Australian Health Ministers' Advisory Council

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Health Policy Priorities Principal Committee

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Mental **H**ealth **S**tanding **C**ommittee

Emergency Mental Health Access to Care Working Group

NATIONAL EMERGENCY MENTAL HEALTH PRINCIPLES

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Forward

Improved service responsiveness, including access to emergency mental health care, is a priority of the mental health reform agenda of the National Mental Health Strategy.

This National Emergency Mental Health Principles have been developed in the context of the rights and expectations of people with mental illness or mental disorders to the same access to services and opportunities for optimal care available to all other people in Australia. The Principles are underpinned by:

1. The United Nations *General Assembly Resolution on the Protection of persons with a mental illness and the improvement of mental health care (General Assembly resolution 46/117 of 17 December 1991), and*
2. The *Mental Health Statement of Rights and Responsibilities* agreed by all Australian Health Ministers in 1991.

It is supported by the *National Standards for Mental Health Services*, first endorsed by Australian Health Ministers' Advisory Council National Mental Health Working Group in 1996.

During the mainstreaming of mental health services, not all elements of the health care system and associated emergency response services were positioned to most effectively respond to the needs of people requiring emergency mental health care. Lack of a common understanding of emergency mental health care and responsibility for its delivery has hampered the ability of the health system to provide optimal services.

In light of this, the AHMAC National Mental Health Working Group (now known as Mental Health Standing Committee) established the Emergency Mental Health Access to Care Working Group as a time-limited special purpose subgroup to provide advice on national policy and strategic directions for strengthening the emergency mental health response to improve access to care. Work focused on the development and agreement to national principles to guide future emergency mental health response in Australia.

These guiding principles will assist services to develop a more a comprehensive and integrated response to all mental health emergencies. They can also be used to support quality improvement activities.

Chair MHSC

Preamble

The *National Emergency Mental Health Principles* recognise that people experiencing emergency mental health problems have the right to comprehensive and integrated mental health care across all sectors of service delivery, and that all emergency and health service providers have a collective and shared responsibility to pursue the best possible outcome for the consumer, carers and families. The Principles should be applied to children, adolescents, adults and aged persons presenting with a mental health emergency.

The vision for the Australian health system is to ensure the provision of timely and effective emergency mental health responses and interventions that meet the needs of the individual and community, and achieve the same standards of excellence as is expected for all other health related emergencies.

In order to achieve such a vision, it is necessary to ensure that mental health care is considered as important to the general health and well being of the Australian community as physical health care needs. Similarly, the mental health service delivery system will need to broaden its current conceptualisation of emergency mental health to embrace crisis intervention and psychosocial intervention as essential components of emergency mental health responses. New skill sets need to be nurtured. New treatment options, collaborative and shared management approaches need to be explored. Appropriate evidence-based management strategies also need to be developed and embedded into the system of care.

The *Principles* are intended to provide a framework for local policy development and to aid the drafting of jurisdictional specific policy and protocols or review of existing documents. They provide a basis for a consistent approach across jurisdictions, reflecting the desirability of a uniform commitment to the fundamental rights of those suffering mental illness, their carers and family. The *Principles* recognise the sovereignty of each jurisdiction to develop and enact its own policies and protocols in this field, and the necessity of retaining flexibility to adapt the *Principles* in line to local circumstances and systems. Jurisdictions are nevertheless encouraged to utilise the framework provided in the *National Emergency Mental Health Principles* to ensure accordance with best practice mental health service provision.

Emergency mental health

The delivery of emergency mental health care is the shared responsibility of many sectors, including specialised mental health services, broader health services and sectors outside the health domain. Emergency mental health responses encompass both emergency psychiatry and crisis responses, and may be provided within primary care settings, community services, inpatient units or emergency departments in either the public or private sectors. Police and ambulance services also have key roles in providing services.

