Australasian College
for Emergency Medicine

5 July 2019

Submission to the Royal Commission into Victoria's Mental Health System

1. Introduction

ACEM welcomes the opportunity to inform the Royal Commission into Victoria's Mental Health System about mental health care in emergency departments. Our submission highlights the experiences of patients presenting to Victoria's emergency departments (EDs) seeking mental health care, and the urgent need for greater capacity to manage this demand. It advocates for strengthened community resources integrated with acute models of care to reduce reliance on EDs.

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 the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

3. Overview of the submission

Emergency departments provides a compelling window into the strengths and weaknesses of Victoria's mental health system. ACEM's analysis of presentation data clearly shows Victoria's EDs being called on 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. 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 over-occupancy and access block, and for strengthened monitoring of the impact of these system failures on the use of restrictive practices in the ED. Capacity building needs to include an ED model of care to respond to children and adolescents needing mental health services and support.

Without more capacity in the community, in EDs and inpatient units, people needing mental health care will continue to experience dangerously long lengths of stay (LOS) in EDs. ACEM is therefore calling for CEO intervention once LOS hits 12 hours, and that this be integrated into key performance indicators. People with lived experience and their advocates have a major role to play in these system reforms and service improvements, including a stronger focus on performance measured against patient reported experiences and outcomes. To reduce reliance on EDs, communities across Victoria need access to mental health care outside of business hours, and ED staff need pathways for referrals into homelessness and drug and alcohol services. An integrated model of care is needed that can provide enhanced, trauma-informed services and support, tailored to respond to the needs of the most vulnerable groups of people with mental illness. Capacity for data linkage would improve the analysis of this cohort's engagement with, and experience of, services and strengthen decision making by system managers.

These components need to be integrated into a unifying vision for mental health care in Victoria. ACEM recommends that the Victorian government develop, fund and evaluate a strategy for mental health care that sets measurable targets for improving access to respectful, patient centred care in the community, from specialist inpatient services and from EDs as and when required. Agreement is urgently needed on joint planning approaches and funding responsibilities in a federated funding and policy system. The next National Mental Health Plan is a key opportunity for strengthened accountability for delivering on this outcome.

4. Recommendations

ACEM recommendations that:

1. Victoria's strategy for mental health care prioritises an immediate increase in access to publicly funded community and acute mental health services and support, based on integrated care models, in Victoria.
2. This strategy recognises and resources EDs to respond to the complex, specialist and episodic needs of people presenting for mental health care and support.
3. VAHI consider reporting on the use of restrictive practices (sedation, seclusion and restraint) in the ED, including when EDs are access blocked and overcrowded.
4. The Victorian government review acute models of mental health care and increase the number of mental health beds to ensure transfers to inpatient mental health units meet the national four hour target.
5. Victoria's strategy for mental health care further develops and expands models for specialised care to manage paediatric and adolescent mental health presentations in the ED.
6. Measures to improve timely access to mental health care across Victoria are monitored and evaluated in terms of their impact on presentations to EDs.
7. The Victorian government enforce a maximum 12 hour length of stay in the ED, with mandatory notification to the Minister for Health and outcomes of case reviews embedded in key performance indicators for public hospital CEOs.
8. Victoria's strategy for mental health care include patient-centred models that measurably improve the experience and outcomes of people who need acute mental health care.
9. Victoria's strategy for mental health care support the contribution of peer workers with lived experience of mental illness to improving the experience of people using EDs.
10. Victoria's strategy for mental health care prioritise evidence based, community-endorsed models for populations over-represented in presentations to EDs, starting with Aboriginal and Torres Strait Islander people.
11. The Victorian strategy for mental health care ensures access to care with a preventative focus outside of business hours across all regions of Victoria, and is funded for all mental health disorders regardless of their level of severity.
12. The Victorian Government ensures that services that respond to homelessness, drug and alcohol use and mental illness are available to patients and their ED and mental health clinician when required.
13. Victoria's strategy for mental health care measurably improves access to community based services offering long term, trauma informed mental health care alongside physical health care and psychosocial support.
14. That the Victorian government invest in data linkage to support decisions about models of care that measurably improve timely access to appropriate care and support for the most vulnerable and complex patient groups
15. Victoria's strategy for mental health care articulates a unified vision for an integrated service system, with care available in the community and from specialist inpatient services where and when required, and strengthened accountability for delivering on these outcomes.

