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Audit on overnight presentations in Mental Health Liaison Team, Lister Hospital, Stevenage, Hertfordshire

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Introduction
Between 9 pm and 9 am, we have noticed that the referrals to mental health liaison team done by A&E Lister Hospital, Stevenage, consist mostly of people with drug and alcohol problems. These patients are a high risk group (often they have taken overdoses of medication or attempted to hurt themselves or end their lives while intoxicated with drugs or alcohol) and they are referred to the mental health liaison team as we don't have a 24 hour CGL (Drugs and alcohol) service- they operate Mondays to Fridays from 9 am to 5 pm.
Because of this, the mental health liaison team is put under strain especially if there is a shortage of staff or if there is a busy shift. A 24 hour CGL service would be able to review patients in A&E quicker, offer appointments and aim to engage the patients in the service to help them reduce and hopefully stop their harmful use of drugs and/or alcohol.

Aims
The aim of this project is to show how many of the cases that are referred to Mental Health Liaison Team by A&E overnight are related to drugs and alcohol misuse and what can we do to improve our services to help support these people, but also help prevent strain on mental health services.

Methodology
- **Sample:** patients who presented to A&E Lister Hospital, Stevenage, Hertfordshire between 9 pm and 9 AM in the period 1st of April 2019 - 31st of May 2019
- **Project Tool:** An audit tool was created collating patient demographics (initials, NHS number, date of birth and age), time of referral to Mental Health Liaison Team by A&E, reason for referral, drugs/alcohol involvement, if currently under CGL, if a referral to CGL was discussed or not and if it was and accepted, did the Mental Health Liaison assessor refer to CGL or advised self-referral, have CGL made contact within one month of presentation to A&E, has there been ongoing contact with CGL after the presentation in A&E, have there been other presentations to A&E after initial episode and if yes, how many times, other information, including hospital admission and deaths. We will rule out the patients who have self-harmed while intoxicated with drugs and/or alcohol, but are not usually taking drugs/alcohol.
- **Method of data collection:** Using Mental Health Liaison Team monthly database, PARIS and CGL databases
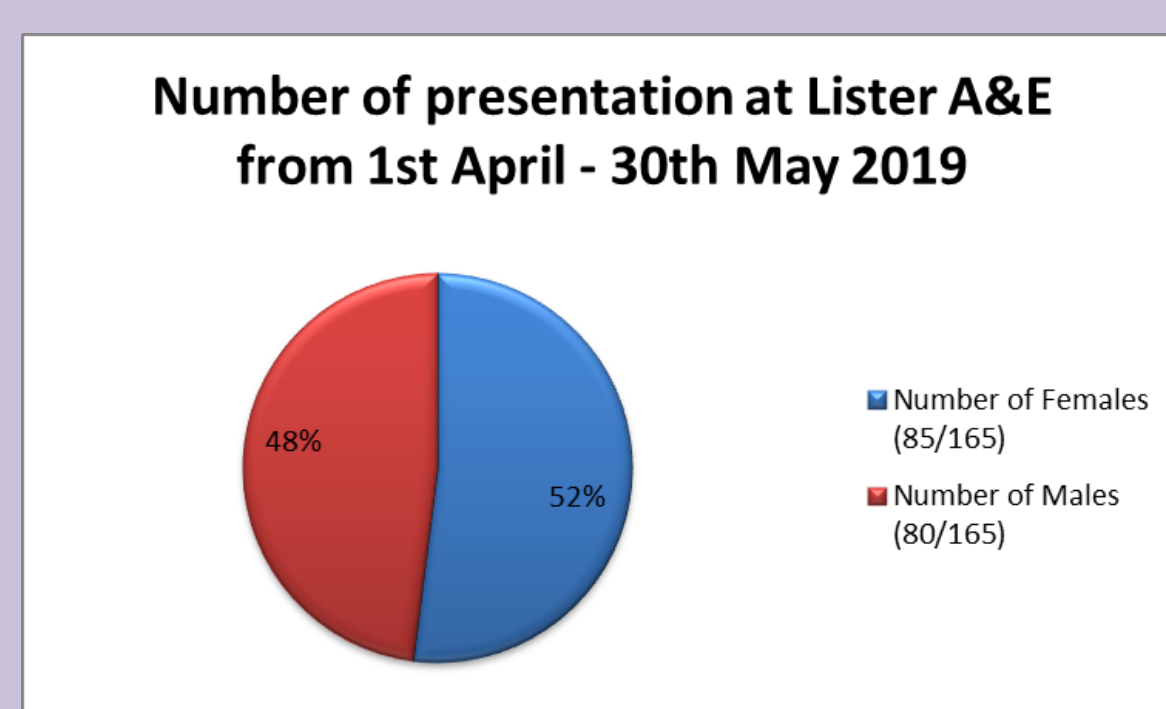
Findings

