

Alternatives to emergency departments for mental health assessments during the COVID-19 pandemic

Dr Nehal Parmar & Dr Jim Bolton

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The Faculty of Liaison Psychiatry

Executive summary

During the COVID-19 pandemic, care pathways and services have been established as alternatives to emergency departments for the assessment of patients with mental health problems. We undertook a survey of UK liaison psychiatry services to describe these alternative models of care and to collect feedback on their benefits and drawbacks.

An alternative care pathway had been established for over 80% of the emergency departments included in the survey. Of these, over two thirds included the provision of a separate assessment facility, usually co-located with other mental health services.

The main benefits of the alternative services included the provision of a more appropriate environment for the assessment of patients with mental illness, a reduction in the emergency department workload, and the greater accessibility of mental health expertise. The main drawbacks were the risk of physical illness being overlooked, a potential increase in the stigmatisation of mental illness by acute hospital staff, staffing difficulties, and delays in the emergency mental health care pathway, often due to the need to transfer patients between sites.

We have used these findings to compile recommendations to inform discussions about the future of these alternative care pathways and assessment units, especially where they may be continued beyond the pandemic.

Introduction

During the COVID-19 pandemic general hospitals have prepared for an influx of physically ill patients. NHS England asked mental health trusts to ensure that efforts were made to divert people away from emergency departments where possible.¹ This was to minimise the risk of cross-infection and to allow emergency departments to focus on physical health care.

From the outset of the pandemic, guidance compiled by the Royal College of Psychiatrists and the Faculty of Liaison Psychiatry has included the provision of alternatives to acute hospital emergency departments for patients presenting with primary mental health problems.² This guidance highlights the importance of planning in collaboration with services in the wider mental health emergency care pathway. It also highlights key areas to consider in planning, including staffing, the degree of physical comorbidity that separate emergency mental health assessment facilities can manage, and the transport of patients between acute and mental health sites.

A variety of new care pathways and service models have been established, including the provision of mental health assessment units that are separate from general hospital emergency departments. Interest has been expressed in whether these new services should continue following the pandemic.

This survey aimed to describe the alternative care pathways and assessment facilities, and to seek feedback from liaison psychiatry services on the benefits and drawbacks.

Methods

We emailed an invitation to participate in an online survey to clinicians working in UK liaison psychiatry services, including members of the Faculty of Liaison Psychiatry, the Psychiatric Liaison Accreditation Network, and an established liaison psychiatry email network. Responses were submitted during the first two weeks of May 2020.

Respondents were asked:

- To identify the hospital within which their liaison psychiatry service was based and their local mental health trust, board or provider;
- Whether there was a newly-established care pathway or facility for the assessment of patients presenting to the emergency department with mental health problems.

If there had been no change in local care pathways, respondents were automatically directed to the end of the survey and invited to provide comments.

Those responding positively were asked about:

- Where assessments are undertaken. Options included whether this was on the acute hospital site, either within or outside the emergency department footprint, or on a separate site where other mental health services were delivered;

- Staffing provision for the new service;
- The referral and triage processes;
- The degree of physical health care the service could deliver;
- The perceived benefits and drawbacks of the service.

Analysis

The questions were digitised using Google Forms software. Responses were exported to spreadsheet software (Excel) for analysis. Data from staff working in the same hospital were combined. Themes were identified from respondents' free-text comments and were subject to semi-quantitative analysis.

Results

We received 65 responses from 56 liaison psychiatry services. Fifty-four (83%) respondents were psychiatrists, 8 (12%) were service or team managers, and the remainder were from other professional groups.

Data were submitted for 68 emergency departments, with some respondents providing information about more than one. Fifty-four (79%) of these were in England, 13 (19%) in Scotland and 1 (2%) in Wales. We received no responses from Northern Ireland.

