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Psychiatric emergencies

Tom Brown

Despite the frequency with which psychiatric emergencies are encountered in medical and other services, the literature, at least in the UK, is relatively sparse, with little systematic research on either service provision or areas of clinical interest. Services have often evolved in an *ad hoc* way and psychiatric emergencies are often seen by very junior trainees early in their psychiatric careers, with little relevant training. Although the vigilance of the Royal College of Psychiatrists on its approval visits has ensured that most trainees are given advice on the recognition and management of violence (at induction courses at the start of their training), it is not uncommon to find that wider areas of training in emergency psychiatry are neglected. It is still the case, for example, that some postgraduate programmes in psychiatry provide little or no formal training on emergency psychiatry.

Here, I will focus on general issues of service provision, assessment and management of psychiatric emergencies and deal with specific issues including safety and the need for adequate supervision. For a comprehensive account of all of the major clinical aspects of emergency psychiatry see McGrath & Bowker (1987) and Brown *et al* (1990).

Planning services

In the only comprehensive review of emergency psychiatric services in this country, Johnson & Thornicroft (1995) comment that the local planning of such services is rarely guided by a coherent policy. I have found that local mental health strategies scarcely mention the provision of emergency services. Many services suffer from poor planning and tend to evolve in response to crises or complaints. This is particularly unfortunate as emergency presentation is one of the most frequent routes to psychiatric care. Moreover, users and their carers often have strong views about the provision of emergency services, which are not infrequently the cause of complaint or concern (Rogers *et al*, 1993).

Johnson & Thornicroft (1995) highlight considerable differences between services which are available in normal office hours, and those available outside these hours. Facilities less available outside of normal office hours include: specialist emergency clinics, emergency domiciliary assessment, multidisciplinary team assessment and assessments by sectorised services. In Johnson & Thornicroft's study service providers and voluntary groups representing the interests of users (Mind and the National Schizophrenia Fellowship), were asked to identify the greatest weaknesses of the emergency services. Service providers most often identified lack of staffing, poor out-of-hours services and lack of crisis intervention teams as being problematic, whereas the voluntary groups identified problems of access, poor out-of-hours service and lack of crisis beds outside of hospital settings as being most problematic. The authors concluded that those responsible for delivering care should respond to expressions of dissatisfaction by the voluntary groups by developing and evaluating service models designed to provide an effective out-of-hours response.

Box 1 highlights some important characteristics of a good emergency psychiatric service. This can be greatly facilitated by adequate medical management and it is recommended that one consultant be given administrative responsibility for the emergency psychiatric service, while recognising that clinical responsibility will have to be shared. If users and their representatives are to be listened to, services need to be local, accessible and rapidly responsive. They need to take into account the fact that psychiatric emergencies present in a variety of locations, including the community, accident and emergency (A&E) departments, general hospital wards, police cells and courts, as well as in psychiatric emergency clinics. Although, for resource reasons, it is unlikely that the same service will be

Tom Brown is Consultant Psychiatrist at St John's Hospital at Howden, Howden Road West, Livingston EH54 6PP. He has a special interest in liaison psychiatry.

available out-of-hours, a good service has to be available 24 hours a day and out-of-hours arrangements need to be clear. There should also be a clear policy for dealing with special groups, including children, adolescents and the elderly. The psychiatric service will establish clear lines of communication to other key services, including other hospital services, social workers and the police. It is helpful to produce written guidelines for the service, which should include a brief and easy-to-understand guideline for users and carers. More comprehensive guidelines are needed for those running the service and other professionals, for example, GPs, A&E departments and social workers. This document, as well as containing necessary information on the administration of the service, should also highlight important policies and contain a list of key contacts and their telephone numbers. Emergency services should also pay considerable attention to the issues of safety and training and supervision of staff.

Services need to be appropriate to the needs of those who use them; what is required in central London may be quite different to the kind of service needed in the Scottish Borders. Audits of emergency attenders can be informative in this regard. McKenzie & Mackie (1993) studied attenders at the Royal Edinburgh Hospital Emergency Psychiatric Service, and noted high rates of self-referral. The people who referred themselves were young, unemployed men, who were often poorly integrated, misused substances and had significant forensic histories but only mild levels of psychiatric disorder. Only 10% of self-referrals were considered appropriate psychiatric emergencies (compared with 69% of those referred by GPs), and very few self-referrals required admission. The authors commented that emergency clinics must not confine themselves simply to assessment of mental disorder, but seek to facilitate crisis resolution. Other surveys have similarly highlighted that self-referral is common and often not associated with psychiatric disorder. It is likely that people present to hospital-based services largely because they are open 24 hours a day, although other types of services may be more appropriate to the needs of these patients.