The diversity of mental health presentations that require an urgent response also contributes to the significant challenges faced by individuals and their families/carers in accessing emergency mental health care. Examples of conditions that may require emergency mental health intervention include:

- Acute exacerbation of an existing or emerging mental illness.
- Acute psychiatric symptoms precipitated by substance use.
- High risk behaviours related to underlying problems, for example, psychosis, mania, disorientation and memory impairment.

- Acute psychological or behavioural symptoms associated with an underlying condition requiring medical intervention (e.g. brain injury, tumour, infection or other organic pathology, drug overdose, toxicity or withdrawal etc).
- Acute suicidal or self-harming ideation or behaviour.
- Psychological crisis/distress associated with severe stress, trauma or situational crisis resulting in impaired judgement/cognition.

Services and organisational responses have generally been established to meet the needs of some of these subsets but not necessarily all. Hence barriers, disputes and disagreement have frequently arisen around issues of entry criteria, service delineation and resource allocation.

For consumers and carers to receive an adequate response to the full range of mental health presentations requiring urgent intervention will require strong commitment, and may require revision of current models of care, training and education for service providers. Opportunities for innovation and creative service partnerships need to be encouraged and supported at all levels of the health care system.

The health system must ensure that standards, quality and existing evidence of best practice are embraced for those clinical presentations/conditions that are recognised as emergency mental health issues.

The National Principles should not only guide the activity of each of the component parts of the emergency mental health care delivery system, but also address the necessary interface between all parts of the system to ensure targeted and integrated services that effectively meet the needs of consumers.

The National Principles underpin all elements of emergency mental health services, including:

1. timely referral;
2. safe and effective transfer between the component parts of the system;
3. objective triage;
4. comprehensive assessment and stabilisation;
5. evidence based treatment;
6. assertive follow-up; and
7. carer and family support.

As part of a health care and crisis delivery system, all services should recognise the full extent of emergency mental health problems that may arise as a consequence of personal life events, social disruption or illness. Services should (ought to) be capable of providing appropriate responses to meet the acute mental health care needs of individuals concerned. The mental health and wellbeing of consumers and the needs of their carers, families and/or significant others should also be responded to with a view to:

1. averting or limiting any imminent harmful biological, psychological and socio-cultural consequences;
2. reducing symptoms of distress;
3. improving the capacity for self-control, self-regulation and self-care; and
4. facilitating a safe return to the individual's identified social support network.

Communication, referral and feedback processes are of major importance in achieving positive consumer, carer and family outcomes.

Overarching Principles

Principle 1: Equity of access

People experiencing emergency mental health problems should receive the same standard of access and care as other people requiring any other form of emergency health care, including the same access to timely and effective intervention. All members of the community have the right to comprehensive information on how to access emergency mental health care services.

Information should be readily available to the community on how to access services when a member of the community perceives that a mental health emergency response is required.

Agencies need to maintain information on service availability, method for establishing contact, where services are provided, and the range of treatment and support options.

It is the responsibility of mental health service agencies to ensure that up-to-date information is disseminated to all agencies/providers responding to mental health emergencies. This information should also be accessible to people experiencing emergency mental health problems, their carers and families.

Information should be culturally and linguistically appropriate and provided in a manner that is user-friendly, respectful and in a language that the person understands.

All health services, regardless of location, should have the capacity to respond to mental health emergencies. Where agencies are unable to provide the level of emergency mental health care required, they should establish clear referral pathways supported by service linkage arrangements. Access issues may be different for different cultural groups and Aboriginal and Torres Strait Islander people and this should be recognised in the provision of appropriate services.

Mental health emergencies represent a genuine health risk and triage processes should reflect the need for timely interventions corresponding to the level of emergency without discrimination on the basis that these are mental health rather than physical problems. If transport is required, this should be in accordance with protocols developed to be consistent with the National Safe Transport Principles. People experiencing a mental health emergency should have the same access to transport as those experiencing medical emergencies of equivalent severity.

