Marie McInerney reported on the Australasian College for Emergency Medicine’s *Mental Health in the Emergency Department Summit*, held in Melbourne on 16 October, 2018, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. [http://croakey.org](http://croakey.org)
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The Long Wait: new report shows need for urgent mental health reform

The Morrison Government has announced it will establish a Productivity Commission Inquiry “into the role of mental health in the Australian economy and the best ways to support and improve national mental wellbeing”.

News of the inquiry comes ahead of a summit convened by the Australasian College for Emergency Medicine (ACEM) aimed at shaping a new national agenda for how Emergency Departments deal with mental health.

The ACEM has also released a new report that provides damning evidence and testimony about a “system under stress”.

The preview article below reveals the distress experienced by many people when they attend an Emergency Department environment during a mental health crisis.
Marie McInerney writes:

Bright lights that never dim. Constant noise. Yelling and screaming. The arrival of police and paramedics, the shadow or threat of violence. Children in pain, others in crisis. Thin walls or curtains that mean others get to overhear the rawest of feelings and actions. And many hours of waiting, in acute distress.

For Renai Searle, presenting with a mental health crisis to the Emergency Department of a busy hospital has too often been a brutal and bruising experience that has served only to exacerbate her pain and validate her sense of worthlessness.

Her experiences include having to wait for up to 18 hours for a decision on her treatment from a specialist care team, only to be discharged because there are not enough beds or her symptoms no longer appear bad enough for admission because she has been medicated during the wait.

The crisis-driven physical environment of the Emergency Department only adds to the distress. Searle told Croakey:

“Even if I don’t know people, everyone can hear through those paper thin walls so I feel silenced.

If you’re “lucky” enough to be put in an isolation booth, then no, you can’t be heard but you feel like an animal in a zoo. The lights are on, the noise is loud, and for me in distress, that’s all very overwhelming.

All of those things can be very triggering for people and make you feel unsafe in a place you are told to go to (in order) to keep safe.”

Searle is a project coordinator at Consumers of Mental Health Western Australia (CoMHWA) and will be a panellist at the Mental Health in the Emergency Department Summit to be hosted by the Australasian College for Emergency Medicine (ACEM).

Diagnosed with bipolar I, obsessive compulsive disorder (OCD), and complex post-traumatic stress, she has been one of a quarter of a million Australians each year who seek help for mental health care at an Emergency Department.

Her experiences over many years are loudly echoed in a report – The Long Wait: an analysis of mental health presentations to Australian emergency departments, released today by ACEM ahead of the Summit.

“An Emergency Department is not a fun place for anyone,” Searle said.

“But we need a way for those who are already experiencing high levels of distress to not be further traumatised by their experience (of seeking help).”

All of that “just validates all of my feelings of worthlessness,” she says.

The Long Wait report, which ACEM describes as “damning”, provides an analysis of key mental health presentation data from the 2016/17 Australian Institute of Health and Welfare’s National Non-Admitted Patient Emergency Department Care (NNAPEDC) Database.

The report says it is “difficult to imagine an environment less conducive than a busy Emergency Department for the extended treatment of people with severe mental illness, where long stays are associated with suboptimal treatment like restraint, seclusion and lengthy periods of sedation”.
A sector under “great stress”

ACEM President Dr Simon Judkins said the Long Wait analysis found that patients are facing “extreme wait times” to be assessed and experience “protracted and harmful delays” in receiving mental health assessment and care.

Its findings include that patients presenting to Emergency Departments with mental health problems:

1. Have to wait longer than other patients with a similar severity of physical illness before they can be assessed and have their treatment commenced. They were 18 per cent less likely to be seen within the appropriate Australasian Triage Scale (ATS) timeframe.

2. Endure a longer period of treatment in the Emergency Department. While 90 per cent of all patients left emergency departments within seven hours, this figure was 11.5 hours for people presenting with acute mental health crises (and much higher in some states). It says that for 10 per cent of presentations, their ED length of stay – or waiting time – “far exceeds these times, further worsening their conditions”.

3. Are more likely than other patients to leave Emergency prior to their treatment being completed – that is, at their own risk and against medical advice.

4. Are 16 times more likely than people with other emergency medical conditions to arrive at Emergency Departments via police or correctional services vehicles, and nearly twice as likely to arrive via ambulance or helicopter rescue and more commonly rated by ED staff as requiring urgent care on the ATS.

5. Are more likely to identify as Aboriginal and Torres Strait Islander than other patients. While Indigenous Australians make up around 3 per cent of the population, they comprise 11 per cent of all Emergency Department mental health presentations across the country.

ACEM said these data suggest “our health system is failing to meet the needs of a large number of people who seek help from EDs for serious mental and behavioural conditions”.

Judkins said the Summit will bring together more than 150 consumers, clinicians and policy and funding participants and will aim to set the agenda for policy reform.

“These are problems that emergency doctors cannot solve alone: they reflect a sector under great stress and lack of a plan for system-wide development.”

Below, see an AIHW depiction of patient progress through the ED.
“No-one wins, least of all the sufferer”

Accompanying each section of the data analysis in the Long Wait report are powerful anonymous vignettes that comment on the major failings identified by people seeking help for their mental health crises, their families and carers, and the ED clinicians working in the system.

They describe a system that is, as one says, “increasingly reliant on police, ambulances, hospitals and the justice system to provide frontline care for people with mental health issues.”

A clinician talks also about the crowded, noisy and confusing environment of the Emergency environment – “babies crying, monitors beeping, staff and patients moving about, phones ringing – constantly”.

This clinician says:

“For patients with acute mental health issues, especially when they are in a state of high arousal, these factors are compounded… patients are often paranoid, confused or suicidal. They need a calm and private environment, with a clear plan and good communication.

When patients are delayed in ED for long periods, they sometimes become angry and upset to the point where they require chemical sedation for their own safety, and the safety of other patients and staff in the ED. Chemical sedation carries risk – side effects and cardiorespiratory depression – there have been deaths from chemical sedation in ED.

...the biggest problem with this is that it is not fair on patients – our environment and processes get them to this point – this is not acceptable and we need to change the system.”

In relation to the high proportion of mental health patients who are brought to hospital by police, a parent talks about the fear that a loved one might lash out during the journey or on arrival at the hospital, which might culminate in a mandatory prison sentence for assaulting a police officer. “Nobody wins, least of all the sufferer,” the parent says.

Also reflecting on how patients arrive in Emergency, another clinician talks about being struck over the years by the unequal access to care that socioeconomic status delivers in our system, and the implications:

“If a teenager starts behaving oddly in an upper middle class home, his parents are likely to call their GP, an ambulance, or take him to see a private psychologist. The parents of the same teenager in a poorer household tend to call the police.

