Mental Health Care in Emergency Departments and General Wards Policy

1. Background

Within the WA Country Health Service (WACHS) general hospitals including Emergency Departments (ED), the provision of Mental Health (MH) care is a common and important role, performed in conjunction with local services, and in partnership with metropolitan and statewide specialist MH providers.

WACHS assessment and care of patients presenting with MH problems is to be in accordance with *Mental Health Act 2014* (WA) [MHA] (including the 'Charter of Mental Health Care Principles'), and the Clinician's Practice Guide to the MHA. The values underpinning such care are also informed by the Chief Psychiatrist's Standards for Clinical Care.

2. Policy Statement

This policy provides a framework for the timely, safe and accurate assessment and care of people seeking MH care by non-MH staff within WACHS EDs and on general hospital wards, and in obtaining specialist MH care.

It provides specific guidance for the assessment and care of people who present at risk of suicide.

Key Principles

Consumers presenting to a WACHS health facility with MH issues are to receive comprehensive assessment of their physical and mental state.

People who present with suicidal thinking or behaviour are of particular concern and, where indicated, will be referred for specialist MH assessment. The Principles and Best Practice for the Care of People Who May be Suicidal outlines how clinical care must strike a balance between managing risk and promoting safety, and include consideration of the person's individual situation, especially an appreciation of the social, cultural, developmental aspects of their presentation. In the case of children and adolescents, this involves assessment of the parent's/guardian's ability to safeguard their child and contain risk.

Where a risk of violence or aggression is identified, there will be a balance between the safety of the family, personal support person, health care staff and other consumers, and the treatment and freedom of the individual receiving care. While safety is the primary consideration, it is important that care is provided using least restrictive practice.

WACHS clinicians are to use a process of structured clinical judgement in the assessment of the individual (including assessing general risks, risks to self and risk of violence/aggression) with the goal of a shared understanding of risk and safety, shared decision making and shared responsibility for safety.

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Regional services are, in collaboration with WACHS and statewide MH services, to plan and implement strategies to ensure specialist MH assessment is available in a timely way.

3. Definitions

Risk to self	Risk of self-harm and suicide, including repetitive self-injury; self-neglect; absconding and wandering; drug and alcohol abuse; unstable medical conditions; quality of life including dignity, reputation, social and financial status
Risk of harm to others	Includes violence or aggression; sexual assault or abuse; property damage including arson; public nuisance; reckless behaviour that endangers others; harassment; stalking or predatory intent
Risk by others / vulnerability	Includes sexual or emotional harm or abuse by others; social or financial abuse or neglect by others

4. Roles and Responsibilities

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

Mental Health Team Leaders are to provide orientation and education to WACHS clinicians to ensure they understand the clinical risk assessment and management process.

WACHS Clinical Directors and Regional Mental Health Managers in conjunction with the WACHS MH Education and Training Coordinator are to ensure staff receive education and training and information on clinical risk assessment and management.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

Evaluation of this policy is to be carried out by the Mental Health every three (3) years, or as required.

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7. Standards

National Standards for Mental Health Services: 1.1, 1.3, 1.4, 1.5, 1.7, 1.18, 2.2, 2.5, 4.13, 4.14

National Standards for Quality Health Service Standards (First edition 2012) - 1.8, 9.9.91

National Safety and Quality Health Service Standards (Second edition 2017) - 1.7, 2.6, 5.1

Office of the Chief Psychiatrist Standard (5) Assessment

8. Legislation

Mental Health Act 2014 (WA)

9. References

SA Health. Guidelines for Working with the Suicidal Person 2012

Preventing Suicide in England. A cross-government outcomes strategy to save lives (2012)

Review of the Admission or Referral to and the Discharge Practices of Public Mental Health Facilities/ Services in Western Australia 2012

Charter of Mental Health Care Principles Brochure

- Charter of Mental Health Care Principles

Mental Health Act 2014 Resources

- Clinician's Practice Guide to the MHA.

