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ISSN 2474-7769

Journal of Psychiatry and Mental Health

Research Article | Volume: 1.2 | Open Access

National Emergency Access Targets and Psychiatric Risk Assessment in Emergency Departments: Implications for Involving Family or Carers

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Received date: 18 Aug 2016; **Accepted date:** 28 Sep 2016; **Published date:** 03 Oct 2016.

Citation: Donley E (2016) National Emergency Access Targets and Psychiatric Risk Assessment in Emergency Departments: Implications for Involving Family or Carers. J Psychiatry Ment Health 1(2): doi http://dx.doi.org/10.16966/2474-7769.107

Abstract

Increasingly mental health and other patients are presenting to Emergency Departments (EDs). To alleviate long waits in ED and the blocking of access to beds, National Emergency Access Targets (NEAT) were introduced. While this has alleviated some access issues for ED and hospital patients, it has also impacted on the service delivery to patients and their families in the ED. This mixed methods study included 7 EDs across metropolitan Melbourne and explored ED mental health clinicians' experiences of NEAT. What became apparent was, without prompt, a significant number of participants acknowledge that in the rush to meet NEAT, families and carers were often disadvantaged. Participants noted that NEAT has resulted in less time to support relatives/carers, less time seeking collateral information from relatives/carers, and less time to properly respond to complex social needs. It is acknowledged that ED mental health clinicians are under significant pressure with high-risk patient workloads and organisational requirements to meet NEAT. This combination is likely to result in adverse or poorer outcomes for mental health consumers and their relatives/carers.

Keywords: Psychiatric; Risk; Emergency; Relatives; Assessment

Introduction

Emergency department mental health presentations and National Emergency Access Targets (NEAT)

Increasingly Emergency Departments (EDs) are required to assess and treat mental health patients in crisis [1]. For this population the role of the ED is to treat any injuries or acute illness (such as an overdose, self-harm, or intoxication), contain the patient and community from any further harm, assess risk, and provide management in the hospital or community [2]. Specialist mental health clinicians provide comprehensive risk assessment and treatment plans for psychiatric patients who present in crisis.

EDs are heavily burdened as patient numbers rise, with mental health patient numbers increasing at a rapid rate and higher than that of non-mental health patients [3,4]. To meet this demand, National Emergency Access Targets (NEAT) were introduced to improve the flow of patients across the hospital, and prevent 'access block' (when acute hospital beds are full, and patients wait in ED for an extended length of stay). The main aim of NEAT is timely assessment, treatment and discharge of patients by; a) recommending that relevant staff from other areas of the hospital assist treating ED patients when service demand is high, and b) assessing and discharging the majority of ED patients within 4 hours [5].

The aim of this study was to explore if the introduction of NEAT has influenced how and if mental health clinicians utilise family and carers in EDs. NEAT has been a success in many respects and NEAT does have its advantages for mental health patients in ED. For example, they are seen and treated more quickly, are less likely to abscond, there are more streamlined methods of documentation and access to care, and it has resulted in greater accountability of mental health staff. However, the disadvantages of NEAT include rushing mental health risk assessments, less time to educate student nurses or allied health, increased stress and pressure on ED and mental health staff, privacy and safety breaches, and poor resourcing [6].

NEAT has the potential to change clinical practice given the 4 hour time-line. NEAT is still in its infancy and its implications for clinical practice, both positive and negative, are just beginning to be known. It is reasonable to assume mental health clinicians (indeed all ED staff) feel the pressure of time, and this may impact on interaction with family/carers, whom are an integral part of information gathering and discharge planning. One group potentially impacted by NEAT initiatives is the family or carer.

Relatives/carers and mental health risk assessment

Working with families and carers is integral to providing quality specialist mental healthcare [7] and essential for recovery-based assessment and treatment. Families and carers are particularly important in providing psychosocial care [8] and can provide crucial collateral information during assessment [9]. The use of families and carers has been associated with better outcomes for patients as they play an integral role with implementing treatment plans, providing support, and reducing relapse rates [10]. Indeed, an overburdened health system that promotes community treatment has relied heavily on family and carers support [8]. Involving families and carers is also a good opportunity to facilitate all parties' engagement in the treatment process and can develop a partnership between consumers, families/carers, and health services [11]. During the assessment process the views of family and carers must be taken into consideration when forming a diagnosis and treatment plan [7]. However, despite this there is a long history of practitioners providing a lack of support and/or involving families and carers of mentally ill persons in the assessment and treatment process [12].

Patients do have some rights not to involve family or carers if they desire and confidentiality is an important consideration. However, in a crisis mental health law, such as the Victorian Mental Health Act (2014) [13] notes that while confidentiality is important, it does not outweigh the need to involve families or carers in the assessment and treatment process when appropriate. If treated sensitively and meaningfully, it is a good opportunity to engage all parties in the treatment process [14]. Families and carers may need support themselves. When patients report they do not want family involved, it may be an moment to understand why, and thus an opportunity may arise to ascertain what may be required to support the patient and their family / carer [15].

