

Multi-presenter mental health patients in emergency departments - a review of models of care

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Abstract

Only a small proportion of the treatment of mental illness occurs in an institution or hospital. By far the most significant treatment happens in the community and in the patient's own social and family environment.

However, de-institutionalisation of mental health services has brought increasing numbers of patients to the emergency department in need of psychiatric assistance. The traditional service model of emergency departments, focusing on physical illness and injury, is being challenged. The literature review identified numerous psychiatric service models in place but dramatically highlighted the lack of a specific service model addressing psychiatric patients who present on multiple occasions [multi-presenters] in emergency departments. At present, accurate data on the effects of multi-presentation of psychiatric disorders are not available. Recent international and local research into models of service delivery management and best practice is examined.

The scope of mental illness

Sometimes I wish I could be	Then they would	Help.....!
Right inside the minds-	Be like me	
Of those around me	And realise	
	That no matter	
What would I do?	What I have become	
Probably nothing -		
Just dwell there	For better	
And watch them	Or for worse	
Going mad	I am still a human being	(Westwood 1992).

It is estimated that mental health problems and mental illness will affect more than 20% of the adult Australian population in their lifetime and between 10 to 15% of young people in any one year (Australian Institute of Health and Welfare 2000). The Tolkein Report (Andrews 1991) pooled a variety of studies to estimate prevalence of mental disorders for Australians. At that time 16% of the population met the International Classification of Disease 9th Revision (ICD9) criteria for mental disorder (NSW Health 2000).

The Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing of adults (1998) found that one in five (18%) had a major mental disorder at some time during the previous 12 months. This corresponds to more than 830,000 New South Wales (NSW) adults. However, very few of these consulted health services for mental disorders with 38% consulting a health service and 29% consulting a general practitioner in the 12 months prior to the survey. Between 1991 and 1996 South Western Sydney had a higher rate of population growth than the rate for NSW (8.4% compared to 5.4%). South Western Sydney Area Health Service (1999) projected that by the year 2001 the Fairfield/Liverpool sector would be providing mental health services to a population of 342,300 - representing a 13% increase on the 1999 population. During 1996/1997 NSW hospital emergency departments experienced an increase of 4.9% or an extra 83,300 occasions of service over the previous 1.7 million (ABS 1998).

The final Report and Recommendations in 1998 by the 'Working Group for Mental Health Care in Emergency Departments' established by the Centre of Mental Health in NSW, concluded that a substantial proportion of emergency department presentations have a psychiatric chief complaint, with estimates varying between 0.6% and 10% of all presentations. All patients presenting to emergency departments may have psychological problems contributing to their presenting complaints while 10%-46% of patients presenting to emergency departments with a psychiatric complaint have a co-existing physical illness, which may in turn contribute to their mental illness (NSW Department of Health 1998).

A significant factor referred to repeatedly in the literature and reinforced anecdotally is the patient who presents on multiple occasions with a mental health related problem. No specific data are reported on this group who consume considerable resources and represent a major challenge to management in emergency departments.

No emergency department service model specifically addressing multi-presentation by psychiatric patients was found in an extensive literature review. The Centre for Mental Health Services (2000), in a systematic review of the scientific literature identified only limited literature on intersectoral service models. However, a number of approaches and models were found to address management of psychiatric crisis in Emergency Departments.

The analysis of published and unpublished service models together with widespread anecdotal impression is in agreement that there is a lack of emergency department staff confidence in managing psychiatric emergencies and no adequate model to address these issues. The development of models for psychiatric multi-presenters is consistent with directions of the National Strategic Plan for quality health care for psychiatric emergency services (Mental Health Promotion and Prevention 2000). Effective organisation and funding arrangements, with the ability to identify needs, direct resources and monitor outcomes are required to bring together the various components. A lateral approach to this problem is required.

Defining quality: evidence-based practice

Determining models of quality service delivery requires definition of standards. Principles, policies and plans, together with relevant research, can serve as a guide for best practice in various service delivery areas. There is not, however, any agreed absolute code of practice across Australia or internationally.

