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Exploring the developmental need for a paramedic pathway to mental health

Original Citation

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Paramedic Pathway to Mental Health

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Abstract

Paramedic Pathway to Mental Health

The following article discusses an organisational development need of a national 'Mental Health Pathway' for to enable paramedics to provide the appropriate care for people who present mental health issues. The Department of Health (DH) (2005a) acknowledges the huge modernisation of the ambulance service in England and faster access to people with immediate life threatening conditions, however the service is also responding to an increasing number of patients who have an urgent primary care need, which includes mental distress, as opposed to clinical emergency.

The DH (2006) policy calls for a "New Vision" where the ambulance service could increase efficiency and effectiveness towards patients who are experiencing non life threatening emergencies. The key aims are to form a programme of advancement to address both improving mental health and accessibility of services for people with poor mental health. The vision of the policy is that by 2020 mental and physical health will have equal priority. The development of a mental health pathway within the ambulance service may help to reduce admissions or re-attendance whilst improving care for patients.

An evidence-based approach is used to provide a balanced, logical and supported argument within a reflection of practice (Borton, 1970,). This is evaluated against a hypothetical patient's case study which reflects common issues faced by paramedics and ambulance technicians. The analytical process considers patient, professional, organisational and multi-disciplinary team perspectives.

Key Words

Paramedic Pathway to Mental Health

Introduction

The following will discuss an organisational development need of a national 'Mental Health Pathway' for paramedic care. The analytical process of presenting the evidence to show the need for the pathway will be discussed in comparison to other paramedic organisations, patient groups and multi-agency working within Britain. Due to the paucity of academic evidence generated in Britain, evidence from comparable international paramedic practices in the west including the USA and Australia will also be utilised to support the discussion.

Evidence available that underpins the rationale for the developmental need will be discussed and evaluated within a reflection on a hypothetical patient's case study which reflects common issues faced in practice (Borton, 1970). It must be stressed that hypothetical case is to be used to maintain confidentiality and consent that would be required if a real life case study was used (Data Protection Act (DPA) 1998). Further to this use of a 'real life' care study would require approval through the NHS which is beyond the remit of this article. During the reflective element of the assignment the first person will be used. The third person as suggested by Webb (1992), states the third person is strongly recommended for academic writing as it creates an objective, unbiased perspective. The first person creates the opposite of this however is essential when eliciting personal values, goals and reflection. This approach is central particularly when establishing personal or professional roles.

Background

Sociological factors

Around 20% of women are more likely to experience mental health problems like depression and anxiety whilst men have far higher rates of successful suicide and problems with substance misuse addictions (Office of National Statistics (ONS), 2011) The Mental Health policy group (2006), have shown there is a clear association between social deprivation, poverty and mental health problems which are affected by physical health needs and visa versa. People with mental health problems are more likely to be in the lowest socio-economic group and are likely to die on average 25 years younger that a person who is 'mentally healthy'. Such people are at higher risk of stroke, diabetes and coronary heart disease, as the risks are increased because of low socio-economic life style and the unwanted high risk side effects of mental health medication (Barry and Yuill, 2012) Coupled with increased problems accessing screening and primary care services it is likely that a person who is concerned about this and their mental health needs may ring 999 and request an ambulance for both physical and or mental crisis. Barry and Yuill (2012) suggest that mental health has lower status with professionals outside mental health services and this is reflected by negative social attitudes generally (DH, 2005).

Gate Keepers

In accordance with the DH National Service Frameworks (NSF) (1999) Crisis resolution and home based treatment teams were developed to improve care for people experiencing acute mental health problems. They were created to be the 24 hour gate keepers for the increasing demand on acute mental health inpatient services with the focus on assessment and caring for people in the least restrictive environment (Barker, 2004). Sainsbury's Centre for mental health (2001) identified that referrals to CRHTT would primarily come from GP's, Community mental health teams (CMHT's), social workers and police. These professionals have been specifically identified, however there is no mention

of the ambulance service referrals that are more likely to encounter people in mental crisis at the initial point of contact.

