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for Emergency Medicine

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Submission to the Victorian Department of Health on the Mental Health and Wellbeing Act: Update and Engagement Paper – July 2021

1. Introduction

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide this submission to the Victorian Department of Health with our feedback on the proposed contents of the new Mental Health and Wellbeing Act that will replace the *Mental Health Act 2014*.

2. About ACEM

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

3. Overview of the submission

This submission is informed by our members' experiences working in EDs across Victoria, wider Australia, and Aotearoa New Zealand. Our submission reflects and reinforces the College's submissions to the Royal Commission into Victoria's Mental Health System, the Productivity Commission Inquiry into Mental Health, and the Australian Parliament's Select Committee Inquiry into Suicide Prevention and Mental Health.

ACEM recognises that the establishment of a new Mental Health and Wellbeing Act to replace the *Mental Health Act 2014* is just one of 65 recommendations (plus the interim recommendations) made by the Royal Commission as part of the Victorian Government's 10-year reform vision.

ACEM notes that the engagement paper seeks feedback only on a select range of topics, and that the engagement paper contends that many aspects of the new Act are already clear from the Royal Commission's recommendations and report. The College is concerned by the assertion that any changes to legislation that impacts on clinical practice may have already been determined without extensively consulting with emergency medicine physicians.

ACEM strongly recommends that the Department provides more information to all the relevant stakeholders about proposed changes to mental health legislation in Victoria, and that these proposals are put through a robust process of consultation with all health providers involved in the care of people with mental health conditions.

Our submission highlights that not all system reform can be achieved by changes to legislation. The issues that certain sections of the Act seek to address 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. The Act should provide an overarching framework that facilitates these models 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.

4. Recommendations

ACEM makes the following recommendations:

1. That the Department of Health puts the full draft Act through a robust process of consultation with all health providers involved in the care of people with mental health conditions
2. That the Act is written to provide an overarching framework that supports models of care which recognise and respond to the full range of health comorbidities that people living with mental health conditions experience
3. That the principles and objectives include common terminology such as 'recovery-oriented' and 'trauma informed'
4. That the Act acknowledges that there are circumstances where clinical judgment should be prioritised i.e., when there is imminent risk of harm to the clinician, patient, and/or others
5. That standards of information sharing between community mental health, EDs, psychiatric wards and emergency services be expected and enforced in order to facilitate collaborative integrated models of care, particularly in emergency situations where EDs need to be able to access information, including access to the Client Management Interface (CMI) in order to optimise patient outcomes
6. That legislative provisions relating to restrictive practices and their use reflects an understanding of the varied contexts and time frames in which risk analysis and balance of patients and others safety is being made, with respect paid not only to patient autonomy, but respecting clinician clinical judgement when there was an imminent safety risk
7. That the Department of Health undertakes specific consultation with emergency medicine physicians and emergency services if it intends to retain provisions similar to s351 under the current *Mental Health Act 2014*
8. That current proposals on chemical restraint are amended to reflect an acknowledgement of the goals being the maintenance of patient, clinician, and others' safety
9. That the Department of Health provide further information on the proposed function of the Mental Health and Wellbeing Commission to issue statutory guidelines on how the principles should be interpreted and applied
10. That newly established entities such as the Mental Health and Wellbeing Commission include the representation of emergency medicine physicians who offer a vital perspective and expert clinical knowledge in relation to ED-specific considerations

5. Objectives and principles of the new Act

It is ACEM's position that all Australians have the right to access mental healthcare, and as such the College broadly supports the proposed overarching objectives and principles outlined by the in the Act.

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

The College would like more information regarding the proposed function of the Mental Health and Wellbeing Commission to issue statutory guidelines on how the principles should be interpreted and applied (p. 11). The interpretation and application of a new Act was not indicated in the Royal Commission's recommendations, and the College is unable to support this proposal without further information as to how the Mental Health and Wellbeing Commission would seek to apply the Act in an ED environment, which differs from the environment of specialist inpatient and community-based mental health services.

The principles and objectives in their current form could be improved by including common terminology such as 'recovery-oriented', 'trauma-informed' and 'least restrictive'.

This section should establish a threshold for determining when clinicians need to make a judgment about what is in the best interest of their patients i.e., what is the scope of clinical judgement that needs to be applied when there is imminent risk of harm to the clinician, patient, and others.

6. Non-legal advocacy, supported decision-making and information sharing

The College is broadly supportive of non-legal advocacy services such as those provided by Independent Mental Health Advocacy (IMHA) being recognised in the new Act. ACEM would like further details on the 'opt out' model before we can support that element of the proposal as there are concerns about the process of opting out, and the implications it might have for protecting the privacy of the patient.

