurses, health care assistants, and doctors in mental health and mental capacity issues.

Background

The care needs of patients with mental health presentations are often complex: they may reach the ED in a state of crisis and with emergency physical healthcare needs.

It is essential that EDs can provide these patients with timely, effective, and compassionate care for both their mental and physical health needs.

What we do know is that 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. Patients with mental illness also suffer disproportionately from physical illness.

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 any other patient group.

Many patients with mental illness report very poor experiences of seeking and receiving care in emergency departments and should be treated with compassionate care and receive parity of esteem.

References

1. *Self-harm: assessment, management and preventing recurrence. NICE. 2022.*
   Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
2. *PLAN standards. RCPSYCH. 2024.*
   https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/psychiatric-liaison-accreditation-network-plan/plan-standards#:~:text=PLAN%20standards%20The%20PLAN%20standards%20provide%20a%20clear,The%20PLAN%20standards%20are%20revised%20every%20two%20years.
3. *RCEM Acute Insight Series: Mental Health Emergency Care. RCEM. 2022.*
   RCEM-Acute-Insight-Series-Mental-Health-Emergency-Care.pdf (cloudinary.com)
4. *Side by side: A UK-wide consensus statement on working together to help patients with mental health needs in acute hospitals.*
   RCPSYCH, RCN, RCEM, RCP. 2020. liaison-sidebyside.pdf (rcpsych.ac.uk)
5. *Mental Health in Emergency Departments: A toolkit for improving care. RCEM. 2023.*
   Mental_Health_Toolkit_April_2023_v1.pdf (cloudinary.com)