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# Emergency psychiatry: a product of circumstance or a growing sub-speciality field?

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**Paul Cammell** Senior Psychiatrist, Department of Psychiatry, Flinders Medical Centre, Adelaide, SA, Australia

**Abstract**

**Objectives:** This article reviews recent trends in the provision of psychiatric services to the emergency departments of tertiary hospitals in Australia, involving the establishment of specialised in-reach or liaison services as well as various forms of short stay unit attached to emergency departments. The Emergency Psychiatry Service at Flinders Medical Centre, South Australia, is described as a case example. Its specialised models of assessment and clinical care are described, highlighting how these are differentiated from more traditional models in inpatient, community and general hospital consultation–liaison psychiatry.

**Conclusions:** Emergency psychiatry, and in particular the application of specialised psychiatric models of in-reach service and short stay units, is an increasingly important and growing field of psychiatry that warrants further exploration in research. The Emergency Psychiatry Service at Flinders Medical Centre has developed a distinct group of assessment and treatment approaches that exemplifies this growing field.

**Keywords:** emergency psychiatry, public health, emergency medicine, crisis intervention

In the public mental health sector in Australia, increasing organisational and political emphasis has been placed upon the psychiatric services delivered to emergency departments. This can relate to politicised issues, such as emergency department waiting times or length of stay, adverse outcomes, such as suicidal or homicidal behaviours of recently discharged patients, or critical incidents within the emergency department environment such as iatrogenic deterioration, the use of physical restraints or staff assault.[1,2]

In recent years, a range of models has developed to address these issues and provide dedicated emergency psychiatric services to emergency departments. In-reach or liaison services are provided to offer parallel assessment and treatment of acute presentations, leading to subsequent discharge or psychiatric admission of the presenting patient. Also, variants of short stay unit, such as Psychiatric Emergency Care Centres (PECC), Psychiatric Extended Care Units (PECU) and Psychiatric Assessment and Planning Units (PAPU), have also been implemented to provide more time intensive, acute responses to undifferentiated psychiatric presentations, with the expectation that many acute crisis presentations can be managed and contained in such units, leading to discharge.[3,4]

What follows is an exploration of these models of care, and a description of a case example, the Emergency Psychiatry Service at Flinders Medical Centre. This will seek to demonstrate the role that dedicated and planned emergency psychiatry service provision can play in emergency departments of any particular health service, region or state, depending upon a range of contextual factors.

## Aspects of psychiatric in-reach or liaison work in the emergency department

The context of the emergency department dictates many elements of what liaison or in-reach services offer and what makes them unique. Part of this involves the timeframes involved, calculated in minutes to hours and usually dictated by regional and national key performance indicators such as the national emergency access targets (NEATs).[5] This requires more parallel processing and more use of shared care models than other settings, working closely with the general emergency department team as well as related services such as drug and alcohol

**Corresponding author:**
Paul Cammell, Department of Psychiatry, Flinders Medical Centre, Bedford Park, SA 5042, Australia.
Email: paul.cammell@sa.gov.au

and social work services to achieve outcomes. This also involves close communication with mental health teams, both inpatient and outpatient, to produce more seamless or continuous care, and better outcomes in terms of patient 'flow'. Clinical work involves containment, therapeutic engagement and assessment for *stepped care* (stepped up to inpatient management or down to acute community crisis team follow up), where sophisticated assessment of known clients (active or recent service clients) and novel or undifferentiated presentations (overdose, intoxication with psychiatric symptoms or features of psychosocial crisis) must occur in a timely and proactive fashion.

Increasingly there is a clinical and organisational focus on 'risk assessment', and a balanced, pragmatic approach to the demands of risk categorisation has been well articulated by a group of psychiatric researchers who emphasise the importance of therapeutic engagement and solution-focused or patient-centred approaches over generic, rating-based approaches that do not adequately inform or guide clinical outcomes.[6]

Relatedly, more experienced and cohesive emergency mental health teams often adopt a range of psychotherapeutic approaches to crisis intervention that assist in the emergency department setting: examples would include the referencing and adoption of dialectical behaviour therapy techniques for individuals living with personality disorder; solution-focused strategies and single session type interventions for psychosocial crisis; motivational interviewing and enhancement for drug and alcohol issues; as well as psychoeducation, and couples and family type interventions.

## The adoption of short stay units attached to emergency departments

In recent decades, the historical process of 'mainstreaming' has seen a gradual decrease in dedicated psychiatric emergency departments, receiving houses and walk-in clinics, as well as, in more recent times, the advent and growth of different forms of short stay unit embedded within or adjacent to hospital emergency departments. These units are designed to provide acute, time-limited and intensive care which can involve further assessment and diagnostic clarification, acute therapeutic interventions such as those described in the section above, and initiation of treatment that can potentially contain the clinical situation and avoid further inpatient care, or deescalate the situation to enable further care that is less restrictive or intensive.

