Original

Meeting standards set for non self-harm presentations to emergency departments

Diane Mullins, Siobhan MacHale, David Cotter

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Abstract

Objectives: The commonest psychiatric presentation in most emergency departments (EDs) is deliberate self-harm. However, there are other significant categories of psychiatric presentation which include alcohol and substance misuse, acute psychosis and mood disorder.[1] In addition to the NICE Guidelines for deliberate self-harm,[2] there are good practice guidelines available for the management of other psychiatric attendances to the ED. The aim of this study was to identify the psychiatric attendances other than deliberate self-harm to Beaumont Hospital ED over a 12-month period with the objective of studying the rates and characteristics of attendances and to investigate whether good practice guidelines were met.

Method: From a total of 657 psychiatric attendances other than deliberate self-harm which were recorded, data was collected on demographics, provision of a psychosocial assessment and adherence to good practice guidelines.

Results: Alcohol (38%) was the most common reason for presentation. Of the total number of attendees, only 44% received a psychosocial assessment compared to 59% of attendees who had presented following deliberate self-harm during the same 12-month period.

Conclusions: The attendees who did not receive a psychosocial assessment represent a vulnerable group in which the levels of psychosocial assessment need to be improved in order to meet good practice guidelines standards of care.

Key words: Emergency department; Psychosocial assessment; Good practice guidelines.

Introduction

Up to 5% of people attending emergency departments (EDs) present with primary psychiatric problems, while another 20-30% have psychiatric symptoms in addition to physical disorders.[3] The Academy of Medical Royal Colleges (2008)[4] recommended that people with mental health problems should receive the same priority treatment as individuals with physical problems and that liaison services should be subject to the quality standards expected of other medical specialties supporting the ED. The Academy of Medical Royal Colleges[4] proposes that ED staff receive training in mental health issues, including assessment and appropriate response, and that the psychiatry team should have a responsibility for delivering this training.

Table 1: Royal College of Psychiatrists (2004) recommendations for alcohol attendances to A&E

- Screening for problem drinking should be included in routine assessment of patients in A&E
- There should be guidelines for the management of detected problem drinking in A&E
- A named mental health worker should liaise between A&E and mental health services
- There should be local policies regarding the management of intoxication
- Any child or adolescent who is intoxicated should be admitted to hospital

Alcohol places a major burden on EDs and is responsible for 10% or more of all ED attendances.[5] In an attempt to decrease alcohol-related harm, EDs have been selected as a possible base for screening people for alcohol misuse and for the delivery of appropriate interventions.[6-8] Few EDs have comprehensive alcohol detection procedures or intervention practices, and staff perceive considerable barriers to the adoption of a preventive role.[9]

Brief interventions for alcohol problems have consistently been found to be effective in reducing alcohol consumption by about 25-30% in excessive drinkers,[10] in general practice and hospital wards/clinics.[11-14] Several studies have demonstrated the efficacy of ED screening and brief intervention programmes, finding reductions in alcohol consumption and in repeat visits to the ED.[15-24] Simply asking questions about consumption can act as an intervention and reduce the levels of alcohol consumption.[14,25] The Royal College of Psychiatrists[26] recommendations for alcohol attendances to EDs are shown in *Table 1*.

Depression can be a risk factor for subsequent suicide. It is therefore necessary to appropriately assess and manage cases that present to EDs. The Kaplan and Saddock[27] guidelines for the evaluation and management of depression in EDs are shown in *Table 2*.

