Urgent psychiatric assessment in an inner-city A&E department

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Data on day time referrals to a liaison psychiatry team from an inner London accident and emergency department (A&E) were analysed over a two-year period. Despite the availability of local community-based alternatives for urgent assessment almost 5000 patients were seen. A quarter were self-referrals and two-thirds had had no previous contact with psychiatric services. The most common reason for referral was aggressive or disruptive behaviour. Characteristics of patients in this inner-city population suggest a continuing need for a high quality liaison service to the A&E department.

Rates of consultation at A&E departments are particularly high in inner-city areas and many are judged to be inappropriate (Davison *et al*, 1983). In relation to mental disorders there are few data available to gauge the numbers of patients who present to A&E. One study reported that 2% of all attendances to A&E at Leeds General Infirmary are assigned a primary psychiatric diagnosis by A&E staff (House & Hodgson, 1994). In psychiatry, community and hospital-based alternatives for urgent assessment are available (Johnson & Thornicroft, 1995). These alternatives have been promoted to enhance continuity of care as part of care in the community and to relieve the pressures on A&E services. This study aimed to document the numbers of people referred for urgent psychiatric assessment in the A&E of an inner-city general hospital. Characteristics of patients were investigated in order to inform future service developments.

The study

The Whittington hospital is a district general hospital in Islington, north London serving a population of 250 000. This is an inner-city area of London that has the sixth highest Jarman index in England and Wales. Local sectorised psychiatric services include two well established Community Mental Health Teams and services for urgent psychiatric assessment (Crawford *et al*, 1996). All psychiatric referrals from casualty during working hours 9 am to 5 pm, (five days a week) are made to a specialist liaison team. Referrals include patients who have presented themselves to the A&E department for medical and other help, and those referred to the A&E department by general practitioners (GPs) and other health care professionals.

Demographic details, source of referral, basic clinical details and outcome of the assessment were recorded by those providing the service. A retrospective analysis of the records of all patients referred from the A&E department during working hours was undertaken from 1 January 1994 to 31 December 1995. An ICD–10 diagnosis was retrospectively assigned to each patient on the basis of clinical details documented at the time of the assessment.

Findings

During this two-year period 4815 patients were seen by the liaison team in the A&E department, 2324 in 1994 and 2491 in 1995. Most were male (3030, 63%) and the majority had had no previous contact with psychiatric services (3246, 67%). Referrals from GPs accounted for 1085 patients (35%), 1107 (23%) had referred themselves, 722 (15%) by the police, 482 (10%) by voluntary sector workers, 337 (7%) by social workers, 289 (6%) by psychiatrists and 198 (4%) by other professionals. Table 1 lists the reasons for referral to the liaison team, and Table 2 the diagnoses assigned; 2889 patients (60%) were given a dual diagnosis. The rate of admission to the psychiatric unit following assessment was low (485, 10%), with referral back to the GP (1920, 40%) and referral to out-patient psychiatric services (1685, 35%) the most frequent outcomes. As part of initial management, 1683 (35%) patients were offered short-term intensive follow-up from the A&E team. Other interventions included referrals to social services (963, 20%), drug and alcohol services (674, 14%), voluntary organisations (386, 8%) and psychologists (289, 6%).

Comment

Although the data are not detailed and were collected retrospectively it is clear that A&E

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services in this inner-city area are being used for urgent psychiatric assessment on a large scale. Despite specialist community-based alternatives, 4815 patients were assessed by the team in the A&E department during this time.

The most likely reason for the high rate of referral is the high demand for emergency psychiatric services. Inner-city London is an area with high rates of severe mental illness (Harvey, 1996) and great numbers of requests to social services for assessments for compulsory admission (Huxley & Kerfoot, 1993). A further factor is the pattern of health service usage in inner-city areas, characterised by a larger proportion of patients having no GP (City and Hackney Community Services NHS Trust, 1996) and the greater use of A&E for primary care services (Bohland, 1984).

