Targeted Review: Mental Health Presentations in the Emergency Department

State-wide Observation

This report is as a result of the Chief Psychiatrist's responsibility under the *Mental Health Act 1996* to monitor standards of care.

It is provided to assist emergency department services in the continuing quality improvement of clinical service delivery.

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Acknowledgements

Contents

List of Figures

List of Tables

Executive Summary

Under the Western Australian Mental Health Act 1996 (MHA), the Chief Psychiatrist had responsibility for the medical care and welfare of all involuntary patients; and in respect to all other patients is required to monitor the standards of psychiatric care provided throughout the state.

In late 2013 there was an increase in the number of incidents of mental health patients absconding from Emergency Departments (EDs) reported to the Chief Psychiatrist. It was unclear whether this increase related to increased compliance with reporting to the Chief Psychiatrist by some ED staff or whether it reflected poor standards of psychiatric care being provided. In response to the increased number of notifiable incidents reported by mental health services, the Chief Psychiatrist conducted this Targeted Review for mental health presentations in Western Australian EDs.

There were three components to this Review. The first examined data obtained from the Emergency Department Data Collection (EDDC) on mental health presentations at WA EDs between 1 September 2013 and 28 February 2014, the second was in-depth clinical review of the clinical records of a sub-set of patients attending an ED during January to February 2014 and the third comprised interviews with clinical staff working in the ED to obtain their perception of their strengths, limitations, and challenges in providing psychiatric care to patients presenting to the ED. The in-depth clinical review of clinical records also assessed the use of the State-wide Standardised Clinical Documentation (SSCD), compliance with relevant recommendations from the Stokes Report (Stokes B, 2012) and examined whether notifiable incidents required to be reported to the Chief Psychiatrist had been reported.

This Review found that many of the standards and guidelines for the care of psychiatric patients are not being met within the ED setting and the quality of the mental health and risk assessments and the management and discharge of mental health patients was variable. Areas of strength included mental health and risk assessments, which were completed for the majority of ED patients. The Review found that the quality of the documentation was higher when a standardised form was used; however, use of standardised forms was low and this may explain the poor quality of some areas of assessment.

Overall, compliance was low with many of the Stokes recommendations in relation to caring for patients presenting with deliberate self-harm/suicidality (DSH/suicidality), carer involvement, and providing discharge plans and emergency contact numbers. The low proportion of patients presenting with DSH/suicidality that were assessed by a mental health professional raises questions about the accessibility of mental health staff in EDs, particularly in rural EDs. Strategies to improve access to psychiatrists, including video conferencing for rural EDs, should be implemented to ensure clinicians receive adequate support when caring for mental health patients.

The Review found that while factors that contributed to the presenting problem are well documented, a lower proportion of clinical records had evidence of the factors that have the potential to protect the patient from a reoccurrence of their mental illness. This indicates that clinicians are not thinking forward about how to assist the patient in preventing future episodes of mental health deterioration and ED presentations, which is a missed opportunity.

In addition, there was little documented evidence of carer involvement in the ED presentation. The Mental Health Act 2014 (part 17) recognises the need to acknowledge and respect the role of carers and close family members. A carer's contribution to the support of a person with mental health illness should not be underestimated and in many cases carers could greatly assist ED staff by providing relevant information about the patient's current and past mental health history.

The relationship between mental health and general trained ED staff was generally, but not universally, reported to be positive. The perception of some staff that discrimination towards mental health staff and patients in the ED setting is an ongoing concern that needs to be addressed. Strategies to improve

the collegiality between mental health and general ED staff should be implemented to ensure the best outcome for mental health patients.

Rural EDs performed more poorly than metro EDs on almost every outcome. This may, in part, be due to limited access to mental health staff in rural EDs. Ongoing education and training for both mental health and general trained ED staff are needed, particularly for rural clinicians where access to mental health staff is limited.

Mental health patients presenting to an ED often have complex mental health and social needs requiring extensive assessment and management. Improvements in mental health assessments, the use of standardised assessment forms and in the provision of information to the patient and carer have the potential to improve both the mental health patient's journey through the ED and patient outcomes.

Introduction

Under the Western Australian Mental Health Act 1996 (the Act), the Chief Psychiatrist had responsibility for the medical care and welfare of all involuntary patients; and in respect to all other patients is required to monitor the standards of psychiatric care provided throughout the state. In monitoring the standards of psychiatric care under the MHA, the Chief Psychiatrist has historically conducted a range of reviews to examine if mental health services are meeting national standards. Reviews include: targeted reviews of the standards of psychiatric care provided to an individual patient or clusters of patients, clinical governance reviews of services, and thematic reviews.

Mental health services are required under the Act to report notifiable incidents to the Chief Psychiatrist. In late 2013, there was an increase in the number of notifiable incidents reported to the Chief Psychiatrist relating to patients with mental health issues absconding from EDs. It was unclear whether this increase related to increased compliance with reporting to the Chief Psychiatrist by some ED staff or whether it reflected poor standards of psychiatric care being provided.

In response to the increased number of notifiable incidents reported by mental health services, the Chief Psychiatrist conducted a Targeted Review for Mental Health presentations in the ED in Western Australia (WA) (the Review).

The standards of psychiatric care provided in WA EDs were reviewed in the context of the National Emergency Access Target (NEAT), Australian Commission on Safety and Quality in Health Care and the Australasian Triage Scale (ATS) key performance targets. This was undertaken using data obtained from the EDDC on mental health presentations at WA EDs and by completing an in-depth review of the clinical records of a sub-set of patients attending an ED. The definition of 'mental health presentation' used in this Review includes both 'mental health' and 'drug and alcohol' diagnoses. This definition was agreed upon by the WA Health Services, Data Integrity Directorate and the Mental Health Commission which includes alcohol and other drug (AOD) presentations (details described within the methodology). The in-depth clinical review only included individuals presenting to EDs with a 'mental health' diagnosis with or without AOD comorbidity.

The in-depth review of clinical records also assessed the use of the SSCD, compliance with relevant recommendations from the Stokes Review (Stokes, 2012) and examined whether notifiable incidents required to be reported to the Chief Psychiatrist had been reported. The OD mandating the use of the SSCD by mental health services was published on the 27 May 2014 (OD 0526/14) (Department of Health, 2014b) and post-dates the time period examined for this Review. However, the use of SSCD was examined to assess consistent recording of clinical information and the results will provide baseline data for monitoring of compliance with the use of the SSCD for mental health presentations to EDs.

In addition, interviews were undertaken with clinical staff working in the ED to obtain their perception of their strengths, limitations, and challenges in providing psychiatric care to patients presenting to the ED.

This Review presents the state-wide wide results and contains recommendations for implementation by EDs across WA. The aim of the Review is to provide health and mental health services with a baseline from which services will be able to measure changes in compliance with expected standards of psychiatric care for patients presenting to EDs with mental health and AOD conditions.

Data Sources and Methodology

This Review was commenced in early 2015 on ED mental health presentations in WA between 1 September 2013 and 28 February 2014. Three primary sources of data were used to inform the Review of ED service provision in mental health services. These were:

The Emergency Department Data Collection (EDDC) data

The EDDC data relating to mental health, alcohol, and other drug presentations between 1 September 2013 and 28 February 2014 was provided by the WA Department of Health, Data Integrity Directorate to two experienced data analysts from the Office of the Chief Psychiatrist (OCP) for analysis and interpretation.

Within an acute setting such as an ED it is often hard to distinguish between AOD and mental health presentations. Therefore, the definition of a 'mental health presentation' used in this Review was based on the definition agreed upon by the Area Health Service, Data Integrity Directorate, and the Mental Health Commission (MDG-04-023). The intention was not to undermine but to provide a more robust approach in managing AOD comorbidity rather than an arbitrary divide. Therefore it is possible that some individuals with AOD presentations identified on the EDDC data and included in this Review may not have any mental health condition identified at the time of their ED presentation.

This definition requires that:

A) a patient is registered in any manner in one of the electronic data collection systems,

B) and is given a mental health code as a diagnosis or a presenting problem as follows:

- Any recorded F code or

- One or more of the following ICD-10-AM diagnoses: T39.1, T40.0, T40.1, T40.2, T40.3, T40.4, T40.5, T40.6, T40.7, T40.8, T40.9, T42.4, T43.9, T50.9, T51.9, T52.0, T52.9, T56.2, Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z50.4, Z54.3, Z65.8, Z65.9, Z81.8, Z86.5, Z91.4, Z91.5, or

- One of the following presenting problem codes: T0000, TC000, TW000, TD000, TE000, TF000, TG000, TGA00, TGB00, TH000, TJ000, TS000, TK000, TM000, TN000, TNA00, TP000.

In the smaller and rural hospital EDs (all Western Australian Country Health Service (WACHS) facilities excluding Bunbury Hospital), a major diagnostic category (AR-DRG) classification is used instead of specific diagnoses (section B of the definition above). In these situations, as per MDG-04-23, presentations classified as mental diseases and disorders (AR-DRG 19) and alcohol/drug use and alcohol/drug induced organic mental disorders (AR-DRG 20) were selected.

The following exclusion criteria were applied to the EDDC data that was received:

- Restricting the age of the client to five years and older;
- Removing any presentations where the age was outside of the scope of the hospital (eg. adults presenting at the children's hospital);
- Removing any presentations with errors in the coding of the ED wait-time (i.e. negative times, where the times were blank but the discharge code was not *'did not wait for attendance'* and where the times were greater than the overall length of episode).
- Removing any presentations where the primary or secondary ICD-10 codes or the major diagnostic category were not 'mental health' and the presentation symptom description was not 'Suicidal', 'Self-harm' or 'Psychological problems' and the person was not seen by a Psychiatrist or Psych Liaison Nurse or placed on Mental Health Act Forms.

Throughout this Review we have presented the EDDC data for those with a mental health diagnosis only and those with AOD +/- a mental health diagnosis. For those where the AR-DRG classification was used individuals were classified as either mental health or AOD, not both.

Figure 1 displays the total number of records (after exclusions) provided for the timeframe selected (n=23,239) and the variables received from EDDC are outlined in Appendix A.

An in-depth clinical review of a subset of patient clinical records

The in-depth clinical review was undertaken by an experienced senior clinician and completed in April 2015. The methodology for the selection of patient clinical records for the in-depth review is displayed in Figure 1. The in-depth review of patient clinical records aimed to examine at least 20 clinical records (both integrated and separate mental health records) for each ED that averaged 20 or more mental health presentations per month (Step 1 in Figure 1). Using information derived from the EDDC outlined above, EDs with an average of 20+ presentations per month were identified. This eventuated in 23 EDs being in scope for the Review (9 metro and 14 rural).

Timeframe for Inclusion

For the larger EDS (7 metro and 2 rural) mental health presentations within a one week period during February 2014 were eligible for inclusion in the study. This period was extended for the smaller EDS (2 metro and 12 rural) to maximise the number of patients sending consent forms.

Selection of Voluntary Patients

The Act requires the Chief Psychiatrist to obtain consent to review a voluntary patient's clinical record. Consent was sought to review the records of voluntary patients with a mental health presentation to an ED. To ensure patient confidentiality, the Chief Psychiatrist did not have access to patient names or addresses. The unit clinical record numbers of eligible voluntary patients were sent to the relevant hospital with a request for them to mail out the patient information and consent form and reply paid envelope. Patients agreeing to participate returned the signed consent form to the OCP via a post-paid envelope. A total of 812 consent packs were distributed to voluntary patients and 123 signed consent forms were returned to the OCP (15% response rate).

Selection of Involuntary Patients

Under the Act, the Chief Psychiatrist and delegates of the Chief Psychiatrist do not require consent to review the clinical records of an involuntary mental health patient. The clinical records of these involuntary patients were automatically eligible for the Review. The mental health status was able to be ascertained for patients attending 7 public metro EDs and for those attending the Albany or Bunbury EDs. However, involuntary status could not be identified through the EDCC data for patients presenting to private and rural EDs due to their use of different data collection systems.

Evaluation Methodology

The clinical records of patients presenting at a metro ED were reviewed on-site. For EDs in rural WA, photocopies of the clinical records were couriered by the hospital to the OCP. All record reviews were undertaken by a senior clinician with experience in both community and inpatient mental health settings (Appendix B).

A total of 205 patient clinical records were reviewed, containing information on 223 mental health ED presentations (15 patients had multiple presentations) (Figure 1). Of these, 145 (65%) were from one of 9 metro EDs and 78 (35%) from one of 9 rural EDs. More than 20 patient clinical records were available for review at 4 metro EDs and the 2 major rural EDs. There were between 10 and 15 clinical records available for 4 metro EDs and 4 for the remaining metro ED. Of the smaller rural EDs, 7 (83%) had fewer

than 10 patients consenting. No patient consent forms were received from Port Hedland and Kununurra Hospitals, and 2 clinical records requested from Kalgoorlie Hospital could not be obtained.

Figure 1 Flow chart indicating the selection process included within the in-depth clinical review of clinical records
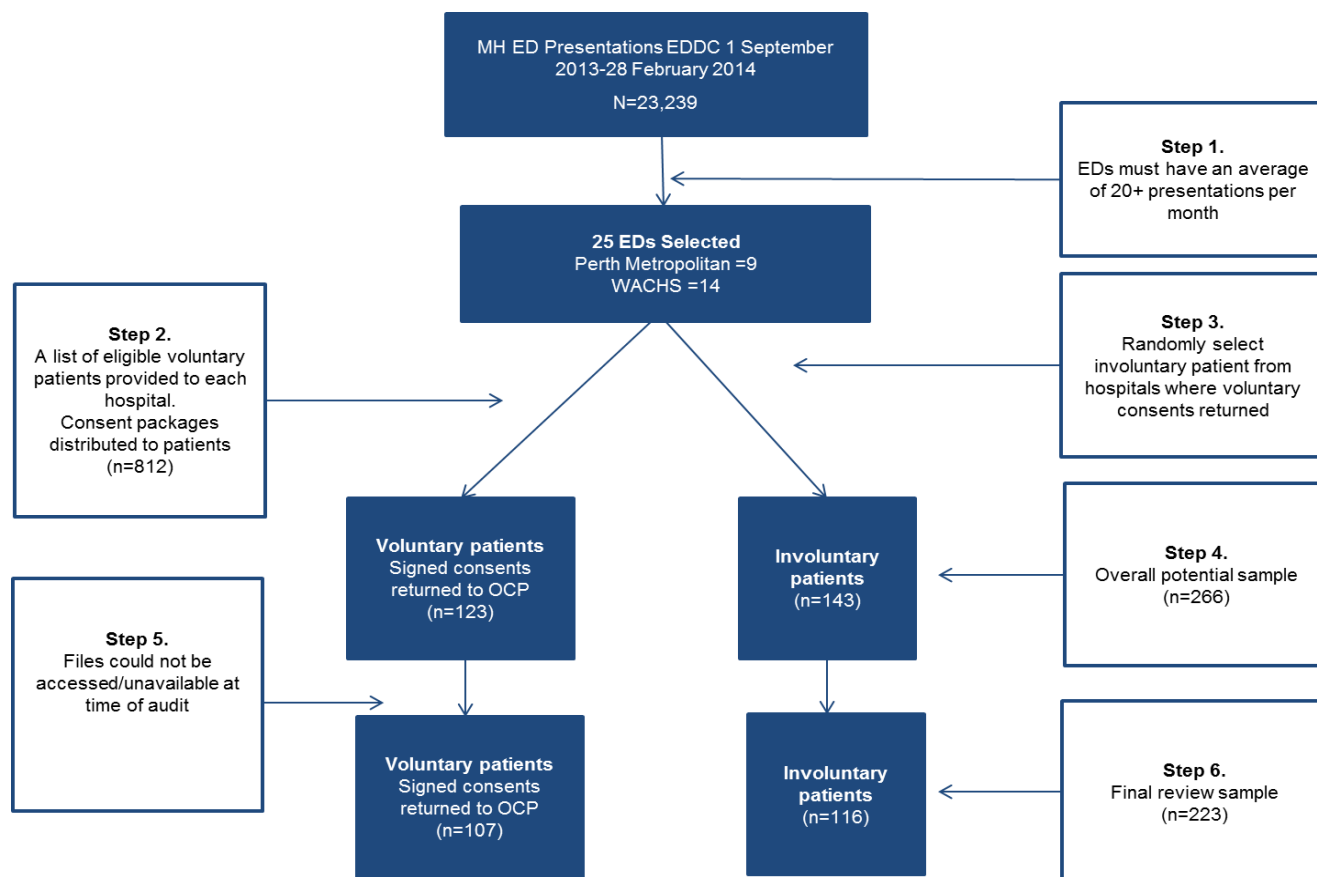
Interviews with clinical staff

Clinical staff were interviewed to obtain their opinions on the processes in place for managing patients presenting to ED with a mental illness that were not able to be captured in the quantitative measures. Staff with the following position titles (or contextual and equivalent) were invited for interview:

- Clinical Director of the ED

- Clinical Nurse Specialist / Nurse Manager of the ED

- Consultant Psychiatrist working within the ED

- Psychiatric Registrar / Medical Officer (MO) working within the ED

- Psychiatric Liaison Nurses (PLN) working within the ED

The interview schedule contained 16 questions, with a further open ended question where staff could provide open comment and/or feedback (Appendix C). Prior to the interview, where requested, the list of 16 questions was emailed to each staff member who agreed to be interviewed. To accommodate staff schedules and circumstances, clinicians agreeing to be interviewed were given the opportunity to respond via email, telephone or a face to face (metro sites). Interviews were conducted by the senior clinical reviewer.

A total of 50 staff completed interviews across 18 hospitals. Fourteen of these were from smaller WACHS ED's, 9 from larger WACHS EDs and 27 from metro Perth EDs. Responses to the interview questions were collated and reoccurring themes identified. Individual's responses may cover multiple themes. Specific quotes were chosen to highlight each identified theme.

Structure and approach of this review

This Review examined the standards of psychiatric care provided to mental health and AOD patients in EDs in relation to the pathway from triage to discharge, including admission or transfer. The clinical management of mental health and AOD patients in the ED was assessed against the standards of psychiatric care set out in the Stokes Review (Appendix D) and the national standards set by the Australian Commission on Safety and Quality in Health Care (2014). The data source used to assess each aspect of psychiatric care is outlined in Table 1.

Table 1 Variables and data sources used to investigate the standards of psychiatric care

Aspect of Provision assessed	Data source		
	EDDC	Clinical record	Interviews
Section 1: Number of Presentations/Demographics	Yes	Yes	No
Section 2: Primary/Presenting Diagnosis	Yes	Yes	Yes
Section 3: Time of ED Presentations	Yes	Yes	No
Section 4: Wait times	Yes	Yes	Yes
Section 5: General Documentation and Risk Assessment	No	Yes	Yes
Section 6: Mental Health Assessment and Formulation	No	Yes	Yes
Section 7: Notifiable incidents	No	Yes	Yes
Section 8: Length of Episode	Yes	Yes	Yes
Section 9: Discharge outcome	Yes	Yes	Yes
Section 10: Information provided to patient/carer	No	Yes	Yes

Results

Throughout this Review the measure of central tendency used is the median, where the median is the middle value of a set of data.

Section 1: Number of Presentations/Demographics

Presentations-Source: EDDC

A total of 23,239 mental health ED presentations to WA hospitals between 1 September 2013 and 28 February 2014 were included in this Review (16,722 metro ED presentations and 6,517 rural ED presentations). The total monthly number of mental health ED presentations for each ED is provided in Figures 2 and 3 for metro and rural EDs, respectively. There is a marked degree of variability in the number of mental health presentations in some of the smaller metro EDs and in many of the rural EDs.

Figure 2 Number of mental health and AOD ED presentations by month - metro EDs
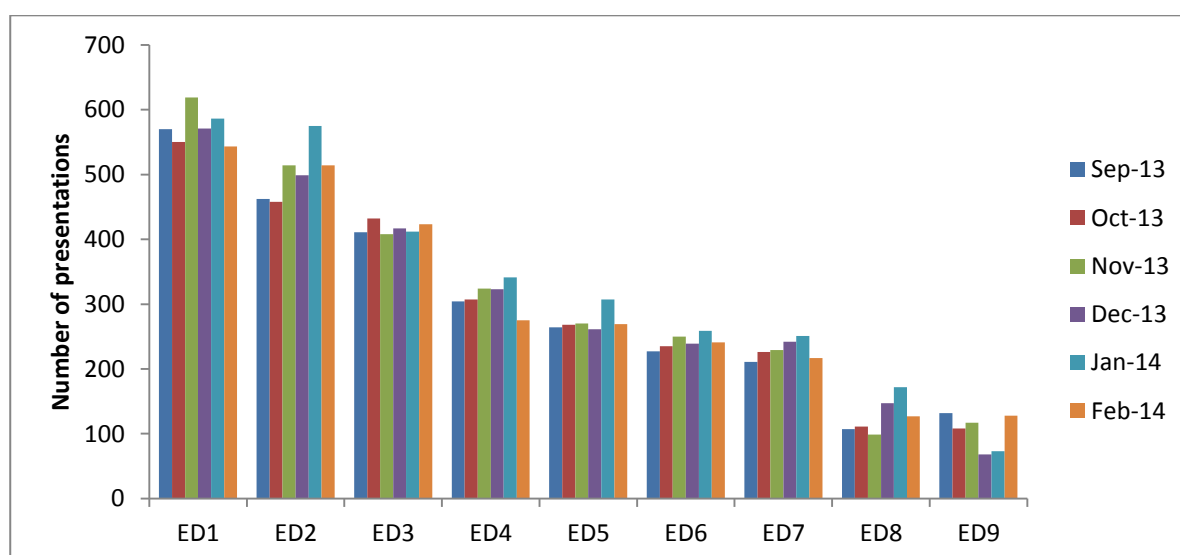
Source: EDDC

Figure 3 Number of mental health and AOD ED presentations by month - rural EDs
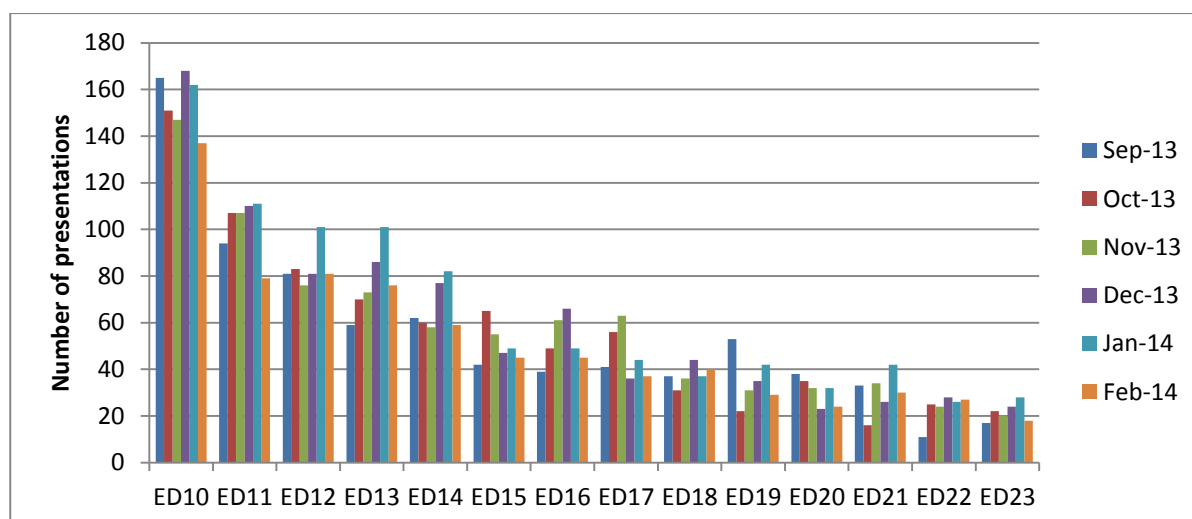
Source: EDDC

Mental Health and Alcohol and Other Drug Presentations: EDDC

In the EDDC data, 85% of patients had a mental health presentation, 9% had an AOD presentation, and 6% had a combination of both. Metro EDs had a higher proportion of mental health presentations than rural EDS (87% vs 80%, respectively) and a lower proportion of AOD (+/- mental health diagnosis) presentations than rural EDs (12.8% vs 20.2%, respectively) (Figure 4 & Figure 5). The proportion of AOD (+/- mental health) presentations to metro EDs was around 10% for all metro EDs with the exception of ED 8 (27.5%) and ED 9 (6.2%) (Figure 4). In contrast, there was considerable variation in the proportion of rural ED AOD (+/- mental health diagnosis) ranging from 8% for ED 11, to 43% for ED 23 (Figure 5).

