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Victorian Department of Health Consultation on the Strategy Towards Elimination of Seclusion and Restraint – July 2023

1. Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to make a submission on the Victorian Department of Health's discussion paper for the Strategy Towards the Elimination of Seclusion and Restraint. Our submission highlights the concerns, experiences, and insights of emergency physicians in Victoria and ACEM's Mental Health Working Group regarding seclusion and restraint reduction and elimination. It also highlights the persistent systemic issues regarding patients presenting to Victoria's emergency departments (EDs) seeking mental health care and the urgent need for greater capacity to manage this demand.

2. About ACEM

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in emergency departments (EDs) across Australia and Aotearoa New Zealand, training emergency physicians in these regions, and accreditation of EDs for emergency medicine training.

3. Overview of Submission

ACEM recognises that the use of seclusion and restraint (restrictive practices) can be confronting for patients, and staff. ACEM supports initiatives that contribute to the reduction of seclusion and restraint; however, they must be evidence-based and address the root cause of why seclusion and restraint are employed within the emergency department (ED).

ACEM has serious concerns about the development and direction of the discussion paper on the Strategy Towards Elimination of Seclusion and Restraint (discussion paper; the strategy). EDs are included as a setting in scope for the strategy, however, the data and evidence used to provide the rationale for the principles and pillars is based on practices that occur within in-patient psychiatric units. This negates the realities of why and the way seclusion and restraint may be medically necessary in the ED. Whilst some of the proposed principles and pillars do have capacity to effect change towards reduction of restrictive practices in EDs, the strategy must specifically address why these practices may be used in the ED, which is considerably different to other services.

Overall, ACEM feels that the discussion paper lacks understanding of the use of restrictive practices within the ED context, and without comprehensive consideration of the scope and limitations of mental health delivery within the ED, this strategy may have unintended consequences for patients, staff, families, and the community.

4. Summary of Recommendations

The submission provides insights into current system gaps and challenges for mental health care provision within the ED, that contribute to use of restrictive practices. Here is a summary of ACEM's

recommendations for inclusion in the strategy, not in order of priority. ACEM believes these must be considered to enable adequate change to restrictive practices:

1. **Recommendation:** Accurately assess physical and mechanical restraint data in the ED.

2. **Recommendation:** ACEM recommends the strategy distinguishes between common therapeutic practice of administration of medicines for safe assessment and treatment, even when consent is not provided.

3. **Recommendation:** That the Victorian Agency for Health Information report on the use of restrictive practices (sedation, seclusion and restraint) in the ED, including when EDs are access blocked and overcrowded.

4. **Recommendation:** Extend operational hours of psychiatry and mental health specialists to the ED, to mitigate long-wait times for assessment, ward transfer or discharge.

5. **Recommendation:** ACEM recommends that the strategy incorporate practical steps as highlighted within this submission to reduce the application of restrictive practices in the ED, like addressing access block for mental health admissions.

6. **Recommendation:** Ensure the strategy clearly highlights the importance of partnership with consumers and healthcare professionals across all settings the strategy applies to reduce/eliminate restrictive practices. It must also be informed by best-practice for stabilisation of patients in acute mental health crisis.

7. **Recommendation:** Embed trained mental health teams in the ED to enable to provision of qualified de-escalation for particularly acute patients.

5. Seclusion and Restraint in Emergency Medicine

ACEM's (S817) Statement on the use of restrictive practices in emergency departments clearly outlines the standard for which any restrictive practice should be employed in an emergency department. This should be read in concert with ACEM's (P32) Violence in emergency departments as the reality is that oftentimes, restrictive practices may be required to manage behaviour or violent individuals who are an immediate threat to the person themself or to others.

The medical needs of an individual patient in the ED must always be balanced against those of other patients and staff.

ACEM has concerns that managing the mental health episodes of some patients is not possible without the use of some form of restraint, the most common being use of medications. It is ideal to gain consent from a patient for this to occur, however, in extreme circumstances due to a multitude of competing reasons (drug use, psychosis, florid mental state); it may not be possible to gain consent. Therefore, there is a significant risk to other patients care, and to staff.

A crucial factor in any initiative towards the reduction and/or elimination of seclusion and restraint in mental health care is addressing the circumstances in which restrictive practices can become medically necessary. Emergency physicians continuously report that patients in extreme distress, or that lack decision-making capacity become agitated, hostile or their florid state exacerbates when there is a delay in their definitive treatment and care.

