Submission No 149

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

Organisation: Australian Paramedics Association (NSW)

Date Received: 25 September 2023

---

apansw.com.au

APA (NSW) Submission for the Inquiry into Equity, accessibility and appropriate delivery of outpatient and community mental health care

Australian Paramedics Association (NSW)

Contents

Introduction....3
The right care at the right time....5
Introduction....5
Access to primary healthcare....6
Appropriateness of Emergency Departments for Mental Healthcare....7
The role of Ambulance in mental healthcare....8
Adequate referral pathways and investment in community mental health....9
Equity of access across the regions....11
Paramedic Experiences....12
Introduction....12
Safety Issues....13
Fatigue....14
Compassion Fatigue....16
Moral Injury....17
Lack of Training and Support....17
Alternative models for provision of mental healthcare by Ambulance and NSW Health....21
MHAAT....22
MHAAP....29
Telehealth models....31
Telehealth programs for patients and first responders in out of hospital environments....31
Mental Health First Responder Program....31
Mobile MHEC....33
Telehealth programs for patients in hospitals and other facilities....34
NMHEC-RAP and PAEAMHATH....34
Police Ambulance Early Access to Mental Health Assessment via Telehealth....35
MHEC....35
Recommendations....37
Annexures....40

Introduction

"It's mentally exhausting going to mental health jobs when I know that by doing my job I may actually be causing them more harm in the long run. I feel like I have to lie to patients when I tell them they should 'go to hospital to receive better care'."

The Australian Paramedics Association (NSW) ('APA (NSW))' is a registered trade union representing the majority of Paramedics employed by NSW Ambulance (NSWA). APA (NSW) is grateful for the opportunity to provide submissions on the mental healthcare crisis. Paramedics work in communities across NSW, from Bondi to Broken Hill. Our observations and recommendations to this Inquiry are informed by on the ground feedback from hundreds of Paramedics across the State.

In response to a survey conducted by APA (NSW), one Paramedic wrote: *"It's mentally exhausting going to mental health jobs when I know that by doing my job I may actually be causing them more harm in the long run. I feel like I have to lie to patients when I tell them they should 'go to hospital to receive better care'".* This response captures the essence of much of the feedback we received from hundreds of Paramedics across the State. In the same survey, 92.19% said they regularly attend jobs with the same patient for the provision of mental healthcare.

Paramedics are at the coal face of this crisis. Respondents to our survey reported that they respond to an average of 8.6 jobs per week involving mental health issues. Every day we see patients suffering with mental health, unable to get the care they need. These submissions will outline the current state of play in access to and provision of mental healthcare and consider some potential solutions to ensure the safety and wellbeing of Paramedics and patients.

This submission will not discuss the efficacy surrounding which practitioners and services are best placed to provide mental healthcare. We will, however, discuss the provision of mental health by NSWA, the alternative programs NSWA is involved in, access and availability issues and the inadequacy of referral pathways. All of which our members experience each day.

In 2021/22 NSW Ambulance paramedics attended 1,020,165 jobs. With 747,308 resulting in transport and 207,858 treated but not transported.

In 2022 on average (per month) NSW Ambulance attended:

- 489 cases relating to self-injury
- 1559 cases relating to suicidal ideation
- 670.3 cases relating to suicide attempt[1]

This is a small snapshot of the total number of mental health cases Paramedics attend each year. At last reported, it was estimated that 15% of the cases attended by NSW Ambulance each year related to mental health. In 2017–18, of the patients presenting at NSW EDs with a mental health-related issue 43% arrived by ambulance, 5% arrived by police or corrective services vehicles with the remaining 51% having arrived by other means.

[1] AIHW: Ambulance attendances: Suicidal ideation, and suicidal and self-harm behaviours

The right care at the right time

"[the] Only option [for patient] was to section and transport to ED. Pt was aware this was the case, and expressed the statement 'great, I'll be there for two hours and they're gonna send me home and do nothing'"[2]

Introduction

Access to, and provision of mental healthcare services across NSW is not uniform. In this discussion, we have considered the unique challenges introduced by distance, population, environment and resourcing, as well as the common themes that have emerged from the experiences of Paramedics across the State.

We have collected feedback from our Paramedic members to include in this submission. Their experiences indicate that the typical journey for mental health patients is an endless cycle of:

1. Not being able to access primary mental healthcare
2. Mental health of the patient deteriorating over time
3. Calling an Ambulance, as this is their only perceived option for care
4. Being transported to an ED, sometimes under section
5. Being seen and discharged, or waiting for hours before leaving the ED without being seen by a healthcare provider

We see our patients become more and more unwell over time, unable to access the right care at the right time. This is not the burden or fault of dedicated professionals on the frontlines of the mental health crisis, it is a systemic failure of our healthcare system. It is important to note that patients who are transferred to an Emergency Department will often be discharged only to re-present in the following days, weeks, or months. This was consistent with responses to our survey, where 79.38% of respondents said they often saw the mental health of regular patients deteriorate over time.

[2] Response from Paramedic in APA (NSW) survey in preparing the submissions for this Inquiry

The importance of early access, diagnosis (where appropriate), and treatment is not unique to mental health treatment. However, there are unique challenges for patients accessing and receiving mental healthcare, including:

1. Stigmatisation of mental health conditions
2. Lack of patient proficiency in accessing services (sometimes as a result of their condition)
3. Insufficient number of mental health services available, especially low cost or free mental health services
4. Extended wait times to access assistance
5. Limitations within Emergency Departments to provide mental healthcare, especially complex care.

Access to primary healthcare

The ability to access primary healthcare is paramount to addressing the mental health crisis and ensuring patients get the right care at the right time. However, access to primary healthcare for mental health is difficult to varying degrees in every part of NSW. A report released by the NSW Branch of the Royal Australian New Zealand College of Psychiatrists repeatedly emphasises that in regional areas, the issue of accessibility is much worse than in urban areas, with some patients having no access even to a GP.[3] There is also stark inequity in terms of affordability, with the private system being available to those who can afford it, and waitlists for public services totally saturated.[4] With no other options, mental health, patients turn to emergency services as a last resort.

Results from our survey show similarly alarming reports:

- 83.66% said their patients are not able to easily access outpatient services for mental health such as psychologists, counsellors, psychiatrists, and GPs.
- 77.34% said that adequate mental health care is not available to patients in their operational Zone.

[3] NSW Branch of the Royal Australian New Zealand College of Psychiatrists Report: The NSW mental health care system on the brink: Evidence from the frontline

[4] Ibid.

- 91.83% said they believe that lack of access to primary healthcare contributes to worsening patient presentations.

One respondent wrote: *"Mental health jobs make up a large portion of ambulance and ED presentations and time. A large portion of these patients are 'regulars'. It highlights that there are not adequate services available to them in the community to live their lives normally and get the appropriate care they need."*

There is an overwhelming feeling among paramedics that patients are not receiving adequate support in the community. Another respondent wrote: *"[Transport to the local ED] still isn't the service or care [the patient] requires but that is currently the only option we have for them."*

Hospital emergency departments are used as the only form of mental healthcare for many patients, including those who present regularly. This means much of the burden of mental healthcare provision is falling on frontline emergency service providers. If more care was available in the community through experienced and specialised mental healthcare providers, emergency healthcare may be reserved for emergencies, and patients will have better outcomes.

Appropriateness of Emergency Departments for Mental Healthcare

Like NSW Ambulance, NSW Emergency Departments are at the coal face of the mental healthcare crisis. The growth in ED presentations for mental healthcare is a symptom of a healthcare system where people's only option to receive care is to call an Ambulance or present to an ED.

Emergency Departments are not the most appropriate place for most patients experiencing mental health concerns or crises, nor for continuity of care. This is not by any means the fault of the dedicated staff in Emergency Departments. These staff are doing the best they can with the circumstances and patients that present. This is a systemic issue that must be addressed. Emergency Departments were not designed to manage patients with complex, low acuity conditions that require complex, long-term management. Of the 85,251 presentations to public hospitals in 2021/22 only 24,358 led to an admission and of those, 50% had been discharged within 7.14 hours. As an ED nurse explained the referral of patients for continuity of care: "*In my experience referrals from ED to community mental health services don't really happen. The patient will be seen and discharged.*" It should be noted that a lack of referrals from ED for mental health was not consistent across all LHDs

and EDs. However, it does point to a systemic issue with the way we use our EDs, and the pressures placed on staff and patients as a result.

