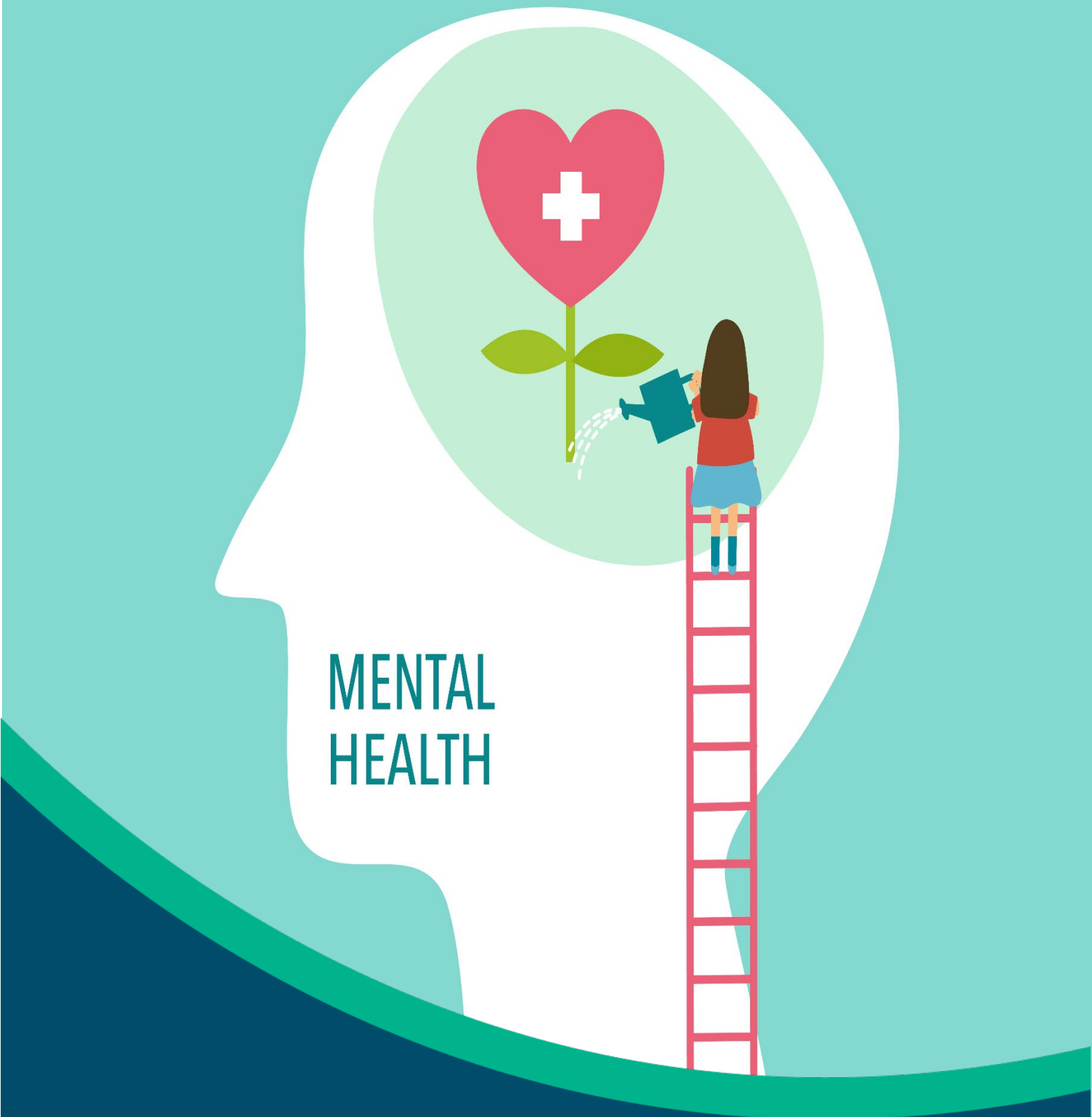


Understanding the reasons for mental health attendances at Royal Blackburn Hospital Emergency Department

September 2024

healthwatch
Blackburn with Darwen

Contents

Contents 2

About Healthwatch Blackburn with Darwen 3

Background to Our Engagement 3

Methodology 4

Executive Summary 5

Recommendations 6

Feedback from Patients Attending Emergency Department 7

Review of attendances across a 2 week period 16

Feedback from Crisis Teams staff members 20

Response from Provider 32

About Healthwatch Blackburn with Darwen

Healthwatch was established under the Health and Social Care Act 2012 as an independent consumer champion to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

There are over 150 local Healthwatch across England. The role of a local Healthwatch is to:

- Listen to people, especially those who are most vulnerable, to understand their experiences and what matters most to them
- Influence those who have the power to change services so that they better meet people's needs now and into the future
- Empower and inform people to get the most from their health and social care services and encourage other organisations to do the same

Find out more at: www.healthwatchblackburnwithdarwen.co.uk

Background to Our Engagement

Mental Health Related Attendances at Emergency Department, Royal Blackburn Hospital

Royal Blackburn Hospital Emergency Department, East Lancashire Hospitals Trust (ELHT) has been experiencing high levels of attendances this year for patients whose main reason for attendance was their mental health. This has resulted in increased pressure on capacity within the department and on Lancashire and South Cumbria Foundation Trust's (LSCFT) Mental Health Liaison team who are located at Emergency Department and are required to make a decision about admission to an inpatient ward for these patients within a 12 hour timeframe. If the admission goes over this timeframe, this is recorded as a 12 hour breach.

Healthwatch Blackburn with Darwen's Engagement

Listening to people's views and experiences of support of mental health patients is key to ensuring that they receive the right support at the right time and in the right place. A busy Emergency Department can be extremely stressful and triggering for patients who are struggling with their mental health and we wanted to understand from patients why they had come there for support and what other support they had accessed or would be willing to access as an alternative to turning up at Emergency Department.

Methodology

Healthwatch Blackburn with Darwen engaged with patients attending Emergency Department for their mental health during September 2024. We carried out surveys with 21 individuals through this engagement.
We also made a log of the referrals made to the Mental Health Liaison Team across a two week period in September to understand the themes for attendance, prevalence of alcohol and substance misuse as a factor and whether patients were known to Lancashire and South Cumbria Foundation Trust as our local mental health provider.
We then triangulated patient feedback with a survey of LSCFT crisis services staff to understand from them why they felt patients were attending Emergency Department for their mental health.

With Thanks

We would like to thank both LSCFT's Mental Health Liaison Team and ELHT's Emergency Department team for facilitating our interviews with patients.

Executive Summary

Feedback from Patients

Over half of the patients we spoke with at Emergency Department reported being suicidal or had taken an overdose and three quarters of the patients had spoken to a mental health professional prior to attending the department. Several had been sent to Emergency Department by another professional including Initial Response Service (IRS), Community Mental Health Teams (CMHT) and Home Treatment teams, or just did not know where else to go because they felt they were in crisis. A third of the patients were currently receiving mental health support in the community but with mixed experiences of this support. Just under half of the patients we spoke with had not accessed the Initial Response Service phoneline due to mainly not knowing about it or because they prefer not to call a mental health service.

The majority of patients stated that they would be most comfortable talking about their mental health face to face with a professional.

Review of Attendances

We reviewed a log of attendances across a 2 week period in September whilst we were carrying out interviews with patients. These highlighted that about 80% of patients seen by the Mental Health Liaison team during this time were known to Lancashire and South Cumbria Foundation Trust. It also highlighted the level of patients with dual diagnosis seen by the team in Emergency Department, with approximately 30% having alcohol misuse as a factor for their attendance and 22% having substance misuse as a factor for their attendance.

The main reasons for attendance were ‘overdose’, ‘self-harm’ and ‘suicidal’.

Feedback from Crisis Service Staff

Staff generally felt that people attended Emergency Department because they wanted to be seen both quickly and face to face, with no real alternative perceived to be available in the community, perhaps due to lack of communication about these services or a community offer which was not meeting patients’ needs.

There were mixed views amongst staff about residents feeling comfortable to talk on the phone about the state of their mental health and the majority did not think that patients would feel comfortable ringing IRS once they were in Emergency Department because they could then be seen face to face.

