NOWHERE ELSE TO GO:

WHY AUSTRALIA'S HEALTH SYSTEM RESULTS IN PEOPLE WITH MENTAL ILLNESS GETTING 'STUCK' IN EMERGENCY DEPARTMENTS

A COMMISSIONED REPORT TO THE AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

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About us

The Mitchell Institute for Education and Health Policy is one of Australia's trusted thought leaders in education and health policy. Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer society. Established in 2013, the Mitchell Institute is part of Victoria University, whose mission is to create exceptional value for any student from any background and uplift the communities in which it operates.

About the authors

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Suggested citation

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Foreword

Everyone has the right to timely access to expert mental health care.

Our members, working in emergency departments across Australia report, and our data confirms, that patients presenting to emergency departments for mental health care routinely experience excessive and unreasonably long waits often in inappropriate, and at times unsafe environments. It is a constant challenge for emergency department staff to find a safe path for patients such as admission to an inpatient bed, or home with appropriate community supports in place. Emergency departments are often considered the 'canary in the coal mine' in identifying failures in the health system and hospitals, and mental health patients presenting to emergency departments in crisis could be described as 'the ambulance at the bottom of the cliff'. These dangerous delays and negative experiences are an indicator of widespread system failure across acute psychiatric and community-based mental health care, are damaging to people who need care and stressful for staff working in emergency departments.

In October 2018, over 170 delegates at the Australasian College for Emergency Medicine's (The College; ACEM) Australian Summit on Mental Health Care in the Emergency Department agreed that the current mental health system fails individuals, families and health services, and that the strain on emergency departments and, more importantly, patients and families, is unsustainable. People with lived experience talked about the harm caused to their health by emergency department overcrowding, the noise, distress, long waits and the impact of restrictive practices on their recovery. These stories highlighted the importance of social support, of services being available when needed, and the positive impact of respectful, culturally appropriate and compassionate responses to people in mental health crisis. Delegates also shared examples of good practice, innovative models of care and the urgent need for reforms to improve emergency care for people in mental health crisis.

Following the summit, ACEM commissioned the Mitchell Institute for Education and Health Policy to conduct an analysis from an ED perspective of why Australia's health system is failing to meet the urgent needs of people presenting to emergency departments for mental health care. The unique lens of an emergency department provides a valuable insight into how the system should be redesigned to improve the experiences for patients seeking care.

This analysis from the Mitchell Institute clearly shows that there are too few services to meet community need, with emergency departments continuing to be the only access point for many people to the mental health system, particularly when someone is experiencing a crisis. The current mental health system planning, coordination and accountability mechanisms are failing. The recommendations from the Mitchell Institute are comprehensive and uncontroversial – they provide the framework for ensuring a whole-of-system response to care for the most vulnerable people in our community. ACEM accepts and endorses the recommendations in this report.
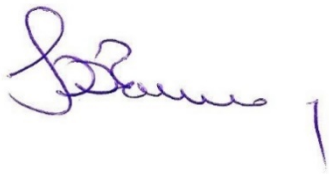
While there is much that emergency physicians and other emergency department staff can do to improve the experience for people seeking help in a mental health crisis, they cannot do it alone. ACEM will advocate for governments to invest in alternative models of emergency mental health care and divert some people to more appropriate crisis services, whilst ensuring that emergency departments provide high quality care for the cohort of patients who need us. ACEM will also continue to advocate for governments to increase the amount of inpatient mental health services and community mental health services to ensure that people with mental health needs have sufficient and equitable access to appropriate services. We will be relentless in our national advocacy for public reporting of 12- and 24-hour waits, and the need for clear reporting pathways and regular audits of restrictive practices to allow for system improvement.

To improve the standard of emergency mental health care, ACEM will work with our colleagues in psychiatry to develop joint standards for physical and mental health care in the emergency department, as well as stipulating requirements for the physical environment of emergency departments as part of our ED Design Guidelines.

ACEM has committed to support workforce development strategies to improve mental health care in emergency departments, including in regional, rural and remote areas.

There is no doubt that the mental health system is highly fragmented, with unclear roles and responsibilities. We will work with national peak bodies to engage and hold all levels of government to account to ensure an equitable system for all people with mental health needs.

Emergency physicians want to work in a system that offers people safe, timely, expert and therapeutic care, regardless of whether they are physically or mentally unwell or distressed. Amidst the new and complex mental health challenges predicted to rise during and after the COVID-19 pandemic, action is needed now more than ever to build and sustain a functioning, integrated mental health system across the whole spectrum of care. This report provides a timely analysis of the national reforms that are urgently needed to achieve this.

Dr John Bonning

President

Australasian College for Emergency Medicine

Dr Simon Judkins

Immediate Past President

Australasian College for Emergency Medicine

Summary

This report was commissioned by the Australasian College for Emergency Medicine (ACEM) to consider the complex issues discussed at the national Mental Health in the Emergency Care Summit (the Summit), convened by the College in October 2018. The report examines the impact of funding and governance factors on demand for emergency department services by people experiencing mental health crises. Drawing on a range of data, international evidence and other publications, it examines the increasing demand for mental health care from emergency departments in Australia and the challenges of ensuring timely and appropriate emergency care in the context of a fragmented, under-funded and under-resourced mental health system.

The Summit brought together over 170 experts to consider survey data on mental health access block, collected by ACEM and published in 2017 (see report here), and ACEM's 2018 report The Long Wait that analysed key mental health presentation data from the Australian Institute of Health and Welfare (AIHW). These reports revealed how patients in mental health crisis who attend emergency departments experience disproportionately lengthy delays in their assessment and treatment, particularly if they require an inpatient admission. These delays, commonly caused by 'bed blocked' inpatient units, result in access-blocked emergency departments and have adverse consequences for safety and other clinical outcomes for these patients as well as other patients and emergency department staff working in these conditions.

This report includes statements (quotations) from participants at the Summit that illustrate the conditions affecting individuals and health professionals, the challenges of providing care in current environments and the support for system reforms to improve the quality and safety of care for this vulnerable patient group.

ACEM's analysis of the AIHW data showed that patients with mental health needs presenting to an Australian emergency department:

- **Wait longer than other patients** with a similar severity of physical illness before they can be assessed and have their treatment commenced. They are 18% less likely to be seen within the appropriate Australasian Triage Scale timeframe.

- **Experience a longer period of treatment** in the emergency department. While 90% of all patients left emergency departments within seven hours, this figure was 11.5 hours for people presenting with acute mental health crises (and much higher in some states). The length of stay exceeded this time for 10% of these mental health presentations, further worsening the mental health condition of these patients.

- **Are more likely than other patients to leave the emergency department at their own risk, that is,** prior to their treatment being completed and against medical advice.

- **Are 16 times more likely than people with other emergency medical conditions to arrive at emergency departments via police or other non-health-services vehicles**, and nearly twice as likely to arrive via ambulance or by helicopter rescue.

- **Are more likely to be assessed by emergency department staff as requiring urgent care** on the Australasian Triage Scale, indicating the acuity of the needs of these patients.

- **Are proportionally more likely to identify as Aboriginal and Torres Strait Islander peoples than other patients**. While Indigenous Australians make up around 3% of the population, they comprise 11% of all emergency department mental health presentations across the country.

Significant differences in waiting times were found between metropolitan/urban and rural/regional hospital settings. Although the percentages of mental health emergency department presentations in rural/regional settings are comparable to those in cities, a significantly higher percentage of people residing in rural/regional settings experienced mental health access block with long waits for inpatient beds.

There is strong national and international evidence that emergency departments have become the first point of access for people needing mental health crisis support even though these services are not designed or resourced to do this.

Rates of mental health presentations in emergency departments are increasing amongst all age groups. People presenting in mental health crisis often have other complex needs including physical health comorbidities, drug and alcohol abuse problems, or require support to address broader social circumstances, including homelessness. A significant proportion present with suicidal thoughts or self-harm. The environment of the emergency department may not be beneficial for people experiencing severe crises. Lengthy delays exacerbate stresses for all patients experiencing mental distress but may be particularly damaging for the most vulnerable people, including children and Aboriginal and Torres Strait Islanders. These delays also increase the risk of violence and aggression in the emergency department.

Many interconnected factors are implicated in driving demand for mental health support in emergency departments, including population growth, increasing social diversity and a changing burden of disease. But there are other factors involved too, intrinsic to the mental health system and its relationship with the broader health system and beyond into the broader public realm.

The mental health system is inextricably connected with a range of other formal systems including criminal justice, housing, income support, and education and training as well as with multiple informal networks including families, communities, faith groups and non-government organisations. The enormous complexity of this web of relationships presents challenges to mental health service coordination in all developed countries.

However, the difficulties of managing complexity is not the only reason for the systemic failures which contribute to access block in emergency departments. Structural weaknesses in the Australian mental health system include insufficient funding, perversities in funding systems and priorities, financial and geographical barriers to services, services which are often not fit for purpose or not available at times of crisis, lack of staff with mental health expertise and a lack of emphasis on monitoring the outcomes of investments in mental health services. Failures in the broader health system, including gaps in service access and availability, mean that responsibilities are effectively shunted onto the emergency department which functions as an overflow valve for people requiring immediate help and treatment, particularly outside business hours.

Participants at the Summit recognised that emergency departments are part of the mental health system and play a vital role in addressing the needs of people who have nowhere else to go. However, emergency departments need to be resourced properly to manage patients with significant mental health needs to ensure that they receive the same quality of care as those with physical health emergencies, and to establish and maintain ways of transferring patients swiftly to appropriate specialist mental health care as required. This cannot be achieved through piecemeal and fragmented service reform but requires a comprehensive commitment to fundamental transformation of the whole mental health system.

Building on discussions and recommendations at the Australian Summit, ACEM has coordinated [the Mental Health in Emergency Departments Consensus Statement](#) which to date has been signed by over 1000 people representing emergency physicians, psychiatrists, nurses, carers and consumer advocates including CEOs of peak bodies for consumers, emergency and mental health nurses and community health services from across Australia. The consensus statement calls for new models of care throughout the mental health system, including for the management of urgent care needs and for discharge and referral. Wrap-around and integrated services and sustained interventions that address the complex and interconnected mental health, physical health and social care needs of people with persistent mental health needs would reduce the need for emergency presentations and provide a clear pathway when emergency hospital care is necessary.

