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Caring for people with acute behavioural disturbance
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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to respond to Safer Care Victoria's Clinical Guidelines for Caring for people displaying acute behavioural disturbance.

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

ACEM supports the key principles of these clinical guidelines and commend Safer Care Victoria for the development of practical and realistic guidelines. However, we wish to raise a number of areas where these clinical guidelines could be enhanced.

1. Use of restrictive practices

The ED is well-recognised as a setting in which violence is more likely to occur. 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.[1] As a result, ACEM acknowledges that restrictive practices (including sedation or physical restraint) may be needed to manage agitated or violent patients who pose a risk to themselves, staff or other patients and when all other de-escalation techniques have been unsuccessful.[2] Evidence also 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 principle diagnosis of mental illness.[3] [4] A metropolitan ED found that of 229 instances where a Code Grey (unarmed threat) had been called, illicit drug use accounted for 40% of patients with acute behavioural disturbance, with the majority due to meth/amphetamine.[5] Other research has also confirmed that methamphetamine use is frequently associated with aggression towards staff and other patients, and the need for restrictive practices.[6]

In addition, we emphasise that the use of restrictive practices in many circumstances is a symptom of system failure. In particular, access block and excessively long waits for definitive care and disposition can further aggravate patient distress, necessitating the use of restrictive practices where EDs are not staffed and resourced to provide clinical supervision of patients over prolonged periods of time.[7]

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[1] Australasian College for Emergency Medicine. (2016). *ACEM Workforce Sustainability Survey Report, November 2016*. Melbourne: ACEM

[2] Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, *Emergency Medicine Australasia*

[3] Yap, C.L., Taylor, D. Kong, D.C.M., Knott, J.C., Taylor, S., Graudins, A., Keijzers, G., Kulawickrama, S., Thom, O., Lawton, L., Furyk, J., Finucci, D., Holdgate, A., Watkins, G., Jordan, P. (2019) Management of behavioural emergencies: a prospective observational study in Australian emergency department. *J Pharm & Prac*, 49 (4): 341-348.

[4] Braitberg, G., Gerdtz, M., Harding, S., Pincus, S., Thompson, M. and Knott, J. (2018) Behavioural assessment unit improves outcomes for patients with complex psychosocial needs, Emergency Medicine Australasia, 30:353-358.

[5] Gerdtz, M., Yap, C., Daniel, C., Knott, J., Kelly, P. and Braitberg, G. (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*.

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

[7] Kennedy MP. (2005) Violence in emergency departments: under-reported, unconstrained, and unconscionable. Med J Aust; 183(7):362–5.

Recent data from the VAHI shows that the number of people waiting over 24 hours in an ED continues to climb, and ACEM data shows that mental health patients are over-represented in this population.[8] During the quarter from October to December 2019, 409 patents waited in the ED for more than 24 hours whereas in the same quarter the year prior there were 170 patients who had a length of stay of 24 hours or more.[9] This increase is particularly concerning given that Victoria has a target of zero patients who wait more than 24 hours.

It is well established that EDs are an inappropriate setting for patients to wait for mental health care, with the high stimulus environment often exacerbating their distress and increasing the risk of behavioural disturbances escalating into violence. Furthermore, such long waits contribute to the prolonged or repeated use of restrictive practices such as sedation.

Reducing the use of restrictive practices will require a coordinated health system approach to prioritising reduction in ED LOS, specifically in vulnerable patient groups such as in mental health and drug affected patients.

2. Debriefing

ACEM supports the guideline messaging to debrief the patient following an instance of restrictive practice use. However, formal debriefing is often not feasible due to the high volume of patients seen within the ED and thus we support the option for this debrief to involve a member of staff resourced for this purpose and not necessarily a member of the ED care team.

Regarding, the care team debriefing following the episode of care, ACEM supports reviewing the care episode to identify opportunities for systemic improvement. However, we note that vital learnings particularly regarding policy or systems improvement should be escalated to the health service for review and implementation, if required.

Recommendation 1: ACEM recommends that clear reporting pathways are established that allow for system improvement recommendations to be progressed to the relevant and governance level.

3. Documentation and reporting

ACEM notes that the clinical guidelines state that all episodes of violence and aggression should be reported to the relevant health services however we are concerned that these guidelines do not identify a mechanism to consistently document and report on the use of restrictive practices. There is a lack of data to improve our understanding of the use of restrictive practices and consistent documentation and reporting of such use are urgently needed, and the association with ED LOS, availability of inpatient mental health beds and community services.

To address this, ACEM recommends that the use of restrictive practices is incorporated into routine discharge and admission procedures including communication to patients about their care using standardised forms or templates built into Electronic Medical Records.