Whether a person with mental health issues enters via the health or forensic system colours the way they are treated for the rest of their life.

We need to have a clear and adequately resourced process which allows all patients with acute mental health issues to access health care to remove this source of discrimination.”

Another parent describes waiting in an ED with a person needing acute mental health care as “akin to being unexpectedly flung into a war zone”.
Another clinician talks powerfully about how the system let down a young Aboriginal man who died by suicide after having had to stay in Emergency for two days because of a lack of mental health beds. The clinician said:

“\textit{I’ll never forget the anguish on his father’s face when he was given the news of his son’s death. We often talk about not having beds leading to deaths, but here it was.}"

“A stark reminder that we are dealing with people’s lives, even though I feel that this message is often not really heard or really understood by those people who have the power to change the system that failed this young man, his family and his community.”

Focus on recovery

Renai Searle’s story overlaps many of those raised in the report though it comes with a strong message of recovery. She said:

“\textit{I was told I would never work, this is my ‘new normal’, I would be on medication for the rest of my life.}"

\textit{My recovery goals were basically to be able to leave the house on my own and relieve some of the dependency on my partner, but my dreams of study or work were probably a bit far-fetched.}"

Now she has a fulltime job, coordinating the CoMHWA’s \textit{My Medicines & Me} project to support people to manage their mental health medications, and recently married.

She has no wish to criticise the staff of Emergency Departments but says her message to the ACEM Summit will be the need to “revolutionise the system” in a way that is strongly informed by people with diverse lived experience.

Searle says that, while she understands that the Emergency Department’s role is primarily triage, if it is to be a place of referral – “given that mental health is not 9-5” – then changes are needed to Emergency Department environments and processes to “minimise the harm” they currently cause.

The most positive care she has seen was that of a close family friend who was put into one of Western Australia’s relatively new mental health observation areas, custom built units near three Emergency Departments that provide “a quieter space – the lights go off, there’s more privacy and a care team on site”.

Acknowledging the critical support that her friends with lived experience have given her in Emergency Departments over the years, Searle wants to see more peer experience and peer programs in Emergency Departments, including initiatives like the Safe Haven Café at St Vincent’s Hospital which provides a safe, therapeutic after-hours space.

She will also highlight the “postcode lottery”, where access to specialist mental health services often depends on the postcode in which someone lives.

Searle says that despite her horrific experiences with Emergency Department, she considers herself “one of the lucky ones”.

She said:

“For me, some things like the yelling and screaming (that happens in EDs) can make me shrink down, be traumatised.”
But for friends I’ve supported who have had a lot of negative experiences with police, for example, or a history of systemic racism, the exposure to that in the Emergency Department environment increases the stress infinitely.

I think the whole system needs an overhaul.”
National summit calls for urgent action on mental health care in emergency departments

Marie McInerney writes:

Australia’s health system is “failing to meet the needs” of people who present to emergency departments needing urgent mental health care, according to participants at a Mental Health in the Emergency Department Summit held in Melbourne.

The summit, hosted by the Australasian College for Emergency Medicine (ACEM) in partnership with the Royal Australian and New Zealand College of Psychiatrists (RANZCP), was attended by more than 170 emergency doctors, psychiatrists, consumers, clinicians, policy makers and researchers.

ACEM President Dr Simon Judkins said it was called to address “protracted and harmful delays” in care and treatment – in one case for up to six days – that “undermine patients’ health and recovery, place considerable stress and strain on emergency department teams and waste limited health resources”.

ACEM issued a communiqué after the summit (read it in full below), vowing to set the agenda for policy reform and declaring that “no one should stay longer than 24 hours in an emergency department”, particularly those experiencing mental health crisis.
“All Australians have the right to access timely and appropriate mental health care that is free from stigma and discrimination. Current arrangements are inadequate to support people experiencing mental health crises and discriminate against some of the most marginalised and vulnerable people,” it said.

“The emergency department should be a place that is safe and supportive for all, not a place that people want to escape from.”

Summit participants, brought together from across professions and sectors to try to avoid ‘silos’ in addressing issues, voted via a conference app on the most important gaps affecting mental health care in emergency departments, and priorities for addressing the most critical issues that put patients at risk or harm.

Not surprisingly, much stronger community services and supports, a bigger focus on the social determinants of health, particularly housing, a much bigger and integrated peer workforce and a safer, calmer, more responsive (and possibly separate) environment in Emergency figured strongly.

Campaigning for a national target

As part of an ongoing campaign, ACEM is also calling for the adoption of a national target for wait times, and mandatory notification every time a patient waits longer than 24 hours in an emergency department.

It is also asking states and territories to look to the Northern Territory, which has just introduced a requirement to report on patients having to wait more than 12 hours.

An ACEM report, released ahead of the summit, showed that 90 percent of all people leave emergency departments within seven hours, but for people presenting with acute mental health crises this figure was 11 hours and longer in some jurisdictions, like South Australia (16 hours), Western Australia (14.5 hours) and Tasmania (14 hours).

In other words, 10 percent of people with acute mental health crises spent more than 16 hours in emergency department in SA, and more than 15 hours in WA emergency departments, and more than 14 hours in Tasmanian ones (see table below).
“Notably for 10 per cent of presentations, their ED length of stay – or waiting time – far exceeds these times, further worsening their conditions,” The Long Stay report said.

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Source: National Non-Admitted Patient Emergency Department Care Database.
Note: All mental health presentations included are those with a principal diagnosis falling within the ICD-10 AM codes F00-F99, or ICD-0 CM or SNOMED equivalent codes. Total does not include presentations for which information was missing or not reported.

A failed system

The summit opened with shocking stories from people with lived experience of mental health crisis, who were also represented on a number of the panels through the day.

Melbourne woman Fiona Nguyen described the devastating treatment she experienced on a highly traumatic day, which began with being handcuffed and thrown to the ground by eight police officers who broke down her door to a 27 hour wait in Emergency, which included shackles, strong medication, and three code grey alerts.

“That particular story still makes me quite emotional,” she said. “It retraumatises me.”

“I felt angry, not listened to, invalidated. The whole thing could have been done so much differently.”

Debra Sobott, from Perth, whose son has acute mental health issues, described the huge family effort – including “wrap around” 24 hour care – involved in keeping him out of the mental health system after his experiences, which traumatised him and those who were there to support him, including his little brother.

“We can’t afford to let him go through what he’s been through before, (held) in a seclusion room where he’s written ‘let me die’ in his own blood.” she said.

