Australasian College for Emergency Medicine
Department of Policy, Research and Advocacy

The Long Wait:
An Analysis of Mental Health Presentations to Australian Emergency Departments

Report
October 2018

1. Background

The Australasian College for Emergency Medicine (ACEM, the College) is the not-for-profit organisation in Australia and New Zealand responsible for training emergency physicians and advancing professional standards in emergency medicine. Fellows of ACEM (FACEMs) – our members – are specialist emergency physicians working in emergency departments (EDs) across Australia and New Zealand, and internationally.

As the peak binational professional organisation for emergency medicine, the College has a vital interest in ensuring that the highest standards of medical care are maintained for all patients seeking help from EDs across Australia and New Zealand, including patients with mental health presentations.

Following on from the release of ACEM's report *Waiting Times in the Emergency Department for Patients with Acute Mental and Behavioural Conditions*, this report is an analysis of key mental health presentation data from the 2016/17 Australian Institute of Health and Welfare's (AIHW) National Non-Admitted Patient Emergency Department Care (NNAPEDC) Database.

Emergency departments often act as the 'front door' to the health system, playing a unique role in the provision of safe, high quality acute medical care to everyone in the community. Each year, more than a quarter of a million Australians present to EDs seeking help for acute mental and behavioural conditions. Yet for many of these patients, the evidence suggests that EDs are not adequately fulfilling their role as a timely and accessible entry point to the mental health system.

It is likely that the poor experiences many people have when they present to EDs with a mental health crisis reflect the ways in which the wider health system treats mental health. When hospitals cannot find an appropriate care pathway for people suffering severe episodes of mental illness, patients end up stuck in the ED until a bed can be found. In some cases, patients refuse to stay any longer and leave the ED at their own risk.

In recent years, ACEM members have consistently reported to the College that this group of ED patients disproportionately experiences unacceptably long lengths of stay while they wait for admission to specialist inpatient care. In other words, inadequate prioritisation of and resourcing for mental health hospital admissions, together with a lack of other options for care, show up in extended stays for mental health patients in EDs.

In many communities, EDs are the only option for people undergoing acute mental health crises. However, it is difficult to imagine an environment less conducive than a busy ED for the extended treatment of people with severe mental illness, where long stays are associated with suboptimal treatment like restraint, seclusion and lengthy periods of sedation.

In February 2018, the College began a campaign with the aim of improving the way people with mental health presentations are managed in EDs across the country. While there is much that can be done to improve the experiences of people who present to EDs with mental health crises, it is also essential that system responses beyond the ED are improved. More needs to be done in the community to avoid the types of crises that precipitate a visit to the ED, and more appropriate, timely treatment options are needed to minimise the time that people with mental health presentations spend in the ED.

> *"Imagine not being able to think straight. Being scared. Hearing voices telling you to kill yourself. Seeing things that aren't there. Confused. You're taken to the emergency department for help. You don't want to be there, but you are held there against your will. You sit in a room with no windows with just a foam block to sleep on and a guard watching you. The lights stay on. It is noisy and there is a constant buzz of activity outside the room. There is no way to tell if it is night or day and you have no idea what is happening. A few people come and talk to you and you get told that you are unwell and need a bed in the hospital. You'll go there – soon. Minutes turn to hours turn to days. There is little sleep and you are confined to a small room. No TV. No music. No distractions. No therapeutic relationships to start the healing. Just the never ending buzz of activity in the emergency department and for you, there is no end in sight. This is what it is like for many mental health patients in EDs all across Australia… It's not care, it's cruel."* **(FACEM)**

2. Summary of key findings

People who present to EDs seeking help for their mental health are likely to do so at a time of acute crisis. The AIHW data[1] suggest that patients presenting with mental health problems:

1 Have to wait longer than other patients with a similar severity of physical illness before they can be assessed and have their treatment commenced. This can reflect a lack of specialist mental health staff;

- People presenting with acute mental and behavioural conditions were 18 per cent less likely to be seen within the appropriate Australasian Triage Scale (ATS) timeframe for their presentation urgency than people with other emergency medical conditions.[2]

2 Endure a longer period of treatment in the ED. This can be due to a slower rate of admission to hospital for patients with severe mental health presentations, reflecting constraints on the admission capacity of hospitals and the lack of other available options;

- People with mental health crises have very long ED lengths of stay. For all ED presentations, 90 per cent of people left the ED within seven hours, while for people presenting with acute mental health crises this figure was 11.5 hours. In South Australia, Western Australia and Tasmania, long stays are more prevalent. For instance, in South Australia, 90 per cent of people with mental health presentations left the ED within 16.5 hours, in Western Australia they left within 15 hours and in Tasmania they left within 14 hours. Notably for 10 per cent of presentations, their ED length of stay – or waiting time – far exceeds these times, further worsening their conditions.

3 Are more likely than other patients to leave the ED prior to their treatment being completed, i.e. at their own risk and against medical advice;

- Of particular concern is the very high rate of people with mental health presentations who come to EDs seeking help, but who leave before their treatment concludes. In most jurisdictions, on average patients in this group were twice as likely as other ED presentations to leave before their treatment and care was completed. Throughout 2016/17, almost 7,000 people who sought help from EDs for their acute mental and behavioural condition left the ED before finishing treatment.

4 Are more likely to arrive at EDs via ambulance services and the police than other patients;

- People experiencing an acute mental and behavioural crisis are up to 16 times more likely than people with other emergency medical conditions to arrive at EDs via police or correctional services vehicles, nearly twice as likely to arrive at EDs via ambulance, air ambulance or helicopter rescue service, and more commonly rated by ED staff as requiring urgent care on the ATS.

5 Are more likely to identify as Aboriginal and Torres Strait Islander than other patients;

- While Indigenous Australians make up around three per cent of the Australian population, they comprise 11 per cent of all ED mental health presentations across the country.

These data suggest that our health system is failing to meet the needs of a large number of people who seek help from EDs for serious mental and behavioural conditions. These general failures give rise to the inadequate quality of mental health care in Australian EDs, as described by the above statistics, and by the clinicians, consumers and carers who shared their experiences for this report.

1 2016/17 data from the AIHW NNAPEDC Database.

2 Overall, 27 per cent of people with other emergency medical conditions were not seen within the appropriate ATS timeframe for their presentation urgency. For people with acute mental and behavioural conditions, 32 per cent were not seen within the appropriate ATS timeframe for their presentation urgency. In some jurisdictions, the difference was more marked, such as in Western Australia, South Australia and Tasmania.