These recommendations are consistent with the *Mental Health in the Emergency Department Consensus Statement*, which to date has been signed by over 850 health professional, representing emergency physicians, psychiatrists, nurses, people with lived experience and their advocates as well as health care leaders and system managers from across Australia.

5. Demand for mental health care from emergency departments

Many people present to EDs for mental health care because they cannot find or afford care in the community. Regardless of whether people are experiencing mental illness for the first time, a crisis outside of business hours or have a long standing condition, the ED is a far from ideal environment to provide this care.

ACEM is concerned about the timeliness and appropriateness of mental health care provided to people in Victoria's EDs. Few EDs in Victoria are adequately resourced, in terms of space, mental

health expertise and service pathways, to safely and therapeutically manage people presenting with mental health related conditions. Spending prolonged periods of time waiting to be moved to a mental health bed may exacerbate the problem that the patient presented with, adversely impacting on their care and outcomes.

Australian Institute of Health and Welfare (AIHW) data shows that over 57,000 people with a principle diagnosis of mental and behavioural conditions presented to Victorian EDs in 2017-18; this is 3.2% of all ED presentations.[1] More than one third (37.6%) of people with this principle diagnosis required an admission. The vast majority (57.2%) of these presentations arrive by ambulance or police, with 5% arriving by police or corrections vehicle. By way of comparison less than 1% of all ED presentations arrive by police or corrections vehicle[2].

Despite mental health accounting for such a small percentage of all 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.[3]

ACEM's 2018 national survey of the prevalence of mental health access block collected snapshot data from 11 Victorian EDs and found that nearly a quarter (23.2%) of all patients in the ED were mental health patients who had been waiting for more than eight hours for a bed[4]. AIHW data for 2017-18 shows that 90% of all mental health patients in Victoria's EDs waited more than 12 hours (13:50 minutes)[5]; this is more than three times the agreed standard set by the NEAT. With this data in mind, ACEM has called for all state and territory health departments to enforce a maximum 12 hour length of stay in the ED, regardless of the presentation type[6].

More recent data suggests a pattern of access block in EDs driven by occupancy rates in mental health units. The Victorian Agency for Health Information (VAHI) data shows mental health bed occupancy in 15 of 22 hospitals averaged at least 90% over the year April 2018 to March 2019, with the Alfred, Casey, Dandenong and Warrnambool averaging 100% or greater occupancy for this time period[7]. Note that Victoria has just 22 mental health beds per 100,000 people – by comparison, New South Wales has 36 per 100,000 people.[8]

VAHI's performance reports for 16 of Victoria's 22 public hospitals with mental health units shows that only three hospitals met the state-wide target of 80% of patients transferred from the ED to a mental health bed in eight hours. It is interesting to note that the three hospitals - Mildura, Bendigo

[1] AIHW (2019), *Mental health services in Australia*, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services, 03 May 2019
[2] Ibid, Table ED.2: Mental health-related emergency department presentations in public hospitals, by arrival mode, states and territories, 2017–18
[3] 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
[4] 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
[5] *Mental health services in* Australia, Opcit, Table ED.13: Mental health-related emergency department presentations in public hospitals, statistics for length of stay by states and territories, 2017–18
[6] Judkins et al, (2019), Mental health patients in emergency departments are suffering: the national failure and shame of the current system. A report on the Australasian College for Emergency Medicine's Mental Health in the Emergency Department Summit, *Australasian Psychiatry*, https://journals.sagepub.com/doi/abs/10.1177/1039856219852282?journalCode=apya
[7] VAHI (2019) *Victorian health services performance*, Statewide - Adult mental health bed occupancy rate, http://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=417&AMHSKey=3
[8] *Mental health services in Australia*, Opcit, Table FAC.13: Public sector specialised mental health hospital beds per 100,000 population, by hospital type and program type, states and territories, 1992–93 to 2016–17 https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities/specialised-mental-health-beds-and-patient-days

and Warrnambool – that meet the department's target are all located in regional Victoria. Averaged over the year (April 2018 to March 2019) seven hospitals recorded at least 50% of their mental health patients access blocked in the ED. Casey, Monash and Sunshine averaged at least one in three of these patients waiting more than eight hours over this period of time.[9]