Figure 4 Metro ED mental health and AOD (+/- mental health diagnosis) Presentations
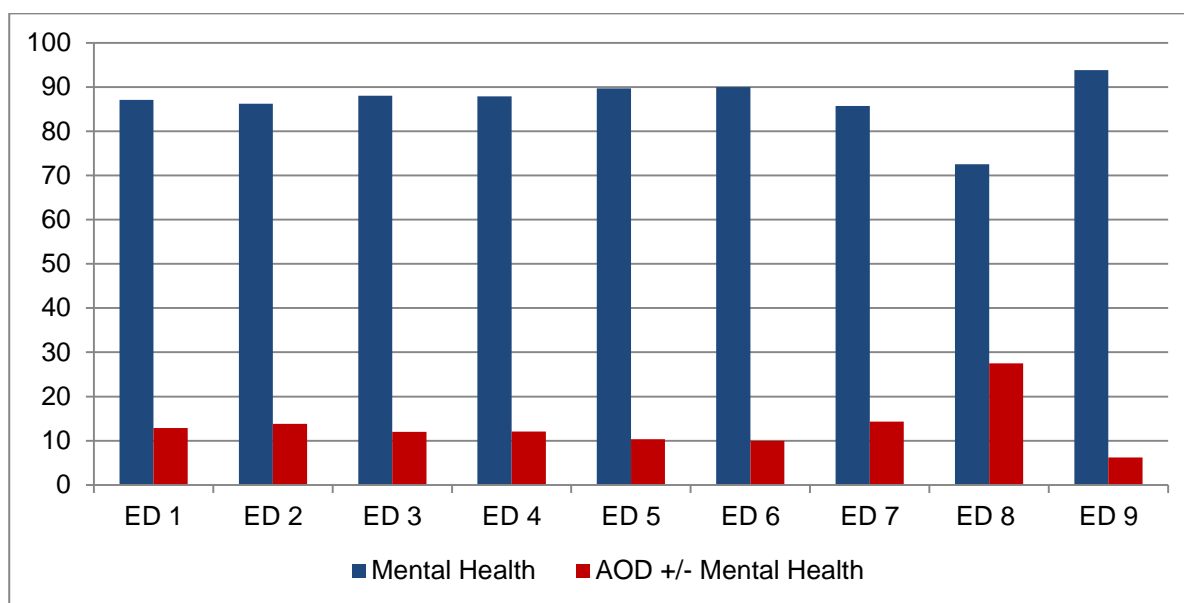
Source: EDDC

Figure 5 Rural ED mental health and AOD (+/- mental health diagnosis) Presentations
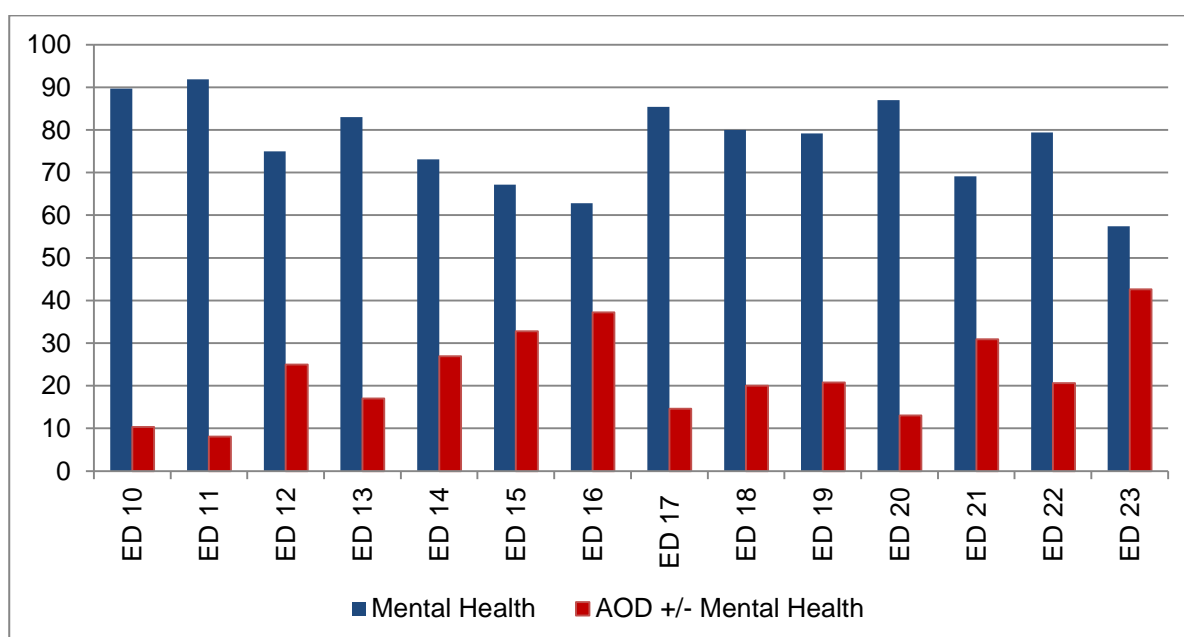
Source: EDDC

Age of Patients Presenting to Metro and Rural EDs -Source: EDDC

The majority of patients presenting to EDs in WA are between 10 years and 49 years of age (Figure 6-7). In metro EDs 76% of mental health and 84% of AOD (+/- mental health) presentations were between the age of 10 to 49 years and for rural EDs the proportions were 80% and 84%, respectively. Individuals aged between 20 and 29 years constituted around a quarter of the presenting population for both metro and rural EDs. In metro EDs, the proportion of patients with an AOD (+/- mental health) presentation was higher than mental health presentations in those aged 10-19 years through to 30-39 years (Figure 6). In rural EDs this was evident in those aged 20-29 years through to 40-49 years (Figure 7). AOD (+/- mental health) was the presenting condition for over half of the rural ED presentations in the 50-59 year age groups. Thereafter, the proportion of mental health presentations increased relative to AOD (+/- mental health) in each year group with the proportion of patients 60 years and older higher in metro (19%) than at rural EDs (14%).

Figure 6 Age distribution of mental health and AOD (+/- mental health diagnosis) patients - metro
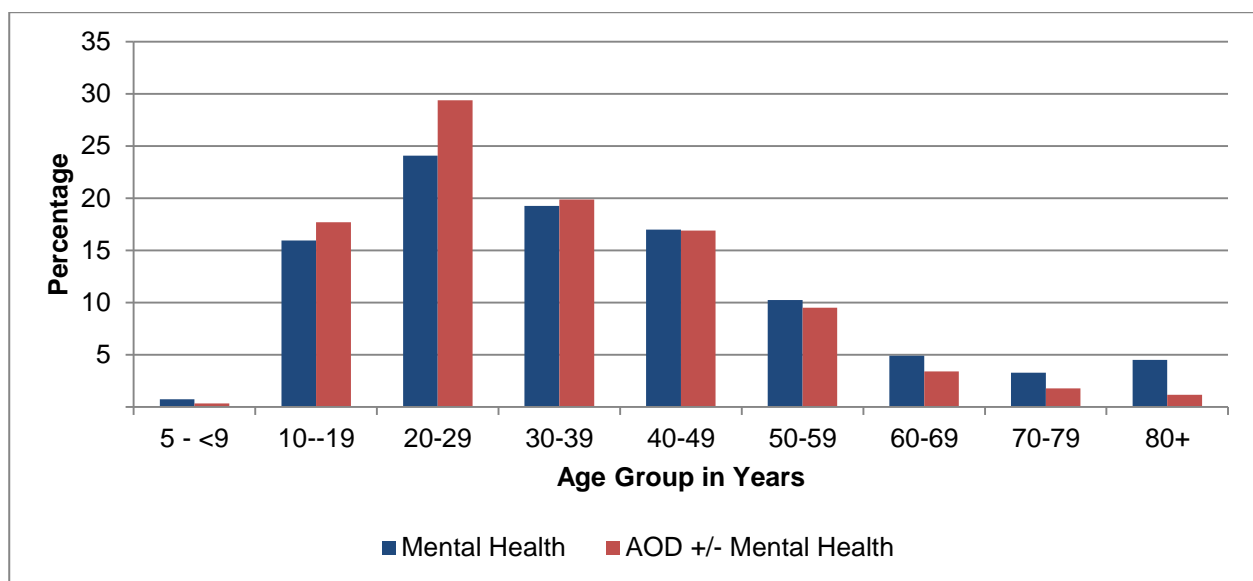
Source: EDDC

Figure 7 Age distribution of mental health and AOD (+/- mental health diagnosis) patients - rural
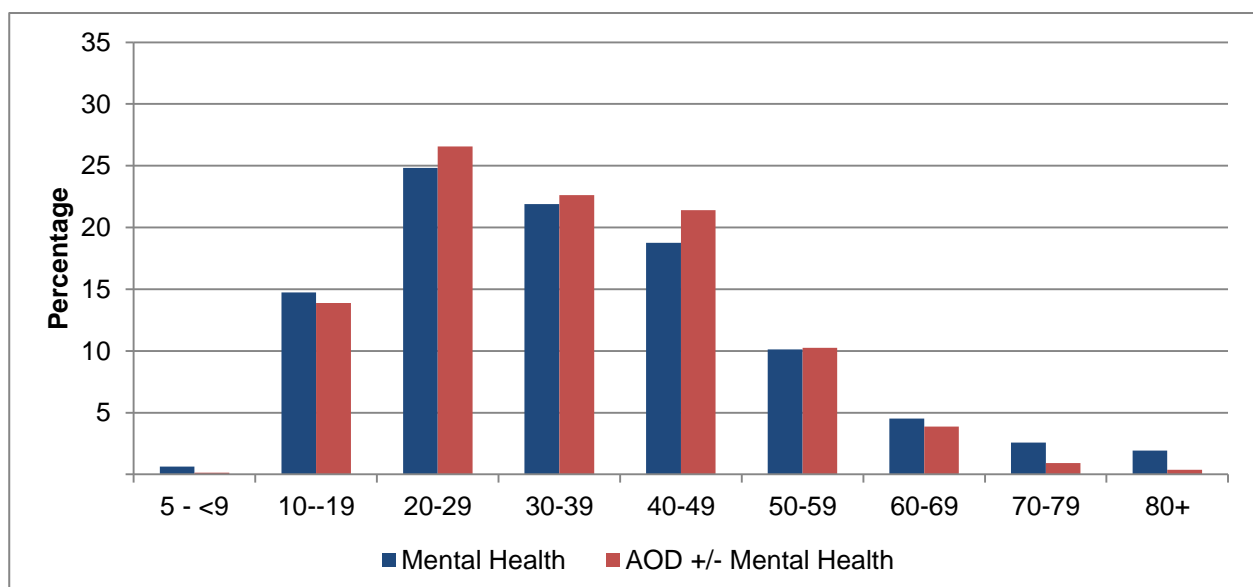
Source: EDDC

Key Findings

- The number of mental health presentations ranged from 104 to 573 per month for metro EDs and between 22 and 155 per month for rural EDs, with variability in numbers of presentations evident for one-third of metro EDs and for all rural EDs.

- Overall, 85% were mental health presentations and 15% were AOD (+/- mental health diagnosis) presentations.
    - For metro EDs, AOD +/- mental health disorders around 10% of presentations for metro EDs and a higher proportion in rural EDs, ranging from 8% to 43%.

- A quarter of all individuals presenting to EDs for mental health issues were aged between 20 and 29 years and almost two-thirds were between 20 and 49 years of age. The proportion of individuals presenting to rural EDs aged 20 to 49 years was slightly higher (66%) than for metro EDs (59%).
    - For both metro and rural EDs, the highest proportion of patients presenting with AOD (+/- mental health diagnosis) was in the 20-29 year age group, followed by the 30-39 year age group.
    - A relatively high proportion of 10-19 year olds (18%) presented to metro EDs with an AOD diagnosis (+/- mental health diagnosis).

Section 2: Primary/Presenting Diagnosis

Principle Diagnosis of Mental Health ED Presentations-Source: EDDC

The ICD-10 code is the final diagnostic category given to each patient on discharge from the ED. The discharge diagnoses for patients attending the EDs and coded as 'mental health' can be seen in Table 2. It should be noted that these codes relate to the mental health diagnosis and may not reflect the combination of factors that preceded the ED mental health presentations. In addition, a number of different codes can be employed to describe similar presentations. Differences in the clinical information systems between metro and rural EDs limited the ability to examine regional differences in the principle and secondary diagnoses. One-quarter (26%) of principle diagnoses were not collected for rural ED patients, so only state-wide results are presented (Table 2).

The most prevalent principle and secondary diagnoses of ED presentations (Table 2) were:

- Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders;
- Mental and behavioural disorders due to psychoactive substance use; and
- Injury, poisoning and certain other consequences of external causes.

Table 2 Principle ICD-10 diagnosis code for mental health patients presenting to EDs

ED Discharge Diagnosis (ICD-10 code, 2015)	Principle n (%)	Secondary n (%)
F01 – F09: Mental disorders due to known physiological conditions	973 (6)	66 (3)
F10 – F19: Mental and behavioural disorders due to psychoactive substance use	3,266 (19)	500 (22)
F20 – F29: Schizophrenia, schizotypal, delusional and other non-mood psychotic disorders	977 (6)	43 (2)
F30 – F39: Mood (affective) disorders	1,540 (9)	155 (7)
F40- F49: Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	4,286 (25)	440 (20)
F50 – F59: Behavioural syndromes associated with physiological disturbances and physical factors	76 (<1)	7 (<1)
F60 – F69: Disorders of adult personality and behaviour	225 (1)	56 (3)
F80 – F89: Pervasive and specific developmental disorders	<5	<5
F90 – F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	366 (2)	21 (1)
F99: Unspecified mental disorder	213 (1)	<5
A00 – R99: Primary diagnosis medical	873 (5)	332 (15)
S00 – T88: Injury, poisoning and certain other consequences of external causes	2,507 (14)	401 (18)
Z00 – Z99: Factors influencing health status and contact with health services (excluding Z91.5 & Z03.2)	648 (4)	61 (3)
Z03.2: Observation for suspected mental and behavioural disorders	137 (1)	12 (<1)
Z91.5: History of Self Harm	1,354 (8)	149 (7)
N/A: Diagnosis not systematically collected (Rural EDs excluding Bunbury)	5,977 (25.5)	----
TOTAL	**23,421**	**2,247**

Source: EDDC

Of the 5,977 patients without an ICD-10 code, 96% had a major diagnostic category, of which 73% were coded as mental illness, 24% as drug and alcohol, and 3.2% as having social problems. The remaining 4% of patients did not have either an ICD-10 diagnosis or a major diagnostic category recorded. These patients were included as a mental health presentation either due to having a symptom code recorded relating to social/behaviour problems including suicidal presentation, psychiatric problems, requesting a psychiatric review or they were reviewed by mental health staff or placed of MHA Forms.

Additional Presenting Factors in ED-Source: In-depth Clinical Review

In addition to the presenting diagnosis, additional factors related to ED presentation were also noted as part of the in-depth clinical review of clinical records. These included specific aspects of presentation which may not be comprehensively coded or could not be accurately identified using routinely collected data; many of which may have added significant complexity to the ED presentation.

The patient's clinical record was examined for documentation of deliberate self-harm (DSH), alcohol or drug morbidity and/or medical co-morbidity relating to the presentation. One or more of the additional factors were documented in 60% of the 241 presentations assessed. Of particular note, 44% of presentations assessed by the clinical reviewer had a presenting complaint of either DSH and/or suicidality.

There was a significant difference between rural and metro locations in the proportion of individuals with DSH or AOD morbidity recorded in their clinical record (Table 3). A higher proportion of patients attending a metro ED had DSH recorded compared with rural ED presentations (48% vs 33%) and AOD morbidity recorded (24% vs 13%), respectively. In contrast, the percentage of individuals with medical comorbidity documented was around 9% for both rural and metro EDs.

Table 3 Additional factors assessed during the ED presentation

	Percentage of Rural Presentations	Percentage of Metro Presentations	Percentage of Overall Presentations
DSH/suicidality	26/79 (32.9%)	78/162 (48.0%)	105/241 (44%)
AOD Morbidity	10/79 (12.7%)	38/162 (23.7%)	47/241 (20%)
Medical Co-morbidity	7/79 (8.8%)	15/162 (9.3%)	22/241 (9%)
Total	34/79 (43.0%)	112/162 (69.1%)	146/241 (60%)

Source: Clinical records

ED presentations-Source: Clinical Staff Interviews

Question: "How are patients presenting to the ED categorised as 'mental health'?"

Interviewees were asked to describe how patients presenting to ED are categorised as mental health. The most frequent response (n=46) revolved around the 'triage process' and more specifically the categorisation of patients as mental health based on their 'presenting factors'. Alternatively, some patients arrive at ED specifically requesting a mental health review. This was described as being either from a community referral such as a GP or community mental health service (n=8) or self-referral (n=3). Finally, some patients are brought to ED via the police or ambulance (n=7) who have 'pre-triaged' the patient as mental health.

> *'The triage nurse gathers presenting information and categorises patients as mental health based on information disclosed at the time of presentation.'*
>
> *'Patients are often brought in by police who communicate the patient is presenting with mental health issues'.*
>
> *'Community Mental Health or the patient's GP may refer the patient.'*
>
> *'Patients present to ED requesting mental health assistance.'*

Question: "Is there a different process for patients presenting with DSH / suicidality?"

Most (n=31) of those who were interviewed felt that there were no different processes for patients presenting to ED with DSH/suicidality. There were 16 responders (34%) who described a different process in the ED for those presenting with DSH/suicidality. This differential response included having medical treatment/clearance prior to being seen by the mental health team, more involvement of the psychiatric consultant/registrar, providing a calm and safe environment, being allocated a guard or other 1:1 special, undertaking safety checks of the patients' belongings, placing in an area that allows increased observation and that the process depends on the highlighted risks and who attended the ED with the patient. There were 3 responders who did not address this question.

Example staff responses to interview questions

> *'A guard is always allocated to a person presenting with such issues.'*
>
> *'Yes - primarily on safety checks on the patient to ensure they are not in possession of implements in which they could potentially harm themselves or others.'*
>
> *'Patients need to be medically cleared prior to PLN risk assessment and interview'*

Question: "What is the process for managing patients with AOD co-morbidity?"

The process for managing patients who present to EDs with a drug and alcohol co-morbidity was described by 12 interviewees as being no different to any other patient. There were 13 responders who described that unless the blood alcohol level was less than 0.05 the patient would not be assessed by mental health staff and 11 said that they would be first cleared medically before any mental health involvement. One respondent felt that persons with drug and alcohol presentations do not always receive mental health assessment. Many of the rural EDs assess the patient and medically manage the patient in ED or admit into the hospital and refer to local drug and alcohol services, community mental health or tertiary centres if necessary. Safety to staff was raised, as intoxicated patients are often violent. A couple of interviewees described that no drug and alcohol services are available within the ED. Information was missing for 5 staff.

Example staff responses to interview questions

> *'If intoxicated risk assess to ensure appropriate management during intoxication period.'*
>
> *'Reassess once sober'*
>
> *'Blood alcohol level has to be lower than 0.05 before a comprehensive mental health assessment can occur'*
>
> *'Nil different process. Medical issues are always stabilised before mental health.'*

Question: "What is the process for managing mental health patients with medical co-morbidity?"

Interviewees described that the process for managing patients with a medical co-morbidity was generally the same (n=13) and that medical issues needed to be addressed/cleared first (n=19). Many of the rural and some of the metro EDs assessed both mental health and medical co-morbidities concurrently (n=10). In larger EDs, patients with severe medical needs could be admitted to a medical ward and receive consultation liaison by a psychiatrist (n=7) with the psychiatric risks assessed. If the risk was found to be high a nurse special or guard could be allocated to the patient (n=2). The ward where admission occurs was dependent on the needs of the patient, with admission to a mental health ward supported by medical consultation liaison possible. In EDs where there is no inpatient mental health service a transfer may be required. It was also described that it is sometimes complex as to 'who's responsibility the patient is'. Information was missing for 1 interview.

Example staff responses to interview questions

> *'Patients are medically cleared first but mental health is taken into consideration concurrently'.*
>
> *'Sometimes. Complexity in ascertaining which team will attend to the presenting issues i.e. intellectual disability "Mental health don't want them, medical team don't want them".'*
>
> *'If the patient requires a medical admission then a consultation liaison request can be made during their hospital stay.'*

Key Findings

- The most frequently occurring principle discharge diagnosis was 'Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders' (25%), followed by 'Mental and behavioural disorders due to psychoactive substance use' (19%) and 'Injury, poisoning and certain other consequences of external causes' (14%).

- The EDDC data and clinical review findings demonstrate the complexity of mental health presentations to ED, with 60% of mental health presentations accompanied by one or more of DSH or expression of suicidal intent, alcohol or other drug co-morbidity, and/or a medical co-morbidity. The proportion of mental health presentations in the clinical review that had one or more of these factors is higher in metro (69%) than rural ED presentations (43%).

- A relatively low percentage of mental health presentations (10%) had physical health co-morbidities identified in the clinical records.

Staff responding to the interview/survey indicated:

- The majority of patients presenting to an ED are classified as a mental health patient through the triage process. Alternative classification processes included classification by a GP or community mental health services and classification by police or ambulance officers;

- The processes for assessing patients presenting to ED with DSH/suicidality were reported to be the same as for other mental health patients. A minority of staff indicated these patients have increased observation/supervision, more involvement of the psychiatric consultant/registrar, and/or medical treatment/clearance prior to mental health assessment;

- Patients presenting with alcohol and other drug co-morbidity are managed in the same way as other mental health patients. However, some EDs require the patient to be medically cleared and/or to have a blood alcohol less than 0.05 prior to mental health assessment.
    - *Comment: We are unable to address whether these differences are process driven rather than the impact of cultural differences.*

Section 3: Timing of ED presentations

Timing of ED presentations-Source: EDDC

Around half (52%) of mental health presentations and 48% of AOD presentations occurred between 12 midday to 21:00 and a quarter, 24% and 28% respectively, presented between 21:00 and 0:300 (Figure 8). Fewer than 12% of mental health or AOD presentations occurred between 03:00 and 09:00. Detailed information on the distribution of ED presentations by time of day and day of week can be found in Appendix E.

Figure 8 Percentage of mental health and AOD (+/- mental health) presentations by time of presentation
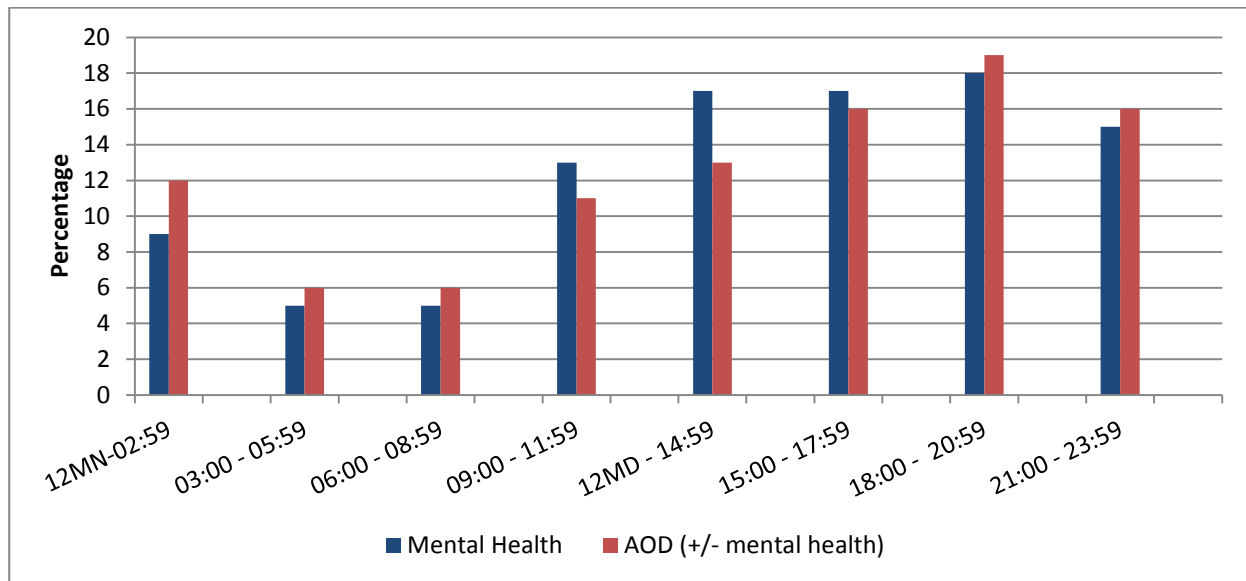
Source: EDDC *Time of presentation unavailable for 496 presentations

There was little variation in the proportion of mental health and AOD (+/- mental health) presentations by day of the week Figure 9. The proportion of mental health presentations was slightly higher than AOD presentations on Monday through Wednesday, with a higher proportion of AOD presentations occurring later in the week, particularly Friday through Sunday.

