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ACCESSIBILITY AND QUALITY OF MENTAL HEALTH SERVICES IN RURAL AND REMOTE AUSTRALIA

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide feedback to the Senate Community Affairs Reference Committee (the Committee) on the *Inquiry into the accessibility and quality of mental health services in rural and remote Australia* (the Inquiry).

About ACEM

ACEM is the not-for-profit organisation in Australia and New Zealand responsible for training and educating emergency physicians and advancing professional standards in emergency medicine. The practice of emergency medicine is concerned with the prevention, diagnosis and management of acute and urgent aspects of illness and injury among patients who present with a spectrum of undifferentiated physical and behavioural disorders.[1] As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients. Fellows of ACEM (FACEMs) – our members – are specialist emergency physicians working in emergency departments across Australia and New Zealand. Emergency departments are uniquely positioned as the first point of access to the health system, and play a unique role in providing targeted, quality acute medical care to everyone in the community.

Executive Summary

Australians in rural and remote areas have poorer health outcomes overall, including mental health, and access to care is a significant challenge.[2] In many communities, emergency departments are the only option for people with an acute mental health crisis. ACEM members consistently report insufficient numbers of consultant psychiatrists for face-to-face mental health service delivery in hospital emergency departments, and inadequate numbers of psychologists, counsellors and specialist mental health services in rural and remote communities. While access to telehealth has been helpful, it does not remove the need for people on the ground. The rates of suicide among people living in rural and remote areas, which are about twice those in metropolitan areas, underscore the need for a well-planned, evidence-based approach to increasing the capacity of the health system to offer expert, integrated and coordinated mental health care.

ACEM calls for a nationally funded, needs based planning process to address systemic failures in the provision of mental health care.

Introduction

ACEM believes that significantly more government investment is required to increase mental health service delivery across the health system, and particularly in rural and remote hospitals and communities. ACEM highlights the need to implement innovative models of care specifically designed to remove barriers to service

[1] Australasian College for Emergency Medicine. Policy on standard terminology (P02). Melbourne: ACEM; 2014.
[2] National Rural Health Alliance. The health of people living in remote Australia. Deakin West: NRHA: 2016. Available from: http://ruralhealth.org.au/sites/default/files/publications/nrha-remote-health-fs-election2016.pdf.

access in rural and remote Australia. When patients present to emergency departments with an acute mental health crisis, emergency physicians need to be confident that hospitals have sufficient expertise, including inpatient bed capacity, combined with adequate specialist mental health services and programs in the community. Having a skilled, safe, competent and coordinated workforce is of paramount importance to care for people living in rural and remote areas of Australia. ACEM is currently advocating for greater transparency around delays in access to specialist inpatient mental health services from emergency departments. The College believes greater transparency is an important lever for improving the safety and quality of acute mental health care.

Key Findings

1. People living with mental illnesses are one of the most vulnerable and disadvantaged populations in Australia. They require a capable mental health workforce that is trained and supported to provide quality specialist treatment and care.
2. Data shows that people living in rural and remote areas are at higher risk of suicide than their metropolitan counterparts. Research consistently suggests this is related to inadequate services in the community.
3. People in rural and remote areas use emergency departments to access emergency medical care when in acute mental health crisis. This is particularly true for Aboriginal and Torres Strait Islander populations.
4. More investment is needed to implement innovative models of care that specifically address barriers to mental health service access in rural and remote Australia.

Recommendations

1. ACEM believes that all hospital emergency departments require access to mental health expertise and capacity at all times, with models of care designed, developed and delivered in partnership with specialist emergency physicians and emergency department staff.
2. ACEM calls for nationally consistent Mental Health legislation.
3. ACEM recommends introduction of a mandatory reporting measure to the relevant health minister, human rights and/or health rights commissioner for patients with mental health presentations who experience emergency department lengths of stay of 12 hours or more.
4. ACEM recommends increasing the size and structure of the rural and remote health workforce, including recruitment and retention of more doctors, nurses, mental health specialists, Aboriginal Health Workers, Aboriginal Health/Hospital Liaison Officers and allied health workers, and developing their capabilities and capacity.
5. ACEM supports increased investment in innovative models of mental health care that specifically target and address barriers to access in rural and remote Australia.
6. ACEM recommends consultation with specialist emergency physicians on national mental health reform to further improve the design and delivery of mental health services and policies. ACEM believes that emergency physicians are well placed to provide a system-level perspective on how this could be achieved.