In 56 (82%) of the emergency departments included in the survey an alternative care pathway had been established for mental health assessments. Mental health providers covering an additional two (3%) emergency departments were planning to introduce alternative care. There were no plans for service changes in the remaining 10 (15%) departments.

The 56 emergency departments where an alternative care pathway had been established related to 33 individual NHS mental health providers. Within these newly established care pathways, the primary location where patients were assessed are listed in Figure 1.

Figure 1. The primary location of assessment within alternative care pathways

Location of assessment (n=56)	No. (%)
On a separate site where other mental health services are delivered	38 (68%)
Away from the emergency department but within the acute hospital	9 (16%)
Within the emergency department footprint	5 (9%)
At home with telemedicine assessment	3 (5%)
Another clinical site	1 (2%)

Staffing for the alternative care pathways or facilities had often been recruited from a number of sources, including liaison psychiatry teams (49 care pathways, 88%), other mental health services (31, 55%), and temporary staffing services (19, 34%).

Psychiatric expertise in the alternative care pathways was most often provided by consultant psychiatrists (44 care pathways, 79%) and doctors in training (42, 75%), but also trust-grade doctors (16, 29%). Such input was either dedicated to the service or provided by a doctor worked primarily within another service.

In addition to self-referrals, alternative assessment facilities generally accepted referrals from a number of sources, including emergency departments, liaison psychiatry services, ambulance services, police, crisis and home treatment teams, primary care, and community mental health teams. Respondents confirmed that the majority of services (51, 91%) conducted a triage assessment.

Forty-nine (87.5%) of the alternative services could not manage any degree of co-morbid physical illness and 7 (12.5%) could manage a minor degree of physical health care (e.g. lacerations not requiring suturing). No services could manage more intensive physical health care (e.g. patients requiring oxygen or intravenous fluids).

The main themes of respondents' perceived benefits and drawbacks of the alternative care pathways and services are listed in Figures 2 and 3 respectively. Nine (16%) respondents reported no perceived benefits and four (7%) identified no drawbacks.

Figure 2: The most common themes in the perceived benefits of the alternative care pathways

Theme	No. (%) of respondents
More appropriate environment for patient care	20 (36%)
Reduction in emergency department workload and enhanced patient flow	14 (25%)
Increased availability of appropriate mental health expertise	9 (16%)
Reduced waiting times for patients	4 (7%)
More space and capacity for social distancing	3 (5%)
Avoidance of potentially unnecessary paediatric admissions	2 (3%)

Figure 3: The most common themes in the perceived drawbacks of the alternative care pathways

Theme	No. (%) of respondents
Physical health problems may be overlooked	19 (34%)
Increased stigmatisation and discrimination of patients with mental illness	16 (29%)
Delays in the emergency mental health care pathway	10 (18%)
Provision of staffing	11 (20%)

The themes identified within the benefits and drawbacks were grouped into four domains:

- Patient experience;
- Clinical care;
- Impact on liaison psychiatry services;
- Impact on the acute hospital.

Patient experience

The most frequently discussed benefit of the alternative services was that assessments took place in an environment that was more appropriate for patients with mental health problems. One respondent asserted that assessment in an emergency department 'is not a good experience for people with [mental health] needs.'

The new models of care were judged by one respondent to provide a more suitable 'front door' to mental health services, whilst facilities were judged by others to have the advantage of being 'calmer', 'quieter' and 'less stimulating'. There was also judged to be less likelihood of patients undergoing repeated assessments.

An identified drawback of diverting patients away from emergency departments was that this might reinforce stigmatisation of mental illness by acute hospital staff. One respondent suggested that patients with mental illness might be viewed as 'different' or 'other' and that the presence of an alternative service 'gives staff in [the emergency department] the impression that people with mental illness are not theirs' even if they were to have co-morbid physical health problems. Another contrasted this with attitudes towards patients with physical illness, noting that 'they will never think of excluding diabetics from A&E'.

