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Personality Disorder Improvement Programme – Crisis and Unscheduled Care Webinar Question and Answer

Tuesday 7 March 2023

Mental Health Assessment Unit (MHAU) Questions

Alcohol/drug use
Question - Why is alcohol/drug consumption an absolute exclusion criterion? Where would these people be seen instead?
Answer – Although it is dictated in our standard operating procedure that alcohol/drug consumption is exclusionary, it is not absolute in practice and is very much a clinical decision on whether an assessment of any accuracy can be achieved. When, for example, a referral is received from Police Scotland, the clinician will ask accompanying police officers of their perception of level of intoxication and will then speak with the patient directly to determine this. If the patient is slurring their words and/or incapable of meaningful discussion, they will be redirected to nearest Emergency Department (ED) as a place of safety until they are sober enough to participate. Police remain with the patient until this is possible and following review at ED will transfer the patient to the unit at this juncture. Responsibility remains with the referrer until the referral is accepted.
Question - How do you manage those too intoxicated to assess when presenting with police/ambulance?
Answer - When making a referral, which is initiated by telephone in the first instance, the clinician will ask police or paramedic what is their perception of patient's ability to engage, and will speak directly with the patient to determine this. In the most part, at this stage, the police or paramedic will be advised to relay the patient to ED as a place of safety. They will be reviewed in ED to ensure presentation is not indicative of or a manifestation of physical illness. Once this is ruled out and the patient sober enough, they will then be referred to and accepted for assessment at the MHAU and transferred from ED. If patient has been accepted for input directly from telephone discussion but are too inebriated upon arrival, the same reasoning

applies. The responsibility for ensuring ongoing safety in these instances, remains with the referrer.

Relationships to other services

Question - Does Greater Glasgow and Clyde Liaison service work 24/7 that you can refer to carry out ED assessments or do you send staff?

Answer – Responsibility for all ED assessments lies within the remit of the MHAU. We attempt to facilitate all with our own staffing. We would request assistance from Liaison colleagues due to staffing issues or high level of clinical activity within the units where releasing staff would be unsafe to do so. It is quite common to send one nurse from each unit to facilitate assessment as clinicians can be away for some considerable time. The Liaison service operates 9am to 8pm weekdays and 9am to 5pm at weekends. Also, they cannot accept referrals one hour before close of business. Requests for help from Liaison colleagues is also dependent upon their available resource and is a matter of negotiation. For example, we could agree to one liaison nurse and one from MHAU to carry out the assessment. This arrangement could also be achieved with a nurse from one of the crisis teams if the patient is already open to a Community Mental Health Team (CMHT) and assessment is necessary during operating times of crisis team but outside core CMHT hours.

Question - Do the teams you refer onto (such as Intensive Home Treatment Team) do a further assessment of patient?

Answer – When making a referral, the assessing clinician should have obtained a clear idea of the patient's current difficulty and indicated treatment to initiate recovery. This should always be conveyed within the ongoing referral with sufficient information to explain their reasoning and recommendations. It should be remembered though, that often, people obtain some relief from disclosure, whilst conversely, a deterioration can also occur. Services have their own criteria for inclusion and will generally complete their own assessment, which hopefully is directed by the information already provided for them to ascertain any change in presentation and requirement for their service or that of another.

Question - When collaboratively working with other services - what can this involve?

Answer – We have a number of regular meetings with both inpatient and community services which include:

- Nurse Team Leads from MHAU and all Crisis Teams within Greater Glasgow and Clyde take place.
- A representative from MHAU will attend bed management meetings at Stobhill and Leverndale.
- A rep from MHAU attends a forum with inpatient management and Police Scotland.
- Nurse Team Leads attend Senior Nurse Group meetings which include community and inpatient leads and discuss current issues with colleagues.

Should the question be in relation to actual clinical practice, we often negotiate with colleagues from Liaison or Crisis Teams to facilitate a joint assessment.