EDs have assumed an increasing role in the provision of acute psychiatric care in recent years.[28] This has been shown by the presentation and subsequent management of acute psychotic episodes relating to functional disorders or organic conditions. The Royal College of Psychiatrists[26] guidelines for

***Diane Mullins**, Senior Registrar/Lecturer in Psychiatry, Royal College of Surgeons in Ireland, Education and Research Centre, Smurfit Building, Beaumont Hospital, Dublin 9, Ireland.
Email: dianetmullins@rcsi.ie
Siobhan MacHale, Consultant Psychiatrist, Department of Psychiatry, Beaumont Hospital, Dublin 9
David Cotter, Consultant Psychiatrist, Department of Psychiatry, Beaumont Hospital, Dublin 9, Ireland.
**Correspondence*

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Table 2: Kaplan and Sadock (1993) guidelines for the evaluation and management of depression in A&E

- Treat any medical problems that may have resulted from suicide attempts or gestures
- Maintain a safe environment for the patient
- Rule out organic and pharmacological causes of depression
- Make an assessment of the severity of depression to determine the patient's disposal

Table 3: Royal College of Psychiatrists (2004) guidelines on the management of psychosis in A&E

- A&E is not an appropriate setting for the management of functional psychoses, and diversion to the safer environment offered by psychiatric services should be rapid
- A&E staff training should facilitate early detection of psychosis, awareness of organic differential diagnoses and management of acute behavioural disturbance

the management of psychosis in EDs are shown in *Table 3*.

Most previous studies of psychiatric disorder attendances to EDs have focused on deliberate self-harm.[29-35] We sought to examine the non-deliberate self-harm psychiatric attendances to Beaumont Hospital ED over a 12-month period, with the aim of studying the rates and characteristics of attendances in an Irish socio-economically deprived population and investigating whether good practice guidelines were being complied with.

Method

The Beaumont Hospital ED Register was studied to identify all subjects who attended the ED with a presentation suggestive of a psychiatric disorder other than deliberate self-harm over a 12-month period between January 1, 2006 and December 31, 2006. The Register records the name, address, date of birth and reason for attendance for every individual who presents to the ED.

All data was compiled by one researcher following an extensive review of all ED records. Cases were excluded if the presentation was due to deliberate self-harm or found not to be due to a psychiatric disorder. A total of 657 attendees which fulfilled our criteria were identified over the 12-month period. From the case notes of each attendee, data was collected on demographics, provision of psychosocial assessment and adherence to good practice guidelines.

Statistical analysis was performed using SPSS-15 statistical package. For dichotomous variables, chi square tests were used to determine differences in proportions. Binary logistic regression was used to investigate the factors influencing the likelihood of a psychosocial assessment being undertaken.

Results

Hospital characteristics

Beaumont Hospital has 720 beds and is one of the largest major general hospitals in Ireland, providing acute hospital care for the North Dublin area. This is a significantly socio-economically deprived region. The ED covers a catchment area of approximately 250,000 people. During 2006, there were 47,284 attendances to Beaumont Hospital ED, 69.3% of people were admitted as emergencies and 30.7% of people were admitted electively.[36]

Figure 1: Age-sex distribution of the attendees

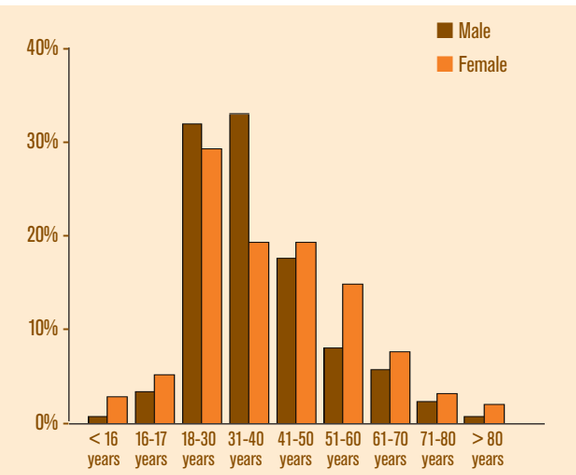
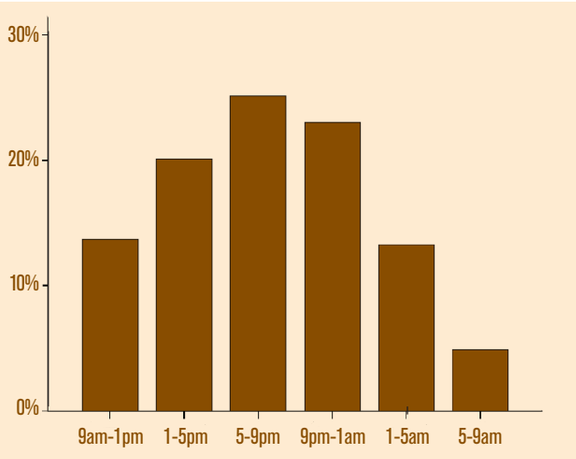


