Still Waiting

Trends in Mental Health Presentations to Australian Emergency Departments

Australasian College
for Emergency Medicine

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About ACEM

The Australasian College for Emergency Medicine (ACEM; the College) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, evidence-based, patient-centred emergency care.

Our mission is to promote excellence in the quality of emergency care to all communities through our committed and expert members.

Acknowledgement

ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Authorisation

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President's message

For someone experiencing acute distress, the timeliness in which a person receives support can shape their recovery and management for years to come.

ACEM's 2018 report *The Long Wait* drew national attention to the lengthy stays experienced by people seeking mental health care in emergency departments (EDs).[1] *Still Waiting* shows that the issues highlighted in the previous report have further deteriorated over the past seven years, demonstrating a lack of progress.

While this report focuses on the numbers, it is vital to remember that every statistic represents a person seeking care. Behind each figure is an individual, loved one or carer who has turned to an ED for help, whether in acute crisis or because no other care was available. These are the human stories behind the data, and they are why reform matters.

Similarly, in shining a light on the pressure facing EDs and the health system at large, the public narrative often defaults to describing the system as 'overburdened'. But it's important for us to be clear that people are not a burden – they are seeking care, often in their most vulnerable moments. The problem is not those who walk through the doors, but a health system that has failed to keep pace with community need.

All Australians deserve high-quality, timely and safe healthcare – including mental health care – wherever they live. Yet beyond a GP or an ED, mental health services remain difficult to access. While in urban centres they can be limited, costly or hard to navigate, for people in regional, rural and remote communities, the barriers are even greater.

The quantitative data in this report also echoes what health workers are reporting on the ground: EDs are seeing increasing numbers of people in acute psychological distress, with waits for admission stretching well beyond clinically safe timeframes. EDs have been left as the default entry point for crisis care, but without the resources to meet growing demand.

The consequences of this are profound – for people who wait too long or do not receive appropriate care, for families and communities who carry the weight of crisis, and for staff working under relentless pressure. Without meaningful investment in community-based mental health services, the system will remain reactive, costly and unsustainable.

ACEM also acknowledges that the voices of people with lived experience of mental health challenges are essential to shaping reform. We encourage readers to engage with the work of Australian lived experience organisations, which provide critical insights into what a person-centred, recovery-focused mental health system should look like.

Dr Stephen Gourley
ACEM President

Executive summary

EDs are open 24 hours a day and are often the first, and sometimes only, point of care for people needing urgent mental health care. From acute distress to severe and complex psychiatric conditions, EDs see the full spectrum of need. This frontline role gives EDs unique insight into the systemic gaps in mental health care and the wider social supports needed to promote recovery.

ACEM has been documenting these challenges for almost a decade. In 2018, *The Long Wait* revealed that people presenting to EDs with mental health conditions experienced significantly longer waits to be seen, treated and discharged than other patients. In 2020, *Nowhere Else to Go* highlighted how systemic failures were leaving people requiring mental health care 'stuck' in EDs and made clear recommendations for reform.[2]

Seven years on from *The Long Wait*, ACEM's new report, *Still Waiting*, shows these problems have only deepened.

Data trends from 2016–17 to 2023–24 reveal:

