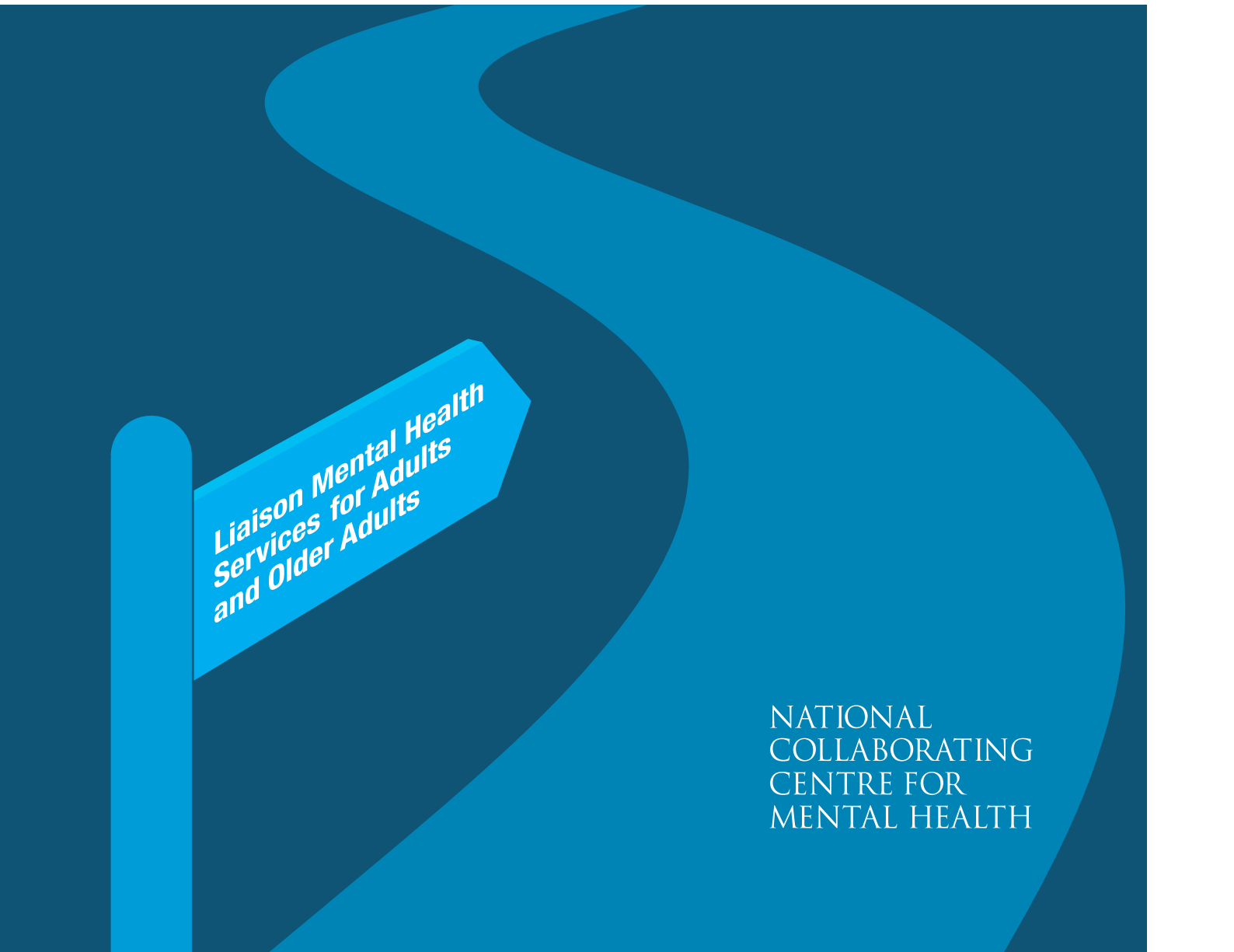
NICE National Institute for Health and Care Excellence

NHS England

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**



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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

Version number: 1

First published: November 2016

Prepared by: NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence

Classification: OFFICIAL

NHS England Publications Gateway Reference 05958

Foreword

The Independent Mental Health Taskforce Five Year Forward View (February 2016) made it clear that improving access to high-quality mental health care must now become a national priority. The Achieving Better Access to Mental Health Services programme has been developed by NHS England, the National Institute for Health and Care Excellence and the National Collaborating Centre for Mental Health to introduce standards for mental health care and ensure that these can be properly measured across the country. The aim? To begin a major national implementation programme to make sure people with mental health problems get prompt access to evidence-based NICE-recommended care, on a par with the care provided for physical health problems. Nowhere within mental health care is the issue of parity more important than in the provision of urgent and emergency care for people experiencing a mental health crisis.

Proper funding for mental health crisis care and its full integration within NHS urgent and emergency care was one of the commitments made in the Five Year Forward View for Mental Health. With the publication of Implementing the Five Year Forward View for Mental Health (July 2016), and this implementation guidance for *Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care*, commissioners and service providers now have some powerful tools at their disposal to improve crisis care for people of all ages across the country.

Liaison mental health services already play a valuable role in supporting people in a crisis, as well as adults and older adults who have both mental and physical health problems in a general hospital setting. They can help people to avoid lengthy stays in hospital and can speed up discharge. We now want to make sure people who experience a mental health crisis have received a response from an urgent and emergency mental health service within an hour, and that within four hours they have received the appropriate support to meet their needs and an evidence-based package of care is in place.

Improving liaison mental health provision has been a long-standing goal for the NHS and is a 'must do' in the most recent two-year planning guidance for 2017-19. In April 2016, as part of the CCG Improvement and Assessment Framework 2016/17, CCGs were also asked to ensure that agreed and funded plans are in place to aim for a core 24 (24 hours, 7 days a week) service by 2020/21.

The pathway set out in this guide will help NHS commissioners and providers to ensure that liaison mental health services can meet these standards and deliver on their improvement plans. If these goals are achieved, adults and older adults presenting in crisis in emergency departments and on physical health general wards will have access to high-quality NICE-recommended care, any time of the day or night, every day of the week.

This implementation guide is one of a series for urgent and emergency mental health care that also covers 'blue light' services (for all ages), community-based crisis response services (for adults and older adults) and children and young people's crisis services. Together they will form a crucial part of the overall implementation plan for transforming urgent and emergency mental health care in England.

Never before has timely access to high quality mental health care been accepted as so necessary by the whole health and social care community. Now we, as commissioners, providers, health and social care workers and partners across the whole urgent and emergency care pathway, must rise to this challenge and meet these expectations.

Professor Tim Kendall
National Clinical Director for Mental Health

Key statements

These statements were developed by the Expert Reference Group based on what they considered to be the key messages for this implementation guide. They have been worded from the perspective of a person experiencing a mental health crisis to highlight the need to develop urgent and emergency mental health services with the person at the centre.

- When I visit hospital experiencing a mental health crisis and I require help and support, this is treated with as much urgency and respect as a physical health emergency and I am able to get a response no matter what time of the day it is, or which day of the week.
- When I experience a mental health crisis in an emergency department or on a general hospital ward, I receive a timely and compassionate response from trained and competent professionals in liaison mental health. If I am an older adult I will receive specialist support from a team skilled in working with older people. I am treated with kindness, compassion and dignity and in accordance with my legal rights.

EBTP STANDARD
Any person experiencing a mental health crisis should receive a response from the liaison mental health service within a **maximum of 1 hour** of the service receiving a referral.

- My physical and mental health needs should not be seen as separate from each other and I receive effective care for both in a general hospital setting.
- Within one hour of a liaison mental health service being contacted, I have received a response and know that help is on its way.
- Within four hours of arriving in an emergency department or being referred from a ward, I receive a response and support that meets my needs. Depending on my situation:
  - *I have had a full assessment of my physical, psychological and social needs, and an urgent and emergency care plan is in place, and*
  - *I am on my way to another service or location, if needed, or I have been accepted for follow-up care by another service*

    OR
  - *I have started assessment under the Mental Health Act.*
  - *If I feel better within four hours, I can go home.*

EBTP STANDARD
Within **4 hours** of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence-based care package (informed by NICE) in place.

- When I am on a general hospital ward and require an urgent response from a liaison mental health service, I receive a full assessment within 24 hours. If I am an older adult I will receive specialist support from a team skilled in working with older people.
- Liaison mental health services have access to appropriate staff either on the team or through contractual arrangements to ensure that there are no delays to the start of a Mental Health Act assessment, should I require one.
- If the difficulties I am facing during a mental health crisis cannot be resolved where I am, I am provided with appropriate support to access and travel to an appropriate and safe place where help is available.
- If I need longer-term support to manage my mental health problems, this is arranged.

Contents

1 Introduction

1.1 Background

This guide builds on a number of policy drivers, reviews and publications including The Mental Health Crisis Care Concordat,[1] the Care Quality Commission (CQC) report Right Here, Right Now,[2] the Urgent and Emergency Care Review[3] and the Five Year Forward View for Mental Health.[4] Together these made an overwhelming case for improving urgent and emergency mental health services, including liaison mental health services.[a] The additional funding announced in the Spending Review and detailed further in Implementing the Five Year Forward View for Mental Health[5] will be used to improve coverage and availability of urgent and emergency mental health care, so that by 2020/21 all general hospitals will have a liaison mental health service and at least 50% will meet the standard for adults and older adults of a core 24 service as a minimum. This will be supported by £120 million additional central funding by 2020/21.

1.2 Purpose and scope of this document

This guide supports implementation of the ambitions set out in the Five Year Forward View for Mental Health to introduce evidence-based treatment pathways across mental health services. It states: '*by 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24'*[b] service standard as a minimum' to ensure provision of liaison mental health services in all general hospitals.

This guide covers the first 24 hours of urgent and emergency mental health care following referral or presentation. The pathway and associated standards should be applied equally regardless of the nature of the mental or physical health problem and any disabilities (including learning disabilities) of the person presenting in a mental health crisis.

The primary aim of this document is to provide guidance on establishing, developing and maintaining urgent and emergency liaison mental health services for adults and older adults in emergency departments (EDs) and general hospital wards. It is acknowledged that liaison mental health teams provide a wider range of services than urgent and emergency mental health care. However, these activities are beyond the remit of this guide and will be addressed in forthcoming implementation guides on integrated mental and physical health services in 2017.

This guide is aimed at commissioners and providers of services for adults and older adults. It is recognised that some adult services provide an urgent and emergency mental health response to young people aged 16 to 18 years. See Part 4 in this series (listed below) for the implementation guidance for urgent and emergency mental health services for children and young people.

This document is one in a series of ***Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care*** implementation guides, which includes:

Part 1: Implementing the Evidence-based Treatment Pathway for 'Blue Light' Services Providing an Urgent and Emergency Mental Health Response for All Ages (forthcoming)

[a] *Also commonly known as 'liaison psychiatry' or 'psychological medicine', the term 'liaison mental health' is used in this guide to reflect the multidisciplinary nature of liaison teams.*

[b] *Core 24 is a liaison mental health service model provided 24 hours, 7 days a week; it is commonly provided across urgent and emergency care pathways.*

Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults

Part 3: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Community Mental Health Services for Adults and Older Adults (forthcoming)

Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming)

Evidence-based treatment pathways and recommendations for services that provide acute mental health care and planned care liaison mental health will be covered in forthcoming implementation guides.

This guide has been organised into four further chapters as described below:

Chapter		Purpose of the chapter
2	**What is a mental health crisis and why is rapid access to a liaison mental health service so important?**	• To provide personal perspectives on mental health crises • To provide key facts regarding mental health crises • To describe the important functions of liaison mental health services in responding to mental health crises
3	**What are liaison mental health services?**	• To provide a description of liaison mental health services and their benefits • To describe the skill mix necessary to deliver care in line with NICE guidance and to ensure that the specific needs of older adults are met • To describe optimal service models
4	**The evidence-based treatment pathway**	• To summarise the NICE quality standards and guidelines relevant to liaison mental health services • To describe all aspects of the pathway, including clock starts and stops • To clarify the approach to measurement for the recommended response times and the delivery of care in line with NICE guidance • To describe the recommended approach to routine measurement of outcomes (clinician and service user reported) • To clarify data collection and reporting requirements
5	**Key commissioning considerations and service development**	• To provide a step-by-step process that local commissioners and providers can follow, working collaboratively with stakeholders, to ensure sustainable delivery of the evidence-based treatment pathway

Additional resources have been brought together in the accompanying *Appendices and Helpful Resources* pack. This pack includes:

- appendices
  - *relevant NICE guidance and outcomes measurement*
  - *the full pathway*
  - *Expert Reference Group members*
- positive practice examples and models
- links to helpful web-based resources.

