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Commonwealth Department of Health
Potential Service Model for Adult Mental Health Centres

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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide comment on the Commonwealth Department of Health's Potential Service Model for Adult Mental Health Centres. ACEM is the peak body for emergency medicine and is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand.

ACEM has long advocated for a health system that offers safe, timely, expert and therapeutic care, regardless of people being physically or mentally unwell. Emergency departments (EDs) are often considered the 'canary in the coal mine' in identifying system failures and play a vital role in addressing the needs of people who have nowhere else to go due to the lack of alternate and more appropriate mental healthcare options, particularly out-of-hours. This submission outlines our responses to the consultation questions provided by the Technical Advisory Group and is informed by our members' experiences working in EDs across Australia.

1. Are the principles which underpin the service model appropriate?

ACEM welcomes the commitment from the Commonwealth Government to establish the Adult Mental Health Centres and acknowledges that this alternative care model has the potential to fill current service gaps in community-level mental health services. We are broadly supportive of the guiding principles, however, believe further clarification is required regarding how the Centres will fulfil their purpose of reducing the need for ED attendance. In particular, ACEM is seeking further details on how the Centres will practically fill the gaps in services available outside of business hours and how will they integrate with existing initiatives implemented by state and territory governments.

ACEM data shows that demand for mental health support in EDs peaks after hours, yet most community mental health services are open from 9am - 5pm, Monday to Friday. It is therefore essential that these Centres provide 7 day-a-week after-hours cover, including 24-hour phone consultation. A highly responsive and accessible service is needed or else it will be abandoned as other community services often are in favour of coming to the ED. ACEM recommends that the guiding principles explicitly state that these Centres will operate outside of business hours, across all days of the week.

ACEM Fellows have expressed concern for several years that patients in mental health crisis experience disproportionately long waits in the ED for inpatient mental health care following admission to hospital. This phenomenon, known as psychiatric 'boarding' or, more latterly, access block, is associated with several negative outcomes including higher mortality rates. ACEM therefore recommends the guiding principles are expanded to specify the role of the Centres in providing a direct route to mental health inpatient services without needing to go via the ED.

ACEM is aware of the highly fragmented nature of the mental health system so is supportive of the principle to "support people to connect to pathways of care through integration with longer term existing community mental health services where these are accessible, local Primary Health Network commissioned services, or GPs and state and territory funded services, as required". However, we are concerned that it is unclear how these Centres will integrate with existing models of care in EDs. There are a number of mental health triage centres and "crisis hubs" already established in locations where trial Centres are proposed so formal relationships must be established with local EDs to ensure the Centres are 'fit for purpose' and don't create additional bureaucracy and confusion for patients to navigate.

2. Are the assumptions appropriate?

ACEM is supportive of the 'no wrong door' approach, however, we are concerned that the age cut-off for people younger than 25 years of age does not align with the approach taken by mental health services that defines children/youth as younger than 18 years of age. We therefore recommend that the 'no wrong door' approach also covers these groups, particularly as headspace and similar services may not be available after-hours. As outlined above, assumptions regarding the 'no wrong door' approach must also consider how these Centres integrate and collaborate with existing crisis and emergency services or else they risk reinforcing existing system fragmentation and difficulties for consumers with service navigation.

3. Are the core services appropriate?

Many people who present to EDs seeking help for a mental health condition often require help with acute or chronic physical health issues, so this is also likely to be the case for these Centres. In particular, AOD needs cannot be easily separated from mental health needs so integrated models of care must be a core part of the Centre's function.

Staffing in the Centre requires greater clarification, especially around AOD, given the paucity of Addiction Medicine Specialists. Whilst there is a stated intent not to limit the scope of these Centres, additional details as to a core group of practitioners needs to be established so that all patients, irrespective of state, can access the same standard of mental health services. ACEM recommends programs such as dual diagnosis and trauma-informed care aimed at improving distress tolerance and deliberate self-harm triggers.

To ensure that Centres have the capacity and capability to deliver the core services, ACEM recommends that staff have a similar skillset to mental health nurses working in EDs. This will ensure that staff have the skills and experience necessary to feel confident to provide crisis care and not direct people to the ED when unnecessary.