1. People living in rural and remote areas rely on emergency departments to access mental health care, with the data suggesting this is particularly the case for Aboriginal and Torres Strait Islander populations

In rural and remote Australia, communities have poorer access to and lower rates of use of specialist mental health services. Emergency departments are the common default providers of acute mental health care where specialist mental health services are required.

ACEM members report that stoicism relating to 'bush identity' can impact on attitudes to mental health and proactive help-seeking, which is supported in the literature.[3] In the absence of appropriate mental health care in rural and remote settings, people may often resort to alcohol and other drug (AOD) use as a way to cope and ameliorate psychological distress. Comorbid AOD use can create cycles of acute trauma in peoples' lives that require access to mental health services and care. Combined with the stigma of mental illness and concerns about confidentiality and anonymity in rural and remote settings, people may deny their need for treatment and delay help-seeking. These issues manifest in a greater likelihood of late presentation to emergency departments for acute mental health and/or suicidal crises. There are opportunities for prevention and harm minimisation with early intervention.

ACEM recognises that emergency departments often function as the first point of access to specialist mental health care in the Australian public health system. This is especially relevant after hours, when there may be no access to other community support services in crisis situations. Generally, access to these support services is even more limited in a rural and remote community.

ACEM's internal analysis of Australian Institute of Health and Welfare data shows a clear difference in patterns of access between people living in metropolitan, regional and rural/remote areas of Australia.

For instance, in rural and remote settings:

- Patients with mental health presentations are more commonly admitted to hospital for specialist inpatient care than people with other emergency conditions. This is often due to a lack of other services offering community based clinical care and support, leaving inpatient admission as the only treatment option.
- Patients with mental health presentations more commonly arrive to hospital emergency departments via police/correctional vehicle transportation than people with other emergency conditions
- Aboriginal and Torres Strait Islander peoples are overrepresented in emergency department mental health presentation data, with this overrepresentation substantially increasing with (emergency department) remoteness. In the Northern Territory, Aboriginal and Torres Strait Islander peoples account for nearly two-thirds of mental health presentations to emergency departments.

These results point to a health system that is seriously constrained by a long history of inadequate resourcing. In rural and remote Australia, people use emergency departments to access emergency medical care when in acute mental health crisis, particularly Aboriginal and Torres Strait Islander peoples. The types of service delivery models employed in large rural Australian centres (such as the hub-and-spoke model) mean that specialist mental health practitioners are often not present outside of hospital emergency department hubs to provide appropriate psychiatric medical care. Often, in locations with already limited services, hours of operation are not aligned to peak patient presentation times. ACEM believes that all emergency departments should be resourced at all times with mental health capacity and expertise, with appropriate models of care designed, developed and delivered in partnership with specialist emergency physicians and emergency department staff.

2. Mental health care in rural and remote areas is inadequate, with specific repercussions for access block

When people with mental illnesses attempt to access care in rural and remote emergency departments, they experience unacceptably long waiting times for access to specialist inpatient mental health care. This is particularly true for those requiring transfer by road or aeromedical transport.

[3] McColl L. The influence of bush identity on attitudes to mental health in a Queensland community. Rural Society. 2007; 17(2):107-124.

In December 2017, ACEM's Prevalence of Mental Health Access Block (POMAB) Study[4] found that while mental health presentations comprise only four per cent of all rural and remote emergency department presentations, this group comprises 33% of patients waiting for specialist inpatient mental health care and 47% of patients experiencing 'access block' (defined as a prolonged stay in the emergency department of eight hours or more because of delays accessing an inpatient bed). ACEM members report instances of people needing mental health care who end up spending six days in an emergency department waiting for a specialist inpatient mental health bed. ACEM considers that these delays for care are not only inequitable, but discriminatory. ACEM's POMAB Study also showed that the prevalence of access block is much worse for patients with mental health presentations in rural and remote hospital emergency departments compared with patients in metropolitan areas (47% vs. 28%). Long waits in emergency departments and access block drive emergency department overcrowding, poor patient experiences and worse patient health outcomes, including for people with mental health issues. Emergency departments operate 24 hours a day and have high levels of ambient noise and activity. People who stay in emergency departments for several days report not being able to sleep. This has particular impacts for mental health where disturbed sleep cycles are an important aspect of therapeutic management. Access block also has negative impacts on the health, wellbeing and sustainability of the rural and remote emergency medicine workforce.[5]