Whilst some respondents indicated that the alternative care pathways had the potential to reduce waiting times for patients, others suggested that they had led to delays, especially if patients had to travel to an alternative site. One respondent described the difficulties with travel and transport in their area where 'the diversion service offers diversion to 5 liaison services on a single site. This is geographically distant from our acute hospital site, a 45-minute taxi ride. Patients are therefore reluctant to travel and it feels inappropriate [to] transfer when they can be turned around quickly [in the emergency department]. It also raises difficulties around risk and suitability for transfer'.

Clinical care

Several respondents described how the local alternative assessment facility on a mental health site had access to a wider range of mental health professionals than was available in the general hospital. Particular mention was made of the facilitation of emergency assessments by child and adolescent mental health staff. This had resulted in a reduction in the routine admission of young patients to paediatric beds to await a mental health assessment on the following day.

Other benefits for clinical care were described. Mental health assessment facilities removed the pressure to meet emergency department attendance time targets. This gave the opportunity for extended assessments of complex cases, calming of agitated or anxious patients, and time to allow intoxicated patients to be 'properly sober prior to assessment'.

There were several comments that diverting patients away from an emergency department carried the risk that acute physical health problems would be overlooked. Alternative assessment facilities were described by respondents as 'dangerous as people diverted straight there may have serious medical conditions missed' and potentially being 'a critical incident waiting to happen'. Delirium was given as an example of a condition that might

present with psychiatric symptoms, but which requires physical investigation and management that is not readily available on a psychiatric hospital site. One respondent gave the example of a confused patient with a traumatic brain injury who had been taken to a mental health assessment unit and not an emergency department, as ambulance staff mistakenly judged them to be experiencing a mental illness.

Some respondents had found that the diversion of patients away from the emergency department had given liaison psychiatry staff more time to assess general hospital inpatients. This was valuable at a time when a high proportion of such patients had complex mental and physical comorbidity in the context of COVID-19 infection.

Uncertainty was expressed about the legal status of patients being assessed in alternative mental health facilities, particularly as to whether they were inpatients or outpatients. This has implications for the use of mental health legislation.

Impact on liaison psychiatry services

Alternative assessment facilities were predominantly staffed by members of liaison psychiatry teams. In comparison to team bases within general hospitals, several respondents had found that their new working environment provided, 'improved space and social distancing for liaison staff'. This boosted morale by making them 'feel valued'. Staff also felt that they were under 'less pressure from ED staff', as, when assessing patients, 'time can be taken without fear of a breach [of attendance time targets].'

Respondents raised concern that cohesion amongst liaison psychiatry team members had been reduced by separating staff across services and sites. Most commonly doctors had remained within the acute hospital whilst nursing staff had been moved to the alternative assessment facility. The need to recruit more staff had often led to the employment of temporary staff who were more expensive and less likely to be familiar with local working practices.

As a consequence of the changes some liaison psychiatry services had found themselves more distant, both physically and psychologically, from the acute hospital they were intended to serve. One respondent described how 'we do not have a team around us' and hence a reduced capacity to assess and manage patients and to provide multidisciplinary care. Those who had experienced such difficulties expressed the concern that if the alternative models of care were to become permanent without an increase in overall staffing, this might be detrimental for mental health care in general hospitals in the long term.

Impact on the acute hospital

A clear benefit identified by a quarter of respondents was the reduction in emergency department pressures due to the diversion of patients to alternative assessment facilities. It was judged that a reduction in emergency mental health presentations had improved the efficiency and capacity of general hospital services at a time when they were focussed on patients with physical illness. Respondents noted that 'the acute trust is happy during a stressful time for them' and 'A&E are very happy because it reduces their load and makes it more manageable.'

A potential drawback of fewer mental health presentations to the emergency department was the potential 'deskilling of acute trust staff' who have less experience of assessing and managing mentally unwell patients.

Discussion

In 82% of the 68 UK emergency departments included in this survey an alternative care pathway for patients with primary mental health problems had been established during the COVID-19 pandemic.