Figure 1- Number of presentations during the audit period- 1st of April to 30th of May 2019
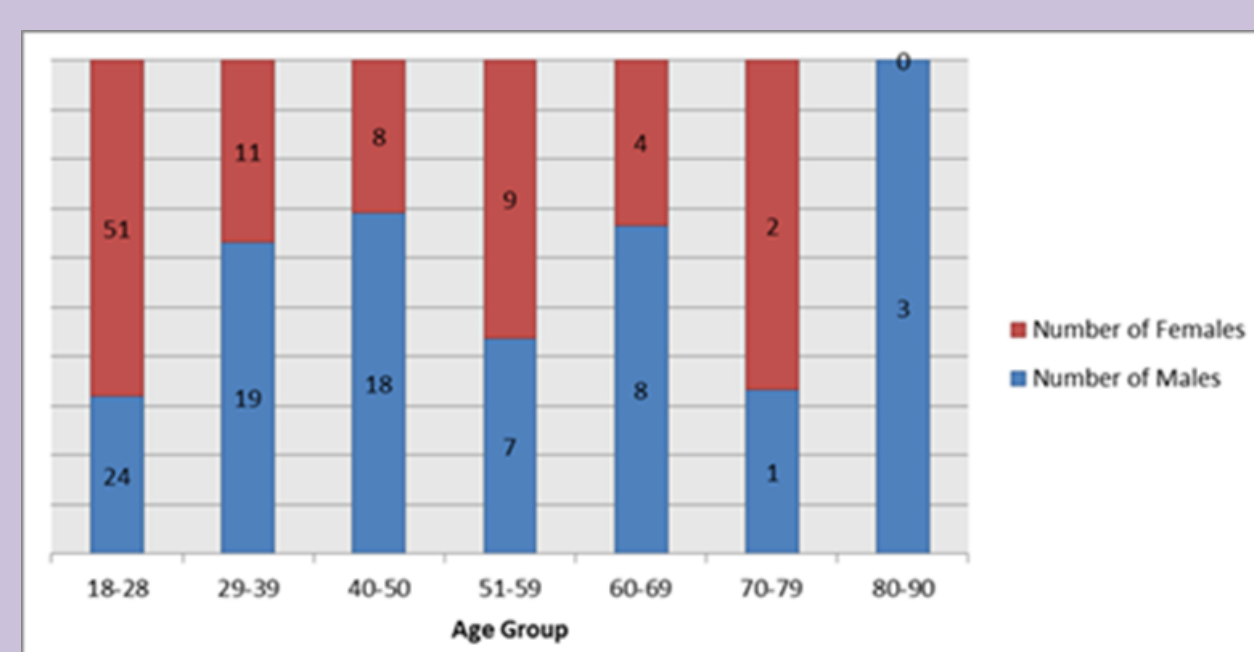