When mental health service capacity is low in metropolitan areas, there are unavoidable flow on effects for referrals from rural and remote emergency department settings. Young people in need of specialist inpatient mental health services are likely to be transferred for care from small rural centres to larger centres, and access to inpatient beds in these facilities is often difficult. ACEM members report being actively discouraged from scheduling mental health patients in rural and remote emergency departments due to known delays with review by mental health telehealth teams (in the absence of face-to-face review). For young patients, this means they can be forced to wait in an isolated room in an emergency department for two to three days until transport is available to send them to an appropriately declared mental health facility, depending on the relevant jurisdictional legislation. During their wait, they receive no specific mental health input or treatment. This – combined with being kept in noisy, crowded conditions in constant artificial light, with limited access to appropriate outdoor areas, physical inactivity, and lack of privacy – inevitably worsens their condition. ACEM members report that in cases where a person's behaviour becomes agitated, sedation is used, sometimes for long periods of time. ACEM considers that this standard of care is unacceptable.

In rural and remote settings, ACEM members have highlighted that mental health patients are frequently transferred long distances to tertiary hospital services without family or friends to accompany them. This is often due to funding and logistic constraints for transportation of escorts. On arrival, these vulnerable patients are left frightened and isolated in unfamiliar hospitals, regional centres and cities, with no social and emotional support. Given the importance of social and emotional support in ameliorating symptomatic mental illness and psychological distress, ACEM believes that family or friends in close proximity to patients for information and support is an integral part of any successful assessment, diagnosis and treatment process.

Cross-border issues further complicate the provision of care to patients with mental health presentations in rural and remote hospital emergency departments. Depending on the hospital location, scheduling involuntary or compulsory patients requiring urgent specialist inpatient mental health treatment is legally complex given large variations in mental health legislation across Australia. Each State and Territory has a different Mental Health Act that provides for different legislative powers. The Mental Health Acts do not cross borders, while patients do.

[4] Australasian College for Emergency Medicine. Waiting times in the emergency department for people with acute mental and behavioural conditions. Melbourne: ACEM; 2018. Available from: https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx.

[5] Australasian College for Emergency Medicine. Workforce Sustainability Survey Report. Melbourne: ACEM; 2016. Available from: https://acem.org.au/getmedia/0da6a4e7-9bc2-4e0f-83ea-95ee51a6f8fc/Workforce-Sustainability-Survey-Final-Report_November-2016.aspx.

For instance, ACEM members report that a South Australian resident with an acute mental health issue who requires retrieval to the closest emergency department, which often happens to be in the Northern Territory, technically requires completion of both South Australian and Northern Territory Mental Health Act documents prior to transport. The tertiary mental health service is located in South Australia, which again requires different documentation and allows for different treatments to be commenced. These legislative variations and complexities not only contribute to further delays for patients while they wait for retrieval in one Australian jurisdiction for transportation to another state or territory for care, but also to access block in the emergency department, which impacts the care of other patients. Such variation can be a significant stressor for the rural and remote emergency medicine workforce. ACEM calls for nationally consistent legislation as relating to the various Mental Health Acts.

ACEM wishes to highlight to the Committee possible measures for reducing emergency department lengths of stay and delays in care for patients with mental health presentations. In Victoria, key performance indicators (KPI) were introduced more than a decade ago to assist health services to focus on the number of patients with extended lengths of emergency department stays. The state-wide benchmark for KPI 4 '*Number of patients with a length of stay in the emergency department greater than 24 hours*' is zero patients. With this measure, the number of patients per month experiencing lengths of stay of more than 24 hours has reduced over time.[6] Failure to achieve the KPI is considered a performance breach, requiring immediate escalation to the Department of Health and Human Services (i.e. within 24 hours of the breach or becoming aware of the breach, advising of the circumstances and response to the breach including whether or not patient safety has been compromised).[7] ACEM recommends introduction of a mandatory reporting measure for patients with mental health presentations who experience emergency department lengths of stay of no more than 12 hours. The College suggests that the Committee investigates the Victorian KPI reporting regime to determine its suitability for both modification and national implementation to improve the acute care experience for this vulnerable population.

