



in association with



**Department of Human Services**

# **Emergency Department Mental Health Service Mapping Project**

**Report B  
Service Development Opportunities  
Final**

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## Glossary of terms

<i>AIS</i>	<i>Acute (Psychiatric) Inpatient Service</i>
<i>AMHS</i>	<i>Area Mental Health Service</i>
<i>APAT</i>	<i>Aged Psychiatry Assessment Team</i>
<i>CASA</i>	<i>Centre Against Sexual Assault</i>
<i>CATT</i>	<i>Crisis Assessment and Treatment Team</i>
<i>CCT</i>	<i>Continuing Care Team</i>
<i>CL</i>	<i>Consultation Liaison</i>
<i>CMHS</i>	<i>Community Mental Health Service</i>
<i>CMI</i>	<i>Client Management Interface</i>
<i>CTO</i>	<i>Community Treatment Order</i>
<i>DHS</i>	<i>Department of Human Services</i>
<i>DNW</i>	<i>Did Not Wait</i>
<i>ECATT</i>	<i>Enhanced Crisis Assessment and Treatment Team</i>
<i>ED</i>	<i>Emergency Department</i>
<i>EDMH Clinicians</i>	<i>Emergency Department Mental Health Clinicians</i>
<i>EFT</i>	<i>Equivalent Full Time (Staff)</i>
<i>EMU</i>	<i>Emergency Medical Unit</i>
<i>GVAMHS</i>	<i>Goulburn Valley Area Mental Health Service</i>
<i>HDM</i>	<i>Hospital Demand Management (Strategy)</i>
<i>HDU</i>	<i>High Dependency Unit</i>
<i>ITO</i>	<i>Involuntary Treatment Order</i>
<i>IWAMHS</i>	<i>Inner West Area Mental Health Service</i>
<i>LOS</i>	<i>Length of Stay</i>
<i>MHSOU</i>	<i>Mental Health Short Stay Observation Unit</i>
<i>MST</i>	<i>Mobile Support and Treatment</i>
<i>NWAMHS</i>	<i>North West Area Mental Health Service</i>
<i>ODS</i>	<i>Operational Data Store</i>
<i>PAPU</i>	<i>Psychiatric Assessment and Planning Unit</i>
<i>PARC</i>	<i>Prevention and Recovery Care</i>
<i>RMH</i>	<i>Royal Melbourne Hospital</i>
<i>SVMH</i>	<i>St Vincent's Mental Health</i>

# 1 Introduction

This Report is based on findings from a series of visits to ten Victorian EDs, consultations with ED and mental health clinicians, examination of data and a brief literature survey. It builds on the Stage A report and focuses on service development opportunities.

The report comprises three components:

- Section 2 which discusses measures for the assessment of good practice in EDs.
- Section 3 which discusses examples of good practice and models of care to identify themes and approaches that DHS should consider in developing policies and service specifications for the provision of mental health services in EDs.
- Section 4 which considers individual EDs and possible opportunities for improvement in practice that may be implemented in the 2007/08 financial year and beyond as part of a longer term strategy for the development of improved models of care.
- Section 5 identifies key factors or resources that DHS should consider in developing guidelines for the provision of mental health care in EDs.

These elements have been informed by a limited review of relevant literature on provision of mental health services in EDs, additional consultations and further information provided by the ten participating health services.

## 1.1 Summary of findings

It is apparent that three major factors have influenced recent improvements in the provision of mental health services in EDs:

- The establishment of a role for **ED mental health workers**. All of those interviewed believed the allocation of mental health clinicians to the ED has not only addressed resource shortages, but has:
  - > Significantly improved relationships between the ED and the broader inpatient and community-based mental health program;
  - > Increased awareness of the needs of people with mental illness in the ED;
  - > Increased the confidence levels of ED workers (triage staff, medical staff and nurses);
  - > Contributed to a change in emphasis from containment to treatment of people who have presented with mental health issues; and

- > Supported the implementation of the mental health triage tool, which has been favourably accepted by ED triage workers.
- **Patient flow initiatives.** Most of the Health Services visited had implemented one or more initiatives to improve patient flow. These include:
  - > Bed management processes including the ED, inpatient units, mental health triage and community-based teams;
  - > A focus on discharge planning to increase availability of services in the inpatient units;
  - > Adoption of practices to manage two or more mental health inpatient units as a single unit for the management of vacancies; and
  - > ED access to dedicated beds in the inpatient unit.

Several Health Services indicated that these measures had made significant contributions to their success against KPIs, particularly the reduction or elimination of 24-hour stays.

- **Medical assessment** of people presenting with mental health conditions. Several Health Services have historically adopted policies that people who are to be admitted to the acute mental health inpatient unit from the ED should undergo a medical assessment, generally referred to as a “medical clearance”. This practice seems to have resulted in blockage in most EDs, as ED physicians are not always promptly available to carry out this assessment. In most instances, the “medical clearance” is not carried out at the same time as the patient undergoes a psychiatric assessment and becomes one of a sequence of activities. In many hospitals medical clearance is no longer required prior to the mental health assessment and admission to an inpatient unit does not require assessment by the psychiatric registrar. Further analysis of this practice is warranted. While individuals who present to EDs should receive assessment that recognises both their physical and psychiatric condition, it would appear that the value of “medical clearance” may be limited in some circumstances.

## 1.2 Definition of Mental Health Presentation

For the purposes of this project, the DHS definition of a mental health presentation in the ED has been used. A Mental Health Presentation is defined in the Victorian Emergency Minimum Dataset (VEMD) as one which meets the criteria as a mental health patient. These criteria are based on the following ICD-10 classification of disease and health related problems:

- All conditions within the ICD-10 F-codes, such as organic mental disorders; mental and behavioural disorders due to psychoactive (ie. drug & alcohol) substance use; schizophrenia; mood disorders; and unspecified mental disorders;

- intentional self-harm;
- suicide risk; and
- examination by authorities.

The VEMD Mental Health Presentation includes a wider range of health-related problems than those treated by the specialist public mental health services and includes drug and alcohol issues, organic disturbances and delirium, and mental retardation.

## 2 Assessment measures

Any consideration of good practice and possible improvements that may be implemented in EDs should be subject to an assessment of their effectiveness.

There has clearly been a strong focus on improving performance in relation to time spent in the ED. A number of measures were noted in Report A as well as variations in performance between the ten participating Health Services. These measures are:

- Percentage of patients with an ED Length of Stay to discharge of less than 4 hours;
- Percentage of patients admitted to a ward within 8 hours;
- Percentage of patients with ED Length of Stay greater than 24 hours; and
- Length of stay in ED;
- Time to treatment; and
- Time from treatment to discharge.

However, these measures focus on only one variable. The nature and standard of care also needs to be taken into account.

It is not necessarily the case that a shorter length of stay means better treatment. Many mental health cases can be highly complex, requiring multiple inputs, time to allow the effects of drugs and/or alcohol to resolve and for a range of community and other contacts to be made. Mental health services aim to achieve a continuum of care, and the effectiveness of the care is not well assessed using time-based measures.

Questions to be considered in relation to initiatives to improve mental health services in EDs should therefore include:

- Are those managing care adequately trained and resourced?
- Is care coordinated across different professionals?
- Are there gaps in care, including acute health care, for patients with complex needs?
- Is mental health care integrated and mainstreamed or viewed as separate?
- Does the model of care minimise the use of restraint and seclusion?
- Are there appropriate facilities to meet the specific needs of those presenting with mental health issues?