This data highlights the pressures on Victoria's over-stretched and under-resourced acute mental health units and the flow on effects in EDs.

Not surprisingly, when patients present in a mental health crisis and are left to wait in unsupported environments, the risk of agitation and behavioural disturbances increases. 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 in with mental health needs are very likely to leave the ED prior to treatment.[10] VAHI should consider including the use of restrictive practices in the ED, and the relationship to access block and overcrowding, in its reporting on seclusion and restraint.

People with mental illness are very likely to have poor physical health. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has reported that people with mental illness typically live between 10 and 32 years less than the general population.[11] Research has clearly established the higher prevalence of chronic diseases including diabetes, cardiovascular diseases, gastrointestinal, headaches/migraine, chronic pain and high cholesterol in people with mental illness.[12]

Research shows that people with mental illness are likely to report harmful levels of alcohol use. In the National Health Survey, 56% of people in Victoria with long term mental and behavioural problems self-reported that in the last 12 months they consumed alcohol in excess of guidelines[13]. ACEM's 2018 survey of alcohol and other drug harm found that more than one in ten ED presentations in Victoria were related to alcohol use[14]. Frequent and heavy alcohol use is associated with an increased risk of suicide, psychosis and behavioural disturbances, major depression and frequent ED presentation. Effective management requires integrated models of care – managing mental health, general medical and AOD/toxicological care – within EDs.

EDs need to be resourced and supported so that they can respond to these complex community health needs in an appropriate way. Models of care need to be developed that include appropriate infrastructure and resources to allow early and effective interventions, avoiding long delays before reaching definitive points of ongoing mental health care. These models should have the capacity to recognise and respond to physical and mental health, the abuse of alcohol and other substances and the complex psychosocial needs of many of these patients.

EDs across Victoria need to know that beds are available for emergency mental health admissions. 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. Bed numbers need to increase to ensure that transfers to mental health units are completed within the national four hour target. ACEM notes Mental Health Victoria's call for the Victorian Government to set an interim target of at least 36 mental health beds per 100,000 Victorians and a longer term target of at least 50 mental health beds per 100,000 Victorians – in line with the OECD average.

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[9] Victorian Agency for Health Information (2019) 'Inner South East Adult Area Mental Health Service - Adult mental health ED presentations transferred to a mental health bed within 8 hours - Quarterly Data", Victorian Health Services Performance, available from http://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=417&AMHSKey=3

[10] 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

[11] RANZCP (2015) Keeping Body and Mind Together Improving the physical health and life expectancy of people with serious mental illness, https://www.ranzcp.org/files/resources/reports/keeping-body-and-mind-together.aspx,

[12] Duggan, M. (2015) *Beyond the fragments: Preventing the costs and consequences of chronic physical and mental disease*, Australian Health Policy Collaboration, Issues Paper no. 2015-05.

[13] Australian Bureau of Statistics (2019) National Health Survey Catalogue no 4364.0.55.001, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012017-18?OpenDocument

[14] ACEM (2019) *2018 Alcohol and Other Drug Harm Snapshot Survey*, https://acem.org.au/News/June-2019/Burden-of-alcohol-and-methamphetamine-harm-reveale, June 2019

Recommendations for better managing demand

1. That Victoria's strategy for mental health care prioritises an immediate increase in access to publicly funded community and acute mental health services and support, based on integrated care models, in Victoria.
2. This strategy recognises and resources EDs to respond to the complex, specialist and episodic needs of people presenting for mental health care and support.
3. That VAHI consider reporting on the use of restrictive practices (sedation, seclusion and restraint) in the ED, including when EDs are access blocked and overcrowded.
4. That the Victorian government review acute models of mental health care and increase the number of mental health beds to ensure transfers to inpatient mental health units meet the national four hour target.

