

# The Rural Mental Health Emergency and Critical Care Access Plan

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## Executive Summary

In rural and remote NSW, the delivery of quality emergency mental health care requires improvements across a number of areas. These include:

1. Access to mental health expertise and support across a network of emergency facilities,
2. Increased support to primary health care staff who provide mental health services in remote areas,
3. The provision of services to support patient transport and/or transfer with appropriate clinical governance,
4. The provision of appropriate staffing to support the delivery of emergency mental health care,
5. Developing appropriate clinical governance, including access to specialist mental health advice and assessment,
6. Developing data systems and practices to enable appropriate evaluation of current and future service models and,
7. Ensuring mental health services meet the needs of Aboriginal people in rural and remote Areas
8. Ensuring the models of care can flexibly address the needs of consumers from all age groups and cultural backgrounds

Mapping of current emergency mental health services against these requirements has identified a number of gaps. These include:

1. Varying levels of access to emergency mental health services across all levels of health care
2. Limited local availability of a range of appropriate mental health services able respond to emergency events in rural and remote areas
3. A lack of facilities in small rural areas for the safe assessment and monitoring of behaviorally disturbed individuals
4. A need for patient transport and security to be provided for pre and inter hospital transport, often across large distances using air and/or road transport
5. Potential difficulties accessing police and ambulance support when significant distances, and time away from the township are involved

This plan is designed to achieve enhancements in Area based models for rural emergency mental health services and needs to be tailored to the specific

geographic and population needs across the four rural Area Mental Health zones. The plan proposes:

- Networked services from regional bases (level 4 facilities and above) to level 1-3 facilities. This will improve access to specialist mental health assessment and support from clinical teams based in regional centres/hubs. These clinical teams will also have the capacity to provide/coordinate transport and potential outreach to these facilities utilising tools and methods appropriate to each locality (e.g. videoconferencing).
- Safe client transport and/or transfer, with appropriate clinical governance, through the provision of appropriately trained staff in each regional hub (level 4 services).
- A Mental Health Telephone Intake Line for 24 hour, 7 day a week access to mental health assessment and triage services, and telephone access to a Psychiatrist on-call 24 hours a day, 7 days a week.

This model recognizes and supports the role of primary care providers, especially Registered Nurses, Enrolled Nurses and general practitioners in remote emergency departments, through the proposed provision of increased access to support, advice, training and links with specialist centres.

It is proposed that each rural Area Mental Health Service develop an Area implementation plan. The plan will be based on a local consultative process, and informed by the specific needs of the population, geography, distances and communities of each Area.

The Area implementation plan should also be informed by the key principles of safety, access to care, appropriateness of care and social inclusion. The development, implementation and evaluation of each Area plan should specifically consider the needs of Aboriginal people in rural and remote NSW. Furthermore, specific consideration is required for the assessment and clinical management of mental health emergencies among older people, children and adolescents (including children whose parents require transfer to distant locations due to a mental health issue).

The development of the Rural Mental Health Emergency and Critical Care Access Plan represents one aspect of the broader task of developing a comprehensive Mental Health Access Plan for New South Wales including hospitals and health services across metropolitan, regional and rural areas.

## Introduction

The following document presents an overview of a plan for emergency mental health services in rural and remote New South Wales. The focus of the rural access plan is the clinical assessment and treatment of individuals who present to emergency departments with acute behavioral disturbance due to mental illness. These patients may also require transportation to other facilities for appropriate care.

The appropriate coordination of emergency mental health services, across Areas, is essential in ensuring access to an appropriate level of service when needed. The aim is to ensure patients receive the most appropriate care at the most appropriate times with due regard to the views and needs of family and carers.

The population of rural and remote NSW (approximately 1.5 million) is provided with emergency health care services from 131 facilities ranging from level 1 facilities, small facilities with an on-call nurse and access by phone to medical support, to level 5 facilities. Level 5 facilities, located in regional centers, offer purpose designed emergency departments with dedicated emergency teams and intensive care. These facilities act as receiving centers for patient transport and/or transfer from more remote areas, and have on-site inpatient psychiatric facilities.