- Are effective follow-up processes in place to reduce the risk of future acute episodes?
- Does the care model provide value for money?

Therefore, in considering the issue of “what is working”, there are a number of perspectives to consider.

## 3 Themes for good practice

This section identifies key themes for improving performance in the provision of mental health in EDs. In discussing these themes, a key principle is that services for people who present with mental health conditions should aim to provide a holistic response, rather than the current common practice of providing a sequential series of referrals to different clinicians and services.

### 3.1 Introduction

Different models of care have been implemented at each sample ED site included in this project. These models have been developed in response to the local environment and issues and therefore, what has worked at one site may not necessarily be effective or applicable at another. Notwithstanding this caveat, it is important to observe that:

- There is inconsistency of approach, philosophy and resourcing across sites that goes beyond local service configuration to suit local needs;
- It is not clear there is a common acceptance of the legitimacy of mental health services in the ED, with some conceptualising mental health presentations as a “problem” rather than as an opportunity to provide a coordinated response to an individual with unique needs;
- Multiple initiatives have been implemented relatively independently across sites and even within sites, without a true understanding of the inter-relationships between these initiatives and/or the duplication of effort/process that may be involved;
- Inconsistent terminology and approach make it difficult to clearly identify and understand the roles and functions of the various mental health workers involved in servicing EDs;
- The availability of funding for specific initiatives has probably been as influential in determining strategy as an understanding of the processes and process failures that occur in the provision of mental health services in EDs.

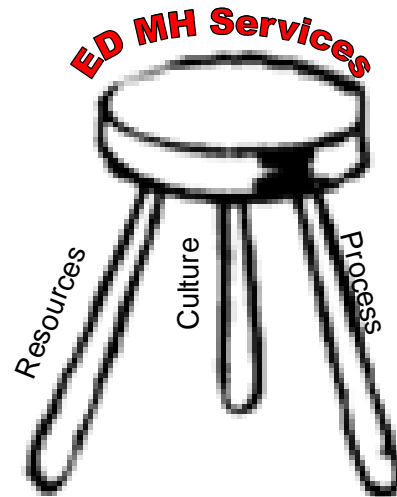
Based on observation of initiatives implemented in the sample EDs and outlined in the Stage A report, there are three key pillars in the provision of integrated mental health services in the ED setting:

- Resources
- Culture
- Process

Weakness in any one of these pillars will result in sub-optimal outcomes.

The three-legged stool (Figure 1) serves as a useful image in considering the dependence of effective ED mental health services on each pillar.

|| **Figure 1 - Pillars of effective ED Mental health services**



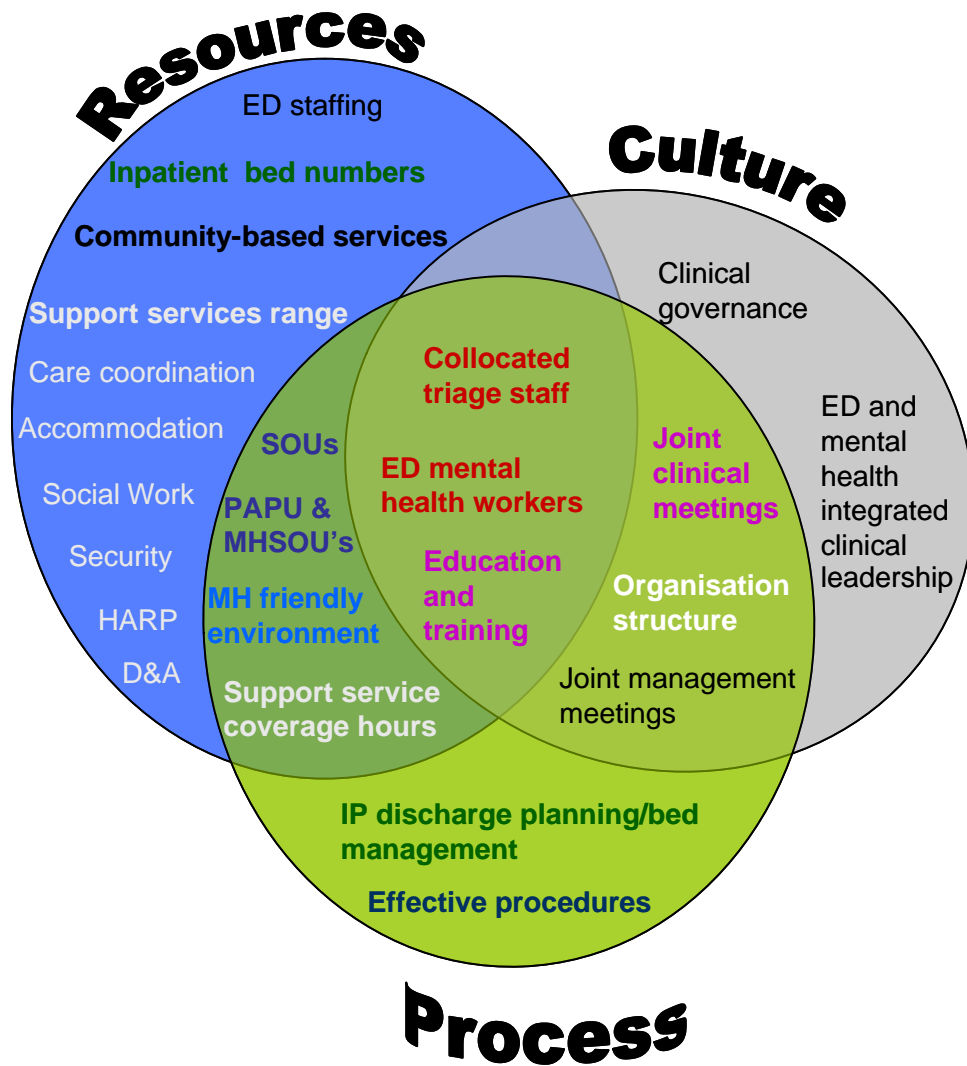
The initiatives that have been described in the Stage A report and that are making a difference, along with other elements considered to be important components of effective ED mental health services are shown within the context of the three pillars in Figure 2.

Key messages from this framework are:

- There are multiple drivers of effectiveness in the ED;
- The drivers are interrelated. For example, provision of education will be ineffective if staffing and infrastructure resources are inadequate and vice versa. Similarly, provision of support services will be ineffective if they are uncoordinated and/or staff are unaware of their availability or capabilities;
- An integrated model would involve using a case-by-case approach to address each of the three pillars and the drivers within each;
- Factors outside of the ED can impact on good practice, including availability of responsive community-based services and attention to patient flow throughout the hospital;
- Factors outside of the mental health service system can impact on good practice, including cultural expectations in other parts of the hospital; and
- Continued monitoring and evaluation of outcomes is essential.

Within this context, this report discusses examples of good practice and models of care and identifies themes and approaches that DHS needs to consider in developing policies and service specifications for the provision of mental health services in EDs.

Figure 2: A Framework for drivers of performance in mental health services in EDs



## 3.2 ED mental health workers

### 3.2.1 Introduction

While a number of titles are used for mental health clinical staff working in EDs and the individual clinicians carry out a number of different roles, “*ED mental health workers*” is used here as the generic title.

There was strong support among the sample Health Services for the role(s) of mental health workers in the ED, on the basis that their introduction has made a significant contribution to improved performance against key indicators as well as improving both culture and process.