"I have sat in distress in ED on multiple occasions. Between the bright lights, yelling, police, pain and chaos of the surroundings – and my distress – I begin pacing, humming, tapping… just to try and block it out. Due to the long wait, I am either chemically restrained because of my distress, or repeatedly pressured to "calm down", which funnily enough does not work. By the time I have waited [for] eight to 13 hours to speak to someone from mental health, I am silenced by the medication, by privacy concerns, and by the increase in my distress. What I consider to be the lowest point of my life, consumed by mania, psychosis and suicidal intent, led to me being [stuck] in ED [for] 17 hours and provided multiple anti-psychotics with sedative effects before being assessed. I was told that they wanted to admit me, but I was so sensitive that they were concerned [admitting me] would add to my distress. I was discharged from ED. While I am sure I was told of referrals made and what to do… it was 5 am, I had been awake for three days and felt unworthy of help. Sitting in my car I began self-harming and phoned crisis support, who referred me [back] to ED. I tried multiple hotlines and kept getting the same advice. I felt so hopeless, overly worthless and almost supported in my decision to end my life. Retrospectively I can [now] explain that feeling as having my pain invalidated." **(Consumer)**

3. Methodology

For the purposes of this report, we undertook a descriptive analysis of 2016/17 publicly available AIHW NNAPEDC data on mental health presentations to EDs. The AIHW compiles these data each year to form the annual NNAPEDC Database. In 2016/17, 287 public hospital EDs reported to the NNAPEDC Database on ED presentations.[3]

In the NNAPEDC Database, mental health presentations to EDs are defined as patient presentations with a principal diagnosis of mental and behavioural disorders. Principal diagnosis refers to the diagnosis primarily responsible for occasioning the ED presentation. The classification encompasses a wide range of groups of psychiatric conditions falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.[4] According to the AIHW, the majority of mental health presentations to EDs are classified by the following principal diagnosis groupings:

- Mental and behavioural disorders due to psychoactive substance use (27%)
- Neurotic, stress-related and somatoform disorders (27%)
- Mood (affective) disorders (12%)
- Schizophrenia, schizotypal and delusional disorders (11%)
- Mental disorder, not otherwise specified (10%).[5]

However, there are limitations with the definitions that are likely to result in an underestimation of the true extent to which people with acute mental and behavioural conditions seek help from EDs. For instance, the definition may not fully capture mental health presentations involving intentional self-harm, which in the ED environment can be difficult to identify and code. Self-harm is classified in the ICD-10-AM codes X60 to X84. Moreover, self-harm may have a principal diagnosis relating to the injury itself. These presentations are not classified as mental and behavioural disorders in the NNAPEDC Database and, as such, are not included in this report.[6]

With the exception of Table 2 and Figure 5, we compared mental health presentation data – according to the principal diagnosis above – with ED presentation data for all other emergency medical conditions (i.e. non-mental health presentations). However, in Table 2 and Figure 5 we were only able to compare mental health presentations with the publicly available data for all ED presentations. Given all ED presentations include those for mental health, comparing the data in this way may underestimate the difference between ED lengths of stay for mental health presentations and non-mental health presentations. Therefore, there is likely to be a larger time difference between the two groups of patients than represented in Table 2 and Figure 5.

Throughout this report, we included vignettes to highlight and contextualise the ED experience for all stakeholders involved – people seeking help for their mental health crises, their families and carers, and the ED clinicians working in the system. Where applicable, names and locations have been changed to protect the identities of individuals.

3 Australian Institute of Health and Welfare. Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. 2017. Canberra: AIHW; 2018. Available from: *https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true.*

4 Mental health services in Australia [Internet]. Canberra: AIHW; 2018. Data source; 2018 [updated 17 Jul 18]. Available from: *https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services/data-source.*

Note: International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) 6th, 7th, 8th or 9th edition, International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) 2nd edition, Systematised Nomenclature of Medicine—Clinical Terms—Australian version Emergency Department Reference Set (SNOMED CT-AU (EDRS)).

5 Mental health services in Australia [Internet]. Canberra: AIHW; 2018. Patient characteristics; 2018 [updated 17 Jul 18]. Available from: *https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services/patient-characteristics.*

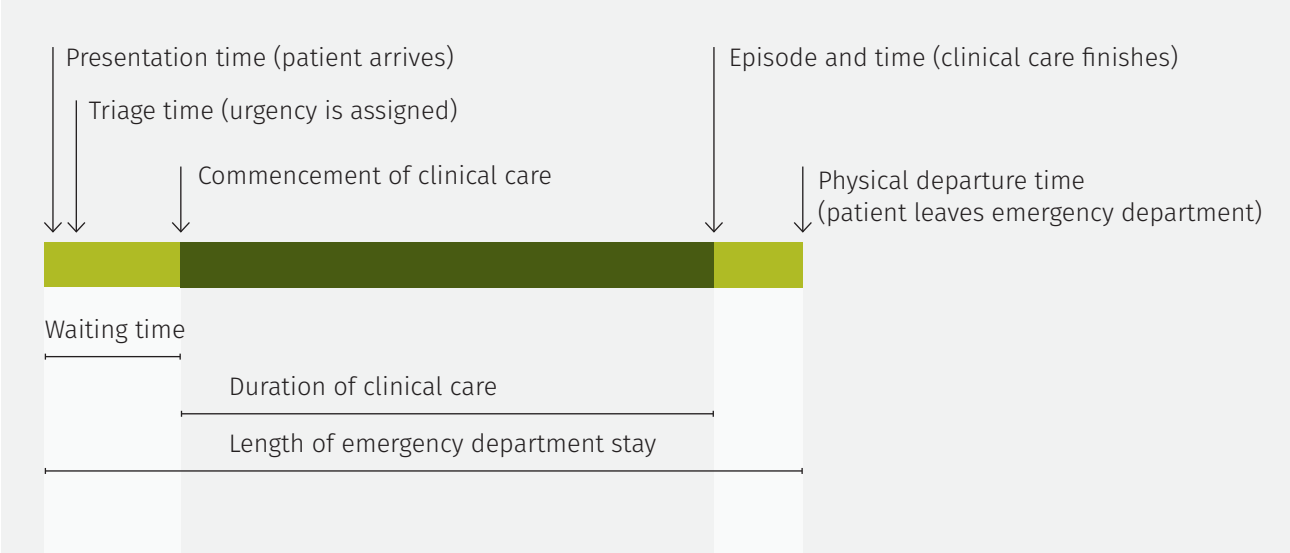
6 Mental health services in Australia [Internet]. Canberra: AIHW; 2018. Data source; 2018 [updated 17 Jul 18]. Available from: *https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services/data-source.*

4. Findings

4.1. Pathways to mental health care

Figure 1 provides an overview of the typical ED care pathway[7] for people who present seeking medical attention for an urgent health issue.