Something exciting is afoot. Illnesses that used to mean long-term incarceration for sufferers are now being treated in the community. Very severe and acute forms of insanity are now rare. Either the disorders are disappearing or growing milder in form, or new methods of treatment and prompt treatment in the community mean that the severe and very chronic varieties of illness are no longer able to develop. Either way, service delivery must be reorganised to cope with the change in circumstances. (Andrews, 1991:3)

The World Health Organisation (WHO) Collaborating Centre for Mental Health and Substance Abuse set out to define examples and models of best practice and identify core management skills. People with "...mental disorders have reduced access to commodities (eg. Physical health care, income, education, housing, transport, legal advice and leisure opportunities)..." (WHO 1997:4).

When a person contacts a service, good clinical practice involves a clinician or team examining the individual, identifying the complaints, and in consultation with the individual deciding whether treatment for these complaints lies within the competency or responsibility of the service. If not, the individual is referred elsewhere

or advised about self-care. No clinician or health service is likely to be expert in the treatment of everything and knowing the limitations of the service is important in order to be fundamentally helpful.

A good outcome means a reduction in symptoms, disability, risk factors and the social consequences of the disorder, not just a change in diagnosis. Reduction in symptoms is the individual's primary concern and the first goal of treatment. Consequently, "...good treatment presumes that a valid diagnosis was made and confirmed by appropriate measures, proven treatments were skilfully applied and accepted by the individual and that the whole response was measured and evaluated using appropriate outcome measures" (WHO 1997:4).

The managing of mental health services has been moving from input and process evaluation to output and outcome evaluation (Jenkins 1990 cited in Whiteford, Macleod and Leitch 1993, Health Department of Western Australia 1997). Outcome evaluation of services needs to pay particular attention to the role of consumers in achieving better outcomes (Victoria's Mental Health Service 1996). How well a service functions may depend not only on the use of budget incentives to improve the quality of the service and the application of key performance indicators, but also upon using consumer outcome measures along with consumer and carer satisfaction measures.

National policies and plans that focus on consumers of mental health services specify that services be guided by consumers' choice in the most empowering setting that respects consumer's social and cultural beliefs, practices and stage of development (Australian Health Ministers Conference 1996). The quality and effectiveness of mental health services are enhanced if the services are responsive to consumers and that their participation in decision making occurs at the individual care level as well as at the group and community level (Australian Health Ministers Conference 1992). Consumers must have a key role in planning and evaluating the services they use (Australian Health Ministers Conference 1997).

The literature suggests a number of guiding principles for best practice in policy and delivery of health and mental health services (Commonwealth Department of Health and Family Services 1996). Best practice approaches to quality assurance involve constant striving to improve all aspects of performance and outcomes (Swansburg 1990). Best practice involves a comprehensive integrated and co-operative approach to the continuous improvement of all facets of an organisation's operations (Clinton and Scheiwe 1995) and is the way leading edge organisations manage the delivery of world class services. It also involves constant setting of new performance targets to progressively improve standards.

Benchmarking in health organisations encourages managers to recognise leaders for best practice in areas that are relevant to health service delivery, processes or practice (Sullivan and Decker 1992). An evidence-based best practice approach should be strongly considered for future investment decisions driven by the potential for attaining an improvement in health status in order to examine the implications of different choices about health care. An epidemiological evaluation of the effectiveness of existing treatments and health outcomes will be required for the achievement of health gain.

Emergency services

The nature of the Emergency Department

The culture of emergency departments is unique within the health service as the physical and psychosocial environment of the emergency department is unpredictable (Anderson 1987). Extraordinary levels of pressures are exerted on clinical and general staff who are the front line in health care, are the first point of contact with the hospital for the general public and experience a volatile and unpredictable working environment. They are the leading crisis intervention/screening health agency for a variety of medical and psychosocial conditions. State and community-based health agencies have minimal resources available to distribute for the increasing numbers of consumers turning to Emergency Departments (Newell 1999:14).

Hospital emergency departments are often utilised in psychiatric emergencies. Provision of psychiatric services to the emergency departments is essential for rapid assessment of patients presenting in crisis but is dependent on the appropriate allocation of resources. The multitude of presenting problems shown by the evidence of repeated presentation of people with psychiatric problems (multi-presenters), indicates the need for a

multidisciplinary approach as far as practicable. Training of emergency and psychiatric services staff dealing with psychiatric emergencies in hospital emergency departments is valuable (Royal College of Psychiatrists 1996).