Following assessment and stabilisation, processes should be in place and options proactively explored to ensure that people experiencing mental health emergencies are referred, and if appropriate, transported as soon as practicable to the environment most conducive to their mental health needs.

People experiencing mental health emergencies who require acute inpatient care should have equitable access to inpatient services (either generalist and/or specialist) as people experiencing other medical emergencies. Access to inpatient care should occur in a timely manner and decisions regarding admission should be based on sound clinical evaluation and assessment of the immediate needs of the individual.

It is important that there be equity of access to services for children, youth, adults and older people. Wherever possible, services should be provided in age-appropriate settings.

Principle 2: Respect

The emergency mental health system should uphold the rights of people experiencing emergency mental health problems, their carers and those of their family members, by respecting their rights to privacy and treating them with dignity.

Health settings should be designed and procedures developed that ensure not only the safety of the individual, but also preserve their privacy, personal dignity, rights and reputation, irrespective of their current circumstances.

Documentation and all other communications should accurately describe history and examination findings without the use of negative language, pejorative terms, inappropriate labeling and trivialisation of the person's situation.

The individual and their carers should be given the opportunity to identify the problem from their perspective and the assessment should include the impact of the emergency for the individual and their carers.

People experiencing mental health emergencies should receive care that is non-discriminatory and aims to be provided in a manner that is sensitive to, and with the understanding of the significance of the social, cultural and spiritual values of the person, their carers, other family members and their community.

Confidentiality should be maintained in accordance with relevant legislation, regulations and instruments respecting both the rights of the individual receiving care and their identified carers. Agencies should support this through documented policies and procedures.

Principle 3: Quality Care

Service providers should endeavor to deliver optimal care in response to mental health emergencies that is evidence based, informed by professional standards and practice guidelines, and supported through intra and inter agency collaboration to achieve the best possible outcomes for the consumer, carers and families.

All emergency and health service providers have a collective and shared responsibility to pursue the best possible outcome for the consumer. Intervention commences with the first contact and opportunities for secondary and tertiary prevention strategies should be recognised at this point. Any delay caused by the need for medical and mental health assessments must be minimised.

The necessary key components of emergency mental health care have been identified as:

1 timely referral
2 safe and effective transfer between the component parts of the system
3 objective prioritisation/triage
4 comprehensive assessment and stabilisation
5 evidence based treatment/s
6 assertive follow-up
7 carer and family support

All of these elements are integral parts of a quality emergency mental health care system and quality improvement processes should reflect this. Quality emergency mental health care should reflect a commitment to the bio-psycho-socio-cultural approach. This is likely to be best achieved in association with clearly defined and well-established intra-agency and inter-agency collaboration. The development of effective intra-agency and inter-agency collaborative networks should be a priority and the effectiveness, appropriateness and responsiveness of intra and inter sectoral linkages should be reviewed as part of the organisation's quality improvement processes.

The delivery of quality emergency mental health care relies on technical expertise, interpersonal skills/competencies and appropriate resource allocation and availability. Quality care should be supported through access to specialised mental health clinicians/psychiatrists where this is appropriate.

Timely referral

In order to ensure that an individual is referred in a timely manner, there needs to be awareness and appreciation of an individual's distress and the possible symptoms and signs of common emergency mental health problems. Enhanced awareness and recognition capabilities of all service providers are essential to this process.

Safe and effective transfer

Once an emergency mental health situation, which requires further assessment, care and possible admission, is recognised, it is incumbent on emergency, community and/or health service providers to ensure that the transfer of an individual to a source of appropriate care is facilitated in the safest possible manner. Evaluation of all identifiable risks should be balanced with sensitivity to an individual's immediate needs. In addition, sensible and responsible use of available resources and collaboration amongst service providers should inform the decision making process.