Methodology

Research question

This study asks specifically, what impact has NEAT had on utilising families/carers during mental health risk assessment in hospital Emergency Departments?

Method

This study was initially part of a wider study looking into the impact of NEAT on psychiatric risk assessment in EDs. The initial aim of the study was exploratory *via* an online survey utilising both qualitative and quantitative data. Participants were asked to discuss both positive and negative features of NEAT during psychiatric risk assessment in EDs. Participants were asked to describe what type of scenarios facilitated meeting NEAT (discharge prior to the four hour time period) or otherwise, and how organisations can be supportive in assisting participants in meeting NEAT. Participants were also asked if their clinical practice had changed at all, if there were any changes to outcomes following assessment, if there had been organisational change to assist in meeting NEAT, and finally, a chance to make any open comment. A letter of invitation to participate in the questionnaire was sent to multiple hospital networks *via* both the mental health managers, and the director of each ED.

A total of 78 participants working across 7 EDs were recruited from metropolitan and surrounds EDs across Melbourne, Australia. Their participation was, voluntary and anonymous. Each participant was a senior and accredited mental health clinician. Most were psychiatric nurses, however a small proportion were allied health professionals (mental health social workers and occupational therapists).

The study utilised a mixed methods design to utilise both qualitative and quantitative data. Mixed method analysis strengthens the understanding of the findings as it uses quantitative data to search for statistically significant trends, and qualitative data to give these trends meaning [16]. For any qualitative responses, a thematic analysis searched for common codes and meaning.

Ethics was approved from multiple health networks covering the seven EDs, and Monash University, Victoria, Australia (LR115-1314, QA2014190, LR/14/PH/26, QA StV HREC, CF15/2691-2015000994). During the course of data collection, it became evident that NEAT had a significant impact on utilising families/carers in ED assessment.

The Study Findings

Respondents rated their overall impression of NEAT with: no respondents describing NEAT as "very positive"; 17.95% rated NEAT as positive; 57.69% rating NEAT as "neither positive of negative"; 21.97% describing NEAT as "negative" and 2.56% described NEAT as "very negative".

Impact of NEAT overall

A range of topics were responded to regarding NEAT and mental health risk assessment in ED. There were positive findings such as; less absconding, improved productivity, improved patient flow, and better team work in the ED. One respondent noting, "Reduced waiting times for clients with subsequent reduced anxiety and distress, more efficient bed flow" (Respondent 70). There were also some negative findings including; the high pressure placed on all staff, poor resourcing, inappropriate risk assessment practice, and rushing assessments. One respondent noting, "People can be rushed in and out the door inappropriately, staffing and ED resources have not been adequately changed to meet the challenge of NEAT. Unnecessary admissions, the focus on time rather than clinical need is potentially dangerous. I have seen ED staff fudge times anyway to meet NEAT" (Respondent 2). When prompted, 63.89% (N=78) of all respondents noted that distressed family was one of a number of factors that prevent NEAT being met. What became evident during the data analysis was the number of times, without prompt, respondents reported how NEAT impacted utilising family/carers directly or indirectly.

High pressure in ED for mental health clinicians

Indirectly, many respondents reported they were continually rushed (42.62%), experiencing high pressure (36.07%) and/or under resourced (26.23%) to keep up with the 4 hour rule. One respondent reporting, "They have actually contributed to poor clinical practice, unfortunately at times the ED service is so obsessed with targets they forget about best practice. The proper assessment of mental health presentations is often highly complex, especially when medical comorbidities are involved" (Respondent number 38). While another respondent noted, "We have been asked to pick up the pace significantly, with no change to our resources, and an increase in patient presentations" (Responded number 50).

Time constraints

Many participants reported that since NEAT was introduced, it directly impacted on their ability to liaise with families/carers. Over a quarter (N=22, 26.26%) of respondents made reference to families or carers being impacted due to NEAT. These responses were coded into themes. Of the 22 respondents citing family/carer impact, 63% stated they saw families or carers less due to NEAT time constraints. Respondents constantly noting: "I seem to have less time for families" (Respondent number 2); "Less time with families" (respondents 17, 32, 47, 76); "less time with consumers and families" (respondent number 38); "Less time spent with clients and families" (respondent number 17); and, "Certainly less time sitting down with relatives" (respondent number 47). While others went into greater details citing; "The extras no longer happen. For example, families miss out. Yesterday I happened to have a quiet day, so I spent 50 minutes talking to a very distressed relative and was able to refer her to support. This should be standard (however) NEAT does not allow this so much" (respondent number 19). With another clinician noting there is, "A lot more awareness of the clock rather than spending that little but extra time ensuring patients and their families receive a useful service-one that will prevent them returning" (respondent number 4).

Collateral information

Other of the respondents citing there was an impact of relatives/carers noted that NEAT effected how often they will utilise a family member in seeking out collateral information during an ED mental health risk assessment (27.28%). One responding, "I am more likely to make a decision if I cannot get collateral information and the presentation seems fairly conclusive" (respondent number 46). Another citing, "I think I have a tendency to discharge people who (prior to NEAT) I may have kept a bit longer due to sedation or to get more collateral history" (respondent number 71). With another noting, "It's all on the clock and ED are not supportive of the time it takes to do a full biosocial psychiatric assessment and develop a proper treatment plan that involves carers and the client" (respondent number 6).