3. Workforce strategies

People living with mental illnesses are one of the most vulnerable and disadvantaged populations in Australia, requiring a capable mental health workforce that is trained and supported to provide specialist quality treatment and care. ACEM believes that funding and incentives for the mental health workforce are inadequate to meet increasing population demand for services.

The imbalance between supply and demand continues to contribute to the overall lower health status of rural and remote populations.[8] Recruitment and retention packages that incentivise rural and remote practice for the medical workforce should be part of any rural and remote health workforce strategy. People who reside in rural and remote settings need increased face-to-face access to specialist mental health practitioners, including psychiatrists, psychologists and mental health nurses and workers, as well as the allied health workforce, counsellors and therapists, social workers and community development workers. Currently, rural bonded medical education programs are not targeted to specialist emergency physicians or psychiatrists. Initiatives like ACEM's Emergency Medicine Education and Training (EMET) program,[9] providing certificate and diploma-level education, training and supervision to non-specialist doctors and other health professionals working in

[6] Department of Human Services. Better, faster emergency care. Improving emergency care and access in Victoria's public hospitals. Melbourne: Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services; 2007. Available from: https://www2.health.vic.gov.au/Api/downloadmedia/%7B3D042E9E-942F-4555-BCA2-9C13A64554C8%7D.
[7] Department of Health and Human Services. Victorian health services performance monitoring framework. Melbourne: DHHS; 2017. Available from: https://www2.health.vic.gov.au/Api/downloadmedia/%7B7C64E794-B166-4E76-8D24-061101D01ADB%7D.
[8] Australian Medical Association. Regional Training Networks – 2014. Barton: AMA; 2014. Available from: https://ama.com.au/position-statement/regional-training-networks-2014#_ftnref2.
[9] Australasian College for Emergency Medicine [Internet]. Melbourne: ACEM; 2018. Emergency Medicine Education and Training (EMET); 2018 Feb 18. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/National-Program/Emergency-Medicine-Education-and-Training.

emergency departments in rural and remote Australia, could be adapted as a model for the mental health workforce to increase the sector's capacity to respond to patient demand. ACEM recognises the importance of robust specialist and generalist workforces to meet rural and remote health care demands.

In 2018, ACEM received funding from the Commonwealth Department of Health under the Specialist Training Program for a Support Project to develop and deliver the *Better Mental Health Care in Rural Emergency Departments* training program. The program aims to educate specialist emergency physicians and FACEM trainees to improve the quality of mental health care in rural and remote emergency departments, as well as promote the mental health of the rural and remote emergency medicine workforce. The focus will be on the current experiences of people with mental illness accessing emergency departments in regional, rural and remote settings, and opportunities for improving outcomes, with a focus on people from Aboriginal and Torres Strait Islander communities.

Workforce strategies that are implemented must impart the unique knowledge, experience, local understanding and resilience required for safe, efficacious and sustainable practice in rural and remote Australia. ACEM members who work in rural and remote contexts report that merely transplanting metropolitan educated and trained medical and mental health workforces to rural and remote settings is not sufficient for safe and effective practice. A permanent, present rural and remote medical workforce must be engaged, competent and capable of providing clinically and culturally safe medical and mental health care. This workforce must be able to recognise and respond to the warning signs for acute mental health crises and self-harm in individual communities, and particularly in Aboriginal and Torres Strait Islander communities.

ACEM considers mental health care for Aboriginal and Torres Strait Islander peoples is a highly specialised area of health that should be given due recognition in specialist training programs. Culturally appropriate Aboriginal and Torres Strait Islander health education and training should be provided for in all accredited vocational and non-specialist training pathways, as well as in medical continuing professional development programs. Part of this education and training should focus on improving physicians' skills, knowledge and cultural competency as mechanisms for improving mental health outcomes among Aboriginal and Torres Strait Islander patients.