Figure 2: Time of presentation



The Department of Psychiatry in Beaumont Hospital provides a consultation liaison psychiatry service for the ED and the general hospital. The hospital does not have an inpatient psychiatric unit. Psychiatry cover is provided for the ED and the general hospital between 9am-5pm Monday to Friday and 10am-2pm at weekends.

Characteristics of attendances

There were 657 psychiatric attendances other than deliberate self-harm (1% of all attendances during 2006); comprising 538 different subjects were recorded over the 12 month study period. The attendees comprised 339 (61%) males. Of the 657 attendees, 456 (69%) were single, 144 (22%) were married and 57 (9%) were either separated, divorced or widowed. The mean age of males was 38 years old (range 14-85 years old) and 40 years old for the females (range 14-85 years old). The age-sex distribution of the psychiatric disorder attendees is shown in *Figure 1*.

The time of presentation is shown in *Figure 2*. More than half (52%) of the attendees presented between 5pm-1am (Pearson $\chi^2 = 657$, $p < 0.001$).

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Table 4: The overall level of compliance with good practice guidelines

Good practice guidelines	Compliance
Alcohol	
Screening for problem drinking should be included in routine assessment of patients in A&E	This was undertaken in the case of 100% of attendees seen by liaison psychiatry but was not part of the routine assessment of triage or the medical team
There should be guidelines for the management of detected problem drinking in A&E	Clear guidelines in the form of an algorithm have been provided by the liaison psychiatry team on the management of varying severity of alcohol withdrawal
A named mental health worker should liaise between A&E and mental health services	A liaison psychiatry nurse formed the link between the A&E and the psychiatry team
There should be local policies regarding the management of intoxication	Attendees who are intoxicated with alcohol and/or drugs are assessed, although an additional assessment may be warranted when the person is no longer intoxicated. These attendees are offered the appropriate medical and/or psychiatric care following assessment
Any child or adolescent who is intoxicated should be admitted to hospital	100%
Depression	
Treat any medical problems that may have resulted from suicide attempts or gestures	Deliberate self-harm attendees were excluded from the current study. Medical treatment was however offered to 100% of these individuals
Maintain a safe environment for the patient	Not measured but recommended in the training programme
Rule out organic and pharmacological causes of depression	100%
Make an assessment of the severity of depression to determine the patient's disposal	Undertaken in 100% of those attendees who did not leave prior a decision on disposal having been reached
Psychosis	
A&E is not an appropriate setting for the management of functional psychoses and diversion to the safer environment offered by psychiatric services should be rapid	66% of psychotic attendees were transferred to a psychiatric hospital. The speed at which the transfer was conducted was not measured but a rapid transfer is recommended in the training programme
A&E staff training should facilitate early detection of psychosis, awareness of organic differential diagnoses and management of acute behavioural disturbance	Medical staff receive appropriate training as part of a training programme. However, nursing or non-nursing staff do not receive training as part of a structured programme

The reasons for attendance were alcohol (38%), depression (25%), illicit substances (15%), anxiety (13%), psychosis (6%), hypomania (1%) and other causes (2%). Regarding alcohol, the primary reason identified for presentation at triage was alcohol-related. There was insufficient detail to allow the diagnosis of alcohol misuse or dependence. Males outnumbered females for presentations due to illicit substances (77%, Pearson $\chi^2 = 11.577$, $p = 0.001$) and alcohol (74%, Pearson $\chi^2 = 30.458$, $p < 0.001$). Females outnumbered males for depression (57%, Pearson $\chi^2 = 27.490$, $p < 0.001$) and anxiety (60%, Pearson $\chi^2 = 7.672$, $p < 0.001$).