Office of Chief Psychiatrist Standards and Guidelines

- Chief Psychiatrist's Standards for Clinical Care.

WA Mental Health Commission 10 year plan

WA Health Clinical Services Framework 2014-2024

10. Related Forms

MR46 WACHS Suicide Risk Assessment and Safety Plan

11. Related Policy Documents

WACHS Patient Discharge, Escort, Transfer and Transportation CPS

WACHS Documentation Clinical Practice Standard

WACHS Sedation for Mental Health Patients Awaiting Aeromedical Transfer Guideline

WACHS Triage, Assessment and Management in the Emergency Department CPS

WACHS Restraint and Seclusion Minimisation - WACHS Clinical Practice Standard.

WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy

WACHS Observations Physiological Clinical Practice Standard.

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WACHS Adult Psychiatric Inpatient Services - Referral, Admission, Assessment, Care, Treatment Discharge Policy.

WACHS Patient Discharge, Escort, Transfer and Transportation CPS

12. Related WA Health System Policies

OD 0484/14 WA Health Clinical Handover Policy

MP 0074/17 Clinical Care of People Who May Be Suicidal Policy attachment Principles and Best Practice for the Care of People Who May be Suicidal

Clinical risk assessment and management (CRAM) in Western Australian Mental Health Services;

OD 0501/14 Clinical Deterioration Policy

13. Appendices

Appendix 1 - Patients Presenting to WACHS ED with Possible Mental Health Issues

Appendix 2 - Assessment of People Who May Be Suicidal including completion of the MR46 WACHS Suicide Risk Assessment and Safety Plan.

Appendix 3 - Screening and Assessment of Mental Health Patients in WACHS Hospitals Flow Chart

Appendix 4 - Safe Transport and Transfer of Care of Country Mental Health Patients Referred for Examination by a Psychiatrist Flow Chart.

Appendix 5 - BACPAC Mental State Assessment

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1- Patients Presenting to ED with Possible Mental Health Issues

1. Triage

Triage is to occur in the first instance using the Australasian Triage Scale (ATS), see Appendix 4 of the WACHS Triage, Assessment and Management in the Emergency Department - Clinical Practice Standard. .

2. Assessment

When completing an assessment for a patient presenting at ED the following are to be considered:

- be professional, non-judgmental, non-threatening
- show genuine interest and concern for the person's situation
- engage with the patient using empathy and active listening
- provide reassurance and hope
- offer an ability and willingness to provide practical assistance, if required
- invite an appropriate level of partnership
- approach in a calm confident manner identifying yourself to the patient
- avoid prolonged eye contact and allow the patient enough personal space
- do not be afraid to ask questions about self-harm and suicidal ideation, but do not threaten or challenge the patient
- maintain personal safety at all times
- always obtain and include collateral information from significant others.

Obtain the patient's health record and review past medical and psychiatric history, current or previous management plans, and documented risks.

- Contact the local MH service or search the MH database (PSOLIS) to obtain additional information including alerts and state-wide information.
- Use RuralLink **1800 552 002** for after-hours access to information from the MH database (PSOLIS). For guidance regarding assessment and management of children and adolescents and their families who present in psychosocial crisis, contact the Child and Adolescent Health Service (CAHS) Child and Adolescent Mental Health Service (CAMHS) Acute Response Team (ART) on 1800 048 636.
- Aboriginal[1] consumers are to be offered access to an Aboriginal Liaison Officer (ALO) or an Aboriginal MH Worker through contacting the local MH service.
- Obtain and share information, whenever possible, from other sources including family and carers.

3. History

History includes:

- description of the presenting problem
- relevant medical, psychiatric, social, family and personal and developmental history
- history of substance use with appropriate screening tools
- prescribed and other medication history.

[1] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

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4. Mental State Examination (MSE)

Practitioners may wish to use the BACPAC mnemonic to assist in completing the elements of MSE. See WACHS 'BACPAC' Mental State Assessment.