1.3 How was this document developed?

NHS England has commissioned NICE to provide a package of implementation support for evidence-based treatment pathways for mental health, including implementation guidance. NICE has asked the National Collaborating Centre for Mental Health (NCCMH)[c] to develop this guide. The NCCMH established an Expert Reference Group including topic experts from the following areas:

- commissioning and public health
- service providers including health and social care professionals from primary and secondary mental and physical health care services and service managers
- academics and health educators
- people and carers with lived experience
- specialist expertise in older adult mental health.

See Appendix C in the *Appendices and Helpful Resources* pack for a full list of members.

In developing this guide, the Expert Reference Group and NCCMH technical team followed a manual for developing implementation guides[d] and were primarily informed by relevant NICE quality standards and guidelines supplemented by data on current service provision. The Expert Reference Group used its knowledge, expertise and judgement to determine the recommendations set out in this guide.

[c] *The NCCMH, a partnership between the Royal College of Psychiatrists and University College London, was one of the national collaborating centres first established by NICE in 2001 to develop clinical guidelines.*

[d] *Forthcoming on the NICE website.*

1.4 The evidence-based treatment pathway

For the purposes of this guidance, 'emergency' and 'urgent' are defined as follows:

An **emergency** is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.

An **urgent** situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.

Urgent and emergency mental health care is a response that health and care service providers deliver 24 hours a day, 7 days a week (24/7) to people who are experiencing a mental health crisis.

This guide sets out an evidence-based treatment pathway (EBTP) for people presenting in general hospital settings in mental health crisis who require urgent or emergency mental health care.

The pathway includes recommended standards (called 'EBTP standards'), which require delivery of an evidence-based package of care informed by National Institute for Health and Care Excellence (NICE) guidance.

1.4.1 Emergency pathway

The evidence-based treatment pathway introduced in this guide requires that people who need urgent and emergency mental health care receive an evidence-based package of care informed by NICE guidance within four hours of presenting in an ED or referral from a ward.

- An urgent and emergency liaison mental health service should respond to the person within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment (see Section 4.2.2)

- Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for follow-up care by a responding service, or*
  - *have been discharged because the crisis has resolved*

    OR
  - *have started a Mental Health Act assessment.*

1.4.2 Urgent pathway

As well as an emergency response to crisis referrals, liaison mental health services should provide an urgent care pathway, with a full assessment taking place within 24 hours of referral. An urgent response is described in Section 4.3.

- An urgent and emergency liaison mental health service should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed and resources required for the assessment
- The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. The principles of assessment described in the emergency pathway (see Section 4.2.2) apply to the urgent care pathway.
- Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for a follow-up appointment by a responding service, or*
  - *have been provided with advice or signposted, where appropriate.*

If at any point the person's mental health deteriorates, or it is deemed they require an emergency response, including a Mental Health Act assessment, the emergency pathway should be followed.

1.5 Expectations of commissioners

Commissioners are responsible for ensuring that local service development plans are created and implemented in collaboration with people with mental health problems and their families or carers, as well as local mental health providers, public health providers and partner organisations. This should include voluntary and third sector organisations, drug and alcohol service commissioners and providers, and local authorities (social care, housing, debt, benefit advice, employment and education) to provide a framework for collaborative action. Development plans should focus on delivering the recommendations in the Five Year Forward View for Mental Health.

Improving provision of liaison mental health has been in the NHS planning guidance for the past three years, and is now set out among the nine 'must dos' for the NHS in the two-year planning guidance for 2017-19. From April 2016, as part of the CCG Improvement and Assessment Framework 2016/17, clinical commissioning groups (CCGs) were further asked to ensure that agreed and funded plans are in place to aim for core 24 service level by 2020/21, as well as conducting a self-assessment of current provision against selected key lines of enquiry.[e] The availability of high-quality liaison mental health services informs CQC inspections of general hospitals, and these EBTP standards will also be taken into account as NHS Improvement develops future iterations of its Single Oversight Framework.

[e] *The key lines of enquiry for liaison mental health are set out on page 68: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf*

In 2016 and 2018, NHS England is making available central transformation funding to help accelerate provision of liaison for the general hospitals with 24/7 EDs that are closest to the minimum core 24 level. This funding was first announced following the November 2015 Government Spending Review.

The reduction of inequalities in access and outcomes should be central to the development of urgent and emergency mental health services. Local commissioners should make explicit in their plans how they have taken into account the duties placed on them under the Equality Act 2010[6] and their duties with regard to reducing health inequalities as set out in the Health and Social Care Act 2012.[7] Service design and communications should be appropriate and accessible to meet the needs of diverse communities (see Guidance for Commissioners on the Equality and Health Inequalities Duties).

2 What is a mental health crisis and why is rapid access to a liaison mental health service so important?

> *I am scared, disorientated, and cannot manage even simple day-to-day tasks. People talk to me, but what they are saying does not make sense, and they cannot understand me. I am very alone, and it gets harder and harder to ask for help. The world is too close, too full of meanings. My mind is glowing.*
>
> *Source: A person with lived experience, 2016*

2.1 What is a mental health crisis?

A mental health crisis is a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.

There are various possible causes or triggers of a crisis. For example, many people experience adverse life events that include a psychological, physical or social element, which leads to a need for an urgent or emergency response from mental health services. All crises will be different in their cause, presentation and progression. It is important to identify the trigger (for example, abuse, trauma or homelessness[8]), associated risks and options for ongoing care, and respond to the crisis according to the individual's need and circumstances.

2.2 Attending the ED when in a mental health crisis

> *I'm not attention seeking or being manipulative when I self harm. I've suffered in my past and I'm coming asking you for help. I'm seeking attention, yes, because I've hurt myself and I need medical attention.*
>
> *Please remember to dress my self harm even if I have overdosed. Often you forget because I'm not well enough to point it out.*
>
> *If I have overdosed I would like a bed to lie in, not forced to sit in a chair.*
>
> *Please remember to validate my emotions. I'm feeling so sad, often ashamed and I often feel suicidal. Yes, it is awful. Yes I've been trying so hard and I feel so vulnerable, just tell me you can see that.*
>
> *Remember to use pain relief for people who need it. Don't carry out procedures without it.*
>
> *Please refer me to liaison psychiatry, don't just let me leave. People who self harm can go on to complete suicide – they need help.*
>
> *It would be amazing if all hospitals had people trained to help people who self harm 24/7 as liaison psychiatry doesn't often operate those hours. Instead people are left to wait until morning tired and in crisis.*
>
> *You don't have to tell me if I leave you will call the police. I'm not a criminal and I'm not that person who runs away. We are all individuals.*
>
> *Source: Dignity and Self-Harm #WMHD*

2.3 How liaison mental health services can help people in a mental health crisis

Given that adults and older adults with mental health problems are three times more likely to attend an ED and five times more likely to be admitted to a general hospital as an emergency,[9] a liaison mental health service must be an essential component of any high-performing general hospital. This has been recognised by the CQC, which recommends that liaison mental health services should be commissioned to meet the needs of the local population, giving consideration to the peak times that adults and older adults in crisis are likely to present in EDs. The CQC is evolving its method of inspecting mental health care in general hospital settings.[2] The primary functions of a liaison mental health service within the context of responding to mental health crises are to:

2.3.1 Identify, assess and respond to mental health crises

- Assess needs
- Respond to the mental health crisis in line with the EBTP standard
- Have on-site access to current clinical (including mental health care) records
- Have access to a consultant psychiatrist with significant experience in responding to mental health crises, including specialists with expertise in older adult mental health
- Have access to a range of health and social care staff with significant experience and competences in responding to mental health crises
- Work with general hospital staff to ensure the person is safe and supported while waiting for, and during, an assessment
- Have protocols in place with social care teams to provide swift access to Mental Health Act assessments.

2.3.2 Treat the symptoms of the mental health crisis

- Provide access to NICE-recommended urgent and emergency care, including NICE-recommended treatment for self-harm.

2.3.3 Provide access to ongoing support

- Offer follow-up care within the service (or refer to another service if clinically appropriate). This has been shown to improve patient care and reduce ED re-attendance rates[10 11]
- Signpost to other support, including voluntary sector and community groups.

2.3.4 Provide service-level support

- Ensure effective and transparent pathways by establishing links with other emergency, health and social care services, including those provided by the voluntary sector
- Provide training to other healthcare professionals who may need to respond to mental health crises (for example, training ED and general hospital ward staff on local protocols, legal frameworks, mental health awareness, and responding compassionately and appropriately). Wherever possible, mental health awareness training should be co-produced and co-delivered with people with lived experience
- Enable data, record and information sharing across mental health services, general hospitals, primary care and other health and social care services to ensure:
    - *rapid, appropriate and safe treatment*
    - *timely and effective community-based follow-up*
    - *that patients' up-to-date histories and preferences are known.*

3 What are liaison mental health services?

Liaison mental health services are specialist services providing mental health care in a physical health setting. They support the work of clinicians working in general health pathways, enabling EDs and wards in general hospitals to assess and manage mental health problems as they present or arise among people being cared for in the general health pathway. While liaison mental health teams provide a range of services to people (which can include follow-up care), this guide is concerned with the aspect of liaison mental health services that provides unplanned, non-elective urgent and emergency mental health care in general hospitals. Referrals come from EDs, medical assessment units and clinical decision units, and may also be made from any other ward within a general hospital.

Liaison mental health is traditionally concerned with the care of a person who presents with both mental and physical health symptoms regardless of presumed cause. In the context of a mental health crisis, liaison mental health services commonly see people when they are experiencing or have experienced any of the following:

- self-harm leading to medical or surgical treatment
- suicidal ideation
- the consequences of alcohol and drug use, including when co-occurring with a mental health problem
- dementia or delirium
- a severe mental illness, such as schizophrenia, bipolar disorder or severe depression, or a personality disorder
- social vulnerability that may have a mental health problem or trauma as a component or root cause, for example, homelessness or domestic abuse.

A liaison mental health service also plays a critical role in enhancing the care provided by the general hospital system, in which expertise in mental health care is still too often lacking. It does this by:

- providing education and support to general hospital staff, both formally and informally
- helping to ensure the same attention is paid to people's mental health and physical needs while they are in hospital
- identifying underlying mental health problems for people primarily presenting with physical health problems
- supporting the efficient running of the hospital through prompt and well-coordinated discharge, increasing the safety of patients and staff, and ensuring a good experience of care.

3.1 Current provision of liaison mental health services

There is wide variation in the degree of provision of liaison mental health services across the country.[12] In the most recent national survey commissioned by Health Education England of liaison mental health services (mid-2016), 174 (98%) of 177 EDs in England responded.[13] While 52% of teams that responded reported that their service had better provision than the previous year, 15% reported that their service was worse-resourced.[13] Some services lack the staff to cope with the overwhelming number of referrals, leading to some people reportedly being turned away.[14]

3.1.1 24-hour services

Most[f] liaison mental health teams report that they provide a 24/7 service, but only around 10% do so with a level of staffing sufficient to provide a core 24 or greater service, meaning that the level of care provided out of hours does not meet the EBTP standards set out in this guide, and 45% of services do not have staff on site at all out of hours.[13] This is despite evidence that people are more likely to experience a crisis outside normal working hours. An audit by the Royal College of Emergency Medicine showed that people are most likely to present to an ED with a mental health problem between 5pm and midnight,[15] and the CQC Right Here, Right Now report[2] found that the peak hours for admissions to general hospitals via an ED were between 10pm and 7am (these admissions were for people with a mental health crisis resulting from drug and alcohol use, self-harm, schizophrenia or mood disorders).

