Australasian College
for Emergency Medicine

34 Jeffcott Street West Melbourne Victoria 3003, Australia
+61 3 9320 0444 | admin@acem.org.au | ABN 76 009 090 715

Productivity Commission

Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth

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Executive Summary

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide this submission to the Productivity Commission's Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

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 the highest standards of medical care are provided for all patients presenting to an emergency department.

In 2016-17 there were over 275,000 mental health presentations to Australian emergency departments (EDs). Australian Institute for Health and Welfare data shows the social and medical complexity within these presentations. People suffering mental illness – often in combination with drug and alcohol dependence, chronic physical ill health or disability, insecure housing or homelessness – come to EDs seeking safety and support that is not available or affordable elsewhere.

People presenting to an ED in mental health crisis have the right to timely access to appropriate care, regardless of the time of day, day of the week or where they live. The break-down in Australia's mental health system is evidenced by not just the high numbers of mental health presentations to EDs, but the long wait for access to mental health care. All Australian governments have committed to a national emergency access target (NEAT) of four hours, but AIHW data shows that mental health patients are twice as likely as other patients to stay in an ED longer than eight hours and are almost exclusively represented in patients staying more than 24 hours. Patient safety requires transfer to specialist inpatient care within eight hours of being assessed for admission, but ACEM research shows regular instances of patients spending three or more days in EDs.

These long waits are harmful for patients, inefficient and costly to health budget, and deeply frustrating for emergency physicians. Our expectation is that mental health should be treated with the same quality of care provided to other patients presenting to an ED, but the reality across Australia is that people in mental health crisis are caught between an over-stretched public hospital system with too few mental health beds and an under-resourced community mental health sector with scant after-hours availability. In chaotic and noisy EDs, it is no surprise that people presenting in mental health crisis are the group most likely to leave the ED prior to treatment, or for agitation to escalate into aggression and/or violence that requires the use of sedation, seclusion or restraint. Emergency physicians are profoundly frustrated and demoralised by trying to providing safe, quality care for people in this environment.

These outcomes are the result of many years of ad-hoc investment in programs and services, without an effective plan for building public health capacity commensurate with mental health need. It is time that

Australian Governments agreed on a unifying vision for an integrated service system that offers timely access to affordable comprehensive multi-disciplinary mental health care, underpinned by strategy and measurable outcomes that all levels of government are held accountable to.

Recommendations

ACEM urges all Australian Governments to commit to reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community. These reforms would include the following priority actions:

1. New models of patient-centred care need to be developed that measurably improve the experience and outcomes of people who need acute mental health care. These models should be developed in consultation with key stakeholders, particularly people living with mental health conditions and their advocates.
2. Agreement is urgently needed on reforms to ensure mental health care is available in the community and from specialist services where and when required, to relieve reliance on EDs. A study comparing the cost of delivering mental health care in different settings would strength decisions on these reforms.
3. New, as well as existing, service models such as HeadSpace should be required to offer access to care outside of business hours.
4. A role should be explored for peer workers who have lived expertise of mental illness in improving the experience of people using EDs in a mental health crisis.
5. Funders need to work with community-led agencies to agree on mental health care strategies to measurably improve outcomes for populations over-represented in presentations to EDs, beginning with Aboriginal and Torres Strait Islander people.
6. Measures to improve mental health resourcing, capacity and integration across EDs, the community and inpatient facilities need to be implemented, and their impact on crisis presentations to EDs and patient-reported outcomes monitored. This would include increasing the number of mental health beds to at least the OECD average.
7. The Primary Health Networks' commissioning framework for mental health needs to prioritise community-based care that is responsive to acute need in children, adolescents and adults, with performance measures linked to reduced ED presentations.
8. Where EDs are required to manage mental health presentations, models of care need to be developed that include appropriately designed facilities, trained staff and the resources to support early and effective interventions, avoiding long delays before reaching definitive points of ongoing mental health care.
9. When psychiatric admission is required, processes need to be timely and streamlined so that acutely unwell people can access an appropriate inpatient bed any time of day or any day of the week.
10. Services that respond to homelessness, family violence and drug and alcohol use should be available to patients and their ED clinician when required, to reduce the occurrence of repeat presentations.
11. Audits of restrictive practices (sedation, seclusion and restraint) in the ED are needed to identify and monitor the impact on patient outcomes and the relationship to the availability and accessibility of acute or community based services and supports.
12. State and territory health departments should adopt a maximum 12 hour length of stay (LOS) in the ED and ensure accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED. The 12 hour policy should include mandatory notification and review of all cases and be embedded in key performance indicators of public hospital CEOs.
13. All episodes of a 24 hour LOS in an ED should be reported to the Health Minister regularly, along with any CEO interventions and mechanisms for incident review.
14. The next National Mental Health Plan is the opportunity to benchmark the Plan's goals against measures of timely access to intensive, early intervention services, care coordination across services

