15/2//2004

Honourable Bronwyn Pike, MP
Minister of Health
Level 22, 555 Collins St
Melbourne
Victoria 3000

Dear Minister,

Re: **Unacceptable levels of bed access for admitted Psychiatric Patients from the Emergency Department at Maroondah Hospital contributes to high suicide and self harm rates.**

For many years now my predecessor (Dr Andrew Rosengarten) and I have attempted to highlight the plight of mental health patients in the Outer Eastern Area of Melbourne. It has been discussed at innumerable forums at all levels of the health service, that there is an unacceptable and ongoing need to manage multiple recommended mentally ill patients in the Emergency Department at Maroondah Hospital for prolonged periods.

Maroondah Hospital ED currently sees over 1600 psychiatric patients per year and many more drug and alcohol patients. This number has rapidly increased in recent times, and more importantly the length of stay of these patients in our facility has reached between 2 and 6 days on 57 occasions in the six moths at the end of lat year, with conditions seeming to be worse this year. At times we have had up to 12 psychiatric patients awaiting admission at once in our 22 cubicle facility. This has included up to 10 involuntary patients and other "so called" voluntary psychiatric patients who are too sick to go home.

ED LOS In Days	2	3	4	5	6	
Alfred	14	3				17
Angliss	1					1
ARMC Austin	2					2
Box Hill	16	2	1			19
Dandenong	59	13	7	1		80
Frankston	4					4
Maroondah	34	10	9	3	1	57
MMC Clayton	6	1				7
Northern	3	2	1			6
RMH	14	1				16
St Vincents	3					3
Sunshine	1					1
Western	4					4

CEO

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it really has reached crisis levels this last 6 months. Despite offers from the Chief Psychiatrist offer to find beds within the Psychiatric system if any patients are waiting, we are left with between 4 and 12 patients waiting for beds every weekend.

Mental Health branch has acknowledged recently that there are not enough beds, yet there is no effective solution offered to assist with this problem except the offer that the new beds at Berwick later this year should help! Dandenong Emergency is currently facing the same problems as us and will fill this facility within days. Aside from that, the geographic inappropriateness of such a solution is obvious. Of note Maroondah Psychiatric ward was cut from its original planned 45 adult beds to 28 adult beds.

This inability to offer adequate care to our patients has many costs. Most importantly it is a fact that from Maroondah Psychiatric Service alone we are losing about 1 patient per month through suicide. **In the past 13 months alone, 13 patients that we are aware of have committed suicide**. Including another patient who hung himself today. He was assessed as high risk but voluntary, kept in our emergency department, and absconded after 14 hrs. Maybe this would have happened anyway, but it is clear to all who work at Maroondah that we are not able to offer these people the level of support they need and also these rates of suicide are far in excess of those in other areas. Without access to beds the pressure is certainly extreme to keep these people out in the community.

I am aware of several other disturbing instances where patients have absconded and self – harmed ending up in intensive care, and one in which a **man went home and killed his partner** after he was assessed and discharged from the ED. He was sent home for community management despite his threats to do this. This is just one of many instances where lack of bed access has contributed to serious errors in judgment regarding hospital admission.

Our staff are also at risk, with frequent assaults and multiple instances of verbal abuse. Last October a man pulled a very large knife whilst being interviewed and cut his arms in order to gain admission to hospital. There are many other incidents of bizarre behaviors including the theft of an ambulance from the ED by a recommended patient who we were unable to contain.

On a personal level, I have not only had to put up with physical assaults and frequent abuse from desperate families and tired staff but also have seen my own relatives keep an adolescent son at home for 3 days after a near fatal antidepressant overdose rather than putting him through the humiliating wait for bed access and psychiatric help. His outcome fortunately, was to survive. However, he developed rhabdomyolysis, neuropraxias in his lower limbs, and needed a 2 day medical admission, to prevent kidney failure, before he was fit for private psychiatric follow up.

As psychiatric facilities are no longer resourced to reliably have beds for these patients when they present, Emergency Departments around Australia have **become de-facto holding bays**. Consequently we are asked to care for and restrain these patients in facilities never designed for the purpose. Emergency

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Departments are high stimulus, highly restricted environments full of potential weapons.

To make matters worse Psychiatric facilities seem to shut off bed access every weekend as they wind down for the break. Unfortunately from Saturday night to Monday night when Emergency Departments reach their busiest peak our staff are given the extra burden of caring for these people who should be in quiet psychiatric inpatient areas. Surely there is no less therapeutic environment that these mentally ill people could be shelved than the 24 hour frantic busy emergency department environment.

