SENATE SELECT COMMITTEE ON MENTAL HEALTH

Personal Submission – Dr Georgina Phillips

This submission is based on my personal observations and experience as a doctor working within the public hospital system for over 10 years. I graduated in 1993 from the University of Melbourne, and have spent most of my working life in inner urban public hospitals, the last eight years based in Emergency Departments (ED) as I have completed my specialisation in Emergency Medicine. I currently work as a full time staff specialist in Emergency Medicine at an inner urban public hospital, which provides inpatient psychiatric care as well as inpatient and emergency services for those in custody. The specific mental health experience enabling me to make this submission derives from my clinical involvement of assessing and managing the acutely unwell psychiatric patient in the ED as well as a six-month placement as a psychiatry registrar in a Community Mental Health Clinic in 2002. The six-month placement included working with Crisis Assessment and Treatment (CAT) teams and the community based care of the chronically mentally unwell patient.

With respect to the Terms of Reference for the Senate Committee inquiry, this submission will focus on issues relating to the acute care and after hours crisis services for people with mental illness, including the practice of detention and seclusion. It will also make comment on community care, and discuss issues pertaining to special need groups such as the aged and those with complex co-morbidities including drug and alcohol dependence.

<u>Acute Care and After Hours Crisis services:</u>

Emergency Departments are open 24 hours/day every day of the year. They are open to all comers and do not charge a fee. They are secure places staffed with experienced medical, nursing and allied health practitioners and many offer additional services such as social work and drug and alcohol counselling and referral. Naturally, then, they have become the most obvious and accessible site for those with acute mental illness to seek help. This is an appropriate role for the ED and many departments have embraced it and sought to improve services with the provision of on-site 24hour psychiatric triage.

Demand for acute psychiatric services in an ED context is increasing. General population increase, better diagnostic techniques and increased community awareness and expectations all contribute to a higher demand for services. The acuity and complexity of mental illness in the community is increasing, with earlier ward discharge for the acutely unwell and an even greater emphasis on community based treatment as well as the impact of drugs, alcohol and other co-morbidities on disease profile. In addition to this, alternative sources of acute containment and assessment, such as police and CAT teams, are increasingly using the ED as the preferred site of care. This is appropriate and desirable from both a patient and service provider perspective, given the safe and secure environment and multiple therapeutic resources available in an ED compared to (for example) a police lock-up. Only this week police

dropped off an armed and disturbed man with a psychiatric history in our ED waiting room, as it was considered too dangerous for the CAT team to assess him ‘in the community’.

Given the ease and appropriateness of accessibility combined with an increase in demand, it is a pity that EDs are poorly equipped to provide the services required to adequately care for those with acute mental illness.

Every patient must have their privacy and dignity respected, however people in acute psychosis or with acute behavioural or mood disturbance are particularly vulnerable to breaches of these. Their ED management is usually carried out in a high acuity, highly visible cubicle in the central part of an ED work area (so that medical and nursing staff can closely monitor them). Many in the ED usually overhear their conversations: staff, security officers, other patients and their relatives. Many observe their appearance and behaviour, and if containment and restraint is required then this is usually carried out in full view of the rest of the ED. This affects not only the mentally ill patient, but can cause distress and potential physical harm to other patients or relatives in the ED. These are daily occurrences in EDs, however few would have space or resources to devise appropriate strategies to provide better and safer care. Staff resources are also often inadequately equipped to deal with the acutely psychiatrically ill person. It takes a high level of training and experience to perform rapid clinical assessments, judge levels of risk, calm a distressed and disturbed patient and administer restraints in a safe and effective way. There is a high incidence of exposure to violence and assault for staff working in EDs and a similarly high incidence of “burn-out”.

These common but disturbing incidents are compounded by time delays to definitive care. It is quite usual for a mentally ill patient to wait hours in the ED for a CAT or formal psychiatric assessment, and to wait for more than 24 hours for an inpatient bed. Recent data collected from EDs around Melbourne showed both voluntary and involuntary patients waiting for up to 5 days in EDs for inpatient psychiatric beds, and multiple mentally unwell patients awaiting definitive care at any one time in the ED. There is neither the geographical space, nor personnel to appropriately care for people in this situation in the ED, and the delay to definitive care potentially contributes to exacerbations of unstable mental state and poorer therapeutic outcomes once treatment has commenced. The issue of containment and restraint is relevant here, as given the lack of geographical space for detention, the ED usually resorts to physical (shackles) and/or chemical (sedating drugs) restraint to contain a disturbed patient and prevent absconding. Whilst this is the least palatable option for most staff working in the ED, it is used commonly to control risk issues for the patient themselves, as well as to protect staff and ensure a safe and therapeutic environment for other people in the ED. This is appropriate in the short-term to allow for the adequate assessment of an acutely disturbed person. However, prolonged restraint is unpleasant, inhumane and probably unethical from a human rights perspective, and carries medical risks associated with physical injury and over sedation. It also requires vigilant and careful nursing. Nevertheless it is used commonly in the ED and sometimes for prolonged periods due to delays in obtaining definitive care.