and sectors, crisis presentations to EDs and patient reported outcomes and experiences. Governments need to commit to accountability for delivery of these goals.

Background information to these recommendations

1. Pressures on emergency departments

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. Due to the twin pressures of increasing demand and failure to provide adequate care in the community, 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.

1.1 Equity of access

The current system for mental health services and social support is failing to meet the needs of the most vulnerable people in our community. Our members see that people presenting to EDs in mental health crisis are often economically disadvantaged, socially marginalised and dependent on the public health system. They are the population most in need of long term therapeutic support but with the least access under a user-pays system. This, combined with the severely limited availability of long term counselling in the public health system for complex psychological trauma, highlights the real lack of any choices for people with mental illness who do not have health insurance or disposable income.

Our members report that people with chronic, acute or deteriorating mental health conditions – including psychotic illnesses – who present with drug and alcohol use, chronic physical health issues including disabilities, and/or social issues such as insecure housing and homelessness, are increasingly common in EDs. This is also the population over-represented in police, prison and child protection systems, reflecting the failure of governments to improve community services as promised when mental health institutions were closed.

Australia's public mental health system needs the capacity to manage people who are mentally unwell as well as socially and medically complex. Significant investment and innovation is needed to develop crisis prevention programs and intensive and ongoing care for populations otherwise at high risk of poorly treated mental health conditions. These populations include homeless people, people with substance dependence, people from culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, people with disabilities and people living outside the major urban centres.

ACEM supports the right of all Australians, regardless of their culture, age or where they live, to access timely and appropriate mental health care free from stigma and discrimination. The 2018 National Healthcare Agreement affirms the principle of universal access to health care. All Australian Governments commit to provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country. Instead, thousands of Australians with serious and complex mental health needs receive little or no support.

Australians need a health system that ensures access to mental health care in the community or from specialist inpatient services where and when required. EDs will always have an important contribution to delivering mental health care but they should be one of many doors into an affordable, high quality, high capacity, evidence-based mental health care system. A functioning service system would see mental health presentations to EDs reduce to the point where EDs are accessed only as a last resort.

1.2 Mental health access block

Access block is the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED because of lack of inpatient bed capacity. Access block results in longer inpatient stays, increased adverse events and an increased likelihood of dying in hospital. All patient groups are affected by access block, but the problems are particularly severe for those who have mental health needs.

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 report on mental health services in Australia shows that in 2016–17 the total of 7,175 public mental health beds was less than it was in 1993–94, when there were 7,606 mental health beds (see table 15 Specialised mental health care facilities report). 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.

The resulting impact for patients presenting to the ED is clear in the data from ACEM's recent reports on mental health access block. In December 2017, ACEM conducted a snapshot survey of the prevalence of mental health access block, with 65 Australian EDs reporting on the number of patient presentations for acute mental and behavioural conditions at a point in time. This snapshot showed that:

- While only 4% of presentations were for mental health, this group comprised 19% of patients waiting for inpatient beds and 28% of those experiencing access block.
- The rate of access block varied from state to state, and was much higher in Western Australia (66.7%) than the national average.
- Two thirds of EDs had patients waiting in the ED longer than 24 hours, with 23% of respondents reporting waits of longer than 72 hours.
- The maximum length of stay for an ED patient with a mental health presentation was 145 hours, or six days.