The use of restrictive practices in many circumstances is a result of system failure. In particular, access block and unreasonable and excessively long waits for definitive care and disposition can aggravate patient distress, necessitating the use of restrictive practices where EDs are not staffed and resourced to provide clinical supervision and non-restrictive de-escalation of patients over prolonged periods of time.

It is important to make a distinction between seclusion and modes of restraint within the ED, particularly as there is a vast difference in practical and emotional impact on an individual between the use of seclusion, physical or mechanical restraint and chemical restraint/.

5.1 Seclusion

ACEM regards seclusion as a practice that has no therapeutic benefit and can disrupt therapeutic relationships between clinicians and the patient. EDs have significant differences in resources including number and ability of security personnel, senior medical and nursing staff, and high acuity bed availability. Despite this every effort should be made for the safe, timely and dignified treatment of people experiencing acute severe behavioural disturbance. This is not achieved though seclusion [1].

ACEM supports the principles to eliminate the use of seclusion across healthcare services and understands that positive, consumer focused change is necessary in the system to make care trauma informed.

5.2 Physical or Mechanical Restraint

ACEM advocates that mechanical restraint may only be used if it is necessary to prevent imminent and serious harm to the patient or to another person, where all reasonable and less restrictive options have been tried or considered, and where it is allowed under jurisdictional guidelines.

ACEM notes that the discussion paper indicates the elimination of mechanical restraint may be prioritised, given data presented suggests it is less frequently used. This data does not include occurrences within the ED, and therefore fore not capture a clear picture of incidences of imminent risk where mechanical restraint has been utilised.

1. **Recommendation:** Accurately assess physical and mechanical restraint data in the ED.

5.3 Chemical Restraint

The term chemical restraint refers to the administration of medication for the primary aim of controlling behaviour, rather than providing safe care. Chemical restraint should not be occurring in the ED. The use of medication to allow the safe assessment and treatment of the patient in the ED is not considered chemical restraint.

It is common practice to provide medicines, or sedation in the form of oral benzodiazepines or antipsychotics. It is ACEM member's experience, that frequently patients who have received medicines in the ED, even when consent was not given or able to be given, have experienced significant relief and even gratitude, and this has facilitated a safe medical assessment, de-escalation, symptom reduction, and may also expediate discharge home. There is a risk that without administration of medications, if consent cannot be gained, that patient symptoms may escalate and contribute increased admissions.

Further, an Australian study of patients who had been sedated to manage behavioural disturbance in the ED showed that despite the use of sedation, most patients understood that it had been for the benefit of both them and staff, and had considered the use of such practices as appropriate or their only option [2].

2. **Recommendation:** ACEM recommends the strategy distinguishes between common therapeutic practice of administration of medicines for safe assessment and treatment, even when consent is not provided.

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[1] ACEM (2022). Statement on the use of restrictive practices in emergency departments.

[2] Yap CL, Knott JC, Kong DCM et al. Don't Label Me: a qualitative study of patients' perceptions and experiences of sedation during behavioural emergencies in the ED. Academy Emergency Medicine. 2017;24(8):957-67.

6. Demand for mental health care from emergency departments

Rates of mental health presentations in emergency departments are increasing amongst all age groups. People presenting in mental health crisis often have other complex needs including physical health comorbidities, drug and alcohol abuse problems, or require support to address broader social circumstances, including homelessness.

Australian data confirms that patients presenting to emergency departments (ED) for mental health care routinely experience excessive and unreasonably long waits for both assessment and ongoing mental health care, often in inappropriate and, at times, unsafe environments. It is a constant challenge for ED staff to find a timely and safe path for patients, such as admission to an inpatient bed or home with appropriate community support in place.

6.1 Access Block

In hospitals, both EDs and acute mental health units are over-stretched and under-resourced. There is an urgent need for increased service capacity to manage this demand, to prevent overoccupancy and access block, and for strengthened monitoring of the impact of these system failures on the use of restrictive practices in the ED.

ACEM has published two reports, The Long Wait (2018) and Nowhere Else to Go (2020) that demonstrate that people presenting with mental health crisis experience disproportionately long wait times and delays in assessment and treatment, particularly if they are awaiting admission to an inpatient unit.