A recent literature review of initiatives to improve mental health services in EDs has identified the key principle for ED mental health workers’ role is that it should “provide direct clinical care to people with mental health and other health problems amenable to psychological intervention, and ... provide and enhance the quality of psychosocial care by working collaboratively with non-mental health colleagues. The core ... activities are mental health promotion, consultation, education, research, supervision and support.”[i]

The approaches taken at the ten sample sites vary significantly. The titles/roles of staff providing ED mental health workers include:

- Enhanced Crisis Assessment and Treatment Team (ECATT);
- Crisis Assessment and Treatment Team (CATT);
- Consultation and Liaison;
- Care Coordination; and
- Education.

However, in broad terms, the roles fall into two main groups:

- **Extension of CATT.** In these cases, the clinical roles are similar to CATT, including triage and risk assessment, bio-psychosocial assessment and crisis intervention and management. Where this approach is used, the clinician forms part of the broader CAT team. In some cases, the clinicians work in the ED on rotation as part of their CATT role, while in other health services, ED mental health workers have a permanent appointment to the ED. Typically, under this model, clinicians are rostered to work across extended hours including evenings, weekends and in some cases nights.

This approach focuses more on the “resources” leg of the three-legged stool.

- **Liaison function.** Other Health Services have prioritised the liaison function. This approach involves supporting the system to help the individual, but does

not support the individual directly. These clinicians provide education and support for ED clinicians, coordinate patient access to inpatient units and/or other services if required and are more likely to be on permanent appointment to the ED. Under this model, resources are often concentrated into morning shifts during Monday to Friday, that is, during the times when most other Units and Departments are fully-staffed.

This approach focuses more on the “process” leg of the three-legged stool and involves longer lead times to effect change.

Irrespective of the approach, ED mental health workers generally undertake the following roles:

- **Triage tool.** Support ED staff to apply the mental health triage tool and to make effective triage decisions.
- **Education and support.** Participate in regular or semi-regular meetings with ED and other clinical staff in order to discuss processes and/or clinical cases. This contributes particularly to the “culture” leg of the three-legged stool.
- **Bed coordination.** In some cases, act as bed managers and in others, participate in and contribute to bed management processes which may be managed by Mental Health Triage or by central hospital bed management groups.

### 3.2.2 Co-located triage staff

In many of the sample EDs, mental health triage staff are also co-located in the ED either permanently or overnight and on weekends. Two reasons are given for this co-location:

- As the ED operates all hours, it is a more secure environment for the Mental Health Triage staff, who would otherwise be working alone in isolated facilities; and
- The Mental Health Triage staff can provide support for other ED mental health workers, or provide mental health liaison services if no other mental health staff are rostered overnight.

However, co-located Mental Health Triage staff cannot be expected to effectively fulfil the role usually played by the ED mental health workers. In general, Mental Health Triage staff are required to prioritise their telephone service and, especially overnight, could spend long periods of time responding to the needs of callers.

### **3.2.3 Nurse practitioners**

Wand and White [i] report that some Health Services in Australia are now considering creating Mental Health Nurse Practitioner roles in their EDs. It is expected the development of the Nurse Practitioner role will provide more options for people presenting with mental health crises. However, they point out that the introduction of such a role cannot be successful if it does not include extensive consultation, nor if the role is seen as providing an alternative to psychiatric medicine. Of the sample Health Services, only The Alfred Hospital reported that it is intending to introduce this role (from February 2008). Amongst the people consulted, there are varying opinions about the efficacy of this approach. Some argue a Nurse Practitioner would represent an over-resource to the ED and would conflict with the legitimate roles of the ED physicians and nurses. In addition, it has been suggested that the empowerment of ED mental health workers is already so broad that there is little additional scope for a Nurse Practitioner. However, others believe the role would provide an effective option for some patients with complex needs and would further enhance the liaison role.

### **3.2.4 Staff mix**

Different approaches exist to the recruitment and deployment of ED mental health workers. In some cases, priority is given to the recruitment of nurses while other Health Services recruit across the spectrum of allied health professionals. Some respondents felt nurses would respond best to the clinical demands of the ED environment, while other respondents valued the range of skills brought by other allied health professionals.

### **3.2.5 Permanent and rotating staff**

A number of EDs have developed staffing models where ED mental health workers are rostered permanently in the ED. The advantage of this approach was reported to be the development of positive working relationships between ED staff and ED mental health workers.

However, others prefer to roster their ED mental health workers on rotation from the CAT team. This approach was based on the need to provide staff with a variety of experience and to ensure that the capabilities and challenges of the community-based mental health services are effectively communicated within the ED setting. This model would support the greater adoption of in-reach capacity in the CAT teams, particularly if a model were adopted where CAT team members were expected to meet the needs of people in the ED as well as in the community.

## Discussion

ED mental health workers are making, and have the potential to make further improvements in the quality of mental health services in EDs and represent a response across all three legs of the three-legged stool:

- *Resources*: the ED mental health workers represent a valued resource in the ED;
- *Process*: the ED mental health workers have been able to establish appropriate processes for EDs, including participation in mental health bed management processes and supporting EDs to effectively refer to community-based services;
- *Culture*: through their educational role and their capacity to communicate across the mental health service system and the ED system, they contribute to greater understanding and respect.

It is apparent that there have been various levels of success in integrating mental health services into EDs. In some, a divide remains between mental health and ED staff, processes and approach, while in others there is a stronger shared-care culture.

However, as drivers are inter-related, the three pillars targeted by the two broad approaches to the mental health workers role (CATT Extension and Liaison) will not be effective if the ED mental health workers are simply seen as resources, and unless the resources to manage mental health presentations are adequate. Equally, improving processes through the CATT Extension approach will not be as effective if cultural issues are not addressed.

To summarise, as Wand and White observe, ED mental health workers “provide the most promising means for raising mental health awareness and integrating mental health care with mainstream services .... (This) presents a cost-effective alternative that has transportability to most ED settings and enables timely access to expert mental health assessment, therapeutic intervention and coordination of care” [i].

### **Opportunity**

Improve the coverage and consistency of ED mental health workers across the system, addressing the fact that approaches to and extent of implementation vary considerably. However, it needs to be recognised that the presence of more ED mental health workers will not necessarily continue to provide benefits. One of the key roles of the ED mental health workers should be to promote improvement in the capacity of all clinicians within the ED to respond to the needs of mental health patients.

Ensure that the model adopted at each site addresses both process and culture pillars of effective ED mental health services.

Develop models of triage that support the effective involvement of the ED mental health workers. The ED triage process should not only address the urgency of the patient's needs, but also whether the primary response should be led by the ED clinicians or mental health clinicians.

### **3.3 PAPU (Psychiatric Assessment and Planning Units)**

The term PAPU is currently being used to describe two quite different models of care. For the purposes of this Report, we have adopted the term PAPU to apply to a unit where the goal is to stabilise patients and provide intensive initial management. It is expected about 80 per cent of patients would then be transferred to a mental health inpatient unit, following a length of stay in the PAPU of up to 48 hours.

The second model, which has been called a PAPU, is more appropriately described as a Mental Health Short-stay Observation Unit (MHSOU). This model is the psychiatric equivalent of a Short-stay Observation Unit, in that its role is to manage and observe the patient while organising appropriate referrals. It is expected about 80 per cent of patients would be discharged back to the community following a length of stay of up to 24 hours.

