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for Emergency Medicine

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Submission to the South Australian Law Reform Institute – Review of the *Mental Health Act 2009* (SA)
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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to participate in the South Australian Law Reform Institute's review of the *Mental Health Act 2009* (SA).

1. Background

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).

2. Overview of the submission

This submission is informed by our members' experiences working in EDs across South Australia. Our submission also reflects and reinforces the College's recent submissions to the Productivity Commission Inquiry into Mental Health, and the Australian Parliament's Select Committee Inquiry into Suicide Prevention and Mental Health.

The issues that are highlighted in certain sections of the discussion document cannot be addressed solely through legislation and will be best met by developing models of care that include appropriate infrastructure and resources to allow early and effective interventions, and avoiding long delays before reaching definitive points of ongoing mental health care.

3. Recommendations

ACEM makes the following recommendations:

1. Establish a formal review of the compulsory treatment criteria, including decision-making capacity.
2. Make language utilised in the MHA gender neutral.
3. The Act should ensure persons at risk of, or who are subject to compulsory treatment under the Act have timely and equitable access to non-legal advocacy services.
4. The *Mental Health Act 2009* should provide suitable medicolegal safeguards that allow clinicians to safely conduct an assessment or provide medical treatment for conditions contributing to or resulting from the patient's mental illness.
5. Changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to immediate risk.

6. That legislative provisions set out a requirement for SA Health to provide the necessary resources for clear clinical governance frameworks for all service providers, standardised documentation tools and reporting pathways that allow for system improvement.
7. Transfer of custody provisions under the Act must undergo a comprehensive review involving all relevant stakeholders.
8. The guiding principles should include provisions to address the structural inequities of care.
9. The MHA should enable better community-based responses so that there are alternatives to the ED.
10. The Act should require timely review of admitted mental health patients by a senior decision-maker in a mental health service to reduce the occurrence of access block.
11. All SA hospitals have ED length of stay for mental health patients as a key performance indicator and this should be publicly reported.
12. Provisions on time-based-targets must demonstrate that the reduction of waiting times for access to mental health care is an urgent priority.
13. All 24 hour waits in an ED should be reported to the Health Minister and Mental Health Minister routinely, alongside any CEO interventions and mechanisms for incident review.

4. ACEM response to the consultation questions

4.1 Fact sheet two questions

4.1.1 Should the MHA include a clearer definition of 'impaired decision-making capacity' for treatment orders?

The definition does not specifically refer to 'treatment orders' in its definition of impaired decision-making capacity – rather it describes a person's capacity to 'make decisions about his or her health care'.

ACEM's members contend that the current definition of impaired decision-making capacity is not fit for purpose because it does not appropriately encapsulate the complexity, nor the circumstances which occur when assessments about a person's capacity to make decisions about their health care are required.

Currently, a requirement to place a person with a mental health condition on an Inpatient Treatment Order (ITO) is to define that the person does not have capacity, and often the lack of capacity is practically applied as the person making the 'wrong' decision due to their mental illness.

Therefore, it is the view of the College that impaired decision-making capacity specific for the use of placing a person on a treatment order must be clearly defined and included in the Act. This should form part of a broader formal review of the criteria for compulsory treatment.

ACEM strongly advocates to participate in any prospective reviews of decision-making and/or compulsory treatment criteria laws.

Recommendation 1: Establish a formal review of the compulsory treatment criteria, including decision-making capacity

Recommendation 2: Make language utilised in the MHA gender neutral

4.1.2 How can the law better protect the human rights of persons with a lived experience of mental illness and provide supported decision-making?

The College is broadly supportive of mechanisms that enable supported decision-making such as statements of rights, advance statements, nominated persons and second psychiatric opinions.

ACEM would support the introduction of any legislative requirement for mental health patients to have access to non-legal advocacy services if they are subject to, or at risk of being subjected to compulsory treatment under the Act. However, the involvement of non-legal advocacy services should not delay the provision of medical treatment in the ED if clinically indicated, nor should it delay the transfer of a patient from the ED to a more appropriate setting.