Figure 1 AIHW depiction of patient progress through the ED



Source: AIHW
Note: The lengths of the segments are illustrative only

The remainder of this section follows the same care 'pathway', analysing:

- Mode of ED arrival
- Waiting time to commencement of ED clinical care
- Duration of ED clinical care
- Departure from the ED
- Characteristics of mental health presentations to EDs.

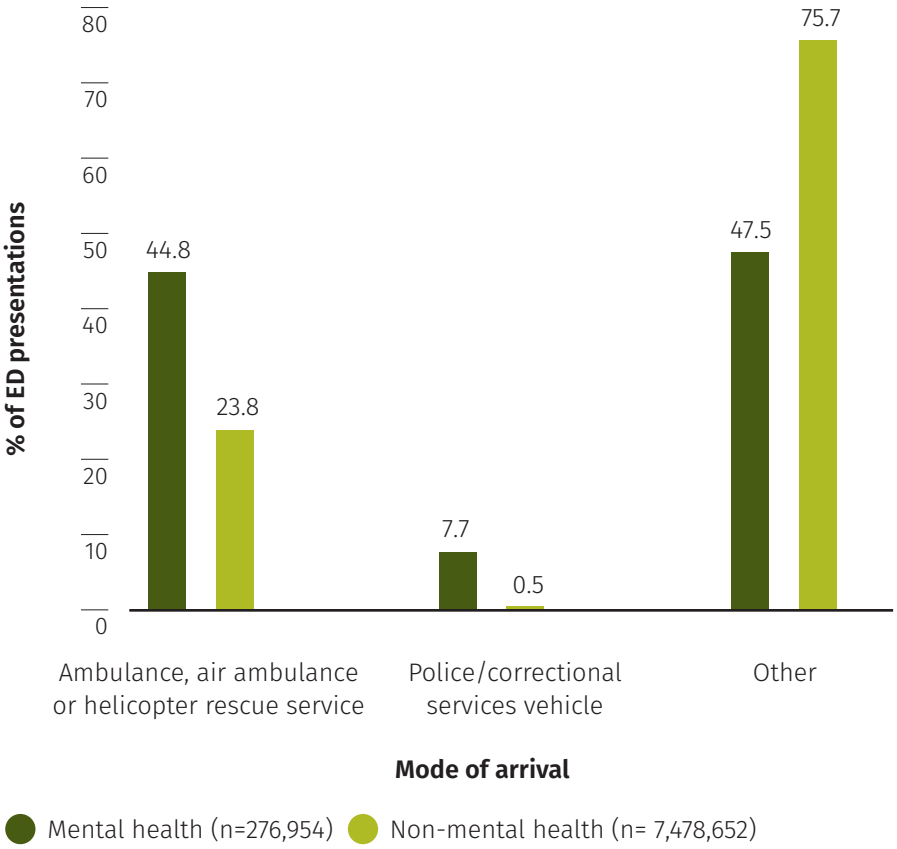
4.2. Arrival mode to ED and urgency of emergency

> *"Chronic underfunding and under-investment by successive governments have left us with a mental health system that is trailing well behind the rest of Australia and is increasingly reliant on police, ambulances, hospitals and the justice system to provide frontline care for people with mental health issues."* **(FACEM)**

Most people seeking help for acute mental and behavioural conditions tend to present to EDs using their own means of transport, as shown in ***Figure 2***. However, in 2016/17 more than 123,000 people with mental health presentations were transported to EDs via ambulance, air ambulance or helicopter rescue service, signifying their need for urgent care. In contrast to people seeking help for other emergency medical conditions, people with mental health presentations more commonly arrive to EDs via police and/or correctional services vehicles.

7 Australian Institute of Health and Welfare. Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. 2017. Canberra: AIHW; 2018. Available from: https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true.

Figure 2 Mental health presentations by arrival mode, 2016/17



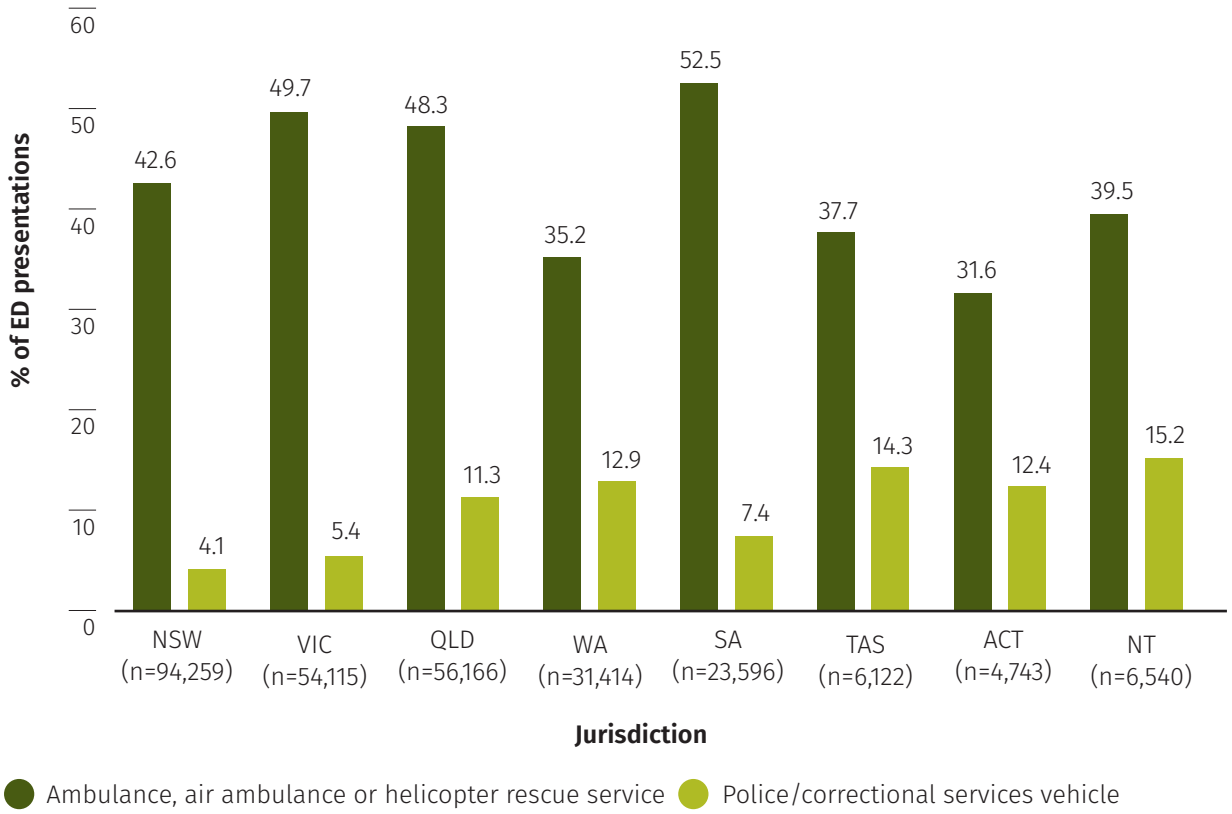
Source: National Non-admitted Patient Emergency Department Care Database.
Note: Percentages shown do not include ED presentations for which the information on mode of arrival was missing or not reported. ED mental health presentations included are those that had a principal diagnosis that fell within ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.