In our survey, a recurrent response from Paramedics was that they know that taking their patients to the ED will not result in the kind of care their patient needs. They know that by transporting patients they will have to wait, sometimes hours, to transfer their patients over to the care of the ED. Even then, patients may be discharged without any referral to other services. This is not the fault of our dedicated healthcare workers in emergency departments. The systems within which they operate provide very few alternatives.

One Paramedic recounted an incident in which they attended a person having a cardiac arrest who could not be revived. The Paramedic was advised that the patient had been responded to by NSWA and subsequently discharged by the ED multiple times in the same week for suicidal ideation. As the Paramedic said, the circumstances: *"resulted in trauma for both family and emergency services."*

Despite this, as the next section will explore, transport to the ED is for many Paramedics the only option available to them for treating many of the patients they respond to – a result of the lack of pathways provided to Paramedics to avoid this outcome.

Emergency Departments will continue to play a critical role in the provision of mental healthcare. However, investment in community and primary mental healthcare would divert many lower risk patients to access more appropriate care in the community. Diverting patients from ED in appropriate circumstances is not just better for patients, it is better for the healthcare system, safer for Paramedics, and it costs significantly less.

The role of Ambulance in mental healthcare

Paramedics are often the first responders to mental health care crises in NSW. Data from the federal government's *Australian Institute of Health and Welfare* shows that, of the over 85,000 mental-health related ED presentations in public hospitals over 2021-2022, 49% arrived by Ambulance – a

total of nearly 42,000 presentations.[5] In comparison, presentations to hospitals arriving by Police accounted for only 6%. This makes the role of Paramedics in providing mental healthcare vital. Improving the ability of Paramedics to provide mental healthcare will be discussed in further chapters.

Fundamentally underpinning many of the issues facing the provision of mental health care by Paramedics is the simple fact that the Emergency Department is rarely the most appropriate place for a patient experience mental health symptoms or crises to be effectively treated. In fact, it can often worsen patient outcomes, heighten risk and cause significant distress. For patients who require investigations to rule out organic causes, or who have physical injuries, often Emergency Departments are the most accessible avenue for this care.

Adequate referral pathways and investment in community mental health

As it currently stands, Paramedics working for NSW Ambulance have two primary options when they attend a patient with mental health concerns. These are to:

- transport the patient to Hospital (usually an Emergency Department), or;
- to undertake a referral (Protocol P5)[6]

P5 is a general non-transfer option and is not specific to mental health. It involves a clinical decision, typically to leave a patient in the community. Our members report that Ambulance has limited referral pathways for mental health (outside of scattered programs and trials, discussed further below). If they decide to undertake a P5, the process is typically to either get the patient to call their GP, or call a GP on the patient's behalf. This is an informal pathway that Paramedics use to enable continuity of care for their patients. The problem with this, of course, is that access to GPs can prove challenging, especially across the regions.

Paramedics who responded to our survey expressed frustration at the lack of treatment and referral options available to them. In particular, 89.89% said they do not have sufficient mental health care

[5] From data available here: https://www.aihw.gov.au/Mental-health/topic-areas/Emergency-departments
[6] Attached and marked "A1".

treatment options to provide mental healthcare to the highest level. Also, 88.33% of paramedics said they did not have adequate referral pathways for mental health patients in their Zone. Adequate community and primary mental healthcare should be available to patients, so that they can access the care they need early.

Of particular concern is that, without adequate referral pathways, Paramedics are unable to prevent patients from being taken to the ED. The current system provides most Paramedics with something approaching an all-or-nothing choice:

- either the patient is clearly not in need of emergency treatment and can therefore be given a standard P5 non-transport referral, or;
- they need to be taken to the ED.

As one respondent illustrates: *"Multiple times in my career have we seen the same mental health patient twice or more in a shift. The pt would be seen and almost immediately discharged with no improvement."*

What this means is that for patients who are agitated and above the low threshold for a P5, Paramedics are essentially bound to take them to the ED or a designated Mental Health Facility. For patients who do not want to attend the ED but do not meet the criteria for a P5,

Paramedics have an incredibly difficult choice, do they 'section' the patient and transport involuntarily or do they leave the patient in the community knowing that they may be at risk. Sectioning involves a compulsory assessment or treatment of the patient without the patient's consent being given. It is a practice that inherently limits the rights of patients and can be distressing for both patients and Paramedics.

Patients who are sectioned less commonly report a positive experience of care than those receiving voluntary care.[7] Expanding the options for Paramedics to provide appropriate mental health care for patients without the need for transport to the ED, and particularly without the need for sectioning

---

[7] https://www.aihw.gov.au/mental-health/topic-areas/involuntary-treatment

patients, is a critical step for improving the effectiveness and equitability of mental health treatment in NSW.

Equity of access across the regions

It is well known that residents of regional, rural and remote communities face unique challenges when it comes to accessing healthcare. Fewer services available, large geographical distances, and the environment all play a role in limiting people's access to adequate care. Residents of these communities experience rates of suicide and intentional self-harm at higher rates than those who live in cities.[8]

> *One member living in rural NSW told us that community mental health was almost non-existent in his town. There was one GP Practice in his town after the closure of the only other. The member noted that healthcare workers in the area saw an increase in ED Presentations after the closure. He reported that other nearby towns had GP Practices, but it was not unusual for them to have their books closed. He was also aware of GP Practices that would refuse registration to people who weren't residents of that town.*

Large distances to access mental health facilities was a common theme in survey responses. Paramedics frequently expressed concerns about taking their patients long distances from their communities and often without a way for them to return home. *In survey responses, 18.28% of respondents said there is not a designated mental health care facility within an hour drive of my community.*

Members raised specific concerns about communities with large indigenous populations, where long transports take patients off country, often with no way to get home. Where distances were too long for a transfer, other transport options were bleak. Often patients who cannot be transferred by road are transferred by air, requiring them to be sedated and intubated for the journey. Paramedics across the state recognise this stark inequality, with 95.33*% of our survey respondents indicating that adequate mental health care was not equitably available to all communities in NSW.*

---

[8] Australian Institute of Health and Welfare, Suicide and Self-harm monitoring.

Paramedic Experiences

Introduction

Our current mental health-care system places patients in a perpetual cycle where they are not able access appropriate care in a reasonable timeframe. Patients repeatedly present to the ED, each time being unable to access the care they need. In 2021-22, half of mental health presentations to Australian EDs were by Ambulance.[9] This demonstrates that Paramedics are often the first to respond to these patients. This state of affairs is not only detrimental to patients, but to the Paramedics who treat them.

In our survey, Paramedics reported that they were responding to an average of 8.6 mental health patients per week. 94.16% of respondents said they regularly transported patients to Hospital Emergency Departments because this is the only option for continuity of care. Many respondents showed concern over the lack of alternative options to the Emergency Department, expressing the view that EDs are not always the most appropriate option for mental healthcare.

Key results from our survey indicate that:

1. *82.49% of respondents believe that current NSWA systems of mental health care provision place Paramedics at increased risk of occupational violence from patients or bystanders.*
2. *86.38% of respondents believe that current NSWA systems of mental health care provision place Paramedics at increased risk of unnecessary fatigue.*
3. *91.01% of respondents believe that NSW Ambulance can do more to ensure Paramedics are supported in their provision of mental health care.*

As a union representing these Paramedics, the impacts that ineffective, inadequate, and inaccessible mental healthcare have on our members are of critical concern to us. Paramedics are put at greater risk, have a higher workload and are more distressed due to inadequacies in mental healthcare. That us and our patients are exposed to such impacts unnecessarily means that reform should be actioned with urgency.

[9] AIHW: Mental health services provided in emergency departments

In a contemporary NSW landscape characterised by Paramedic burnout, mass attrition, and a bleeding of experienced practitioners. The impact on Paramedics of inappropriate mental healthcare contributes to the erosion of the service provided to the people of this state. Government data showed that in 2022, fewer than in 1 in 4 Paramedics did not feel burnt out by their work.[10] The 2022 attrition rate for Paramedics is the highest in a decade, having jumped 65% from the year before.[11] We do not attribute these damning statistics to mental health treatment issues alone – clearly they are the result of systematic issues pervading the NSW Ambulance service. In this environment, however, the further degradation of Paramedics' working conditions, clinical capacity, mental health, and worsening fatigue through ineffective mental health treatment options exacerbates the retention crisis gripping the state. Our communities need healthy, safe, mentally well and appropriately tasked Paramedics to ensure their safety.

