Training psychiatrists in emergency and out-of-hours care

Report of the Emergency Psychiatry Training Taskforce
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Psychiatry Training Taskforce membership</td>
<td>4</td>
</tr>
<tr>
<td>Executive summary</td>
<td>6</td>
</tr>
<tr>
<td>Introduction</td>
<td>8</td>
</tr>
<tr>
<td>Taskforce and methods of working</td>
<td>10</td>
</tr>
<tr>
<td>Current training</td>
<td>11</td>
</tr>
<tr>
<td>Evidence</td>
<td>13</td>
</tr>
<tr>
<td>Survey of the College’s patient and carer forums</td>
<td>19</td>
</tr>
<tr>
<td>Other themes and issues</td>
<td>20</td>
</tr>
<tr>
<td>Recommendations</td>
<td>24</td>
</tr>
<tr>
<td>References</td>
<td>26</td>
</tr>
<tr>
<td>Appendix 1. A carer’s perspective</td>
<td>28</td>
</tr>
<tr>
<td>Appendix 2. Survey of College patient and carer forums: free-text comments</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 3. Emergency psychiatry in the Foundation Programme and GP specialty training</td>
<td>32</td>
</tr>
</tbody>
</table>
Emergency Psychiatry Training Taskforce membership

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Core trainees have reported concerns that they are not getting enough emergency psychiatry experience to practice safely and confidently as they progress to higher training. The Royal College of Psychiatrists’ Psychiatric Trainees’ Committee (PTC) has considered this an issue of key importance for several years.

In particular, core trainees have reported changes to their working patterns that have resulted in decreased opportunities to work outside of normal working hours (9 am to 5 pm). Trainees feel that the nature and frequency of cases they see out of hours, as well as the working environment, significantly differs from what they experience within normal working hours. Their key concern is that their training does not equip them to manage emergency psychiatry situations as higher trainees, when they are not only expected to manage such situations but also supervise others.

This is a complex area that involves service reconfiguration, training and, most importantly, patient safety. The backdrop to the concerns regarding emergency psychiatry training includes:

- financial pressures on the National Health Service (NHS);
- acute shortage of in-patient psychiatric beds (Royal College of Psychiatrists, 2014);
- a need to improve patient safety and quality of care, particularly in the wake of the Mid Staffs scandal and Francis report (Francis, 2013);
- Care Quality Commission inspections and review of mental health crisis care (Care Quality Commission, 2014);
- the need for parity of esteem between physical and mental health care;
- patient and carer views and reports frequently describing poor experiences when they are seen outside normal working hours (Mind, 2011);
- a call for broader early training pathways to meet the need for a medical workforce with more generalist skills (Greenaway, 2013).

The Royal College of Psychiatrists set up the Emergency Psychiatry Training Taskforce to look at the issue in detail and to make recommendations regarding standards for emergency psychiatry training. The Taskforce members comprise liaison psychiatrists, employers, trainers, trainees, patients and carers. We gathered evidence through literature searches, a review of previous College reports, a call for evidence to liaison psychiatrists, and a survey we conducted of the
views of patients and carers from the Royal College of Psychiatrists’ Service User Forum.

The Taskforce found that the frequency of patients (and the nature of their illnesses) presenting to accident and emergency (A&E) departments outside of normal working hours is different to that seen during the day. Patients present more frequently out of hours and tend to present with more acute problems, requiring more complex decision-making. The A&E environment is also significantly different when working out of hours, and requires non-technical skills in dealing with complexity, uncertainty, working with the multidisciplinary teams, making assessments with limited information and decision-making.

From our survey of patients and carers, we found they generally had poor experiences of out of hours care. Patients and carers felt strongly that trainee psychiatrists should be exposed to crisis presentations during their training.

The Taskforce makes two sets of recommendations. First, we describe a set of minimum standards for the provision of emergency psychiatry training. These are designed to ensure trainees gain experience, well-supported and supervised training out of hours. Second, we make a number of further recommendations that aim to improve the quality of emergency psychiatry training.

We believe that emergency psychiatry training can be delivered safely within consultant-led teams. Responsibility for ensuring these recommendations are met lies with Health Education England and local education and training boards, working together with employers.
Introduction

The Royal College of Psychiatrists’ PTC (2009) produced a report called *Finding the Balance: The Psychiatric Training Value of Out of Hours Working*. The report lists curricular competencies related to emergency psychiatry in core and higher specialist curricula. In September 2012, the PTC set up an Out of Hours Working Group to update the report with patient and carer perspectives and evidence on how out-of-hours work differs from daytime emergency work.

The working group stated (M Husain, personal communication, 2013):

“We believe that out-of-hours training can and should be delivered safely within consultant-led teams. We recognise this is a complicated area in which issues of service reconfiguration, training and most importantly, patient safety are all involved. We feel the College should have a role in setting standards and leading work in this area.”

The working group recommended that the College’s Exams, Standards and Training Committee (ETSC) set up a College-led working group to look at the issues relating to emergency psychiatry training in more detail and to make recommendations. The proposal was agreed upon by the ETSC in June 2012, and the Emergency Psychiatry Training Taskforce was formed.