Whilst these Centres will provide services for people experiencing distress and in crisis, there needs to be a clear approach to patients who experience suicidality as a chronic phenomenon. It is the experience of ACEM's members that many other health services automatically refer patients to ED as soon as a patient says they have had suicidal thoughts irrespective of context. This creates an enormous strain on the ED setting, which is not the right environment to assess patients where suicidality is a daily occurrence, unless there is evidence of a new stressor or trigger where assessment is warranted. If this is not properly addressed in the service model, there is a real risk that these Centres will become physical manifestations of 'Nurse on call' and 'Health Direct' that are protocol driven and risk averse.

4. Is the list of out of scope services clearly explained?

As mentioned above, EDs have become the 'front door' for people needing help with their mental health, without the resourcing and support to manage this workload. While the intended function of EDs is to provide rapid management for emergencies and potentially life-threatening cases, they are also serving as a means for supporting unmet health service needs within the community without being designed or resourced to do so. It is ACEM's view that EDs should have an acknowledged and defined role to play within a reformed mental health system however there lacks a clear definition of what constitutes the need for urgent ED care versus the crisis care provided by these Centres. It is ACEM's view that these roles need to be defined properly to ensure referrals to EDs are targeted and specific, and that Centres do not unnecessarily direct consumers to EDs due to narrow definitions of appropriate cases. ACEM would welcome the opportunity to work further with the Technical Advisory Group to develop the criteria for assessing the need for urgent ED care.

ACEM recognises that these Centres are not appropriate for people requiring urgent ED attention, however, having a means for both the ambulance service and EDs in the local area to direct appropriate patients to the Centre would be ideal. Patients often present via ambulance to an ED due to the lack of appropriate community services so these patients would be entirely appropriate for the Centres. ACEM therefore recommends expanding the service scope to include the ability for EDs to integrate and move patients between EDs and Centres.

Given there are a number of related services out of scope for the Centres and they are intended to complement these existing services, consultation with local community and hospital mental health services must be prioritised. ACEM is concerned that there is limited explanation as to how planning will include these key stakeholders. Planning needs to be done in partnership with these services or else duplication will occur or further reinforce silos and service fragmentation/complexity.

5. **Will the service model meet the establishment aims to provide inclusive, non-stigmatising and culturally appropriate mental health support and/or treatment for individuals, and their family and carers who seek advice or assistance?**

ACEM believes that mental health care, regardless of the setting, should be respectful, patient-centred and recovery oriented. People with a lived experience of mental illness must be central to the design of these Centres and the involvement of peer workers will be a critical component of improving the experience of people accessing these services. ACEM recommends that Centres collaborate with community-led agencies to agree on mental health care strategies to measurably improve outcomes for populations that are over-represented in presentations to EDs, particularly Aboriginal and Torres Strait Islander people

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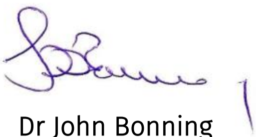
6. **What factors could make a national brand easily identifiable?**

As outlined throughout this submission, ACEM is concerned that these Centres are not clearly distinguished from existing state services and risk confusing consumers about what service is appropriate for their needs. Rather than focusing on the branding, ACEM recommends there is first a focus on ensuring access and defining how the services integrate with other community and hospital services. For example, headspace has a well-recognised brand but people with diagnosed mental health conditions can't access their services so come to the ED instead. It is therefore critical that clear communication strategies are developed that help consumers, carers and referrers have a clear understanding of where to go when experiencing a mental health crisis.

Thank you for the opportunity to provide feedback on the draft service model for this valuable mental health reform initiative. Given that one of the goals of the Service Model is to reduce ED presentations, collaborating with EDs will be essential to avoid creating additional service fragmentation, bureaucracy and confusion for consumers. ACEM would therefore welcome the opportunity to nominate a representative to the Technical Advisory Group to provide expertise from the emergency medicine perspective. To discuss this further, please do not hesitate to contact Nicola Ballenden, Executive Director of ACEM Policy and Strategic Partnerships (Nicola.Ballenden@acem.org.au; +61 3 9320 0479).

Yours sincerely



Dr John Bonning
President