It is increasingly seen that these units can offer unique forms of assessment and management that are no longer available in the general emergency department environment due to time, physical environment and other resourcing constraints; while the staffing models, and time-critical and crisis-focused models of assessment and therapeutic intervention make them distinct from typical inpatient units which operate with average lengths of stay between 1 and 3 weeks.

A review of the range of units functioning throughout Australia would indicate that there are variations about staffing models, allied health membership and operational relationships with the emergency department and broader mental health service.[3,4,7] This would partly be due to historical and contextual factors related to the health service that have seen the units arise.

## Examples from the Flinders Emergency Psychiatry Service

The Flinders Emergency Psychiatry Service provides numerous examples of the trends and models outlined above. Established in 2002 by Professor Ross Kalucy, the service began as an in-reach service with a senior psychiatrist, psychiatry registrar and senior mental health nurse providing consultation liaison type input within the emergency department, with the majority of patients seen eventually discharged with appropriate engagement with community supports, and the remaining proportion of psychiatric presentations receiving initial assessment and care before timely transfer to inpatient units.[8] Over time, this emergency psychiatry team developed specific roles and skills involving time critical crisis responses (e.g. to police and ambulance presentations, to behavioural escalation in the emergency department), specific therapeutic approaches involving solution-focused and trauma-focused care as well as approaches to personality disorder-related crises informed by dialectical behaviour therapy and transference-focused psychotherapy,[9–12] involving case review, consensual management plans and strategic crisis plans. The team's expertise was disseminated in a range of emergency department, mental health service and allied service (police, paramedical and drug and alcohol) education, consultation and liaison meetings. The service has also developed medical student, mental health nursing student, emergency medicine and psychiatry training positions which have grown in interest and popularity.

With gradual increases in demand and presentations, and remodelling of the emergency department from 2008–2013, the staffing numbers gradually increased to it becoming a 24/7 service with a doubling of mental health nursing and junior medical staff and overnight nursing staff. In 2014, a dedicated 8-bed short stay unit was commissioned after a range of system research and design studies. This unit, over its 18 months of operation, has led to significant impacts in terms of decreasing emergency department length of stay by 70%, a reduction in adverse incidents and related issues (e.g. use of restraints and guards), and improved system wide flow (e.g. demand for inpatient beds). This has occurred in the context of increasing pressure upon the emergency department related to demands, space restrictions and the advent of NEATs. The emergency department has less capacity to admit patients for short stay in any

form of extended care environment. As a result, there has been a significant increase in drug and alcohol, post-overdose and social crisis presentations being more rapidly admitted under psychiatry. These have accounted for 45–50% of patients admitted to the short stay unit, equal to primary mood and psychotic disorder presentations.[13] These time pressures have also necessitated earlier proactive assessment and engagement with undifferentiated patient presentations to assist the emergency department to make timely management decisions within its own environment.

The Flinders Emergency Psychiatry Service has also included other therapeutic strategies including its own 7-day social worker input, the creation of an embedded low intensity cognitive behaviour therapy follow up service (IAPT@ED),[14] the development of a 'float team' (psychiatrist and junior doctor) which manages prospective inpatients in the short stay unit and general hospital as well as specific care pathways for drug and alcohol, eating disorder, psychogeriatric and personality disorder presentations. The short stay unit was designed and subsequently demonstrated to operate with a 'residual capacity' function where there is an average 60% occupancy but with rapidly changing variance up to 100% occupancy in any 24 hour cycle, thus promoting efficient flow and throughput.

The 15 year history of the Flinders Emergency Psychiatry Service demonstrates the growth in prominence and importance of such a service within a teaching hospital and area health service.

## Conclusions

Emergency Psychiatry has developed gradually over the past 10–20 years in terms of unique, specialised and dedicated service provision, such as the adoption of in-reach or liaison services, and the use of short stay units. The degree to which these developments have been strategic and pre-formulated, or reactive and ad hoc is a matter of contention. If the services on offer are more reactive and ad hoc, in-reach or liaison services can resemble something more like a series of cover arrangements offered by other psychiatric services (such as the inpatient, community or general hospital consultation-liaison psychiatry services); and any short stay unit function may resemble something more like an 'overflow' or 'holding' type ward to facilitate further assessment and management of patients, but without stable or dedicated staff, or an established environment and model of care.

The way emergency psychiatry services evolve and function will determine how they are thought of as learning environments with specific experiences and skills on offer for undergraduate, postgraduate and specialist training in medicine, psychiatry and mental health nursing. Different approaches to the planning and provision of these services will also impact upon the ease with which approaches and findings can be generalised at the level of policy and research. This is clearly different to *de novo* services that are developed and applied in a more homogenous and strategic manner across a state or nation, with less diversity and contextual variance.[15] However, it is certainly conceivable that this growing field will lead to further outcomes research, policy development and shared knowledge that could lead to a more systematised sub-speciality of emergency psychiatry to emerge more fully.

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