Received: 29 February 2024 | Accepted: 12 May 2024

DOI: 10.1111/inm.13362

International Journal of Mental Health Nursing

ORIGINAL ARTICLE

Disproportionate mental health presentations to emergency departments in a coastal regional community in Australia of first nation people

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Abstract

Emergency department (ED) presentations for mental health (MH) help-seeking have been rising rapidly in recent years. This research aims to identify the service usage demographic for people seeking MH care in the ED, specifically in this case, to understand the usage by First Nation people. This retrospective cohort study examined the sociodemographic and presentation characteristics of individuals seeking MH care in two EDs between 2016 and 2021. Data were collected using existing records and analysed using descriptive univariate analysis with statistical significance between the two sites determined using chi-squared test, $p<0.05$. The overall data presented in this analysis show an overall ED mental health presentation rate of 12.02% for those who identified as 'Aboriginal but not Torres Strait Islander origin', 0.36% as 'Both Aboriginal and Torres Strait Islander' and 0.27% as 'Torres Strait Islander' totalling 12.63%. This is an overrepresentation compared to the regional population of 4.9%. One site recorded 14.1% of ED presentations that identified as *Aboriginal and/or Torres Strait Islander*, over double the site's demographic of 6.3%. Given the disproportionately high representation of First Nation people in MH-related ED presentations, further research is required to prioritise a First Nation research perspective that draws on First Nation research methods, such as yarning and storytelling to understand the unique cultural needs and challenges experienced by First Nation people accessing MH care via ED. Understanding the demographic is but one step in supporting the Cultural Safety needs of First Nation people. Additionally, research should be designed, governed and led by First Nation researchers.

KEYWORDS

Aboriginal, emergency department, first nation, mental health, Torres Strait Islander

INTRODUCTION

Colonisation has disrupted traditional ways of life, eroded cultural practices and undermined social structures within First Nation communities (Paradies, 2016). This historical trauma has contributed to enduring disparities in health, education, employment and overall well-being experienced by First Nation populations (Paradies, 2016). Moreover, colonisation has left a legacy of intergenerational trauma, systemic discrimination and ongoing socio-economic disadvantage that continues to shape First Nation experiences and outcomes in contemporary society (Smallwood et al., 2021). Recognising and addressing these enduring impacts of colonisation is essential for advancing reconciliation, promoting social justice and fostering meaningful improvements in the lives of First Nation people (Taylor

& Habibis, 2020). Additionally, First Nation communities confront a disproportionate burden of mental health (MH) challenges compared to their non-First Nation counterparts in Australia (Australian Institute of Health and Welfare, 2023). Suicide rates among First Nation populations are nearly twice as high, hospitalisation rates for deliberate self-harm are three times greater, and the prevalence of high/very high psychological distress is 2.4 times higher when compared to non-First Nation Australians (Australian Institute of Health and Welfare, 2023). From 2009–2010 to 2018–2019, the hospitalisation rate for MH-related conditions among First Nation Australians escalated by 52% (from 19 to 29 per 1000 hospitalisations) (Australian Institute of Health and Welfare, 2023). This increase was even more pronounced among First Nation females, with a notable 58% rise, and among First Nation males, it increased by 46% (Australian Institute of Health and Welfare, 2023). While First Nation Australians utilise some MH services at elevated rates compared to non-First Nation Australians, gauging whether this utilisation aligns with the underlying need remains a complex task. First Nation MH researchers and advocates assert that the provision of MH care for First Nation communities continues to fall short, marked by inadequacy and inequity (Dudgeon et al., 2020).

