Managing Acute Severe Behavioural Disturbance (ASBD) during COVID-19

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NSW GOVERNMENT

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For use by	NSW Mental Health Community of Practice

NSW GOVERNMENT

This is interim advice pertaining to the period of the COVID-19 pandemic. This advice is additional to, but does not replace existing NSWH, LHD/SHN, and local policy, guidance and protocols.

The recommendations in this guidance represent the view of the Mental Health COVID19 Community of Practice, arrived at after consideration of the evidence available.

When exercising their judgement, professionals and practitioners are expected to take this guideline into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

1. COVID-19 screening questions and risk assessment for mental health services

NSW public hospital and health services require staff, patients, visitors and contractors to be screened when entering all health facilities. Screening will help identify anyone who may require testing and increase protection for everyone in these facilities.

Detailed information on COVID-19 screening is available at COVID-19 screening at NSW healthcare facilities

Rapid Antigen Tests (RAT) is being made available for mental health inpatient settings. Frequent rapid antigen screening can reduce the risk of infections in mental health inpatient settings, especially amongst people who do not show any symptoms. To maximise the benefit, screening individuals on admission and then two to three times per week is recommended.

The benefits of RAT are relative to the amount of disease that is present in a population (prevalence), with greater benefit from settings with high prevalence. Further information about RAT is available in the Framework for the Provision of Rapid Antigen Screening for COVID-19 in Clinical and Non-Clinical Settings

What happens after screening?
Patients who are found to be at high risk of COVID-19 after screening should be tested and isolate prior to entering the general ward population. Similarly, pathways should be developed for managing positive results during surveillance screening of admitted patients and staff.

Mental Health Services should consult their local Infection Control and Pathology Services to develop pathways for these instances.

What happens if a patient declines testing?
Advice from the local public health unit and LHD legal services should be sought for options to manage **patients who screen as high risk and decline to be tested** and/or require involuntary mental health admission.

Some general considerations include:

- Provide accessible information, support and encouragement.
- Consider if a family member or support person may be able to provide additional information and encouragement (may need to use phone or other means if the person is unaccompanied and restrictions prohibit attendance).
- If the patient is agitated and this is impacting on their decision making, consider de-escalation techniques and offer medication. Revisit the testing request when the person is calmer.
- If the patient is unable to provide information/history, obtain corroborative history from family/carers to clarify whether they have visited any venues of concerns (as listed in NSW Health COVID-19 case locations) or have been identified as close contact of someone with COVID-19.

- The person should remain isolated from other patients (managed in designated room in the relevant unit) while continued efforts are made to encourage testing.
- Staff managing this patient must wear full PPE (contact, droplet and airborne- link to IPAC manual Appendix 4A). The patient should be requested to wear a face mask.

See NSW Government - Symptoms and testing for further advice on COVID-19 screening and testing including and additional symptomology.

2. COVID-19 in NSW

The COVID-19 situation in NSW is constantly evolving. Please check the link below for the latest information.

COVID-19 in NSW: https://www.health.nsw.gov.au/Infectious/covid-19/Pages/stats-nsw.aspx

3. Patient (risk)

People with mental illness have a higher risk of contracting COVID-19 and are more likely to experience morbidity and mortality as a result, compared to the general population.

Vulnerabilities can compound, especially for those with additional communication needs, cognitive disability, those who are marginalised, have experienced trauma and those who are unable to comprehend current circumstances. These individuals may find the current situation particularly distressing and may need additional support to understand COVID-19 implications and requirements.

COVID-19 requirements, such as the use of PPE and restrictions on contact with carers, may further impede communication and therapeutic engagement and heighten fear for some individuals.

A collaborative approach to care should involve specialist services and consultation wherever possible. In particular, the early involvement of family and carers may aid communication and help alleviate a patient's concerns. Opportunities to use telehealth should be considered.