Emergency Psychiatry Training Taskforce

ETSC asked the Emergency Psychiatry Training Taskforce to:

- describe standards for the aims and delivery of out-of-hours and emergency psychiatry training;
- describe a model that supports and enhances out-of-hours service provision;
- identify and share examples of good practice in which out-of-hours training is embedded in safe, high-quality services.

The Taskforce was asked to keep the key principles of patient safety, quality of care and delivering high-quality psychiatric training uppermost in mind.

A number of other themes and issues were identified as being within the Taskforce’s remit:

- patient and carer views;
- service and on-call rota reconfiguration;
the value of experience making Section 136, self-harm and seclusion decisions;
changes to multi-professional working practices;
geographical variations in the provision of training and care services;
emergency-psychiatry competencies and the clinical and supervisory skills we expect of a psychiatric trainee after core training;
evidence regarding differences in psychiatric presentations out-of-hours;
examples of current practice.

National reports relating to postgraduate medical training

The work of the Taskforce has been informed by some key reports and documents relating to the changing nature of medical training. The Royal College of Psychiatrists (2013) has said:

Moving to seven-day working would be an important step for all NHS patients, including those with mental health problems and those who are vulnerable.

A move towards consultant-present care is also an opportunity to provide coaching and supervision of trainees out of hours. In the Academy of Medical Royal Colleges’ report Seven Day Consultant Present Care: Implementation Considerations, it says:

...time should be allowed for consultants to deliver training as well as service at weekends. However, this must not discourage the development of decision making skills in junior doctors.” (Academy of Medical Royal Colleges, 2013a)

In Securing the Future of Excellent Patient Care, Greenaway (2013) made wide-ranging recommendations with implications for the future of both postgraduate medical education and the NHS workforce. These included recommending broader training pathways and credentialing after specialist training.

The Academy of Medical Royal Colleges (2013b) published Value of the Doctor in Training: A Charter for Postgraduate Medical Training. The charter describes a set of guiding principles for the delivery of high-quality training and the responsibilities of trainees and trainers.

A Centre for Workforce Intelligence Review on the future of the psychiatric workforce was published in November 2014. Although it did not directly address out-of-hours care, it made recommendations on the geographical and specialty distributions of trainee numbers.
The Taskforce's membership consisted of:

- a chair appointed by the Dean of the Royal College of Psychiatrists
- one representative from employers/commissioners
- one representative from postgraduate Deaneries/Local Education and Training Boards
- one Core Trainee representative from the PTC
- one Higher Trainee representatives from the PTC
- one patient representative
- one carer representative.

The Taskforce gathered evidence via:

- a search of the medical and medical education literature
- a survey of the view of the patient and carer for a of the Royal College of Psychiatrists
- a call for evidence from liaison psychiatrists through the liaison psychiatry e-group
- reports from the PTC.
College curricula and guidance

The Royal College of Psychiatrists (2008) recommends:

‘A number and range of emergencies will constitute relevant experience. Trainees must have experience equivalent to participation in a first on-call rota with a minimum of 55 nights on-call during the period of basic specialist training (i.e. at least 50 cases with a range of diagnosed conditions and with first-line management plans conceived and implemented.) (Trainees working part-time or on partial shift systems must have equivalent experience.)Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes trainees from the initial assessment of individuals who self-harm liaison psychiatry consultations in a district general hospital, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.’

However, it has been recognised that the minimum number of nights is a somewhat arbitrary number and focuses on the time served rather than the quality of training or the competencies achieved. This guidance has been loosely interpreted and has not prevented trainee psychiatrists from being placed on daytime-only rotas.

The Competency-Based Curriculum for Specialist Core Training in Psychiatry (Royal College of Psychiatrists, 2010) lists several competencies across a number of domains unique or opportune to working out of hours or in emergency settings.

Non-technical skills

Non-technical skills have been defined as generic skills that underpin and enhance technical tasks, improving safety by allowing people to anticipate, identify and mitigate against errors. Out-of-hours working provides an opportunity for trainees to achieve non-technical skills even where the technical skills involved can be learnt in normal working hours. These skills include the nuances of risk assessment in unusual situations, negotiation with multidisciplinary colleagues, containment of anxiety on many levels simultaneously and lateral thinking with considered decision making.
Working in A&E is recognised as different from, and more challenging than, daytime working:

- high turnover of patients
- patients and those accompanying them often presenting in acute states of physical and emotional distress
- time constraints
- multiple distractions and interruptions
- involvement of multiple specialties
- technological complexities across organisations
- limited historical and diagnostic information
- shift work with different shift times across groups.
Evidence

Frequency of presentations

There is a lack of national data on the frequency with which people with mental health problems present to A&E outside the hours of 9 am to 5 pm. However, the Taskforce found a great deal of published and unpublished data from local liaison psychiatry departments demonstrating a striking variability in the frequency of crisis presentations to A&E according to time of day.

The majority of presentations occur outside office hours. Cassar et al (2002) reported that 70% of mental health cases attending an inner-city A&E department were outside office hours, whereas Hislop et al (1996) found the figure to be even higher, at 81%. This is not a recent phenomenon. Analysing the notes of 464 patients seen over 6 months in 1986, Dunn & Fernando (1989) reported that patients presented most commonly in the evenings: 131 (28%) arrived between 9 am and 5 pm, 207 (45%) between 5 pm and midnight, and 125 (27%) between midnight and 9 am.