6. Paediatric and adolescent mental health in the ED

Increasingly, children and adolescents are presenting to EDs across Australia with concerns relating to their mental health. AIHW data for Victoria shows that in 2016-17, 2,302 presentations for mental health were for patients aged up to 14 years.[15] In NSW between 2010 and 2014, there was a mean annual increase of 27% in adolescents presenting to the ED with suicidal ideation/behaviour or self-harm,[16] while in Victoria between 2008-09 and 2014-15 there was a significant rise in paediatric mental health presentations, particularly related to self-harm, depression, and behavioural disorders, with a disproportionate increase in those aged 10-14 years[17].

Further, young people with mental health and/or behavioural problems often present in the context of significant ongoing issues including autism, intellectual disability, childhood trauma, parental mental illness, child abuse, and/or involvement in out of home care. Adolescents and children are at higher risk of acute severe behavioural disturbance than adult patients[18], and are therefore at higher risk for restraint and/or chemical sedation within the ED.

An ED visit provides a key opportunity to address acute risk and provide early intervention, with the potential to alter the trajectory of mental illness and subsequent disability and disease burden in later life.[19] However, provision of adequate care is often difficult. The dramatic increase in paediatric and adolescent mental health presentations is challenging to ED staff, with this population requiring separation not just from adults but from other unwell children. Ensuring children are able to be assessed in a suitable, calming, child-friendly environment is rarely possible. Furthermore, there are few options for a child or adolescent who requires inpatient admission for mental health problems. There are only two specialised wards in the state (based at the Austin and Monash Hospitals) for children with mental health issues, and two adolescent wards (at Royal Children's, Boxhill and Monash Hospitals).

ACEM welcomes the Victorian Government's investment in developing mental health crisis hubs in EDs, based on the Alfred model, at Monash, Frankston, Western, Geelong and Royal Melbourne hospitals. A similar investment is needed to develop and expand models of care to ensure there is state-wide access to expertise in paediatric and adolescent mental health.

Recommendation for paediatric and adolescent mental health

5. That Victoria's strategy for mental health care further develops and expands specialised models for managing paediatric and adolescent mental health presentations in the ED.

[15] AIHW (2019) *Mental health services in Australia,* available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services
[16] Perera J, Wand T, Bein KJ, et al. (2018) 'Presentations to NSW emergency departments with self-harm, suicidal ideation, or intentional poisoning, 2010-2014', *The Medical Journal of Australia* 2018; vol. 208, no. 8, pp. 348-53.
[17] Hiscock H, Neely RJ, Lei S, Freed G. (2018) 'Paediatric mental and physical health presentations to emergency departments, Victoria, 2008-15', *The Medical Journal of Australia*; vol. 208, no. 8, pp.343-8
[18] Baeza I, Correll CU, Saito E, et al. (2013) 'Frequency, characteristics and management of adolescent inpatient aggression', *Journal of child and adolescent psychopharmacology* vol. 23, no. 4, pp. 271-81.
[19] Perera et al. (2018)

7. Unacceptable standards of care

A chronically under-resourced mental health system means too many people cannot find or afford an appointment in the community, while stigma and a lack of confidence in the system means many people delay presenting until they are in crisis. In this chronically under-staffed and under-resourced service system, the regular state of bed block in inpatient mental health units and the shortage of after hour's care in the community contribute to dangerous levels of access block and overcrowding in the ED. People who are often in extreme distress or behaviourally disturbed regularly wait for hours and often days in EDs, with breaches of admission targets being routinely tolerated by hospital administrators and governments. Emergency physicians are profoundly frustrated and demoralised by trying to provide safe, quality care for people in this environment.