Figure 9 Timing of mental health and AOD (+/- mental health) presentations by day of the week
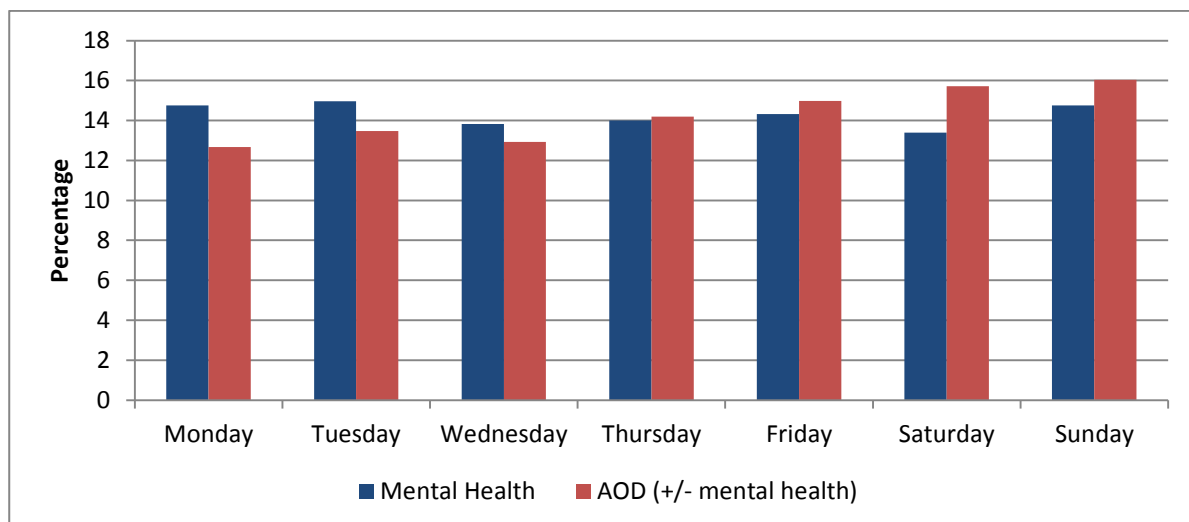
Source: EDDC

Key Findings

- Half of mental health and AOD (+/- mental health) presentations to an ED were between midday and 21:00.

- There was little variation in the proportion of mental health and AOD (+/- mental health) presentations by day of the week with a slight trend for a higher proportion of AOD presentations to occur over the weekend.

Section 4: Wait times

Wait times to service commencement were assessed for both the EDDC data and the clinical review data. The EDDC data provided access to a large number of records with overall wait times (to first contact with any health professional) and the clinical review enhanced the EDDC data by enabling a more in-depth examination of the wait time to service commencement to be conducted. The clinical review data provided wait time from general triage to assessment by a (i) PLN, (ii) ED medical review, and (iii) review by a Psychiatric Registrar. The wait times reflect the time the patient 'waited' for the clinical assessment to occur. These times do not take into account that mental health staff may not have been 'called' until sometime after the general triage and therefore the wait times may not be representative of the 'actual' time taken for mental health staff to respond. Detailed information on definition of 'wait time' is contained within Appendix F.

Wait times in ED presentations-Source: EDDC

In metro EDs, the wait times varied between mental health and AOD (+/- mental health) presentations and across individual EDs (Figure 10). Overall, the median wait time for mental health presentations was longer than for AOD (+/- mental health) presentations. The median wait times for mental health presentations in metro EDs ranged from 14 minutes (ED 7) to 83 minutes (ED 3). The wait times for mental health presentations were 2 to 5 times longer than for AOD (+/- mental health) presentations, which ranged from 6 minutes (ED 2) to 34.5 minutes (ED 3).

Figure 10 Median mental health and AOD (+/- mental health) presentation wait time to first contact (by any health professional) – metro
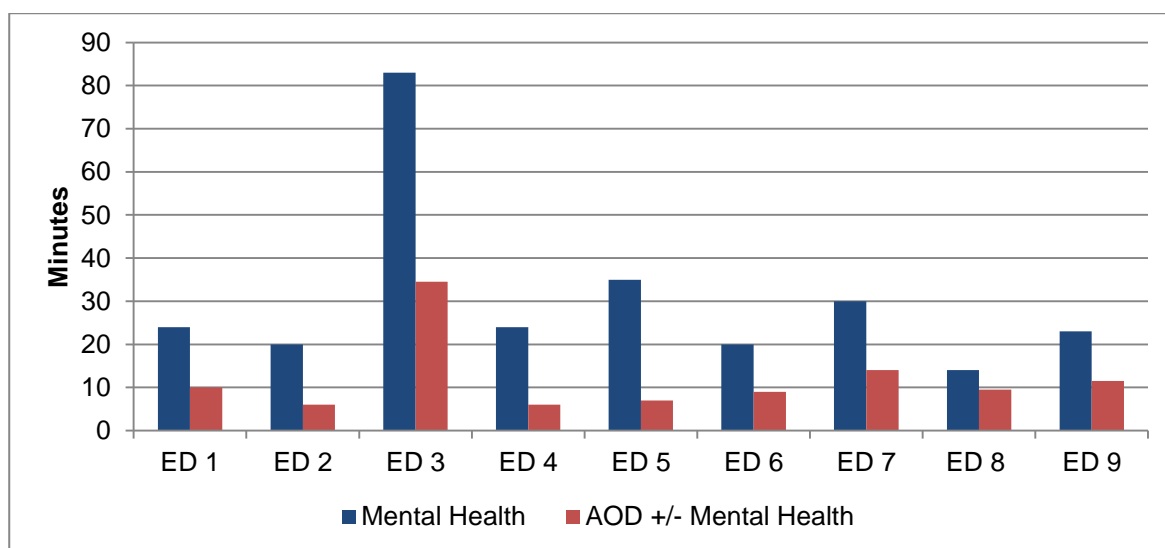
Source: EDDC; Note: Outliers have not been removed

A similar pattern was seen for mental health and AOD (+/- mental health) presentations at rural EDs, with the median wait time for mental health presentations longer than for AOD presentations, with the exception of ED 18 where the wait time was shorter for mental health patients (Figure 11). The median wait times for mental health presentations in rural EDs ranged from no waiting time (ED 15, ED 21, and ED 23) to 23 minutes (ED 11). However, we were unable to confirm whether the 'no waiting time' for the three EDs was an accurate representation of wait times at these EDs or due to data errors. The median wait times for the other AOD presentations ranged from 1 minute (ED 17) to 13 minutes (ED 11, ED 12). The majority of wait times for mental

health presentations were between 0.7-fold to 10-fold higher than for AOD (+/- mental health) presentations.

Figure 11 Median mental health and AOD (+/- mental health) presentation wait time (by any health professional) – rural
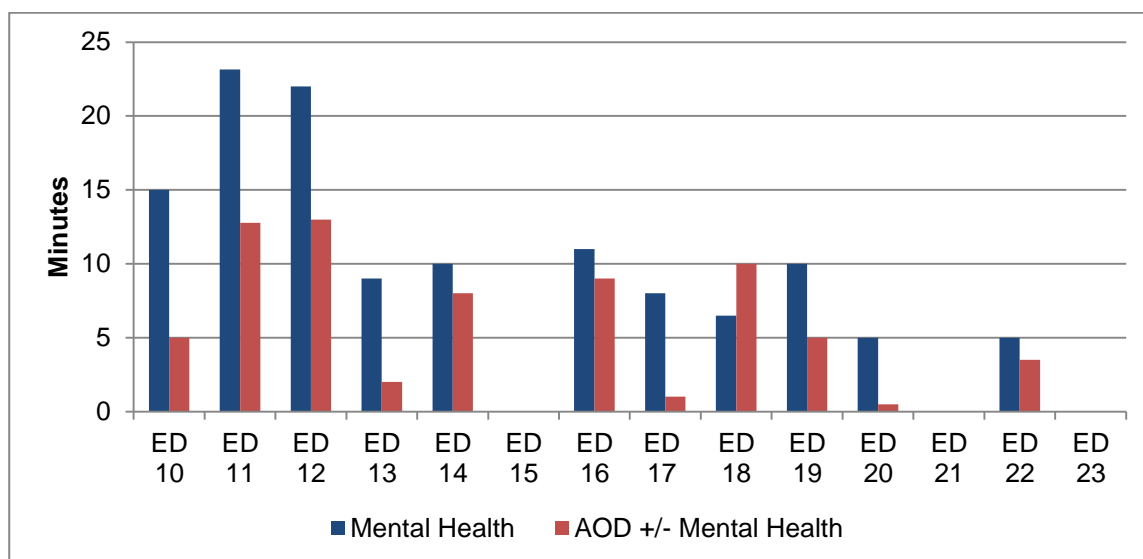
Source: EDDC; Note: Outliers have not been removed

Wait times in ED presentations-Source: In-depth Clinical Review

Valid wait time to first contact/service commencement and the type of health professional (mental health; medical) could be calculated in 194 (87%) of the 223 clinical records reviewed, of which 130 were from metro and 64 from rural EDs. Of those with available data, the majority received a medical review (83%), whilst 60% of patients were seen by a mental health professional (55% of metro and 70% of rural ED patients) (Figure 12). Half (50%) of the patients (n=97) were assessed by a PLN, 42% (n=54) of patients in a metro ED and 67% (n=43) were in a rural ED. A small proportion (10%) was seen only by a PLN (no medical review or concurrent mental health review with another professional) (data not tabled). Conversely, a higher proportion of metro patients were reviewed by a consultant psychiatrist than at rural EDs (8% metro vs 3% rural), with similar results for review by a psychiatric registrar (22% metro vs 6% rural).

The median wait times are provided in Figure 13. Wait times to first service contact and medical consultation were similar, with both less than 30 minutes across metro and rural sites. However, the time to first contact with a PLN was longer in metro EDs, with the median wait time of 1 hour, 40 minutes in metro EDs versus 21 minutes for rural locations. The median wait time for the small number of metro ED patients examined by a psychiatric registrar was 1 hour 20 minutes and 40 minutes where a patient was reviewed by a psychiatrist. Fewer than 5 rural clinical records had documented wait times to review by a psychiatric consultant or psychiatric registrar so regional comparisons were not made for these items.

Figure 12: Number of records reviewed with valid entries relating to first contact and contact with medical and mental health staff in the ED
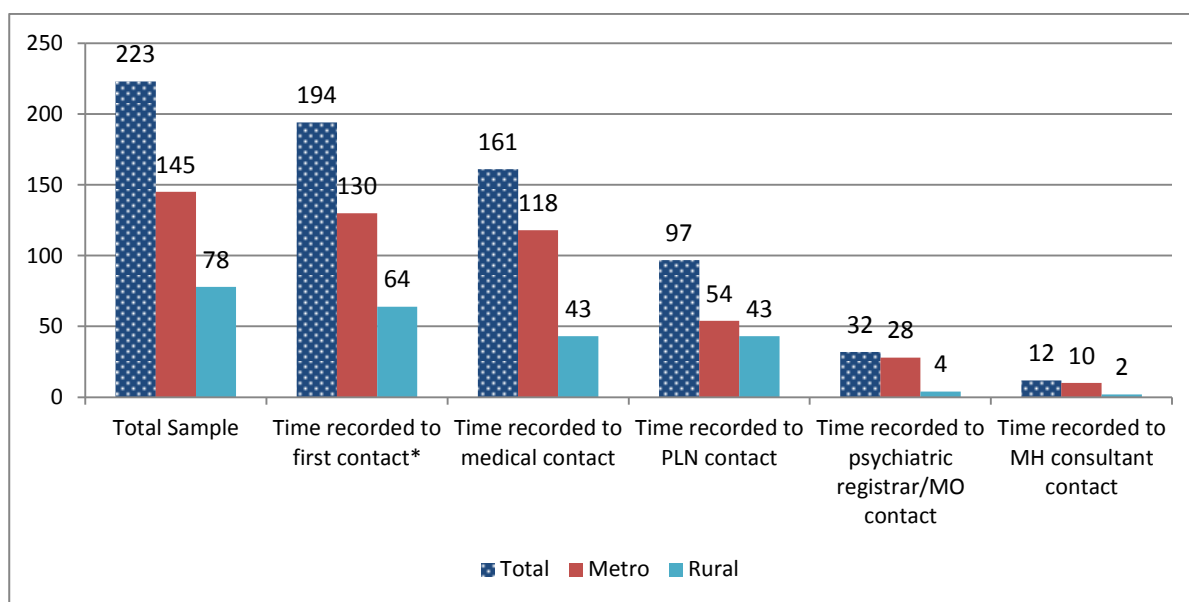
Source: Clinical records

Determinants impacting on wait time for initial assessment included patient intoxication or withdrawal and patient sleeping; in one case the patient's assessment was delayed for over 10 hours until the patient slept off the alcohol intoxication and it was clinically appropriate to conduct a clinical assessment.

Figure 13 Median wait times relating to first contact and contact with selected staff in the ED
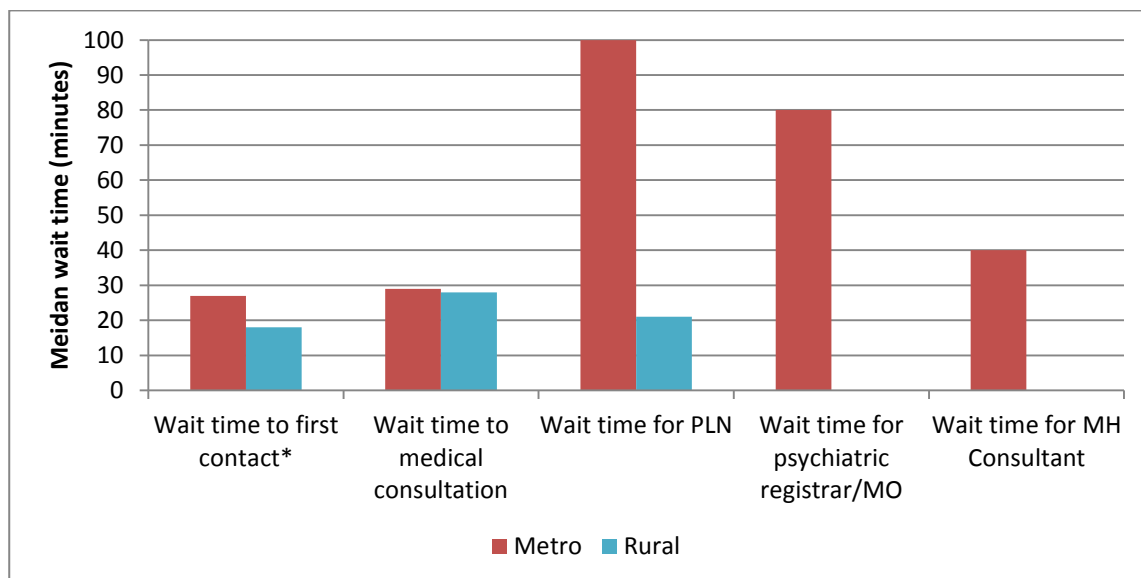
Source: Clinical records *Either medical or mental health staff; Note: The wait time for mental health staff does not take into account when the staff received the call to attend.

Wait times in ED presentations relative to ATS category-Source: EDDC

Of the 23,239 ED presentations in the EDDC data, the wait time could be assessed against the ATS recommendations for 97% of presentations; 19,217 mental health presentations and 3,366 AOD (+/- mental health) presentations (Table 4). The proportion of patients seen within the recommended ATS category was higher for AOD (+/- mental health) presentations than for mental health presentations. Detailed information on the definition of each ATS category is contained in Appendix F.

In metro EDs, 59% of mental health presentations and 73% of AOD (+/- mental health) presentations were seen by a clinician within the recommended time (Table 4) for the relevant ATS category. Almost all patients (98%-99%) categorised as ATS 1 were seen immediately, and for ATS 5, 87% of mental health and 100% of AOD (+/- mental health) presentations were seen within the recommended 120 minutes (Table 4). Compliance with the ATS recommended times was lowest for ATS 3, with 50% of mental health and 60% of AOD (+/- mental health) presentations seen within the recommended time of 30 minutes.

Compliance with the ATS wait times in rural EDs was higher than in metro EDs for most ATS categories (Table 4). The exception was for rural mental health presentations classified as ATS 1 where 94% of rural presentations were seen on time compared with 99% at metro EDs. Overall, 87% of rural mental health presentations and 94% of AOD (+/- mental health) presentations were seen within the recommended ATS time, with the range for mental health presentations from 83% (ATS 3) to 98% (ATS 5) and from 91% (ATS 2) to 100% (ATS 1) for AOD (+/- mental health) presentations.

Table 4 Wait time by ATS category - EDDC

Population	ATS Category	Treatment Urgency	Mental Health Patients n (%)	Mental Health seen on time (%)	Median wait time (minutes (range))	AOD +/- Mental Health Patients n (%)	AOD +/- Mental Health seen on time (%)	Median wait time (minutes (range))
Total†								
	ATS 1	Immediate	187 (1.3)	98	0 (0-14)	112 (3.3)	98	0 (0-14)
	ATS 2	10 mins	2468 (15.4)	84	4 (0-275)	1032 (30.7)	86	4 (0-99)
	ATS 3	30 mins	9891 (50)	58	24 (0-445)	1424 (42.3)	72	13 (0-285)
	ATS 4	60 mins	5880 (28.9)	69	33 (0-1445)	649 (19.3)	86	11 (0-349)
	ATS 5	120 mins	791 (4.2)	92	20 (0-647)	149 (4.4)	97	5 (0-174)
	TOTAL		**19,217***	**67**	**N/A**	**3,366**	**81**	
Metro†								
	ATS 1	Immediate	139 (1.0)	99	0 (0-14)	85 (4.0)	98	0 (0-14
	ATS 2	10 mins	1,841 (13.0)	83	4 (0-147)	809 (38.3)	85	4 (0-99)
	ATS 3	30 mins	7,447 (52.5)	50	30 (0-445)	928 (44.0)	60	21 (0-285)
	ATS 4	60 mins	4,360(30.7)	62	44 (0-443)	271 (12.8)	74	28 (0-349)
	ATS 5	120 mins	402 (2.8)	87	38 (0-647)	18 (0.9)	100	34 (0-78)
	TOTAL		**14,189**	**59**	**N/A**	**2,111**	**73**	
Rural								
	ATS 1	Immediate	48 (1.0)	94	0 (0-7)	27 (2.2)	100	0 (0-0)
	ATS 2	10 mins	627 (12.5)	87	2 (0-275)	223 (17.8)	91	0.3 (0-91)
	ATS 3	30 mins	2,444 (48.6)	83	9 (0-399)	496 (39.5)	93	3 (0-109)
	ATS 4	60 mins	1,520 (30.2)	88	10 (0-1445)	378 (30.1)	95	5 (0-270)
	ATS 5	120 mins	389 (8.3)	98	7 (0-270)	131 (10.4)	97	4 (0-174)
	TOTAL		**5,028**	**87**			**94**	

Source: EDDC; Note: Outliers have not been removed. *Wait time was not available for 615 (2.6%) ED presentations. † Other includes patients (n=41) were directly admitted or were already an inpatient.

Wait times in ED presentations relative to ATS category-Source: In-depth Clinical Review

Wait times were documented in 194 (87%) of clinical records (Table 5). In the clinical review compliance with the recommended ATS wait times was lower than indicated in the EDDC data, with 54% of patients seen within the recommended ATS time (Table 5) compared with 67% in the EDDC data (Table 4). Compliance was highest for ATS 5 (80%) and ATS 4 (72%) and lowest for the most urgent categories. None of the patients classified as ATS 1 were seen immediately and fewer than 50% of patients classified as either ATS 2 or ATS 3 were seen within the recommended times. However, small numbers limit the reliability of the estimates for ATS 1 and ATS 5. Small numbers precluded comparison of metro and rural ED performance against ATS categories.

Table 5 Proportion of mental health presentations that were seen within the recommended ATS wait times and median wait time by ATS category (Clinical Review)

ATS Category	Treatment Urgency	Patients n=223 n (%)	Percentage seen on time (%)	Wait Time First Assessment (minutes) Median (range)	Wait Time for ED Medical Assessment (minutes) Median (range)	Wait Time for PLN Assessment (minutes) Median (range)
ATS 1	Immediate	3 (1)	0 (0)	28.5 (21-36)	N/A	N/A
ATS 2	10 mins	23 (12)	45	15 (0-122)	7 (0-50)	97 (0-843)
ATS 3	30 mins	135 (61)	49	31 (0-735)	31 (0-735)	65 (0-765)
ATS 4	60 mins	57 (26)	72	25 (0-671)	29 (3-194)	38 (0-369)
ATS 5	120 mins	5 (2)	80	21 (5-98)	21 (5-98)	98 (98)
TOTAL		223*	54	N/A	N/A	N/A

Source: Clinical records; Note: Outliers have not been removed *Wait time to first assessment was not available for 29 (13%) of ED presentations

Wait Times and Wait Processes-Source: Clinical Staff Interviews

Question: Where do patients wait for mental health assessment?

The place where a patient waits for their mental health assessment was described by 30 staff as specifically dependent on their presentation, with patients assessed as low risk waiting in the main ED waiting room and patients assessed as high risk brought immediately into the ED. Some staff indicated that where the patient waits is dependent on the capacity of the ED at the time and whether anyone accompanied the patient e.g. friend, family member. The remaining 20 interviewees described the various places where patients may wait. Once within the ED, patients can be asked to wait in the 'distressed relative's room', assessment bay (single bay or most visible bay), mental health 'safe rooms', 'fast track' wait rooms, resuscitation bay when sedation is required, or on a trolley/chair in the corridor or interview room. Patients, who are brought in by Police, especially if highly aroused, are often made to wait inside the police van until they can be assessed.

Example staff responses to interview questions

'Depends on triage score. If low – in the waiting room with other patients. If behaviour / violence or a high score then the patient may be brought directly into ED awaiting assessment.'

'We try not to have mental health patients waiting in the waiting room for too long and prefer to bring them into the department, even if it means they wait on a chair or corridor trolley. So

patients may wait: in an ED cubicle, on a trolley in the corridor, in a chair in the corridor, in our one consult room or in the waiting room.'

'The Fast track system requires us to in reach into the Waiting room, the back of Police Vans, parked cars, hospital carparks and anywhere else a person in distress may be and we will see the patient wherever we can.'

'The majority of mental health patients wait in the "Fast Track Wait room" ……….. Sadly they can remain on a plastic chair in this spot for hours awaiting a bed - beds are given to patients with medical problems as a priority. In times of acute bed shortage mental health patients may be moved off their beds back to a Plastic chair in the morning, then placed back onto a bed at night or when one becomes available. The ED team work hard to ensure this practice does not happen as much as possible.'

'When presenting via WA Police, if the patient cannot be immediately accommodated then the patient (if aggressive) will be held in the police van whilst bed movements and staffing is arranged (in a timely fashion).'

Key Findings

EDDC Data
- In metro EDs, the median wait time from triage to first contact with any health professional was between 2 to 5 times longer for mental health presentations than for AOD (+/- mental health) presentations.
  - o These differences were evident in rural EDs with the median wait time for mental health presentations up to 10-fold longer than for AOD presentations.

- Compliance with each of the ATS categories was varied between metro and rural EDs and a greater proportion of AOD (+/- mental health) presentations were seen within the relevant ATS category than mental health presentations.
  - o Almost all mental health and AOD (+/- mental health) presentations classified as ATS 1 were seen on time; 98%-99% for metro and 94%-100% for rural EDs, respectively.
  - o Compliance with the recommended ATS wait time was lowest for ATS 3 in both metro (50%) and rural (83%) EDs.

Clinical Review Data
- Overall, 60% of patients in the clinical review were seen by a mental health professional.

