editorial

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Reforming emergency care: implications for psychiatry

The National Health Service (NHS) plan has arrived (Department of Health, 2001). It heralds a revolution in accident & emergency (A&E) medicine. Acute trusts will have penalties imposed for failing to meet certain targets. Within A&E departments, 75% of patients must complete their attendance episode within 4 hours of arrival. Such completion involves physically leaving the department, having either been admitted to an appropriate ward or discharged home. Within 12 months, the target becomes 90% of all attendees and a year later 100%. How might this affect the users and providers of mental health services?

The A&E department is the major interface between mental health services and acute trusts, yet these trusts are frequently separated not only geographically, but also in terms of goals and priorities. For mental health, the priorities are enshrined within the National Service Framework (Department of Health, 1999), which focuses largely on psychotic illness in contrast to the cases of deliberate self-harm, substance misuse and somatoform disorders most commonly seen in the general hospital (Creed *et al*, 1993; Hislop *et al*, 1996; Dennis *et al*, 1997). Conflict already exists as to whose responsibility such patients are. The penalties, such as missing out on a certain 'Star' rating, incurred by trusts who fail to meet these targets, have the potential to exacerbate such conflicts. A recent audit in a south London teaching hospital showed that even informal admissions to a psychiatric bed took on a mean of 7.5 hours in total; compulsory admissions took 14 hours (A. Hicks, personal communication). Although we accept that our experience in inner London may differ from those in other inner cities, the key point remains – which trust would incur the financial penalties in these cases?

Although scrutiny of waiting times at this interface is long overdue, there may be sound clinical reasons why patients presenting with psychiatric disorder require longer to assess than those with physical health problems. The assessment of psychiatric patients can be time consuming. A rapport needs to be established and frightening or upsetting themes sensitively discussed. Psychological distress can present in a number of guises and the precise nature and severity of the symptoms can be difficult to elicit. Full assessment of the patient's mental state can be made even more difficult by the patient being intoxicated with alcohol, or illicit or prescribed drugs. The option of admitting the patient for 'observation' rarely exists in psychiatry. Psychiatric beds often have occupancy tests well in excess of 100% (Johnson *et al*, 1998; Shepherd *et al*, 1997). Frequent short admissions of patients with personality disorders can also induce dependence and hamper attempts to find more lasting solutions to their problems – admission itself might be counter-therapeutic. Compulsory admission to hospital under the Mental Health Act can be a slow process, with several significant rate-limiting steps. The availability of general practitioners or independent doctors to provide second opinions varies considerably. Contacting them, and the approved social worker, can take several hours and each then has to make their own assessment. Both may wish to discuss admission with the patient's nearest relative, which takes still more time. In some presentations (e.g. deliberate self-harm in intoxicated patients) there is little point in making a detailed assessment of the patient's mental state before they are sober, which may take several hours. Finally, there are logistical problems in locating psychiatric beds that may not apply in other medical specialities. Almost always the patient will be admitted away from the general hospital, often several miles away. Organising transport adds to the delay.

Imaginative solutions to these complex problems need to be found and a debate about the responsibility for the care of psychiatric patients in A&E is needed. Informal admissions could be expedited by the presence of specialist teams, akin to those used for trauma patients. Such teams would consist of psychiatric nurses and doctors with skills in assessing patients presenting with *these problems* in *this setting*. Such teams would need to work closely with community mental health services, arranging appropriate out-patient or in-patient support as indicated, as well as staff within the general hospital itself. The time taken to facilitate a formal admission needs to be addressed separately. The current Mental Health Act was not designed for use in the A&E department and it functions poorly in this setting. It does not seem that this has been addressed in the draft of the new Mental Health Act. Alternative models of compulsory care might warrant consideration, including, for example, the power to detain a person presenting to A&E

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for 24 hours in order to assemble the full team needed to assess properly for a formal admission. Transfer to a psychiatric unit could occur within this time frame.

With the 4 hour limit being applied increasingly rigidly over the coming years, psychiatric patients will form the majority of those 'taking too long' and causing acute trusts to incur penalties. Without a clear pre-emptive strategy to manage this, psychiatric patients, already stigmatised, will be viewed as causing further problems. The A&E department can be an inappropriate environment for those with mental health problems. A realisation that they are a 'problem' may add to their distress. Mental health trusts and acute trusts need to work together, sharing ownership, to address these issues. A better provision of liaison psychiatry services would be a good first step and it is heartening to see the Royal Colleges of Physicians and Psychiatrists already working on an updated version of their 1995 joint report (Royal College of Physicians & Royal College of Psychiatrists, 1995). A national set of standards for the care of psychiatric patients within the A&E department could help, but would be hampered by differences in the provision of psychiatric services across the country, with particular difficulties in London. Nevertheless, the difficulties of adhering to such a tight time-frame will force psychiatrists working in the A&E department to address a fundamental question – is it worth compromising patient care in order to chase an externally-imposed 4 hour time limit?

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