Similar findings have been seen, on a larger scale, outside of the UK. An Australian study of 3702 mental health patients in A&E showed that ‘the majority of presentations occurred outside normal working hours, particularly in the evening, and continued throughout the night’. Approximately 65% arrived outside normal working hours (Department of Human Services, 2006).

Fig. 1 shows a similar picture, using 6 months of data from a UK inner-city A&E department with over 100,000 attendances annually (P. Byrne, personal communication, 2014).

Nature and complexity of presentations

There is little published literature on whether the nature of psychiatric presentations differs according to the time of day at which patients attend or contact mental health services. However, the available evidence suggests that evening and night-time presentations involve a higher degree of complexity.

Rund et al (1981) divided 200 presentations at a general urban emergency room into day (8 am to 4 pm) and night (midnight to 8 am) groups. In total, 65% of the night group were judged to have current
or past psychiatric illnesses, compared with only 36% of the day group. It has been suggested that certain conditions are more likely to present out of hours (Dunn & Fernando, 1989), for example acute severe mental illness, substance abuse, self-harm, aggression, delirium, and personality disorder in crisis.

The Oxford Centre for Suicide Research found in 2011 that the majority of incidents of self-harm at night are related to alcohol consumption (K Hawton, personal communication, 2015; Fig. 2). In fact, only a quarter of patients who presented to the John Radcliffe hospital in 2011 with self-harm did so in daytime hours (Hawton et al, 2013). The finding is replicated by Blenkiron (2000) who describes ‘a marked circadian variation in timing of the act’, with 72.0% of presentations occurring outside office hours (peaking between 8 pm and 3 am).

Emergency powers of detention are more common at night. Borschmann et al (2010) analysed data concerning 887 consecutive detentions under Section 136 of the Mental Health Act 1983 between 2005 and 2008 in south London: 665 (75%) were made after 5 pm or at weekends. Greenburg et al (2002), similarly, reported that only 26% of their Section 136 detentions occurred within working hours, in a rural sample.

Fig. 1 Mental health presentations, by time of day, over 6 months (January–June) at a UK A&E department.
Blenkiron (2000) has shown that self-harm associated with alcohol use and interpersonal problems presents more frequently during the late evening or night, and at the weekend. Rund et al (1981) demonstrated the night-time prevalence of a diagnosis of alcoholism was 29%, while the daytime prevalence was less than half this (11%).

According to Moore et al (2009), frequent attenders (for any reason) are more likely to attend outside daytime hours. Frequently attending patients might be more likely to have psychiatric co-morbidities. It is known that patients with delirium tend to be maximally disorientated and disturbed at night, with improvement in their symptoms in the day (Edlund et al, 2007).

**Out-of-hours working and psychiatric training**

In general there are little qualitative or quantitative data on how trainee psychiatrists learn and which interventions or environments best facilitate their learning. There is a similar paucity of research looking at the effects of out-of-hours or emergency working on learning outcomes in trainee psychiatrists.

The Taskforce found evidence that trainee psychiatrists view out-of-hours work as essential training. Callaghan et al (2005) showed that senior house officers in psychiatry appreciated their time on call as a learning experience and said that ‘experience gained on-call was considered to be different from that gained during conventional working hours’.

![Fig. 2 Time of self-harm presentation to an emergency department: with alcohol involved, without alcohol involved, and overall.](image)
A report by the Royal College of Psychiatrists’ PTC (2009) looked at the changing nature of out-of-hours work for junior psychiatrists, in particular a notable reduction in opportunities for trainee psychiatrists to undertake emergency assessments. New rota systems had been widely introduced in the context of service reconfigurations (e.g. the ‘New Ways of Working’ reports), working hours legislation (e.g. EU Working Time Directive 2003/88/EC) and the increasing prevalence of shift-work. Combined, these factors reduced the average trainee’s exposure to out-of-hours working.

Mason et al (2006) demonstrated that, over a 2-year period, there was a 76% reduction in the number of acute assessments conducted out-of-hours by junior psychiatrists on call. Trainees themselves have expressed concern over a lack of emergency on-call exposure (Conn & Husain, 2013). The PTC have also heard reports that trainees are experiencing fewer Section 136 assessments during their 3 years of core training.

Consideration must be given for training opportunities outside the A&E setting. Out-of-hours, trainees may cover in-patient wards in addition to A&E departments. Between 73 and 100% of calls about in-patients after midnight were for assessment of patients in seclusion and rapid tranquillisation (Mason et al, 2006) – essential learning opportunities for trainees.

The Taskforce also recognise that there are arguments for removing trainees from out-of-hours settings. These include:

- Improved continuity of care with patients seen in daytime hours
- Increased attendance at daytime teaching programmes (e.g. MRCPsych, case presentations, journal clubs)
- More consistency to clinical supervision in daytime hours
- Financial savings for trusts

**Child and adolescent mental health services**

The tendency for cases to present to psychiatric services after 5 pm is most marked in child and adolescent mental health services (CAMHS). Hillen & Szaniecki (2010) demonstrated significant diurnal variation: 72.5% presented outside of the hours of 5 pm to 9 am. More referrals were made when daytime liaison services were closed, peaking between 5 pm and 1 am.