- The proportion of patients assessed by a PLN was lower in metro EDs (42%) compared with rural EDs (67%). Conversely, a higher proportion of patients in metro EDs were examined by a psychiatric consultant (8%) than in rural EDs (3%).
  - o *Comment: These results may be explained by the availability of a psychiatrist through the Consultation Liaison (CL) Teams in metro EDs. The CL Teams aren't available in rural hospitals.*

- The median wait time to first contact with a PLN was longer in metro EDs was 100 minutes (1 hour, 40 minutes) compared with 21 minutes in rural EDs.

- In contrast to the EDDC data, the clinical record review found poor compliance with ATS categories 1-4, with 54% of patients in the medical review seen within the recommended ATS times.
  - Compliance was lowest for the most urgent categories with none of the patients classified as ATS 1 and fewer than 50% of patients classified as ATS 2 or ATS 3 seen within the recommended times.

Staff responding to the interview/survey indicated:

- The place where patients wait for the mental health assessment varies dependent on the assessment of the patient's risk, the capacity of the ED at the time, and whether the patient was accompanied.
- Patients brought in by police are often left in the police van until assessment.

Section 5: Documentation of General Information

The percentage of clinical records with the general information completed is shown in Figure 14 for metro EDs only. The patient clinical records relating to rural ED presentations were copied by each service and couriered to the Chief Psychiatrist. The majority of these did not include the front page with the demographic information. It was decided that requesting staff to send the missing page to the Chief Psychiatrist would be an impost to mental health services so these items were not examined for rural EDs.

Completion of the general information in clinical records of metro EDs was of a high standard (Figure 14). Recording of demographic information and identification of primary carers and their details, along with consumer contact numbers were present in 100% of the files reviewed. All other general items were completed for more than 80% of presentations.

Figure 14 Documentation of general information in metro EDs.
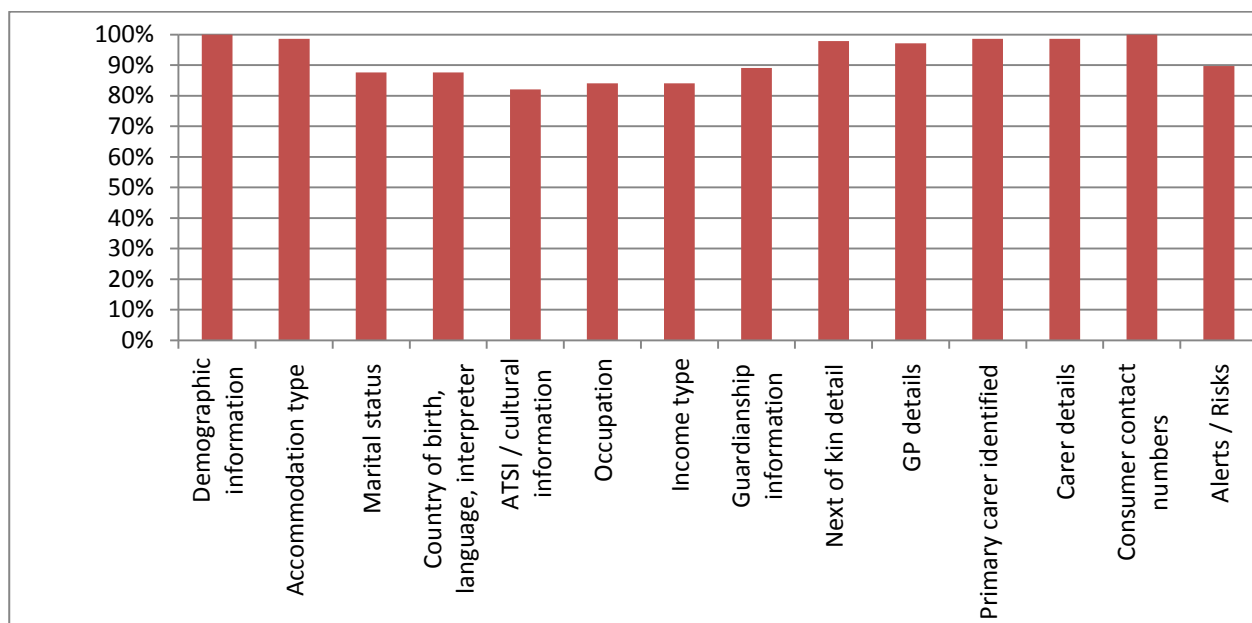
Source: Clinical records

Key Findings

- The proportion of metro ED clinical records with general information completed for each item was greater than 80%, with compliance greater than 90% for the majority of items and 100% compliance for consumer and 99% for carer details.
  - o This item was unable to be assessed for rural EDs.

Compliance with Stokes recommendations

The names and contacts of carers should be recorded where appropriate - Stokes recommendation 2.12
- Details of the primary carer were recorded in the clinical records of all (99%) of metro ED patients. This item was unable to be assessed for rural EDs.

Section 6: Risk Assessment: In-depth Clinical Review

An assessment of risk is conducted by ED staff for each mental health patient at the point of presentation. The patient clinical records were assessed against the criteria contained within the SSCD 'Risk Assessment and Management' forms (Appendix F). The clinical review examined the level of compliance with assessment of completion of risk for each of the key domains, recording of the severity of risk for each patient (low, medium, high) and the use of a standardised risk assessment tool.

Domains reviewed as part of the patient risk assessment

The SSCD Risk Assessment and Management Plan assesses information on background and current risk factors for six items; general risk factors (e.g. alcohol/drug abuse history and current intoxication, emotional distress/agitation) suicide, violence/aggression, other risk factors (e.g. absconding), overall assessment/grading of the level of risk, and documentation of risks to be addressed in the IMP/care plan (Figure 15). The reviewer examined the quality of the risk assessment in relation to completion of these six risk factors.

The clinical reviewer found that the overall assessment of risk assessment was adequate in 94% of all clinical records reviewed, ranging from 99% of metro ED patients to 86% of rural ED patients (Figure 15). The general risk factors were documented for 96% of all ED presentations, suicide risk for 86%, violence or aggression for 83%, and 69% of records documented protective factors. Completion of each of these six risk criteria was higher in the clinical records of metro EDs compared with rural EDs. In metro EDs compliance was 97%-99% for five categories and 86% for the sixth category, protective factors. In rural ED clinical records, the only category with greater than 90% completion was the general risk factors domain (91%) with compliance of less than 80% for the other five domains, ranging from 37% for protective factors to 78% for overall assessment of risk.

Figure 15 Risk assessments: recording of important risk factors
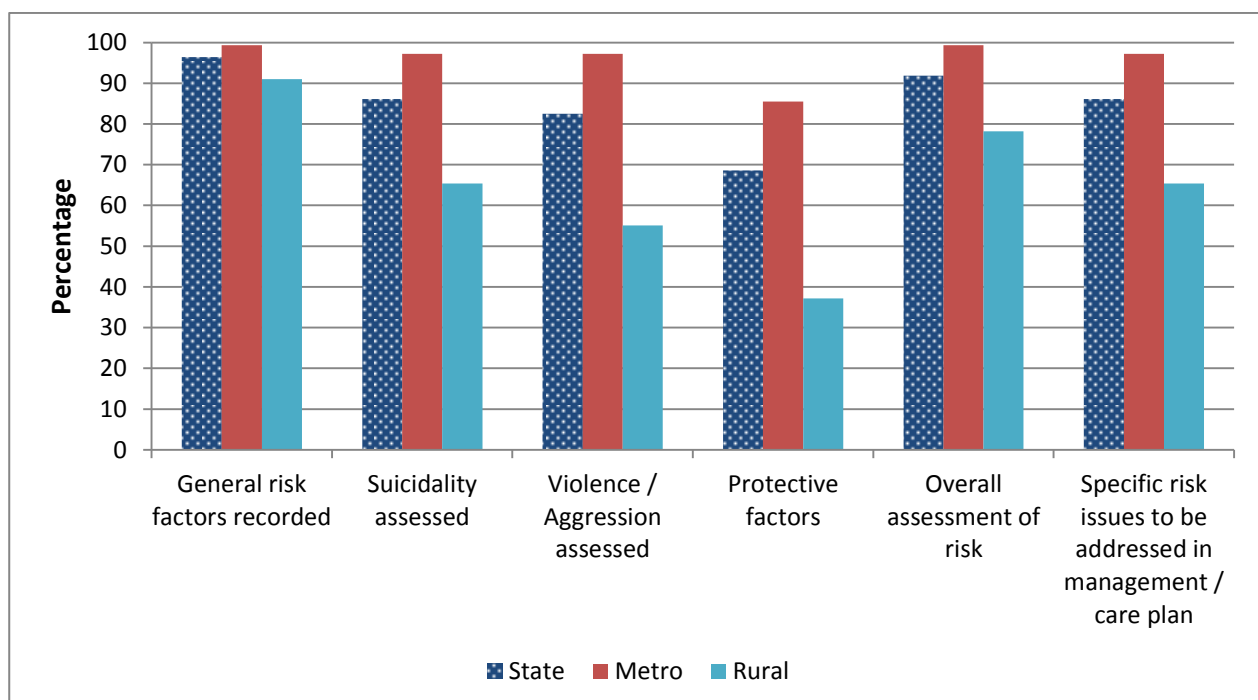
Source: Clinical records

There were 92 presentations with a presenting problem of deliberate self-harm (DSH)/suicidality equating to 41% of the 223 clinical records reviewed; 46% of metro and 32% of rural presentations (results not tabled). In addition, a further 21 patients who did not present with DSH/suicidality were identified through the risk assessment as being at medium to high risk of DSH/suicidality. This gave a total of 113 patients (51%) identified as at-risk of DSH/suicidality; 79 in metro and 34 in rural EDs. A risk assessment was recorded for 97% of patients at-risk of DSH/suicidality; 100% in metro and 94% in rural EDs. Half of these patients were at medium risk (52%) and 10% were assessed as high risk of suicide and risk of DSH was identified as medium risk for 34% and high risk for 6% of patients, respectively. Overall, 35% of patients had medium to high risk for both risks.

Of the 113 patients identified with DSH/suicidality, information on the clinical staff that had seen the patient was available for 99 (88%, 70 metro and 29 rural). Of these, 60% of the 70 patients in a metro ED were examined by one or more mental health staff and 90% were seen by a medical doctor. In rural EDs, 66% of the 29 patients were reviewed by a mental health professional and 72% by a medical doctor. Only one rural patient was seen by a psychiatric registrar and none were seen by a psychiatric consultant. There were 2 patients (3%) who were only reviewed by a PLN in the metro EDs compared to 7 patients (24%) in the rural EDs. An IMP/care plan was completed for 98% of patients presenting with DSH/suicidality (100% metro 94% rural). Of these the risk issues of 93% of patients with DSH/suicidality were addressed in their management/care plan; 100% in metro and 75% in rural EDs and of these, 73% had been discussed with a psychiatrist and/or a senior clinician.

Risk severity assessment

The overall rating of risk of suicide, self-harm, violence/aggression, vulnerability, absconding and other risks is presented in Figure 15. The clinical records reviewed show that, where a patient had a completed risk assessment, 31% received a rating of 'low' for all risk factors. The remaining cases had at least one risk factor rated as either medium or high or more commonly, the patient was assessed as having more than one risk factor.

Overall, risk ratings of medium to high were given for suicide to 31% of patients and to 21% of patients at-risk of self-harm. For 42% of cases, a high and/or medium risk was assessed for both suicide and self-harm.

There was a marked difference across metro and rural ED clinical records in the proportion of risk assessments which either did not record an assessment of a given domain or in which the reviewer was unable to assess if a domain had been addressed (Figure 16). Information was missing on the risk of absconding in the records of 32% of metro ED patients and in 67% of patients at rural EDs. Information on 'other' risks was missing in 75% of metro and 42% of rural ED clinical records reviewed. In rural EDs, assessment of the risk of suicide, self-harm violence/ aggression, and vulnerability was missing in 35% to 49% of clinical records reviewed compared with between 3% and 9% in metro EDs.

Figure 16 Risk assessments: risk ratings by Metro or Rural ED
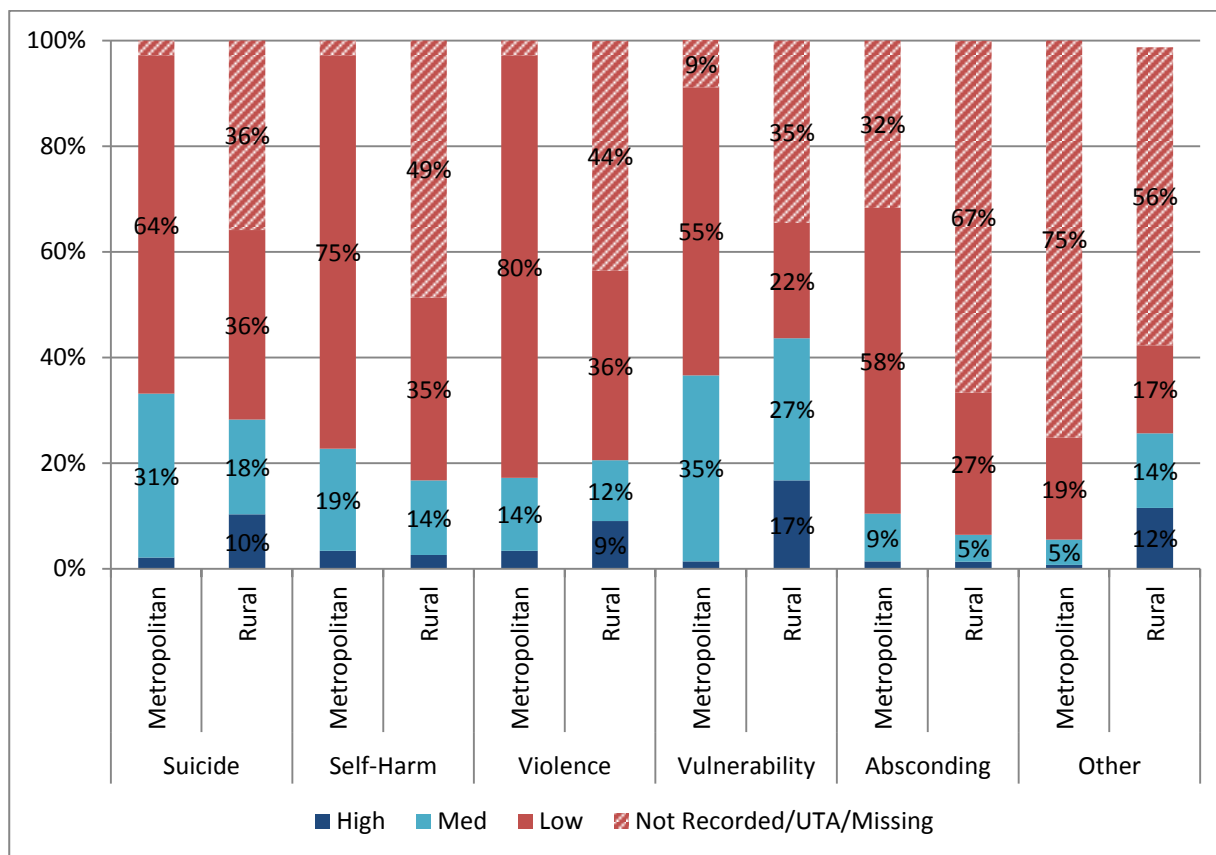
Source: Clinical record

Risk Assessment sign off and documentation

The overall administrative items in the risk assessment and management plan were complete for between 89% and 96% of records reviewed (Figure 17). The proportion of documentation completed in metro EDs was at or in excess of 99% and for rural EDs between 72% and 90%.

Figure 17 Risk assessments: documentation of clinical staff details

Source: Clinical records

Risk assessment using a standardised risk assessment tool

Patient clinical records were examined for evidence that a risk assessment was completed using a standardised document such as the Brief Risk Assessment (BRA) or the SSCD Risk Assessment and Management Plan (RAMP). The clinical reviewer noted marked variability in the content and standard of completion of the risk assessment when a standardised instrument was not used to assess and record risk.

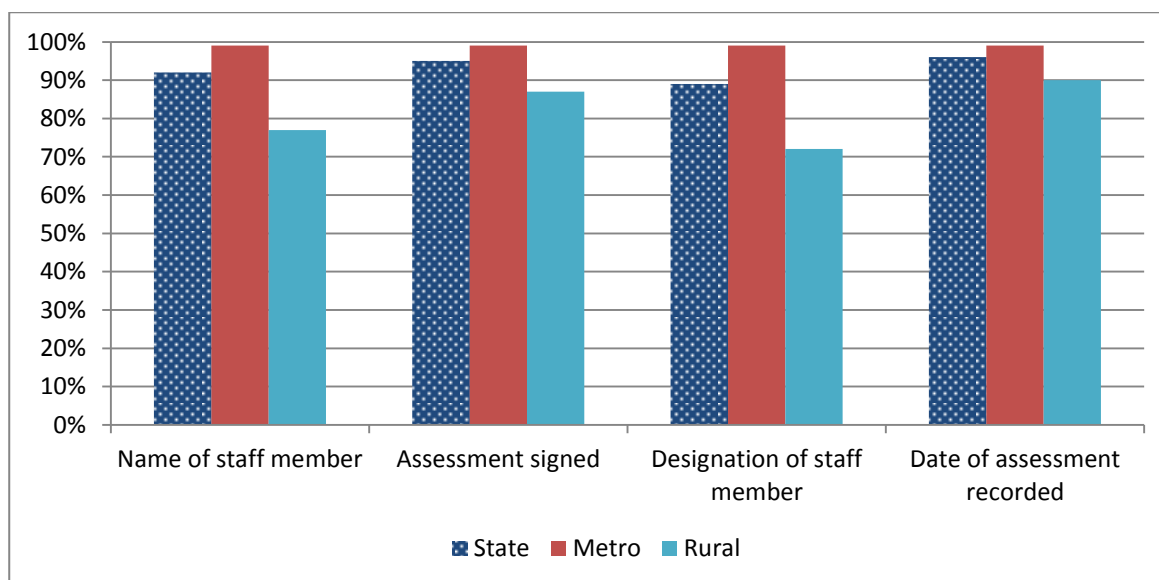The clinical review found that two-thirds (66%) of risk assessments were recorded in the Integrated Progress Notes (IPN), with a small proportion of risk assessments (28%) being completed on a standardised risk assessment or other proprietary form (Table 6). The proportion of risk assessments recorded in the IPN was similar across both metro (64%) and rural (69%) EDs. However, the use of standardised risk assessment tools was higher in metro EDs, with 28% of clinical records reviewed having either the BRA or the RAMP, compared with 3% in rural EDs. Rural EDs used a higher proportion of proprietary instruments to assess risk (12%) compared with 8% in metro EDs. Examples of the other instruments used across the EDs were the Child and Adolescent Mental Health Service (CAMHS) risk assessment tool, the psychiatric assessment and service plan, and the ED triage assessment document.

For patients presenting or assessed as at-risk of DSH/suicidality, a standardised risk management tool was used to assess risk in 100% of metro and 82% of rural EDs.

Table 6 Risk assessment tools

	Brief Risk Assessment	Risk Assessment & Management Plan	IPN	No adequate risk assessment	Other	Total
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Metro	16 (11)	24 (17)	93 (64)	1 (1)	11 (8)	145 (100)
Rural	1 (1.3)	1 (1.3)	54 (69)	13 (17)	9 (12)	78 (100)
State-wide	17 (7.6)	25 (11.2)	147 (65.9)	14 (6.3)	20 (9.0)	223 (100)

Source: Clinical records

Risk Assessment Processes-Source: Clinical Staff Interviews

Question: "What risk assessments are done, and by whom?"

Various risk assessments used within the ED setting were described by the interviewees. These included a 'Suicide Risk Assessment' or 'WACHS MR46' (n=12) which was used in many of the rural locations that do not have mental health staff, a BRA (n=5), a RAMP' (n=4) and a few staff reported that a 'Mental State Evaluation' (n=3) is completed and risk is documented in the IPN.

Other standardised and non-standardised assessments mentioned less frequently were the 'security risk and behavioural risk assessments', 'standardised risk assessment tools', Clinical Risk Assessment and Management Plan (CRAMP), ACE templates, BACPAC mental health assessments, 'standard pro-forma' and risk assessments with no specific types described. There were two instances where measures of urgency rather than risk assessment were described, including the 'Hobart Triage Score' and also the 'Australian Triage Score'.

In regards to who does the risk assessments, on 3 occasions it was described that all staff do risk assessments. In EDs that have access to mental health staff, interviewees indicated that mental health assessments were completed by the Mental Health Liaison Nurse (MHLN) or PLNs whilst other risk assessments may be completed by medical staff. In some instances it was described that

mental health staff have 'their own' risk assessments and that medical staff do not always get to see these. In EDs where mental health staff members are not available, ED nurses generally complete the risk assessments. There were a few comments regarding the accuracy of risk assessments with the 'quality being dependent on who completes them', 'staff intuition and experience being better than standardised forms' and that they are considered 'not effective' and 'useless paperwork exercise'.

Example staff responses to interview questions

> *'Risk Assessment and Management plan is performed by the MHLN.'*
>
> *'The ED MHLN usually conducts risk assessments on Psolis ie Brief Risk assessment.'*
>
> *'The Psych DMO will usually summarise risk assessment in their notes as well'*
>
> *'Security risk upon presentation where there is cause for concern for staff/patient/visitor risk'.*
>
> *'Numerous risk assessment tools are available however the appropriateness and benefit of such a tool in ED's is questionable'.*
>
> *'Psychiatric Registers and Consultants also complete risk assessments. We don't see the Psychiatric notes, only a separation letter if one is completed. It's all a bit 'secret squirrel'.'*
>
> *'The Current standardised mental health assessment form is a risk assessment by definition, it is accompanied by a Risk assessment and management plan that is widely dismissed as an inaccurate way to determine risk and most times is ignored as a meaningless paperwork exercise.'*

Question: "At what intervals is risk re-assessed?"

The intervals at which risk is re-assessed was described by most of the interviewees (n=38 (81%)) as being dependant on the patient's presentation and how long they have been in the ED, with risk assessments being completed when clinically required. The interview responses highlighted the dynamic nature of risk and the requirement for continuous risk assessment. The outcome of the initial risk assessment was described by some (n=4) as influencing the intervals that risk is reassessed, with those with a high risk being re-assessed more frequently. When a specific time frame was described this included a minimum of one per day (n=4), a minimum of once whilst in ED (n=1), every time that they are reviewed (n=1) and only once whilst in ED (n=2). There were missing responses for 3 interviewees.

Example staff responses to interview questions

> *'This can be dependent on the length of stay in ED and changes within a patient's presentation whilst in ED in terms of presenting risk factors.'*
>
> *'Score dependent: High risk (patients) reassessed each shift; Medium risk reassess every 24 hours; Low as required.'*
>
> *'Risk is variable. A staff member can assess the risk to be low however in the blink of an eye the patient can abscond, or inflict violence towards self/others. Risk changes regularly and is unpredictable'*
>
> *'At initial assessment - unsure if reassessed. Most mental health patient's conditions don't change from initial presentation in the ED.'*

Key Findings

- Risk assessments were completed for 99% of metro and 86% of rural ED mental health presentations.

- Completion of the background and current risk factor information for each of the six risk factor domains was high in metro EDs (>85%), compared with rural EDs where compliance was 90% for general risk factors and less than 80% for the five other domains.

- There were 113 patients identified with DSH/suicidality of which DSH/suicidality was the presenting problem for 81% and a further 21 patients (19%) were identified as at-risk of DSH/suicidality through the routine risk assessment.
  - Over half (60%) of metro ED presentations and 66% in rural EDs were seen by a mental health professional.
  - A risk assessment was recorded for all (100%) of metro and 82% of rural ED patients with DSH/suicidality.

- All (100%) of metro and 71% of rural ED patients identified with DSH/suicidality had this risk addressed in their management care plan.
  - Just less than three quarters of the management plans (73%) had been discussed with a psychiatrist and/or a senior clinician.

- Staff compliance with administrative items, such as name, designation, and signature was very high for metro EDs (99%) and between 72% and 90% for rural EDs.

- The use of a standardised risk assessment tool improved the content and standard of completion of the risk assessment.

- The majority (66%) of risk assessments were recorded in the patients IPN. A standardised risk assessment form was used in less than one-third (29%) of risk assessments in metro EDs and 3% in rural EDs.
  - For patients identified as at-risk of DSH/suicidality, a standardised risk management tool was used in 100% of metro and 82% of rural EDs.