Watch this interview with Sobott and Renai Searle.
Royal Australian and New Zealand College of Psychiatrists President Dr Kym Jenkins said a lot of good care is provided in Emergency Departments across Australia, but “very few people would think ED is the ideal place for mental health care”.

That was clear from graphic videos shown by Professor Daniel Fatovich, an emergency physician from the Royal Perth Hospital, illustrating distressing experiences of both patients and staff in Emergency.

“It took only 17 seconds for security to arrive,” he said of one incident where a patient assaulted a staff member, “but how would you like to be in a chokehold for 17 seconds?”

But he said the greatest impact on staff was the experiences of adolescents in mental health crisis “who can wait up to 100 hours on the ED floor waiting for care”.

“Staff are basically heartbroken trying to look after them in a suboptimal environment.”

He said delegates should ask policy makers: “What you think a truly failed system would look like?”

“I think (they’d) see what we have now,” he said.

Judkins said he hoped the combination of voices with a common message would send a stronger call for change than previous “siloed” approaches. The Summit had brought together strong data and presentations with powerful human stories.

“I think it’s really, really hard to ignore this message,” he said. See this interview with Judkins.

Communiqué

16 October, 2018: Australia’s health system is failing to meet the needs of people who present to emergency departments needing urgent mental health care. Today, at the Australasian College for Emergency Medicine’s Mental Health in the Emergency Department Summit, over 170 delegates, representing doctors, nurses, patient advocates and system managers, heard how presenting to an emergency department with a mental health crisis too often means a long, distressing wait for care. These long, uncertain waits in emergency departments increase the risks and undermine people’s recovery and long-term health and wellbeing.

The task of the Summit was to set the agenda for policy reform to improve the experiences of people with mental health conditions seeking help from emergency departments across Australia.

Delegates at the Summit noted the data demonstrating the poor experiences of mental health patients and discussed the needs of these patients when they were in crisis.

People with lived experience of seeking assistance spoke of crowding, noise, distress, long waiting times, and high use of restraint and seclusion. The delegates shared experiences of good models of care, innovations in service delivery and structures that addressed the core elements needed to improve emergency care for people in mental health crisis. Stories from emergency departments highlighted the importance of social support, of services being available when needed, and the beneficial impact of respectful, culturally appropriate and compassionate responses to people in mental health crisis.
The Summit discussed options for where to invest – including in resources, people, culture and support – both inside and outside of the emergency department.

The Summit delegates agreed on seven key principles:

1. All Australians have the right to access timely and appropriate mental health care that is free from stigma and discrimination. Current arrangements are inadequate to support people experiencing mental health crises and discriminate against some of the most marginalised and vulnerable people.

2. Alternatives to emergency departments may be appropriate for many people who currently present in crisis; these alternatives should be explored, resourced and evaluated for their impact.

3. The emergency department should be a place that is safe and supportive for all, not a place that people want to escape from. Long, uncertain waits are unacceptable.

4. Mental health care, regardless of the setting, should be respectful, patient centred and recovery oriented; the use of seclusion and restraint should be eliminated or at the very least, minimised.

5. No one should stay longer than 24 hours in an emergency department, particularly those most vulnerable members of the community.

6. More work needs to be done to build and sustain a functioning, integrated, mental health system that supports the prevention, early intervention and better management of mental health crises.

   There is not enough capacity in either hospitals or the community.

7. People living with mental health conditions, their advocates, health care providers and governments have an important role to play in addressing this crisis.

Delegates at the Summit agreed that collective action was urgently required to improve the care of people suffering mental health crisis across Australia, including within emergency departments.

The Australasian College for Emergency Medicine was tasked with taking today’s discussion and data and working with key people and organisations to develop a Consensus Statement that has recommendations and actions to improve the care of people experiencing mental health crises.

The Summit agreed that the current situation was unacceptable and that all delegates commit to do better.
National summit calls for urgent action on mental health care in emergency departments

#MHED18

You can track Croakey’s coverage of the conference here.

Rob Mitchell @robdmitchell · 13h
Glad to see @acemonline and @JuckinsSimon giving prominence to emergency mental healthcare - lots of work to be done in this space

ACEM @acemonline
Following today’s #MHED18 Summit, ACEM has issued a Communiqué. Read and download it here aca.mn/acemmm5aa7f The work has only just begun, our advocacy efforts will continue. Thank you to everyone...

Melissa Sweet @croakeyblog · 16h
Thanks to all those hard-tweeting peeps at #MHED18 today! Putting the spotlight on the need for better prevention and care #mentalhealth #Trending @CroakeyNews @mariemcinerney @acemonline @JuckinsSimon

Australia trends - Change
#kidsoffnauru
tonga
#wfd2018
#racism
#togetherforchoice
jerusalem
morrison's israel
prince harry
#mhed18
scomo
When hospitals strive to address homelessness, good things can happen

Marie McInerney writes:

The creation of a specialist Homeless Team at the Royal Perth Hospital is bringing dramatic changes to the health and wellbeing of homeless people who have traditionally been part of a “crisis carousel” in the health system, particularly in hospital emergency departments.

A national summit called by the Australasian College for Emergency Medicine (ACEM) heard that the Homeless Team’s work not only leads directly to big reductions in emergency department presentations, but also addresses some harsh or misguided attitudes towards homeless people among “frustrated” hospital staff.

The ACEM Mental Health in the Emergency Department summit also heard of other efforts to address the social determinants that force many vulnerable people into emergency departments.
You can track Croakey's coverage of the conference here.

Research shows that homeless people make up among the most frequent presentations, unplanned admissions, and longer lengths of stay in Australia’s emergency departments. Yet, said Dr Amanda Stafford, Clinical Lead of the Royal Perth Hospital Homeless Team, they often miss out on critical mental health assessment or review in hospitals because they are “passed off as being a social problem rather than a mental health problem”.

She said:

“Many marginalised people work out that if they present first with a mental health problem they will simply be pushed away, so they will often present with an illness or injury.

But underlying their presentation will always be aspects of mental health, either straight out psychiatric illnesses such as schizophrenia, very often overlaid with drug use – extremely common when people are living on the streets particularly.

Almost all have a long life history of trauma, which very much colours the way they present and the frequency with which they present.”

However, in a system where people are “churned” through, and the problems of alcohol and drugs and social vulnerability are not dealt with, “we just have this crisis carousel which is not working for anyone, most of all patients,” Stafford said.

She believed hospital staff want to help, but without a service that specifically addresses homelessness, they feel helpless, “and often they become angry and dismissive and rejecting of homeless people”.