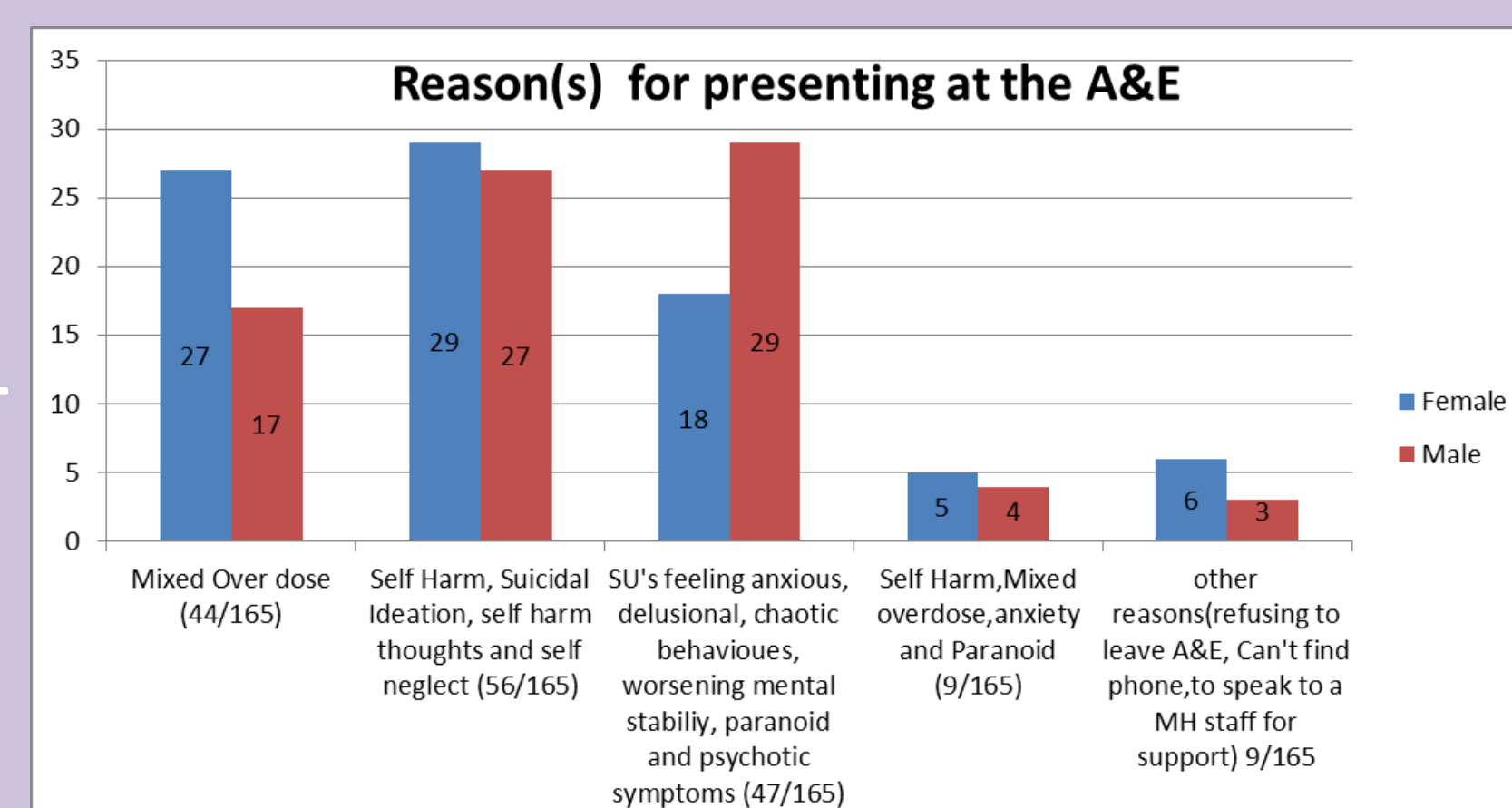Figure 2- Number of presentations during the audit period by age group and gender

