4 EQUITABLE, ACCESSIBLE SERVICES

To provide equitable, accessible, comprehensive mental health services for all the people of Wales based on need, irrespective of where they live, their age, gender, sexuality, disability, race, ethnicity or their social, cultural and religious background.

National Service Framework: key action 13 and 23

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

Any individual with an identified serious mental illness should be able to contact local services on a 24-hour basis in order to have their needs assessed and receive appropriate advice, treatment, care and/or support. [key action 13 paragraph 18.4]

Out of hours access to services, including CMHTs, should be available during public holidays, at weekends and during the evening. [key action 23 paragraph 24.1]

What is the impact of providing 24 hour support and out of hours care?

The *statements* | The *evidence*

4.1 Extended and out-of-hours care

4.1a The project showed the potential of **nurses** to meet the demands of an **out-of-hours on-call service**. Of the 88 patients referred during the pilot period, 33 (37.5% of the total) were admitted to psychiatric wards and four to medical wards. Although a range of professionals was needed during the 12-week period, the nurses dealt with 42 (47.7%) of the referrals without any other professional involvement. On 33 occasions (37.5%) the junior doctor was involved, turning these figures around, the junior doctor was not disturbed on 55 occasions (62.5%) where prior to the pilot scheme, they would have been required to respond to the referral.[i] **Caveat:** Findings must be treated cautiously as the pilot scheme only ran for 12 weeks and authors state patients' questionnaire response is low (though rate is not reported).

i Beech B, Parry L, Valiani D. A pilot project to determine the demand for and utility of an out-of-hours psychiatric service run by on-call psychiatric nurses in an A&E department. *Journal of Psychiatric and Mental Health Nursing* 2000; **7**: 547-553

(Type III evidence – 12 week pilot study of an out of hours liaison project delivered by 2 psychiatric nurses between 10pm and 8am at an A&E department in the Midlands. The project aimed to reduce pressures on on-call junior doctors. Data were collected on day and time, length of contact, diagnosis and disposal. Patients and 21 medical and nursing A&E staff completed questionnaires to determine their satisfaction with the service.)

The *statements*

The *evidence*

4.1b Results indicate that both a **primary care-based** model of service delivery and an **extended day hospital service with secondary care** reduced overall needs and the users' need for information (p<0.01). The mean number of needs reported in the **Primary Care Mental Health Team** (PCMHT) fell from 7.97(SD 2.88) to 6.97(3.00) (z=2.97, p<0.01). In the extended day hospital sample the mean number of needs fell from 8.71(3.08) to 5.59(2.83) (z=3.94, p<0.01). The primary care service also reduced the need for help with psychotic symptoms (p<0.05) whereas the secondary care service reduced users' need for help with benefits (p=0.01) and occupation (p=0.01). There were no major differences in terms of satisfaction or quality of life. Primary care-based services therefore appear to have the potential to be as effective as more traditional secondary care services. However, a more comprehensive range of services is required to address the whole spectrum of needs, a conclusion supported by the views of staff and carers. [i]

i. Secker J, Gulliver P, Peck E, Robinson J, Bell R, Hughes J. Evaluation of community mental health services: comparison of a primary care mental health team and an extended day hospital service. *Health and Social Care in the Community* 2001; **9(6)**: 495-503

(Type IV evidence – survey of users of a primary care mental health team in England (PCMHT, n=50) and an extended day hospital service providing 24 hour secondary care for people with serious long-term mental illness (EDH, n=35). Focus group discussions were held with 7 carers of PCMHT users and 1 EDH user, and the views of staff members were examined. Data were collected at 3 points over 18 months.)

4.1c Although the aims of the new **extended hours community mental health service** included reducing in-patient utilisation and improving social functioning, there were few significant differences between the 2 groups. While the number of admissions (1.9 for the post-CMHT group compared with 2.5 for the pre-CMHT group) and length of stay were lower in the post-CMHT sample, most were admitted rather than treated in their homes by the CMHT. Better outcomes might have been achieved if the aims of the Community Mental Health Team (CMHT) had been limited to **either crisis or rehabilitation** interventions, but not both. More attention needs to be paid to the service context in which model programmes are introduced can be more closely tailored to the realities of what is likely to be achievable.[i]

Caveat: The results of this study may have limited generalisability to UK setting.

i. Habibis D, Hazelton M, Schneider R, Bowling A, Davidson J. A comparison of patient clinical and social outcomes before and after the introduction of an extended-hours community mental health team. *Australian & New Zealand Journal of Psychiatry* 2002; **36(3)**: 392-398

(Type IV evidence –naturalistic study of 2 matched groups of seriously mentally ill patients (37 patients in each group; 15-65 years of age) one recruited prior to the addition of an extended hours community mental health team (CMHT) to a mental health service in Australia, and one following introduction of the new service. Primary outcomes measured clinical data, activity levels and social relationships at 12 months follow-up.)