In October 2018, ACEM published The Long Wait, an analysis of AIHW data on mental health presentations to Australian emergency departments. This report showed that people needing urgent mental health care:

- were 16 times more likely than people with other medical conditions to arrive at ED via police or other non-health-services vehicles, and nearly twice as likely to arrive via ambulance or helicopter rescue.
- were more likely to identify as Aboriginal and Torres Strait Islander than other medical patients.
- waited longer than other patients with a similar severity of physical illness before they were assessed and treated.
- were much more likely to stay longer than eight hours and regularly stayed more than 24 hours while waiting for a bed.
- were more likely to leave the ED at their own risk than other patients, prior to their treatment being completed and against medical advice.
- presented at higher rates to EDs in remote and regional hospitals compared with major cities.

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. These outcomes are avoided in hospitals that offer timely access to specialised mental health staff and beds.

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 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.

It would be useful for the Productivity Commission to conduct a study comparing the cost of care for mental health across community, emergency department and acute mental health settings, to inform policy and funding reforms.

2. Strategic failures in funding and governance

The failures of Australia's mental health system reflect systemic problems with the funding and governance of the health system that are a barrier to innovation, responsiveness to changing demand and the translation of evidence into effective models of care. These issues need to be addressed in order to improve the capacity of the health system to meet the community's growing need for mental health care.

2.1 Disparities in demand and expenditure

The most recent National Health Survey (2017–18) reported that 4.8 million (or one in five) Australians are currently living with mental health conditions. This is a significant increase from the findings of previous surveys, representing a 20% increase from 2014-15. Over the past decade expenditure on public mental health care has not kept pace with these increases in the number of people living with mental illness and the impact on demand for mental health services.

Current funding arrangements are well summarised in the Productivity Commission's Issues Paper. ACEM highlights the following examples of increases in demand and the disparity with increases in expenditure.

In the decade prior to 2016–17 the number of patients receiving Medicare-subsidised mental health services doubled from 1.2 million (or 5.7% of the population) to 2.4 million (9.8%). Public and private hospitals have experienced a similar increase in demand, with the overall rate of overnight mental health-related visits increasing by an average of 3.9% in each of the five years to 2016–17, a rate four times higher than non-psychiatric admissions.

Total spending on mental health by governments has increased over this 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 2016-17 (see table 12, AIHW 2019). 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. Note that in 2014-15, mental health received around 5.25% of the overall health budget while representing 12% of the total burden of disease.

The results of these funding arrangements are 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. As a result, people who are often economically disadvantaged, socially marginalised and dependent on the public health system come to EDs for mental health care, especially out of hours, and experience long waits in EDs for access to an inpatient bed that are harmful to their health outcomes and an inefficient use of scarce hospital resources.

2.2 Policy support for equity of access

While many of the problems with the delivery of mental health care can be addressed within the context of the health system, there are underlying drivers of demand that need to be considered in the wider societal context. These include the growing inequality in our communities between the most and least advantaged and the inequity of current funding arrangements, resulting in a widening gap between access to care for the most privileged and most disadvantaged.

In all areas of health care, those who are wealthy and insured have better access to care and a greater choice of services. However, the impact of this differential access is most acute in people with mental illnesses, due to the compounding impact of other factors, such as employment, drug and alcohol addiction, homelessness and social dislocation. Caught in a vicious cycle, mental health problems make it harder for people to maintain employment and housing, and to access the care and services they need to maintain their health and wellbeing, with the consequent instability resulting in mental health problems deteriorating to a point of crisis.

2.3 Impact of the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is an important and overdue initiative to improve the quality of life for people with a disability, but its implementation has been a major challenge for the mental health sector. In Victoria, Mental Health Victoria's analysis has shown that only a small proportion of the estimated 150,000 people experiencing severe mental illness each year will be eligible for the NDIS. Funding has been transferred from a model of community mental health that offered psychosocial support as well as recovery services, to NDIS. This has resulted in the loss of mental health services and created new gaps in service coverage. This loss of access to mental health care is occurring at the same time that figures released in the 2019 Federal Budget show a significant underspend on the NDIS.

2.4 Outdated funding mechanisms

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.

Health care funding reinforces current health care structures and practices. 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 rarely sensitive to changes in demand or evidence-based practice. This results in people accessing services, such as Medicare-funded GP care and 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.

Central to Australia's universal health system is Medicare, which was designed to support face-to-face episodic care. Medicare funding depends on the availability of medical providers without having a mechanism for ensuring their equitable distribution. This reinforces the inverse care law, whereby regions and populations with the greatest health care need are under-served by health services and medical specialists. Governments have not developed Medicare to incentivise innovation and support the efficient translation of new clinical evidence into appropriate models of care.

