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for Emergency Medicine

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Submission to the Victorian Department of Health on the Suicide Prevention and Response Strategy Discussion Paper August – 2022

1. Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide this submission to the Victorian Department of Health on the questions contained within the *Suicide Prevention and Response Strategy Discussion Paper*.

2. About ACEM

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to emergency departments (EDs).

ACEM is committed to advocating for adequate mental health service provision including but not limited to: improved funding and service models, greater emphasis on prevention, increasing the number of rural mental health services, improved workforce capacity, effective services coordination and accountability, and ensuring best practice emergency mental health care.

3. Overview of the submission

Our members' experiences working in EDs across Victoria informed this submission. Our submission reflects and reinforces the College's submissions to the Royal Commission into Victoria's Mental Health System, the Productivity Commission Inquiry into Mental Health, and the Australian Parliament's Select Committee Inquiry into Suicide Prevention and Mental Health.

Our submission focuses on consultation question five – suicide prevention and response initiatives and actions contained in the discussion paper. The themes discussed in the below sections describe how EDs can enhance their responsiveness to people presenting to EDs experiencing psychological distress and to support improved patient pathways to achieve a better-integrated system.

4. Summary of Recommendations

ACEM makes the following recommendations for inclusion in the Strategy:

1. Invest additional resources to increase inpatient mental health beds and non-hospital alternatives, e.g., step up/step down services, mental health short stay units and hospital in the home models of care.
2. Resource and support EDs to offer a safe and supportive environment for people seeking help for mental health problems, with a particular focus on the needs of young people with complex mental health conditions
3. Resource EDs to implement mechanisms to contact the patient, family/carer and/or Area Mental Health Service if any patient thought to be at risk leaves without being seen

4. Invest in community-based mental health and suicide prevention, particularly for high risk populations
5. Ensure that health services monitor and report on excessive lengths of stay (>12 hours) in EDs, use of restrictive practices, and patients who abscond or leave prior to being seen or having their period of care completed. In addition, all episodes of a 24-hour length of stay in an emergency department should be reported to the relevant health minister regularly, alongside CEO interventions and mechanisms for incident review
6. Adopt a maximum 12-hour length of stay in the ED by providing accessible, fit-for-purpose, and appropriately resourced facilities for ongoing care beyond the ED
7. Adopt ED length of stay for mental health patients as a publicly-reported key performance indicator for all Victorian health services
8. Ensure use of restrictive practices in emergency departments are governed by clear clinical governance frameworks, standardised documentation tools, clear reporting and auditing pathways that allow for system improvement recommendations to be progressed to the relevant governance level
9. Invest in the following capabilities:
    a. Building the capability of clinical and non-clinical staff to provide trauma-informed care
    b. Rural mental health workforce development, considering staff capabilities, skill mix and role diversification
    c. Social work capabilities in hospital EDs to enhance referral pathways

5. Mental health care in emergency departments

5.1 ED Demand

Victorian EDs have been highlighted as a key part of the mental health system by the Royal Commission into Victoria's Mental Health System and the Productivity Commission's Mental Health Inquiry Report. This is because EDs deliver mental health care to a broad range and often complex cohort of patients in large volume. This typically occurs without the resources, infrastructure, or systemic support necessary to provide high quality, appropriate mental health care consistently.

Gaps in mental health service availability, particularly after-hours, mean that EDs have become a major and often default entry point into the system for people seeking access to mental health care – because, put simply, there is nowhere else to go.

Our members working in EDs report, and our data confirms that patients presenting to EDs for mental health care routinely experience excessively long wait times to receive mental health care, often in inappropriate and unsafe environments.

Mental health conditions are increasing as a proportion of the population and overall numbers. Australian Institute of Health and Welfare (AIHW) data shows that over 64,000 people with a principal diagnosis of mental and behavioural conditions presented to Victorian EDs in 2019-20, making up 3.6% per cent of all ED presentations[1][2]. More than one-third of people with this principal diagnosis required admission.

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[1] Australian Institute of Health and Welfare. *Mental health services in Australia* [Internet]. Canberra: Australian Institute of Health and Welfare, 2021 [cited 2022 July 27]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services

[2] Australian Institute of Health and Welfare. *Emergency department care* [Internet]. Canberra: Australian Institute of Health and Welfare, 2021 [cited 2022 July 27]. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care

There has been a marked increase in the number of young persons presenting to EDs experiencing acute mental distress. The service models of the most widely available community-based youth mental health services are not equipped to respond to the complexity that service users are presenting with.

