

Mental health care

Framework for emergency department services



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Background

Mental health care: Framework for emergency department services has been developed by the Department of Human Services to provide direction for delivery of emergency mental health care in Victoria's public hospital emergency departments (EDs).

The framework is intended to assist health services to:

- plan appropriate emergency department care for people who present with mental health needs
- promote service coordination and collaboration between specialist mental health services and emergency departments
- promote best-practice management and care coordination.

The framework is intended to complement existing policies and health service protocols rather than replace them. It is not intended to provide prescriptive details of mental health care requirements in emergency departments. As all public health services are responsible for providing care in accordance with evidenced-based best-practice standards and regulatory, legislative and accreditation requirements, each health service will have its own protocols and procedures adapted to meet these requirements.

The framework provides a set of overarching guidelines that encompass the areas of service delivery and clinical care.

- **Service delivery** includes guidelines for the range of services, access expectations, staffing, safety and environment, training and development, patient rights, and performance management and quality.
- **Clinical care** includes guidelines for general triage, mental health assessment, treatment, inpatient care, and discharge.

Where appropriate, notes and examples follow the individual service guidelines. These provide prompts, directions and specific references.

Development of the framework

The framework has been developed by the Department of Human Services in consultation with the Emergency Access Reference Committee (EARC) mental health subcommittee during 2006.

It is anticipated that the framework will be reviewed and revised over time to ensure it reflects changes in emergency mental health care. Public health services are expected to continue to work with stakeholders to identify and act on opportunities for continuous quality improvement.

Much of this document has been freely adapted from the *National Standards for Mental Health Services*.

Context

The prevalence of mental health problems is a significant issue in Australia.¹ In Victoria, there have been increasing numbers of mental health presentations to emergency departments in the six years to 2006, which is consistent with the overall increase in general emergency presentations. This has occurred within a context of increased awareness of mental illness in the community and decreased general practitioner accessibility.

¹ *The Australian Bureau of Statistics identified that in 2001, 9.6 per cent of the Australian population (1.8 million people) reported having a long-term mental or behavioural problem that lasted, or was expected to last for six months or more.*

Also, the mainstreaming of mental health services since the 1990s has changed the way mental health services are provided. Emergency departments now have an increased role in providing care to people with mental health needs. Emergency departments now regularly provide treatment to people across a spectrum of mental health/behavioural problems. These include people who:

- are registered mental health patients
- require general medical treatment but have a psychiatric co-morbidity
- are first psychiatric presentations, including drug-induced psychosis
- present with a situational crisis
- have drug and alcohol issues
- need emergency mental health treatment.

As well, system capacity to meet the demand for mental health inpatient care can require emergency departments to care for some mental health patients while beds are being sought.

Guiding principles

The care of people with mental health needs in the emergency department should be underpinned by the following principles:

- Recognition of the human rights of people with mental disorders as proclaimed by the *Australian Health Ministers' Mental Health Statement of Rights and Responsibilities*, *Victorian Human Rights Charter 2007*, including:
 - Informed decision-making by individuals and their families about their treatment.
 - Promotion of equitable access to appropriate care.
 - Treatment and care in accordance with all relevant legislative requirements (eg. *Victorian Mental Health Act 1986*).
 - Active involvement of consumers accessing emergency departments, to inform the planning, implementation and ongoing evaluation of service quality.
- Timely access to mental health assessment and care for people who present to the emergency department with a mental health illness or disorder.
- A collaborative team approach between the emergency department, mental health service, and other services where appropriate (eg. community health, general practitioners (GPs)).
- Continuity of care through the development of links between hospital emergency departments, internal departments, and other organisations.
- Integration with the broader health system, with a clear role and linkages to other services (eg. mental health telephone triage, community care, mental health inpatient units), to ensure appropriate access and continuity of service.
- Best care within available resources (and a clear plan to manage times when resources are overwhelmed).

1.0 Service delivery

1.1 Range of service and access guidelines

Mental health presentations to the emergency department include people with depression and other mood disorders, anxiety conditions, psychotic disorders, behavioural disturbances associated with substance use, attempted suicide and other acts of deliberate self-harm and reactions to personal crises. People with mental health problems may present with associated or unrelated physical problems, and symptoms of mental illness may be caused by an underlying physical illness.