Collaborative model

In response to all these issues, the Homeless Team was set up in July 2016 as a collaboration between Royal Perth and the Homeless Healthcare General Practice (HHC GP), modelled on the UK Pathway charity organisation.

Royal Perth’s Homeless Team works closely with the HHC GP service and community-based organisations to address the underlying health and psychosocial needs of homeless patients – in particular, Stafford said, the need for low cost stable housing.

The impact of providing that support is profound, for them and the system. Stafford said:

“People who are stably housed for six months drop their ED presentation rates by 50 percent and by one year (of stable housing) they drop by 80 percent.

When the doors open to housing and support, we see dramatic changes in people’s health and wellbeing.”

A report published on the first 18 months of operation of the Royal Perth Homeless Team found that 634 patients in the three years prior to their first contact with the team had nearly 4,700 ED presentations and 2,000 inpatient admissions, for a total cost of $19 million.

“Since the start of the team’s operation, there has been a marked reduction of homeless patients accounting for the top 20 frequent ED presenters, reducing from 80 percent (July-Dec 2016) to 45 percent (Jan-March 2018),” it said.

“A central tenet of the RPH HT and HHC model of healthcare is that homelessness is both a medical and social issue, and that addressing homelessness is, itself, an important form of healthcare, not a separate “non-health” issue.”
When hospitals strive to address homelessness, good things can happen

Powerful case study

A graphic example of the merits of this approach came in a case study in the report, described by Dr Nigel Hewett, head of UK Pathway, who was in Perth in 2017 to support progress of the Royal Perth team.

The case study from Perth points both to shocking failures in care and what benefits can come when hospitals step out of medical models to attend to the social determinants of health, like housing.

Hewett reported:

“Just as the Homeless Team arrived at the bedside of this patient, (he was) being examined by the consultant in charge and as we walked up to the bedside, the consultant was just saying to her team of junior doctors, I think this man is about to baseline we could discharge him home.

He was severely distressed, medically under treated, his psychosis was ignored and the key social fact, which was that he was street homeless [sleeping rough] was being, I think, wilfully ignored by the team in charge.”

Thankfully, there was a better intervention waiting, Hewett said:

“The really exciting thing was that within a few minutes of being assessed, seeing a (Homeless Healthcare) HHC GP who knew him and had access to his medical records, and there was a Plan A and Plan B.

In the meantime, the HHC nurse, a part of the evening outreach team, was aware of plans in the background to try and get this man into long term accommodation in a mentally ill, old aged specific hostel associated with St Barts which would have a wait but he’d be the ideal person to go there.

This man went within ten minutes from potential to be discharged onto the streets because of a wilful disregard of his central social need, to having both a Plan A and a Plan B to stabilise him in hospital and then get him transferred to a permanent solution to his complex problems.”

This was inspirational, Hewett said.
Stafford said the more she worked with this very marginalised group of patients, the more she realised the solutions to “unload” the mental health system are in the community, and in the contribution of peer workers who can act as navigators, particularly for Aboriginal and Torres Strait Islander people.

Watch part of her presentation here.

Safe café spaces

The summit also heard about other initiatives to address the social determinants of health or provide much earlier interventions so people with mental health crises can avoid having to present to emergency departments.

St Vincent’s Hospital in Melbourne said that for many people with mental health issues, the emergency department is the “only option” for after hours care if they are feeling unsafe or need to talk to someone.

In response to that, and based on a successful trial of the model in the UK, the hospital has set up onsite Safe Haven Café, as an alternative.

It’s not aiming to replace clinical services, but is a peer-led, non-clinical therapeutic service that “supports consumers to maintain their wellbeing, could enhance current treatment or directs them to mainstream services”.

Most importantly, St Vincent’s says in this video presentation shown at the summit, the café was “designed by consumers for consumers”.

Fran Timmins, Director of Nursing in Mental Health at St Vincent’s, told the summit that 42 percent of those who have attended the Safe Haven Café since it opened in May 2018 “have done so as an alternative to going to ED”.

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You can track Croakey’s coverage of the conference here.

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Watch part of her presentation here.

<table>
<thead>
<tr>
<th>Box 1: Aims of the RPH HT</th>
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<tbody>
<tr>
<td>1. Review and offer assistance to all homeless patients identified within RPH.</td>
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<tr>
<td>2. Link patients to community services to assist with housing and support services.</td>
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<td>3. Improve discharge planning and aftercare for homeless patients at RPH.</td>
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<tr>
<td>4. Link homeless patients to long term GP care.</td>
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<td>5. Reduce hospital healthcare utilisation via improvements in social situation and access to GP care.</td>
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<td>6. Facilitate long-term improvements in health and welfare by addressing social determinants of health.</td>
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Timmins had heard of the Hampshire UK model when working in the UK.

“I brought that back with me and was lucky enough to work in a system that actually does embrace innovation,” she said.

That included having the support of the hospital CEO and Executive and the Victorian Department of Health and Human Services “to try this idea and see if it can make a difference”.

The biggest challenge has been getting information about the café to the people who matter, who are often living very isolated lives.

But success has come via peer workers in the Emergency Department who raise the café while talking to patients who are waiting for treatment, to say ‘next time you’re feeling lonely, or isolated, or can’t afford a cup of tea, pop over there and they can help you out’.

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**Partners in Prevention**

The summit also heard of cross-sectoral efforts to apply specialist mental health skills to emergencies involving ambulances and police in both Queensland and Victoria.

Associate Professor Ed Heffernan, Director of the Queensland Forensic Mental Health Services, outlined a pilot program placing a mental health clinician into the 000 emergency call centre (7 days a week, 8am to midnight on weekends and 4pm to midnight on week nights), to help police respond better to the 160-plus mental health crisis calls, mostly suicide related, that come in each day from across the state.

To date, he said, there has been a fairly static model of response for police: welfare check, ‘everything’s okay, we’re out of there’, emergency department, criminal justice system.

“It’s a pretty blunt instrument,” he said.

“They are able to enhance police situational awareness in real time when they arrive at a mental health crisis, and are also able to enhance the responses of emergency partners and mental health systems when there is a mental health crisis.”

The pilot program, which has a research component (*Partners in Prevention*: Understanding and Enhancing First Responses to Suicide Crisis Situations), involves training police but also is letting the health system learn more about how police act and respond.

“If we can improve the understanding of these mental health crises and police responses, we can look at alternatives to criminal justice or emergency health responses,” he said. “We can look at psychosocial responses, for example, involvement of NGOs (non government organisations) and also enhance the responses of primary care.”

For example, he said, many cases can be referred back to the person’s GP, psychiatrist or other treatment team who often don’t know their patients are having crises out of hours.