The burden of ineffective healthcare manifests itself in four themes that typify Paramedics' experiences of mental healthcare: safety issues, physical fatigue, compassion fatigue, and moral injury. These will be explored in this section of the submission.

Safety Issues

Ineffective mental health treatment can exacerbate the already too-high rates of occupational violence against Paramedics. Data from a 2016 NSWA report showed that of 51% of recorded instances of occupational violences over a six-month period were attributed to Mental Health patients.[12]

Our intent is not to stigmatise patients experiencing mental health crisis, but to recognise the highly distressing mental state that patients in crisis experience. A state that is worsened when contributing factors outside the control of Paramedics or patients are introduced. Patients experiencing agitation may be physically or verbally abusive towards paramedics. This is made worse by Paramedics transporting patients to EDs because there are limited other options for treatment. Paramedics suffer

[10] People Matters Employee Survey – NSW Ambulance.
[11] https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/ambulance-services
[12] NSWA: Occupational Violence Prevention Strategic Advisory Group Report, November 2016.

some of the highest rates of psychological injury of any professional. 11.9% of these psychological injuries occur as a result of occupational violence.[13]

In response to our survey, some respondents noted feeling unsafe at hospital due to lack of security supervision. One person wrote, *"just saw yesterday a crew get abused by a sectioned patient as they were delayed on stretcher for 3 hours. Then the patient started abusing paramedics, security did nothing to protect them, all because [the patient] was annoyed at the hospital system."* Another wrote about *"Hospitals forcing violent patients onto our stretchers and not providing security. Both driver and treating officer concerned for safety on transport."*

While patients threatening violence can be restrained or sedated, this is not an ideal outcome for patients or paramedics. Survey respondents also noted that patients who were sectioned or sedated typically took longer to be seen at hospital.

Fatigue

One factor that extends shift times for Paramedics is ramping, or bed block. The impact of bed block on Paramedics has been extensively covered by APA (NSW) in its submission to the 2022 Ramping Inquiry. The degradation of patients' conditions while waiting to be transferred from Ambulance care significantly degrades the mental health of Paramedics, an issue compounded by feelings of helplessness that often accompany long bed block waits. The impact on Paramedics when subject to constant bed block for mental health patients is further worsened by the knowledge that the ED, they are waiting for is not where the patient will receive the best care.

Another factor is extended patient transfers. This is more prevalent in areas lacking dedicated mental health facilities. In response to our survey, 38.04% of respondents said there was not a designated mental health care facility within 30 minutes' drive of their community, and 18.28% said there was not a designated mental health care facility within an hour's drive of their community. One of our survey respondents was asked to transport a patient 300km to a mental health facility at night, which would been a 600km round trip. These unnecessarily long transfers increase risks to Paramedics.

---

[13] **Psychological injury in the New South Wales Healthcare and Social Assistance industry"** report by the Healthy Working Lives Research Group, Monash University. Part of the Design for Care research project.

Transports in regional areas often involve the only crew in town meaning their communities are left without coverage for extended periods. Transports of this kind also lead to excessive fatigue due to extension of shifts (or callouts).

When bed block and extended transfers are combined, Paramedics spend countless hours with patients waiting to receive care at hospital. One respondent wrote:

> *"I transported a patient over 3hrs to a mental health facility and was then informed they required clearance in the ED. The patient had been violent and verbally abusive at the beginning of the transport. Once arrived at ED they were stuck on the stretcher for nearly a total of 5hrs before being unrestrained and allowed the use of a bathroom. It was dangerous for the paramedics and the patient. An awful experience to be involved in. Mental health patients are not criminals and should not be treated as such. Unfortunately long drives and wait times have made this patient's experience awful and dangerous for all involved."*

This example perfectly encapsulates the burdens of the inadequate mental healthcare system. Aside from this instance being a safety risk for the Paramedics involved, the patient had to wait eight hours for care while being restrained. The respondents' concern for their patient indicates the immense psychological effect that these jobs can have on healthcare workers.

Another respondent wrote that in dealing with an agitated patient:

"We had to stand and listen because any interruption escalated the patient. We did 2 hours overtime after being yelled at and there was nothing we could offer or say that wasn't something that we all knew didn't work or help."

These extensions of shift in emotionally tense situations means paramedics feel more emotionally and physically fatigued at the end of their shift. Among respondents to the survey was a general feeling of hopelessness around lack of options they can provide patients.

Compassion Fatigue

Compassion fatigue describes the psychological and physical impact of helping others, and is extremely relevant in the area of mental healthcare. One study characterises it as *"the convergence of secondary traumatic stress (STS) and cumulative burnout (BO), a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment."*[14] Compassion fatigue can lead to serious issues, as it can *"impact standards of patient care, relationships with colleagues, or lead to more serious mental health conditions such as posttraumatic stress disorder (PTSD), anxiety or depression."*[15]

In response to our survey, a respondent expressed concern over lack of mental health training for paramedics, describing mental health jobs as "having an emotional toll" and being "extra stressful and emotionally taxing." Other respondents describe similar feelings of "emotional and mental fatigue" and "burnout".

Mental health call-outs are often emotionally taxing for paramedics, not least of all because they recognise that the lack of referral pathways for patients will only see their condition decline. Paramedics want to provide their patients with the best possible care, but are unable to. One respondent expressed a "deep sense of unease and exhaustion" while another noted their "distress at the lack of appropriate facilities and beds for patients in need."

The lack of appropriate care pathways means Paramedics often see the decline of mental health patients up close and personally – sometimes responding to the same patients multiple times after their continued discharging from Emergency Departments. As the patient's condition worsens, Paramedics carry this emotional burden.

While the mental healthcare system creates a toxic work environment that degrades paramedic wellbeing, some respondents also expressed a need for better mental health support in their

---

[14] Cocker F, Joss N. Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review. Int J Environ Res Public Health. 2016 Jun 22;13(6):618. doi: 10.3390/ijerph13060618. PMID: 27338436; PMCID: PMC4924075.
[15] Ibid.

workplace. Psychological support and the opportunity to debrief can help to alleviate the mental burden placed on staff by emotionally exhausting work. Respondents also noted "insufficient access to managerial support".

Moral Injury

Moral injury refers to the significant impact on an individual that occurs when, in response to an event or high-stakes situation, they betray their own moral beliefs. As emergency healthcare providers, Paramedics are often faced with difficult decisions that involve their extremely vulnerable patients, making them more susceptible to moral injury. In the context of emergency mental health responses, this effect is exacerbated by the lack of referral options available to patients.

In response to our survey, Paramedics often expressed feelings of guilt in knowing that Emergency Departments are not appropriate care pathways for mental health patients most of the time. When considered alongside compassion fatigue, it becomes clear that the current system is detrimental to Paramedic psychological wellbeing. One respondent wrote:

"I am never comfortable sedating or restraining a human being. I have several jobs that still weigh heavy on me."

Many paramedics feel like they are left without options. One paramedic acknowledged the adverse effect this has on patients, where *"scheduling a patient and taking them to ED is often inappropriate and causes more trauma."*

As healthcare providers, paramedics have a duty to treat their patients as best they can. However, a system should not be so broken that patients are made worse-off by the people they are seeking help from. Paramedics are robbed of the ability to properly care for patients because they often have no choice but to take them to hospital. In these situations, every party is left worse-off.

Lack of Training and Support

"Mental health jobs take an emotional toll on paramedics and ultimately we don't have that much training regarding mental health, which makes these jobs extra stressful and emotionally taxing."

