Australasian College for Emergency Medicine

March 2024

Supplementary Questions and Responses to:

Inquiry into Equity, Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in New South Wales

1. How are Emergency Medicine staff in public hospitals in regional New South Wales skilled and supported to manage mental health admissions in country hospitals?

Provision of mental health care is core to emergency medicine training and practice regardless of the location of practice. Emergency clinicians in emergency departments (EDs) undertake initial assessment, de-escalation, stabilisation, and ensure patients experiencing mental and/or behavioural crisis are safe while ongoing assessment and a definitive clinical management plan are being determined.

Patients presenting with mental and/or behavioural conditions are triaged by a triage nurse according to their clinical and situational urgency based on the Australasian Triage Scale. This will inform prioritisation of review by emergency clinicians and the mental health team servicing the ED. The acuity and severity of the condition will also determine the level of risk and the care and observation requirements for the duration of their episode of care in the ED.

A presentation to the ED for mental health concerns may result in admission, discharge or transfer, depending upon acuity, response to initial management by the emergency clinician and community-based treatment options available as a suitable alternative to inpatient care. The determination for admission to a mental health in-patient unit will be made in consultation with a mental health team and psychiatrist. Emergency physicians will work with mental health clinicians to perform initial assessments and then determine whether admission is the most beneficial course of action for the patient.

There is no one consistent model-of-care for delivering mental health care across NSW regional, and rural EDs. For example, there may or may not be mental health clinicians embedded in the ED workforce. This is often dependent on whether a hospital has a psychiatric in-patient facility. EDs that do not have a co-located psychiatric inpatient service and/or local mental health team are likely to rely on off-site support from a psychiatrist and mental health clinicians, for example via telehealth.

ED staff, including emergency physicians, nursing and mental health teams aim to use best-practice, evidence-based care, dependent on the acuity, symptoms and working diagnosis for each patient. However, an issue regarding skills and training in regional, rural and remote EDs is the variability of staff experience and training in emergency mental health care. This is where a mental health liaison nurse embedded within the ED provides immense value, as they have specialised training, comprehensive knowledge of mental health issues, and a sound understanding of referral pathways and local resources.

Once the decision has been made that a patient requires admission, the ED will continue to provide care, treatment, and safety until the transfer to a ward can be facilitated. While emergency treatment can commence in the ED, this is not the appropriate treatment location for the provision of definitive psychiatric care, which is best delivered in a mental health unit by a psychiatrist and specialised mental health nursing and allied health staff. It should be noted that some patients requiring inpatient treatment may need to be transported significant distances, by road or air, to an appropriate facility.

A major concern is that patients requiring specialist mental health care often experience waiting times in the ED of 8 hours or more.[1] Patients awaiting transfer to a different hospital often wait even longer. EDs are generally not therapeutic environments for patients with mental health concerns, and not all EDs will have quiet spaces or assessment rooms where someone in acute psychological distress can wait for treatment and/or transfer to a specialist mental health service.

2. Do they have access to clinicians who can help them manage mental health patients?

Emergency physicians are clinicians with training and expertise to manage mental health patients in the emergency phase of their presentation. However, higher-acuity and more complex patients require specialist psychiatric assessment and care, often encompassing specialised medical, nursing and allied health input.

Regional, rural or remote hospitals will have different models of care and access to mental health clinicians and services. Typically, hospitals with a mental health inpatient unit will have an embedded mental health clinician in the ED (generally a nurse), or a mental health team on the ward that can be utilised. Hospitals without a mental health inpatient facility, including many regional, rural and remote facilities, will have partnerships with surrounding referral hospitals (for example utilising telehealth), which may include afterhours support. However, this is not consistent across all services.

Regional, rural and remote areas often experience workforce shortages[2] across the spectrum of healthcare. In mental health care, this can sometimes mean a mental health clinician or psychiatrist is not available when a patient requires assessment. This is a particular problem outside business hours, when clinicians are on leave, or have unplanned unavailability such as sickness. As a result, patients may be left in ED for excessive periods of time awaiting specialist assessment.

There is always room for improvement in how EDs provide mental health care. Greater access to mental health clinicians that can promptly triage, assess, and stabilise patients presenting with mental health conditions, minimising wait times to be seen or transferred for admission should be the priority for improving mental health care in EDs.

3. Do the regional hospitals have the right infrastructure to physically care for mental health patients? Particularly those exhibiting acute and potentially risky behaviour?

The appropriateness of ED infrastructure must be considered from the context of the ED as a whole and its purpose to care for a wide range of presentations and needs. It is widely agreed that EDs are busy, high stimulus environments, which can often exacerbate a person's psychological and mental health disturbance. EDs are not appropriate places for patients in crisis to wait for extended times for assessment and definitive care.

This is exacerbated by access block, which leads to overcrowding and ambulance ramping.[3] This is when patients are waiting for admission or transfer to a hospital in-patient ward and remain the in ED for an extended period of time due to lack of available in-patient beds. Therefore, if ED beds are occupied by patients that require medical resources for their care, mental health patients are often waiting in assessment rooms or hallways. This is not therapeutic care and can be intimidating and concerning for those in crisis. It can lead to deterioration of psychiatric symptoms including

[1] Australian College for Emergency Medicine. (2020). Nowhere Else To Go: why Australia's health system results in people with mental illness getting 'stuck' in emergency departments.

[2] Rishaan, P., Mahajan, N., Wangoo, E., Khan, W. & Bailey, J. (2022). *Staff perceptions of the management of mental health presentations to the emergency department of rural Australian hospital: qualitative study.* BMC Health Services Research. Vol.22, no. 87.

[3] Sax Institute, 2022. Access block: a review of potential solutions. Accessible from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block-(1)/Hospital-Access-Targets

escalation of aggression, challenging behaviours, and risk of patients taking their own leave prior to completion of assessment and treatment.[4]

EDs will typically have a quiet room for initial patient assessment. These spaces are limited, and smaller hospitals will have less space and fewer specialised facilities to care for mental health patients that are awaiting assessment or transfer for admission. Space and infrastructure appropriateness is dependent on other competing pressures within the ED, for example multiple patients with mental health concerns, or patients with infectious conditions requiring isolation spaces and single rooms.

In cases where a person may be exhibiting risky behaviours, the mix of patient needs can be difficult to manage and may lead to risk of harm to the patient as well as other patients, visitors and staff in the ED. Whilst EDs try to manage and separate different patient cohorts this may be difficult dependent on space available and competing treatment priorities. The risk is further exacerbated in smaller departments that have limited or no access to dedicated and trained hospital security staff for support. EDs generally do not have the environmental safety considerations required of a mental health inpatient unit, for example management of ligature points, sharps and access to medications. This leads to risk of harm for high acuity patients, particularly when they are experiencing long length of stay in the ED.

For patients in acute crisis requiring psychiatric admission, the best place for them to be is in a mental health inpatient unit that is best suited to optimise safety and commence their therapeutic treatment. There is a major issue state and nationwide where mental health patients wait unreasonably long wait times for transfer of care.

[4] Australian College for Emergency Medicine. (2020). Nowhere Else To Go: why Australia's health system results in people with mental illness getting 'stuck' in emergency departments