Effective transfer between all service providers and the component parts of the system is essential. Transfer does not necessarily involve the physical re-location of an individual, but should include the accurate relay of all relevant information and appropriate handover to another individual and/or service provider who comprehends the nature of

the circumstances and is capable of managing the on-going care requirements of the individual experiencing a mental health emergency.

Comprehensive communication, which ensures continuity of care is essential and is expected to occur at all interfaces. This includes service providers as well as individuals and carers/supporting family members. All necessary information pertaining to the care received further instructions, follow-up arrangements and key contact personnel needs to be provided.

Objective prioritisation / triage

Fundamental to the accurate identification of mental health emergencies is the need for objective, unbiased, systematic and competent evaluation of the presenting situation based on clearly established criteria. Wherever possible these criteria should be defined in plain and understandable terms free from jargon or specialist terminology. Formats used should be orderly, methodical and demonstrate a logical progression in terms of problem identification and decision-making.

Comprehensive assessment and stabilisation

The clear aim of assessment of emergency mental health problems is the accurate identification of the presenting problem/s. Assessment processes and procedures should reflect a thorough and comprehensive evaluation of all available information and may include information from a range of sources and by a variety of means (e.g. face to face, telephone, other technologies). Where an individual consumer is unable to give full personal history due to impairment then every effort should be made to obtain collateral history from significant others.

Assessment processes should reflect appropriate consideration of and, where necessary, exclusion of any underlying or co-morbid general health condition which may be contributing to the current circumstances. Where identified, the appropriate care/management should be initiated.

Where emergency intervention is deemed necessary prior to more comprehensive assessment, the goal of management is to prevent any further deterioration of the individual's condition. Stabilisation should be viewed as part of a process of evaluation and not definitive management of the problem. The consumer's care should be regularly reviewed, particularly upon receipt of new and/or additional information and/or observed clinical developments during the course of intervention.

Best practice management needs to extend beyond the limits of symptom control and include interventions aimed at restoring the capacity for self-control, self-regulation and self-care and facilitate safe return to the individual's social support network where appropriate.

Individuals who require on-going care should be transferred from the general emergency department to a more therapeutic environment as soon as clinically indicated. This may include a short stay unit attached to an emergency department, an inpatient unit or an appropriate care setting in the community.

Evidence based treatments

Accepted and professionally endorsed treatments, "best practice", standardised approaches and established clinical pathways for intervention need to be balanced with the recognition and need to respond to an individual's unique circumstances. Within a health care network, a full range of evidence based treatment options (biological, psychological and socio-cultural) should be made available to individuals with emergency

mental health problems. The treatment provided and any proposed care should be formalised in an integrated individual care plan.

Services are responsible for ensuring that mechanisms are in place to facilitate timely access to consultant psychiatrist opinion in a manner commensurate with the level of emergency and in accordance with legislative requirements.

Assertive follow-up

Following the management and stabilisation of emergency mental health problems, assertive follow-up care is often required for consumers to achieve positive outcomes. Responsibilities for follow-up should be clearly identified and recorded in the care plan and associated documentation. Relevant agencies should be notified of discharge arrangements and commitments to follow up care should be clearly communicated and recorded. Consumer tracking procedures should also be implemented.

Principle 4: Safety

People experiencing a mental health emergency should be provided with services in an environment that is safe for them, their carers, families, staff and the community.

Thorough and accurate risk evaluation, appraisal and sound judgement should be exercised to balance individual consumer need with the safety and/or well-being of significant others and/or the broader community. Such considerations need to be reflected and recorded in documentation and health care records.

Individuals have the right to receive care in the least restrictive environment and with the least restrictive and intrusive treatment that is appropriate to their immediate circumstances and total health care requirements. Wherever possible, the environment should be used in ways that are conducive to the development of effective therapeutic relationships.

Restriction of rights and choice should be balanced with the need for immediate treatment, stabilisation and further evaluation. The purpose of such restrictions should be clearly compatible with safety concerns and not used as a punitive measure. Any restrictive procedures or interventions must comply with relevant legislation, regulations and other safety monitoring requirements.