Compliance with international standards

Individuals presenting to Beaumont Hospital ED are allocated a triage rating according to the Manchester Triage System[37] which is determined predominantly by their physical needs rather than their mental state and level of distress. In this system, service users with the highest priority are selected first, not on the basis of diagnosis but instead on an evaluation of the presenting complaints and symptoms using flowcharts to guide the triage nurse's approach.

The liaison psychiatry team assesses and manages mental health problems in the ED. A liaison psychiatry nurse forms the link between the ED and the psychiatry team to encourage closer cooperation between the liaison psychiatry service and the ED. Out of hours service is provided by an adjacent acute psychiatric unit which undertakes emergency assessments, with the option of admission if appropriate.

Screening for problem drinking is included in the routine assessment by the liaison psychiatry team but not by triage or the medical team. Clear guidelines in the form of an algorithm on the management of varying severities of alcohol withdrawal have been provided by the liaison psychiatry team to the ED. The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated. All of the alcohol attendees (100%) who were aged under the age of 18 years (8% of the alcohol attendees) were medically admitted to hospital.

Medical treatment was offered to all attendees (100%) even if they did not wish to receive a psychosocial assessment. In the case of those attendees presenting due to depression, this included ruling out organic and pharmacological causes of depression. The severity of depression was assessed in order to determine the appropriate disposal which included referral to the GP (14%), to the psychiatry outpatient department (26%) or transfer to a psychiatric hospital (33% voluntarily and 1% under the Mental Health

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Act). The remaining depression attendees were either admitted medically, discharged home, or left prior to the decision on disposal having been reached.

The liaison psychiatry team provides a session within the weekly ED medical training programme in order to increase the awareness of the needs of people with mental health problems. The training also incorporates the need for early detection of psychosis, awareness of organic differential diagnoses and management of acute behavioural disturbance.

The liaison psychiatry team has produced an algorithm for the management of acute behavioural disturbance which is incorporated into the training and is available for consultation in the ED. Informal teaching around individual case discussion between liaison psychiatry and a range of ED staff (medical and nursing) takes place on a daily basis.

The majority of psychotic attendees were transferred either by the medical or psychiatry team, to the safer environment of a psychiatric hospital (Pearson's $\chi^2 = 52.518$, $p < 0.001$); 22 (54%) voluntarily and five (12%) on an involuntary basis. *Table 4* demonstrates the overall level of compliance with good practice guidelines.

A psychosocial assessment was undertaken by a member of the liaison psychiatry team in 286 (44%) of attendees. A psychosocial assessment was more often undertaken in the case of those attendees who had presented due to depression (69% of all depression attendees, Pearson $\chi^2 = 16.034$, $p < 0.001$), psychosis (81% of all psychotic attendees, Pearson $\chi^2 = 12.016$, $p = 0.001$), or hypomania (88% of all hypomania attendees, Pearson $\chi^2 = 6.369$, $p = 0.012$). A psychosocial assessment was less often undertaken in the case of attendees who had presented due to alcohol (15% of all alcohol attendees, Pearson $\chi^2 = 68.924$, $p < 0.001$), or illicit substances (28% of all illicit substance attendees, Pearson $\chi^2 = 11.241$, $p = 0.001$). Factors influencing the likelihood of a psychosocial assessment being carried out are shown in *Table 5*.

Significantly more of the females, attendees who disclosed a past psychiatric history, and those who presented during normal working hours, received a psychosocial assessment. The strongest association was for those attendees who presented during working hours and those who disclosed a past psychiatric history. Attendees under the age of 45 years were 0.1 times less likely to be assessed by psychiatry than those over the age of 45 years (Pearson $\chi^2 = 16.67$, $p < 0.001$).