During normal working hours, most A&E departments have access to a full range of CAMHS, so that young people who present to A&E or are admitted to paediatric wards can be assessed in a timely and appropriate way by those expert in recognising and working with the mental health crises that present in this age group. Out of ours, however, there is great variation in the availability of services across the country.
In an ideal situation, young people would have access to a higher trainee with further training in CAMHS, and these trainees would be supported by a child and adolescent consultant psychiatrist (Shine et al, 2014). But in some trusts it is not uncommon for on-site child psychiatry services to stop operating at evenings, overnight and weekends. In these situations, the responsibility of coordinating the assessment of young people falls to core trainees, who might have limited experience in child and adolescent mental health. In most cases, young people under 16 years of age are admitted to acute paediatric wards until services become available again the following morning. However, as paediatric services become increasingly stretched, the availability of beds for under-16 admissions is becoming more limited. The situation is highly variable for those over 16 years of age, who might be managed in an acute medical adult setting or even discharged home. Young people in the 16–18 age range can present complex challenges, including emerging serious mental health problems and psychosocial factors and their presentation in crisis need careful assessment and management.

The Taskforce recognises that a large increase in the numbers of higher trainees and consultants would be required to staff what we consider to be the optimal service, described above, but it is our belief that this is what should be provided.

The patient and carer perspective

It is commonly reported by patients and carers that out-of-hours services in their area are skeletal and insufficient. According to a survey conducted by the charity Rethink Mental Illness (2003), the one of the most frustrating aspects for carers about mental health systems was accessing crisis help, including out-of-hours assessments. Outside daytime hours, patients tend to have their least support from family, friends, mentors etc. They also have their least stability in terms of daily structure (work, activities, routine). They often report loneliness and isolation, which can increase acts of self-harm and thoughts of suicide.

Data from the charity Samaritans reflects this diurnal pattern, with the number of contacts made via email, phone and text message increasing dramatically after 5 pm (Fig. 3; Samaritans, personal communication, 2015).

A Royal College of Psychiatrists audit of people attending A&E with self-harm found that there were delays to discharge in 29% of attendances. Half of these incidents were due to the patient being ‘not fit for assessment’, but 22% were due to a lack of out-of-hours provision, in contrast to 11% attributed to a lack of working-hours provision (Academy of Medical Colleges, 2008).
At a 2011 meeting of the Psychiatric Trainees Committee, Adrian Fisher (Royal College of Psychiatrists Service User Forum Co-Chair, Psychiatric Trainee Committee Service User Representative) summarised the patient perspective:

‘Service Users are concerned that in crisis, at times which fall outside the working week, they do not see a Psychiatrist (including trainees) when they attend Accident and Emergency departments in their local hospital. Contact is usually through a senior nurse who directs them into the mental health services or back to their [general practitioner]. Service Users feel that it is often at night and weekends that crises occur and that Psychiatrists should be able to assess them when their condition is at its worst, giving them a strong initial assessment right from the outset. Furthermore, access to Psychiatrists should not be restricted to the working week, also giving valuable experience to professionals seeking to improve their practice.

Safety of the service user and attending to their needs should be of prime importance and this responsibility should fall to Psychiatrists who should be available at all times, within reason and definitely within a four hour wait.’

The Taskforce also heard evidence from carers on the importance of trainees being aware of advance directives. Appendix 1 provides a personal account from a carer describing why training on advance directives for out-of-hours work is important and highlights the need to have systems in place to allow advance directives to be readily accessible outside normal working hours.
The Taskforce surveyed the service user and carer groups of the Royal College of Psychiatrists. All responses were anonymous. The key findings of the survey were as follows.

- The vast majority of responders have needed out-of-hours care.
- Fewer than half knew who to contact in these scenarios.
- 60% described their experience of the quality of NHS out-of-hours service as poor and 20% as adequate. Only 10% felt that it was either good or excellent.
- Only 25% reported that mental health professionals made their roles clear when conducting an assessment (i.e. specifying if they were nurses/doctors/social workers).
- 20% said that a doctor was ‘always’ present when they presented out of hours. 38% said a doctor was ‘rarely’ or ‘never’ present.
- When asked if they would wish to be seen by a doctor in these circumstances, 81% said yes, 13% said ‘not necessarily’, and 7% had no view on the matter. No respondent expressed a wish not to be seen by a doctor.
- 94% considered it ‘extremely important’ that trainee psychiatrists have exposure to crisis presentations.

The survey also collected qualitative views of patients and carers (Appendix 2).

‘It is my opinion that without the chance to learn from working in “out of hours” situations they will be less able/prepared for this type of crisis situation when qualified. As a parent this is a scary thought.’ (A carer’s view)
Other themes and issues

The Taskforce focused on core standards for psychiatric training in A&E departments. However, over the course of this work, we identified a number of other issues related to emergency psychiatry training.