Apparent lack of awareness of alternative services such as general practitioner or community-based mental health crisis teams has reportedly led to an increase in mentally ill patients in emergency departments. Smart et al (1999) suggest that the reported difficulty of mentally ill patients in accessing such services after hours is a major contributing factor, increasing the acuity of this group of patients when they do present in the emergency department.

Katsching and Cooper (1991) discuss whether psychiatric emergency services should be provided by specialised or comprehensive services. They describe a trend away from separate specialist emergency and crisis intervention towards comprehensive psychiatric services that provide emergency and crisis intervention components as an integrated part of the whole service. Specialised crisis services included telephone hotlines, ambulatory and mobile services. They are flexible and responsive enough to deal adequately with acute psychiatric emergencies and crises without providing a separately labelled service.

Attitude of emergency staff to mentally ill patients

A negative staff attitude to mental illness is a major obstacle to introducing effective structural changes in emergency department service delivery. Up to 90% of emergency nurses had difficulty interacting with mentally ill patients (Jones et al 1984). Emergency nursing staff are more comfortable with physical injury or, tangible and treatable illness than less tangible psychiatric illness (Curry 1993:405). The lack of confidence or competence in managing psychiatric emergencies such as self-harm is clearly exhibited by emergency department staff (Owens et al 1991:218-22).

Stereotyping of mental illness creates conflict with the traditional nursing role (nurses' self-image) in the emergency department (Yoder and Jones 1982) and provides an expectable means to rationalise the *avoidance activities* perpetrated on such patients (Hunt 1993:375). Discrepancies between patients' expectations and actual quality of nursing care given to psychiatric patients comes from the misperception by nurses that they are ineffectual in providing active positive care to psychiatric patients. This leads to avoidance behaviour, and the labelling of mentally ill patients as 'less worthy of nursing time and care'. Labelling a patient as mentally ill provokes negative attitudes promoting biases from health professionals with resultant dismissal of the patient's complaints as unimportant (Seide and Miller 1983). Nurses belief systems; their own perception of their professional competency, communication skills and the need for professional support are factors reflected in service delivery and management in emergency departments to mentally ill consumers (Heaven and Maguire 1996).

Emergency department health professional staff have punitive attitudes towards and little sympathy for patients with suicidal behaviours (Hogarty and Rodatis 1987; Bailey 1994; Tehan and Murray 1996). Nurses have negative attitudes towards the provision of care for suicidal patients (Pederson 1993). Triage nurses exhibit frustration at the apparent low priority and inappropriateness of some perceived non-urgent psychiatric attenders (Roberts 1998). Multi presentation of non-urgent cases engenders negative feelings towards patients (Toulson 1996 cited in Roberts 1998).

The print media is in an influential position to shape the public perception of health issues. Mental health stories provide classic examples of this influence (Schultz 1994, Tiffen 1993, Torrey 1994, Westwood 2001). A series of papers have examined the link made between mental illness and violence portrayed in the media and the effect upon audiences' beliefs and the impact of those beliefs (Harper 1995, Platt and Secker 1996, Philo 1997). Since health professionals are part of this audience their avoidance activities and negative behaviour toward psychiatric patients in emergency departments is put in perspective.

Models to address management of psychiatric crisis in emergency departments

The Final Report on the Establishment of *Psychiatric Services* in the South West Corridor in Western Australia (O'Brien 1997) defines a model of service delivery for psychiatric emergency services by means of a set of general principles and service goals. It recognised the need to maintain and support individuals within their own environment together with collaboration between different components of the mental health system.

The benefit of early intervention in minimising distress and turmoil to patients and families was noted along with the benefit of prevention of inappropriate hospitalisation, reducing the incidence of completed suicide and the necessity of coping with de-institutionalisation.

The Report also identifies principles for emergency services with provision of a single point of entry to the psychiatric system for individuals in crisis; assessment and management of psychiatric emergencies in the most effective manner while linking individuals in crisis with appropriate resources in the community. The least restrictive /least intensive course of action should be used. Services should be provided to difficult to reach people with reduction of hospitalisation by mobilising treatment resources and environmental support with 24 hour 7 day per week access. High quality training is desirable for a wide variety of service providers.