Agencies should have formal risk assessment policy and procedures in place and these should include identification and management strategies for a broad range of risk factors commonly associated with mental health emergencies (e.g. vulnerability, deterioration, and harm to self or others). Consideration should also be given to relevant social factors, such as the presence of dependent children.

Agencies should develop and implement protocols that promote safety within the treatment environment, support safe practice and utilise safe and clinically valid interventions. This should include formal restraint and seclusion policy and procedures. Any intervention that restricts or potentially compromises an individual's responsiveness should be subject to regular and frequent clinical review including formal observations of vital signs.

Strategies that support the national safety priority areas:

- reducing suicide and deliberate self harm in mental health services;
- reducing use of, and where possible eliminating restraint and seclusion;
- reducing adverse drug events in mental health services; and
- safe transport of people experiencing mental health disorders,

as specified in the *National safety priorities in mental health: a national plan for reducing harm (2005)* should be actively pursued by individual service providers, collaborative networks and organisations.

Principle 5: Consumer Participation

Individuals experiencing a mental health emergency should be informed of their rights, options for service along the treatment pathway, and given the opportunity to actively contribute to decisions regarding their care.

Service providers should give individuals the opportunity to identify the problems they are experiencing from their perspective, including their immediate psychosocial needs. Specific needs relating to age, gender, language, culture, spiritual values, disability and other health requirements should be ascertained and services should be provided in a manner that is sensitive and responsive to those needs.

Service providers are responsible for ensuring individuals are supported to actively contribute to their care by providing them with accurate and complete information on their rights, their options for treatment, and the range of service settings where appropriate treatments can be provided. Individuals experiencing a mental health emergency should, wherever possible, be provided with the opportunity to exercise personal choice regarding options for their care. Where impairment renders an individual unable to make an informed choice and/or their judgment is impaired, service providers should observe their legal duty of care and patient advocacy responsibilities with the best interests of the consumer in mind at all times.

Service providers will encourage and provide opportunities for consumers to involve others to support them in their care and seek appropriate consent for that involvement.

Agencies need to ensure consumers have the opportunity to be actively involved in emergency mental health service planning, implementation, evaluation and quality improvement processes.

Principle 6: Carer Participation

Carers and/or family members should be supported to optimise their contribution to the care of individuals experiencing mental health emergencies.

Carers should be recognised, respected, valued and supported as partners in providing care to individuals experiencing a mental health emergency. In addition, the often stressful and distressing nature of mental health emergencies for carers and family members needs to be acknowledged and recognised as deserving of support and assistance.

Service providers should actively endeavour to identify carers and/or appropriate family members, including young carers and dependents, as early as possible. Additionally, service providers should ensure that carers and/or family members are provided with information in a manner that best facilitates their understanding of the situation.

Service providers should ensure that carer and family participation occurs with the knowledge and consent of the individual. Where impairment renders an individual unable or unwilling to give consent, service providers are required to observe their legal duty of care, relevant legislative requirements, and exercise sound judgement in meeting their dual responsibilities to individuals in receipt of care and significant others who may be impacted by the mental health emergency.

Where consent is obtained, service providers should actively involve the carer or family member in the care planning process and seek their views regarding treatment options and follow-up arrangements.

Where service providers do not involve identified carers or family members, the reasons for this decision should be clearly documented.

Regardless of whether the individual has consented to the carer or family member being involved in the current episode of care, service providers should be responsive to the needs of carers and family members and provide appropriate support as required.
As a minimum, service providers should offer an identified carer or family members (including young carers and dependants as appropriate) the following:

- the opportunity to contribute information that may assist in the assessment and treatment planning process;
- information on mental health emergencies and mental illness;
- information on the local services available;
- information on carer, family and other support services and assistance to access services to meet their own needs, if required.