Emergency departments (ED) are complex and challenging environments for people with mental health conditions. They are excessively loud, busy, crowded and clinical, operating 24 h per day with high levels of activity, exacerbating distress for many people (Clarke et al., 2007). The high volume of presentations to ED with MH problems can lead to long wait times, overcrowding and delays in treatment for those who present (Duggan et al., 2020), which can result in frustration and dissatisfaction among consumers (Digel Vandyk et al., 2018; Morphet et al., 2012). Compared to consumers presenting with other conditions, MH consumers experience significantly longer lengths of stay and wait times for admission to an inpatient bed in the ED (Duggan et al., 2020). General care emergency clinicians report a lack of strategies and knowledge to care for people requiring MH interventions (Derblom et al., 2021). The triage processes are crucial in ensuring that consumers with MH problems receive timely and appropriate care, but many EDs struggle to implement effective triage systems (Morphet et al., 2012).

The prolonged waiting periods for MH consumers have been linked with adverse safety and clinical consequences. These include heightened mortality rates, increased incidents of violence and aggression in the ED and instances of patients leaving before receiving care. Consequently, this contributes to a perception among consumers that their needs have not been acknowledged (Duggan et al., 2020). This issue has also been documented in research focusing on young First Nation people, who reported feeling unheard or not listened to (Cerreto, 2018). Despite the efforts to improve the consumer journey, many MH consumers still report unsatisfactory experiences in the ED, including long wait times, lack of specialised care and inappropriate treatment settings (Digel Vandyk et al., 2018; Morphet et al., 2012). Overall, the difficulties MH presentations pose in EDs highlight the need for improved infrastructure, resources and knowledge to offer specialised and timely care to persons with MH problems (Digel Vandyk et al., 2018).

The Central Coast of New South Wales is located close to Sydney, Australia. According to the Australian Bureau of Statistics (2021a), 4.9% of the population within the Central Coast identify as 'Aboriginal and/or Torres Strait Islander peoples', compared to 4.2% in NSW and 3.8% in Australia (Australian Bureau of Statistics, 2021e). The Central Coast experiences poorer health outcomes compared to both NSW and Australia, with a higher prevalence of MH conditions such as anxiety and depression, at 11.0%, compared to 8.0% in NSW and 8.8% in Australia (Australian Bureau of Statistics, 2021a) and higher than average increases in high psychological distress over 2015–2021 (NSW Health, 2023). Public health services require robust evidence outlining the response and processes associated with MH presentations in EDs. This evidence is crucial for informed planning and the effective and efficient delivery of services that meet the needs of the catchment population, all while staying within budgetary and resource constraints.

This research aims to identify the service usage demographic for people seeking MH care in the emergency departments, specifically in this case, to understand the usage by First Nation people.

The ED is often the only place available 24 h a day for people experiencing mental ill health to seek help. However, many First Nation people report feeling unsafe when accessing health care due to actions undertaken by the Australian government since colonisation, such as the removal of First Nation children from their families (Ware, 2013). Significant barriers exist in access to healthcare for First Nation people in Australia, resulting in a frustrating experience for many First Nation people (Nolan-Isles et al., 2021), less positive health outcomes (Gwynne et al., 2018) and a likelihood of accessing services later in the disease process if at all (Campbell et al., 2018). Therefore, it is imperative that the service usage demographic for people seeking MH care in the ED, specifically in this case, First Nation people, is understood. This research will further enable the development of care and service delivery models that address cultural needs.

METHODS

Design and sample

The study elucidates the demographic profile of individuals seeking Mental Health (MH) care at Site A and Site B Emergency Departments (EDs) from 1 January

2016, to 30 December 2021. Employing a retrospective cohort design, existing data collected in routine care were utilised. The study adheres to a cross-sectional descriptive epidemiological method outlined by Liamputtong (2021, p. 212). This methodology was selected to provide a systematic framework for characterising the cohort in terms of temporal, spatial and demographic aspects (Liamputtong, 2021, p. 212). A descriptive univariate analysis was conducted to scrutinise individual elements.

