

**Working Group for Mental Health Care  
in Emergency Departments**

**Final Report and Recommendations**



# **Working Group for Mental Health Care in Emergency Departments**

**FINAL REPORT AND RECOMMENDATIONS**

**Centre for Mental Health  
May 1998**

**NSW HEALTH**

This report has been developed in response to an increasing awareness of the importance of Emergency Departments in delivering mental health care to the NSW community. It has been developed by the Working Group for Mental Health Care in Emergency Departments in conjunction with the Centre for Mental Health and the College of Emergency Medicine. This report has also been subject to wide consultation with Area Health Services and professional organisations.

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## **EXECUTIVE SUMMARY**

This Working Group was convened in response to an increasing awareness of the importance of Emergency Departments in delivering mental health care to the citizens of NSW, and concerns that systemic problems in the provision of Mental Health Services in Emergency Departments may result in sub-optimal mental health care. Particular concerns were identified in relation to assessment and management of patients with mental health problems, accessing appropriate Mental Health Services, co-ordination with other agencies and ensuring appropriate education and training for Emergency Department and Mental Health staff.

At the same time as these problems are identified, and steps taken to rectify them, it is important to acknowledge that overall the Emergency Departments and Mental Health Services in NSW are providing quality services under often difficult conditions.

The recommendations made by the Working Group are predicated on there being spirit of co-operation between Emergency Department and Mental Health Services, and on action being taken at a local level to implement the recommendations in order to provide a coordinated, effective and accessible Mental Health Service to the citizens of NSW.

The recommendations have been divided into two sections, according to whether responsibility for acting on the recommendations lies primarily with the NSW Department of Health or with the NSW Area Health Services.

The recommendations broadly support the principles that

- All NSW Emergency Departments have 24 hour access to specialist Mental Health consultation, with a single point referral system and delineation of clear lines of responsibility.
- Improved co-ordination between Emergency Departments and Mental Health Services be a priority, with each Emergency Department and its attendant Mental Health Service developing a collaborative review process and memoranda of understanding.
- There be regular supervision and quality improvement of the Mental Health Services provided at the Emergency Department.
- Education programs be improved for staff, students, ancillary personnel and consumers to specifically target Mental Health Service provision in Emergency Departments.
- Emergency Department and Mental Health Services organise regular liaison at both a State and Area Health Service level with ancillary services such as ambulance and police.
- Emergency Departments develop triage guidelines which incorporate psychiatric illnesses.
- The development of a concise practical manual to aid in the management of common mental health problems relevant to Emergency Departments be supported.

## **TERMS OF REFERENCE**

### **General objective**

To explore current practice models for the triage, assessment and management of people with mental health problems and disorders presenting to Emergency Departments and to develop a set of guidelines to address this issue.

People with mental health problems and disorders presenting to Emergency Departments in NSW would be covered by such guidelines. This would include those people with mental health problems and disorders presenting with clear psychiatric symptoms and those who may present in other ways, for instance following a suicide attempt, but for whom psychiatric disorder is a potential and significant diagnosis.

### **Specific objectives**

1. To explore current practices in the triage, assessment and management (immediate and ongoing) of people with mental health problems and disorders presenting to Emergency Departments in NSW. Current staff training and data collection in relation to the issues outlined would also be considered. Local implementation of Policy Guidelines on Suicidal Behaviour - Key Assessment Criteria for NSW Health Area and District Staff, Circular 94/54, in Relation to Emergency Departments could also be reviewed.
2. To develop guidelines concerning the triage, assessment and management (immediate and ongoing) of people with mental health problems and disorders who present to Emergency Departments in NSW. The guidelines would be consistent with the literature of evidence-based practice and developed in consultation with key stakeholders. Where possible, operational models will be developed. The specific issue of suicide would be addressed.
3. Provide recommendations for the implementation, monitoring and review of such guidelines in NSW.

## **MEMBERSHIP**

### **Co-chairpersons**

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## **SUMMARY OF RECOMMENDATIONS**

The recommendations of the “Working Group for Mental Health Care in Emergency Departments” are in two sections. Section One consists of recommendations mainly applicable to the NSW Department of Health while Section Two consists of recommendations mainly applicable to Area Health Services.

### **SECTION ONE**

**The “Working Group for Mental Health Care in Emergency Departments” recommend to the NSW Department of Health:**

#### **SERVICE EVALUATION**

1. That evaluation of Mental Health Service provision in Emergency Departments be included in the annual review of Mental Health Services provided by NSW Hospitals (“section 237” assessments - formerly known as “301” assessments).
2. That a requirement that these recommendations be implemented by Areas be incorporated into Performance Agreements between NSW Health and Area Health Services.

#### **EDUCATION**

3. That resources be provided for the development of a concise practical manual relating to care provision for people with mental health problems presenting to Emergency Departments.
4. That the Centre for Mental Health revise the NSW Department of Health circular setting out guidelines for dealing with suicidal patients (circular 94/54).

#### **CONSULTATION**

5. That the final report of the ‘Working Group for Mental health Care in Emergency Departments’ be referred to all the other Mental Health Working Groups for consideration.

6. That formal central liaison be continued with the NSW Police Service and the NSW Ambulance Service in order to review and clarify relevant issues, including this report.
7. That the Centre for Mental Health liaise with the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian and New Zealand College of Mental Health Nurses and the Emergency Nurses Association regarding the establishment of a Working Group to review and address issues raised at a National level.
8. That the Centre for Mental Health liaise with the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian and New Zealand College of Mental Health Nurses, the Emergency Nurses Association and other key stakeholders to incorporate psychiatric conditions into Emergency Department triage scales.
9. That the NSW Department of Health should ensure that any building or refurbishment of Emergency Departments should involve consultation on design issues with local Mental Health Services and consumers, and reference to the relevant guidelines of the ACEM Standards sub-committee which has responsibility for Emergency Department design.
10. That the Centre for Mental Health liaise with tertiary educational institutions, clinical schools and the learned colleges to encourage the establishment of requirements that all undergraduate medical and nursing students and postgraduate trainees receive appropriate training in Emergency Department psychiatry. This may include the provision of a placement / attachment in an Emergency Department or a 24 hour community mental health service.
11. That the Centre for Mental Health consult with key stakeholders to examine how patients in Emergency Departments who have co-existing psychiatric illness and developmental delay can be better assessed and managed.
12. That the Centre for Mental Health consult with the NSW Department of Health Legal Branch concerning the role of security staff in restraining and detaining patients in Emergency Departments, and develop guidelines to aid Area Health Services in their use of security staff.
13. That the Centre for Mental Health consult with the Centre for Disease Prevention and Health Promotion to examine how patients in Emergency Departments with dual diagnosis can be better managed (dual diagnosis in this instance refers to patients with co-existing psychiatric illness and substance abuse / dependence).

## **RESEARCH**

14. That resources be made available to test the validity and reliability of the psychiatric illness triage guidelines developed in Recommendation 8.
15. That pilot project sites be established to research best practice models for the provision of Mental Health Services to patients presenting to Emergency Departments.
16. That a framework to monitor outcomes of patients presenting to Emergency Departments and requiring Mental Health Services be progressively developed.
17. That existing data collection systems in Emergency Departments be reviewed, and the development of a more accessible information system be facilitated.

## **AREAS OF SPECIAL NEED**

18. That recommendations arising out of other Working Groups relevant to the provision of Mental Health Services in Emergency Departments be linked into the recommendations of the Working Group for Mental Health Care in Emergency Departments.
19. That the mechanism for deploying resources to Area Health Services with rural responsibilities be investigated, with the aim of ensuring fairness and equity of access with regards to the provision of Mental Health Services in Emergency Departments
20. That consideration be given to re-allocation of resources to appropriate bodies with responsibilities for special groups (such as Aboriginal and Torres Strait Islander people or persons of NESB), to facilitate implementation of the recommendations of the Emergency Department Working Group and other relevant Working Groups for these populations.