Please see additional guidance for specific patient cohorts and groups:

- Aboriginal peoples
- Cognitive impairment
- Communication and sensory impairments
- Coronavirus (COVID-19) advice for people with disability
- COVID-19 translated resources
- Health Professionals Disability Advisory Service
- Homeless persons
- Information for Disability Support Providers and Workers
- Information for families
- Information for health and mental health workers supporting people with disability
- Information for health workers in emergency departments supporting people with disability
- Information for health workers in hospitals supporting people with disability
- Intellectual disability
- Safe care for people with cognitive impairment during COVID-19: Poster
- Safe hospital care for people with cognitive impairment during COVID-19: Fact Sheet for clinicians

4. Staff (risk)

Situation

Shift handover/team meeting/team huddle

- There may be circumstances that are relevant to the workplace on any given day. Clinicians discuss the specific concerns, risks or requirements for the shift (patient interaction, patient transfer or home visit etc).
- There is a sharing of situational awareness.
- There is discussion and agreement about the care and safety procedures for the immediate period.

Context

- There may be contextual issues that are relevant to clinicians' considerations of COVID safety and/or general safety. E.g. bed availability, access to specialty tertiary beds, demand pressure on ED, closure of a ward for cleaning, staff off work in isolation due to COVID exposure.
- Consideration of these issues may inform decisions and actions required of mental health clinicians and teams.

Example questions for staff and teams to consider

- In the past two weeks, have you had any COVID-19 symptoms?
- Have you had close contact with anyone with a confirmed or probable case of COVID-19?
- Is it business-critical that you come on-site or can you conduct your work virtually?
- What is the vaccine status of our team today?
- During our shift, how often will people be exposed to undifferentiated patients?
- During our shift, how long might people be exposed to undifferentiated patients?
- During our shift, how effective are current controls in reducing exposure to undifferentiated patients?
- During our shift, could any changes in patient demand or acuity increase the likelihood of exposure to undifferentiated patients?
- During our shift, is exposure to undifferentiated people more likely because of the working environment (ambulatory patients, shared treatment rooms, waiting areas, common meal areas etc.)?
- During our shift, could the way people act and behave effect the likelihood of exposure to undifferentiated patients (e.g., taking clinical shortcuts, increased stress or fatigue, not using PPE, not coming back from breaks on time)?
- During our shift, do the differences between individuals in the workplace make it more likely for exposure to undifferentiated patients to occur (e.g., do we have new staff, staff with disabilities, visitors, contractors, or members of the public visiting)?
- Do you agree to follow our COVID-19 precautions to help prevent the spread of COVID-19?

5. Mental Health PPE Quick Reference Guide

Personal protective equipment (PPE) in mental health services during the COVID pandemic

Appendix 4A of the CEC Infection Prevention Control Manual also provides general advice on PPE for health staff. The table below is an excerpt from this document:

Appendix 4A: COVID-19 risk assessment guide for PPE selection for direct care of patients

Patient Characteristics			Precautions Required					
			Frequent hand hygiene	Surgical mask[3]	P2/N95 Respirator[3,4]	Eye Protection	Fluid Resistant Gown	Gloves
No acute respiratory infection (ARI) symptoms AND no recognised COVID-19 epidemiological risk[2]	STANDARD PRECAUTIONS FOR ALL[1]	Subject to current NSW Risk Level and/or Public Health Order	✓	✓	✗	As per standard precautions	As per standard precautions	As per standard precautions
ARI without COVID19 epidemiological risk[2] (important to test for other respiratory viruses)		CONTACT + DROPLET	✓	✓	✗	✓	✓	✓
Patients with suspected[2] or confirmed COVID-19 OR as identified as a close contact by NSW Public Health Unit[5]		CONTACT + DROPLET + AIRBORNE[4]	✓	✗	✓	✓	✓	✓

Mental Health Services should follow specific Local Health District directives or guidance in relation to PPE.

PPE to be used when involved in physical restraint of a patient

- P2/N95 respirator for unknown, suspected or confirmed COVID-19 person
- Protective eyewear/face shield
- Gloves
- Disposable fluid repellent gown

For use in	Hand Hygiene	Disposable gloves	Disposable fluid repellent apron	Disposable fluid repellent gown	Surgical mask	P2/N95 respirator	Eye protection (safety glasses / face shield)
Physical Restraint for unknown, suspected or confirmed COVID-19 status OR Identified as a close contact by NSW Public Health Unit	✓	✓	✗	✓	✗	✓	✓

PPE to be used when involved in administering electroconvulsive therapy (ECT)

- P2/N95 respirator for unknown, suspected or confirmed COVID-19 +ve person
- Protective eyewear/face shield
- Gloves
- Disposable fluid repellent gown

For use in	Hand Hygiene	Disposable gloves	Disposable fluid repellent apron	Disposable fluid repellent gown	Surgical mask	P2/N95 respirator	Eye protection (safety glasses / face shield)
ECT (electroconvulsive therapy) for unknown, suspected or confirmed COVID-19 status OR Identified as a close contact by NSW Public Health Unit	✓	✓	✗	✓	✗	✓	✓

6. De-escalation during the COVID-19 pandemic

De-escalation includes three key areas; prevention and minimisation, planning and specific verbal de-escalation.

