MENTAL HEALTH IN THE EMERGENCY DEPARTMENT

CONSENSUS STATEMENT JULY 2020

TO ALL MEMBERS OF PARLIAMENT (COMMONWEALTH, STATE AND TERRITORIES)







SUMMARY

We, the undersigned, are people who have worked in an Australian Emergency Department in a public hospital, have worked with an emergency department (ED) or have sought help from an ED while experiencing a mental health crisis. We wish to share our deep concern at the unacceptable state of mental health support available to people seeking help through EDs and to urge you to act immediately to improve this situation.

As health professionals, we commit to doing everything we can to provide timely and appropriate care in response to people in mental health crisis, and to advocate for improved care and support based on the principles and priorities set out below. We appreciate that effective reform takes time and that system improvements will require collaboration between governments and key stakeholders. We have therefore identified four actions that can be immediately implemented by governments to improve the safety and quality of mental health care and support for people presenting to an ED in crisis.

TOP FOUR RECOMMENDATIONS

We ask that:

All Australian Governments act urgently to engage people with lived experience in reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community.

When psychiatric admission is required, processes need to be timely and streamlined so that acutely unwell people can access an appropriate inpatient bed any time of day or day of the week.

State and territory health departments adopt a maximum 12 hour length of stay in the ED, by providing accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED, with mandatory notification and review of all cases embedded in the key performance indicators of public hospital CEOs.

All 24 hour waits in an ED should be reported to the Health Minister regularly, alongside any CEO interventions and mechanisms for incident review.

...WE URGE YOU TO ACT IMMEDIATELY TO IMPROVE THIS SITUATION.

OVERVIEW OF THE ISSUES

The burden of mental health distress and illness across the community is clear; depression is now the fourth highest cause of disability in Australia and suicide claims more lives than the road toll. A poorly coordinated and underfunded mental health system is seeing more and more people turning to EDs for care. Too often the ED is the only option available for people who are experiencing an acute mental health crisis, especially after-hours or when other services are not available. Combined mental health and social crisis presentations are the growing 'tip of the iceberg', with increasing numbers of distressed people reliant on public EDs for support because of unmanageable personal, family and financial burdens. We see that demand peaks after-hours, when access to more appropriate services such as social work, Aboriginal Health Liaison Officers, drug and alcohol or homeless services are rarely available. The ED is open when everyone else goes home.

Each year more than a quarter of a million people seek help from an ED for their mental health. In far too many cases their experience in the ED is not only unhelpful but harmful. Too often, it is characterised by very long, sometimes multi-day waits with no end in sight, in a noisy and chaotic environment. The situation is often worse in rural and remote areas and for children and adolescents. The national shortage of psychiatric beds and mental health services exacerbates the wait for access to appropriate care.

The data shows that people who present to an ED in mental health crisis are the group most likely to wait more than 24 hours for care. This is clearly discrimination. These long waits often result in people being sedated, secluded and physically restrained. Aboriginal and Torres Strait Islander people are over represented in groups who present to the ED seeking support in a mental health crisis. ED doctors often struggle to find appropriate services for young people. Many who seek help from an ED give up and leave before their treatment is complete. This is not good enough. Everyone in Australia, regardless of their culture, age or where they live, is entitled to timely access to appropriate care; EDs should just be one door into a high quality, evidence based, mental health care system. While there is much that we, as people working in the system, can do to improve the experience for people seeking help in a mental health crisis, we cannot do it alone. Dangerous delays in receiving definitive care are part of a widespread system failure across acute psychiatric and community based mental health. There is a growing consensus amongst stakeholders that current arrangements unfairly burden individuals, families and health services and that the strain on the health system is unsustainable.

Depression

is now the fourth highest cause of disability in Australia and **suicide** claims more lives than the road toll.

250,000

Each year more than a quarter of a million people seek help from an ED for their mental health.

Everyone in Australia, regardless of their culture, age or where they live, is entitled to timely access to appropriate care. The 2018 National Summit on Mental Health Care in Emergency Departments, hosted by the Australasian College for Emergency Medicine, brought together more than 170 delegates who work in or use mental health services.

The delegates' consensus was that a better response to mental health crises is now critically overdue.

The Summit agreed on the following seven principles and priorities for action:

1 THE PRINCIPLE OF RESPECTFUL, PATIENT-CENTRED CARE

Mental health care, regardless of the setting, should be respectful, patient centred and recovery oriented. People with a lived experience of mental illness are central to the design or redesign of mental health policy and services.