## **SECTION TWO**

### **The “Working Group for Mental Health Care in Emergency Departments” recommend to NSW Area Health Services:**

#### **SERVICE ORGANISATION**

21. That the Area Health Service is responsible for ensuring that each Emergency Department within an Area Health Service has a clearly designated provider of specialised Mental Health Services for patients of all ages.
22. That Area Mental Health Services should develop internal memoranda of understanding among all of its components providing service to an Emergency Department, with the aim of clarifying and co-ordinating the roles and responsibilities of each component.
23. That there should be a single point of contact for all Mental Health Services to an Emergency Department, and ideally a “one phone call” referral system should be developed.
24. That the line of clinical responsibility for the specialised Mental Health Service consultation to the Emergency Department must be clear and accountable.
25. That where possible, designated Mental Health staff should be rostered to provide consultation to Emergency Departments, in order to foster a team working relationship.
26.
  - A. That access to data be improved so that an Emergency Department is able to identify if a presenting patient is a client of a mental health service (anywhere in the state).
  - B. That provision must be made for all medical and psychiatric records (of the hospital in which the Emergency Department is located) to be available to the Emergency Departments at all times, including after hours.
27. That Area Mental Health Services should develop memoranda of understanding with each Emergency Department to facilitate the provision of Mental Health Services to Emergency Departments and clarify issues of mutual concern.
28. That Mental Health Services should establish memoranda of understanding with drug and alcohol services to ensure patients in Emergency Departments with dual diagnoses are adequately managed.

## **SERVICE PROVISION**

29. That all Emergency Departments and NSW Health clinical facilities should have 24 hour access to specialist Mental Health consultation.
30. That all Rural NSW Emergency Departments should have access, at least by phone, to 24 hour specialist Mental Health Service consultation.
31. That in accordance with current practice regarding consultations requested from other specialties, a basic mental health assessment and examination should be performed by the Emergency Department clinician, prior to a specialist mental health consultation being sought.
32. That Mental Health Services will respond to Emergency Department consultation requests with equal clinical priority to other emergency requests.
33. That a psychiatrist should oversee Mental Health professionals involved in direct (or indirect) consultation to Emergency Departments.
34. A. That if a Mental Health professional has serious concern about the safety of a patient assessed in an Emergency Department, then that assessment should be discussed in formal consultation with a psychiatrist or psychiatric registrar who is attached to the Mental Health Service, to determine the appropriate clinical management.  
  
B. That if there is a disagreement between the Emergency Department clinician and the Mental Health professional about the safety of a patient, then that assessment should be discussed with a psychiatrist or psychiatric registrar who is attached to the Mental Health Service, prior to a proposed discharge of the patient.
35. That it is the responsibility of the Mental Health Service to ensure that any plan for psychiatric management of a patient, once it has been agreed with Emergency Department staff, is carried out.
36. That regular Mental Health Service liaison with Emergency Department staff should be a priority as part of the service to Emergency Departments.

## **POLICY AND PROTOCOLS**

37. That all patients presenting with a suicide attempt, or suspected of having attempted suicide, must receive assessment by specialised Mental Health Services.

38. That specific assessment, management and follow-up protocols must be developed for patients of Emergency Departments who have attempted suicide. These protocols should be consistent with the guidelines incorporated in Circular 98/31.
39. That specific assessment, management and follow-up protocols should be developed for patients who have psychiatric diagnoses which have specific relevance for Emergency Departments.
40. That follow up protocols be developed to maximise compliance with follow up arrangements.
41. That all Emergency Departments adopt triage guidelines for psychiatric conditions once such guidelines are available.
42. That when dealing with "Out of Area" patients, it is the responsibility of the Area Mental Health Service staff associated with the hospital at which the patient first presents to fully assess the patient and then arrange appropriate follow-up or admission as required.
43. That if admission is required, wherever possible it should be to a psychiatric unit within the "Area of Origin" of the patient; however this should not significantly delay proper management.
44. That an arranged psychiatric admission should usually be admitted directly to the inpatient admission facility, rather than being admitted via the Emergency Department.

## **REVIEW PROCESSES**

45. That a collaborative process should be established between each Emergency Department and its attendant Mental Health Service to regularly review the provision of Mental Health Services to the Emergency Department.
46. That any incident which involves adverse outcomes (or has the potential to cause adverse outcomes) for patients or staff associated with the provision of Mental Health Services in Emergency Departments must be reviewed.
47. That Mental Health Services should establish formal supervision and quality improvement programs to ensure regular monitoring of the services provided to Emergency Department.

## **EDUCATION AND TRAINING**

48. That specific training regarding the assessment, recognition and management of suicidal patients should be provided to all relevant Emergency Department and Mental Health Service staff.
49. That “in service” training concerning the management of difficult patients, common and significant psychiatric problems, “primary care” psychiatric assessment techniques and legal issues should be provided to all relevant Emergency Department and Mental Health Service staff.
50. That the assessment and management of psychiatric emergencies in the Emergency Department form part of intern training and orientation.
51. That the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of weekly training sessions mandated by the Postgraduate Medical Council for junior medical officers.
52. That the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of in service education provided to nursing staff by Staff Development Units (or equivalent).
53. That Emergency Department staff should be given specific training in the management of patients displaying violent and aggressive behaviour.
54. That Mental Health staff should be given training in issues which create specific problems for Emergency Departments, such as the assessment and management of patients who recurrently self-harm or have dual diagnoses, or those referred by police or magistrates for assessment.
55. That Security personnel should receive training concerning the roles they will be expected to perform when requested to assist in Emergency Departments.
56. That in conjunction with the Centre for Mental Health, targeted educational programs concerning issues related to mental health services in emergency departments be developed for each of: police and ambulance services, consumers, carers, and relevant NGOs. These educational programs should then be provided at a local level by Mental Health Services, in collaboration with Emergency Department Services, to each of: police and ambulance services, consumers, carers, and relevant NGOs.
57. That pamphlets and written information detailing locally available Mental Health Service resources should be available in Emergency Departments.
58. That written material providing information about common mental health problems should also be made available to consumers and carers in Emergency Departments.

## **CO-ORDINATION WITH OTHER AGENCIES**

59. That Area-wide and / or local committees, or other mechanisms, should be established to regularly review the interaction of police, ambulance, Mental Health and Emergency Departments.
60. That current policies concerning the transport of patients to and from Emergency Departments should be examined, with regard to optimising the role of each of the agencies involved in such transport (Mental Health Services, Ambulance and Police).
61. That memoranda of understanding between police, ambulance, Emergency Department and Mental Health Services be established at a local level to establish formalised agreement on issues of mutual concern.
62. That each Area Health Service and Hospital needs to clarify the roles "Security" staff will be expected to perform when requested to assist in emergency departments.

## **OTHER**

63. That provision should be made for the "debriefing" of staff involved in critical incidents such as having a patient suicide or dealing with violent patients.
64. That any building or refurbishment of Emergency Departments should involve consultation on design issues with local Mental Health Services and consumers, and reference to the relevant guidelines of the ACEM Standards sub-committee which has responsibility for Emergency Department design.

## **PREAMBLE**

The Mental Health Care in Emergency Departments Working Group was jointly chaired by Dr Paul Cunningham, Australasian College for Emergency Medicine, and Prof Beverley Raphael, Director Centre for Mental Health, NSW Department of Health. The Working Group met on seven occasions from July 1996 to June 1997.

The Mental Health Emergency Department Working Group arose out of recognition of the increasingly important role of Emergency Departments in providing care to people with Mental Health problems in NSW. Accompanying this recognition was the aim to improve the coordination of Mental Health and Emergency Department Services with the result of optimising the care for patients with mental health disorders. A preventable scenario is one in which a patient attending the Emergency Department has not been recognised as being suicidal, and subsequently commits suicide.

The Health Care Complaints Commission has supported the activities of the Working Group. On 7 November 1995, the Health Care Complaints Commission advised the Director-General of Health that the Commission was intending to hold a section 59 investigation in relation to the treatment of people with mental illness in public hospital Emergency Departments. The Director-General of Health advised the Commission that it would include the issues of concern to the Commission in the planned strategic review of Mental Health Services. As a result of the Department's response, the Commission, under section 60 of the Health Care Complaints Act, agreed that it would await the outcome of the review before it decided whether or not it would proceed to a section 59 investigation<sup>1</sup>.