"... Police intervention, often causing extreme fear in your loved one resulting in lashing out, and in Western Australia, culminating in a mandatory prison sentence (for assaulting a police officer) or an arrest which could result in a custody order courtesy of the heinous Criminal Law (Mentally Impaired Accused) Act... Nobody wins, least of all the sufferer." **(Parent)**

"It is not unusual and it is not the first time it's happened – this particular case was an Aboriginal man who was in his 30s or 40s whose family was worried about him because he was expressing thoughts of self-harm. He was walking down the street and the police were called to help get him to hospital. And their approach was to take him down and restrain him and bring him in in the paddy wagon... He was brought into the emergency department handcuffed with maybe five or six police officers holding him down and he was put in one of the resus beds. So he was surrounded by police on the bed and I went in as the doctor... And as has almost always been the case when I've been in these situations... the first thing I said [to the police] was "Okay, take the handcuffs off." And they said, "Doc he's really violent, Doc are you sure you want to do this?" And I said "Yep, you're all here, can you take the handcuffs off?" So, they took the handcuffs off – begrudgingly – and he was fine. So I said "Okay, can you all take your hands off him?" And they said "Doc he's really violent, he's really violent," and I said, "You're all here, yeah? Let's see how he goes." And they took their hands off him, and he was fine. And I said, "Okay that's grand," and we left it like that for a moment and I said, "Okay look he's fine." And he was talking to me and I said [to the police] "Can you leave the resus room?" And they said, "Ah..." I said, "I think it will be fine, can you do that? You'll still be around". So they did and he was fine and I was able to have a conversation with him. The cops eventually left. I suppose when I went up to the police officer in charge and I explained my point of view to him that "People react when they're being held down, and they resist, especially when they're not in a good state." He just looked at me – he did look at me with a bit of confusion – when I said that it was clear that when the restraints were taken off, he was actually compliant and happy enough to be there. And he (the patient) was really thankful for me, you know? Like, because we didn't need to chemically restrain him, he could sit there and then he went to the mental health unit because he was having a pretty hard time." **(FACEM)**

Figure 3 provides a jurisdictional breakdown of the way people experiencing mental health crises arrived at EDs in 2016/17, excluding the category 'other'. As shown, the most common use of police and/or correctional vehicles[8] was in the Northern Territory, Tasmania and Western Australia. Relative to other jurisdictions, ambulance, air ambulance or helicopter rescue services were most commonly used in South Australia, Victoria and Queensland.

Figure 3 Arrival mode for mental health presentations, by jurisdiction, 2016/17



Source: National Non-admitted Patient Emergency Department Care Database.
Note: Percentages shown do not include ED presentations for which the information on mode of arrival was missing or not reported. ED mental health presentations included are those that had a principal diagnosis that fell within ICD-10 AM codes F00-F99, or ICD-9-Cm or SNOMED equivalent codes. Presentations to EDs by 'other' modes of transport are excluded from the figure.

"Something that has struck me over the years is that socioeconomic status plays a major role in how patients with mental health issues first access care. If a teenager starts behaving oddly in an upper middle class home, his parents are likely to call their GP, an ambulance, or take him to see a private psychologist. The parents of the same teenager in a poorer household tend to call the police. Whether a person with mental health issues enters via the health or forensic system colours the way they are treated for the rest of their life. We need to have a clear and adequately resourced process which allows all patients with acute mental health issues to access health care to remove this source of discrimination." **(FACEM)**

