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COMMENTARY

Deterioration in mental state: A National Standards conundrum

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INTRODUCTION

Expedited interventions are integral to reducing mental health related morbidity and mortality in general hospital settings. The early recognition of a worsening mental state is essential for optimizing care and treatment of patients in need of specialist assessment, escalation and response. However, a lack of mental health training provides a challenge for generalist clinicians in recognizing clinical cues of variance consistent with a change in mental state, and subsequently acting upon them.

In April 2010, Australian Health Ministers endorsed the National Consensus Statement 'essential elements for recognising and responding to clinical deterioration' as the standard national framework for recognition and response to patient clinical deterioration in acute care facilities. In 2012, this consensus statement informed the first National Safety and Quality Health Service Standard for recognizing and responding to acute deterioration, which became part of the inaugural Australian Commission on Safety and Quality in Healthcare (ACSQH) National Standards (hereafter National Standards).

Generalist healthcare facilities were thus required to develop systems, processes, education and training to address the criteria contained within this National Standard, which initially focussed on physiological deterioration only. However, the 2012 National Standards have since been rescinded and superseded in 2017, where recognizing and responding to acute deterioration also encompasses acute changes in mental state. Consequently, significant attention within healthcare organizations now focusses on screening, monitoring, escalation and referral for, and of, acute deterioration in a person's mental state. However, screening and assessment of a deteriorating mental state has unique nuances and complexities not found in its physiological counterpart, which provide a significant challenge for Australian healthcare organizations, and perhaps consultation liaison nurses in particular, in meeting accreditation mandates and requirements.

This commentary explores the concept of a deterioration in mental state, the challenges for healthcare practitioners in addressing this if efforts are misguided, and finally outlines suggestions for healthcare organizations in meeting the requirements set out in the National Standards, which may confound some organizational attempts and thinking to date.

CONCEPTUALIZING DETERIORATION IN MENTAL STATE

The absence of a professionally and globally accepted operational definition of what constitutes a deterioration in mental state underpins the challenge faced by healthcare organizations in addressing this issue. Notwithstanding, some attempts have been made to conceptualize this. In reports commissioned by the ACSQHC, deterioration in mental state has been broadly operationally defined as:

> A change for the worse in a person's mental state, compared with the most recent information available for that person, which may indicate a need for additional care

In the same reports, it is recommended to assess for the following indicators of deterioration: *reported change*, *distress*, *loss of touch with reality or consequences of behaviours*, *loss of function*, or *elevated risk to self, others or property* (Gaskin, 2019; Gaskin & Dagley, 2018). Elsewhere, in a systematic review of indicators for deterioration in young patients with mental illness by Dewa et al. (2021), the authors suggested assessing for the following as indicators of deterioration in that respective cohort: *changes in mood*, *behaviour*, *affect*, *thought*, *perception* and *cognition*. So it can be seen that qualitative descriptions are positioned within this space of recognizing a deterioration in a person's mental state, which may not 'speak to' quantifiable or measured values.

RECOGNIZING DETERIORATION IN MENTAL STATE

As a consequence of the 2017 inclusion in the National Standards, considerable professional debate has arisen in relation to the 'how to' of recognizing a person's deteriorating mental state. The National Standards make reference throughout to organizational processes and behaviours (Actions) relevant to the recognition of this (See Box 1 for key elements relevant to this context).

Within the 'Standard', deterioration in mental state positions after its physical health counterpart with clinicians screening for or monitoring biological or physical health biomarkers such as: *blood pressure*, *heart* and *respiratory rate*, *oxygen saturation*, *level of consciousness* and *body temperature* (Gaskin, 2019; Gaskin & Dagley, 2018). It is perhaps unsurprising then, that some organizational efforts to meet this deterioration in mental state addition to the 'Standard' have seen comparisons with its well established physiological counterpart. Attempts at developing similar screening tools and alerts to that of physical health screening have emerged, aimed at scoring or aggregating a deterioration in mental state. Whilst these efforts may at first seem a logical solution, they reflect a quantitative paradigm which may be misguided. Elsewhere, authors have recently proposed a 'distress' framework for non-mental health professionals in tracking deterioration (Forster et al., 2022). Perhaps the ACSQHC statement, found in the 'Standard' guidance (Box 1), relating to the current absence of a tool which tracks mental state deterioration has enthused a pursuit of efforts in this space.

