Submission to NSW Health: September 2017

REVIEW OF SECLUSION, RESTRAINT AND OBSERVATION OF CONSUMERS WITH A MENTAL ILLNESS IN NSW HEALTH FACILITIES

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback to NSW Health on the review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities (the Review). The Review aims to consider the consistency of NSW legislation, policy, clinical governance and oversight, principles and practice standards with national standards, leading evidence, best practice, and consumer and community expectations, and the application and extent to which these have been adhered to across NSW Health facilities with acute mental health units, mental health intensive care units and declared emergency departments (EDs).

According to the Review, the NSW Mental Health Act (2007) (the Act) and existing NSW Health policy require NSW Health staff to ‘undertake all possible measures to prevent and minimise disturbed or aggressive behaviour, and reduce the use of restrictive practices such as seclusion and restraint’.1

In 2005, reducing use of restrictive interventions was identified by the Commonwealth Government’s National Mental Health Working Group as one of the four safety priorities in mental health services, with EDs identified as a secondary target group outside inpatient mental health services.2 More recently, to ensure safety and quality in mental health care, version two of the Australian Commission on Safety and Quality in Health Care’s National Safety and Quality Health Service Standards has been developed with new mandatory actions specific to mental health that will be assessed in mental health services and EDs from January 2019.3

ACEM is the not-for-profit organisation in Australia and New Zealand responsible for the training and education of emergency physicians and advancement of professional standards in emergency medicine. The practice of emergency medicine is concerned with the prevention, diagnosis and management of acute and urgent aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders.4 As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients. Fellows of ACEM (FACEMs) are specialist emergency physicians working in EDs across Australia and New Zealand. For the Review, NSW Fellows provided narrative responses to ACEM on their use of restraint with mental health populations in the ED. ACEM’s policy position is to treat all patients presenting to the ED with an acute mental and

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behavioural condition with the same dignity and respect afforded to patients presenting with any other condition requiring emergency medical care.⁵

Emergency departments are often the first point of access to specialist mental health care in the Australian public health system. In 2014/15 mental health-related presentations were estimated to account for 256,178 (3.4%) ED occasions of service. During the same period, in NSW there were 88,469 mental health-related ED occasions of service, or 117 per 10,000 population. Of these, 52,907 (53%) had an episode end status of ‘non-admitted patient ED service episode completed’, where the patient departed the ED without being admitted or referred to another hospital.⁶ ACEM wishes to strongly underscore to the Review the significant underestimation in national and jurisdictional data collections of the impact of acute mental and behavioural conditions in EDs, e.g. presentations involving self-harm are currently excluded and those involving multiple comorbidities may be classified under other primary causes.⁷

SECLUSION AND RESTRAINT

Seclusion is defined as the ‘confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented’, with the purpose, duration, structure of the area and awareness of the patient irrelevant to this determination. Restraint is defined as the restriction of an individual’s freedom of movement by physical or mechanical means.⁸ Although not included in the definition, rapid sedation, as an alternative to restraint in mental health emergencies, is still considered restraint by consumers, carers and others. There is a close relationship between serious adverse events and the use of restraint and seclusion.⁹ NSW public health facilities are mandated to complete an incident report for all episodes of aggression and enter all episodes of seclusion and restraint into the NSW Health Seclusion/Restraint Register.¹⁰

Emergency departments in NSW are subject to several NSW Health Policy Directives and Guidelines. For instance, the mandatory NSW Health Policy Directive 2015-004, governing use of restraint in NSW public health facilities, focuses on dealing with behaviourally disturbed and/or aggressive patients or other individuals who pose a risk of harm to themselves or others, and clearly states that manual and mechanical restraint should be used only as a last resort. This policy does not cover pharmacological restraint.⁹ Pharmacological restraint is governed by Policy Directive 2012-035 and, in NSW, emergency sedation or rapid tranquillisation to manage disturbed behaviour resulting from a mental illness is not considered restraint.¹⁰ The supporting guideline to Policy Directive 2015-004 (Guideline 2015-007)

states that in NSW EDs, sedation is indicated for patients with an acute severe behavioural disturbance whose behaviour puts them or others at immediate risk of serious harm, with brief physical restraint indicated for the purposes of administration of sedation where necessary.\textsuperscript{11}