Induction

Core trainees starting psychiatry training might not have performed a psychiatric assessment since their medical-student years. As such, an induction period, during which trainees are better supported, supervised and gradually introduced to their roles, is essential. This principle also applies to emergency psychiatry. Many trusts have systems in place to allow more experienced trainees to undertake on-call shifts at the start of new rotations, allowing new trainees time to get used to daytime working and to approach their first on-call shift later, in a planned manner, with appropriate support from their clinical or educational supervisors.

The OSkER (Observed Skills in the Emergency Room) trial at the South London and Maudsley NHS Foundation Trust paired new trainees on their first on-call shifts with volunteer trainers (consultants or higher trainees; Thomson et al, 2013). The trainers all attended sessions that explained their role and how to make the best use of the time. The trainers were asked to be present for a 4 h period of the trainee’s on-call shift. The scheme used a 1:1 apprenticeship model to provide:

- observation of assessments
- feedback on assessments
- teaching on topics
- modelling in more complex cases.

The scheme garnered positive feedback from both trainers and trainees. Trainees appreciated the tailored teaching and reassurance and felt more confident as a result.

Simulation training

Many trainees encounter challenging psychiatric and medical situations for the first time when working out of hours, such as the use of restraint or rapid tranquillisation in the event of behavioural disturbance involving a risk to the safety of others.
Some trusts are using high-fidelity simulation as a means of preparing trainees for these events, and providing feedback, correcting mistakes and increasing confidence before the situations are encountered in real life. The South London and Maudsley NHS Foundation Trust has developed a 1-day, high-fidelity simulation course for new trainees (Thomson et al, 2013). High-fidelity simulation allows the safe development of skills away from patients. Learners were engaged through an immersive environment involving multiple participants in each scenario. Structured, facilitated debriefing was a key component and was given more time than the scenario itself.

**Interprofessional education**

Out-of-hours work in emergency psychiatry always involves a multi-disciplinary team, drawn from emergency medicine and mental health and made up of nurses, doctors and other health professionals. There is scope for training programmes to include interprofessional education and tools to help trainees prepare for working with others.

The Central and North West London NHS Foundation Trust and the London Deanery’s Simulation and Technology-Enhanced Learning Initiative (STeLI) have designed an interprofessional training course based on video scenarios for mental health work in the emergency department:

- a 22-min video, ‘Simon and Meg’, based on a common A&E scenario developed from the testimony of patients, carers and staff;
- teaching on human factors and patient safety;
- facilitated small-group work responding to the video.

The key aim of the course is to highlight systemic and process problems experienced by teams that work collaboratively and to help staff reflect on and improve their non-technical skills.

**Admission/discharge decisions and gatekeeping**

The Taskforce noted that, in some trusts, trainees are asked to discuss cases with senior colleagues when patients are admitted to mental health wards but not when patients are discharged. This might be related to pressure to ensure that the limited numbers of in-patient beds are not used before considering alternatives. However, this does create a situation in which seeking advice from a senior colleague is not mandatory in the riskier situation of discharging patients. The Taskforce is concerned that high-risk discharge decisions might, consequently, be viewed as less important to discuss with a senior colleague and believe that learning opportunities are present when both admitting and discharging patients. Limiting trainee exposure to out-of-hours discharge decision-making could result in admission
Occasional Paper 95

being reverted to as the safe option without adequate consideration of less-restrictive alternatives.

Section 136 assessments

Detentions under Section 136 of the Mental Health Act 1983 have been the subject of considerable attention over the last year (Independent Commission on Mental Health and Policing, 2013; Mental Health Partnership Board, 2013). The on-call duties of core psychiatric trainees often include assessments of people detained under Section 136 in a place of safety. Although this is outside the immediate remit of the Taskforce, we noted there is considerable variation in core trainee duties and procedures related to Section 136 assessments. We consider this an area for further work, and one in which the development of guidelines and specific training might be of benefit.

Foundation Programme and GP specialty training

The Taskforce considered the role of emergency psychiatry training for doctors in the Foundation Programme and the General Practice Vocational Training scheme (GPVTS). Appendix 3 summarises the aims of emergency-psychiatry working for these groups and current guidance. Guidance on emergency psychiatry training for groups of doctors other than core psychiatric trainees is likely to be increasingly important if the recommendations of the Securing the Future of Excellent Patient Care report on broader training pathways are implemented (Greenaway, 2013).

Interface with primary care

As Gask & Croft (2000) noted, ‘it is certainly possible and not at all uncommon for trainee psychiatrists never to meet face-to-face with their patients’ [general practitioners]. The Taskforce identified the interface with primary care as an area in which further specific training interventions and guidance could be developed. This will be particularly important for preparing trainee psychiatrists for newer models of working at the interface with primary care, such as consultation/liaison psychiatry.

Home treatment and community care

The Taskforce recognises that emergency psychiatry does not stop at A&E. It is important to note that there are valuable training opportunities for core trainee psychiatrists in the community setting. In
particular, we feel that experience with home treatment teams is an area where trainees could benefit from further opportunities in the form of ‘tasters’ and placements.

The Lancashire NHS Foundation Trust has been running a system in which a Band 7 crisis resolution and home treatment (CRHT) practitioner works on-site in the liaison psychiatry office outside of working hours. Patients attending the emergency department can be seen by a psychiatric trainee, a member of the liaison team or the CRHT. This means that the trainee usually develops a good working alliance with the practitioner and there is thus some discussion of cases between them also has an element of peer supervision.