### 3.3.1 Psychiatric Assessment and Planning Unit (PAPU)

#### Overview

This model involves providing access to **ED-controlled beds** within the inpatient unit, focused principally on psychiatric care and staffed by mental health staff.

The client group for PAPUs is adults presenting with acute mental health problems who:

- Are agitated and distressed or at risk; and
- Are awaiting availability of a longer-term bed in an AIS at the same or another facility; or
- Are likely to achieve discharge to the community within 48 hours; and
- Are sufficiently medically stabilised.

The purpose is to provide:

- Extra (short term) mental health beds for disturbed patients where management within the ED environment is difficult;
- Capacity for the ED to access inpatient psychiatric beds as required;
- Intensive psychiatric assessment, care and treatment planning over a short period (<48 hours);
- Reduced use of restraint in the ED;
- A better ED environment for non psychiatric patients by reduced exposure to agitated behaviours and reducing risks presented by these behaviours; and
- A care path back to community or to inpatient care where required.

Potential issues for this model include:

- *Access:* Control of beds by the ED is necessary to ensure that they are not occupied for long periods by patients on long term admissions or allocated to patients transferred from agencies.
- *Bed utilisation:* Access to beds in the PAPU must be maintained in order for the model to be effective. This may lead to concerns about under-utilisation when beds in the AIS or at other agencies are under pressure.

There may be no value in the PAPU in agencies that do not experience waits in ED due to non-availability of AIS beds.

- *Bed management:* The model avoids the need to address AIS bed management practices. Further, by providing ED-controlled AIS beds, it avoids the need for ED and mental health to take joint ownership of patient flow issues.
- *Drug and alcohol:* The model does not provide an area for the management of people presenting the effects of drugs and/or alcohol.

### Discussion

A PAPU has been operating at RMH since January 2007.

A similar model has also recently been opened at Werribee.

Whereas the AIS beds at RMH are for patients residing in the catchment area of Melbourne and Moonee Ponds, the PAPU beds are for:

- Patients presenting to the RMH ED who require admission to other hospitals in the North West Area Mental Health Service and where no bed is available; and
- Inner West Area Mental Health Service community patients who would otherwise be sent to the RMH ED if there were no RMH acute bed available.

The RMH initiative was prompted by data showing that mental health patients make up a significant proportion of those waiting longer than 24 hours in ED. It aimed to "reduce waiting time ... (and) provide a better standard of care for psychiatric patients, in a more appropriate and therapeutic environment ..." In addition it was envisaged that it "may reduce the need for mechanical restraint and parenteral sedation and decrease the overall length of admission" [ii].

While the beds are managed by the mental health service, they are effectively funded via the ED budget by DHS.

RMH aims to have less than 100 per cent occupancy at any time to ensure that there is always access to beds.

It was anticipated that 48 hours would permit repatriation of "out of area" clients to their home units and reduce waiting times in ED while waiting for RMH AIS beds. [ii]

RMH reports in its evaluation that there have been a number of improvements in performance including:

- No mental health patients waiting in ED longer than 24 hours between January and August 2007;

- A reduction in the number of mental health patients waiting eight hours and 12 hours;
- A reduction in the number of mental health patients presenting to the ED (due to an increase in the number of direct admissions to the AIS);
- Reduced use of Specialising in the ED;
- Reduced use of mechanical restraint in the ED; and
- A reduction in “code greys” in the ED, accompanied by an increase in the number in the AIS.

In summarising the outcomes of the introduction of the PAPU, the Report states:

*“... the reduction in mechanical restraint and code greys in ED is a marker of a more humane and potentially less traumatic experience for psychiatric patients during their stay in ED. As well as this, mental health patients are now transferred out of the chaotic environment of the ED more quickly, as a result of PAPU, which is also likely to contribute to their perception of a more therapeutic experience of psychiatric care in the Royal Melbourne Hospital.*

*In the months since this initiative has been fully operational, we have learned that a unit such as PAPU can assist with the safe and timely management of mental health patients presenting to ED and provide patients and their families with a more specialised and therapeutic environment to begin the episode of care.*

*With the greater throughput of patients in the (AIS), there has been a greater demand on medical and nursing staff, including greater admission and discharge paperwork, transfers back to out-of-area beds and a more admissions overnight. While we have not directly measured this in this evaluation, there have been a greater number of Riskman incident reports regarding overdue discharge summaries, medication errors and lost patient property.*

*While processes have been established to address these issues, there is potentially greater scope for resources to match the increased workload in any funding revision.”*  
[ii]

RMH has indicated that ideally, PAPU beds would be located within or adjacent to the ED – in other words, what we have called a MHSOU. However, this would necessarily involve a change of focus and approach. The current PAPU beds are “virtual” and a high proportion of PAPU admissions are subsequently admitted to the AIS. By contrast, the MHSOU approach appears to be more oriented towards those who are less likely to be admitted and who require more effective management in an ED-like environment.

RMH has also noted that there is one group whose needs remain problematic in the ED despite the availability of the PAPU - high-risk patients who are severely affected by drugs or alcohol. These patients cannot be transferred to the inpatient unit or the PAPU as they require medical management and are not admitted to a medical ward as this is not considered an appropriate setting for effective management. This is a group that would be more effectively managed in a MHSOU or in an appropriately structured medical Short Stay Unit.

It is also noted that the benefits and appropriateness of PAPUs are not universally accepted or at least understood. Some other hospitals have suggested that improved access to inpatient beds can be achieved through better discharge management rather than the allocation of beds to the ED.

Concern was also expressed that these beds may remain vacant while units and EDs in other parts of Melbourne are being refused access on the basis that there are no beds available. There was also a sense that other initiatives are regarded by many as more basic than the development of PAPUs. These include:

- Ensuring that the availability of AIS beds is adequate for the population;
- Ensuring bed management is coordinated across sites where required;
- Developing effective bed management practices to ensure that timely admission is available to those requiring inpatient care; and
- Ensuring that services in the community are effective in minimising the need for emergency mental health care.

However, in response, it is noted that:

- Some of the benefits cited by RMH relate to the nature and quality of care rather than the issue of bed access alone. In the absence of space to develop more appropriate facilities in the ED, the PAPU does provide a more appropriate environment more quickly for a particular cohort of patients.
- The PAPU beds at RMH are funded through the acute rather than the mental health program.

### 3.3.2 Mental health short-stay observation unit – MHSOU

#### Overview

This model provides an area for short term **shared medical and psychiatric care** located within or close to the ED and staffed by ED and mental health staff.

The **target client group** is adults presenting with acute mental health problems and/or the effects of drugs and/or alcohol who:

- May be placed at increased risk by longer admission to an AIS;
- Are agitated and distressed, at risk of self-harm or who are at risk medically and psychiatrically;
- Are not medically stabilised sufficiently to allow transfer to community based care or to an acute psychiatric ward; and
- Are likely to achieve discharge to the community within 24-48 hours.

The **purpose** is to provide:

- An appropriate area and staff mix to manage this group of patients;
- Intensive shared psychiatric and medical assessment, care and treatment planning;
- Shorter lengths of stay;
- Reduced use of restraint in the ED;
- A care path back to community or to inpatient care where required, following stabilisation of medical issues;
- Processes to minimise inappropriate admissions to the AIS;
- A better ED environment for non psychiatric patients by reduced exposure to people with agitated behaviours and the risks presented by these behaviours; and
- Reduced demand on acute medical beds.