The service follows up to them with emails to let the appropriate clinicians in the community know that “Joe Smith presented last night to police in crisis. Things have calmed down, but it’s probably worth checking”.

Heffernan said the model was also very efficient.
“One of the big advantages of this model is it can cover multiple mental health crises in real time. For example, in one 12-hour shift, our clinicians can be involved in 20 crises across Queensland, a huge geographical area.”

Meanwhile, Victoria’s various Police, Ambulance and Clinical Early Response (PACER) initiatives has brought mental health practitioners together with police – “on the beat” – to try to stop a mental health crisis escalating unnecessarily and involving an emergency department.

Evaluations of the pilots found that people suffering an episode of mental illness were less likely to end up in the local emergency department and that police units could be released to other duties more quickly, according to the State Government.

Police reported that a similar co-response in Western Australia meant that 75 percent of their callouts on mental health issues no longer went to emergency departments, Stafford said.

“Not rocket science”

Please watch this short video interview with Dr Shalini Arunogiri, an addiction psychiatrist with Turning Point Eastern Health and Monash University in Melbourne.

A summit panellist, Arunogiri stressed a social determinants approach to mental health crises, saying it was “not rocket science” to know that people with co-occurring issues like mental health and addiction, were affected by a whole range of difficulties including homelessness, family violence, and childhood trauma.

“We do ourselves a disservice by not understanding how to intervene to put a roof over someone’s head, get them their next meal, understand how we can keep them safe in the community,” she said.

“Those are conversations we really need to start to bring to our model of care in the ED space.”
You can track Croakey’s coverage of the conference here.

When hospitals strive to address homelessness, good things can happen.
Building a movement to improve safety and quality of care for people with acute mental health needs

Fiona Nguyen shares a consumer perspective on traumatising systems. Photo credit: tweet by ACEM

The Australasian College for Emergency Medicine (ACEM) expects to issue a consensus statement early next year with recommendations for improving the care of people presenting to hospitals with mental health problems.

The statement will be developed out of the Mental Health in the Emergency Department Summit.

The videos and interviews below have been compiled by journalist Marie McInerney for the Croakey Conference News Service.

Why call the summit?
ACEM President Dr Simon Judkins talks to Croakey about why ACEM and RANZCP called the summit and how they hope the combination of clinicians’ and consumer voices will “send a really strong message to policy makers and politicians”.

In the leadup to the summit, ACEM published: The Long Wait: An Analysis of Mental Health Presentations to Australian Emergency Departments.

What do we mean by ‘safe’?

Panel facilitator Dr Sue Ieraci, a specialist emergency physician, talks about risk averse systems and what ‘safe’ means, after admitting she was relieved to recently leave the public hospital system because “we were managing our own risk, rather than our patients”.

She said:

“When we say ‘safe’, all of us should ask ourselves, ‘What do we mean by safe? Who is it safe for? Is it safe for their mental health, their physical health? Does ‘safe’ mean they can’t run away? What are we scared of? What is the patient scared of?”

Many health professionals dealing with people with acute mental health issues are driven by a fear of ‘missing some diagnosis’ because they are often seen as ‘complicit or even responsible’ if harm occurs as a result, Ieraci said.

“But paradoxically, if we create distress by ‘containing’ that person, we’re not held to account for the distress we’ve caused them.

We’re actually in a sense worsening a patient’s safety in order to protect our own sense of safety, and I think that’s actually creating a bad workplace as well as a bad service.”
Ieraci put these issues to New South Wales Chief Psychiatrist Murray Wright, who last year conducted an independent review of seclusion, restraint and observation of consumers in NSW after the tragic death at Lismore Base Hospital of Miriam Meron.

The review was called after footage emerged of Meron naked, wandering the corridors covered in faeces, before dying of a brain injury after repeatedly falling and hitting her head.

Wright told the summit that a clear message from consumers and families to the review was that risk averse practice “sometimes happens at the expense of a compassionate and humane interaction with the person individually”.

“We need to give (health professionals) permission though to prioritise the engagement and individualised planning with the consumer and family and balance that against some of the rather rigid requirements we have in our policies and guidelines.”
Associate Professor John Allan, Executive Director of the Mental Health Alcohol and Other Drugs Branch at Queensland Health, also urged the summit to dig deep into issues like stigma and discrimination after watching a graphic dramatisation of the treatment of a patient in an Emergency Department setting.

“How did we get to this position... from people who are caring and want to do a good job, actually accepting this as a normal way of behaving?” said Allan, who is also President Elect of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Healing personal connections
Renai Searle and Debra Sobott, both from Perth, talk about their lived experiences of acute mental health crisis from different perspectives and what needs to be done to address harms that are too often inflicted when people present via emergency departments.

They advocate the importance of a “healing personal connection” when a person is in mental health crisis – an overriding message from people with lived experience, peer workers, and many clinicians at the summit.

In her raw keynote account, consumer Fiona Nguyen talked about the lack of empathy she experienced during one presentation in Emergency, from the police who broke down her door at home and from hospital staff over the 27 hours she waited for a care decision.

“(Consumers) are looking for hope, relief, safety, salvation, connection, dignity and respect,” said consumer consultant Emma Bohmer. Instead they too often faced neglect and punitive responses, like restraint, forced medication and seclusion, and where “being mentally ill is almost criminalised”.

A delegate from Tandem, the peak body for friends and families of mental health consumers in Victoria, said standard emergency department practice should be to ask: “Is there someone who would like to know where you are, who you would like to sit beside you?”
Supporting peer power

In this short video interview that was played at the summit, Anthony Stratford, Mind Australia’s Principal Advocate Lived Experience, talks about his work on a research project.

It is looking to identify the optimal role for peer workers in emergency departments, given they are “often poorly equipped, in relation to the physical environment, knowledge and personnel, to respond appropriately to people who present with mental distress”.

Stratford, who is diagnosed as having bipolar, said peers are very good at building a relationship with a patient quickly because of the shared journey, but “just because you have a lived experience of mental ill health and recovery does not equate to becoming a good peer worker”.

Peers, he said, need to be properly trained and supervised.

“If you want to create an effective peer workforce, it has to be top down, with education also for the rest of staff about peers, what they bring, and how they can become an integral part of a multidisciplinary team.”

What peer workers uniquely bring, he said, is the ability to stabilise a patient “but also to find out in a deeper sense what has led them here (to the ED).

“(It’s about) instilling hope in the people they work for. If the person themselves doesn’t have that hope for recovery, then the peer will hold their hope until they can take it back.”
Concerns for rural and regional patients

In this quick vox pop, Professor Neale Fong, chair of the Western Australian Country Health Service talks about the distressing treatment faced by rural and regional people in mental health crisis, particularly many Aboriginal people, who are often anaesthetised while they are flown to capital cities for treatment.

