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Submission to the New Zealand Government Inquiry into Mental Health and Addiction
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The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide a submission to the New Zealand Government's Inquiry into Mental Health and Addiction (the Inquiry). The Inquiry was established in response to widespread concern about mental health and addiction services in Aotearoa New Zealand.

About ACEM

ACEM is the not-for-profit organisation in New Zealand and Australia 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) are specialist emergency physicians working in emergency departments across New Zealand and Australia. As at 2018, ACEM has accredited 17 emergency departments in New Zealand, which are staffed by 296 FACEMs and 239 emergency medicine trainees.

SUMMARY OF THIS SUBMISSION

ACEM's expertise arises from our knowledge of evidence based care and demand management in emergency departments (EDs), the impact of access block on patient and population health outcomes and best practice in ED models of care, including system and facility requirements.

ACEM is concerned about the inequities in access to timely and appropriate care for people needing mental health and addiction services in New Zealand. In this context, our submission makes four recommendations that aim to;

- make it easier, faster and more affordable to identify when someone is facing mental health or addiction challenges and get them help more quickly,
- improve the quality of the clinical care, support and interventions provided in EDs and the broader health system to those who need it, and
- have these issues addressed in the appropriate environment in a timely and preventative fashion without financial barriers, to help to unburden EDs, particularly after hours.

Drawing on evidence, ACEM supports increased investment in the mental health and addiction sector to minimise time spent in the ED.

[1] Australasian College for Emergency Medicine. *Policy on standard terminology* (P02). Melbourne: ACEM; 2014.

Recommendations

The College makes four recommendations for transforming New Zealand's health system so that it can respond more effectively to the needs of people experiencing mental health and addiction challenges, including people affected by suicide. These are:

1. Increase access to mental health expertise in emergency departments.
2. Increase the range and availability of alternative models of care.
3. Improve ED design to ensure these settings support the wellbeing of patients experiencing acute mental and behavioural conditions, particularly those who are agitated and distressed.
4. Use data to strengthen service planning and integration, clinical care and accountability.

Key Messages

New Zealand's emergency physicians are caring for people with mental health and addiction needs. This population is presenting to EDs for services that would be more efficiently and effectively provided in the community, or as inpatient services.

Major reform is required to strengthen the primary care system. People with mental health and addiction conditions need affordable access to General Practice (GP) services that are integrated with mental health and addiction assessment and early interventions, close to where they live.

ACEM data[2] shows that people needing mental health and addiction care comprise less than four per cent of ED presentations, but make up 25 per cent of those experiencing access block, which is when people have been admitted for care but forced to wait in the ED for more than eight hours.

Mental health patients wait longer than other patient to get treatment, putting their lives and future health at risk. Long waits in the ED are associated with excess morbidity and mortality and exacerbation of patient harm.

Access block is an indicator of system failures across primary and acute health services. It highlights the inequities in access to appropriate and timely care, and the discrimination that people with mental health and addiction issues routinely experience under current arrangements. Access block also highlights the diversion of ED teams' time, expertise and space to monitoring and caring for patients who would be better served in other parts of the health system.

Recommendation One

Increase access to 24 hour mental health expertise in emergency departments.

Discussion

- Data clearly show the co-occurrence of mental health and addiction in the New Zealand population, as well as the higher incidence in Māori, Pacific Islander and prison populations. The Mental Health Commissioner reports that one in five New Zealanders live with mental health and addiction in any one year, with this rate rising to one in three Maori, one in four

[2] Australasian College for Emergency Medicine, *Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions*, February 2018, Melbourne, p4

Pacific Peoples and two in three people in prison.[3] Combined with physical health issues, this population is in need of greater access to prevention and comprehensive early intervention services.

- EDs are open at all times to respond to all manner of acute presentations. Ministry of Health data for 2014/15 shows that a third of presentations occurred on the weekend.[4]
- Many people needing mental health and addiction services present to EDs in crisis because of the challenges in accessing affordable, appropriate and timely services in the community. These challenges are well described in the People's Mental Health Report.[5]
- Systemic access block is experienced by mental health patients waiting in New Zealand's EDs for admission to an inpatient hospital bed. ACEM's snapshot survey at seven of the country's ED found that although only four per cent of ED inpatients present with mental health issues, they make up 25 per cent of the patients experiencing access block.[6]
- Rural areas are worst affected. Many EDs do not have dedicated mental health staff on site, meaning long transfers to centres with mental health and addiction services, or long delays while they wait for staff to come to them.
- Waits of more than eight hours lead to increased likelihood of psychological distress among patients with mental health presentations, often resulting in a cascade of interventions to manage behavioural disturbances. These include physical and chemical restraint in EDs and containment in safe assessment rooms.
- The system needs improved access to inpatient specialist mental health services. Clinical staff trained in mental health assessment must be present at the times patients with mental health and addiction issues present to EDs, which disproportionately occurs on evenings and weekends.
- Increased access to psychiatric consultation liaison services should be developed based on minimum standards for large, medium and rural EDs across the 24 hours that emergency departments operate. The health system needs increased service infrastructure and workforce to meet the requirements of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.
- The role of consultant liaison psychiatrists should be supported to include training to other front-line professionals and particularly GPs. Telehealth support services could be investigated as part of the solution for rural and remote settings.
- Increasing the multidisciplinary nature of the workforce to encompass psychiatrists, psychologists, mental health nurses, auxiliary staff and peer workers would strengthen ED capacity to offer timely and appropriate mental health and addiction services.