IRS was seen by staff as a triage and signposting service, however some felt there should be face to assessments delivered by this team for urgent referrals.

There were mixed responses from staff as to whether they would make a referral to the Mental Health Liaison team at Emergency Department and there was a perceived lack of information being provided in referrals to the team. Some felt that referrals were made because there was a lack of ‘an appropriate safe place’ in the community.

Factors impacting on numbers of residents attending Emergency Department included lack of support in the community, social issues combined with lack of support and an expectation of an urgent response from patients coupled with a lack of awareness of community services.

Improvements to help reduce Emergency Department attendances included increased face to face appointments through IRS, increased offer from Community Services, an increased primary care offer and reconfiguration of the support for mental health within Emergency Department.

Recommendations

Based on the feedback received, we would suggest the following recommendations to help reduce attendances at Emergency Department for mental health issues.

1. Increased promotion of Initial Response Service and consider face to face assessments by this team for urgent referrals.
2. Review current community offer to ensure this meets patients needs including an effective and warm transfer of care to a named worker whilst staff members are on leave to avoid people attending Emergency Department because they do not feel comfortable calling a generic phone line for the duty team.
3. Increase promotion of mental health services available in primary care and increased awareness amongst primary care staff to reduce GP referrals to Emergency Department.
4. Consider an alternative safe space such as a crisis café in the community to avoid attendances at Emergency Department.
5. Better understanding of the roles of each team within the local Mental Health Service, their criteria for support and better linkage between these teams.
6. Better information sharing between mental health teams and between ELHT and LSCFT for people attending Emergency Department.
7. Easier routes for patients to be re-referred into community services to avoid crisis attendances at Emergency Department.
8. Increased partnership working between mental health services with the voluntary sector including drug and alcohol services to ensure patients get the right help at the right time and reduce attendances at Emergency Department [we have introduced the Mental Health Liaison team to Blackburn Foodbank and Phoenix Hub because they will be seeing the same residents on a regular basis.]
9. All patients to have a clear safety and care plan which has been coproduced with them so that they are aware of the support networks available to them and how to care for their own wellbeing.

Feedback from Patients Attending Emergency Department

Below is a summary of responses from 21 patients we spoke with who had attended Emergency Department for mental health issues during September 2024. Whilst we were at Emergency Department, attendance numbers were high and corridor care was in frequent use. On a couple of occasions it was difficult to find somewhere private to carry out interviews with patients and had to use a staff training room for one conversation and had to change rooms during a very personal conversation with a patient.

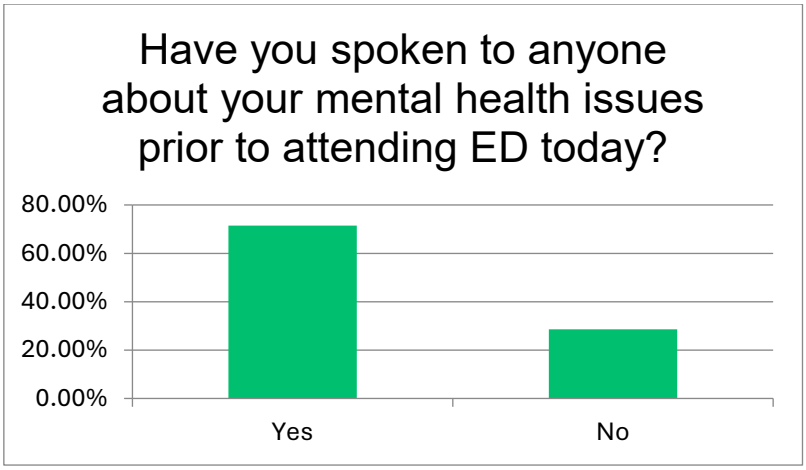
What caused you to come to Emergency Department today?

Attempted suicide	3
Suicidal	6
Overdose	4
Low mental health/depression	6
Alcohol/substance misuse	2

Responses from patients included:-

"Rang IRS suicidal yesterday and still feeling the same. Am struggling"
"I'm hearing voices and feeling suicidal. I have visual hallucinations too. Home Treatment told my support worker at Healthier Heroes house to bring me here."
"Low mood, feel like I'm not coping. I'm suffering from PTSD after a sexual assault last year"
"I'm on the frequent attenders list but my contact is on annual leave. I'm feeling suicidal."
"My CPN sent me [community psychiatric nurse]. I was feeling really suicidal."
"I've overdosed on paracetamol. IRS have sent me but they didn't ask about my state of mental health."
"Mental health issues I am out of control. I feel like I'm a danger to myself and I just need to be safe in a hospital."

One patient was refusing to speak but her husband spoke on her behalf. She was an asylum seeker and did not speak much English. She had a 9 month old baby and was suffering from depression, not eating or sleeping much.
Another patient had been to Emergency Department over 20 times in the last two months, ending up there whenever he got drunk. The Mental Health Liaison team have now arranged a meeting with Inspire to discuss his support.



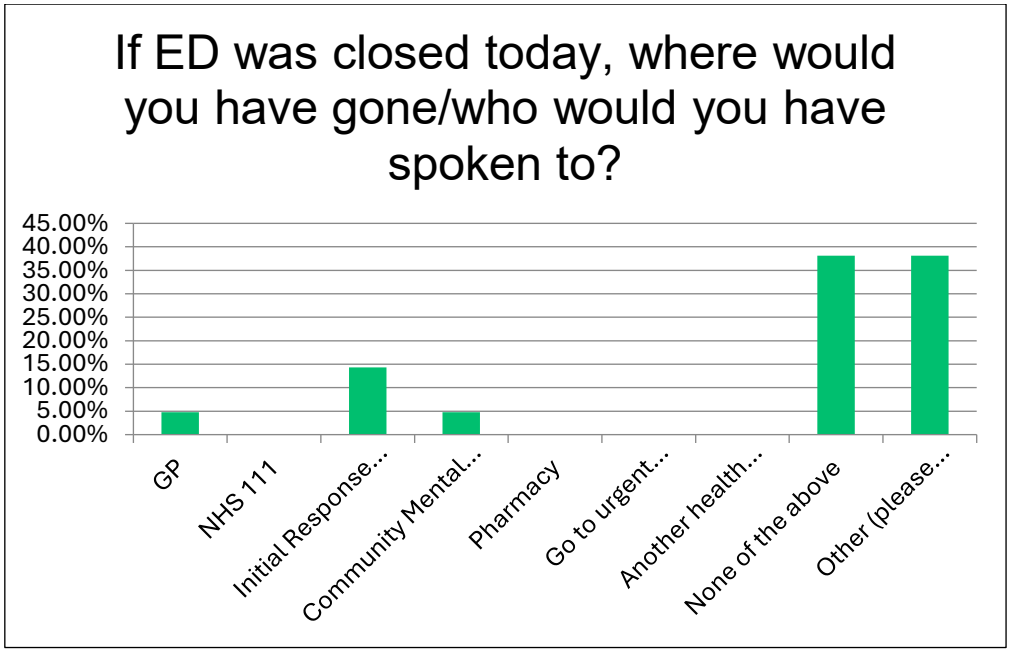
If yes, who did you speak with?

15 patients had spoken with someone else before attending Emergency Department.