Data collection and ethical considerations

The initial data collection process involved the review of pre-existing data spanning from 1 January 2016, to 30 December 2021, obviating the need for participant recruitment. Relevant ED data were identified by applying the following criteria to the presenting problem field: '%suici%' OR '%MH%' OR '%self harm%' OR '%psych%', OR '%Mental%'. A subsequent data collection phase was undertaken to extend the data set further and establish connections between ED presentations and local MH service data. This linkage involved extracting data from the electronic medical records and extending the time frame to encompass the period from 1 January 2015 to 30 December 2021. The research received approval from Hunter New England Human Research Ethics Committee, 2022/ETH01597 (approved on 18/11/2022), and site-specific approval from Central Coast Local Health District, granted on 14/12/2022. Subsequently, data extraction and linkage processes were undertaken by researchers on 16 December 2022. To ensure the research is safe, respectful, responsible, of high quality and of benefit to First Nation people and communities, this research was conducted in accordance with the National Health and Medical Research Council's (NHMRC) 'Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for researchers and stakeholders' (National Health Medical Research Council, 2018).

Data analysis

The Central Coast Local Health District encompasses four hospitals, with two housing public Emergency Departments (EDs). These two locations exhibit distinct sociodemographic profiles and levels of public accessibility. To account for these disparities between the sites, the research team conducted a comparative analysis using chi-squared (χ^2) tests, with a statistical significance threshold set at $p<0.05$. To ensure data integrity, missing data were addressed through case deletion, as recommended by Kang (2013). This process resulted in a final data set comprising 26 616 records, with 515 records (1.93%) lost during the data cleansing procedure.

RESULTS

It is important to note that these data are a collection of presentations and not individual people. As Medical Record Numbers (MRN) were not included in the complete data set, the researchers could not interpret the data in a way that allowed exploration of the individuals' frequency and history of presenting to the EDs included in the study. As such, an individual may present once or several times, but the data cannot accurately reflect high service usage for individual people. Most presentations reported themselves as 'Neither Aboriginal nor Torres Strait Islander origin' at 86.44%, with the number of presentations identifying as 'Aboriginal and/or Torres Strait Islander origin' totalling 12.63%. At Site A, 11.2% of presentations identified as 'Aboriginal and/or Torres Strait Islander origin' compared to 14.1% at Site B, with a significant difference between the two sites ($p<0.0001$) (Table 1, Figure 1), and a higher percentage of presentations by First Nation people at Site B where the First Nation People population has higher residential density.

Overall, the age profile structure and presentation frequency provide useful information for service planning. While it is not possible to determine the number of individuals that may repeatedly present, the presentation numbers independently identify sufficient

TABLE 1 First Nation status.

First Nation	Site A	%	Site B	%	Total	%	*p**
Aboriginal but not Torres Strait Islander origin	1356	10.55	1790	13.44	3146	12.02	0.0000*
Both Aboriginal & Torres Strait Islander origin	30	0.23	48	0.36	78	0.30	0.0596
Declined to Respond	10	0.08	13	0.10	23	0.09	0.5889
Neither Aboriginal nor Torres Strait Islander origin	11 275	87.74	11 343	85.18	22 618	86.44	0.0000*
Torres Strait Islander but not Aboriginal origin	44	0.34	36	0.27	80	0.31	0.2912
Unknown	135	1.05	86	0.65	221	0.84	0.0003*

Note: *p* is the comparison between Site A and Site B Emergency Department presentations.