The data currently available regarding demand for emergency mental health services in rural general hospitals are limited. Nevertheless, where Emergency Data Information System (EDIS) data are available, figures for 2003 indicate that level 3 to level 5 facilities in rural areas had on average up to 25,000 presentations per year, of which 3.1% were primarily for a mental health problem (3.4% state-wide average). Level 3-5 facilities in urban areas reported 29,000 presentations, with 3.4% of these for primarily mental health problems. These prevalence rates for mental health presentations in emergency departments are an underestimation of the scope of the clinical need due to variations in the detection and coding of mental health problems and related co-morbidities.

National and international data indicate prevalence rates of up to 10% for those presentations to emergency departments of general hospitals with a primary psychiatric problem (NSW Health Department, 1998). Higher rates again are given for presentations in which there is a psychological problem, and between 10-46% of those people presenting with a psychiatric complaint have a co-existing physical illness that may be contributing to their mental health problems (NSW Health Department, 1998). More recent reports also suggest an increasing demand for mental health services in emergency departments over time; particularly the more severe or complex conditions (Kalucy et al, 2005).

These data suggest that the clinical demands on rural hospital emergency departments are not greatly dissimilar to urban centres, yet in rural areas health care resources are more limited, more widely dispersed and more difficult to access. This is especially true for mental health services.

Aboriginal people represent a greater proportion of the population in rural and remote Areas and may experience higher rates of co-morbid physical and mental

health problems. Emergency assessment services need to be developed, in collaboration with Aboriginal people, to ensure that physical and mental health assessments are appropriate and sensitive to the emotional, social and cultural needs of Aboriginal people.

The geographic distribution of services varies greatly across rural Area Health Services. Some metropolitan Area Health Services with semi-urban areas also have smaller hospitals providing immediate triage and emergency care for those communities.

Other rural data indicates significantly higher rates of hospital admission with a primary diagnosis of psychiatric disorder, chiefly under the care of general practitioners and general hospital nursing staff (Hungerford, 2005). The appropriateness of such care, and the health outcomes for those patients, requires separate analysis but represents an important issue in addressing the capacity and support needs of rural general hospitals to provide inpatient care for common psychiatric emergencies. There is a need to review current practices. This will be the subject of a subsequent phase of the Rural Access Plan.

There is also a need to develop a model of emergency mental health services tailored to the specifics of the rural areas of New South Wales. Development of the model should consider geographic distances, transport links, varying population distribution and health service resources across rural and remote NSW. In addition, there is also a need to provide a framework for the identification of resource requirements to meet a desirable level of service across the breadth of rural and remote areas.

## Policy context

The following key policy directions, within Australian and NSW government public policy for mental health, have informed the development of this plan.

The National Mental Health Plan 2003-08 identifies the need to increase the capacity of emergency departments to provide assessments, triage/referral and acute care through ongoing staff support and the promotion of evidence-based practice.

The 2002 NSW Select Committee Inquiry into Mental Health Services recommended greater clarity and support for the role of Emergency Departments in mental health assessment and care. The Committee also recommended enhanced funding for NSW Health to increase numbers of specialist mental health staff trained in the management, detention and care of a person brought to facilities by police under sections 21, 22 and 24 of the Mental Health Act 1990. This was followed by a Government commitment of \$15 million over five years to improve responsiveness and access to emergency services.

The NSW Government Action Plan for Health - Emergency Department Services Plan (2001) recommends that mental health care remain a priority area within Emergency Department services. As a result, since 2001 an additional 60 mental health liaison nurse positions have been created across Area Health Services to improve access to, and assist with, the management of mental health clients presenting to Emergency Departments.

The 2004 NSW Health Sustainable Access Plan is currently being implemented, and will include strategies for reducing access block for mental health patients in Emergency Departments. These include the provision of Psychiatric Emergency Care Centres and better access to timely management in rural Areas.

The NSW Strategic Plan for Mental Health 2005-2010 is currently under development. In July 2005 the NSW Premier released the NSW Interagency Plan for Better Mental Health, which is currently being implemented and monitored by NSW Government agencies. Both are aligned and include Emergency Mental Health Response as a key platform for service development.