Staff responding to the interview/survey indicated:
- Mental health staff, including PLNs, psychiatric consultants, and psychiatric registrars, generally complete risk assessments. Where a mental health staff member is unavailable, ED nurses will complete the risk assessment.
- The quality of the risk assessment is dependent on who completes the assessment, their intuition and experience rather than on whether a standardised form is used.
- Risk assessments are completed when clinically required, with high-risk patients being re-assessed more frequently.

Compliance with Stokes recommendations

Patients presenting with DSH/suicidality must have a risk assessment - Stokes recommendation *7.1*
- A risk assessment was conducted for all (100%) of metro and 94% of rural ED patients identified as at-risk of DSH/suicidality.
- A standardised risk management tool was used to assess risk in all (100%) of metro and 82% of rural ED patients presenting with DSH/suicidality.

A care plan must be formulated for patients presenting with DSH/suicidality - Stokes recommendation 7.1 part 2
- A clinically appropriate care plan was completed for 98% of patients presenting with DSH/suicidality (100% metro 94% rural)
    - Of these the risk issues relating to DSH/suicidality were addressed in the IMP/care plan for 93% of patients; 100% at metro EDs and 75% at rural EDs.

Section 7: Mental Health Assessment

The mental health assessment is a key component of assessing a person's psychological functioning and whether additional psychiatric follow-up is required. Domains examined include appearance, behaviour, mood and affect, speech, cognition, thoughts, perception, insight and judgement. The developmental level of the person and age-appropriateness of the noted behaviours need to be taken into consideration.

Recording of assessment details related to mental health assessments

The patient clinical records were reviewed against the criteria contained within the SSCD 'Mental Health Assessment' forms (Appendix F). Each of the items required on these forms was assessed by the clinical reviewer for compliance and quality as part of the in-depth clinical record review.

A mental health assessment consists of:

- Patient history
- Mental state examination
- Physical examination
- Formulation (only completed formulations were taken as evidence of compliance)
- Diagnosis
- Risk assessment and management plan

A mental health assessment was completed for all ED patients and was either recorded in the IPN (76%) or on a standardised form (20%) (information missing for 8 patients). A standardised form was used more frequently in metro EDs (25%) in comparison to rural EDs (12%) (results not tabled). Twenty six separate criteria were reviewed, with the exception of the functional assessment, family focussed assessment, and genogram components of the mental health assessment as these are rarely completed in the ED setting (Figure 18).

There were marked differences in the proportion of clinical records in metro and rural EDs that completed each of the components of the mental health assessment (Figure 18). Five items were completed in 90% or more clinical records for both metro and rural EDs. These included the history of the presenting problem and clinically appropriate initial management plan (IMP/care) (100% in metro and 96% in rural EDs) and the items relating to the date, location and source of the information.

An alcohol and drug history was completed in 67% of the files reviewed, ranging from 87% for metro EDs to 31% in rural EDs. However, few clinical records had the standardised form completed; 0.7% in metro and 1.3% in rural EDs.

Regional differences were also observed for other items in the mental health assessment with completion higher in metro compared with rural EDs. This included parental status (86%% vs 27%), formulation (88% vs 39%), details of current functioning and supports (92% vs 59%) and evidence that a consultant psychiatrist or senior clinician had been consulted (73% vs 50%), respectively (Figure 18).

Few of the clinical records reviewed had evidence that the carer was involved in providing information to the clinician during the assessment. Carer involvement was documented in 14% of presentations state-wide, ranging from 19% in metro EDs to 4% in rural EDs (Figure 18).

Overall, 65% of the ED mental health presentations were discussed with a consultant psychiatrist/ senior doctor (73% of metro and 50% of rural EDs) (Figure 18). Details of the proportion of IMP/Care plans discussed with a consultant psychiatrist/senior doctor for each type of patient outcome are presented in Table 7. The highest proportion of IMP/Care plans discussed with a

consultant psychiatrist/senior doctor (100%) occurred when the patient left against medical advice or absconded (Table 7).

Table 7 Patient outcome by consultation status with Psychiatric Consultant/Senior Doctor

ED presentation Outcome	IMP/Care Plan discussed with Psychiatric Consultant/Senior Doctor	
	No	Yes
	%	%
Discharge, no further action	32	68
Discharged GP follow up	48	52
Left Against Medical Advice/Absconded	0	100
Medical admission	43	57
Mental health admission - involuntary	33	67
Mental health admission - voluntary	33	67
Referred to Community mental health	32	68
Referred to Other Service/ED	35.7	64
Outcome not recorded	67	33
Overall	35	65

Source: Clinical record   Note: 1.3% of records reviewed did not have information on the patient outcome.

Patients identified with DSH/suicidality

A mental health assessment was recorded for all patients identified with DSH/suicidality, with a standardised form used in 33% of metro and 6% of rural clinical records (results not tabled). Around half (54%) of these patients were examined by a mental health professional (PLN, psychiatric registrar, psychiatric consultant), with similar proportions in both metro and rural EDs. Almost all of the patients identified with DSH/suicidality (98%) had a clinically appropriate IMP/care plan; 100% at metro and 94% at rural EDs. Where an IMP/care plan was completed, it was discussed with a psychiatrist or senior clinician in 72% of cases; 76% at metro and 63% at rural EDs.

Figure 18 Mental health assessments: recording of information.
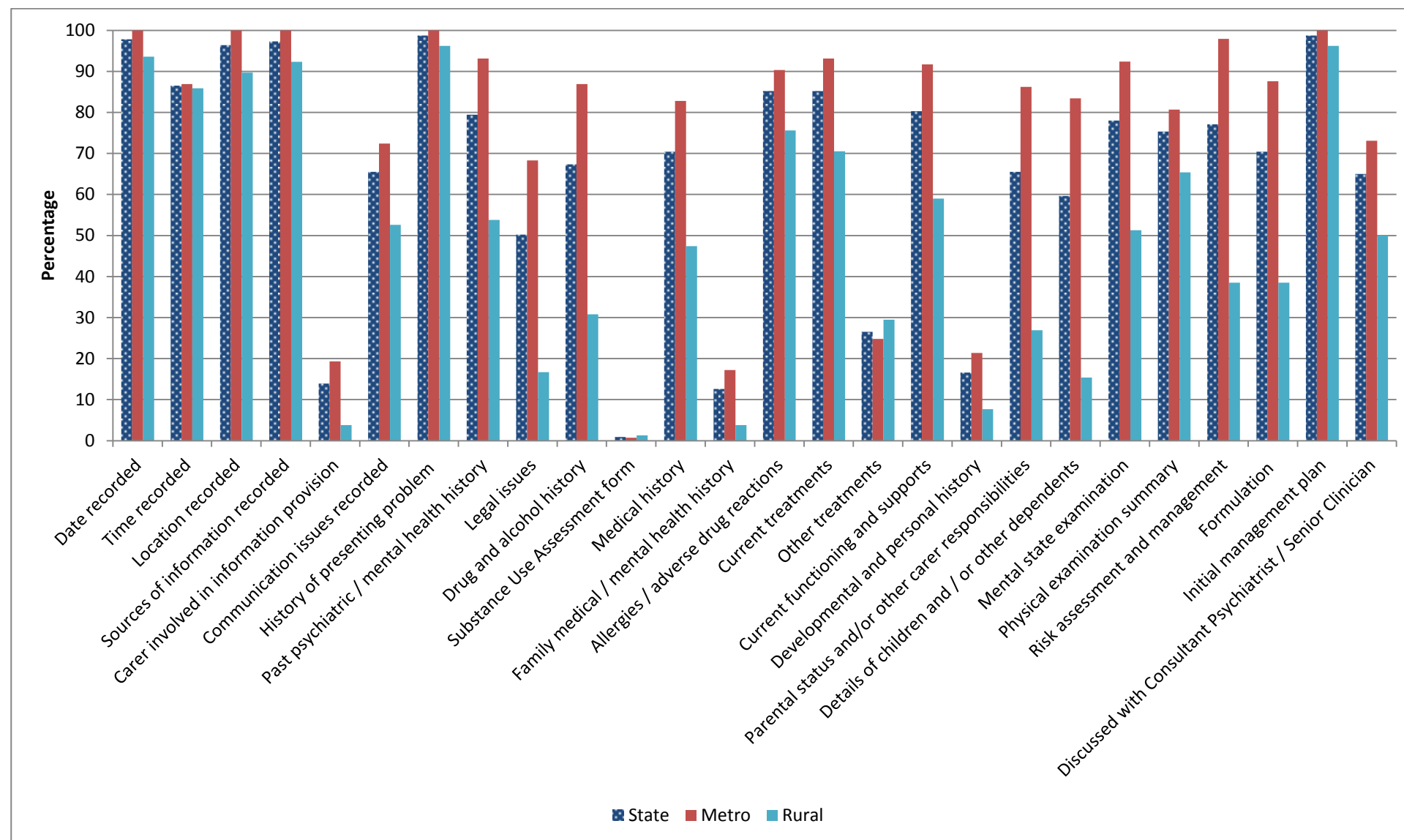
Source: Clinical record

Quality of Mental State Examination

Compliance with recording the mental state examination items ranged between 73% and 92%, state-wide with the highest proportion completed being for mood/affect (92%) and behaviour (89%) (Figure 19). The proportion completed was lowest for 'thought stream' (73%) and 'thought form' (76%). However, these two factors are often described together in a mental state examination, which makes it difficult to assess compliance individually.

Completion of the various domains of the mental state examination varied between metro and rural EDs, with compliance in rural EDs considerably lower than in metro EDs (Figure 19). Over 90% of the clinical records reviewed for metro EDs included information on each of the domains, compared with rural ED clinical records where compliance was 60% or less for the majority (80%) of the items.

Figure 19 Identification of components recorded in mental state examination
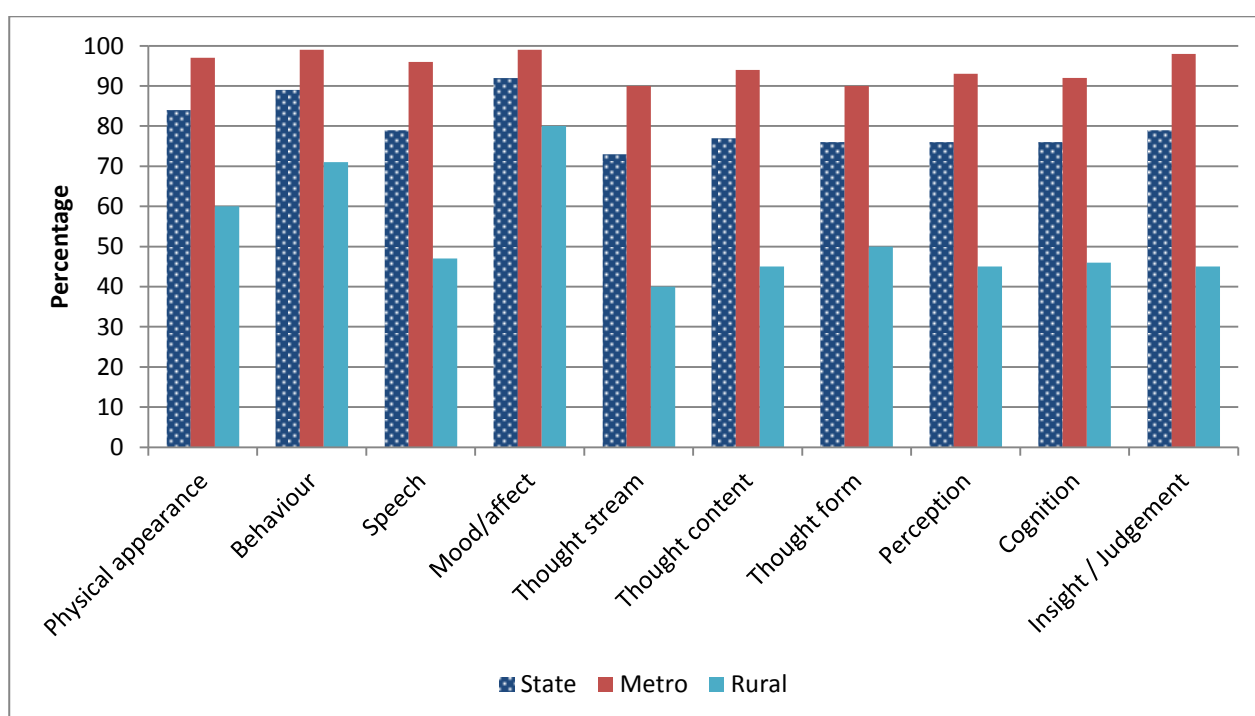
Source: Clinical records

Quality of formulation

For the purposes of this Review, formulation was defined as a summary of the client's presentation, gained from assessment, which draws together important features to facilitate the development of a treatment plan (Appendix F). It should be noted that while partial formulations were not counted in the sections above, they were considered in this section. The formulation structure used by clinicians varies according to discipline, with some trained in a '3P' structure, which records predisposing, precipitating and perpetuating factors and others a '5P' structure, using all five of the items listed below. For the purposes of this Review both a '5P' formulation structure and '3P' structure were evaluated:

1. Predisposing
2. Presenting
3. Precipitating
4. Perpetuating

5. Protective factors

A formulation was evident in 88% of metro and 39% of rural ED clinical records, with a high proportion of the formulations in the rural clinical records assessed by the clinical reviewer as 'partially' completed (58%) (i.e. not containing all clinically relevant elements) compared with 12% of formulations assessed as 'partially' completed in the metro ED records (results not tabled).

A high level of compliance was evident with completion of two elements of the 3P formulations for recording predisposing (93%) and precipitating factors (91%), whilst there was a reduction in compliance for perpetuating (66%) across the state (Figure 20). Compliance varied by location from 95% to 100% in metro and 79% to 95% in rural EDs. There was a marked reduction in completion of one of the other factors that are contained within a 5P formulation (protective factors 49%) whilst the majority completed the factor presenting (99%). Completion of the two factors with lowest compliance (perpetuating and protective) was two to three times higher in metro than in rural EDs (Figure 20).

A formulation was present in the clinical records of 92% of patients presenting with DSH to a metro ED and 53% of these patients presenting to a rural ED, with 44% of formulations in rural clinical records assessed as 'partially' completed (results not tabled).

Figure 20 Presence of specific 5P structural items in the formulation
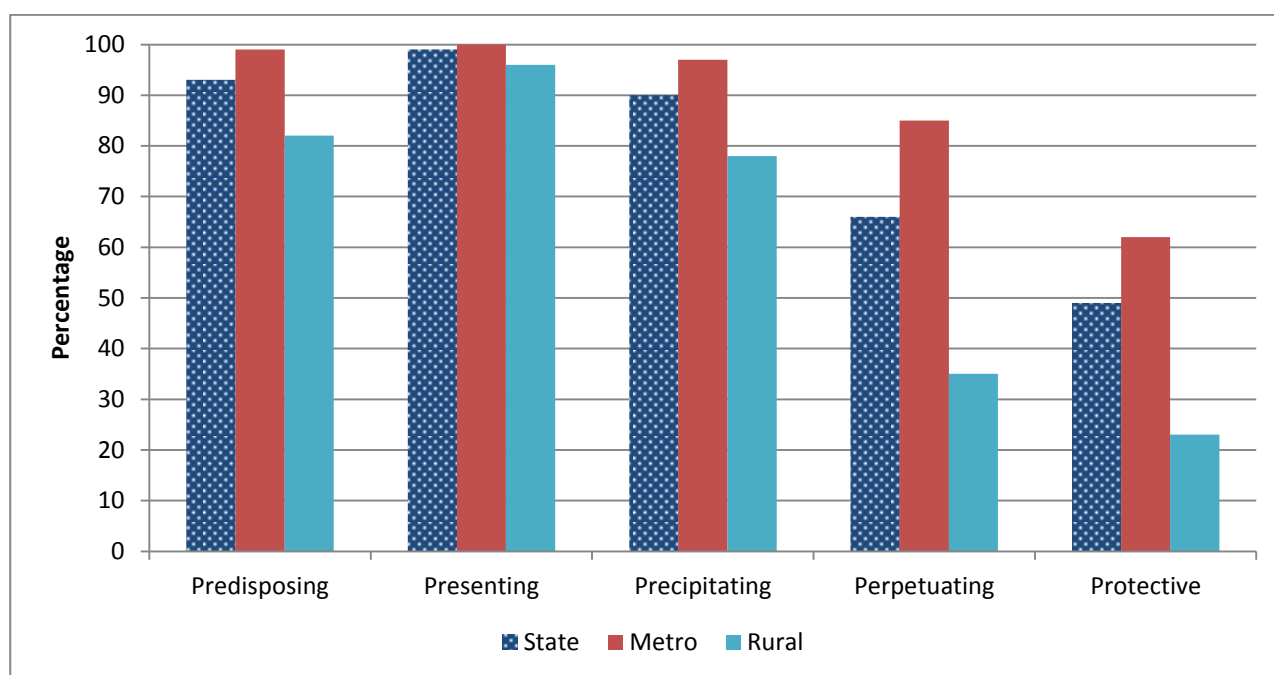
Source: Clinical records

Sign off and proper recording of assessment documentation

Completion of each of the four measures assessed (staff name, signature, designation, and date), was in excess of 80% across the state, with compliance in metro EDs 96% to 100% for each domain (Figure 21). Compliance was lower in rural EDs, ranging from 75% for recording of staff designation to 91% for recording the date of assessment. However it was noted by the reviewer that while staff name and designation were present, they were illegible in 41% of rural ED records.

Figure 21 Sign off and completion of mental health assessments

Source: Clinical records

Mental Health Assessment-Source: Clinical Staff Interviews

Question: "Who does the initial mental health assessment?"

Many rural EDs do not have mental health staff located within the ED and therefore there is a diverse array of staff members that complete the mental health assessment. Within these settings (n=14) it is generally the ED nurses, general doctors and nurse practitioners who complete the mental health assessment. In rural locations where community mental health services are available, patients are often referred to these services for further assessment. Within the Perth metro area (n=27) and larger rural EDs (n=9) where mental health staff members are available in the ED or in a CL capacity, mental health assessments are generally completed by MHLN or PLN.

Access to specialist mental health staff is described as being dependent on staff availability, the capacity of the ED, the timing of the presentation, and the acuity of the patient presentation (n=11). In places where mental health liaison services are not available 24/7 (n=3), the timing of the presentation influences who undertakes the mental health assessment. When mental health staff are unavailable, general medical nurses will often complete mini and basic mental health assessments. Interviewees reported that registrars and consultants tend to complete assessments only when there is a more acute presentation or a person arrives at the ED on MHA forms.

Example staff responses to interview questions

'A registrar or consultant is usually only called upon if the patient is presenting on forms under the Mental Health Act from the community.'

'ED Nurse, Doctor, then if 'in hours' referred to community mental health team - will attend department for assessment'.

'General emergency medical staff do MSE Mini MSE and brief risk assessment and referral to EDMHLT when identified risk of harm to self or others.'

> *'PLN, psych registrar, ED doctor. Depends on which staff members are available and the acuity of the presentation.'*

Question: "Is every mental health presentation discussed with medical staff?"

The overall response to this question was 'Yes'. Staff described how a medical review is undertaken on all patients presenting in ED and only in rare cases where the presentation is 'simplistic' this might not occur.

Example staff responses to interview questions

> *'Yes, all* mental health *patients must have a medical assessment and be medically cleared.'*
>
> *'Yes - patient is owned by ED: under ED bed card. No patient is discharged from …… ED without a discussion with a Dr.'*
>
> *'If the presentation is very simplistic and a patient can be discharged very promptly then this might not occur however occasions are rare.'*

Question: "Under what circumstances are mental health patients seen by a psychiatrist or psychiatric registrar? What is the process?"

Respondents indicated that access to a psychiatrist or psychiatric registrar in the ED varies across the state, with less availability in rural EDs. Where they are available, the decision to request a psychiatrist or psychiatric registrar to review a patient is made by either the PLN/MHLN and/or ED medical officer. Reasons given for requesting a psychiatrist or psychiatric registrar to review the patient included high risk or complex patient (n=9), patient referred on MHA forms (n=7), clinical advice/guidance (n=3), inpatient admission required (n=3) or prescription for medication (n=2).

In EDs where a psychiatrist and psychiatric registrar are unavailable, patients are transferred to another hospital or referred to the community mental health team. The MHLN/PLN and/or ED medical officer usually make the referral.

Example staff responses to interview questions

> *'Generally if the patient is referred directly. It is often workload dependant. If the* mental health *doctor is available then he/she will attend.'*
>
> *'Usually Psych Registrar involved if need medications or complexity of presentation*
>
> *Would say we see Psych Registrar in ED no more than twice in a week.'*
>
> *'No* mental health *doctor in ……. Psychiatrist visits once a month for appointments. Referral to Perth if necessary.'*

Key Findings
- Clinically appropriate mental health assessments were identified for all patients reviewed.

- There was regional variation in the quality of completion of individual components of the mental health assessment with metro EDs achieving over 70% compliance with each of the question criteria, in contrast to rural EDs where compliance was 60% or less for the majority (80%).

- Completion of IMP/care plans was high (metro 100%; rural 96%) and of those with a care plan it was discussed with the consultant psychiatrist/senior clinician for 73% of metro and 52% of rural ED patients.
  - Half (54%) of patients presenting with DSH/suicidality were assessed by a mental health professional and their IMP/care plan was discussed with a psychiatrist or senior clinician for 76% of metro and 63% of rural ED presentations.
  - *Comment: due to the limited availability of senior mental health staff within rural EDs this review suggests the need for alternative options for rural ED staff to access psychiatrists. This may include better access to on call psychiatrists via telephone or video conferencing.*

- An assessment of alcohol and drug history was completed in 87% of metro and 31% of rural ED presentations. However, the standardised Substance Use Assessment form was completed for only a small proportion of patients (0.7% metro; 1.3% rural).

- There was little evidence of carer involvement in the mental health assessment, with 14% having carer input recorded in the document; 19% in metro and 4% in rural EDs.
  - *Comment: It is likely that some individuals self-presented to ED and may not have been accompanied by either a family member or carer. However, this information was not collected by the clinical reviewer. Ideally, the denominator for this item would be based on individual presenting circumstances so using the total number of records reviewed as the denominator may not have given a true reflection of the level of compliance.*

- The mental health assessment content, structure, and quality were of a high standard in metro EDs with all components completed for 90% or more of the patients reviewed compared with rural EDs where compliance was 60% or less for the majority of items.

- A high quality formulation was present in 88% of metro ED clinical records and 39% of rural ED clinical records. The rural result of 39% reflects the high proportion of partially completed (58%) formulations in rural clinical records compared with metro (12%).
  - The three key items for a 3P formulation (predisposing, perpetuating and precipitating factors) were completed for 85% or more of the metro ED presentations and between 35%-82% of the rural ED presentations.
  - *Comment: the poorer completion of the perpetuating and protective elements of formulation suggest staff are examining what has occurred prior to the patient presenting at ED, but not placing the same emphasis on looking forward to identify protective factors that could reduce the risk of the patient representing to ED in the future.*

- The sign-off and completion of documentation was of a high quality. The exception was the legibility of staff names and designation in rural EDs where 41% of entries were illegible.

Staff responding to the interview/survey indicated:
- The limited availability of psychiatric consultants and psychiatric registrars in rural EDs results in some mental health patients being transferred to another hospital or community mental health team for assessment.

- When a mental health professional is unavailable, the ED nurses, general doctors and nurse practitioners complete the mental health assessment.

Compliance with Stokes recommendations

For patients presenting with DSH/suicidality, a care plan must have a formulation - Stokes recommendation 7.1
- The proportion of patients identified with DSH/suicidality with a completed formulation in a metro ED was high, 92%. In contrast, compliance was lower at rural EDs (53%), which had a high proportion of partially completed formulations (44%).

Patients presenting with self-harm must be assessed by a mental health professional – Stokes recommendation 2.9
- Almost half (46%) of patients presenting with DSH/suicidality were not reviewed by a mental health professional.

Care plans of patients presenting with self-harm must be approved by a psychiatrist or psychiatric registrar - Stokes recommendation 2.9
- The IMP/care plan for (72%) of patients with DSH/suicidality was discussed with a psychiatrist or senior clinician; 76% for metro EDs and 63% for rural EDs.

Carers must be involved in care planning - Stokes recommendation 3.2.
- Few of the clinical records reviewed (14%) had documented evidence of carer involvement.