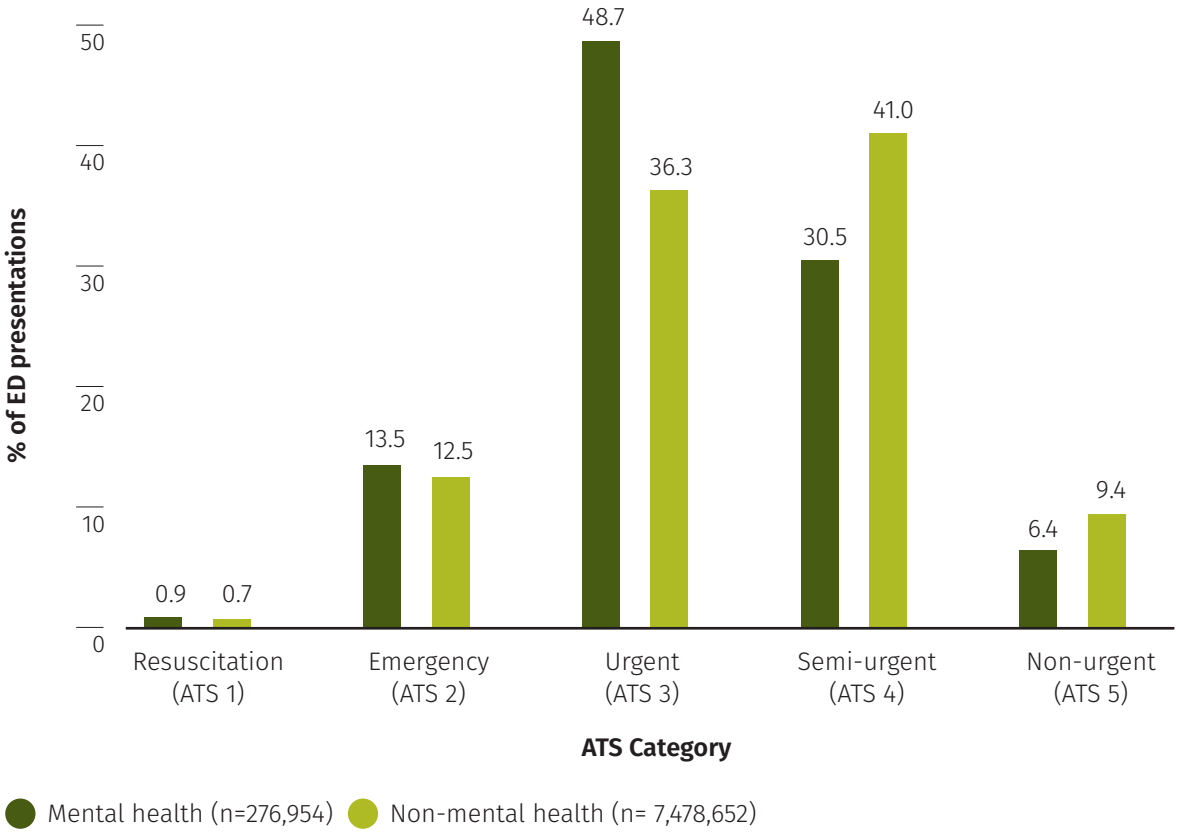
8 I.e. to transport people with acute mental and behavioural conditions to EDs.

4.3. Urgency

The *ATS* aims to ensure that patients presenting to EDs are treated in order of their clinical urgency and allocated to the most appropriate assessment and treatment area. There are five categories to signify treatment acuity, and the maximum waiting time for medical assessment and treatment (with performance thresholds).[9] As part of the *Emergency Triage Education Kit*, the *Mental Health Triage Tool* was developed to guide emergency clinicians in the rapid assessment and identification of mental illness risk factors at triage, and apply an ATS category that reflects the person's need for emergency intervention.[10]

In ***Figure 4***, the percentages of people with mental health presentations seeking help from Australian EDs are compared with those with non-mental health presentations, according to ATS category. As shown, in 2016/17 mental health presentations were most commonly allocated as urgent, semi-urgent or emergency. For these categories, the maximum wait times for assessment and treatment should be no longer than 30 minutes, 60 minutes and 10 minutes, respectively. Similar patterns were reported across jurisdictions (data not shown). Urgent presentations are described by the Mental Health Triage Tool as those in which there is possible danger to self and/or others, severe distress, and acute psychosis/thought-disorder, with a requirement to alert mental health triage.

Figure 4 Mental health presentations by Australasian Triage Scale category, 2016/17



Source: National Non-admitted Patient Emergency Department Care Database.

a ATS categories are: ATS 1 (immediate, 100% performance indicator threshold (PIT)), ATS 2 (10 mins, 80% PIT), ATS 3 (30 mins, 75% PIT), ATS 4 (60 mins, 70% PIT), ATS 5 (120 mins, 70% PIT). See the Mental Health Triage Tool.

Note: Percentages do not include presentations for which mode of arrival data were missing or not reported. ED mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.

9 Australasian College for Emergency Medicine. Policy on the Australasian Triage Scale (P06). Melbourne: ACEM; 2013.

10 Australian Government Department of Health and Ageing. Emergency Triage Education Kit Triage Quick Reference Guide. Canberra: AGDHA; 2013. Available from: *http://www.health.gov.au/internet/main/publishing.nsf/Content/387970CE723E2BD8CA257BF0001DC49F/$File/Triage%20Quick%20Reference%20Guide.pdf.*

4.4. Waiting time until commencement of clinical care and duration of clinical care

Waiting time until commencement of clinical care

Waiting times in EDs are defined by AIHW as 'the time elapsed for each patient from presentation in the ED to commencement of clinical care'.[11] In ***Table 1***, waiting times are shown for people with mental health presentations compared with those with non-mental health presentations, by jurisdiction. The median waiting time is the time within which 50 per cent of presentations had their clinical care commenced, while the 90th percentile waiting time is the time within which 90 per cent of presentations commenced clinical care. The percentage seen on time is the proportion of presentations for which the waiting time was in the specified ATS timeframe.[12] Overall, lower percentages of people with mental health presentations were seen on time compared with those presenting with other emergency medical conditions (68% vs. 73%). In other words, 32 per cent of mental health presentations were not seen on time compared with 27 per cent for other presentations.

Table 1 Measures of waiting times[a] for mental health presentations, by jurisdiction, 2016/17

	Median (min)		90th percentile (min)		% seen on time[c]	
	Mental health	Non-mental health	Mental health	Non-mental health	Mental health	Non-mental health
NSW	14	14	79	76	76.5	81.0
VIC	18	20	90	97	72.0	73.0
QLD	21	20	107	96	66.3	69.0
WA	30	28	138	115	56.3	64.0
SA	26	22	134	117	55.8	64.0
TAS	30	28	128	111	57.2	65.0
ACT	28	30	127	116	57.9	62.0
NT	26	30	129	125	58.3	61.0
Total[b]	**19**	**19**	**103**	**95**	**68.0**	**73.0**

Source: National Non-admitted Patient Emergency Department Care Database.
a Waiting time is the time from presentation to clinical care commencement
b The total shown does not include ED presentations for which information on waiting time was missing or not reported.
c Excludes presentations where missing information prevented evaluation of timeliness of assessment.
Note: ED mental health presentations included are those that had a principal diagnosis that fell within ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.