The attendees who did not receive a psychosocial assessment by a member of the psychiatry team in ED are represented in *Table 6*. Of those who did not receive a psychosocial assessment, 178 (48%) were single males under the age of 45 years (Pearson $\chi^2 = 13.123$, $p < 0.001$), 205 (55%) had a past psychiatric history (Pearson $\chi^2 = 47.093$, $p < 0.001$) and 68 (18%) had a past history of deliberate self-harm.

Of the total number of attendees who did not receive a psychosocial assessment 94 (14%) re-attended during the same 12-month period. None of these attendees received a psychosocial assessment when they re-attended (Pearson $\chi^2 = 84.562$, $p < 0.001$).

Table 5: Factors influencing the likelihood of a psychosocial assessment being carried out

Factor	P value	Odds ratio (95% C.I.)
Gender (female v male)	0.03	1.47 (1.04-2.07)
Age (< 45 years v ≥ 45 years)	0.01	0.60 (0.41-0.86)
Disclosure of past deliberate self-harm (yes v no)	0.56	1.49 (0.99-2.26)
Disclosure of a past psychiatric history (yes v no)	< 0.001	2.67 (1.81-3.92)
Time of presentation (9am-5pm, Monday to Friday v out of hours)	< 0.001	2.53 (1.69-3.78)
Medical admission (yes v no)	0.19	1.45 (0.84-2.51)

Table 6: Attendees who did not receive a psychosocial assessment by a member of the psychiatry team in the ED

	Attendees who did not receive a psychosocial assessment by a member of the liaison psychiatry team in the ED	
	N	%
Left after registration but before triage	3	1
Left after triage but before seeing an ED doctor	109	29
Took their own discharge from the ED	20	5
Left after being seen by an ED doctor but prior to a psychiatry assessment	18	5
Discharged home by an ED doctor	169	46
Transferred to a psychiatric hospital by an ED doctor (outside normal working hours)	21	6
Admitted medically	31	8
Total	**371**	**100%**

Discussion

Our study set out to investigate over a 12-month period, attendances indicative of a psychiatric disorder other than deliberate self-harm in order to evaluate if good practice guidelines were being met. The psychiatry team was compliant regarding the routine screening for problem drinking, which however, did not form part of the routine assessment of either triage or the medical team. All of the alcohol attendees (100%) who were aged under the age of 18 years were medically admitted to hospital, which was fully compliant with good practice guidelines. The severity of depression was assessed in order to determine disposal. The majority (64%) of psychotic attendees were transferred to the safer environment of a psychiatric hospital which is considered to be the desirable practice. As is recommended, a clear training programme was provided to medical staff to enhance their understanding of the needs of people with mental illness and to facilitate the early detection of psychosis, awareness of organic differential diagnoses and management of acute behavioural disturbance.

Alcohol misuse constitutes a major problem in our modern

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society and both physical and mental alcohol-related harm result in a large number of ED attendances, thus imposing a significant burden on EDs.[38,39] However, few departments currently offer a comprehensive alcohol screening or intervention service and, although most ED workers support developing a preventive role, the lack of time and staff represents a considerable barrier.[40] This was shown in our study by the fact that triage and the medical team did not routinely screen for alcohol misuse. This was however undertaken by the psychiatry team in Beaumont Hospital ED. Perhaps the employment of key personnel such as alcohol specialist nurses trained in alcohol-related problems might be beneficial in developing a hospital policy for coping with the burden posed by alcohol.

While the triage nurses' accuracy of assessment for medical presentations has been shown to be high,[41] the accuracy of assessment for mental health presentations has been found to be much lower.[42] Triage nurses have expressed their deficient experience and confidence in undertaking psychiatric assessments.[43-45] There is a sense among mental health service users and the general public that psychiatric presentations are triaged lower than medical concerns in EDs.[46,47] The risk of people being under-triaged may be that those at risk leave the ED without being seen and subsequently attempt or complete suicide, or may require subsequent admission under the Mental Health Act.

