Australasian College
for Emergency Medicine

Access to Care for Patients With Acute Mental and Behavioural Conditions

P41

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Document review

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1. Purpose and Scope

This is a policy of the Australasian College for Emergency Medicine (ACEM; the College). It provides guidance to emergency department (ED) staff in Australia and Aotearoa New Zealand on equitable and timely access to quality care for patients presenting to the ED with an acute mental and/or behavioural condition.

This policy will also be of interest to clinical and administrative staff external to the ED, specialist mental health practitioners, hospital security personnel, senior hospital executives and administrators, health system managers, law enforcement personnel, paramedics, and patient transport personnel.

2. Policy

All people presenting to the ED are entitled to receive high quality care, regardless of whether they are physically and/or mentally unwell or distressed.

When patients present with a condition requiring emergency care, the role of the ED is to assess, stabilise and refer to definitive care as necessary. The ED is not a suitable environment for ongoing care of patients with an acute condition who require inpatient admission, including patients attending the ED with an acute mental and/or behavioural condition. Patients presenting to the ED who are experiencing psychological distress should receive culturally responsive and trauma-informed care as soon as possible.

Those with an acute mental and/or behavioural condition requiring admission should be transferred to an in-patient ward promptly, following a clinical decision to admit. Mandatory notification to the Minister for Health, Minister for Mental Health, Human Rights and/or Mental Health and/or Health Rights Commissioner should occur when transfer does not occur within 24 hours of arrival to the ED. Notifications should be issued for every additional 24 hours that the transfer to the ward has not occurred.

3. Background

In Australia and Aotearoa New Zealand the demand for mental health services is increasing, with community need continuing to outstrip the availability of appropriate and coordinated services.

Patients presenting to EDs for mental health conditions routinely experience unnecessary and excessively long waits, often in inappropriate and unsafe environments. [1,2]

Patients with mental health conditions are over-represented among those that experience access block, yet there are decreasing acute psychiatric beds. [3-5]

4. Procedures and Actions

4.1 Access to Care

All people presenting to the ED are entitled to receive high quality care. However, the ED is a high stimulus environment, which has specific implications for the ongoing management of patients with an acute mental and/or behavioural condition.

4.2 Hospital Access Targets

ACEM recommends that all patients presenting with an acute mental and/or behavioural condition have a total ED time in line with the ACEM Hospital Access Targets, which is the same as patients with any other emergency condition. [6]

ACEM recommends the introduction of mandatory notification requirements to relevant authorities when a patient stay exceeds 24 hours.

4.3 Triage and Initial Assessment

All patients with an acute mental and/or behavioural condition will be triaged in line with the appropriate category on the Australasian Triage Scale. [7,8] ED staff involved should have training and experience in mental health triage.

After initial triage, medical and psychiatric co-assessment and management should be commenced in alignment with the triage category.

Emergency departments may have multi-disciplinary teams including specialist mental health practitioners and/or social workers with a role in triage and mental health assessment. [9] Mental health assessments should occur in parallel with the patient's medical assessment.

4.4 Alcohol and Drug Intoxication or Withdrawal

Judgment of whether a patient is intoxicated due to alcohol or other drugs should be determined by clinical assessment of that persons decision-making capacity.

Blood alcohol level has not been demonstrated to be a reliable predictor of capacity to participate in an assessment. It should not be used as a determinant to commence assessment in the ED or admission to psychiatric services. [10]

A period of observation may be warranted to determine if symptoms resolve as intoxication levels decrease, but this should not delay an initial mental health assessment.

4.5 Transfer of Care

Following triage and initial co-assessment in the ED, referral should occur for patients likely to benefit from further mental health care and support. This may include referral to a primary care service and/or general practitioner, community mental health service, or acute mental health service. Transfer of care should occur in a timely manner and within the timeframes contained in the ACEM Hospital Access Targets.

4.6 Risk of Violent Behaviours

Violence often occurs in EDs, and health services must ensure a safe environment for employees, patients, and carers. Hospital administrators must provide policies, procedures, staffing models, preventative training and education, verbal de-escalation and safe restraint training and education. ED design and incident reporting systems also contribute to the prevention, minimisation, and effective management of violence in the ED. [11]

ACEM provides advice on use of restrictive practices [12], and violence in EDs. [13]

EDs must ensure local arrangements are in place for safe custodial practice and transfer of care for patients presenting with acute mental and/or behavioral conditions brought to the ED by police.

4.7 Information Sharing

Discharge documents should be completed prior to discharge and (with the consent of the patient) information provided to the patient's care provider/s, and in line with local legislation regarding information sharing.

Follow-up arrangements should be in place, with a focus on shared decision making, including crisis contact information. The patient's family/whānau/support persons should be included (with the consent of the patient) in decision-making and safety planning.

5. System Design and Components of Quality Care

5.1 Quality, Safety, and Risk Management

Emergency departments and specialist inpatient mental health services should have established, functional and cooperative relationships. Regular liaison meetings will enable evaluation of performance and quality issues, engagement with other relevant stakeholders, review of local communication processes, benchmarking of data and activities, and development of site-based local service agreements.