> *"A few weeks ago, I was working in a regional centre when a young girl with a known history of depression and other mental health diagnoses was brought into the ED... She had self-inflicted wounds... was in an agitated state and needed inpatient admission. However, the region does not have inpatient facilities for adolescent patients and while we urgently called around to find a bed, the only place to look after her was the ED, with its bright lights and loud noises... so she was given medication to sedate her. By the end of day two, and more sedation, a bed had been found. In the meantime, [she] had been visited by her family, who became visibly upset by the ordeal... The stress... was palpable. On day three transport arrived, and after a four-hour journey with her mother, [she] was finally admitted."* **(FACEM)**

11 Australian Institute of Health and Welfare. Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. 2017. Canberra: AIHW; 2018. Available from: *https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true.*

12 Australian Institute of Health and Welfare. Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. 2017. Canberra: AIHW; 2018. Available from: *https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true.*

Total ED length of stay (waiting time plus duration of clinical care plus time from end of care to ED departure)

The AIHW defines ED length of stay as the time from presentation to the time of physical departure from the ED, as set out in ***Figure 1*** on page 5.[13] Length of stay includes waiting time from presentation, the duration of the clinical care received, and the time between the end of clinical care and ED departure. In ***Table 2***, ED lengths of stay are shown for people with mental health presentations compared with all ED presentations, by jurisdiction. The median length of stay is the time within which 50 per cent of presentations spent in ED, while the 90th percentile length of stay is the time within which 90 per cent of presentations spent in ED.

Table 2 Measures of length of stay for mental health compared with all ED presentations, by jurisdiction, 2016/17

	Median (hr:min)		90th percentile (hr:min)	
	Mental health	**All ED presentation**	**Mental health**	**All ED presentation**
NSW	3:08	2:35	10:13	6:50
VIC	3:33	2:57	12:18	7:16
QLD	3:15	2:52	9:02	6:40
WA	3:52	2:43	14:55	6:25
SA	4:20	3:08	16:24	7:50
TAS	4:06	2:58	14:14	9:01
ACT	3:37	2:49	10:40	6:33
NT	3:27	2:59	11:01	9:20
Total	**3:27**	**2:48**	**11:28**	**7:00**

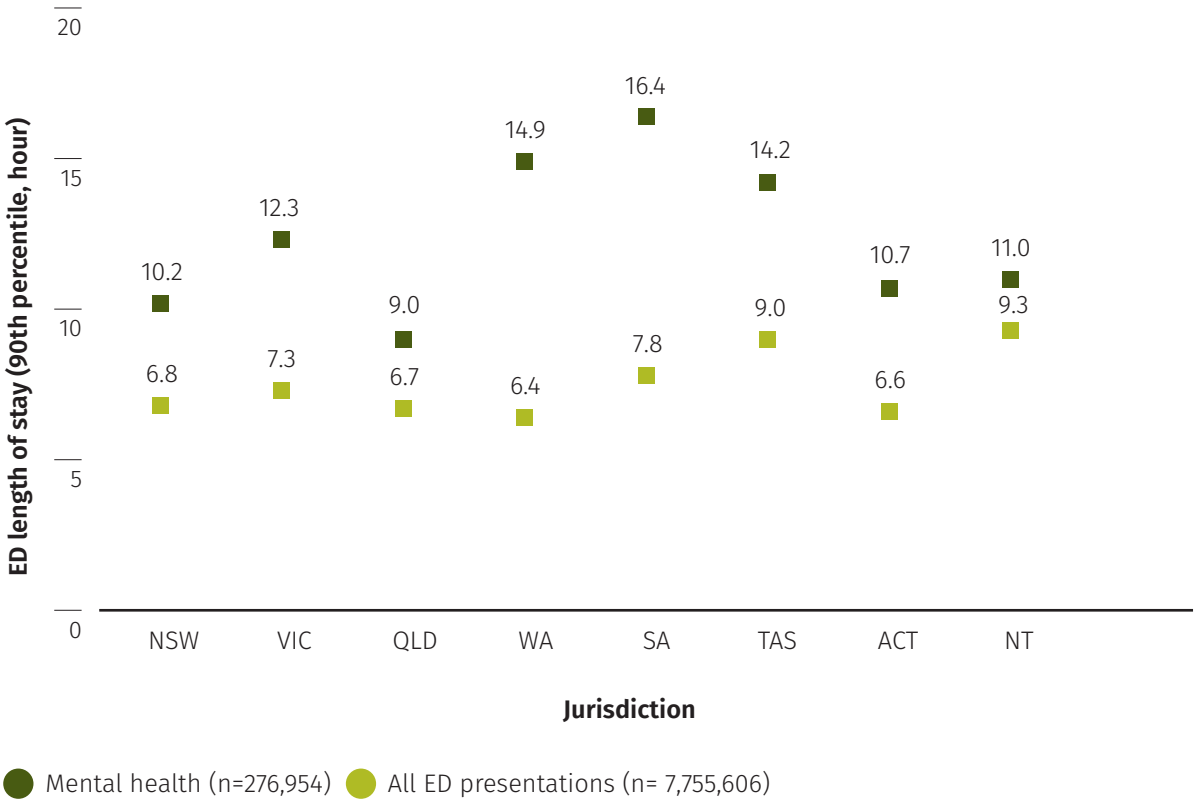
Source: National Non-admitted Patient Emergency Department Care Database.
Note: ED mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes. Total does not include presentations for which information was missing or not reported.

"ED is a difficult environment for all patients… It is crowded, noisy and confusing. The lights are on 24 hours a day. There are babies crying, monitors beeping, staff and patients moving about, phones ringing – constantly. ED clinicians have multiple competing demands and cubicles lack privacy. It can be difficult to understand what is going on… For patients with acute mental health issues, especially when they are in a state of high arousal, these factors are compounded… patients are often paranoid, confused or suicidal. They need a calm and private environment, with a clear plan and good communication. When patients are delayed in ED for long periods, they sometimes become angry and upset to the point where they require chemical sedation for their own safety, and the safety of other patients and staff in the ED. Chemical sedation carries risk – side effects and cardiorespiratory depression – there have been deaths from chemical sedation in ED… The biggest problem with this is that it is not fair on patients – our environment and processes get them to this point – this is not acceptable and we need to change the system." **(FACEM)**

13 Australian Institute of Health and Welfare. Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194. 2017. Canberra: AIHW; 2018. Available from: *https://www.aihw.gov.au/getmedia/981140ee-3957-4d47-9032-18ca89b519b0/aihw-hse-194.pdf.aspx?inline=true.*

The difference between the 90th percentile length of stay (hours) for mental health presentations and all ED presentations is graphically represented in ***Figure 5***.

Figure 5 ED length of stay (90th percentile/hours) for mental health and all ED presentations, by jurisdiction, 2016/17



Source: National Non-admitted Patient Emergency Department Care Database.
Note: ED mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes. Total does not include presentations for which information was missing or not reported.