4 EQUITABLE, ACCESSIBLE SERVICES

The *statements* | The *evidence*

4.2 Mental health triage

4.2a A limited **overnight nurse triage service** was ineffective on its own as a means of reducing the **out-of-hours workload** of junior doctors, and even slightly increased it. A more comprehensive triage service, with a greater range of alternatives to admission, might have had a different result. The number of 'work episodes' went up especially during the night shifts from (4.8 shifts 95%CI 4.4 – 5.3, to 8.4 95%CI 6.8-10.0, p<0.001), but the average length of each episode went down (at night 39.3 minute episodes 95%CI 35.0 – 43.6, to 29.0 minutes 95% CI 24.2 – 34.1, p<0.001). The net result was a slight increase in workload in terms of total time spent dealing with episodes, most notably at night. [i]

i. Moore AP, Wilmott S. Does a limited nurse triage service reduce junior doctor psychiatric on-call workload? *Psychiatric Bulletin* 2004; **28**: 268-370

(Type IV evidence – observational study to investigate whether nurse triage might reduce 1 junior doctors' on-call workloads in a general adult psychiatry in-patient unit in Crewe, UK. The sample size was 205 pre-triage shifts and 90 post-triage shifts. Changes in workload after the introduction of a limited (overnight and weekend mornings) nurse triage service on the unit were compared with pre-triage work levels with levels 1 year later.)

4.2b The **Mental Health Triage Scale** brought about significant change to the **assessment and triage** of clients with mental health problems in the Emergency Department. Nurses' confidence in triaging clients with mental health problems improved; at pre-implementation only 6 nurses (26%) were moderately to very confident, rising to 26 (96.2%) post implementation. Perceptions of timeframe to intervention by mental health staff also rose; at preimplementation 6 nurses (26%) felt clients with mental health problems were seen in an appropriate timeframe, increasing to 24 (88.8%) perceiving suitable timeframe to attention postimplementation. [i]

Caveat: The results of this study may have limited generalisability as only a small sample participated in this Australian study.

i. Broadbent M, Jarman J, Berk M. Improving competence in emergency mental health triage. *Accident and Emergency Nursing* 2002; **10**: 155-162

(Type III evidence – evaluation of the implementation of a Mental Health Triage Scale (MHTS) at an Emergency Department (ED) in Australia. The scale was designed to highlight mental health emergencies and aid the triage staff to assess and appropriately refer clients to a 24- hour, 7 day a week Mental Health Triage Service. Of the 30 ED triage staff, 23 completed questionnaires pre-implementation, and 27 staff returned questionnaires after the implementation of the MHTS.)

The *statements*

4.2c A substantial proportion of **deliberate self-harm** (DSH) patients discharged directly from accident and emergency (A&E) departments do not receive a **psychiatric assessment.** Nonassessed patients may be at greater risk of further DSH and completed suicide than those who are assessed. Of DSH patients who were discharged directly from the A&E department 58.9% did not have a psychiatric assessment. Nonassessed patients were more likely to have a past history of DSH, to be in the 20-34 year age group, and to have exhibited difficult behaviour in the A&E department. Patients presenting between **5 p.m. and 9 a.m.** were less likely to be assessed than those attending between 9 a.m. and 5 p.m. Further DSH during the subsequent year occurred in 37.5% of the nonassessed patients compared with 18.2% of matched assessed patients. They were also more likely to have psychiatric treatment. [i]
Caveat: Only 62 GPs (70.5%) responded for the nonassessed group and 59 (67.0%) for the control group.

The *evidence*

i. Hickey L, Hawton K, Fagg J, Weitzel H. Deliberate self-harm patients who leave the accident and emergency department without a psychiatric assessment. A neglected population at risk of suicide. *Journal of Psychosomatic Research* 2001; **50**: 87-93

(Type IV evidence – cohort study examining the characteristics of DSH patients discharged from an Oxford A&E department comparing those who had a psychiatric assessment (n=101) with those who did not (n=145). The outcome of a group of patients who did not receive a psychiatric assessment was compared with that of a group of patients who were assessed in 88 matched pairs via questionnaires with their general practitioner and medical records for the 1 year period after their index hospital presentation.)