5. Physical Examination

Physical examination in the ED is focussed according to the history obtained and patient presentation. The main objective is to exclude relevant medical/ organic illness that may be contributing to, or part of, the MH presentation, and to assess the patient's general physical health.

6. Risk Assessment and Safety Planning

All patients presenting for MH care are to receive an assessment of risk according to the Clinical Risk Assessment and Management (CRAM) Policy in Western Australian Mental Health Services.

In the ED, risk assessment is to include consideration of:

- harm to self and others
- self-neglect
- risk of absconding or wandering
- risk to reputation
- risk of property damage
- risk of not receiving essential medical care.
- risk of harm/neglect from others (particularly children and the elderly).

7. Assessment of people who may be suicidal

Appendix 2 provides specific guidance for the assessment of people who may be suicidal.

8. Assessment of people who may be a risk of aggression or violence

Assessing risk of aggression or violence may identify a propensity for violence or aggression, but individual incidents are difficult to predict. Violence/aggression risk assessment is an evaluation of danger or threat **in the present situation** and is not a predictor of future events. Assessment processes should remain sensitive to individual circumstances and should not take the form of a blanket approach which results in unnecessary restrictions. Specific factors associated with a higher risk of violence or aggression in MH consumers include:

- a previous history of violence / aggression
- serious mental illness (especially paranoid psychosis, command hallucinations and mania if limits are imposed
- substance abuse
- childhood experience of maltreatment/cruelty (parental and to animals), and fire setting
- a history of self-harm
- personality traits of impulsivity, serf-centeredness, projection of blame.

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Safety planning for consumers with risks of violence and aggression should, if possible include gathering information about these risk factors, understanding the person's immediate needs/wants, and supporting any possible problem solving by the consumer. Involvement of family and carers, as well as culturally informed practices and other social supports can be helpful in reducing the risk of aggression and violence. The physical environment should be improved or optimised. Training and support for de-escalation strategies should be provided. Clear guidelines concerning early decision making about sedation (where this may be appropriate) should be employed. The WACHS Sedation for Mental Health Patients Awaiting Aeromedical Transfer Guideline details selection, preparation, administration and monitoring of medication in the agitated patient.

Use of physical restraint should be minimised as much as possible. Refer to WACHS Restraint and Seclusion Minimisation - WACHS Clinical Practice Standard.

The WACHS Triage, Assessment and Management in the Emergency Department - Clinical Practice Standard details further information about aggressive behaviour in the ED

9. Admission to a general hospital ward

Patients requiring MH care may be admitted to WACHS hospitals under the care of the hospital's medical staff (GP, Visiting Medical Officer or Salaried Medical Officer including Psychiatrist). Handover of care will follow the Operational Directive OD 0484/14 WA Health Clinical Handover Policy

The admitting doctor may refer any MH patient to MH Services for further specialist assessment and ongoing review. This review is to generate recommendations for the inpatient care plan incorporating general ward and MH staff as appropriate. If at all possible this should also include the role of family and carers. This advice should include specific plans for the extent and frequency of nursing observations (including the need for a nurse or security "special"), medications (including **pro re nata** medication) any agreed leave from the ward, the type and frequency of further MH review, and advice on nursing and allied health care. After hours advice about patient care can be sought from on-call MH services, if available, or from RuralLink.

General ward nursing and medical staff are to provide appropriate observations and care of patients admitted to the ward. Observations are to include mental state and risk assessment and safety planning (MR46) and assessment of the need for and administration of *pro re nata* medications as well as specific medical observations and care outlined within:

- Operational Directive OD 0501/14 Clinical Deterioration Policy
- WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy
- WACHS Observations Physiological Clinical Practice Standard.