The Emergency Department is increasingly becoming a major portal through which people with mental illness access the health system. Mental Health services and Emergency Departments have a joint responsibility to ensure that people presenting to Emergency Departments are adequately assessed and managed, and receive optimal follow up by the service most appropriate to best meet the needs of the patient.

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<sup>1</sup> Section 59 allows the Health Care Complaints Commission to investigate a complaint about the delivery of health services which arises out of a complaint or out of more than one complaint. The commission can investigate only after the Director-General of Health has been notified and given an opportunity to provide a report. Under section 62 and section 63 the Commission can report to the Minister and Parliament if the proposed actions by the Director-General are not sufficiently responsive to the concerns raised by the Commission.

## **Nature of the Problem**

Internationally there is an increasing trend for Emergency Departments to be used by patients with mental illness as a source of mental health care. It has been consistently shown that a substantial proportion of Emergency Department presentations have a psychiatric chief complaint, with estimates of the proportions varying between 0.6% and 10% of all presentations (1-6). Other reports estimate that up to 50% of patients presenting to Emergency Departments may have psychological problems which are contributing to their presenting complaint (2,7,8). It is also of note that 10-46% of patients presenting to Emergency Departments with a psychiatric complaint have a coexisting physical illness which may in turn contribute to their mental illness (7,9-11).

Common presentations to Emergency Departments include patients with depression, with or without somatic complaints, psychosis, disturbed behaviour, anxiety disorders, somatoform disorders, organic brain disorders, substance abuse, suicide attempts and other episodes of self harm. Psychiatric symptoms may be prominent, but often are masked, with the overt presentation being of a somatic complaint.

Sayer et al. (1996) analysed NSW Health data relating to episodes of self harm in NSW in 1992 (12). They reported that there were 741 suicides in NSW in 1992, with 53 of these deaths occurring in hospital. Over 3,000 patients were admitted to hospital after episodes of self harm in 1992, on a background of an estimated 4,600-9,000 Emergency Department presentations for self harm (admission was a stay of more than four hours in hospital). This compares with an estimated 400-1,200 attendances at general practitioners following self harm, and clearly demonstrates that the major port of call following self harm is Emergency Departments. The authors conclude that the "Emergency Department should be a major focus for interventions to reduce the risk of people making another [suicide] attempt".

There is no accurate way of estimating how many of those who committed suicide sought help at Emergency Departments, or of how effective even the best Emergency Department and Mental Health services may have been in preventing these suicides. Nonetheless the figures indicate that suicide is a very serious health problem in NSW, and that one of the main opportunities to "capture" those at risk is in Emergency Departments.

## **What problems have been identified in relation to people with mental health problems and disorders presenting to Emergency Departments?**

The Working Party sought to identify the most common difficulties encountered in providing care in Emergency Departments to people with mental health problems. The sources of information were a review of the literature, a postal survey of the NSW Area Health Services and the individual experiences of the members of the Working Party. A range of problems were identified, and these were superficially classified into those affecting patients, staff and others.

### *Problems experienced by patients*

- The most concerning problems are those of not recognising that a patient has a psychiatric illness, or not recognising the severity of the risk of self harm. This lack of recognition may occur at triage, during assessment by Emergency Department staff or even during assessment by specialised Mental Health staff.
- Conversely, coexisting physical illness may also be missed or ignored in patients presenting with psychiatric illness.
- Problems in management of the patients psychiatric illness.
- Difficulty in safely supervising patients with psychiatric illness (from leaving prior to assessment, absconding, self harming or harming others).
- Long waiting times.
- Difficulties in obtaining follow-up by Mental Health Services.
- Difficulties in maintaining privacy and confidentiality.
- Difficulties in readily accessing specialist Mental Health assessment.
- Difficulties in accessing out of hours Mental Health Service assessment.
- Difficulty in accessing Mental Health beds when needed.
- Difficulties in easily accessing Mental Health care when presenting “out of Area” (ie when attending an Emergency Department in an Area Health Service other than the Area Health Service covering their normal place of residence).

### *Problems experienced by staff include*

- Difficulties in appropriately triaging patients with mental health problems.
- Difficulties in recognising some forms of mental illness, the severity of the illness or the risk of self harm or harm to others.
- Difficulties in recognising that some physical presenting symptoms may be a result of mental illness, and vice versa.
- Difficulties dealing with disturbed or violent behaviour.
- Difficulties in dealing with patients who recurrently self harm.
- Difficulties in knowing how to access appropriate Mental Health Services.
- Difficulties in obtaining adequate and timely specialised Mental Health Service backup.
- Difficulties in organising appropriate follow-up to Mental Health Services.
- Difficulty in finding appropriate Mental Health inpatient beds, particularly for “out of Area” patients, and transferring patients when a bed is located.
- Logistical and legal problems associated with the need to keep patients overnight or longer in Emergency Department.

*Problems experienced by other service providers and relatives include:*

- Police may have to wait for long periods in Emergency Department while a patient is being assessed or awaiting transport.
- Ambulances may be subject to long waits while the transport of patients is coordinated with police.
- Family and friends may feel alienated or neglected by Emergency Department and Mental Health staff.

### **Suggested reasons contributing to these problems**

It is clear that the problems are multi-faceted and relate to the varying and complex needs of patients, staff, other service groups and carers. Areas which may contribute to these problems include the need for specific training and education, difficulties in coordination of services, resource and infrastructure limitations and, importantly, difficulties intrinsic to the management of some patients with psychiatric illness (such as unwillingness to accept help, disturbed behaviour or impaired judgement).

Specific identified issues include:

- The need for appropriate triage, including the importance of recognising the serious nature of the presentation. The lack of accepted standard triage guidelines for psychiatric illness contributes to this problem.
- The education and training of junior Emergency Department staff in dealing with psychiatric presentations, both at undergraduate and postgraduate levels.
- The design of physical facilities for assessing and observing patients with psychiatric illnesses in Emergency Departments.
- The utilisation of resources, overly busy and crowded Emergency Departments.
- Staff attitudes, particularly toward those who repeatedly self harm, and stigmatisation of patients with psychiatric illness.
- Coordination difficulties between Mental Health Services and Emergency Departments.
- Coordination difficulties between hospital-based and community-based Mental Health Services (this impacts on follow-up, and also accessibility to past psychiatric records).
- Coordination difficulties between Mental Health and drug and alcohol services.
- Difficulty in accessing patient's past psychiatric history, particularly if community and hospital Mental Health services are at separate locations, or it is an out of Area presentation.
- Pressure for ambulatory care related to a lack of available Mental Health and substance detoxification inpatient beds.
- Access to mental health resources generally (eg lack of public psychiatrists), or for specific groups (eg children and adolescents, the elderly, Aboriginal and Torres Strait Islander people, patients from non-English speaking background).

## RECOMMENDATIONS

The recommendations of the “Working Group for Mental Health Care in Emergency Departments” are in two sections. Section One consists of recommendations mainly applicable to the NSW Department of Health while Section Two consists of recommendations mainly applicable to Area Health Services.

### SECTION ONE

The “Working Group for Mental Health Care in Emergency Departments” recommend to the NSW Department of Health:

#### SERVICE EVALUATION

1. ***That evaluation of Mental Health Service provision in Emergency Departments be included in the annual review of Mental Health Services provided by NSW Hospitals (“section 237” assessments-formerly known as “301” assessments).*** These assessments will be incorporated into the annual report of the Centre for Mental Health to the Director-General of the NSW Department of Health.
2. ***That a requirement that these recommendations be implemented by Areas be incorporated into Performance Agreements between NSW Health and Area Health Services.*** This will require the development of service and performance indicators to be incorporated into CEO performance contracts.