Australia needs to implement a new vision for integrated mental health services, with care available in the community and in hospitals. Emergency departments should have an acknowledged and defined role to play within a reformed mental health system. For this to be effective, emergency departments must be resourced and supported to work in collaboration with specialist in-patient and community-based services as required. It is vital that these shifts are accompanied by strong partnership, governance and rigorous accountability measures focused on patient outcomes. Strong policy leadership is necessary to achieve this.

The forthcoming Sixth National Mental Health Plan (the Sixth Plan), creates the opportunity to set out a new and transformative vision and goals for mental health care in Australia, with a fully funded implementation strategy, with goals benchmarked against measures of timely access to intensive, early intervention services; care coordination across services and sectors; crisis presentations to emergency departments; and patient reported outcomes and experiences. Governments need to commit to accountability for delivery of these goals.

Findings and recommendations

Australian governments should commit to reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community as a viable alternative to emergency departments. The Sixth Plan must include the following priority actions to reduce the reliance of mental health patients on emergency departments through the development of adequate services to meet community mental health needs and reduce presentations.

1. **ENSURE ADEQUACY OF SERVICES TO MEET NEED**

   Mental health funding should be increased to better reflect the burden of disease and to acknowledge parity of esteem for mental illness with physical illness. Australia's provision of 41 acute psychiatric beds per 100,000 population is significantly lower than the Organisation for Economic Co-operation and Development (OECD) average of 71 mental health beds per 100,000[1]. Most states and territories have invested heavily in step-up or step-down services and community mental health services as an alternative. However, hospital-type services – whether they occur in a hospital or not – are needed to provide a pathway for people experiencing severe mental distress to be admitted directly from an emergency department. Depending on the jurisdiction and its current services, these services may include inpatient beds, hospital in the home services, short stay units or specialised step-down mental health services.

RECOMMENDATIONS

1.1. State and Territory Governments should undertake strategic needs assessments to scope the requirement for inpatient mental health beds in line with international best practice evidence and standards.

1.2. Additional resources must be invested to increase inpatient mental health beds and non-hospital alternatives, such as step up/step down services, short stay units, hospital in the home etc., depending on local needs.

2. IMPROVE FUNDING AND SERVICE MODELS TO PROVIDE BETTER OUTCOMES

Existing funding arrangements, particularly the current fee for service approach, don't support best practice care for people living with mental health conditions. Services are rewarded for providing a service with an immediate benefit and not for anticipating and preventing avoidable future need. There is little reward for providing tailored individualised care or for innovative cost-effective patient-focused services. There is an urgent need for innovative funding arrangements that support comprehensive, coordinated and sustained community mental health care, initially targeted at people identified as at risk for frequent emergency department presentations.

There are a number of easily replicable examples of innovative service models around Australia that address the complex needs of people who are frequent attenders at emergency departments. In addition, there are robust models of shared care available which may be adapted for use with these groups of patients, including, for example, maternity care. A first step would be to focus on collaboration across services and facilities to improve the pathways for patients out of the emergency department.

RECOMMENDATIONS

2.1. The National Cabinet Health Reform Committee and health ministers should support and encourage innovative mental health funding arrangements that provide ongoing and sustained care for people with persistent mental health needs.

2.2. State and territory governments should explore innovative diversion or alternative care models in communities with high levels of mental health patient presentations to emergency departments.

2.3. All government-funded mental health services should be required to expand their operating hours to provide flexible after-hours services as a condition of receiving funding.

2.4. Emergency department resourcing must provide for adequate clinical care and accommodation by including mental health expertise in emergency department staffing; providing ongoing mental health education, training and professional support for all staff; developing new workforce models including peer workers within emergency department teams; and applying emergency department design principles that create low stimulus, reassuring environments for people in mental health crisis.

2.5. All jurisdictions should implement a centralised follow-up service that ensures all mental health patients, especially when presenting due to suicidal ideation or following an attempt on their life, receive a phone call within 24 hours of discharge to offer advice on available services, check on referrals (for example, if a GP appointment has been made) or other appropriate actions.

3. **ESTABLISH EFFECTIVE SERVICES COORDINATION AND ACCOUNTABILITY IN ALL JURISDICTIONS**

There is currently a lack of accountability and reporting of mental health presentations to the emergency department, leading to inadequate action to address preventable mental health presentations. Mental health service providers should provide regular reports on their activity and the impact of this activity for people relying on their services. All jurisdictions should improve efforts to share timely data at the local level between health services, community mental health services, Local Health Networks (LHNs), and Primary Health Networks (PHNs). This would aid system planning, promote better practice and provide knowledge about pressure points and gaps in the system.

PHNs are the Commonwealth's main commissioning mechanism for community based mental health services and are currently required to work with LHNs, the administrative bodies for public health services and other community based health services in each jurisdiction, to develop joint regional mental health and suicide prevention plans. This integrated planning and delivery provides an opportunity to develop shared governance mechanisms for care pathways, referral mechanisms and review of adverse events, so is therefore a valuable mechanism to coordinate actions needed to prevent avoidable mental health emergency presentations.

RECOMMENDATIONS

3.1. Primary Health Networks should have an explicit goal of preventing avoidable mental health emergency presentations in their catchment areas. PHNs and LHNs should form area mental health service steering bodies to align, coordinate and monitor care pathways for all individuals requiring continuing mental health services.

3.2. Area mental health service steering bodies should be accountable to both Commonwealth and State and Territory governments. LHNs should monitor and report on excessive (>12 and 24 hours) stays in emergency departments, restrictive practices and walk outs. PHNs should monitor and report on primary care provision both pre and post an acute presentation or hospital admission for all individuals requiring continuing mental health services.

3.3. The Commonwealth should establish a robust mechanism for monitoring system performance against the National Standards for Mental Health Services established by the Australian Commission on Safety & Quality in Health Care.

4. **ENSURE BEST PRACTICE EMERGENCY MENTAL HEALTH CARE AND TREATMENT**

Emergency department lengths of stay and wait times for admission to an inpatient bed are disproportionately longer for mental health patients compared to patients presenting with other conditions. Described as 'boarding' or 'access block', the long waits for mental health patients are associated with several negative safety and clinical outcomes including higher mortality rates and increased risk of violence and aggression in the emergency department.

While recognising that the safety of staff and other patients is paramount, the evidence that the use of restrictive practices such as sedation and restraint may cause serious harms to patients is clear. Hospital funding arrangements must improve the capacity of emergency departments to provide appropriate clinical care that will reduce reliance on restrictive practices, particularly for people at risk of frequent emergency department presentations. Reducing the incidence of long waits in the emergency department would also minimise the need for prolonged use of restrictive practices. Any progress towards reducing and potentially eliminating the use of restrictive practices in emergency departments will require resourcing of the clinical team, security personnel and the ED environment.

RECOMMENDATIONS

4.1. State and Territory health departments should adopt a maximum 12-hour length of stay (LOS) in the emergency department by providing accessible, appropriate and resourced facilities for ongoing care beyond the emergency department. Mandatory notification and review of all cases exceeding a 12-hour LOS should be embedded in key performance indicators of public hospital CEOs.

4.2. All episodes of a 24-hour LOS in an emergency department should be reported to the relevant Health Minister regularly, alongside CEO interventions and mechanisms for incident review.

4.3. Use of restrictive practices (sedation and restraint) in emergency departments should be governed by clear clinical governance frameworks, standardised documentation tools and clear reporting pathways that allow for system improvement recommendations to be progressed to the relevant governance level.

4.4. Audits of restrictive practices in the emergency department should be conducted to identify and monitor the impact on patient outcomes and the relationship with the availability and accessibility of acute or community-based services and support.

4.5. All security personnel working within the emergency department should be appropriately resourced and trained in de-escalation techniques to reduce the need for restrictive practices and ensure patient and staff safety.

5. ENSURE ADEQUACY OF RURAL MENTAL HEALTH SERVICES AND HEALTH WORKFORCE CAPACITY

Australians living in rural and remote areas experience a unique contribution of factors that impact upon the availability and accessibility of mental health services. In addition, Aboriginal and Torres Strait Islander peoples face cultural barriers and a lack of mental health services which are culturally appropriate. There is a shortage of psychiatric leadership and trained mental health professionals, particularly in rural areas, so new workforce measures are urgently needed to attract and retain these professionals across the public mental health system.

RECOMMENDATIONS

5.1. The Sixth National Mental Health Plan should be accompanied by a fully funded rural mental health strategy that addresses the severe inequities in access to safe, culturally appropriate and evidence-based treatment and care experienced by people with mental health needs in remote and rural areas.

5.2. Investment in rural mental health workforce development is essential, including staff capabilities, skill mix and role diversification, in order to deliver the goals of an effective, best practice, comprehensive mental health services system.

Introduction

One in five Australians have a mental health condition.[2] Mental health conditions incur major economic costs and personal suffering.

Many people with mental health conditions manage their own care with support from primary care health professionals, families and friends. A minority use specialised mental health services for help with the management of severe and enduring mental illnesses or during crises. Mental health crises can be very difficult to manage with or without specialist help. When specialist mental health services are lacking or inaccessible, the emergency department of a local hospital is often the only resource available for people who need immediate help.

The emergency department is frequently the first and only available option for people experiencing a mental health crisis, either because they cannot afford care or because they cannot find it. The numbers of people with mental health needs presenting to emergency departments across Australia is rising. Australian Institute of Health and Welfare (AIHW) data shows that, in 2017-18, mental health related presentations to emergency departments was estimated at 286,985 and comprised 3.6% of all ED occasions of service.[3] Nationally, the number of mental health-related ED presentations as a proportion of total ED presentations has increased from 3.3% in 2013–14 to 3.6% in 2017–18.[4]

Data collected by the ACEM in 2017 shows that patients who attend emergency departments for help with mental health needs also experience lengthy and potentially discriminatory delays to assessment and treatment. These delays are known to exacerbate an individual's health conditions and to have extremely negative impacts on many people. They also contribute to avoidable costs and consequences for emergency services, including on capacity to offer timely and appropriate responses to other people requiring emergency medical care.

