the columns

correspondence

Reforming psychiatric care

Henderson and colleagues (*Psychiatric Bulletin*, March 2003, **27**, 81) make a number of flawed assumptions regarding the use of accident and emergency (A&E) departments by people with mental health problems, and the impact that assessment and waiting targets will have upon these patients. On the one hand, they agree that A&E departments can be an 'inappropriate environment' for psychiatric patients, yet at the same time appear to be advocating that targets to reduce such patients' length of stay in this setting be ignored, as they might compromise patient care.

The implication that A&E departments continue to be a 'major interface between mental health services and acute trusts' should be viewed as a significant failure by health policy planners, managers and clinicians. The fact that so many individuals who are experiencing mental distress end up accessing services via A&E is a reflection of the poor planning, lack of development and under-funding of mental health crisis and home treatment services. It is also, in our view, a reflection of the fact that psychiatrists and other mental health professionals continue to regard the A&E department as a 'default' location for the assessment and treatment of psychiatric emergencies. In the absence of viable alternatives, it is not unusual for mental health staff to advise patients and families to use A&E as the access point for services when faced with a psychiatric emergency or crisis. Such action should be discouraged and the needs of the patient and carer placed to the fore. The majority of patients are clear that A&E is not the place they want to be cared for when in crisis or acutely mentally unwell. There is also a significant amount of evidence that highlights the generally negative attitudes and lack of confidence that non-mental health staff display towards individuals with psychiatric problems (Pacitti, 1998; Hemmings, 1999). It is this information that needs to inform the way that services develop, rather than advocating resistance to 'externally-imposed' performance targets.

While there is often an issue regarding lack of 'ownership' of patients within the A&E department, this should be more accurately viewed as a failure on the part of mental health services to develop meaningful, relevant and accessible care and treatment plans for individuals experiencing mental health crisis. It is interesting to note that the authors of this article do not identify what percentage of patients attending their local A&E department in crisis are already known to mental health services. In our experience, these individuals can account for up to 50% of those attending (or advised to attend) A&E. Of these, a significant number do not have up-to-date care and treatment plans, and there is rarely any attempt to identify crisis management strategies during the period of remission. Add to this the lack of access to patient records and information systems within A&E, and it is easy to understand why this aspect of assessment and care is handled so badly in the emergency setting.

The fact that psychiatric assessments are often complex and time consuming is no reason to advocate that individuals with mental health problems should not have the right to expect the same standards in terms of assessment and waiting times as patients attending with a physical health problem. The time frames quoted by Henderson and colleagues are meaningless without an indication of *why* these assessments take so long. We would argue that this is again a reflection of under-resourced and poorly-planned arrangements for responding to crisis presentations and that, contrary to these authors' implication, there is no direct correlation between the length of time taken to perform an assessment and the quality of patient care.

It could be argued that, as mental health professionals, a 4-hour wait for psychiatric patients within A&E is something that we should be celebrating, as it has the potential to focus the attention of health commissioners on the importance of ensuring that dedicated and appropriately staffed mental health liaison services are provided within every district general hospital. This is an effective and established model of service delivery that remains underdeveloped. The establishment of separate teams 'akin to those used for trauma patients' would only serve to confuse commissioners, service users and general hospital colleagues.

HEMMINGS, A. (1999) Attitudes to deliberate self-harm among staff in an accident and emergency team. *Mental Health Care*, **2**, 300–302.

PACITTI, R. (1998) Damage limitation. *Nursing Times*, **94**, 38–39.

Anthony Harrison, Consultant Nurse (Liaison Psychiatry) and Visiting Fellow, University of the West of England, **William Bruce-Jones**, Consultant Psychiatrist, Mental Health Liaison Team, Hillview Lodge, Royal United Hospital, Combe Park, Bath BA1 3NG. E-mail: william.bruce-jones@awp.nhs.uk

Service changes without professional appraisal or consensus

With the modernisation of the National Health Service (NHS), much of the proposed changes in the mental health services are positive and benefit patients. Changes are not always debated fully within the health community and with service users, however. Changes introduced have repercussions elsewhere, which may not have been foreseen.

Within old age psychiatry, NHS continuing care has been less frequently considered necessary in recent years. Therefore, fewer dementia sufferers continue receiving their care within NHS facilities and are discharged to privately-run care homes. This shift leaves continuing care wards within the NHS unoccupied.

The majority of continuing care wards in recent years were purpose-built in the community, occupying isolated local hospital facilities. They were designed and built to accommodate medically-stable dementia sufferers and other long-term mentally disordered patients. These units do not have the same medical cover, nursing staffing levels and investigative facilities as centrally-located dementia assessment facilities. What future use should these sites be put to?

There may be expectation in many parts of the country to convert these units into dementia assessment facilities. The location, design and staffing (particularly outside working hours) of these units makes them far from ideal for this purpose. The Royal College of Psychiatrists' guidance is certainly at variance and raises clinical risk worries.

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