

Access to mental health services continues to be under duress

Access to mental health services continues to be a significant problem for most Australians.¹ This problem has been exacerbated in regional and rural areas.¹ Most recently though, psychiatrists in the public hospital system in New South Wales threatened to walk off the job en masse due to a myriad reasons, the most prominent being the substantial pay gap for clinicians in NSW compared with other states.¹ In this issue of the *MJA*, Huber and colleagues² tried to identify modifiable causes of stress in clinicians and administrators working in NSW psychiatric emergency care centres. The study design was qualitative and 35 participants across 12 sites were interviewed. Systemic challenges at three levels were identified in staff interactions with patients and carers, the broader health system and the hospital. The study found that relational work (the core of clinician–service user interactions) is both meaningful and difficult. Psychiatric Emergency Care Centres (PECC) are the nexus of suicide risk management, with conflicting system expectations of staff to ensure safe care while making risky discharge decisions, which causes anxiety and high turnover. Moreover, there is tension between the model of care and the frequent reality of PECCs being used to manage patient flow, which leads to clinicians feeling professionally undervalued by the hospital. Two protective themes enabling staff to meet these challenges were developed. First, well defined treatment protocols enhanced clinical satisfaction, continuity of care for patients, and supported wellbeing. Second, working in a collaborative team environment with a flattened hierarchy fostered autonomy and robust teamwork.

On the other end of the spectrum is access to community-based paediatricians and psychiatrists, especially for attention deficit hyperactivity disorder (ADHD) and developmental assessments. Rates of ADHD diagnosis have increased substantially in the past ten years and the reasons for this are complex and multifactorial.³ In this issue of the *MJA*, Bradlow and colleagues⁴ examine adult ADHD in Australia and how its current commercial model for diagnosis and treatment may be encouraging misdiagnosis. The rise in ADHD diagnoses and the most appropriate management approaches are debated. This rise is particularly pronounced among adults, the authors write, and could be in part attributed to growing public awareness, amplified by social media platforms such as TikTok, where ADHD-related content is reported to have had over 36 billion views. The authors note that “most adults with ADHD are diagnosed by private psychiatrists”. The dearth of public services for ADHD raises serious concerns regarding equity of access and the potential that normal behavioural variability is “medicalised”. Their view is that there is a risk that

complex psychosocial issues may be misattributed to ADHD. This latter concern is grounded in psychiatry's history of oversimplified biological explanations to complex psychosocial causes. Pharmacotherapy for the condition is not without harm, they write, although the rise in stimulant prescriptions has not led to an increase in stimulant-related deaths, there has been a rise in hospital presentations for stimulant-related poisonings.

It is important to consider how the current ongoing issues around the cost of living will affect access to essential health care services without causing a significant burnout within health professionals and researchers.

This issue of the *MJA* also includes clinical practice guidelines for hepatocellular carcinoma surveillance for people at high risk in Australia.⁵ With metabolic syndrome and prevalence of fatty liver on the rise, these guidelines provide up-to-date information regarding the surveillance of high risk populations. The recommendations were developed by a working group of experts in liver cancer control and included evidence reviews, synthesis and adaptation of existing guidelines for the Australian context, and predictive modelling. The updated guidelines formalise recommendations for people with cirrhosis, identify other patient groups who are recommended for surveillance, and highlight gaps in evidence where the benefit of surveillance is unclear. ■

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- 2 Huber JP, Milton A, Brewer M, et al. Identifying modifiable causes of stress in clinicians and administrators working in New South Wales psychiatric emergency care centres, 2023–24: a qualitative study. *Med J Aust* 2025; 223: 410–417.
- 3 Kazda L, McGeehan K, Bell K, et al. Increased diagnosis of attention-deficit hyperactivity disorder despite stable hyperactive/inattentive behaviours: evidence from two birth cohorts of Australian children. *J Child Psychol Psychiatry* 2023; 64: 1140–1148.
- 4 Bradlow RCJ, Armstrong F, Ogden E. Adult attention deficit hyperactivity disorder in Australia: how its current commercial model for diagnosis and treatment is encouraging misdiagnosis. *Med J Aust* 2025; 223: 384–386.
- 5 George J, Allard NL, Roberts SK, et al. Clinical practice guidelines for hepatocellular carcinoma surveillance for people at high risk in Australia: summary of recommendations. *Med J Aust* 2025; 223: 426–436. ■