Mental Health in the Emergency Department Summit

In response to the growing scale of this problem, ACEM hosted the Mental Health in the Emergency Department Summit in October 2018. The Summit brought together 170 experts working in or involved in mental health services to consider potential solutions to these problems. Summit participants concurred that the experience of emergency departments for vulnerable people was, too often, traumatising and harmful. There was agreement that:

- Emergency departments have become the 'front door' for people needing help with their mental health, without the resourcing and support to manage this workload. While the intended function of emergency departments is to provide rapid management for emergencies and potentially life-threatening cases, they are also serving as a means for supporting unmet health service needs within the community without being designed or resourced to do so.[5]

- There is strong evidence that standard models of emergency care, including the design of physical space, means that emergency departments are not always safe places for vulnerable people, particularly those experiencing a mental health crisis.[6] [7] Emergency departments need ways of efficiently and safely transferring these patients to appropriate specialist mental health care facilities. This process requires a shared care approach that relies on better coordination with primary care and mental health providers; and liaison between mental health specialists and the emergency department.[8]

- Failures in the broader mental health system, including gaps in service availability, mean that responsibilities are, effectively, shunted onto the emergency department, which functions as an overflow valve for people requiring immediate help and treatment, particularly outside business hours. Many of these people will have multiple, complex needs including problems with their physical health.

Discussions at the Summit highlighted that current services and funding arrangements for people living with a mental health condition are inadequate. In many areas across Australia existing services are insufficient, without enough capacity to meet demand. In almost all areas, services are not fit for purpose. More services, and different kinds of services, are required urgently.

Summit participants agreed that there is an urgent need for a comprehensive approach to system transformation in order to ensure that people experiencing mental health emergencies receive the same quality of care as those with physical health emergencies.

Summit discussion was captured via an electronic conference communications and interaction platform, enabling participants to pose questions or comment on discussions through posted statements. These comments, along with the responses to free text questions included in a participant survey conducted on the day, provided rich information to support the analysis in this report, with quotes reflecting the quantitative analysis and common themes used throughout this report to emphasise the issues under discussion.

Mental Health in the Emergency Department Consensus Statement

Delegates at the Summit agreed overwhelmingly that there is an urgent need for a safer and more appropriate response to people in mental health crises than what is currently available through emergency departments. In the intervening months, ACEM has coordinated the Mental Health in the Emergency Department Consensus Statement (the Consensus Statement), which, by June 2020, has been signed by over 1000 people and over 20 organisations representing emergency physicians, psychiatrists, nurses, consumers, carers and advocates as well as health care leaders and system managers from across Australia.

Purpose of this report

This report follows discussions at the Summit regarding the complexities of the health system in Australia. It discusses some of the identified failures across the system that result in people with mental health conditions seeking help from emergency departments and in so doing makes the case for the core message of the Consensus Statement that there is a critical need for new resources and better responses to this vulnerable group. The paper concludes with a series of options for reform and improvement proposed by the expert participants at the Summit.

Scope

This report provides an overview of the range of challenges affecting both the adult mental health service system and the interface with emergency care provided by hospitals. It does not address the specific challenges faced by children, young people or older people. These groups also face system-wide problems in receiving the most appropriate treatment and care for mental health emergencies. The paper does not

address interactions with Aboriginal community-controlled health services or migrant health services although many of the systemic issues discussed in the paper are also relevant to these and other vulnerable population groups. Whilst the significant needs of these groups were identified at the national summit, the primary focus was on the major structural barriers and issues that affect all people with mental health conditions who present to emergency departments. The unique needs, barriers and solutions for specific population groups, including children and young people, members of culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander peoples, requires further research.

Significant differences in waiting times were found between metropolitan/urban and rural/regional hospital settings. Although the percentages of mental health emergency department presentations in rural/regional settings are comparable to those in cities, a significantly higher percentage of people residing in rural/regional settings experienced mental health access block with long waits for inpatient beds.

Context

Emergency departments in Australia and many developed countries are experiencing increasing pressure due to rising numbers of patient presentations and emergency admissions.[9] [10] [11] Together with limited inpatient bed capacity, this contributes to 'access block,' a term used to describe the situation which occurs when multiple patients who need to be admitted to a hospital inpatient unit are delayed for at least eight hours from leaving emergency departments due to lack of capacity elsewhere in the hospital or broader health system.[12]

Safe hospital care requires that patient access to hospital beds should occur in no more than eight hours.[13] Protracted delays are associated with significantly poorer clinical outcomes including increased mortality and increased workload in the emergency departments.[14] People most affected by access block and emergency department overcrowding are those who require unplanned hospital admissions because of their medical condition. ACEM has carried out yearly surveys on access block since 2011. These data show that in Australia and New Zealand the continued monitoring and management of patients experiencing long waits for inpatient hospital beds represents one-third of the emergency departments' workload.[15]

ACEM Fellows have expressed concern for several years that patients with acute mental and behavioural conditions experience disproportionately long waits in the emergency department for inpatient mental health care following admission to hospital. This phenomenon, known as psychiatric 'boarding' or, more latterly, access block, is associated with several negative outcomes including higher mortality rates.[16] The concerns expressed by emergency department staff reflect strong international evidence that emergency departments are frequently both the first and last resort for people with mental health needs.

In December 2017, ACEM undertook a survey of mental health presentations in Australian and New Zealand emergency departments.[17] In the following year, AIHW data on mental health presentations were analysed in a subsequent publication, *The Long Wait,* published in October 2018.[18]

The data analysis found that, although mental health presentations account for only around 4% of emergency presentations, these patients:

- **Wait longer than other patients** with a similar severity of physical illness before they can be assessed and have their treatment commenced. They are 18% less likely to be seen within the appropriate Australasian Triage Scale timeframe.

- **Experience a longer period of treatment** in the emergency department. While 90% of all patients left emergency departments within seven hours, this figure was 11.5 hours for people presenting with acute mental health crises (and much higher in some states). The length of stay exceeded this time for 10% of these mental health presentations, further worsening the mental health condition of these patients.

- **Are more likely than other patients to leave the emergency department at their own risk, that is,** prior to their treatment being completed and against medical advice.

- **Are 16 times more likely than people with other emergency medical conditions to arrive at emergency departments via police or other non-health-services vehicles**, and nearly twice as likely to arrive via ambulance or by helicopter rescue.

- **Are more likely to be assessed by emergency department staff as requiring urgent care** on the Australasian Triage Scale, indicating the acuity of the needs of these patients.

- **Are proportionally more likely to identify as Aboriginal and Torres Strait Islander peoples than other patients.** While Indigenous Australians make up around 3% of the population, they comprise 11% of all emergency department mental health presentations across the country.

Significant differences in waiting times were found between metropolitan/urban and rural/regional hospital settings. Although the percentages of mental health emergency department presentations in rural/regional settings are comparable to those in cities, a significantly higher percentage of people residing in rural/regional settings experienced mental health access block with long waits for inpatient beds.

"There is probably a huge unmet need within the community and as we slowly grow services they will quickly be used. We have a long way to go before we reach an appropriate capacity."

"There is a lack of dual diagnosis services throughout the mental health system given the high incidence of complex, co-existing AOD (alcohol and other drugs) and mental health problems."

"There is a gap between resource demand supply; essentially, human resources and beds."

Rising need and complexity

The proportion of people with mental health conditions is increasing, the volume of people presenting to emergency departments is increasing and the complexity of patients' challenges is rising. There are insufficient mental health services to meet this rise in prevalence, complexity and severity of mental health needs in the population so people with mental health conditions (including people who present multiple times) have limited support options. The result is that an unmanageable number of people with mental health issues are presenting at emergency departments.

In 2017-18, mental health related presentations to emergency departments was estimated at 286,985 and comprised 3.6% of all ED occasions of service.[3] Nationally, the number of mental health-related ED presentations as a proportion of total ED presentations increased from 3.3% in 2013–14 to 3.6% in 2017–18.[4]

Increasing prevalence of mental health conditions

The number of individuals with mental health conditions is increasing as is the proportion of the population bearing the effects of this increase. The National Health Survey 2017-18 reported 4.8 million Australians living with mental health conditions, 20.1% of the population.[2] This number was a significant increase from the 2014-15 survey (4.0 million people, 17.5% of the population).

Mental health conditions can vary in severity and be episodic in nature. A recent review estimated that 600,000 Australians (2-3% of the population) have severe disorders, indicated by diagnosis, intensity and duration of symptoms, and degree of disability.[4] This group includes people with psychotic disorders, who represent about one third of those with severe mental disorders, and people with severe and disabling forms of depression and anxiety.

Mental health conditions such as depression, anxiety and drug addiction are major causes of disability. Mental health conditions were the leading cause of the non-fatal burden of disease in Australia in 2011, accounting for a quarter of the total non-fatal burden.[19]

Poor mental health may also be associated with suicidality. The 2007 National Survey of Health and Well Being estimated that 94.2% of persons who attempted suicide in the previous 12 months had experienced a mental disorder in the same time period.[20] According to the Australian Bureau of Statistics, deaths due to suicide have increased in recent years: in 2017 3,128 people died in Australia from intentional self-harm compared to 2,866 in 2016, highlighting the need for immediate and effective mental health strategies to prevent these tragedies from occurring. A recent study evaluated population trends in presentations to NSW emergency departments for mental health problems during 2010 to 2014, particularly presentations with self-harm, intentional poisoning, or suicidal thoughts or behaviour.[21] Researchers found significant increases in rates of all mental health-related presentations to emergency departments across all age groups and including those involving self-harm, suicidal ideation and behaviour, and intentional poisoning, with the biggest increases occurring amongst adolescents. In addition, people with suicidal ideation are more likely to present to emergency departments multiple times to seek care, increasing their interactions with emergency departments. As not all emergency department presentations will end with an inpatient admission, there is a critical need for timely referral to aftercare for discharged patients presenting with suicidal ideation, self-harm or following an attempt on their life.[22]

"The physical health of people with mental health is significantly poorer than the general population, (so) mainstream emergency department access is important."

"There is a lack of social services especially around appropriate housing; for instance, in Step Down care, supported community beds with mental health or drug and alcohol supported beds, and low cost and crisis housing."

"We need to look at the more systematic issues: affordable housing, increasing Newstart, address the social isolation issues."