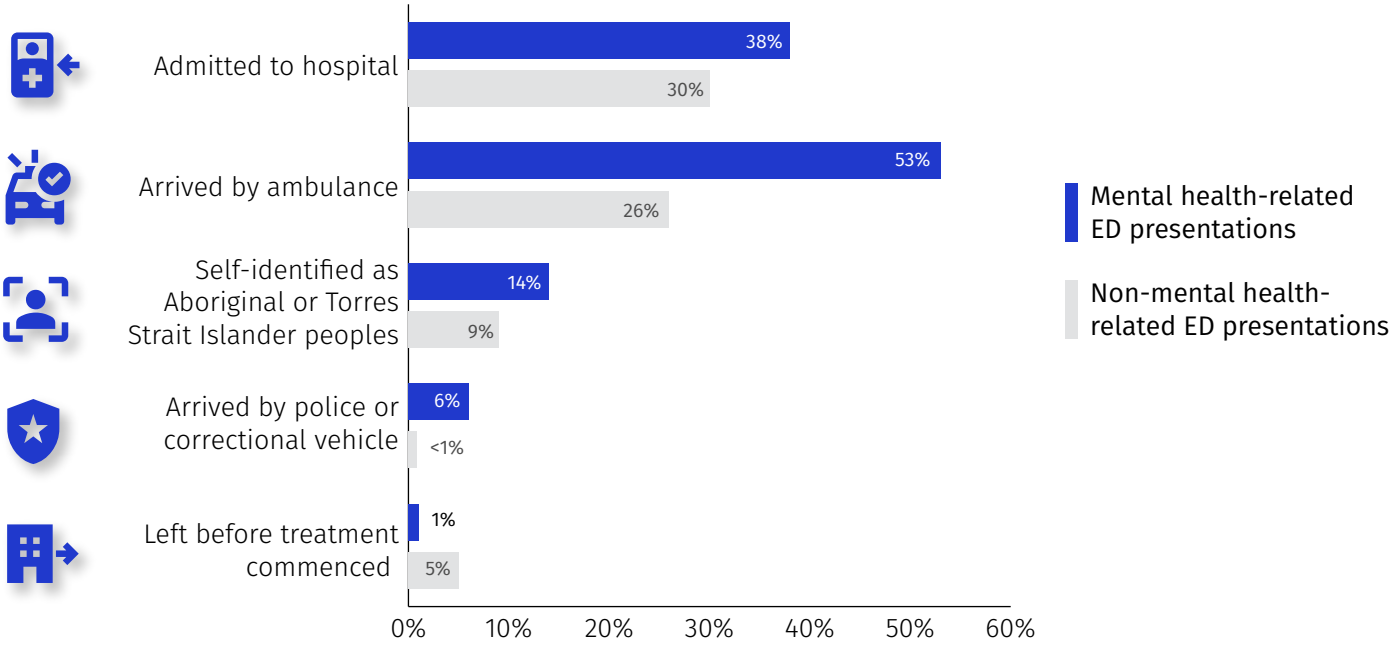
- **Rising demand:** Mental health-related presentations to EDs are increasing, particularly among Aboriginal and Torres Strait Islander peoples and those aged 65 years and over.
- **Greater complexity and acuity:** ED presentations are increasingly urgent and complex, with more patients needing mental health care arriving by ambulance, triaged as high acuity (Australasian Triage Scale 1–3), and more likely to require hospital admission compared with other ED patients.
- **Excessively long waits for admission:** Length of stay in EDs continues to worsen. In 2023–24, 10 per cent of patients with a mental health diagnosis waited more than 23 hours for an inpatient bed.
- **Beyond access block:** Excessive waiting times in EDs are affecting not only admitted patients but also those who were discharged without admission, highlighting broader system failures beyond hospital bed access block.

Despite repeated recommendations from ACEM and the broader health sector in the face of these ever-increasing problems, federal, state and territory governments have made limited progress towards reform. The latest data makes clear that demand now far outstrips the resources and services available.

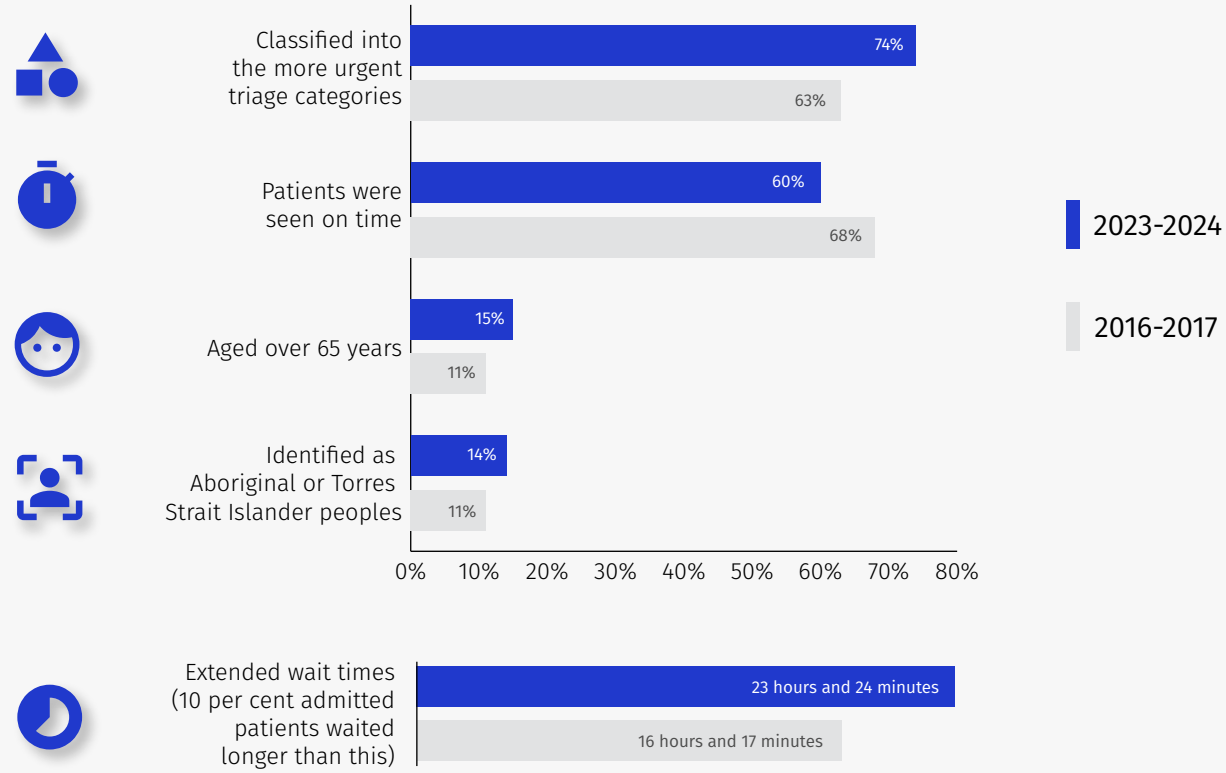
While increased presentations may reflect positive trends such as reduced stigma and greater help-seeking, they may also reflect major gaps in accessible, community-based care.[3] EDs are not designed or resourced to provide diagnoses or long-term recovery support. Yet for too many people in crisis, the ED remains the only option, not because it is the right place for care, but because no appropriate alternatives exist.