"Waiting in an ED accompanied by a person suffering florid psychosis, paranoia and akathisia is akin to being unexpectedly flung into a war zone. The illusion (or delusion) of being ushered into a caring environment where the mentally unwell person, suffering chronic paranoia, can await professional assessment is rapidly replaced with reality. Time stops as you re-direct your efforts from calming your deeply troubled companion to shielding the other patients from the unwell person who views everyone as a combatant – patients, clinicians and security alike. Tragically, the buck stops with whomever is accompanying the mentally unwell person (often a family member already suffering severe distress) to ensure the unwell person doesn't attack one of the perceived 'enemies'." **(Parent)**

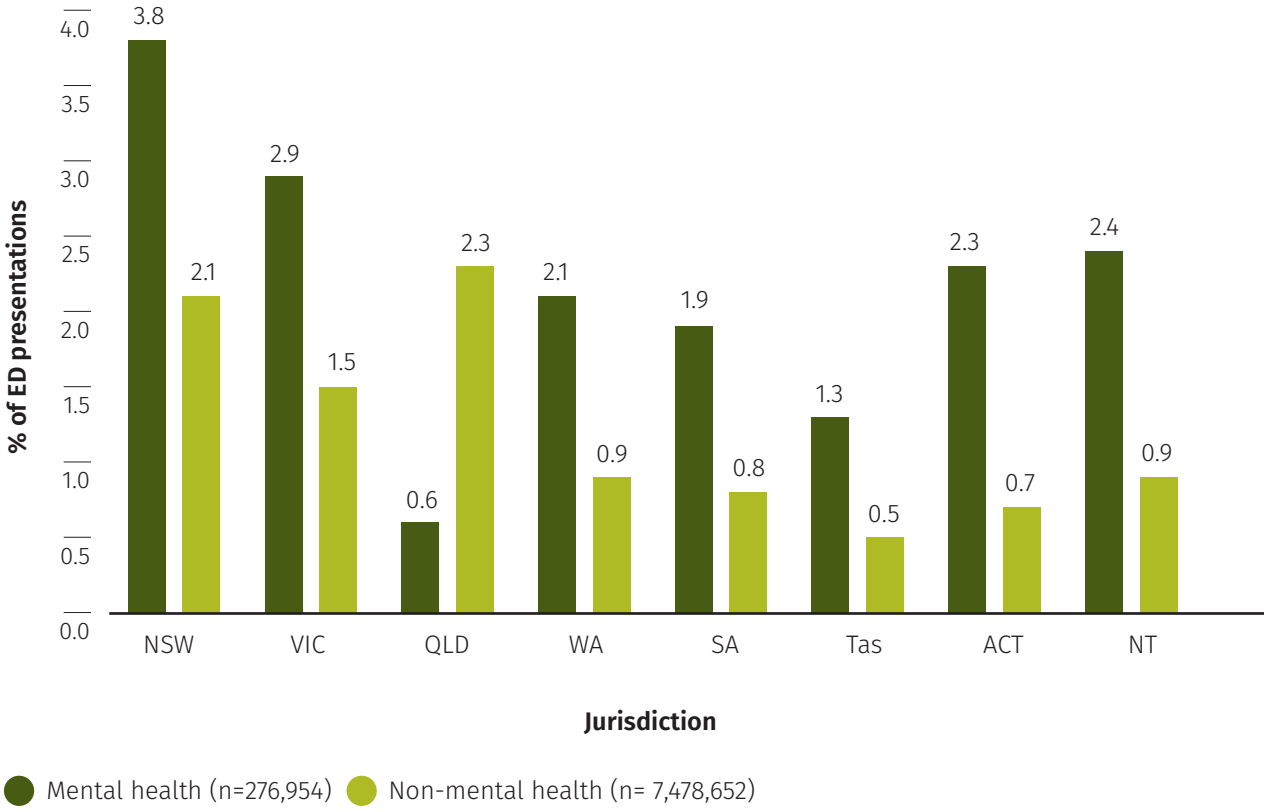
4.5. Episode end status

Across Australia, in 2016/17 more than a third (35%) of people with mental health presentations seeking help from EDs were subsequently admitted to that hospital for specialist inpatient care. Four per cent were referred to another hospital for admission. The highest admission rates were seen in the Northern Territory (54%), Tasmania (43%) and Queensland (41%). Most patients (58%), however, departed EDs without being admitted or referred to another hospital. Almost three per cent of patients across Australia were deemed to have left EDs at their own risk.

The 'Left at Own Risk' episode end status is recorded when a patient is deemed to have left the ED at their own risk following attendance by a health care professional, but prior to completing their ED care. ***Figure 6*** shows the percentages of people with mental health presentations seeking help from EDs whose episode end status was recorded as 'Left at Own Risk', according to jurisdiction. As shown, patients most commonly left the ED at their own risk in NSW, Victoria and the Northern Territory. Across the country, the number of patients leaving EDs prior to finishing care is significant at 6,827 people, particularly in terms of their vulnerability to risk and worsening mental and behavioural health outcomes. It is worth noting that the 'Left at Own Risk' patients may reduce the 'duration of care' statistics referred to above, relative to the level had these patients been treated in accordance with the ED's recommendation.

"Nathan turned up to the triage desk again. This time, he was pretty agitated. I'd seen him that night and the night before that. The poor kid had a history which would horrify most people: abused by an uncle, his father had died when he was very young and his mother was drug dependent and on the streets. Now he has a provisional diagnosis of borderline personality disorder, but no one is really quite sure. He uses cannabis regularly, ice frequently; he couch surfs or sleeps on the streets... when he is in trouble, he comes to us. I offer him food and drink, some sedatives to bring him down. I request a psych review. It takes too long for Nathan and he wants to leave. Swearing and abusive, he's having a bad impact on the staff and other patients. We try to surround him while trying not put ourselves in harm's way, to talk him down, but he storms past us. I follow him to the ambulance bay but he's fast. And, once he's off the hospital grounds, it's up to the police. Five minutes later, our security guys come back: "We've found him." I race out and Nathan is on the bridge next to the hospital. One of the nursing staff stops the traffic and I stand under the bridge. After some tense negotiation, I manage to talk Nathan into getting back over the fence and to meet me on safer ground. He says: "I'm sick of this. No one gives a f---. No one cares. I just want somewhere to live, somewhere safe." We talk for some time. I tell Nathan that he has a choice: to come back to the Emergency Department so we can try again or to go with his cousin, who has just arrived. I can hear police sirens approaching. Nathan and his cousin are gone ... they heard them before me. The police arrive and ask a few questions. They know Nathan and they know he'll turn up again soon." **(FACEM)**

Figure 6 Mental health presentations' episode end status 'Left at Own Risk', by jurisdiction, 2016/17



Source: National Non-admitted Patient Emergency Department Care Database.
Note: ED mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.