Prevention and minimisation

- Visible leadership with clear communication strategy for changes to care.
- Accessible education for patients and carers regarding COVID-19 safety precautions - hand hygiene, physical distancing, and the need for PPE.
- Information in patient areas (including in Easy Read format) - see COVID-19 (Coronavirus) resources.
- Adequate therapeutic intervention/diversional therapies/engaging in meaningful activity.
- Make use of TOP 5, wellness plans and safety pans for people with additional needs
- Access to belongings including telephones/smart phones/tablets especially for those in isolation and where visitor restrictions are in place.
- Increased opportunities for social connections (virtual family/friend/carer visits through virtual platforms).
- Virtual visits by care coordinators (case managers), NDIS supports, Community Managed Organisation support workers, psychologists etc.
- Physical activities i.e. virtual gym/exercise-based programs.
- Ensure collaborative care plan is up to date and advanced care directive is clear.
- Early assessment of nicotine dependence and proactive prescribing of Nicotine Replacement Therapy (NRT).
- Management of drug and alcohol withdrawal.
- For people identified as having a history of aggression, proactive medication management plans including PRN (as required) in line with local guidance.

Planning

- Risk assessment and patient led safety planning for patients with COVID-19 and risk of ASBD.
- Simulation training and mock training in de-escalation, restraint and PPE in patients that are COVID-19 positive.
- Staff to ensure duress alarms work under PPE.
- Environmental risk assessments with infection control unit advisor.
- Consultation with LHD Respiratory Protection Program Lead in relation to PPE, fit checking procedure and fit testing.
- PPE training for all staff.
- Regular practicing of donning/doffing PPE.
- For observation Level 1, skilled staff are used with regular relief opportunities (See also PD2017_025 - Engagement and observation in mental health inpatient units)
- Ensuring that PPE emergency packs are readily available for ASBD.
- Staff understand the environmental cleaning requirements.
- Refer to CEC - Respiratory protection program and .Education, training, posters and videos.

Verbal de-escalation

- The patient should be asked to wear a surgical mask.
- Where safe to do so staff should attempt verbal de-escalation from a Far Safe Zone (defined as beyond a punch and a kick) of a minimum 2 metres.
- Even though de-escalation is undertaken at a safe physical distance (beyond 2 metres) it is recommended that staff be prepared in full PPE (PPE as per COVID-19 risk assessment guide for direct care of patients).

De-escalation frequently takes the form of a verbal loop in which the clinician listens to the patient, finds a way to respond that agrees with or validates the patient's position, and then states what they want the patient to do, e.g., accept medication, sit down, etc.
This should include clear instruction as to infection control requirements and PPE e.g. "I understand that this may be scary. Staff are wearing masks and gloves to protect you and others from infection, please sit down".
The loop repeats as the clinician listens again to the patient's response. The clinician may have to repeat their message multiple times before it is heard by the patient.

Reference: Richmond J S et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. Western Journal of Emergency Medicine. 2012 ;XIII(1):17-25.

7. Physical restraint during the COVID-19 pandemic

Physical restraint is a high-risk intervention for health care workers and patients in terms of injuries and COVID-19 transmission. It should be avoided wherever possible and the principles in section 6 should minimise the need for restrictive practices.

Therapeutic alliance, meaningful engagement, careful listening and open communication are key to providing information and reassurance and will minimise the need for de-escalation and more restrictive practices.