**Potential issues** include:

- *Staffing:* ED staff may not be confident to nurse in the model and it may therefore be difficult to find suitable staff or it may be necessary to rotate ED staff on a regular basis.

- *Segregation:* There is a question as to whether patients in this group should be managed in a medical short-stay observation unit rather than in a separately designated area for mental health patients.
- *Need:* Other approaches to reducing long stays in ED have been effective in a number of instances, potentially obviating the need for a MHSOU.
- *Utilisation:* Many EDs do not have the number of presentations required to maintain effective utilisation of such a unit, particularly given the impact of other approaches to management of mental health patients.
- *Management:* Consideration would need to be given to whether the unit should be managed by mental health staff or by the ED.

## Discussion

Models of this type are only beginning to be developed. They would be oriented to those expected to be discharged, as opposed to PAPUs, which are oriented to those expected to be admitted or who require intensive treatment over a period of up to 48 hours.

Implementation of a unit at Dandenong is in its early stages and an expression of interest from Frankston Hospital has been received.

The MHSOU model may be regarded as an extension of current ED services for mental health patients, but with the provision of more segregated facilities. It could be staffed in a number of ways. Firstly it could be structured on a similar basis to the ED – that is with ED staff, supported by ED mental health workers.

A second approach (suggested and preferred by Peninsula Health) is a shared unit between Psychiatry, ED and Medicine to include management of patients who present with delirium and overdose as well as those with other behaviours of concern.

Thirdly, at the extreme end of the MHSOU model is what is described in the literature as a Psychiatric Emergency Care Centre (PECC). These are specialised, separate emergency centres dealing exclusively with mental health. While there are currently no examples in Victoria, the Mental Health Council of Australia has questioned their effectiveness and value following the establishment of PECCs in NSW and Queensland, stating that:

- *Their creation continues the stigmatisation of people with mental illness;*
- *They are not an efficient use of resources relative to community-based services. Forty percent of AIS beds are occupied by consumers who do not need acute care services but cannot be discharged because the community (step down and recovery) services do not exist.*

- *By creating a separate entry point, they miss an opportunity for integrated care and are therefore a diversion from mainstreaming within health services; and*
- *They are a simplistic measure to ease access-block with no clear evidence-based model of care [iii].*

Wand and White [i] note that there is considerable variation in the organisation and structure of PECC services in North America, with 64 per cent delivering ‘freestanding, parallel’ care and the remainder providing integrated, but different, models. They also note that the suitability of PECCs is limited to larger hospitals due to the high cost and the high number of mental health presentations required to make them viable.

The implementation of PECCs in Victoria would therefore require a greater concentration of psychiatric emergency services in a smaller number of centres. This is not supported.

### **Opportunity**

The RMH experience indicates that the PAPU model offers significant opportunities to improve performance across a range of measures. There is interest in the concept from a number of EDs, but not from others. This may stem from the use of the term to describe two quite different models.

The MHSOU model has the potential to more effectively deal with a group of patients whose needs are currently not well managed – those who require treatment/observation, who are unlikely to require inpatient admission, but who present with disturbed behaviour.

Consideration of the impact of this model outside its immediate catchment would be valuable.

## **3.4 Mental Health friendly environment (ED facilities)**

EDs require specific facilities to meet the needs of patients with mental health issues. It will be important to incorporate design elements required for effective provision of mental health services into future capital works programs for EDs [iv].

Facilities should be structured to:

- Protect the privacy and dignity of people with mental health issues in ED; and
- Protect the security of staff and patients.

These objectives are essential to the integration of mental health services into mainstream emergency care and should not be regarded as mutually exclusive. Facilities to meet these objectives may include:

- Interview rooms with appropriate access/egress and fixtures/fittings;
- A behaviour assessment or safe room;
- Ensuring medical short-stay observation units are suitable for management of a range of patients including those with behavioural or other issues;
- Discrete or passive approaches to security;
- Addressing line of sight, egress and access issues for patient management and monitoring; and
- A lounge area for people awaiting a community-based response.

### **Discussion**

Design features to support provision of mental health services are not always available in existing facilities and some EDs have developed strategies to meet their needs, using staff offices, meeting rooms, relatives' lounges and other spaces for interviewing people presenting with mental health issues. Those waiting for assessment are often placed in resuscitation cubicles as these are generally closest to the ED nurse station, but there is competition for these spaces. Not all EDs have quiet spaces or seclusion rooms for mental health patients who needed to be calmed.

As growth in ED workloads generally places pressure on facilities and resources and as mental health represents only a minority of ED presentations, the capacity to allocate additional space to mental health within most facilities is limited.

Flexibility to meet the needs of diverse groups including and within the mental health cohort is essential and a range of facilities including general cubicles, short stay units, fast track areas, safe rooms, behaviour assessment rooms, interview rooms etc are required.

### **Opportunity**

Review existing EDs to ensure that they have specific mental health or multi-purpose facilities to meet the needs of mental health patients, taking into account the fact that the viability and relevance of specific facilities will vary by location depending on patient numbers, available space and resources.

Ensure that ED developments in the future make specific provision for the delivery of mental health services.

### 3.5 ED short-stay observation units

In 2001 a number of new observation medicine models were established across Victoria through the Hospital Demand Management Strategy (HDMS). As part of this strategy, Short Stay Observation Units (SOUs) were opened to manage patients likely to be discharged within 24 hours [v]. SOUs are extensions of EDs and enable better diagnosis, thereby reducing costs and inappropriate admissions and discharges [vi].

However, the consultation process for this project indicated that:

- Some EDs have no SOU;
- In others the capacity of the SOUs to meet the needs of mental health patients is limited due to location, fit-out, layout or resourcing; and
- Some staff have had “bad experiences” in the past and are wary about placing patients with potentially aggressive or challenging behaviours in that environment.

Within a model of integrated medical and mental health services in EDs, SOUs would ideally be available for those patients who require medical management, while at the same time being able to deal with issues arising from mental health and/or drug and alcohol issues.

#### **Discussion**

Within a model of integrated medical and mental health services in EDs, SOUs would ideally be available for those patients who require medical management, while at the same time being able to deal with issues arising from mental health and/or drug and alcohol issues.

However, it also needs to be recognised that mental health patients represent only a small proportion of the throughput of SOUs and the primary design driver will be to meet the requirements of medical patients.

It should also be noted that mental health-friendly SOUs will not be required where an ED-collocated PAPU is in operation.

#### **Opportunity**

Review the effectiveness of existing SOUs and opportunities to re-structure them to manage mental health patients.

Ensure that where possible, SOU developments in the future make specific provision for the delivery of mental health services by paying attention to fit-out and layout. In particular, these units would need to be designed so that staff can maintain a line of sight to cubicles where mental health patients are placed.

## 3.6 Education and training

Education and training is one component in building staff knowledge, skills and confidence in the management of mental health presentations in EDs. This may be provided via the liaison role and through other informal and formal mechanisms.

Approaches include:

- Regular case review/clinical meetings involving ED and mental health staff as well as those involved in support and related capacities. The effective implementation of this approach takes some years to achieve and requires a high level of commitment, staff engagement and effective leadership from both ED and mental health;
- Participation of ED mental health workers in ED departmental meetings and shift handovers;
- Inclusion of a mental health placement in rotations for ED registrars;
- Aggression management training for ED staff in the first instance and for all hospital staff over time;
- Ongoing support and education provided by ED mental health workers to ED staff;
- Ongoing support and education provided by other relevant staff to ED and mental health staff, particularly in relation to management of drug and alcohol issues;
- Education of AIS managers in effective bed management and discharge planning; and
- Education of the broader service system including ambulance, police, psychologists and GPs in the management of mental health issues and the role of the ED.