1.1.1 The emergency department responds to all mental health presentations to the department including psychiatric disorders, behavioural disturbances associated with substance use, and complex psychosocial problems

Notes and examples: The response to people with mental health problems presenting to EDs is not the exclusive responsibility of mental health practitioners.² ED clinicians require skills in the assessment and management of the various mental health problems they are likely to encounter, and the ability to provide support, information and appropriate referral for mental health clients and their families/carers.

1.1.2 The emergency department ensures access to mental health practitioners and other relevant service providers to meet the needs of people with symptoms of mental illness and/or psychosocial problems

Notes and examples: Access to mental health services can occur via mental health clinicians located in the ED, off-site community mental health teams, on-call clinicians, and psychiatric triage phone services. It is understood that not all components of a mental health service are readily available to every ED, but a crisis intervention function should be available that can facilitate prompt referral to other programs and providers.

Also, EDs should identify and establish cooperative arrangements with relevant service providers such as general practitioners, private psychiatrists, drug and alcohol services, family support services and so on.

1.1.3 Roles and responsibilities of mental health practitioners and emergency department clinicians are clearly defined and agreed

Notes and examples: The group of patients assisted by mental health practitioners located in the ED is broader than the target group for public mental health services and includes those who may not require ongoing involvement with or referral to such services. ED clinicians and mental health practitioners in the ED require a shared understanding of appropriate response to and management of different types of mental health presentations within the ED. Both emergency clinicians and mental health practitioners may have input into the assessment and management of all levels of mental health/behavioral presentations to the ED.

² The definition of mental health practitioner may be found at 1.2.1.

1.2 Staff training, development and supervision guidelines

1.2.1 Mental health care in the ED is provided by a combination of general ED clinicians and mental health clinicians

Notes and examples: A mental health practitioner is a registered nurse (Division 1 or Division 3), psychologist, social worker, occupational therapist, medical officer/psychiatrist or other suitably qualified staff member who works as part of a mental health program. The Mental Health Act describes certain responsibilities of mental health practitioners.³

1.2.2 The health service regularly identifies development needs of its emergency department staff and facilitates training relevant to managing clients with mental health problems

Notes and examples: Education programs may cover topics such as critical incident debriefing and the *National Standards for Mental Health Services*, and should involve consumers and carers where appropriate. Performance appraisal, surveys, supervision and industry-validated core competencies for ED staff should be considered.

1.2.3 The health service ensures that emergency department staff have access to formal and informal supervision relevant to managing clients with mental health problems

Notes and examples: Potential areas for involvement include multidisciplinary, discipline specific, group or individual supervision, case reviews and peer review.

1.2.4 Emergency department staff involved in providing mental health care receive specific training in mental health assessment and are supervised by a more experienced colleague

Notes and examples: Training topics may include assessment methods, assessment of risk, medico-legal issues, engaging consumers and carers, and cultural sensitivity, including competence in working with interpreters. Individual and group supervision should be considered.

³ To access the act, go to: www.legislation.vic.gov.au.

1.3 Safety and environment guidelines

1.3.1 Policies, procedures and resources are available to promote the safety of patients, carers, staff and the community

Notes and examples: There are opportunities for safety promotion relating to communication and alert systems, debriefing processes, staffing levels, complaints procedures, independent monitoring, and critical incident reports.

1.3.2 Emergency department staff are regularly trained to understand and respond appropriately and safely to aggressive and other challenging behaviours

Notes and examples: Recognised safety training courses are used.

1.4 Legislation guidelines

1.4.1 As part of its duty of care to people presenting with mental health problems, the emergency department complies with a range of human rights and anti-discrimination legislation and instruments

Notes and examples: General legislation and instruments relevant to ED mental health care include: *Resolution on the Protection of People with a Mental Illness and Improvement in Mental Health Care*; the Australian Health Ministers' Mental Health Statement on Rights and Responsibilities; occupational health and safety legislation; and anti-discrimination legislation.