Mental Health professional	8
GP	2
Family	2
Community Support worker	2
Work	1

Responses from patients included:-

"I called IRS yesterday"
"I rang home treatment team"
"I called IRS and my sister"
"My GP sent me"
"CHMT"
"Inspire"
"I called IRS and they called an ambulance"
"I called frequent attenders team but it was just ringing out. I then called IRS who were going to put me through to frequent attenders team"
"My CPN sent me. Community mental health team have sorted a room for me apparently but am just in waiting room"

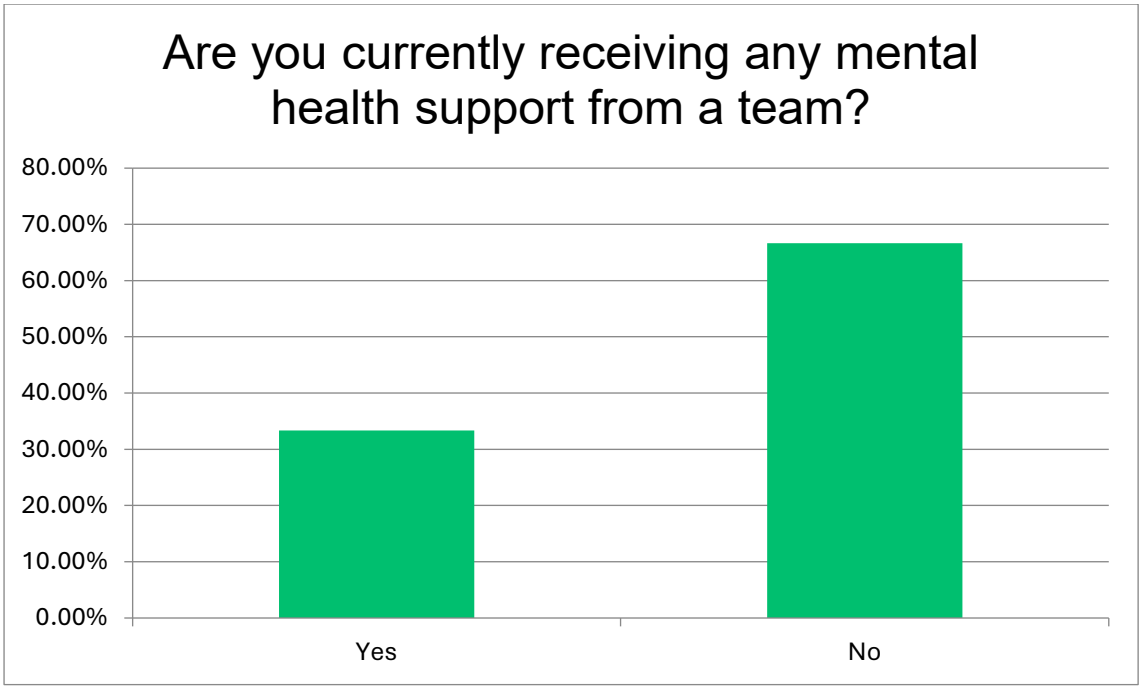


Responses to "Other" included "Not sure where to go", "Frequent Attenders team", "See a friend", "Police" and "Police or community mental health".

What stopped you going there/contacting them today?

The 15 patients who responded to this question answered the following:-

"Home Treatment/ Support Worker sent me here."
"I've been seen by the IRS and it's not helping I didn't know where else to go"
"I went to my GP and they sent me here"
"They sent me here"
"Called them and sent up here"
"Called them with thoughts of causing harm to myself and hearing voice to kill self and told the home to send me here"
"I worry about being judged and have trust issues so don't always feel comfortable. I just got overwhelmed yesterday. My normal CMHT worker is off on annual leave and I didn't want to call the duty line."
"I didn't know where else to go"
"My family sent me here"
"The police brought me here"
"Head hurts. Feels safer in A and E" [This patient's Frequent attenders contact was on annual leave so had turned up at Emergency Department on two consecutive days and did not accept that his physical symptoms were related to anxiety]
"Because was suicidal"
"In crisis"
"I'm not sure where I'd have gone."
"I don't trust services"

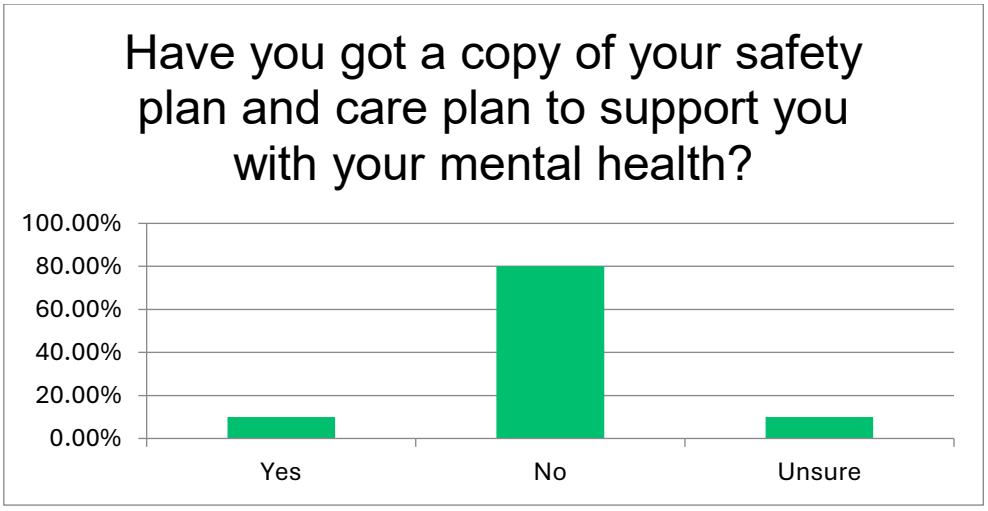


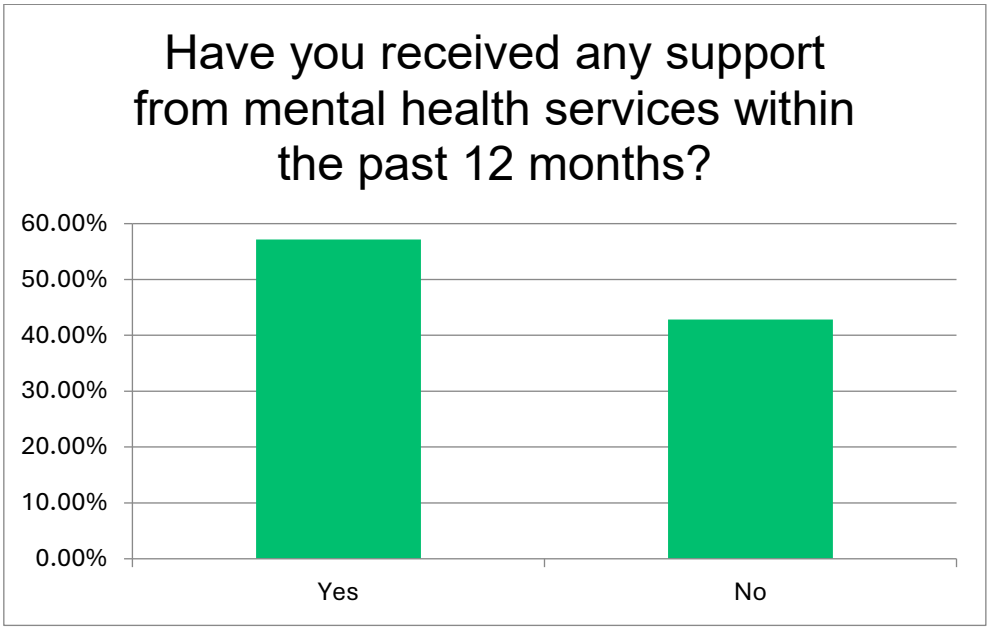
If yes, which team?

Patients currently under Mental Health support services, responded:-

“Home Treatment team”
“CHMT”
“Daisyfield SEN worker”
“Home treatment team”
“Community team at the mount”
“Frequent attenders team”
“Community mental health team”

In addition, one patient stated that they had been discharged by IRS two days ago and another patient was with the community perinatal team but had been discharged in June. She did not speak English but her husband explained that she was not consistent in taking her antidepressants and had not been coping as well since discharge.



