Research Bulletin 17

Emergency services and mental illness

sane AUSTRALIA

What do people affected by a mental illness and carers say about the help they receive from emergency services? What is needed to improve the response of police and ambulance services, mental health crisis teams, and hospital emergency departments when someone has a mental health crisis?

About this study
A survey was conducted between November 2012 and January 2013, using a convenience sample of 606 responses to an anonymous questionnaire accessed via www.sane.org. Most respondents were female (77%) and aged predominantly 25-49 (36%). The diagnoses reported most frequently were depression (27%), bipolar disorder (18%), schizophrenia (15%), anxiety disorders (11%), and personality disorders (7%). The survey was intended to investigate the experience of respondents when they had used emergency services for an urgent mental health concern. Results have been used to identify barriers to effective care, and to make recommendations for improvements.

What happens?

Most emergency calls were prompted by concerns about suicide or self-harm.

A mental health crisis, such as an episode of psychosis, was associated with all the respondents' calls to emergency services.

In the majority of cases, however, the emergency call was triggered by urgent concern about the person who was unwell being at risk of self-harm or suicide (72%).

The majority of calls to emergency services occurring when someone is so profoundly unwell strongly suggests that many people are not receiving timely treatment. Their symptoms have been allowed to worsen until there is an actual risk to physical safety before they receive help.

As well as indicating the inadequate level of resourcing for mental health services, this situation also places an inappropriate responsibility on emergency services staff.

How often?

The majority of respondents had called on emergency services multiple times.

Over 80% of respondents had needed to dial 000 or use other emergency services on numerous occasions.

Almost a quarter (23%) of those who completed the survey reported 10 or more emergency situations.

These results suggest that emergency service use by people with mental health problems is dominated by a sub-group who are repeat users: people who are not receiving effective treatment and support while symptoms deteriorate, and become so unwell that they eventually have a crisis. They may be hard to reach, not in contact with services, or in some cases resist treatment because of self-stigma or delusional symptoms.

Whatever the causes for the intense use, this is a high-priority group of people who are not receiving the help they urgently need.

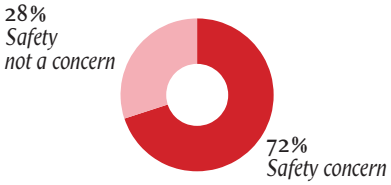
Who gets help?

People are profoundly unwell by the time emergency services are called.

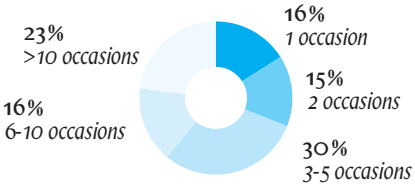
Responses to the survey suggest that people with mental illness assisted by emergency services have become very unwell indeed. The majority (80%) were transported to directly to hospital. Of these, one third (34%) needed to be taken involuntarily, usually with the assistance of the police as well as a mental health crisis team, because of concerns about their safety or that of others. Most (70%) were then admitted to an acute psychiatric ward because of the severity of their symptoms.

Respondents reported that emergency services often showed little awareness of the traumatic impact of the crisis on family or friends (64%). A similar proportion reported they did not receive information about what would happen next (64%) and most were not provided with referral to services to support them (73%).

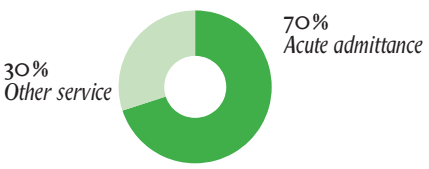
Reason for emergency call



Number of emergency callouts



Outcome of hospital admission



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How long?

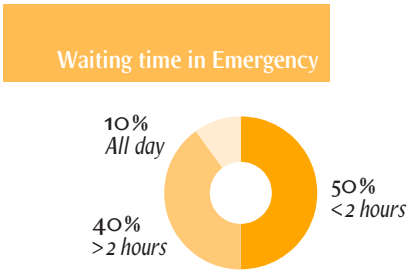
People in mental health crisis often face very long waits in emergency departments.

Despite being severely unwell, people with mental illness can spend many hours waiting in hospital emergency departments before being assessed and admitted to a mental health ward if necessary (and if beds are available).

Emergency departments can be frustrating, difficult places to wait as well as to work, especially during the evening or night. The anxiety surrounding other medical emergencies can also be stressful, on top of the frustration and severe symptoms being experienced.

Emergency department staff may sometimes prioritise people with physical health conditions over those with mental illness. This can be for understandably urgent medical reasons, but it can sometimes be because of stigma too – a perception by some staff that mental health problems are not as 'serious' and can wait.

While half of those surveyed were assessed in two hours or less, 40% had to wait for much longer, and 10% reported waiting all day before being seen.



What next?

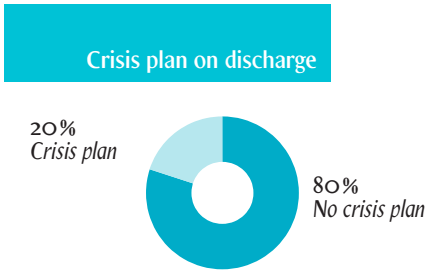
Crisis plans are not prepared for many people on discharge after an emergency admission.

An emergency admission is the climax of a disrupted period in someone's life as they become more and more unwell. A crisis plan helps to ensure the person receives ongoing treatment and support in the community, and so lessens the risk of further emergency admissions.

The majority of respondents (80%) reported that they had not received a crisis plan on discharge from hospital after an emergency admission to an acute mental health ward.

Even in the minority of cases where a crisis plan was developed, few family or other carers were involved in the process. Only 30% of respondents with crisis plans reported that families were included in discussions, despite being crucial to care of the person in the community.

Involvement and support for carers of people with mental illness is widely recognised at a policy level, yet often remains unimplemented at the service delivery level. This not only increases stress on the unwell person and the carer, it also ignores a valuable resource in community care.



Recommendations

Education + training for emergency staff

Ambulance, police, and other emergency services staff need improved education and training on the nature and impact of mental illness. This should include the impact on family and other carers, and where to refer them for support following an emergency call – through a service such as SupportLink, for example.

Emergency department improvements

Improved training of all emergency department staff is needed to better manage and triage mental health patients, based on initiatives such as the ARCHI projects in News South Wales and the NHMRC-supported Mental Health Emergency Care Interface project. Dedicated emergency department areas should also be considered which are less stressful.

Improved discharge protocols

Provision of crisis plans on discharge is an important aspect of treatment and support which is not sufficiently used – an issue highlighted in the National Mental Health Commission's Report Card for 2012. Crisis plans should be an integral part of the discharge process, along with involvement of, and support for family and other carers.

Mental health service funding

A call to emergency services is very often a sign that a person has not received the treatment and support they need, and symptoms have been allowed to deteriorate. More effective and adequately-funded mental health services would help prevent people reaching the stage where emergency services need to be called.

SANE Australia

A national charity helping all Australians affected by mental illness lead a better life.

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