Personal protective equipment during physical restraint

Mental Health staff should refer to the general health staff advice in Appendix 4A of the CEC Infection Prevention Control Manual:

Appendix 4A: COVID-19 risk assessment guide for PPE selection for direct care of patients

Patient Characteristics			Precautions Required					
			Frequent hand hygiene	Surgical mask[3]	P2/N95 Respirator[3,4]	Eye Protection	Fluid Resistant Gown	Gloves
No acute respiratory infection (ARI) symptoms AND no recognised COVID-19 epidemiological risk[2]	STANDARD PRECAUTIONS FOR ALL[1]	Subject to current NSW Risk Level and/or Public Health Order	✓	✓	✗	As per standard precautions	As per standard precautions	As per standard precautions
ARI without COVID19 epidemiological risk[2] (important to test for other respiratory viruses)		CONTACT + DROPLET	✓	✓	✗	✓	✓	✓
Patients with suspected[2] or confirmed COVID-19 OR as identified as a close contact by NSW Public Health Unit[5]		CONTACT + DROPLET + AIRBORNE[4]	✓	✗	✓	✓	✓	✓

For use in	Hand Hygiene	Disposable gloves	Disposable fluid repellent apron	Disposable fluid repellent gown	Surgical mask	P2/N95 respirator	Eye protection (safety glasses / face shield)
Physical Restraint for unknown, suspected or confirmed COVID-19 status OR Identified as a close contact by NSW Public Health Unit	✓	✓	✗	✓	✗	✓	✓

When caring for patient suspected, probable or confirmed COVID-19, physical restraint requires:

- P2/N95 respirator
- Protective eyewear/face shield
- Gloves
- Disposable fluid repellent gown

P2/N95 masks are more effective than a surgical mask only when fitted correctly and when a seal is maintained. See CEC Respiratory Protection Program and education, training, posters and videos for advice on fit checking.

Considerations for managing PPE during physical restraint

- If the patient does not have a mask on already, a staff member should assist them to apply a surgical mask as soon as it is safe to do so.
- If there is scope not to engage in immediate close contact, including restraint and it is safe to do so, staff should apply full PPE before making contact with the patient.
- If there is an immediate risk to the safety of staff and others and there is no time to apply full PPE, staff should remove others from the immediate area and secure the scene whilst a team in full PPE is assembled. Any initial respondents in such circumstances should don at minimum surgical mask and gloves.
- Where a staff member's PPE is damaged, that staff member should be immediately relieved by staff in intact PPE.
- In the case of a PPE breach or unprotected contact, any affected staff should shower and change clothes immediately. The local infection prevention and control and Public Health Units should be consulted to determine whether the staff is required to self-isolate (See Health Care Worker COVID-19 Exposure Risk Assessment Matrix and COVID-19 Advice for Healthcare Professionals) .

General principles for risk mitigation and safety during physical restraint

- Restrictive intervention, including restraint must be for the minimum time.
- Prone restraint has been associated with sudden patient death, this risk is higher for patients with physical health (including respiratory issues) and increases with administration of parenteral medication.
- The physical wellbeing of the patient must be closely and continuously monitored throughout any restrictive intervention, including restraint - document respiration rate, and level of consciousness (See also PD2020_018 Recognition and management of patients who are deteriorating).

Seclusion principles

- Seclusion is a last resort where other attempts to manage ASBD have failed and must be used for the shortest amount of time possible (See PD2020_004 Seclusion and restraint in NSW Health Settings).
- The seclusion room must be cleaned and disinfected post use.
- Seclusion is **not** to be used for the sole purpose of isolating a patient with COVID-19.
- Staff should consult with their local Public Health Unit for advice on the use of a public health order where isolation is required for a patient in a mental health facility.

If isolation is required due to COVID-19 risk:

Patients must be informed of:

- why COVID-19 isolation is required
- the nature and purpose of COVID-19 isolation
- the health benefits, risks and consequences of COVID-19 isolation
- their rights to appeal their detention under the Mental Health Act 2007 NSW.

Staff must ensure that patients are given:

- reasonable period of time to discuss the decision with the treating team
- support with adequate information regarding public health advice for COVID-19
- access to timely advice and support from public health professionals if requested
- opportunities to discuss this advice with their designated carers.

Level 1 constant observation (1:1 nursing)

The risk to the staff could potentially be twofold:

- risk of exposure to COVID-19
- risk of assault due to close proximity to patient

Level 1 observation for a patient with confirmed or suspected COVID-19 must be deemed absolutely necessary and the following considerations discussed with the nurse unit manager and/or on-call executive in conjunction with infection control:

- Level 1 observation (arm's length) will require the staff providing observation to be wearing full PPE for the period they are in the room.
- Level 1 observation (visual) will require PPE as above. Where mental health clinical risk assessment indicates it is safe to do so:
    - The observing staff may sit either within or outside of the room, maintaining line of si of the patient
    - staff completing Level 1 observations must be relieved at regular intervals or no less than each hour.

