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Submission to the Select Committee Inquiry into Mental Health and Suicide Prevention - March 2021

Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide this submission to the Select Committee Inquiry into Mental Health and Suicide Prevention.

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring that the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

This submission is informed by our members' experiences working in EDs across Australia. In line with the Committee's Terms of Reference, our submission reinforces the College's responses to the Productivity Commission Inquiry into Mental Health, the Victorian Royal Commission and other recent strategic reviews of the current mental health system.

The submission highlights the experience of patients presenting to Australian EDs seeking mental healthcare, and the urgent need for greater capacity to improve care and address unsustainable pressures on hospital EDs. 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.[1]

Recommendations

The Australian Government must commit to reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community as a viable alternative to EDs. The next iteration of the National Mental Health and Suicide Prevention Plan must include the following priority actions to reduce the reliance of mental health patients on EDs through the development of adequate services to meet community mental health needs and reduce presentations.

ACEM recommends that:

1. State and territory governments should undertake strategic needs assessments to scope the requirement for inpatient mental health beds in line with international best practice evidence and standards.
2. Additional resources must be invested to increase inpatient mental health beds and non-hospital alternatives, such as step up/step down services, short stay units, hospital in the home etc., depending on local needs.

[1] Duggan M, Harris B, Chislett WK & Calder R. Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments. Melbourne: Mitchell Institute, Victoria University; 2020. Available from: https://acem.org.au/nowhereelsetogo

3. The National Cabinet Health Reform Committee and health ministers should support and encourage innovative mental health funding arrangements that provide ongoing and sustained care for people with persistent mental health needs.
4. State and territory governments should explore innovative diversion or alternative care models in communities with high levels of mental health patient presentations to EDs.
5. All government-funded mental health services should be required to expand their operating hours to provide flexible after-hours services as a condition of receiving funding.
6. ED resourcing must provide for adequate clinical care and accommodation by including mental health expertise in ED staffing; providing ongoing mental health education, training and professional support for all staff; developing new workforce models including peer workers within emergency department teams; and applying ED design principles that create low stimulus, reassuring environments for people in mental health crisis.
7. All jurisdictions should implement a centralised follow-up service that ensures all mental health patients, especially when presenting due to suicidal ideation or following an attempt on their life, receive a phone call within 24 hours of discharge to offer advice on available services, check on referrals (for example, if a GP appointment has been made) or other appropriate actions.
8. Primary Health Networks (PHNs) should have an explicit goal of preventing avoidable mental health emergency presentations in their catchment areas and form area mental health service steering bodies with Local Hospital Networks (LHNs) to align, coordinate and monitor care pathways for all individuals requiring continuing mental health services.
9. Area mental health service steering bodies should be accountable to both Commonwealth and state and territory governments. LHNs should monitor and report on excessive (>12 and 24 hours) stays in EDs, restrictive practices and walk outs. PHNs should monitor and report on primary care provision both pre and post an acute presentation or hospital admission for all individuals requiring continuing mental health services.
10. The Commonwealth should establish a robust mechanism for monitoring system performance against the National Standards for Mental Health Services established by the Australian Commission on Safety & Quality in Health Care.
11. State and territory health departments should adopt a maximum 12-hour length of stay (LOS) in the ED by providing accessible, appropriate and resourced facilities for ongoing care beyond the emergency department. Mandatory notification and review of all cases exceeding a 12-hour LOS should be embedded in key performance indicators of public hospital CEOs.
12. All episodes of a 24-hour LOS in an ED should be reported to the relevant Health Minister regularly, alongside CEO interventions and mechanisms for incident review.
13. Use of restrictive practices (sedation and restraint) in EDs should be governed by clear clinical governance frameworks, standardised documentation tools and clear reporting pathways that allow for system improvement recommendations to be progressed to the relevant governance level.
14. Audits of restrictive practices in the ED should be conducted to identify and monitor the impact on patient outcomes and the relationship with the availability and accessibility of acute or community-based services and support.
15. All security personnel working within the ED should be appropriately resourced and trained in de-escalation techniques to reduce the need for restrictive practices and ensure patient and staff safety.
16. The next iteration of the National Mental Health and Suicide Prevention Plan should be accompanied by a fully funded rural mental health strategy that addresses the severe inequities in access to safe, culturally appropriate and evidence-based treatment and care experienced by people with mental health needs in remote and rural areas.
17. Investment in rural mental health workforce development is essential, including staff capabilities, skill mix and role diversification.

