
Side by side:

A UK-wide consensus statement
on working together to help
patients with mental health needs
in acute hospitals

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Consensus statement from:

The Royal College of Psychiatrists,
The Royal College of Nursing,
The Royal College of Emergency Medicine, and
The Royal College of Physicians.

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The importance of working side by side

“One time I needed medical help but I was unwell with my mental health too. When I saw police vehicles outside the emergency department, the beliefs and fears I had about police at the time meant that I couldn’t go in. By the time I went back in the afternoon I was so sick I was taken straight into resus. Being in resus can be frightening for anyone. My mental health was deteriorating, and my beliefs and fears meant that I couldn’t accept the urgent medical care I needed. I could see it was obviously frustrating for the ED staff who were trying to stabilise me, and it was terrifying for me. In this ED there was not an option for all of my needs to be met at the same time.

“I was told that the mental health team wouldn’t come to help me until I was ‘medically cleared’, which wouldn’t be until at least the following day. Instead of urgent mental health help which would have reassured me and could have helped me accept treatment, I was restrained and forced to have medical treatment. Childhood memories of being held down and forced to do horrible things flooded over me. As I became more and more frightened I couldn’t differentiate between the restraint and what the person had done to me as a child. As soon as I was well enough to stand, I left the department without completing medical treatment and without any help from the mental health team. There was a focus on mental health in an emergency being only about assessment of whether or not I should be admitted to a psychiatric ward, when what was needed was immediate help, understanding and advocacy for me plus specialist advice for the ED staff when I was in resus.”

Background

In acute hospitals in the UK, the purpose of assistance from liaison psychiatry includes:

- support to patients, families and treating medical teams
- advice about clinical care or diagnosis in hospital
- advice and support on mental health and mental capacity law
- assessment of ongoing mental health needs and arrangement of suitable aftercare.

Despite recent expansion in liaison psychiatry, there are still many UK hospitals where mental health services insist that a patient be ‘medically cleared’ before they will help them. This may be because the existing services do not have the necessary competencies to provide concurrent mental health assistance. The *Treat as One* report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) identified harms and poor practice associated with such delays in psychiatric assistance and made a recommendation that:

“All healthcare professionals must work together to eradicate terms such as ‘medically fit’ or ‘medical clearance’. The terms ‘fit for assessment’, ‘fit for review’ or ‘fit for discharge’ should be used instead to ensure parallel working.”

The terms ‘medically cleared’ and ‘medically fit’ have no standardised definition and appear to be generally used as shorthand either for confirmation that a patient has no

medical needs warranting acute hospital admission or that the patient has had adequate evaluation for medical causes of psychiatric symptoms (Reeves 2010). Such terms do not safeguard against diagnostic overshadowing or missed medical diagnosis and risk giving false reassurance in place of an adequate clinical history, physical examination and investigations as indicated. Where people with an existing psychiatric condition attend the ED with characteristic symptoms, routine screening tests rarely change management (Janiak 2012; Shah 2012).

The *Treat as One* guidance is consistent with recommendations from the National Institute for Health and Care Excellence and the Psychiatric Liaison Accreditation Network regarding the timing of psychiatry assistance (NCCMH 2012; NICE 2004; PLAN 2017). The ability to work collaboratively is considered a fundamental competency for both nurses and doctors in liaison psychiatry, including the necessary knowledge and skills to help people who have concurrent psychiatric, addiction-related and medical conditions (London Liaison Mental Health Nurses' Special Interest Group 2014). The ability to respond to and meet mental health needs is also a fundamental competency for medical and nursing staff in acute and emergency medicine (RCN 2017). Integrated physical and mental health care is an important aspect of ensuring parity of esteem for people with mental health conditions (RCN 2019; RCPsych 2013). Where such working practices do not yet exist, a lack of concurrent working has been identified as a factor leading to risk of harm by the Healthcare Safety Investigation Branch (HSIB 2018).