The engagement paper promotes tools that enable supported decision making such as statements of rights, advance statements, nominated persons and second psychiatric opinions. A possible unintended consequence of this is an assumption that a person lacks decision making capacity without this.

The mental health system is inextricably linked with a range of other formal systems including criminal justice, housing, family violence, child protection, income support, and education and training as well as with multiple informal caring networks including families, communities, faith groups and non-government organisations. The enormous complexity of this web of relationships presents challenges to service coordination and information sharing.

Too often, inconsistency in treatment occurs due to delays in information sharing. For instance, doctors in EDs currently do not have access to the Client Management Interface (CMI), and therefore are unable to access mental health care plans and provide tailored care from the time of presentation. Information sharing between community mental health, EDs, psychiatric wards, emergency services and criminal justice facilitates improved outcomes for patients, particularly in emergency situations.

It is noted that the Department has flagged further consultation with all relevant stakeholders regarding the level of information able to be shared with and without patient consent under a new Mental Health and Wellbeing Act. The College requests involvement in further consultation activities, whether it is via representation on key working groups or submissions to subsequent consultations.

7. Treatment, care and support

ACEM acknowledges the recommendations made by the Royal Commission about compulsory treatment and assessment, and the 10-year goal to eliminate seclusion and restraint. Whilst ACEM supports the development of new models of patient-centred care that measurably improve the experience and outcomes of people who need acute mental health care, extensive consideration must be given to the context in which restrictive practices are used.

The College recognises the justification of a new Act is driven by the intention of the Victorian Government to set a strong new base for the mental health and wellbeing system in Victoria. However, not all changes to the system can be driven through legislation. 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 misuse of alcohol and other substances, and the complex psychosocial needs of many of these patients.

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). 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. Clinical judgement must be acknowledged and respected in assessing complex presentations and managing harmful behaviour.

EDs provide a compelling window into the strengths and weaknesses of Victoria's mental health system. ACEM's analysis of presentation data clearly shows that Victoria's 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 some circumstances is a symptom of system failure.

The sections below highlight the common challenges that can result in the use of restrictive practices in EDs.

7.1 Delays to mental health treatment

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

Mental health conditions are increasing as both a proportion of the population and in overall numbers. Australian Institute of Health and Welfare (AIHW) data shows that over 64,000 people with a principal diagnosis of mental and behavioural conditions presented to EDs in 2019-20, making up 3.6% percent of all ED presentations[12]. More than one third of people with this principal diagnosis required an admission. The majority of these presentations arrive by ambulance (57.6%), and a further 3.2% arrive by police or corrections vehicle.

Despite mental health accounting for a relatively small percentage of all presentations, mental health patients are overrepresented in the data on access block, defined as the situation where ED patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours due to a lack of inpatient bed capacity. They are also overrepresented for patients with a length of stays of 24 hours or more in the ED. ACEM's 2018 national survey on the prevalence of mental health access block collected snapshot data from 11 Victorian EDs and found that mental health patients accounted for nearly a quarter (23.2%) of all access blocked ED patients at the time of the survey[3].

Unsurprisingly, when patients present in a mental health crisis and are left to wait in inappropriate 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.

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 supervision over prolonged periods of time.

7.2 Co-occurring intoxication

There is substantial overlap between mental health and alcohol and other drugs, yet this is scarcely included in the discussion paper. A study on the characteristics and outcomes of patients brought to EDs by police under s10 (now known as s351) found that a proportion of patients were diagnosed with drug and alcohol issues rather than psychiatric diagnoses, reflecting the complex interplay that can at times exist between psychological problems and alcohol and other drug harm[4]. How the Act applied in these complex considerations, such as a person in the ED experiencing an acute episodic mental health condition resulting from alcohol or drug use (e.g., drug induced psychosis), are not reflected in the discussion paper.

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

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

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

[4] Al-Khafaji K, Loy J, Kelly A 2014, *Characteristics and outcomes of patients brought to an emergency department by police under the provisions (Section 10) of the Mental Health Act in Victoria, Australia, International Journal of Law and Psychiatry*, 37, 415-419

The management of agitated or violent patients in the ED can be challenging and poses a safety risk to individuals, the staff and the people accompanying them. A survey of ACEM members found that 88% had been threatened by a patient in the past year and 43% had been physically assaulted in the past year[5].

The use of restrictive practices under mental health legislation in Victoria must be considered in the context of a co-occurrence of alcohol and other drug harm. Evidence suggests that patients who are intoxicated with alcohol or other drugs are less likely to respond to verbal forms of de-escalation and are more likely to require sedation compared to patients with a principal diagnosis of mental illness[6,7]. A metropolitan ED found that of 229 instances where a code grey (unarmed threat) had been called, illicit drug use accounted for 40% of behavioural disturbance, with the majority due to amphetamine and methamphetamine[8]. Other research has also confirmed that methamphetamine use is frequently associated with aggression towards staff and other patients, and the need for restrictive practices[9].