Background

Demand for mental health care from EDs

Mental health conditions are increasing as both a proportion of the population and in overall numbers, with one in five Australians living with a mental health condition in 2017–18.[2] Due to the twin pressures of increasing demand and failure to provide alternate acute mental health services in the community, particularly after-hours, EDs have become a major and often default entry point for people seeking access to mental health care. Often by the time people present to an ED, their potentially preventable or manageable condition is very serious and they are in crisis.

In 2018–19, there were 303, 340 public hospital ED presentations with a mental health-related principal diagnosis recorded, representing 3.6% of all ED presentations.[3] Despite mental health accounting for a small percentage of all presentations, mental health patients are over–represented in the data on access block (defined as patients waiting eight hours or more in the ED for an admission or transfer to an inpatient bed)[4] and length of stays of 24 hours or more in the ED, largely due to a lack of inpatient psychiatric beds or alternative care options.[5,6]

Mental health access block is inevitable in the Australian mental health system, with AIHW data showing the chronic shortage of mental health beds, including that the total number of beds has decreased in absolute terms. The 2019 AIHW report on mental health services in Australia shows that in 2016–17 the 7,175 public mental health beds were fewer than it was in 1993–94, when there were 7,606 mental health beds. International comparisons confirm this shortfall, with Australia's rate of 41 acute psychiatric beds per 100,000 population falling significantly below the OECD average of 71 mental health beds per 100,000.[7]

EDs are designed to provide efficient management of emergencies and potentially life-threatening presentations, and not to address the gaps in the provision of inpatient and community-based health and social services. They are staffed and resourced to provide appropriate initial management, not supervision over prolonged periods of time. It is clear to our members that long waits increase the risk of adverse events, particularly behavioural escalation that results in seclusion, restraint and sedation.[8] Any progress towards reducing and potentially eliminating the use of restrictive practices in EDs will require resourcing of the clinical team, security personnel and the ED environment, plus clear reporting requirements and audits to identify and monitor the impact on patient outcomes and the relationship to the availability and accessibility of acute or community-based services and support.

Reliance on EDs to access mental health care and support is also an inefficient use of ED resources. The 2017 Emergency Care Costing Study was commissioned by the Independent Hospital Pricing Authority (IHPA) to understand the cost drivers in emergency care at the patient level. It found that the average cost per episode of mental health care was much higher than the overall average cost of emergency care in the ED, where:

- the overall average cost for all emergency care was $696
- the average cost for management of severe mental health disorder with diagnostic modifiers was $889
- the average cost of involuntary mental health care with diagnostic modifiers was $1,074
- the average cost of distress/confusion/agitation with diagnostic modifiers was $1,225.

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[2] Australian Bureau of Statistics (ABS). National health survey: first results, 2017-18. Cat no 4364.0.55.001. ABS, Canberra; 2018. Accessed 23 Feb. 2021 from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

[3] Australian Institute for Health & Welfare (AIHW). Mental health services in Australia. AIHW, Canberra; 2020. Accessed 23 Feb. 2021 from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-inaustralia/report-contents/summary

[4] Australasian College for Emergency Medicine (ACEM). Position statement: Access block (S127). ACEM, Melbourne; 2020. Available from https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx

[5] Australasian College for Emergency Medicine (ACEM). Waiting times in the emergency department for people with acute mental and behavioural conditions. ACEM, Melbourne; 2019. Available from https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx

[6] Australasian College for Emergency Medicine (ACEM). The long wait: An analysis of mental health presentations to Australian emergency departments. ACEM. Melbourne; 2018. Available from https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[7] Allison S, Bastiampillai T, Licinio, J, Fuller DA, Bidargaddi N & Sharfstein SS. When should governments increase the supply of psychiatric beds? Molecular Psychiatry. 2018;23(4):796.

[8] Kennedy MP. Violence in emergency departments: under-reported, unconstrained, and unconscionable. Medical Journal of Australia. 2005;183(7):362–365.

Based on the above, ACEM is therefore strongly supportive of the recommendations put forward by the Productivity Commission and Victorian Royal Commission to address gaps in community mental healthcare and prioritise the development of alternative services outside the ED, including peer- and clinician- led after-hours services and mobile crisis services. The benefits of these models are clear in improving patient experience and ensuring that appropriate care is delivered.[9,10]

There is also an urgent need to increase the number of inpatient mental health beds and non-hospital alternatives (e.g. step up/step down services and hospital in the home). This will ensure people have timely access to inpatient care and reduce long and harmful ED waits currently widespread throughout Australia. While we recognise that bed numbers cannot be increased overnight, shortfalls must be estimated immediately at a state, territory and regional level and the Australian Government must set minimum targets per head of population to ensure States and Territory Governments are held to account and commitments made for tangible change.