The Urgent Response and Transport (URT-SOG) Seniors Officers Group, representing government departments involved in emergency mental health response, developed a Memorandum of Understanding (MOU) in 2002 to work on this issue. A statewide Inter-Department Committee (IDC) has since been established to monitor progress on the MOU. More recently, flow charts have been developed to clarify the roles of each agency and Local Protocols Committees established to ensure co-ordination across agencies.

It is likely that the current review of the Mental Health Act will also contain a number of improvement areas; however changes to the legislation may be some way off.

## The Current Situation

An audit was conducted of emergency mental health services across level 1 to level 5 facilities in rural NSW (GWAHS, HNEAHS, GSAHS and NCAHS) to establish the current level of service provided and its concordance with the recommendations of the NSW Government Action Plan for Health - Emergency Department Services Plan (2001). The audit also collected data on transport needs (e.g. distances to specialist inpatient services, ambulance and police transport).

A total of 131 hospital emergency units across rural and remote NSW were surveyed.

These comprised:

- Twelve level 1 facilities
- Seventy one level 2 facilities
- Thirty level 3 facilities
- Thirteen level 4 facilities and
- Five level 5 facilities.

### The key issues to emerge from these data are:

1. Varying levels of access to emergency mental health services across all levels of health care, including a significant proportion of level 2 and 3 facilities with limited or no access to an after hours mental health intake service.
2. The significant role of Registered Nurses (RN) and Enrolled Nurses (EN) as primary mental health service providers in rural and remote emergency departments.
3. Rural and remote areas have limited local availability of an appropriate range of mental health services to respond to emergency events. These include:
  - limited access to mental health workers (nursing or allied health) for face to face assessments in smaller rural communities, and,
  - limitations in the availability of on-call psychiatrists for level 2 and 3 facilities.
4. Small rural hospital emergency departments, often comprising 1-2 beds, are not equipped for the safe assessment and monitoring of individuals with severe behavioral disturbance.

With access to assistance, these facilities can be appropriate for those with less severe disturbance or risk. This is a key factor in reducing unnecessary demand on the specialist inpatient units.

5. When patients in rural or remote areas require transport for more intensive mental health emergency treatment, safe transfer often requires security



involvement and air and/or road transport across large distances. There is marked variability across the state in terms of the distances from a rural or remote hospital to an acute inpatient facility. Some locations have substantial distances (maximum >500 kms) to the nearest inpatient psychiatric facility, particularly in the remote regions of Greater Western and Greater Southern Area Health services.

6. A number of level 2 facilities have no ambulance or police in their towns. This makes it very difficult to obtain support to transport a mental health patient between health facilities.
7. Where police and ambulance services are available, the significant distances from remote hospitals to acute inpatient facilities have implications both in terms of enlisting the support of these agencies for mental health emergencies, and also for the impact that involvement has on the availability of police and ambulance services to the community. It often means that police or ambulance staff will be lost to that town for a significant period and can limit an officer's ability to report for duty in the morning following transfer.
8. There are substantial limitations in the current data and information systems available regarding mental health emergencies in rural and remote hospitals. There is limited comparable and systematic data concerning emergency presentations and outcomes at these facilities.

## **Aim of the Rural Mental Health Emergency and Critical Care Access Plan:**

The key aim of this plan is to improve the clinical management of patients with acute behavioural disturbance who present at rural and remote emergency departments. Clinical management includes meeting the requirements for safe and comprehensive assessment, treatment and (if required) the transfer of patients with appropriate consideration of the patient's family and carers.

This framework for emergency mental health care is designed to achieve improvements in the following key areas:

### **1. Safety**

- a. Safety at the point of assessment for patients, health staff (including ambulance personnel) and police.
- b. Safety in transport.
- c. Ensuring family support needs are in place

## **2. Access to care**

- a. Access to the level of care required; and
- b. Minimizing delays to specialist assessment, treatment and/or support where required.