Patients referred for examination by Psychiatrist (*Mental Health Act 2014* Form 1A), may on occasion be admitted to a general hospital pending transfer to an authorised place. (see Appendix 4 WACHS Safe Transport and Transfer of Care of Country Mental Health Patients Flow Chart.) The patient's personal support person or carer is to be informed of any person referred under Form 1A who is admitted to a general hospital. In such cases regular review from the local MH Service is to be provided.

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Patients who leave the hospital without notifying staff or who discharge themselves against medical advice, are to be managed according to the agreed MH care plan and the WACHS CPS Patient Discharge, Escort, Transfer and Transportation.

10. Admission to Inpatient Mental Health Ward

Patients requiring specialist inpatient MH care are to be admitted to a WACHS acute MH unit according to regional procedure, or by transfer to another WACHS or metropolitan acute MH inpatient service according to WACHS Adult Psychiatric Inpatient Services - Referral, Admission, Assessment, Care, Treatment Discharge Policy.

11. Discharge from the Emergency Department

Discharge may occur from the ED or from the general ward according to the WACHS Patient Discharge, Escort, Transfer and Transportation Clinical Practice Standard and is to be determined in consultation with the MH service and with consideration of:

- patient's functional status
- patient's risk of harm to self or others
- patient's Mental Health Act status (refer to WACHS Interhospital Patient Transfer of MH Patients Guideline)
- availability and reliability of supports, including accommodation and assistance to care for children and significant others
- patient's insight and judgement, and their ability to plan and adhere to an agreed course of action, including taking medication
- access to, and engagement with, community based care including the GP and the local MH service.

All patients discharged are to be provided with a discharge plan which is to include, as a minimum:

- follow up appointment time and date with the community MH service or the patient's GP, including the name of the treating doctor, MH clinician or other relevant service provider
- contact details of emergency services
- medication and consumer medicine information
- an undertaking to return to the current service if needed
- where there is a carer involved, the carer is to be included in the discussion of the care plan and the discharge plan
- carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity.

Information is to be provided verbally and in writing. This discharge information is to be shared with a carer/family member if at all possible.

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Appendix 2 - Specific Considerations in the Assessment of People Who May Be Suicidal

The challenges for an individual clinician faced with the assessment of a person who may be suicidal are twofold: firstly, it is an uncommon event, even within Mental Health Services, with rates of around one person per one thousand episodes of care or hospital admissions; and secondly, there is no set of risk factors that can accurately predict suicide in the individual patient.

MH practitioners and other care providers are to consider the consumer's personal experience, using structured clinical judgement as the preferred approach to the assessment of suicide risk at the individual patient level.

Engagement with the consumer is vital in obtaining a more reliable assessment and forms the basis for a mutually agreeable care plan. In this respect the MH assessment can also be therapeutic in that it promotes engagement and a shared responsibility for safety.

During the assessment, consider information obtained about:

- suicidal ideation– thinking / plan / intent / lethality of plan
- current mental state
- access to means including prescribed medications, weapons, illicit drugs etc.
- protective factors e.g. family, children, spouse, pets and work
- available social supports – does the person live alone? How much time does the person spend on their own?
- current or pending events that may increase patient's risk
- does the patient have children in their care? Are they safe?
- other possible risks: harm to others, harm from others, capacity to make decisions.

A Guide to the completion of the (MR46)

The MR46 WACHS Suicide Risk Assessment and Safety Plan Form is the recommended form of documentation of the suicide risk and safety assessment, **supplementing** the information obtained from the broader history and examination which is to be documented in the clinical record.

Intoxication precludes a valid immediate assessment. If suicide risk is identified in an intoxicated person they should be detained in an appropriate and safe setting until a further assessment can be conducted.

Steps in completing the MR46 WACHS Suicide Risk Assessment and Safety Plan

1. **Decide whether to use the MR46**

   The MR46 is to be used in all patients when the initial MH assessment identifies any suicidal or self-harm thoughts or behaviours.

