GLOBAL LAW ENFORCEMENT AND PUBLIC HEALTH ASSOCIATION
MENTAL HEALTH SPECIAL INTEREST GROUP

# Mental Health, Distress and the Emergency Department
# NATIONAL SUMMIT
# 18 October 2019, Edinburgh, Scotland
# Communique

Care pathways for people in distress or with mental health problems who present to emergency departments or services are inadequate. This is a global issue, and one which profoundly affects Scotland. A coherent multi-agency whole system national strategy is urgently needed in order to prevent potentially avoidable poor health and justice outcomes of those affected. On 18 October 2019, at the Law Enforcement and Public Health Mental Health Special Interest Group Summit, 85 delegates met to discuss the current situation domestically and internationally.

The purpose of the Summit was to *develop plans for best inter-agency practices for dealing with mental health and distress in or around the emergency department, with a further aim being that these be applicable to national and international implementation.* Delegates included people with lived and living experience, doctors, nurses, police officers, paramedics, academics, and policy makers. Experiences were shared with particular attention paid to examples of innovations in service delivery locally and internationally, and models of care that sought to address what were considered as key components required to improve responses to those presenting to emergency departments or services in mental health distress. *Seven key areas were highlighted for action:*

1. ***Police time in ED & the four-hour waiting time:*** Police are spending a disproportionate amount of time in ED with people in mental health distress. In Scotland, the four-hour waiting time metric is in force in EDs, and while this is applicable for physical health, it is much less appropriate for people presenting with symptoms of distress or mental ill-health. People presenting in distress have the right to person-centred, trauma-informed approaches that are free from stigma and discrimination. A time-pressured response is not conducive to creating a safe, dignified and trusting environment for disclosure; a more sophisticated person-centred triage system co-managed with practitioners with expertise in managing distress or mental ill-health will improve patient experience.

2. ***Intoxication and distress in ED:*** Current arrangements between health and police to support people who present to the ED as intoxicated are inadequate. For the purposes of ED assessment, there needs to be an agreement regarding what constitutes intoxication and the methods by which this is reliably determined. The four-hour waiting time metric operating in Scotland is frequently inappropriate for dealing with intoxication, and alternative environments and care pathways with longer timelines within ED should be explored.

3. ***Alternative care pathways:*** Mental health problems and distress should be addressed in the community where possible, with ED being the last resort. There is a need to move away from the use of police custody as a 'safe' place. Focus should be on primary health prevention, and building local community responses, including those that operate out of hours. Alternative pathways should incorporate health care practitioner engagement co-located with other services in a 'community hub' model, as well as 'self-healing trauma-informed communities', which draw on resources like Recovery Colleges.

4. ***Alternative safe spaces to ED or in the ED environment:*** In order to justify going to ED, people in distress may feel a pressure to present as the most distressed version of themselves. Instead, people expressed a need for a place where they can make a meaningful connection with others, to enable feeling safe, supported, validated and compassionately heard. A dedicated community, or ED-based, safe space could potentially de-escalate the need for most severe presentations. Safe space should be triaged depending on levels of risk to self or to others, with consideration given to ruling out potential 'masked' serious head

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injury, and with minor first aid services administered safely and with compassion in safe settings. Safe space needs to be quiet with few distractions, and where people can be supported without restraint whenever possible.

5. ***Managed discharge from ED:*** There are clear gaps in the provision of care for people once discharged from ED; as such, basic safety and wellbeing needs are potentially left unaddressed. People can feel unsafe to leave the ED and would benefit from active signposting and/or 'warm' (personal introduction) handovers to other agencies. Out of hours signposting is a particular gap which requires better attention, and these services and agencies should be community-based, with flexible access hours to allow for a continuity of support. Best practice indicates that follow-up after discharge should routinely be offered, and in consideration of combined navigator/ peer support worker model.

6. ***Children & Young People:*** It is vital to believe children and young people when they say they want to harm or kill themselves. The emphasis of the approach to responding to children and young people who present to ED needs to be on prevention and early intervention, with sensitive consideration given to early life adversity, those living in more deprived communities, and RFG patterns (recency, frequency and gravity). Age thresholds for defining children and young people remain unclear and inconsistently operationalised, therefore, they must be specifically formalised. The ongoing service gap between referral and triage by Child and Adolescent Mental Health Services (CAMHS) needs to be addressed and other equivalent community-based alternatives actively explored; access to early help is difficult when the only referral pathway is to CAMHS. A concordat that clearly sets out the agreed upon roles and responsibilities for and between agencies is required, along with regular multi-agency roundtable meetings to ensure the concordat needs are being met.

7. ***Information, intelligence, data & technology:*** People with lived or living experience of distress or mental health symptoms who use emergency services expect information sharing between health, ambulance and police services, and were shocked this is not routine practice. People indicated a willingness to carry cards or use an electronic platform which sits outside of health (e.g. an app or website) to provide co-constructed (police, health or peers) information on e.g. de-escalation strategies, or self-completed advanced directives that can be accessed by police, paramedics and other relevant services. Individual preferences regarding differential levels of access would need to be determined in advance and adhered to. Enshrined in advanced directives should be any specification to override wishes in an absolute emergency. Deterioration of symptoms monitored via technology should be discussed as an option.

Summit participants agreed that urgent, collaborative action is required to improve care pathways and associated outcomes of people presenting to emergency departments with mental health distress. Delegates agreed that no one service has sufficient resources or skills to adequately meet the needs of people who present in distress or with mental health symptoms. Delegates made a commitment to whole-system approaches with ongoing collaborative discussions with the aim of leading to reform of the health and justice systems.

The Policing, Health, and Social Care Consensus Statement[1], published in February 2018, provides an excellent springboard to identify common ground across the health and justice sectors to help shape and guide these ongoing discussions. Further, resources such as the Emergency Services Hub, developed by the Royal Society for Public Health[2], provide a starting framework for developing consensus statements and operationalising the collective vision and opportunities afforded by a joined-up approach to responding to mental health distress that is evidence-based and utilises shared resources and capabilities.

## References

1. https://www.npcc.police.uk/Publication/NEW%20Policing%20Health%20and%20Social%20Care%20consensus%202018.pdf
2. https://www.rsph.org.uk/our-work/resources/emergency-services-hub.html