Over the 2020-2021 reporting period Victorian EDs witnessed 66,165 mental health presentations (3.5% of total ED presentations). Of these, 24,818 (37.5%) were then admitted and 41,347 (62.5%) were not admitted. The 90th percentile of patients were admitted within 19 hours and 13 minutes and the wait time was 11 hours and 49 minutes for non-admitted patients[3]. The majority of these patients arrive by police (3.9%) or ambulance (58%), demonstrating acuity of these patient arrivals. By way of comparison less than 1% of all ED presentations arrive by police or corrections vehicle. Arriving to the ED by police, is by virtue in a restrictive manner, that has implications on people's mental state and increased agitation. Having a health condition responded to with law enforcement is dehumanising and treatment of people outside of the ED must be considered as a contributing factor to their heightened symptoms and behavioural state.

Despite mental health accounting for such a small percentage of overall presentations, mental health patients are over–represented in the data on access block (defined as patients waiting eight hours or more in the ED for an admission or transfer to an inpatient bed) and length of stays of 24 hours or more in the ED.

Overcrowding and access block result in serious, predictable and preventable risks for patient safety, compromising quality of care and patients' immediate and longer-term health outcomes. The longstanding national emergency access target (NEAT) sets a target for 90% of all patients to be admitted, transferred or discharged from the ED within four hours. This target is based on an international body of evidence that overcrowding and access block is strongly associated with preventable harm, including increased deaths in hospital.[4] ACEM strongly suggests NEAT targets are considered as a systemic approach to reduce wait times for mental health presentations, in turn positively impacting patient care, safety, and reducing agitation and escalation.

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[3] Australian Institute of Health and Welfare, 2022. Mental health services in Australia. Canberra: Australian Institute of Health and Welfare. *Available from: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments#data-source*

[4] Geelhoed and de Klerk (2012) Emergency department overcrowding, mortality and the 4-hour rule in Western Australia, The Medical Journal of Australia, vol. 196, no. 2, pp. 122-126; Richardson, D. and Mountain, D. (2009), 'Myths versus facts in emergency department overcrowding and hospital access block', The Medical Journal of Australia, vol. 190, no. 7, pp. 369-374

There is a significant gap in evidence and research of how access block contributes to use of restrictive practices in EDs. Not surprisingly, when patients present in mental health crisis and are left to wait in unsupportive environments, the risk of agitation and behavioural disturbances increases. It is beyond the ED's capabilities and resourcing to provide all patients in crisis the level of medical attention required to reduce symptoms and behaviours.

ACEM believes that systemic issues, including a lack of appropriate resourcing, exacerbate the risk of behaviours escalating into abuse and violence, putting frontline ED staff and other patients at risk of violence. In many cases, this situation will require the use of sedation, seclusion or restraint. In addition, research shows that people presenting with mental health needs are very likely to leave the ED prior to treatment.[5]

Considering, the information provided in this section pertaining to access block and its contribution to seclusion and restraint, the Victorian Health Agency (VAHI) should include the use of restrictive practices in the ED, and the relationship to access block and overcrowding, in its reporting on seclusion and restraint.

> 3. Recommendation: That VAHI report on the use of restrictive practices (sedation, seclusion and restraint) in the ED, including when EDs are access blocked and overcrowded.

6.2 Comorbidity Related Presentations

In the Australian Institute of Health and Welfare 2021-2022 data, 23% of Victorian mental health presentations to the ED were classed as an emergency. The highest principal diagnosis was for mental and psychological disturbance due to psychoactive substance, at 27% of presentations. The next was 22% of presentations were neurotic stress relation and somatoform related disorders, and schizophrenic and delusional disordered making up 16%.[6] This data demonstrates that the characteristics of a high proportion of presentations are highly complex whereby the mere purpose of the ED does not have the time, space and skill resources to significantly deescalate patient cohorts with severe cognitive impairment at the time and duration of their presentation.

To provide a practical scenario of such presentations and its complexity an ACEM member reported the following:

> *We regularly manage patients who present in acute alcohol or drug intoxication who present in Acute Severe Behavioural Disturbance and are not able to be verbally de-escalated and will not accept oral sedation. These patients often pose an acute real risk to themselves, our staff, other patients and those in the community. This again is very different to the inpatient setting due to the filtering effect of ED managing this intoxication stage. Many of these patients do not need a mental health admission but in fact need a place of safety to allow their acute intoxication to resolve. We have a duty of care to these patients to care for them and without the last resort use of physical restraint as a bridge to chemical sedation we would have no ability to keep those patients in the ED. This would potentially expose them and the community to significant risk of harm and would often result in police involvement and diversion into the justice system with all the risks of harm or deterioration in custody. This flies in the face of our pledge to first do no harm and our desire to help all our patients as well as our duty of care under the guardianship act.*

In addition, mental health patients arrive at the ED undifferentiated; with uncertainty relating to alcohol and drug use or other complicating medical problems contributing to their presentation until they can be assessed. The ED is a mixed patient cohort ward, including vulnerable patients, such as the elderly and children, with little capacity to adequately separate mixed cohorts. ED staffing skillsets are different to a mental health inpatient unit, and therefore priorities are too.