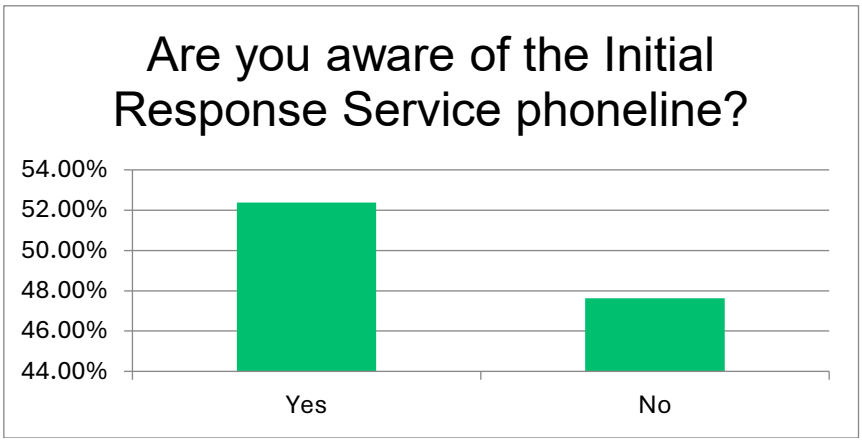


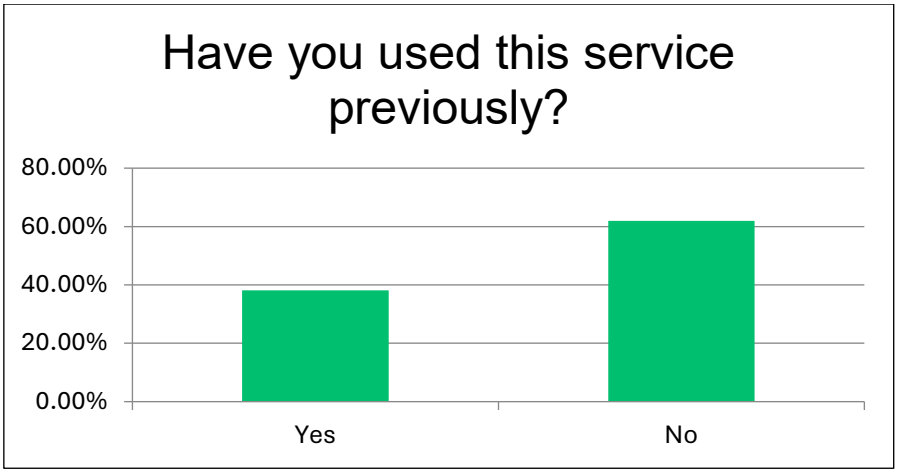
If yes, did this help and were you given enough information to support you with your mental health?

We received the following responses from patients:-

"Yes but I can struggle and I used 1/2 gram at cocaine at the weekend and that has affected me. I've been trying to keep off that and alcohol and it's usually the alcohol that affects me so it's made me more scared and I need help."
"No it's not been working"
"I have CBT - I have had 22 sessions so far for my PTSD"
"No I'm still ill"
"No - i need to keep coming here"
"I've been referred to CMHT but taken off books for not engaging."
"Yes but in between sessions I can get overwhelmed and my worker is on annual leave"
"It helped"

“No, I don't feel like the home treatment team read my notes. I asked for women only staff and they keep sending male”
“I don't think so. I’m struggling to accept head pains are related to anxiety.”
“Awaiting ADHD assessment. I had a referral to home treatment referral but they didn't accept it”
“No”
“I was hospitalised last year and that helped. I had some support in the community but it didn't work the same for me.”





If no, what is the reason for this?

11 patients responded to this question as below.

Did not know about it	4
Prefer not to call services	3
No access to a phone	1
Under other services	1
Not needed it	2

Answers included, “I just feel safer in a hospital”, “I’m under Home Treatment and Inspire”, “I’ve been given the number before but never rang them”, “I’ve no phone and am homeless.”

How would you feel about speaking to a Mental Health professional about your concerns over the phone?

It would be ok to speak on the phone	6
I would feel more comfortable face to face	13
Tried but unable to get through	1
Currently not engaging with anyone	1

Responses included, “I would rather see someone face to face. My sister had to make the call for me today”, “Needed face to face because I’m struggling with any kind of communication”, “I called IRS yesterday and they gave me a few other numbers to call and discharged me” and “I called Home Treatment team and was ok.”

How would you feel about being directed by Emergency Department professionals to contact the Initial Response Service via phone for support with your Mental Health from ED?

Prefer face to face	10
It would be ok	5
Ok if I was in a safe space	3
Cannot speak English	1
Unsure they are suitable for my needs	2

Responses included,

“I think now am up at ED I'd rather speak to someone in person rather than another phone call.”

“Ok I phoned them today but couldn't get through to team who help me”

“Don't like talking to someone I don't know on the phone”

“Only if there was someone here I wouldn't feel comfortable using phone”

What techniques or resources do you use to support your mental health and wellbeing?

7 out of 20 respondents stated that they did not do anything to support their mental health and wellbeing. Other responses included,

"Not much at the moment, I can't work because am struggling to concentrate."

"I'm not very good. Am up and down. The gym is good for me. I'm just in my room all the time. I've tried meditation and breathwork but it wasn't working this time."

"I've been given techniques but I don't really use them I don't think they help"

"Sitting in bed listening to music. Watching TV. Lost motivation for gym. I like singing."

"I take a cold shower"

"I struggle. I'm not sleeping or eating and my mind keeps racing"

Is there anything else that would be helpful?

7 out of 18 respondents stated that nothing else would be helpful and 4 were unsure. The other 7 responses were,

"Support"

"To be able to keep myself safe"

"Help to regulate emotions"

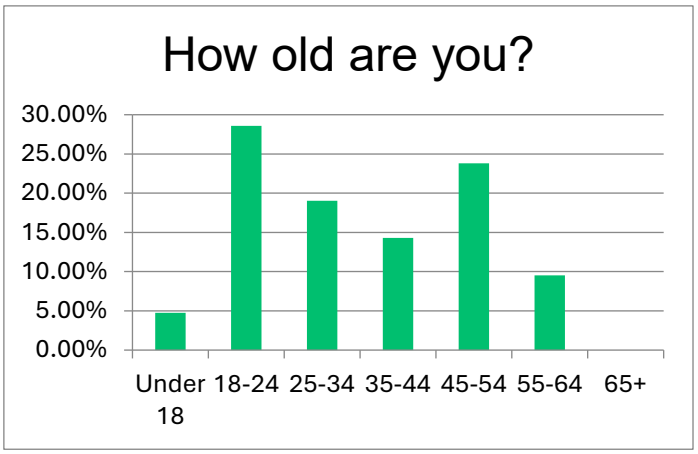
"Not sleeping or eating"

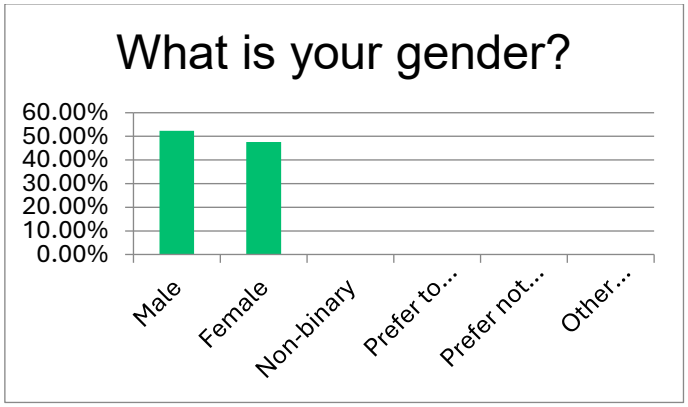
"Possibly talking to someone about it would help"

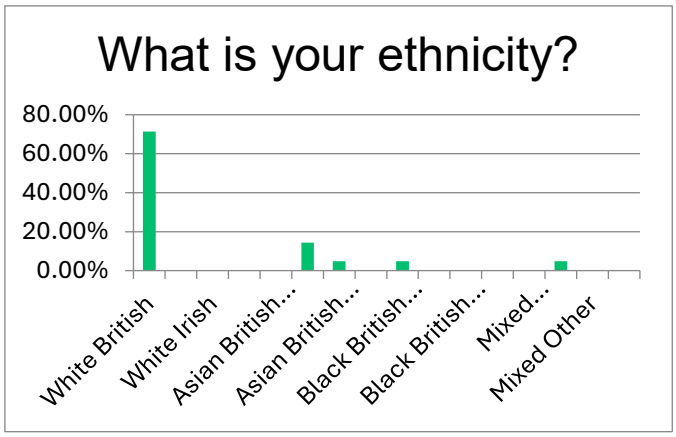
"Mental health support"

