Australasian College
for Emergency Medicine

34 Jeffcott Street West Melbourne Victoria 3003, Australia
+61 3 9320 0444 | admin@acem.org.au | ABN 76 009 090 715

Submission to the Government of Western Australian Mental Health Commission on the Statutory Review of the Mental Health Act (2014)

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to participate in the Statutory review of the Western Australia *Mental Health Act* (2014).

1. Background

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

2. Overview of the submission

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

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

3. Recommendations

ACEM makes the following recommendations:

1. That the Act should enable better community-based responses so that there are alternatives to the ED
2. That provisions on time-based-targets must demonstrate that the reduction of waiting times for access to mental health care is an urgent priority
3. All WA hospitals have ED length of stay (EDLOS) for mental health patients as a key performance indicator and that this is publicly reported
4. That the legislative provisions pertaining to transport orders should stipulate strict timeframes for completion of transport orders, with escalation policies for instances where the specified timeframes lapse and clear lines of accountability
5. That legislation should prioritize a health response over a criminal justice response where safe and appropriate to do so

6. That all 24 hour waits in an ED should be reported to the Health Minister and Mental Health Minister routinely, alongside any CEO interventions and mechanisms for incident review
7. That 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
8. That legislative provisions set out a requirement for the Western Australian Department of Health to provide the necessary resources for clear clinical governance frameworks for all service providers, standardised documentation tools and reporting pathway that allow for system improvement
9. That persons subject to the Act have timely and equitable access to independent advocacy services

4. Mental Health in the ED

EDs across Australia have been highlighted as a key part of the mental health system by the Royal Commission into Victoria's Mental Health System and the Productivity Commission's Mental Health Inquiry Report. This is due to the volume, range and complexity of mental health care delivered to patients, typically without the resources, infrastructure, or systemic support necessary to consistently provide high quality, appropriate care[1,2].

Demand for mental health care is outpacing the availability of acute mental health services, particularly after-hours, which has created a situation where EDs have become a major and often default entry point for people seeking access to mental health care, often when in crisis – put simply, there is nowhere else to go.

In 2019-20 there were 37,885 mental health related presentations to Western Australian EDs, equating to 104 presentations per day.[3] This figure is nearly 20% higher than the national rate, at 143.6 per 10,000 population, with the rate of mental health related presentations in the WA population increasing at a significantly greater rate than the national average over the last six years (Figure 1, data obtained from the Australian Institute of Health and Welfare).

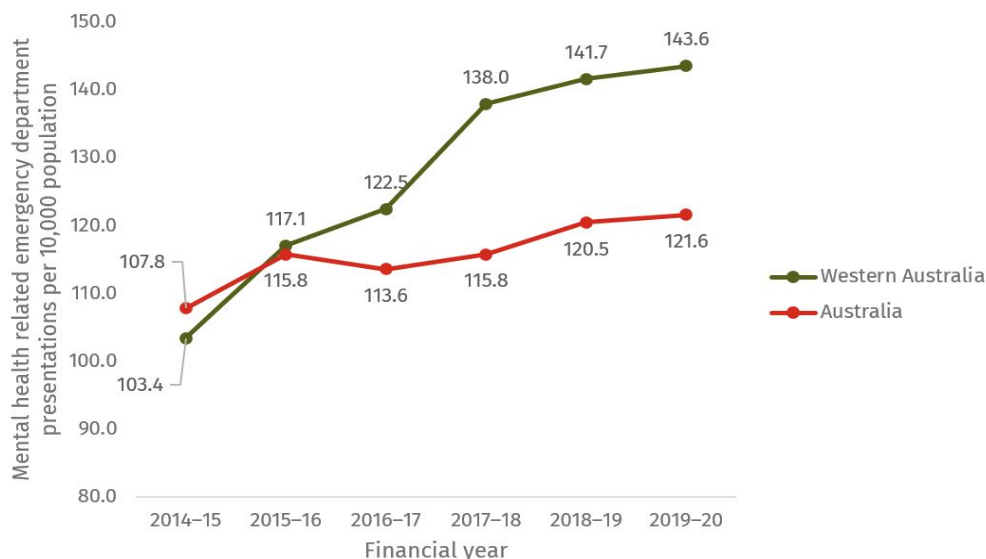

Figure 1: Six-year trend in rate of mental health related emergency department presentations.