1.4.2 All clinical staff who care for mental health patients comply with and have an understanding of the *Victorian Mental Health Act 1986* in so far as it affects the emergency care of mental health patients. Specific, but not exclusive, reference is made to the following sections of the Act:

- Criteria for involuntary treatment (Section 8(1))
- Initiating involuntary treatment (Section 9)
- Apprehension of mentally ill persons in certain circumstances (Section 10)
- Involuntary treatment orders (Section 12AA)
- Community treatment orders (Section 14)
- Revocation of community treatment orders (Section 14D)
- Mechanical restraint (Section 81)⁴
- Seclusion (Section 82)⁵

⁴ This section of the Victorian Mental Health Act applies only to people who are receiving care under the Act at a facility gazetted for mental health treatment. In non-gazetted facilities, the Act allows restraint to be applied where a person has been recommended for involuntary mental health treatment under Section 9 of the Act. In other circumstances, common law/duty of care applies to the use of restraint.

⁵ This section of the Act applies only to people who are receiving care under the Act at a facility gazetted for mental health treatment. There are no provisions of the Act relating to seclusion in non-gazetted facilities: common law/duty of care applies in these circumstances.

- **Consent (53B; 83–85)**
- **Confidentiality (Section 120A)**
- **Transport of a person under the Mental Health Act to another service.**

Notes and examples: A basic understanding of the *Victorian Mental Health Act 1986* is necessary for health professionals working in emergency departments. The Act governs the care and treatment of people in Victoria who experience a mental illness or disorder. It establishes procedures for initiating involuntary treatment, the provision of involuntary treatment in both inpatient and community-based settings, and independent review. The Act states that people who have a mental health problem are to receive the best possible care and treatment in the least possible restrictive environment and least possible intrusive manner. The Chief Psychiatrist's *Guidelines for seclusion and restraint* are available at www.vic.gov.au/mentalhealth/cpg.

1.5 Performance management and quality improvement guidelines

1.5.1 The health service meets key performance indicator targets for mental health patients through collaborative relationships between the emergency department and other departments

Notes and examples: There is a range of resources used to compile data and monitor ED performance: the Victorian Admitted Episode Dataset (VAED), Victorian Emergency Minimum Dataset (VEMD), and RAPID-CMI (Redevelopment of Acute and Psychiatric Information Development - Client Management Interface Operational Data Store). The Department of Human Services publishes emergency access key performance indicator targets in *Performance monitoring framework and business rules*.

1.5.2 The health service monitors performance and utilises data collected to improve performance as part of a quality improvement process

Notes and examples: Health services are required to continually monitor and review performance indicators, including those specified by the Department of Human Services.

1.6 Patient rights, consent, and confidentiality guidelines

1.6.1 Staff of the emergency department comply with relevant legislation, regulations and instruments protecting the rights of people affected by mental disorders and/or mental health problems

Notes and examples: Relevant documents include *Resolution on the Protection of People with a Mental Illness and Improvement in Mental Health Care*, the Australian Health Ministers' Mental Health Statement on Rights and Responsibilities, mental health legislation, equal employment opportunity legislation, anti-discrimination legislation, occupational health and safety legislation, professional and departmental codes of conduct and registration acts, disability services acts.

1.6.2 Emergency department staff seek the patient's informed consent to all psychiatric and non-psychiatric treatment, and act in accordance with relevant legislation and duty of care requirements where the person is unable, or refuses, to give informed consent

Notes and examples: Section 9 of the Mental Health Act outlines the requirements for initiating involuntary treatment where a person is unable to consent to psychiatric treatment. Sections 83–85 of the Act outline requirements for obtaining consent to non-psychiatric treatment (medical treatment) for patients under that Act. If a patient is incapable of giving informed consent to non-psychiatric treatment, the Act sets out a process and lists the categories of people able to give substitute consent on behalf of the patient. The non-psychiatric treatment regime does not apply to people receiving mental health care on a voluntary basis. The common law requirements for informed consent to medical treatment apply to this group. If such a person is unable to consent to medical treatment, the *Guardianship and Administration Act 1986* provides a substitute consent regime for adults. The Chief Psychiatrist's guideline for *General medical health needs, annual examination, non-psychiatric treatment, special procedures, and medical research procedures* is an additional source of information, available at www.vic.gov.au/mentalhealth/cpg.