Box 1. Characteristics of a good emergency psychiatric service

- Accessible to service users
- Able to respond rapidly
- Available 24 hours a day
- Able to deal with emergencies arising on a variety of sites: A&E departments, general hospital wards, the community, police cells and courts
- One consultant has administrative responsibility
- Clear arrangements for special groups, e.g. children and adolescents, the elderly
- Access to other services, e.g. social work, police
- Clear lines of communication (within the service and to and from other services)
- Attention to safety, training and supervision

Assessment and management

Telephone referrals

Although there has been a growth in walk-in emergency facilities accepting self-referrals, it remains the case that more emergency referrals to psychiatric services are made over the telephone by GPs, the police and social workers than by patients and their carers. It is important at this early stage to obtain the necessary information to allow an immediate decision to be made as to whether the service is appropriate for the patient – the service may have a defined catchment area, may have policies for dealing with children, adolescents and the elderly, or it may be that the referral should go to another service. If the patient is known to the service, the telephone contact should be used to gather enough information to allow the patient's case notes to be obtained, which will allow more thorough preparation for the assessment. It is important that the referrer's expectations are clarified, for example, do they want a home visit, a hospital admission, or simply an urgent assessment?

When talking on the telephone the issue of confidentiality is paramount. Information should not be given over the telephone unless the clinician is clear who they are talking to and knows that the caller is entitled to have that information. It is not unusual for people to telephone psychiatric emergency services to obtain information (police and social workers regularly do this). Information should not be given to third parties without the consent of the patient.

Preparing for assessment

It is important at this stage to collect all information already available about the patient and to make suitable arrangements for the assessment. Sources of information will include case records, but also other staff who may know the patient. Many patients attending the emergency service already have

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keyworkers, in the psychiatric services or in other statutory services. Much time can be saved by consulting at this stage with the keyworker. The focus should be on acquiring information relevant to making an immediate management decision, including:

(a) nature of previous psychiatric contact;
(b) any current contact with psychiatric services;
(c) any contact with other services;
(d) any recent change in contacts (this is a common reason for presenting to emergency services) – does the patient often present as an emergency? If so, why? For example, alcohol misuse, relationship break-up, homelessness, financial crisis;
(e) are there particular problems associated with their contact, such as, violence, substance misuse, self-harm?

Having acquired such information the next step is to ensure that the arrangements are adequate. This makes the clinician's job in assessing the patient easier, and also puts the patient at their ease. There should be a safe, suitably equipped room available to interview the patient (see below). Other staff who need to know about the patient's arrival, including reception staff, need to be informed. It is normal for the clinician to see the patient alone, although the question should always be asked as to whether this is appropriate, particularly in patients with a past history of violence or disturbed behaviour, or if there is anything about the presenting problem, or indeed the patient's appearance and demeanour, which alerts the clinician to the potential for violence. Anyone accompanying the patient who may have important information should not be allowed to leave until they have been seen.

Assessment interview

The clinician should introduce him/herself, and anyone else present (medical student, nurse) and should ask the patient's permission for any third party to stay, unless the risk of violence necessitates that the patient is not seen alone. As most patients attending emergency assessments are anxious, the clinician should tell the patient what they already know about the problem and acknowledge that they understand the patient's anxiety. It is important at the beginning of an interview to let the patient talk uninterrupted for a few minutes (assuming they can do this). This yields useful information about the patient's mental state while demonstrating a willingness to listen. It is important that the interview is structured, otherwise important things may be omitted. Although the history should focus on main current problems and their precipitants, and identify the patient's expectations, the normal key areas for enquiry in a routine interview cannot be omitted with impunity. They should, however, be focused in a way that will enable the clinician to deal with the current crisis (Box 2). Not all patients will give this information, for a variety of reasons, some of which will be directly related to their current mental state. A variety of techniques have been described in dealing with such difficulties in emergency psychiatry (Brown *et al*, 1990).