Conceptually, 'deterioration in mental state' is arguably ill-aligned with a biological and quantifiable approach. A person's 'mental state', values and preferences are idiosyncratic and unique, which challenges the norms seen in other health parameters. Consequently, there are arguably no universal 'healthy' or 'normal' parameters from which deviation or deterioration can be measured. Consider, for example, persons with long-term suicidal ideation who do not self-harm, or persons living with and functioning highly with 'voices'. Such is the dynamic and idiosyncratic nature of a mental state, a comprehensive assessment of each person's baseline would have to be undertaken in the first instance, before recognizing if an acute deterioration exists.

BOX 1 Recognizing deterioration in mental state—key elements and strategies (Action 8.05).

The health service organization has processes for clinicians to recognize acute deterioration in mental state:

- Initial screening should identify people who are at risk of acute deterioration in their mental state, including patients at risk of developing delirium.
- If screening identifies risk of deterioration in a person's mental state, conduct a complete mental state examination.
- People who have not been identified as being at high risk can also experience deterioration in their mental state. Be alert for changes in mental state in all patients.
- Develop systems to routinely monitor patients at risk of deterioration in mental state.
- No tool currently sets out objective criteria for tracking deterioration in a person's mental state equivalent to observation charts for physiological deterioration. Nonetheless, there are parameters that can indicate deterioration in a person's mental state, and these can be used to develop individualized monitoring plans in collaboration with the person, and their carers' and families.

Within mental health settings, ongoing psychiatric assessment and mental state examinations will generally identify changes, and thus potential deterioration, in a person's mental state. The key components of observation, direct questioning and formulation, in assessing: *behaviour*, *mood*, *affect*, *thought content*, *thought processes*, *perceptual disturbance*, *cognition*, *insight* and *judgement*, require time, skills and expertise. Such assessments have obvious resource and feasibility challenges in non-mental health settings. Likewise, the subjective, dynamic and idiosyncratic nature of signs and symptoms of a potential deteriorating mental state makes it particularly challenging to be embedded into existing track and trigger or scoring systems that are quantitative in nature (Sands et al., 2017).

So what does this mean for non-mental health settings in meeting the obligations set out in the National Standards? Given that 'deteriorating mental state' remains a somewhat nebulous concept which is yet to be defined

in any helpful or systematic way, we advise that attempts to develop quantitative screening or assessment methods in this context are unnecessary, and akin to the proverbial 'square peg in a round hole'. Whilst the most recent guidance from ACSQHC in 2022 falls short of instructing organizations and individuals within against pursuing this, it does provide the clearest indication yet that efforts should focus elsewhere. For example, the guidance states that the 'Actions' which organizations must undertake

> …do not call for a chart to be used to monitor a person's mental state;

instead suggesting that processes are in place to: (1) screen for risks; (2) assess needs and risks identified through screening; (3) develop comprehensive care plans; and (4) establish protocols for escalation of an acute change to specialist health professionals.

To that end, we propose that non-mental health organizations focus their attention on processes and systems that recognize deterioration in mental state and guide escalation and referral. The subjective observation of distress alone or change in behaviour are arguably enough to trigger these assessment and escalation processes. We recommend that healthcare organizations identify existing governance processes, screening points and assessment frameworks which support deteriorating mental state recognition and response, throughout a patient's hospital presentation and admission trajectory. Such screening points typically occur in the emergency department (e.g. triage), on admission to ward (e.g. nursing and medical assessments), throughout hospital stay (e.g. routine surveillance, monitoring and physical assessment practices); and on discharge (e.g. GP or specialist referrals). Our organization's approach to this; what clinicians actually do to recognize a deterioration in mental state at each of the screening points along the care continuum, and the response of ACSQHC surveyors to this approach during accreditation in June 2022, will be reported elsewhere and can guide other healthcare organizations in meeting accreditation requirements.

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DATA AVAILABILITY STATEMENT

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