4 EQUITABLE, ACCESSIBLE SERVICES

The *statements*

4.2d The emergency department (ED) mental health triage and consultancy service positively impacted on the functioning of the emergency department. Evidence was provided regarding the value of the **emergency mental health triage and consultancy service** and highlighted the advanced practice role undertaken by **mental health nurses** in this position. This was evidenced by staff' perceptions regarding the value of the service and through shorter "seen by times", a reduction in the number of patients with psychiatric/psychosocial problems who left the department without being seen, and the effective management of patients presenting with psychiatric/psychosocial problems, particularly those presenting with deliberate self-harm.[i]

Indepth interviews with 11 ED doctors and nurses found staff perceived that the service made a valuable contribution to the overall functioning of the ED and the advanced practice role undertaken by mental health nurses in the ED.[ii]
Caveat: The response rates to the survey were extremely low which could have introduced bias. The study results may have limited generalisability to a UK setting.

The *evidence*

i. McDonough S, Wynaden D, Finn M, et al. Emergency department mental health triage consultancy service: an evaluation of the first year of the service. *Accident and Emergency Nursing* 2004; **12**: 31-38

(Type IV evidence – review of the first year of a night emergency department mental health triage and consultancy service (EMTaCS) in Australia, established following a 3 month clinical trial. During the first 12 months data on key performance indicators were entered into a EMTaCS database. In addition, 33 staff (22%) completed a satisfaction survey prior to the service being implemented, and 47 staff (31% response rate) completed the post-survey.)

ii. Wynaden D, Chapman R, McGowan S, McDonough S, Finn M, Hood S. Emergency department mental health triage consultancy service: a qualitative evaluation. *Accident & Emergency Nursing* 2003; **11(3)**: 158-65

(Type IV evidence – qualitative study of indepth interviews with 11 ED staff on duty on the night of data collection at the end of the 3 month clinical trial of the EMTaCS.)

National Service Framework: key action 14

Raising the standard. Cardiff: Welsh Assembly Government, October 2005

People with mental health problems are to be made aware of the national mental health helpline CALL and other available helplines. [Key action 14 paragraph 19.1]

Are national helplines meeting the needs of callers with mental health problems?

Are telephone helplines effective in supporting people with mental health problems?

4.3 Evaluation of national helplines

NHS Direct

4.3a Improvements could be made in the mechanisms for **referring callers on to other services**, and training to increase nurse advisers' knowledge of mental health problems. **Mental health calls** accounted for 3% of NHS Direct's workload, although these calls were often longer and more complex than other calls. The majority of callers to the service were in touch with other services for their mental health problems (59%), typically their GP. Most callers had 'moderate' mental health problems. Generally callers were satisfied with the service they received, although satisfaction was lower in some areas than previous studies of NHS Direct.[i, ii]

Training in mental health can lead to increases in confidence and a change in attitudes and would be beneficial for all nurses working in **NHS Direct** and in other primary care fields. It would also be beneficial to repeat the study with a larger number of nurses and after a longer period of time to assess the long-term effects of training. Confidence increased in nurses who received **mental health training**. Although there was no statistically significant increase in knowledge scores after training, those who had received training increased by on average one point. After training nurses felt more positive towards their role in treating depressed patients.[i, iii]

With regards to NHS Direct information about local mental health services, less than half of the information held on community mental health services was completely accurate. Most of the information held on crisis intervention services and out of hours services was accurate.[i]

Caveat: Response rates to the training questionnaires were low (55% pretraining and 56% posttraining). Only 111 patient satisfaction interviews were conducted. This is low in comparison to the number of mental health calls received overall to the service during the study period. This study only includes NHS Direct sites in England.