A full mental state examination needs to be carried out in every case, where possible. It is, however, recognised that at times this will not be possible, for example with patients who are mute, stuporous or simply uncooperative. Assessment of suicidal ideas should be carried out in every case, and in some cases an assessment of risk of harm to others will be needed (Royal College of Psychiatrists Special Working Party, 1996). Testing of cognitive functioning in emergency assessment will of necessity be guided by the patient's age, physical condition and by the history. Cognitive functioning assessment would normally be more detailed in an 80-year-old woman with comorbid physical illness, presenting with memory loss, for instance, than in a 20-year-old

Box 2. History-taking in emergency assessments

List current problems and their precipitants
Why are they presenting now?

Past psychiatric history
Is the current presentation similar to previous presentations?
What treatment helped before?
History of self-harm?

Medical history
Is there a medical problem which could explain the presentation?
Is there a medical contraindication to your proposed treatment?
Would drug side-effects/toxicity explain the presentation?

Family history
Does family history provide a clue to diagnosis?

Personal history
Identify previous crises and how they were dealt with

Social history
Any substance misuse?
Recent change in social circumstances?

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having a panic attack. Assessment of conscious level, orientation for time and place and short-term memory are mandatory with all patients, and if these reveal abnormalities, fuller testing may be necessary.

Physical examination may be an important part of the assessment of people presenting as psychiatric emergencies, and although it will not always be carried out, there is good evidence that psychiatrists do far too few physical examinations (Viner *et al*, 1996). In particular the psychiatrist cannot assume that the patient who has been referred by another doctor has already been examined. I have seen patients with subdural haematomas, transient ischaemic attacks, cardiac failure and Klebsiella pneumonia sent to a psychiatric emergency service, as their key presenting features were mental state abnormalities. It is important to remember that physical and psychiatric problems commonly coexist and that physical illness may either precipitate psychiatric illness, or may present with psychiatric symptoms. One potential pit-fall is the patient smelling of alcohol, in whom mental state abnormalities, such as drowsiness, and physical abnormalities, such as ataxia, are often assumed to be due to intoxication. Such assumptions can be disastrous in light of the associations between alcohol, head injury, subdural haematoma, hypoglycaemia and epilepsy.

Immediate management of psychiatric emergencies

After assessment a decision will be required as to whether or not the person needs psychiatric treatment. If they have clear psychiatric illness, the answer to this question will probably be 'yes'. It may be that after initial assessment the presence or absence of psychiatric illness remains uncertain, in which case further assessment may be required and a decision will need to be made as to whether this can take place as an out-patient or an in-patient.

The level of arousal of some patients in emergency situations can lead to overuse and even misuse of drug therapy, and the temptation to resort to this should be resisted. Explanation, reassurance and support, simple behavioural techniques (e.g. anxiety management) and crisis intervention techniques (Bancroft, 1979) can all be useful. Any relevant concurrent physical illness should also be dealt with. When assessing the need for urgent treatment and/or admission, a number of things need to be considered (see Box 3). Admission is usually appropriate in the presence of severe illness, marked self-neglect and a high risk of harm to self or others. The use of emergency detention orders under the Mental Health Act often arises and training in this is important. Junior trainees tend to be preoccupied with risk of suicide or harm to others, and sometimes fail to recognise that patients can be detained in the interests of their health, without there necessarily being a risk of suicide or of harming others. Recent studies have looked at the factors associated with the decision to admit patients presenting as emergencies to hospital (Rabinowitz *et al*, 1994, 1995; Taylor *et al*, 1996). The most consistent findings are that self-referrals are admitted considerably less often than referrals from other sources, and that patients deemed to be at risk of self-harm and patients suffering from psychotic illness are more likely to be admitted. Taylor *et al* (1996) noted that, compared with subjects assessed at home, those assessed at the psychiatric hospital were more likely to be admitted.

Merson *et al* (1996) compared the costs of treating psychiatric emergencies in hospital and in the community. Patients presenting as emergencies were randomly allocated to either a community-based or hospital-based service and their use of a range of services subsequently recorded and costed. The use of non-psychiatric services was similar for both groups, but the use of psychiatric services differed: total treatment costs of the community group were considerably lower than those of the hospital group, suggesting that a community-based psychiatric service is a cost-efficient alternative to hospital-based care for patients presenting as emergencies.