[1] State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and Recommendations*, Parl Paper No. 202, Session 2018-21. Available from: https://finalreport.rcvmhs.vic.gov.au/download-report/

[2] Productivity Commission, 2020, *Mental Health*, Report no. 95, Canberra. Available from https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

[3] 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

Our members 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.

In September 2020, ACEM published the *Nowhere Else To Go Report*, which considers the complex issues that were discussed at the national Mental Health in the Emergency Department Summit convened by the College in 2018. The report contains a series of recommendations to drive reform and improvement of the Australian mental health system, of which the College has steadfastly advocated for across Australia and Aotearoa New Zealand. The *Nowhere Else to Go Report* can be accessed here.

5. ACEM response to the discussion paper

5.1 Part 6: Involuntary patients & Part 15: Health Care of People in Hospitals

Recommendation 1: The Act should enable better community-based responses so that there are alternatives to the ED

The College is extremely concerned by the practice of mental health patients being brought to the ED despite being formed in the community, and subsequently experiencing lengthy delays to access definitive care. An overcrowded high stimulus ED is an inappropriate location to conduct an examination by a psychiatrist. Additionally, there is a significant risk to the patient, staff and other patients posed by behaviourally disturbed mental health patients that could be managed elsewhere, but are brought into the ED by police/ambulance or directed specifically to the ED for care due to the lack of available, appropriate alternatives.

The sheer volume of demand for mental health care results in an overreliance on EDs to fill gaps in the system and highlights ever increasing issues pertaining to the accessibility of specialist mental health services who are equipped to respond appropriately to the needs of the population. The AIHW mental health related ED presentation data highlighted that mental health patients were more likely to be referred to another hospital for admission in WA than in any other State or Territory in 2019-20, demonstrating a dire lack of capacity in the system for people experiencing crises to access timely and appropriate care in Western Australia.

On the consequences of a system facing serious capacity issues, an emergency physician working in a Western Australian ED states:

> *"These patients are unwell and need psychiatric treatment. This is not what they receive in ED. They are contained until an appropriate mental health bed becomes available. This containment is achieved by a mixture of chemical and physical and at times mechanical restraint. We have decided this is less barbaric than for example, police custody, but it is not.*
>
> *These patients languish in ED for days. I recall one recent example, where a patient was in our ED for over 100 hours. A terrible record. In that time, they are seen by the psychiatry team briefly, each day. They are denied access to fresh air, nicotine, TV. If they become aggressive (understandably), they are sedated with dangerous amounts of medications that make other specialities such as anaesthetics cringe."*

Another emergency physician recalls:

> *"As an Emergency Physician with more than twenty years of experience working with a range of patients across a range of emergency departments, I still find it distressing to sedate and / or restrain a mentally unwell patient in the emergency department. Especially when the driver is knowledge that there is a lack of timely care, inability to provide a rapid assessment…*

> *I have seen an increasing use of restrictive practice for agitated patients, as a result of practitioner fatigue and frustration. Clinicians are now resigned to the inevitability of delayed assessment, lack of treatment options other than admission …. managing a mental health patient for days …*
>
> *A mental health patient once said to me "This is not hospitalisation, this is incarceration." He was expected to just lie quietly on his allocated ED trolley. Instructed not to disturb the other people around him. Separated from the noise, lights and melee of ED by curtains. For two days. All the while wrestling aimlessly with thoughts in his own head."*

The following video was created by a Fellow of ACEM, Professor Daniel Fatovich. The video provides a compelling window into what an episode of care commonly looks like for a person presenting to the ED with mental health crises: https://vimeo.com/296327788

The quotes and video provided by Fellows of the College offer a harrowing insight of the all-too-common experiences that persons experiencing mental health crises can expect in the face of the extreme challenges facing the mental health system.