Recommendation 3: The Act should ensure persons at risk of, or who are subject to compulsory treatment under the Act have timely and equitable access to non-legal advocacy services

4.1.3 Response to suggested changes contained in Fact sheet two

ACEM does not support the proposed change to require medical professionals to provide written reasons to explain why they have concluded that a person does not have capacity *at the time* an ITO is made. However, our members are supportive of retrospectively documenting episodes of care where a person has been assessed as having impaired decision-making capacity.

4.2 Fact sheet three questions

4.2.1 Should the definition of 'treatment' be expanded to include an assessment or other medical/health issues?

ACEM is supportive of modifications to the Act that to provide appropriate medicolegal safeguards for clinicians which would allow them to conduct an assessment and/or provide medical treatment whilst under an ITO or Care and control. Furthermore, the definition of treatment under the Act must also allow for clinicians to provide treatment of medical conditions resulting from the mental illness (or treatments).

Recommendation 4: The MHA should provide suitable medicolegal safeguards that allow clinicians to safely conduct an assessment or provide medical treatment for conditions contributing to or resulting from the patient's mental illness

4.3 Fact sheet five questions

4.3.1 Should the MHA allow the use of reasonable force and control powers? If so, when?

The use of restrictive practices in EDs and the drivers of their use are complex and sometimes necessary to protect an individual patient, and/or the people around them (staff, carers and other patients). EDs provide a compelling window into the strengths and weaknesses of South Australia's mental health system. ACEM's analysis of presentation data clearly shows that South Australian EDs are being called upon to provide a volume, range and complexity of mental health services without the resources, infrastructure or whole –of-hospital systems necessary to provide timely and appropriate care. The use of restrictive practices in many circumstances is a symptom of system failure.

ACEM recommends that any proposed changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to immediate risk. Specialist emergency physicians are highly trained and skilled at making rapid determinations about the best course of action for the care of a patient. Clinical judgement must be acknowledged and respected in assessing complex presentations and managing harmful behaviour.

The definition of a restrictive practice in the current Act requires modification to better define each individual restrictive intervention (i.e., physical, mechanical, chemical, seclusion).

Temporary acute sedation may be required for the initial treatment of acute behavioural disturbance and/or to facilitate an ED assessment to differentiate organic or co-existent medical concerns such as overdose/poisoning, delirium or head injury.

ACEM defines chemical restraint as:

> *"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."*

Recommendation 5: Changes to mental health legislation regarding restrictive practices and their use must be balanced by the need to protect patients and others in response to short-term risk

4.3.2 What is 'reasonable' and how should this be defined?

People presenting to the ED with acute behavioural disturbance should be treated with empathy and respect. Restrictive practices are a last option after initial approaches are unsuccessful and there is an ongoing risk to the safety of patients or staff. A graded, collaborative approach is required utilising verbal de-escalation, trauma-informed communication, stimulus reduction, and where appropriate anxiolytic medication voluntarily taken before application of a restrictive practice.

When using medications as a restrictive practice, a minimally restrictive approach should be maintained. Where possible a person should be invited to consent to administration of medication, in a manner without pressure or coercion.

The aim of safe assessment is never to render the patient unconscious, but to reduce their level of arousal in order to safely assess and care for them. The person must be placed in an area of the department with access to appropriate staffing, monitoring and resuscitation equipment to maintain a safe level of sedation.

ACEM advocates that physical or mechanical restraint may only be used if it is necessary to prevent imminent and serious harm to the patient or others. Physical restraint may be used to administer medical treatment including to facilitate safe assessment. Any physical or mechanical restraint should be used for as short a duration as possible, and only as a bridge to effective de-escalation.

ACEM regards seclusion as a practice that has no therapeutic benefit and can disrupt therapeutic relationships between patient and clinician. EDs have significant difference in resources including number and availability 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 severe behavioural disturbance. This is not achieved through seclusion.