Not all the people who present to psychiatric emergency services require psychiatric follow-up and treatment. Many people may have considerable personal problems, and a good psychiatric emergency service ought to be able to direct them to other appropriate sources of help. My service has a booklet available for patients (produced by a local user group) detailing how to contact resources which may be helpful, for example, social workers, councils

Box 3. Factors to consider in assessment of need for urgent treatment and/or admission

- Severity of illness
- Ability to care for self (is there evidence of neglect or emaciation?)
- Risk of self-harm
- Risk of harming others
- What other supports are available?
- Level of insight? (If insight is poor and the person is not admitted, contact may be lost)
- Age (the very old may be vulnerable)
- Need for supervision (e.g. with medication)
- Need to clarify diagnosis/severity of illness

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on alcohol, self-help groups, religious organisations, marriage guidance and voluntary organisations. Some patients in crisis may not be able to contact such agencies themselves and initial help may need to be given in making these contacts for them.

Safety risk and management

It is of paramount importance that issues of safety, security, risk assessment and management are accorded a high priority by those managing emergency services. A useful account of the assessment and management of risk of harm to others (including staff themselves) has been produced by the Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk (1996) and this should be available to service managers and those directly involved in providing the psychiatric emergency service. This document details the responsibilities of service managers with regard to risk assessment and management (Box 4).

Safe environment

No environment is completely safe, but there are things which can be done to reduce the risk of harm. A balance has to be struck between the need for privacy and confidentiality, and the need to reduce risk of harm. Although it is preferable to see patients alone, this is not always possible, particularly in those with a previous history of violence or who are overtly threatening. Attention needs to be paid to the interview room itself. It should be comfortable and in a quiet setting, but accessible to other staff. Potential weapons should be removed, as far as is possible (e.g. heavy glass ashtrays, paperweights). The room should have a door which opens both ways, and an emergency buzzer accessible to the interviewer, and which when pressed guarantees an immediate response. It is also recommended that the room has a window (made of unbreakable glass), to allow others to see in if necessary. A mistake regularly made is to ensure that safe interview facilities exist in psychiatric emergency clinics, but to fail to ensure that these facilities exist in other places where psychiatric emergencies present. This is particularly true of A&E departments.

Box 4. Resposibilities of service managers in risk assessment and management

- To prioritise allocation of resources to assessment of those at increased risk of harming others
- To provide a safe environment in which to carry out assessments
- To develop a risk management strategy with clinicians including policies on clinical assessment, training, serious incident review and audit
- To ensure adequate supervision from senior staff
- To assess training needs and provide training
- To develop links with other agencies involved in managing individuals atsignificant risk of harming others

Assessment and management of risk of violence

Those providing psychiatric emergency services need to ensure that all staff are trained in the assessment and management of risk of harm. The interview skills required in dealing with such patients should be taught to trainees early in their careers. They are described by McGrath & Bowker (1987) and Brown *et al* (1990) and more comprehensively by Betts & Kenwood (1992). Although some disorders are associated with violence (e.g. antisocial personality disorder, paranoid psychosis, mania and organic brain syndrome) aspects of an individual's history and mental state are more important than diagnosis *per se* in making a judgement about the seriousness and immediacy of risk (Box 5). Where trainee psychiatrists identify a risk of violence, they should always discuss the management plan with a more senior colleague. Issues that should be covered by the management plan are shown in Box 6.

After any incident of threatened or actual violence, services need to have a system to ensure adequate recording of the incident and a mechanism for post-incident review involving senior colleagues.

Training and supervision

Working as part of a psychiatric emergency service should be an educational experience, yet for many trainees it is frequently the least rewarding part of their job. There are many reasons for this, including the fact that many people who use psychiatric emergency services are not suffering from a psychiatric disorder. Another common cause for complaint, however, is that training and supervision

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Box 5. Factors of particular relevance in assessing risk of violence

History
Previous history of violence
Poor compliance with treatment
History of substance misuse
Social rootlessness (poor employment record, frequent changes in domicile, lack of supportive relationships, etc.)

Mental state
Persecutory delusions
Delusions of passivity
Actual threats of violence
Emotional states linked to violence (e.g. irritability, hostility, sense of grievance, shouting or talking loudly)
Behaviour (e.g. pacing, refusing to sit down, invading personal space)

in the areas of emergency work are neglected. It is attendant on those providing psychiatric emergency services to ensure that those working in them have adequate training and supervision. Some of the essential components of a training programme in psychiatric emergencies are listed in Box 7. This list is not exhaustive but highlights areas of training which need to be given prior to a trainee's involvement with an emergency service.