The conditions created by the systematic underfunding of specialist mental health services and lack of inpatient capacity has caused a growing discontent among ACEM's members, at the variety of tactics used to delay accepting referrals into in-patient wards. 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. Our members regard the indefinite detention of mental health patients in EDs as 'anti-therapeutic'.

Response to Amendment 5: Provide for continuation of detention at a general hospital to allow for further examination by a psychiatrist

ACEM notes that the discussion paper highlights a series of proposed legislative amendments that will have the effect of relaxing the current time-based-targets for access to specialist mental health care. The College does not agree with the proposed amendment allowing for the extension of the maximum time period allowed for an examination to be conducted after a person is received at a general hospital.

In the current mental health system, people experiencing mental health crises are subjected to unacceptably long waits in the ED for examination by a psychiatrist and admission into a mental health bed.

These access issues are systemic, and relaxing time-based-targets is not a solution and will likely further exacerbate the problem of long delays to access mental health care. The amended legislation must build in provisions to ensure there is an adequate level of system capacity, and a guarantee of timely access to mental health care in safe and appropriate therapeutic environments.

Recommendation 2: Provisions on time-based-targets must demonstrate that the reduction of waiting times for access to mental health care is an urgent priority

It is ACEM's position that all Australians seeking mental health care are entitled to access appropriately and timely care. The College would like to highlight the importance of implementing a set of time-based-targets that is both realistic and achievable.

ACEM believes that a more carefully constructed set of targets, supported by appropriate funding and reporting, will reduce the time spent in EDs and help move patients to definitive care more efficiently. ACEM's Hospital Access Targets (HAT) are a nuanced measure that consider the complexity of possible patient pathways from the ED.[4] The HAT very deliberately refers to hospital access rather than emergency access, reflecting our desire for patients that are unwell enough to need admission into hospital to be seen in the appropriate environment, such as the inpatient ward, and by the right people for their health needs.

---

[4] ACEM 2021, *A new approach to time-based targets and why we need one,* *https://acem.org.au/getattachment/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets/It-s-About-Time_Abridged.pdf?lang=en-AU*

To ensure there is accountability for patient flow across different aspects of the hospital, it is recommended that ED length of stay targets are set for different patient streams:

- A primary measure for the admitted/transferred patient stream; and
- Secondary measures for the discharged and short stay units (SSUs) patient stream

Having multiple streams can ensure the ED, inpatient teams and hospital management have targets that encourage accountability for the length of time patients spend in the ED. The maximum length of ED stay recommended by the HAT for any one stream is 12 hours. Patients that endure prolonged times in the ED awaiting an inpatient bed, referred to as access block, end up having longer stays in hospitals. Patients experiencing delays of more than 12 hours in the ED have a 67% increased chance of dying in hospital.

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

Notifications to the appropriate Minister should only be seen as one avenue of escalation available to manage access blocked mental health patients. Hospitals should also have a range of additional escalation policies that can be activated to improve patient flow, as well as documented notifications to hospital executives.

In-patient mental health teams should accept patient transfer within 8 hours of referral. Mandatory notification to the Health Minister and the Mental Health Minister should occur when transfer does not occur within 24 hours of arrival to the ED, and notifications for every additional 24 hours that the referral has not been accepted. Short Stay Units are considered part of the ED for the purpose of these notification requirements.

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

Recommendation 3: All WA hospitals have ED LOS for mental health patients as a key performance indicator and that this is publicly reported.

5.2 Part 10: Transport Orders & Part 11: Apprehension, Search and Seizure Powers

Response to Amendment 9: Transport Orders

ACEM is supportive of the proposed amendments to transport orders. However, we would like to express our concern at the poorer outcomes for people living in regional, rural and remote areas. For persons requiring admission to a specialist inpatient service, a transfer from a regional location to a metropolitan location is most often required due to inadequate or absent regional mental health services. Our members have reported that persons requiring assessment and treatment are heavily sedated for prolonged periods (sometimes requiring intensive care, i.e., being placed into an induced coma for the purpose of containment) whilst waiting for and during transportation. This often contributes to further deterioration in the mental health of these patients.