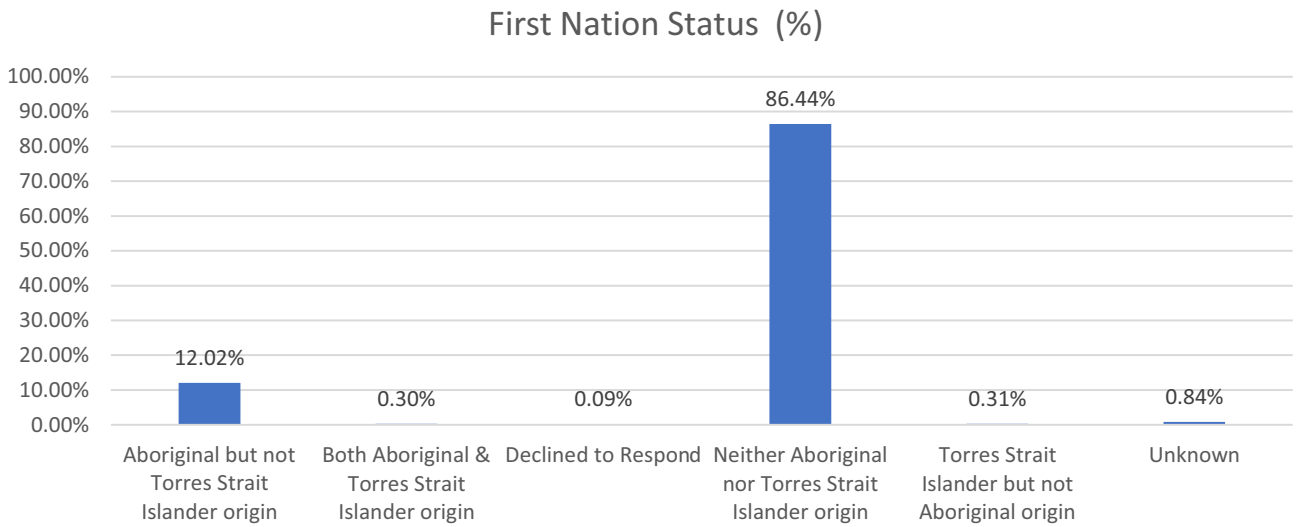

FIGURE 1 First Nation status %.

TABLE 2 Presentations to ED by age group and First Nations status.

Age	Non First Nation	%	First Nation	%	Total	%	*p**
0–11	350	1.53	82	2.48	432	1.65	0.0001*
12–17	3318	14.51	725	21.94	4043	15.45	0.0000*
18–24	4285	18.74	809	24.49	5094	19.47	0.0000*
25–34	4512	19.74	799	24.18	5311	20.30	0.0000*
35–44	4206	18.40	427	12.92	4633	17.71	0.0000*
45–54	3077	13.46	313	9.47	3390	12.96	0.0000*
55–64	1657	7.25	111	3.36	1768	6.76	0.0000*
65–74	801	3.50	29	0.88	830	3.17	0.0000*
75–84	446	1.95	8	0.24	454	1.74	0.0000*
Above 85	210	0.92	1	0.03	211	0.81	0.0000*

information to demonstrate a level of distress indicative of health response. The data presented in Table 2 highlight the percentage of individual presentations within each age bracket who attended the ED seeking MH care. The results reveal a significant discrepancy in healthcare access between non-First Nation and First Nation populations across all age groups. Notably, the percentage of First Nation occasions of service in the younger age groups consistently exceeds that of their non-First Nation counterparts. This pattern is particularly pronounced in the 12–17 years (Non- First Nation = 14.51% First Nation = 21.94%) and 18–24 years (Non-First Nation = 18.74%, First Nation = 24.49%) age groups, where First Nation people seeking help and access to care is markedly higher (Figure 2).

DISCUSSION

First Nation people represent approximately 3.8% of the Australian population (Australian Bureau of Statistics, 2021e) but account for 12.0% of MH-related ED presentations and 7.5% of all ED presentations across Australia (Australian Institute of Health and Welfare, 2022). On the Central Coast of NSW, 4.9% of the population identify as 'Aboriginal and/or Torres Strait Islander' (Australian Bureau of Statistics, 2021a). The overall data presented in this analysis show an overall ED mental health presentation rate of 12.0% for those who identified as 'Aboriginal but not Torres Strait Islander origin', 0.4% as 'Both Aboriginal and Torres Strait Islander' and 0.3% as 'Torres Strait Islander' totalling 12.7%. These results align with the Australian data (Australian Institute of Health and Welfare, 2022) and demonstrate a significant disproportionate representation on the Central Coast. However, further disproportion is evident when data are examined to reflect each local hospital catchment area separately. Site B has 6.3% (Australian Bureau of Statistics, 2021d) of its population identifying as 'Aboriginal and/or Torres Strait Islander', Site A 4.0% (Australian Bureau of Statistics, 2021b) and 3.4% for NSW (Australian Bureau of Statistics, 2021c).