Paramedics are highly skilled medical professionals, who make clinical decisions outside of the Hospital environment every day. However, their lack of training and specific mental health qualifications means Paramedics are asked to make treatment and referral decisions without being provided the tools or experience to do so. As one Paramedic put it: *"The last time I did mental health training was probably 12 years ago when I joined the job"*

Until July 2018 the only protocols Ambulance Paramedics had for mental health were:

- S3 Mental Health Emergency
- S6 Suicide Risk Assessment and Management

In July of 2018 NSWA commenced large scale introduction of skills, pharmacology and protocols for Paramedics. The rollout contained 65 new protocols and pharmacologies including the following for mental health:

MH1	Mental Health Emergency
MH2	Suicide Risk Assessment and Management
MH3	Enacting S20 & S81 of the Mental Health Act 2007
MH4	Mental Health - Mechanical Restraint
MH5	Mental Health - Search Protocol - C
MH6	Behavioural Disturbance - Mental Health - C
M28	Behavioural Disturbance —Medical

This rollout involved a significant increase to Paramedics' scope of practice, but no training was provided. Paramedics primary avenues for accessing training are through NSW Ambulance initiated in person currency training referred to as 'MCPD' and online modules provided by NSW Health and NSWA.

The problems associated with Paramedics learning clinical, hands-on skills through online modules are self-evident. The additional problem is that Paramedics are never given an opportunity during work hours to complete these modules. A typical day of a Paramedic involves signing on and

checking their vehicle, being immediately tasked to a job and spending the remainder of their shift between ED and scenes until they get back to station, often hours after their rostered finish time.

Closely related to the lack of training is the lack of supported provided by NSWA to enable Paramedics to practice safely. We have used an example to illustrate this.

The P5 non-transport protocol states:
"All patients who are not transported under the P5 disposition protocol must be provided with a written P5 referral form prior to paramedics departing the scene. The provision of a P5 referral form must be documented on the Clinical Record."

We regularly receive reports from members that they are pressured to clear scene while still completing paperwork because there are outstanding jobs. Further, in May of this year an email was send from the Directors of Metro and Regional Operations to staff stating that in accordance with the PD2019-024 - Clinical Records Policy Directive: "*response to a subsequent time critical incident should not be delayed in order to complete the CR [clinical record]."*

Reproduced below is a table from the Bureau of Health Information ('BHI') which provides information about various job categories. P3 jobs are considered 'time-critical' with P1 and P2 jobs being considered more urgent than P3.

Table 1 Table 1 Incident and response priority codes

Code	Priority	Description	Example	Response required
1	1A Emergency	Highest priority – life-threatening case	Cardiac or respiratory arrest, unconscious, ineffective breathing	Immediate response – median within 10 minutes – under 'lights and sirens'
	1B Emergency	High priority	Unconscious	Emergency response – under 'lights and sirens'
	1C Emergency	Priority	Breathing problems, chest or neck injury, serious haemorrhage	Emergency response – under 'lights and sirens'
2	Urgent	Urgent	Abdominal pain	Urgent response without 'lights and sirens' within specified timeframes
3	Time-critical	Time-critical	Medical responses requested by medical practitioners often pre-booked	Undelayed response within specified timeframes

Source: Bureau of Health Information

Of the 357,491 incidents that NSW Ambulance attended in the April-June 2023 quarter 350,260 were categorised P3 (time critical) or higher. In the same quarter the median response time for a P2 case was 25.9 minutes. The BHI does not currently report on P3 response times in the Healthcare Quarterly.

The aforementioned email further reads:

"*All staff are reminded of the ongoing clinical risk to patients when emergency responses are delayed."*

Paramedics will regularly clear from Hospital, respond single or delay completion of paperwork to attend the highest urgency cases. Paramedics know that a patient in cardiac arrest's chances of survival diminish every minute care is delayed.

However, it is unacceptable to expect Paramedics to put themselves at professional risk by not fully fulfilling their clinical duties. It is unacceptable to expect Paramedics to clear scenes thereby leaving patients who they don't transport without adequate referrals. By failing to support Paramedics, we fail our healthcare system. Between 2012/13 and 2021/22 there was a nearly 8% increase in the proportion of patients that were treated and not transported by Paramedics. This equated to an additional 78007 patients who were managed through a non-transport option. Year on year, Paramedics are expected to take on more and more professional and personal risk to prop-up our failing healthcare system with little support and no ability to affect change.

Alternative models for provision of mental healthcare by Ambulance and NSW Health

Introduction

Ambulance, in conjunction with NSW Health have initiated various programs and trials across NSW to provide mental health care in the community. These will be discussed in detail in this section and include:

- MHAPP
- MHAAT
- Various Mental Health Telehealth programs (such as MHAPP, MHAAT)
- Mental Health First Responder Program

In preparation of this submission APA (NSW) spoke to members who had been involved in these programs. Our submission is informed by these discussions alongside the references quoted throughout. Common themes in feedback from Paramedics who had worked on or used alternative models are outlined below:

The benefits differed depending on the Service but broadly included:

1. Higher rates of ED avoidance
2. Providing a better patient experience, as it prevented patients unnecessarily sitting in EDs/not being transported without consent under Section.
3. Reducing long distance transfers to mental healthcare facilities for assessment.
4. Increasing available crews due to not being stuck in bed block with patients who didn't need to be there.
5. Providing more referral pathways, meaning:
    a. Less patients unnecessarily transported EDs.
    b. Ability to provide higher quality continuity of care.

6. That the clinicians had better tools for assessment and were able to provide assistance with de-escalation.

Suggested general improvements from members was consistent. Members suggested the following improvements in large numbers:

1. 24/7 coverage
2. Expansion into other areas especially whole of metro and large regional centres.
3. Increase resources for these models. For example, MHAAP often only has one clinician on for the whole Illawarra Shoalhaven.

Limitations of current analysis on alternative models

The literature APA (NSW) has reviewed for this Inquiry has primarily focused on the success of these programs in ED avoidance. While ED avoidance is an important consideration for patient experience and demonstrates the efficacy of acute mental health interventions outside of the Hospital environment, there is no publicly available data on the patient journey over time. One of the key issues respondents in our survey raised repeatedly was the lack of access to primary care. Our members repeatedly stated that they were concerned their patients were not given the care they needed and that over time their health deteriorated as a result. We know that Emergency Departments do not provide patients with the most appropriate care, but currently there are limited options for alternative referral pathways.

MHAAT

The Mental Health Acute Assessment Team (MHAAT) commenced as a trial in Western Sydney that has had various iterations in various locations. The original trial was for six-months in Western Sydney and commenced in December 2013. The original model included an ECP and a mental health nurse.[16] The goal of the program is to reduce inappropriate emergency department (ED) presentations by diverting patients to specialist mental health clinicians. We have been advised that the current model operating in Western Sydney is a single vehicle with two clinicians – a CNC and a Paramedic. We have been advised that the program has changed to a P1 Paramedic over an ECP.

[16] NSW Ambulance Year in Review 2013/14

Benefits of Program

The MHAAT model has been shown to significantly improve the quality of care provided to mental health consumers, while saving costs and maximising use of other mental health resources. Within three months of implementation, MHAAT diverted 76 per cent of calls away from Cumberland Hospital ED, 24 per cent of which were provided with referrals to mental health services in the community.[17] Key benefits of MHAAT include:

- Increases rates of non-transports
- Reduces unnecessary ED presentations
- Reduces number of transfers to receive definitive care.
- Provides the ability to transfer patients directly to dedicated mental health facilities. The effect of this is two-fold
    - It is a better experience for the patient.
    - It decreases use of health resources.

Action Alternatives to emergency departments

State and Territory Governments should provide more alternatives to hospital emergency departments (EDs) for people with acute mental illness.

Population

There are people who attend EDs for a mental health-related reason who could have been treated elsewhere. Treating these people elsewhere could lead to better outcomes and cost savings from a reduction in ED presentations. The estimated cost savings arise from two different populations, based on the method of arrival. Those who arrive by ambulance potentially have cost savings from mobile crisis services, while those who arrive via walking, private/public transport, community transport, or taxi could have cost savings from after-hours/peer-led services.

Costs and cost savings

- The cost per ED presentation for a serious mental illness is assumed to be $805 (2019 dollars) (IHPA 2017).
- Costs for mobile crisis services include increased expenditures as well as cost savings. It is assumed that, in the first instance, an additional five sites are trialled nationally.
    - For the Mental Health Acute Assessment Team (MHAAT), between 2015 and 2017, about 50% of mental health-related callouts resulted in patients bypassing EDs in favour of more appropriate care (WSLHD 2017), while a pilot trial in Victoria found 75% of attendances were diverted (Barwon Health 2019).
    - Cost data provided by NSW Ambulance suggested a cost of $600 000 per year, covering two ambulance and two mental health FTEs. The trial results indicate that 51.5% of shift time (or 5.7 hours per day) is spent on MHAAT cases, with an average of 3.9 cases per day. Using the proportion of shift time spent working on mental health-related cases as a lower bound on the cost, this suggests a cost between $1.5-3 million, and a cost saving between $2.9-4.3 million (2019 dollars).

