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Submission to the Department of Health
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REVIEW OF THE CLINICAL GOVERNANCE OF PUBLIC MENTAL HEALTH SERVICES IN WESTERN AUSTRALIA

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide a submission to the Health Department on the Review of the Clinical Governance of Public Mental Health Services in Western Australia (the Review).

ACEM is the peak body for emergency medicine in New Zealand and Australia, with responsibility for training and educating emergency physicians and advancing professional standards in emergency medicine. As the trusted authority for emergency medicine, ACEM has a vital interest in ensuring a sustainable emergency medicine workforce that provides high quality patient care for all patients and upholds the highest possible professional standards in emergency medicine. Fellows of ACEM (FACEMs) are specialist emergency physicians working in Emergency Departments (EDs) across Australia and New Zealand.

Inadequate capacity in Australia's mental health system means that many people turn to EDs in crisis for mental health care and support. Often the ED is the only service available in rural and remote areas, or after hours, or when people suffer acute psychiatric illness for the first time. According to AIHW data[1], in 2016/17 there were over 31,400 mental health presentations in Western Australia's EDs, representing year-on-year increased from over 29,800 in 2015/16 and over 26,100 in 2014/15.

Although Western Australia has set a four hour target for all ED care, the data shows that people presenting to an ED in a mental health crisis are the group most likely to wait more than 24 hours for inpatient care. These long waits are harmful for patients and frustrating for clinicians. People presenting in a mental health crisis are more likely to leave the ED prior to their treatment[2] or experience their agitation escalate into aggression, requiring the use of chemical and/or physical restraint. These outcomes are common in the absence of service interventions in the community, hospital and EDs that offer timely, safe and respectful care.

In our submission we wish to raise a number of matters to inform the Review. These matters include:

- Roles and responsibilities in clinical governance
- Clinical outcomes data
- Underlying system issues
- Recommendations for improvement and reform.

Roles and responsibilities in clinical governance

ACEM identifies the dual governance system in Western Australia as a critical factor limiting the health system's efficacy. By design, the system has separate governances: the Mental Health Commission is responsible for leading the mental health system in the State, with the Health Department leading the rest of the health system. Funding, staffing, resourcing and data monitoring/reporting arrangements in the two systems operate independently.

[1] Datasets accessible from AIHW's Mental health services in Australia page.
[2] ACEM. (2018). The Long Wait: An Analysis of Mental health Presentations to Australian Emergency Departments.

In practice, this results in a disorganised and uncoordinated health system. For patients that require access to both sides of the health system (for example patients presenting to the ED in mental health crisis), they must navigate mental health services funded and governed by a separate body to that of public hospitals; staff of mental health services are not hospital staff, and vice versa. At a governance level there is little accountability for patients accessing services on both sides of the system, resulting in an inadequate number of beds for mental health and alcohol and other drug (AOD) patients.

Transferring patients between these two systems is fraught and continuity in care is not always assured. Additionally, there is a lack of overall accountability for clinical outcomes patients accessing services from both sides of the system. Particularly vulnerable patient groups, such as those seeking AOD services, are more likely to experience disjointed care, extended wait times and lengthy stays. Flow-on effects from these issues include ED access block, violence and poor patient outcomes in terms of their vulnerability to risk and worsening mental and behavioural health outcomes.

No one service is responsible for outcomes for mental health and AOD patients. In order to address the issue, a new model of care must be agreed to manage patients that require treatment from mental health services in EDs, public hospitals and community mental health services, and a new model of clinical governance to ensure a systematic approach to maintaining and improving the quality and safety of mental health care in WA. This would include oversight of outcomes from funding, developing and supporting clinical leadership and ensuring accountability for quality, safety and compliance with standards of care.

ACEM Data

Western Australia experiences particularly high levels of mental health access block compared to the rest of Australia. ACEM's analysis[3] of AIHW ED data identified that:

- the median wait for mental health patients in WA was 30 minutes (vs. 19 minutes nationally)
- in the 90th percentile, patients waited 138 minutes (vs. 103 minutes nationally)
- only 56.3% of mental patients are seen on time (vs. 68% nationally)

On Monday 8 October 2018 at 10:00 am local time, ACEM conducted a binational voluntary survey of 147 Australian and New Zealand public emergency departments accredited by ACEM to estimate the point-prevalence of mental health access block.[4] The findings from this survey indicated that although 5% of patients in WA were mental health presentations, mental health patients made up 20.4% of patients waiting for beds and 18.4% of patients experiencing access block (a delay of more than eight hours for a bed).

Hospital Data

In 2003 and 2004, WA had the lowest number of mental health attendances per population, at approximately 50 per 1,000. As of 2019, WA has the 3rd highest rate of mental health presentations to EDs in Australia, and overall ED mental health attendance numbers have tripled (from 10,000 in 2003/4 to 30,000 in 2017/18). In the last five years, attendances have increased by approximately 9% per annum. WA Emergency Access target (WEAT) data shows that for the two year period 2016 to 2018, attendances continued to grow at a rate of 7%.

EDs in WA are carrying the burden of increases in mental health presentations in terms of the normalisation of patients waiting in the ED in excess of 12 hours. This is a completely unacceptable standard of care. It is the result of over a decade of under-investment in mental health capacity, which as a result has not kept pace with demand.