This suggests that in order to provide accessible and timely care for all, services need to be available all day, every day. In the same way that it is essential to ensure the provision of 24/7 care for people with urgent and emergency physical health needs, people experiencing a mental health crisis should also be able to receive 24/7 care that meets their needs.

3.1.2 Distinct specialty

Currently, there are areas in which crisis resolution and home treatment teams (CRHTTs) provide in-reach to general hospitals for people with urgent and emergency mental health needs. However, liaison mental health teams are unique in being fully integrated with ED and general hospital pathways, rather than delivering an in-reach function from a neighbouring mental health base.

Many of the benefits from specialist liaison teams arise from their ability to care for such a wide range of people with the most complex needs in general hospitals.

Where services are provided with crisis team in-reach to general hospitals, they tend to focus on self-harm or acute mental health presentations in EDs only. These teams would not usually provide the mental health support described in Section 2.3 to the wider range of people with undiagnosed or complex common mental health needs in general hospitals.

3.1.3 On-site service

The pathway set out in this guide (see Section 4) recommends that liaison mental health teams should be available to respond to mental health crises within one hour, and then to conduct a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan and refer for onward treatment, transfer or discharge within four hours. To achieve these response times, personalised risk assessment and information gathering need to start as soon as the person presents to the ED reception or triage point. In practical terms, this means the liaison service must have a base in or near to the ED.

Busy community-based CRHTTs providing in-reach to general hospitals are highly unlikely to be able to meet these response times. Attempting to do so is likely to compromise their core function of providing a 24/7 community-based urgent and emergency mental health response, and providing intensive home treatment as an alternative to mental health acute inpatient admission.

The evidence base for general hospital liaison and CRHTTs shows that these are rightly distinct teams that have different functions and different skills. Therefore, services that are commissioned as a hybrid do **not** meet the minimum core 24 service level set out in this guidance (see Section 3.3.1).

In order to achieve the core 24 service standard, liaison mental health teams should at a minimum achieve the following criteria:

- They are commissioned to operate 24/7, as an on-site distinct service in the general hospital
- They have the skill mix and staffing level to operate a 24/7 rota effectively (see Section 3.4.1 for further detail)

[f] 55% of those who responded to the HEE survey.

- They provide a response within one hour to emergency referrals from wards or the ED and within 24 hours for urgent referrals from inpatient wards.

3.2 Benefits of liaison mental health services

Historically, many liaison mental health services have been commissioned from CCG mental health budgets because the provider has typically been the local NHS mental health provider. However, there is increasing recognition that this arrangement fails to reflect the fact that the quality and productivity benefits achieved through investment in liaison mental health services are realised almost exclusively in the general hospital setting.[12] Future models of payment for all urgent and emergency care are likely to include liaison mental health services as a core component, recognising that liaison services must be an integral part of any high quality integrated urgent and emergency care response. Commissioners should recognise this in their approach to service development and investment plans and commissioning arrangements. (See Section 5.7).

3.2.1 Benefits for people experiencing a mental health crisis

Adults and older adults presenting with a mental health crisis in EDs and general hospital wards, and their families and carers, will benefit from 24/7 access to liaison mental health services, more specifically a swift and compassionate assessment of their mental health needs and:

- a reduction in inappropriate general hospital inpatient admissions
- improved discharge planning and coordination resulting in shorter lengths of stay and reduced general hospital re-admissions for adults and, particularly, older adults (who account for 80% of inpatient hospital stays) who are admitted[11]
- an overall improved experience of services resulting from care provided by well-trained and knowledgeable general hospital staff who are not necessarily trained as mental health specialists but can more readily recognise mental health needs
- clearer referral routes and a better understanding of how to ask for help in their local area.

3.2.2 Benefits to service providers

Evaluations of liaison mental health services[10] have demonstrated that:

- Effective collaborative working by inpatient, liaison and community mental health services helps to avoid lengthy inpatient stays and delayed transfers of care
- Effective working with social care and housing services assists in reducing discharge delays by helping people move to a stable environment in the community
- General hospital staff are able to better support people with mental health problems, through training, support and formal and informal networks
- Providing 24/7 liaison mental health services enhances responsiveness; services such as the Birmingham Rapid Assessment, Interface and Discharge (RAID) model and the North West London Optimal model provide a rapid response and have shown significant reduction in length of stay, re-attendances at EDs and emergency general hospital admissions.[16]

3.2.3 Economic benefits of liaison mental health services

There is an established body of research[17] suggesting that liaison mental health services are cost effective and generate savings. These are mainly related to a reduction in the length of stay of older adults admitted to general hospital wards, many of whom have significant mental health needs linked to dementia, depression or anxiety. Recent evaluations of service models found that:

- The RAID model at the City Hospital in Birmingham identified savings of £3.55 million; 90% of these savings related to older people, with around half resulting from a

reduced length of stay in a general hospital, and half from reduced rates of readmission;[18] this equates to a saving of £4 for every £1 invested in the service.[18] Other hospitals in Birmingham that introduced RAID services realised savings of £3 for every £1 spent.[18]

- When a similar model to RAID was introduced across four hospitals in east London, there were also substantial savings of between £1.4 million and £1.7 million across 3,052 hospital beds.[19] These were realised primarily through reductions in inpatient length of stay, particularly for older adults
- A substantial return on investment in liaison mental health services has consistently been demonstrated and commissioners. The Centre for Mental Health estimated this at an initial level of £3 for every £1 of investment, stabilising over time at £2.50.[18] High quality, integrated liaison mental health services also have a positive impact on averting avoidable pressures on the wider health and social care system.

3.3 Liaison mental health service models

Despite wide variation in service configuration, a number of models developed over recent years have shown a demonstrable impact,[10 20] including the RAID model, the North West London Optimal model and the Leeds Liaison Service. Consensus has emerged around three main service model descriptions: 'core 24', 'enhanced 24' and 'comprehensive'. There is also the 'core' model, which describes a basic level of service for hospitals that do not have a 24/7 ED.[20]

3.3.1 Core 24

Where the hospital has a 24/7 ED, then it should have a core 24 service level as a minimum to ensure 24/7 mental health cover. The core 24 model provides the following functions on a 24/7 basis. This includes consultant psychiatrists being available 24/7 (on-call out of hours) to:

- Provide a response to mental health crises in EDs and inpatient wards within one hour and to all urgent ward referrals within 24 hours
- Complete a full biopsychosocial assessment and formulation and contribute to treatment and collaborative care plans
- Offer brief evidence-based psychological interventions[g] as inpatient or short-term outpatient follow-up
- Work with general hospital teams to reduce length of stay in general hospitals and improve follow-up care, particularly for older adults
- Provide advice and support to general hospital staff regarding mental health care for their patients
- Provide specialist care for older adults.

This model provides urgent and emergency, as well as unplanned, care pathways (that is, non-elective admissions to general hospitals). The North West London model forms the basis of the core 24 model.[20]

3.3.2 Enhanced 24

As well as providing all of the features of the core 24 model, the enhanced 24 model provides more specialist care, offering enhanced expertise in addictions and drug and alcohol use, and mental health problems in people with learning disabilities. An enhanced 24 service will have a higher level of consultant psychiatrist input and be able to provide increased follow-up care. The RAID model was developed as a pilot for enhanced 24 in City Hospital, Birmingham.

[g] *These will be covered in more detail in a forthcoming programme on integrated care for mental and physical health (planned care liaison mental health services and psychological therapies for people with or without long-term physical conditions or with medically unexplained symptoms).*

3.3.3 Comprehensive

Comprehensive model services are usually suitable for large secondary care centres with regional and supra-regional services. In addition to delivering core 24 services, they provide enhanced expertise and input to planned care pathways spanning all inpatient and outpatient areas, including assessment and treatment for conditions such as chronic pain and medically unexplained symptoms. The comprehensive model has greater numbers of senior staff, including consultants, senior nurses and psychologists. (The service once offered by Leeds and York Partnership NHS Foundation Trust formed the basis of the comprehensive model of care.)

3.3.4 Core

The core model delivers the same functions as a core 24 service, but operates during reduced hours. This may be, for instance, a nine-to-five service in an urgent care centre that does not operate out of hours.

3.4 The workforce

Having the right workforce with the right skills is essential to delivering care in line with NICE guidance. The key staff roles, functions and necessary competences for a liaison mental health service to deliver urgent and emergency mental health care are described below. Table 2 shows key competences for liaison mental health staff and further information is provided within the Psychiatric Liaison Accreditation Network (PLAN).[21]

Key competences for children and young people's liaison mental health services can be found in the forthcoming implementation guide (*Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People*).

3.4.1 Workforce for core 24, enhanced 24 and comprehensive service models

One of the key differences between the levels of service described above relates to workforce capacity, skill mix and competences.

A team with a robust skill mix should include sufficient numbers of practitioners from a range of regulated professions and support workforces (clinical and administrative/business support).

Core 24

- This model has adequate staff to cover a 24/7 rota
- This model has fewer medical staff than any of the other models
- Consultant psychiatrists should have expertise in common presentations, for example mental health problems in older people and drug and alcohol use
- Proportionately, this model has the highest number of nurses within it. The out-of-hours rota is nurse-led, with on-call consultants accessible during these hours.

Enhanced 24

- This model has more consultants per number of beds, with specialisms in working with older people, adult mental health and addictions
- Consultant psychiatrists are available on-call on a 24-hour basis
- Band 7 nurses lead sub-teams that are organised by consultant specialism.

Comprehensive

- Due to economies of scale, staffing of the medical and nursing workforce for this model is proportionately lower per bed than for the core 24 and enhanced 24 services.

Table 1 provides sample staffing levels for the models in this guide. Different service models will require different levels of staffing, which will also need to be adapted according to local need, hospital size, population size and ED footfall. By way of illustration, the comprehensive model in Table 1 is set for a hospital of around 2000 beds.

Table 1: Staffing approaches with different service models[22]

Staff	Core 24	Enhanced 24	Comprehensive (illustrative for a 2000-bed hospital)
Consultants	2	4	5
Other medical	2	2	2
Nurses	6 band 7	3 band 7	2 band 8b
	7 band 6	7 band 6	17 band 6
			10 band 5
Other therapists	4	2	16
Team manager	1	1	
Clinical lead	0.4	0.4	1
Admin and business support	3	3	13

Commissioners and providers should consider other roles that could be utilised in liaison mental health services, including clinical support workers and new roles such as nursing associates.

All considerations regarding indicative staffing and skill mix levels for liaison mental health services should be flexible and take into account the forthcoming Health Education England national mental health workforce strategy and the forthcoming Department of Health Mental Health Core Skills Education and Training Framework.

3.4.2 Other staffing

> *Adult social services should ensure they have effective workforce management and succession planning in place to enable ongoing sufficiency of AMHPs and good workload management.*
>
> Source: The College of Social Work

There is a legal requirement for approved mental health professionals (AMHPs) to carry out Mental Health Act assessments and make applications for admission to mental health hospitals that are supported by the medical recommendations from the section 12 approved doctor.

Liaison mental health services should have access to appropriate staff either on the team or through contractual arrangements to ensure that there are no delays to the start of a Mental Health Act assessment should one be required.

Consideration should be given to the availability of independent mental health advocates (IMHAs) and independent mental capacity advocates (IMCAs), and people should be informed how to access them.

3.4.3 Integrated governance

Liaison mental health teams are only able to maximise their impact when fully integrated governance arrangements (involving senior clinical staff) are in place with EDs and other general hospital departments. This will help with the development of relationships, processes and shared learning between liaison mental health teams and EDs and ward teams, including to improve quality and safety. There are opportunities for shared learning from adverse incidents, such as people leaving EDs and delays in pathways. In practice, integrated governance could be achieved through, for example, regular meetings involving professionals from both mental health and acute medicine, with clear reporting lines to hospital boards and links to other relevant in-hospital professional groups.

Liaison mental health services should have joint ownership and governance arrangements between acute trusts, mental health trusts and other local providers including senior clinical and operational leadership from those providers. This should improve partnership working by the liaison service and local providers of community, primary, social care, housing, public health (including drug and alcohol use) and voluntary sector services.