Liaison psychiatry staff identified the main benefits of the alternative care pathways and assessment facilities as the provision of a more appropriate environment for the assessment of patients with mental illness, a reduction in the emergency department workload, and the greater accessibility of mental health expertise. The main drawbacks were the risk of physical illness being overlooked, a potential increase in the stigmatisation of mental illness by acute hospital staff, staffing difficulties, and delays in the emergency mental health care pathway, often due to the need to transfer patients between sites.

In England the Care Quality Commission has identified changes in service design and delivery that have been introduced as a response to the pandemic.³ These include the establishment by South West London & St George's Mental Health NHS Trust of a 24/7 mental health emergency department for patients of all ages based within a psychiatric hospital. The provision of a separate emergency assessment facility, co-located with other mental health services, was the commonest alternative model of care identified in this survey.

The most frequently identified benefit of alternative mental health assessment facilities was the provision of a more appropriate environment for the assessment of patients. There is national guidance for the provision of psychiatric assessment rooms in emergency departments.^{4,5} However, a national survey of these rooms found that less than one quarter met the necessary criteria for safety and privacy.⁶ Where these were appropriately equipped, they were often criticised for being stark and insufficiently calming for distressed and agitated patients. The establishment of a specific emergency mental health assessment facility gives an opportunity to create an environment that is more conducive to patient care than can be provided in an emergency department.

A drawback identified in some care pathways was the need for patients to travel a greater distance for mental health assessment, or to be transferred from an emergency department to another site. Accessibility and issues of transfer should be considered if alternative assessment facilities are continued in the long term.

Another identified drawback of the alternative care pathways was their potential to increase the stigmatisation of mental illness by emergency department staff. Within a general hospital there is a risk that prejudicial attitudes amongst staff translate into discriminatory behaviour towards patients.⁷ The provision of a separate mental health emergency assessment facility on another site may reinforce the erroneous view that the assessment

and management of mental health problems is not a role for an emergency department. This could be detrimental to patient care when patients with either primary or co-morbid mental illness do require care in an emergency department.

The majority of new assessment facilities identified in the survey could not manage any degree of co-morbid physical illness and the remainder could only manage a minor degree. Therefore, many patients with emergency mental health presentations would still need to be assessed in an emergency department due to physical co-morbidity, such as the physical consequences of self-harm.

The commonest drawback identified of diverting patients away from emergency departments was that acute physical health problems might be overlooked. Staff within mental health assessment units should be able to identify such problems. Where these are identified, there should be protocols for seeking urgent medical advice and for transferring patients to an emergency department if necessary.

In nearly 90% of alternative care pathways, a proportion of staff had been recruited from liaison psychiatry services. Where liaison psychiatry staff had been transferred to another site, respondents often indicated that this had had a detrimental effect on the remaining team and the care they could provide. This was at a time when services continued to receive inpatient referrals, often of a high degree of complexity. The longer-term provision of separate mental health assessment units should not be at the expense of liaison psychiatry staffing, especially when there is a need to provide a robust 24-hour service for general hospital wards and emergency departments.⁸

A recognised deficit in many mental health services and general hospitals is the lack of access to a specialist 24-hour liaison mental health service for children and young people.⁸ A benefit of emergency mental health assessments for this age group being undertaken on mental health sites was improved access to child and adolescent mental health services and a consequent reduction in potentially unnecessary paediatric admissions. Assessment of the clinical and cost effectiveness of the new facilities should take this into account.

In addition to patients being transferred from emergency departments to alternative assessment facilities, referrals from community mental health services were also generally accepted. This indicates the establishment of wider changes to urgent and emergency care pathways than simply diversion away from emergency departments. A more detailed evaluation would be required to determine the benefits and drawbacks of these care pathways for community mental health care.