[17] Western Sydney LHD, Innovative Service Delivery Report https://aci.health.nsw.gov.au/ie/projects/innovative-service-delivery-model

Source: Mental Health Productivity Commission Inquiry Report No. 95 (30 June 2020)

The data backing the efficacy of the MHAAT program is not only found in Government statistics. A 2017 peer-reviewed study published in the Royal Australian & New Zealand College of Psychiatrists' *Australasian Psychiatry* journal studied the impact of the MHAAT teams during their trial between December 2013 and May 2014 in the Western Sydney LHD area. It found nearly 70% of patients responded to by the MHAAT were treated outside of the ED.[18]

Surveyed Paramedics involved in the MHAAT trial express near-unanimous enthusiasm for the program and its outcomes. Feedback included in our member survey from Paramedics either involved in the program or operating within the same areas at the time of the MHAAT operations include:

- *"When working in western Sydney the MHAAT care was invaluable and saved so much time and resources from inappropriate use"*
- *"It [MHAAT] was not only a great education tool for the paramedics but the psych nurses as well. Patients were treated and referred in their own home, or they were transported directly to the appropriate mental health facility. Fabulous and effective outcomes"*
- *"MHAAT allows for patients to be assessed by the mental health nurse and potentially left at home with referral treatments therefore creating positive experiences for the patients as opposed to just being taken to ED where they wait for hours to be reviewed and then D/C with minimal follow up.* ***Makes the patients feel more heard.****"*
- *"MHAT runs in our area and is great but there needs to be more as we can't get access to them most of the time"*
- *"The benefits for myself and colleagues include qualified mental health practitioners assessing and creating a plan for mentally unwell patients. Reduction in the escalation of physical and verbal violence towards paramedics. Reduced scene time trying to work out options for a patient."*

[18] The Mental Health Acute Assessment Team: a collaborative approach to treating mental health patients in the community. Australasian Psychiatry.

Limitations of Program

- There is only one crew operating in the whole of Western Sydney.
- Under resourcing of community mental health creates limitations for non-transport options as well as options for continuity of care.

ECPs as more appropriate clinicians

We have asked NSW Ambulance why the model changed from an ECP to a P1. Their response was that an ECP is not a specialist in mental health and therefore is no more appropriate than a P1. We disagree with the rationale of this decision for a number of reasons articulated below.

The core role of a Paramedic on the MHAAT vehicle is not mental health assessment. In the case of ECPs, their core role on MHAAT's also was not mental health assessment. The mental health assessment is primarily undertaken by Clinical Nurse Consultant (CNC) who has greater expertise in mental health assessment.

The Paramedic will work cooperatively with the CNC but their core role as explained by members is:

1. Staff safety
2. Scene Safety
3. Operations
4. To assess the patient medically and as deeply as possible to rule out any organic causes.

The importance of ruling out organic causes is illustrated by the following example from a member:

"I remember a patient who it appeared was clearly having a manic episode. He was opening all the curtains and dancing and singing, taking off his clothes. It ended up that he had vascular lupus with neurological symptoms."

Differences between ECPs and P1s

There are key differences between P1s and ECPs as clinicians that we say makes them more appropriate to undertake roles such as those with MHAAT.

Clinical level

Best practice mental healthcare includes as a first step, ruling out any organic causes for the presentation. Approximately 10% of all mental health presentations to EDs in 2021/22 were due to organic causes.[19] ECPs have additional skills and protocols that enable them to undertake a more thorough physical assessment.

ECPs can undertake the following additional skills and assessments that are important for treating patients with mental health presentations:

- BETA HCG (pregnancy) testing – *one of the first symptoms of pregnancy is behavioural changes.*
- Urinalysis for UTIs
- Advanced cardiac and respiratory assessment
- Advanced abdomen and musculoskeletal assessment.
- Wound assessment and care including dressing and suturing – which would otherwise require ED attendance.
- Advanced neurological assessment.
- Ketone testing

As one ECP member explained their experience on the MHAAT car. They would use their assessment tools to rule out many potential organic causes, they would then write a referral letter explaining their assessment and advising of further tests or assessments that should be considered such as a thyroid function test. The patient could then be transferred directly to a mental health facility where a more comprehensive mental health assessment and testing could be done.

[19] AIHW: Mental health services provided in emergency departments

Style of practice

ECPs are specialists in non-transports and the provision of definitive care. Their role, the type of patients they attend and the type of clinical practice they engage in is vastly different to any other clinician in Ambulance. ECPs were introduced to reduce the number of ED presentations. Their core work is to treat patients in their homes, to avoid taking them to hospital.

To do this, ECPs undergo additional training in:

- patient assessment
- recognition and management of minor illness and minor injury presentations
- the provision of definitive care
- referral to community-based health services for a range of presentations.

This is demonstrated by the data. ECPs have a much higher non-transport rate than P1 Paramedics.

The ECP average non-transport rate of 39.5%

The regional ECP non-transport rate is 40–54%

This is compared to Standard Care 14%.[20]

It is worth noting that at least part of the reason ECP non-transports are not higher is due to inappropriate tasking. In NSWA trials where ECPs were tasked appropriately – ie. to work that fit the clinical scope for ECP. The non-transport rate was much higher – often more than 80%.

Availability of ECPs

[20] Agency for Clinical Innovation: Extended Care Paramedic *https://aci.health.nsw.gov.au/resources/aged-health/building-partnerships/building-partnerships/extended-care-paramedic*

The way the ECP program operates in practice is that there are dedicated ECP rosters across NSW. The last time we received documentation from Ambulance, the following locations had funded ECP rosters:

Station	**Funded**
Point Clare	6
Artarmon	3
Narrabeen	3
Kogarah	12
Haberfield	11
Liverpool	6
Bankstown	12
Campbelltown	3
Penrith	6
Blacktown	6
Northmead	6
Hunter	6
Illawarra	3
Total	**83**

Our understanding is that at least the Illawarra has had an enhancement since this time. There are many more ECPs than funded positions in NSW Ambulance. When ECPs are not on an ECP roster, they typically work on a dual crew standard care or Intensive Care car. ECPs still use their scope of practice while on dual crew cars. However, a common concern ECP members raise is that they are not able to get on an ECP roster, sometimes for years.

The effect of this is that there are plenty of ECPs available to undertake work on MHAAT cars. There is no clear logistical or financial reason why ECPs and their advanced skills should not be utilized.

MHAAP

Mental Health, Ambulance and Police Project

The Illawarra Shoalhaven Local Health District describes MHAAP in the following way:

"An experienced mental health clinician is available during periods of peak demand to work with ambulance and police to provide telephone and onsite support for people experiencing a mental health crisis, including access to a mental health assessment and advice on de-escalation, transport and referral options. The MHAPP clinician is based at Illawarra Community Mental Health and has access to a health vehicle to travel to the scene."

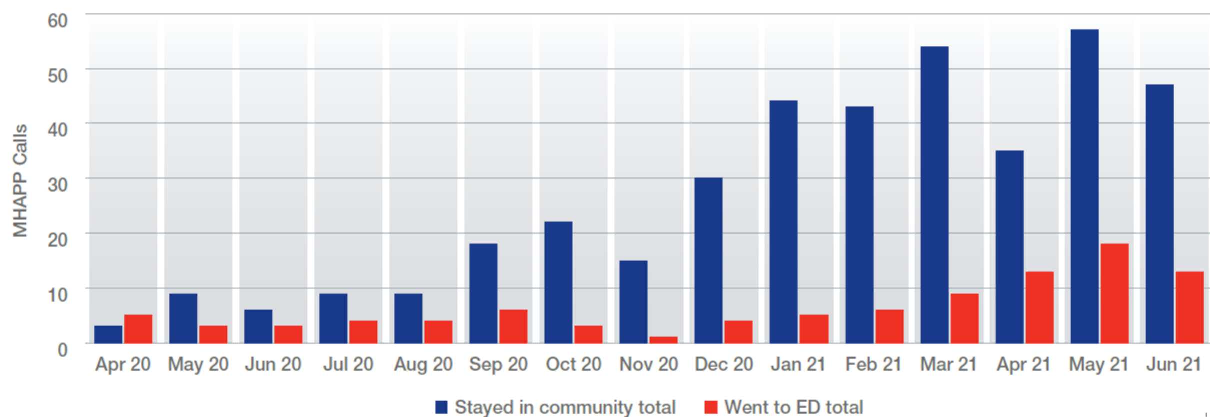
The project has been running for around 4 years and has been hugely successful in reducing emergency department presentations. Paramedics report that the MHAPP program gives them more options for treatment and continuity of care for a patient.