Section 8: Notifiable incidents

The Chief Psychiatrist must be notified as a matter of priority, of any notifiable incident and associated issue that may reflect on the standards of mental health care in WA. During the period of this study, the relevant OD was "Matters to be reported to the Chief Psychiatrist"(OD 0242/09). Notifiable incidents include, but are not limited to death, aggression and assault, alleged sexual assault and absconding of any forensic or involuntary patient. Notifiable incidents form a separate section in this report due to the fact that this Review was partially motivated by an increased number of notifiable incidents which occurred in the ED and were reported to the Chief Psychiatrist.

The management of the notifiable incidents reported to the Chief Psychiatrist was examined in the clinical review. Clinical records were also examined to identify patients who had a notifiable incident during their presentation in the ED but were not reported to the Chief Psychiatrist. Clinical records were reviewed to how these notifiable incidents are recorded in the patient clinical record and the strategies implemented in the ED to minimise the risk of further notifiable incidents occurring whilst the patient remained in the ED.

Notifiable Incident Review-Source: In-depth Clinical Review

Of the 223 cases in the clinical review, there were 16 records (7%) where a notifiable incident had been recorded to have occurred in the ED which had not been reported to the Chief Psychiatrist. The two categories of notifiable incidents identified were Absconding (n=13, (68%)) and Aggressive/Violent behavior (n=6 (32%)). Of the 13 patients who absconded, 3 attempted to abscond and two both absconded and displayed aggressive/violent behavior.

Notifiable Incident Review-Source: Clinical Staff Interviews

Question: "What kind of patient supervision is available?"

The most frequently mentioned form of patient supervision was 'nursing staff' (n=30), followed by security staff (n=22), patient care assistants or orderlies (n=11), non-specified 'specials' (n=8) and guards/companions (n=5). Specials and security staff are often obtained through external request (n=6), with internal security being described as unavailable or limited after hours (by five pm). Responders in two rural EDs stated that police are called to assist if patients are aggressive and/or violent. Organising specials was described as difficult by staff at one ED as the staff provided often lack the necessary mental health experience to handle acutely unwell patients. Another staff member said that MHLN are requested when a special is required, but they are usually not available due to workload and limited resources.

Example staff responses to interview questions

> *'Varying depending on escalating risk – nursing staff, security guards, mental health liaison nurses.'*
>
> *'Our team always request a Mental Health Nurse special/supervise a person, however this seldom can occur due to resources and availability.'*
>
> *'We do not have on-site security, so in the case of an aggressive patient we need to call the police for assistance.'*
>
> *'Security are not always available in extended hrs - 3rd party security is hired as required.'*

Question: "What are the factors/barriers to absconding?"

The ED Environment was the described as the biggest facilitator to absconding (n=30), more specifically the structure of the ED, including layout and fire escapes (n=14); not having any locked areas with the ED being open (n=11); limited security (n=8); no smoking policy within the ED (n=7); limited staff supervision (n=4); and security and specials with inadequate mental health training (n=3). Delays in transferring patients (n=5), delays in psychiatric assessment (n=2), delay in PLN response (n=2) and patient factors such as boredom and lack of insight into their mental health were also described as factors related to absconding.

The most frequently described barrier to absconding was close supervision with companions and specials (n=13). Other factors that reduced the risk of a patient absconding included security staff (n=9), locked doors (n=8), close patient observation (n=5), the positioning of the patient whilst waiting in ED (n=5), chemical restraint (n=5), ability to lock down the ED (n=4), police presence (n=4), identifying risk for absconding early via risk assessments (n=3) and physical restraint (n=3).

A number of other factors were mentioned and it was unclear whether the responder considered them as a facilitator or barrier to absconding; family members, duress, changing how ambulance doors open and medication.

Example staff responses to interview questions

> *'ED environment is highly stimulating noisy with alarms and lights on 24 hours so non therapeutic for patients who are acutely mentally unwell.'*
>
> *'Identify those at high risk of absconding through early assessment.'*
>
> *'Guards assist to reduce absconding. Some new guards however have not been a barrier due to incidences such as being on mobile phones etc…. Guards in ED need good education/ training to be effective.'*
>
> *'The only physical barrier is an unlocked door. We have no security nor locked door.'*
>
> *'PLN's assessment takes up to 2 hours and although I understand the complexity of this it doesn't help not having them unavailable for that length of time. Also the delay in response time from PLNs doesn't help, but again I understand the pull as covering….as well and pull to be at their Dept.'*

Question a: Is chemical restraint used in the ED?

Question b: If chemical restraint is used, how often would this occur?

There is no national definition of chemical restraint and therefore for this interview question what is considered 'chemical restraint' was left up to the interpretation of the clinical staff being interviewed.

All responders indicated that chemical restraint is used within the ED when required.

Example staff responses to interview questions

> *'Yes especially with intoxicated/ medically compromised patients presenting with significant risk factors to themselves and/or others along with a gross impairment in judgement.'*
>
> *'Yes. But not happy with using it due to potential complications.'*

The frequency of chemical restraint use described by the interviewees varied, ranging from daily (n=20), weekly (n=9), monthly (n=9) and yearly (n=3). There were 5 responders who indicated that the frequency chemical restraint was used varied and 2 responders said it's used occasionally. Information was missing for 2 responders. Responders from rural EDs reported a lower frequency of chemical restraint.

Example staff responses to interview questions

> *'Every day. Can sometimes be many times a day with numerous patients.'*
>
> *'We get runs of it. Sometimes none in a week other times more.'*
>
> *'On one occasion police were present in the resuscitation bay and tazered one patient that attempted to attack a security guard. Physical restraint is much preferred over chemical restraint as it is considered to be a safer option.'*
>
> *'Less than monthly, probably a few times each year.'*

Key Findings

- The clinical reviewer identified 16 notifiable incidents that had not been reported to the Chief Psychiatrist.

- Two-thirds (67%) of the notifiable incidents identified in the clinical record review related to absconding. However, assessment of the absconding risk was not undertaken for 32% of mental health patients in metro EDs and 67% in rural EDs (section 6, page 34).

Staff responding to the interview/survey indicated:

- That the ED Environment and limited security staff and specials were the biggest facilitators to patients absconding;
- The biggest barrier to absconding was close supervision with companions and specials.
    - However, obtaining staff with the necessary experience to handle acutely unwell mental health patients is difficult and many specials lack these skills.
    - *Comment: We were unable to determine whether the patient supervisor/special is aware of the limitations of their role and whether a risk assessment was completed before allocation to determine their functional role and the appropriateness of using a special rather than implementing other options, such as appropriate sedation.*

Section 9: Length of episode

Length of episode (LOE) was calculated as the time between a patient's presentation to ED and the time they physically departed from the ED. LOE is often assessed as a quality indicator, with a length of episode in ED of less than four hours taken as an indicator of quality clinical care. In some instances the needs of the patient may require a longer period of care in the ED than 4 hours and this does not necessarily detract from the quality of clinical care that they have received. The pragmatics of bed pressure may delay admission into an inpatient mental health bed, thereby increasing LOE for mental health patients. Therefore, some occasions where the LOE is greater than 4 hours may still be in the realm of quality clinical care.

Results are assessed against the NEAT benchmark whereby 90% of all patients presenting to a public hospital ED are required to physically leave the ED for admission to hospital, referral to another hospital, or be discharged within four hours (Appendix F).

The LOE is presented separately for patients with a mental health diagnosis and those with an AOD diagnosis (+/- mental health diagnosis). There was a large degree of variability in the LOE between metro and rural EDs and the LOE varied based on the outcome of care. Therefore, results and episode lengths were assessed separately for metro and rural EDs and for presentations resulting in admission (this includes those admitted to OBS ward and transferred for admission elsewhere) and those not resulting in admission to hospital (includes those who were either discharged after ED completion, died within ED, left against medical advice or before being seen, or returned to a nursing home.)

Length of Episode-Source: EDDC

Metro patients who were admitted

The overall median LOE for metro ED patients with a mental health diagnosis was 5 hours 6 minutes, with values ranging from 0 hours to 146 hours (6 days). Two EDs (ED 1, ED 9) (22%) achieved the NEAT target of 4 hours for 50% of ED presentations (Figure 22). Overall, the NEAT 4 hour target was met for 39% of metro ED patients with a mental health diagnosis subsequently admitted.   However, extended LOE was evident in five EDs (EDs 1, 2, 3, 4, 8) which had a maximum LOE in excess of 100 hours, with the longest episode 146 hours (data not tabled).

Figure 22 Median LOE of metro ED presentations that resulted in an admission
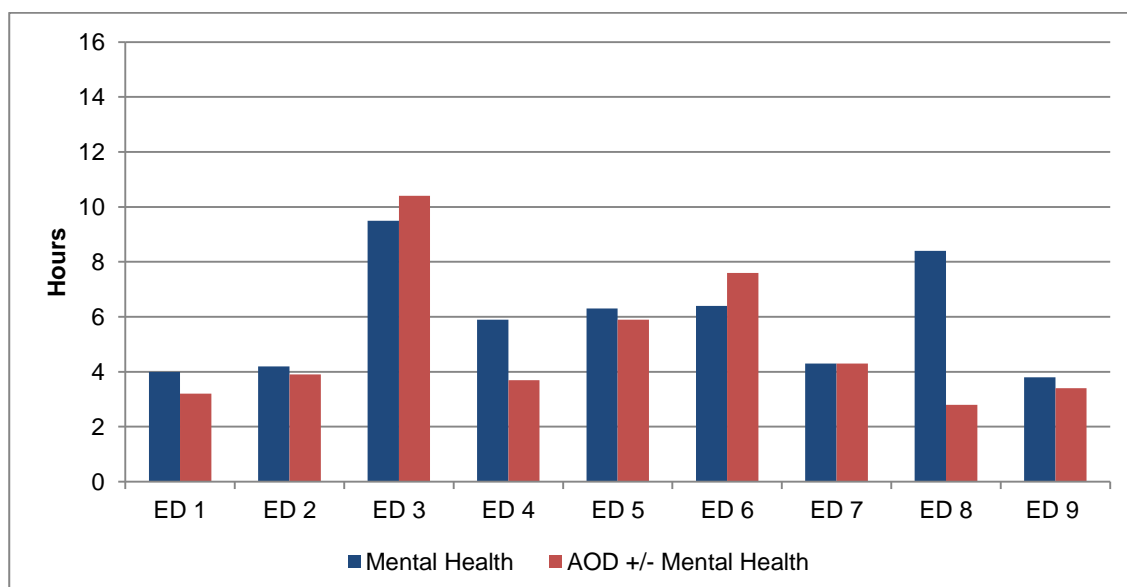
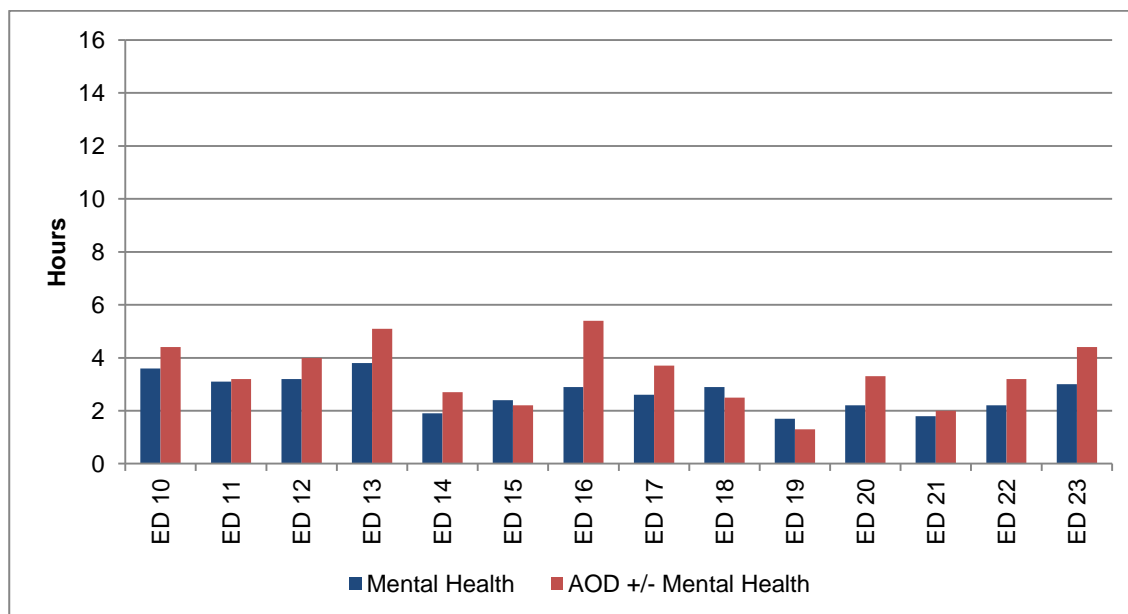Source: EDDC; Note: Outliers have not been removed

The median LOE for patients with an AOD diagnosis (+/- mental health diagnosis) was shorter than the LOE for mental health patients, median 4 hours, ranging from 0 hours to 124 hours 42 minutes (5 days). The majority (56%) of metro EDs achieved the NEAT 4 hour benchmark for 50% or more of their admitted patients (Figure 22). Overall, the NEAT benchmark was achieved for 74% of metro patients with an AOD diagnosis (+/- mental health diagnosis) admitted (data not tabled).

Rural patients who were admitted

The overall median LOE for rural ED patients with a mental health diagnosis was shorter than in metro EDs, with a median of 2 hours 30 minutes, ranging from 0 hours to 6 days 17 hours. All rural EDs (100%) met the NEAT target of 4 hours for 50% of mental health patients (Figure 23), with 75% of the rural ED mental health presentations ending within 4 hours and 86% of rural EDs having a maximum LOE less than 50 hours (data not tabled).

The median LOE for patients with an AOD (+/-mental health diagnosis) was similar to the LOE for rural patients with a mental health diagnosis (median 2 hours 36 minutes). A high proportion of rural EDs (71%) met the NEAT target of 4 hours for 50% of the patients with an AOD presentation (Figure 23). For patients presenting with an AOD (+/- mental health diagnosis) diagnosis who were subsequently admitted, the maximum LOE was less than 40 hours in all rural EDs and 51% of patients were admitted within the NEAT 4 hour benchmark (data not tabled).

Figure 23 Median LOE of rural ED presentations that resulted in an admission

Source: EDDC; Note: Outliers have not been removed *smaller rural EDs are included in the overall but data is not shown independently

Metro patients who were not admitted

For metro ED patients with a mental health diagnosis who were not admitted, the overall median LOE was 3 hours 18 minutes, ranging from 0 hours to 139 hours (5 days 19 hours) (Figure 24). Almost all (78%) metro EDs achieved the NEAT target of 4 hours for at least 50% of non-admitted

psychiatric presentations. Overall, the NEAT target was achieved for 62% of metro mental health patients not admitted. The maximum LOE ranged from 24 hours to 139 hours, with 78% of EDs having a maximum LOE of less than 100 hours (data not tabled).

The median LOE for non-admitted patients with an AOD diagnosis (+/- mental health diagnosis) was longer than for mental health patients without an AOD diagnosis, with an overall median 4 hours 24 minutes and a maximum of 221.2 hours (9 days, 5 hours) (Figure 24). One-third (33%) of metro EDs achieved the 4 hour NEAT target for 50% or more of patients with an AOD presentation, but who were not admitted (data not tabled). Overall, the NEAT target was achieved for 46% of non-admitted metro patients presenting with AOD diagnosis (+/- mental health diagnosis). The maximum LOE was shorter than for mental health patients without an AOD diagnosis, with 67% of EDs having a maximum LOE of less than 35 hours and three EDs (33%) having a LOE of more than 100 hours.

Rural patients who were not admitted

The overall median LOE for rural ED patients with a mental health diagnosis, who were not admitted, was 1 hour 30 minutes, ranging from 0 hours to 1 day 18 minutes (Figure 25). All rural EDs met the NEAT 4-hour benchmark for at least 50% or more of patients with a mental health presentation who were not subsequently admitted (data not tabled). The maximum LOE was less than 25 hours for all rural EDs. Overall, the NEAT target was achieved for 88% of rural mental health patients not admitted.

For non-admitted rural patients with an AOD presentation (+/- mental health diagnosis) the median LOE was similar to that of patients with a mental health diagnosis, with an overall median of 1 hour 48 minutes (Figure 25). The NEAT 4-hour benchmark was achieved for 50% or more patients by almost all (93%) of rural EDs. For patients presenting with an AOD (+/- mental health diagnosis), the maximum LOE was 20 hours or less for all rural EDs. Overall, the NEAT target was achieved for 81% of AOD (+/- mental health diagnosis) rural patients not admitted.

Figure 24 Median LOE of metro ED presentations that did not result in an admission
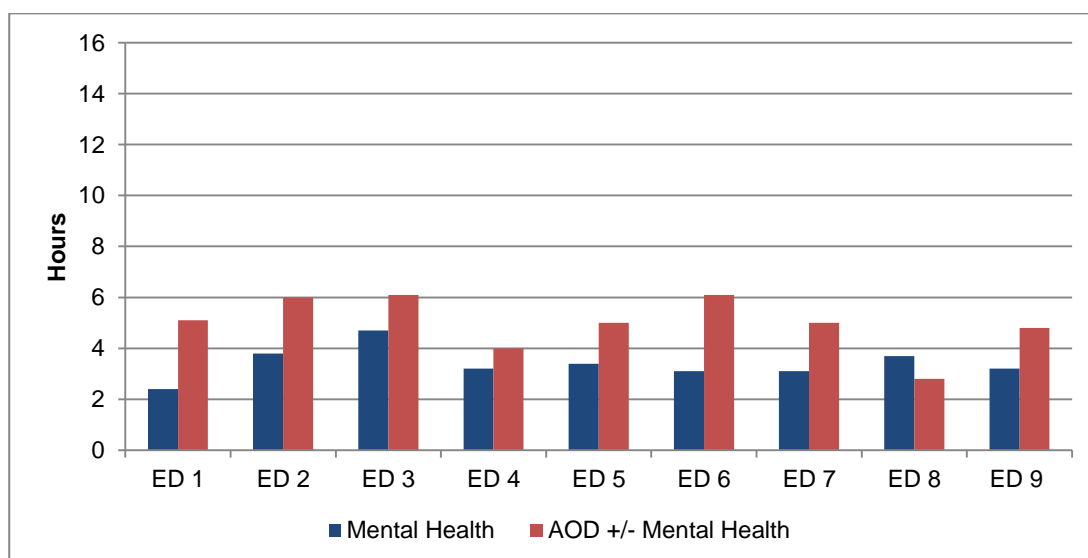
Source: EDDC; Note: Outliers have not been removed

Figure 25 Median LOE of rural ED presentations that did not result in an admission
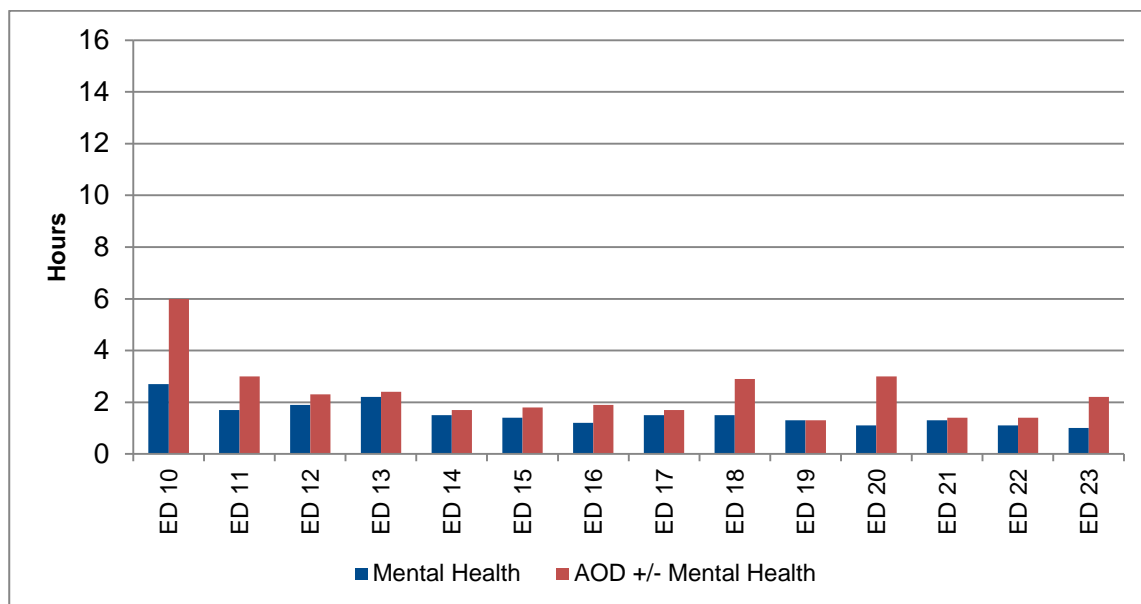
Source: EDDC; Note: Outliers have not been removed *smaller rural EDs are included in the overall but data is not shown independently

Length of Episode-Source: Clinical Staff Interviews

Question: Do you have any comments about the relationship between the mental health and non-mental health teams working within the ED?

Many of the staff interviewed from rural EDs stated that there are no mental health staff located within their ED (n=10) and that they rely on the community mental health team.

Working relationships between mental health staff and general ED staff were described positively including 'Good/Strong/Works well' by just under half of responders (n=23).

A small number of responders indicated that there was friction in the working relationship between mental health and general ED staff. Length of stay of mental health patients was the most common cause for friction (n=5) with ED medical staff wanting mental health patients to be discharged early.

Other concerns or more 'negative comments' included the perception that there was some discrimination of both mental health staff and mental health patients (n=2). Some staff stated that there was a need for both groups to work together better (n=2), that PLNs needing to be more 'proactive' (n=2). Other concerns raised included a lack of understanding of the role of a PLN, that mental health patients shouldn't attend ED, that staff did not understand the <-0.05 BAL rule, limited access to a consultant psychiatric after-hours and on weekends, mental health staff needing to write in medical files more and PLNs not having cover. Information was not provided by three responders.

Example staff responses to interview questions

'Two different perspectives but generally a good working relationship.'

> *'It is strained. There is always pressure of medical (staff) wanting patients discharged but mental health staff not being able to. Staff are on stress leave due to pressures regarding patient Length of Stay'*
>
> *'Very good working relationships - We work well as a team with our PLNs. We are lucky to have very proactive PLNs with good initiative.'*
>
> *'There remains discrimination of mental health staff and patients: they get treated differently.'*
>
> *'There are no Mental Health teams working within the ED and we find resistance from the community mental health team for referral/assistance for anything acute.'*

Key Findings

- There is a high degree of variability in the LOE across different facilities for mental health presentations, although there was generally more consistency in rural EDs than metro.

- The LOE were longer in metro EDs for both admitted and not admitted patients, compared with patients presenting to rural EDs.

- The LOE was more variable for patients who were admitted compared with patients who were not admitted.

- Two metro EDs (22%) achieved the NEAT 4-hour rule for 50% of patients admitted to hospital.
    - Staff stated that there was a need for both groups to work more collaboratively.
    - Staff stated that discrimination of mental health staff and patients continues to occur in some settings.

- For patients not admitted, almost all (89%) of metro EDs achieved the NEAT 4-hour rule for at least 50% of mental health patients, with fewer metro EDs (33%) achieving this benchmark for patients presenting with an AOD ((+/- mental health diagnosis).
    - When the patient was admitted to hospital, the proportion of metro EDs achieving the NEAT benchmark was (22%) for MH and 56% for AOD ((+/- mental health diagnosis) patients.

- In contrast, a higher proportion of rural EDs met the NEAT benchmark for 50% or more for admitted mental health (71%) and AOD ((+/- mental health diagnosis) (64%) patients and 100% and 93%, respectively, achieved the benchmark for patients not admitted to hospital.

Staff responding to the interview/survey indicated:

- The relationship between general trained and mental health ED staff and/or community mental health staff is variable. Some staff reported that there is friction between the two groups, which is contributing to high levels of stress.
- Some staff stated that there was a need for both groups to work more collaboratively.
- In some EDs the mental health and ED patient records were in separate files and not shared, which makes a collaborative working environment difficult resulting in tension between staff. The mental health notes need to be incorporated in the general medical files to improve communication with the general ED staff.

Section 10: ED presentation outcome

Discharge outcomes examined included admission to an inpatient mental health ward, admission to a medical ward, referral to a community mental health services, referral to a general practitioner (GP) and discharged with no follow-up. The discharge outcomes were also assessed against the ATS category given to the patient at triage.

The clinical review examined the presence and quality of the discharge and care plan, discharge medication information, referral information including evidence of receipt of referral to a community mental health service, the provision of written discharge information to the patient and, where appropriate, to the care, about emergency contacts and appropriate clinical information.