## **3. Appropriateness of services to the level of patient need and environment**

- a. Clinical services that are appropriate to the patients' level of need including:
  - i. breadth of specialist expertise,
  - ii. location of care for acutely behaviorally disturbed individuals,
  - iii. the range of physical and mental health problems that may be experienced by Aboriginal people,
  - iv. appropriate assessment of physical conditions (such as neurological illness) and
  - v. substance-related disorders.
- b. Where the patient requires transport, management practices are appropriate to the mode of transport (e.g. sedation/restraint for air transport) and to the local environment (e.g. distance).
- c. Specialist services are supported by clinical teams to transport and/or transfer patients, videoconference assessment and appropriate clinical governance.

## **4. Social inclusion.**

This refers to the provision of mental health care in a way that is mainstreamed with other health services and reduces the stigma of mental illness by:

- a. Reducing the involvement of police in inter-hospital transport through options that support safe transport of patients across the distances required,
- b. Increasing the capacity of general health services to assess, treat and monitor common mental health emergencies across all age groups (e.g.; developing appropriate facilities, workforce training, support and links to specialist services),
- c. Increasing access to mental health expertise in remote areas and
- d. Reducing the need to transport patients to distant facilities.

## 5. Attending to the specific needs of Aboriginal people in rural and remote Areas.

This includes active participation by Aboriginal people in the design implementation and evaluation of Area Rural Emergency Mental Health and Critical Care Access Plans with specific consideration of:

- a. the involvement of Aboriginal health staff and liaison workers to assist in the appropriate assessment and support of the patient and family,
- b. the attention to potential physical co-morbidities that may be more frequently encountered in Aboriginal people and
- c. consideration of the specific needs of Aboriginal people in the hospital setting and when transport is required

## 6. Recognition and attention to the specific needs of:

- families and carers
- children and adolescents (including the children of parents with mental illness).
- older people
- people with drug/alcohol-related mental disorders
- culturally and linguistically diverse people

## The Purpose

This plan has been developed with a view to achieving a range of enhancements to rural emergency mental health care. The plan will outline a general service framework, and provide the underlying principles that inform this framework.

*Area Health Service implementation plans will need to reflect local geographic and population characteristics in the identification of specific service improvements, transport practices, resource needs, facility requirements and, in some Areas, a long-term focus on workforce development.*

1. **It is recommended that each rural Area Health Service develop a model of emergency mental health care based on consideration of population needs, geography, distance and local communities including the needs of Aboriginal people.** The models should consider:
  - a. Networked services from regional bases (level 4 and above) to level 1-3 facilities to provide access to specialist services.

- b. Specialist clinical teams in regional centers/hubs with the capacity to provide specialist mental health assessment and support, coordinate transport and potential outreach to these facilities and use tools and methods appropriate to each locality (e.g. videoconferencing). These teams will provide training in the management of acute behavioral emergencies for health staff located in linked smaller units.
- c. The provision of safe client transport and/or transfer with appropriate clinical governance with appropriately trained staff in each regional hub (level 4 service). These staff may be on-call specifically for this task e.g. the Health Security Assistants and Transit Nurse Specials roles developed in the North Coast Rural Critical Care pilot, or consideration of specific roles for Aboriginal health staff. These steps are designed to increase the capacity of the health workforce to meet the transport objectives.

**2. It is recommended that Area models be informed by components of the current Rural Critical Care Pilot Project being conducted by North Coast and Hunter Area Mental Health Services.** The components include:

- a Mental Health Intake Line for 24 hour, 7 day a week access to mental health assessment and triage services;
- employment of Transit Nurse Specials and Health Security Assistants for the safe transport and / or transfer of mental health patients;
- access to a Psychiatrist on-call 24 hours a day, 7 days a week;
- mechanisms for mobilizing the appropriate transport services and identifying available beds to receive the patient; and
- safe operating procedures and training programs to support the implementation of these services.

**3. An implementation plan should be developed for each Area,** which includes provision for adequate consultation with local stakeholders. Consultation should focus on the identification of local service patterns, available resources, the specific needs of stakeholders including those groups listed in points 5 and 6 of the Plan Aim, and an estimate of required resources to achieve any proposed changes.