Profile of people presenting in emergency departments

Clinical complexity

AIHW data shows that the most frequently recorded mental-health-related principal diagnosis groups of those presenting in emergency departments were mental and behavioural disorders due to psychoactive substance use (such as alcohol dependency disorders) and neurotic, stress-related and somatoform disorders (such as anxiety disorders) (26.9% and 26.7%, respectively).[23]

Many people who present to emergency departments seeking help for a mental health condition may also require help with acute or chronic physical health problems. There is strong evidence that patients who suffer from co-morbid chronic physical conditions and poor mental health status have shorter life expectancy than those who suffer from a physical chronic disease alone. [24] [25] [26] [27] [28]

People living with severe mental illness die 10 to15 years earlier than the average Australian. Nearly three quarters of these deaths occur in people with co-morbid mental health and chronic physical health conditions.[29] Cardiovascular diseases and cancer are the two major causes of these early deaths, which is consistent with the leading causes of death for the general population in Australia.[30] [31] While there have been significant decreases in mortality rates for these conditions in recent decades, the relative outcomes for people with severe mental illness have worsened over this period. Many of these early deaths are preventable. [32] [33] [34]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has drawn attention to the seriousness of this problem and called for systemic, collaborative action between psychiatrists, other health disciplines, the pharmaceutical industry and governments to reverse "the culture of endemic low aspirations and system fragmentation" that contributes to these poor outcomes.[35]

Social complexity

People presenting to emergency departments with a mental health condition have been identified by the AIHW to be more likely to be affected by socioeconomic disadvantage. People with the lowest socioeconomic status (quintile 1) have the highest rate of mental-health-related emergency department presentations (26.8%), with the rate decreasing with increasing socioeconomic status to 13.8% for people in the least disadvantaged area (quintile 5). This contrasts with the use of psychology services subsidised by Medicare, which are more likely to be utilised by people of higher socioeconomic status.[36]

Barriers to mental health service access also relate to affordability for many people. These barriers are created from out-of-pocket/co-payment costs and caps on Medicare rebates and are compounded by the relative socioeconomic disadvantage of many people with severe and enduring mental health conditions and co-morbidities. Even when consumers are able to access care, they often face financial hardship as a result, and this compounds the disadvantage they experience from their mental health condition.[37] When people are unable to afford specialist treatment or support, their only source of help is the publicly funded emergency department.

In addition:

- Aboriginal and Torres Strait Islanders peoples (3.3% of the Australian population)[38] are over-represented amongst mental health emergency department presentations (10.7% of mental health presentations compared with 6.7% of all emergency department presentations).

"Specifically, in relation to mental health needs of Indigenous people, and related interaction with EDs (emergency departments), we need to prioritise investment and support of Aboriginal community-controlled services to design, develop and deliver mental health and social and emotional well-being services in their communities."

"Accessing appropriate inpatient and community mental health care is a major issue for people suffering from poor mental health leaving EDs as the place of last resort."

"A continued acceptance of the separation of mental health and alcohol and other drugs services including in ED is clearly inefficient and not expecting MH and AOD services to integrate to better manage patients with co-occurring disorders. Coronial inquiries and recommendations, at least in Queensland, have consistently recommended integration of mental health and alcohol and other drug services."

- The rate per 10,000 population of mental-health-related emergency department presentations for patients living in major cities was the lowest (101.2) while that for patients in remote and very remote areas was the highest (185.3).[39]

Overall, there is evidence that people already at risk of social and geographical disadvantage do not have adequate access to mental health services in the community or cannot afford them, driving demand in emergency departments. Lack of access to specialist services for these patients is intensified in rural and remote areas.[40 41]

Frequent attenders at emergency departments

There is evidence that, in most jurisdictions, a small number of individuals account for a disproportionately high number of visits to emergency departments.[42] The mental health conditions associated with their emergency department presentations relate to acute mental distress, suicidality and consequences of intoxication with alcohol or other substances. Despite having access to primary and community mental health care, most people use emergency departments due to the lack of timely access to other services and scant supply. Furthermore, community providers or social networks often encourage patients to seek care from emergency departments in the event of a mental health crisis.

Frequent attenders have reported that emergency department visits were unavoidable and that hospital was the last or only option.[43] This is in distinct contrast to the views of some hospital personnel who perceive visits as unnecessary even though patients may be as unwell as other, non-frequent attenders. Frequent attenders are often perceived as time-consuming and inappropriate users of emergency department resources. There is evidence that patients' perceptions of the need for urgent care may be at odds with those of emergency department staff.[42] There is a need to better understand the relationship of structural and social changes to the choices and motivations of individual patients in seeking help and the attitudes and perceptions of staff.[29 43]

Impact of alcohol and other drugs

ACEM's 2018 survey of alcohol and other drug harm found that more than one in ten emergency department presentations were related to alcohol use and, at peak times in some EDs in Australia, one fifth of presentations were associated with alcohol abuse and 6% were methamphetamine related.[44] Recreational drug toxicity is also a common cause of presentation to the emergency department and of hospital admission in many countries, and patterns of use of recreational drugs are constantly changing.[45]

Frequent, heavy use of alcohol is associated with an increased risk of suicide, psychosis, behavioural disturbances, and major depressive disorder as well as with frequent emergency department presentation.[46] Use of drugs and alcohol has been associated with an increased risk of unpredictable or agitated behaviour in the emergency department.[47 48 49] Presentations in emergency department for AOD misuse reflect patterns of behaviour in the whole population and there is limited data to accurately assess the prevalence of comorbid mental illness and AOD abuse.

Current data collection systems are not adequate and do not capture the full range and scale of the harms associated with AOD misuse. [50 51] These harms include detrimental impacts on ED staff, other patients, and accompanying persons.[52] Patients with complex needs, who may self-harm or are threatening to others

"Decisions are often delayed for many hours meaning the delay for a bed can be many hours or even days. This prolonged time in a busy emergency department can make patients experiencing mental health crises angry and sometimes aggressive, leading to code greys, de-escalation, sedation and restraint .... an appalling cycle of events that is not good for patients or staff."

"People are often traumatized by their experience - brought in by ambulance workers or police, shackled, chemically restrained and left for days until the next place for them to go to. The staff in EDs often don't have the skills to work with someone affected by their mental illness and the culture in EDs is often 'they are taking up beds" - like the person with mental illness is not justified in being there. The ED is often the last place anyone wants to go."

"Our processes are focused more on containment than recovery because of two main reasons: one, there are sanctions against allowing patients to 'escape' but not against traumatising the patient; and two, EDs cannot have perimeter security."

and may present with co-existing mental health needs and AOD misuse, require specialist treatment and support and meeting these needs effectively may be challenging. There may be limited options to provide a calming, private and therapeutic environment in a busy emergency department and the lack of these may enhance distress and unpredictable behaviours.[53] Access to specialist services for people with complex needs including AOD misuse, is limited, with demand outstripping supply and the emergency department is often the only option available at times of crisis. Many emergency departments are unable to provide a dedicated environment where risks of harm can be screened and managed effectively.[54] [55] Local mental health systems need to be able to divert these patients to evidence-based multi-disciplinary services for treatment and support for complex needs.[56]

Use of restrictive practices

Restrictive practices (including sedation and restraint) may be used by emergency departments when an individual's behaviour is deemed to pose an immediate threat to themselves or others, and when other de-escalation techniques have been unsuccessful.[57] Use of alcohol and other drugs may also increase agitation, with research indicating that such patients are less likely to respond to verbal forms of de-escalation and may be more likely to require sedation compared to patients with a sole diagnosis of a mental health condition.[58] [59] Broader systemic issues such as access block also contribute to aggravating patient distress, as the use of restrictive practices may increase when emergency departments are not staffed and resourced to provide clinical supervision of patients over prolonged periods of time.[60]

There is evidence of long-standing trauma to those who have been subjected to restrictive practices, compounding existing mental health conditions and leading people to avoid care in the future.[57] [61] An American study of the use of physical restraint found negative experiences for patients included isolation, distrust and feeling violated.[62] In comparison, an Australian study of patients who had been sedated in the emergency department found that most patients understood it had been for the benefit of both themselves and staff, viewing the use of such practices as appropriate or their only option.[63] These conflicting findings demonstrate the need for more comprehensive research to understand patients' differential experiences of sedation and restraint in the emergency department.

Whilst most jurisdictions have strong regulation of these practices, including exclusions on their use or special provisions for vulnerable groups including children and Aboriginal and Torres Strait Islander peoples, the use of restrictive practices in the emergency department is not part of routine data collection.[64] [65] There is a clear need for consistent data collection and audits of the use of restrictive practices in emergency departments to identify and monitor the impact on patient outcomes and the relationship to the availability and accessibility of acute or community-based services and support. For example, an audit of patients who had attended four Victorian hospitals in 2016 found that Code Greys (unarmed threat) were called for 1.49% of all patients, with restrictive interventions applied in 24.3% of such cases.[57] The majority (62.8%) of restrictive interventions were applied under a Duty of Care framework rather than under legal provisions of mental health legislation, indicating the need to implement clinical governance frameworks to support the use and documentation of such practices.

Audits of the use of restrictive practices in emergency departments are critical to understand how they are being used and for whom but reducing or eliminating them requires the application of evidence into mainstream practice. Staff confidence in responding to the needs of people with agitation and distress, who may also have substance abuse comorbidities is enhanced when there is skilled (expert mental health) psychiatric support staff to assist in clinical decision-making for complex cases and with the

"To improve mental health care in emergency departments we should ensure there is always peer, family or cultural support and keep training staff in trauma informed care."

"Aboriginal Health Professionals in mental health need to become more involved in shared skill training with emergency departments and mental health, particularly around de-escalation and how to engage and help the highly distressed person."