This aim of a seamless 24 hour service has not been realised in every area however with many trusts interpreting the recommendation differently and attaching a CRHTT member to A & E which still requires the person in crisis to attend the department and the associated method of transportation which is often an ambulance. To complicate matters further the criteria for CRHTT response does not include people who are under the influence of alcohol or other mind altering substances like illicit drugs and will often refuse to attend a domiciliary visit. This protocol does not consider a person may be experiencing mental distress and may have used such substances to 'self medicate'.

Many people with mental health problems are within the lower socio-economic bracket (Barker, 2004). Therefore if they are experiencing 'out of hours' mental health crisis may be unable to afford fares for taxis or even bus fares and will often call 999 for ambulance instead (Barry and Yuill, 2012). To compound the issue further, changes to the National Out of Hours Contract (2004), mean fewer GP's offer a service outside traditional office hours which also increases call outs for ambulance assistance (Ball, 2012). This by default delegates the responsibility and duty of care to the attending paramedic who's only option in many areas is to transfer to A&E.

Current Paramedic Training

Current training provision has responded to the publics' perception of the ambulance service as an emergency service and organised the main body of training provision around trauma or life threatening medical emergencies like acute coronary conditions or severe breathing problems (Joint Royal Ambulance Liaison Committee, (JRCALC), 2006). However with only 10% of the 999 calls relating to life threatening emergencies it remains that the service is also responding to an increasing number of patients who have an urgent primary care need as opposed to emergency. These individuals continue to present with

minor or no physical injury but an overriding social or mental health problem (Barry and Yuill, 2012, Office of National Statistics (ONS) 2011).

JRCALC, (2006) Devise the clinical guidelines for care for paramedics and ambulance practitioners including the approach recommended for people with mental health issues. These guidelines are broadly categorised into 3 areas which relate to; the transportation of a person subject to detention under the Mental Health Act (MHA)(1983) amended (2007); assessing capacity in relation to consent to treatment and or conveyance, Mental Capacity Act (MCA,(2005); and assessing risk in relation to self harm and or suicide. There are no other paramedic approved directives or guidance statements that practitioners can refer to in order to support their clinical decision making when presented with a person with mental health needs.

New Vision

The World Health Organisation (WHO) (1946) defines health as "a state of complete, physical mental and social well-being and not merely the absence of disease or infirmity". DH (2011b) validates this as a contemporary statement in the policy "No health without mental health" and calls for greater emphasis on mental health issues including; mental illness, severe mental impairment, and sociopathic or psychopathic disorder. Also considered in the document are the conditions of immoral conduct and sexual deviancies. These were previously excluded as stand alone conditions and not viewed as a mental disorder prior to the mental health act revision (MHA, 1983 amended 2007). Significantly to this article the only remaining exclusions relate to people who misuse alcohol or drugs where this is now considered a social issue (DH, 2011b).

The DH (2006) policy calls for a "New Vision" where the ambulance service could increase efficiency and effectiveness towards patients who are experiencing non life threatening emergencies. Sutton, chief executive of South East Coast Ambulance Service NHS Trust (SECAMB) (2010) said paramedics have historically been trained in trauma and emergency care but now are more sophisticated and trained to recognise other symptoms

like mental health problems and are able to treat a person as opposed to a condition. Shabon, (2006) furthers this and states that mental health issues are being prioritised on an international level with calls for increasing need to develop the mental health skills of all health professionals including paramedics to improve the co-ordination of services.

The idea of developing a mental health pathway for ambulance services is supported in the mental health focussed DH (2009) New Horizons document which calls for multi-agency collaboration to seek out new, dynamic approaches in mental health care which is innovative and cost effective particularly during a period of recession. The key aims are to form a programme of advancement to address both improving mental health and accessibility of services for people with poor mental health. The vision of the policy is that by 2020 mental and physical health will have equal priority. Maintaining the equity of importance in relation to physical and mental health needs will be accepted as the solution to maintaining overall health and wellbeing which may reduce the incidence of 999 call outs for the ambulance services.