Recommendation Two

Increase the range and availability of alternative models of care.

Discussion

[3] Health and Disability Commissioner, *New Zealand's mental health and addiction services The Monitoring and advocacy report of the Mental Health Commissioner* February 2018, p79
[4] Ministry of Health*, Emergency department use in 2014/15,* report released 2016, p24
[5] Action Station Aoteraroa, *People's mental health report, A crowdfunded, crowdsourced story based report*, Wellington, 2017
[6] Australasian College for Emergency Medicine *Waiting Times in the Emergency Department*, opcit

- Reforms to the mental health and addiction sector needs to include after-hours mental health support models, options for next day services and mechanisms for care pathways to support communication and coordination across community and acute services.
- Improved access to community based, comprehensive and affordable prevention and intensive early intervention services can relieve the pressures on EDs to manage presentations for crisis care, including responding to people who are suicidal.
- Research shows that adults with mental health disorders are more likely to access primary healthcare services, to experience greater levels of unmet need for these services and higher levels of dissatisfaction with the primary care services they receive[7]
- Primary Health Organisations provide the platform for universal access to comprehensive primary health care and should be funded to develop and deliver targeted multi-disciplinary GP, mental health and addiction programs and services that are responsive to local need. InnerSpace and Health Works are two models, based in Melbourne Australia, of wrap around services for people using drugs and their families[8].
- Members of ACEM report people presenting to EDs because of homelessness. There is also a cohort of frequent presenters who would benefit from intensive wrap around support services. Programs such as school based mental health nurses and prison based mental health and addiction services should be more universally available. More training for GPs in mental health assessment, and affordable access to therapeutic counselling, would reduce demand for crisis interventions in the ED.
- Inequities in health outcomes reflect poor access to services and programs that support the social determinants of health. A report commissioned by the RANZCP on affordability issues found that the relatively high cost is a barrier to accessing GP services, particularly for an initial diagnosis. A likely consequence of this is a lack of early diagnosis and treatment, leading to more serious, but preventable, conditions[9].
- Exacerbating the cost issues in New Zealand are workforce shortages, particularly for GPs and psychiatrists. This shortage is likely to result in an undersupply of providers, particularly in disadvantaged or remote areas. Co-payments and shortages of GPs are barriers to timely, affordable care.
- Strengthening the mental health and addiction sector needs to include targeted strategies for populations who experience the greatest inequities in access and health outcomes. Demand is increasing for specialist adolescent and youth mental health and addiction services. Ministry of Health data shows that the suicide rate among Māori men (across all age groups) is around 1.4 times that of the non-Māori-population.[10] In the development of services and models of care, Te Ao Maori should be prioritized at all levels and Māori service providers funded to meet the needs of their local community.

[7] Lockett et al Primary healthcare utilisation among adults with mood and anxiety disorders: an analysis of the New Zealand Health Survey, *Journal of Primary Health Care,* Vol 10, No. 1, March 2018, p68

[8] For models of community based, comprehensive GP, mental health, drug and alcohol and other allied health services see https://www.cohealth.org.au/locations/innerspace/ and https://www.cohealth.org.au/locations/healthworks/ .

[9] Royal Australian and New Zealand College of Psychiatrists K*eeping Body and Mind Together Improving the physical health and life expectancy of people with serious mental illness,* 2015, p 17

[10] See https://www.health.govt.nz/publication/suicide-facts-2014-data

ACEM is committed to equity for Māori patients, their whānau and staff in EDs. The College is about to begin work on a Māori Health Strategy, with our commitments including:

1. encouraging Māori doctors to take up emergency medicine as their specialty of choice,
2. increasing the cultural competency of New Zealand Fellows and emergency medicine trainees, and
3. providing culturally appropriate education and training on Māori health in accredited vocational and non-specialist training pathways, and in continuing professional development programs. This education and training includes improving the skills, knowledge and cultural competency of emergency physicians as a mechanism for improving patient outcomes.