- Should Crisis Staff be involved in work that cannot be resolved within their operational timeframe, they make contact with MHAU to request staff be released and MHAU take responsibility for completion. This, for example, could involve MHAU staff attending a home visit where detention is necessary. It could also involve MHAU staff taking over where a medical opinion is desired and the patient has been escorted to a unit to meet with a duty doctor.
- At our Stobhill site, we are co-located with the Crisis Outreach Team. Where there is dubiety over which speciality is most needed, either problematic use of alcohol or underlying mental health problems being masked by such use, we would work collaboratively to ascertain immediate need. This often necessitates discussion only, but can involve joint assessments.

Older adults

Question - Is your service accessed by Older Adults with mental health difficulties?

Answer – It can be, but very much depends upon presentation, whether likely to be functional or organic in nature. If an older adult is voicing suicidal ideation, then of course, it is imperative that they are assessed as an emergency. In this instance, if within core hours, we would contact the locality older adult team and if they are unable to facilitate an assessment, we would of course offer it. Where there is a marked and recent behavioural change, we would require a medical review to rule out for example possible infection or delirium. There was a recent referral where a very elderly person in a care home with a confirmed diagnosis of dementia was referred as the care home were struggling to meet the needs of the individual. This is very

much a social difficulty and an emergency mental health assessment provided no benefit to their care. Older adult psychiatry is a speciality in its own right and they understandably prefer to compete assessments themselves. Should speedy engagement warrant our input, then of course we would oblige.

Question - Do people who access your service also have other conditions such as dementia?

Answer – Yes. Our referral sources such as Police Scotland will make contact following for example a behavioural disturbance leading to their involvement. Depending upon time of day, we would liaise with colleagues if they are known to a service, to achieve best outcome for them. If not within core hours, we would, as a matter of course, request medical review to rule out any physical causes, especially if presentation is markedly different in terms of what is already known in terms of their diagnosis. Co-morbidity with either known physical, mental illness or neurodiversity is very common.

Service design

Question- What band are your Registered Mental Nurse (RMN)?

Answer – Our service consists of band 5, 6 and 7 RMN's.

Question- I'm guessing there will be far more people that qualify for the service than there are provisions for, so I'm wondering how it's decided who gets access?

Answer – Provided someone meets our criteria, we offer access to all. We would never refuse a referral on the basis that we are clinically busy. If possible, we will ask colleagues from Liaison or Crisis Teams to offer help if they can. If this is not possible, then we will advise the referrer that we will get back to them as soon as we can to facilitate transfer. We only accept referrals from other professionals and the transfer from their service to ours is direct. Therefore, the patient will remain the responsibility of the referrer until we can agree to accommodate them at a unit.

Question- What paperwork do you complete for those who attend frequently?

Answer – We use the Brief Assessment Tool for all face to face assessments and either initiate or update a Clinical Risk Assessment Framework for Teams (CRAFT). If an assessment has been achieved over the telephone, if first contact with services then this documentation is also used. If well known, then we can use an SBAR (Situation, Background, Assessment,

Recommendation) and update the CRAFT but would recommend using the Brief Assessment Tool (BAT).

Question- Are assessments completed by one or two clinicians as standard or is it risk dependant?

Answer – It is dependent upon risk mainly, whether assessment is carried out by one or two clinicians. Most are carried out by two due to the unpredictability factors but of course, we do take into account the wishes of the patient and what would be most comfortable for them.

Question- Regarding MHAU providing diagnosis, is that new diagnoses or changes to existing diagnosis with known individuals?

Answer – It can be either. A diagnosis can be very fluid, so it can reflect historical evidence or be in addition to. In our assessment documentation, we would always include previous diagnosis so any emergence of new symptoms would be highlighted within that context.

GAMH Compassionate Distress Response Service (CDRS) Question

Question – Is CDRS now called Distress Brief Intervention (DBI) or are they different?

Answer – CDRS are aligning with the core principles of DBI as an Associate Member. This partnership will allow us to continue to meet the needs of Glasgow as well as addressing the ambitions of the Scottish Governments national distress response model. We will continue to be called CDRS.