Data on the mental health status of the patient (voluntary, involuntary, referred) were obtained through the clinical record review, but were not available for the EDDC data.

ED Presentation Outcomes-Source: EDDC

For patients presenting with mental health problems, the outcome status was similar for both metro and rural. One-third (33%) were admitted to the same hospital, 4%-5% were transferred to another hospital for admission; equating to 37%-38% of mental health patients being admitted (Figure 26). Of those admitted to the same hospital 41% were admitted to an ED observation ward (ED OBS ward) in metro EDs compared to 3% in rural EDs. Over half of mental health patients (57%-59%) were discharged following completion of ED treatment and a small proportion (2%-3%) of mental health patients presenting to the ED either did not wait to be examined by a clinician or left against medical advice (DAMA).

The outcome status for patients presenting with AOD +/- mental health problems varied across metro and rural EDs (Figure 26). In metro EDs, just under half (49%) of these patients were admitted to hospital and 4% were transferred to another hospital for admission; equating to 53% of AOD (+/- mental health) patients being admitted. Of those admitted to the same hospital 42% were admitted to an ED OBS ward in metro EDs and 10% in rural EDs. The proportion of AOD (+/- mental health) patients admitted to hospital at rural EDs was half that at metro EDs (26%) and few were transferred to another hospital for admission (2%); equating to a total of 28% of AOD (+/- mental health) patients being admitted. Nearly two-thirds (65%) were discharged and 4% did not wait to be assessed and 3% were DAMA.

Figure 26 Outcome by State, Metropolitan and Rural EDs
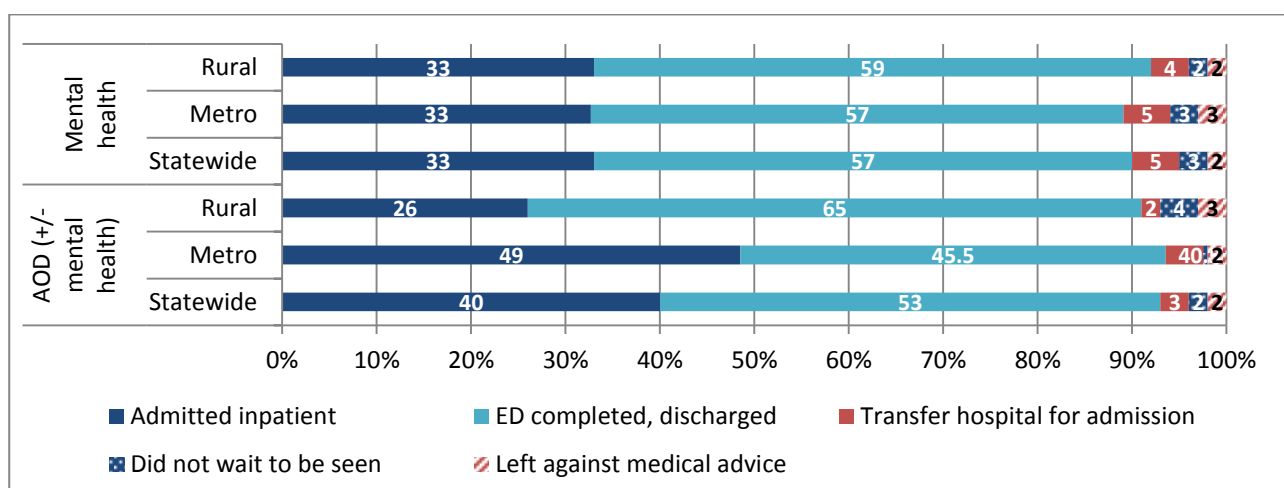
Source: EDDC

The discharge outcomes for metro and rural EDs by ATS category are shown in Figure 27 for metro EDs and Figure 28 for rural EDs. Over half of all patients classified as ATS 1 at a metro ED were admitted to hospital (mental health (59%); AOD (+/- mental health) (64%)) and an additional 6% transferred to another hospital for admission (Figure 27). The proportion of patients admitted to hospital decreased as the urgency of the ATS category lessened. For mental health patients classified as ATS 2 38% were admitted decreasing to 22% classified as ATS 5. For patients with AOD (+/- mental health) the proportions decreased from 55% to 33%, respectively. In contrast, the proportion of mental health patients who did not wait for assessment or were DAMA increased with the decreasing urgency of the ATS classification.

Figure 27 Discharge outcomes by ED by Australian Triage Scale (ATS) categories for Metro EDs
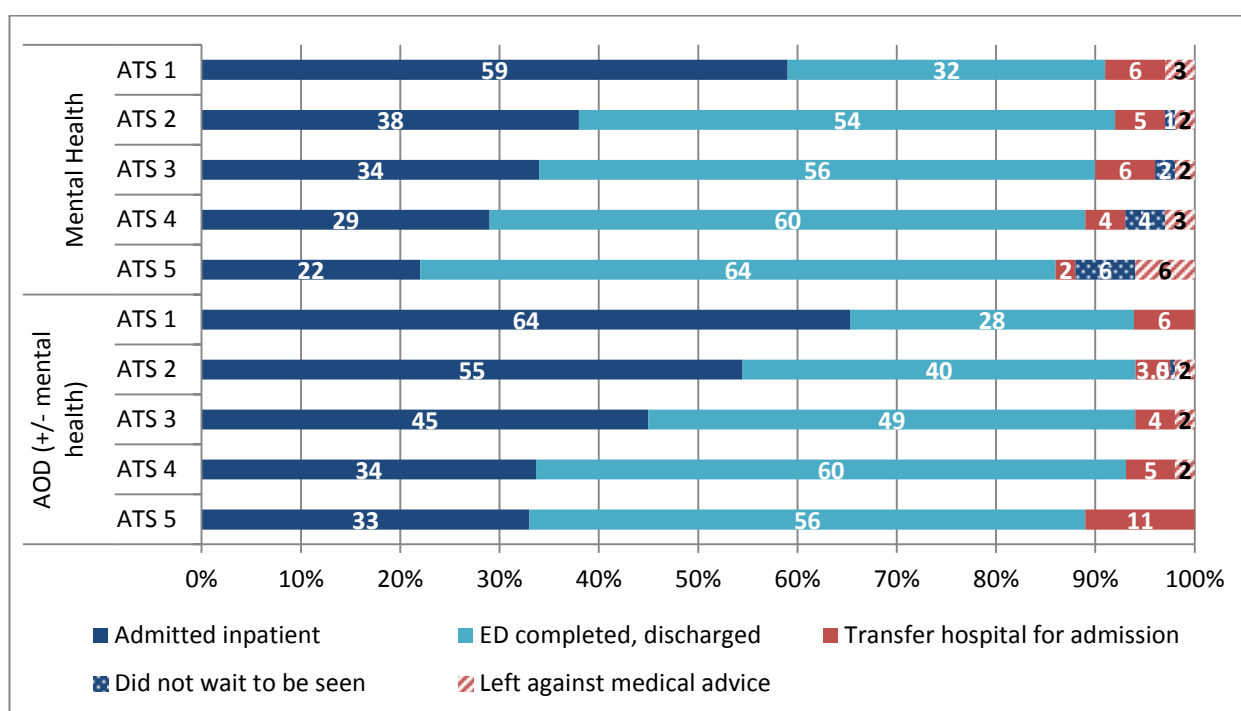
Source: EDDC

At rural EDs, the proportion of ATS 1 patients admitted (40%) was lower than at metro EDs (59%); however, the proportion of patients transferred was higher (Figure 28). Fewer than half (40%) of mental health patients were admitted to the same hospital, however 30% were transferred to another hospital for admission. The ATS 1 proportions were similar for AOD (+/-mental health) with 48% admitted and 11% transferred to another hospital for admission. The proportion of patients discharged from a rural ED showed the same relationship noted at metro EDs, with the proportion of patients discharged increasing with the decreasing urgency of the triage category. This ranged from 24% of patients classified as ATS 1 to 82% of patients classified as ATS 5, with similar proportions for AOD (+/- mental health) patients at rural EDs (41% and 89%, respectively). The proportion of rural ED patients not waiting for assessment increased with decreased urgency for both mental health and AOD (+/- mental health) presentations; however, a greater proportion of those who left against medical advice were in the more urgent ATS categories.

Figure 28 Discharge outcomes by ED by ATS categories for Rural EDs
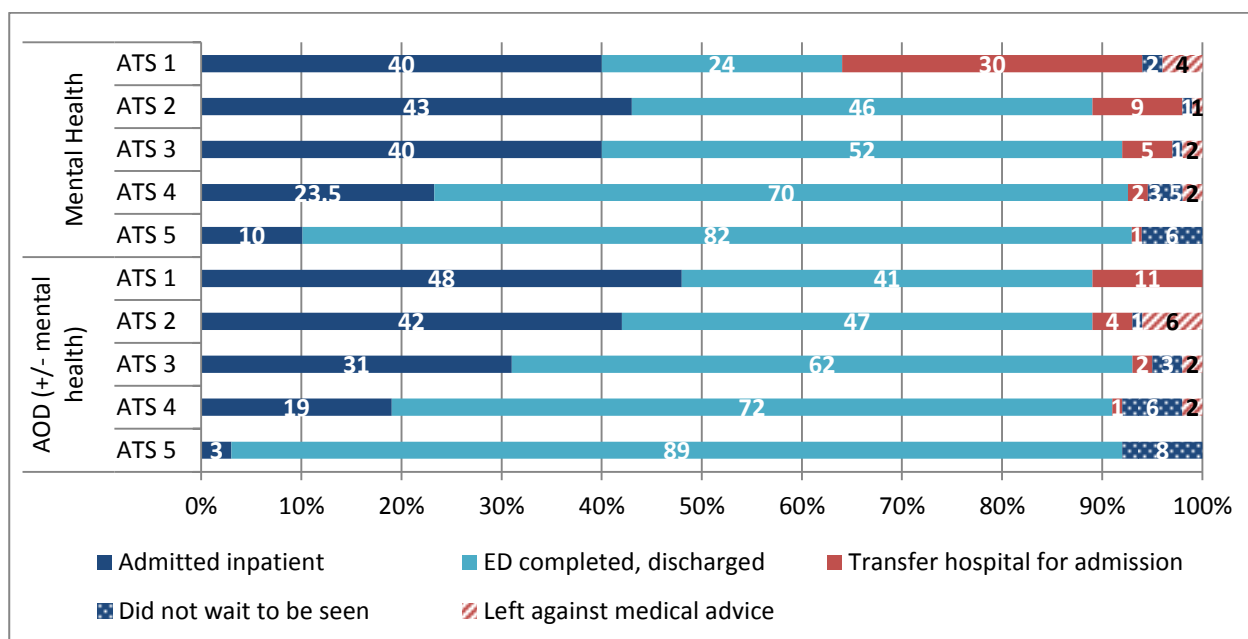
Source: EDDC

Presentation Outcomes-Source: In-depth Clinical Review

Of the 223 ED presentations reviewed, 58% of patients were discharged, of which 57% had no documented evidence of follow-up, 16% were referred to a GP for follow-up, and 26% were referred to a community mental health or other community health service (Table 8). Slightly more than one-third (37%) of patients presenting to ED with mental health problems were admitted to hospital, of which nearly two-thirds were admitted as a voluntary patient and nearly a third were admitted as an involuntary patient. A small percentage of patient clinical records (3%) did not have discharge outcomes recorded, and were unable to be assessed.

The proportion of patients in the clinical review that were admitted to hospital in metro EDs was slightly lower (33%) than the state average of 37%, whilst the proportion was higher in rural EDs (44%) (Table 8). A higher proportion of patients were discharged from metro EDs without any documented evidence of further follow up (60%), than from rural EDs (50%). A higher proportion of patients were referred to their GP for follow up (21% vs 14%) or community mental health services (18% vs 17%) post discharge from rural EDs in comparison to metro EDs.

Of the metro patients who were discharged and had no documented evidence of follow up, nearly all (95%) had a documented risk assessment and the majority 81% had an appropriate IMP/care plan. These proportions were lower in rural EDs, with 84% having a completed risk assessment (98% for metro EDs) and 26% had an IMP/care plan (100% metro EDS).

In contrast to the EDDC state-wide data, transfer to an ED OBS ward was not recorded as an outcome in any of the clinical records reviewed.

Table 8 Outcome of ED presentation

Outcome of ED Presentation	State-Wide n=223 %	Metro n=145 %	Rural n=78 %
Inpatient Admission	**37 (n=82)**	**33 (n=48)**	**44 (n=34)**
Mental health admission – voluntary	*62*	*60*	*65*
Mental health admission – involuntary	*29*	*33*	*23*
Medical inpatient admission	*9*	*6*	*12*
Discharged	**58 (n=129)**	**63 (n=91)**	**49 (n=38)**
No further action noted (no follow up)	*57*	*60*	*50*
GP to follow up	*16*	*14*	*21*
Referred to community mental health service	*17*	*17*	*18*
Referred to other community health service	*9*	*9*	*11*
Left against medical advice	**1 (n=3)**	**2 (n=3)**	**0**
Absconded and did not return	**0.4 (n=1)**	**0.7 (n=1)**	**0**
Sent to alternate ED	**0**	**0**	**3 (n=2)**
Unable to assess – no details noted	**3 (n=6)**	**1 (n=2)**	**5 (n=4)**

Source: Clinical Records *To prevent potential identification of patients the % of patients for cells where the number of patients was <5 will not be displayed.*

Discharge Outcomes-Source: Clinical Staff Interviews

Question: "Are there any barriers to discharging patients from the ED?"

The greatest barrier faced by staff in EDs when discharging patients is social issues (n=24), such as homelessness (n=12), guardianship, care and family support/supervision concerns (n=9), transport from ED (n=5), carers not accepting minors home (n=3) and no drug and alcohol support in ED. This is reflected by the need for greater social work support within EDs (n=5). The second greatest barrier is the lack of available mental health beds (n=21) resulting in an extended length of stay. There are also concerns regarding limited availability of community mental health support and inadequate follow-up (n=13); limited staff available for mental health review prior to discharge (n=6); concerns regarding patient safety and/or compliance with follow-up (n=3), medical co-morbidities (n=2) and patient sedation (n=2). Some other concerns or comments included the limited availability of Acute Response Team (ART) staff and the need for two ART clinicians to attend ED, the no 'proactive' attitude of mental health service and that a collective care plan should be used which means ED and community and inpatient staff can all access the same patient information. Three responders felt there were no barriers and two did not answer the question.

Example staff responses to interview questions

'Community follow up is the biggest difficulty. Support in the community for mental health patients is very limited.'

'The lack of available mental health beds is the most common barrier to discharging a patient from the ED.'

'Homelessness - no services for accommodation in the town, only 1 refuge available.'

'Yes, with patients at chronic risk of self-harm or suicide, or with new patients with situational crises the barrier is often that they have no support at home'

Key Findings

EDDC Data

- Over half (57%) of patients with a mental health diagnosis were discharged, 38% were admitted, and 3% did not wait to be assessed and 2% were DAMA. Of those admitted, 27% were admitted to an ED OBS ward and 12% admitted to another hospital. There were slightly more patients presenting with AOD (+/- mental health diagnosis) who were admitted (43%), of which 50% were admitted to ED OBS ward and 7% transferred to another hospital for admission.
    - Regional differences were noted for admissions to an ED OBS, which occurred primarily in metro hospitals.
    - A greater number of AOD (+/- mental health diagnosis) were discharged from rural EDs in comparison to metro EDs (65% vs 45.5%).
    - The proportion of patients admitted to hospital varied by ATS category and was similar for metro and rural EDs and highest for ATS 1. However, rural EDs had a higher proportion of patients transferred for admission to another hospital for presentations with higher urgency.

Clinical Review Data

- The admission and discharge patterns were similar to those observed in the EDDC data.
    - Over half (58%) of patients were discharged, of which 57% had no documented evidence referral for follow-up in the community and of the patients referred, equal proportions were referred to community mental health services and GPs.
        - *NOTE: Additional information on these patients was not collected in this Review. But the majority did undergo appropriate risk assessment whilst in ED and had a documented IMP/care plan, especially in metro EDs.*
    - A higher proportion of patients at metro EDs were discharged without documented evidence of further action, than at rural EDs; 60% vs 50% respectively.
    - A higher proportion of patients in rural EDs were admitted to hospital (44%) than in metro EDs (33%).

Staff responding to the interview/survey indicated:

- The three greatest barriers to discharging ED patients that were nominated by staff were:
    - Social issues;
    - The lack of available mental health beds; and
    - Limited availability of community mental health support and inadequate follow-up.

Section 11: Information provided to patient/carer: In-depth Clinical Review

The clinical review examined whether carer, family, or next of kin (NOK) were involved in the patient's ED presentation, and in addition, whether consumers and/or carers were provided with the following:

- IMP/care plan/discharge plan and whether a written copy was provided to the patient;
- For patients who were discharged, follow up arrangements and relevant timeframes;
- Contact details of emergency services;
- In-depth information about prescribed discharged medication.

In regards to the IMP/care plan/discharge plan there is often confusion regarding the various terminologies of the different summaries. A care plan can be defined as a 'written statement developed with the involvement of consumers, carers and relevant others, for consumers, which outlines the treatment and support to be undertaken, the health outcome to be achieved and review of care which will occur at regular intervals'. A discharge summary is a 'written document containing clinical and administrative information about a patient's admission or hospital/ED stay that is necessary for continuity of care in the community'. For the purpose of this Review the clinical reviewer examined the clinical record for any evidence of a 'care plan', 'management plan' 'recovery plan', 'transfer discharge summary' 'crisis awareness plan' or 'initial management plan' as part of the SSCD and included these as an IMP/care plan/discharge plan.

Information provided to the patient-Source: In-depth Clinical Review

A clinically appropriate IMP/care plan/discharge plan was evident for 94% of patients discharged from metro EDs and 73% discharged from a rural ED (Figure 29). Of these, there was evidence in the clinical record that the discharge plan was discussed with 93% of metro ED patients and a copy of the discharge plan was provided to 7% of metro patients. For rural EDs the proportions were 56% and 0%, respectively.

Just over half (54%) of patients who were referred to community mental health services had documented evidence in their clinical record that information on follow-up arrangements had been provided, 60% in metro EDs and 43% in rural EDs. Of those not referred to community mental health services 55% had documented evidence of follow-up arrangements (63% metro and 40% rural). There was documented evidence that information and contact numbers for emergency services was provided to 61% of metro ED patients and 15% or rural ED patients. A discussion with a carer or next of kin regarding the patient's discharge was documented to have occurred for 36% of cases; higher in metro EDs (45%) compared with rural EDs (21%).

There was evidence in the clinical record of 21 patients that they had been prescribed medication in the ED and 71% of these clinical records had evidence that the patient was provided information about the medication. However, it was not clear whether the information was written or verbal.

Figure 29 Discharge information
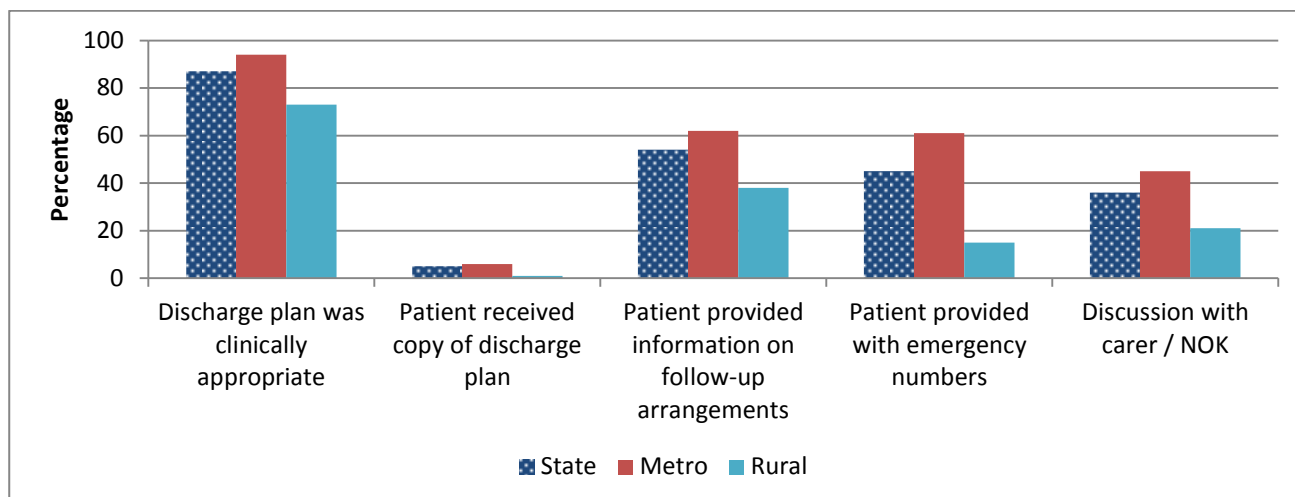
Source: Clinical records

Information provided to the patient-Source: Clinical Staff Interviews

Question: "Do you provide follow up for patients where urgent intervention is required?"

The majority (n=20) of responders indicated that EDs provide referrals for community follow-up for patients where urgent intervention is required. No follow-up by ED was described by 17 responders and 13 indicated that their ED does provide follow-up. There were four missing responses.

Example staff responses to interview questions

'Yes. We have a Discharge Support Nurse who works as part of the ED mental health team....will follow up on any referrals made of patients discharged from the ED. We also have a Youth Self Harm Social Worker who takes referrals of any patients aged 16 - 24 who are discharged from the ED.'

'Not ED but we refer to community mental health for this service.'

'No, we are an emergency department.'

Key Findings

- The majority of clinical records reviewed had a clinically appropriate care/discharge plan; 94% in metro and 73% in rural EDs.
    - Of those with a discharge plan, it was discussed with 93% of metro ED patients, compared with 56% of patients discharged from a rural ED.
    - Few patients received a copy of their discharge plan; metro 7%, rural 0%.
- Emergency services contact numbers were provided to 61% of metro and 15% of rural ED patients.
- Information on follow-up arrangements was provided to 62% of metro and 38% of rural ED patients.
- Almost three-quarters (71%) of the 21 patients prescribed medication had evidence in their clinical record that they had received information about the medication prescribed.

- Few clinical records had documented evidence that the patient's discharge had been discussed with a carer or NOK; metro 45% and rural 21%.
- Staff responding to the interview/survey indicated:
    - Referrals for community follow-up are mostly made when urgent intervention is needed.

Compliance with Stokes recommendations

Every patient must have a care plan and be given a copy of it - Stokes recommendation 2.2; No patient is to be discharged from an ED or another facility without an adequate care plan – Stokes recommendation 2.10.
- The majority of mental health patient records had evidence of a clinically appropriate IMP/care plan/discharge plan; metro 94% and rural 73%.
- 7% of metro and none of the rural patients received a copy of the discharge plan.
- *NOTE: This Review was unable to determine whether the IMP/care plan/discharge plan developed in ED was discussed in such a way that the patient understood it and signed the plan.*

With the discharge plan, the carer is also involved, as appropriate –Stokes recommendation 2.2; Where there is a carer clearly involved, the carer should be included in the discussion of the care plan and the discharge plan - Stokes recommendation 2.10
- Discussion with the patient's carer or next of kin about the patient's discharge was not routinely documented in the ED setting; metro 45% and rural 21%.

If a patient is discharged they must receive an agreed and signed comprehensive discharge plan – Stokes recommendation 7.2
- There was documentation that the IMP/care plan/discharge plan was discussed with the majority of metro ED patients (93%) compared with 56% of rural ED patients.
- Few clinical records had documented evidence that the patient received a copy of the plan.
- This Review did not examine whether the patient had signed the plan.

Where a person has undergone risk assessment in an ED and is not to be admitted to any facility but referred to a CMHS (community mental health service), the person and their carer are to be provided with written advice as to their relevant CMHS and contact numbers – Stokes recommendation 7.10.4
- There was documented evidence that information regarding follow-up arrangements was provided to just over half (53%) of ED patients who had been referred to CMHS.

The contact numbers should include 24-hour service emergency numbers and people should be advised these can be accessed by anybody at any time and trained workers, who have the ability to call out emergency teams if necessary, will respond – Stokes recommendation 7.10.5; No person should leave and ED without being provided with written advice as to who to contact in case of a crisis – Stokes Recommendation 7.10.7

- There was evidence documented 61% of metro and 15% of rural ED patients' clinical records that emergency contact information had been provided.

Information about medication - Stokes recommendation 7.2

- Of the patients prescribed medication on discharge 71% were provided with information about their medication.