### Discussion

While not underestimating the importance of this educative role, the opportunity in relation to the increasing and more effective deployment of ED mental health workers is probably the most important element in improving education and empowerment among ED staff.

## 3.7 Access to inpatient beds

### 3.7.1 Inpatient discharge planning/bed management

Strong feedback has been provided about the impact of improving access to inpatient beds. For example, RMH has reported that "greater bed availability on the inpatient units across North Western Mental Health has come about through the Access Improvement Project, which became fully operational in May 2007" [ii]. Similar feedback was received at other agencies, underscoring the view that effective discharge planning and bed management are critical to reducing waiting times in EDs.

These strategies are reported to have had a significant impact, although their effectiveness also needs to be considered in the context of:

- The impact on patients and whether community-based services are effectively supporting those who have been discharged;
- The overall availability of beds; and
- Their relatively recent introduction.

These initiatives fall into two main categories:

- Improved discharge planning and target-setting for AISs; and
- Improved bed management.

The first approach is widespread and generally involves setting explicit discharge targets, sometimes daily or in anticipation of weekends. Improved bed availability is reported to have resulted in increased rates of admission to AIS beds direct from the community rather than via ED and to decreases in ED length of stay.

The second category of initiatives relates particularly to the question of who controls access to and coordination of AIS beds. For example, the management of beds across the three AIS units within Southern Health is treated as a single resource and is managed by ECATT. At many other sites such as The Alfred, Latrobe Regional Hospital and Maroondah Hospital, beds are managed by mental health triage. This approach is said to allow for one arm of the service to assemble information from the community clinics, CATT, ED and the Units about bed movements.

Another approach to the bed management issue is to split beds between those controlled by mental health and those controlled by ED – a feature of the PAPU.

### 3.7.2 Inpatient bed numbers

While this project has not examined the issue of the availability of AIS beds in each area, it needs to be recognised that this is a factor that impacts significantly on the

provision of services to mental health patients in EDs. Among the 10 sample EDs included in this project, AIS beds per 10,000 population vary from ~1.36 to ~2.78. These are significant differences and indicate that improved discharge planning and bed management cannot be considered in isolation from overall bed availability.

### **Discussion**

The availability of inpatient beds has a significant impact on the ability of EDs to meet length of stay targets and to ensure that patients are transferred to an appropriate level of care at the earliest opportunity.

Differences in the number of available beds relative to population undoubtedly have an impact. However, it is also clear that initiatives to improve bed management and discharge planning have made significant differences in a significant number of cases.

### **Opportunity**

There is a clear opportunity to ensure that effective discharge planning and target-setting practices are promoted throughout the system. Strategies should be put in place to ensure that active discharge planning does not result in inappropriate discharge.

The most effective approach to bed management is less clear, other than to say that a single point of entry and daily bed management meetings appear to be desirable features.

Monitoring of the number of AIS beds per 10,000 population will undoubtedly continue.

## **3.8 Support services**

A range of support services operates in the ED context, generally providing services to both mental health and other patients. These services include:

- Drug and alcohol services;
- The Hospital Admission Risk Program (HARP);
- Social work;
- Care coordination;

- Accommodation support; and
- Security.

A network of these services to deal with the multiplicity of issues presenting in the ED is important to effective management. However, the key issue for EDs is service availability. This varies across EDs, with the spread of days and hours meaning that capacity to meet the needs of patients in the ED is limited and does not always coincide with periods of peak demand.

Of the support services listed, access to drug and alcohol services and HARP are of particular importance.

### **3.8.1 Facilities for people affected by alcohol and other drugs**

Most EDs experience many presentations of people affected by alcohol and/or other drugs. Depending on the conscious state of the patient, several strategies are employed:

- Unconscious patients are admitted to an SOU or are placed in a cubicle and their condition monitored until they are sufficiently alert to participate in a mental health assessment. Some EDs experience such numbers of presentations that they believe the creation of a dedicated area for these patients would be warranted.
- Conscious patients are assessed and either admitted to a medical ward or AIS or discharged once they are sufficiently well.
- Patients who have become volatile as a result of their intoxication may be placed in a secure room or may be monitored and secured in a cubicle.

None of the sample group had dedicated roles for alcohol and other drugs clinicians, in the ED, but most reported having access to suitable clinical support and secondary consultation. Several reported they had limited options to refer patients to community-based services, although patients affected by alcohol and other drug addictions were usually able to access HARP-funded care coordinators.

The most important features of a suitable response to the needs of this group of patients include:

- Access to appropriate and safe facilities within the ED;
- ED nursing, medical and support staff who are informed and confident in relation to the management of drug and alcohol issues;
- Collaborative models of assessment;
- Availability of specialist advice and intervention when required; and

- Rapid follow-up with community-based or hospital-based services.

### 3.8.2 HARP

The availability of HARP funded programs to assist in managing ED mental health presentations is variable across sites. One ED reporting having no access to HARP-funded services.

The nature of HARP programs also varies. However, the focus of the psycho-social element of HARP is those clients who are “falling through the gaps” and as a result, those with existing mental health support are less likely to be recruited onto the program. Hours for HARP workers are also usually limited to 9.00 am to 5.00 pm weekdays, thereby limiting access.

However, the *ALERT in the ED* program at St Vincent’s operates on a 7 day per week basis, offering care coordination, referral, discharge planning and facilitation of appropriate accommodation options for recruited clients as well as advocacy for access to services. St Vincent’s reports that a recent study showed reductions in hospital utilisation, supporting the view that HARP–CDM interventions successfully reduce ED presentations, hospital admissions and length of stay in hospital.

#### **Discussion**

The availability of support services across the system is inconsistent in terms of location and in terms of day/hours of access. These services are not principally focussed on mental health and issues of service availability go well beyond the scope of this project.

There is no doubt that increasing hours of access and coverage would impact favourably, not only on mental health services, but on services generally.

However, this is an area where multiple providers have the potential to increase complexity.

#### **Opportunity**

As one of its key targets, the HARP program includes people with psychosocial support needs. In some instances, it appears EDs may have taken advantage of the ED mental health liaison role to reduce or de-emphasise the role of the HARP-funded services in responding to the needs of this group. Any review of the mental health model of care in EDs should include a strong consideration of the role of HARP services.

### 3.9 Effective procedures

There are many examples where procedures have been or could be improved to provide better outcomes for ED mental health patients. For example:

- Many Health Services have changed their processes and requirements around the need for “medical clearance” before mental health assessment or admission to an AIS bed;
- The use of the mental health triage tool has not been universally adopted, suggesting that there is a not complete agreement that it meets the needs of EDs or that some EDs are not implementing best practice;
- There remains division in some EDs about the “classification” or “ownership” of patients, with inappropriate referrals of those with delirium or Parkinson’s disease;
- Some EDs have implemented processes to manage patients in the ED in accordance with a standard inpatient care plan once the decision to admit has been made, potentially reducing inpatient length of stay;
- Many EDs have reduced the use of specialising by adopting better overall supervision models, or have reduced the involvement of security staff in the supervision of patients by developing a cohort of trained Division 2 nurses;
- The conduct of parallel rather than sequential assessments by medical and mental health staff is not universal, indicating further opportunities to improve processes and cooperation between mental health and ED staff;
- Alternative approaches to initial assessment have been implemented, with initial referral to ECATT where indicated, with a medical response ordered by ECATT if required;
- Increased focus on referral of patients back to the community (eg GPs) rather than seeking to meet the needs of all patients within the Health Service;
- Effectively utilising available IT resources such as CMI/ODS and electronic assessment where/when available; and
- The more effective use of and access to care plans.