"I went to a teenage patient in emotional distress. I called MHAPP on the way but I couldn't get through in first instance. We were going to do a non-transport, the parents were happy with this. Before we had left scene, MHAPP called back and said they would go back and check on the patient the next day. This gave me a referral pathway for continuity of care rather than leaving her with no follow-up."

Paramedics in the area report that the program is hugely beneficial for supporting their clinical practice. Paramedics also report that the program is much better for their patients. As one member said:

"I've used them heaps of times. Every second shift. I ring them as soon as the job drops down, as they can provide advice on a patient's history. I even ring them for advice on behavioral stuff."

Paramedics reported that some patients they saw already had behavioural management plans so they could call MHAPP to receive advice on the plan and how to best manage the patient.



Source: 2020-21 NSW Ambulance Safety and Quality Account

Referral pathways for MHAPP

Current common referral pathways for MHAPP were reported as:

1. The Suicide Prevention Program run by Safe Haven.

2. The acute care team – for follow-up within 48 hours.

3. Private services such as GPs and psychologists.

4. NGOs such as NDIS accredited services.

Summary of Benefits of Program

- Specialist mental health and patient management advice for Paramedics
- More clinically appropriate referral pathways for Paramedics
- Additional referral pathways
- Increased rates of non-transports
- Reduced unnecessary ED presentations

Limitations and Improvements for Program

Paramedics were consistent and steadfast in their feedback on improvements. They said that they want to see MHAPP with more staff and better availability. They also wanted to see the staff well looked after, saying that they noticed retention was a problem.

1. We would want to extend our hours.
2. More staff - 1 person staffing the whole Illawarra sometimes two because they have had recruitment issues, people leaving etc.
3. There definitely needs to be a lot more education about the service and for Paramedics.

Telehealth models

A number of trials to provide telehealth mental healthcare have been conducted, with some being subsequently implemented. These models can be separated into two broad categories.

- The provision of specialist mental health triage outside the Hospital environment
- The provision of access to specialist mental healthcare in regional and remote hospitals.

Telehealth programs for patients and first responders in out of hospital environments

This section discusses the current models available for emergency services workers to access specialist mental health triage for patients outside the hospital environment.

Mental Health First Responder Program

According to NSW Ambulance the Mental Health First Responder Program aims to help patients in the Hunter New England community who are mentally unwell or disturbed in the out of hospital setting.[21]

"This program is aimed at enabling out of hospital mental health triage and referrals, improving the care pathways for patients with low acuity mental health presentations. When encountering an eligible patient, paramedics or police officers may use iPads, provided by NSW Health, to contact dedicated mental health clinicians at the Northern Mental Health Emergency Care-Rural Access Program. These clinicians can then conduct a specialised mental health triage in the pre- hospital environment."[22]

The program is still in an evaluation phase.

One member described the benefits of the Program in the following way:

"Ability to assess Pts in less threatening environments. Allows for alternate treatment opportunities."

Summary of Benefits of Program

- Specialist mental health and patient management advice for Paramedics
- Paramedics have direct access to this service
- Increased rates of non-transports
- Reduced unnecessary ED presentations

We understand the project has been successful thus far, we are awaiting the final data and results from the project.

[21] NSW Ambulance | 2020-21 Safety and Quality Account
[22] NSW Ambulance | 2020-21 Safety and Quality Account

Mobile MHEC

Mobile MHEC is currently being trialed at a number of sites in Western NSW including Condoblin and Wellington. Where Police and Paramedics identify there is a need they can arrange a consultation with a MHEC clinician. They can then dial in from provided iPads within patients' homes or videoconferencing machines set up in police station cells.

As a member described it, the benefit of the program is that they can do a preliminary triage, provide their opinion on the patient disposition and make recommendations to clinicians on scene.

Summary of Benefits of Program

- Specialist mental health and patient management advice for Paramedics
- Paramedics have direct access to this service
- Increased rates of non-transports
- Reduced unnecessary ED presentations

Mobile MHEC is still in a trial phase, and we are yet to see any data evaluating the project. However, given its similarity to the *Mental Health First Responder program* we are hopeful that the trial will prove similarly successful.

- MHET-RAP
- MHEC
- NMHEC
- PAEAMHATH

"Due to limited training and lack of access to mental health professionals, approximately sixty percent of people who phone 000 experiencing a mental health emergency, are transported to hospital by Police and Ambulance. Forty-six per cent of these transportations do not result in admission to hospital."[23]

[23] Hunter New England Local Health District Mental Health Service Strategic Plan 2019-2021

Telehealth programs for patients in hospitals and other facilities

This section discusses the current models available to provide patients access to specialist mental healthcare in regional and remote hospitals. Such models provide patients in regional communities access to mental healthcare in their communities reducing the need for long transfers to larger facilities.

NMHEC-RAP and PAEAMHATH

The Northern Mental Health Emergency Care - Rural Access Program is a Ministry of Health funded, joint project between:

- Hunter New England LHD,
- Mid North Coast LHD,
- Northern NSW LHD.

Hunter New England LHD, describes the service in the following way:

*"The **Northern Mental Health Emergency Care - Rural Access Program** (**NMHEC-RAP**) provides coverage to three Local Health Districts in NSW. The focus is to provide mental health expertise via telehealth to remote Emergency Departments where local Mental Health specialists are not readily available. NMHEC-RAP is a supplement to the existing services in those local areas to ensure timely and appropriate access to mental health care."*

We could find very little information on this service. So will discuss the benefits of these types of telehealth programs in the MHEC section which uses a similar model of care.

Police Ambulance Early Access to Mental Health Assessment via Telehealth

Information about this program was again difficult to find. Further details on the success of these types of programs will be discussed in subsequent sections.

The data APA (NSW) was able to find on this program is reproduced below:

"Police and/or Ambulance transport around 60% of mental health patients who call Triple Zero
From the 46 people triaged 13 were transported to hospital at a cost of $52,958.90
33 people safe to stay at home with a cost avoidance of $121,954.50
At an average saving of approximately $3,695.59 PP
Saving 79.72 hours for NSW Police
Saving 79.88 hours for NSW Ambulance"[24]

MHEC

Mental Health Emergency Care Program

"MHEC teams provide specialist mental health assessments via videoconferencing from mental health hubs to emergency departments (EDs) and other inpatient and outpatient facilities across rural and remote NSW."[25]

The MHEC model has been operating in Western NSW since 2006. Under the program, only 25% of people who receive MHEC assessments are admitted to mental health facilities. MHEC assessment may be undertaken in 47 EDs across WNSWLHD and FWLHD.[26]

MHEC teams are staffed by a multidisciplinary team which may include:

- registered nurses
- social workers

[24] PAEAMHATH Presentation, attached and marked "A2".
[25] Spotlight on virtual care: Virtual Mental Health Emergency Care (MHEC) in NSW
[26] Spotlight on virtual care: Virtual Mental Health Emergency Care (MHEC) in NSW

• occupational therapists
• psychologists
• other allied health professionals.

EDs, GPs, CMHTs and Aboriginal Community Controlled Health Services (ACCHSs) can refer patients to MHEC. MHEC is available 24/7 and usually has access to a psychiatrist for consultation.

Current referral pathways for MHEC were reported as:

- discharge the person home with appropriate follow up, which may include the community mental health team (CMHT) or GPs
- keep the person in ED temporarily with MHEC support to enable further assessment or stabilisation or
- transfer to a mental health inpatient facility.