Table 2: Competences of the liaison mental health team

Role	Key competences
Common to all roles	• Up-to-date knowledge of relevant legal frameworks (for example, Mental Health Act and Mental Capacity Act) • Ability to complete personalised risk assessments, including for self-harm and suicide prevention • Up-to-date knowledge of the general hospital system • Knowledge and skills around the care and treatment of older adults, people with drug or alcohol use problems, people with learning disabilities and people with physical health problems • Skills in providing training and support to general hospital staff around mental health problems • Knowledge of local services for people who use drugs or alcohol, including social care and voluntary sector services.
Medical	• Expertise in pharmacological treatments • High level of competence in biopsychosocial assessment • High level of leadership • Specialist training in working with older adults and people who use drugs or alcohol (in enhanced 24 or comprehensive services)
Nursing	• High degree of clinical leadership, providing clinical expertise and supervision • Specialist training in working with older adults and people who use drugs or alcohol • Ability to work autonomously and complete biopsychosocial assessments See the competence framework for liaison mental health nursing[23]
Drugs and alcohol	• Skills in addiction treatment, including comprehensive assessments, care planning, medically-assisted alcohol withdrawal, detoxification, psychological interventions and relapse prevention support • Skills in brief intervention • High level of competence in assessment of co-occurring drug or alcohol use and mental health problems • Specialist training in drug or alcohol use in line with National Occupational Standards (NOS) Skills for Health • Ability to train, advise and supervise others in co-occurring drug or alcohol use and mental health problems • High level of skills in engaging, liaising and co-ordinating across organisational boundaries See the Dual Diagnosis Competency Framework[24] or the Leeds Dual Diagnosis Capability Framework[25]

Role	Key competences
Older adults	• Specialist expertise in old age psychiatry • Knowledge of particular presentations and treatments of mental health problems in relation to coexisting physical health problems • Ability to identify social factors in the presentation of mental health problems in older adults • Expertise in the assessment and management of those presenting with delirium • Specialist expertise in dementia identification, assessment and diagnosis
Developmental and learning disabilities	• Expertise in developmental and learning disabilities • Knowledge pertaining to complex needs and completing comprehensive assessments

4 The evidence-based treatment pathway

4.1 Evidence-based treatment

There is no single NICE guideline or quality standard for urgent and emergency mental health that defines NICE-recommended treatment and care in liaison mental health services, but the Expert Reference Group considered the following to be directly relevant:

- Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
- Borderline Personality Disorder: Recognition and Management (NICE clinical guideline 78)
- Dementia: Support in Health and Social Care (NICE quality standard 1)
- Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
- Self-harm (NICE quality standard 34)
- Service User Experience in Adult Mental Health Services (NICE quality standard 14)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE clinical guideline 136)
- Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings (NICE guideline 10)

The relevant statements and recommendations from the NICE quality standards and guidelines that define NICE-recommended care for liaison mental health services are listed in Table 3 and Table 4.

The type of outcomes measures that should be used and the methods for measuring them can be found in Appendix A in the *Appendices and Helpful Resources* pack.

Table 3: NICE quality standards

Quality statement
Service User Experience in Adult Mental Health Services (NICE quality standard 14)
1. People using mental health services, and their families and carers, feel optimistic that care will be effective.
2. People using mental health services, and their families and carers, feel they are treated with empathy, dignity and respect.
3. People using mental health services are actively involved in shared decision-making and supported in self-management.
5. People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6. People can access mental health services when they need them.
7. People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8. People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9. People using mental health services who may be at risk of a crisis are offered a crisis plan.

Quality statement
Service User Experience in Adult Mental Health Services (NICE quality standard 14)
10. People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
15. People using mental health services feel less stigmatised in the community and NHS, including in mental health services.
Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
1. Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.
2. Health and social care staff opportunistically carry out brief screening and brief interventions for hazardous and harmful drinking as an integral part of practice.
Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
7. Mental health professionals supporting people with borderline or antisocial personality disorder have an agreed level and frequency of supervision.
Self-harm (NICE quality standard 34)
1. People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.
2. People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide.
Dementia: Support in Health and Social Care (NICE quality standard 1)
8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.

Table 4: NICE guidelines

Recommendations
Service User Experience in Adult Mental Health (NICE clinical guideline 136)
1.5.6. Health and social care providers should provide local 24-hour helplines, staffed by mental health and social care professionals, and ensure that all GPs in the area know the telephone number.
1.5.10. Consider the support and care needs of families or carers of service users in crisis. Where needs are identified, ensure that they are met when it is safe and practicable to do so.
1.5.11. Health and social care providers should support direct self-referral to mental health services as an alternative to accessing urgent assessment via the emergency department.
Violence and Aggression (NICE guideline 10)
1.5.1. Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.
1.5.2. Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

In addition, other NICE guidelines on specific mental health problems may be relevant and are available on the NICE website and in the *Appendices and Helpful Resources* pack.

4.2 Emergency care pathway

For full pathway diagram, see Appendix B.1 – Appendix B.8 in the *Appendices and Helpful Resources* pack.

The EBTP standard for a person experiencing a mental health crisis states that they should receive an evidence-based package of care informed by NICE guidance within four hours.

- An urgent and emergency mental health service should respond to the person within one hour of receiving a referral. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment
- Within four hours of arriving in an ED or being referred from a ward it is recommended that the person should:
    - *have received a full biopsychosocial assessment if appropriate, and*
    - *have an urgent and emergency mental health care plan in place, and*
    - *as a minimum, be en route to their next location if geographically different, or*
    - *have been accepted and scheduled for follow-up care by a responding service, or*
    - *have been discharged because the crisis has resolved*

      OR
    - *have started a Mental Health Act assessment.*

The pathway describes the delivery of evidence-based interventions for adults and older adults with a range of needs. At all stages, the principles of personal choice, capacity and collaboration should be embedded to improve recovery and experience of care and there should be an integrated health and social care response to the person experiencing a mental health crisis.

In order to meet the EBTP standard, as well as the wider ED performance standards set out in the NHS Constitution,[26] general hospitals will need a robust pathway (which includes the liaison mental health functions set out in this pathway) to ensure emergency referrals are made at the earliest opportunity after a person arrives in the ED. This will also require ED staff, particularly those conducting triage assessments, to be competent in identifying possible mental health problems in people who are attending the ED. Liaison mental health teams can help ensure this by providing support and training to ED staff.

See Figure 1: Summary of the pathway for an emergency response from liaison mental health services.

4.2.1 EBTP CLOCK STARTS – Identification

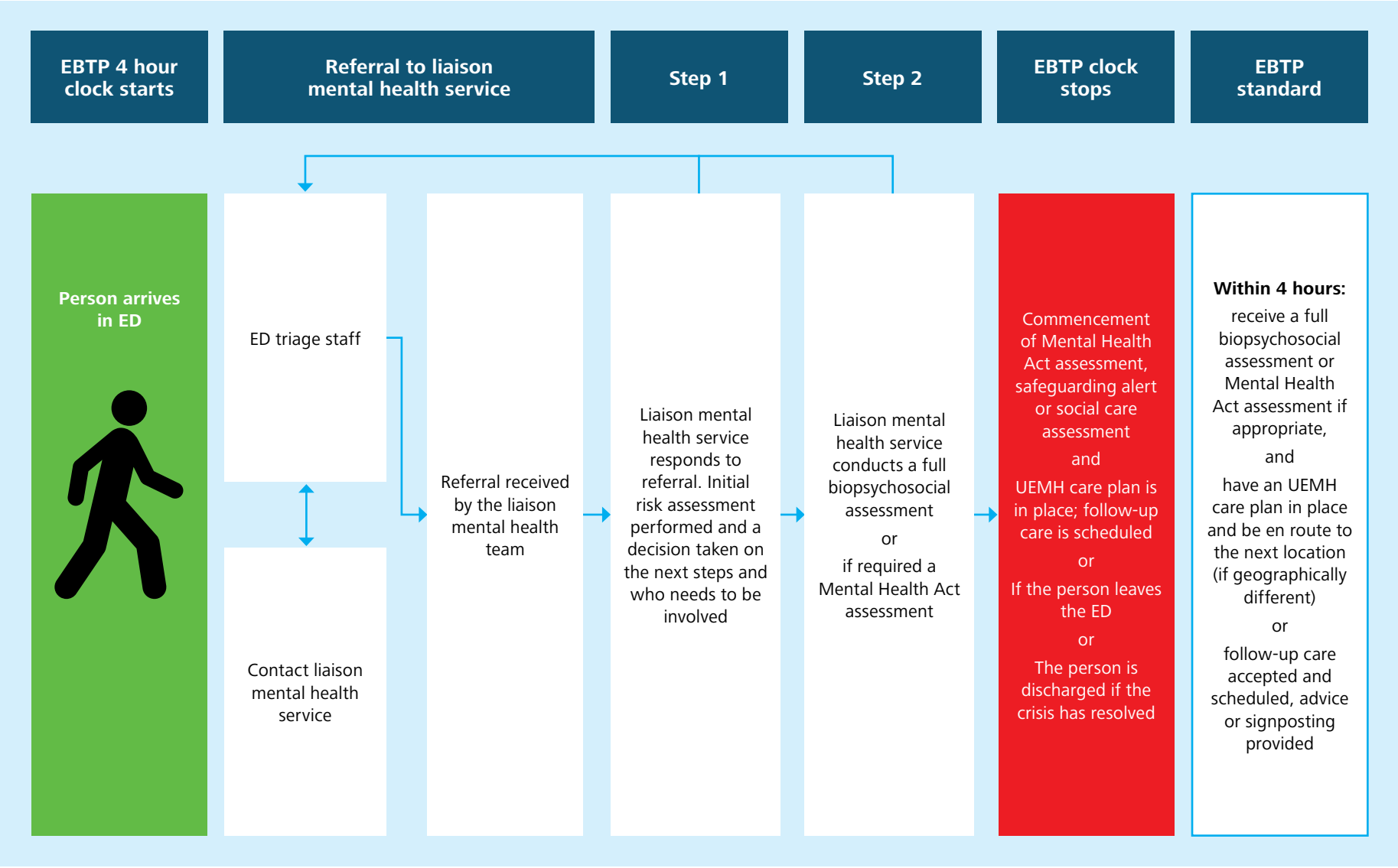
The EBTP CLOCK STARTS when: (1) the person arrives at an ED, or (2) the person is referred to the liaison mental health team from a ward. The liaison mental health service should be notified at the earliest opportunity when a need is identified.

A basic review should be conducted by ED triage staff or appropriate staff on the ward. This should be undertaken with compassion and understanding and include:

- a physical assessment; a decision as to whether they need emergency physical care should be taken as a priority (see Appendix B.2 and B.3 in the *Appendices and Helpful Resources* pack)
- a personalised risk assessment, including a decision as to the appropriate action needed should the person leave the ED while waiting for review by the liaison mental health team
- observations on behaviour and mental state.

If there is a lack of clarity about whether an urgent or emergency mental health response is needed, staff should call the liaison mental health team for advice. This will put the liaison mental health service on alert. See Section 4.4.2 for guidance on the difference between referrals and alerts.

Figure 1: Summary of the pathway for an emergency response from liaison mental health services



Key: UEMH = urgent and emergency mental health

4.2.2 Step 1 – Response

The liaison mental health team should **respond to a referral within one hour**. A response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment.