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2. **Ensure optimum time and an appropriate place for completion**

   The MR46 will take between 10 -20 minutes to complete. Ordinarily this will be at the end of the initial assessment (e.g. in the ED) or can be utilised as a way to structure allocated time for review of the patient (on the ward).

   As far as possible ensure this time is available uninterrupted with the patient and is free from other distractions. If this is unlikely, inform the patient that if you are called away you will return as soon as possible to continue the assessment.

3. **Introduction and engagemen**t

   Introduce yourself and your role. Tell the patient that part of the care is to understand and support them to be as safe as possible in hospital or at home.

   Show the patient the MR46 form and tell them that this form can be helpful in sharing any concerns about suicide/self-harm risk and what can be done to support their safety.

   If carers or family are present ask the patient if they would like them to be included in the discussion of the plan. Mark the sources of information in the first section.

4. **SECTION 1: Assessing for risk**

   Talk with the patient about their current situation using the 5 prompts to enquire about changes in the patients feelings, behaviour and thoughts, including discussing thoughts of self-harm or suicide. Mark the Likert scale according to a **shared** understanding of the changes discussed.

   Specifically enquire about whether others have concerns and mark this on the scale

   Complete the items of prior history as present or absent by reference to the records, and by discussion with the patient.

   Explore the patient's protective factors using the prompts and mark these as reasons to live on the Likert scale

   Discuss your own concerns or those of other clinicians with the patient, including acknowledging issues with communication and engagement.

5. **SECTION 2 : Planning for safety**

   Talk with the patient using the prompts in the three areas of actions, connections and professional support and care, marking on the Likert scale the patient's preparedness to commit to specific items.

   Include any other contact details/phone numbers nominated by the patient or suggested by the clinician e.g. GP, MH clinic.

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6. Summary section

With the patient, look back on the items in Section 1 and summarise an agreed level of risk as high, medium or mild. Do the same from items in Section 2 and agree on a level of current safety factors as high, medium or low. Then agree on an overall risk and safety level,

7. Action plan

Using the agreed level of overall risk and safety discuss the further plan for the patient's care including whether remaining in hospital is important or if discharge can occur. Moderate or mild overall risk and safety may permit discharge.

If discharge is appropriate, use this section to add any other items that are part of the patient's post-discharge care. This would include any appointments arranged after discharge and advice about re-entry as required.

If hospitalisation is appropriate, use the prompts for hospital based care/supervision according to the checklist.

If the patient is already in hospital, use the form to review current safety planning and determine appropriate actions by the treating team and the patient.