“That’s not good enough,” he said.

“Imagine you’re a mental health patient in a mental health crisis and suddenly you end up in an ICU with a tube down your throat. That’s just unacceptable.”

Also in the clip is NSW Mental Health Commissioner Catherine Lourey, calling for a greater focus on the physical health of people with mental health issues, who can expect to die up to 20 years earlier than other Australians, and Maureen Lewis, interim Chief Executive Officer of the National Mental Health Commission.

Dr Stephen Gourley, Deputy Chair of the National Rural Health Alliance and Director of Emergency Medicine at Alice Springs Hospital, also talks about the “highly problematic” lack of access to specialist mental health care in regional and remote regions.

In particular are the unique challenges for Aboriginal and Torres Strait Islander people if they are sedated and taken by plane, away from family, community and culture.

“What we’re really trying to do is to make sure people can access the care they need much closer to home,” he said.
The summit also heard from Kim Mulholland, a descendent of the Larrakia Nation and Yanyuwa Clan group of the Northern Territory, about providing culturally safe care for Aboriginal and Torres Strait Islander people.

Mulholland warned that many services try to deliver culturally appropriate or relevant services for Aboriginal and Torres Strait Islander people, but don’t think about the larger system they operate in that is “often at odds with community and cultural needs”.

Cultural supervision “should be as mandatory as clinical supervision, built into our clinical governance frameworks,” he said. “Otherwise we do run the risk of pathologising culture.”
The PANDA strategy

Watch this short video interview shown to the summit with Associate Professor Paul Preisz, Acting Director of Emergency Medicine at St Vincent’s Sydney. He describes the new $17 million St Vincent’s Hospital Psychiatric Alcohol and Non-Prescription Drug Assessment (PANDA) Unit.

It was one of number of featured initiatives aiming to provide better spaces or mixes of specialties in emergency departments for people with acute mental health issues.

Preiz said the new unit, to be opened by mid 2029, is being developed so the Emergency Department can better manage, physically and clinically, an increasing number of patients presenting with mental health as well as drug and alcohol related conditions.

He said between 10-15 percent of ED presentations now involved both mental health and drug and alcohol conditions – “quite unwell patients, very demanding on staff, who need quite specialised physical requirements, safe for them and safe for other patients”.

He said:

“We needed a place where we could safely admit patients, give them acute medical care, get early involvement with clinical pharmacology or drug and alcohol, and really good early involvement with physical and mental health.

What we’ve ended up with, I hope, is a completely different way of managing this, and to do that we’ve effectively redesigned the whole department.”

While some of the budget for the new unit has come from NSW Health, after “a process of writing endless submissions and making business cases”, much of the funding has come via philanthropic sources.

This is an avenue that others at the summit noted is not available to many other emergency facilities, particularly those in suburban or rural and regional areas.

Preisz revealed that landing on the PANDA acronym was contrived and allowed a “cute” logo. The unit’s advocates ran a “guerrilla campaign” while trying to get approval and funding, putting up photos of pandas around the hospital “to get a groundswell of support.”
Wrapping the tweets, news and views from #MHED18

Acknowledging #MHED18 tweeps.

Below is our final post from the recent Mental Health in the Emergency Department Summit, compiling #MHED18 tweets.

Warm thanks to all who contributed to sharing the news and discussions. See our previous articles about the summit at this link.

Introductions
You can track Croakey’s coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Simon Stafrace @SimonStafrace · Oct 15
Ron Jones, Wurundjeri Elder, calls for alternatives to ED for people suffering from mentalillness #MHED18 @acemonline @RANZCP

Jason Atkler and 5 others liked

Croakey team @CroakeyNews · Oct 15
‘Instead of building more jails, build better support for people with mental health issues’ Wurundjeri Elder Ron Jones. ‘I think the gap’s getting wider, politicians need to be more accountable.’ #MHED18

AMA President @amanpresident · Oct 15
#mhed18 Mental Health in the Emergency Department open @JudkinsSimon more needs to be done in community but also address issues such as substance abuse. Need a National multi disciplinary approach. @KymJenkins38 also agreed more community services and step down care @GregHuntMP

ACEM @acemonline · Oct 15
Opening address from @RANZCP President @KymJenkins38 at #MHED18 ‘All of us here want to move to a better way of delivering patient care’ @mariemcinerney @croakeyblog @sophiescott2

Wrapping the tweets, news and views from #MHED18

#MHED18

Croakey
“Conference News Service”
You can track Croakey's coverage of the conference [here](#).

Wrapping the tweets, news and views from #MHED18

The program

Panel 1 at #MHED18: 'Mental health & the ED: experience using and working in the system', with: @renaisearle (consumer, peer worker), Dr Stephen Gourley @NRHAIlance dep chair, @eimearmuir, Debra Sobott (parent), Prof David Castle @stvincentsmelb

Panel 2 #MHED18: 'Meeting clinical needs in an acute mental crisis': Dr Cameron Burrows (ED, WA), @timwand, Assc Prof Paul Preiz, St Vincent's Sydney, psychiatrists @SimonStafrae & negin @SArunogin, Dr Clare Skinner (EM, NSW)
Wrapping the tweets, news and views from #MHED18

**PANEL 3 gets stuck into looking at new models of care that better meet patients’ needs before or out of EDs.**

Panelists:
- @volveGen @NSWHealth @CroakeyNews @crocrokeyblog @mariemcinerny @sophiescott2 #MHED18

**Panel 4: System Reform**

**Panelists:**
- Professor Tarun Bastampillai, Head, Mental Health, Flinders University, South Australia
- Professor Stephen Buckett, Director, Health Program, Grattan Institute, Victoria
- Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, Tasmania
- Dr John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health, Queensland
- Associate Professor Andrew Singer, Principal Medical Adviser, Australian Government Department of Health, Australian Capital Territory

**Key Questions for Panel and Discussion:**
- What is the role of governments at the state and Commonwealth level in supporting the required changes?
- What should we measure in order to effect change?
Discussions

Fiona Shand @FionaShand1 • Oct 15
Complex issues re managing MH in the ED raised from the get-go at #MHED18 - managing patient flow in a fragmented and under-resourced system, ensuring discharge plans are made and followed through, that people are not discharged into homelessness or other untenable situations

Larter @LarterHealth • Oct 15
The inaugural Mental Health in the Emergency Department Summit: what could be done to better meet patient needs? Are we providing trauma informed care? Are we even providing care or are we harming people? #MHED18 acem.org.au /mental-health...