#### Discussion

These are some of a range of changes or issues that have been identified. However, the application of systematic approaches to examining processes and process failures on a comprehensive basis are limited.

### **Opportunity**

Identify and fund approaches to enable Health Services to systematically map processes and identify process failures and opportunities to improve service design in a way that results in a detailed understanding of the drivers of best practice and their inter-relationships.

## **3.10 Community-based services**

It was generally reported that the capacity of the community-based service to respond to the needs of people with mental illness has a significant impact on the number of presentations to ED and can reduce length of stay by providing effective referral options.

Community-based mental health services have a key role in maintaining people in the community with effective management and care planning, establishing processes for appropriate referral to EDs when required, arranging direct admissions to inpatient beds rather than via EDs where possible and so on.

More effective education and resourcing of primary care services is also needed. Some EDs reported that some GPs have developed a practice of a routine referral to ED for any patient whose needs appear to be complex. However, the creation of new models of Medicare-funded allied health care in general practice may reduce this practice over time.

It has also been noted in some EDs that there may be increasing numbers of people presenting with high prevalence disorders (depression, anxiety etc), possibly indicating increased awareness and/or that primary care systems are not operating effectively to manage these conditions in the community.

Some options that may be available to increase the capacity of community-based services include:

- Implementation/expansion of sub-acute mental health services (Prevention and Recovery Care) that provide a diversionary service in a residential model;
- Increased support for GPs; and
- Changed work practices in community-based teams to support the provision of increased after-hours response including alternatives to CATT response.

### 3.11 Structure

Two elements of organisation structure were noted as impacting positively on ED mental health services:

- The fact that ED and Mental Health functions report to the same Executive Director at St Vincent's Health was seen to assist in addressing management issues across the two functions;
- The placement of drug and alcohol services under the mental health program was seen to be beneficial at Maroondah Hospital.

### 3.12 Resources

There were frequent references to the need for improved availability of psychiatrists or psychiatry registrars. These included proposals for:

- Increased resources for consultation and liaison psychiatry in order to better support ED medical staff and inpatient units so that discharge practices could be improved;
- Psychiatrist input on a timely basis during an ED stay, with availability leading to reduced delays in assessment and admission or disposition;
- 24x7 access to psychiatry registrars to enable patients being admitted to an AIS to be medically assessed.

In summary, comments were received at a number of sites that additional resources for psychiatrists and registrars would be welcomed, although it was recognised that this was an issue that goes well beyond consideration of ED mental health requirements.

### 3.13 Conclusion

Before considering initiatives in ED mental health individually, it is important to note that there are some important high level principles.

#### 3.13.1 Process review

The development of future approaches should be based on an improved understanding of the processes involved in providing mental health services in EDs. This project has provided some understanding of what is currently occurring, but was not intended to assess detailed processes, process failures, duplication and opportunities for improvement.

While it is recognised that mental health services are a small subset of service delivery in EDs, the complexity and multiple inputs required to deliver these services to a less than homogenous client group warrants a more detailed understanding and a more rigorous approach to process improvement.

It is also apparent that while there are elements of good practice evident throughout the system, there is no reference site where all of these components have been brought together in an integrated manner.

### **3.13.2 Distributed approach to emergency mental health**

It is assumed that Victoria will continue to provide emergency mental health services in a distributed rather than centralised manner. This means that a capacity to respond effectively to mental health presentations will be required of all EDs rather than focusing services in a small number of psychiatric emergency centres.

This will mean that the system must remain flexible and have the capacity to manage mental health presentations within a general ED context.

### **3.13.3 Critical mass**

There is a scale/critical mass issue involved in the applicability of some drivers of effective mental health services in EDs. Departments with a large number of mental health presentations undoubtedly warrant the provision of specialised staff and facilities whereas those in smaller facilities will not. As a result, approaches that may be applicable to a large Metropolitan hospital may not be applicable in a small regional setting.

For example, engagement of nurse practitioners and the establishment of PAPUs or other specialised ED mental health facilities will remain the province of large metropolitan health services. This means that smaller metropolitan and rural EDs must work to provide a more generalist, but nonetheless professional and empathetic response.

### **3.13.4 Assessing culture**

The adage that “if you can’t measure it, you can’t manage it” applies to the provision of mental health services in EDs. While anecdotal evidence suggests that there are differences between EDs in relation to the acceptance of the mental health service system among staff, there has been no attempt to objectively measure this or the impact of initiatives that have been implemented.

Therefore, in addition to moving forward armed with better and more detailed information about processes, tools to measure the impact of new initiatives on staff culture and attitude should be developed.

## 4 Improvements in practice

Objectives of this project included:

- Promoting a more effective, consistent and integrated model of mental health care in EDs;
- Planning for the further development of mental health care in EDs; and
- Developing recommendations on how DHS can promote a more effective, consistent and integrated model of ED mental health care.

Based on the discussion of examples of good practice and models of care in the previous section, consideration is now given to individual EDs and possible opportunities for improvement in practice. In doing so it is recognised that this project only visited 10 departments and that resource allocation decisions need to take into account the needs and performance of all EDs. It is therefore not proposed to consider each of the 10 EDs individually, but instead to make some observations about specific actions required to improve system performance.

However, it should be noted that there is some concern about “where to from here” because there is only a limited understanding of how the current system works, how it varies from ED to ED and only a limited understanding of the drivers of improved performance.

Therefore, as an over-riding qualifier, it should be stated that there is a need to ensure that funding and initiatives are not continually layered on each other without developing a clearer understanding of the core elements of the model of care for mental health services in the ED. A basic pre-requisite should therefore be detailed process re-design with a view to bringing together the various elements of good practice into an integrated model of care. This would be assisted by a clear understanding of the improved or sustained good performance at sites such as St Vincent’s, Royal Melbourne, and Dandenong.

Within this context it is submitted that the following short-term issues should be considered as priority issues:

- Review the availability of ED mental health workers and provide funding if necessary to ensure that they are available to all EDs with an appropriate critical mass of presentations;
- Investigate the substantial growth in the proportion of mental health presentations and increase in overall length of stay at Latrobe Regional Hospital;
- Investigate the unacceptable length of stay at Werribee Mercy Hospital which appears to be driven by a combination of factors including bed access;

- Audit SOUs and other ED facilities to determine the feasibility and cost of providing mental health friendly areas in those EDs where these are currently lacking;
- Address the inter-relationship between medical and psychiatric assessment and intervention in EDs to reduce blockages and delays;
- Encourage Health Services to improve the culture of collaboration between acute health and mental health services, particularly in the ED; and
- Establish common nomenclature within the system to enable more effective discussion and analysis of system structure and performance.

The following medium-term issues should be considered as priority issues:

- Review the implementation of the Nurse Practitioner model which is planned to be introduced at The Alfred Hospital to determine whether the model would be of value in EDs generally;
- Explore options to increase support by alcohol and drugs workers in those EDs that experience significant numbers of these presentations;
- Lead discussions across Health Services about the effectiveness of planned discharge strategies in reducing ED length of stay.
- Ensure that adequate data is collected on the use of restraint in EDs;
- Develop at least two MHSOUs in larger EDs, with ED staffing and specialist mental health support; and
- Develop a tool to measure ED mental health culture so that progress can be assessed over time and the impact of various initiatives measured.