Recommendation 2: ACEM recommends that all EDs have clear reporting requirements for the use of restrictive practices.

4. Audits of restrictive practices

ACEM considers a key gap in these clinical guidelines is the auditing of restrictive practices in the ED to identify and monitor the impact on patient outcomes. In Victoria, researchers undertook an audit of patients who had attended four Victorian hospitals in 2016 to understand clinical practice when responding to behavioural emergencies, determined by a Code Grey (unarmed threat) being called. [10] This audit found that Code Greys were called for 1.49% of all patients, with restrictive interventions applied in 24.3% of such cases.[11]

In addition, the majority (62.8%) of restrictive interventions were applied under a Duty of Care framework rather than under the legal provisions of mental health legislation, indicating the need to implement clear clinical governance frameworks to support both the use and documentation of such practices. [12] Furthermore, where a Code Grey had been called, less than one in six patients were admitted to an inpatient

[8] Victorian Agency for Health Information (2020) *Length of stay,* available online at: https://vahi.vic.gov.au/emergency-care/length-stay, accessed 7 February 2020.
[9] Victorian Agency for Health Information (2020)
[10] Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, *Emergency Medicine Australasia*
[11] Knott et al. (2019)
[12] Knott et al. (2019)

bed, indicating that such presentations could have potentially been prevented through the provision of alternative and adequate community and crisis services.[13]

Recommendation 3: ACEM recommends that audits of restrictive practices are conducted to identify and monitor the impact on patient outcomes and the relationship with the availability and accessibility of community and inpatient mental health services.

5. Alternative models

While we understand that this is beyond the scope of the clinical guidelines, more innovative and alternative models of emergency care for psychological crises are required. Various models have been trialled which involve collaborative and multidisciplinary care in a safe, low-stimulus and secure environment. Examples include the Behavioural Assessment Unit (BAU) at the Royal Melbourne Hospital, Mental Health Observation Area at Joondalup Health Campus in Perth and the Psychiatric Alcohol and Non-prescription Drugs Assessment (PANDA) Unit at St Vincent's Hospital in Sydney. An evaluation of one of these models found that it reduced the number of security calls, the use of restrictive practices and patient length of stay.[14]

6. Transitions from the pre-hospital environment

The use of restrictive practices in the ED may also be predicated on their use in the pre-hospital environment. Data from the AIHW shows that mental health patients are more likely to arrive via ambulance (46.6%) or police/correctional vehicles (7.1%) compared to all ED presentations (25.2% and 0.7% respectively). Therefore, the use of restrictive practices in the pre-hospital environment must also be taken into account when assessing their use in the ED. In particular, the pre-hospital environment poses greater challenges and risks to the safety of patients, staff and the community and are often determined by differing legislation or through Duty of Care arrangements. In addition, the use of restrictive practices in the pre-hospital environment may be compounded by restricted access to resources including but not limited to suitable numbers of people, suitably qualified personnel, suitable safe environment/room and equipment. As a result, early escalation such as through sedation and intubation may be needed. There is inadequate data on these factors and the use of restrictive practices. Thus there is a need to better understand pre-hospital management prior to arrival for such patients through audits and guidelines on the use of restrictive practices in this environment.

Recommendation 4: ACEM recommends that audits of restrictive practices should be conducted to identify the use of restrictive practices in the pre-hospital environment and the impact on patient outcomes with guidelines developed in regards to their use.

7. Security personnel

It is vital that security personnel working within the ED environment are appropriately resourced and trained in de-escalation techniques as an integrated part of the ED clinical team. Well-trained, experienced hospital security personnel with strong physical presence, excellent communication skills, an aptitude for learning, and a positive 'customer service' attitude can be successfully utilised in the ED to problem solve and eliminate unnecessary conflict.[15] Often, rural and remote EDs are not resourced to contract after-hours security personnel and instead rely on the on-call use of private security firms and/or local police. Security personnel and police are therefore unlikely to be able to respond to a violent ED incident in an appropriately short timeframe. In these contexts, specific local arrangements must be in place, including memoranda of understanding.

Recommendation 5: ACEM recommends that security personnel working within the ED are appropriately resourced and trained in de-escalation techniques to reduce the use of restrictive practices and ensure safety for patients and staff.

Thank you for the opportunity to provide a response to the Guidelines. If you have any questions please do not hesitate to contact policy@acem.org.au .

Yours sincerely

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Immediate Past President

Dr Mya Cubitt
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[13] Knott et al. (2019)
[14] Braitberg et al. (2018)
[15] York T, MacAlister D. (2015) *Hospital and healthcare security*. Sixth ed. Oxford: Elsevier Inc.