By the numbers

Mental health-related presentations compared with non-mental health presentations in 2023-24



Changes in mental health-related presentations between 2016-17 and 2023-24



About the report

This report provides an updated, data-driven snapshot of mental health presentations to Australian EDs, including presentation numbers, patient demographics, clinical urgency and waiting times.

The primary data sources are the Australian Institute of Health and Welfare's (AIHW) publicly available releases. These include annual data on ED presentations from the National Non-Admitted Patient Emergency Department Care (NNAPEDC) database,[4] as well as specialised AIHW releases on mental health-related ED presentations.[5,6] Data from 2016–17 to 2023–24 was analysed for this report.

Medical diagnoses in the AIHW datasets are coded using the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). Under this system, mental health presentations are classified as 'mental and behavioural disorders' (Chapter 5, codes F00–F99). However, this method underestimates the true number of mental health-related presentations, as it does not capture other relevant factors such as self-harm or suicidal ideation. Importantly, presentations for self-harm or suicidal behaviour are often the first time a person accesses mental health care, yet they are not included in mental health diagnostic categories. This factor limits understanding of the full emergency care needs of this group.

This report does not incorporate the views of people with lived experience, and the datasets used cannot by themselves provide a complete picture of the barriers to access and affordability in mental health care. Nonetheless, the consistent rise in presentations, combined with findings from multiple large-scale government inquiries, highlights where systemic challenges persist.[7] Investment is urgently needed across the spectrum of mental health needs, particularly for the 'missing middle' – people who do not qualify for high-acuity services but are at risk of their condition increasing in complexity and severity without the right level of care.[8]

Part 1: Overview of mental health-related emergency department presentations

A comparison of mental health-related and non-mental health presentations

Between 2016-17 and 2023-24, mental health-related presentations to Australian EDs have fluctuated, reflecting changing demand and external factors such as the COVID-19 pandemic **(Figure 1)**.

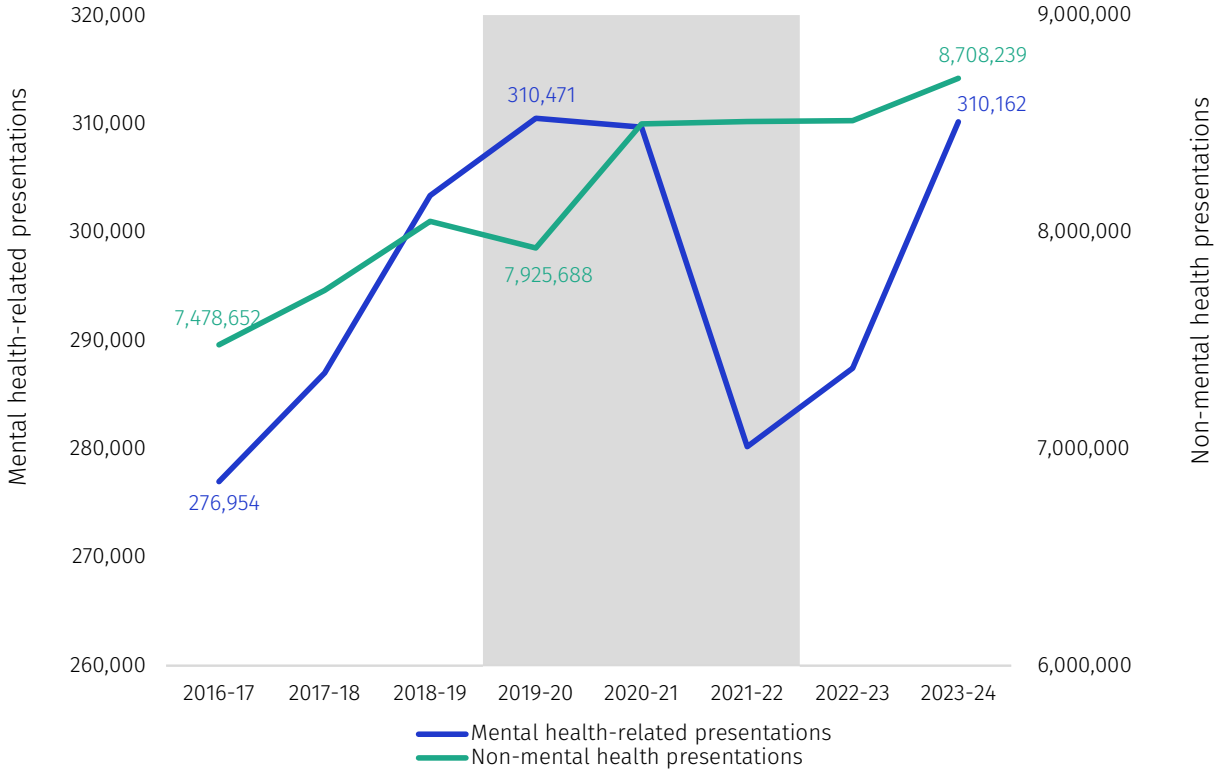


Figure 1: Total number of mental health-related presentations and non-mental health presentations between 2016-17 and 2023-24.