Forward thinking Ambulance services like the SECAMB and the Kent and Medway and Social Care Partnership Trust (KMPT) have already established a protocol which was implemented in July 2010 (Commissioning for Quality and Innovations (CQIN), 2010). It was developed to enable Ambulance staff direct access to a full range of mental health services twenty four hours a day, seven days a week thus relieving pressure on the accident and emergency (A & E) departments (DH, 2010). A number of ambulance services do not have such a protocol therefore their only option is A & E. This presents a disparity of approach for the paramedics and technicians who may find themselves 'out of area' and are expected to present a patient 'in crisis' to the nearest receiving A & E without prior knowledge of the local protocol.

Paramedic expectations

During the meantime paramedics and technicians are expected to address the needs of people in mental health crisis by removing the person to A & E, which is not considering the holistic needs of a person in mental health crisis (Barker, 2006) (DH, 2009). This is in opposition to the first standard of professional conduct and ethics by the regulatory body, Health Professional Council (HPC) (2008) (p3) which states the paramedic "must act in the best interests of the service user". For a person who is experiencing mental distress and does not meet the mental health Crisis Resolution, Home Treatment Team (CRHTT) criteria a four hour waiting (as indicated in the targets for emergency departments, DH 2011a) may be expected and is not in their best interest. The development of a mental health pathway may help to reduce admissions or re-attendance in addition to the frustration experienced by both the service user and staff may reduce the incidences of aggressive behaviour (DH, 2009).

Reflection

The following section is written in the first person and is a reflection of a person's journey from the initial point of contact through to referral to appropriate service provision. As previously stated this is a hypothetical patient that is based on a commonality of experiences that I have been directly involved with throughout my career as a paramedic and including my time as a student. Whilst it is not uncommon for these experiences to happen I must stress that any similarity to a particular person is purely co-incidental. The reflective elements however are real thoughts and feelings that I have experienced when in similar situations.

Reflection in care provision has long since been utilised as a way of improving and developing practice however it is relatively new concept in terms of paramedic training. Boud et al. (2005) (p.19) defines reflection as "an important human activity in which people recapture their experience, think about it, mull it over and evaluate it". Reflection can be used to highlight process and analyse difficult experiences on a personal and professional

level. Pearce (2003) however warns against reflecting too intensely or in a naive manor as the heart of the issue may be lost over time and with the distortion that time distance creates. The reflective tool recommended by Johns (2004) is particularly useful and allows for reflexivity (reflection in action) however a naive or inexperience reflector may easily be lost in this complicated model and the value of reflection will be missed. Good reflective practice would include the reflector being able to recognise any areas for development, consistent approaches and or an ability to address those needs as required. Johns 2004).It is with this in mind I prefer to use the model by Borton (1970) for the simplicity of the model which is; 'What? So what? Now what? However it will be furthered with my addition of 'then what?' This allows me to consider the wider issues of the patient, profession and organisation.

Case study

What?

For the initial "What?" element of the reflection I am going to describe a hypothetical incident around a lady who for the purpose of this piece of work will be called Sally.

Sally is a 38 year old lady who lives in a lower socio-economic area with her 10 year old son. The area is in the catchment of a local ambulance service trust that does not currently have a specific mental health pathway other than conveying to A&E or involving the police.

Sally called 999 and requested ambulance assistance at 22.00 one Friday evening. She described herself as having a mental health crisis to the dispatcher who mobilised the ambulance crew I was part of to attend. She stated that she was 'hearing voices' and needed urgent assistance as she was feeling suicidal. The dispatcher reassured Sally that there would be an ambulance on its way and not to worry.

On arrival it was apparent that Sally was indeed in great distress. She presented as agitated, tearful and had cut off her hair. The scissors she had used were still in her hand and her opening statement was that if I didn't help her then she would cut her own wrists.

Her young son was present but sat in the corner of the room quietly crying and at that point said nothing. The room whilst in a state of disarray appeared clean and well maintained however there was evidence of a half bottle of wine on the table.