Consistent with NSW Health Policy Directives and Guidelines, ACEM policy on access to ED care for mental health populations advises – with simultaneous regard for autonomy – urgent management of patients with an acute mental and/or behavioural condition that causes them to be an immediate threat to themselves or others. ACEM advocates for a team-based approach by staff trained and practised in verbal de-escalation, therapeutic sedation and physical restraint. Physical restraint is advised as a measure of last resort and ACEM considers prolonged physical restraint in the ED inhumane. ACEM actively discourages the use of prone restraint, which carries increased risks of musculoskeletal injury and respiratory compromise.\textsuperscript{6}

Pharmacological restraint – or emergency sedation – has become an increasing necessity in contemporary emergency medicine practice given emergency physicians’ duty of care to protect themselves, ED staff, patients and others from patients exhibiting escalating aggression and violent behaviour, which according to Fellows is on the increase.

Seclusion and physical or pharmacological restraint is occasionally an unavoidable step required to ensure safety for all involved. It has to be used in conjunction with other modalities, but ... I will follow the advice of the police and physically restrain [the patient] whilst I am ensuring pharmacological restraint is achieved and full assessment ... is possible. The existing mental health legislation cannot address this issue of extreme violence, which is increasing in our EDs (FACEM).

In these cases, disturbed behaviour in the ED may relate to distress associated with mental illness, symptoms of psychosis and increasing presentations involving alcohol and other drug intoxication and withdrawal, combined with factors associated with acute health system dysfunction such as excessively long ED wait times, limited safe assessment facilities, and access block.

Chemical restraint is frequently required (several times per shift, for up to six to seven patients). While this is sometimes unavoidable, in other cases it is required because of lack of a treatment space to assess the patient. The patients are often spending many hours in the ambulance bay, where the atmosphere is not the peaceful and supportive environment required to assist [them] to regain reasonable self-control. These patients then lose the small amount of patience which they may have had on arrival, and behave in a way which threatens the safety of themselves and/or others. This triggers ED staff to utilise chemical restraint, or the patient is allowed to leave without having received the care requested (FACEM).

NSW Fellows consistently report that restraint is used in the ED as a means of mediating and protecting against aggression and violence in patients who are non-responsive to verbal de-escalation strategies and offers of oral sedation, or to ‘buy time’ while waiting for sedation to take effect. ACEM wishes to note to the Review, however, that most patients in this group are cooperative and consent to emergency sedation when required, mitigating any need for manual restraint. Nonetheless, there appears to be uncertainty around procedures and actions for monitoring restraint among some emergency physicians in public EDs in NSW.

Unfortunately in the rare situation in emergency for the protection of staff and the patient, physical restraint is required whilst awaiting the effects of pharmacological restraint. Having seen … the violence that can on occur with patients with mental illness (often triggered with concomitant use of illicit drugs), seclusion and restraints are required when all other avenues have been explored in a timely manner. There needs to be a guideline (our hospital has one) that monitors the use of physical restraints to ensure the patient does not suffer from harm with [their] use (FACEM).

Limited ED resources – human, clinical, temporal and material – allocated to safe assessment and management of behaviourally disturbed patients also contribute to an inability among specialist emergency physicians to reduce restrictive practices. Perversely, at the same time interventions involving seclusion and restraint consume and constrain valuable ED resources in an already time-pressured environment. Such dilemmas are faced by NSW Fellows on a shift-by-shift basis.

Restraint, be it chemical or physical or generally both, is not something lightly entered into by ED staff. In doing so it means mental health assessment is delayed, patient invariably occupies a high value resuscitation bed, and observation during this time is labour intensive for nurses and doctors (FACEM).