"We need to be working collaboratively with ambulance officers, primary health and police on how we respond to people in distress and ensure that there is ongoing, recovery oriented, trauma informed support and treatment available for people."

provision of a safe emergency department environment.[58] In addition, more innovative and alternative models of providing emergency care for people experiencing mental health crises are required. There is clear evidence supporting these alternative models, with reported reductions in the number of security calls, the use of restrictive practices and patient length of stay.[59]

Other factors

Beyond these individual level factors, ACEM Fellows overwhelmingly identify the impact of entrenched systemic problems contributing to clinical management problems for patients with mental health and substance abuse comorbidities. These include a lack of specialist services including detoxification, rehabilitation and employment-related programs, out-of-hours services, support groups and resources for families. Homelessness is a large contributing factor and there is evidence that services which integrate responses to mental health and substance abuse and address accompanying, complex social needs may achieve better outcomes.[66] Emergency departments may face additional problems regarding the coordination of care across mental health and alcohol and drug services for patients with complex needs. These may include disputes over the duty of care between agencies. Difficulties with intersectoral communication and coordination have been found to be more pronounced in the alcohol and drug sector compared to the mental health sector.[67]

Cultural competence and safety

Aboriginal and Torres Strait Islander peoples experience poorer health status and higher hospitalisation rates for most diseases and a significantly lower life expectancy than that of non-Indigenous groups.[68] Mental health status is also much poorer than in the non-Indigenous population. Suicide rates amongst Aboriginal and Torres Strait Islander peoples are almost double that of the rest of the population.[69] A 2012 report from the Close the Gap Clearing House set out data that demonstrate that Aboriginal and Torres Strait Islander peoples faced a mental health crisis.[70] The December 2017 Australian Institute of Health and Welfare report found the mortality and life expectancy gaps are actually widening due to accelerating non-Indigenous population gains in these areas.[71]

Research on hospital services utilisation by Aboriginal and Torres Strait Islander peoples has primarily focused on admitted patients with limited research into the use of emergency departments. Furthermore, there are doubts about the quality of the data that exists.[72] [73] Evidence indicates the mental health presentation rate of Aboriginal and Torres Strait Islander people is proportionally higher than for non-Indigenous people at both metropolitan and rural hospitals, with significantly higher presentation rates in rural emergency departments. There is also evidence to suggest proportionately more Aboriginal or Torres Strait Islander patients choose to walk out of the emergency department before receiving treatment, possibly indicating greater dissatisfaction with emergency department care.[73]

The Lowitja Institute has drawn attention to research with mental health consumers demonstrating that Australia's mainstream mental health system is not aligned with the worldview and perceptions of Aboriginal and Torres Island Strait peoples and, hence, is unable to respond effectively to deeply personal and culturally distinct mental health needs.[74] Cultural safety is of particular importance in mental health practice because of the need to recognise and respect individual psychosocial processes, which are influenced by culture as well as personal experiences. Mental health care must maintain patient dignity by promoting equity, freedom from stigma and discrimination and respect for human rights.[75] Culturally safe practice requires an understanding of the historical and contemporary circumstances of Aboriginal

and Torres Strait Islander peoples and the impact of trauma in the creation and exacerbation of mental health conditions for these groups. A lack of both cultural competence and cultural safety is identified as a key barrier to better health and wellbeing.

Aboriginal people have reported that health services are alienating and unfriendly due to staff attitudes, including racism, unwelcoming environments, lack of continuity of care and lack of cultural competencies by staff.[76] [77] Staff, in turn, report that they feel unprepared to provide cultural safety to Aboriginal and Torres Islander patients and that this is influenced by a lack of understanding of the histories of these peoples and an absence of support in providing appropriate care.[78] Several national frameworks have been proposed to address cultural diversity and inequities in health including cultural awareness, cultural competence and cultural safety but these have not empowered staff in this area. In order for these frameworks to have impact, the concept of cultural safety needs to be operationalised as an outcome to cultural competence at both individual and organisational levels.[77] For under-resourced emergency departments struggling to respond to the complex and urgent needs of many kinds of patients, this represents a desirable but extremely aspirational ambition. In this context, long waits in emergency departments for mental health crises may hold additional risks for Aboriginal and Torres Strait Islander peoples. These and other culturally unsafe practices may serve to re-traumatise patients at the time they are most in need of help.[79]

In order to mitigate harms, there is an urgent need to ensure that trauma-informed care, and the skills to implement these practices, are embedded by the specialist and non-specialist services which respond to acute mental health crises. This requires a significant investment in strengthening the cultural competencies of the broad health workforce as a minimum. It also requires a fundamental review of the suitability and risks of the emergency department environment for all patients experiencing a mental health crisis and the establishment of culturally safe, non-discriminatory options for onward referral and treatment.

What is the mental health system?

The mental health system is a complex network of multi-disciplinary specialists, non-specialists and services who work with people with mental health needs in a range of primary, secondary and tertiary health settings. Due to the range of services accessed by people experiencing mental health conditions and the various ways in which they provide support, the system itself is difficult to define or measure. The sheer complexity of this system is reflected in the WHO publication, the Assessment Instrument for Mental Health Systems, a 92-page tool developed for countries or regions to systematically assess the strengths and weaknesses of their mental health system. This document states that the mental health system includes all organisations and resources focused on improving mental health, reducing the burden associated with mental and neurological disorders, including substance use disorders, and the promotion of the mental health of the whole population.[80] As emergency departments frequently address acute mental health symptoms, they are part of the mental health system, not peripheral to it. However, the role of emergency departments in acute mental health care is not well-defined, meaning treatment may not be optimal for these patients. The development of a 21st-century mental health system which is fit for purpose in addressing the needs of the population requires that this vital emergency department role is both understood by all, including providers of emergency department care and treatment, and fully resourced to fulfil this function.

Mental health systems and services need strong and reciprocal links with a wide range of other public services including social care, housing, education and training, criminal justice and welfare agencies. An effective mental health system also includes and involves patients and carers by reaching out to personal and community social support networks, as well as a wide range of civil society organisations and institutions (such as churches, libraries, community centres and local non-government organisations). Moreover, the mental health system is bound by a raft of legislation which confers powers on agencies to act in protection of the best interests and safety of individuals as required, to make provision for assessed needs, and ensure freedom from discrimination and stigma and maintain human rights. Hence, this system rests on a foundation of organisational and workforce values, attitudes, and practice capabilities, including those of cultural safety. To function effectively, policy and funding need to be aligned to work with and manage these complexities.

Capacity to respond to rising need and complexity

Most developed countries struggle with a range of barriers to providing necessary and appropriate mental health care. These include information barriers, resource insufficiency, resource distribution, resource inflexibility and timing. These barriers are all present in the Australian system and contribute to the overall growth and trends in usage of public hospital emergency departments by people needing mental health care in Australia.[81]

Simply put, there is a lack of appropriate services to support people with a mental health condition and to prevent avoidable presentations to emergency departments.[82] Contributing factors include payment systems that rely on fees for services and effectively limit the potential for care to be planned and managed over time and to enable prevention of deterioration and crisis. The mental health system is based on supply rather than demand, with poor integration and poor accountability for quality and safe health care for people with significant mental health needs.

"We need to ensure a more seamless and accessible service system so emergency departments are the last, rather than the first, port of call."

"There is a lack of capacity throughout the system due to often fragmented and disjointed services."

"Community mental health funding and bed allocation needs to be based on population data."

ACEM's analysis of the 2017 survey of mental health presentations in Australian and New Zealand emergency departments led to the conclusion that the health system is failing to meet the needs of a large number of people who seek help from emergency departments when experiencing mental health crises.[18]

Funding for mental health care

Mental health costs account for 6.5% of all health care costs. The AIHW estimates that around $8.5 billion per annum is spent on mental-health-related services in Australia.[83] Services include residential and community services, hospital-based services (both inpatient and outpatient) and consultation with specialists and general practitioners. It is generally acknowledged that there are significant deficits in mental health funding across the board. In 2014-15, mental health received around 5.25% of the overall health budget despite representing 12% of the total burden of disease.[84] There is evidence of significant underfunding across many mental health services, in particular, community mental health services, services for Aboriginal and Torres Strait Islander people and services in regional and remote areas.[85]

Overall health expenditure is increasing in Australia and internationally. The main determinants of increasing costs are related to population ageing, costs of technology and the burden of disease due to chronic physical and mental health conditions.[86] These determinants are expected to persist and maintain the upward trend in expenditure over coming decades.

Health care funding reinforces current health care structures and practices. Medicare, for example, was designed as a public insurance mechanism to manage one-off or episodic illnesses, based on a fee for service for each consultation. Fee for service and activity-based funding does not incentivise the coordination of long-term, though often episodic, care required by people with mental health conditions who may also have co-morbid physical health problems. These funding arrangements are no longer fit for purpose. They have not been changed to account for changing patterns of health and disease in the population, the concurrent rise in costs and the increasing challenges of provision of quality care with rising complexity.

The 'uncapped' elements of health care funding (i.e. Medicare supported consultations, the Pharmaceutical Benefits Scheme and health care in public hospitals) either pay for services provided without limit and/or do not constrain the number of people able to access services. That every Australian has the right to treatment in a public hospital means that cost pressures in health are more difficult to manage in these parts of the system.

Other elements of the health funding system are 'capped', with services receiving funding which does not increase or decrease with changes in demand. Many programs in health receive this type of fixed funding, including many mental health services, community-based services and prevention programs. Some services have a hybrid model, with a combination of uncapped and capped elements of their funding.

Where there are funding pressures, it is generally easier for policy makers to constrain the capped elements of health funding than to make policy changes seeking to influence the uncapped parts of the system. In many cases it is easier to control a fixed program than to influence demand for an uncapped program such as Medicare or hospital care.

"Strategic funding of services is a necessity."

"This (access block, trauma and suffering) is a symptom of system wide underinvestment in mental health and addiction"

"Some of the ideas around standard of care would be particularly difficult to implement in rural areas due to the high cost involved. Similarly, such things as having MH practitioners attending crisis calls with police or ambulance are difficult to provide due to small populations of appropriate staff simply as a result of having smaller populations and thus less resources."

Underfunding and activity-based funding for services are unlikely to incentivise the creation of effective models of care for those with complex needs, including integrated patient pathways which enable individuals to 'step up' and 'step down' to appropriate levels of treatment and support depending on the severity of their health needs. Ineffective models of care compound the problems of underfunding and lack of capacity at all levels and contribute to access blocks. All patient groups are affected by access blocks, but the problems are particularly severe for those who have mental health needs.

Access

Many health services also struggle with access and capacity issues. For example, there are fewer medical specialists in less advantaged parts of the country, including outer suburbs and rural areas. There are few general practitioners in many parts of regional Australia. Major hospitals are in central locations (or at least locations that were central when they were established). For fixed funding programs, these factors are often magnified.

Underfunding impacts on the capacity of the system to respond to the needs presented to it. The number of hospital beds at any given time is fixed, meaning that if demand surges, people may not get the care they need or will have to wait for it. The capacity of general practice is limited by the available workforce. Programs with limited budgets, including many community mental health services, often struggle to provide services to new clients with severe needs as they are managing existing clients. This can result in waiting lists, or people missing out on services altogether.

There have been significant increases in hospital admissions and emergency department presentations, with almost no increase in the funded capacity of hospitals to meet this demand. The rate of available beds in Australia reduced from 2.86 beds per 1000 in 1998–1999[87] to 2.51 beds per 1000 in 2016-17.[88] The number of public psychiatric beds has actually decreased in absolute terms, from 2,943 beds in 1998-99[87] to 2,186 beds in 2016-17.[88] Psychiatrists have argued that the numbers of acute psychiatric beds in Australia fall significantly below the Organisation for Economic Development (OECD) average – 41 per 100,000 population compared with the OECD average of 71 per 100,000.[89] [90]

From 1998-99 to 2016-17, the number of emergency department visits increased over 77% from 3.8 million to 6.74 million. Compared with 1998–1999 rates, there are now fewer available beds, while the number of emergency department presentations has increased significantly. Access block interventions may temporarily reduce some of the symptoms of access block, but many measures are not sustainable. The root causes of the problem are systemic and will remain unless overall capacity and care models are reformed to bring about better system integration and more effective prevention.

