Submission to the Legislative Council Committee:

Inquiry into Acute Health Services

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Preface

The Mental Health Council of Tasmania (MHCT) is a member based peak body. We represent and promote the interests of community managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian.

MHCT welcomes the opportunity to respond to the Legislative Council Committee Inquiry into Acute Health Services. We note that our responses are informed by ongoing consultation with our members and relate specifically to the provision of acute mental health services rather than acute health services generally.

1. Current and projected state demand for acute health services

In recent months a fierce debate has waged in the public domain about the capacity of Tasmania's acute health services to respond to current levels of demand. Notably, much of this dialogue has centred on acute mental health services and the availability of psychiatric beds within public hospital settings.

While MHCT is not privy to public hospital admission data, we are advised anecdotally by sources within the Tasmanian Health Service (THS) that since February 2017 emergency departments in all regions of the state have experienced an unprecedented increase in mental health presentations. This increase appears to go beyond the existing upward trend of mental health-related emergency department presentations in Tasmania which had been sitting on a steady increase of 5% per year[1]. Additionally, we understand that the reported escalation of mental health presentations has been accompanied by an increased need for onward admission into inpatient psychiatric beds.

MHCT is firmly of the opinion that solutions must be implemented in each region as a matter of urgency to enable Tasmanian emergency and inpatient units to respond appropriately to patient need. However, we are at pains to emphasise that it is not yet known whether the recent increase in mental health presentations and admissions represents a spike in demand, peak demand within a trend, or ongoing exponential growth.

Until this data becomes available we urge the Tasmanian Government and other key stakeholders to exercise caution in relation to the creation of additional acute care infrastructure that may be unnecessary or inefficient in the longer term. We make this plea based on the body of national and international evidence—borne out time and again by the lived experience of consumers and their families—indicating that an effective mental health system provides acute hospital-based care for those who need it in conjunction with a full range of sub-acute and psychosocial stepped supports delivered in non-hospital settings[2].

The Tasmanian Government acknowledged this evidence in their 10-year mental health strategy, *Rethink Mental Health – Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025*, naming up 'shifting the focus from hospital based care to support in the community' as one of ten key directions within the document[3].

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[1] *Adult mental health in Tasmania*. Primary Health Tasmania, 2016, pg.4.

[2] *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 1*. National Mental Health Commission, 2015, pg. 74.

[3] *Rethink Mental Health – Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025.* Department of Health and Human Services, 2015, pg. 22.

2. Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services

MHCT contends that there are two key factors influencing the capacity of Tasmanian hospitals to meet the current demand in the provision of acute mental health services: an existing service system that lacks 'step-up step-down' treatment options for mental health consumers; and the under-resourcing of the sub-acute structured supports that do exist. (As stated above, we don't believe the data yet exists to justify basing future projections on the current presentation trend.)

A feature of virtually all contemporary literature on mental health service design is the emphasis on developing a stepped model of care that, in the words of the Australian Government, "will ensure people get the right clinical service at the right level and at the right time, linked to other non-health supports as required"[4]. Tasmania's *Rethink* strategy aligns itself with this principle, stating that its "goal is to re-orientate the Tasmanian mental health system to increase community support and reduce the reliance on acute, hospital based mental health services"[5].

Rethink is a ten-year strategy which means we can expect to see the evolution of a Tasmanian stepped care model in the near future, but it won't appear instantaneously. If we scrutinise the system at the current moment we see a number of new interventions in 'step down' care—one example is Anglicare's Early Intervention Referral Service (EIRS) which provides intensive psychosocial support following hospital presentations after a suicide attempt—but very little yet in the way of 'step up' supports. It is arguably too early to assess the systemic benefits of any nascent initiatives in this space. What this means is that a Tasmanian experiencing mental ill-health who is not already connected to the service system has essentially two presentation options: primary care (GPs) or acute care (emergency departments). There are no self-referring support options available between these two extremes.