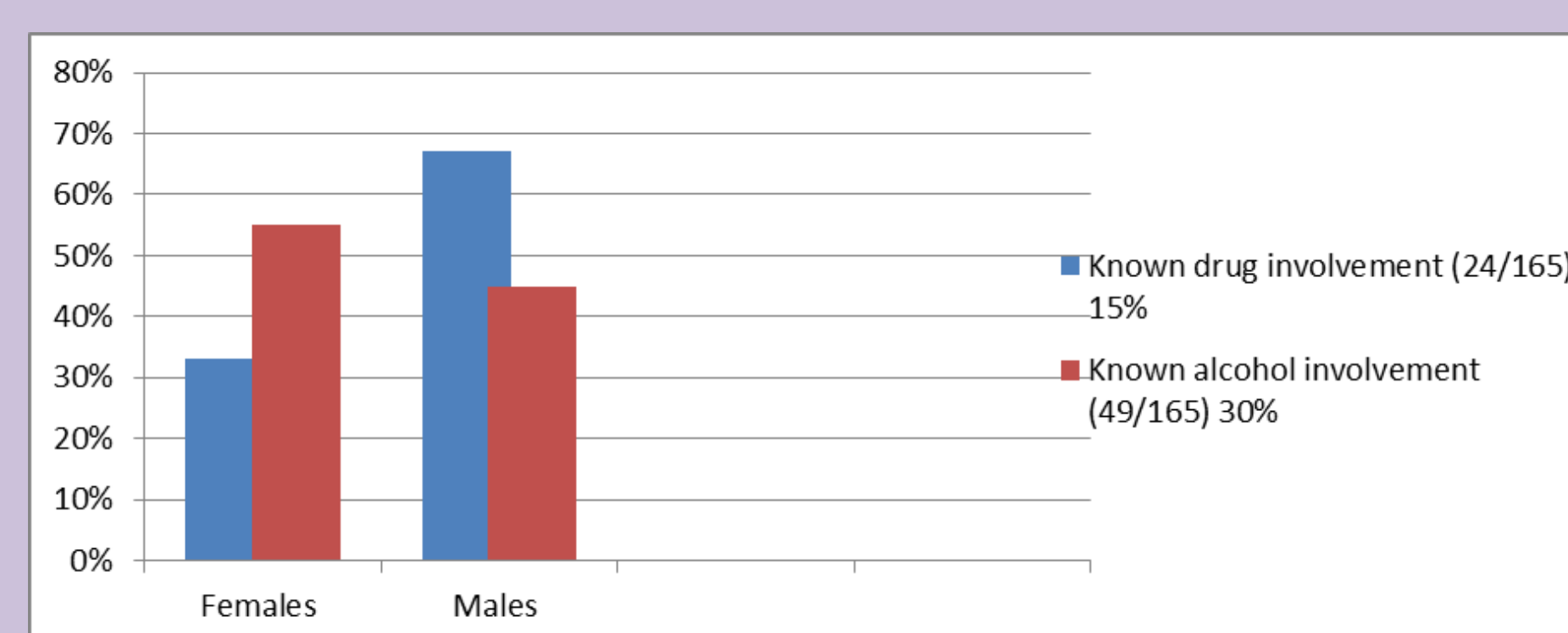Figure 3- Reason(s) for presenting to A&E

