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National Safety Priorities in Mental Health
Queensland Government Consultation
June 2020

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide a written submission to the Queensland Government review of the National Safety Priorities in Mental Health.

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. The practice of emergency medicine is concerned with the prevention, diagnosis and management of *acute* and *urgent* aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders.[1] ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED) and we have long advocated for a health system that offers people safe, timely, expert and therapeutic care, regardless of whether they are physically or mentally unwell.

Mental health conditions are increasing as both a proportion of the population and in overall numbers, with one in five Australians living with a mental health condition in 2017–18.[2] Due to the twin pressures of increasing demand and failure to provide adequate care in the community, EDs have become a major and often default entry point for people seeking access to mental health care. Often by the time people present to an ED, their potentially preventable or manageable condition has become very serious and they are in mental health crisis. In 2016-17 there were over 275,000 mental health presentations to Australian EDs. A significant number of these presentations are underpinned by social and medical complexity, with these people often experiencing mental health issues in combination with drug and alcohol dependence, chronic physical ill health or disability, insecure housing or homelessness.[3]

EDs are often considered the 'canary in the coal mine' in identifying failures in the health system and play a vital role in addressing the needs of people who are unable to access appropriate community or primary mental health services. Our members working in EDs across Australia have reported, and our data confirms, increasing numbers of patients are presenting to EDs seeking help for mental health crises and experience unacceptably long waits for access to definitive care. As such, the College believes that improving the quality and safety of mental health care in the ED must be a key focus of the review of the National Mental Health Safety Priorities. ACEM's recommendations are outlined below and are consistent with the principles and priorities outlined in the Mental Health in the Emergency Department Consensus Statement[3] released by ACEM in 2019.

[1] Australasian College for Emergency Medicine (ACEM). Policy on standard terminology (P02). Melbourne: ACEM; 2014. Available from: https://acem.org.au/getmedia/e5cf7ac4-dae5-4193-be9a-6746b0d85009/P02_Standard_Terminology_Dec-14.aspx
[2] Australian Institute of Health and Welfare. Mental health services in Australia. Cat. no. HSE 228. Canberra: AIHW; 2019.
[3] Australasian College for Emergency Medicine (ACEM). Mental health in the emergency department: consensus statement. Melbourne: ACEM; 2019. Available from: https://acem.org.au/getmedia/0309ba59-d37b-478b-b5c9-e96b272ff837/Consensus-Satement-110419

1. Mental Health Access Block

Exacerbating an already acute psychiatric episode, patients presenting to EDs with mental health concerns have unacceptable lengths of stay following triage, initial assessment and management, which is known as access block. Access block is defined by ACEM as the situation in which patients who have had their initial care in ED by emergency medical staff and been admitted and need a hospital bed (including in specialist mental health services) are delayed from leaving the ED because of lack of inpatient bed capacity.[4] Access block has historically been seen as 'an ED only problem'; however, it is symptomatic of a health system in crisis, with a lack of hospital inpatient bed supply compared with demand, just that the systemic-wide problem is manifest in ED.

Mental health access block is inevitable in the Australian mental health system, with data from the Australian Institute of Health and Welfare (AIHW) data showing the chronic shortage of mental health beds, including that the total number of beds has decreased in absolute terms. The 2019 report on mental health services in Australia shows that in 2016–17 the total of 7,175 public mental health beds was 500 less than those available in 1993–94, when there were 7,606 mental health beds (see table 15 Specialised mental health care facilities report).[2] International comparisons confirm this shortfall, with Australia's rate of 41 acute psychiatric beds per 100,000 population falling significantly below the OECD average of 71 mental health beds per 100,000.[5]

ACEM's analysis of mental health presentation data[6] shows that mental health patients are over-represented in access block data, with these patients:

- twice as likely as other patients to stay in an ED longer than eight hours;
- almost exclusively represented in patients staying more than 24 hours; and
- 16 times more likely than people with other medical conditions to arrive at ED via police or other non-health-services vehicles and nearly twice as likely to arrive via ambulance or rescue helicopter

In addition, there are significant differences in waiting times between metropolitan, urban and rural/regional hospital settings. Although the percentages of mental health ED presentations are comparable across all settings, significantly higher percentages of people in rural/regional areas experience mental health access block with long waits for inpatient beds.[6] These delays in treatment are often further exacerbated by the need to transfer patients to hospitals in larger urban settings due to the lack of accessible and appropriate mental health services in rural/regional settings.[7]

Patient safety best practice requires transfer to specialist inpatient care within four to six hours of arrival in ED (after being assessed for admission), but ACEM research shows regular instances of patients spending three or more days in EDs due to access block[6] clearly an utterly unacceptable and discriminatory state of affairs. These long waits and overcrowding are harmful for patients and their families, inefficient and costly to the health budget, and deeply frustrating and a cause of moral injury to emergency physicians and nurses.