In its assessment of the use of seclusion, restraint and observation of mental health consumers in NSW health facilities, ACEM urges the Review to give due consideration to the indications for restrictive practices in the emergency medicine context and examine closely ED resourcing and design across all NSW public hospitals.

MENTAL HEALTH ACCESS BLOCK
Exacerbating an already acute psychiatric episode, patients presenting to EDs with mental health concerns have unacceptable lengths of stay following triage and assessment, which is known as access block. Access block is defined by ACEM as the situation in which patients who have been admitted and need a hospital bed (including in specialist mental health services) are delayed from leaving the ED because of lack of inpatient bed capacity. Access block has historically been seen as ‘an ED only problem’; however, it is symptomatic of a health system in crisis, with a lack of hospital inpatient bed capacity compared with demand.

Reducing access block in EDs would allow these (and all other) patients to be assessed and treated in a more humane manner (FACEM).

12 ACEM. Statement on access block (S127). Melbourne: ACEM; 2014.
While playing an essential role in the initial assessment and management of patients with mental and behavioural conditions, ACEM emphasises to the Review that the ED is inappropriate for the ongoing care of this patient group. The high stimulus ED environment and design can contribute to further distress and agitation.5

EDs should not be used to contain involuntary patients beyond the initial assessment and stabilisation period (FACEM).

ACEM wishes to highlight to the Review the high prevalence of access block facing mental health patients in the acute health system, which is very concerning. Data from ACEM’s 2016 Annual Site Census suggest that of all mental health presentations to the ED, the majority wait more than eight hours following assessment for an inpatient admission.13 ACEM is currently piloting research in EDs to estimate the prevalence of ‘mental health access block’.14 Preliminary data are suggesting around one-third of patients with an acute mental and behavioural condition wait more than eight hours in the ED, with some of these patients reportedly waiting in the ED for days.15

Very poor access to mental health beds that keep scheduled patients in the ED for days at a time (FACEM).

In NSW, it is the responsibility of mental health services to locate an appropriate bed in an inpatient mental health unit. However, according to NSW Fellows demand for beds is not being met and patients in distress are being held in EDs for excessive lengths of stay while they wait for admission. ACEM advocates for measures across the entire health system to address the dangerous levels of access block facing patients in hospital EDs across NSW. ACEM proposes to the Review that restrictive practices in EDs could potentially be reduced by health system interventions that target mental health access block across NSW public hospitals and increase access to inpatient mental health services for this population.

EMERGENCY DEPARTMENTS WITH NON-GAZETTED MENTAL HEALTH FACILITIES

ACEM estimates that approximately 175 public EDs are in operation across the state of NSW, with 38 of these accredited by ACEM for the purposes of specialist emergency physician training. As at 2014, about 40 public EDs were in the ‘mental health emergency assessment’ class according to the Act and are gazetted as declared mental health facilities.16 Emergency departments in this class are typically attached to a major acute care provider and referral hospital in an area health service. These EDs are restricted to the provision of acute assessment functions, insofar as a patient can be held in anticipation of discharge should their clinical condition rapidly resolve, or transferred to a declared mental health facility of the ‘mental health assessment and inpatient treatment’ class where required.

13 Data from the ACEM 2016 Annual Site Census (N=134), an annual survey of Directors of Emergency Medicine Training (DEMTs) in ACEM-accredited EDs across Australia and New Zealand. In 2016, 92% of DEMTs reported that mental health patients wait more than eight hours for inpatient admission in their ED, and 74% reported that patients wait for more than 24 hours.

14 Mental health access block is defined by ACEM as waiting in the ED following assessment for eight hours or more for an inpatient mental health bed.

15 Preliminary data from EDs participating in the ACEM 2017 Mental Health Access Block Point Prevalence Survey pilot.

NSW Fellows working in non-gazetted EDs in smaller, regional hospitals without declared mental health facilities report that seclusion and restraint is often the only option available to them for the management of behaviourally disturbed patients. This is particularly the case for non-declared EDs that receive scheduled, psychotic and/or suicidal patients via police and ambulance services.