The Royal College of Nursing, the Royal College of Psychiatrists, the Royal College of Emergency Medicine and the Royal College of Physicians therefore support and endorse the NCEPOD recommendation to eradicate unhelpful terms such as 'medically fit' or 'medical clearance' in favour of providing timely, appropriate mental health assistance and side by side working between mental health teams and other specialties in acute hospitals in England, Northern Ireland, Scotland and Wales. We recommend three broad principles:

- 1 Dignity and equality of access.
- 2 Working side by side.
- 3 Clarity of communication.

These principles are explained below and are followed by examples of good practice pathways in use in the UK.

Principles

1. Dignity and equality of access

- Access to mental health care should follow the same principles as access to any other hospital specialty and be guided at all times by the needs of the patient. Timing of mental health assistance should be based on the needs of both the patient and referrers rather than rules around 'medical clearance'. Even prior to interview, liaison psychiatry staff can give advice on the basis of past records, take collateral history from family or carers, support patients, advise clinical teams and plan appropriate timing for psychiatry interview. If a person is agitated, distressed or aggressive then timely assistance from mental health professionals may alleviate distress, prevent escalation and improve both safety and patient experience.
- Above all, the purpose of mental health assistance in the acute hospital should be to promote dignity, ensure a positive experience of healthcare and advocate for all the person's needs being met. Interventions which are aimed at discouraging hospital attendance or discouraging help-seeking are not effective, can be harmful and should not be used.
- People with mental health or addiction-related needs in acute hospitals must have access to staff with sufficient expertise in liaison psychiatry to help them, including: advice on investigation; diagnosis and treatment; advice on mental health and capacity law; and sufficient knowledge and skills to help people who have concurrent psychiatric, addiction-related and medical conditions. Where a senior liaison psychiatry opinion is needed this should be as timely and accessible as for any other hospital specialty.