Agencies should ensure carers have the opportunity to be actively involved in emergency mental health service planning, implementation, evaluation and quality improvement processes.

Principle 7: Continuity of Care

Individuals with emergency mental health problems should expect to receive continuity of care characterised by coordinated agency responsiveness (including public and private sectors), effective transfer and seamless transition between agencies/service providers.

Continuity of care should maximise the exchange of significant and relevant pieces of information pertaining to a mental health emergency and minimise any potential for deterioration, harm or complications of management. Continuity of care depends upon the establishment of linkages that are supported by effective professional communication, feedback and information to referral sources.

Efforts should be made by all service providers to determine whether an individual experiencing a mental health emergency is the subject of any legal orders (e.g. community treatment orders) that specify particular treatments and/or interventions.

Collaboration and exchange of information needs to occur between relevant agencies, including public, private and non-government services. Polices and protocols that facilitate the seamless transfer of people experiencing mental health emergencies between these agencies, or that support shared care arrangements, should be developed.

The roles and responsibilities of all parties, including the service provider/s, consumer and carer/s or family member/s should be clearly articulated in a care plan. Service providers should ensure that any instructions are fully understood and that the individual and/or identified carer/s are capable of acting in accordance with the care plan. This information should be provided in writing to the consumer and identified carer/s to assist with self-management and to facilitate access to other services as required.

Principle 8: Staff Knowledge and Skills

Specific emergency mental health training and ongoing professional development and support should be provided to people who are involved in service provision to individuals experiencing mental health emergencies.

Service providers should have a thorough working knowledge of the legislative frameworks regulating their work and the variations that exist when arranging transfers across jurisdictional borders.

Service providers involved in the component parts of emergency mental health delivery should receive comprehensive training relevant to their role, including training in engagement, prioritisation/triage, systematic assessment, problem identification, safety and risk assessment, and emergency intervention strategies. The development of technical skills and expertise, effective interpersonal skills and the application of psychosocial interventions need to be supported through continuous education, professional development, specific training and competency assessments. The opportunity for regular knowledge update, clinical practice review and reflective learning in order to maintain clinical standards should be supported by agencies.

Agencies should provide access to information on evidence based interventions in emergency mental health and endorsed clinical practice guidelines to service providers.

Service providers should have a comprehensive working knowledge of intra-agency and interagency networks, service linkage arrangements and referral options.

Professional bodies should define the competency standards required by emergency service providers, generalist service providers and specialist mental health providers to ensure effective response and performance within the context of an emergency mental health situation. Competencies should comprise the specification and the application of knowledge and skills within a range of settings where mental health emergencies may arise.

Principle 9: Information Management

Agencies should work towards development of information management systems that facilitate the collection and analysis of data to enable review of emergency mental health activity and outcomes - both at an individual level and as a service monitoring and quality improvement initiative.

Agencies should maintain information management systems that enable the analysis of the key components of emergency mental health service: referral, transfer, prioritise/triage, assessment and stabilisation, treatment, follow-up and carer and family support, across all domains of quality. The aim of such analysis is to accurately identify mental health emergencies, assess the efficacy of treatment and improve processes in order to improve outcomes for individuals experiencing a mental health emergency.

Consistent with other parts of the health system, emergency mental health information management systems/processes are necessary for, but not limited to, the review of sentinel events, critical incidents, analysis of complaints, tracking of risk reduction strategies and monitoring of key performance indicators.

Services should work collaboratively to develop data sets and information that examine the effectiveness of service linkages, particularly in relation to common referral pathways and transfers between different agencies/service providers.

Where possible the component parts of the emergency mental health service sector should work collaboratively and build on existing initiatives such as the National Institute of Clinical Studies (NICS) Emergency Care Community of Practice: Mental Health-Emergency Care Interface Project 2004–2006 and the Key Performance Indicators for Australian Public Mental Health Services to develop a consistent or comparable set of emergency mental health indicators.