My biggest issue is working regularly in a couple of hospitals … without a mental health service and having the police and ambulance officers, as well as community mental health, continue to bring scheduled … mental health patients to these non-gazetted facilities where I have no other option but to sedate and isolate these patients, often for 24 to 48 hours, until they are accepted by, and transportation [is] available to [take] them to the designated [mental health] facility in our [local health district] … I would love to see [negotiations with ambulance and police services] … to bypass these [smaller] hospitals, just like trauma bypass, as often [they] don’t have the resources to deal with these patients, and keeping them locked up for long periods of time without a formal [mental health] assessment is not only detrimental to their health, but a violation of human rights... (FACEM).

In these cases, NSW Fellows argue that such problems in smaller hospital EDs could be ameliorated by undertaking mental state examinations in the community prior to transfer to determine the appropriate stratification for patients highly at risk and who require specialist inpatient mental health services. Disposition of patients to a more appropriate facility could be expedited, as currently occurs with severely injured trauma patients.

SAFE ASSESSMENT ROOMS
Safe assessment rooms have been established in larger public EDs in NSW.17 Under the Act, in NSW many EDs resourced with safe assessment rooms are also declared mental health facilities. Safe assessment rooms are designed as multipurpose rooms that provide ED staff and patients with an enclosed private space to manage sensitive needs, including ‘to manage behaviourally disturbed patients, for patients requiring high-level observation and to undertake assessments of mental health patients’.18

While safe assessment rooms are not intended for seclusion, according to its definition a person held alone in an environment from which they believe they cannot exit meets that definition and incurs clinical, procedural, reporting and review requirements.8, 13 In some cases, NSW Fellows report that safe assessment rooms can be used in the ED to contain involuntary mental health patients, which is again indicative of inadequate acute and community mental health resourcing and poor inpatient mental health unit capacity.

ED … facilities are inappropriately used for the containment of mental health patients because there is no perimeter security for EDs – as opposed to mental health units. Therefore, EDs are unsuitable places for the containment of involuntary [mental health] patients, beyond the initial assessment/stabilisation period (FACEM).

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Some NSW Fellows talked about the design of their EDs as impediments to reducing restrictive practices. For instance, in a large major tertiary hospital ED with a ‘huge mental health caseload’ the safe assessment room is inappropriately located ‘two arms lengths away from the ward clerk’, creating a safety risk. The requirement to move sedated patients from safe assessment rooms to a bed on the ED floor for observation and monitoring can also be a regular safety dilemma for NSW Fellows when caring for behaviourally disturbed patients.

[There is a lack of] consistency about where to keep sedated patients for safe observation vs. security risk to rest of the [ED] (FACEM).

ACEM considers that mental health short stay units (SSUs) – also known as psychiatric intensive care units or psychiatric assessment and planning units – led by specialist mental health practitioners may provide better access to assessment, treatment and quality care for patients in this group. These units can be located within hospital and community-based psychiatric facilities or co-located with EDs. Where mental health SSUs are co-located with EDs, ACEM recommends geographical separation from the ED and the ED SSU. Clinical governance of the mental health SSU should remain with the specialist mental health service. ACEM believes that ED SSUs run by specialist emergency physicians are not an appropriate substitute for mental health SSUs.

**EMERGENCY DEPARTMENT SECURITY PERSONNEL**

ACEM considers that security personnel are an important ED resource to prevent and respond to aggression and violence that should be adequately funded and trained by jurisdictional health system managers and hospitals as an integrated part of the ED clinical team. Well-trained, experienced hospital security personnel with strong physical presence, excellent communication skills, an aptitude for learning, and a positive ‘customer service attitude’ can be successfully utilised to problem solve and eliminate unnecessary conflict.

Several narrative responses from NSW Fellows commented on inconsistencies with security personnel working in their hospital EDs, suggestive of inadequate training for the specific skillset required in such an important health care role.

Often security officers will not be specifically trained in the needs of the behaviourally disturbed patient, and may indeed work for a company that also provides ‘bouncer’ services for nightclubs, with staff treated homogeneously. They may not be trained in techniques such as verbal de-escalation and safe physical restraint (FACEM).