Recommendation 4: Legislative provisions pertaining to transport orders should stipulate strict timeframes for completion of transport orders, with escalation policies for instances where the specified timeframes lapse

Response to Amendment 10: Apprehension by Police for assessment

ACEM strongly rejects the proposal outlined in the discussion paper for Police (or other Emergency Services) transporting patients who require supervision to hand a patient over to ED staff and leave without appropriate assessment and transfer of care. This is unsafe for both the patient and staff, and a recipe for worse clinical outcomes.

Recommendation 5: Legislation should prioritize a health response over a criminal justice response where safe and appropriate to do so

The apprehension of persons in the community by Police is an issue that combines both health and justice. It is the College's position that behavioral disturbance is primarily a health issue and therefore considers where appropriate and safe to do so, health professionals should be prioritized to exercise the power to apprehend, while acknowledging that a police officer may still need to do so in some circumstances.

We also consider that that all less restrictive options must be tried or considered first. We note that the success of this approach will be highly contingent on the resourcing and structures made available through the implementation of any such process.

The transfer of custody must be safe for the patient and staff and agreed to by the prescribed person (health professional). While we are cognisant that police officers should not spend unnecessarily long periods with people who are best served by a health response, it remains relatively common for them to remain to ensure the safety of other patients and staff. The solution is not to change the process of apprehension and safe handover to medical staff. Rather the focus should be on addressing the underlying issue which is the delay in assessment and admission of mental health patients in the ED through reducing access block for admitted mental health patients.

5.3 Part 13: Provision of Treatment Generally & Part 14: Regulation of certain kinds of treatment and other interventions

Recommendation 6: All 24 hour waits in an ED should be reported to the Health Minister and Mental Health Minister routinely, alongside any CEO interventions and mechanisms for incident review

Recommendation 7: 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

See also: Recommendation 2

ACEM acknowledges the broad range of initiatives under way to reduce the use of seclusion and restraint in all States and Territories across Australia. 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, however, extensive consideration must be given to the context in which restrictive practices are used.

The use of restrictive practices in EDs and the drivers of their use are complex and sometimes necessary to protect an individual patient, and/or the people around them (staff, carers and other patients).

EDs provide a compelling window into the strengths and weaknesses of the health system and hospitals. The use of restrictive practices in many 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:

5.3.1 Delays to mental health treatment

Demand for mental health care is outpacing the availability of acute mental health services, particularly after-hours, which has created a situation where EDs have become a major and often default entry point for people seeking access to mental health care, often when in crisis.

As noted above, patients presenting to EDs for mental health care routinely experience excessively long wait times to receive mental health care.

Despite mental health accounting for a relatively small percentage of all presentations, persons presenting for mental health related reasons are overrepresented in the data on Access Block, defined as the situation where ED patients who require in-patient admission and need a hospital bed are delayed from leaving the ED for more than eight hours due to a lack of inpatient bed capacity.

Access block compromises both the patient experience and the delivery of safe, high-quality emergency medical care. Recent research[5] shows that when more than 10 per cent of patients in an ED are experiencing access block, subsequent patients arriving have a 10 per cent greater chance of dying within seven days of their admission.

People seeking help for mental health conditions in Western Australia currently experience unacceptably long waits in our EDs; it took nearly 15 hours for most (90%) mental health patients to depart from the ED, whilst it took equally as long to admit most (90%) of those requiring an in-patient admission.

5.3.2 Co-occurring intoxication

There is substantial overlap between mental health and alcohol and other drugs, yet this is scarcely included in the discussion document. How the Act is applied in these complex circumstances, such as a person in the ED experiencing an acute episodic mental health condition in combination with alcohol or drug use (e.g., drug induced psychosis), are not reflected in the discussion paper.