- The liaison mental health team reviews the person face to face to:
  - *establish initial mental state*
  - *establish with the person whether they are experiencing a mental health crisis*
  - *obtain a general history of mental and/or physical health problems*
  - *obtain any existing care or crisis plan and/or advance decision or statement*
- Patient records, including primary care records, drug and alcohol records and any other records from specialist services, should also be reviewed
- If the liaison mental health team confirms with the person that they are experiencing a mental health crisis, they should arrange appropriate support while the person is waiting for a full biopsychosocial assessment or an assessment under the Mental Health Act if appropriate. This should include an agreed level of contact with health or social care staff, and a point of contact within the department
- If the person is severely intoxicated or demonstrating behaviour that challenges, the liaison mental health team should not assume that their mental state is a consequence of drug and alcohol use without adequate assessment and should:
  - *ensure that appropriate support is available for the person's physical care*
  - *consider whether the person has the capacity to agree to an assessment or to self-discharge (and whether it would be safe for them to do so)*
- The liaison mental health team should decide whether a full biopsychosocial assessment or an assessment under the Mental Health Act is appropriate
  - *If a full biopsychosocial assessment is required, it should start without delay. The priority is to ensure the person has been assessed and a NICE-recommended care package is in place for onward care or discharge, where appropriate.* ***The clock does not stop when the full biopsychosocial assessment starts.***
- The liaison mental health team should decide whether there are safeguarding concerns. If there are, they should raise a safeguarding alert, following their local safeguarding processes.

4.2.3 Step 2 – Assess

The EBTP CLOCK CONTINUES as the liaison mental health team assesses the person and decides on the appropriate outcome.

- The person, and their family/carers where appropriate, should be kept informed of plans while waiting for an assessment
- The assessment should start as soon as practicably possible
- The assessment should take place in an appropriate and safe environment[27] where any physical health concerns can still be addressed
- During a full biopsychosocial assessment, if the liaison mental health team suspects or identifies physical health concerns, such as intoxication or overdose, the liaison mental health team should refer the person back to the ED triage staff
- While conducting a full biopsychosocial assessment, if it is decided that a Mental Health Act assessment is needed, the full biopsychosocial assessment should be paused and the attendance of an AMHP and section 12 approved doctor(s) arranged to undertake the Mental Health Act assessment
- During the full biopsychosocial assessment, a need for an assessment under the Mental Health Act may be identified. If an assessment under the Mental Health Act is required (adhering to the Mental Health Act Code of Practice), the following should be considered:
  - *if the person is already admitted as an inpatient on a general hospital ward, it should be considered whether a holding power (section 5(2) of the Mental Health Act) is necessary*

- *the appropriate professionals should be informed as soon as a location for the assessment is confirmed (for example, if there is no AMHP available on site one needs to be called)*
- *whether use of a section 136 is needed involving the police; if so, the assessment should take place in a designated health-based place of safety[h] if possible and practicable.*

4.2.4 EBTP CLOCK STOPS – Agreed treatment plan in place

The EBTP CLOCK STOPS when the mental health crisis is resolved and the appropriate follow-up arranged OR a Mental Health Act **assessment starts.** The assessment should be done as quickly as possible, but without compromising good clinical practice. It should be remembered that the consequences of a Mental Health Act assessment are potentially the loss of liberty or the saving of life.

- The duration of the assessment and the cause of any delays in either starting or completing the assessment should be recorded as these data from AMHPs can be used to improve the quality of services
- The following should be covered in a full biopsychosocial or Mental Health Act assessment:
  - *the person's wishes and feelings about their treatment and care including, where relevant, any advance decision or statement*
  - *the factors that may have contributed to the mental health crisis*
  - *the physical, psychological and social consequences of the crisis*
  - *the presence and severity of coexisting mental and physical health problems, including coexisting drug or alcohol use problems*
  - *current risk (physical and/or mental health including self-harm) and whether inpatient stabilisation or intensive home treatment is needed*
  - *a person's history including whether they are currently receiving any treatment for mental or physical health problems and any social factors that may be impacting on their mental health*
  - *the person's level of consumption of drugs and/or alcohol*
  - *the level of motivation of the person and, if appropriate, their family/carers, to engage in appropriate treatment, including:*
    - *aspects of motivation that may not be immediately apparent or are hidden by feelings of despair and hopelessness*
    - *whether the person feels that they will be able to engage in treatment*
    - *any protective factors with regard to future crises, for example, personal/social relationships, and the strengths, resilience and capacity of families/carers to support treatment in the community*
- Based on the assessment and discussions with the person's family, if appropriate, and health and social care professionals relevant to the care of the person, the liaison mental health team should ensure that:
  - *An urgent and emergency mental health care plan is in place if the person is to be discharged and a copy given to the person before they leave (and, if the person agrees, to their family/carer). This plan should include:*
    - *details of who to contact at any time if the crisis reoccurs*
    - *an outline of appropriate care for the person if the crisis reoccurs*
    - *any advance decision or statement that the person wishes to add*
    - *contact details for the service and individual with whom follow-up care is arranged*
    - *contact details of services that may help the person to address factors that are thought to have contributed to the crisis, for example Citizens Advice or the local housing association.*

[h] *See Part 1: Implementing the Evidence-based Treatment Pathway for 'Blue Light' Services Providing an Urgent and Emergency Mental Health Response for All Ages (forthcoming, 2016).*

See Appendix B.5 in the *Appendices and Helpful Resources* pack for the process for ensuring an urgent and emergency mental health care plan is in place

- *The appropriate facilities are available for the person after discharge from the liaison mental health service. Alternative discharge locations may include:*
  - *their residence, or the residence of a family member or friend, if appropriate*
  - *crisis house (or similar facility)*
  - *a bed on an appropriate ward*

See Appendix B.6 in the *Appendices and Helpful Resources* pack for the process for ensuring an appropriate discharge location is available before the person leaves the department

- *All services that need to be involved in follow-up care are notified and have accepted the person into their care (see Appendix B.8 in the Appendices and Helpful Resources pack).*

4.3 Urgent care pathway

For the pathway see Appendix B.9 and B.10 in the *Appendices and Helpful Resources* pack.

As well as a rapid response to emergency referrals, liaison mental health services should provide an urgent care pathway, with a full assessment taking place within 24 hours of referral.

- An urgent and emergency liaison mental health service should respond to the referrer within one hour of receiving a referral from a general hospital ward to ascertain its urgency, the type of assessment needed and resources required for the assessment
- The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. The principles of assessment described in the emergency pathway (see Section 4.2.2) apply to the urgent care pathway.
- Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should:
  - *have received a full biopsychosocial assessment, and*
  - *have an urgent and emergency mental health care plan in place, and*
  - *at a minimum, be en route to their next location if geographically different, or*
  - *have been accepted and scheduled for a follow-up appointment by a responding service, or*
  - *have been provided advice or signposted, where appropriate.*

If at any point the person's mental health deteriorates, or it is deemed they require an emergency response, including a Mental Health Act assessment, the emergency pathway should be followed.

It should be borne in mind that:

- An urgent referral would usually be received from a ward in a general hospital, and relate to an emergent or deteriorating mental health problem that is not considered a crisis requiring an emergency response
- The majority of urgent referrals are likely to be for older adults (including dementia), and the response should be carried out by staff with training in working with older people
- If general hospital staff are unsure whether or not an emergency or urgent response is required, they should consult the liaison mental health team
- If an emergency mental health need is identified, the liaison mental health service should follow the emergency pathway (see Section 4.2.2). Clinical judgement should be used to establish on which pathway a person starts
- Follow-up care may be provided by the liaison mental health service over a number of sessions. This may take place in an inpatient or outpatient setting

See Figure 2: Summary of the pathway for an urgent response from liaison mental health services.

4.4 Pathway principles

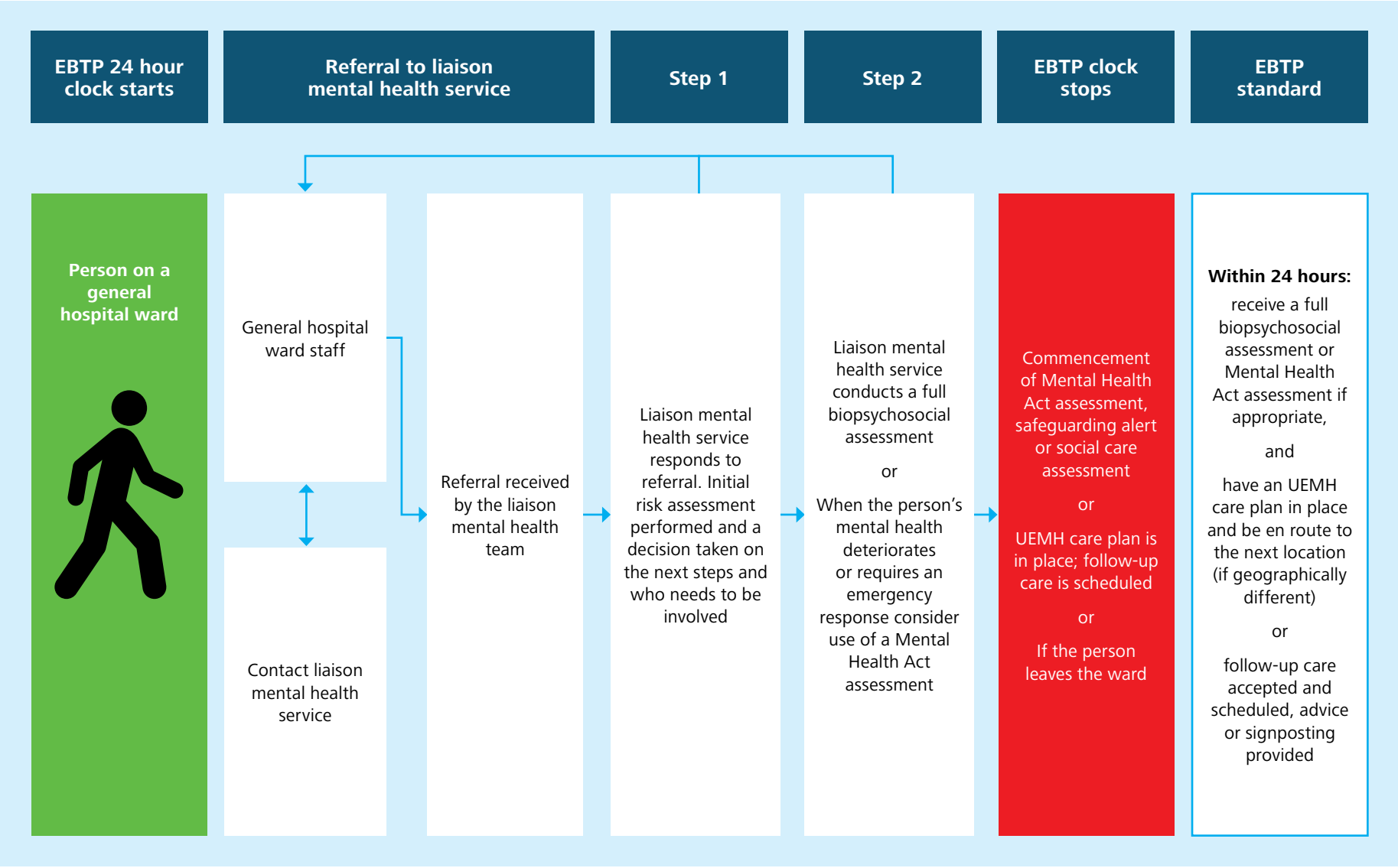
The evidence-based treatment pathway set out in this guidance is designed to inform responses to mental health crises, and it is expected that individual clinical decisions will need to be made to provide a response that is tailored to the person's circumstances and presentation. The pathway describes the most common situations, but it is expected that some people will not follow this pathway if they have different needs.

4.4.1 Providing age-appropriate treatment

Children and young people

Some adult services provide an urgent and emergency mental health response to young people aged 16 to 18 years or provide an all-age response that reflects the organisation of urgent and emergency services locally. If an adult or all-age liaison mental health service provides an urgent and emergency mental health response for children and young people under the age of 18 years, there should be a well-defined 24/7 pathway for this age group. This will ensure that the majority receive a response from staff with experience, competence and training in working with children and young people, particularly if a full biopsychosocial assessment is required. See *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming).*

Figure 2: Summary of the pathway for an urgent response from liaison mental health services



Key: UEMH = urgent and emergency mental health

Staff whose specialist experience and training does not include children and young people's mental health should be provided with additional training to support their work with children and young people and they should be able to access specialist staff within the team for professional consultation and on-call consultation, if appropriate.