Summary of Benefits of Program

- 24/7 specialist mental health assessment and advice for emergency departments and other facilities
- Reduced number of long distance transfers to receive mental health care meaning:
    - Patients are not unnecessarily transported to mental health facilities by police or ambulance which can traumatize them.
    - Patients are not taken far away from their home communities without transport options to get home.
    - Patients are not displaced from their home communities and social supports.
    - Reduces the incidence of Indigenous patients being taken off country.
    - Paramedics in regional communities (that often only have a single resource) are not taken away from their home communities leaving them uncovered, often for hours.
    - Paramedics are not put at greater risk of occupational violence due to patients becoming increasingly agitated due to length of transports.

Recommendations

The issues canvassed by APA (NSW) and other stakeholders in this Inquiry paint a picture of a health system in crisis, unable to meet the health needs of its patients. This is not a failure or oversight of the dedicated healthcare workers who work in EDs across the country. It is a symptom of a healthcare system pushed to breaking point. Our emergency departments are bearing the brunt of a failing healthcare system. It is time for us to stop using them, and their staff, as a crutch to avoid engaging in large scale reform and investment into community healthcare. Early intervention and care is not just better for patients, it is better for the healthcare system, healthcare workers and the economy.

APA (NSW) makes the following recommendations to the Committee with the view that greater investment in programs and services to support community and emergency mental healthcare will make inroads into resolving the issues canvassed in this enquiry. By supporting and adequately resourcing our dedicated frontline workers we will improve the experience for our patients and ease the burden shouldered by our emergency healthcare system.

RECOMMENDATION ONE: Invest in community and primary mental healthcare

The success of alternatives to ED mental healthcare requires more than just an investment in these programs. If we are to divert the 85,000 presentations from Emergency Departments each year to more appropriate pathways for care, there must be large scale investment in primary and community mental healthcare. Diverting patients from ED will be a band-aid fix while these programs are not able to refer patients to other services to give them the help they need. To illustrate this with an example, in the case of MHAPP one of the referral pathways used is the Suicide Prevention Program. In the Illawarra this program currently only runs Wednesday – Saturday from 2pm-10pm.

Another member told us: *"we found that with the acute mental health team they are not always available. They were so under-resourced and often had a waiting list of patients."*

RECOMMENDATION TWO: Evaluation and expansion of NSWA-Health Programs including MHAAT and MHAPP.

Programs such as MHAPP and MHAAT have demonstrated excellent results in giving patients the care they need in the community. This is better for the patient and reduces strain on EDs. Programs should be evaluated to identify any potential opportunities for improvement including the re-introduction of ECPs. These programs should then be introduced across the State.

RECOMMENDATION THREE: Provide Paramedics better and more regular mental health training

There is a significant gap in training for Paramedics in mental healthcare. This must be bridged if we are to provide patients with the most appropriate care. There are many avenues for achieving this, some suggestions from members included:

1. Short term placements or 'ride alongs' with community mental health care (this is especially important for Paramedics engaged in MHAAT or other similar programs)

2. In person training on mental healthcare including:

    a. Caring for patients with different specific mental health conditions
    b. De-escalation
    c. Referral pathways for care
    d. The use of Section 20 powers
    e. contextualising organic causes to mental health symptoms.

RECOMMENDATION FOUR: More staff in rural and regional hospitals

Undertake a review looking at which local hospitals would benefit most greatly from increased capacity in the provision of mental healthcare and dedicated mental health facilities.

RECOMMENDATION FIVE: Evaluate and improve integrations between services offering mental healthcare

The current systems exist as a patchwork of different systems, run across multiple differing agencies, spread across different areas, operated by different LHDs, with differing treatment methods, inclusion criteria, and referral pathway systems. What this creates, in effect, is a disjointed set of treatment pathways and options. There should be an evaluation of current integrations to identify gaps between EDs, mental health facilities, Ambulance and primary and community mental health services.

RECOMMENDATION SIX: Supporting staff to keep retention high

In preparing our submission for this Inquiry an issue that arose again and again was the difficulty mental healthcare services had in retaining staff. It is an issue that is not unique to the health system now, but it was particularly significant amongst mental health clinicians. Burnout was a significant factor in retention rates. Under-resourcing combined with a lack of support left staff feeling that they had to leave.

Annexures

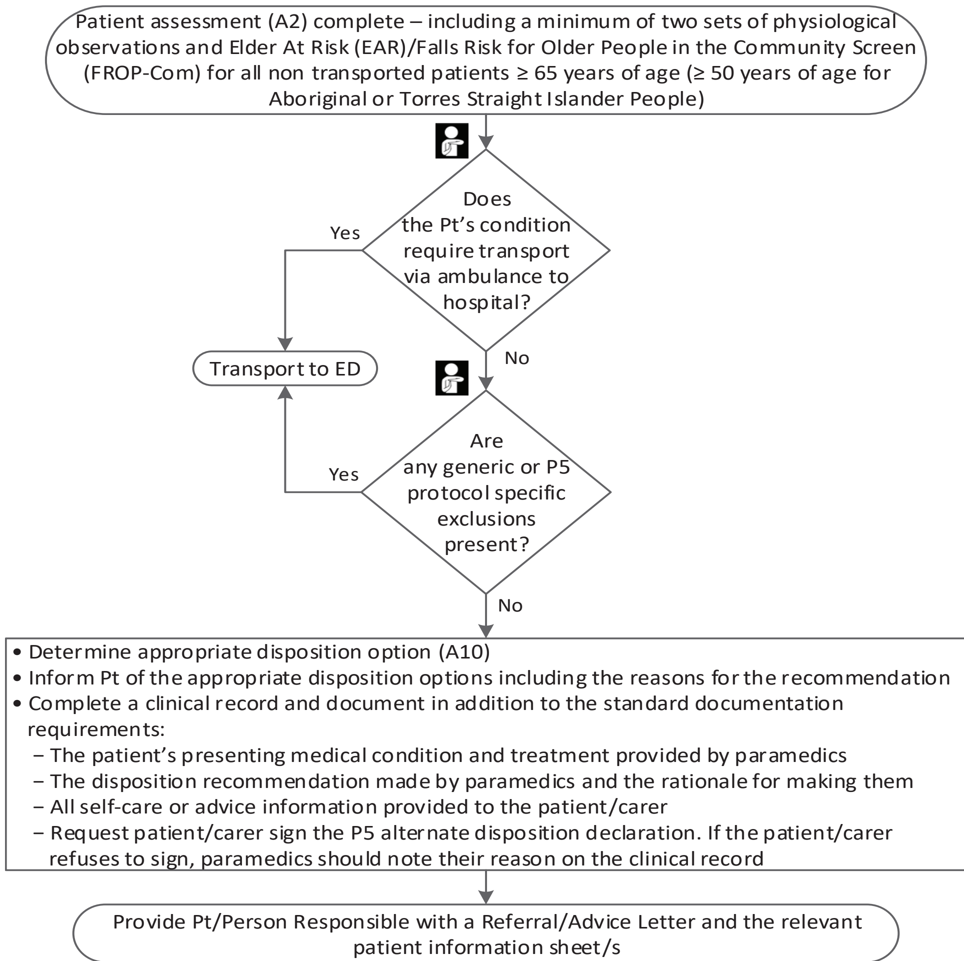
Paramedics must, in consultation with the patient and/or person responsible (where appropriate), make recommendations on the disposition options available for the patient's condition where transport to hospital via ambulance is not required.

Paramedics may recommend alternate disposition pathways to patients at the completion of a thorough assessment, which includes a minimum of two sets of physiological observations, as per protocol A10.

Protocol P5 should be used in cases where alternate disposition options are available and the patient does not require transport to hospital via ambulance or have any P5 Generic or P5 Protocol Specific Exclusion Criteria.

All patients who are not transported under the P5 disposition protocol must be provided with a written P5 referral form prior to paramedics departing the scene. The provision of a P5 referral form must be documented on the Clinical Record.