The failure of de-institutionalisation has resulted in a dramatic increase in the number of mentally ill people presenting at hospital emergency departments (Curry 1993, Holecz 1993, Borges et al 1995, Walsh 1995). The response of emergency staff to psychiatric patients is often inefficient, slow and inappropriate (Heslop 2000, McIndoe et al 1994). A variety of psychiatric service provisions has been identified to deal with the increase of mentally ill people. They include on-call psychiatric emergency teams, based in hospital psychiatric units; full range of psychiatric emergency facilities within hospital emergency departments; and/or purpose built psychiatric emergency rooms staffed by multidisciplinary psychiatric teams on a full-time basis.

Seide and Miller (1983) suggest that when separate specific establishments are created, major difficulties and problems occur in the provision of holistic quality psychiatric care. These difficulties relate specifically to situations where '*expert facilities*' are required simultaneously to address the physical needs of mentally ill consumers.

Specialist psychiatric nursing in emergency care is one option for addressing problems of service delivery for mentally ill consumers in emergency departments (Kordilla 1994). Staff in emergency departments generally have limited psychiatric knowledge and are faced with time constraints, which inhibit the provision of appropriate psychiatric care to mentally ill people seeking help. McIndoe et al (1994) describes a study conducted by a psychiatric nurse specialist in the development, implementation and evaluation of a program in which the average waiting time for mentally ill patients, and the percentage of patients medicated decreased both in time and average treatment dose.

A nine month trial study conducted in two Melbourne emergency departments demonstrated the effectiveness (outcomes for consumers) of introducing psychiatric nurse clinical consultants (PNCC) in improving service delivery to people with mental illness. Recommendations from the study supported the introduction of a PNCC into all emergency departments (nation -wide) for the improvement of psychiatric management care (Gillette et al 1996).

Fisher (1989) suggests that the discrepancy between the organisational structure of work allocations in emergency departments and the actual requirements of the patient population is an issue in service delivery. These are magnified for special groups of patients (psychiatric) where continuity of care is difficult. Mentally ill patients are more likely to want a solution for their problem immediately (with a single visit) while they are in crisis (Walsh 1995).

Frankston Hospital (Victoria) in conjunction with the School of Nursing, Faculty of Medicine, Monash University developed a screening tool for at-risk patients (Heslop 2000). Emergency department staff concerned by the poor quality and continuity of psychiatric care of mentally ill patients identified areas for inclusion in clinical pathways such as effective skill development in the assessment and management of psychiatric patients. The screening tool formed the basis of three pathways of care for patients seeking psychiatric services and pinpointed timing and type of referral needed. The three broad groupings at triage consisted of patients having indications necessitating psychiatric referral; those at risk for self- harm or suicide; or those at risk for aggression/violence.

As a model of co-ordinating care, the risk assessment tool incorporated all health practitioners in the emergency department in the care of mental illness, acknowledging that specific referrals needed to be facilitated for crisis intervention (Heslop 2000:7). It differs from other models described in the literature because it recognises structural constraints affecting the department as opposed to devolving responsibility to one particular position, for example the clinical nurse specialist.

Liaison and consultation mental health services to the emergency department

Liaison and consultation are vital activities provided by the mental health service to the emergency department and can safely be conducted by psychiatrists (Barrow 1989:243-250) or by other disciplines including junior medical staff, mental health nurses and social workers (Hall 1994). They are crucial to the quality of service and care received by mental health consumers and their subjective experience of the ordeal.

Consultation is an activity in which a mental health worker responds to a request for 'expert' assistance with diagnosis and/or management for a mentally ill patient under the care of another health professional (Fry et al 1999:37). Liaison refers to an attachment of the mental health professional over an extended period of time for the purposes of assessment, co-management and education (Barrow 1989). In the emergency department, the mental health liaison worker responds to certain role expectations from colleagues, but still remains an outsider in a different health service environment and culture (Fry et al 1999).

Although psychiatric patients in emergency departments rarely initiate the request to see mental health professionals (nurse/psychiatrist); they are usually receptive to talking to specialists, particularly when they are perceived to be part of a health care team (Schuster 1995). The liaison psychiatric service to the emergency department should provide a 'safety net' for patients with complaints that are not identified by other services (Anderson 1987:419). Safety and privacy are important issues in the emergency department environment that are relevant to the care of mentally ill patients.