"... Paradoxically, it is common for patients who really need acute medical help to leave ED before completing their care... because they find the environment difficult to tolerate, or they do not want to follow treatment recommendations, or they... need access to drugs or alcohol – or sometimes just because they are impatient. With acute mental health issues, there is often a limited window where a patient is willing to seek treatment – if this moment passes because of a lack of treatment space, or delays to see a clinician, then the opportunity to intervene can be lost. Also, the patient loses faith in the health system, and may not seek care next time they need help. It is not right that we accept that ED is always overcrowded with long waiting lists – this is not safe for patients or staff... We need make sure EDs are well-designed and adequately resourced... With patients who leave ED at their own risk – we don't know what is going to happen to them next. The worst nightmare for any ED clinician is a patient who leaves before their care is finished, before assessment and management can be completed, who goes home to deteriorate, or is found dead in a ditch the following day." **(FACEM)**

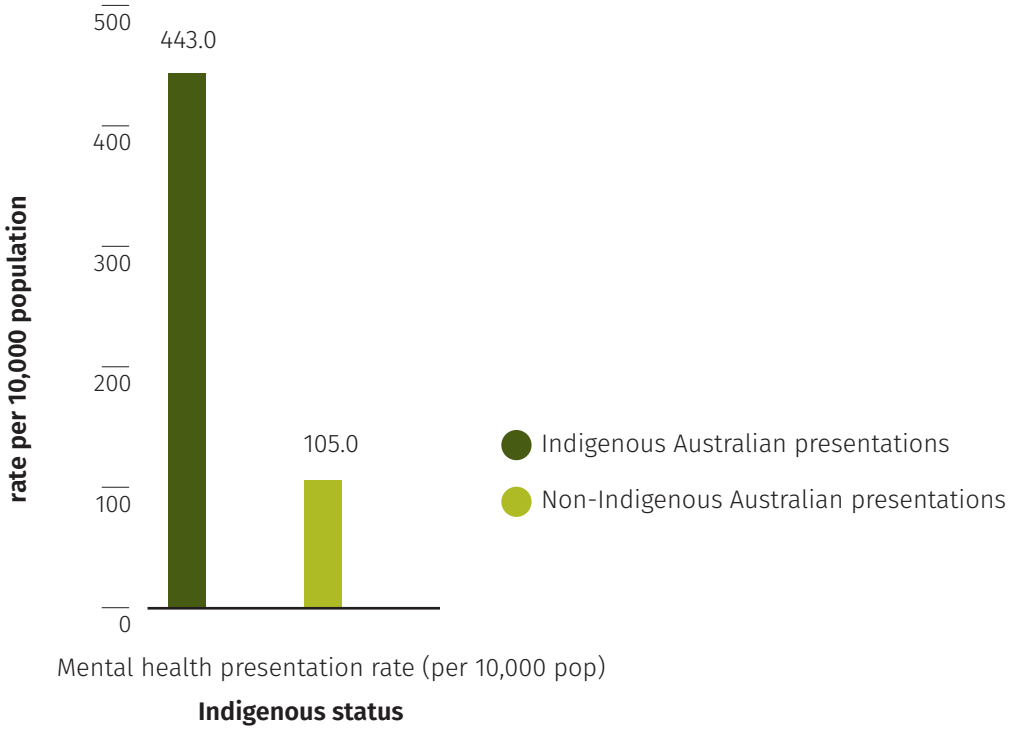
4.6. Presentation characteristics

People with acute mental and behavioural conditions seeking help from EDs in Australia are:

- Most commonly aged from 15 to 24 years (22%), 25 to 34 years (21%) and 35 to 44 years (19%);
- 52% male and 48% female, representing rates per 10,000 population of 119.0 for males and 108.2 for females; and
- Presenting at higher rates per 10,000 population in remote and very remote areas (185.3), outer regional areas (128.3) and inner regional areas (126.7) compared with major cities (101.2).

People who identify as Aboriginal and Torres Strait Islander are over-represented in mental health presentations to EDs. Eleven per cent of people with mental health presentations in EDs identify as Indigenous, compared with seven per cent of all ED presentations. Figure 7 compares mental health presentation rates per 10,000 population for Indigenous Australians, Non-Indigenous Australians and all ED presentations.

Figure 7 Mental health presentation rate (per 10,000 population) according to Indigenous status, 2016/17



Source: National Non-admitted Patient Emergency Department Care Database.
Note: ED mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-9-CM or SNOMED equivalent codes.

"I remember when a young and proud Aboriginal man in his 20's was brought into the ED by his father. He was agitated and upset. He said he wanted to kill himself but wouldn't engage with us any further. He was seen in the ED and detained under the Mental Health Act. He was seen by the Psychiatry team and admitted as an involuntary patient. Unfortunately, there were no beds available and he was to stay in the ED until one became available. Like many EDs, the mental health rooms are located in an area where there's a lot of activity and also near exits, like ours. We can't lock doors (there are rules against this) and so we do not have a truly secured area to keep people safe. On his second day in the ED, he managed to abscond. It was no one's fault, it was a fault of the system, which let him down. A few hours later, a distraught member of the public ran up to the ED. There was someone hanging in the tree at the bus stop down the road from the ED. It was him. I'll never forget the anguish on his father's face when he was given the news of his son's death. We often talk about not having beds leading to deaths, but here it was. A stark reminder that we are dealing with people's lives, even though I feel that this message is often not really heard or really understood by those people who have the power to change the system that failed this young man, his family and his community." **(FACEM)**

5. Acknowledgements

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7. Contact for further information

Nicola Ballenden
Executive Director Policy, Research and Advocacy

Australasian College for Emergency Medicine
34 Jeffcott Street
West Melbourne VIC 3003
Australia
T +61 3 9320 0444

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia

t +61 3 9320 0444
e policy@acem.org.au

acem.org.au