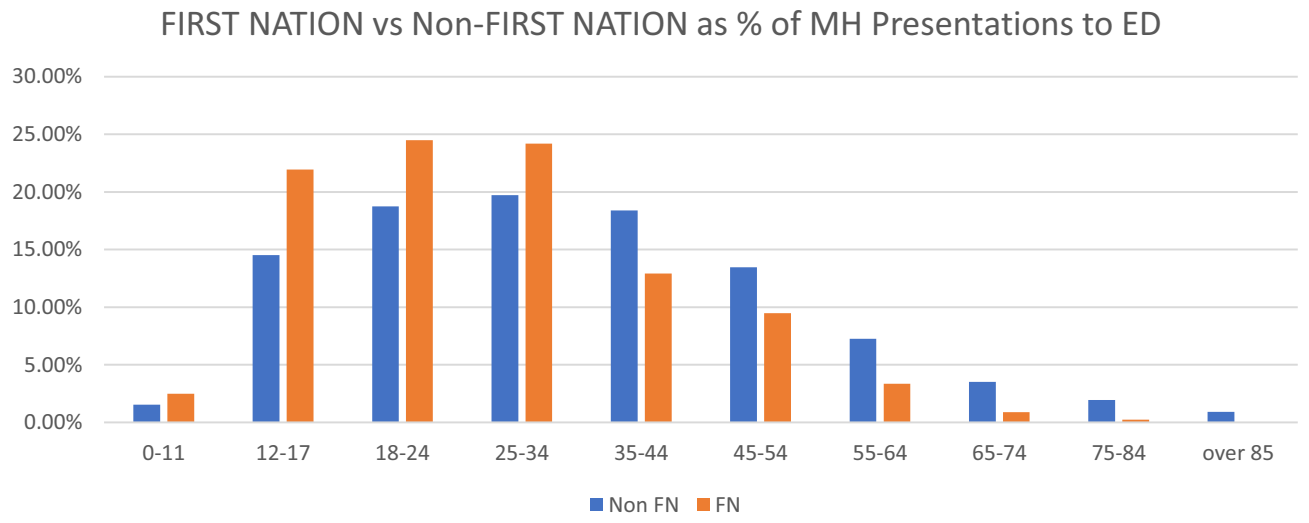

FIGURE 2 First Nation percentage comparison.

By contrast, Perera et al. (2018) conducted a retrospective, descriptive analysis of linked ED presentation data for NSW over five calendar years, 2010–2014 and observed that 6.7% of presentations for MH in 36 EDs identified as 'Aboriginal and/or Torres Strait Islander', proportionally similar to that of the overall presentations. However, the findings from this study show a much higher overall presentation for 'Aboriginal and/or Torres Strait Islander' consumers at Site B at 14.07% and Site A at 11.13%. With a *p*-value of <0.00001, this difference between the two sites is significant and raises concerns about the health outcomes and access to healthcare for First Nation people in the Central Coast of NSW, especially at Site B. Further research is needed to understand the root causes of this overrepresentation and develop targeted strategies to improve mental health outcomes for all First Nation people. This imbalance suggests a tailored response is needed to achieve equitable access to quality healthcare for all individuals, accommodating their specific background and/or ethnicity.

The age profiles presented in this research align with similar research conducted in Australia. It is known that First Nation Australians under 25 years were 1.4 times as likely as non-First Nation Australians to access Medicare Benefits Schedule (MBS) subsidised primary MH services (13.5% compared with 9.5%) (Australian Goverment Productivity Commision, 2020). In 2017–2018, there were 902 900 service contacts recorded by community MH teams for people who identified as First Nation, proportionally 10% of all MH contacts across Australia (Australian Institute of Health and Welfare, 2023). The adjusted contact rate for First Nation people was 3.3 times the rate of non-Indigenous Australians and was higher across all age groups peaking for those aged 25–44 years (Australian Institute of Health and Welfare, 2023).