PRIORITY ACTIONS

- New models of care need to be developed in consultation with key stakeholders and particularly people living with mental health conditions and their advocates, to improve the experience of people who need these services.
- The role of peer workers, who have lived expertise of mental illness, in improving the experience of people using EDs in a mental health crisis should be explored.

24 hrs[®]

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MENTAL HEALTH PATIENTS AT EMERGENCY DEPARTMENTS DESERVE BETTER.

2 THE PRINCIPLE OF PREVENTION AND EARLY INTERVENTION

Many people presenting to the ED are more appropriately cared for in the community. Service models that provide timely access to expert, early, intensive and multidisciplinary care need to be explored, resourced and evaluated for their impact and scaled up where they are shown to be effective.

PRIORITY ACTIONS

- Additional community based mental health care, particularly after-hours crisis services, for people experiencing mental health problems should be developed as a viable alternative to EDs.
- Services that respond to homelessness, family violence and drug and alcohol use should be available to patients and their ED clinician when required.

3 THE PRINCIPLE OF TIMELY ACCESS TO APPROPRIATE CARE

All Australians have the right to access timely and appropriate mental health care that is free from stigma and discrimination. Current arrangements are inadequate to support people experiencing mental health crises and discriminate against some of the most marginalised and vulnerable people in our community.

PRIORITY ACTION

- Agreement is urgently needed on reforms to ensure mental health care is available in the community and from specialist inpatient services where and when required, to relieve reliance on EDs.
- Where EDs are required to provide care, appropriate infrastructure and resources must be in place to allow early and effective interventions, avoiding long delays to definitive points of ongoing mental health care.

4 THE PRINCIPLE OF SAFE AND SUPPORTIVE CARE IN THE ED

The ED should be a safe and supportive environment for all distressed and traumatised people, and models of care should draw on contemporary clinical practice for managing emergency mental health care. Sedation should be used rarely in the ED, and then only when indicated for clinical need and patient safety, while other forms of restrictive practice should only be used as a last resort where all other strategies have failed. Better mental health resourcing is needed to minimise the use of restrictive interventions in EDs.

PRIORITY ACTIONS

- Appropriate models of care for the management of mental health presentations need to be developed in EDs.
- When psychiatric admission is required, processes need to be timely and streamlined so that acutely unwell people can access an appropriate inpatient bed any time of day or any day of the week.
- Audits of restrictive practices in the ED are needed to identify and monitor the impact on patient outcomes, particularly in the context of inadequate resources in the ED and across the mental health sector.

"Long waits

in EDs often result in people being **sedated**, **secluded and physically restrained**."

5 THE PRINCIPLE OF CULTURALLY SAFE CARE

Culturally responsive and safe care in the ED, particularly for mental health care, is vital.

PRIORITY ACTION

Funders need to work with community-led agencies to agree on mental health care strategies to measurably improve outcomes for populations overrepresented in presentations to EDs, beginning with Aboriginal and Torres Strait Islander people.

6 THE PRINCIPLE OF A MAXIMUM LENGTH OF STAY IN THE ED

It is essential that people presenting to an ED receive urgent care, regardless of their reason for presentation. All state and territory governments should adopt a maximum length of stay (LOS) of 12 hours for all patient groups. Any incident of 24 hour LOS in an ED is intolerable; there is no better indicator of operational performance failure in hospital management.

PRIORITY ACTIONS

- State and territory health departments adopt a maximum 12 hour LOS in the ED, by providing accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED, with mandatory notification and review of all cases embedded in the key performance indicators of public hospital CEOs.
- All 24 hour waits in an ED should be reported to the Health Minister regularly, alongside any CEO interventions and mechanisms for incident review.

7 THE PRINCIPLE OF INCREASED COMMUNITY AND INPATIENT CAPACITY

There should be clear pathways into a coordinated network of support for people experiencing a mental health crisis, offering certainty about where and when they can access the care they need. There is not enough capacity in either hospitals or the community, especially in rural and remote areas. Children and adolescents have specialist needs that are not being met. The ED should be only one access point into these pathways.

PRIORITY ACTIONS

- Measures to improve mental health resourcing, capacity and integration across EDs, the community and inpatient facilities need to be implemented and their impact on crisis presentations to EDs and patient reported outcomes monitored.
- More work needs to be done to build and sustain a functioning, integrated, mental health system that supports the prevention, early intervention and better management of mental health needs for children, adolescents and adults.

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