[5] ACEM (2018) The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments, available from: https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[6] Australian Institute of Health and Welfare. Mental health services provided in emergency departments. Canberra: Institute of Health and Welfare. Accessible: https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

There are significant limitations to ED staff's ability to dedicate sufficient time to de-escalation of many patients in acute crisis.

Lastly, within reason the ED does hold a duty of care to detain and treat patients who lack capacity and are at harm to themselves. This again, is unlike an inpatient unit where patients are differentiated into a secure ward specifically designed to remove any life threats for patients and staffed with qualified mental health professionals to treat mental illness.

6.3 Patients Awaiting Psychiatric Assessment in the ED

A significant cause of long-wait times and risk of escalation for mental health patients is the interface of ED, psychiatry and definitive care. A patient may be held in the ED for multiple hours/overnight in an ED, awaiting specialist psychiatry services to resume the next day. This is because there is no other mechanism to ensure a patient can be assessed for treatment. ACEM argues that this is unacceptable.

Therefore, ACEM recommends extending psychiatry operational hours, particularly provision to the ED to provide a timely assessment for patients' emergency clinicians have deemed acutely unwell and may be at risk of leaving without being seen or lacking the capacity to make decisions about their symptoms and illness, and consent to care. This would considerably reduce instances where restrictive practices are deemed medically necessary.

> 4. Recommendation: Extend operational hours of psychiatry and mental health specialists to the ED, to mitigate long-wait times for assessment, ward transfer or discharge.

7. ACEM's Response to Discussion Paper for Strategy Towards Elimination of Seclusion and Restraint

7.1 Survey

ACEM has concerns about the purpose and use of responses to the survey attached to this consultation. ACEM acknowledges that from a systemic level the ten selected principles are all considered important within the scope of the strategy's intended goals and whole-of-system improvement.

The level of importance of each principle is highly contextual. Therefore, selecting a level of importance alone does not comprehensively divulge anything about reduction of seclusion and restraint in the context of the ED. Therefore:

> 5. Recommendation: ACEM recommends that the strategy incorporate practical steps as highlighted within this submission to reduce the application of restrictive practices.

7.2 Vision Statements

The vision statements are consumer focused and not inclusive of the entire health system that supports mental health and wellbeing. If services, specialities, and the whole range of health professionals can't see themselves in the strategy then it will lack the buy in, and leadership required to apply the principles of the strategy to healthcare practice.

The 'how' statement stating, 'all those who work in it', is an unsatisfactory mention of the health professionals working on the frontlines delivering critical care. Particularly considering the 'why' statement stipulates it is 'centred on lived experience'. Mental health treatment and care cannot occur in vacuum of lived experience and must appropriately consider medical expertise.

Leadership of the strategy should be informed by lived experience but works continuously with the medical and health profession to adapt practices.

6. Recommendation: Ensure the strategy clearly highlights the importance of partnership with consumers and healthcare professionals across all settings the strategy applies to reduce/eliminate restrictive practices. It must also be informed by best-practice for stabilisation of patients in acute mental health crisis.

7.3 Draft Principles and the relationship with the ED

The principles highlighted below are the key priorities for ACEM, with transparency and appropriately resourced system being the top priorities for emergency medicine. Acknowledging that ACEM recognises all principles are important for system-wide improvement.

Transparency

ACEM members working in Victorian EDs reported uncertainty around how and by what measures seclusion and restraint data is collected in the ED and how it is reported to the Office of the Chief Psychiatrist.

There is a lack of data regarding the use of restrictive practices in EDs and conclusions are drawn within the strategy that have not acknowledged how seclusion and restraint is employed in the ED context. Use of restrictive practices in EDs should be governed by clear clinical governance frameworks, standardised documentation tools that include patient discharge summaries, and clear reporting pathways. Reporting processes must be straightforward and efficient, not to take away from staff time to patients.

3. Recommendation: VAHI should consider reporting on the use of restrictive practices in the ED, and the relationship to access block and overcrowding.

Appropriately-Resource System

This has been identified as the most important priority for ACEM as it is evident that the cracks and gaps in the mental health system are a cause of inadequate system resourcing. In the experience of members there has been no additional investment to adequately resource EDs and mental health teams that would lead to a change where elimination of restrictive practices is possible.