ACEM has long been supportive of the idea that restrictive practices in the ED have clear clinical governance frameworks, standardised documentation tools and reporting pathways that allow for system improvement. The College emphasises the importance of establishing reporting mechanisms that are simple, in recognition of the time pressures in an ED environment (i.e., one report to one place).

The minimum data recorded for each restrictive practice event should include:

- The reason/s for using the restrictive practice. Multiple reasons may apply, including but not limited to:
  - Prevention of serious harm to the patient
  - Prevention of serious harm to another person
  - Facilitation of medical assessment and/or treatment
  - Facilitation of mental health assessment and/or treatment
- The measures used prior to the restrictive practice being utilised
- The type of restrictive practice
- Level of access block at the time of the restrictive practice was utilised
- Length of stay for admitted patients
- Waiting times to see a mental health clinician

Our members report that they would experience great difficulty in safely managing many presentations without the ability to use physical restraint, combined with sedation as a medical treatment. Therefore, it is ACEM's view that any treatment that has a therapeutic impact or allows for the safe assessment or treatment of a medical condition falls outside the definition of a restrictive practice.

Any legislative measures to regulate the use of restrictive practices must be 'two-way' and not solely focused on capturing data – regulation must be in place for the primary purpose of driving system improvements.

Recommendation 6: That legislative provisions set out a requirement for the SA Health to provide the necessary resources for clear clinical governance frameworks for all service providers, standardised documentation tools and reporting pathways that allow for system improvement.

4.4 Fact sheet 8 questions

4.4.1 Should SAPOL be involved in the enforcement of the MHA? If not, who should be given these powers?

It is the College's position that behavioural disturbance is primarily a health issue and therefore considers where appropriate and safe to do so, health professionals should be prioritized to exercise the power to detain and use force, while acknowledging that in some circumstances a police officer or security officer may need to do so to ensure the safety of healthcare workers, other patients and members of the community. We also consider that that all less restrictive options must be tried or considered first.

4.4.2 Should the law allow hospital staff to use reasonable force to 'hold' a person until SAPOL arrives?

The current provisions relating to the transfer of custody of a person under the Act are not fit for purpose, and any prospective changes made to the Act must be made after exhaustive consultation with all relevant stakeholders. ACEM recommends that legislative provisions relating to custodial arrangements needs to undergo a comprehensive formal review.

Recommendation 7: Transfer of custody provisions under the Act must undergo a comprehensive review involving all relevant stakeholders

4.4.3 Should the law allow the use of care and control powers to enforce across border arrangements?

This would be an appropriate provision that will require individual agreements with each of the States and Territories.

4.5 Fact sheet 9 questions

4.5.1 How can these guiding principles be enforced into practice?

ACEM notes that the discussion paper references law reform activities in Victoria, particularly with regard to the inclusion of objectives and principles to support access to care and treatment.

The guiding principles of the MHA should be thought of in a broader sense rather than at the point of service delivery. The guiding principles must be reflected in the way that the system is designed, funded and delivered.

The College is supportive of provisions that address structural inequities of care (i.e., Aboriginal and Torres Strait Islander peoples), people living in regional, rural and remote communities, and other marginalised groups.

Any amendments to model the inclusion of objectives and principles as seen in Victoria (or other jurisdictions) must also take into account that various healthcare disciplines will be informed by the guiding principles of their profession and/or professional registration body.

Recommendation 8: The guiding principles should include provisions to address the structural inequities of care

4.5.2 How might the MHA provisions be changed to improve consumer's access to services?

The College is concerned by the lengthy delays to access definitive care that is experienced by people with acute mental health care needs. In the current mental health system, people experiencing mental health crises are subjected to unacceptably long waits in the ED for examination by a psychiatrist and admission into a mental health bed.

The conditions created by the systematic underfunding of specialist mental health services and lack of inpatient capacity has created a situation where patients who should be bypassing EDs altogether are being directed to the ED to await assessment simply because gaps in community and inpatient mental health services have left these people with nowhere else to go.

EDs are designed to provide efficient management of emergencies and potentially life-threatening presentations. They are staffed and resourced to provide appropriate initial management and stabilisation, not for the longitudinal management of people with acute mental health conditions. Our members regard the indefinite detention of mental health patients in EDs as 'counter-therapeutic'.