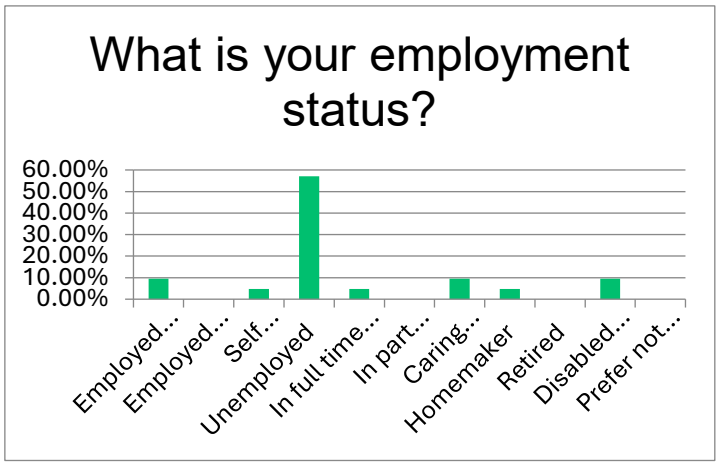
"People to talk to"

Demographics Of Patients We Spoke With







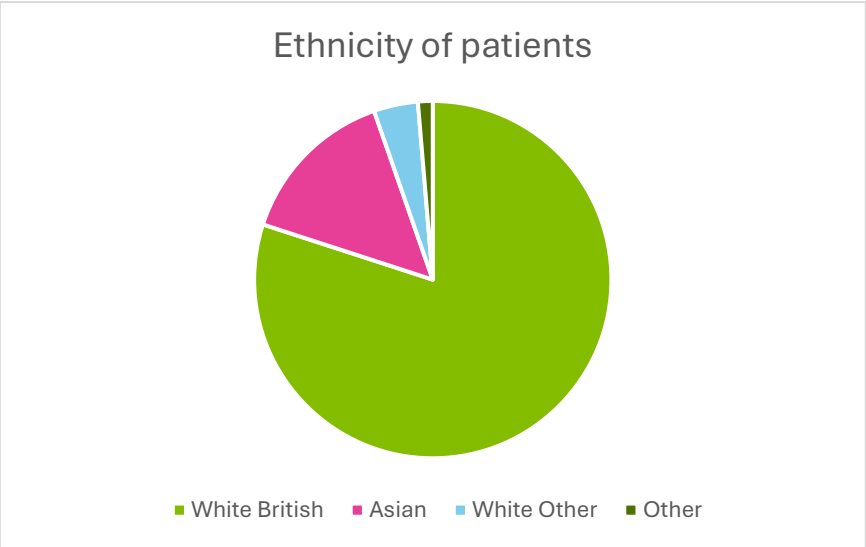


Review of Attendances Across a 2 Week Period in September 2024

Whilst we were at Emergency Department, we created a summary of the log of referrals for the weeks commencing 16th September and 23rd September 2024 to understand the reasons for mental health patient attendances and other pertinent information.

In the week of 16th September, 81% of the 75 patients were recorded as being known to Lancashire and South Cumbria Foundation Trust. 31% had alcohol misuse as a factor and 25% had substance misuse as a factor contributing to their poor mental health.

The split between genders was almost equal with 39 women attending and 36 men. The ethnicity of patients was predominantly White British as shown below.



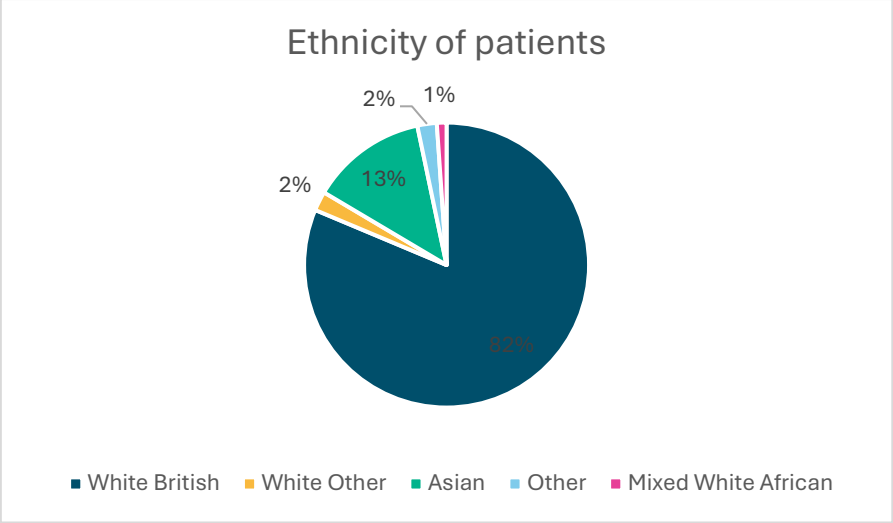
The reasons for attendance are shown in the table below as recorded by the mental health liaison team, with the 3 highest reasons being overdose, self-harm and suicidal.

Bipolar	1
Depression	2
Depressive feeling	3
Delusion	1
Deterioration in mental health	1
Hallucinations/psychosis	1
Hearing voices	1
Low mood	2
Mental illness	1
Overdose	12
Overdose/sucidal	1

Paranoia	1
Psychosis	5
Risk to self	1
Self harm	10
Self harm/section 136	1
Self harm/overdose	2
Strange behaviour	3
Strange behaviour/depression	1
Strange behaviour/suicidal	1
Suicidal	6
Suicidal/ 136	1
Suicidal/ low mood	2
Suicidal/ depression	1
Suicidal/overdose	6
Suicidal/ psychosis	1
Suicide attempt	3
Unexplained behaviour	1
Unknown	1
Unusual behaviour	2

In the week of 23rd September, we noted similar statistics of attendances. 79% of the 75 patients were recorded as being known to Lancashire and South Cumbria Foundation Trust. 27% had alcohol misuse as a factor and 19% had substance misuse as a factor contributing to their poor mental health.

The split between genders was again almost equal with 44 women attending and 47 men. The ethnicity of patients was again predominantly White British as shown below.



The reasons for attendance are shown in the table below as recorded by the mental health liaison team, with the 2 highest reasons being overdose and suicidal.

Anxiety	2
Behaviour	2
Confusion	3
Decline in mental health	1
Delusional	1
Depression	4
Hallucinations	1
In crisis	4
In crisis, suicidal	1
Intoxicated	1
Low mood	5
Overdose	29
Overdose, self harm	1
Overdose, suicidal	1
Psychosis	1
Section 136	2
Self harm	3
Suicidal	21

Suicidal thoughts	1
Suicidal, depression	1
Suicidal, hearing voices	1
Suicidal, low mood	2
Suicidal, self harm	1
Suicide intention	1
Unknown	1

Staff Survey Feedback

We circulated a survey to members of the LSCFT crisis teams (mental health liaison team, Initial Response Service and Home Treatment team) to understand from them what they see as the reasons why patients attend Emergency Department when struggling with their mental health and how these could be avoided.

We had 24 responses to the survey as detailed below.

What do you feel are the main reasons for people coming to Emergency Department about mental health issues?

11 out of 24 responses related to the **need from a patient to be seen both quickly and face to face** with no real alternative perceived to be available in the community, perhaps due to lack of communication about these services. They also felt that patients saw ED as a place of safety.

"Lack of alternative opportunities for timely face to face contact with health professionals"

"Place of Safety and to be seen quickly"

"People not having access to early face to face support."

"lack of face to face assessments being offered"

"People feel that they need support and see ED as a place of safety"

"They want to see a professional face-to-face same day and they feel they will be able to access a hospital admission."

"They feel their needs will be met quicker than working with community mental health services"

"They feel they can get seen immediately. They feel attending keeps them safe when in crisis. They feel they may get medication. IRS cannot offer immediate safety for them"

"Anxiety/depression"

"I think people want an immediate response to their distress/crisis and are not willing to wait for services in the community to respond. I also believe that there could be more service users who could access IRS/HTT services although communication around these services is poor. I also feel that at times, practitioners from these services direct service users to ED inappropriately."