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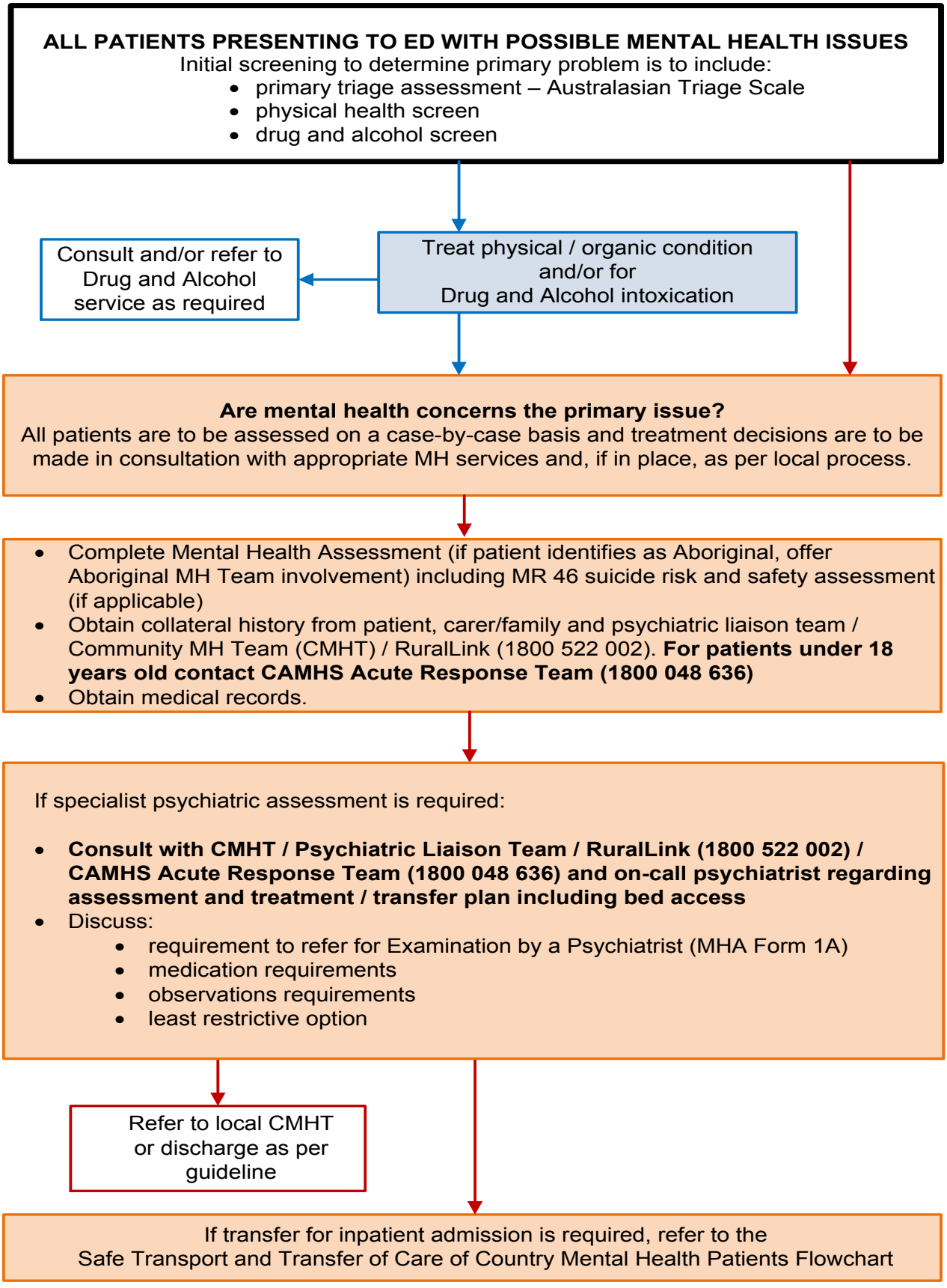
Appendix 3 - Screening and Assessment of Mental Health Patients in WACHS Hospitals