We propose several well-accepted theoretical perspectives that may assist in explaining our results. Firstly, we suggest that the results need to be considered in the context of poorer mental health outcomes related to cultural disruptions as the logical consequence of pervasive and intergenerational traumas related to colonisation for First Nation people (Wilson & Waqanaviti, 2021). An ontological consideration occurs within the inherent biases within default Western models of mental health service delivery and difficulty in aligning this with holistic Indigenous models that value culturally enriched ways of knowing, being, doing and belonging applied to concepts of social and emotional well-being (Gee et al., 2014; McGough et al., 2022).

Many First Nation people, for example, the Stolen Generations, experienced dislocation from their cultural lands and families and were required to assimilate, while others have endured generational housing, economic and social insecurity (Wilson & Waqanaviti, 2021). First, Nation people born before 1972 (>44–50 for the data period) experienced a period of extensive trauma and have significantly worse outcomes associated with mental health (Australian Institute of Health and Welfare, 2021). The access to care in the older age groups that is present in the results of this research is potentially related to feeling unsafe when accessing healthcare (Nolan-Isles et al., 2021; Ware, 2013) and echoes the findings of Campbell et al. (2018) in a reduced likelihood of access to services much later in the disease process, if at all. Thus, we can hypothesise that where populations have high-density representation, these populations are likely to experience higher levels of mental health disadvantage and will be likely to require higher levels of mental health care, and more often.

Limitations

Several limitations to this study should be noted. A unique person identifier was not included in the data set

under analysis, which made it impossible to establish if a person had presented once or multiple times. This study did not include after-hours MH presentations that did not go directly to the ED, such as police arriving at the MH unit or direct community admissions. Due to how the data are coded and sourced, not all MH presentations may be coded correctly and may not be present in the data. Likewise, there may be instances where an individual may present and be coded as an MH problem initially but require non-mental health care, and the MH team may not have direct input while they are in ED, such as for a person presenting with intoxication. These limitations should be considered when interpreting the findings of this study and may impact the generalisability of the results.

Recommendations

Improving First Nation cultural safety in ED

First Nation people are overrepresented in not just MH (12.0%), but ED presentations overall at 7.5% across Australia, yet account for only 3.3% of the population (Australian Institute of Health and Welfare, 2022). Priority 14 of Australia's National Strategy for 'Closing the Gap' highlights the importance of First Nation people social and emotional well-being (SEWB) (Commonwealth of Australia, 2020). The strategy reports on SEWB as measured by the number of suicides of First Nation people. Any recommendation must reflect care appropriate to and consistent with First Nation people cultural and spiritual beliefs and practices, including the involvement of traditional healers, Elders and other cultural healers (Commonwealth of Australia, 2020; Rooney et al., 2023).

In Australia, Cultural Safety has gained recognition as a vital framework for enhancing healthcare access and quality for First Nation communities and addressing health disparities (McGough et al., 2022). Due to the diverse context of First Nation communities, strategies led by communities are required for each approach, and caution should be used when applying previous approaches to different settings. Persistent misunderstandings surround this concept, highlighting the need for evaluation and research to generate evidence-based knowledge on effectively integrating Cultural Safety into clinical practice (McGough et al., 2022).

Health services and practitioners need to look beyond the traditional view of Cultural Safety and examine their behaviours, beliefs and practices that continue to support issues such as institutional racism (Ramsden, 2002). Moving beyond cultural sensitivity training to a model of Cultural Humility to understand the impact of colonisation and racism on healthcare for First Nation people. For example, in Nursing and Midwifery, programmes, such as *Murra Mullangari: Introduction to Cultural Safety and Cultural Humility*, aim to provide an understanding of the history, origins and concepts of Cultural Safety and Cultural Humility and offer insights into the culture of power and its implications on the Nursing workforce (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2022).

