

## **Reducing A&E Attendances and Admissions: The Role of Mental Health Services**

At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. <sup>1</sup>

### **1 Introduction**

This paper sets out information requested by the Health Overview and Scrutiny Committee (HOSC) for the meeting to be held on 3 February 2012. This meeting is the third part of a review looking at the impact of current attendance at A&E on the sustainability of health services across Kent and Medway and how levels of attendance can best be reduced.

To inform the review, the Committee has asked for the following:

- Do the current levels of attendance at A&E pose any particular challenge for the commissioning and provision of mental health services?
- What is the role of mental health services in reducing attendances at A&E?
- What is the place of urgent and emergency care in the QIPP programme?
- From the perspective of the mental health service what are the main challenges to reducing attendance at A&E?

Information to answer these questions is set out in the sections below.

### **2 The challenge of current levels of attendance at A&E for mental health services**

The context of a mental health response to A&E is the service currently in place to provide urgent and emergency care for people in a mental health crisis.

This service is provided by the Crisis Resolution and Home Treatment (CRHT) teams, offering acute mental health care for people living in the community and experiencing a severe crisis requiring emergency treatment.

---

<sup>1</sup> (McManus s, Meltzer h, Brugha T et al. (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information centre for health and social care)

Previously, such treatment could only have been provided by admitting the person to an acute inpatient mental health service.

The introduction of CRHT services was a key element in the 1999 National Service Framework for Mental Health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health's 2002 Public Service Agreement included targets for numbers of teams and people treated by them.

The main aim is to provide people in a mental health crisis with the most appropriate and beneficial treatment at home. CRHT was also intended to reduce admissions to acute inpatient adult mental health wards and bed occupancy, support earlier discharge from those wards and reduce out-of-area treatments. The service is available around the clock, every day of the year; and provides immediate assessment and treatment for people who are experiencing a major mental health crisis, and support to their relatives, carers and social systems to resolve the crisis.

Referrals to the CRHT teams come from a number of sources. These include:

- Ambulance service
- GPs
- Kent Police
- NHS Direct
- Mental Health Matters Helpline
- A&E departments
- Secondary care community mental health teams
- Self referral by people known to secondary care mental health services

In Kent and Medway last year (2010/11), 2,646 people were seen by the CRHT teams, resulting in the provision of 3,387 episodes of home treatment and facilitation of 1,615 admissions to acute inpatient adult mental health beds.

Within this context the challenges for mental health services to respond to demand from A&E are as follows:

- CRHT teams are receiving referrals from a range of sources, with A&E only one among them. The teams have finite resources and need to prioritise who they respond to. This might mean that they may be unable to prioritise someone who is in A&E (and therefore in a place of safety) above someone who is in a mental health crisis at home, in the street or in a police station.
- KMPT and mental health commissioners recognised that this service model is making best use of resources within the mental health system but possibly not helping the use of resources within the general hospitals / acute trusts.
- According to the SHA Quality Observatory's ranked opportunity listings 2011 for each of Kent and Medway's four Acute Trusts, self harm is the

third (west Kent and Medway) and sixth (east Kent) highest reason for attending A&E.

- A fully functioning liaison psychiatry service is in place in eastern and coastal Kent, located in EKHUFT A&E departments and wards
- From April 2011 in west Kent, some parts of the secondary care mental health services were separated off, attached to the local A&E departments and called liaison psychiatry Services. These services are now embedded in the A&E departments and able to respond to acute trust priorities.
- These west Kent liaison psychiatry staff currently operate from 9 am to 5pm daily and respond to urgent or emergency calls from A&E; assessing need, managing difficult behaviours, linking up with primary and secondary care mental health services and facilitating patient transfers. (This includes facilitating a Mental Health Act assessment if needed.)
- Response times are good (majority under 2 hours) when the liaison psychiatry staff are in place, and the service works well. Feedback from acute trust staff and patients suggests that the service has been very helpful, improving patient experience and contributing to reducing A&E attendances and re-attendances.
- We know from analysis of attendance data that there are two peaks in attendance at A&E by people with a primary diagnosis of mental health needs. One is in the morning when the liaison team can respond and one is in the evening. During the evening, the referrals return to the CRHT team and response times can be longer for reasons described above. Increasing west Kent liaison psychiatry resources to enable them to cover A&E from 5 pm to midnight as well, and the wards, will improve response times and should enhance the acute trusts' efficiency.