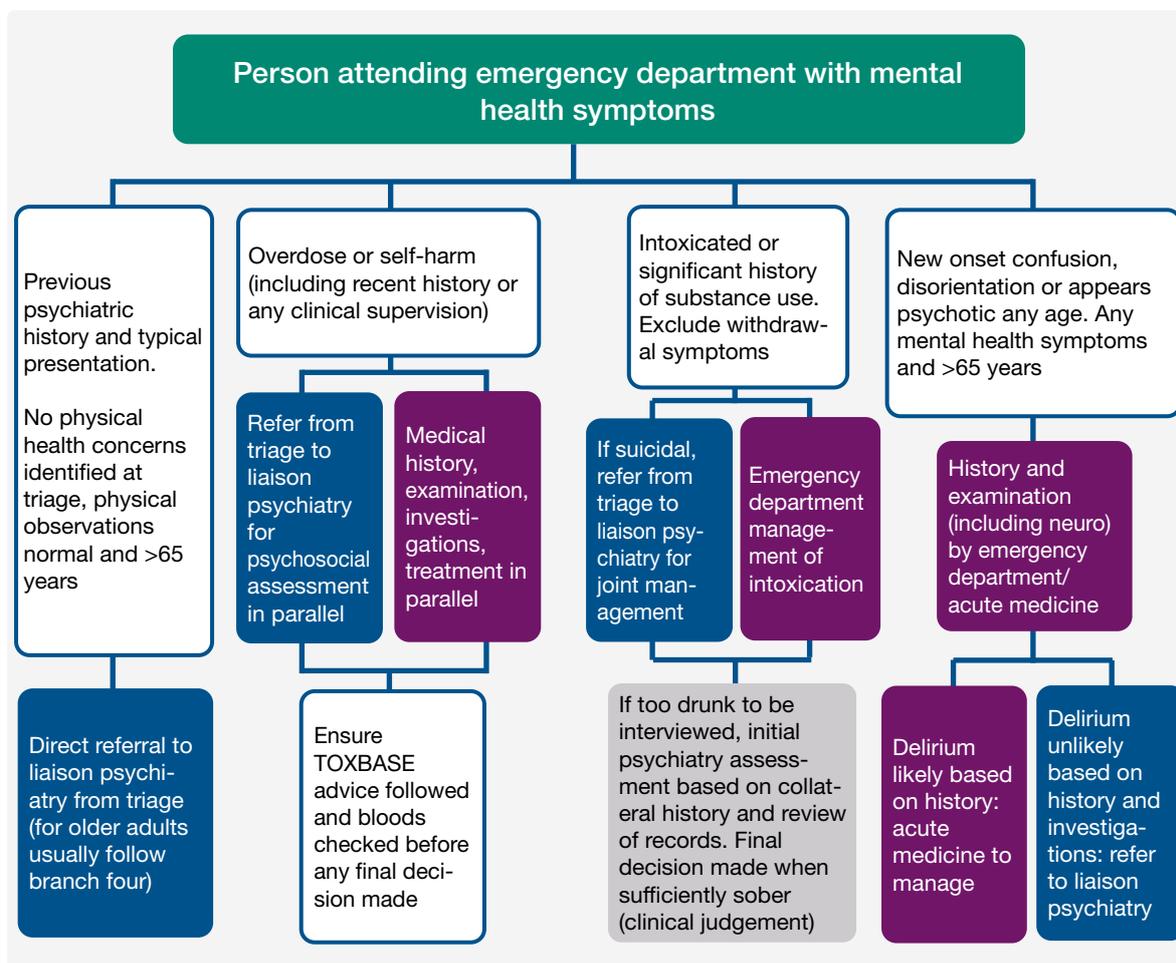
2. Working side by side

- Co-location: Acute hospital mental health services should be physically based in the hospital, ideally as a 24/7 multidisciplinary liaison psychiatry department with integrated governance arrangements.
- Reciprocal competences: All medical staff working directly with patients must have adequate appropriate competence in assessing and responding to people with mental health needs, including in investigating or excluding medical causes for psychiatric symptoms. In turn, mental health staff must have sufficient competence to provide timely assistance whilst medical care is ongoing. Arrangements should be supported by clear local good practice pathways for collaborative working.
- Joint ownership: Patients who are being helped by mental health teams while receiving concurrent medical care must remain under joint care. Given that liaison psychiatry services rarely have direct access to beds, there should not be an expectation of mental health services taking over care of patients until the point at which they have left the hospital.

3. Clarity of communication

- Referrals should be made to liaison psychiatry as soon as it becomes clear that a patient has a mental health need which requires specialist assistance. The purpose of referral should be made as clear as possible at the outset and include a brief narrative handover including the patient's current medical needs, mental health concerns, planned investigations and treatment.
- The terms 'fit for assessment', 'fit for review' and 'fit for discharge' are useful to allow prioritisation of patients needing assessment by liaison psychiatry and to know where the patient is in the process of joint assessment. However, caution should be taken that these terms do not merely replace the phrases 'medically cleared' or 'medically fit' in deferring mental health assistance without achieving meaningful improvements in collaborative working.
- Where care is transferred to either a psychiatry inpatient ward or to a community-based mental health service, there should be local standards for handover. These may include: a narrative handover; completed discharge summary; details of medications; details of outstanding investigations; and an action plan with recommendations about what to do in the event of deteriorating health.

Good practice example: Emergency department referral pathway to liaison psychiatry



Notes

- 1 Do not use the term 'medically cleared'. This is ambiguous and does not affect timing of psychiatry assessment.
- 2 Patients remain under JOINT CARE of ED and psychiatry until they have left the ED – psychiatry cannot 'take over' patients in the ED.
- 3 Even if a patient cannot be interviewed, liaison psychiatry assistance may be needed in taking collateral history, supporting a distressed patient to receive medical care or advising staff on diagnosis or treatment.
- 4 Delirium is a clinical diagnosis based on acuity of onset, fluctuating course and clouding of consciousness and can occur even with normal observations and investigations. Most hallucinating/confused elderly patients should be referred to medicine rather than psychiatry.
- 5 Breathalysers or drug/toxicology screening may form part of a clinical assessment but should not be used to delay psychiatric assistance where this is needed.

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