The OECD has emphasised that an effective mental health system requires a balance between adequately funded community-based services and in-patient services.[91] There is emerging evidence that the national policy emphasis on the reduction of psychiatric bed numbers in favour of community services has had several adverse consequences including on rising rates of psychiatric boarding in emergency departments.[92] In 2014 in South Australia, the lack of acute beds (27 per 100,000 population) created what has been termed 'a tipping point' where psychiatric bed occupancy rose above 100%. This led to spikes in lengths of stay in emergency departments for all patients including those requiring acute admission and waits of over 36 hours for people with acute mental health needs.[89]

"Broad and significant investment in mental health and drug and alcohol inpatient and outpatient care is needed. Not just more beds (which are needed) but community resources."

"There needs to be reprioritisation of funding for mental health beds and community services."

"Emergency departments lack access to inpatient beds, adequate physical environment, appropriate staffing levels and resources to provide timely care."

This, in turn, created a cascade of problems including increased use of restrictive practices in emergency departments, increased need for informal care from carers and friends and an increase in suicide rates during this crisis.[93] [94] Subsequent increased investment by the South Australian Government in publicly-funded hospital beds (to 30 per 100,000 of population) reduced average emergency department waits to their lowest in a decade despite a continuing increase in mental health presentations and a reduction in the suicide rate.[95]

Reliance on emergency departments to access mental health care and support is also an inefficient use of emergency department resources. The 2017 Emergency Care Costing Study was commissioned by the Independent Hospital Pricing Authority to understand the cost drivers in emergency care at the patient level. It found that the average cost per episode of mental health care was much higher than the overall average cost of emergency care in the emergency department, where:

- The overall average cost for all emergency care was $696
- The average cost for management of severe mental health disorder with diagnostic modifiers was $889
- The average cost of involuntary mental health care with diagnostic modifiers was $1,074
- The average cost of distress/confusion/agitation with diagnostic modifiers was $1,225.

A supplier-led system

Too many mental health services operate on historical principles focussed on the supply of services that do not meet the needs of people effectively. This is evidenced by the traditional business operating hours for mental health services, the types of services available, and the lack of support for patient needs that creates barriers to discharge planning.

Data collected by ACEM show that demand for mental health support in emergency departments peaks after hours, yet most community mental health services are open from 9am-5pm, Monday to Friday.[17] There are a few extended hours general practices in some locations, but not for most areas of Australia. Specialist mental health providers, such as psychiatrists and psychologists, are rarely available for drop-in appointments after hours. Overall, mental health services are provided during traditional business hours, while mental health crises can occur at any time. This can lead to people feeling that an emergency department is the only option available after-hours.

In 2016-17, more than 123,000 people (over 44% of the total) with mental health presentations were transported to emergency departments by ambulance, air ambulance or by helicopter rescue services, and almost 8% of all mental health presentations were transported by the police. These modes of transport indicate patients' acute need and attendant risk.[18] Waiting until another service is open is not a realistic option.

"A major gap in mental health care in emergency departments is mental health liaison nurses are not being employed after hours, especially on weekends."

"One recommendation for policy reform includes providing sufficient after-hours access to services."

"ED diversion is key which requires enhanced business/out of hours MH and AOD services, services in-reaching to the ED to support discharge; MH services embedded more in court, police and ambulance."

Once a person receives treatment in an emergency department, they may need referral to other services (for example, a community-based health or social service). Most emergency departments operate 168 hours a week, while many community-based services are open for less than a quarter of these weekly hours. This can lead to delays in accessing services.

The practical, downstream consequence of all of this is that when hospitals cannot find an appropriate care pathway for people suffering severe episodes of mental health crisis, as is frequently the case, the person may be 'boarded' in the emergency departments until a bed or an alternative service can be found. This can be extremely hazardous for these patients. Patients in severe crisis may have to wait without treatment in noisy, overcrowded conditions, sometimes for days. They may be sedated, restrained or exposed to a range of risks to their safety.[96] There is some evidence that the most vulnerable patients, including children and young people, receive the most sub- optimal care.[97] ACEM has drawn attention to the high numbers of people with mental health needs who prematurely leave the emergency department against medical advice and at their own risk.[18]

Access block for people with mental health needs also has consequences for other patients in the emergency department and for the whole hospital. Patients who are 'boarded' reduce the capacity of the emergency department, increasing pressures on staff who have responsibility to keep them safe as well as to respond to the range of medical needs presented by all patients.[10]

Multiple and complex responsibilities for funding and services

Australia's complex, hybrid health system can pose problems for policy and service coordination and therefore for navigation by consumers.

The Australian government is responsible for health care planning. In addition, the Australian Government subsidises the insurance program, Medicare, which covers visits to specialists and family doctors, while State and Territory governments are involved in the provision of hospital care and community mental health services. The Australian Government also subsidises the cost of medication through the Pharmaceutical Benefits Scheme. In addition, for those who purchase private health insurance, hospital care and some community-based health care services are subsidised.

There is, in effect, a two-tier health system in place in Australia. Primary care should, in theory, be responsible for treating the so-called 'common' mental health conditions such as mild anxiety or mild depression, while specialist mental health services concentrate on the severe forms of these conditions, psychosis or other severe mental health diagnoses.[98] The lack of effective patient pathways and local linking arrangements between these two levels are strong barriers to coordinated care over time for people with persistent mental health conditions and chronic physical diseases.

"The more information given to policy makers and those in hospital administration to guide patient care models the better."

"Policy reform should move away from mainstreaming mental health, resulting in ED being the primary access point for mental health services."

"Focusing on access, rather than whole of government approach to improving MH services misses the point of the poor services people with MH face. The physical health of people with MH is significantly poorer than the general population, mainstream emergency department access is important."

Mental health policy frameworks

There have been five National Mental Health Plans since 1992, with the long term aims of promoting public mental health, increasing the quality and responsiveness of services, and building a consistent approach to mental health service system reform. These systematic cycles of planning have first allowed a shift in reliance on psychiatric hospitals as the focal point of the mental health care system and the expansion of community-based services.[99] The initial policy focus on deinstitutionalisation and shifting people with severe mental illness into the community was expanded subsequently to address the broader range of mental health needs in the population, including the recognition and treatment of anxiety, depression and substance abuse.[100]

In the intervening decades, the structure and funding of mental health services has undergone profound shifts. Acute mental health care has been significantly, but not entirely, 'mainstreamed' into the same environment as general health care, with the intention of improving service quality and reducing the stigma associated with psychiatric care. Psychiatric bed numbers have been reduced in favour of innovative community care services, however, there are gaps in provision of both acute and community care for people with mental health conditions across the nation and these are particularly evident in remote and rural areas.[101] There has been increased investment in mental health at the national level but with wide variations between the states.[99]

The availability and timeliness of information or data to enable states and territories to specify service levels, including bed numbers, across the full spectrum of mental health care from the community to the tertiary level compounds structural and funding issues.[99] There are wide regional variation in the provision of mental health services and in the use of Medicare mental health items.[102] [103] These variations reflect long-standing geographic inequities in the availability of health care in Australia, particularly in areas of socio-economic deprivation and in remote and rural regions.[104] The 'inverse care law' where populations with the highest health needs have the lowest levels of investment and access to health services may be implicated in the use of emergency departments by patients with mental health needs.[105]

In 2012, Australia established a National Mental Health Commission (NHMC), complementing the development of state-based commissions in Western Australia, Queensland and New South Wales. The NHMC advocates for mental health but also undertakes annual monitoring of system performance. However, there are concerns that the Commission does not have the tools or the reach to drive the reform needed across the whole mental health system nationally.[106] Critically, whilst the NMHC contributes to mental health policy, it does not have responsibility to implement it nationally and implementation in some areas is now devolved to regional level.

"A whole system approach is needed to address mental health including prevention community services, ED process and discharge/transfer planning, infrastructure design and downstream options with step-up step-down services."

"We need to continue to advocate for increased resourcing of community mental health services and better communication and support between EDs and community services. Support trauma and culturally informed care throughout all health systems."

The Fifth National Mental Health and Suicide Prevention Plan

The Fifth National Mental Health and Suicide Prevention Plan,[107] published in August 2017, has been criticised, particularly for the lack of targets and new resources, including by the Consumers' Health Forum. Whilst welcoming the Fifth National Plan's regional focus, the aim of improving services to Aboriginal and Torres Strait Islander peoples and the attempt to address 'parity of esteem' between physical and mental health, the Consumers' Health Forum considered that the Plan lacks real traction in addressing these key issues. One particularly trenchant critic suggested that, although the goal of the Plan is to promote integration, the mental health system 'has never been more fragmented'.[108]

The redistribution of responsibility for implementing the Fifth National Plan to thirty-one Regional Primary Health Networks (PHNs) working with their state counterparts, Local Hospital Networks (LHNs), moves responsibility for system reform away from the Commonwealth and jurisdictional governments. PHNs now have mental health care as a core responsibility but have little transparency or accountability. The Fifth National Plan stipulates that PHNs are required to develop joint regional mental health and suicide prevention plans, however there is limited evidence so far of how these plans are being implemented.

Approximately 10% of Commonwealth mental health funding is channelled through PHNs, but a recent review has highlighted a range of issues, including the lack of objective criteria available to reliably measure the relative performance of PHNs.[109] There appears to be significant variation among PHNs' capability and progress, meaning that Australians living in different parts of the country are likely to be receiving different levels of service in terms of access and type of service. The PHN Advisory Panel felt that whilst regional variations in the planning approach were important, a national framework is needed to address distinct local and regional variations. The PHN Advisory Panel was particularly concerned about slow progress in achieving a 'stepped care' approach which would strengthen integration between levels of mental health services and the broader health system, particularly with drug and alcohol, suicide prevention and social and emotional wellbeing service providers.