A core function of ACEM is to set the standard for emergency medical care across Australia and New Zealand. People presenting to an ED needing mental health care have the right to timely access to appropriate care, regardless of the time of day, day of the week or where they live. ACEM believes that the data summarised above is evidence of systemic discrimination against people needing mental health care, clearly capturing the chronic failure of government policy to enable mental health services to respond to community needs.

Victoria has been a leader in mandating zero tolerance of 24 hour LOS in the ED, with mandatory reporting of incidents to the Health Minister. An increasing number of jurisdictions have adopted this performance measure (see for example the announcement from the WA Government earlier this year) while national surveys of access block consistently show Victoria with the lowest number of 24 hour waits.[20]

ACEM is therefore extremely concerned to see that there were 564 incidences of 24 hour LOS in Victorian EDs, with VAHI data showing the number of 24 hour waits increasing nearly fivefold in just 12 months in, from 40 in March 2018 to 190 in March 2019.[21] Just three hospitals - Mildura, Monash and Casey - accounted for half (or 289) of all the incidents of a 24 hour LOS in Victoria.

The deteriorating performance of Victoria's hospital system will exacerbate the problems of mental health access block in EDs and further undermine timely access to safe, quality care for these patients. There needs to be greater transparency about the underlying drivers for this deteriorating performance, and stronger accountability for its impact on patient experiences and outcomes as well as staff morale.

ACEM believes that a 24 hour LOS in the ED should never occur. We recommend introducing a requirement for CEO intervention at 12 hours and mechanisms for incident review that ensure that operational and system issues are remedied.

Recommendations for improving standards of care

6. Measures to improve timely access to mental health care across Victoria are monitored and evaluated in terms of their impact on presentations to EDs.
7. The Victorian government enforce a maximum 12 hour length of stay in the ED, with mandatory notification to the Minister for Health and outcomes of case reviews embedded in key performance indicators for public hospital CEOs.

8. Improving patient experiences

At the National Mental Health in the Emergency Department Summit, held in Melbourne in October 2018, consumers described experiences of care that were unwelcoming, hostile and traumatising, while highlighting the difference that peer workers in a safe comfortable space like the Safe Haven

[20] ACEM (2018) CEM (2018c) *2018-1 Access Block Point Prevalence Survey Summary*, June 2018, available from https://acem.org.au/getmedia/fa6f17ec-3926-4078-ac5c-529e7939e115/Access-Block-2018-1

[21] Victorian Agency for Health Information (2019) Victorian Health Services Performance, *Statewide - Number of presentations where the patient stayed longer than 24 hours* , available from http://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=147

Café can make. St Vincent's Hospital in Melbourne has a peer worker employed in the ED and the Safe Haven Café, physically close to the ED. The café offers respite in a warm, caring and respectful environment to people needing mental health support as well as social connection, but not necessarily acute care. The model was developed by and for consumers.

At the summit, the President of ACEM spoke of the profound difficulties faced by emergency physicians trying to navigate a complex, fractured service system to get urgently required mental health care for already vulnerable patients, especially in cases of homelessness, young people in regional towns, and for Aboriginal and Torres Strait Islander people. Note that AIHW data shows that over 2,000 Aboriginal and Torres Strait Islander people presented to Victorian EDs for mental health care in 2016 – 17.[22] This is 3.4% of all mental health presentations for a population that made up less than 1% of Victoria's population in 2016.[23] Consistent with this, the President of the RANZCP highlighted the variability in models of care, and that listening to the experiences of people who use the system and taking the lead from people who have lived experience of mental illness, was an essential component of service reform.

ACEM supports the development of new models of patient centred care, in consultation with people living with mental health conditions and their advocates. ACEM is currently working with the Lowitja Institute on national research to better understand the experience of Aboriginal and Torres Strait Islander people in EDs, and their health care professionals. ACEM has committed to implement the resulting recommendations, which are due in 2020.

Recommendations for improving the experience of patients

8. Victoria's strategy for mental health care includes patient-centred models that measurably improve the experience and outcomes of people who need acute mental health care.
9. Victoria's strategy for mental health supports the contribution of peer workers with lived experience of mental illness to improving the experience of people using EDs.
10. Victoria's strategy for mental health prioritises evidence-based, community-endorsed models for populations over-represented in presentations to EDs, starting with Aboriginal and Torres Strait Islander people.