Post incident management

- Patient debrief
- Patient is offered support by peer worker where available
- Open disclosure principles, including with family as required
- Immediate 'hot debrief' with staff post incident
- Plan for 'cold debrief' with staff
- Opportunity for ward debrief if required
- Auxiliary services conduct terminal clean of exposed environmental areas and equipment
- Replace and reorder PPE stock as required
- Post COVID-19 exposure management processes for staff (Review HCW Exposure risk matrix)

8. Sedation of acute severe behaviourally disturbed patients known or suspected to have COVID-19 infection

With the increasing prevalence of COVID-19 in hospitalised populations, the management of ASBD is likely to be a significant issue because of:

- **Patient factors:** patient vulnerability characteristics: e.g. difficulty comprehending and adhering to infection control principles [1, 2])
- **Environmental factors:** difficulties maintaining physical distancing in these settings, factors to do with staffing and layout, e.g. communal living spaces, shared bedrooms and bathrooms
- **Disease factors:** delirium – most commonly due to hypoxia - with associated ASBD a common presentation of COVID-19 [3]
- **Treatment factors:** Some potential treatments for COVID-19 can have adverse psychiatric effects (e.g. dexamethasone) [4]

Restraint and sedation remain a last resort and only to be used when the risk of injury outweighs the risks of sedation. Refer to guidance for de-escalation and physical restraint.

Assessment

Management of ASBD should be based on local protocols with emphasis on de-escalation strategies and use of oral medication to reduce the need for restraint and parenteral sedation. Different protocols exist for patients under 18 and over 65. NSW Health - Guideline for the management of patients with Acute Severe Behavioural Disturbance (ASBD) in Emergency Departments is available as a companion to local protocols.

Out-of-hospital treatment of a mental health patients with a respiratory illness, possibly COVID-19, is a challenging situation. Local organisation-specific procedures and policies should be observed throughout the treatment, transport and handover of the patient to the receiving facility. Caring for adults with COVID-19 in the Community outlines guidance to assist staff with triage, monitoring and escalation.

These protocols should be augmented by the following specific considerations in patients with known or suspected COVID-19:

Before restraint and pharmacological management

- Restraint and involuntary administration of sedation is a potentially traumatising experience for the patient and is likely to be even more distressing during the pandemic with a generally increased levels of anxiety and the potentially confronting nature of staff PPE.
- All efforts should be made to reassure and de-escalate the situation, ideally by a clinician known to the patient.
- All staff members involved in sedation should be dressed as for contact and droplet and airborne precautions.
- There should be sufficient staff available for physical restraint and ensure patient and staff safety including during medication administration.

- It is essential to obtain baseline physical observations prior to pharmacological intervention or as immediately as possible following sedation, especially **oxygen saturation and ECG.**
- The aim in management of ASBD is conscious sedation. Deeper sedation should only be undertaken in settings where staff have advanced airway management skills and equipment and have appropriate PPE (airborne precautions).

Pharmacological considerations in sedation for people with suspected, probable or confirmed COVID-19

Considerations for early pharmacological treatment

- **Restraint is a high risk for clinical staff and patients and should be avoided if possible**. The aim should be to reduce the length of each episode of restraint and need for recurrent episodes of restraint as far as possible.
- To reduce recurrent restraint, careful **consideration should be given to early pharmacological treatment, preferably administered by the oral route,** to address the underlying cause of ASBD, with a focus on agitation.
- This may lead to the decision to treat with antipsychotic medication early and not rely on sedating agents alone.
- Be aware of time to action of commonly used medications.

Dosing considerations

- **Ensure the medication used for acute disturbance is an effective dose**, as ineffective dosing may lead to repeated injections.
- Consider risk of over-sedation and assess patients for history or signs of intoxication with alcohol or substances.
- Caution is especially required in those who are antipsychotic naïve as the risk of over-sedation increases with increasing doses. Over-sedation can lead to loss of protective airway reflexes. If over-sedated, use continuous pulse oximetry (if available) and visual observation until rousable. Then continue the usual monitoring protocol.
- **Always consider COVID-19 Drug Interactions.** The NSW Therapeutic Advisory Group website includes up-to-date information about medicines use in the treatment of COVID-19. Some medications that are currently being trialled or utilised for COVID-19 treatment may have clinically significant interactions with psychotropic medications used in sedation.
- Always consider concurrent medications and relevant comorbidities when prescribing sedating agents.