In particular, Areas should involve Aboriginal Mental Health Workers and community representatives in the development of the Area implementation plan. Stakeholders could also include, but are not limited to, service clients, carers, health staff, police and ambulance services and other government departments (e.g. the Department of Community Services).

**4. The model recognises and supports** the role of primary care providers, especially Registered Nurses, Enrolled Nurses and general practitioners in remote emergency departments, through the proposed provision of increased access to support, advice, training and links with specialist centres.

5. **The Area implementation plan should be informed by the key principles of safety, access to care, appropriateness of care, and social inclusion.**
6. **The models should substantially reduce the need for police involvement in the transport of patients between health facilities.** Police should only be involved when there are serious safety concerns and alternate options have been exhausted. The existing MOU between NSW Police and NSW Health outlines flow charts, i.e. 5B of that document, which clearly articulates protocols and agency responsibilities for use of police in the transportation of patients.
7. **The models should recognise the role of, and utilise, existing health transport services in rural areas** (e.g. NSW Air Ambulance) and the role of the Royal Flying Doctor Service (RFDS).
8. **The models will provide a framework to inform the development of health resources** required to meet the tasks of appropriate mental health assessment, coordinated treatment plans, provision of outreach and appropriate transport needs. Model development should emphasise the need for comprehensive clinical assessment that includes physical and psychological assessments at the time of the patients' presentation to the Emergency Department.
9. **It is recommended that a multi-agency process be established in each Area Health Service to oversee the implementation and management of the emergency plan**, such as currently exists with the Joint Service Agreement. This multi-agency process should include Police, Ambulance Services (including Air Ambulance), Health Service staff, general practitioners, Department of Community Services and the RFDS. This process will build upon the current work of Local Protocols Committees (LPC) established to ensure clear roles and cross agency protocols.
10. **It is also recommended that a separate plan be developed to identify current and future requirements for improved access to a full range of psychiatric emergency services.** This plan should outline the methods of support available from regional centres to more remote and smaller health facilities. Elements of the plan should focus on:
  - a. an increased capacity for individuals to receive specialist psychiatric care as close as possible to their place of residence through:
    - i. review of the number and distribution of inpatient psychiatric beds across rural and remote areas, and,
    - ii. the steps required to support viable inpatient services in remote centres.

- b. the provision of resources for the timely and safe transport of patients when required,
- c. increasing the workforce to meet the requirements for increased access to specialist advice and support,
- d. the provision of communication tools between specialist mental health services and rural and remote health services (such as videoconferencing),
- e. the provision of appropriate and adequate workplace training for primary health care, mental health and ambulance staff in mental health emergency care. This training should focus on remote access support and emphasise the needs of Aboriginal people in rural and remote Areas. Delivery could utilise videoconference technologies in clinical practice where appropriate.
- f. the provision of an appropriate physical environment in hospital facilities for the assessment of mental health emergencies.
- g. strategies to link with specialist mental health programs and service plans within Child and Adolescent Mental Health Services, Forensic Mental Health Services and Specialist Mental Health Services for Older Persons.

## **The Proposed Model:**

The following model of rural and remote emergency mental health services is proposed to meet the Plans' objectives:

1. Provision of mental health expertise and support across a network including support for emergency facilities in remote areas.
2. Area-wide coordination of emergency mental health services, including outreach into rural and remote areas and assessment and treatment based on clinical need.
3. Provision of appropriate transport and/or transfer practices with appropriate clinical governance. These practices will be consistent with the roles of each agency defined in an Inter Agency Agreement.
4. Provision of, and access to, appropriately trained staff to support the delivery of emergency mental health care.
5. Provision of adequate clinical governance for emergency mental health services including access to specialist mental health advice and assessment, and on-call psychiatrist/s 24 hours a day, seven days a week.
6. Data systems and practices to support the appropriate evaluation of current and future service models.