Older adults

It should be noted that a large proportion of the caseload of liaison mental health services tends to be older adults with mental health problems and dementia on inpatient wards, and indeed the majority of the financial benefits of liaison services are accrued through assessment and treatment of older adults. Nearly two-thirds of people aged 65 or older in general hospitals have a significant mental health need (mainly depression, delirium or dementia).[28] A liaison mental health team should therefore include staff with specialist expertise in working with older people, in order to support the specific needs that come with age.

If the person has reduced awareness of the environment, impaired cognition and is experiencing behavioural or emotional disturbances, it is important to rule out a physical health condition, particularly delirium, when the person is in the ED. Although services may be aware that a person has a diagnosis of dementia, a mental health crisis should not be dismissed automatically.

4.4.2 Using referrals and alerts

Referrals and alerts can be made via a range of methods (for example, in writing, by telephone, email or face-to-face) including when a member of the liaison mental health team observes a person in the ED who they suspect is experiencing a mental health crisis.

- A referral is any formal request for clinical assistance from the liaison mental health service where it is reasonable to assume that the correct outcome for the person's health is an advancement to the next stage of the pathway (for example, from referral to assessment). A referral may be formal (such as an electronic form) or informal (such as a phone call)
- An alert is any informal request for assistance to the liaison mental health service where a healthcare professional could reasonably assume that the next stage of the pathway is impossible at the current time (for example, the person is unconscious)
- When receiving an alert, the liaison mental health team should attend in person or make contact with the referring team. Liaison mental health teams include the necessary expertise in caring for people with comorbid mental and physical health problems and they work in parallel with medical teams. They should therefore be proactively involved in the person's treatment and be ready to provide mental health input as soon as the person is able to be seen. This should not be just a request to be notified when the person is declared medically cleared, which can often lead to undue delays in the pathway.

4.4.3 Mental capacity

Professionals working with people experiencing a mental health crisis should understand legislation relevant to capacity, consent and information sharing as outlined in the Mental Capacity Act[29] and Mental Capacity Act Code of Practice[30] and refer to these for further guidance on this topic. Mental health professionals should pay particular attention to sections 1 to 6 of the Mental Capacity Act in order to understand legal duties as well as limitations. Guidelines on capacity and information sharing should always be followed and considered at all times throughout the pathway.[31] If a person does not have capacity, additional support will be needed in order to conduct an assessment. Capacity may be lacking not only due to a mental health problem but may also be impaired because of severe delirium or anaesthesia.

4.4.4 Safeguarding

Professionals working with people experiencing a mental health crisis should always have the person's wellbeing and safety in mind. All professionals have a duty to raise a safeguarding alert when they are concerned about a vulnerable person.[32] [33] Safeguarding should be considered as part of the full biopsychosocial assessment and throughout care, and any safeguarding concerns should be addressed in a timely manner following local safeguarding protocols.

For adults, the Care Act 2014 should be observed and the Social Care Institute for Excellence (SCIE) has published information for implementing reform in line with the Care Act.[34]

If there is a concern around safeguarding (this may relate to the person themselves or any dependants in their care), then professionals have a duty to raise a safeguarding alert, following local processes for doing so.

Safeguarding children and young people is covered in *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People (forthcoming).*

4.4.5 Transport

For the pathway see Appendix B.7 in the *Appendices and Helpful Resources* pack.

If someone needs to be transported from the general hospital to another location, this should always be done in a manner that preserves dignity and privacy and allows for management of their safety and that of others. The liaison mental health team should assist in arranging transport based on a personalised risk assessment in discussion with ambulance personnel and police if necessary. If appropriate, a mental health professional should provide support for the journey. Ambulances should take no more than one hour to respond to a transport request. If other transport is needed, the person should start their journey within one hour of the request for transport being received.

Where a person is discharged, the liaison mental health team should assist in arranging transport, preferably with the person accompanied by a friend or family member if they are available and the person agrees.

4.4.6 Managing intoxication due to drug or alcohol intake

For the pathway, see Appendix B.4 in the *Appendices and Helpful Resources* pack.

As a general principle, intoxication, any drug or alcohol problems, or coexisting mental health and drug/alcohol problems, must not prevent people in crisis from accessing physical or mental health services.[35]

People with mental health problems who are intoxicated may first present to EDs, which can be a challenge to ED and liaison mental health staff. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness showed that 54% of people who die by suicide had a history of either alcohol or drug use or both.[36] In 2014 there were approximately 3,000 alcohol-related admissions to EDs every day.[4]

One of the challenges is the difficulty recognising an underlying mental health problem if the person is in withdrawal or is intoxicated (for example, if they are unconscious or semi-conscious, have severely impaired cognition, perception or judgement and/or other symptoms that warrant urgent and emergency care). Furthermore, both intoxication and withdrawal may be associated with transient suicidality or psychosis, which will warrant an urgent and emergency mental health intervention.

The general principle when managing people who are intoxicated is to ensure that they are kept safe physically, and assessed clinically as having sufficient mental capacity to access urgent and emergency mental health care if there is a reasonable suspicion of mental health needs. Equally, not everyone who is intoxicated should be assumed to need mental health care. However, if the person is severely intoxicated or in withdrawal, a medical response is needed regardless of the person's drug or alcohol use history or whether a mental health problem is suspected.

- The outcome of the physical assessment would indicate if the referral to the liaison mental health service should be made and

whether referral to a drug or alcohol service is required. The EBTP clock starts when a person first arrives in an ED, but will only applied if a person is subsequently referred to a liaison mental health service

- A person who is intoxicated or going through severe withdrawal may need to be detained in hospital for their own safety, following a best interest decision
- If a Mental Health Act assessment is needed, the AMHP and section 12 doctor should consider the risk to the person if assessment is delayed.

4.4.7 Managing people who leave (or are likely to leave) before an assessment

If a Mental Health Act assessment has been arranged and the need for urgent and emergency mental health care is still in place, then the EBTP clock does not stop if the person leaves the ED or ward and is reported to the police as a 'missing person'.

If there are concerns that the person is likely to leave before an assessment and there are concerns regarding immediate harm, all efforts should be made to support the person.

The following should also be considered:

- Whether there is reason to suspect the person lacks mental capacity and powers to hold under the Mental Capacity Act can be used
- Whether it is appropriate to contact the police to consider the use of Mental Health Act section 136 (if the person is in a place to which the public has access, such as the ED)
- Whether Mental Health Act holding powers should be used:
    - *If a person is already receiving physical health treatment, the doctor in charge of their care can apply section 5(2) holding powers*
    - *If a person is already receiving mental health treatment, a registered mental health nurse can apply section 5(4) holding powers.*

If no urgent and emergency mental health care is required and the person leaves the general hospital of their own accord, the EBTP CLOCK STOPS and the conditions under which they left should be recorded. The liaison mental health team should consider whether further referral and/or follow up is necessary (for example, referral to a community mental health team).

4.4.8 Supporting a person when they no longer need urgent and emergency care

Not all crises indicate a need for mental health service involvement, but where support is required, presenting problems can subside at different rates. Once the crisis starts to subside, the person can appear more settled and it is not uncommon for people to not want or need any further follow-up by specialist mental health services.

The person's wishes together with clinical judgement should decide whether further care is required. If the person feels there is no longer a need for urgent and emergency mental health care, and there is no immediate risk to their safety, their rights and wishes should be respected, and the clock would stop at this point.

4.4.9 Collecting data

Complete, timely and accurate data collection and subsequent submission to national NHS datasets should be viewed as an integral part of the pathway and the responsibility of all service providers. Appropriate data collection helps improve service quality overall and is essential for services involved in follow-up care. In August 2016, the National Mental Health Dementia and Neurology Intelligence Network at Public Health England launched a crisis care profiling tool and data catalogue, which lists metrics and datasets relevant to mental health crisis care. The data catalogue is for commissioners, policy makers, planners and service providers and includes links to data sources. The aim of the data catalogue is to enable services to identify data that is available on crisis care and to ensure that there are effective services in place. As improvements are made to national datasets, the profiling tool will also be updated and improved.

4.5 Measuring and reporting performance against the pathway and standards

4.5.1 Submission of data items

From April 2017, liaison mental health services that are provided by mental health trusts will be expected to submit the following data items in the Mental Health Services Data Set to begin measurement of times and interventions related to this pathway. These will need to record:

- the time of the referral received by the liaison mental health team
- the time of the initial response by the liaison mental health team
- that a full biopsychosocial assessment has taken place
- that an urgent and emergency mental health care plan has been agreed and is in place
- the time that the person is either:
    - *en route to their next location if geographically different, or*
    - *has been accepted and scheduled for follow-up care by a responding service, or*
    - *has been discharged because the crisis has resolved*

    OR
- the time that a Mental Health Act assessment started.

Further guidance will be issued by NHS Digital about this new data collection in due course.

In time, we expect that the clinician-reported outcomes measures (CROMs) and patient-reported experience measures (PREMs) set out in Section 4.5.2 will also be collected via national datasets, but further testing will be taking place as part of the quality assessment and improvement programme (see Section 4.5.3) that will begin from mid-2017.

The above requirements will only measure part of the evidence-based treatment pathway from when the liaison mental health team receives the referral.

ED waiting times as set out in the NHS Constitution should continue to be submitted for all people who attend EDs, including people who present with mental health needs, via the A&E National Statistics collection and the A&E HES Dataset.

A new Emergency Care Data Set is currently in development, with the intention of improving the quality of data about ED activity. In the interim, we encourage liaison mental health services to contribute to improvements in local primary and secondary mental health ED diagnostic coding. Work is underway to determine how the full evidence-based treatment pathway will be measured through national datasets, and guidance will be issued in due course.

4.5.2 Outcomes measurement

Patient and clinician-reported outcomes measures

While there are a large number of validated patient-reported outcomes measures (PROMs) and CROMs in mental health that can be used to track change over time, they are not generally useful in a single episode such as an urgent or emergency mental health assessment. However, it is recommended that the Clinical Global Impression Improvement Scale (CGI-I) is used as a CROM to measure the person's condition at the end of every assessment (see Table 5).

PREMs are useful for gauging the quality of the person's experience. See Table 6 for a suggested PREM to use. This has been developed from the Service User Experience in Adult Mental Health NICE guideline and the Service User Experience in Adult Mental Health Services NICE quality standard and should be used retrospectively and confidentially.

Providers and commissioners should work together to ensure the routine collection and review of outcomes data in line with existing national guidance. Nationally the intention is that, in time, these outcomes measures will be collected through national datasets.

The Liaison Psychiatry Faculty at the Royal College of Psychiatrists has developed a Framework for Routine Collection of Outcome Measurement in Liaison Psychiatry (FROM-LP). This resource will be updated in the future, and commissioners and providers should consider using any new outcomes measures included within this framework.

Table 5: Clinical Global Impression Improvement Scale (CGI-I)[37]

Compared to the person's condition at the start of assessment, his/her condition is:

Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7

Table 6: Patient-reported experience measure

The following statements are adapted from the Service User Experience in Adult Mental Health NICE guideline and the quality standard. They were identified by service users as important to them when they are receiving care and support from mental health services. Please state, on a scale of 1 to 5, whether these statements reflect your experience of using liaison mental health services (with 5 meaning that they completely reflect your experience, and 1 meaning that they do not reflect your experience at all):

	Statement	Please circle one number				
1	If I experience a mental health crisis again, I feel optimistic that care will be effective.	1	2	3	4	5
2	During the treatment for my crisis, I was treated with empathy, dignity and respect.	1	2	3	4	5
3	During the treatment for my crisis, I felt actively involved in shared decision-making and supported in self-management.	1	2	3	4	5
4	I feel confident that my views are used to monitor and improve the performance of mental health care for crises.	1	2	3	4	5
5	I can access mental health crisis services when I need them.	1	2	3	4	5
6	During the treatment for my crisis, I understood the assessment process, diagnosis and treatment options, and received emotional support for any sensitive issues.	1	2	3	4	5
7	During the treatment for my crisis, I jointly developed a care plan with mental health and social care professionals, and was given a copy with an agreed date to review it.	1	2	3	4	5
8	When I accessed crisis support, I had a comprehensive assessment, undertaken by a professional competent in crisis working.	1	2	3	4	5
9	The mental health crisis team considered the support and care needs of my family or carers when I was in crisis. Where needs were identified, they ensured that they were met when it was safe and practicable to do so.	1	2	3	4	5

4.5.3 Quality assessment and improvement programme

All services will be expected to participate in a quality assessment and improvement programme. This will be organised and administered by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) through the existing quality network for liaison psychiatry services (PLAN).