Identifying and managing adverse effects

- Be prepared for management of serious dystonic reactions (laryngeal spasm) - it is often a confusing presentation. Administration of benztropine or alternate anticholinergic should be parenteral, MET or Code Blue should be called, and anticholinergics should be administered for at least the following 48 hours.
- Extrapyramidal side effects are more likely in the elderly.
- Neuroleptic Malignant Syndrome (NMS) is also possible and may present as high fever (that is also common in COVID-19) without additional clinical manifestations of NMS.

Respiratory depression

- Avoid medication that may lead to respiratory depression [5].
- Risk of respiratory depression from benzodiazepine use is unlikely when used as monotherapy but may increase when combined with other respiratory depressants.
- Parenteral midazolam has the advantage of early onset of action which may allow for earlier release of restraint but has increased risk of respiratory depression and need for airway support.
- Avoid diazepam or clonazepam if possible [6] and ensure ready availability of flumazenil. [7, 8, 9].
- Flumazenil should only be used when the prescriber is confident that the patient does not have a history of long-term benzodiazepine abuse.
- Ensure awareness that **respiratory status can deteriorate precipitously with COVID-19**. Therefore, long-acting medicines, which may have respiratory depressant activity such as diazepam should be avoided, unless there are clinical grounds for suspecting alcohol or benzodiazepine withdrawal.

Zuclopenthixol acetate (Acuphase®)

- Consider **Zuclopenthixol acetate (Acuphase®)**, particularly in the group of patients with a clear diagnosis and previous exposure to antipsychotic medication.
- Avoid use in antipsychotic naïve patients.
- An ECG should be performed prior to administration of Acuphase®.
- Sedative effects peak 12 hours, but effects may last 72 hours. Acuphase® does not provide rapid tranquilisation and a faster-acting sedative may need to be co-administered. Peak plasma concentrations occur at 24 to 36 hours.
- Reduced doses are recommended in the elderly (max 100 mg per dose).
- Dystonic reactions requiring anticholinergics will need repeat dosing for the duration of action of zuclopenthixol acetate. This may have implications for any delirium.

Ketamine

- **Ketamine** has been associated with an increase in psychotic symptoms.
- If possible, ketamine should be avoided in patients with a history of a psychosis as it may lead to the increased need for subsequent and parenteral sedation.

Post-sedation considerations

- Monitoring of vital signs, especially of **oxygen saturation**, should be especially stringent.
- If not practicable, continuous observation of the patient's colour, respiratory rate and level of consciousness and agitation with escalation of safe monitoring of other parameters.
- If a patient is over sedated (not rousable to verbal stimuli) continuous visual observation should be maintained until rousable. Note, protective airway reflexes are lost when patients are over sedated.
- Monitor for emergent central nervous system difficulties, seen in 25% of COVID- 19 patients in one series, although these were mostly mild and transient [11].

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9. Managing mental health presentations to emergency departments during the COVID-19 pandemic

Mental health presentations to emergency departments (EDs) will be subject to all usual COVID-19 screening processes for the clinical area.

Where a person presents with both COVID-19 symptoms and mental health issues a collaborative, patient centred approach to care is key to improving patient outcomes.

Emergency department avoidance for mental health patients

To ensure the surge capacity of the EDs and to protect mental health patients from any unnecessary exposure to a COVID-19 high risk environment, all efforts are being made to divert patients from EDs where it is assessed as safe and appropriate.

The Emergency Department Mental Health Avoidance Framework provides advice and examples of alternative pathways to care for patient cohorts including:

- patients assessed by the Community Mental Health team for mental health admission
- low behavioural acuity patients seeking mental health support for situational crisis including risk of harm to self
- patients detained by Police and Ambulance under the Mental Health Act
- patients on a section 19 order under the Cognitive Impairment Forensic Provisions Act 2020
- patients seeking drug and alcohol support with low level intoxication, without need for acute medical or mental health intervention, following brief assessment
- patients brought to emergency by staff from community managed organisations (CMOs), referred by residential aged care facilities or supported living accommodation.