While those referred by their GP might be diverted to other services, one-third of referrals were self-referrals or referred by voluntary organisations. Many of these patients have no GP, and additional factors such as insecure accommodation, high mobility, immigration and English as a second language may act as obstacles to reaching community or primary health services. The problems associated with psychiatric assessments in emergency settings are considerable (Shuster, 1995) but even so 40% of those assessed by the A&E team were referred because of concerns about aggressive and disruptive behaviour and 15% has been taken to the A&E department by the police.

Table 1. Reason for referral to the A&E team

Reason	Number (%) Total *n*=4815	
Aggressive/disruptive behaviour	1927	(40)
Mood disturbance	1685	(35)
Alcohol/drug misuse	963	(20)
Hallucinations and delusions	724	(15)
Self-harm	241	(5)
Memory/orientation	209	(4)
Physical problems	193	(4)
Other mental health problems	1926	(40)

Table 2. Diagnosis of patients referred to the A&E team

Diagnosis (ICD-10)		Number (%) Total *n*=4815	
Dementia	(F00–9)	96	(2)
Drug/alcohol	(F10–9)	963	(20)
Psychosis	(F20–9)	1489	(31)
Affective disorder	(F30–9)	1718	(37)
Neurosis	(F40–9)	1401	(29)
Stress/crisis/eating/sleep	(F50–9)	1652	(34)
Personality disorder	(F60–9)	482	(10)
Other	(F70–9, F80–9, F90–9)	18	(0.4)

While the further development and extension of services for crisis intervention (in accordance with the recommendations of the NHS Trust Federation (1996)) would allow an increased proportion of emergency assessments to be conducted outside the A&E department, the characteristics and needs of many patients will continue to create a demand for assessment in the A&E department. It is therefore essential that in addition to encouraging further development of alternatives, attention is paid to ensuring that arrangements for psychiatric assessment in A&E are of a high quality (Royal College of Psychiatrists and British Association for Accident and Emergency Medicine, 1996).

References

BOHLAND, J. (1984) Neighbourhood variations in the use of hospital emergency rooms for primary care. *Social Science and Medicine*, **19**, 1217–1226.

CITY AND HACKNEY COMMUNITY SERVICES NHS TRUST (1996) Mental Health Link (July).

CRAWFORD, M. J., KOHEN, D. & DALTON, J. (1996) Evaluation of a community based service for urgent psychiatric assessment. *Psychiatric Bulletin*, **20**, 592–595.

DAVISON, A. G., HILDREY, A. C. & FLOYER, M. A. (1983) Use and misuse of an accident and emergency department in the East End of London. *Journal of the Royal Society of Medicine*, **76**, 37–40.

HARVEY, C. A. (1996) The Camden schizophrenia surveys. I. The psychiatric, behavioural and social characteristics of the severely mentally ill in an inner London health district. *British Journal of Psychiatry*, **168**, 410–417.

HOUSE, A. & HODGSON, G. (1994) Estimating needs and meeting demands. In *Liaison Psychiatry. Defining Needs and Planning Services* (eds S. Benjamin, A. House, & P. Jenkins), pp. 3–15. London: Gaskell.

HUXLEY, P. & KERFOOT, M. (1993) Variation in requests for social services departments for assessment for compulsory psychiatric admission. *Social Psychiatry and Psychiatric Epidemiology*, **28**, 71–76.

JOHNSON, S. & THORNICROFT, G. (1995) Emergency psychiatric services in England and Wales. *British Medical Journal*, **311**, 287–288.

NHS TRUST FEDERATION (1996) *Inner City Mental Health*. NHS Trust Federations Mental Health and Learning Disability Standing Committee.

SCHUSTER, M. D. (1995) Psychiatric consultation in the general hospital emergency department. *Psychiatric Services*, **46**, 555–557.

ROYAL COLLEGE OF PSYCHIATRISTS AND BRITISH ASSOCIATION FOR ACCIDENT AND EMERGENCY MEDICINE (1996) *Psychiatric Services to Accident and Emergency Departments. Report of a Joint Working Party of the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine*. (Council Report CR43). London: Royal College of Psychiatrists.

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