Barrow (1989) indicates that liaison activities for the purpose of reviewing specific cases and general patient management have been criticised due to poor documentation of cost-effectiveness and an implied lack of measurable outcomes. Similarly, Schuster (1995) points to the importance of cost effectiveness in management plans while Hall (1994:141) argues that the lack of adequate record keeping has prevented the audit of the quality of services taking place.

Findings of previous studies

A number of previous studies have identified relevant issues. We will mention three here.

Mental Health Triage Guidelines Project Report

South Eastern Sydney Area Health Service (SESAHS) is unusual in not containing a large psychiatric hospital or separate psychiatric admission centre. The critical role of the emergency department has been recognised with a key priority being the development of responsive and accountable mental health services in the emergency department. The SESAHS *Development and Implementation of Mental Health Triage Guidelines for Emergency Departments* addresses some of these key priority areas (Tobin et al 1999). The guidelines were developed by Sutherland Hospital where staff identified inconsistencies in approaches to the triage of mental health patients in the emergency department (Chandler and Carey 1998). These patients were generally allocated low priority contributing to long waiting times in situations where there is considerable risk or increased patient distress (Gill 2000).

The need for mental health triage guidelines in emergency departments to provide standardised and consistent approaches to mental health patients complies with one key strategy within the National Mental Health Policy - the mainstreaming of psychiatric care (Pollard 1998). A recent working group of the Centre for Mental Health, NSW Department of Health and the Australasian College of Emergency Medicine has recommended the development and validation of emergency triage guidelines for mental health problems (Tobin et al 1999).

Blacktown Youth: Suicide Prevention Project

Gaps in mental health services were identified in an analysis of young suicidal people presenting to the Blacktown and Mt Druitt hospitals emergency departments. The Blacktown Local Government Area has a high number of young people attempting suicide. Professional development was needed for health care workers to identify prevalence of risk factors in this group. The Emergency Department Information System revealed a serious problem with 296 people during the period June 1995 to April 1996 presenting with 'intentional self-harm'; of these, 102 (34%) were under the age of 24 years (Fry et al 1999).

The project aimed to improve health care to young people at risk of suicide presenting to the emergency department; implement a co-ordinated care plan of active follow up for each young client at risk of suicide after comprehensive assessment and following departure from the emergency department with development of corresponding protocols; and to improve strategic alliances between existing services and key stakeholders concerned with caring for young people at risk of suicide, by developing educational programs and reciprocal learning opportunities (Fry et al 1999:3).

The project concluded that clinical support in the emergency department can have a positive effect on outcomes, the measurement of outcomes needs to be routinely applied, Clinical Guidelines outlining effective approaches to deliberate self-harm among young people should be considered, long-term evaluations of policy changes in the emergency department need to be done, a system of monitoring presentations to the emergency department by current clients of the mental health service who have a history of self-harm be developed, education programs are needed for emergency department staff regarding mentally disturbed and self-harming patients, and support and supervision should be provided to all staff who come in contact with suicidal youth, as needed (Fry et al 1999:7).

Hunter Health Emergency Social Work Project

This twelve-month project assessed the need and possible benefits of social work service for clients of the emergency department at John Hunter Hospital (Newell 1999). It was anticipated that a full time social worker in the emergency department would assist with social admissions and more multiple presenters would be more appropriately assessed and case managed.

The project achieved increased referral to Social Work for psychosocial issues impacting on health outcomes, enhancing quality of care, improving continuum of care and reduction of multiple presentations; improved co-ordination of referrals to community organisations with an improvement in continuum of care; and an increased awareness of the need for information to enhance staff ability to care for patients and identify risk management issues (Newell 1999).

Recommendations from the project were that a full time Social Worker should be appointed to work within the Division of Emergency Medicine with continued data collection and customer satisfaction survey to target both clients and community agencies; and that specific issues should be targeted that are significant to the work in the emergency department - homelessness, bereavement and violence (Newell 1999, Harrison 2000 personal contact).