This situation is exacerbated by the under-resourcing, or under-representation, of existing sub-acute community and clinical supports. At MHCT we field phone calls on a weekly basis from individuals within the community whose family members experiencing mental ill-health have presented to a GP and been referred onward to specialist care, only to find that there is a three-month waiting period for an appointment with a private psychiatrist. For an individual in the escalating stages of a mental health crisis this is woefully inadequate and there is every likelihood this person will present to an emergency department in a state of distress and desperation before three months has elapsed.

What this also means is that individuals who are experiencing worsening symptoms of mental ill-health may present to hospital because there are no other options, only to be triaged and told that they are not sufficiently unwell to be treated. This is not only a deeply unsatisfactory care outcome for the individual but adds significantly to the burden of emergency department presentations.

Likewise, we know anecdotally that the available mental health beds in Tasmania's private clinical settings are often at capacity, meaning that even individuals who can afford to access private inpatient care may not in fact have a treatment option outside of public health services.

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[4] *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. Australian Government Department of Health, 2015, pg. 8.

[5] *Rethink Mental Health – Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025.* Department of Health and Human Services, 2015, pg. 22.

An additional factor influencing the capacity of our hospitals to meet demand in relation to mental health presentations is the apparent lack of a clear and consistent process for the discharge or transition of a patient into appropriate sub-acute or step-down care, following a hospital admission.

As we have noted, Tasmania does not yet boast a full range of step-down mental health programs and facilities, but they do exist, and many of them are delivered successfully in the community by MHCT's member organisations. The public health system's failure to implement consistent discharge planning and transition processes mean that the onward referral of patients into these non-acute settings is at the discretion of individual clinicians. Based on our understanding of existing referral pathways between acute health services and the community sector, we believe the subjective nature of current discharge practices may be a contributing factor to what is often termed 'bed block' in emergency and inpatient units.

3. The adequacy and efficiency of current state and commonwealth funding arrangements

It is widely recognised within Tasmania's mental health sector that state and commonwealth funding arrangements are in combination deeply inefficient. While the State Government is solely responsible for the provision of mainstream public health services (i.e. hospitals), both levels of government channel funds into a range of non-clinical mental health supports without the benefit of any overarching strategy or collective arrangement in relation to system design, implementation or outcomes.

This lack of coordination is acknowledged unilaterally, within the Commonwealth Government's review of mental health services[6], the State Government's mental health plan[7], and now within the *Fifth National Mental Health and Suicide Prevention Plan*[8]. MHCT wholeheartedly welcomes this inter-governmental commitment to the development of an integrated and coordinated mental health system, and urges all agencies responsible for the delivery of funding into existing services to work collaboratively and pragmatically to ensure that current inefficiencies in service design and delivery—evidenced in fragmentation, service gaps and duplication—are eliminated going forward.

Tasmania's state-owned *Rethink* strategy goes so far as to identify "blended funding initiatives" as an example of the kind of formal linkages that are "most effective" in supporting system integration. Until our current funding channels are streamlined in this way MHCT expects a continuation of the piecemeal approach to system design, with stepped-care 'solutions' patched into current healthcare structures but no true continuum of care for mental health patients. Additionally, without a whole-of-system approach to mental health infrastructure, there is no entity responsible for the oversight of system trends or outcomes, meaning there is very little scrutiny or insight into the factors contributing to scenarios like the one we are witnessing in Tasmanian emergency departments at present.

It should be noted, however, that funding inefficiencies do not necessarily correlate to funding inadequacies. MHCT's member organisations tell us consistently that Tasmania's state funding arrangements are not insufficient in terms of monetary spend but rather misapplied in terms of emphasis, with acute end hospital care still absorbing a high percentage of funds at the expense of essential upstream community and psychosocial supports.

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[6] *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. Australian Government Department of Health, 2015, pg. 8.
[7] *Rethink Mental Health – Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025.* Department of Health and Human Services, 2015, pg. 19.
[8] *Fifth National Mental Health and Suicide Prevention Plan 2017-2022*. Commonwealth of Australia, 2017, pg. 19.