The following patient cohorts are generally not suitable for ED diversion unless to a specially designed and appropriately resourced clinical area. The Emergency Department Mental Health Avoidance Framework provides key considerations for developing pathways for these patients:

- behaviourally disturbed patients requiring immediate assessment and containment of clinical risk, including those with acute intoxication issues
- patients with co-occurring mental health and acute medical issues including major self-harm and overdose, requiring a collaborative approach to care.

10. Managing delirium during the COVID-19 pandemic

Refer to Tahir et al (2020). Delirium Management Guidelines - COVID-19. Cardiff, Cardiff & Vale University Health Board: 1-2.

These resources have been produced as part of Aged Health Community of Practice. They are targeted towards NSW Health services outside the aged health/older people's mental health , who are less familiar with managing delirium, and may be useful for adult mental health services:

- NSW Health - COVID-19 and delirium
- ACI - COVID-19 and delirium

11. Liaison to hospital wards

Please refer to the following guidance:

- Clinical Excellence Commission - Management of COVID-19 in Healthcare Settings
- Tahir et al (2020). Delirium Management Guidelines - COVID-19. Cardiff, Cardiff & Vale University Health Board: 1-2.
- https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/liaison-psychiatry-services

12. One-to-one therapeutic interventions during the COVID-19 pandemic

This guidance pertains to one-to-one therapeutic engagement (e.g. talking therapies), where there is a **low risk** of COVID-19 infection.

Additional advice related to the restoration of rehabilitation activities including inpatient and outpatient therapeutic groups is available at https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Pages/guide-restoration-rehabilitation.aspx

One-to-one therapeutic interventions

Where possible ensure 4m^2 rule per person and maintain physical distancing of 1.5 metres.

- Pre-screening questions and rapid antigen tests help identify a person who is unwell or has a risk for COVID-19 and needs to be rescheduled for an alternative telehealth session. Screening results may also guide patients to be referred for medical review and rescheduled when they are well (or released from self-isolation if COVID-19 positive).
- Patients/clients perform hand hygiene prior to entering the waiting room and again before entering the room for their appointment.
- Maintain as much distance as able to during the session (minimum 1.5 metres).
- Minimise the number of people in the room. Students and/or carers may join via telehealth rather than being in the room.
- For extended sessions, a combination of telehealth and face-to-face may be recommended. The options for this are:
    - Two separate sessions
    - One session with face-to-face in one room and then the clinician uses another room to consult further by telehealth. This would reduce the amount of time spent in a small room together.
- Consider providing information/registration forms etc. prior to the session to reduce waiting and session times on the day.

During the sessions, PPE should be applied as per the COVID-19 Risk Monitoring Dashboard and CEC Infection Prevention and Control Manual. Condense use of materials and objects to those that can be wiped clean and disinfected, and those which can be disposed after one use.

If the patient is suspected, probable or confirmed COVID-19, and the care provision within 1.5 metres include physical contact, then full PPE as per the CEC Infection Prevention and Control Manual is required.

Therapeutic intervention for a patient who is COVID-19 positive may be an important part of their treatment and recovery and may help them to deal with anxiety and distress associated with their illness or need for isolation. Telehealth may be the preferred option to ensure patients are still able to access the supports they need in such circumstances.

13. Discharge home of mental health patients/patients suspected or confirmed to have COVID-19

A patient with suspected, probable or confirmed COVID-19 who is medically and mentally fit for discharge may be discharged home to self-isolate where they are able to do so.

Where a person's ability to self-isolate is unclear, seek advice form the local Public Health Unit and infection prevention and control. Consideration should be given regarding the possibility to manage the patient in special health accommodation or via hospital-in-the-home or other similar arrangements.

The patient and their carer should be given advice on the requirements to isolate at home. Consideration must also be given to the person's journey home from the hospital.

Verbal and written handover to other care providers must include the patients COVID-19 positive status to ensure all staff involved in providing follow up are aware of PPE requirements.

For socially isolated patients, the additional potentially negative effects of self-isolation on a person's wellbeing must be considered in formulating community follow up plans.