#### EDUCATION

3. ***That resources be provided for the development of a concise practical manual relating to care provision for people with mental health problems presenting to Emergency Departments.*** The proposed manual will cover key mental health issues relevant to Emergency Departments, and while primarily aimed at inexperienced staff will hopefully prove a useful resource for all staff.
4. ***That the Centre for Mental Health revise the NSW Department of Health circular setting out guidelines for dealing with suicidal patients (circular 94/54).*** Circular 94/54 was released on 4 July 1994 by the NSW Department of Health, and detailed the responsibilities of NSW Health staff in relation to the management of suicidal and deliberate self harming behaviour. It is

currently being revised by the Health Department and will be released in mid 1998. The issue of dealing appropriately with suicidal patients is paramount to the provision of Mental Health Services in Emergency Departments, as the most common serious complaints in this respect relates to the suicide of patients who have absconded from an Emergency Department, or have recently attended an Emergency Department but not received effective intervention. (also see recommendations 37, 38 and 48)

## CONSULTATION

5. ***That the final report of the 'Working Group for Mental Health Care in Emergency Departments' be referred to all the other Mental Health Working Groups and relevant bodies for consideration.*** The Centre for Mental Health has convened a number of Working Groups and Task Forces in order to examine issues of relevance to the delivery of Mental Health Services in NSW. The report will also be referred to the Ministerial Health Care Quality Advisory Committee. It is hoped that the final report of the 'Working Group for Mental Health Care in Emergency Departments' will inform the deliberations of these other groups, and equally that relevant comments from these groups will be fed back to the 'Working Group for Mental Health Care in Emergency Departments' (also see Recommendation 18 and 20).
  
6. ***That formal central liaison be continued with the NSW Police Service and the NSW Ambulance Service in order to review and clarify relevant issues, including this report.*** There are considerable costs to Police and Ambulance services involved with the transport of patients with mental health problems and disorders to and from Emergency Departments, and the supervision of such patients in Emergency Departments. These services have expressed concern over perceptions of an increasing reliance on them to provide transport in the absence of a realistic threat to the safety of patients or staff, and where other means of transport would be more consistent with a "least restrictive care" philosophy. In order to foster and maintain a good working relationship it is essential that their assistance be sought only in appropriate circumstances. The Centre for Mental Health has established an ongoing group which will be meeting regularly with police services, ambulance services and a representative of the ACEM in an effort to address these and other problems centrally. However, it is clear that liaison with these services at a local level is also required, and it is hoped that local liaison efforts will be aided by this central liaison process (also see Recommendations 59, 60 and 61).

- 7. That the Centre for Mental Health liaise with the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian and New Zealand College of Mental Health Nurses and the Emergency Nurses Association regarding the establishment of a working Group to review and address issues raised at a National level.** As many of the issues canvassed by the Working Group are relevant to all states it is sensible to pool resources to minimise duplication of effort and ensure easy dissemination of innovative and effective responses. The development of a committee formally liaising between the ACEM and the RANZCP, with input from the Australian and New Zealand College of Mental Health Nurses and the Emergency Nurses Association, is supported by the Working Group to review and address these issues at a National level. It is hoped that this liaison will be actively pursued by the NSW Branches of the RANZCP and ACEM. The initiative of the ACEM in proposing a Joint Fellowship between the ACEM and RANZCP to travel overseas to review best practice in this area is supported (also see Recommendations 8, 14 and 63).
- 8. That the Centre for Mental Health liaise with the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian and New Zealand College of Mental Health Nurses, the Emergency Nurses Association and other key stakeholders to incorporate psychiatric conditions into Emergency Department triage scales.** This will necessitate the Centre for Mental Health liaising with the Australasian College for Emergency Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Australian and New Zealand College of Mental Health Nurses, the Emergency Nurses Association and other key stakeholders. The consensus of the Working Group is that appropriate triage of patients with psychiatric illness is vital to the provision of quality services to patients with mental disorders. However the absence of accepted guidelines and standards relating to psychiatric triage impedes the ability of the Working Group to recommend their application. Therefore the Working Group would like to foster the development of such guidelines by the appropriate bodies (also see Recommendations 14 and 41).
- 9. That the NSW Department of Health should ensure that any building or refurbishment of Emergency Departments should involve consultation on design issues with local Mental Health Services and consumers, and reference to the relevant guidelines of the ACEM Standards sub-committee which has responsibility for Emergency Department design.** Emergency Department environments are often crowded, noisy, busy and sometimes experienced as frightening places. These environments may therefore not be seen as ideal for providing mental health consultations. Psychiatric patients may currently have to be placed in rooms which do not afford good observation, or that may have fittings which enable the patient to

self harm. Prior to the construction or major refurbishment of any Emergency Department in NSW consideration must be given to the inclusion of features necessary to the provision of optimum mental health care. Issues of patient safety, staff safety, confidentiality, providing a sympathetic interview environment and rooms for relatives are among those that need to be taken into account. Features such as observation beds in easily supervised areas, interview rooms with safe exits for staff, duress alarms, quiet and private interview rooms and removable fixtures are suggested. In order to ensure that features necessary to optimise mental health care in emergency departments are consistently incorporated, it is vital that relevant guidelines are developed and referred to throughout NSW (also see recommendation 64)

- 10. *That the Centre for Mental Health liaise with tertiary educational institutions, clinical schools and the learned colleges to encourage the establishment of requirements that all undergraduate medical and nursing students and postgraduate trainees receive appropriate training in Emergency Department psychiatry. This may include the provision of a placement / attachment in an Emergency Department or a 24 hour community mental health service.*** The recognition, assessment and management of patients with psychiatric illness in the context of an Emergency Department setting requires specific skills which can best be acquired by coupling in-situ exposure with academic learning. Didactic teaching in the disciplines of both psychiatry and emergency medicine should specifically target Emergency Department psychiatric presentations and management. Ideally, the psychiatric aspects relevant to each clinical discipline should be emphasised during the whole of the undergraduate curriculum.
- 11. *That the Centre for Mental Health consult with key stakeholders to examine how patients in Emergency Departments who have co-existing psychiatric illness and developmental delay can be better assessed and managed.*** There is considerable concern about the potential for patients with developmental delay to receive less than optimal treatment. Some patients with co-existing psychiatric illness and developmental delay may require special understanding and interventions in Emergency Departments, particularly in the assessment and management of difficult and challenging behaviours. There is little opportunity presently in either mental health or Emergency Department training for gaining expertise in the management of problems common to this group, and thus it is necessary to call on the experience of interested parties to offer guidance. The Centre for Mental Health will consult with relevant groups to develop guidelines for the provision of Mental Health Services to persons with developmental delay, and will be asked to specifically consider the development of guidelines for managing these patients in emergency departments. Key stakeholders include will include representatives of consumers, carers, the Department of Community

Services, the “Intellectually Handicapped Special Interest Group” of the Royal Australian and New Zealand College of Psychiatrists (NSW Branch), the Professional Association of Nurses in Developmental Disability (PANDDA) and other relevant bodies.

**12. That the Centre for Mental Health consult with the NSW Department of Health Legal Branch concerning the role of security staff in restraining and detaining patients in Emergency Departments, and develop guidelines to aid Area Health Services in their use of security staff.**

Security staff are increasingly being used in all parts of hospitals, including the Emergency Department. They may be called upon to aid in the restraint or detention of patients, or to protect staff from patient assault. There exists some confusion among security staff, Mental Health staff, Emergency Department staff and carers alike as to the roles, responsibilities and restrictions of security staff, particularly in relation to the detention of patients. Clear agreement needs to be reached among all stakeholders concerning these matters, and legal advice will be needed to guide this agreement (also see Recommendations 55 and 62).

**13. That the Centre for Mental Health consult with the Centre for Disease Prevention and Health Promotion to examine how patients in Emergency Departments with dual diagnosis can be better managed (dual diagnosis in this instance refers to patients with co-existing psychiatric illness and substance abuse / dependence).**

There is considerable concern about the potential for patients with dual diagnosis to receive less than optimal treatment, in part because of the separation of Drug and Alcohol and Mental Health Services which may allow patients to “fall between the gaps”. As patients with dual diagnosis are frequently seen in Emergency Departments, it is important to ensure co-ordination of services in this arena. This matter will be referred to the Dual Diagnosis Project (“Management of people at risk of or affected by co-morbid substance abuse and mental health problems across the life span”) being jointly co-ordinated by the Centre for Mental Health and the Centre for Disease Prevention and Health Promotion (CDP&HP) (the CDP&HP incorporates the Drug and Alcohol Directorate<sup>2</sup>) (also see Recommendation 28).

## RESEARCH

**14. That resources be made available to develop and test the validity and reliability of psychiatric illness triage guidelines developed in Recommendation 8.**

It is the hope of the Working Group that psychiatric triage guidelines will prove effective in improving the quality of provision of

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<sup>2</sup> Now the Drug Programs Bureau.