Note: The shaded area represents the timeframe during which the COVID-19 pandemic was at its most prevalent.

- The number of mental health-related presentations increased from 276,954 in 2016-17 to 310,471 in 2019-20.
- Mental health-related presentations reduced in 2021-22 to 280,176, then began to rise in 2022-23, eventually reaching pre-COVID-19 pandemic numbers, with 310,162 mental health-related presentations in 2023-24.
- Comparatively, the number of non-mental health presentations has gradually increased from 7.5 million in 2016-17 to 8.7 million in 2023-24, with a slight reduction in 2019-20.
- The number of mental health-related presentations per 10,000 population remained consistent throughout the period observed.
- Mental health-related presentations accounted for 3.6 per cent of total ED presentations in 2016-17, increasing to 3.8 per cent in 2019-20, and then decreasing slightly to 3.4 per cent of presentations in 2023-24.

The demand for mental health care in Australian EDs has changed over time and is influenced by a range of health and wellbeing, societal and health system factors. There are a limited number of publicly funded psychiatric beds and community-based mental health services, while private psychology and psychiatry can be costly. EDs provide a necessary service in terms of providing the initial crisis response and some therapeutic input. However, the next point of patient care is crucial and will ultimately provide the necessary therapeutic support, improvement of symptoms and long-term recovery.

As highlighted, this aggregated mental health-related presentation data does not include presentations relating to intentional self-harm and suicidal ideation. Published evidence suggests that around a quarter of mental health-related presentations are not captured in the mental and behavioural disorders chapter of the ICD-10-AM (including diagnoses relating to intentional self-harm and suicidal ideation).[9]

This exclusion significantly under-represents the true extent of mental health-related presentations to Australian EDs. The AIHW acknowledges the self-harm reporting gap in ED mental health presentation data and is working with states and territories to improve the accuracy and consistency of quality data.[10]

Mode of arrival

A considerably higher number of mental health-related presentations arrived to the ED by ambulance or police/correctional vehicle than non-mental health presentations (**Figure 2**).

- In 2023-24, the proportion of mental health-related presentations arriving by ambulance (53.4 per cent) was double the proportion of non-mental health presentations arriving by ambulance (25.6 per cent).
- Since 2016-17, the proportion of mental health-related presentations arriving by ambulance increased by 8.6 per cent, while a 1.8 per cent increase was observed across non-mental health ED presentations.
- The proportion of mental health-related presentations arriving by police/correctional vehicle (6.4 per cent) was 16 times higher than non-mental health presentations arriving by police/correctional vehicle (0.4 per cent).