9. Prevention and early intervention

ACEM believes that investment in improved access to care in the community for patients with mental health and other chronic conditions, alongside family violence, substance abuse and psychosocial problems, will improve health and wellbeing and decrease the need for episodic acute care in an ED. There is a known correlation between the wellbeing of patients with mental illness and their mental health. The Victorian Government needs to give effect to the social determinants of health in its policy decisions and particularly the provision of safe, affordable housing so that no one is ever discharged from hospital to homelessness. Addressing these health determinants will decrease demand on acute care services.

Programs must be integrated such that non-mental health problems are comprehensively managed in conjunction with mental health care, to ensure that wellbeing and health in this population is optimised. There is an urgent need for more community based alternatives, including step down care and community living options as well as easier access to care outside of business hours. AIHW data

[22] AIHW (2018) Emergency department care 2016/17: Australian hospital statistics, Health services series no. 80, Catalogue number HSE 194, 2017, Canberra: AIHW.
[23] Australian Bureau of Statistics (2018) *2016 Census QuickStats: Victoria,* available from https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/2?opendocument

shows that over 42% of all presentations to EDs are outside of business hours, and that this pattern is broadly consistent across all days of the week.[24]

Recommendations for strengthening prevention and early intervention

11. The Victorian strategy for mental health care ensures access to patient centred care with a preventative focus outside of business hours across all regions of Victoria, and is funded for all mental health disorders regardless of their level of severity.
12. The Victorian Government ensures that services that respond to homelessness, drug and alcohol use and mental illness are available to patients and their ED and mental health clinician when required.

10. Care for the most vulnerable

ACEM's expectation is that mental health should be treated with the same quality of care provided to other patients presenting to an ED, but the reality across Victoria is that the most vulnerable people are caught between an over-stretched public hospital system with too few mental health beds and an under-resourced community mental health sector with scant after-hours availability.

This system cannot help but fail the most vulnerable people in our community. This group present to EDs with chronic, acute or deteriorating mental health conditions – including psychotic illnesses – alongside drug and alcohol use, chronic physical health issues including disabilities, and/or social issues such as insecure housing and homelessness. This is also population at greatest risk of involvement with police, prison and child protection systems.

This cohort struggles to engage with community-based models of care and instead are managed by a combination of police, ambulance and EDs. Many cycle for months or years through homelessness, rehabilitation, mental health wards and the courts. This model of refuge and short-term support does not focus on longer-term welfare and recovery. For these patients, particularly those with psychosocial and behavioural problems, usual care in the ED offers containment, crisis review and attention to immediate needs. However, the severely limited availability in the public health system of long term counselling for complex psychological trauma highlights the real lack of options for recovery for the people in greatest need.

The loss of the community mental health model, which offered psychosocial support as well as recovery services, and the transfer of a limited number of eligible patients to the National Disability Insurance Scheme has compounded inequities and fragmentation in Victoria's mental health system. Community mental health provided integrated care across the otherwise siloed sectors responding to homelessness, drug and alcohol, family violence, poverty and disadvantage to a shared group of clients. In Victoria, the lack of data linkage across government agencies, social support services, primary and acute health and other relevant sectors undermines researchers' ability to clearly define health care needs, and to understand the relationship between interventions and outcomes. Without this information and analysis, it is difficult to achieve consensus on how to design the most effective community intervention strategies.

The State Government needs to commit to sustaining a functioning, integrated community based mental health service system that supports comprehensive psychosocial clinical care and social support for the mental health needs of children, adolescents and adults in their local community.

Recommendation for strengthening care for the most vulnerable

13. Victoria's strategy for mental health care measurably improves access to community-based services offering long-term, trauma-informed mental health care alongside physical health care and psychosocial support.