i. Payne F, Jenkins C, Harvey K, et al. *Evaluation of the National NHS Direct Mental Health Project. An independent research study carried out by the Immediate Access Project on behalf of the Department of Health*. London: Kings College, 2001 **http://www.kcl.ac.uk/depsta/medicine/gppc/IAP/MHfullpdf.pdf** [accessed 29/07/05]

ii. Payne F, Jessopp L, Harvey K, Plummer S, Tylee A, Thornicroft G. Is NHS Direct meeting the needs of mental health callers? *Journal of Mental Health*. 2003; **12(1)**: 19-27

iii. Payne F, Harvey K, Jessopp L, Plummer S, Tylee A, Gournay K. Knowledge, confidence and attitudes towards mental health of nurses working in NHS Direct and the effects of training. *Journal of Advanced Nursing*. 2002; **40(5):** 549-59

(Type IV evidence – evaluation study of the NHS Direct Mental Health Project to ensure that NHS Direct could meet the needs of callers with a mental health problem. The evaluation took place at the 17 NHS Direct sites in existence during June 2000. Satisfaction when using NHS Direct for mental health problems was assessed using routine computer data provided by 12 sites, forms completed by nurse advisers and 111 questionnaires administered over the telephone with callers. To measure confidence, knowledge, and attitudes in dealing with mental health calls 527 postal questionnaires of nurse advisers were completed before mental health training, and 283 follow-up questionnaires after training. NHS Direct information about local mental health services was checked by contacting randomly selected services (1 community service, 1 crisis intervention service and 1 out of hours service) randomly chosen from each site. Data on service providers was available from 9 of the 17 sites and checked against the information supplied by the site databases.)

The *statements* | The *evidence*

4.4 Effectiveness of telephone contact with people with mental health problems

4.4a **Telephone interventions** seem to have an effect on patients who at their **suicide attempt** had other treatment than psychiatric and in those with no treatment. At follow-up treatment attendance was high (72% in the intervention group and 65% in the control group had psychiatric or other treatment) and did not differ between the randomised groups. Among those with an initial treatment contact other than psychiatric, more patients in the intervention group had such contact at follow-up (55.6%) as compared to the control group (10.6%). The randomised groups did not differ in repetition of suicide attempts during follow-up or in improvement in GSI (SCL-90), GAF and SSI. Concerning the nine primary symptom dimensions of SCL-90, the intervention group improved in seven dimensions; obsession-compulsiveness ($p<0.05$), sensitivity ($p<0.05$), depression ($p<0.001$), anxiety ($p<0.05$), psychotisism ($p<0.01$), paranoid ($p<0.001$) and additional ($p<0.05$), while the control group improved in one dimension; sensitivity ($p<0.05$).[i]
Caveat: The analytic sample was based on only the 178 patients who completed followed up.

See Sections 7.20 – 7.22 for suicide prevention

i. Cedereke M, Monti K, Ojehagen A. Telephone contact with patients in the year after a suicide attempt: does it affect treatment attendance and outcome? A randomised controlled study. *European Psychiatry* 2002; **17(2)**: 82-91

(Type II evidence – randomised controlled trial of 216 patients in Sweden allocated 1 month after their suicide attempt to either 2 telephone interventions in addition to treatment as usual, or a control group. Main outcomes measures were Global Assessment of functioning (GAF), Symptom Checklist (SCL-90), Global Severity Index (GSI), and Scale of Suicide Ideation (SSI). 12 months follow-up.)

The *statements*

The *evidence*

4.4b An **urgent telephone consultation** service for **deliberate self harm** (DSH) patients is feasible to run and may result in a reduced requirement for other health-care services. On present evidence such a service should be confined to patients with no previous history of DSH. Only a minority (17%) of intervention subjects given a Green Card actually used it and most calls (85%) lasted 30 minutes or less. Subjects with no previous history of DSH were less likely to make calls than were those with a previous history (OR=0.29, 95% CI 0.16-0.50). Intervention group subjects were offered fewer psychiatric out-patient appointments (OR=0.75, 95% CI 0.57-0.99) and fewer non-psychiatric in-patient admissions (OR=0.70, 95% CI 0.48-1.10) than controls.[i] **Caveat:** There is no information reported on whether the groups were similar at the start of the trial. It is unclear how many patients were followed up.

i. Evans MO, Morgan GHA. Crisis telephone consultation for deliberate self-harm patients: how the study groups used the telephone and usual health-care services. *Journal of Mental Health* 2000; **9(2)**: 155-164

(Type II evidence – randomised controlled trial of 827 deliberate self-harm (DSH) patients in England allocated to either control or intervention groups. In addition to treatment as usual, the intervention group was offered a 'Green Card' 24-hour crisis telephone consultation with an on-call psychiatrist for a 6-month period after the index DSH episode.)