Between 2007 and 2011, the Dudley and Walsall Mental Health Partnership NHS Trust piloted an innovative training scheme to provide its core trainees with CRHT training opportunities. The scheme offered 4 weeks of partial secondment to a CRHT team, during which the core trainee worked under the supervision of the CRHT consultant (or senior psychiatrist) and alongside Band 6 nurses, and was involved in the assessment, monitoring and follow-up of patients. This experience was considered to be a community counterpart to training in the in-patient setting.
Minimum standards

The Taskforce makes the following recommendations for minimum standards for the provision of emergency psychiatry training.

1. Core and higher trainees should regularly work in acute settings that will provide experience of emergency psychiatry assessments and decision-making between 5 pm and 9 am on weekdays or at weekends.
2. For Core trainees, regular work in emergency psychiatry settings is defined as a minimum of 55 nights on call over 3 years of training. The trainee should see at least 50 cases with a range of diagnosed conditions and conceive and implement first-line management plans.
3. All trainees working out of hours must work within consultant-led multidisciplinary teams with appropriate supervision and training opportunities.
4. Core trainees’ out-of-hours work should include both A&E assessments and psychiatric-ward cover.
5. All trainees should be provided with opportunities to gain experience in assessment and decision-making in the community and home setting (e.g. through work with a home treatment team).

Further recommendations

The Taskforce identified a number of opportunities to further improve the quality of emergency psychiatry training.

1. Incorporate minimum standards for emergency psychiatry training into the core curriculum and the Royal College of Psychiatrists’ guidance regarding training in psychiatry to raise awareness of standards and help ensure their implementation.
2. Use high-fidelity simulation training, particularly around the induction period, for training on emergency situations in a safe and supportive setting.
3. Encourage inter-professional training with other members of the multidisciplinary team in emergency psychiatry settings.
4. Provide structured induction programmes with gradual, supervised introduction to out-of-hours working to improve training opportunities and patient safety outcomes.
5 Recognise different training needs for different grades of doctor, particularly Foundation Programme doctors, GPVTS doctors and first-year core trainees.

6 Improve emergency psychiatry training by expanding opportunities for trainees to gain experience in a range of settings, including working in primary care, home-treatment teams, approved mental health practitioners, community crisis teams, etc.

7 Improve emergency and general psychiatry training with specific training relating to patients and carers, particularly around the Triangle of Care (Worthington, 2013) and advance statements in emergency settings.

8 Address the relative lack of data on training experiences, caseloads seen by doctors in training in emergency settings, and trainee and patient outcomes by conducting qualitative and quantitative research.
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Academy of Medical Royal Colleges (2013a) Seven Day Consultant Present Care: Implementation Considerations. AMRC.

Academy of Medical Royal Colleges (2013b) Value of the Doctor in Training: A Charter for Postgraduate Medical Training. AMRC.


Centre for Intelligence Workforce (2014) In-Depth Review of the Psychiatrist Workforce. CFIW.


Appendix 1. A carer’s perspective

Carers Trust (www.carers.org) definition of a carer: ‘A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.’

A carer, then, is someone who has a relationship with a person where emotional commitment is part of the equation. Most carers of this type don’t know they are a carer. In fact, I didn’t know for 2 years, until I met a carer support worker from Rethink Mental Illness who told me I was a carer. For many of us there is a grief reaction, as the realisation of the increase in commitment to someone is suddenly realised. And in many cases we don’t want to put this label on ourselves. We are simply a wife, husband, parent, friend, or family.

However, in an emergency, when it comes to supporting the person we care for to access medical services, in spite of our mixed feelings around the use of our own label, we desperately need and expect the reassurance of the presence and participation of a psychiatrist. An expert with plenty of experience of mental illness which we have little or no training in. Someone who can make informed decisions in a highly complex situation where access to outside resources is poor to nonexistent. In my case, the doctor’s understanding of Asperger syndrome is vital to my loved one having a positive experience that can be built on. The original diagnosis was schizophrenia, which is a common error. As the vast majority of children diagnosed with autism spectrum disorders develop mental illness, a great many patients have this added complexity for psychiatrists to deal with.

By the time a patient needs emergency medical care, those who care for them are exhausted, frightened and often ill and frail themselves, sometimes because they’ve not known how, or been able, to help the situation. Wouldn’t it be nice if all this happened in the light of day, during the working week? But our worst, and most frequent, experience of emergency is at night, often late at night, and at weekends when the availability of our sources of support is not there. This is also true for the psychiatrists attending out of hours, but as the majority of emergency cases are repeat patients, a care co-ordinator who is part of the community mental health team (CMHT) has been assigned to the patient and their records are often available electronically to psychiatrists. The carer also knows what the patient is like when they are well, and the course of events that led them to require medical
care. They are a particularly valuable resource for the psychiatrist on duty, because they are the most consistent and long-lived source of support the patient has. However, without the psychiatrist actively engaging with the carer, and being trained in methods to do so, this information can be lost as often the carer doesn’t come forward for a variety of reasons, but mostly because of a feeling of intimidation in the setting as well as lack of recognition of their key role. The psychiatrist’s misunderstanding of the use of confidentiality is also a barrier. Excellent guidance on this subject is available in documents produced by the Royal College of Psychiatrists.