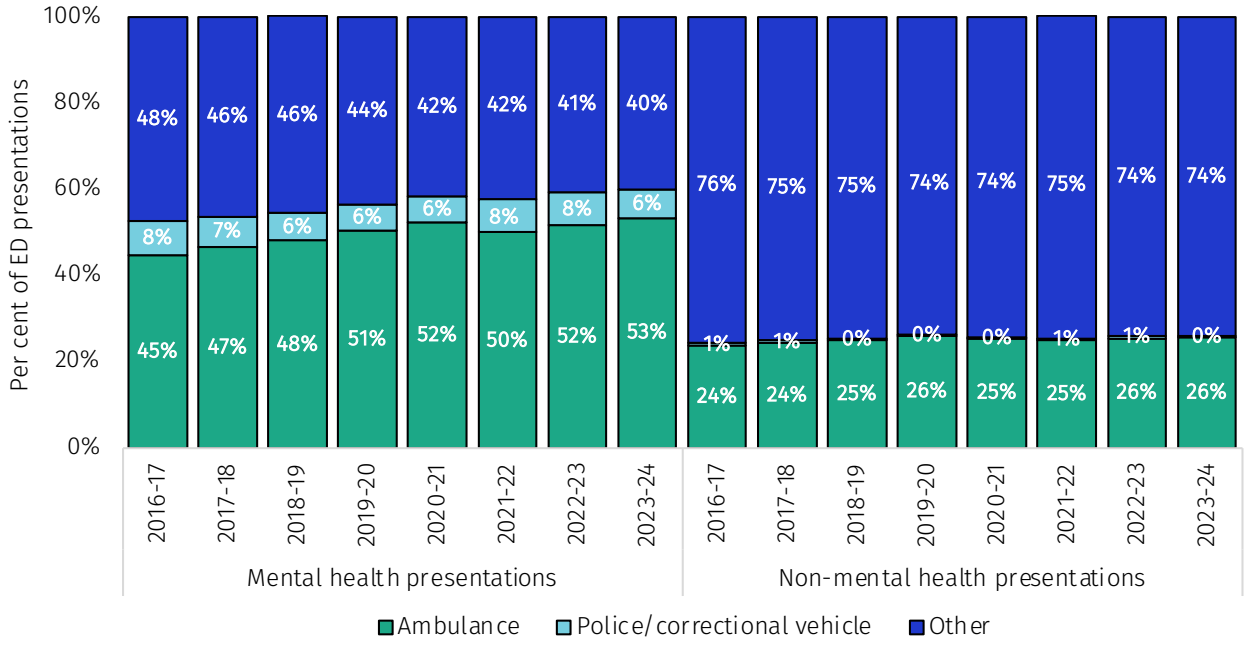


Figure 2: The proportion of mental health-related presentations and non-mental health presentations who arrived at the ED by ambulance, police/correctional vehicle, or by other means between 2016-17 and 2023-24.

Note: Other means of arrival include those who walked into the ED or came by private transport, public transport, community transport or taxi.

While the number of arrivals by police or corrections vehicle has remained consistent over the period observed, the increase in ambulance arrivals suggests that there are greater numbers of people in the community with higher acuity mental health conditions that require treatment and support. Ambulance services are limited in the interventions that they can provide to patients with mental health and/or behavioural disturbance, and often the next point of care for these patients is the ED.

As first responders to mental health crises, police and ambulance paramedics are more likely to enact local legislation to detain a person presenting with acute behavioural disturbance and transfer them to an ED for an involuntary mental health assessment. The management of involuntary patients significantly increases ED workload as these patients are deemed urgent and higher risk when they arrive due to involuntary status. Research has demonstrated that very few involuntary patients require hospital admission, with the majority discharged after determining that inpatient services are not required. Involuntary detentions are associated with negative and potentially traumatic patient experiences if force or restraint is used by first responders, and can also exacerbate symptoms and create further challenges to providing care in the ED.[11]

Community tri-response models, such as the Police, Ambulance and Clinician Early Response (PACER), have been widely adopted across the country and have reduced the number of involuntary orders and unnecessary ED transfers.[12] These models offer a patient-centred and clinically effective approach to supporting people in crisis by enabling timely mental health assessment, care and intervention in the community. In circumstances where transfer to ED is required, patients are more likely to arrive having already received an initial assessment and some therapeutic input, which both supports ED clinicians and improves the patient's experience.

Presentation demographics

Collecting demographic data of ED presentations is essential for identifying trends, monitoring equity, targeting interventions and planning services. Table 1 compares mental health-related presentations with non-mental health presentations and shows changes over time between 2016-17 and 2023-24.

Table 1: The proportion of presentations by key demographic variables in 2016-17 and 2023-24 and the percentage point change between the years.

	Mental health-related presentations			Non-mental health presentations		
	2016-17	2023-24	Change	2016-17	2023-24	Change
Sex						
Female	48.0%	48.4%	+0.4%	49.7%	50.8%	+1.1%
Male	52.0%	51.6%	-0.4%	50.3%	49.2%	-1.1%
Age						
0 – 24 years	26.3%	22.6%	-3.7%	35.0%	32.2%	-2.8%
25 – 64 years	62.7%	62.7%	0%	43.5%	44.1%	+0.6%
65+ years	11.0%	14.6%	+3.6%	21.5%	23.7%	+2.2%
Indigenous status of patient (identified as Aboriginal and/or Torres Strait Islander)						
Indigenous	10.7%	14.4%	+3.7%	6.4%	8.8%	+2.4%
Non-Indigenous	89.3%	85.6%	-3.7%	93.6%	91.2%	-2.4%
Remoteness of patient's usual residence						
Major city	65.5%	65.9%	+0.4%	64.0%	62.6%	-1.4%
Regional area	31.0%	29.6%	-1.4%	32.8%	33.7%	+0.9%
Remote area	3.5%	4.5%	+1.0%	3.3%	3.7%	+0.4%
Socioeconomic advantage and disadvantage of patient's usual residence						
SEIFA Q1	26.8%	26.2%	-0.6%	*24.0%	24.6%	+0.6%
SEIFA Q2	22.9%	23.4%	+0.5%	*22.7%	23.5%	+0.8%
SEIFA Q3	19.0%	19.7%	+0.7%	*21.5%	21.1%	-0.4%
SEIFA Q4	17.4%	17.1%	-0.3%	*17.3%	17.2%	-0.1%
SEIFA Q5	13.8%	13.6%	-0.2%	*14.4%	13.5%	-0.9%

*Notes: *Data from 2017-18, as 2016-17 data was not available. The Socio-economic Indexes for Areas (SEIFA) are categorised by those in SEIFA quintile 1 as living in the most disadvantaged areas and those living in SEIFA quintile 5 as the least disadvantaged areas. Each variable may not equal 100 per cent due to rounding of the data to one decimal place.*

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples make up around 4 per cent of the Australian population yet accounted for 14 per cent of mental health-related presentations in 2023-24, an increase of 3.7 per cent since 2016-17.[13] Aboriginal and Torres Strait Islander peoples are more likely to be impacted by the social determinants of health, which includes enduring impacts of colonisation, marginalisation, racism and intergenerational trauma, increasing the likelihood of poor mental health. Self-harm, suicidal ideation and suicide are disproportionately high among Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people. Aboriginal and Torres Strait Islander peoples are more likely to leave the ED before they have been seen or before their care is completed.