The Manchester Triage System[37] which is used in Beaumont Hospital ED focuses on physical needs rather than mental state and level of distress. The introduction of a mental health triage system such as the Australian Mental Health Triage System[48] has been recommended by NICE.[2] The latter triage system has been designed to be used by non-mental health staff.

A study conducted by Broadbent[49] looked at the levels of confidence of ED triage nurses both pre and post implementation of the Australian Mental Health Triage System.[47] In that study[49] it was shown that pre implementation, 78% of staff felt under-confident in assessing patients and 65% considered that patients were unnecessarily delayed before seeing a psychiatrist. Post implementation, staff considered that a greater number of individuals were triaged correctly and attended to in a timeframe suitable for the person's condition. Staff also believed that their knowledge and confidence had significantly improved and that their attitudes towards individuals with mental illness had positively changed. Furthermore, triage staff reported enhanced ability to prioritise and organise workloads, engage in effective time management and improve patient satisfaction. There is an urgent need to develop national standards that inform the commissioning of services, thereby guaranteeing that people in need receive prompt assessment and management by appropriately trained professionals.

The time commitment and staff resources required, as well as the brevity of the triage staff contact with attendees to ED, make routine alcohol screening and interventions difficult to implement in routine care.[50-54] The development of comprehensive alcohol screening and monitoring guidelines could however be a positive step in encouraging EDs to respond appropriately to alcohol attendances. Guidelines could offer standardised means of measuring and recording alcohol-related attendances while being mindful of the need for simple, speedy, sustainable procedures which could be easily implemented into current practice.

The importance of training for medical and ED staff with regards to appropriately catering for the needs of people with mental health difficulties should not be underestimated. It is essential that subjects presenting with psychiatric disorders are treated with adequate care and respect. The training programme provided to medical staff in Beaumont Hospital includes guidance on the importance of treating individuals with mental health difficulties with the same care, respect and dignity as other patients. It is also imperative that a sufficient assessment and management of the individual cases is undertaken. The training provided to medical staff in Beaumont Hospital incorporates guidance on early detection of psychosis and transferring psychotic individuals to a psychiatric hospital for appropriate management.

Only 44% of the total number of attendees received a psychosocial assessment. Attendees presenting due to alcohol or illicit substances were less likely to receive a psychosocial assessment than those presenting due to depression, psychosis or hypomania. Other work undertaken by the same research team has shown that 59% of deliberate self-harm attendances during the same 12-month period received a psychosocial assessment.[55]

Conclusion

In the current study, a psychosocial assessment was not undertaken in the case of 48% of the single males under the age of 45 years, 55% of the attendees who had a past psychiatric history, or 18% of attendees who had a past history of deliberate self-harm. Each of these factors are separately associated with an increased risk of suicide. We will re-evaluate the provision of a psychosocial assessment following the proposed introduction of a 24/7 psychiatric service to the hospital. We aim to increase the rate of psychosocial assessment.

The strengths of the study include a relatively large sample size of subjects whose presentation was clearly identified as being due to a psychiatric disorder other than deliberate self-harm. The study was undertaken over a 12-month period. The same person extracted the data during this interval. A weakness of the study was the lack of data on the duration of time it took for psychotic attendees to be transferred to a psychiatric hospital and the lack of documentation on whether the attendees who presented with depression were appropriately maintained in a safe environment. Future studies will endeavour to evaluate these areas more closely.

Good practice guidelines provide recommendations for the management of subjects presenting to the ED with psychiatric disorders. This study showed that we have achieved a significant proportion of these guidelines but have some way to go with regards to improving psychosocial assessment levels and implementing a comprehensive alcohol screening programme for all attendees presenting to the ED. We recommend that all EDs consider formal methods of identifying hazardous drinkers such as the Single Alcohol Screen Question[56] or Paddington Alcohol Test.[57]

Declaration of Interest: None.

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