Overall, there is a significant lack of investment in system change that would make reduction/elimination of restrictive practices possible. Especially considering the well documented constraints of EDs.

Safety for All

Emergency physicians are experiencing increasing presentations that are violent, forensic, and/or dysregulated due to intoxication. This is a major risk to staff and co-patients. There are many variables (not always mental health grounds) on why an undifferentiated patient may be presenting with violent behaviours.

People who fall through the gaps in the social security system; housing, substance dependency, employment, and access to basic healthcare, are susceptible to serious mental health conditions and escalated behaviours, that can result in an ED presentation. Without a greater safety net in the community for people to remain well and seek care in less acute settings, the likelihood to acute crisis remains. This is particularly relevant considering the high rates of drug dependency and lack of access to treatment.

Human Rights

The decision to employ restrictive practices is a balance of duty of care with the human rights of the individual. There is a natural tension between safety vs human rights in the context of mental health crisis.

Should the implication of reduction/elimination of restrictive practices mean EDs are unable to use legislative powers, medications, or other methods to try keep a patient secure in the ED; there must be full acknowledgement that if people who are unwell leave, may come into harm due to misadventure.

ACEM expects that any restrictions (or not) on patients leaving the ED is clearly reflected in legislation and is not stipulated in a way that up for interpretation. This further highlights the issue that the ED is not a secure ward and therefore the ED is limited by the means in which it can make people who are in acute crisis and lack decision-making capacity to remain.

Evidence-based Practice

ACEM has concerns that evidence-based practices successful in one-setting, will be applied to the ED whereby currently research, data, and understanding of use of restrictive practices is lacking.

Currently ED psychiatric research is centred around therapies, like sedation, that can be provided to patients in the ED to support safe assessment. The tenant of this strategy suggests the is undesirable without consent, therefore, it is unclear what best practice looks like in the context of managing acute crisis in the ED.

7.4 Draft Pillars

The responses to the pillars below are priority areas for ACEM and feedback should be considered in the strategy development.

Leadership and Strategy

EDs must be considered as a service with specific opportunities and limitations exclusive to in-patient units. Further, safety of staff from consequences due to not employing restrictive interventions must be prioritised, with clear expectations of what to do when there is likely to be an increased risk of self-discharge should proposed changes come into effect as currently articulated.

Data and Accountability

This pillar links to transparency as a principle and should prioritise access to data for all stakeholders in the mental health system to ensure there is a clear picture of the shifts, changes, and potential consequences of amendments to restrictive practices. Data collection and reporting must also be accurate and include the ED.

Best practice & Workforce

Best practice in the context of mental health care in the ED must include a trained mental health workforce embedded in the ED. Whilst emergency physicians and their teams can provide a certain level of mental health care, de-escalation and treatment, it is unrealistic and unreasonable to expect the same standard of care that can be provided by psychiatrists and mental health teams on wards.

> 7. Recommendation: Embed trained mental health teams in the ED to enable to provision of qualified de-escalation for particularly acute patients.

Environment

Any progress towards reducing and potentially eliminating the use of restrictive practices in EDs will require resourcing of the clinical team, security personnel and the ED environment and infrastructure, but most importantly, will require dramatic improvements in the ED overcrowding, which is currently occurring due to crippling hospital access block across the system.

The environment of the emergency department may not be beneficial for people experiencing severe crises. The design of emergency departments to provide therapeutic care to patients in mental health crisis must be re-thought and addressed. The high-stimulus environment can contribute to escalation of behaviours and symptoms. To enable reduction or elimination of restrictive practices in EDs, ED design principles that create low stimulus, reassuring environments for people in mental health crisis but be prioritised.

8. Comment on Safewards

ACEM does not believe there is conclusive evidence of the success or reduction of violence in the ED with the trial of Safewards. Therefore, strongly recommends Safewards is not utilised as an initiative in the ED to achieve the strategy intended goals.

9. Conclusion

ACEM is committed to working in partnership with the Victorian Government, mental health stakeholders and consumers to improve current service delivery and the multitude of system failures that currently exist. As mentioned, oftentimes the use of restrictive practices is a cause of system failures elsewhere, where no other options are available to provide quality and safe care to patients in crisis.

ACEM urges the careful consideration of the contents of this submission in the development of the strategy.

Thank you again for the opportunity to provide feedback to this consultation. If you require further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager, Lee Moskwa (t: (03) 8679 8893, e: lee.moskwa@acem.org.au).

Yours Sincerely

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