5.2 Long waits

Despite mental health accounting for a relatively small percentage of all presentations, patients admitted for mental health-related reasons are over-represented in the data on access block, defined as the situation where ED patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours due to a lack of inpatient bed capacity.

This patient cohort is also overrepresented in the data on patients with ED length of stays of 24 hours or more. ACEM's 2018 national survey on the prevalence of mental health access block collected snapshot data from 11 Victorian EDs and found that mental health patients accounted for nearly a quarter (23.2%) of all access-blocked ED patients at the time of the survey[3]. Our members regard the unacceptably long waiting times for admitted patients with psychological distress to access definitive care as 'counter-therapeutic'.

The over-reliance on EDs to fill the substantial gap in mental health care availability is placing an additional strain on already overstretched EDs in a near-constant state of crisis. EDs are designed to provide efficient management of emergencies and potentially life-threatening presentations. They are staffed to provide appropriate initial assessment and stabilisation, not provide supervision over prolonged periods.

Our members' ever-increasing experience of managing access-blocked mental health patients confirms that long waits heighten the risk of adverse events, particularly behavioural escalation that results in seclusion, restraint and sedation.

Additionally, long waits increase the risk of patients leaving the ED without being seen (with the associated risk of attempted and completed suicide).

5.3 Cost to the system

The 2017 Emergency Care Costing Study was commissioned by the Independent Hospital Pricing Authority (IHA) to understand the cost drivers in emergency care at the patient level. It found that the average cost per episode of mental health care was much higher than the overall average cost in the ED, where:

- The overall average cost for all emergency care was $696
- The average cost for management of severe mental health disorder with diagnostic modifiers was $889
- The average cost of involuntary mental health care with diagnostic modifiers was $1,074
- The average cost of distress/confusion/agitation with diagnostic modifiers was $1,225

5.4 What interventions are needed?

A key issue facing our members is that the lack of available services has raised the threshold for referral, delaying care and leading to poorer patient outcomes.

ACEM has long called for the Victorian Government to prioritise increased access to publicly funded acute mental health and community-based services, including step-down care. This must include patient-centred models that measurably improve the experience and outcomes of people who need community and/or acute mental health care, ensuring equitable access across Victoria.

Based on the above, ACEM supports system reforms that strengthen the community-based response. As such, we strongly advocate for alternative services outside the ED, including peer and clinician-led

[3] ACEM 2018, Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department/Research-Reports, [February 2018]

after-hours and mobile crisis services. There is also an urgent need to increase the number of inpatient mental health beds and non-hospital alternatives (e.g., step-up/step-down services and Hospital in the Home models of care).

Expanding ED alternatives will enhance the availability of local services and provide additional, more appropriate care and support pathways for people presenting to the ED for mental health-related reasons, and ensuring that people have timely access to definitive care where they want it when they want it, and reduce the harmful waits in EDs for people experiencing mental health crises.

Finally, ACEM calls for a commitment to increasing investment on mental health and suicide prevention. This would include, but is not limited to, an increase in funding and capacity for early interventions, investing in addressing inequities in social determinants of health for marginalised communities and improving access to social and emotional wellbeing supports for high-risk groups[4], including adolescents, First Nations Peoples, men, culturally and linguistically diverse people, LGBTIQ+ people, and rural and remote Victorians.

ACEM acknowledges the establishment of new services around the state of Victoria which will enable a stronger community-based response to mental health and suicide prevention will not become operational overnight, and EDs will continue to be called upon to fill service gaps. Whilst the College is supportive of increasing the availability of mental health care and support, these services the College strongly advocates for resourcing and staffing that enables EDs to better respond to the demand for mental health care and support.

Recommendations

1. Invest additional resources to increase inpatient mental health beds and non-hospital alternatives e.g., step up/step down services, mental health short stay units, hospital in the home
2. Resource and support EDs to offer a safe and supportive environment for people seeking help for mental health problems, with a particularly focus on the needs of young people with complex mental health conditions
3. Resource EDs to implement mechanisms to contact the patient and/or family/carer and/or Area Mental Health Service if any patient thought to be at risk leaves without being seen
4. Invest in community-based mental health and suicide prevention, particularly for high risk populations

6. Governance, coordination and accountability measures

Australia's complex, hybrid health system creates many challenges for policy and service reform. While acute mental health care has been mainstreamed into hospital services, care in the community is funded from multiple sources, with limited criteria for measuring efficacy. The system is overseen by multiple ministers and departments. The Productivity Commission's report highlighted the need to resolve the blurred line of responsibilities that exists between the Commonwealth and the States and Territories to address the lack of service coordination at the state-wide level.