Responding to Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing requires culturally relevant models for recovery that encompass physical, cultural and spiritual health, ideally provided by trusted members of their communities.[14] Continuous improvement to ED and hospital processes, focused on cultural safety, is critical for improving care provided to Aboriginal and Torres Strait Islander peoples.[15] Investment in culturally appropriate mental health services for referral, follow-up and ongoing care in communities will also have a positive impact on Aboriginal and Torres Strait Islander mental healthcare access and service engagement.

> *'For Aboriginal and Torres Strait Islander patients, psychological safety will always begin with cultural safety.' – Emergency physician*

People aged 65 and over

Ageing is linked to greater medical complexity, cognitive decline and more frequent emergencies, driving higher ED demand and poorer outcomes.[16] Nationally, mental health-related ED presentations among people aged 65 and over rose by 3.6 per cent between 2016-17 and 2023–24, compared with a 2.2 per cent increase for other presentations. Those aged 85 and over had the highest rate, at 228 per 10,000 population. Despite this growing demand, Australia has only 200 specialist older person mental health beds per 10,000 population, limiting appropriate admission and care for this group.[17]

AIHW mental health-related presentation data includes dementia and delirium, which are common among older people but rarely lead to inpatient admission for psychiatric treatment. Complex diagnoses, limited specialist consensus and a lack of appropriate inpatient services often prolong ED stays for this group. With tertiary services responsible until discharge pathways are available, patients experience access block, overcrowding and undignified care. Urgent investment is needed in specialist aged care facilities and suitable discharge options for older patients with psychological illness, behavioural disturbance and dementia.

ACEM members report that ED referral, transport and prolonged waiting can contribute to delirium and worsen dementia symptoms among older patients. In-situ and in-reach models of care can help prevent such crises. Programs like Hospital in the Home and Geriatric Emergency Department Intervention already support patients and relieve pressure on EDs and hospitals but will need to be rapidly scaled to meet the needs of Australia's ageing population.

> *'Patients presenting to the ED experiencing a mental health crisis want the same thing as any of our patients: a safe space, empathy and to be treated with respect and dignity.' – Emergency physician*

The clinical urgency of emergency department presentations

Triage is an essential function in EDs, where patients may present simultaneously with a wide range of health conditions and symptoms. The Australasian Triage Scale (ATS) is a clinical tool used in EDs to prioritise patients according to clinical urgency.[18] The maximum waiting time for medical assessment and treatment in each ATS category refers to the recommended timeframe within which patients should begin receiving care. ATS 1 is the most urgent category and ATS 5 is the least urgent category.

- In 2023-2024, mental health-related presentations triaged as ATS 1-3 (to be seen within 30 minutes) was 74.4 per cent, which increased from 63.1 per cent in 2016-2017 (**Figure 3**).
- The triage category assigned to mental health-related presentations was consistently higher than the proportion of non-mental health presentations in the same ATS categories across the period observed (**Figure 3**).