1.6.3 The emergency department supports and involves families and carers in the treatment and care of people with mental health problems wherever possible.

Notes and examples: Families and carers play vital roles in supporting people with mental illness, and their involvement should be supported wherever possible. Clinicians should seek the patient's consent to disclose information to family members and carers. However, if the patient does not give consent under Section 120A of the Mental Health Act, family members, guardians or primary carers can be given information where it is needed by them for the ongoing care of the person with mental illness.

1.6.4 The emergency department ensures that only authorised persons have access to information about the patient

Notes and examples: Boards (such as whiteboards in a ward setting or in a crisis team office) used to record consumer information should be only visible to authorised persons. Consumer files should be stored according to Australian Standards for medical records, as are passwords for computer files.

1.6.5 Emergency department staff have access to information about the range of health resources available to the patient and provide information on how to access relevant services

Notes and examples: Resources and access points may include an up-to-date resource folder, education and information from mental health clinicians and by other health service providers including general practitioners, private psychiatrists and other private therapists.

2.0 Clinical Care

This section describes the guidelines for minimum standards of mental health-related care that a patient can expect to receive in any Victorian emergency department.

2.1 Triage guidelines

2.1.1 People who present to the emergency department with a mental health problem are triaged in a timely and appropriate way and managed according to the principles set out in the *Victorian Emergency Department Mental Health Triage Project Training Manual*

Notes and examples: The *Victorian Emergency Department Mental Health Triage Project Training Manual* (2006) provides nurses with information about the triaging process for mental health presentations, general management principles, and an overview of the mental status examination, along with case scenarios.

2.1.2 Where people presenting with mental health problems have been triaged and are awaiting treatment in the ED, the emergency department ensures their safety and that of others in the general waiting area

Notes and examples: While in the ED waiting room, consideration should be made of the specific needs of some people with mental health problems (eg. those needing low-stimulus environment to limit exacerbation of symptoms) as well as other members of the public who are in the waiting room. There should be appropriate care and monitoring regimes for people with mental health problems who are awaiting treatment in the ED, both in the general waiting area and any separate areas.

2.2 Assessment guidelines

Mental health assessment in the emergency department is not the exclusive role of mental health practitioners, and may be conducted by other ED staff. Assessment starts with and includes the triage process when the patient arrives in the ED.

2.2.1 People who present with a mental health problem have appropriate physical assessment

Notes and examples: Appropriate physical assessment should be conducted to exclude potential organic issues and assess and monitor co-morbidities. ED staff should refer to other specialist health care providers (eg. drug and alcohol) and initiate diagnostic tests where appropriate.

2.2.2. A basic mental health assessment capability, appropriate to people of all age groups and needs, is available in the emergency department

Notes and examples: It is expected that all clinicians working in the ED will be able to conduct a basic mental health assessment, including risk assessment, of all presenting conditions regardless of the level of service provided in that ED or health service. A more detailed and/or specialised assessment can be arranged with a suitable mental health practitioner from the ED thereafter.

2.2.3 Access protocols and service linkages to specialised mental health services are in place

Notes and examples: Specialised mental health services include age-related assessment and inpatient services (eg. child, adolescent, aged persons) as well as services particular to conditions (eg. post-natal, eating disorders).

2.2.4 The mental health assessment is timely, comprehensive, and documented. Where possible, it includes the patient's carers, other service providers, and other people nominated by the patient

Notes and examples: An assessment may include physical, social and psychological strengths, risks, family and functional components, relevant history (including previous treatments such as medication), diagnosis and short-term individual care plan, and is recorded in a standardised format for the health service.

2.2.5 The mental health assessment is conducted using appropriate methods and tools

Notes and examples: Assessment tools and methods include the diagnostic classification system, functional assessments, psychometric testing, collaborative interview, family interview, suicide and other risk assessment, problem-oriented assessment, formal clinical interview and mental status examination.