Ineffective models of care compound the problems of under-funding and lack of capacity at all levels. Current payment systems based on activity mitigate against integrated 'patient pathways' that offer step-up and step-down to appropriate levels of treatment and support, depending on the severity of the patient's health needs. This is particularly the case in primary care, where GPs need to be incentivised to offer a centralised planning and service coordinating function for their patients that includes monitoring of health status.

There is an urgent for 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.

2.5 National mental health planning

Australia has an ineffective governance system for mental health, with little accountability for the implementation of agreed policies and strategies. Australia is currently implementing its fifth National Mental Health and Suicide Prevention Plan since 1992. Overseeing the development of these plans (since 2012) is a National Mental Health Commission (NHMC) that complements the roles of the state-based commissions in Western Australia, Queensland and New South Wales. The NHMC also has responsibility for coordinating national mental health policy and undertaking annual monitoring of system performance. This governance system has influenced some major policy changes, such as de-institutionalisation, but has failed to ensure a coordinated and integrated system of mental health care that both consumers and providers can rely on. A major reason for this is that NHMC does not have responsibility for the funding and implementation of national plans, the ability to enforce implementation or to hold the Australian Government, states and territories accountable.

Compounding these weaknesses in the oversight and strategic development of the service system is the limited engagement of consumers and their advocates in defining standards of mental health care and in measuring experiences of and outcomes from care.

3. Mental Health in the Emergency Department Summit

To stimulate the debate about solutions to these issues, in 2018 ACEM held a Mental Health in the Emergency Department Summit. The summit was attended by over 170 delegates, representing emergency doctors, psychiatrists, consumers, clinicians and key decision makers, who were unanimous in their view that current arrangements for people in mental health crisis are untenable.

Delegates noted the data demonstrating the poor experiences of mental health patients and discussed the needs of these patients when they were in crisis. People with lived experience of seeking assistance spoke of crowding, noise, distress, long waiting times and the high use of restraint and seclusion. The delegates shared experiences of good models of care, innovations in service delivery and structures that addressed the core elements needed to improve emergency care for people in mental health crisis. Stories from EDs highlighted the importance of social support, of services being available when needed, and the beneficial impact of respectful, culturally appropriate and compassionate responses to people in mental health crisis. The Summit discussed options for where to invest – including in resources, people, culture and support – both inside and outside of the emergency department. (Videos of presentations and panel discussions from the Summit are available here.)

Delegates called for health ministers to intervene to ensure equity of access to mental health care, starting with a mandatory reporting regime based on zero tolerance of ED stays longer than 24 hours. They were unanimous in their support for policy reform to the current arrangements so that the mental health system offers adequate and appropriate resourcing in EDs and pathways from the ED to access comprehensive and integrated community and inpatient care. (The Communique from the Summit is available here.)

The Summit highlighted the immediate need for more after-hours services, for greater investment in community-based care, and for more options for safe, short term admissions that offer safe and specialist care for people who are in crisis, behaviourally disturbed or drug-affected. The Summit provided a forum for exploring models of care that value peer workers as part of the care team, that integrate mental health support into emergency services, that offer extended hours mental health liaison services, or proactive health and housing support, or where emergency doctors work alongside mental health and addiction experts in a dedicated, quiet and safe space.

These findings have been translated into seven principles for reform of the Australian mental health system as set out in the Mental Health in the Emergency Department Consensus Statement, and form the basis for ACEM's 14 recommendations to the productivity commission.

4. Multidisciplinary models for acute mental health care

While there are many challenges involved in reforming Australian's mental health system, ACEM notes the following range of models of mental health care that engage with emergency departments and are designed to offer 24 hour access to an affordable, comprehensive, integrated and multidisciplinary service.