Mental Health Service in Emergency Departments. However the Working Group understands that there are significant difficulties in assessing the utility of triage guidelines, and indeed the practice of triage itself, in general. In light of this it is imperative that any proposed psychiatric triage guidelines are subject to testing of their reliability, validity and efficacy. Ultimately inclusion of psychiatric items in the National Triage Scale is desirable. Specific funding has been allocated for a pilot project (also see Recommendations 8 and 41).

- 15. *That pilot project sites be established to research best practice models for the provision of Mental Health Services to patients presenting to Emergency Departments.*** It is important that research into ways of best providing Mental Health Services to Emergency Departments is encouraged. There are many areas which would reward investigation, such as finding means of improving the efficacy of interventions in Emergency Departments, of increasing compliance with follow-up appointments and of increasing the psychiatric diagnostic skills of Emergency Department staff. The work carried out in the Hunter region concerning the provision of joint toxicological and psychiatric services is one example of an innovative project which is commended. Specific funding should be allocated to establish pilot projects (13).
- 16. *That a framework to monitor outcomes of patients presenting to Emergency Departments and requiring Mental Health Services be progressively developed.*** Currently there is no systematic collection of data concerning the outcomes of patients seen in Emergency Department and requiring Mental Health Services. There is a need for systematic and appropriate data and reporting with regard to these issues. The Mental Health Evaluation Strategy of the Centre for Mental Health which is currently being developed will examine ways in which this task can be effectively accomplished (also see Recommendation 17).
- 17. *That existing data collection systems in Emergency Departments be reviewed, and the development of a more accessible information system be facilitated.*** There is an urgent need for more accurate information to be gathered concerning the volume and types of services being provided in Emergency Departments to people with mental health problems. The Emergency Department information system (EDIS) currently used in most Emergency Departments in NSW is unable to provide the desired information. The ideal information system should adequately capture data concerning the provision of services to patients with mental health problems, in addition to gathering data on all other groups of patients attending Emergency Departments. It is imperative that such a system only be developed following extensive consultation with Emergency Department staff and Mental Health staff, as unless there is acceptance, enthusiasm and accuracy from those who will actually enter the data, any such system will not be effective (also see Recommendation 16).

## AREAS OF SPECIAL NEED

- 18. *That recommendations arising out of other Working Groups relevant to the provision of Mental Health Services in Emergency Departments be linked into the recommendations of the Working Group for Mental Health Care in Emergency Departments.*** Several Working Groups have reviewed and made recommendations relevant to the provision of Mental Health Services in Emergency Departments. The particular needs of people across the lifespan presenting to Emergency Departments with significant and emergency mental health related problems need to be addressed. Specific attention should be given to the needs of children and adolescents, older people, people living in rural areas, Aboriginal and Torres Strait Islander people, people from non-English-speaking background (also see Recommendation 5).
- 19. *That the mechanism for deploying resources to Area Health Services with rural responsibilities be investigated, with the aim of ensuring fairness and equity of access with regards to the provision of Mental Health Services in Emergency Departments.*** Given the multiple restraints of distance, isolation, and limited availability of and access to services in rural Areas, currently complying with these recommendations may be difficult for rural Areas, and a modified pattern of service provision may be required. Clearly examination of means by which equality of service provision can be achieved across the state is required. In particular, as new services are being built account should be made of the extra difficulties of rural Areas in this regard. It is anticipated that the Working Group for Rural and Remote Mental Health Care will give some guidance in this regard. (also see Recommendation 30).
- 20. *That consideration be given to re-allocation of resources to appropriate bodies with responsibilities for special groups (such as Aboriginal and Torres Strait Islander people or persons of NESB), to facilitate implementation of the recommendations of the Emergency Department Working Group and other relevant Working Groups for these populations.*** It is anticipated that some of the other Working Groups will make specific recommendations concerning Mental Health Services in Emergency Departments for specific groups of patients. Some of these recommendations may require direction of resources to ensure they are achieved (also see Recommendation 5).

## SECTION TWO

The “Working Group for Mental Health Care in Emergency Departments” recommend to the NSW Area Health Services:

### SERVICE ORGANISATION

21. ***That the Area Health Service is responsible for ensuring that each Emergency Department within an Area Health Service has a clearly designated provider of specialised Mental Health Services for patients of all ages.*** Each Emergency Department must be clearly aware of, and easily able to contact, the service which is designated to provide Mental Health Services.
22. ***That an Area Mental Health Service should develop an “internal” memorandum of understanding among all of its components, with the aim of clarifying the roles and responsibilities of each component in order to provide a co-ordinated service for the full range of age groups that present.*** There may be multiple Mental Health Service components who may provide service to an Emergency Department (such as Community Teams, consultation-liaison services, Child and Adolescent Services, Psychogeriatric services, private psychiatrists and other medical practitioners). Mental health consultation in the Emergency Department should serve a number of patient-centred functions: assessment (eg primarily psychiatric or primarily medical (or other) problem, in need of inpatient, general hospital or community Mental Health follow-up); immediate mental health treatment (eg one-off and crisis interventions); and as a portal of entry into ongoing mental health treatment. It is important that the Mental Health Service components clarify their roles and responsibilities, in order to ensure that a comprehensive “whole of life span” service is provided, with minimal opportunity for patients to “fall between the gaps”. Patients who are at risk but leave before appropriate assessment or care may also need to be dealt with. In particular there should be agreement on how referral from one component of the service to another (eg from a consultation liaison to a community service) can be made as foolproof as possible, in order to minimise the number of patients failing to attend follow up appointments (also see Recommendations 23 and 27).
23. ***That there should be a single point of contact for all Mental Health Services to an Emergency Department, and ideally a “one phone call” referral system should be developed.*** It is anticipated that the simpler a system is, the less chance there is for things to go wrong. The Area Health Service should ensure that there is a simple and consistent mechanism which

can be used by the Emergency Department to arrange Mental Health Services consultation or referral. Models of service provision vary and reflect local solutions to the service need: Consultation-liaison Services, Community Mental Health Services, designated Emergency Department or Acute Care teams, or visiting practitioners may be involved. It should not be the responsibility of the Emergency Department to determine which component of the Mental Health Service should be contacted. There should be a single point of contact for all Mental Health Services to an Emergency Department, and ideally a “one phone call” referral system should be developed. If arrangements are to vary (eg after hours), this must be clearly notified to the Emergency Department and understood by the relevant Mental Health personnel (also see Recommendations 22 and 27).

24. ***That the line of clinical responsibility for the specialised Mental Health Service consultation to the Emergency Department must be clear and accountable.*** Patients presenting in Emergency Departments are patients of the Emergency Department clinician, until and unless agreement has been reached with the consulting Mental Health Service to transfer clinical responsibility. Additionally there must be a clear line of responsibility from the Mental Health Service personnel providing the consultation to the overseeing psychiatrist (also see Recommendations 33, 34 and 47).
25. ***That where possible, designated Mental Health staff should be rostered to provide consultation to Emergency Departments, in order to foster a team working relationship.*** Staff involved in consultation to Emergency Departments should be consistent and limited in number, within the constraints of service provision, in order to foster meaningful working relationships with Emergency Department staff.
26. ***A. That access to data be improved so that an Emergency Department is able to identify if a presenting patient is a client of a mental health service (anywhere in the State).***  
***B. That provision must be made for medical and psychiatric records (of the hospital in which the Emergency Department is located) to be available to the Emergency Departments at all times, including after hours.*** Medical records often contain very significant information which may affect assessment and management decisions concerning the patient. There have been several complaints to the Health Care Complaints Commission (HCCC), which precipitated this Working Group, in which an adverse outcome was in part attributed to a failure to consult the medical record of the patient in question. It is hoped that in the future Community Mental Health Centre records will be accessible to Emergency Departments, but it is accepted that this may be impractical at present. In lieu of this, a statewide system of patient identification is needed, so that patients may be quickly linked with the appropriate service providers.