Our expectation is that mental health should be treated with the same quality of care provided to other patients presenting to an ED, but the reality across Australia is that people in mental health crisis are caught between an over-stretched public hospital system with too few mental health beds and an under-resourced community mental health sector with scant after-hours availability of services. Furthermore, the lack of appropriate prevention and early intervention service models and alternative models of emergency mental health care and crisis services in the community means that people seeking mental health support are turning to EDs as their first point of access even though these settings are not designed or resourced for this purpose.

[4] ACEM. Access block. Melbourne: ACEM; 2019. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block

[5] Organisation for Economic Cooperation and Development (OECD). OECD Health Statistics 2015. Available from: https://stats.oecd.org/#

[6] Australasian College for Emergency Medicine (ACEM). The long wait: an analysis of mental health presentations to Australian Emergency Departments. Melbourne: ACEM; 2018. Available from: https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[7] Senate Community Affairs References Committee. Accessibility and quality of mental health services in rural and remote Australia. Canberra: Commonwealth of Australia; 2018.

In chaotic and noisy EDs, it is no surprise that people presenting in mental health crisis are the group most likely to leave the ED prior to treatment, or for agitation to escalate into aggression and/or violence that requires the use of sedation, seclusion or restraint. Adverse consequences for safety and other clinical outcomes also extend to other patients affected by this overcrowding and long wait times, as well as ED staff working in these conditions.[6]

Recommendation 1: ACEM recommends that State and Territory Governments undertake strategic needs assessments to scope the requirement for inpatient mental health beds reflecting international best practice evidence and standards.

Recommendation 2: ACEM recommends that States and Territories invest additional funding and resources to increase inpatient mental health beds and non-hospital alternatives, such as step-up/step-down services, short stay units, hospital in the home etc., depending on local needs.

Recommendation 3: ACEM recommends that State and Territory health departments provide accessible, appropriate and resourced facilities for ongoing care beyond the ED to ensure that no patient waits more than 12-hours in the ED. Mandatory notification and review of all cases with a length of stay (LOS) greater than 12 hours should be embedded in key performance indicators of public hospital CEOs.

Recommendation 4: ACEM recommends that all episodes of a 24-hour LOS in an ED are reported to the relevant health minister regularly, alongside CEO interventions and mechanisms for incident review.

Recommendation 5: ACEM recommends that the new National Cabinet and health ministers support and encourage innovative mental health funding arrangements that provide ongoing and sustained care for people with persistent mental health needs.

Recommendation 6: ACEM recommends that State and Territory governments explore innovative diversion or alternative care models in communities with high levels of mental health presentations to EDs.

Recommendation 7: ACEM recommends that all government-funded mental health services are required to expand their operating hours to provide flexible after-hours services including evenings and weekends as a condition of receiving funding.

Recommendation 8: ACEM recommends that all jurisdictions implement a centralised follow-up service that ensures all mental health patients, especially when presenting due to suicidal ideation or following an attempt on their life, receive a phone call within 24 hours of discharge to offer advice on available services, check on referrals (for example, if a GP appointment has been made) or other appropriate actions.

2. 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.[8] The management of agitated or violent patients in the emergency department can be challenging and poses a safety risk to the individual patient, staff, other patients and people accompanying them 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.[9] 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 sole diagnosis of mental illness.[10,11]

[8] ACEM. ACEM workforce sustainability survey report: November 2016. Melbourne: ACEM; 2016. Available from: https://acem.org.au/getmedia/0da6a4e7-9bc2-4e0f-83ea-95ee51a6f8fc/Workforce-Sustainability-Survey-Final-Report_November-2016.aspx

[9] Knott J, Gerdtz M, Dobson S, Daniel C, Graudins A, Mitra B, et al. Restrictive interventions in Victorian emergency departments: A study of current clinical practice. Emerg Med Australas. 2020;32(3):393-400.

[10] Yap CL, Taylor D, Kong DCM, Knott JC, Taylor S, Graudins A, et al. Management of behavioural emergencies: a prospective observational study in Australian emergency department. J Pharm & Prac. 2019:49(4):341-348.

[11] Braitberg G, Gerdtz M, Harding S, Pincus S, Thompson M, Knott J. Behavioural assessment unit improves outcomes for patients with complex psychosocial needs. Emerg Med Australas. 2018;30:353-358.

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).[6] Therefore, the use of restrictive practices in the pre-hospital environment must also be considered 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 sedation and even intubation may be needed. There is inadequate data on these factors and the use of restrictive practices. It is ACEM's view that 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.

ACEM emphasises 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.[8] 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. There is evidence of long-standing trauma to those who have been subjected to restrictive practices, compounding existing mental health conditions and leading people to avoid care in the future.[8,12]

Whilst most jurisdictions have strong regulation of these practices, including exclusions on their use or special provisions for vulnerable groups (for example children and Aboriginal and Torres Islander peoples) the use of restrictive practices in the ED is not part of routine data collection. As such there is limited data available to improve our understanding of the use of restrictive practices and the association with ED length of stay, availability of inpatient mental health beds and community services.