The College believes that Primary Health Networks and Local Hospital Networks, in partnership, are best placed to coordinate specialist mental health and related services. However, we recognise that EDs need improved governance strategies for managing mental health presentations because this is not happening.

There is currently a lack of accountability and reporting of ED mental health presentations, leading to inadequate action to address preventable emergency department presentations. ACEM believes the

[4] The Department of Health and Aged Care. Evaluation of Suicide Prevention Activities – Results [Internet]. Canberra: The Department of Health and Aged Care, 2014 [cited 2022 August 25]. Available at https://www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~Appendices~appendixe~results

Suicide Prevention and Response Strategy must include targets for ED, inpatient mental health units and community mental health services.

Recommendations

5. Ensure that health services monitor and report on excessive lengths of stay (>12 hours) in EDs, use of restrictive practices, and patients who abscond or leave prior to being seen or having their period of care completed. In addition, all episodes of a 24-hour length of stay in an emergency department should be reported to the relevant health minister regularly, alongside CEO interventions and mechanisms for incident review
6. Adopt a maximum 12-hour length of stay in the ED by providing accessible, fit-for-purpose, and appropriately resourced facilities for ongoing care beyond the ED
7. Adopt ED length of stay for mental health patients as a publicly-reported key performance indicator for all Victorian health services
8. Ensure use of restrictive practices in emergency departments are governed by clear clinical governance frameworks, standardised documentation tools and clear reporting and auditing pathways that allow for system improvement recommendations to be progressed to the relevant governance level

7. Workforce

ACEM supports reforms to strengthen the mental health workforce and invest in future workforce development as part of the Victorian Mental Health Workforce Strategy, noting that a Victorian Health Workforce Strategy will commence development this year.

All healthcare staff must have the appropriate skills and knowledge to respond to the needs of people with mental illness and enable consumers and their carers to navigate the system effectively. As EDs are often the entry point into the system for people experiencing crises, investment in the ED mental health workforce must also be prioritised.

To mitigate harms, there is an urgent need to ensure that trauma-informed care and the skills to implement these practices are embedded in the specialist and non-specialist services which respond to acute mental health crises. This includes ensuring that non-clinical staff are also appropriately trained.

Furthermore, the availability of a healthy and resilient ED workforce is essential to the strategy's success. Therefore, initiatives to attract and retain the workforce and maintain ED workforce wellbeing must be included in the process.

ACEM notes that the strategy emphasises the importance of improved referral to services. Therefore, ACEM considers it vital that additional social work positions are created as dedicated roles within the emergency department. The professional competencies of the social work profession to provide clinical and case management services makes them an invaluable workforce in EDs and allow medical professionals to focus on providing medical care rather than completing referrals.

ACEM would also like to highlight our Mental Health in Rural Emergency Department (MHrED) project. MHrED is a purpose built website that will house a collection of guidelines, articles, tools and resources to assist ED staff in increasing their competence and confidence with assessing and managing patients who present with mental health issues. This site will tie into the broader 'safer ED' initiative within ACEM, and link to a number of relevant MH guidelines and initiatives within the College. Through this project, we hope to start changing the culture within EDs to be more MH friendly for both staff and patients.

Recommendations

9. Invest in the following capabilities:
    a. Building the capability of clinical and non-clinical staff to provide trauma-informed care

b. Rural mental health workforce development, considering staff capabilities, skill mix and role diversification

c. Social work capabilities in hospital EDs to enhance referral pathways

8. Conclusion

ACEM believes that all Australians have the right to access mental healthcare. EDs in public hospitals are free, open 24 hours per day, and provide physical and mental health emergency care. Emergency physicians are honoured to provide this service to the community.

EDs should be resourced and supported to offer a safe and supportive environment for people seeking help for mental health problems. ED clinicians should be engaged in implementing reform to ensure barriers to, unintended consequences of and further improvements can be made in mental health reform.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 423 251 383).

Yours sincerely

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