The CCQI is working with a subset of the Expert Reference Group that oversaw the development of this guide, to produce:

- an assessment framework, setting out expectations for care in accordance with the implementation guide, and an accompanying four-point performance assessment scale
- a web-based self-assessment tool, which allows services to gauge their performance. Self-assessment returns will be validated and scored, and results from the self-assessment will be published. Services will be provided with benchmarking data to see how they compare to others nationally. Commissioners and providers will be able to use self-assessment information to target areas for service development and quality improvement.

Throughout the process, the CCQI will facilitate shared learning between clinical teams. The CCQI will also provide quality improvement advice and support to services.

Those services that choose to take part in the full PLAN accreditation process will receive additional support, such as peer review visits by trained clinicians and services users and access to additional training and learning activities.

5 Key commissioning considerations and service development

> *If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There's no support out there during these times. It's crucial that this is changed for the benefit of service users, their families and carers.*
>
> *Source: Five Year Forward View for Mental Health*

Most areas have a liaison mental health service in place, but getting them to meet the recommendations set out in this guide will require significant service development by commissioners and providers. Creating a new service or increasing the capacity of an existing service is central to improving outcomes; however, this alone will not achieve the necessary transformation in the quality of liaison mental health services across England. The following is a practical guide for commissioners and providers.

5.1 Step 1: Understand local demand

Commissioners should undertake an assessment of local need that involves people with relevant lived experience and their families/carers. Their engagement in assessing need, reviewing current services, deciding priorities and designing services will enhance the commissioning process.

Any assessment of local need and reviews of attendance at EDs and admission to general hospitals should:

- predict the number of referrals of people who may be in need of urgent and emergency mental health care in the general hospital setting
- predict patterns of presentation
- include a gap analysis
- include a clear understanding of how children and young people's specific needs will be met if the service provides an all-age response
- understand the reasons for ED attendances and general hospital admissions for people with mental health problems, including referral routes from primary care and NHS 111, and transport by ambulance services, for example
- review the completeness and quality of diagnostic coding of mental health in general hospitals and put improvement plans in place accordingly.

When liaison mental health services are developed fully, identification of mental health problems by general hospital staff, and therefore referrals, will also increase accordingly.[10]

Commissioners should ensure they have access to appropriate data to inform commissioning decisions. Where liaison mental health services are underdeveloped, it is likely that existing referral levels will not be an accurate indicator of the level of demand. Therefore, commissioners should not assume that current referral data are a reliable estimate of demand in these areas. The *Appendices and Helpful Resources* pack that accompanies this guide provides examples of liaison mental health services that are working at sufficient capacity and with general hospitals to identify cases; if both of these factors exist, the number of referrals received are more likely to be a reliable indicator of demand.

5.1.1 Commissioning for a hospital population

Where NHS trusts have more than one ED across their hospitals, a liaison mental health service should be commissioned specifically to meet the needs of each hospital, rather than considering the trust population as a whole.

However, a significant number of hospitals serve local populations across more than one CCG. In these cases, CCGs should identify a lead commissioner and contribute to funding on a proportionate basis, rather than having a number of separate contracts. This will ensure that services avoid duplication and provide an equitable service to different CCG populations. These arrangements could be identified as part of local Sustainability and Transformation Plans. There is an opportunity through Urgent and Emergency Care Networks to establish arrangements over a wider geography, ensuring that comprehensive pathways for access to liaison mental health services and wider crisis care are considered.

5.2 Step 2: Develop an outline service model

Commissioners should consider the examples of service models in this guide and the *Appendices and Helpful Resources* pack, while taking into account staffing, geography and location. Service delivery should reflect local demand, therefore different models may be required in rural and urban areas. The liaison mental health service should provide a range of options to ensure provision of urgent and emergency mental health care for those in rural communities or areas of low population density. Consideration should be given to traditional face-to-face service provision as well as options made available through new technology, for example telemedicine, particularly for ward referrals in hospitals that do not have an ED.

5.2.1 Consider the appropriate service model

Given that services need to provide 24/7 care, only the core 24, enhanced 24 and comprehensive models should be considered by commissioners where EDs in general hospitals operate on a 24/7 basis.

All liaison mental health services within hospitals providing regional and supra-regional services should aim to implement the comprehensive service model.

5.2.2 Identify and understand current referral pathways

Commissioners need to understand:

- external and internal referral sources (for example, self-referrals, GPs, NHS 111, general hospital wards, drug and alcohol services and the police)
- partners in service delivery (for example, voluntary and community organisations, and social care)
- discharge pathways (for example, into community mental health teams, home treatment teams, voluntary sector services, primary care, general wards, or intermediate care and residential care for older adults).

5.2.3 Consider establishing drug and alcohol use services

There is evidence that the provision of drug and alcohol use services working alongside liaison mental health teams, in particular alcohol use services (sometimes known as alcohol liaison services or alcohol care teams),[38] improves outcomes for those who have experienced a mental health crisis. Benefits include:

- a reduction in general hospital admissions and length of stay for those with alcohol-related problems
- a reduction in mortality related to the use of alcohol through early identification of alcohol-related conditions
- a reduction in alcohol-related ED attendances
- avoiding unnecessary lengthy hospital stays during full detoxification by completing treatment in the community.

There is also evidence to support a significant return on investment through the provision of a specialist-led alcohol team that provides case identification, comprehensive physical and mental health assessment, specialist care planning, medically-assisted alcohol withdrawal, psychotherapeutic interventions and liaison with community alcohol services for ongoing treatment.[39] (See also Section 5.5.2.)

5.3 Step 3: Obtain baseline current service provision and identify gaps

As set out in the CCG Improvement and Assessment Framework 2016/17, commissioners should be working with providers to undertake a baseline assessment of service provision and produce a service development and improvement plan (SDIP). The baseline assessment should include the current service model, the number of whole-time equivalent staff, skill mix and competences in the service.

Commissioners should establish how liaison mental health services respond to mental health crises currently and if they meet the recommended response times and provide an evidence-based package of care informed by NICE guidance as set out in this guide. If they do not meet these requirements, commissioners should work with other relevant services to either commission a new liaison mental health service (if one does not exist) or alter their current service provision in line with requirements.

5.4 Step 4: Agree staffing, recruitment and training plans

Providers will be required to show they have sufficient staff trained in evidence-based interventions, collaborative practice and the use of outcomes measures to meet the predicted need, or have a plan to develop the staff through a transformation programme. See Section 3.4 for further details.

5.5 Step 5: Design local referral to treatment pathways and accompanying protocols and guidance

5.5.1 Providing appropriate and safe environments for assessments

Commissioners need to ensure that EDs have sufficient and appropriate rooms to provide a confidential and safe place to support the person in need of care. See the PLAN for details on providing such an environment.

If the service will be providing support for children and young people, commissioners should refer to *Part 4: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Mental Health Services for Children and Young People* (forthcoming) for further details on an appropriate environment for this age group.

> *"Having to wait in loud fluorescent busy echoing waiting rooms for a long time. I can't always do it."*
>
> *Source: Service user, 2016*

5.5.2 Providing support for people with drug or alcohol use problems

General hospital admissions data show that coexisting alcohol use and mental health problems are common among people presenting in crisis. Commissioners need to ensure that people who are intoxicated and experiencing mental health problems do not get turned away by liaison mental health services,[40] but are assessed and given appropriate support. All hospitals have access to a drug and alcohol liaison service, which is either part of a liaison mental health service or via another model, such as an alcohol care team. CCG and local authority public health

commissioners should work together to ensure that all hospitals have access to such a service.

Liaison mental health services should provide referrals and signposting to drug and alcohol services and these details should be included in the person's urgent and emergency mental health care plan.

Drug and alcohol and liaison mental health services should work together closely, ensuring clear agreements are in place for screening, assessment and ongoing treatment, and that people under their care receive seamless, joined-up support.

5.5.3 Managing frequent attenders

Given that frequent attendances have both a human cost as well as a cost to the NHS, it is important for services to provide appropriate support and care in a way that minimises the stigmatisation of people who frequently attend EDs. Early identification of mental health problems and effective follow-up helps to reduce re-attendances at EDs. The Royal College of Emergency Medicine has produced guidance on the management of frequent attenders in EDs.[41]

Liaison mental health services play a critical role for EDs in identifying not only primary mental health presentations, but also underlying mental health problems for frequent attenders with physical health needs. They can also recognise the most common attenders, understand the needs of certain groups (for example, people who use drugs and alcohol, people who self-harm, and older people), review care and crisis plans and refer to other services. Liaison mental health services can work with local partners to review local care pathways and identify potential gaps in provision (for example, third sector and voluntary services or peer support) that lead to attendances at EDs.

Innovative programmes such as the 'Frequent Attenders Project' developed by Central North West London NHS Foundation Trust in collaboration with general hospital trusts across North West London have shown promising results.[42] Significant clinical improvements have been made and there has been a reduction in attendances through integrated case management and attendance planning.[42]

A national 'CQUIN' scheme for acute and mental health providers was announced in the two-year planning guidance for 2017-19 to incentivise care in a similar way to the North West London project, and a final version of the scheme for 2017-19 was published by NHS England in November 2016.

Commissioners should consider putting in place a policy to ensure that those with mental health needs who need to attend EDs frequently are offered appropriate support, including multi-agency care planning. Clinicians should have access to integrated electronic health and social care records so that they can provide the most effective care.

5.5.4 Providing care between assessments and reviews

There should be agreements in place to ensure continuing support between assessment and treatments for those receiving care while they are in the ED or on a ward. General hospital staff such as healthcare assistants, with appropriate training, can support liaison mental health service staff with this.

5.6 Step 6: Establish data collection and outcomes measurement protocols

5.6.1 Overview

There is currently widespread difficulty for professionals involved in responding to mental health crises to access full and relevant healthcare records. This is a significant barrier to improving the safety, efficiency and effectiveness of care because professionals should have quick and easy access to key, relevant patient information for those in crisis. Where records are available, the person's circumstances may have changed without the opportunity to update the records, or liaison staff may have to double enter patient information on IT systems. Liaison staff working in EDs and general hospital staff should have access to current clinical (including mental health care) records, ideally in an integrated and editable electronic format, including:

- community records on mental health, for example primary care records and those associated with drug and alcohol use
- records from the liaison drug and alcohol/ addiction team
- records from acute trusts
- existing care and/or crisis plans.

Commissioners and providers should take steps to establish ease of access for liaison mental health staff to interoperable, integrated electronic care records where they are not already in place, covering physical, mental and public health, and social care. The basic or enhanced NHS Summary Care Record is currently the only nationally available electronic care record containing key patient information and can also be used as an enabling platform. The Multi-agency Information Sharing and Suicide Prevention Consensus Statement and the revised Caldicott Principles[43 44] set out the circumstances under which information should be shared in a crisis situation.

Caldicott Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

'Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.'[36]

The Quick Guide to Sharing Patient Information for Urgent and Emergency Care produced by NHS England and the Information Governance Alliance is designed to help frontline providers and commissioners confidently share information to support the delivery of safer, faster and better urgent and emergency physical and mental health care. Commissioners, acute providers, mental health providers and other partners (such as local authorities, NHS 111 and ambulance services) should have in place data collection and sharing policies and agreements to optimise patient care, the means to collect and analyse such data and the ability to review and make service changes based on the analyses. Patient views should inform the quality of the service. The Centre of Excellence for Information Sharing also provides a range of resources to support this.

5.6.2 Developing reports for monitoring performance

Commissioners and providers will need to develop and produce reports on outcomes measures and service activity and quality, and agree how the data from these reports are best used to support service monitoring and development and future commissioning.

The parameters that need to be considered to judge what 'good' looks like are:

- Response to the crisis: all responses should be as rapid as possible and within the timelines outlined in Section 4
- Delivery of an evidence-based package of care informed by NICE guidance as defined in this guide
- Effective management and support of the person in care until resolution of the crisis; satisfaction with case management and support should be appropriate and measurable.