7.3 Pre-hospital environment

The use of restrictive practices in the ED may also be influenced by the context in which in the decision is being made and this may include their use in the pre-hospital environment. AIHW data shows that mental health patients are most likely to arrive by ambulance (57.6%) or by police or corrections vehicle (3.2%). Therefore, the use of restrictive practices in the pre-hospital environment may impact the behaviour of the patient on arrival in the ED.

The College notes that the Department has not provided an opportunity to review s351 of the *Mental Health Act 2014* as it will appear in the new Mental Health and Wellbeing Act. s351 sets out the powers of a police officer to apprehend a person who appears to have a mental illness and arranging for that person to be taken to a registered medical practitioner or mental health practitioner to be examined. Emergency medicine physicians have raised concerns about the use of this law, and this is supported by research that found out of a survey sample of 206 people transferred to EDs for mental health assessments, just 26% required psychiatric admission[10]. The study showed that self-harm ideation/intent was the most common reason for presentation, most presentations occurred out of hours, most were discharged home with approximately 60% of cases not requiring sedation or physical restraint.

If the government intends to retain provisions similar to that of s351 in the new Act, ACEM strongly recommends specific consultation with emergency medicine physicians and emergency services in order to ensure that it is appropriately framed.

7.4 Response to the proposals about seclusion and restraint

The College does not support the definition of chemical restraint contained in the discussion paper. There are a variety of clinical interventions which are primarily therapeutic in nature, that may also result in a patient being sedated. The current proposals on chemical restraint do not distinguish between chemical restraint and treatment for the purposes of the Act. ACEM recommends that amendments also acknowledge maintaining the safety of the patient, clinician, and others.

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[5] ACEM 2016, *ACEM Workforce Sustainability Survey Report*, [November 2016], https://acem.org.au/getmedia/0da6a4e7-9bc2-4e0f-83ea-95ee51a6f8fc/Workforce-Sustainability-Survey-Final-Report_November-2016.aspx

[6] Yap et al., 2019, *Management of behavioural emergencies: a prospective observational study in Australian emergency department*, *J Pharm & Prac,*49 (4): 341-348

[7] Braitberg et al., 2018, *Behavioural assessment unit improves outcomes for patients with complex psychosocial needs, Emergency Medicine Australasia*

[8] Gerdtz et al., 2020, *Prevalence of illicit substance use among patients presenting to the emergency department with acute behavioural disturbance: Rapid point-of-care saliva screening*, *Emergency Medicine Australasia*

[9] Unadkat A, Subsasinghe S, Harve RJ, Castle DJ 2019, *Methamphetamine use in patients presenting to emergency departments and psychiatric facilities: what are the service implications? Australasian Psychiatry*, 27 (1): 7-14

[10] Al-Khafaji K, Loy J, Kelly A 2014, *Characteristics and outcomes of patients brought to an emergency department by police under the provisions (Section 10) of the Mental Health Act in Victoria, Australia, International Journal of Law and Psychiatry*, 37, 415-419

The ACEM Mental Health Working Group has provided the following definition of chemical restraint for consideration:

"Chemical restraint; when medication is involuntarily administered with the purpose of reducing the movement of a patient or activity that is otherwise preventing their safe assessment and care. The choice of agent may also have a role in providing treatment for illness."

In past submissions, ACEM has 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 engagement paper lacks detail on regulation and accountability, however, the College suggests that the Victorian Agency for Health Information (VAHI) should consider reporting on the use of restrictive practices in the ED, and the relationship to access block and overcrowding, in its reporting on seclusion and restraint.

8. Governance and oversight

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. Whilst the engagement paper provides high level summaries of the scope of roles of the new entities, it does not include any detail about their composition and membership. Historically, such panels have not included the representation of emergency medicine physicians who offer a vital knowledge and perspective in relation to ED-specific considerations.

9. Conclusion

It is ACEM's position that all Australians have the right to access mental healthcare. 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 legislation may be necessary but cannot drive most required reform activities relating to the Victorian mental health system.

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 the implementation of reform to ensure barriers to, unintended consequences of and further improvements can be made in mental health reform.

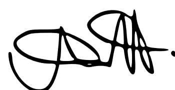
Changes to mental health legislation regarding restrictive practices and their use must respect and acknowledge the complex risk analysis, clinician judgement, context and time frames in assessing and managing behaviour.

The expert knowledge of emergency physicians must be represented amongst appointees in establishing new entities in the new governance structure proposed by the Department.

When the new Act has been drafted, it is essential that further consultation is undertaken to ensure that it is fit for purpose. The engagement paper that formed the basis of this consultation lacks the necessary detail.

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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