Submission
No 19

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Name: Name suppressed

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Partially
Confidential

Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

Addressing the terms of reference – Portfolio Committee No. 2 – Health

a. equity of access outpatient mental health services

Working in a regional emergency department at Maitland Hospital (MHED) there has been an increase in mental health activity within this setting.

Two reporting periods identified a significant increase in mental health presentations over this period.

Statistical evidence for reporting periods of July – December 2021 identified 887 mental health presentations compared to July to December 2022 period of 1229. An increase of 38.5% over the respective period. It is important to note that COVID 19 had a significant impact on ED activity levels over this period. Telehealth interventions were also promoted during the peak of the pandemic (2021) with increase in presentations in the 2022 period being the residual lock down effect of the pandemic.

Data collection period of Jan-Jun 2022 = 1159 mental health presentations compared to Jan-Jun 2023 of: 1288. This has seen an increase of 11% over this period.

Presentations to ED are potentially due to:

- The reduced access to Medicare funded GP appointment rebates with presenting concerns around cost to access GP care
- Lack of mental health community based interventions through mental health care plan initiative
- Limited specialist community mental health and NDIS related interventions being directed to ED setting for non-emergency interventions (unable to manage a person's mental health needs).
- Emergency services who are contacted through the 000 portal have limited access to alternative care pathways leading to ED attendance for mild to moderate mental health issues

Rural and remote areas are disproportionately affected by a lack of access to outpatient mental health services effectively relying on telehealth interventions (Craythorn & O'Sullivan (2023).

b. navigation of outpatient and community mental health services from the perspectives of patients and carers

GPs have limited understanding around referring into mental health services. This often sees GPs directing consumers to the ED setting for non urgent mental health concerns. This often sets up unrealistic expectations with consumers and carers often frustrated when needing to face lengthy weight times. ED has become the default referral centre for those needing urgent but non acute mental health concerns. A recent change in service delivery from this ED identified community based clinicians being redirected back to their community hub thereby increasing response times for those who need a specialist mental health intervention. Often consumers and their carers do not know where there care provider is located with poor communication identified from service providers.

c. Capacity of State and other community mental health services, including in rural, regional and remote New South Wales.

Community based mental health services, private and public are either non existent, at capacity or unable to respond to increases in demand. This often leads to local EDs being the only place for people to access (Duggan et al, 2021).

d. integration between physical and mental health services, and between mental health services and providers

There is often poor interface between primary health care and secondary services increasing the risk of a person needing to attend ED for general health needs. The lack of access to GPs and other primary health services including those that can effectively respond to and address the social determinants of health.

e. appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

Mental health nurses who are credentialed through the Australian College of Mental Health Nurse are currently denied appropriate levels of Medicare billing compared to allied health practitioners. This resource is being underutilised thereby reducing the capacity of services to provide timely access and promote a holistic, relational based model of care. Access to other community based specialist services such as Psychiatrists remains limited with telehealth interventions promoted through metropolitan facilities. This can cause issues for the consumer as often this clinician is not available during times of urgent need and/or directs the person to the local ED for mental health assessment, inpatient care or medication purposes. Often the presenting person does not meet the criteria for inpatient care and is discharged accordingly with pathways identified and consistent with universal referral process eg: mental health line.

F. the use of Community Treatment Orders under the Mental Health Act 2007

CTOs continue to be a form of restrictive practice and at times of breach then present to ED. The local community mental health service has been instrumental in reducing the impact on ED with proactive care utilising resource allocation following relocation of mental health clinicians back to community hub (O'Sullivan, 2022).

G. benefits and risks of online and telehealth service

Whilst telehealth remains an alternative care pathway consumers report that they prefer access to a face to face intervention. Telehealth is limited for those who present to rural EDs as they are not deemed to be designated facilities and will not provide an assessment when someone is under the mental health act. This often leads to extended travel times taking ambulance or police off the road to transport to a designated facility. Services such as health direct are limited in their advice and referral streams with hospital EDs identified as a first line intervention.

h. accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

Regional and rural EDs do not have access to First Nations staff, or CALD service provision. In the local area Aboriginal Medical Services do a great job in assisting their people to access mental health care within their facility.

People presenting and identifying as LGBTQIA+ are provided with available care and attempts to link in with appropriate services facilitated. In the nearby metropolitan area there are services set up to assist this cohort with evidence based interventions provided (psychological and medical).

Young people are provided with age appropriate space with links into the community mental health services a key partner when discharging from ED. Inpatient facilities for those who need a medical intervention eg. overdose of medication, are limited in when and how they will accommodate this cohort. Schools and social media access is a main precipitating factor for mental health concerns eg: suicidal expression. Schools need to be better resourced to interact with families who are experiencing a mental health crisis but do not need to present to a busy ED.

i. alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

Mental health first responders program has been rolled out in the local upper and Hunter Valley region. To date this intervention has not shown to reduce ED presentation rates with commencement of this program starting in January 2023. There are nil services who will assist with acute intoxication with drug health services limited in their follow up and intervention. Aged care facilities are under resourced to effectively respond to those experiencing psychotic symptoms in line with delirium or dementia

(j) any other related matter – there is a need to act on providing community based mental health interventions leaving the ED for those who need a life threatening intervention (eg: medication overdose, suicidal related injury) and access to mental health inpatient care facilitated by the community team when needed. This has been trialled in author's local area with good results however community mental health hubs, urgent care centres, safe haven café and peer related interventions need to be installed in regional and rural areas so that there are alternatives to ED.

The author's workplace a mental health nurse practitioner is embedded in the ED space enabling timely, specialist intervention as needed. A mental health nurse practitioner role/s or Clinical Nurse Consultant role fully embedded – operationalised and clinically governed by the ED has been implemented in the author's ED workplace with nil adverse events or SAC1 or 2 incidents reported (Wand et al, 2021).