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.[8] This audit found that Code Greys were called for 1.49% of all patients, with restrictive interventions applied in 24.3% of such cases. 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. Importantly, where a Code Grey had been called, less than one in six patients were admitted to an inpatient bed, indicating that such presentations could have potentially been prevented through the provision of alternative and adequate community and crisis services.

While audits of the use of restrictive practices are critical to understand how they are being used, any progress towards reducing or eliminating the use of restrictive practices in EDs requires adequate resourcing in terms of the clinical team, security personnel and the ED environment. Staff confidence is enhanced by better availability of skilled (expert mental health) psychiatric support staff to assist in clinical decision-making for complex cases and via the provision of a safe ED environment.[13]

Recommendation 9: ACEM recommends that the use of restrictive practices (sedation and restraint) in EDs are governed by clear clinical governance frameworks, standardised documentation tools and clear reporting pathways that allow for system improvement recommendations to be progressed to the relevant governance level.

Recommendation 10: ACEM recommends that audits of restrictive practices in EDs 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.

[12] Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot JA, Cousins VC, et al. Special section on seclusion and restraint: patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatr Serv. 2005;56:1123–33.

Recommendation 11: ACEM recommends that audits of restrictive practices in the pre-hospital environment are conducted to assess the impact on patient outcomes, with guidelines developed for their use.

Recommendation 12: ACEM recommends that ED resourcing is improved to enable adequate clinical care and accommodation by including mental health expertise in ED staffing; providing ongoing mental health education, training and professional support for all staff; developing new workforce models including peer workers within ED teams; and applying ED design principles that create low stimulus, reassuring environments for people in mental health crisis.

Recommendation 13: ACEM recommends that all security personnel working within the ED are appropriately resourced and trained in de-escalation techniques to reduce the need for restrictive practices and ensure patient and staff safety.

3. Innovative models for acute mental health care

The current situation of mental health access block and ED overcrowding demonstrates that more innovative and alternative models of emergency care are urgently needed for people experiencing mental health crises. There is clear evidence supporting these alternative models, with reported reductions in the number of security calls, the use of restrictive practices and patient length of stay.[14]

ACEM has identified several innovative Australian models of mental health care that improve the quality and safety of emergency mental health care. The below examples offer affordable, integrated care with sustained proactive engagement with EDs and have the potential to be replicated at scale. These include:

- The Psychiatric Alcohol and Non-prescription Drugs Assessment (PANDA) Unit at St Vincent's Hospital in Sydney. This is a six-bed ward close to the ED, where patients can be admitted for safe observation, management and nursing. It provides a model of concurrent management of acute mental health crisis with co-existent medical problems, where patients can be managed medically in a safe setting until medically fit for mental health review. The PANDA unit has been developed in response to the high proportion of people with mental health illness and regular drug and alcohol users presenting to the ED. Data suggests around 15% of the patient presentations to the emergency department involve mental illness and/or the effects of drug use. The PANDA model is a 7 day a week, 24 hour a day service, managed by a combination of clinical pharmacology and drug and alcohol teams in close collaboration with the emergency department and the Mental Health Service. Other similar units are modelled overseas (for example in Canada) called Acute Behavioural Stablisation Units (ABSU) or similar.

- The Mental Health Observation Area (MHOA) in Joondalup Health Campus, Perth, Western Australia, is a collocated area with interview rooms and overnight beds that has taken mental health patients out of the main ED, 'bringing the emergency department back under control'. Victoria is in the process of rolling out its version of the MHOA – the Emergency Department Crisis Hub.

- Royal Perth Hospital has a Homeless Team to address one of the biggest drivers for re-presentations to the ED – discharging a patient into homelessness. The team offers an outreach service that provides patients with follow-up care and support in the community, so those who remain homeless can still access health care.

- Royal Prince Alfred Hospital in Sydney has successfully trialled a nurse practitioner-led extended hours mental health liaison nurse (MHLN) service based in the ED. The MHLN team see mental health presentations and begin the process for coordinating care. This has been shown to provide prompt and effective access to specialised mental health care for people with 'undifferentiated health problems' and remove a significant workload from nursing and medical staff.

[14] Braitberg G, Gerdtz M, Harding S, Pincus S, Thompson M, Knott J. 2018. A behavioural assessment unit improves outcomes for patients with complex psychosocial needs, *Emerg Med Aust* ;30(3):353-8

- The Queensland Mental Health Intervention Project is a partnership between the Queensland police, health and ambulance services where mental health clinicians work alongside police to better manage crisis situations involving people with a mental illness, staff are supported with training in de-escalation strategies and regional coordinators work to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative referral pathways and review procedures.

- St Vincent's Hospital in Melbourne has a peer worker employed in the ED and a Safe Haven Cafe physically close to the ED. The Cafe offers respite in a warm, caring and respectful environment to people needing mental health support as well as social connection, but not necessarily acute care. The model was developed by and for consumers.

Further details including interviews and presentations about these models are available here.

Thank you for the opportunity to provide a response to this important review that will shape the safety of the mental health care system. If you have any questions or require further information, please do not hesitate to contact ACEM via policy@acem.org.au.

Yours sincerely

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