Because of the unacceptable nature of the ED as a ‘holding bay’ for mentally unwell patients awaiting admission, there is constant and intense pressure on psychiatric wards to discharge patients. Many unstable patients are discharged prematurely with the aim of providing a high level of community support via the CAT teams. However there is a limit to what the community teams can do with their current resources, and an early discharge becomes less of a priority than a psychotic person threatening their

family (for example), so the CAT team spends their time running from one crisis to a slightly more drastic crisis and so on. The patient who gets discharged early to make space for the more acutely disturbed person often find themselves floundering, and often require re-admission or just disappear “lost to follow-up”.
Intensely guarded regional boundaries for the provision of mental health services compound these issues, both from an admission and discharge perspective. We struggle to find beds for ‘out of area’ patients as each hospital jealously protects precious space for it’s ‘own’ patients. For over-committed and under-resourced community based and CAT teams, a patient moving to another geographical area is a neat way to effect a discharge.
Naturally, more and better-resourced community-based acute care and crisis teams would help control the demand for acute care, but simply providing more psychiatric inpatient beds is not an adequate solution for this complex problem. It denies the reality of the increasing profile of EDs as the site for assessment, containment and short-term management of acutely mentally unwell people. Novel approaches by individual EDs have included using dedicated rooms as sites for brief assessment and chemical/physical restraint application prior to managing the patient in the main department. A more appropriate model would include a dedicated subsection of an ED or stand alone department specialising in the assessment and short-term management of the acutely disturbed patient, with all the equipment, personnel and adjuvant services required to provide a high level of care. This would require a radical rethinking of the role and structure of the EDs, and many financial and other resources. However we have seen the evolution of ‘trauma centres’ throughout Australian EDs, whilst the acute care of the mentally ill remains unchanged and under-resourced and is often a profoundly unsatisfying experience for both patient and caregiver.

Community Care:

There are not enough resources for both acute and longer-term support in the community and public mental health has become a kind of crisis management issue. Basically it is only hard-core psychotic illness that can be looked after in the public system, with access to adjuvant supports such as case managers, linkage to employment and rehabilitation services etc. Yet there are a huge number of needy, but not wealthy people who simply cannot access the services that would help them. A large number of these have mood or personality disorders, and many of them are young. There are significant financial barriers to accessing medical models of mental health care with declining rates of bulk-billing and the rise of a “user-pays” system, and even greater barriers to accessing non-medical models of care which are known to have lasting therapeutic value. General Practitioners (GPs) cannot offer all that is required. Community mental health services are overwhelmed with mostly young people referred for assessment by GPs, who need longer-term talking or behavioural therapies, yet no affordable and available services can be found.

Special Needs Groups:

Aged:

There is a growing trend for EDs to be used as a form of crisis containment for the mentally unwell aged (psychogeriatric) person. By the time these people end up in an ED, their degree of mental and behavioural disturbance is severe, and chemical and/or physical restraint is necessitated. It is a particularly frustrating phenomenon as often the mental and behavioural issue is not new, but because of inadequate community assessment, management and support, the nursing home/hostel/families/neighbours end up in a crisis situation. The aged are particularly vulnerable to the stresses of ED care and can suffer exacerbations of their mental illness, dementia or delirium simply from prolonged time in such a non-therapeutic environment, as well as a higher risk of physical injury from falls, physical restraints etc.

Expert assessment and definitive care is particularly delayed in the aged population, as CAT teams, psychiatric triage and community mental health services limit themselves according to patient age (usually < 60yrs). Psychogeriatric services are less experienced in acute care and crisis management, and often do not have resources to provide immediate or even 'same-day' assessment. Similarly, psychogeriatric inpatient beds do not have a high patient turnover, and the delay to accessing these in an acute situation often stretches to days. Naturally to keep an elderly, acutely mentally unwell person in an ED for 24 hours or beyond is unacceptable practice (although certainly occurs in Australian EDs), and many patients in this situation will end up admitted to a general medical ward as a last resort. They do not get expert psychogeriatric care in this setting.

Dual Diagnosis – drug and alcohol:

A major failing of our current mental health system is the inability to integrate the care of the increasing population of people with underlying psychiatric illness and harmful drug and alcohol use. These people are young, highly mobile, live a chaotic and crisis driven lifestyle and are particularly vulnerable to social risks such as homelessness and assault, as well as medical risks associated with hazardous drug and alcohol use (eg; communicable diseases, liver disease, accidental self harm). They particularly use the ED for crisis management and containment (often brought to the ED by other service providers including police) as well as to access psychiatric care and drug and alcohol "detox". For ED staff this population are often the most stressful and difficult to manage, not only because of acute behavioural disturbance, but also because of numerous re-presentations to the ED over days and weeks during a drug +/or alcohol binge or acute psychiatric crisis. The key to the re-presentations and escalating stress for ED staff is the inability and unwillingness of drug and alcohol or psychiatric services to take "ownership" of the patient and direct appropriate management. Our current model of care allows for psychiatric disturbance to be acknowledged as an illness, however drug and alcohol use is understood more as a lifestyle issue, for which our acute medical services have limited offerings. People with combined problems slip between the neat diagnostic categories that define service provision ("not psych", "not drug and alcohol", "not medical"), yet suffer a high burden of illness which puts them at real risk of harm, and of which they have little insight. The only medical service that provides care for patients such as these are EDs, which is only during acute crisis situations, with no capacity for long-term management or therapeutic interventions.

A young woman on a prolonged alcoholic binge developed disturbed, violent and suicidal behaviour whilst intoxicated and had over 30 presentations to our ED within a month, including transfers from police cells. Neither psychiatric nor drug and alcohol services felt able to intervene as her ED presentations were characterised by violence, chemical and physical restraint, sobering up and self-discharge. Finally the cycle was broken by invoking the mental health act and enforcing involuntary status and psychiatric inpatient admission for withdrawal and formal psychiatric assessment and management. This was initiated by ED staff without the support of the psychiatric services, which subsequently continued their involvement after the initial admission. The example illustrated the limitations of our current system for complex patients, and the lack of a patient-centred approach, as well as the increasing role of the ED as a necessary and appropriate site for crisis assessment, containment and management. Resource allocation in the future must acknowledge this to ensure that the care provided is safe, humane and therapeutic.