5.2 Culturally Responsive and Safe Care

Health care cannot be clinically safe unless it is also culturally safe. Health care staff need explicit and rigorous training in anti-racism to develop the tools to provide culturally safe care for Aboriginal and Torres Strait Islander peoples.

Additionally, healthcare services must provide care that is respectful of, and relevant to, the health beliefs, health practices, cultural and linguistic needs of communities whose members hold those affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language, or language spoken at home.

5.3 Mental Health Short Stay Units

Mental health 'short stay units' (SSUs) are psychiatric assessment and planning units. They may be located within hospital and community-based psychiatric facilities or co-located with EDs but are governed by mental health clinicians. Mental health SSUs provide specialist care to patients requiring a length of stay greater than four hours but no more than 24 hours. [14]

5.4 Innovative Models of Care

Mental health leadership in partnership with emergency physicians and other specialties (addiction medicine, toxicology, general medical) is essential for the design of safe, responsive system-wide models of care for patients seeking help in the acute care context. These models should be co-designed with consumers and seek to expedite access to specialist inpatient mental health care. [15-18]

5.5 Unit Naming Conventions

To reduce stigma and discrimination associated with mental and behavioural conditions, ACEM recommends adopting a neutral approach to naming areas within the hospital or co-located with the ED for the assessment and treatment of patients in this group. Naming conventions should be adopted that describe the design of the environment instead of the patient cohort, for example low stimulus room/area.

6. Definitions

6.1 Acute Behavioural Disturbance

Acute behavioural disturbance (ABD) has been defined as any manner in which a person conducts themselves that (i) does not respond to normal verbal intervention, (ii) interrupts the normal activities of the ED and (iii) has the potential to place the individual and/or others at risk. [19]

6.2 Assessability and 'Interviewability'

The terms *assessable* and/or *interviewable* and/or *interviewability* may be used to denote that a patient is fit and ready for assessment and interview. This determination is made by the interviewing clinician.

6.3 Behavioural Assessment Room

A *Behavioural Assessment Room* (BAR) is a designated area within or adjacent to the ED that provides for the safe, therapeutic management of behaviourally disturbed, aggressive and/or violent patients. [20] Ideally, BARs should also provide an appropriately low stimulus environment.

6.4 Cultural Safety and Responsiveness

Culturally safe care is important for all patients, and particularly for those from indigenous cultures. In the Australian context, consideration must be given to the definition of cultural safety provided by the Australian Health Practitioner Regulation Agency. [21] In Aotearoa New Zealand, the College supports the definition of cultural safety provided by the Medical Council of New Zealand (MCNZ). [22]

The ACEM Te Manaaki Mana Strategy is a commitment to create EDs in Aotearoa New Zealand that embody Pae Ora. They will provide quality, culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued, and where leaders actively seek to eliminate inequities.

6.5 Medical Assessment

There is a lack of standard terminology to describe the medical evaluation of patients who present to the ED in with mental health or behavioural disorders before admission and transfer to psychiatric care. ACEM promotes the use of the term 'completed medical assessment' to indicate the point in time that a patient has been assessed as not having an acute medical need that requires an emergency intervention and that they are appropriate for admission and transfer to psychiatric services, if required, or safe for discharge.

The term 'medical clearance' should not be used.

6.6 Mental and Behavioural Disorders

Mental and behavioural disorders is a term used by the World Health Organization (WHO) in its classification system to describe the clinical features of a wide range of groups of psychiatric conditions measured using International Classification of Diseases and Related Health Problems (ICD-10) criteria. Mental and behavioural disorders are classified in the ICD-10 codes F01 to F79. [23]

6.7 Patients Presenting with Deliberate Self-harm

Self-harm includes self-injury (an intentional act to cause self-harm without intending death), suicide attempt and 'self-poisoning or self-injury, irrespective of the apparent purpose of the act'. [23] Self-harm is classified in the ICD-10 codes X60 to X84. [24]

6.8 Trauma-informed practice

Trauma-informed practice considers trauma (broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness, or horror) in all aspects of healthcare. It does not necessarily require health professionals to elicit disclosures of trauma; rather, it requires recognition of the lived experiences of individuals and awareness of triggers which can lead to re-traumatisation and that efforts are made to minimise re-traumatisation. [25]

7. Related Documents

The following are available within through the ACEM Standards Library:

- ACEM and RANZCP *Mental Health in the Emergency Department Consensus Statement*
- S127 *Statement on Access Block*
- S817 *Statement on the use of restrictive practices in emergency departments*
- G15 *Emergency Department Design Guidelines*
- G24 *Guidelines on the Implementation of the Australasian Triage Scale in EDs*
- G36 *Guideline on Clinical Handover in the Emergency Department*
- G554 *Emergency Department Short Stay Units*
- P06 *Policy on the Australasian Triage Scale*
- P18 *Responsibility for care in Emergency Departments*
- P28 *Policy on a Quality Framework for Emergency Departments*
- P32 *Policy on Violence in the Emergency Department*

8. References

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22. Medical Council of New Zealand. *Statement on Cultural Safety.* Online: MCNZ; 2019.

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