The amended legislation must build in provisions to ensure there is an adequate level of system capacity, and a guarantee of timely access to mental health care in safe and appropriate therapeutic environments.

Recommendation 9: The MHA should enable better community-based responses so that there are alternatives to the ED

4.5.3 What, if any, measures for accountability and monitoring should be included in the MHA?

The access issues described above are systemic, and the absence of legislated time-based-targets will continue to perpetuate the problem of long delays to access mental health care.

The occurrence of 24 hour waits in the ED should be regarded as a failure of the healthcare system, and the frequency of long waits in the ED warrants immediate and serious consideration by the stewards of the South Australian healthcare system. The current lack of accountability measures has created conditions where ED lengths of stay are increasing year-upon-year. ACEM would like to see robust and clear accountability measures introduced to reduce the frequency of unacceptably long waiting times in the ED.

Mental health patients should be transferred to the ward within 8 hours of admission to the ED to avoid experiencing access block. It is ACEM's view that effective accountability measures are required to address unacceptably long stays in EDs.

ACEM recommends that all patients presenting to the ED with an acute mental and behavioural condition have a total ED length of stay within Australia and Aotearoa New Zealand in line with ACEM's Hospital Access Targets (HATs) (i.e., the same time period as patients with any other emergency condition).

ACEM's HATs are a nuanced measure that consider the complexity of possible patient pathways from the ED. The HAT very deliberately refers to hospital access rather than emergency access, reflecting our desire for our shared patients once assessed, to be seen in the appropriate environment and by the right people for their health needs.

The maximum length of ED stay recommended by the HAT for any one stream is 12 hours. Waiting in the ED More than eight hours for a hospital bed leads to longer stays in the hospital. Delays of more than 12 hours significantly increases the chance of dying in hospital. When a patient is assessed in the ED as requiring inpatient admission, a bed should be made available immediately by the delegated receiving unit.

In addition to the HAT, ACEM suggests long wait times could be reduced by explicitly ensuring that hospitals have ED length of stay stratified for mental health patients as a key performance indicator. This should be framed as a way of ensuring that acute inpatient mental health teams have sufficient capacity and resources to support all their patients, including those in the ED. Failure to meet this KPI should have direct consequences for hospital leadership.

ACEM recommends the introduction of mandatory notification requirements to the Health Minister, Mental Health Minister, Chief Psychiatrist, Human Rights and/or Mental Health and/or Health Rights Commissioner should occur when transfer does not occur within 24 hours of arrival to the ED, and notifications for every additional 24 hours that a transfer to the ward has not occurred. Emergency Short Stay Units are considered part of the ED for the purpose of these notification requirements.

There must be a process in place that gives clear guidance on who should be notified under mandatory reporting requirements, including their legal responsibility to manage instances of 24-hour waits in the ED. The reporting process should be automated and otherwise made as simple as possible for clinicians (i.e., one report to one place).

Recommendation 10: The Act should require timely review of admitted mental health patients by a senior decision-maker in a mental health service to reduce the occurrence of access block

Recommendation 11: All SA hospitals have ED length of stay for mental health patients as a key performance indicator and that this is publicly reported

Recommendation 12: Provisions on time-based-targets must demonstrate that the reduction of waiting times for access to mental health care is an urgent priority

Recommendation 13: All 24 hour waits in an ED should be reported to the Health Minister and Mental Health Minister routinely, alongside any CEO interventions and mechanisms for incident review

5. Conclusion

EDs in public hospitals are free, open 24 hours a day, and provide physical or mental health emergency care. Emergency physicians are honoured to provide this service to the community.

The College believes that legislative amendments are necessary to improve aspects of the system function, however, the challenges our system faces cannot be solved through legislation alone.

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 system planning and implementation to ensure barriers to, unintended consequences of and further improvements can be made.

When amendments to the Act have been drafted, it is essential that further consultation is undertaken to ensure that all proposed amendments are fit for purpose.

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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