In addition, the following may be considered on the basis that while they are not principally focussed on EDs, they do have an impact on patient flow through the ED:

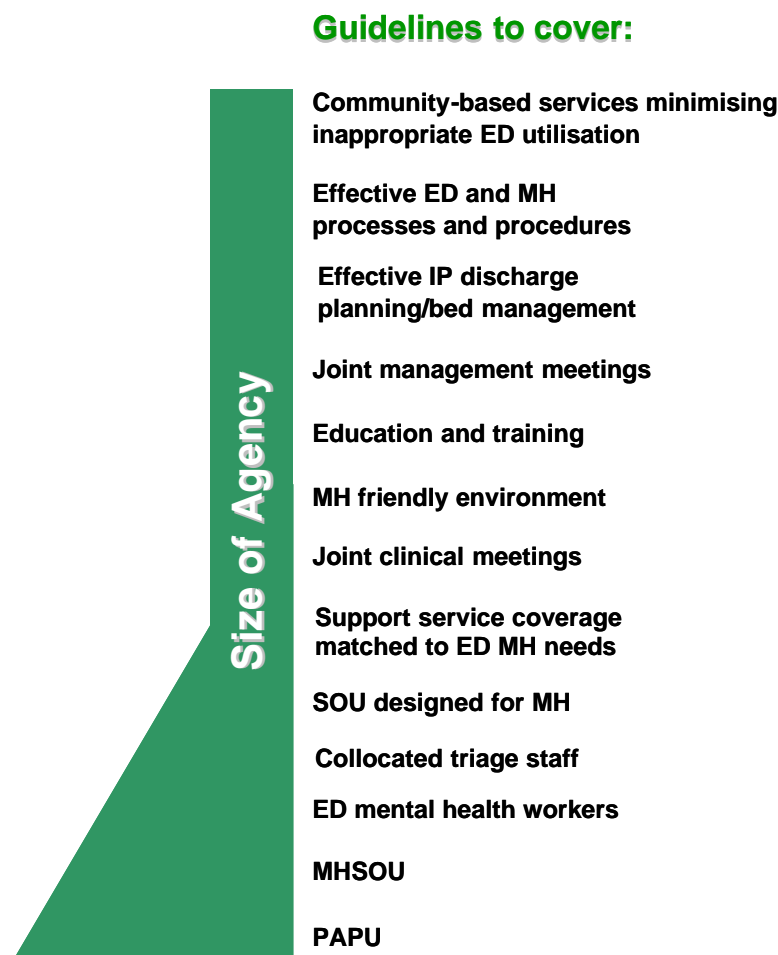
- The impact of available psychiatrist and registrar resources; and
- The variability in support services across EDs.

## 5 Guidelines for MH in EDs

This section identifies key factors or resources that DHS should consider in developing guidelines for the provision of mental health care in EDs.

DHS has already developed the document *Mental health care: Framework for emergency department services* to provide direction for delivery of emergency mental health care in Victoria's public hospital emergency departments (EDs). The development of future guidelines should be based on this document as well as the themes for good practice that have been described in Section 3.

Guidelines should incorporate the basic elements of practice that should be evident in all EDs, but should also recognise that there are some strategies that can only be deployed in larger EDs. The following figure illustrates the relationship between size of ED and practices/initiatives that could be incorporated into guidelines for the provision of mental health in EDs:



Guidelines should also recognise the various elements of the ED role in the provision of mental health services and the approaches that can be used to address the processes of screening, assessment, treatment and disposition. Examples are shown in the table on the next page. Again, these recognise that the three elements – resources, process and culture all need to be addressed in order to provide a best-practice model of care.

Finally, in relation to the development of guidelines, it needs to be reiterated that an improved understanding of the processes involved in providing mental health services in EDs is a prerequisite to developing best practice models and guidelines. This involves a more detailed understanding of processes, process failures, duplication and opportunities for improvement.

	<b>Screening</b>	<b>Assessment</b>	<b>Treatment</b>	<b>Disposition</b>
<b>Resources</b>	<ul style="list-style-type: none"> <li>■ Triage tool.</li> <li>■ Access to community-based referrals for diversion.</li> </ul>	<ul style="list-style-type: none"> <li>■ Consultation and liaison.</li> <li>■ MH clinician in ED.</li> <li>■ Interview rooms, time-out rooms, Safe Rooms, Behaviour Assessment Rooms.</li> <li>■ Drug and Alcohol.</li> </ul>	<ul style="list-style-type: none"> <li>■ MH clinician in ED.</li> <li>■ Short Stay Observation Unit</li> </ul>	<ul style="list-style-type: none"> <li>■ Care coordination.</li> <li>■ HARP</li> <li>■ Facilities for patients waiting for treatment / discharge / admission (PAPU?).</li> <li>■ Accommodation support.</li> <li>■ Care Coordination.</li> <li>■ Social Work.</li> </ul>
<b>Processes</b>	<ul style="list-style-type: none"> <li>■ Care plans.</li> <li>■ Waiting room management.</li> <li>■ Effective mental health triage.</li> </ul>	<ul style="list-style-type: none"> <li>■ Consultation and liaison approach.</li> <li>■ Multidisciplinary teams.</li> <li>■ Clarification of role of medical assessment / "medical clearance".</li> <li>■ Restraint minimisation.</li> </ul>	<ul style="list-style-type: none"> <li>■ Multidisciplinary teams.</li> </ul>	<ul style="list-style-type: none"> <li>■ Bed management tools and protocols.</li> <li>■ Active discharge strategies from inpatient units.</li> <li>■ Active case management by community-based teams.</li> <li>■ Dedicated Division 2 nurses for "specialling".</li> </ul>

	<b>Screening</b>	<b>Assessment</b>	<b>Treatment</b>	<b>Disposition</b>
<b>Culture</b>	<ul style="list-style-type: none"> <li>■ Education for triage staff.</li> <li>■ Shared triage decisions-making processes.</li> <li>■ Shared understanding about what is a "mental health presentation".</li> </ul>	<ul style="list-style-type: none"> <li>■ Mutual acceptance of different goals of ED service and MH service - ED is point-in-time-and-place while MH is continuum of care.</li> </ul>	<ul style="list-style-type: none"> <li>■ Shared responsibility</li> </ul>	<ul style="list-style-type: none"> <li>■ Shared commitment to best outcome.</li> <li>■ Role clarity.</li> <li>■ Shared commitment to privacy and dignity for people with mental illness.</li> </ul>

## References

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  - ii PAPU Evaluation, Melbourne Health, August 2007
  - iii Mendoza J. Psychiatric emergency care centres (PECCs): show me the evidence! Mental Health Council of Australia newsletter. Canberra: Mental Health Council of Australia, June 2006
  - iv The Australian College for Emergency Medicine's Emergency Department Design Guidelines provide some information in this regard at:  
[http://www.medeserv.com.au/acem/open/documents/ed\\_design.htm](http://www.medeserv.com.au/acem/open/documents/ed_design.htm)
  - v Department of Human Services , Statewide Emergency Program, New Models of Care, <http://www.health.vic.gov.au/emergency/models.htm>
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