*Poor training of security staff leading to unsafe practice in restraint. Security risk to medical and nursing staff (FACEM).*

**Ensure minimum training standards for security staff (FACEM).**

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ACEM stresses that security personnel working in EDs must be highly skilled in working with distressed mental health populations and be appropriately trained for the acute health system context. Evidence shows that de-escalation and debriefing strategies can be helpful in mitigating the use of seclusion and restraint.\textsuperscript{21} ACEM considers that training and education by the employing hospital in verbal de-escalation, early intervention and prevention strategies and restraint techniques must be a minimum standard for ED security personnel to protect the safety of staff, patients and others.

CLINICIAN AND PATIENT HEALTH AND WELLBEING

It is recognised that restrictive practices can cause trauma and injury to health care staff as well as patients.\textsuperscript{4} In 2016, ACEM surveyed 1,187 members (FACEMs and emergency medicine trainees) across Australia and New Zealand on their health, professional satisfaction, and career longevity.\textsuperscript{22} Burnout was measured using the Maslach Burnout Inventory-Human Services Survey. Among respondents, 70\% showed a moderate to high degree of emotional exhaustion and 62\% showed a moderate to high degree of depersonalisation – a great concern to ACEM. In addition, the majority reported feeling threatened (88\%) by a patient in the past year, and two-fifths reported they had been physically assaulted (43\%). While inferential analyses are yet to be undertaken, it is reasonable to suggest a correlation between the high rates of burnout observed among the emergency medicine workforce and specialist emergency physicians’ experience of aggression and violence in the ED.

SUMMARY OF RECOMMENDATIONS

ACEM commends NSW Health for the Review and the willingness to seek input from stakeholders and provides the following recommendations:

1. Review of the legislative and policy framework governing restrictive practices in NSW health facilities based on version two of the National Safety and Quality Health Service Standards.
2. Inclusion of self-harm in national and jurisdictional ED data collections for a more reliable estimate of the number and extent of mental health-related occasions of service in NSW EDs.
3. Use of physical restraint in EDs under medical supervision as a measure of last resort and for the shortest time possible to allow safe administration of pharmacological restraint.
4. Development of clearer and consistent NSW Health policies, procedures and guidelines governing the use of restraint and seclusion in EDs.
5. Appropriate resourcing of NSW public EDs to safely manage mental health patient demand, including improving safety of staffing models, ED design, adequacy of facilities and bed capacity.
6. Implementation of measures across the entire NSW health system to address the dangerous levels of access block facing mental health patients in NSW EDs. Restrictive practices in EDs could potentially be reduced by interventions that target mental health access block across NSW public hospitals and increase access to inpatient mental health services.
7. Development of innovative service models that provide access to emergency care for mental health patients across NSW area health services, such as the 24-hour Triage and Assessment Centre at Nepean Hospital campus in the Blue Mountains.


8. For patients in regional NSW, utilise community mental health services, ambulance services and police to undertake mental state examinations in the community to bypass smaller, non-declared hospital EDs.

9. Consideration of bypassing smaller, non-declared hospital EDs for high-risk patients in regional NSW requiring specialist inpatient mental health services to expedite disposition to a more appropriate facility.

10. Implementation of mental health SSUs led and clinically governed by specialist mental health practitioners, either located within hospital and community-based facilities, or co-located with EDs.

11. Implementation of a minimum training and education standard for hospital security personnel.

Thank you for the opportunity to provide feedback to NSW Health on the review of seclusion, restraint and observation of consumers with a mental illness in NSW health facilities. ACEM looks forward to receiving any updates and correspondence regarding the Review’s progress and anticipates further consultation with NSW Health on the use of seclusion, restraint and observation in NSW EDs. ACEM welcomes future meetings with Review representatives to discuss the above recommendations in more detail. Should you require clarification or further information, please do not hesitate to contact the ACEM Policy Officer Shelley Cogger on (03) 9320 0444 or via email at shelley.cogger@acem.org.au.

Yours sincerely,

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