In an optimal situation, over time the care co-ordinator creates a care plan and a crisis relapse and contingency plan or advance statement/directive with the help of the patient, and often also the carer, when the patient becomes well. These are scanned (as they are forms usually filled in by hand) into the database of the CMHT the patient is registered with. It gives a holistic picture of that person that states their preferences and guides the mental health professional to what is needed for them to become well. The patient would be given a copy, and the carers often have a copy, which can be vital when it’s inaccessible to those outside the CMHT because it is closed for the day.

But whether someone experiencing mental ill health is looking for emergency medical care for the first time or the tenth, the psychiatrist’s implementation of the guiding principles of the Triangle of Care is vital to the long-term success of the treatment of the patient and their carer. Originally a concept created by the Carers Trust, the Triangle of Care is now a kitemark for mental health trusts to set standards of support and services for carers to promote recovery by including them in the care team. In so doing, when we take our loved ones home, we are in a position to continue to care for them, which can ensure that recovery comes sooner and lasts for longer, for them and for us.

Taj Gilligan, Carer Representative, Carer Forum and Psychiatric Trainee Committee member, Royal College of Psychiatrists.
"...every situation is different, sometimes the difficulties that present in normal working hours are not the “crisis” ones people struggle with during evenings and weekends and they need to gain this perspective and experience."

"This should be automatic work behaviour just as other professions that work 7/24. This profession is one of medical therefore individuals entering it to make a difference MUST realise that individuals can become unwell at any time therefore should have the right to correct treatment and not be at a disadvantage to their outcomes because there are no doctors on-duty."

"Being able to think creatively when options may be limited due to services not being available/closed ... Being able to reassure me as they have previously been in similar situation with another patient previously so do have appropriate experience, knowledge and working relationships with other [out-of-hours] service providers, e.g. police, A&E. Specialist current knowledge of available interventions, e.g. medication and short term management of crisis."

"How to act and react in a crisis. That patients are individuals with feelings and fears. That stress thresholds in carers reduce over time and both service users and carers can be particularly vulnerable at night. That if it is late in the evening or during the night that this is when you feel at your lowest at times and can be frightening."

"To use their initiative, be prepared to take risks and accept responsibility for their decisions."

"It is my opinion that without the chance to learn from working in “out-of-hours” situations they will be less able/prepared for this type of crisis situation when qualified. As a parent this is a scary thought."

"[Out-of-hours] psychiatrists training may be in statutory settings (e.g. A&E, triage settings, police, etc.) but also experience should be gained via helplines, Samaritans, specialist support services. The recognition of wide cultural and religious variations on crisis management and..."
traditional ways of coping in specific communities (e.g. faith healers). Being willing to discuss the crisis with me and or colleagues afterwards as reflective practice and learning.’

‘Opportunities to see me when I am well and not in crisis.’

‘... it is essential to learn these extremely difficult things on the job and so essential that trainee psychiatrists train during weekends and evenings and are not thrown in at the deep end.’

‘... the carer(s) job is often 24/7 anyway, so why should they be left without sound professional guidance and support whenever they need it in order to be able to continue to care?’

‘... it is so important that a trainee sees what the work place is like ‘out of hours’ as it is a very different place from 9–5 when there are (hopefully) a full complement of staff on duty.’
The Foundation Programme

The Foundation Programme is a 2-year generic training programme that forms the bridge between medical school and specialist/general practice training. The Foundation Programme (Academy of Medical Royal Colleges, 2012) aims to:

- ‘build on undergraduate education by instilling recently graduated doctors with the attributes of professionalism and the primacy of patient welfare, which are required for safe and effective care of patients with both acute and long-term conditions
- provide generic training that ensures foundation doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- provide each foundation doctor with a variety of workplace experience during their foundation programme in order to best inform career choice’.

Almost all practising doctors will see patients with common mental health problems as part of their clinical practice, and many doctors in non-psychiatric specialties will provide treatment for some of these mental health problems. In the Foundation Programme, doctors are expected to develop a range of clinical skills across several specialties, and they gain supervised experience in managing both acute and chronic conditions (Health Education England, 2014).

The Foundation Programme recognises the need for core clinical skills in psychiatry to be developed during Foundation Year 1 (F1) and Foundation Year 2 (F2), including basic skills in acute and emergency
psychiatry. The Foundation Programme curriculum sets out the competences in managing acute mental disorder and self-harm, with an expectation that all doctors achieve these competences by the end of the F2 year (Academy of Medical Royal Colleges, 2012):

- describes and recognises common presenting features of acute mental disorder including disturbance of behaviour, mood, thought/cognition, and perception
- performs a mental state examination
- recognises potential risks to patient and health care professionals
- takes appropriate steps to protect the patient, dependants, self and colleagues from harm
- considers underlying causes of severe mental disturbance including acute confusional states, psychosis and substance use/withdrawal, early signs of dementia
- ensures appropriate screening for metabolic, medical and drug induced changes in mental state
- understands and applies the principles of managing a patient with acute mental disorder and self-harm
- understands the spectrum of therapeutic interventions for the management of the acutely disturbed patient, including restraint
- recognises the need to seek help from appropriate health care professionals
- understands the importance of liaising with community care and specialist teams to ensure seamless care between acute and long-term care providers

Many Foundation programmes now offer rotational posts in psychiatry but, in 2011/12, psychiatry posts accounted for just 2% of F1 posts and 4% of F2 posts (Health Education England, 2014). Therefore most Foundation doctors will be expected to achieve their psychiatry competences in non-psychiatric posts. Typically some learning opportunities in acute psychiatry may be provided from posts in emergency medicine, general practice, acute medicine and other specialties.