Croakey team @CroakeyNews • Oct 15
'Patient flow in acute units drives e'thing, (they are) crisis containers. Patients often discharged into precarious living arrangements, care planning is about symptoms not recovery. That's a function of the system.' @eimearmuir
#MHED18

Croakey team @CroakeyNews • Oct 15
ED clinician on a powerful video: I’d like to ask policy makers: ‘What you think a truly failed system would look like? I think you’d see that’s what we have now.’

Croakey team @CroakeyNews • Oct 15
ED clinician: ‘Think the greatest impact on staff is experience of adolescents who can wait up to 100 hours on ED floor waiting for care. Staff are basically heartbroken trying to look after them in a suboptimal environment.’ #MHED18

ACEM @acemonline • Oct 15
‘How many of you would like to be in a choke hold for 17 secs,’ Professor Daniel Fatovich asks #MHED18. ‘We must look after our staff.’ The system has let us all down - patients, clinicians, families

Croakey team @CroakeyNews • Oct 15
‘Someone taking two minutes out to listen to your story is incredibly important and may be the only treatment someone needs’. Comment from audience re interactions in the pathway experienced by mental health patients #MHED18 - needs changing culture, education, not $$$

Vinay Lakra and 2 others liked

Simon Stafrace @SimonStafrace • Oct 15
No change in the ED can take place without changing the system of care more broadly. Everything I’m hearing tells me we should aim for the shortest possible times in EDs before patients move into definitive care settings @RANZCP @JudkinsSimon @acemonline #MHED18
You can track Croakey's coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Croakey team @CroakeyNews · Oct 15
#MHED18: @debtweets wants to see teams operating from a trauma informed and trauma practice approach, led by peer workers, psychologists, to provide a wrap around as soon as you arrive just as trauma teams provided for car accidents victims.

Croakey team @CroakeyNews · Oct 15
Different views here re having a nationwide access to patient notes: registrar says important because sometimes takes hours to be available, @renaisearle says too often leads to terrible treatment based on contested notes #MHED18

JohnBon @johnubonn · Oct 15
Perhaps an ABSU is an example of a purpose-built unit in an ED - this in St Pauls Hospital ED in Vancouver - better environments to assess & look after mental health patients in EDs #MHED18 @acemonline @Sueleraci @CroakeyNews

ABSU
Acute Behavioral Stabilization Unit

Renai Searle @renaisearle · Oct 15
Dr Simon Stafarce discussing the need for this discussion not to be limited by the current funding resources. We need to ‘raise our expectations’ and look to what ideals and good actually looks like #MHED18 @acemonline

Fiona Shand @FionaShand1 · Oct 15
Term of the day at #MHED18? ‘The soft bigotry of low expectation’ - we know what good looks like and we need to think beyond currently available resources that constrain good practice in responding to mental illness/suicidality in the ED

CoMHWA @CoMHWA · Oct 15
@acemonline #MHED18

Croakey team @CroakeyNews
Consumer consultant on what people with lived experience are looking for when they present to ED: “They’re looking for hope, relief, safety, validation, respect, and dignity, facilitated by peer support.” #MHED18

Hazel Fetherston @H_Fetherston1 · Oct 15
Peer support is a strong key theme and action coming out from #MHED18. Appropriately trained peers and facilitation can be very significant to improve mental health conditions. Peers can instil hope @acemonline @sophiescott2 @CroakeyNews #policy
You can track Croakey's coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Simon Stafrace @SimonStafrace · Oct 15
Trauma a feature of #mentalhealth care in ED for both patients & staff. Understanding trauma is a pathway to empathy & connection for consumers, families & clinicians. We have more in common than we think @RANZCP @acemonline @renaearle #MHED18

Marie McNerney @mariemcnerny · Oct 15
Hearing about a pilot placing a mental health clinician into the emergency call centre - can lead to better justice interventions and primary care responses #MHED18

ACEM @acemonline
Here is Associate Professor Ed Heffernan’s video ace.mn/mhed14a95e #MHED18 @sophiescott2 @croakeyblog @CroakeyNews @mariemcnerny

Simon Stafrace @SimonStafrace · Oct 15
Ideas flying through to improve emergency M/H care. @JudkinsSimon @acemonline @RANZCP NGO-run crisis centres with peer services; nurse practitioners in ED; local community-based approaches that emphasise respect & include peers of diverse backgrounds; #MHED18

Croakey team @CroakeyNews · Oct 15
Soapbox session at #MHED18: hearing calls for "Safe Haven cafe (@STVincentMelb) on steroids", more nurse practitioners in mental health, and forcing Ministers to be accountable when someone in ED for more than 12 hours.

Common Loon @Commonloon99 · Oct 15
Important comment to Panel 3 that for someone with lived experience, symptom reduction is not necessarily the same thing as healing @acemonline @sophiescott2 @RANZCP #MHED18

Simon Stafrace @SimonStafrace · Oct 15
Stephen Maylan from @BarwonHealth advocates for collaborative targets in ED to create transparency of #mentalhealth performance. Must include patient-centred outcomes @acemonline @JudkinsSimon @RANZCP @KymJenkins36

Simon Stafrace @SimonStafrace · Oct 15
@JudkinsSimon @KymJenkins36 The power of collective action emphasised by @benharris1971 as instrument for change in improving #mentalhealth care across nation. @RANZCP & @acemonline must join with researchers, policy makers, consumers & families in forming this collective #MHED18

Dr Shalini Arunogiri @SArunogiri · Oct 15
#MHED18 #stigma #parity #nohealthwithoutmentalhealth via @renaearle

Sarah Lovell @SarahLovellMLC
“We don’t offer ten treatments for patient diagnosed with cancer, and tell them if those treatments don’t work, come back next calendar year for the next ten treatments” Connie Digolis, @MHCTas CEO #politics Why are mental health consumers treated so differently? @acemonline
You can track Croakey's coverage of the conference here.

Croakey team @CroakeyNews · Oct 15
Family member urges automatic questions from ED staff to those presenting with acute mental health issues: Is there someone who would like to know where you are, someone who you would like to sit beside you? #MHED18

Croakey team @CroakeyNews · Oct 15
Appeal from the audience: in Vic and NZ, 90 pc less 24 hour stays than the rest of us. It can be done, we know how to do it. Please let #MHED18 call on every Health Minister to ban 24 hour stays in ED forthwith.