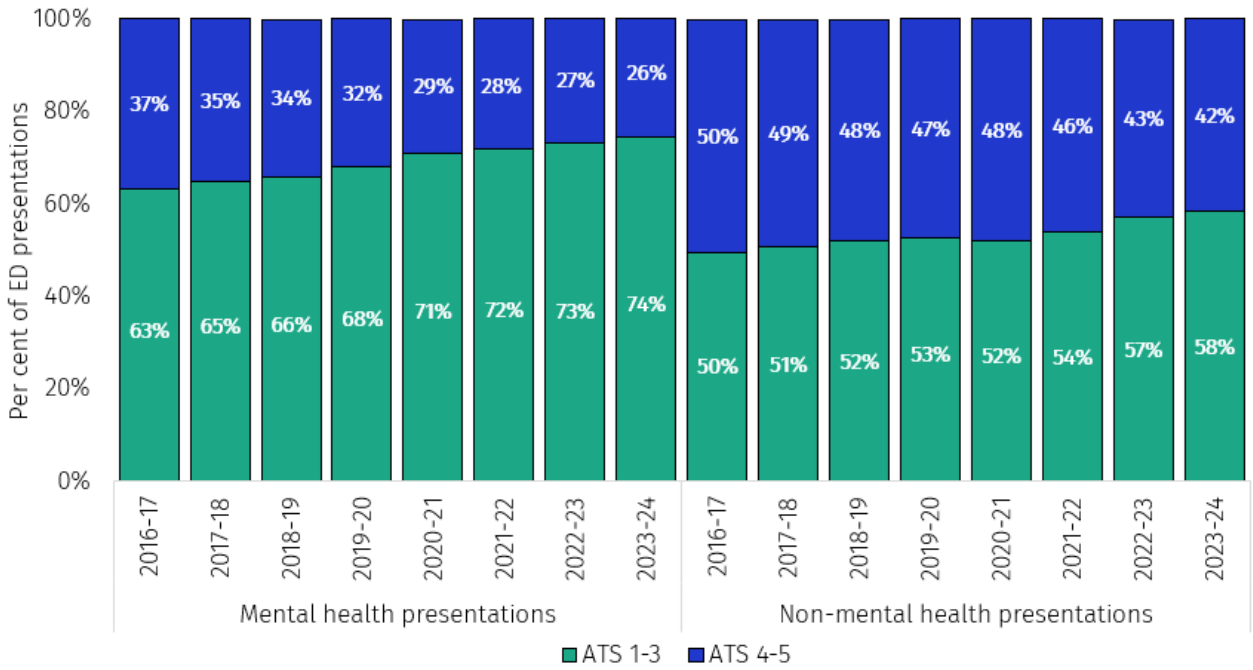


Figure 3: The proportion of mental health-related presentations and non-mental health presentations triaged into the Australasian Triage Scale (ATS) categories between 2016-17 and 2023-24.

Note: ATS categories have been combined to provide easier visualisation.

The increase in mental health-related ATS 1-3 presentations demonstrates that more people are presenting to EDs with higher acuity and complex needs. This underscores the urgent need to invest in early intervention actions to address people's needs before their condition worsens. While ensuring adequate staffing and resourcing is available to respond to acute care needs, there is also a need to expand community-based mental health services to intervene before people's conditions worsen.

> *'Patients seek emergency departments as places of refuge and support, yet prolonged waits and limited therapeutic care exacerbates their condition.' – Emergency physician*

Part 2: Waiting, admitted, discharged – an episode of emergency department care

Wait times for assessment and treatment

Reducing the excessive and unsafe ED wait times for mental health-related presentations requires continuous investment and an ongoing commitment to improvement from governments and health services. The data shows that, across Australia the proportion of total ED presentations seen on time has declined, as have the proportion of mental health-related presentations. These trends demonstrate that investment and resourcing is not aligned with population's healthcare needs.

ED waiting time is defined by the AIHW as 'the time elapsed for each patient from presentation in the ED to the commencement of clinical care'.[19] The proportion of patients seen on time is determined by the proportion of patients with a waiting time less than or equal to the maximum time stated in the category assigned at triage.[20] There will be additional waits to see a mental health team, which may be extended for reasons such as other clinical needs of the patient, mental health staff availability, weekend service availability, or in some cases transfer to another hospital.

The proportion of mental health-related presentations seen on time decreased from 68 per cent to 60 per cent between 2016-17 and 2023-24 (**Figure 4**), which means that only six in every 10 mental health-related presentations were seen on time in 2023-24.