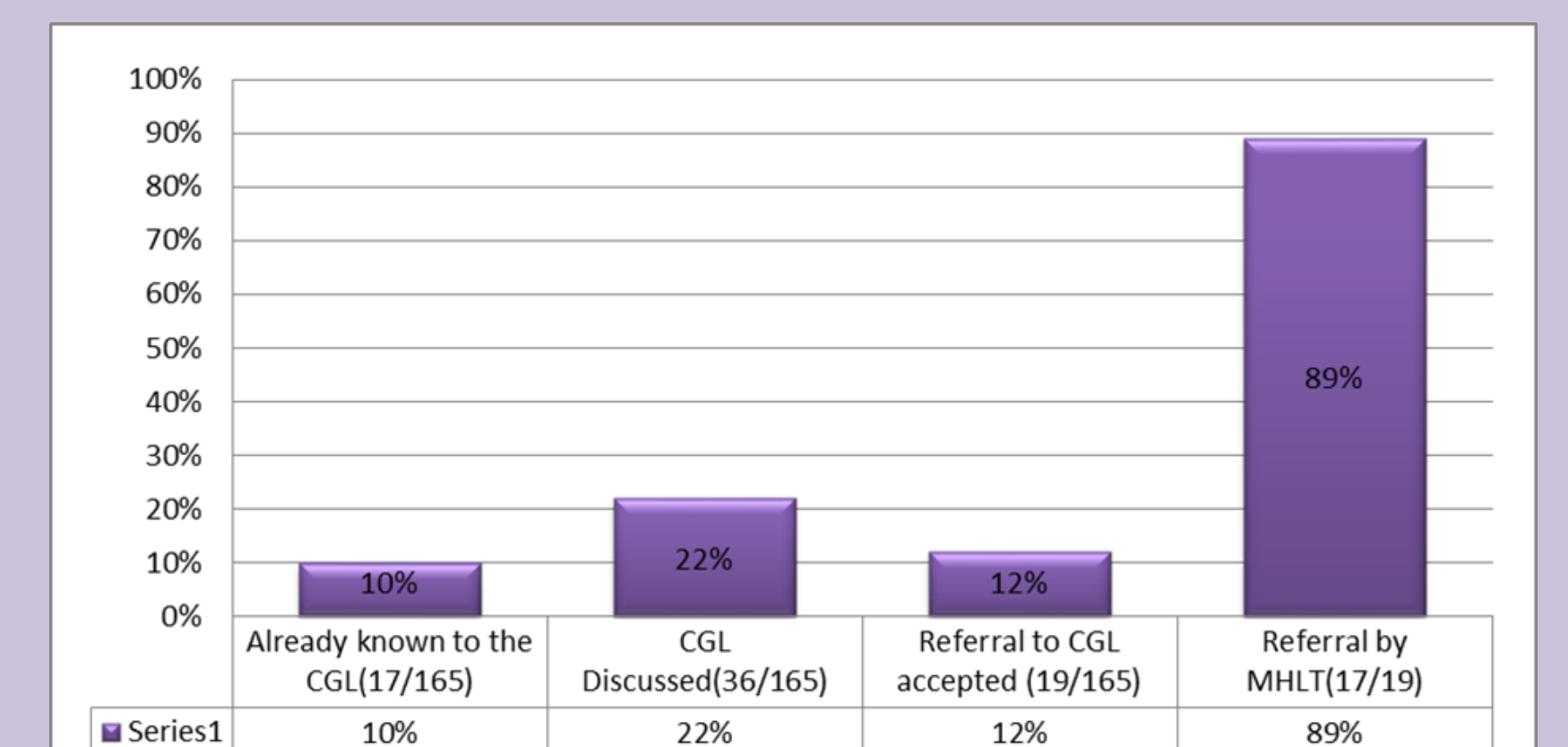Figure 4- Drug and alcohol involvement at time of presenting to A&E

Figure 5- CGL involvement prior to presentation to A&E and discussion about and referral to CGL at presentation to A&E
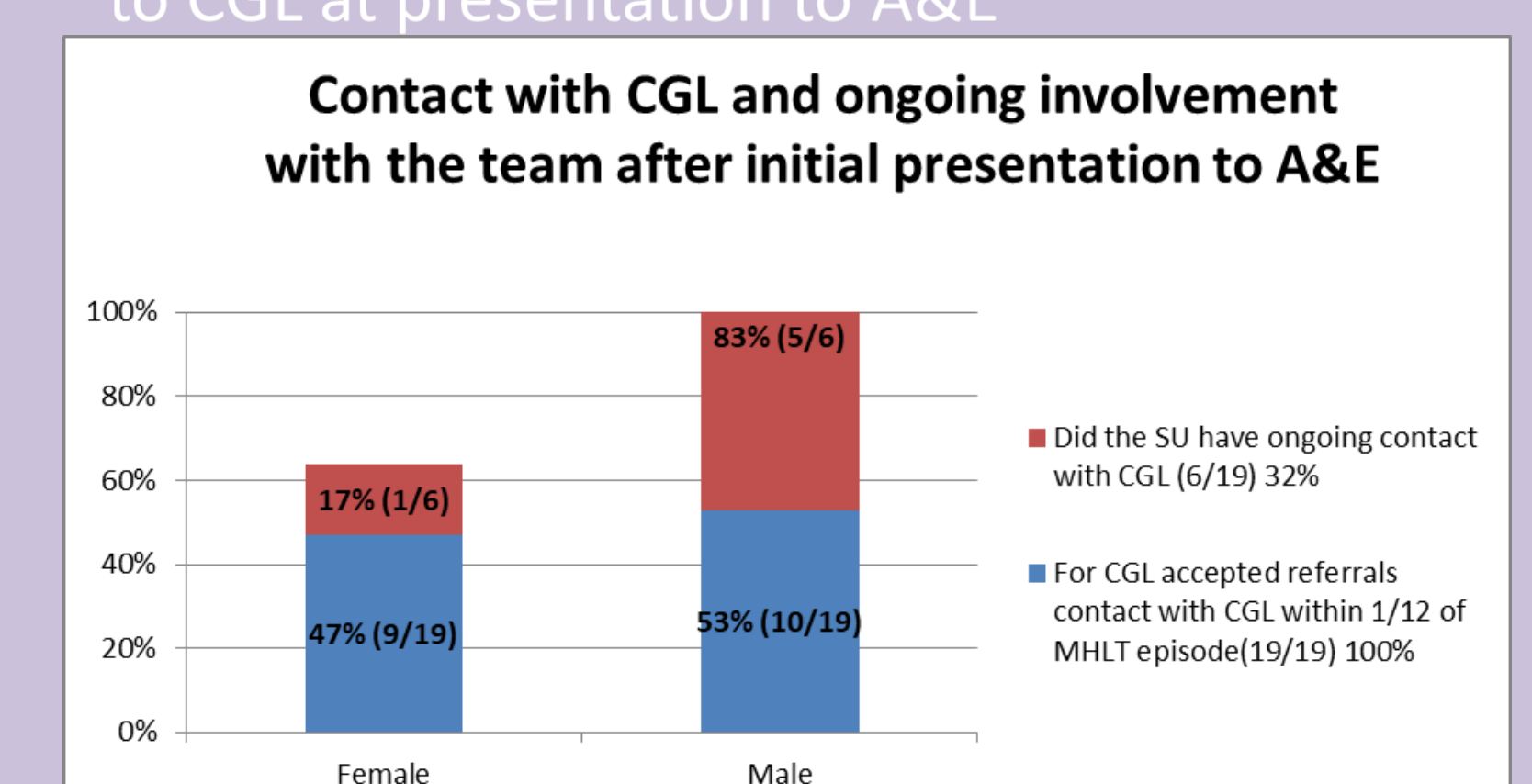