When asked, she said that she had a long standing mental health history of schizophrenic illness that was in the main well managed however she had had a recent period of stress and could feel her mental health deteriorating rapidly as was her relapse signature (Barker, 2004). She reported that she had tried to contact her Community Psychiatric Nurse (CPN) who is her key worker earlier in the day but she was not available as she is part time and does not work on Fridays. There were no other team members available to attend and Sally was advised to contact her GP. The GP's receptionist had informed Sally that there were no appointments available for a week and to call back Monday for a cancellation or ring her CPN. Sally again rang her CMHT who called the CRHTT for an emergency assessment. By this time Sally was very distressed and had had a glass of wine to "calm her nerves". As she had been drinking the CRHTT refused to attend but advised Sally to attend A&E.

Sally described feeling agitated and her voices saying that people were 'out to get her' and felt unable to sit in A&E until the on call psychiatrist was available. Instead she drank more of her wine. By this time her mental health was deteriorating further to the point where she was feeling the need to harm herself and time was pressing on into the evening. Sally realised that she did indeed need to see a mental health professional urgently but by this time she did not have any money for a taxi so called 999.

So what?

The following will be broken up into sections that will cover the main points of the reflective scenario in relation to a mental health pathway which will include; risk, personal, organisational, and MDT issues. This list is not exhaustible but for the constraints of the

article criteria others may be acknowledged but not elaborated for their nature is not entirely relevant to the proposed pathway.

The initial question I asked when I was asked to attend this detail was what part of the estate did this lady live? As I was familiar with this particular ambulance services patch I was aware that there were some personal safety issues that needed to be taken into consideration as parts of this area were high risk in terms of substance misuse and the associated crimes (Barry and Yuill 2012). This may have implications on whether I may request police assistance at some point.

The second question that I asked was did Sally mention how she intended to commit suicide? The mode of suicide would determine further possible issues again in relation to personal safety. If Sally intended to take an overdose of medication then my personal safety may not be an identified risk however as in the case of Sally she was in possession of scissors they could equally be used as a weapon. Further to this I asked if Sally had expressed what her voices were saying. If the voices were merely a running commentary of her actions or indeed a benevolent style of discourse then the risk would be minimal (Barker, 2004, Sainsbury Centre for Mental Health, (SCMH) 2000). However if the voices were malevolent, as is often the case with schizophrenia of the paranoid nature then this may increase the risk, particularly if the auditory hallucinations were commanding and could have been directing her to "kill the man in green". (Barker, 2004; SCMH, 2000).

Sally met us at the door with scissors in hand however she was holding them and not brandishing them. I asked her to put them down which she did immediately and it was apparent that she was not an immediate threat to us. Her hair was chopped and she said this was an expression of how bad she was feeling. It was clear she had had a drink as there was evidence in the smell of alcohol however she did not appear overtly intoxicated.

As people who are experiencing mental health crisis are on the increase, Terry, (2011) suggests there is a need for mental health training programmes to be delivered to all people working in statutory organisations. Australia is one of 16 countries who provide 'Mental Health First Aid' (MHFA) which is aimed at providing help and support prior to

specialist professional help is available. Whilst the project is viewed as successful there needs to be a clear infrastructure in relation to training and support including monitoring the quality of the training. Shabon (2004) however reported that despite 'training' paramedics still reported they were unprepared when addressing mental health needs and felt at times under physical threat. Miller et al (2008) described the dangers of being alone with an aggressive person in a confined space like an ambulance as deeply concerning. Whilst not every person who experiences mental health crisis are aggressive, pain; whether physical or emotional is an identified risk factor in relation to violence and aggression which clearly puts at risk the attending paramedic or ambulance technician. (Barker, 2004. SCMH 2000)