Limitations

The emergency departments included in the survey constituted 29% of the estimated 236 type one or major departments in the UK.⁹ These are emergency departments that deliver a 24-hour consultant-led service. However, the aim was not to compile a comprehensive list of all newly established care pathways, but to describe the features of a range of alternatives and to collect feedback on their operation.

The response rate for the survey is unknown as we did not send an invitation to participate to specific services or individual staff. However, based upon the number of English liaison psychiatry services identified in a recent survey we received responses from 28% of these.¹⁰

Although we invited responses from staff working in emergency departments where no service changes had been introduced, we speculate that we were more likely to receive feedback from areas where an alternative care pathway had been established. There is also potential bias in the feedback, with those respondents having the strongest views being more likely to reply. However, the responses did provide a range of views, both positive and negative.

The survey elicited feedback on the alternative care models from one professional group. Although some respondents indicated that acute hospital staff had a favourable view of the new care pathways, a future evaluation of such services might seek feedback from service users, emergency department staff, staff working in the wider urgent mental health care pathway, and other referrers to the service.

We did not collect information about the geographical location of services (e.g. whether they were in urban or rural areas), emergency department activity, or pre-existing mental health care pathways. However, we hope that the themes identified in the feedback will inform discussions about whether aspects of the newly established care pathways and assessment facilities are continued beyond the pandemic.

The alternative services were set up to meet an urgent clinical need without time for a detailed evaluation of their potential cost-effectiveness. We anticipate that this would be a consideration if services continue, especially the additional cost of funding separate mental health emergency assessment units, of which staffing is likely to constitute a high proportion of the budget.

Conclusions

The need to ensure safe and efficient health care has led to the establishment of mental health care pathways to provide alternatives to assessments being undertaken in emergency departments during the COVID-19 pandemic. Most often, these have included the creation of emergency mental health assessment facilities, usually on sites where other mental health services are delivered.

A dedicated mental health emergency assessment unit has the potential to provide a more appropriate care environment for patients with mental illness. It can also reduce the time until a patient receives a specialist mental health assessment. However, the disadvantages in separating mental and physical health care include challenges for the management of mental and physical co-morbidity and an increase in the stigmatisation of mental illness.

When considering the future of urgent and emergency mental health care, we must ensure that patients receive the care they require from staff with the necessary expertise in a timely manner and in an environment that is conducive to their emotional wellbeing and recovery.

Recommendations

These recommendations are intended to inform the evaluation of alternative emergency mental health care pathways and assessment units established during the COVID-19 pandemic, especially where there is consideration of the long-term provision of such services.

- Evaluation of an existing or planned emergency mental health assessment facility for a wide geographical area should consider the accessibility for patients.
- Provision of a 24-hour service for the assessment of children and young people, whether on a general hospital or mental health site, should be included in urgent and emergency mental health care pathways.
- The establishment of a separate mental health assessment unit should not be at the expense of liaison psychiatry staffing as there will remain a requirement for a robust 24-hour liaison psychiatry service for general hospital wards and emergency departments.
- Where there is a separate mental health emergency assessment facility, it should be borne in mind that patients with mental and physical comorbidity will still require assessment and care within an emergency department. In concordance with national guidelines, all emergency departments should have a psychiatric assessment room that meets standards for safety and privacy.
- Where patients are transferred from an emergency department to an alternative assessment facility, there should be protocols for transport with minimal delay and which take account of any significant risks and indicate how staff escort can be provided when necessary.
- Where patients with mental illness are diverted from emergency departments, senior staff on the acute hospital site should be alert to a reduction in staff expertise, and any indications of staff attitudes and behaviour that are indicative of stigmatisation.
- Staff working on mental health assessment units should be able to identify possible acute physical health problems. Where these are identified, there should be protocols for seeking urgent medical advice and for transferring patients to an emergency department if necessary.
- The legal status of patients in a mental health assessment facility, specifically whether they are deemed to be inpatients or outpatients, should be communicated to staff so that mental health legislation is implemented correctly.

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