"Sent there by IRS. Instant response to perceived need. Face to face contact"

"In order to see someone face to face urgently or if they feel the risks are high and they don't feel safe, ED is the only place of safety".

2 further responses alluded to **potentially inappropriate referrals** to Emergency Department, in addition to some of the points raised above.

“Unsure of community services to access. GP signpost to ED. IRS advise to attend ED if feel risks too high.”

“GP advice. Unaware of other gateway services such as IRS. alcohol/drug intoxication, police & ambulance often bring to ED”

Social issues came up as a main reason for attendance in 6 responses, alongside other issues.

“overdoses. substance misuse and life experiences triggering thoughts of suicide and not seeing a way out (hopelessness and helplessness). sense of immediate danger due to high levels of anxiety.”

“Extreme Poverty in the area causing distress. Homelessness. Treating Mental Health Services as Social Services , as Social Services not easy to access. Can’t get GP appointments. Sent to ED by Community Teams as a place of safety (Which it is not) Not able to access Drug or Alcohol Services in the community. Many Attendees (well over 50 % of referrals with alcohol or drug related issues) Failed discharges from Mental Health Wards. Frequent Attenders Team Understaffed and Overloaded Dearth of Experienced Community Practitioners to avoid Crisis Admissions”

“SOCIAL ISSUES Care Issues Financial Issues”

“social deprivation, inequalities (postcode lottery), unemployment poverty leading to higher health related problems . RBH being expected to cover a large geographical area- BGH A&E should never have been decommissioned.”

“Lonely, place they feel there are safe. feel looked after and cared for. feel they have a voice”

“Drugs and alcohol also relationship issues”

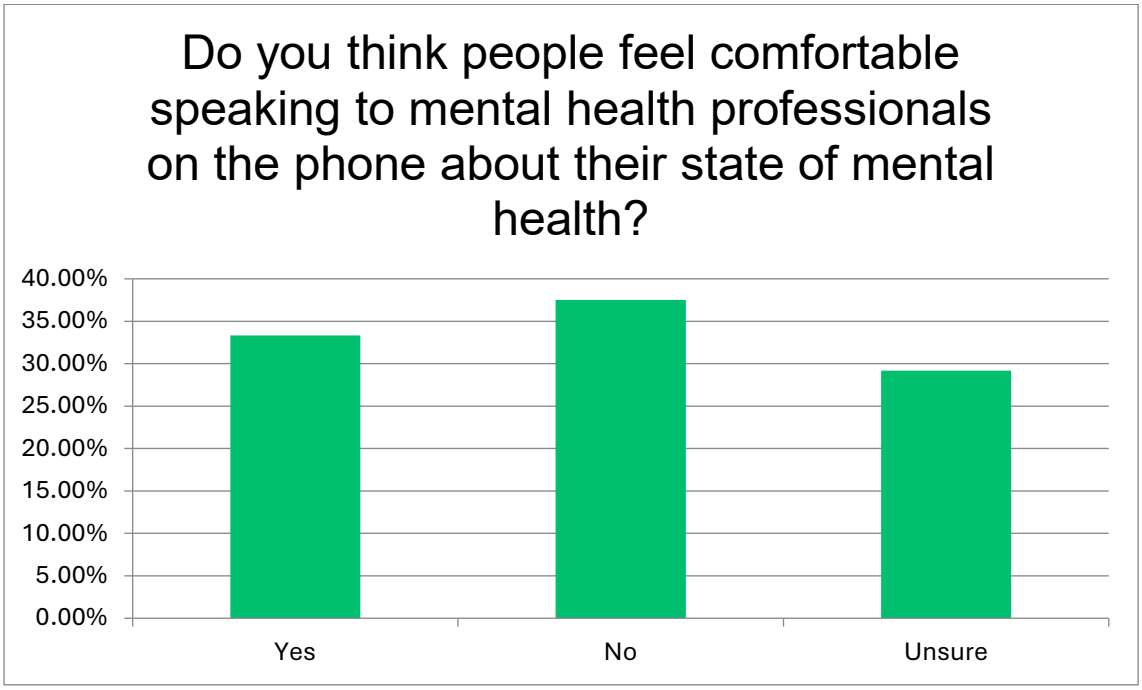
A **lack of consistent or appropriate community services** was raised in 4 responses.

“A & E/MHLT often respond by prescribing medications often benzodiazepines and initiate antipsychotics when community services have refused. Clinicians not completing the risk management within community assessments, directing people to A & E rather than utilising other strategies or step down options. Seeking access outside of own care teams to try and navigate an alternative response. Threshold of CMHT's and ongoing 3.5 gap.”

“They require urgent treatment the current community crisis services are unable to provide, when a service user, or their family/support network, are convinced they are unable to maintain their own safety, when they have no social network to provide necessary support, and need to be in a place of safety. Or they have already significantly self-harmed or attempted to end their life, by overdose for example, or they are reporting strong thoughts of hanging - having collected the means to do this etc”

“Lack of community services. Poor response from IRS. Knowing Blackburn ED has a mental health service attached. Knowing that Blackburn ED has Mental Health Unit on site.”

"Lack of community mental health services. Lack of GP's and difficulty securing a timely GP appointment. Advised to attend ED by other health professionals."



Please expand on your answer above

The detailed responses from staff do not match the percentages above with 50% no, 25% yes and 25% unsure.

Yes - People do feel comfortable speaking on the telephone about their mental health

"When people need help and support they generally happy talking over the phone"

"There is a lot of phone calls received from Patients so they must be comfortable to ring in"

"Provides a sense of anonymity people don't have to travel to get help and advice"

"I do extra shifts with IRS service. I have not had many problems with the triage process, I find people are comfortable discussing things via telephone"

"As long as confidentiality is adhered to."

"They feel comfortable however the service is not an emergency one and is limited to what it can offer immediately"

No - Telephone seen as a barrier to engaging with staff

"I think generally most of them do not feel comfortable talking about their mental health on the phone."

"Some people will feel comfortable to discuss their mental health briefly but the phone is a barrier and people feel more comfortable in a face to face appointment."

"Anecdotal evidence from service users would suggest that people prefer face to face assessments."

"No - I am only going off what I personally would feel like"

"Individuals vary in their preferences, but phone screening is associated with depressing bureaucracy of services avoiding direct customer contact"

"I think that some people would be uncomfortable telling someone over the phone of personal difficulties. I have had experience of someone telling me that she preferred seeing someone face to face as she felt more able to trust."

"An overview of a person's mental health cannot be fully taken into account via telephone. Patients want to see people face to face to feel as though they are getting a service. Seeing a patient face to face allows the patient to see that you are a human, compassionate and caring and are actively listening."

"People with MH difficulties want face to face as this demonstrates empathy and compassion which isn't often displayed over the phone conversation"

"I think people find it difficult to express how they are feeling"

"I believe people trust more with face to face"

"I think people prefer to have face to face assessments and potentially feel more listened to - when you are talking about sensitive and distressing symptoms, talking to a telephone does not feel very compassionate or responsive"

"Assessing mental health is always more therapeutic in person so that a therapeutic relationship can be established"

Unsure - Split on view

"I think that this is dependent on the person, some people feel comfortable others clearly struggle with articulating the needs over the phone"

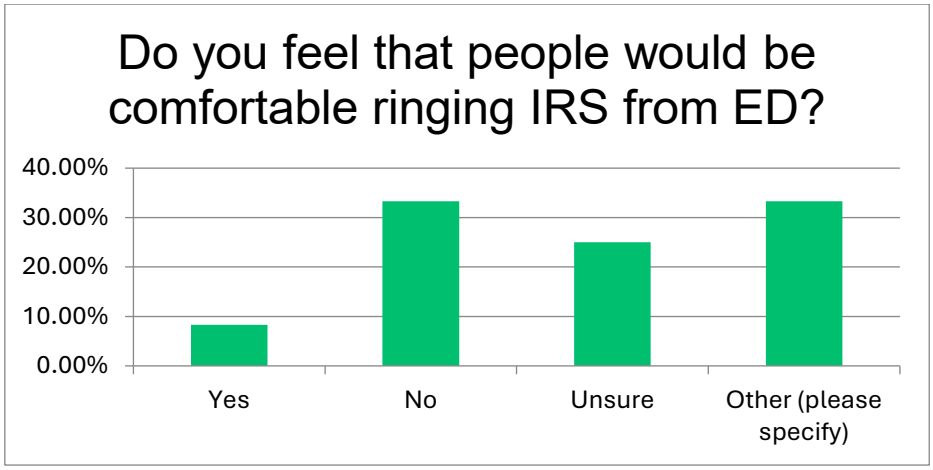
"I am spilt for some people telephone conversation will be helpful others prefer face to face where they feel there are being heard and have a voice, interact better face to face VALADATION hoe they are feeling"

"Most people seem to be comfortable talking with an MHP by phone, some people say they prefer it, feel they can say more than they would face to face, but this is not appropriate for everyone"

"There's no yes or no answer given the range of mental health difficulties and people we work with. Most people are comfortable speaking on the phone, but some are not (too anxious, too unwell, impulsivity)."