Members of the Panel further suggested that 'design of the system of governance for the PHNs was inadequate given the significant public funds entrusted to them'. All members of the Panel agreed that more publicly available information would help build accountability and trust. However, there was consensus amongst panel members that PHNs are undermined in their efforts to transform mental health services by 'uncertainty associated with (their) funding contracts', their short-term scope and short notice of renewal in many instances. Overall, the Panel found that, in many areas, the level of funding received by PHNs is 'inadequate to support best practice.' The Panel brought forward 17 recommendations for a range of stakeholders addressing the 'complex operating environment in which mental health reform is occurring'.[109]

There have, in addition, been many critiques of the 'narrowness 'of the overall vision of the Fifth National Mental Health and Suicide Prevention Plan. These suggest that it does not adequately acknowledge the significant contribution to mental health care provided by non-government organisations and non-health services.

"There needs to be more support across governments for integrated service responses."

"The fragmentation and silo mentality of craft groups leads to patients' journey being very bumpy and often disrupted due to scarcity, or lack of co-ordination between inpatient and outpatient services."

"A comprehensive fully integrated set of community based mental health and suicide mitigation services can dramatically reduce the number of people who go to an ED."

Many commentators consider that successive Mental Health Plans have failed to address the legacy of piecemeal reform.[110] [111] [112] The Fifth National Plan is also considered to have failed, specifically in specifying the resources and incentives for meaningful integration, despite the stated aims of the Plan. Furthermore, by failing to clarify a vision for the full spectrum of care and requiring agreement by all jurisdictions, the effect is that none of them, and no organisation, is accountable for outcomes.[113]

Australia is not alone in facing challenges in strengthening accountability for mental health system performance. These challenges include a lack of sufficient evidence regarding appropriate mental health care, poorly defined quality measures, limited descriptions of mental health services from existing clinical data, and lack of linked electronic health information.[114] In addition, the Australian context with a federated health system involving nine governments and tiers of services across public and private sectors imposes additional obstacles. Whilst standards for mental health services have underpinned all the national five-year plans and have become the basis for accreditation surveys for all Australian mental health providers, these have also been criticised as incomplete and diluted.[115] Moreover, these standards address individual services, patients, and carers. Hence, there is no way of judging the efficacy and efficiency of mental health systems overall. The system is left, effectively, to manage itself. The Australian Commission on Safety and Quality in Healthcare, which is charged with developing and monitoring standards for all health services should be required to work collaboratively with Primary Health Networks in setting standards for system performance, not just organisational performance, to drive quality and outcome improvement.

The National Disability Insurance Scheme

The challenges above have been compounded by the implementation of the National Disability Insurance Scheme (NDIS). The NDIS has responsibility to support the non-clinical care of people who experience a psychosocial disability due to a mental health condition. Funding may be provided for supports that help people with the activities of daily living, such as domestic support and participation in community activities. Federally funded mental health programs have been transferred to the NDIS. Transitional funding has been provided until 2021 for people who previously received supports through these programs, however it is unclear what supports will be available beyond this timeframe particularly for people deemed to be ineligible for NDIS funding.[116] Commentators have raised concerns about the consequences of the NDIS for system integration. It is suggested that the NDIS may intensify current inequities and fragmentation by enabling some of the bigger players in Australia's mental health landscape to offer 'separate services to separate clientele under different mandates.'[108] These issues were considered in the independent Tune Review report on the functioning of the NDIS, which was made public in January 2020.[117] The Federal Government has committed subsequently to implementing the 29 recommendations from the Tune Review which aim to cut wait times, improve services, enhance flexibility in the use of funds, and clarify access for people with a disability.

Psychosocial support and rehabilitation are essential in the promotion of mental health, prevention and recovery. The fissure between clinical and non-clinical aspects of the mental health system may be illogical in the context of the episodic nature of mental illness for many people, the complexity of symptoms and needs and the requirement for personalised and flexible pathways or regimes of care and support.

"Sadly, we need more resources in our local environment, such as EDs and hospital beds and a safe collocated area to progress patients through, just as a response to our crisis. Policy reform is too far away to contemplate when I work in what is effectively a detention centre with a constant bombardment of sensory overload for staff and patients."

"Australia is so behind in how we address mental health crisis. With better community supports we can have less demand on emergency departments."

Separate funding regimes, priorities and administrative structure have the potential to create additional and profound barriers to the development of pathways of care in the absence of a new, integrated, strategic vision for mental health.

A broken system

The issues with Australia's health system, including funding models, supplier-led services not matching demand, and a lack of accountability, are not just problems for emergency departments or even for hospitals. However, systemic deficiencies in current arrangements mean that emergency departments, which are often the only resource available after hours, and which have an open-door policy, become the first and last option for those in mental health need either through direct access by patients or by transfer by other agencies including police.

The result is that people with multiple conditions are reliant on a fragmented system with services and providers working in isolation from each other, they experience lack of continuity of care and treatment and there is both wasteful duplication and gaps in services. These structural barriers militate against good outcomes for people with complex conditions who require proactive, long-term, coordinated, evidence-based management and team care. These outcomes represent a poor return on rising public and private investment in healthcare.

There is an urgent need to reform payment methods and establish incentives to promote integrated care delivery models, such as Patient Centred Medical Homes and Accountable Care Organisations, and to build integrated primary care and mental health care and support. Integrated care models rely on interdisciplinary service teams to provide comprehensive clinical and social patient care; health information and other technologies to assure, monitor, and assess quality; and financial incentives such as bundling, pay-for-performance, and gain-sharing to encourage value-based health care.[118]

The Mitchell Institute has considered the challenge of reforming health care funding to address chronic diseases and has concluded that a mandatory integrated (public and private funding) health insurance market with regulated competition provides the best model for Australian health funding given the long standing mixed economy of separated public and private funding of health care.[119] This would provide the necessary components of a universal and sustainable health insurance model purposefully designed to provide for chronic health conditions and incentivise and reward practice change.[120] Australia's reliance on fee-for-service medicine imposes barriers for people with chronic health conditions including mental health conditions and creates complex navigational problems for patients who need help from multiple providers. A funding model for mental health care that provided funding for episodes of care rather than individual services was developed in the 1990s. However, it has not been systematically used as an alternative funding model for mental health.[121] The structural perversities of current funding for mental health treatment and care appear to be a particularly entrenched systemic barrier.

New models of mental health care

ACEM has identified several innovative Australian models of mental health care that offer affordable, integrated care with sustained and proactive engagement with emergency departments which can be replicated at scale. These include:

- The Psychiatric Alcohol and Non-prescription Drugs Assessment (PANDA) Unit at St Vincent's Hospital in Sydney is a six-bed ward close to the emergency department, where patients can be admitted for safe observation, management and nursing. It provides a model of concurrent management of acute mental health crisis with co-existent medical problems, where patients can be managed medically in a safe setting until medically fit for mental health review. The PANDA Unit has been developed in response to the high proportion of people with mental health illness and regular drug and alcohol users presenting to the emergency department. Data suggests around 15% of the patient presentations to the emergency department involve mental illness and/or the effects of drug use. The PANDA model is a 7 day a week, 24 hour a day service, managed by a combination of clinical pharmacology and drug and alcohol teams in close collaboration with the emergency department and the Mental Health Service.

- The Mental Health Observation Area (MHOA) in Joondalup Health Campus, Perth, Western Australia, is a collocated area with interview rooms and overnight beds that has taken mental health patients out of the main emergency department, 'bringing the emergency department back under control'. Victoria is in the process of rolling out its version of the MHOA – the Emergency Department Crisis Hub.

- Royal Perth Hospital has a Homeless Team to address one of the biggest drivers for re-presentations to the emergency department – discharging a patient into homelessness. The team offers an outreach service that provides patients with follow-up care and support in the community, so those who remain homeless can still access health care.

- Royal Prince Alfred Hospital Sydney has successfully trialled a nurse practitioner-led, extended hours Mental Health Liaison Nurse (MHLN) service based in the emergency department. The MHLN team see mental health presentations and begin the process for coordinating care. This has been shown to provide prompt and effective access to specialised mental health care for people with 'undifferentiated health problems and remove a significant workload from nursing and medical staff.

- In a partnership between the Queensland police, health and ambulance services, a mental health intervention project has enabled mental health clinicians to work alongside police to better manage crisis situations involving people with a mental illness. Staff are supported with training in de-escalation strategies and regional coordinators work to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative referral pathways and review procedures.

- St Vincent's Hospital in Melbourne has a peer worker employed in the emergency department and a Safe Haven Café physically close to the emergency department. The café offers respite in a warm, caring and respectful environment to people needing mental health support as well as social connection, but not necessarily acute care. The model was developed by and for consumers.

Fixing the problems

Providing crisis mental health care in emergency departments is often both unsuitable and harmful to people who require expert mental health care. It is an expensive and often inefficient way to provide care and support. Improving mental health care across the whole health system will reduce inappropriate, unsuitable or harmful attendance at emergency departments. There is a fundamental need for a new vision for mental health in Australia which recognises the reach and complexity of the system and puts in place the mechanisms and the resources to tackle the factors that prevent it from working seamlessly, in the interests of patients and the population as a whole.

The next National Mental Health and Suicide Prevention Plan must address the priority areas for improvement include providing more options for care, prevention, management of urgent care needs and for discharge and referral. The development of wrap around integrated services for comorbid mental health, physical health and social needs for people with persistent mental health conditions will reduce the need for emergency presentations and provide a clear pathway when emergency hospital care is necessary. There are emerging models of good clinical practice in emergency mental health care in Australia which provide a platform upon which to build the new system.

Even with broad, systemic transformation, it is likely that emergency departments will sometimes be the front door to the mental health system for people experiencing mental health crises. Emergency departments therefore need to be acknowledged as being part of the mental health system, not peripheral to it. To fulfil this role safely, emergency departments must have clear definitions of their roles in mental health crises and be resourced appropriately to manage mental health crises with enhanced capacity to provide mental health expertise. There is a need for psychiatric leadership in the emergency department particularly in relation to managing vulnerable populations such as children and youth. This must include resources for new liaison and care coordination roles to facilitate the transfer of patents from the emergency department to other settings and sources of support.

The forthcoming National Mental Health Plan offers a timely opportunity to benchmark its goals against measures of timely access to intensive, early intervention services, care coordination across services and sectors, crisis presentations to emergency departments, lengths of stay, use of restrictive practices and patient-reported outcomes. All governments need to commit to accountability for the delivery of these goals.

The roles, skills and training of both specialist and non-specialist health professionals must be clarified and defined in the next National Mental Health Plan to ensure that the common occurrence of mental health conditions in the population is understood in all healthcare settings. This is essential to enable health services staff to respond appropriately to people with mental health needs and to communicate effectively with all agencies across the system.