4.1 The Psychiatric Alcohol and Non-prescription Drugs Assessment (PANDA) Unit

St Vincent's Hospital, Sydney, has created a six bed ward close to the Emergency Department, where patients can be admitted for safe observation, management and nursing. It provides a model of concurrent management of acute mental health crisis with co-existent medical problems, where patients can be managed medically in a safe setting until medically fit for mental health review. The PANDA unit has been developed in response to the high proportion of people with mental health illness and regular drug and alcohol users presenting to the ED. Data suggests around 15% of the patient presentations to the ED involve mental illness and/or the effects of drug use. The PANDA model is a 7 day a week, 24 hour a day service, managed by a combination of clinical pharmacology and drug and alcohol teams in close collaboration with the Emergency Department and the Mental Health Service.

4.2 Mental health and addiction in the emergency department

The Alfred Hospital, Melbourne, has established an integrated approach to the delivery of mental health and addiction services in the emergency department. The Alfred's emergency psychiatry is part of the Alfred Mental Health Service, is available 24 hours a day, 7 days a week and works in the Alfred Emergency Department, seeing patients who are displaying mental health difficulties or where mental ill-health is contributing to their presentation. The multidisciplinary team is made up of specialist mental health nurses, nurse practitioners, social workers, occupational therapists, clinical psychologists and neuropsychologists, and psychiatrists and trainee psychiatrists. The Alfred's emergency psychiatry service also has a team of mental health clinicians who work with the Victoria Police, responding to 000 calls where mental health issues may be involved.

4.3 Other innovations in mental health care

- The Mental Health Observation Area in Joondalup Health Campus, Perth, Western Australia, is a co-located area with interview rooms and overnight beds that has taken mental health patients out of the main ED, 'bringing the ED back under control'. Victoria is in the process of rolling out its version of the MHOA – the ED Crisis Hub.
- Royal Perth Hospital has a Homeless Team to address one of the biggest drivers for re-presentations to the ED – **discharging a patient into homelessness**. The team offers an outreach service that provides patients with follow-up care and support in the community, so those who remain homeless can still access health care.
- Royal Prince Alfred Hospital, Sydney, has successfully trialled a **nurse practitioner-led, extended hours, mental health liaison nurse** (MHLN) service based in the ED. The MHLN team see mental health presentations and begin the process for coordinating care. This has been shown to provide prompt and effective access to specialised mental health care for people with 'undifferentiated health problems', and remove a significant workload from nursing and medical staff.
- The Queensland Mental Health Intervention Project is a partnership between the Queensland police, health and ambulance services where **mental health clinicians work alongside police** to better manage crisis situations involving people with a mental illness, staff are supported with **training in de-escalation strategies** and **regional coordinators** work to identify issues, discuss complex cases,

develop preventative interventions (such as pre-crisis plans) and identify alternative referral pathways and review procedures.

- St Vincent's Hospital in Melbourne has a **peer worker employed in the ED** and a safe haven café, physically close to the ED. The café offers respite in a warm, caring and respectful environment to people needing mental health support as well as social connection, but not necessarily acute care. The model was developed by and for consumers.

These models provide the basis for developing an evidence based, system-wide vision for improving the care of people with mental health presentations in hospital EDs. Further details including interviews and presentations about these models are available here.

Conclusion

People with mental illnesses deserve access to high quality care at all times of the day and night and in all regions of Australia. 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.

ACEM believes that EDs should be a safe and supportive environment for people seeking help for mental health problems. The models of care used in EDs should draw on contemporary clinical practice for managing emergency mental health care. This requires the appropriate mix of staffing, resourcing and facilities to ensure timely and effective interventions, avoiding long delays to definitive ongoing mental health care.

To achieve this outcome, ACEM believes that all mental health stakeholders need to work together to build and sustain a functioning, integrated mental health system that supports the prevention, early intervention and better management of mental health needs for children, adolescents and adults including older adults. People with a lived experience of mental illness are central to the redesign of mental health policy and services.

ACEM understands that many of the underlying causes of these problems will take time and ongoing efforts to address. We have highlighted a number of short-term strategies that could build on successful models of care throughout Australia to immediately improve the care of people with mental illnesses. These reforms provide the basis for developing broader policies and programs that deliver the improvements required to genuinely meet the needs of people with mental health conditions and thereby improve both their well-being and productivity.

Thank you for your consideration of these issues in the course of your inquiry. Please do not hesitate to contact the Executive Director, Policy and Strategic Partnerships, or Manager of Policy and Advocacy if you require further information.

Yours sincerely

Dr Simon Judkins
President
Australasian College for Emergency Medicine
president@acem.org.au