Interaction with family/carer

Further, themes arose of a change to practice when ED mental health staff are involving relatives or carers (N=22, 18.19%); "I spend less time with relatives. I stand up whilst talking to them to give the impression I am in a hurry. If I sit down with them in a family room it can take too long" (respondent number 4). Another reporting that, "I am more likely to encourage families to be involved in the assessment rather than go through everything with them again after the assessment" (respondent number 47). While another respondent stated, "I don't spend as much time with carers as I used to, especially if they are distressed. Last week I told a crying wife to tell the ward how she was feeling." Finally, a respondent also noted the potential difficulties for families when it comes to less than convenient discharges by "Calling up a relative at 2am instead of waiting until the morning" (respondent number 28).

Complex social circumstances

Many respondents felt that NEAT did not allow ED to address any complex social issues that are common in ED mental health presentations (22.73%). "NEAT discriminates against complexity as most of our clients have multiple mental health and family/social issues that are not open to a quick fix" (respondent number 13). With another noting that, "Not all mental health patients fit within the target windows, particularly those with multi-axis presentations or poor functioning families" (respondent number 12).

Resourcing

A further issue was noted that has the potential to impact on all ED relatives and carers; with ED staff also noting that often the only designated interview space was the ED family room (13.67% of respondents noting relative/carer service gaps). One respondent replying that, "ED often requesting assessment to be done in the relative's room which has no security alarms making it a risk for danger to clinicians and families in this space" (respondent number 15).

No change to practice

A number of clinicians did wish to make the point in the study that NEAT does not change their clinical practice (34% of the full 78 participants reported such, but of those 13.3% later cited examples where practice had actually changed). One participant particularly citing the needs of family/carers reporting that, "I refuse to short change the consumer by not doing a complete assessment and getting collateral" (respondent number 71).

Discussion

Impact on relative/carer

NEAT has affected mental health risk assessment in both positive and negative ways and its inception is still relatively new. It would appear in this study that the rush to meet NEAT has impacted on how ED mental health staff interacts with relatives. This in turn has an impact on outcomes for relatives/carers, and the patient.

In the rush to achieve NEAT the mental health clinician is less likely to seek out appropriate collateral, whether this is by rushing the time spent with relatives, or by not speaking with relatives at all. While this does not happen all of the time, there is a trend to suggest this happens too often. Collateral and utilising family or carers is an integral part of a comprehensive mental health risk assessment [17], especially when the consumer is unable, or unwilling, to provide accurate testimony.

The relative/carer requires support and can also provide support to the consumer [18]. It is well established that when relative/carers have a supportive role in discharge planning it increases the likelihood of better outcomes for consumers and families [19]. If carers are not consulted in providing, or receiving support, further presentations or poor outcomes are more likely.

Some basic courtesies to improve the consumer and carer experience are also being missed, for example, assessing mental health patients in the presence of family/relatives. This would appear to be considered more time efficient and at times this is good practice and can prove very useful. However, it can also lead to agitation in ED when there is family conflict, or may result in the mental health consumer not being as open or honest if a loved one is listening. There are also potentially issues of family violence that could be missed or poorly managed [20] for the consumer or family/carer. Essentially, achieving NEAT is not an appropriate driver for having family/carers present during mental health risk assessment.While other courtesies such as poor active listening or rushed body language suggest to the relative or carer that there are more important things the ED can be doing rather than listening to them.

Finally, complex family and social circumstances were a barrier to meeting NEAT. It is most likely that the mental health consumer will be experiencing this type of disadvantage. When social complexity arises rushing assessments to meet NEAT will either result in the problem being ignored or poorly addressed, may lead to unnecessary mental health admissions, or long delays for other ED patient care. It should also be noted that many respondents in this study have done well to note how NEAT has impacted their ability to deal with families, which on some level, notes that family/carer sensitive practice is acknowledges as what should be a standard part of ED risk assessment.

Limitations

As noted, the findings from this study were part of a wider study that was not targeting relatives/carers specifically, but became evident during data analysis. It would be useful to ask clinicians, or families, specifically about their experiences of mental health risk assessment in EDs. This study covered metropolitan EDs in an Australian city of over 4 million people and is not representative of rural, country or other cities and countries. Comments from respondents reflect their own views and open to participant bias.

Conclusion

This was a brief study and the findings are only preliminary. However, findings reflect that if ED mental health staff are rushed and pressured, something is likely to give way. NEAT does have many advantages, however, has the potential to promote short cuts. In this case it is the family or carer who misses out in the rush for throughput. This is not best practice and will likely have caused adverse outcomes for both relatives/carers, and the mental health consumer.

Acknowledgements

The author wishes to express gratitude to Deborah Randall, Robyn Jones and Professor Rosemary Sheehan for their support.

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