### **3 The role of mental health services in reducing attendances at A&E**

A number of reports published over the last few years set out the case for developing better links between mental and physical health services and the establishment of liaison psychiatry services. These include:

- Case for change – mental health liaison service for dementia care in hospitals (Department of Health 2011)
- No Health Without Mental Health: The supporting evidence (Academy of Medical Royal Colleges 2010)
- NICE 2010 (CG90) The treatment and management of depression in adults and social care
- NICE 2010 (CG103) Delirium: diagnosis, prevention and management
- Healthy mind, healthy body (NHS Confederation 2009)
- No Health Without Mental Health: The ALERT Summary Report (Academy of Royal Medical Colleges 2009)

- Managing urgent mental health needs in the acute trust (Academy of Medical Royal Colleges 2008)
- NICE/SCIE 2006 (amended 2011) (CG42) Supporting people with dementia and their carers in health and social care
- Who Cares Wins: Guidelines for the development of Liaison Mental Health Services for older people (Royal College of Psychiatrists 2005)

These highlight a number of ways that mental health services can work with people with mental health needs in acute hospitals to ensure that they get timely access to appropriate services and reduce inappropriate attendance at A&E.

Some examples are:

### 3.1 Working with ambulance services

Ambulance crews attend to people with a wide range of mental health problems. Mental health commissioners supported KMPT to introduce a protocol with SECamb in January 2011 that enables crews to refer to mental health services rather than convey to A&E those people who do not require a medical or physical intervention by A&E. An ambulance paramedic practitioner or paramedic attending an incident in Kent and Medway can contact the local mental health service for advice or directly to refer a person aged 18 and over at risk as a consequence of anxiety/panic attacks; depression, psychosis or mania; reaction to severe distress (maybe related to unemployment, bereavement, isolation, loneliness, physical disability or significant illness); eating disorder; self harming behaviour or expression of a wish to self harm or end their life.

### 3.2 Developing new pathways

KMPT and commissioners are working in partnership, preparing for the introduction of the 111 number supplied by NHS Pathways and the Directory of Services. This will ensure that people with mental health problems who have an urgent need which is not so severe as to call 999 or go to A&E, can be directed to appropriate mental health services or their GP. Also work is underway to develop the emergency ambulatory care pathway and KMPT is in support, with a particular focus on self harm, offering advice on best practices to support key clinical quality components to be included in a self harm pathway.

### 3.3 Robust care planning for those known to mental health services

For people who are known to mental health services, robust care plans with clear information about how individuals can access urgent help from mental health services will contribute to A&E attendance avoidance.

### 3.4 Timely diagnosis

For people who are not known to mental health services and presenting at A&E, the A&E role is to ensure that mental illness is diagnosed at attendance and these people are linked in with mental health services as appropriate. This group includes those whose mental illness has brought them to A&E and also those who present with physical illness that has been stimulated by mental illness e.g. despair leading to self harm or illness induced through substance misuse. Among people with a physical illness or injury serious enough to require admission, a high proportion have a mental health problem that is frequently masked or overlooked, which can impact on recovery. This includes people with a cognitive impairment or dementia.

### 3.5 Improving physical health care for those with mental illness

There is another area too that mental health services can address positively to affect attendance at A&E and this is in the area of being more proactive in meeting the physical health needs of those who are in their care. We know that people with a long term mental health condition have reduced life expectancy and are more likely to have poor physical health, including serious conditions such as respiratory and cardiovascular diseases, diabetes, cancer and epilepsy. The Care Quality Commission recently highlighted that inpatients in acute mental health services currently have limited access to general hospital services, other than access via A&E.