Mental health funding

Total spending on mental health by governments has increased over time, but not proportionately to demand; recurrent expenditure per capita on specialised mental health care services has increased by an average of just 1% per annum between 2005-06 and 2018-19.[11] Nationally, the average total recurrent expenditure per head of population of just over $200 per annum demonstrates the inadequacy of government investment in developing and resourcing the mental health system.

Current funding arrangements mean that the current public health system has limited capacity to provide intensive and integrated interventions to people with complex mental health and social support needs.[12] As a result, people who are often economically disadvantaged, socially marginalised and dependent on the public health system come to EDs for mental healthcare, especially after-hours, and face long waits for that are harmful to their health outcomes and an inefficient use of scarce hospital resources. There is no doubt that mental health funding should be increased to better reflect the burden of disease and to acknowledge parity of mental illness with physical illness. The cost of implementing a more effective response has been estimated by leading mental health advocates as over $1 billion per year from the Australian Government, with similar investments from the states and territories.[13]

The longstanding under-investment in mental health care is compounded by outdated mechanisms for ensuring Australia's universal health care system offers timely access to quality health services based on need, not ability to pay, and regardless of where people live. Australia's health system is designed around the principle of uncapped access to health care through Medicare, the Pharmaceutical Benefits Scheme and public hospital services. This is augmented by a range of funding models that are ignore changes in demand or evidence-based practice. This results in people accessing services, such as public hospital EDs, when alternatives may have been more effective.

Current funding systems attach funding to the supply of services rather than outcomes and have not been responsive to the evidence supporting the benefits of consumer-centred, multidisciplinary and integrated health care across sectors and jurisdictions. The current fee for service approach mitigates against integrated 'patient pathways' that offer step-up and step-down to levels of treatment and support, depending on the severity of the patient's health needs. Services are rewarded for providing a service with an immediate benefit and not for anticipating and preventing avoidable future need. There is little reward for providing tailored individualised care or for innovative cost-effective patient-focused services.

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[9] Grey F and O'Hagan M. The effectiveness of services led or run by consumers in mental health: rapid review of evidence for recovery-oriented outcomes: an evidence check rapid review brokered by the Sax Institute for the Mental Health Commission of New South Wales. Sax Institute, 2015.

[10] Braitberg G, Gerdtz M, Harding S, Pincus S, Thompson M & Knott J. Behavioural assessment unit improves outcomes for patients with complex psychosocial needs. Emergency Medicine Australasia. 2018;30(3):353–358.

[11] Australian Institute for Health & Welfare (AIHW). Mental health services in Australia. Expenditure on mental health-related services AIHW. 2020. Accessed 23 Feb 2021 from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services

[12] Meadows GN, Enticott JC, Inder B, Russell GM & Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. Medical Journal of Australia. 2015;202(4):190–194.

[13] Hickie I. Mental health reform: are we serious this time around? Insight+ Medical Journal of Australia. Issue 1, 2021. Accessed 23 Feb 2021 from: https://insightplus.mja.com.au/2021/1/mental-health-reform-are-we-serious-this-time-around/

ACEM believes there is an urgent need for innovative funding arrangements that support comprehensive, coordinated and sustained community mental health care, initially targeted at people identified as at risk for frequent emergency department presentations. There is also an urgent need for funding reforms to support integrated and multidisciplinary teams that can offer tailored expertise (chronic health, alcohol and addiction, mental health and allied health) in the most appropriate setting and taking into account the social determinants of health. The organisation of the health and social services sectors into siloed sectors, services and programs, with significant variation depending on where people live, compounds the barriers to timely and appropriate access to care and support.

Governance, coordination and accountability

Australia has an ineffective governance system for mental health, with little accountability for the implementation of agreed policies and strategies. ACEM has previously commented that this is largely due to the failure to assign responsibility to the National Mental Health Commission (NMHC) to fund and implement national plans, the ability to enforce implementation or to hold the Australian Government, states and territories accountable.[14] We are therefore strongly supportive of the recommendation of the Productivity Commission to assign these responsibilities and powers to the NMHC as a statutory authority.