27. ***That Area Mental Health Services should develop memoranda of understanding with each Emergency Department to facilitate the provision of Mental Health Services to Emergency Departments and clarify issues of mutual concern.*** The roles which the Emergency Department and the Mental Health Services expect each other to perform, and the expectations as to how these roles are to be fulfilled, need to be clarified and agreed upon. Formalised agreement in terms of memoranda of understanding will hopefully maintain clarity of purpose, and at the same time allow adjustments to be agreed to as circumstances change. Local initiatives designed to improve the provision of Mental Health Services to people attending Emergency Departments are encouraged, and should be included in such memoranda of understanding (also see Recommendations 22 and 23).
28. ***That Mental Health Services should establish memoranda of understanding with drug and alcohol services to ensure patients in Emergency Departments with dual diagnoses (mental health and substance use disorder) are adequately managed.*** Patients with dual diagnosis have the potential to “fall between the gaps” of service components. As patients with dual diagnosis are frequently seen in Emergency Departments, it is important to ensure co-ordination in this arena. Responsibility for the consultation service to Emergency Departments should include establishing and maintaining links, and considering cooperative treatment programs with, other elements of local Mental Health Services, drug and alcohol services and other appropriate services / agencies (also see Recommendations 13 and 22).

## SERVICE PROVISION

29. ***That all Emergency Departments and NSW Health clinical facilities should have 24 hour access to specialist Mental Health consultation.*** Access to specialist Mental Health consultation includes the ability to provide direct specialist Mental Health assessment if required by Emergency Department staff. If circumstances such as distance preclude this, the very minimum should be a telephone consultation service. It is clear that hospitals and other NSW Health facilities without designated emergency departments may also at times require access to mental health specialist consultation to deal with mental health emergencies, particularly suicide attempts, that present to them.
30. ***That all Rural NSW Emergency Departments should have access, at least by phone, to 24 hour specialist Mental Health Service consultation.*** Notwithstanding the limitations acknowledged in the discussion accompanying Recommendation 19, the very minimum acceptable standard is 24 hour

phone availability of Mental Health Service consultation. It needs to be emphasised that wherever possible, face to face consultation is to be preferred, and that every effort should be made to achieve this. It is acknowledged that the ability of rural and remote areas to provide continuous and comprehensive Mental Health Services to patients presenting to Emergency Departments is constrained by resource and environmental limitations. Issues of particular concern in these Areas include transporting patients long distances to inpatient units, lack of available psychiatric or at times even medical expertise, and concerns about staff safety as staff numbers may be very limited especially at night. Each rural Area Health Service will need to address the unique problems of providing Mental Health Services to Emergency Departments, and clearly local adaptations of the Emergency Department Working Group recommendations will be necessary. Rural Area Health Services will be supported to examine means of improving the quality of Mental Health Services in Emergency Departments which will be of special significance to rural areas. Useful starting points could be providing education packages to rural Mental Health workers and general practitioners, utilizing tele-psychiatry services and developing guidelines concerning patient transport between rural hospitals. Negotiation with intra- and extra-Area Mental Health Services to provide on-call back up to places which do not have this capacity should be encouraged (also see Recommendation 19).

**31. *That in accordance with current practice regarding consultations requested from other specialties, a basic mental health assessment and examination should be performed by the Emergency Department clinician, prior to a specialist mental health consultation being sought.***

Emergency Department clinicians should be competent to perform a basic "primary care level" psychiatric assessment which, together with necessary medical assessment, should precede referral for specialist Mental Health opinion (also see Recommendations 48 and 49).

**32. *That Mental Health Services will respond to Emergency Department consultation requests with equal clinical priority to other emergency requests.***

Provision of a high quality service to patients in Emergency Departments is dependent on a close and effective working relationship between the providers of Mental Health consultation and the Emergency Department staff, and on a respect for the requirements of the Emergency Department setting. Mental Health Services providing consultation to Emergency Departments should respect the time frames of Emergency Department work.

**33. *That a psychiatrist should oversee Mental Health professionals involved in direct (or indirect) consultation to Emergency Departments.***

Psychiatric registrars, community Mental Health professionals, or psychiatric clinical nurse consultants may be initially involved in direct patient assessment. Medical / psychiatric co-morbidity is however common and

access to a psychiatrist for backup and supervision is necessary. A psychiatrist should take ultimate responsibility for the consultation, unless resources preclude this (also see Recommendations 24, 34 and 47).

- 34. A. That if a Mental Health professional has serious concern about the safety of a patient assessed in emergency department, then that assessment should be discussed with a psychiatrist or psychiatric registrar who is attached to the Mental Health Service, to determine the appropriate clinical management.**

***B. That if there is a disagreement between the Emergency Department clinician and the Mental Health professional about the safety of a patient, then that assessment should be discussed with a psychiatrist or psychiatric registrar who is attached to the Mental Health Service, prior to a proposed discharge of the patient.*** The experience and qualifications of Mental Health staff providing consultations to Emergency Department will vary widely. In order to ensure uniform high quality of mental health consultations it is important that each assessment be discussed with a psychiatrist. The timing and extent of this discussion is left to the discretion of the Area Health Service, and will depend on factors such as the skills of the staff, the urgency of the situation, the time of day and the availability of the psychiatrist. In the rare instance in which a disagreement may arise, concerning safety issues, between the mental health professional and the Emergency Department clinician, then the Mental Health professional must consult with the psychiatrist or psychiatric registrar who is clinically accountable (also see Recommendations 24, 33 and 47).

- 35. *That it is the responsibility of the Mental Health Service to ensure that any plan for psychiatric management of a patient, once it has been agreed with Emergency Department staff, is carried out.*** For example, if it is agreed that admission to a psychiatric unit is required, then it is the responsibility of the Mental Health staff to organise such an admission.

- 36. *That regular Mental Health Service liaison with Emergency Department staff should be a priority as part of the service to Emergency Departments.*** Once immediate requirements for a consultation service for referred patients are met, programs involving regular (at least once per week) Mental Health Service liaison with Emergency Department staff should be a high priority as part of the service to Emergency Department. Such services may include psychiatric clinical nurse consultant (or other Mental Health professional) attachment to Emergency Departments.

## POLICY AND PROTOCOLS

37. ***That all patients presenting with a suicide attempt, or suspected of having attempted suicide, must receive assessment by specialised Mental Health Services.*** It cannot be overemphasised that the most accurate predictor of suicide is a past attempt. Therefore it is vital to treat each attempted suicide with the utmost seriousness, and to view each such episode as a time at which a potentially life-saving intervention may be made (also see Recommendations 4, 38 and 48).
38. ***That specific assessment, management and follow-up protocols must be developed for patients of Emergency Departments who have attempted suicide. These protocols should be consistent with the guidelines incorporated in Circular 98/31.*** Both Emergency Departments and Mental Health Services will need to develop protocols in response to these guidelines. It would be sensible to develop these protocols in partnership with each other (also see recommendations 4, 37 and 48).
39. ***That specific assessment, management and follow-up protocols should be developed for patients who have psychiatric diagnoses which have specific relevance for Emergency Departments.*** This includes patients who recurrently self harm, have co-existing substance use disorders, or suffer from somatoform or certain personality disorders. Patients with depressive and anxiety disorder also may present problems, particularly if presentations are clearly somatic eg. panic attacks. These patients may present special challenges to both Emergency Department and Mental Health staff, and require special skills to be successfully managed. They are typically “heavy” users of Emergency Department services, and effective management of mental health issues can significantly reduce patient morbidity, staff counter-transference and costs associated with repeated Emergency Department visits and investigations. However, most importantly, these patients are often considerably distressed, and at significant risk of suicide - the development of protocols to deal with these patients will hopefully increase staff awareness of the problems associated with these diagnoses and result in more effective management (also see Recommendation 40, 48, 49 and 54).
40. ***That follow up protocols be developed to maximise compliance with follow up arrangements.*** A considerable problem is that patients seen in Emergency Departments may not be adequately followed up by Mental Health Services after discharge. For some patients, being given a card with a number to call and make an appointment may be sufficient, but for many it will not be. It is likely to be more effective if techniques such as making a firm follow up appointment at the time of initial assessment, reminder calls, home visits and follow up by the same Mental Health staff member are employed (also see Recommendation 39 and 49).