Other patients, including children and the elderly, at the times they are least likely to cope, have to face the constant presence of many aggressive and behaviorally disturbed Mental Health patients. With 25-40% of our trolleys occupied by mental health clients for the major part of every weekend there is frequently nowhere to see the new patients who arrive resulting in many patients discharging themselves prior to medical assessment, or being seen inappropriately in the waiting areas.

Additionally the ring of security staff, at times, makes the ED seem more like a prison area than a hospital. Many patients have been inappropriately "cared for" by security guards, as Psychiatric Nurse Specials are not reliably available 24/7/365.

It is only the fact that **these patients have limited ability to access legal and complaints mechanisms that we are able to get away with the sub-humane care that they currently receive.**

As far as system issues, through a number of forums, symposiums, and working groups both locally and with Department of Human Services, we have attempted to describe, raise awareness and find solutions to resource issues, bed access and other system problems. We have collected data for 29 months now to show the scope of the problem. DHS have similar data, Which, shows that far from resolving these length of stay issues they have lengthened by 50%. I have sat on the Mental Health Working Parties and participated in reviews of the service. Only to be told that we need more evidence that there is a problem! The DHS commissioned study that is to be undertaken by Dr Knott from the Royal Melbourne Hospital will take a minimum of 2 years before analysis is undertaken. How long before any outcome?

We can't afford to wait any longer! There are **obvious immediate solutions that will assist with this crisis and longer term solutions** that will take some time.

Our patients are just as deserving of mental health beds as any others. It would be simple to set up a **centralized bed finding agency** to place these patients into the closest vacant beds. Such a facility could easily be incorporated into the Emergency and Critical Care offices at St Vincent's Hospital. Currently, each of the 21 local area mental health services holds on to their own beds, and frequently there are many empty beds in the state whilst our patients wait.

There should be **centralized performance management of these local area mental health services**, so that there can be accurate reporting of bed availability and psychiatric length of stay. The Chief Psychiatrist and the

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Director of Mental Health for Victoria should be able to utilize these beds just as intensive care beds are used for the good of the whole state.

The illogical and archaic **rigid geographical boundaries** that consign patients to particular mental health services mean that patients can never choose to move to services that better handle their needs. There is no other area of health where this occurs. The abolition of these boundaries would improve the access. The perfect illustration of the inappropriateness of these boundaries, is the recommended suicidal 31 weeks pregnant patient in our department since yesterday, who we were forced to accept despite her having no ability to access antenatal care at this hospital. Despite our appeals for this lady with a very high-risk pregnancy to be taken to a more appropriate facility, the rigid geography tools were applied.

Demand management initiatives have enabled emergency departments to significantly alter ambulance access and bypass. Similar initiatives applied to mental health would hopefully achieve good outcomes.

Performance based funding models for each of the area mental health services would mean that the growing outer areas of Melbourne could be adequately funded to keep up with growing demands (I note Dandenong has similar issues which may be partially relieved by a new service at Casey later this year). The new projections for the Outer East show the population projected to increase some 17% instead of the 1% growth figures that we had previously. (Maroondah City Council Data)

There has been an acknowledgement from Dr Vine- Director of Mental Health, that there are not enough **psychiatric beds** in the system (the outer east being the most affected). We need to act now to commence planning and building and fast track any proposed outer eastern beds such as the 10 bed sub-acute facility planned for Box Hill.

CATT teams need to stop being gatekeepers and be allowed to work on being carers, as they were intended to be. It is clear that not all mental health patients are community treatable. This situation will not change until there are adequate hospital based beds to take the pressure off them.

Community psychiatric services need to be adequately resourced to deal with patients before they become suicidal and in the sprawling outer east we need to enhance facilities at Lilydale, Ferntree Gully, Yarra Junction and Healesville.

I raise all of these issues with you at this time as my level of concern for the patients of the outer east and the staff who care for them is great. I would be very keen to discuss these issues further.

Yours Sincerely

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Dr Peter Archer
Director of Emergency Services

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c.c. Mr Steve Bracks, Premier of Victoria
c.c. Associate Professor Amgad Tanhahow, Chief Psychiatrist Victoria
c.c. Dr Ruth Vine, Director Mental Health Branch Human Services, Victoria.
c.c. Ms Liz Burgat, Chief General Manager, Mental Health Program Eastern Health.
c.c. Ms Tracy Batten, Chief executive Officer, Eastern Health
c.c. Prof. John Rasa, Chief General Manager Acute Services Program Eastern Health.