The number of Foundation doctors taking a post in psychiatry is set to rise steeply, with a stated aim that 22.5% of F1 posts and 22.5% of F2 posts should be in psychiatry from August 2014 (Health Education England, 2014. Foundation posts in psychiatry offer the opportunity for the acute mental disorder and self-harm competences of the Foundation curriculum to be achieved more systematically and with specialist supervision, which can be expected to embed good practice at an early stage of a doctor’s training.

**Supervision**

In the Foundation Programme, there is a strong emphasis on the dual goals of patient safety and personal development as a clinician.
It is recognised that a key factor in both to occur simultaneously is appropriate clinical and educational supervision. Most junior trainees in psychiatry continue to have daily contact with their clinical supervisor, and it is expected that Foundation doctors in psychiatry posts will have at least as much contact with their clinical supervisor. It is particularly important, where Foundation doctors are seeing patients in acute settings or as emergencies, that they are able to access senior advice and support immediately when needed, and that the level of clinical responsibility given to the Foundation doctor is commensurate with their experience. A more senior clinician should be involved in assessing the appropriateness of any acute or emergency patient allocated to a Foundation doctor, reviewing possible risks before judging which clinician should undertake the assessment, and taking responsibility for putting in place any measures needed to ensure the safety of the patient, family and staff before the assessment starts.

**Out-of-hours work and psychiatry on-call rotas**

Patients who present with psychiatric emergencies outside normal working hours can provide valuable learning opportunities for Foundation doctors. However, when trusts design services, Foundation doctors should not be seen as equivalent to core trainees. ‘Foundation doctors must always have direct access to an appropriate senior colleague for advice in any clinical situation. They must never be left in a situation where their only help is outside the hospital or the place where they work’ (General Medical Council, 2011).

In most mental health trusts, the higher specialist trainee and consultant undertake their on-call duties from home. It is not permissible for a Foundation doctor to participate in an on-call rota unless there is a more senior colleague physically present on site with the Foundation doctor for the whole shift. This does limit the opportunities for Foundation doctors to participate in acute psychiatry out-of-hours rotas. However, it is permissible for the senior colleague to be a clinician from another discipline (such as mental health nursing or social work), as long as it is clear that final clinical responsibility does not lie with the Foundation doctor and there are appropriate arrangements for supervision.

**General practice training programmes**

The Royal College of General Practitioners (RCGP) acknowledges that 90% of contacts with people with mental health problems are in primary care (Royal College of General Practitioners, 2013). Only by gaining experience assessing and treating people with mental health problems will general-practice specialty trainees be properly prepared for this important aspect of their work. The RCGP identifies postgraduate placements in psychiatry as one of the five learning
strategies by which general-practice specialty trainees can gain the knowledge and skills to provide care to people with mental health problems. To this end, many training programmes include placements in psychiatry in some rotations.

The RCGP (2010a) has produced learning objectives that illustrate the role of general practitioners in initiating assessments in psychiatric emergencies, such as the following:

- Understand and empathise with people who are distressed and fully assess them (including risk) and offer appropriate support and management.
- Understand the initial management of a patient with a suspected psychosis.
- Be able to co-create and implement an immediate safety plan with a suicidal patient.
- Be able to assess and manage risk/suicidal ideation.

In addition, the RCGP (2010b) lists the following as some of the expected competences for general practitioners:

- Recognise the signs of illnesses and conditions that require urgent intervention.
- Make the patient’s safety a priority.
- Be able to make mental state assessments and ensure the safety of others.
- Act calmly in emergency situations and follow agreed protocols.
- Be aware of how the management of patients with continuing conditions affects the need to give urgent and unscheduled care.

Taken together, these points illustrate the value of opportunities for general-practice specialty trainees to work in psychiatry training posts that include a component of emergency and unscheduled work. Clinical supervisors should recognise that the level of clinical experience of general-practice specialty trainees varies considerably from one doctor to the next. It is important for this to be taken into account when allocating acutely presenting patients or emergency assessments to a general-practice specialty trainee. Considerable reciprocal learning is possible when general-practice specialty trainees work in psychiatry placements, not least in emergency presentations where physical illness may need to be considered in the differential diagnosis.

**References**

Academy of Medical Royal Colleges (2012) *The UK Foundation Programme Curriculum*. AOMRC.


Royal College of General Practitioners (2010a) *Statement 3.10 Care of People with Mental Health Problems*. Royal College of General Practitioners.

Royal College of General Practitioners (2010b) *Statement 3.03 Care of Acutely Ill People*. Royal College of General Practitioners.