5.7 Step 7: Create a benefits realisation plan

Commissioners should outline in their plans how the development of liaison mental health services will improve care and lead to efficiencies. The benefits realisation plan should use a baseline of 2016/17 to set out and publish how the following outcomes will be achieved and monitored:

Health and patient experience outcomes:

- People requiring urgent and emergency mental health care from a liaison mental health service have an improved experience of care
- The liaison mental health service will provide NICE-recommended care, as set out in (Section 4.1 and Appendix A in the *Appendices and Helpful Resources* pack)
- People who frequently use the ED and have underlying mental health problems will have individual care packages that result in improved health outcomes and experience
- People receive treatment promptly accorded to the EBTP standards set out in Section 4.
- Adults and older adults receive care appropriate to their needs, from teams that have specialist training.

Healthcare utilisation, efficiency and financial benefits:

- Average length of stay and re-attendance rates will be reduced for people receiving care from the liaison mental health service
- Associated financial savings will be identified and realised
- Staff from different agencies will be able to access all relevant records at the time that a person requires urgent or emergency care from a liaison mental health team
- Links and protocols are in place to better support people who require support for drug and alcohol use.

Definitions of terms and abbreviations

Table 7: Definitions

Term	Definition
Appropriate and safe environment	In this document the term 'appropriate and safe environment' refers to a locally agreed place to which a person experiencing a mental health crisis, who has not been detained under section 135(1) or 136 of the Mental Health Act, can be taken to be supported and assessed by the appropriate professionals before the next step in their care is in place (whether this be discharge, referral or admission to a ward). The Royal College of Psychiatrists provides information on what facilities should be provided in an appropriate and safe environment (see the PLAN).
Carer	Any person who cares for a family member, friend or other person in need of support and assistance with activities of daily living. Carers may be paid or unpaid and include those who care for the frail older adults, people with long-term medical conditions, disabilities, mental health problems and people receiving palliative care.
Crisis plan	A document put together jointly by the person and the healthcare professional(s) which outlines the management plan in the event of a mental health crisis. The plan should include advice and instructions for both the person and the healthcare professionals supporting the person, when the person is experiencing a crisis. It should include key contact details, including phone numbers, and details of coping and self-management strategies.
EBTP clock	The 'evidence-based treatment pathway' or EBTP clock is the term for the clock referenced throughout this guide, pertaining to the recommended response times for mental health crises and access to an evidence-based package of care informed by NICE guidance as set out in the pathway in this guide.
Emergency	An unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.
Expert Reference Group	A group of experts with a variety of different experiences, expertise and/or qualifications, established by the NCCMH to support the development of the implementation guides and the evidence-based treatment pathways. The Expert Reference Group included topic experts from areas such as commissioning and public health, service providers, health and social care professionals (including liaison psychiatrists), 'blue light' service representatives, academics and people with lived experience of using mental health services.
Full biopsychosocial assessment	A comprehensive and person-centred assessment that obtains information about a person's physical and psychological health, including any drug and/or alcohol problems, current risk (physical and/or mental health including self-harm), relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment. Biopsychosocial assessments should be consistent with the Service User Experience in Adult Mental Health NICE clinical guideline and quality standard.

Term	Definition
Intoxication/ intoxicated	A condition that 'follows the administration of a psychoactive substance and results in disturbances in level of consciousness, cognition, perception, judgement, affect or behaviour, or other psychophysiological functions and responses'.[45] 'Severely intoxicated' describes a person who may be unconscious or semi-conscious, and/or has severely impaired cognition, perception or judgement and/or other psychophysiological functions and responses that warrant emergency care.[46]
Liaison mental health	The sub-specialty that provides mental health care to people attending general hospitals, whether they attend outpatient clinics, EDs or are admitted to inpatient wards. Also commonly known as 'liaison psychiatry' or 'psychological medicine', the term 'liaison mental health' is used in this guide to reflect the multidisciplinary nature of liaison teams.
Liaison mental health service	A service providing support and treatment for those presenting in general hospitals with (for example): • a mental health crisis • coexisting physical health problems that are affecting their mental health • self-harm that may first require medical attention • mental health problems triggered or exacerbated by drug or alcohol use (where physical health stabilisation is a priority).
Mental health crisis	A situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.
Urgent	An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.
Urgent and emergency mental health care	The range of responses that health and care services provide 24/7 to people who are experiencing a mental health crisis. This can be an immediate emergency response to a situation (which may threaten life, long-term health or the safety of an individual or others), or urgent advice, attention or treatment for situations that are not immediately life threatening.
Urgent and emergency mental health care plan	A document put together jointly by the person requiring urgent and emergency mental health care and mental health professional(s), which includes details of treatment options, goals, advice, and coping and self-management strategies. A crisis plan can also be included as an element of this care plan.
Urgent and emergency mental health service	Any responding mental health service attending to a person experiencing a mental health crisis, including a crisis team, 24/7 mental health service and street triage team.

Table 9: Abbreviations

Abbreviation	Full term
CCG	clinical commissioning group
CCQI	Royal College of Psychiatrists' Centre for Quality Improvement
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	crisis resolution and home treatment team
CROM	clinician-reported outcomes measure
EBTP	evidence-based treatment pathway
ED	emergency department
GP	general practitioner
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PLAN	Psychiatric Liaison Accreditation Network
PREM	patient-reported experience measure
RAID	Birmingham Rapid Assessment, Interface and Discharge
WTE	whole time equivalent

References

[1] Department of Health and Concordat Signatories. Mental Health Crisis Care Concordat. Improving Outcomes for People Experiencing Mental Health Crisis. London: Crown; 2014.

[2] Care Quality Commission. Right Here, Right Now. People's Experiences of Help, Care and Support During a Mental Health Crisis. London: Care Quality Commission; 2015.

[3] NHS England. Transforming Urgent and Emergency Care Services in England. Urgent and Emergency Care Review. End of Phase 1 Report. London: NHS England; 2013.

[4] NHS England. Five Year Forward View. London: NHS England; 2014.

[5] NHS England. Implementing the Five Year Forward View For Mental Health. London: NHS England; 2016.

[6] HMSO. Equality Act. London: Her Majesty's Stationery Office; 2010.

[7] HMSO. Health and Social Care Act 2012. London: Her Majesty's Stationery Office; 2012.

[8] Mind. Understanding Mental Health Problems. London: Mind; 2014.

[9] Dorning H, Davies A, Blunt I. Focus on: People with Mental Ill Health and Hospital Use. Exploring Disparities in Hospital Use for Physical Healthcare. London: The Health Foundation and Nuffield Trust; 2015.

[10] Parsonage M, Fossey M, Tutty C. Liaison Psychiatry in the Modern NHS. London: Centre for Mental Health; 2012.

[11] Mental Health Partnerships. Evidence Base for Liaison Psychiatry Services. London: Mental Health Partnerships; 2014.

[12] Joint Commissioning Panel for Mental Health. Guidance for Commissioners of Liaison Mental Health Services to Acute Hospitals. London: Joint Commissioning Panel for Mental Health; 2012.

[13] Barrett J, Lee W. Report of the 3rd Annual Survey of Liaison Psychiatry in England. Forthcoming 2016.

[14] Dupin M, Soni M, Palmer L. Psychiatric Liaison Accreditation Network Annual Report: Cycle One 2009-2010. London: The Royal College of Psychiatrists; 2011.

[15] The Royal College of Emergency Medicine. Mental Health in the Emergency Department Clinical Audit 2014-15: National Report. London: The Royal College of Emergency Medicine; 2015.

[16] Tadros G, Salama RA, Kingston P, Mustafa N, Johnson E, Pannell R, et al. Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. The Psychiatrist. 2013;37:4-10.

[17] Wood R, Wand A. The effectiveness of consultation liaison psychiatry in the general hospital: a systematic review. Journal of Psychosomatic Research. 2014;76:175-92.

[18] Parsonage M, Grant C, Stubbs J. Priorities for Mental Health. Economic Report for the NHS England Mental Health Taskforce. London: Centre for Mental Health; 2016.

[19] Becker L, Saunders R, Hardy R, Pilling S. The Raid Model of Liaison Psychiatry: Report on the Evaluation of Four Pilot Services in East London. London: UCL Partners Academic Health Science Partnership; 2016.

[20] Mental Health Partnerships. Developing Models for Liaison Psychiatry Services - Guidance. London: Mental Health Partnerships; 2014.

[21] Psychiatric Liaison Accreditation Network. Quality Standards for Liaison Psychiatry Services. London: The Royal College of Psychiatrists; 2014.

[22] Aitken P, Lee W. Providing Effective Liaison Psychiatry Services to English Hospitals with an Accident and Emergency Department: Findings from a Census Survey. London: The Royal College of Psychiatrists; 2014.

[23] London Liaison Mental Health Nurses' Special Interest Group. A Competence Framework for Liaison Mental Health Nursing. London: London Liaison Mental Health Nurses' Special Interest Group; 2014.

[24] Hughes L. A Capability Framework For Working Effectively With People With Combined Mental Health And Substance Use Problems (Dual Diagnosis). London: Care Services Improvement Partnership; 2006.

[25] Hughes L, Trippier J, Kipping C, Bell R, Group Z. The Leeds Co-occurring Mental Health and Substance Use (Dual Diagnosis) Capability Framework. Huddersfield: University of Huddersfield; 2015.

[26] NHS England. The NHS Constitution. The NHS Belongs to Us All. London: NHS England; 2015.

[27] Home Office. Alternative Place of Safety. The West Sussex Pilot Evaluation. London: Home Office; 2015.

[28] The Royal College of Psychiatrists. Who Cares Wins. London: The Royal College of Psychiatrists; 2005.

[29] HMSO. Mental Capacity Act 2005. London: Her Majesty's Stationery Office; 2005.

[30] Department for Constitutional Affairs. Mental Capacity Act 2005: Code of Practice. London: Office of the Public Guardian; 2005.

[31] NHS Institute for Innovation and Improvement. Demand and Capacity - Basic Concepts. UK: NHS Institute for Innovation and Improvement; 2008.

[32] NHS England. Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework. London: NHS England; 2015.

[33] Office of the Public Guardian. Safeguarding Policy. London: Office of the Public Guardian; 2015.

[34] Department for Constitutional Affairs. Care Act 2014. London: Her Majesty's Stationery Office; 2014.

[35] Public Health England. Better Care for People with Co-occurring Mental Health and Alcohol/ Drug Use Conditions. A Guide for Commissioners and Service Providers. In press.

[36] Healthcare Quality Improvement Partnership. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales. Manchester: University of Manchester; 2015.

[37] Guy W. ECDEU Assessment Manual for Psychopharmacology. Rockville, MD: US Department of Health, Education and Welfare; 1976.

[38] NICE. Alcohol Care Teams: Reducing Acute Hospital Admissions and Improving Quality of Care. NICE Quality and Productivity: Proven Case Study. London: The British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust; 2016.

[39] Public Health England. Alcohol Care in England's Hospitals: An Opportunity Not to Be Wasted. London: Public Health England; 2014.

[40] Holmes D. New initiative aims to tackle shortfalls in mental health crisis care. The Lancet Psychiatry. 2014;1:15-16.

[41] Smith MS, Chambers D. Best Practice Guideline: Frequent Attenders in the Emergency Department. London: The College of Emergency Medicine; 2014.

[42] Ng A, Natarajan V, McIver S, Reid C, Schofield E, Sachar A. Frequent attendances to a London emergency department: a service improvement project embedding mental health into the team. Journal of Primary Care. 2015;7:70-77.

[43] Department of Health. Information: to Share or Not to Share. Government Response to the Caldicott Review. UK: Department of Health; 2013.

[44] National Data Guardian. National Data Guardian for Health and Care. Review of Data Security, Consent and Opt-Outs. London: National Data Guardian; 2016.

[45] World Health Organization. Lexicon of Alcohol and Drug Terms. Geneva: World Health Organization; 1994.

[46] World Health Organization. ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization; 1992.