"I think everyone is different and although some do feel comfortable speaking about their mental health over the phone i feel that the majority of people feel more comfortable and better listened to by seeing someone face to face to discuss their mental health."

"dependant on the sensitivity of the issues"



Responses to other include:-

"I think they will do with support if needed as this depends on their situation/presentation."

"IRS is usually only telephone contact and if a patient has attended ED they want support from a practitioner face to face."

"Again what I would personally like is face to face"

"If at the hospital shouldn't need to call IRS"

"If supported to do this i feel that they would"

"not all people with severely enduring mental health do prefer face to face"

"I think once they have presented at ED that they probably feel that their needs will be met there and i feel that a further phone call to IRS may make them feel that they are not being taken seriously or being "passed over" as their needs "aren't as important as someone else's"."

"Imagine the scenario - the service user calls 111 feeling in a mental health crisis and taking the enormous and frightening decision to reach out to people unknown for help, the service user is able to explain the reason for the call, 111 then transfers the call to the IRS, (AS PER NATIONWIDE PROTOCOL) usually not as a warm transfer, so then the service user talks initially to an IRS Call Handler and repeats the issues behind the call for help, then, in the case of an urgent call, the call is transferred to an IRS Practitioner and is again expected to repeat the issues that have caused so much distress that they need to call a mental health service, so following an in depth triage call between service user and the MHP, or a face to face assessment, the decision is made that this service user need to be seen in A&E for the reasons outlined above - so they get to A&E and after a while they are asked if they would like to an IRS Practitioner by phone. This may serve to lighten the service load in A&E but it certainly doesn't support the needs of the service user, or provide a meaningful experience through mental health services - when already there is such a lack of any infrastructure to support community teams - which - if a realistic infrastructure was in place - would cut referrals to the HTT and A&E probably by up to 70%. Let's look at the service users' needs, as we should be, and not the needs of the service."

What do you see as the key functions of IRS?

The overriding view from staff was that IRS is a triage and signposting service. Responses included,

“first point of contact, assess the situation on the phone or home visit when necessary, identify mental health needs, offer support and reassurance, sign post to other services when necessary.”

“To avoid attendance at ED”

“Triage/assessment service. Assess the need for more intensive support and develop clear safety netting on completion of assessment”

However some felt that staffing issues and widening of its offer have resulted in a change in its key focus.

“Key function of the IRS is as the front door into mental health services, where services users, and referring professionals, can get a timely response to referral with initial telephone triage , which is targeted in terms of service targets, which then supports signposting or referral to other appropriate services. Referrals come from all areas, professionals, service users and/or their families. IRS provide the information through triage and assessment to support referrals to other mental health services - HTT, EIS, CMHT, OACMHT, RITT, NHS Talking Therapies. IRS liaise between service users needs and GP via the written assessments. The role of the IRS has widened to take the out of hours calls from service users open to other, care co-ordinated, mental health services, such as the CMHT/RITT, EIS, ELCAS, CAMHS, the HTT, SPNCMHT, the Frequent Attenders Team. The IRS is an adult focused service with MHPs very experienced in dealing with this cohort, but not as experienced with young people, and despite the widening role there has been no training for this and this can be problematic at times. The IRS also provides, following initial triage/assessment, and MDT discussion, Psychiatrist assessments, reviews around medication and there is access to a mental health pharmacist who can advise service user and doctors around medication. The IRS also benefits from clinical discussion meetings where an MHP may request a wider perspective of a service users’ needs, following initial triage.”

“Due to drift in function and limited staffing it functions as a telephone triage. Inclusion of the term, Response, is optimistic.”

“Currently they are a referral team. Who redirect referrals. I believe they should function as a face to face assessment team.”

What level of communication takes place about referrals to the Mental Health Liaison team at ED?

6 respondents stated that they were 'unsure'. Other responses received were very varied.

Some stated that they **would not make a referral to ED**.

"IRS does not refer to the MHLT directly. A person will attend MHLT directly or will be transferred by an ambulance."

"Never referred to ED for a mental health reason"

"Within HTT if it is thought that a SU may attend A & E then contact with liaison to advise should be completed."

Some simply **stated the form of referral** – "Telephone" or "Strata System."

However, others stated that they **would make a referral to the Mental Health Liaison team in certain circumstances**.

"Unclear from an IRS perspective - the only time HTT would advise anyone to attend ED is with a medical need or an issue requiring medical attention"

"IRS Practitioners never feel good about sending a service user to A&E (ED) and will look at every alternative before making the decision to advise a service user to attend A&E or to call an ambulance. Sometimes hands are tied by what the service user is reporting. The IRS would try to talk to with the MHLT once it is established a service user requires A&E to provide an overview - not always possible - but comprehensive records would be provided on RIO"

"this depends on who his making the referral"

"reason for referrals. what has been tried in the community. what are the person's strengths. what are the risks to self or others what support is already available to the person. what the person is expecting from the referral. what's important to them. details of NOK and consent to information sharing."

Issues were raised by the **lack of information provided** as part of the referral process from IRS or ELHT's Emergency Department team.

"Limited information via Strata. The onus is on the Mental Health Liaison Team to seek information via ELHT electronic records and by having a conversation with ED staff."

"Minimum info shared from IRS to MHLT. This is done via telephone however they have not been assessed and are often sent there when a patient appears to be in crisis via telephone."

"Dependent on the IRS practitioner There are a number of experienced staff who rarely send anyone to ED unless a valid reason unfortunately this is the minority with these practitioners helpful in contacting MHLT with the plan. Most of the time communication is poor"

“ED [ELHT] refer when still intoxicated or not MFFD, referral information can be basic especially if service user is known to MH.”

“Some communications from ED [ELHT] to MH Liaison are very limited, with little information - sometimes just a few words”

“Very little - electronic referral that could have one word ie behaviour, suicidal”

For Home Treatment and IRS staff, when have you felt the need to refer people to Emergency Department?

Overriding responses related to the level of immediate risk that staff felt the individual was in, both to themselves or to others. Some expanded on this to include “physical health issues arising as a result of self-harm” and “if there is an urgent medical need where the patient needs urgent medical attention that cannot be sough immediately elsewhere”

However, other responses included,

“When risks have not been able to be managed appropriately in the community and they have escalated.”

“Lack of safe venue for a service user who declares themselves unable to wait for service response”

“When deemed it is needed by a MHP”

“Personally I haven't. If risks are escalating then HBTT intervention options should be discussed and utilised to prevent attendance. At times when face to face contact cannot be made due to acuity, that all safety netting options have been exhausted with an explicit plan regarding harm to self or behaviours that are not manageable in a community setting for multiple reasons.”

“I work for IRS on bank shifts & have advised only a small handful of people to ED, always with a clean plan in place & verbally handed this over to MHLT”

“When they have taken an over dose and not sought medical attention.
When they have self-harmed or cut themselves and i am unable to see the severity of the wound however the service user is reporting his is severe. If i have been unable to calm the situation down and the service user is still saying they are unable to keep themselves safe.”

These responses suggest a lack of “appropriate safe place” in the community and a lack of ability to meet patients face to face before making a referral to Emergency Department.

Are there any other factors you feel impact on numbers of residents attending ED?

Responses from staff fell into a range of themes.