41. ***That all Emergency Departments adopt triage guidelines for psychiatric conditions once such guidelines are available.*** (Also see Recommendations 8 and 14).
42. ***That when dealing with “Out of Area” patients, it is the responsibility of the Area Mental Health Service staff associated with the hospital at which the patient first presents to fully assess the patient and then arrange appropriate follow-up or admission as required.*** “Out of Area” patients (ie patients attending the Emergency Department who reside outside the Area Health Service in which the Emergency Department is situated) present a situation in which the potential for patients “to fall between the gaps” of services is great. The guiding principle is that patients should have continuity of care. In order to clarify matters, the Working Group recommends that patients should have a formal mental health assessment at the Emergency Department at which they first present, rather than being transferred to another hospital for assessment. The assessing Mental Health staff should communicate with the Mental Health staff in the patient’s Area of origin to facilitate appropriate management (also see Recommendation 43).
43. ***That if admission is required, wherever possible it should be to a psychiatric unit within the “Area of Origin” of the patient; however this should not significantly delay proper management.*** The principle of “continuity of care” dictates that a patient is likely to get more comprehensive and appropriate care if contact is maintained with their treating clinicians. Accordingly every effort should be made to ensure that the patient receives treatment by those who are most familiar with them. It is also hoped that this guideline will minimise “cross border” disputes between Areas about responsibilities for particular patients (also see Recommendation 42).
44. ***That an arranged psychiatric admission should usually be admitted directly to the inpatient admission facility, rather than being admitted via the Emergency Department.*** In order to avoid unnecessarily using the services of the Emergency Department, if a patient has been assessed by Mental Health Services within the community and admission to a psychiatric inpatient facility is deemed necessary, wherever possible the patient should be taken directly to the inpatient admission facility, rather than being admitted via the Emergency Department.

## REVIEW PROCESSES

45. ***That a collaborative process should be established between each Emergency Department and its attendant Mental Health Service to regularly review the provision of Mental Health Services to the Emergency Department.*** In addition to reviewing services, activities such as

co-ordinating educational sessions to staff, developing performance guidelines (such as response times for consultations), developing referral criteria for Emergency Department staff would be both useful in themselves and also facilitate communication between the services (also see Recommendations 27, 46 and 59).

- 46. *That any incident which involves adverse outcomes (or has the potential to cause adverse outcomes) for patients or staff associated with the provision of Mental Health Services in Emergency Departments must be reviewed.*** In addition to the regular monitoring and communication envisioned in recommendation 45, incidents such as patients absconding from Emergency Department or assaulting staff, need to be urgently and jointly reviewed by the Mental Health Service and the Emergency Department in order to detect and correct problems in the management of these patients (also see Recommendations 27 and 45).
- 47. *That Mental Health Services should establish formal supervision and quality improvement programs to ensure regular monitoring of the services provided to Emergency Department.*** In addition to the collaborative review processes recommended above, it is reasonable to expect that the Mental Health Service will build in quality improvement monitoring of the services it provides to Emergency Departments. All Mental Health staff providing service to Emergency Departments should have access to regular and appropriate ongoing group and/or individual supervision; this supervision should be by appropriately trained senior Mental Health staff (also see Recommendations 24, 33 and 34).

## EDUCATION AND TRAINING

- 48. *That specific training regarding the assessment, recognition and management of suicidal patients should be provided to all relevant Emergency Department and Mental Health Service staff.*** Increasing efforts are being focused on reducing the tragic incidence of suicide, which results in over 700 deaths each year in NSW. The Emergency Department is for many reasons central to any strategy aimed at reducing this incidence, particularly as the single greatest predictor of eventual suicide is a history of a previous suicide attempt. These patients are frequently seen in Emergency Departments, and it is hoped that opportune intervention at this point may prevent some suicides. To this end training specifically aimed at recognising, assessing and managing patients with suicidal ideation is needed. (also see Recommendations 4, 37 and 38).

- 49. That “in service” training concerning the management of difficult patients, common and significant psychiatric problems, “primary care” psychiatric assessment techniques and legal issues should be provided to all relevant Emergency Department and Mental Health Service staff.** Apart from suicidal patients, there are a number of other psychiatric emergencies and related issues which are particularly applicable to Emergency Department practice. There is also a significant rate of missed psychiatric diagnosis in patients presenting in medical settings, and Emergency Department medical and nursing staff may at times feel insufficiently skilled in dealing with perceived psychiatric problems and disturbed patients. These and other issues could fruitfully be addressed by appropriate in-service training. The WHO Primary Care Educational Package for Mental Health could be useful in this regard. Recognition of the fact that there is rapid turnover of Emergency Department staff (especially junior RMOs) means that education packages will have to be repeated regularly (also see Recommendations 31, 39, 40, 50 and 51).
- 50. That the assessment and management of psychiatric emergencies in the Emergency Department form part of intern training and orientation.** A number of hospitals now insist that interns attend specialised training or orientation prior to the commencement of internship. It is recommended that the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of these programs (also see Recommendations 31, 39, 40, 49 and 51).
- 51. That the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of weekly training sessions mandated by the Postgraduate Medical Council for junior medical officers.** The Postgraduate Medical Council requires that interns and junior RMOs should attend weekly training sessions. It is recommended that the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of these programs (also see Recommendations 31, 39, 40, 49 and 50).
- 52. That the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of in service education provided to nursing staff by Staff Development Units (or equivalent).** Each Area Health Service has a body (such as a Staff Development Unit) which is responsible for providing continuing education programs to nursing staff. It is recommended that the assessment and management of psychiatric emergencies in the Emergency Department form part of the curricula of these programs (also see Recommendations 31, 39, 40, 49 and 50).

- 53. That Emergency Department staff should be given specific training in the management of patients displaying violent and aggressive behaviour.** Given the need to care for all patients attending Emergency Departments, including those who are intoxicated or referred by police, and the often emotionally charged atmosphere resulting from grief and fear, there is significant potential for violence to occur in the Emergency Department. While most mentally ill patients are not violent, it must be acknowledged that a small proportion of acutely disturbed patients may pose a risk to the safety of themselves, other patients and staff. Emergency Department staff should be given specific training in the management of patients displaying violent and aggressive behaviour. This training should be regularly updated for all Emergency Department staff.
- 54. That Mental Health staff should be given training in issues which create specific problems for Emergency Departments, such as the assessment and management of patients who recurrently self-harm or have dual diagnoses, or those referred by police or magistrates for assessment.** To Mental Health staff the Emergency Department environment may appear foreign, and its organisational processes and priorities different to those of Mental Health Services. Additionally, while there are large areas of overlap between mental health problems seen in the community and those seen in Emergency Departments, there are a range of presentations that are much more common to the Emergency Department. In order to understand these problems, and to feel comfortable in the Emergency Department environment, education and training is necessary (also see Recommendations 39 and 40).
- 55. That Security personnel should receive training concerning the roles they will be expected to perform when requested to assist in Emergency Departments.** Security personnel are increasingly being used in all parts of hospitals, including the Emergency Department. They may be called upon to aid in the restraint or detention of patients, or to protect staff from patient assault. In order to carry out their roles effectively and legally, they should be given appropriate training and education. This training should encompass basic concepts of psychiatric illness, communication with patients, aggression management, restraint techniques, and legal responsibilities and rights (also see Recommendations 12 and 62).
- 56. That in conjunction with the Centre for Mental Health, targeted educational programs concerning issues related to mental health services in emergency departments be developed for each of: police and ambulance services, consumers, carers, and relevant NGOs. These educational programs should then be provided at a local level by Mental Health Services, in collaboration with Emergency Department Services, to each of: police and ambulance services, consumers, carers, and**

**relevant NGOs.** Education and training needs to focus on identified problems relevant to each group (see Preamble) and to increase awareness of general issues relevant to people with mental health problems. For example, Police and Ambulance services could benefit from educational programs examining topics such as recurrent self poisoning, the limitations of the *Mental Health Act* and violent behaviour (also see Recommendations 57, 58, 59, 60 and 61).