Another significant theme in the Productivity Commission's Report was the difficulty of successfully implementing the proposed recommendations without first addressing unresolved federal and state responsibilities and the lack of focus on service coordination at the regional/statewide level. It is ACEM's view that requiring Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) to form area mental health steering bodies to align, coordinate and monitor care pathways for all people requiring continuing mental health services will be an immensely valuable mechanism to overcome this implementation barrier. ED Directors must be at the table for local health planning and be actively involved in the design and implementation of joint regional planning for integrated mental health and suicide prevention services.

There is currently a lack of accountability and reporting of ED mental health presentations, leading to inadequate action to address preventable ED presentations. ACEM believes the National Mental Health and Suicide Prevention Plan must include targets for EDs, inpatient mental health units and community mental health services. Goals should be benchmarked against measures that have a direct impact on outcomes for people in mental health crisis e.g. fewer presentations to EDs, shorter waits for care, more pathways out of EDs and services funded that have a measurable reduction on people presenting to EDs in mental health crisis. Governments need to commit to accountability for delivery of these goals. Data linkage involving ED and PHN data will help support these measurements and promote efficient and effective use of funding.

The mental health system is inextricably connected with a range of other formal systems including criminal justice, housing, income support, and education and training as well as with multiple informal networks including families, communities, faith groups and non-government organisations. The enormous complexity of this web of relationships presents challenges to service coordination and ACEM members overwhelmingly identify the impact of entrenched systemic problems contributing to clinical management of mental health and substance abuse comorbidities. These include a lack of specialist services including detoxification, rehabilitation and employment-related programs, out-of-hours services, support groups and resources for families. Homelessness is a large contributing factor and there is evidence that services which integrate responses to mental health and substance abuse and address accompanying, complex social needs may achieve better outcomes.[15] As recommended by the Productivity Commission, there is a desperate need to reduce this fragmentation through a new whole-of-government National Mental Health Strategy aligning the efforts of health and non-health sectors.

Workforce

ACEM supports reforms to strengthen the mental health workforce and invest in future workforce development. We endorse the recommendations put forward by the Victorian Royal Commission and Productivity Commission pertaining to the need to upskill non-mental health professionals and develop a national plan to increase the number of psychiatrists and psychologists, particularly outside major cities and in sub-specialities with significant shortages. All healthcare professionals require appropriate skills and

[14] Australasian College for Emergency Medicine (ACEM). Submission to the Productivity Commission inquiry into the role and improving mental health to support economic participation and enhancing productivity and economic growth. ACEM, 2019. Available from: https://www.pc.gov.au/__data/assets/pdf_file/0006/241764/sub516-mental-health.pdf

[15] Flatau P, Conroy E, Clear A & Burns L. The integration of homelessness, mental health and drug and alcohol services in Australia. Australian Housing and Urban Research Institute, 2010.

knowledge to respond to the needs of people with mental illness and enable consumers and their carers to effectively navigate the system. The next National Mental Health and Suicide Prevention Plan must address the roles, skills and training needs of both specialist and non-specialist health professionals. As EDs are often the first point of call for people in crisis, investment in the ED mental health workforce must also be prioritised.

In order to mitigate harms, there is an urgent need to ensure that trauma-informed care, and the skills to implement these practices, are embedded by the specialist and non-specialist services which respond to acute mental health crises. This requires a significant investment in strengthening the cultural competencies of the broad health workforce as a minimum. ACEM agrees with the recommendations of the Victorian Royal Commission and Productivity Commission that peer workers are a valuable and under-utilised part of the mental health workforce and that using these roles more effectively is key to developing a person-centred mental health system. ACEM welcomes opportunities to strengthen the peer workforce and their opportunities throughout the healthcare system, particularly in EDs.

Conclusion

ACEM has long advocated for a health system that offers safe, timely, expert and therapeutic care, regardless of people being physically or mentally unwell. While there is much that emergency physicians and other ED staff can do to improve the experience for people seeking help in a mental health crisis, they cannot do it alone. The problems being experienced in hospitals EDs reflect the failure of Australia's mental health system to adequately respond to the care needs of the population.

Amidst the new and complex mental health challenges predicted to rise during and after the COVID-19 pandemic, action is needed now more than ever to build and sustain a functioning, integrated mental health system across the whole spectrum of care. The Australian Government has an important leadership role to achieve this vision and ensure the recommendations previously put forward by countless commissions, inquiries and committees are translated into genuine action.

Thank you again for the opportunity to provide feedback to this inquiry. If you have any questions or require further information, please do not hesitate to contact Nicola Ballenden, Executive Director of Policy, Research and Partnerships on 03 9320 0444 or Nicola.Ballenden@acem.org.au.

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