"Policy should create far better access to acute MH services: alternative points of access, rapid/crisis access and 'step down' care after acute admissions to shorten length of stay. Greater efficiency and improved culture in mental health services generally."

"This has to be more than a conversation about what happens in EDs. We need to be preventing people developing mental illnesses and being in distress in the first place. We need to provide options other than emergency departments."

"We should have an expectation that health outcomes for people with physical and mental health illnesses are equivalent; which requires improved access to inpatient and mental health services."

The next National Mental Health Plan must be accompanied by a rural mental health strategy to address the entrenched problems of historical underfunding, inequities in service supply, the lack of an appropriately skilled workforce and the need for culturally sensitive and safe services.

Many people with mental health conditions do not feel safe or comfortable accessing mental health services. Aboriginal and Torres Strait Islander people feel that services are unable to respond effectively to deeply personal and culturally distinct mental health needs due to a lack of understanding. Further, people who have experienced trauma, such as a history of abuse, often report distress at presenting to an emergency department. There is a need to invest in mandatory emergency department staff training in relation to providing culturally appropriate care and treatment to improve outcomes for acute mental health presentations. ACEM and other professional and registration bodies and service providers should make provision for training and assessment in cultural safety and trauma-informed care for staff in emergency departments.

Recommendations

The forthcoming Sixth National Mental Health and Suicide Prevention Plan (the Sixth Plan) creates the opportunity to set out a new and transformative vision and goals for mental health care in Australia. The Sixth Plan must include a fully funded implementation strategy, with goals benchmarked against measures of timely access to intensive, early intervention services; care coordination across services and sectors; crisis presentations to emergency departments; and patient reported outcomes and experiences. Governments need to commit to accountability for delivery of these goals.

There is an urgent need for Australian governments to commit to reforms that deliver timely access to appropriate mental health care, with an immediate focus on after-hours care in the community as a viable alternative to emergency departments. The National Cabinet Health Reform Committee should direct that the Sixth Plan includes the following priority actions to reduce the reliance of mental health patients on emergency departments through the development of adequate services to meet community mental health needs and reduce presentations.

1. ENSURE ADEQUACY OF SERVICES TO MEET NEED

Mental health funding should be increased to better reflect the burden of disease and to acknowledge parity of esteem for mental illness with physical illness. Australia's provision of 41 acute psychiatric beds per 100,000 population is significantly lower than the Organisation for Economic Co-operation and Development (OECD) average of 71 mental health beds per 100,000[1]. Most states and territories have invested heavily in step-up or step-down services and community mental health services as an alternative. However, hospital-type services – whether they occur in a hospital or not – are needed to provide a pathway for people experiencing severe mental distress to be admitted directly from an emergency department. Depending on the jurisdiction and its current services, these services may include inpatient beds, hospital in the home services, short stay units or specialised step-down mental health services.

RECOMMENDATIONS

1.1. State and Territory Governments should undertake strategic needs assessments to scope the requirement for inpatient mental health beds in line with international best practice evidence and standards.

1.2. Additional resources must be invested to increase inpatient mental health beds and non-hospital alternatives, such as step up/step down services, short stay units, hospital in the home etc., depending on local needs.

2. IMPROVE FUNDING AND SERVICE MODELS TO PROVIDE BETTER OUTCOMES

Existing funding arrangements, particularly the current fee for service approach, don't support best practice care for people living with mental health conditions. Services are rewarded for providing a service with an immediate benefit and not for anticipating and preventing avoidable future need. There is little reward for providing tailored individualised care or for innovative cost-effective patient-focused services. There is an urgent need for innovative funding arrangements that support comprehensive, coordinated and sustained community mental health care, initially targeted at people identified as at risk for frequent emergency department presentations.

There are a number of easily replicable examples of innovative service models around Australia that address the complex needs of people who are frequent attenders at emergency departments. In addition, there are robust models of shared care available which may be adapted for use with these

groups of patients, including, for example, maternity care. A first step would be to focus on collaboration across services and facilities to improve the pathways for patients out of the emergency department.

RECOMMENDATIONS

2.1. The National Cabinet Health Reform Committee should support and encourage innovative mental health funding arrangements that provide ongoing and sustained care for people with persistent mental health needs.

2.2. State and territory governments should explore innovative diversion or alternative care models in communities with high levels of mental health patient presentations to emergency departments.

2.3. All government-funded mental health services should be required to expand their operating hours to provide flexible after-hours services as a condition of receiving funding.

2.4. Emergency department resourcing must provide for adequate clinical care and accommodation by including mental health expertise in emergency department staffing; providing ongoing mental health education, training and professional support for all staff; developing new workforce models including peer workers within emergency department teams; and applying emergency department design principles that create low stimulus, reassuring environments for people in mental health crisis.

2.5. All jurisdictions should implement a centralised follow-up service that ensures all mental health patients, especially when presenting due to suicidal ideation or following an attempt on their life, receive a phone call within 24 hours of discharge to offer advice on available services, check on referrals (for example, if a GP appointment has been made) or other appropriate actions.

3. ESTABLISH EFFECTIVE SERVICES COORDINATION AND ACCOUNTABILITY IN ALL JURISDICTIONS

There is currently a lack of accountability and reporting of mental health presentations to the emergency department, leading to inadequate action to address preventable mental health presentations. Mental health service providers should provide regular reports on their activity and the impact of this activity for people relying on their services. All jurisdictions should improve efforts to share timely data at the local level between health services, community mental health services, Local Health Networks (LHNs), and Primary Health Networks (PHNs). This would aid system planning, promote better practice and provide knowledge about pressure points and gaps in the system.

PHNs are the Commonwealth's main commissioning mechanism for community based mental health services and are currently required to work with LHNs, the administrative bodies for public health services and other community based health services in each jurisdiction, to develop joint regional mental health and suicide prevention plans. This integrated planning and delivery provides an opportunity to develop shared governance mechanisms for care pathways, referral mechanisms and review of adverse events, so is therefore a valuable mechanism to coordinate actions needed to prevent avoidable mental health emergency presentations.

RECOMMENDATIONS:

3.1. Primary Health Networks should have an explicit goal of preventing avoidable mental health emergency presentations in their catchment areas. PHNs and LHNs should form area mental health service steering bodies to align, coordinate and monitor care pathways for all individuals requiring continuing mental health services.

3.2. Area mental health service steering bodies should be accountable to both Commonwealth and State and Territory governments. LHNs should monitor and report on excessive (>12 and 24 hours) stays in emergency departments, restrictive practices and walk outs. PHNs should monitor and report on primary care provision both pre and post an acute presentation or hospital admission for all individuals requiring continuing mental health services.

3.3. The Commonwealth should establish a robust mechanism for monitoring system performance against the [National Standards for Mental Health Services](#) established by the Australian Commission on Safety & Quality in Health Care.

4. ENSURE BEST PRACTICE EMERGENCY MENTAL HEALTH CARE AND TREATMENT

Emergency department lengths of stay and wait times for admission to an inpatient bed are disproportionately longer for mental health patients compared to patients presenting with other conditions. Described as 'boarding' or 'access block', the long waits for mental health patients are associated with several negative safety and clinical outcomes including higher mortality rates and increased risk of violence and aggression in the emergency department.

While recognising that the safety of staff and other patients is paramount, the evidence that the use of restrictive practices such as sedation and restraint may cause serious harms to patients is clear. Hospital funding arrangements must improve the capacity of emergency departments to provide appropriate clinical care that will reduce reliance on restrictive practices, particularly for people at risk of frequent emergency department presentations. Reducing the incidence of long waits in the emergency department would also minimise the need for prolonged use of restrictive practices. Any progress towards reducing and potentially eliminating the use of restrictive practices in emergency departments will require resourcing of the clinical team, security personnel and the ED environment.

RECOMMENDATIONS

4.1. State and Territory health departments should adopt a maximum 12-hour length of stay (LOS) in the emergency department by providing accessible, appropriate and resourced facilities for ongoing care beyond the emergency department. Mandatory notification and review of all cases should be embedded in key performance indicators of public hospital CEOs.

4.2. All episodes of a 24-hour LOS in an emergency department should be reported to the relevant Health Minister regularly, alongside CEO interventions and mechanisms for incident review.

4.3. Use of restrictive practices (sedation and restraint) in emergency departments should be governed by clear clinical governance frameworks, standardised documentation tools and clear reporting pathways that allow for system improvement recommendations to be progressed to the relevant governance level.

4.4. Audits of restrictive practices in the emergency department should be conducted to identify and monitor the impact on patient outcomes and the relationship with the availability and accessibility of acute or community-based services and support.

4.5. All security personnel working within the emergency department should be appropriately resourced and trained in de-escalation techniques to reduce the need for restrictive practices and ensure patient and staff safety.

5. ENSURE ADEQUACY OF RURAL MENTAL HEALTH SERVICES AND HEALTH WORKFORCE CAPACITY

Australians living in rural and remote areas experience a unique contribution of factors that impact upon the availability and accessibility of mental health services. In addition, Aboriginal and Torres Strait Islander peoples face cultural barriers and a lack of mental health services which are culturally appropriate. There is a shortage of psychiatric leadership and trained mental health professionals, particularly in rural areas, so new workforce measures are urgently needed to attract and retain these professionals across the public mental health system.

RECOMMENDATIONS

5.1. The Sixth National Mental Health Plan should be accompanied by a fully funded rural mental health strategy that addresses the severe inequities in access to safe, culturally appropriate and evidence-based treatment and care experienced by people with mental health needs in remote and rural areas.

5.2. Investment in rural mental health workforce development is essential, including staff capabilities, skill mix and role diversification, to deliver the goals of an effective, best practice, comprehensive mental health services system.

Conclusion

The poor experience of many people with mental health needs in emergency departments is a symptom of a systemic failure. The causes involve a complex network of interwoven processes ranging from hospital workflow to gaps, failures and perverse incentives in the broader health system as well as the choices and behaviours of consumers and other health care providers.

Future mental healthcare must involve a mix of access block reduction initiatives within emergency departments and system-wide reform.[122] National leadership, through the anticipated Sixth National Mental Health Plan, must give priority to reducing the unnecessary pressure on emergency departments that results from the failure of current service and funding arrangements to provide adequate treatment and care for people with mental health conditions.

Immediate commitment to the development of creative and innovative partnerships between the emergency department, the wider health sector and consumers is desperately needed. This will provide opportunities to direct people to more appropriate mental health services, whilst ensuring that emergency departments succeed in the assessment, treatment, and follow-up of people who most need emergency mental health care.

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