Digital and online supports

There are a number of high-quality mental health and wellbeing services that people can access free from home:

- Accessing MH services in NSW - https://www.health.nsw.gov.au/Infectious/factsheets/Factsheets/covid-19-accessing-mental-health.pdf
- NSW Health has published a factsheet with tips on managing mental health in languages other than English - https://www.health.nsw.gov.au/Infectious/covid-19/Pages/translated/topic-mental-health.aspx
- Beyond Blue Coronavirus Wellbeing Support Service has published resources in languages other than English - https://coronavirus.beyondblue.org.au/i-need-support/information-in-languages-other-than-english.html
- The Australian Government has developed a list of accessible mental health and wellbeing resources that can be provided to patients - https://www.health.gov.au/sites/default/files/documents/2020/09/coronavirus-covid-19-digital-and-telephone-support-for-mental-health-during-covid-19-coronavirus-covid-19-digital-and-telephone-supports-for-mental-health-during-covid-19.pdf

NSW Health has partnered with Sonder to provide a free personal wellbeing service, available to provide additional support for people in isolation. The app provides access to confidential 24/7 multilingual chat and phone access to a range of mental health and wellbeing support services. Individuals can download the app at https://be.sonder.io/wellbeing-nsw-health and enter the code HERE2HELP.

14. Patient transport/ambulance of patients suspected or confirmed to have COVID-19

All agencies involved in the transfer/transport of COVID-19 suspected, probable or confirmed patients are to implement their agency-specific standard, droplet and contact precautions.

For patient transport in a car refer to chapter 4.9 of the Clinical Excellence Commission - COVID-19 Infection prevention and control guidance for home visits.

If tolerated, a surgical mask should be placed on patients during the transfer.

The transferring health facility is to notify NSW ambulance or other transport agencies on the patient's condition, including their COVID-19 risk status, to ensure all staff involved in the patient transfer are aware of the PPE requirements prior to arrival. The transporting agency is to notify the area receiving the patient where possible.

15. Electro Convulsive Therapy (ECT)

Electro Convulsive Therapy (ECT) is an approved evidence-based intervention and in many cases is a critical service that should be regarded with the same parity as a life-saving intervention in physical health care. The delivery of ECT occurs with support from an anaesthetist either in a dedicated ECT suites within mental health services or from theatre space in general hospitals.

The individuals who require this intervention are likely to have a life-threatening mental health condition including severe depression, severe depression with high suicidal risk, a severe eating disorder with secondary depression, depressive stupor, postpartum psychosis, catatonia or severe intractable mania.

As the COVID-19 pandemic has progressed there have been concerns about the potential for the provision of ECT to be limited or curtailed due to the reduction in availability of staff including anaesthetists, lack of theatre space, lack of adequate PPE supply, the suitability of ECT suites in relation to space available for donning and doffing of PPE and the ventilation requirements to carry out the procedure.

Delay or lack of provision of ECT in urgent cases with severe mental illness can result in further deterioration in mental state with high risk of self-harm, prolonged admission and compromised medical comorbidity.

Considerations:

- Where services are challenged due to availability of resources to deliver ECT, mutual support arrangements should be negotiated with other services to support each other and offer a level of provision.
- It may be important to prioritise ECT services for the most urgent cases and take steps to ensure that those in most need are able to access ECT.
- Clinicians could also explore alternatives to ECT such as switching to antidepressant treatments, consideration of high dose antidepressant medications, augmentation with mood stabilising medication, Lithium or Thyroxine, or exploration of neuromodulation techniques such as Ketamine.

Personal protective equipment during the administration of ECT

For use in	Hand Hygiene	Disposable gloves	Disposable fluid repellent apron	Disposable fluid repellent gown	Surgical mask	P2/N95 respirator	Eye protection (safety glasses / face shield)
ECT (electroconvulsive therapy) for unknown, suspected or confirmed COVID-19 status OR Identified as a close contact by NSW Public Health Unit	✓	✓	✗	✓	✗	✓	✓

- P2/N95 respirator for unknown, suspected or confirmed COVID-19 +ve person
- Protective eyewear/face shield

- Gloves
- Disposable fluid repellent gown

P2/N95 masks are more effective than a surgical mask only when fitted correctly and when a seal is maintained. See CEC Respiratory Protection Program and education, training, posters and videos for advice on fit checking.

For general guidance on PPE for mental health staff, please refer to **Chapter 4** of the CEC Infection Prevention and Control Manual.

ECT practice guidelines
https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/ranzcp-information-ect-and-covid.aspx

16. Basic life support (BLS) guidance

Basic Life Support Guidance is available at https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Pages/guide-basic-life-support.aspx

Cardiopulmonary resuscitation advice provided in appendix 4C of the CEC Infection Prevention and Control Manual

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