- 57. That pamphlets and written information detailing locally available Mental Health Service resources should be available in Emergency Departments.** Consumers, carers and staff need to be aware of the network of services available, and appropriate access points to treatment. Emergency Departments may not be the most appropriate place for patients to receive Mental Health Services. Consumers should be encouraged to access Mental Health Services through Community Mental Health Services, other Mental Health Services, psychiatrists, general practitioners, and attend Emergency Departments only in emergencies. However once patients requiring Mental Health Services attend an Emergency Department, they should be accorded the same respect, consideration and care as all other patients (also see Recommendations 56, 58 and 59).
- 58. That written material providing information about common mental health problems should also be made available to consumers and carers in Emergency Departments.** The prevalence of mental health problems in the community is significant, and it is likely that a considerable proportion of patients attending Emergency Departments with a physical concern have a primarily psychiatric condition. Additionally, co-existence of psychiatric and physical illness is common. Providing information may be useful in a variety of ways, such as aiding consumers and carers to recognise mental health problems and seek appropriate help, or in demystifying and reducing the stigma of mental illness (also see Recommendations 56, 57 and 59).

## CO-ORDINATION WITH OTHER AGENCIES

- 59. That Area-wide and / or local committees, or other mechanisms, should be established to regularly review the interaction of police, ambulance, Mental Health and Emergency Department .** The proposed committees should comprise representatives from police, ambulance, Mental Health and Emergency Department services, consumers, carers and other relevant stakeholders. The purpose of the committee would be to identify and address local problems relating to the interaction of these services. Particular issues to be addressed should include i) long waiting times for police at Emergency Departments ii) the transport of patients to and between hospitals iii) the establishment of a mechanism to review critical incidents involving these services. It is anticipated that central liaison referred to in Recommendation 6

will help provide some guidance on these matters (also see Recommendations 6, 56, 60 and 61).

- 60. *That current policies concerning the transport of patients to and from Emergency Departments should be examined, with regard to optimising the role of each of the agencies involved in such transport (Mental Health Services, Ambulance and Police).*** Numerous problems have been identified concerning the transport of patients. Complaints have been made from patients and carers about perceptions of inappropriate use of force, unsafe conditions in paddy wagons and “shuttling” between hospitals. Police, ambulance and other services have complained about tying up personnel for long periods transporting patients on schedule, or being forced to wait for the arrival of other services (eg police and Mental Health staff waiting for the ambulance, or vice-versa). There is room for rational discussion regarding co-ordinating, optimising the use of and humanising the transport of patients. An overriding principle should be that the philosophy of “least restrictive care” needs to be extended to the transport of patients (also see Recommendations 6, 56, 59 and 61).
- 61. *That memoranda of understanding between police, ambulance, Emergency Department and Mental Health Services be established at a local level to establish formalised agreement on issues of mutual concern.*** It is anticipated that the committee or other mechanism proposed above (Recommendation 56) should develop material suitable for inclusion in such memoranda of understanding (also see Recommendations 6, 56, 57 and 60).
- 62. *That each Area Health Service and Hospital needs to clarify the roles “Security” staff will be expected to perform when requested to assist in emergency departments.*** There exists some confusion among security staff, Mental Health staff, Emergency Department staff and carers alike as to the roles, responsibilities and restrictions of security staff, particularly in relation to the detention of patients. Clear agreement needs to be reached among all stakeholders concerning these matters, and legal advice will be needed to guide this agreement. The Centre for Mental Health will help develop guidelines in this area (also see Recommendations 12 and 55).

## OTHER

63. ***That provision should be made for the “debriefing” of staff involved in critical incidents such as having a patient suicide or dealing with violent patients.*** Stress debriefing (often called critical incident stress debriefing (CISD)) is frequently seen as a part of an organisation’s obligation to an employee following exposure a critical incident. Although there is an absence of clear evidence that CISD can prevent the development of psychiatric morbidity, it can aid in the formalisation of an organisational response which may impart non specific benefits such as general support and recognition. Consequently, provision should be made for the “debriefing” or other support of staff involved in such critical incidents. As it is however not appropriate for all those involved it should never be compulsory. In addition all such incidents should be subject to analysis and review as detailed in Recommendation 46.
64. ***That any building or refurbishment of Emergency Departments should involve consultation on design issues with local Mental Health Services and consumers, and reference to the relevant guidelines of the ACEM Standards sub-committee which has responsibility for Emergency Department design.*** Emergency Department environments are often crowded, noisy, busy and sometimes frightening places - and may not be ideal for providing mental health consultations. Psychiatric patients may currently have to be placed in rooms which do not afford good observation, or may have fittings which enable the patient to self harm. Prior to the construction or major refurbishment of any Emergency Department in NSW consideration must be given to the inclusion of features necessary to the provision of optimum mental health care. Issues of patient safety, staff safety, confidentiality, providing a sympathetic interview environment and rooms for relatives are among those that need to be taken into account. Features such as observation beds in easily supervised areas, interview rooms with safe exits for staff, duress alarms, quiet and private interview rooms and removable fixtures are suggested. In large emergency departments consideration should be given to the building of a dedicated psychiatric section, which may include beds for psychiatric patients to remain in the Emergency Department overnight. In order to ensure that features necessary to optimise mental health care in Emergency Departments are consistently incorporated, it is vital that relevant guidelines are developed and referred to throughout NSW (also see Recommendation 9).

## REFERENCES

1. Smith G, Clarke D, Herman H: Establishing a consultation liaison psychiatry clinical data base in an Australian general hospital gen hosp. *Psych* 15, 243-253, 1993.
2. Ellison J, Wharff E: More than a gateway: the role of the Emergency psychiatry service in the community Mental Health network. *Hosp. & Community Psych* 36, 2, 180-185, 1985.
3. Seguel M, Munoz P, Nalegach E, Santander J: (Abstract) Prevalence of mental disorders at Emergency service. *Revista medica de Chile*, 121, 6, 705-710, 1993.
4. Oyewumi L, Odejide O, Kazarian S: Psychiatric Emergency services in a Canadian city I. *Can J Psychiatry*, 37, 91-95, 1992.
5. Cillette J, Bucknell M, Meegan E. *Evaluation of psychiatric nurse clinical consultancy in Emergency Departments project*. 1996 RMIT Faculty of Nursing.
6. Stebbins L, Hardman G: A Survey of Psychiatric consultations at a Suburban Emergency Room, *Gen Hosp. Psych* 15, 234-242, 1993.
7. Thienhaus O: Rational Physical Evaluation in the Emergency Room. *Hosp. & Community Psych* 43,4, 311-312, 1992.
8. Bell G, Reinstein D, Rajiyah G, Rosser R: Psychiatric screening of admissions to an Accident and Emergency ward. *Br. J. Psych* 158, 554-7, 1991.
9. Lewis L, Miller D, Morley J, Nork M, Lasater L. Unrecognised delirium in Emergency Department in geriatric patients. *American Journal of Emergency Med.* 13, 2, 142-5, 1995.
10. Puryear D, Lovitt R, Miller D: Characteristics of elderly persons seen in an urban psychiatric Emergency room. *Hosp Comm Psych.* 42, 8, 802-7, 1991.
11. Naughton B, Moran M, Kadah H, Heman-Ackah Y, Longano J. Delirium and other cognitive impairment in older adults in an Emergency Department *Annals of Emergency Med.* 25. 6. 751-5, 1995.
12. Sayer G, Stewart G, Chipps J: Suicide attempts in NSW: Associated Mortality and Morbidity. *Public Health Bulletin*, NSW Health. 7, 6, 55-63, 1996.
13. Carter G, Whyte I, Dawson A, Buckley N: Self Poisoning patients: assessment, management, prevention and clinical outcomes 1989-1994. Report to NSW Department of Health, 1996.

## **APPENDIX**

### **GLOSSARY OF ACRONYMS**

ACEM	Australasian College for Emergency Medicine
ANZCMHN	Australian and New Zealand College of Mental Health Nurses
ENA	Emergency Nurses Association
ATSI	Aboriginal and Torres Strait Islander
CISD	Critical Incident Stress Debriefing
CEO	Chief Executive Officer
HCCC	Health Care Complaints Commission
NGOs	Non Government Organisations
NESB	Non-English Speaking Background
PANDDA	Professional Association of Nurses in Developmental Disability
RMO	Resident Medical Officer
RANZCP	Royal Australian and New Zealand College of Psychiatrists