ACEM supports the integration of Aboriginal Health/Hospital Liaison Officers into emergency department teams, as well as Aboriginal Health Workers working in partnership with emergency departments in rural and remote areas. Senior clinical FACEM leaders who work in rural and remote Australian emergency departments have seen the tangible benefits of having Aboriginal Health Workers and Aboriginal Health/Hospital Liaison Officers employed in emergency departments and support expanding this workforce. ACEM also supports programs for more Aboriginal and Torres Strait Islander doctors, nurses, midwives, psychiatrists, psychologists and other allied health professionals in hospitals. ACEM recommends increasing the size and structure of the rural and remote health workforce, including recruitment and retention of more doctors, nurses, mental health specialists, Aboriginal Health Workers, Aboriginal Health/Hospital Liaison Officers and allied health workers, and developing their capabilities and capacity.

4. Investing in models of care for rurality and remoteness

ACEM believes that better alignment, integration and coordination of services for managing mental health in the community will assist in reducing hospital presentations and admissions, provide options for earlier discharge of patients admitted to hospital and, in some contexts, reduce demand on inpatient hospital beds. In addition, ACEM members report that better assessment capability in rural and remote hospital emergency departments can reduce the numbers of patients requiring transfer to larger centres, which not only benefits patients and their families, but health services at both ends.

While a range of rural and remote service models exist in Australia,[10] ACEM underscores the enduring therapeutic benefit for communities when they are enabled to build relationships with permanent, present specialist mental health practitioners who understand the specificities and complexities of local life in rural and remote Australia. Investments in models of care for rurality and remoteness should have face-to-face mental health service provision and care at their core. Although technology-based models of care provide genuine opportunities for increasing access to quality mental health care, face-to-face communication with patients and their families remains integral to treatment and recovery processes. While a place for telehealth exists as a component of specialist mental health service provision, ACEM strongly believes that telehealth should not be considered the solution for filling mental health service gaps in rural and remote communities. ACEM considers that high quality, safe mental health care requires capable people on the ground to provide quality clinical care.

At the same time, ACEM considers that technology-based models have utility in rural and remote mental health service provision, integration and coordination. For instance, technology-based models of care may be useful for analysing service demand and better coordinating service delivery to people in areas of need. Telehealth can also be utilised to assist with monitoring chronic psychiatric patients in remote locations. However, in the absence of local specialist inpatient mental health services, telehealth does not resolve issues of service stress when patients require transfer to a tertiary centre. ACEM also sees potential for telehealth as an adjunct to care for lower acuity mental health presentations, having particular benefits for patient follow-up and minimising the need for long-distance travel. However, trust between practitioner and client remains paramount and in these contexts ACEM advocates for continuity of care wherever possible. ACEM strongly supports increased investment in innovative models of mental health care that specifically target and address barriers to service access in rural and remote areas.

ACEM supports the National Rural Health Alliance's call for the Council of Australian Governments to develop a national rural mental health strategy, informed by the National Mental Health Commission's (NMHC) collation of Public Health Network service mapping in rural and remote areas and other data that identifies health care service shortfalls. The College welcomes the recent 2018/19 Budget announcement for additional resourcing of the NMHC to provide national leadership and advice for mental health reforms, and the strengthening of its review and reporting capabilities. For all future national mental health reforms, ACEM recommends consultation with specialist emergency physicians and hospital emergency department staff to further improve the design, development and delivery of mental health services and policies.

5. ACEM's mental health summit

Following the commencement of a major campaign on Mental Health Access Block in February 2018, ACEM plans to host a National Summit on Mental Health and Emergency Departments in Melbourne in October 2018. The Summit will involve a range of key stakeholders to build profile on the issue and develop a consensus statement. The consensus statement will focus on the priority policy changes required to ensure timely and appropriate access to mental health care in acute and community settings to relieve pressure on emergency departments.

Thank you for the opportunity to provide feedback to Senate Community Affairs Reference Committee on the *Inquiry into the accessibility and quality of mental health services in rural and remote Australia.* We would welcome the opportunity to provide further information to the Committee on the issues described in this submission. Please do not hesitate to contact the ACEM Policy and Advocacy Manager Helena Maher

[10] Roufeil L & Battye K. Effective regional, rural and remote family and relationship service delivery. Australian Family Relationships Clearinghouse Briefing No. 10 2008. Melbourne: Australian Institute of Family Studies; 2008. Available from: https://aifs.gov.au/cfca/publications/effective-regional-rural-and-remote-family-and-relationship.

Yours sincerely,

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