[24] AIHW (2018) *Emergency department care 2017–18: Australian hospital statistics*, Table 4.4: Proportion (%) of presentations by day of week and time of presentation, 2017–18, available from https://www.aihw.gov.au/reports/hospitals/emergency-department-care-2017-18/contents/table-of-contents.

14. That the Victorian government invest in data linkage to support decisions about models of care that measurably improve timely access to appropriate care and support for the most vulnerable and complex patient groups

11. A shared vision for mental health care

Despite significant investment and concerted attention from state health and mental health ministers, their departments and many deeply committed health professionals, the mental health system in Victoria is failing both those who experience acute need and those health professionals dedicated to supporting them. Victoria allocated $1.3b (recurrent) in 2016-17 to funding specialist mental health care. At approximately $200 per head of population, this is the lowest rate of expenditure by jurisdiction in Australia.[25]

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. There is significant variation in the services that are available across different regions of Victoria, with seemingly no consistent approach to measuring demand and ensuring a minimum level of service for all communities.

The issues created by the current arrangement of national and state funding alongside weak accountability measures in the mental health system are not just problems for EDs. However, systemic deficiencies in current arrangements mean that EDs, often the only service always available after-hours and open to everyone, become the first and last option for those needing mental health care. The data on service demand shows that 24 hour access to crisis mental health care is as vital for police as it is for patients, their family, friends or carers. The role of EDs in Victoria's mental health system, and the resources and infrastructure required to meet this capability, needs to be agreed in policy and funding.

In addition to reforms to ensure system wide capacity across community, ED and hospital services, there is an urgent need for an agreed vision for mental health care and strengthened accountability measures. This should begin with reform of the mechanisms for cooperative planning between state and federal governments as well as alignment of funding with service commitments. The next National Mental Health Plan provides the opportunity to strengthen joint planning and accountability and to benchmark the Plan's objectives against this outcome.

Recommendation for a unified vision for mental health care

15. Victoria's strategy for mental health care articulates a unified vision for an integrated service system, with care available in the community and from specialist inpatient services where and when required, and strengthened accountability for delivering on these outcomes.

12. Promising directions in service development

ACEM highlights the following range of models of mental health care that engage with EDs and are designed to offer 24 hour access to an affordable, comprehensive, integrated and multidisciplinary service.

12.1 Mental health and addiction in the emergency department

The Alfred Hospital, Melbourne, has established an integrated approach to the delivery of mental health and addiction services in the emergency department. The Alfred's emergency psychiatry service (EPS) is part of the Alfred Mental Health Service, is available 7 days a week, 24 hours a day and works in the Alfred Emergency and Trauma Centre (E&TC), assessing patients and providing

[25] AIHW (2019) *Mental health services in Australia*, Table EXP.1: Recurrent expenditure ($'000) on state and territory specialised mental health services, states and territories, 2016–17, available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services)

intervention for those who are displaying mental health difficulties or where mental ill-health is contributing to their presentation. The multidisciplinary team is made up of specialist mental health nurses, nurse practitioners, social workers, occupational therapists, clinical psychologists and neuropsychologists, and psychiatrists and trainee psychiatrists. The Alfred's emergency psychiatry service also has a team of mental health clinicians who work with Victoria Police, responding to 000 calls where mental health issues may be involved. This service has resulted is some patients being successfully managed in the community and therefore preventing transfers to the E&TC.

The Royal Melbourne Behavioural Assessment unit, a six bed collocated facility staffed by onsite mental health, social work, drug and alcohol clinicians and experienced emergency medical and nursing staff. An evaluation of this model showed a decrease in restrictive interventions, a reduction in the waiting time to see a mental health clinician and a marked reduction in Emergency Department length of stay[26] . Like the St Vincent's Hospital model, it has been built to care for patients with physical complaints (including poisoning and intoxication) and psychosocial crises and allows emergency medical and emergency mental health staff to work in parallel.