Local work is underway to address these needs in better ways, in particular through a new joint protocol between KMPT and Kent and Medway's four acute trusts to facilitate access to urgent physical health care or opinion for patients admitted to mental health units. This is supported by an increased awareness of physical health and checks by acute inpatient mental health ward teams for earlier detection of physical health deterioration.

### 3.6 Early intervention for those with long term physical health conditions

We know that having a long term physical health condition brings significant psychological challenges. For example, there are high levels of depression present in people with a range of long term physical health conditions and the level is associated with higher general hospital use. The evidence is summarised in *No Health Without Mental Health: The supporting evidence*. For example, people with depression are twice as likely to use A&E services as those without it<sup>2</sup>. People with chronic obstructive pulmonary disease who are also depressed have longer hospital stays. Addressing co-morbidities by developing better links between physical and mental health services can lead to reduced attendances and re-attendances at A&E as well as reduced general hospital admissions and referrals to outpatient services.

---

<sup>2</sup> (Mykletun A, Bjerkeset O et al (2007) *Anxiety, Depression and cause-specific mortality: the Hunt study. Psychosomatic Medicine*)

### 3.7 Develop liaison psychiatry services

One clear recommendation in the reports is that each general hospital should have a dedicated liaison psychiatry or mental health service, embedded to provide mental health care throughout the entire hospital to adults of all ages and including people with dementia. The principle is that patients with mental health problems in general hospitals should have the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems.

The overall aim of a liaison service is for mental health to be assimilated into the routine care of people attending or admitted to a general hospital. It requires a proactive approach, not limited to direct patient contact. The core functions are to:

- raise awareness of the importance of mental health in a general hospital;
- facilitate the general hospital staff's acquisition of basic skills of assessment and treatment of people with mental ill health; and
- represent the cause of people with mental health problems who are under the care of a general hospital.

## 4 The place of urgent and emergency care in the QIPP programme

The QIPP Programme includes action to integrate the delivery of mental and physical health services, informing 2012/13 PCT contracts with KMPT and acute trusts to include financial incentives for improved performance in relation to:

- reducing attendance and reattendance at A&E by KMPT service users with no physical presentation who are held on open mental health pathways;
- improving the identification and management of people with mental health needs presenting at A&E or as inpatients in general hospital beds, leading to timely access to mental health pathways and less practice variation across Kent and Medway (especially in A&E responses to people who present with self harm);
- improving the diagnosis of dementia in general hospitals; and
- reducing the use of antipsychotic medication among people with dementia in both mental health and general hospital services.

Additionally, KMPT acute mental health services will be:

- working more closely with the mental health helpline provider in order to ensure appropriate referrals of people to CRHT rather than A&E;
- increasing the capacity for CRHT assessments at home for people and home treatment interventions; and
- evaluating the SECamb to mental health services pathway.

## **5 The main challenges to reducing attendance at A&E from a mental health perspective**

The main challenges to reducing A&E attendances from a mental health perspective are to:

- continue to work on ensuring that robust care plans are in place for people known to the mental health system;
- develop the capacity in emergency and urgent care mental health services to enable the development of Liaison Psychiatry from 5 pm to midnight in Dartford and Gravesham and Maidstone and Tunbridge Wells Trusts' A&E departments and during office hours for wards; and
- improve early intervention for those with long term physical health conditions by further developing access to primary care psychological therapy services.

## **6 Conclusion**

The provision of mental health services that can respond to emergency and urgent mental health needs wherever they present is a core part of the mental health services. A&E departments are one area where people present with emergency needs and developing liaison psychiatry services will increase responsiveness. KMPT and commissioners are committed to continuing work on ways to develop these services and as part of whole systems with health and social care partners through the Urgent Care Boards and Whole Systems Boards.