From the situation I observed in the house, Sally functioned at a very high level in terms of her day to day life and was in what appeared to me to be a time of crisis (Norman and Ryrie 2009, Barker 2004). I felt that had she been able to access her key worker CPN, GP, or crisis team directly as per the requirements of her advanced directive which she informed me was in place then her perceived need to ring an emergency ambulance would have been averted (DH, 2007). The NICE guidelines (2011) recommendations have far reaching implications for all primary and emergency care services including the ambulance service and police by stating that all people who are in mental health crisis should be able to access their treatment plan including an advanced directive which should include details of their preferred care (DH, 2007, DH, 2009). The guidance recommends that all patients are treated with dignity and respect however the lack of it has been highlighted in the DH, (2009) 'No health without mental health' which identifies people with mental health problems are unlikely to receive the same standard of health care than the general population. Typically, it is often problematic to identify mental illness as opposed to physical illness which is visible or measurable by a trained professional (Barker, 2004, JRCALC, 2006). There is physiological evidence available unlike mental

illness where the assessor has to rely on the information offered by the individual and their knowledge of mental health conditions (Barker 2005).

I was equally concerned for the psychological safety of her son who at that point had not spoken and remained unobtrusive in the corner of the living room and I identified this as a safeguarding issue. (DH 2003, DH 2004a, DH 2004b)

Now what?

In terms of caring for a person who is in mental health crisis and does not meet any of the MDT system criteria for support I feel the system is failing it its' duty to care for people who are arguably among the most vulnerable sections of the community (Barker 2006 Barry and Yuill 2012, HPC, DH). The Bradley report (DH, 2005) encouraged the development of clinical staff to complete advanced training in supporting primary care particularly during the 'out of hours' window. With approximately 15% of care provided by the ambulance service now facilitated at home, paramedics and ambulance technicians are using an amalgamation of their clinical judgment supported by additional training or the triage skills of the dispatcher to refer people to appropriate pathways (Information Centre for Health and Social Care (ICHCS) (2010). Unfortunately there remains a dissonance between governmental policy supporting paramedic role advancements and the traditional viewpoint of the ambulance service as just a way of transporting a person rapidly to hospital (Heath and Radcliffe, 2009).

Then What?

In conclusion the proposal shows that whilst the role of the paramedic is not to diagnose a mental illness per se they should be able to identify key indicators in mental deterioration and as are result be qualified to signpost or activate an appropriate care pathway People who have experienced mental health crisis report they are dissatisfied and distressed by long waits for treatment particularly in A&E departments in addition to the intimidating environment this presents.

Teams like the CRHTT and A&R departments could be pre-alerted in the same way that a cardiac arrest may be pre-alerted which would allow for the patient to be effectively triaged by a specially trained mental health professional. An approach like this would foster positive working partnerships between mental health, ambulance and A&E teams whilst facilitating a change of perception of what the ambulance service provides.

DH (2005), DH (2008), DH (20011a) reports that whilst there is an increase of effectiveness at the point of delivery, frontline staff like paramedics have received less investment for development. As a result the ambulance services whilst working harder are prevented from the opportunity to work smarter. By investing in a national clinical pathway in relation to mental health emergency which would include the concept that paramedics and ambulance technicians would be able to refer appropriate people directly to CRHTT. The pressure on frontline workers including A & E would be alleviated and fulfil the directives of DH, 2004, DH, 2006, DH, 2010, DH, 2011b to create a seamless service and quality care for all.

Key Points

- The findings show an organisational development need of a national 'Mental Health Pathway' for paramedic care.

- The service is also responding to an increasing number of patients who have an urgent primary care need like mental illness as opposed to emergency.

- Other than directives from JRCALC there are no other paramedic approved directives or guidance statements that practitioners can refer to in order to support their clinical decision making when presented with a person with mental health needs.

- There is an increasing need to develop the mental health skills of all health professionals including paramedics to improve the co-ordination of services.

- By investing in a national clinical pathway for the ambulance service in relation to mental health emergency, paramedics and ambulance technicians would be able to refer appropriate people directly to CRHTT, thus the pressure on frontline workers including A & E would be alleviated and fulfil the directives of DH, 2004, DH, 2006, DH, 2010, DH, 2011b to create a seamless service and quality care for all.

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