Croakey team @CroakeyNews · Oct 15
“We can’t continue to be planning in election cycles,” @SarahLovellMLC - providing feedback in final session at #MHED18

Ronal Soarle @renaisaarl · Oct 15
Tasie mental health shadow minister highlights the similarities of issues despite the diversity within the room reaffirming the need for long term planning #MHED18

Croakey team @CroakeyNews · Oct 15
On weekends, the only people (in acute mental care) with the lights on are us and you, says ambulance officer at #MHED18. Not just hospitals with “bed block” also ambulances. Says on the same page with rest of the room here.

Melanie Rule @rulesrule1 · Oct 15
So often patients have all of these. Integrated care is the key but who will provide this is the challenge. #MHED18 @acemonline

Shahina Braganza @ShahinaBraganza
The patient does not considered their issue to be psychiatric vs alcohol or drug related vs physical. This segregated definition of their illness does them a disservice, and does our staff a disservice - Shahini...

Dr Shalini Arunogiri @SArunogiri · Oct 15
Vinay Lakra @FRANZCP at @acemonline #MHED18 highlights need for chronic disease management model of care for severe mental illness just like any other chronic illness, diabetes hypertension cardiovascular illness. Long term view needs to be the expectation not the exception #parity

Show this thread

Michael Edmonds and 1 other liked
JohnBon @johnuborn · Oct 15
Replying to @preexcitation13 @SAHealth and 5 others
My take is we need to resource community care and MH nurses to see patients in ED to get them back out into the community rather than more inpatient beds. You will have seen that we have fewer beds per 100k in NZ than Australia & yet we do not have the access block #MHED18
You can track Croakey’s coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Dr Shalini Arunogiri @SARunogiri · Oct 15
Duckett @GrattanNet at @acemonline #MHED18 highlights importance of performance indicators for #mentalhealth

Renae Searle @renaeearle · Oct 15
Stephen Duckett alerting the rooms to some myths and making suggestions so take responsibility, design the funding system that works and the perfect is the enemy of good! #MHED18

Croakey team @CroakeyNews · Oct 15
Some mental health myths from @stephenjduckett #MHED18

- If you have a National Mental Health Plan, things will be better.
- Vague indicators will drive better performance.
- The Commonwealth government is omniscient, omnipotent, transcendent, perfectly good.
- If you have a designated Minister for Mental Health, things will be better.
- Activity-based funding is bad.

Common Leon @CommonLoon99 · Oct 15
Prof Tatum Bastiaampillai making a compelling case for more acute psychiatric beds as we are well below OECD average and not meeting basic needs @acemonline @sophiescott2 @RANZCP #MHED18

Dr Shalini Arunogiri @SARunogiri · Oct 15
Excellent presentation from Prof Bastiaampillai @Flinders @acemonline #MHED18; how many (#mentalhealth) beds do we need. Elephant in the room is #parity, #mentalhealth with #physicalhealth. First mention today! Psychiatric hospital beds: an Orwellian crisis

Fiona Shand @FionaShand1 · Oct 15
Small reduction in MH beds led to large increase in ED wait times for MH patients, turned around when MH beds increased again #MHED18
You can track Croakey’s coverage of the conference here.

Simon Staftrace @SimonStaftrace · Oct 15
Tarum Bastianpillai says in SA, minor reduction in acute #mentalhealth beds led to increase in ED waiting times. Minor increase reduced waiting times. Short term subacute beds had no impact. #MHED18 @JudkinsSimon @acemonline @KymJenkins36 @RANZCP

Dr Shalini Arunogiri @SARunogiri · Oct 15
Bastianpillai @acemonline #MHED18 Australia is a country with a LOW number of beds in an international context. Beds are not the answer to everything, but we need more beds. Minimum number of public psychiatric beds needs to be at 50, and we are at 30 per 100,000.

Dr Shalini Arunogiri @SARunogiri
Excellent presentation frm Prof Bastianpillai @Flinders @acemonline #MHED18: how many (#mentalhealth) beds do we need. Elephant in the room is #parity, #mentalhealth with #physicalhealth. First mention today! Psychiatric hospital beds: an Orwellian crisis thelancet.com/journals/lan...
You can track Croakey's coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Chrisie Fearon @ChrisieFearon · Oct 16
Check out #MHED18 to follow the AECM Summit discussion on MH and ED’s. Mental Health IS part of public health and visa versa. We need to stop the silos of separation in funding, academic research, advocacy, policies, politics and practice!

Gabriel Blecher @gabyblech · Oct 16
I hope today’s Mental Health summit by @acemonline isn’t the summit of this work but the trailhead. And that the calls for action don’t fall on deaf ears. (i.e. government) #MHED18

Emergency Care Institute @eci_nwaci · Oct 16
Evocative stories from consumers, carers and clinicians at the @acemonline Mental Health Summit. Varying perspectives, collaboration a consistent theme. Call for action passionately expressed. Look forward to the consensus statement and subsequent actions. #MHED18 @sophiescott2

drmolly @drmollyRG · Oct 16
Nearly 5000km, 3 flights & 11 hours to get to #MHED18 today to represent @ACRRM remote communities & it was worth it: thanks @acemonline @RANZCP @sophiescott2

Renai Searle @renaisearle · Oct 16
Finally home from the long day of #MHED18. Thank you @acemonline for making sure the #liveexperience voice had a space in the conversation and all attendees for being open to the perspectives we shared.

Amie Beattie @beattie_amie · Oct 16
#MHED18 “Superspecialisation is an enemy of humanism” - Simon Stafraos. Emergency medicine is an arena to advocate for multidisciplinary care. @SimonStafraos @JudkinsSimon @acemonline @sophiescott2

Amie Beattie @beattie_amie · Oct 16
#MHED18 Emergency medicine is such an amazing area to work in as it is a generalist discipline. Equally, it creates challenges to advocate for patients who require multiple teams to assist in their care (eg mental health plus drug/alcohol) @Sueleraci @sophiescott2 @JudkinsSimon

Amie Beattie @beattie_amie · Oct 16
What a wonderful collaboration of minds at #MHED18. Buzzing with ideas regarding systemic improvement and the importance of modelling cultural leadership and kindness @JudkinsSimon @sophiescott2 @acemonline @CroakeyNews
You can track Croakey’s coverage of the conference here.

Wrapping the tweets, news and views from #MHED18

Twitter analytics

The Summit trended nationally on Twitter and the analytics show 315 participants used the hashtag, creating almost 9.5 million Twitter impressions during the period of Croakey’s coverage. They can be seen in full here and below. Also see the Twitter transcript at Symplur.

Croakey Conference News Service

• Reporting by Marie McInerney
• Editing by Melissa Sweet
• Layout and design by Mitchell Ward

Wrapping the tweets, news and views from #MHED18