*While the Rural Critical Care Pilot informs this model, it will require adaptation due to the varying demographic and geographic characteristics present across rural and remote areas of NSW.*

In line with the proposed model, Area Mental Health services have been broken down into five levels, each offering a different range of facilities and services. These are outlined below:

Level 1:

- Mental Health Telephone Intake Line for 24/7 triage and assessment
- Capacity to transfer to level 4 (where the need for transfer and admission is clear) or to level 3 (where appropriate - for management/stabilisation and reassessment)

Level 2:

- Mental Health Telephone Intake Line for 24/7 triage and assessment
- Capacity for on-site assessment and treatment from local community mental health service (if available)
- Videoconference link with level 4 facility or other appropriate method of remote access support
- Capacity to transfer to level 4 (where the need for transfer and admission is clear) or to level 3 (where appropriate - for management/stabilisation and reassessment)

Level 3:

- Mental Health Telephone Intake Line for 24/7 triage and assessment
- On site assessment from local community mental health team (with capacity for after-hours face-to-face assessment on site)
- Videoconference link to level 4 facilities
- Capacity to transfer to level 4 (where the need for transfer and admission is clear)

Level 4:

- As for level 3
- Mental Health Unit
- On site Mental Health Clinical Nurse Consultant. Access to a multidisciplinary mental health clinical team to support assessment and transport when needed (examples many include CNC, psychiatrist, Transit Nurse Special, Health Security Assistants)
- Purpose-built mental health assessment rooms
- Videoconference link with level 2 and level 3 facilities for consultation

Level 5:

- As for level 4
- May be a site for Rural Psychiatric Emergency Care Centres (RPECC), but with modifications to metropolitan PECC models for rural emergency departments

Table 1: Mental health services and facilities offered by each level of Emergency Department are shown below:

Service	Emergency Department Level				
	Level 5	Level 4	Level 3	Level 2	Level 1
Rural Psychiatric Emergency Care Centres (RPECC) *	✓				
Mental Health Unit	✓	✓			
Mental Health Assessment Room	✓	✓			
Psychiatrist	On site	On call	Phone Consult.	Phone Consult.	Phone Consult.
Medical Officer	On site	On site	VMO – on call	VMO – on call	VMO – on call
Mental Health CNC/CNS	16 hours per day/7 days per week	16 hours per day/7 days per week	8 hours per day, & days per week + visiting	Visiting	Visiting
Tele-psychiatry facility	✓	✓	✓	✓	
Transport Team	✓	✓			
On call mental health staff to support transport e.g. HSA and TNS	✓	✓			
Mental Health Telephone Intake Line-Triage /Assessment		✓	✓	✓	✓

**NB:** Variability in current services across Areas needs to be noted. For example, all level 1 facilities in the remote Far West area have access to videoconference facilities.

\* may be applicable in limited locations only, with modification to metropolitan model for rural emergency departments.



## **Desired Outcomes:**

Successful performance against the Plan objectives will be evidenced by:

1. Reduction in adverse incidents.
2. Improved coordination of emergency mental health care at hospitals, including patient assessment, outreach and transport and/or transfer with appropriate clinical governance.
3. Reduction in time taken to receive appropriate care – the right patient receives the right form of treatment in the right place within an appropriate timeframe.
4. Improved patient, carer and service partner (Emergency Department staff, Police and Ambulance) satisfaction.
5. Improved training in mental health emergencies for all levels of health and health related staff involved in assisting individuals and families in mental health emergencies
6. Reduction of police involvement in mental health patient transfer between health facilities. The aim is to utilise primarily health staff in the transport or transfer of mental health patients.

An evaluation framework will be needed including clinical, service delivery and interagency co-ordination Key Performance Indicators based on the above objectives. This could be progressed through the NSW Mental Health Emergency program, which has developed a system for evaluating the metropolitan Psychiatric Emergency Care Centres.