The management of agitated or violent patients in the ED can be challenging and poses a safety risk to individuals, other patients, the staff and the people accompanying them. The management of agitated or violent patients in the ED can be challenging and poses a safety risk to the individual, the people accompanying them, other patients in the department and the ED staff. A research article by ACEM Fellows and staff[6] in 2016 found that alcohol-related verbal aggression from patients had been experienced in the past 12 months by 97.9% of respondents, and physical aggression by 92.2%. ED nurses were the group most likely to have felt unsafe because of the behaviour of these patients (92% reported such feelings). Alcohol related presentations were perceived to 'negatively' or 'very negatively' affect waiting times (noted by 85.5% of respondents), other patients in the waiting room (88.3%). Alcohol-affected patients were perceived to have 'negative' or 'very negative' impact on staff workload (94.2%), wellbeing (74.1%) and job satisfaction (80.9%).

The use of restrictive practices under mental health legislation must be considered in the context of a co-occurrence of alcohol and other drug harm. Evidence indicates 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 acute sedation compared to patients with a principal diagnosis of mental illness[7,8]. A metropolitan ED in Australia 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[9]. Other research has also confirmed that methamphetamine use is frequently associated with aggression towards staff and other patients, and the need for restrictive practices[10].

5.3.3 Pre-hospital environment

---

[5] Jones, PG and van der Werf, B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emerg. Med. Australas. 2020 Dec 10. Doi: 10.1111/1742-6723.13699. Online ahead of print

[6] Egerton-Warburton et al., 2016, *Perceptions of Australasian emergency department staff on the impact of alcohol-related presentations, Med J Aust,* 204(4): 155

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

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

[9] 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*

[10] 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

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. Mental health related behavioural disturbance is primarily a health issue. Therefore, it is ACEM's position that where appropriate and safe to do so, transport should ideally be via a health service/ambulance, with police used in a support role where required for the safety of emergency service providers.

However, AIHW data shows that mental health patients are most likely to arrive by ambulance (37.2%), and we are seeing an increase in the number of arrivals by police or corrections vehicle (10.9%), which is above the national average of 6%. The apprehension of a person experiencing behavioural disturbance in the community can be a traumatic experience, therefore, the use of restrictive practices in the pre-hospital environment may impact the behaviour of the patient on arrival in the ED.

5.4 Part 16: Protecting patients' rights

Recommendation 8: That legislative provisions set out a requirement for the Western Australian Department of Health to provide the necessary resources for clear clinical governance frameworks for all service providers, standardised documentation tools and reporting pathway that allow for system improvement.

Recommendation 9: Persons subject to the Act must have timely and equitable access to independent advocacy services

5.4.1 Quality and safety

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 stewardship of such frameworks, documentation and reporting should sit with the Western Australian government and should not be an extra bureaucratic burden on healthcare workers to manage.

The engagement paper lacks detail on regulation and accountability, however, the College suggests that hospital services should be resourced, and be required, to report on the use of restrictive practices in the ED. The level of access block and overcrowding in EDs at the time restrictive practices were used should also be included in any reporting requirements to examine the correlation between ED capacity and restrictive practices, without placing undue bureaucratic burden on clinical staff.

5.5 Part 20: Mental Health Advocacy Services

5.5.1 Supported decision-making

Response to Amendment 19: Mental Health Advocacy Service – Access to voluntary patients

The College is broadly supportive of tools that enable supported decision-making such as statements of rights, advance statements, nominated persons and second psychiatric opinions. ACEM acknowledges the importance of mental health patients having access to non-legal advocacy services such as those provided by the Mental Health Advocacy Service (MHAS) and welcomes the proposed amendments contained in the discussion paper.

5.5.2 Information sharing

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 always have access to the appropriate information systems, 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.

6. Conclusion

It is ACEM's position that all people living in Western Australia 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.

EDs should be resourced and supported to offer a safe and supportive environment for people seeking help for mental health problems. ED clinicians should continue to be engaged in the reform process 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 (overcrowding and high stimulus environment) and time frames in assessing and managing behaviour.

When revised sections from the Act has been drafted, it is essential that further consultation is undertaken to ensure that it is fit for purpose. The discussion paper with proposed amendments 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,

Peter Allely
Faculty Chair, Western Australia Faculty Board
Australasian College for Emergency Medicine