St Vincent's Hospital, Sydney, has created a six bed ward close to the emergency department, where patients can be admitted for safe observation, management and nursing. It provides a model of concurrent management of acute mental health conditions with co-existent medical problems, where patients can be managed medically in a safe setting until medically fit for mental health review. The PANDA unit has been developed in response to the high proportion of people with mental health illness and regular drug and alcohol users presenting to the ED. Data suggests around 15% of the patient presentations to the ED involve mental illness and/or the effects of drug use. The PANDA model is a 7 day a week, 24 hour a day service, managed by a combination of clinical pharmacology and drug and alcohol teams in close collaboration with the Emergency Department and the Mental Health Service.

13. Other innovations in mental health care

The following models have been developed in other states of Australia. These examples should inform agreement on a system-wide vision for improving the care of people with mental health needs and reducing the dependence hospital EDs for mental health care.

The Mental Health Observation Area (MHOA) at Joondalup Health Campus, Perth, Western Australia, is a co-located area with interview rooms and overnight beds that has taken mental health patients out of the main ED, 'bringing the ED back under control'. Victoria is in the process of rolling out its version of the MHOA – the ED Crisis Hub.

Royal Prince Alfred Hospital, Sydney, has successfully trialled a nurse practitioner-led, extended hours, mental health liaison nurse (MHLN) service based in the ED. The MHLN team see mental health presentations and begin the process for coordinating care. This has been shown to provide prompt and effective access to specialised mental health care for people with 'undifferentiated health problems', and remove a significant workload from nursing and medical staff.

The Queensland Mental Health Intervention Project is a partnership between Queensland Police, health and ambulance services, where mental health clinicians work alongside police to better manage crisis situations involving people with a mental illness. Staff are supported with training in de-escalation strategies and regional coordinators work to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative referral pathways and review procedures.

Royal Perth Hospital has a Homeless Team to address one of the biggest drivers for re-presentations to the ED – discharging a patient into homelessness. Over two years, Royal Perth Hospital's Homeless Team has demonstrated how a hospital can break the cycle of homeless people presenting to emergency departments. Most EDs are only resourced to respond to immediate medical issues, with

[26] Braitberg G, Gerdtz M, Harding S et al. (2018) 'Behavioural assessment unit improves outcomes for patients with complex psychosocial needs', *Emergency Medicine Australasia,* vol. 30, no. 3, pp. 353-358.

homeless people then discharged back to the streets. The evaluation shows that tailored care, linkages with GPs and follow up care in the community are reducing ED re-presentations and lengthy inpatient admissions at Royal Perth. The Homeless Team has been proactive in connecting people with stable housing and support and it is this vulnerable population who have had the greatest reduction in hospital presentations. This is a program that needs recurrent funding and should be replicated and resourced in hospitals across Australia.

Further details including interviews and presentations about these models are available here.

14. Conclusion

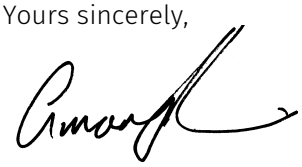
Emergency Departments in public hospitals are free, open 24 hours a day, and there for everybody with a physical or mental health need for emergency care. Emergency physicians are honoured to provide this service to the community.

ACEM believes that EDs should be resourced and supported to offer a safe and supportive environment for people seeking help for mental health problems. The models of care used in EDs should draw on contemporary clinical practice for managing emergency mental health care. This requires appropriate infrastructure alongside new models of care that support pathways into effective interventions from appropriate specialist inpatient and/or community-based services. This needs to include access to multidisciplinary care and support that is sensitive and responsive to the needs of young people, people from Aboriginal and Torres Strait Islander communities and people with complex, chronic and multiple physical and psychosocial needs.

Achieving this simple vision will require significant reforms to funding, governance, service development and accountability arrangements in Victoria. To achieve this outcome, ACEM believes that state and federal governments need to work cooperatively to agree on a vision for a sustainably funded, integrated, mental health system that supports timely, coordinated and multidisciplinary management of need in children, adolescents and adults. ACEM looks forward to working with other clinical leaders, people with a lived experience of mental and their advocates and system managers to strengthen mental health policy and services in Victoria.

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, Helena Maher (t: (03) 9320 0444, e: helena.maher@acem.org.au).

Yours sincerely,



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