Summary

"Paradoxically, if you survive them, it's in the bad conditions that you learn most about yourself" (McCartney-Snape 1996).

The literature review demonstrated that the issues surrounding multi-presenters in emergency departments and appropriate service models are complex, and that they demand multi-faceted approaches. The Mental Health Taskforce (1996) advised on models of service delivery based on the principles that a community-based clinical team be responsible for ensuring both community- and hospital-based services to a catchment population. Services should be easily accessible and user-friendly. Access to emergency assessment and treatment for all age groups should be available 24 hours per day, 7 days per week. New and innovative methods involving general practitioners should be developed for accessing support and immediate specialist advice. Case management should be supported by an identified staff member as a core method by which continuity of care can be delivered using a multidisciplinary team that provides a biopsychosocial approach with carers and consumers given training and formal involvement in decision making (Mental Health Branch 1997).

Research on the phenomena of multiple presenters in the emergency department still mainly focuses on traditional medical illnesses and injuries and rarely on the mentally ill who are at risk or currently exhibiting actual problem behaviour. There is little focus on service models specifically dealing with mentally ill multi-presenters to emergency departments.

However, there is consensus in the models reviewed in the literature about the primary tenets considered to be important in dealing with issues of mental illness and service delivery models in emergency departments. These included the need to:

- develop clinical pathways, risk assessment tools and mental health triage guidelines for emergency departments;
- address the gap in services to target the needs of those with mental health problems, particularly those at risk;
- address issues of equity in mental health in emergency departments;
- provide accessible and acceptable service to the community;
- develop and implement avenues for interventions;
- educate staff in understanding mental illness by providing insight to how a negative attitude and language is the biggest barrier to effective service delivery and reflects the quality of care and treatment provided to mentally ill people;
- increase multidisciplinary teams on a full time basis to provide for 24 hour coverage 7 days a week;
- create positions for dedicated psychiatric staff in emergency departments such as psychiatric clinical nurse consultants;
- collaborate with community-based clinical teams to ensure both community- and hospital-based services are available to a catchment population;
- develop good communication between all stakeholders;
- develop quality management to provide a continuous evaluative process;
- identify performance outcomes and evaluate effectiveness (cost effective); and
- provide resources for on going research in the area of quality service delivery in mental health.

These principles are supported by several studies such as the Emergency Social Work Project at John Hunter Hospital, with a strong recommendation for a full time social worker presence in the emergency department so that multiple presenters would be more appropriately assessed and case managed. They are also supported by the South Eastern Sydney Area Health Service Mental Health Triage Guidelines for Emergency Departments.

Several practical models are in place with useful components although not described in the literature. They include the Liverpool (NSW) hospital psychiatric registrar and consultant psychiatric on-call service to the Emergency Department (Clark 2000), Northern Beaches (NSW) Mental Health Services Extended Hours Team agreement with Manly Hospital that provides for acute assessment by a member of a multidisciplinary community-based team (Codd 2000), and Gold Coast Health Service (QLD) District Integrated Mental Health Service - a one-stop, door to inpatient status with 24-hour cover by on-call registrars and consultants (Albrecht 2000, Bell 2000). None of these models however specifically address multi-presenters to the emergency department.

The move from the traditional hospital-based public sector system to a mix of public, private institutional and private community-based services has led Australia to one of the lowest psychiatric bed ratios of any developed nation (Andrews 1991, AIHW 2000). However, literature on mental health service models in emergency departments indicates a crisis in the management of mental health in this area. The average length of stay in public acute hospitals has fallen from 5.1 days in 1993-1994 to 4.0 days in 1997-1998 (Department of Health and Aged Care 1999, AIHW 2000).

It could be argued that the cumulative effect of these coinciding policy directions may be responsible for the increased use of hospital emergency department services by mentally ill consumers. Mental disorders account for the third largest disease group for health expenditure in Australia, costing a total of \$3.0 billion or 9.6% of the total health system costs (Mathers et al 1998, Mathers and Penm 1999a, 1999b). The development of an appropriate bipartisan mental health service model to address mental health issues in emergency departments, particularly for multi-presenters, may contribute to a clear direction for mental health strategies and equity in mental health care. This may ultimately result in a significant reduction in direct healthcare expenditure without compromising quality of service or health care in this area.

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