[3] ACEM. (2018). The Long Wait: An Analysis of Mental health Presentations to Australian Emergency Departments.
[4] ACEM. (2018). Prevalence of Mental health Access Block (POMAB) study (unpublished)

We provide some snapshot data below from three tertiary referral hospitals from the North and South metro areas in Perth:

- At Sir Charles Gairdner Hospital (SCGH), the number of mental health patients facing extended lengths of stays in excess of 12 hours is increasing steadily despite initial performance improvements following the introduction of the WEAT. In 2017, an average of 121 patients per month waited 12 hours or more, increasing to 143 patients per month in 2018. Over the first 3 months of 2019, an average of 166 patients a month have waited 12 hours or more.

- At Fiona Stanley Hospital (FSH) there was on average 5 mental health patients per month waiting longer than 48 hours in the ED in 2015, increasing to 20 patients per month in 2018/19. The rate at which patient stays longer than 24 hours has increased from 20 to 70 per month over the same time period. In March 2019, FSH had 110 patients staying longer than 24 hours (almost four patients per day).

- At Royal Perth Hospital (RPH), an average of 24 patients per month were waiting longer than 24 hours in 2017, increasing to 62 patients per month in 2018. Over the same period there was an increase in patients waiting over 48 hours at RPH, from 10 patients per month in 2017 to 14 per month in 2018.

The data clearly shows that people who present to an ED in mental health crisis are the group most likely to wait more than 24 hours for care. This is clearly discrimination. The foremost aim of the introduction of time based targets in EDs was to improve patient safety and quality of care by removing obstacles to patient flow that contribute to emergency department overcrowding. In doing so, the time based target of four hours seeks to reduce the morbidity and mortality linked to access block and to improve the patient experience throughout the hospital system. Instead, these long waits for mental health patients increase their risk of adverse outcomes, including the immediate risks related to being sedated, secluded and physically restrained.

Aboriginal and Torres Strait Islander people are over represented in groups who present to the ED seeking support in a mental health crisis. ED doctors often struggle to find appropriate services for young people. Many who seek help from an ED give up and leave before their treatment is complete.

WEAT Performance Data

Department of Health performance data measuring the WA Emergency Access target (WEAT) demonstrates worsening wait times for all patients over the course of just one year. Between February 2018 and February 2019:

- WEAT performance in the North Metro area decreased from 73% to 62.4%
- WEAT performance in the East Metro area decreased from 74.6% to 69.4%.

Total mental health attendances in WA (from WEAT data) shows that in the last 3 years, admissions increased year-on year by 6.8% in 2016/17 and by 11.4% in 2017/18.

Violence in the ED

While ED and acute psychiatric staff are committed to providing high quality care to all patients, the lack of resources, extended wait times and ED design can contribute to violence and aggression amongst mental health patients who present in crisis. According to data from the WA Health Department, in 2017/18 there were 11,304 incidents of aggression in WA tertiary hospitals. In the 2018/19

WA Government budget, the issue of violence against staff was seen as an increasing issue facing hospitals[5].

Underlying System Issues

ED staff are fighting a system characterised by inadequate numbers of mental health professionals and beds, no definitive timelines for inpatient admission, and severely constrained access to ongoing and integrated community mental health care and social support. The Mental Health Commission's Alcohol and Other Services Plan 2015-2025[6] identifies significant gaps in the service provision to meet future demand. Existing and future gaps in service provision will result in a situation where excessive wait times for those most vulnerable will become the norm, rather than the exception.

Further, EDs are by their nature noisy and stimulating environments which is the opposite of a therapeutic environment for this patient cohort. The stimulation from the constant noise and lighting is a source of stress to already frightened and often traumatised people, and the ED space is full of hazards for people who may be at risk of harm or self-harm. Specialised areas to serve mental health patients in EDs, such as the Mental Health Observation Area (MOHA)[7] at the Joondalup Heath Campus, are critical to better serving patients presenting in crisis. The MOHA provides a more appropriate setting for mental health patients through a quieter and safer environment separate from the general accident and emergency patients.

Recommendations for improvement and reform

To address the issues surrounding care of mental health patients, ACEM urges the Review Panel to incorporate the following recommendations:

- Merge governance of hospital and mental health services under one system
- Require inpatient mental health services to meet the same timelines as general medical patients – e.g. seen by a psychiatrist within 30 minutes of request, transferred to a bed within four hours of arrival
- The Health Department to enforce a 12 hour maximum length of stay in the ED, with mandatory notification and review of all cases embedded in the key performance indicators for public hospital CEOs
- Any incident of a 24 hour wait in an ED be immediately escalated to Ministerial notification, CEO intervention and mechanisms for incident review and reporting on findings to the Minister for Health.
- Adopt new models of care that enable mental health services and hospital services to operate with improved coordination and continuity of care, such as after-hours mental health support models
- Ensure integration of AOD and mental health services to avoid patients with dual diagnoses slipping through the gap
- Increases to funding for community-based and inpatient mental health and AOD services
- Look at all possible ways of expanding acute psychiatric services to provide timely and humane care in appropriate environments and to allow patient egress to supportive community care. These increases are particularly required for acute care services where the sickest patients currently face the most inhumane and degrading delays.

[5] Western Australian Government. (2019). 2018/19 Budget – Part 5 Health.
[6] Mental Health Commission. (2019). Draft Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (2018 update).
[7] Joondalup Health Campus. (2018). Mental Health Observation Area opening a benefit to local community.

Thank you for the opportunity to provide feedback to the Review of the Clinical Governance of Public Mental Health Services in Western Australia. Should you require clarification or further information, please do not hesitate to contact Ryan Angus (ACEM Policy Officer) on (+61) 03 9320 0452 or via email at ryan.angus@acem.org.au.

Yours sincerely,

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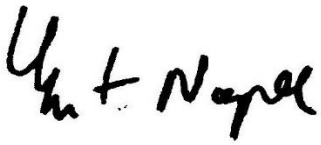

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