Consultants responsible for supervising junior doctors doing emergency work face a number of problems. In some large services the consultant may not know the trainee for whom they are providing on-call cover and in some situations they may even work in a different hospital. This can increase the trainee's reluctance to ask for adequate supervision

Box 6. Key issues for the management plan

Need for admission
Need for detention in terms of the Mental Health Act
Level of security needed (e.g. locked ward)
Observation levels required to manage the patient effectively
Need for medication
Need for physical restraint
Need to involve the police (i.e. if threatened or actual violence persists, despite adequate attempts to manage the situation)

Box 7. Essential components of a training programme in psychiatric emergencies

Assessment and management of deliberate self-harm
Assessment and management of risk of harm to others
Use of the Mental Health Act
Use of crisis intervention techniques
Dealing with difficult or uncooperative patients

and support and this leads to a tendency to call consultants only as a last resort. There is a case for making it mandatory for trainees at the beginning of their training to contact consultants about all cases they see. However, supervision over the telephone between a consultant and a trainee who do not know each other is unsatisfactory and must be augmented by other arrangements. The trainee needs to be able to have supervision from his own consultant after a night on call, particularly in the early stages of their training. In Scotland, the Mental Welfare Commission has recently expressed concerns about the level of supervision received by trainees doing out-of-hours emergency work, again emphasising the need for this to be taken very seriously.

The Royal College of Psychiatrists (1994) suggests that in at least five cases the consultant supervisor should see the patient with the trainee and observe the trainee assessing the patient. Many consultants balk at this, citing pressure of work and time as reasons why this is not feasible, but it should be regarded as time well spent. It may not be unreasonable to ask a consultant to spend a day with trainees at the beginning of their training and to see emergency presentations with them. In some cases the consultant could carry out the assessment in front of the trainee. This is something trainees find enormously helpful and should not be underestimated as a teaching tool. Likewise, the opportunity for the trainer to observe the trainee face to face is extremely valuable, and although it requires an initial investment of time, it can be an efficient use of time in the long term. Much more can be learnt by observing trainees in this situation than by having the trainee present a case orally at a later date.

The provision of a good doctor's handbook can be very useful to new trainees working in emergency services. In addition to detailing administrative arrangements, some handbooks contain valuable guidelines on the management of particular problems, such as deliberate self-harm, substance misuse, etc.

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Feedback

Supervision arrangements for emergency services should include the opportunity to give feedback to a consultant or senior/specialist registrar at the end of the period on call. This should be in addition to, and not instead of, any contact required during the time spent on call. This gives the trainee the opportunity to discuss all the patients they have seen and their management, making emergency work a useful and important part of training in psychiatry.

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Multiple choice questions

1. The following were identified by user groups as weaknesses of emergency psychiatric services:
   a lack of access to consultant psychiatrists
   b inadequate out-of-hours service
   c poor local access to services
   d lack of crisis beds, other than in hospitals
   e reluctance to prescribe psychotropic drugs.

2. The following are characteristic of those who self-refer to psychiatric emergency clinics:
   a most are suffering from psychotic illness
   b poor social integration and other social problems are common
   c substance misuse is more common in self-referral patients than in those referred by GPs
   d most self-referrals require admission
   e psychiatric disorder is more common among self-referrals than among GP referrals.

3. The following are important in determining the need for admission in patients presenting as psychiatric emergencies:
   a the patient's age
   b evidence of self-neglect
   c the patient's level of insight into their illness
   d need for supervision with medication
   e risk of harming others.

4. The following are important in assessing the risk of violence in a patient:
   a the ethnic origin of the patient
   b previous history of violence
   c history of poor compliance with treatment
   d history of deliberate self-harm
   e the presence of persecutory delusions.

5. The following are common errors among trainees working on psychiatric emergency service:
   a unnecessary physical examination of patients
   b a tendency to focus on risk of self-harm or harm to others rather than on risk to the patient's health, when considering detention
   c reluctance to contact the consultant on call
   d over-reliance on drug treatments, particularly in very aroused patients
   e over-reliance on the diagnosis as a guide to need for admission.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a F
b T	b T	b T	b T	b T
c T	c T	c T	c T	c T
d T	d F	d T	d F	d T
e F	e F	e T	e T	e F

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