2.3 Treatment and documentation guidelines

2.3.1 Medication and other technologies used are evidence-based and reflect clinically accepted psychiatric and medical standards

Notes and examples: Medications and technologies used in the ED should be selected by staff with appropriate expertise. ED staff should be trained in the appropriate use and administration of all relevant medications and technologies.

2.3.2 Agreed emergency department clinical and management protocols are available for common presenting conditions and issues

Notes and examples: Individual services should formulate their own list of clinical protocols; however, the following conditions and issues, common to many EDs, may require management guidelines:

- substance abuse, intoxication and withdrawal
- aggression
- restraint (including sedation and physical and mechanical restraint)
- use of seclusion
- frequent attendees
- treatment of children and adolescents
- transfer of mentally ill patients
- mental health patients who do not wait in the ED.

2.3.3 Treatment is provided in the least restrictive and most supportive, respectful manner possible

Notes and examples: Treatment should be provided in accordance with the principles and requirements of the Mental Health Act.

2.3.4 Each mental health patient has an individual care plan within their individual clinical record

Notes and examples: Each clinical record should document relevant history, assessment, investigations, diagnosis, treatment and support services required, other service providers, progress, follow-up details, and outcomes.

2.3.5 There is appropriate transfer of information between the patient's ED record and other relevant records

Notes and examples: ED staff should determine whether alternative files on the patient exist within the health service (eg. in the mental health or drug treatment service) and ensure the information collected or care plans developed in the ED are transferred to these files. Subject to privacy legislation (eg. the *Health Records Act 2001* and Section 120A of the *Mental Health Act 1986*), relevant information from the ED record should also be communicated to external service providers who will be involved in the patient's ongoing care (see 2.5.1).

Mental health practitioners should be able to access records of registered area mental health service (AMHS) clients from the ED and should ensure that treatment and care planning in the ED is consistent with that of the AMHS.

2.4 Inpatient care guidelines

2.4.1 Appropriate handover, transfer and supervision protocols are in place and observed when a mental health patient is transferred from the emergency department to an inpatient ward (general or mental health)

Notes and examples: Handover by ED staff should include clinical handover, documentation of mental health assessment, and a treatment plan, including recommendations to manage clinical risk.

2.4.2 When a patient is identified as needing admitted care and no inpatient bed is available, there is a clear process detailing how to access an appropriate inpatient bed. An escalation policy exists to resolve delays in access to inpatient beds

Notes and examples: Protocols should be developed that clarify bed management responsibilities, provide access pathways to inpatient units, ensure appropriate care of patients, and where no bed can be obtained, describe escalation procedures that overcome impediments to access. These should be consistent with the Chief Psychiatrist's guidelines *Access to Beds*, available at www.vic.gov.au/mentalhealth/cpg.

2.5 Discharge guidelines

2.5.1 ED clinicians identify and communicate with key service providers or others who will provide follow-up care for people presenting to the ED with mental health problems

Notes and examples: Subject to privacy legislation, ongoing healthcare providers, such as GPs, case managers, and private psychiatrists, should be contacted prior to discharge where possible or as soon as practicable afterwards. Frequent attenders should be referred to providers of HARP-Chronic Disease Management programs, where these are available.⁶

2.5.2 All patients have a documented discharge plan, which is well communicated to them, their carers and other healthcare providers, stating specific treatments, ongoing care arrangements and any interim crisis measures

Notes and examples: Identification of risk is a key component of discharge planning. Interim crisis measures include plans that provide contacts and resources to cover after-hours contingencies or services, and alternatives to ED care. The Chief Psychiatrist's *Discharge planning guidelines* is available at www.vic.gov.au/mentalhealth/cpg.

2.5.3 The emergency department facilitates the involvement of staff, patient and carers with other service providers

Notes and examples: Linkages with other service providers may be facilitated by referral mechanisms, sharing of resources and/or sharing of expertise between other service providers and the ED.

⁶ HARP-CDM psychosocial guidelines can be accessed via: www.health.vic.gov.au/harp-cdm/harp_cdm_guidelines.pdf

References and useful websites

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