Summary

The Review found significant variability in the number, type, urgency, severity and complexity of mental health presentations, particularly in smaller EDs. A high proportion of patients presenting to an ED with mental health problems expressed suicidal intent and many had alcohol and other drug and/or medical co-morbidity. This complexity often required a high level of observation and assessment, which placed increased demands on ED staff, particularly in smaller EDs where there are limited, and in some cases no, specialist mental health staff.

There were noticeable differences in the availability of mental health staff across regions. More than half of the patients presenting with a mental health problem to an ED across WA were assessed by a mental health professional. In rural EDs, a higher proportion of mental health patients were assessed by a PLN and seen more quickly than at metro EDs where wait time to review by a PLN was three-times longer. In contrast, consultant psychiatrists and/or psychiatric registrars were more available at metro EDs than at rural EDs.

Overall, mental health presentations at rural EDs were seen more quickly by a clinician after triage than in metro EDs and the ED LOE was shorter at rural EDs. This translated to a higher compliance with the recommended ATS assessment times in rural compared with metro EDs, particularly for the presentations classified as the most (ATS 1-2) and least (ATS 5) urgent. Two-thirds of mental health and a quarter of AOD (+/- mental health) presentations admitted to an inpatient ward from metro EDs did not meet the NEAT 4-hour target. Whereas for patients discharged, over half had a LOE that was within the NEAT 4-hour target. The proportion of patients admitted to an inpatient ward and/or an ED Observation ward (metro only) were similar across regions and there was no regional difference in the proportion of patients classified in ATS bands 1-3 who were admitted. Comments received from staff highlighted that key barriers to discharging patients from ED were the lack of available mental health beds and limited community mental health support for patients.

Notwithstanding the observed dedication and skill of ED staff this Review highlights the need to enhance both mental health and general trained ED staff competency around the triage, assessment, care, and management of mental health patients. Many of the staff comments supported the Review finding, with respondents stressing the need for additional resourcing to support the provision of mental health services, particularly in rural EDs where there are limited or no mental health professionals. The relationship between mental health and general trained ED staff was generally reported to be positive although some staff highlighted tension between the two groups and a lack of understanding of the role of the PLN. The lack of integrated mental health and ED patient records at some sites was mentioned by staff as a barrier to collaboration. However, some staff in ED noted some discrimination of mental health staff and patients, which may underpin the continued separation of mental health and general ED medical records.

Risk assessments, mental health assessments and care/discharge plans were completed for the majority of patients reviewed; however there was considerable variation in the quality of these documents in both rural and metropolitan EDs. Where a standardised assessment form was used, the assessment was generally of a higher quality. The Operational Directive (OD) mandating the use of the SSCD by mental health services was published on the 27 May 2014 (OD 0526/14) and post-dates the time period examined for this Review. However, the use of SSCD and other standardized documents was examined to assess consistent recording of clinical information and the results will provide baseline data for monitoring of compliance with the use standardized documents for mental health ED presentations.

Standardised risk assessment forms were not widely used with fewer than 30% of metro and 3% of rural risk assessments reviewed completed on a standardised form. A high proportion of assessments were completed by non-mental health clinicians and this may have contributed to the variation in the quality of risk assessments. Education and training on assessing risk using the standardised form should be provided to ED staff, particularly in rural EDs with few (or no) mental health clinicians.

Compliance with certain key Stokes (2012) recommendations for the care of mental health patients was variable. The majority of patients had an IMP/care plan in their clinical record. In contrast, patients were not routinely provided with discharge information and documentation such as emergency contact details; with 61% of metro and 15% of rural patients receiving emergency contact information. However, strategies to improve compliance with this recommendation have been implemented since this review was undertaken. The Office of Mental Health (OMH) has produced State-Wide Emergency Contact Cards designed for mental health patients and commenced distributing these cards in July 2015. The contact cards are available on the OMH website and there is evidence of widespread uptake of these cards, so it is likely that compliance has increased.

Involvement of carers or next of kin was limited, with few clinical records documenting carer input to the patient's mental health assessment (14%); however a higher proportion of carers were involved in discussions about the patient's discharge (38%). It is possible that communication with carers occurred more frequently than was documented in the medical records or that many patients were not accompanied by a carer/Next of Kin. These are likely to have contributed to the low proportions reported.

Feedback from staff interviews indicated that many staff did not see the need for providing the patient with information about follow-up arrangements (this Review did not differentiate between general or mental health staff responses to interview questions). There is a need for all ED staff to understand the minimum level of information required to be provided to mental health patients being discharged from an ED.

The Stokes Review (2012) highlighted a number of recommendations around the assessment and management of patients presenting with deliberate self-harm/suicidal intent. This Review found that almost all metro ED patients identified with deliberate self-harm/suicidal intent had a risk assessment completed and that these results were included in their IMP/care plans. However, compliance was low in the rural ED setting. Compliance with the Stokes recommendation that the IMP/care plans of these patients must be approved by psychiatrist or psychiatric registrar/MO was low in both metro (73%) and rural (50%) EDs.

A number of patients were identified who had a notifiable incident documented in their clinical record, which hadn't been reported to the Chief Psychiatrist. During the period of this Review, reporting of notifiable incidents to the Chief Psychiatrist was via a paper-based notification form and it was well recognised that reporting compliance was variable. The transition to an electronic notification system (Datix-CIMS) in February 2015 has improved compliance through streamlining the reporting process, which is likely to have reduced the number of unreported incidents.

Given the substantial numbers and challenges of mental health patients through the ED sector the existing levels of care are acknowledged. The ED presents a particular challenge to managing mental health and there are significant opportunities for improvement to care for that part of the patient's journey. Improvements in mental health assessments, the use of standardised assessment forms and in the provision of information to the patient and carer have the potential to improve the mental health patient's journey through the ED.

Recommendations

Department of Health Western Australia

1. All acute public service health providers should have access to timely electronic system wide information critical to clinical continuity.
2. Additional education and training and other resources should be available to support rural services to meet national and local standards such as the Stokes recommendations relating to assessment of mental health patients including those presenting with DSH/suicidality.

Emergency Department

General

1. At each service, mental health records should be integrated with general health records.
2. Staff name, designation, date and time must be legibly recorded against every entry within the clinical record. All entries must be signed.
3. Standardised forms should be used where available; this includes using the substance use assessment form for the assessment of alcohol and other drug use/history.
4. Strategies to improve communication and collegiality among general trained ED staff and mental health staff and/or community mental health staff should be considered.
5. Strategies to improve access to social workers, community mental health and other support services need to be developed to address the barriers for discharging ED patients.
6. There should be clear local strategies to improve the temporary management and/or subsequent transfer of high risk patients in ED.

Risk assessment

7. All ED medical and nursing staff, including attached mental health staff, must be trained in risk assessment and management and the use of a standardised risk assessment tool.
8. Dynamic assessment of absconding, including noting likely risks if absconding occurs must be part of ED risk assessments.

Mental health assessment

9. Standardised mental health assessment forms should be used in ED.
10. All attempts should be made to include carer input into the mental health assessment, where appropriate.

Information on discharge

11. For all mental health (including mental health with AOD comorbidity) patients leaving an ED the following written information should be provided, discussed with the patient and documented in their clinical record:
    o Diagnosis
    o Signs of relapse (crisis awareness plan)
    o What helps in a crisis (crisis awareness plan)
    o Information about prescribed medication
    o Details of follow-up arrangements
    o Contact details of clinic or other relevant person(s)
    o Emergency contact information and numbers

12. Where appropriate, the carer or next of kin should be provided with information about the patient's discharge

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ISSUE FOR FURTHER CONSIDERATION

It is acknowledged that triage is the first point of contact and acts as a general function and therefore it is not expected that staff have specialised psychiatric knowledge. This Review did not collect any additional information on the subsequent outcome of the patients who did not wait to be seen after triage but before being seen by medical or psychiatric staff or those who were seen but then chose to leave against medical advice. However it raises the issue of whether there is a consistent approach across EDs in dealing with patients who leave before being assessed or are DAMA and how the general triage process can be maximised to ensure maximum safety of patients. Further consideration should be given as to how we can capture the needs and document the risk of this group consistently.

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Appendices

Appendix A – Emergency Department Data Collection – Variables

- Patient clinical record number / UMRN
- Hospital name
- Health Service Area
- Admission date and time
- Age at presentation
- Presenting Problem
- Triage category, date, and time
- Service commencement date and time
- Principal diagnosis
- Major diagnostic category (as assigned at the end of the ED episode of care)
- Secondary diagnosis (where captured)
- Consultant type (where captured)
- Wait time to service delivery
- Wait time to hospital admission (where applicable)
- Discharge date and time
- Episode End Status
- Service episode length

Appendix B - Clinical Documentation Review Assessment

MENTAL HEALTH PRESENTATIONS TO EMERGENCY DEPARTMENTS
Clinical Record Review Recording Sheet

Review Information

Service: _____

Region:　　　☐ NMAHS　　　☐ SMAHS　☐ WACHS　☐ CAHS

Clinical record Number: _____

Review Record Number: _____

Review Date: _____/_____/_____

Record Information

Date of ED Presentation: _____/_____/_____

Triage category: _____

Time of arrival at ED: ____:____

Time of general triage: ____:____

Time of medical review: ____:____

Time of mental health assessment (nurse): ____:____

Time of mental health assessment (registrar): ____:____

Time of mental health assessment (consultant): ____:___

Is the patient active at a mental health service at the time of presentation? ☐ Yes　　　☐ No　 If yes, which service:

Mental Health ED notes (tick all that apply):

☐ Recorded on SSCD Mental Health Assessment Form

☐ Recorded on SSCD alternate form

☐ Recorded on service-specific Form

☐ Recorded in general ED notes

ITEM FOR REVIEW	COMPLIANCE				
Mental Health Assessment					
Mental Health Assessment – General Information					
1. Demographic information recorded in full	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
2. Accommodation type recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
3. Marital status recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
4. Country of birth, primary language, need for interpreter recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
5. ATSI / cultural information recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
6. Occupation recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
7. Income type recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
8. Guardianship information recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
9. Next of kin detail recorded (Stokes 2.12)	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
10. GP details recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
11. Pharmacy details recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
12. Initial liaison and contact (Stokes 2.12) (a) has a primary carer been identified under the MHA 1996?	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
(b) If yes, are all necessary details recorded?	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
13. Consumer contact numbers recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
14. Alerts / Risks recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
Mental Health Assessment – Assessment Details (Stokes 7.11.1)	COMPLIANCE				
15. Assessment recorded on: ☐ Standardised Form ☐ IPN					
16. Date recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
17. Time recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
18. Location recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
19. Sources of information recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
20. Communication issues recorded	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
21. History of presenting problem	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
22. Past psychiatric / mental health history	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
23. Legal issues	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
24. Drug and alcohol history	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
25. Medical history	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
26. Family medical / mental health history	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
27. Allergies / adverse drug reactions	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
28. Current treatments	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
29. Other treatments	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
30. Current functioning and supports	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
31. Developmental and personal history	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
32. Parental status and / or other carer responsibilities	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
33. Details of children and / or other dependents	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
34. Mental state assessment **(*See Further Assessment)**	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
35. Physical examination summary (Stokes 2.9)	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
36. Risk assessment and management **(*See Further Assessment)**	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
37. Formulation	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
38. Initial management plan (Stokes 2.10)	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
(a) Does the patient's management include admission to an inpatient ward?	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
Mental Health Assessment – Signed	COMPLIANCE				
39. Staff name	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
40. Signature	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
41. Designation	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
42. Date	☐ Yes	☐ Partial	☐ No	☐ N/A	☐ Unable to assess
Risk Assessment and Management (Stokes 7.10.1, 7.10.3, 7.11.2)	COMPLIANCE				

ITEM FOR REVIEW	COMPLIANCE			
43. Tool used				
44. Demographic information recorded in full	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
45. General risk factors recorded	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
46. Suicidality assessed	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
47. Violence / Aggression assessed	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
48. Protective factors	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
49. Overall assessment of risk	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
50. Specific risk issues to be addressed in management / care plan	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
Risk Assessment and Management Plan – Signed				
51. Staff name	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
52. Signature	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
53. Designation	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
54. Date	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
Sentinel Event / Absconding while in the ED				
55. A sentinel event occurred while the patient was in the ED (√ all that apply)	☐ Absconding ☐ DSH ☐ Violence ☐ Other			
Discharge from ED				
56. Date of mental health discharge	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
57. Time of mental health discharge	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
58. Outcome of ED presentation	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
59. Discharge medication prescribed	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
60. Referral to new service includes relevant information about ED presentation, and urgency of review required. (Stokes 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
61. Evidence of active contact made with referred service (Stokes 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
62. Clinically appropriate care plan / discharge plan written	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
Information Provided to Patient / Carer				
63. Patient informed of care plan / discharge plan (Stokes 2.10, 7.10.4, 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
64. Discussion with carer/family/NOK (Stokes 2.10, 7.10.4, 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
65. Patient received information regarding follow up arrangements and relevant time frames (Stokes 7.2, 7.10.4, 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
66. Patient received contact details of emergency services – available 24 hours. (Stokes 7.2, 7.10.5, 7.10.7, 7.11.4)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess
67. Patient received information about medication (Stokes 7.2)	☐ Yes	☐ Partial	☐ No	☐ N/A ☐ Unable to assess

Appendix C – ED Staff Interview questionnaire

Chief Psychiatrist's Clinical Targeted Review – Mental Health Presentations to EDs
ED Staff Interview

Hospital: _____ Date of Interview: _____/_____/_____

Interviewee Details

Name: _____

Job Title: _____

Management reporting line: Through hospital ☐   Through Mental Health Service ☐

Interview Questions

1. How are patients presenting to the ED categorized as 'mental health'?

2. Where do patients wait for mental health assessment?

3. Who does the initial mental health assessment?

4. (a) Is every mental health presentation discussed with medical staff – either mental health medical staff or general medical staff?

    (b) Under what circumstances are mental health patients seen by a mental health doctor? What is the process?

5. (a) What risk assessments are done, and by who?

    (b) At what intervals is risk re-assessed?

6. Is there a different process for patients presenting with deliberate self-harm / suicidality?

7. What is the process for managing patients with alcohol / other drug co-morbidity?

8. What is the process for managing patients with medical co-morbidity?

9. What is the process for managing patients referred under the MHA (Form 1)?

10. What kind of patient supervision is available?

11. What are the facilitators / barriers to absconding?

12. There is no nationally agreed definition of chemical restraint. However, Tasmania's MHA 2013 provides a definition of chemical restraint of *"chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition".*

    (a)   Is chemical restraint used in the ED?

    (b)   If yes, how often would this occur (monthly, weekly, daily)?

13. (a) Are there any barriers to discharging patients from the ED?

    (b)   Do you provide follow up for patients where urgent intervention is required?

14. Do you have any comments about the relationship between the mental health and non- mental health teams working within the ED?

Any other comments / issues

Appendix E - Stokes Recommendations (Stokes, 2012)

Recommendation 2: Patients

2.2   Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan, the carer is also involved, as appropriate.

2.9   Where a patient has indicated the possibility of performing self-harm, that patient must always be comprehensively assessed by a mental health practitioner and their care plan be approved by a psychiatrist or psychiatric registrar and not discharged until that approval occurs.

2.10   No patient is to be discharged from an ED or another facility without an adequate care plan. Where carer clearly involved, carer should be included in the discussion of the care plan and the discharge plan.

2.12   The names and contacts of carers should be recorded for each patient where appropriate.

Recommendation 3: Carers and Families

3.2   Carers must be involved in care planning and most significantly in a patient's discharge plan, including the place, day and time of discharge.

Recommendation 7: Acute Issues and Suicide Prevention

7.1   Patients presenting anywhere in the public health system with suicidal intent must undergo a best practice risk-screening process and, where required, a comprehensive assessment by a mental health professional. A care plan must be formulated and all decisions to discharge require medical oversight and approval.

7.2   If a patient is discharged they must receive an agreed and signed comprehensive discharge plan that includes a carer, if involved, stating:
   o   Appointment time and date with the community mental health services;
   o   Contact details of emergency services;
   o   Medication and consumer medicine information;
   o   An undertaking to return to the current service if needed;
   o   Name of the mental health clinician or caseworker.

Recommendations from the Deputy State Coroner

7.10.4 Where a person has undergone risk assessment in an ED and not admitted but referred to a CMHS, the person and their carer are to be provided with written advice as to their relevant CMHS, contact numbers and their proposed management plan and relevant time frames.

7.10.5 The contact numbers should include 24-hour service emergency numbers and people should be advised these can be accessed by anybody at any time and trained workers, who have the ability to call out emergency teams if necessary, will respond.

7.10.7 No person should leave an ED without being provided with written advice as who to contact in case of crisis.

Appendix D – Section 3: Timing of ED presentations

Percentage of mental health presentations by time and day of the week

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12MN-02:59	2.0%	1.2%	1.2%	1.2%	1.1%	1.3%	1.5%
03:30-05:59	.9%	.5%	.6%	.6%	.6%	.6%	.8%
06:00-08:59	.8%	.7%	.7%	.7%	.7%	.7%	.7%
09:00-11:59	1.6%	2.2%	2.2%	2.0%	1.9%	1.9%	1.6%
12MD-14:59	2.3%	2.8%	2.8%	2.5%	2.5%	2.4%	2.1%
15:00-17:59	2.3%	2.8%	2.9%	2.3%	2.5%	2.6%	2.1%
18:00-20:59	2.5%	2.8%	2.6%	2.5%	2.6%	2.6%	2.4%
21:00-23:59	2.2%	1.9%	2.2%	1.9%	2.0%	2.1%	2.2%

Percentage of AOD (+/- mental health) presentations by time and day of the week

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12MN-02:59	2.4%	1.6%	1.4%	1.7%	1.5%	1.8%	2.0%
03:30-05:59	1.5%	.4%	.5%	.9%	.7%	.8%	1.4%
06:00-08:59	.7%	.8%	1.2%	.7%	.7%	.7%	1.0%
09:00-11:59	2.0%	1.3%	1.3%	1.6%	1.7%	1.9%	1.4%
12MD-14:59	2.0%	2.0%	1.5%	1.8%	1.8%	2.2%	1.7%
15:00-17:59	2.5%	2.5%	2.4%	1.9%	2.0%	2.5%	2.6%
18:00-20:59	3.0%	2.1%	2.9%	2.5%	3.2%	3.0%	2.8%
21:00-23:59	2.3%	2.2%	2.5%	1.8%	2.4%	2.0%	2.8%

Appendix F

Wait Times

The Department of Health policy *Recording and Reporting of Clinical Care Commencement Date and Time in the ED* (Department of Health, 2014a) that came into effect on 1 August 2014, states: "*The waiting time for emergency department care is defined nationally (Refer: METeOR AIHW) as the time from presentation to the Emergency Department, until the commencement of clinical care (page 1).*"

The policy also states that in an ED, "*clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the ED*" (Department of Health, 2014a, page 2). Although this policy came into effect after the study period it has been used to define the categories for wait times in this review.

Australasian Triage Scale (ATS)

The ATS is used to categorise the urgency of patients presenting to WA Emergency Departments, with the most urgent clinical feature determining the ATS category (The Western Australian Centre for Evidence Informed Healthcare Practice, 2011). There are five ATS categories ranging from ATS 1 where the patient requires immediate assessment and treatment to the least urgent category, ATS 5, where assessment and treatment should be conducted within 120 minutes of presentation to the ED.

ATS Category	Assessment and treatment	Descriptor	Performance Indicator
ATS 1	Immediate and simultaneous	• Immediately life-threatening condition	100%
ATS 2	Within 10 minutes (often simultaneously)	• Imminently life threatening • Important time-critical treatment • Very severe pain	80%
ATS 3	Within 30 mins	• Potentially life-threatening • Situational urgency	75%
ATS 4	Within 60 mins	• Potentially life-threatening • Situational urgency • Potentially serious • Significant complexity or severity	70%
ATS 5	Within 120 mins	• Less Urgent • Clinico-administrative problems	70%

As with other ED patients, patients presenting with mental health or behavioural problems are triaged according to their clinical and situational urgency. Where physical and behavioural problems co-exist, the most appropriate triage category is applied based on the combined severity and urgency of the presentation. (The Western Australian Centre for Evidence Informed Healthcare Practice, 2011*).*

Length of episode

The WA Government signed the National Health Reform Agreement - National Partnership Agreement (NPA) with the Federal Government in March 2011 (Council of Australian Governments, 2011). Under this Agreement, WA Health committed to achieving performance targets against the NEAT. By 2015, 90% of all patients presenting to a public hospital ED are required to physically leave the ED for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours (Council of Australian Governments, 2011).

To analyse EDDC data, performance indicators associated with NEAT and ATS were used. Under the NEAT, 90% of all patients presenting to a public hospital ED are required to be discharged from the ED within a four hour timeframe. Discharge includes: admission to hospital; transferred to another hospital for treatment; or be discharged to community (Council of Australian Governments, 2011). The ATS is used to categorise the clinical urgency of patients presenting to EDs, the most urgent clinical feature determining the ATS category. There are five ATS categories ranging from ATS 1 where the patient requires immediate assessment and treatment to the lowest category, ATS 5, where assessment and treatment should be conducted within 120 minutes of presentation to the ED. The Statewide Standardised Clinical Documentation (SSCD) comprises multiple items and provides a guiding framework for the in-depth clinical review which services were assessed for compliance.

State-wide Standardised Clinical Documentation (SSCD)

The Operational Directive (OD) mandating the use of the State-wide Standardised Clinical Documentation (SSCD) by mental health services was published 27 May 2014 (OD 0526/14) and post-dates the time period examined for this Review (Department of Health, 2014b). However, the use of SSCD was examined in the in-depth clinical review to provide baseline data for compliance with the use of the SSCD for mental health presentations to EDs. Data on the use of SSCD are not available in the EDDC data. Standardised assessment tools enable consistent recording of clinical information from triage through discharge, which will assist in informing clinical care decision. Use of SSCD has the potential to:

• provide support for hypotheses developed during the course of an informal assessment;
• highlight issues that may not have appeared salient during the informal assessment;
• provide an objective measurement of the client's circumstances;
• provide an objective means to measure change and treatment success;
• provide the means to develop a data base that allows comparability between treatment;
• enhance comparability between clients accessing treatment services and enhances information regarding what works for the patient.

Notifiable clinical incidents in the ED
The Chief Psychiatrist must be notified as a matter of priority, of any serious incident and associated issue that may reflect on the standards of mental health care in WA. During the period of this study, the relevant Operational Directive was "Matters to be reported to the Chief Psychiatrist" OD 0242/09 (Department of Health, 2009). Notifiable incidents included serious clinical incidents relating to a patient under the care of any mental health service. Serious clinical incidents include, but are not limited to death, aggression and assault, alleged sexual assault and absconding of any forensic or involuntary patient.

Mental Health Assessment

Within the category mental health assessment two assessments were included in this review, mental state assessment and risk assessment and management. These further assessments are contained within the SSCD (Department of Health, 2014b). Although the OD mandating the use was not in effect during the dates of the review, this review was done retrospectively and therefore the use of SSCD was examined to provide baseline data. The SSCD fulfils the priority recommendations made in the Stokes Review (Stokes, 2012). Where possible, the items assessed for compliance in this Review were linked to recommendations made in the Stokes Review (Stokes, 2012) that were relevant to the ED setting.

Mental Health Assessment - Formulation

The Department of Health, describes formulation as '*a summary of the client's presentation, gained from the thorough assessment, which draws together important features to facilitate the development of a treatment plan*' (Department of Health, 2003). There is no universally agreed definition of formulation and assessment of the factors varies by professional groups. For example many mental health professionals use a 5P formulation structure consisting of predisposing, presenting, precipitating, perpetuation, and protective factors, while medical officers often use a 3P formulation structure comprising the first three items.

Risk assessment and management

As part of an initial psychiatric assessment clinicians are required to complete a Brief Risk Assessment which will identify if a subsequent more in depth risk assessment is required and a related risk management plan is to be implemented.

The Chief Psychiatrist recommended in the Stokes recommendation 7.11.2a (Stokes, 2012), that WA mental health services adopt the *'Clinical Risk Assessment and Management (CRAM) Policy and Standards'* (Department of Health, 2008).

Patient records should show evidence that a risk assessment is repeated if there is a change in the patient's status or when clinical concerns regarding risk are evident. These risk assessments should be completed on a standardised document.