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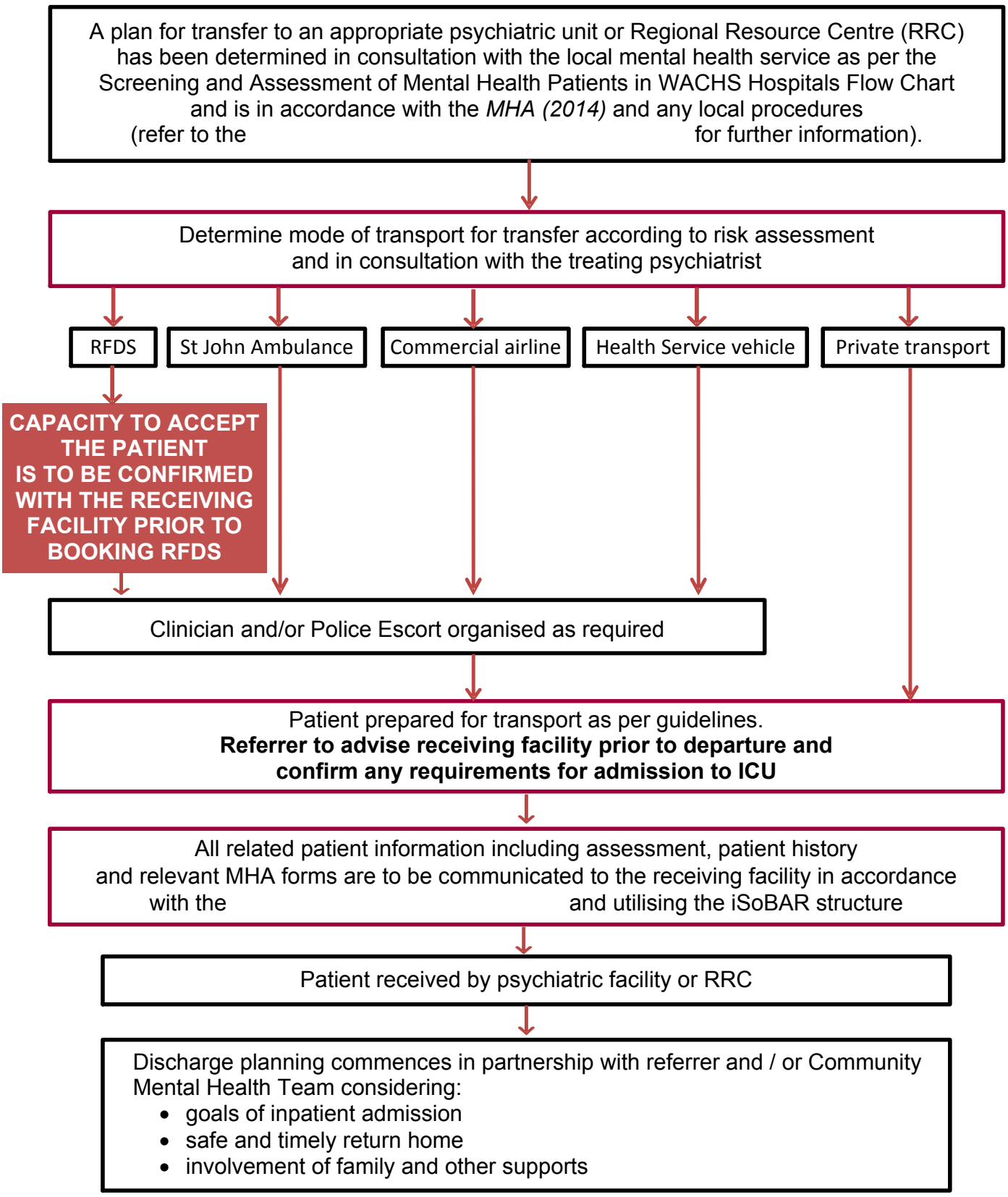
Appendix 4 - Safe Transport and Transfer of Care of Country Mental Health Patients Referred for Examination by a Psychiatrist Flow Chart



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Appendix 5 – BACPAC Mental State Assessment

Behaviour

Describe the person's behaviour:

- abnormal responses to environment
- overt responses to internal stimuli (eg apparent responding to ‘voices’)
- attitude towards interviewer, others and surrounding
- stereotypica; movements, gestures, mannerisms.
- akathisia (restlessness), tremor, rigidly (EPSfx) and abnormal involuntary movements.

Appearance

- general appearance, personal hygiene and grooming
- appropriateness of clothing and make up
- eye contact, facial expression, posture etc.

Conversation

- speech prosody, rate, flow and form
- predominant content – appropriate to topic, unusual ideas, delusions
- congruence of speech content to affect
- abnormal or bizarre thoughts.

Perception

- illusions: distorted sensory perceptions
- hallucinations – auditory, visual, tactile, gustatory, olfactory
- general feelings of unreality.

Affect and Mood

- patients expressed internal emotions and feelings (mood)
- clinicians observed expression of emotion and feeling (affect)
- as inferred by facial expression, body posture, overall presentation

Cognition

- intellectual level of functioning
- memory, concentration, attention span
- judgement and insight
- ability to interpret actions and surroundings.

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