Figure 6- Contact with CGL and ongoing involvement with the team after initial presentation to A&E

Conclusions
- The overall number of presentations out of hours was 165 and 48% were males and 52% were females
- The majority of presentations to A&E department out of hours were in the age group of 18-29 years of age
- The main reason for attending A&E out of hours was following an intentional overdose of medication (18% of presentations)
- Out of all presentations, 15%(8/24) of females and 67%(16/24) of males had drugs involvement and 55%(27/49) of females and 45%(22/49) of males had alcohol involvement- a total of 73 patients out of 165 presentations to A&E out of hours
- 10%(17/165) of the patients who presented to A&E out of hours that had drugs and alcohol involvement were already known to CGL, for 22%(36/165) of patients a referral to CGL was discussed and out of these 12%(19/165) accepted the referral
- 12% (19 patients) of presentations (47% [9 patients] females and 53% [10 patients] males) had contact with CGL within one month of the initial presentation to A&E. 8% (6 patients) of presentations (17% [1 patient] females and 83% [5 patients] males) had ongoing contact with CGL

Recommendations
1. Better documentation of drugs and alcohol history, including previous history of involvement with Drugs and Alcohol services and discussion about CGL referrals. Also, if this information cannot be obtained, a reason for this should be documented in the notes.
2. From the CGL documentation we don't know the reason why patients did not have ongoing contact with the service after a month of presenting to the A&E department and being seen by the mental health liaison team- it could be purely because they had their treatment and remained abstinent from drugs and/or alcohol. We should not assume that the patients disengaged with the services and to find out the reason for the absence of ongoing contact with CGL a new audit should be completed.
3. Read only access to CGL patient records system for the mental health liaison team staff to help in finding out whether a patient has any involvement with CGL prior to assessment in A&E
4. PACE (Practice Audit and Clinical Effectiveness) team have recommended that CGL 24/7 service suggestion should be shared with the senior service line leads with a view for them discuss with the commissioners to review funding arrangements for CGL. It was also advised that report should be shared with Senior managers of West SBU to review how appropriate it would be to recommend commissioners re 24/7 CGL and how best this would support our services users and MHLT.
5. We recommend that CGL offers a 24/7 service in A&E to support the mental health liaison team and also we believe that if CGL would be available to review patients in A&E out of hours the rates of engagement with the service would be higher
6. Re audit- A re audit will be useful to review if the results have improved and justify the need of recommendation 3 and 4