Lack of support in the community

"bad past experiences with community services therefore they do no ring for support prior to attending ED"

"Lack of proactive work at a primary care level. If services were front loaded at primary care this would reduce the attendance but also people becoming unwell in the first place"

"Lack of GP access, long waits for primary care level interventions"

"Lacks of face to face assessments on offer in the community by external resources"

"'place of safety' this is a term often documented in notes that they have been advised to come to keep themselves safe. ED is a designated place of safety in terms of the section 136 there is nothing safe about a vulnerable or volatile individual being sent to ED where there are often 100+ physically unwell patients to care for. It takes time for the referral to come through to MHLT, time to assess the person or allow for period of sobriety & put plans in place. all the while the person is in a very busy environment alone. Police reluctant to 136 patients just dropping them off with no handover. Call handlers advising IRS patients to come to ED if feeling unsafe."

"Poor community services"

"Unable to access face to face appointment in a timely manner"

Social issues mixed with lack of support

"Poverty and social deprivation. Substance misuse. Alcohol misuse. Unrealistic expectations of what mental health services can provide. ED covers a wide geographical area."

"definitely lots of social care needs housing, benefits not the appropriate care within the community and the very lack of community support. A great feeling of being misunderstood by the wider community"

"Social determinants such as income, employment, socioeconomic status, education, food security, housing, social support, discrimination, childhood adversity. Lack of robust community mental health support from CMHT."

"People reaching out to services as a first port of call for everyday unpleasant life experiences and feelings and an expectance that services will provide for everything - coupled with the profile of the local people in terms or fractured families, poor socioeconomic conditions, no family/social support, no money, no jobs, no hope and no resilience, which community services are not set up to support where needed. And this will get worse - a telephone response to a crisis

might help in the immediate, but when the call ends there is nothing but referral to a waiting list. So going to ED at least provides access to being actually seen by a professional and its safer than being on your own feeling desperate”

“Family issues”

“Social deprivation. Expectations of having a service right now. High numbers of people who use drugs and alcohol. GP's/IRS sending people up. People having a lack of understanding as to what ED is - people often documents "sent to ED as place of safety" People having a lack of understanding as to how busy the department is”

Expectation of urgent response from patients and lack of awareness of community services

“Frequent service users”

“No consequences when time wasting or misusing services”

“Hoping to be detained onto a mental health ward due to unaware of services that are provided in the community.”

“Increasing medicalisation of distress. Gulf between expectations cultivated and services available.”

“Prescribing of medications and access to inpatient admission. patients feeling unsupported”

“A&E being the 'easy' option for crisis management than community teams dealing with it. Patients not feeling as though they have had a service via telephone.”

“No fixed abode appears to be a factor recently. Medication seeking. Lack of realistic expectation from Service.”

“Service user feels they have no other option to access mental health support. Want support/advice/medication asap.”

“Frequent attenders.

“Unable to meet the immediate need as even referrals into HTT will not be contacted until the next day. Despite efforts to de-escalate or offer options some people are not accepting of this and are in crisis and feel they need immediate help. There are no other options for IRS. When people are told that attending MHLT would not mean the outcome would be different they still choose to attend”

“Mainly to receive urgent mental health assessment/support”

What improvements or changes do you feel would help reduce the number of people attending ED for mental health issues?

Responses received fell into the following themes.

Increased face to face appointments through IRS and more in-depth triage

"more face to face than phone calls assessments."

"If initial response services were able to provide face to face appointments frequently. Better risk management from IRS. More support form IRS to unpick situations that patients present with rather than directing a patient to ED"

"Patient being seen face to face and going back to having a specific assessment team."

"The pathway being followed correctly. IRS have the option to see people face to face urgently if required. Services being consistent in the approach for example there was an IRS patient who said he was coming to ED against advice from IRS & HTT, so I reiterated the plan in place"

Increased offer from Community Services

"Easier access to community mental health services. Expansion of community mental health services. Expansion of substance misuse/alcohol services. Education. Investment in staff."

"Less failed discharges from Mental Health Wards. More staffing in the Community Teams to provide patients with more support at home to avoid Crisis admissions. Mental Health Teams to be available at GP surgeries"

"Focus on family issues"

"Community staff exploring risk factors in more detail and problem solving this and either increasing support, consider crisis house, ATS, referral to HTT, MHA, medic review etc. Ensure that concerns are validated at first point of contact."

"more social care services. more community walk in services. Definitely a separate department for mental health patients called a crisis centre instead of A&E where there is not the greater need of staff to be able to address a person's social care need or mental health crisis"

"Intensive input from CMHT's. Assertive engagement teams. Offer more Face to face assessments by IRS, if no medical need to attend ED."

"More face to face assessments to be offered in the community by professionals ie IRS, HTT, GP's"

"well ..... how long have you got .....Currently the model is top heavy - everyone has to fit into the top of the triangle, ie crisis services and inevitably ED, in order to get any effective timely psychiatric input. The bottom broad base of the triangle, which should be supporting the majority of service users to prevent their difficulties escalating, has no statutory services of note. The NHS Talking

Therapies Service, which sits at the broad base, will only take people who meet their narrow criteria in order to meet good performance targets - the majority of the complex, multi-issue local population don't fit this criteria, so they can't access therapy which could help in the long run."

"I feel that there needs to be more community teams for people to link into."

"Community support to be accessed rather than thinking ED is the only answer"

"Declining to see frequent attenders and having a plan of care in place for these people via the FAT or their CMHT. Educate the people who use our service via leaflets/digital means to understand that attending the ED will not necessarily affect the outcome."

Increased Primary Care Offer

"Improved access to primary care services, such as ARRS, Talking therapies, improved access to GPs, reduced waits for medication reviews at IRS, more public awareness of face-to-face assessments via IRS on a more urgent basis."

Changes to Emergency Department/Urgent Care Centre for Mental Health

"Opening of an Urgent Care equivalent for mental health. This would need to be robustly staffed, safe and integrated with Home Treatment, Street Triage, Initial Response and medical urgent care."

"IRS input within ED supporting those with no medical need offering triage and follow up appointments . More input from CMHT dealing with their service users who present in ED . More communications about IRS facility and how to access MH services to the general public"

"These are systemic issues and no one idea will solve this, you need to look at this from wider perspective"

"I don't think anything can be done to reduce the amount of people attending EDs however i feel that if there are more staff at EDs and more EDs open that the waiting times could be reduced and the stress on the staff at EDs reduced."

Healthwatch Report Response – Royal Blackburn Hospital (RBH) Mental Health presentations

It's imperative that people can access support for their mental health support when they need it, and in Lancashire and South Cumbria NHS Foundation Trust (LSCft) we are committed to delivering this through our Quadruple Aim outlined in our Trusts three year strategy. This focuses on delivering the best possible care, improving health within our population, ensuring that our colleagues have joy and pride in their work and doing so by delivering all of these in the financial boundaries that we have offering the best value for money.

It is extremely valuable to hear from people using our services, and our colleagues working within them on how our current services are working and areas for improvement. LSCft is currently undertaking a number of key transformation programmes alongside partners, including Community Mental Health Care and our Patient First pathway review, which aim to address a number of the recommendations in this report. The Trust also recognises improvements are needed in the Initial Response Service (IRS), which was launched three years ago within East Lancashire and Blackburn with Darwen.

It is reassuring that the findings from the Healthwatch report align to areas of work already taking place, which include:

- Reviewing the IRS processes, including the pathways for face to face assessments within the service.
- Supporting timely allocation of individuals referred to our Community Mental Health teams, and working closely with Mental Health practitioners based within Primary Care as part of Community Mental Health transformation.
- Exploring with local partners how to work closely with the Voluntary, Community and Faith Sector to provide additional mental health crisis support in the areas most in need using the basis of a crisis café model
- Closer working with East Lancashire Hospital NHS Trust (ELHT) to identify people who are attending A&E multiple times to ensure they have support in place to meet their needs.

The recommendations within this report will be progressed and progress reported through the local Urgent and Emergency Care Board.

We would like to thank Healthwatch for undertaking this work, and to our service users and colleagues for sharing their experiences with us with the aim of continuing to improve our services.