## **Strategies recommended to develop the model for local implementation**

To assist in the achievement of these outcomes, the following strategies are recommended:

1. The formation of key partnerships with police, ambulance, general practitioners, nurses, allied health professionals, Aboriginal health staff / organisations, and rural communities.
2. The development of a plan that:
  - a. is informed by a critical evaluation of the strengths and weaknesses of existing service configurations.
  - b. addresses workforce issues including:
    - i. the availability of appropriately skilled and experienced staff,

- ii. workload demands on the existing workforce,
  - iii. availability of organisational support for health workers (including primary care, general hospital, mental health and ambulance staff) and,
  - iv. identifying the required workforce composition and specific competencies needed to deliver appropriate mental health emergency care.
- c. identifies resource requirements and how to source these.
  - d. identifies strategies for data collection and service evaluation that can regularly monitor mental health critical care activity and outcomes.
  - e. ensures that new service models and their principles are documented in the form of operational policies and procedures.
  - f. promotes the development of appropriate facilities designed to meet the demands of emergency mental health care across a spectrum of small rural hospitals through to regional centers.
  - g. identifies specific transport needs and options in remote areas, such as Air Ambulance, and the necessities for safe transport.
  - h. Incorporates an implementation and evaluation strategy that is based on multi-agency agreements and negotiation (e.g. between Police, Ambulance, Mental Health Services, general hospitals, RFDS).
3. The development of a timetable for implementing these changes in an appropriately staged manner, following consultation, within each Area Health Service. It is recommended that, in the first instance, this entails:

Stage 1: Area-wide access to a mental health intake and triage service

Stage 2: Increased resources at level 4 Emergency Departments to provide the recommended outreach services, including the provision of on-call mental health staff (e.g. HSA and TNS services).

It is acknowledged that there are significant barriers to meeting the workforce needs underpinning these goals. These will need specific recognition and consideration in each Area plan. Attention to the education and training of staff in emergency mental health care will form a key component of this stage. This could involve communication strategies to keep stakeholders informed about the plan's progress, training in mental health first aid, Aboriginal mental health issues, and the importance of a thorough medical as well as psychological assessment on presentation. Staff rotation between general and mental health facilities could also be used to broaden skills and enhance networking.

- 4. This document is the initial phase of rural mental health services planning and will form the basis for the future development of a more comprehensive range of emergency mental health services in rural and remote areas.

The strategies for achieving the main goals of the rural access plan need to be addressed at three levels: the Centre for Mental Health, Area Health Service, and local health services and facilities.

Strategy	Centre for Mental Health	Area Health Service	Services and facilities level
Partnerships	<p>Senior Officers Group</p> <p>MOU: Police/Ambulance</p> <p>State Emergency Services Planning</p> <p>State-wide Access Planning</p>	<p>Area Implementation of MOUs</p> <p>Clinical Services (e.g. emergency services, GPs)</p> <p>Carer and consumer partnerships in service development</p> <p>Consultation with Aboriginal Communities</p>	<p>Emergency health services staff in each facility</p> <p>Local GPs</p> <p>Local police, ambulance</p>
Facility Development	<p>Models and recommendations.</p> <p>Identification of resource needs</p>	<p>Area level determination of needs according to network links across level 1 to 5 Emergency Depts.</p>	<p>Implementation of policy</p> <p>Identification of OHS issues</p> <p>Needs evaluation</p>
Workforce	<p>NSW Health Workforce Development Strategy.</p> <p>Identification of workforce needs within model of care</p>	<p>Development of workforce strategies</p> <p>Identifying current capacity and future needs across networked services /communities</p> <p>Local implementation according to geographic and service needs</p> <p>Provision of training and workforce development</p>	<p>Identification of current workforce capacity</p> <p>Identification of training and development needs</p> <p>Participation in network based training towards implementation of emergency care practices</p>

Strategy	Centre for Mental Health	Area Health Service	Services and facilities level
Operational Policy	Identify service models, key principles, and desired outcomes (KPIs)	Inclusion of emergency models within Area Clinical Services Plan according to local geographic and resource needs to achieve desired outcomes	Review existing policies and procedures  Participate in networks model service planning (e.g. level 1 to level5)
Evaluation	Identify core data-set requirements  Monitoring of sentinel events  Cross-area analysis	Identify data needs  Implementation of core data set  Develop monitoring systems relevant to local needs (e.g. remote transport)	Data collection resources  Staff training and development  Facility events

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