Given the disproportionate representation of First Nation people in MH-related ED presentations, it is imperative to prioritise a research perspective centred on First Nation communities. This necessitates not only employing First Nation research methods such as yarning and storytelling (Dudgeon et al., 2020; Walker et al., 2014), but also ensuring that research priorities, governance and benefits are led by First Nation people within their respective communities. This research should avoid 'Deficit Discourse', which refers to negative language and behaviour that represents people in terms of their deficiencies and failures (Lowitja Institute, 2018). This focus on failure and dysfunction can eclipse the complex reasons for inequalities and overlook diversity, capability and strength (Lowitja Institute, 2018). Instead, future research must seek to move towards a 'Strengths-based approach' to change the language of the narrative to one that aligns with existing First Nation approaches (Lowitja Institute, 2018). This approach is essential for comprehensively understanding the unique cultural needs and upstream factors influencing First Nation individuals seeking help and accessing MH care through ED.

CONCLUSION

There is a significant over-representation of First Nation people, particularly in the Site B hospital catchment area, and this highlights the need for targeted strategies to improve mental health outcomes and access to MH care for First Nation people. Future research should focus on the following:

- Service design, codesign and health practices must prioritise the Cultural Safety of First Nation people and draw on Indigenous research methods, such as yarning and storytelling, to understand presentation and access prevalence for MH care via ED.
- The intricate nature and sheer volume of data in mental health care underscore the need for extensive analysis and the advancement of service delivery systems. These systems are pivotal in identifying care needs, predicting care pathways, improving decision-making and uncovering crucial variables and their interrelationships. Ultimately, they contribute to bolstering clinical decision support and a deeper understanding of service delivery in the field of MH care for First Nation people.

RELEVANCE TO PRACTICE

Mental health nurses and other health professionals require an understanding of the demographic profile of people in the community where they practice. Recognising the population trends will assist in planning to improve supportive cultural safety needs for Aboriginal and Torres Strait Islander people and aligning service provision to match the requirements of the community of interest. Significant barriers persist in access to healthcare for First Nation people in Australia, resulting in a negative experience for many First Nation people. The service usage demographic for people seeking MH care in the ED must be understood to enable the development of care and service delivery models that address cultural safety needs.

AUTHOR CONTRIBUTIONS

OH was involved in concept development, project design, data collection, data analysis, manuscript preparation. RSR was involved in data analysis, contribution to manuscript. SC was involved in data analysis, contribution to manuscript, supervision of project. RW was involved in concept development, project design, data collection, data analysis, manuscript contribution, supervision of project.

ACKNOWLEDGEMENTS

Authors would like to acknowledge the support of Central Coast Local Health District. This research was conducted on traditional Darkinjung Country. We pay respect to elders past present and emerging. The authors wish to acknowledge that while many First Nations researchers and scholars are working towards improving mental health outcomes for First Nations people, it is not scientifically relevant to the reporting of this research to cite all of them in this report. However, we recognise their broadly related contributions to scholarship and research focussed on improving mental health outcomes for First Nations people. One of the authors (RW) identifies as an Aboriginal person, and all authors pay respect to First Nation mental health and social and emotional well-being researchers and scholars, joining with them in the urgent work of improving mental health outcomes for First Nations people. Open access publishing facilitated by RMIT University, as part of the Wiley - RMIT University agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

Partial financial support was received from the NSW Ministry of Health as part of the Towards Zero Suicides initiative.

CONFLICT OF INTEREST STATEMENT

Prof. Rhonda Wilson is an Editorial Board Member of the International Journal of Mental Health Nursing.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS APPROVAL

Ethical approval was granted by the Hunter New England Human Research Ethics Committee 2022/ETH01597. Central Coast Local Health District granted site-specific approval 2022/STE03296.

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How to cite this article: Higgins, O., Sheather-Reid, R.B., Chalup, S.K. & Wilson, R.L. (2024) Disproportionate mental health presentations to emergency departments in a coastal regional community in Australia of first nation people. *International Journal of Mental Health Nursing*, 33, 2063–2070. Available from: https://doi.org/10.1111/inm.13362