Procedure:



Generic Protocol Exclusions:

- Any red observations for adults (Reference R28) or yellow observations not adequately reconciled
- Patient does not demonstrate competency and capacity (including acute confusion) in the absence of a person responsible
- Patients with multiple co-morbidities, not adequately reconciled, which are likely to complicate treatment for their presenting condition and/or their presenting condition is unresponsive to treatment
- Patients suspected to be under the influence of alcohol/drugs and/or medication which alters haemostasis and with signs of trauma (e.g. swelling/bruising to face post assault/fall)
- Recent history of unreconciled syncope
- Medical practitioner requests for transport to ED via ambulance
- Recent surgical procedure and/or hospital admission/ambulance presentation related to the primary presenting condition and/or where hospital intervention is required

Generic Paediatric Specific Protocol Exclusions (In addition to Generic Protocol Exclusions):

- Any unreconciled paediatric (Reference R18) observations outside of the ranges listed
- Parental concern for the patient
- Patients ≤ 3 months of age
- < 16 years of age (excluding mature minors) with no adult supervision or paramedics are unable to contact a parent/carer to discuss treatment/disposition options

Protocols with P5 Protocol Specific Exclusions:

Medical/Surgical
- M1 – Abdominal Pain
- M4 – Asthma
- M6 – Nausea & Vomiting
- M7 – Croup
- M8 – Dehydration
- M9 – Seizures
- M16 – Anaphylaxis & Allergic Reactions
- M17 – Epistaxis
- M18 – Dental Problems
- M20 – Gastroenteritis
- M21 – Hypoglycaemia
- M27 – Headache
- M30 – Foreign Body Ingestion

Trauma
- T4 – Head Injuries
- T7 – Limb Injuries & Fractures
- T14 – Electric Shock
- T18 – Wound Care
- T19 – Falls in the Elderly
- T25 – Inhalation Injuries

Cardiac/Cardiovascular
- C1 – Acute Coronary Syndrome

Environment/Envenomation
- E6 – Bites, Stings & Envenomation

Specialised Care
- S11 – Incapacitating Agents
- SE1 – Elder at Risk

Toxicology
- DT2 - Alcohol

A2

Police Ambulance Early Access to Mental Health Assessment via Tele-Health (PAEAMHATH)

PAEAMHATH
Service Collaboration

- 2016 HNELHD Mental Health service was awarded some innovation funding
- Three major organisations involved
- Promoting care in the home and HOSPITAL AVOIDANCE
- Police and/or Ambulance transport around 60% of mental health patients who call Triple Zero
- People are often unable to get home if **NOT** admitted.

PAEAMHATH
Service Collaboration

Case for Change: The situation pre-PAEAMHATH

Calvary Mater Hospital

1765

Transportations by NSW Ambulance within Hunter New England Health 01/2014 - 09/2015

683

NSW Police transportations within Hunter New England 01/2014 - 09/2015

PAEAMHATH
Service Collaboration

Nelson Bay NSW 2315

Waratah NSW 2298

1 h
64.8 km

58 min
62.5 km

51 min
55.3 km

ONE Mental Health Assessment will take that response vehicle out of the area for three hours

THE DIAGNOSTIC REALITY

Three organisations, working in silos, driven by risk management and accountability conflicts…
The consequence is always poor experience of the patient

PAEAMHATH
Service Collaboration

Project objective

- Reduce trauma that carers and patients experience around this process
- Provide alternative referral pathways
- Develop a model of care that affords mental health patients, wherever possible, the ability to self-advocate and make decisions regarding their own health outcomes.

PAEAMHATH
Service Collaboration

Scope

Who's IN?

- Adults aged over 18 years
- People presenting symptoms of Mental Illness
- Psychiatric Emergency Service, Calvary Mater Hospital

Who's OUT?

- Children or adolescents
- Person's presenting under Mental Health Act
- People in Police custody

PAEAMHATH
Service Collaboration

They didn’t have to take me away, I get stressed when I have to be taken away, in my home was great’
Patient

PAEAMHATH
Service Collaboration

Quick and provides feedback ASAP

Police

Easy to use, great tool

Ambulance

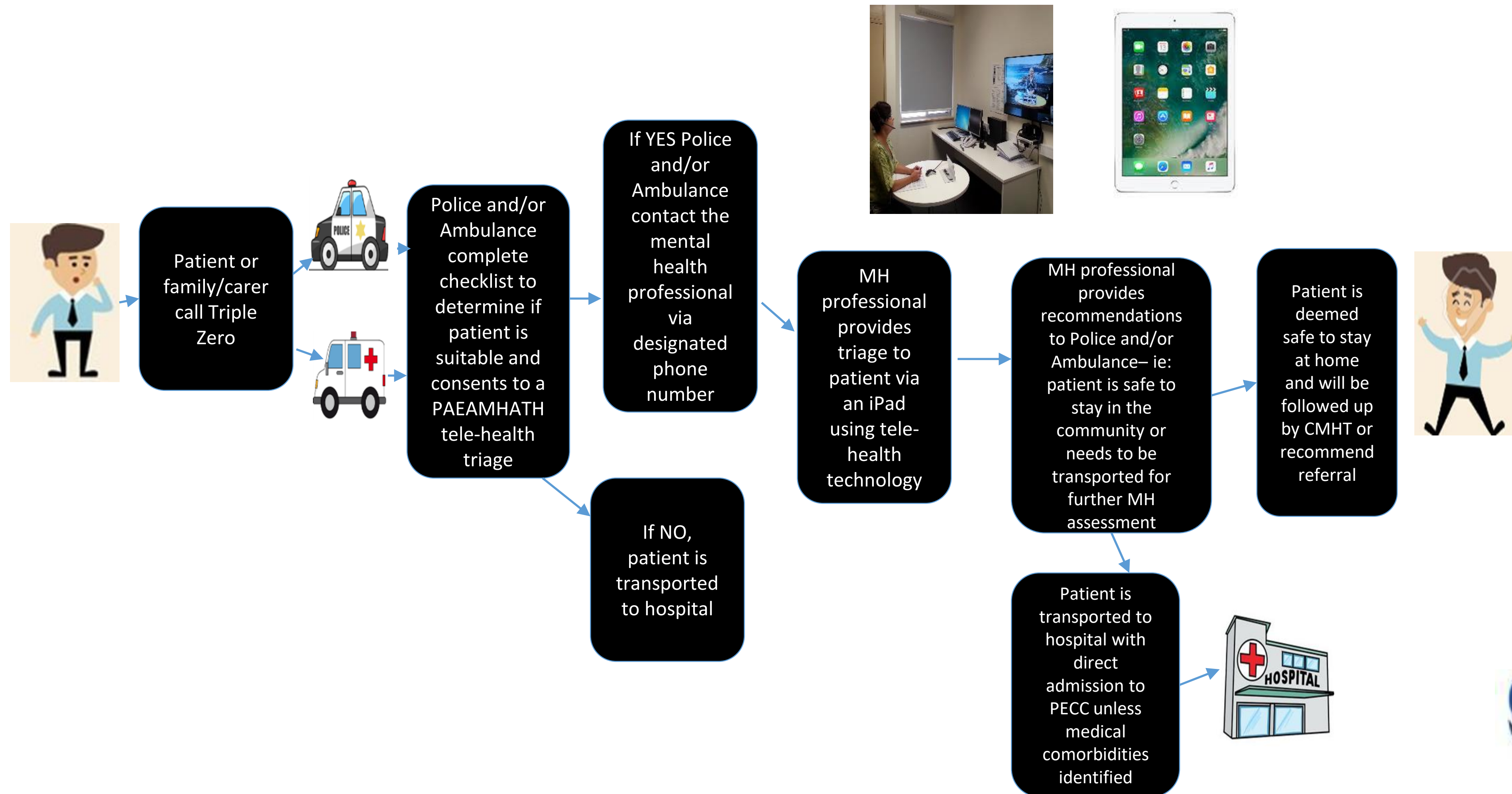
SOME OF OUR ASSUMPTIONS WERE SLAPPED IN THE FACE BY A **BIG** WET FISH

PAEAMHATH
Service Collaboration

My life is already like a movie – everyone talks about me, looks at me, watches me, talk to each other about me,
but never TO me.

T V-H, Patient

The NEW Patient Journey



PAEAMHATH
Service Collaboration

Results continued

From the **46** people triaged

13 transported to hospital at a cost of **$52,958.90**

33 people safe to stay at home with a cost avoidance of

$121,954.50

At an average saving of approximately **$3,695.59 PP**

- ✓Saving **79.72** hours for NSW **Police**
- ✓Saving **79.88** hours for NSW **Ambulance**

Savings for patients

=

INCALCULATABLE

PAEAMHATH
Service Collaboration
Plans
for
GLOBAL
DOMINATION