Recommendation Three

Improve emergency department design to support the wellbeing of patients experiencing acute mental and behavioural conditions, particularly those who are agitated and distressed.

Discussion

- People with acute mental and behavioural conditions are among the most vulnerable people presenting to EDs. This busy environment, including being surrounded by people who are stressed and in pain, is not an appropriate therapeutic setting for people with mental health and behavioural disturbances.
- EDs are not necessarily safe and secure for the detainment of distressed and agitated mental health patients. This, along with delays in assessment, can result in patients leaving the ED prior to assessment in a worse state than when they arrived.
- ACEM's 2016 Alcohol Harm Snapshot Survey, taken at 2:00 am Saturday 17 December, found that one in four patients in New Zealand's EDs were there as a result of harmful alcohol use. This burden has a detrimental effect on the health and wellbeing of clinical staff, as well as other patients and the functioning of the ED[11].
- Often, agitation and other symptoms will be exacerbated by over-stimulation and long waits for referral to an appropriate service. Aggressive and violent patients can require a significant commitment of resources to keep staff and patients safe. Previous research by ACEM found that:
    - 98% of emergency department clinical staff have experienced verbal aggression from an alcohol-affected patient and
    - 92% of emergency department clinical staff have experienced physical aggression from an alcohol-affected patient[12].

We note the allocation of funding to District Health Board's in the 2018 budget for facility upgrades. The College would welcome the prioritisation of capital works to create a more therapeutic environment for people affected by mental health and addiction conditions.

[11] Egerton-Warburton D, et al, Public health in Australasian emergency departments: Attitudes, barriers and current practice. *Emergency Medicine Australasia*, 2015 Vol. 27, No. 6 pp522-8

[12] Egerton-Warburton D, et al. Survey of alcohol-related presentations to Australasian emergency departments, *Medical Journal of Australia*, 2014; Vol. 201, pp584-587

Recommendation Four

Use data and mandatory reporting against targets to strengthen service planning and integration, clinical care and accountability.

Discussion

- ACEM's research has clearly described the increased volume of presentations to EDs related to mental illness and the way that inefficiencies in the health system drive access block. This research informs our advocacy for increased mental health capacity in the acute and community sectors across New Zealand and Australia. We are planning a summit about mental health in the ED with key stakeholders, to be held in Melbourne in October 2018. A similar forum will explore mental health issues in the ED in the New Zealand context.
- There is a need for standardized national data sets to inform funding and planning for health care delivery, including mental health and addiction related care, and coordinated, longitudinal reporting. Improved data and analysis would strengthen decisions about priorities for demand management and opportunities for strengthened care. Australian Bureau of Statistics and the Australian Institute for Health and Welfare[13] provide models for consideration.
- Consistent measurement against clinical and patient defined outcomes and experiences of EDs, primary care and psychiatry services would help drive improvements across New Zealand. Implementation should consider inclusion in the National Non-Admitted Patient Collection of SNOMED CT® codes for all chief complaints, procedures and diagnoses, in this instance specific to mental health issues, and increased government investment to support this transition.
- ACEM supports introduction of a mandatory reporting measure for patients with mental health presentations who experience ED lengths of stay of 12 hours or more. In Victoria, key performance indicators (KPI) were introduced more than a decade ago to focus health services on the number of patients with extended lengths of stay in EDs. The state-wide benchmark for the *number of patients with a length of stay in the emergency department greater than 24 hours* is zero patients.[14] Failure to achieve the KPI is a performance breach, requiring immediate escalation to the Department of Health and Human Services. The number of patients experiencing lengths of stay of more than 24 hours has reduced over time.[15] ACEM's most recent survey of access block found that Victoria was the only state or territory in Australia to not have any patients waiting in the ED for 24 hours or more[16].

[13] See *Mental health services in Australia*, available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/data and the ABS catalogue of reports on health, available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/ViewContent?readform&view=productsbyCatalogue&Action=Expand&Num=4.3

[14] 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.

[15] 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.

[16] ACEM, *2017-2 Access Block Point Prevalence Survey Summary*, available from: https://acem.org.au/getmedia/ea1d5fa4-12ab-4680-8ab6-546276144ab0/Access-Block-28-Sept.aspx, p2

Opportunity to Present to the Inquiry

Thank you for the opportunity to provide a submission to the New Zealand Government on the Inquiry into Mental Health and Addiction. We would welcome the opportunity to provide further information to the Inquiry on the issues described in this submission. Please do not hesitate to contact the ACEM Policy and Advocacy Manager Helena Maher on (03) 9320 0444 or via email at helena.maher@acem.org.au.

Yours sincerely,

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