This imbalance is not peculiar to Tasmania but rather symptomatic of outdated mental health system planning and infrastructure nationwide. The National Mental Health Commission's seminal 2015 *Review of Mental Health Programmes and Services* made the following statement on this subject:

> Accessing treatment when it is needed is important—it is essential—but hospital admissions often can be seen as evidence of the failure of the system to keep people well and in the community. The centre of gravity in Commonwealth mental health funding needs to shift upstream, to prevention, primary health care, early intervention and recovery. Conversely, unless action is taken now to change the system and the current incentives, hospitals will continue to absorb an increasing amount of funding and people will continue to end up in crisis when it could have been avoided.[9]

MHCT recognises that both State and Commonwealth Governments are making concerted efforts to address funding inefficiencies and correct this imbalance, yet the current crisis of mental health presentations to emergency departments in Tasmania indicates that there is still a long way to go.

4. The level of engagement with the private sector in the delivery of acute health services

MHCT has chosen not to respond on this topic as we are not privy to details of private sector engagement with acute health services.

5. The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services

In the context of public emergency departments and psychiatric units that are stretched by heightened rates of demand, there are clear adverse outcomes for mental health patients. One obvious factor is that emergency departments, of all possible settings within a hospital, are perhaps the least conducive to emotional wellbeing. Particular factors here include incessant intense stimuli—artificial light, repetitive noises, continual human and mechanical interruptions—as well as the stress of being surrounded by other critically unwell patients.

MHCT has heard anecdotally that individuals presenting to the Royal Hobart Hospital (RHH) emergency department have recently had waits of upwards of 24 hours before a bed has become available in the Department of Psychiatry for onward admission. For an individual experiencing a mental health crisis this extended period in treatment 'limbo'—whether within the emergency department or another temporary care setting—can be intolerable, and consumers talk of reaching a point where they feel they have no option but to threaten harm to themselves or others in order to expedite care.

We should also note that the nature of temporary care settings means they do not necessarily contain the safety and harm-reduction features that are requirements within contemporary inpatient psychiatric units. One obvious and potentially devastating example is access to hanging points.

On the subject of harm minimisation, we also recognise that mental health patients who experience longer inpatient stays are at greater risk of exposure to restrictive practices through means of seclusion and restraint. Data from the Australian Institute of Health and Welfare shows that overall in Australia rates of seclusion and restraint in public sector acute mental health hospital services are reducing. Yet compared with other states, Tasmania's rates of seclusion incidents in 2015-2016 were second only to those of the Northern

[9] *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, Volume 1*. National Mental Health Commission, 2015, pg. 74.

Territory, and our rates of physical restraint incidents in the same period were higher than all states except the Northern Territory and Victoria[10].

MHCT acknowledges that Tasmania's *Mental Health Act 2013*, which commenced in February 2014, will encourage progress towards a reduction in these rates, and yet it remains true that mental health patients in Tasmanian acute care settings are still subject to restrictive practices that are now universally recognised as detrimental to recovery. In 2015 the National Mental Health Commission declared that:

> There is a lack of evidence internationally to support seclusion and restraint in mental health services. There is strong agreement that it is a human rights issue, that it has no therapeutic value, that it has resulted in emotional and physical harm, and that it can be a sign of a system under stress.[11]

6. Any other matters incidental thereto

In conclusion, MHCT urges the Tasmanian Government to work collaboratively with the state's acute health services and other key stakeholders to identify solutions in each region that will enable Tasmanian emergency and inpatient units to respond appropriately to heightened rates of patient demand in the immediate term.

With equal urgency, we call on both levels of government to expedite key actions within their articulated mental health strategies to integrate planning and funding mechanisms with the goal of rebalancing mental health activity and expenditure towards sub-acute residential and psychosocial supports. We emphasise again that any short-term investment into acute health services must not come at the expense of established intergovernmental objectives in relation to the development of a stepped model of mental health service delivery that supports the individual's access to the right level of care at the right time and in the right way.

We would welcome the opportunity to provide further information on any aspect of this submission at the Committee's request.

[10] *Use of restrictive practices during admitted patient care*. Australian Institute of Health and Welfare, 2017.
[11] *Seclusion and restraint Position Paper released.* National Mental Health Commission, 29 May 2015.