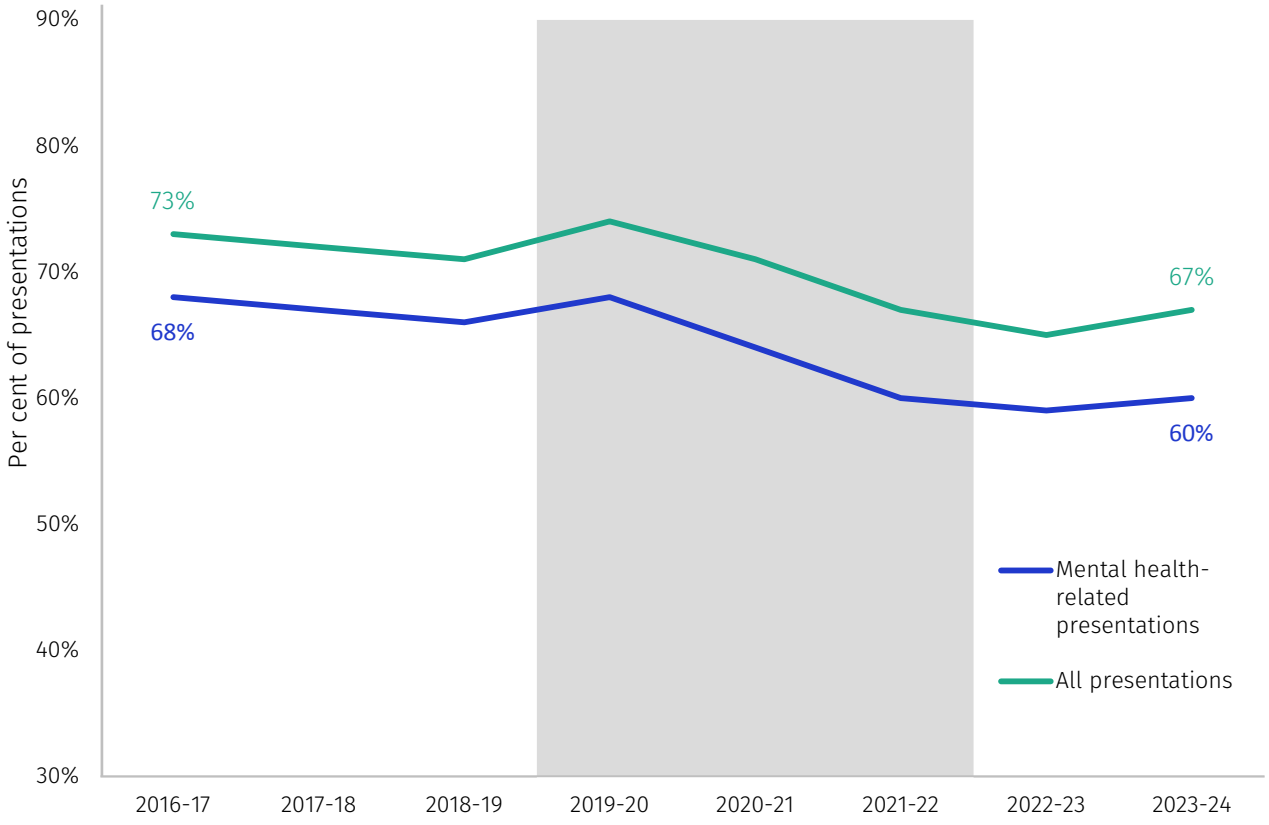


Figure 4: Proportion of mental health-related presentations and all presentations that were seen on time nationally, from 2016-17 to 2023-24.

Note: Mental health-related presentations were also included in the 'all presentations' total, as exclusion was not possible with the publicly available dataset.

Note: The shaded area represents the timeframe during which the COVID-19 pandemic was at its most prevalent.

A reduction in the number of both mental health-related and all presentations seen on time was observed across all jurisdictions except for Queensland (QLD). South Australia (SA), Tasmania, and Western Australia (WA) consistently reported lower proportions of mental health-related presentations seen on time when compared with other jurisdictions (**Table 2**).

Table 2: The proportion of presentations seen on time in 2016-17 and 2023-24 in each jurisdiction and the percentage point change between the years.

	Mental health-related presentations			All presentations		
	2016-17	2023-24	Change	2016-17	2023-24	Change
Australian Capital Territory	58%	50%	-8%	62%	62%	0%
New South Wales	76%	68%	-8%	81%	74%	-7%
Northern Territory	58%	50%	-8%	61%	47%	-14%
Queensland	66%	66%	0%	69%	70%	+1%
South Australia	56%	40%	-16%	64%	49%	-15%
Tasmania	57%	42%	-15%	65%	51%	-14%
Victoria	72%	65%	-7%	73%	71%	-2%
Western Australia	56%	41%	-15%	64%	48%	-16%

Note: Mental health-related presentations were also included in the 'all presentations' total, as exclusion was not possible with the publicly available dataset.

Time for most (90 per cent) people to leave the emergency department

The 90th percentile ED length of stay represents the time within which 90 per cent of patients are seen, treated and leave the ED. In other words, 10 per cent of patients spend longer than this time in the ED.

Extended lengths of stay in the ED, caused by bottlenecks in other parts of the system, is a patient safety risk. When patients requiring admission to hospital have an ED length of stay greater than eight hours it results in increased patient mortality, greater morbidity, more clinical errors, delayed time-critical care, and longer ambulance turnaround times.[21]

ED length of stay data is presented on (**Table 3**) and demonstrates the following:

- Nationally, the 90th percentile length of stay for mental health-related presentations resulting in admission increased by seven hours and seven minutes, while also increasing by four hours and 26 minutes for non-admitted mental health-related presentations during the same period.
- Among mental health-related presentations resulting in admission, the 90th percentile ED length of stay was, on average, five hours longer than that of all presentations resulting in admission (23 hours 24 minutes vs 18 hours 17 minutes) in 2023-24.
- South Australia (35 hours 46 minutes) and Tasmania (34 hours 7 minutes) had the longest 90th percentile ED length of stay for mental health-related presentations resulting in admission in 2023-24.
- For non-admitted mental health-related presentations, the 90th percentile ED length of stay was six hours longer than that of all non-admitted presentations (13 hours 28 minutes vs 7 hours 27 minutes) in 2023-24.
- The longest 90th percentile ED length of stay for non-admitted mental health-related presentations was observed in WA, Victoria, Tasmania and SA, which exceeded the national average in 2023-24.

Table 3: The 90th percentile ED length of stay (in hours and minutes) in 2016-17 and 2023-24 and the change between the years.

	Mental health-related presentations (hr/min)			All presentations (hr/min)		
	2016-17	2023-24	Change	2016-17	2023-24	Change
Admitted						
Australian Capital Territory	16hr 39min	11hr 46min	-4hr 53min	9hr 14min	10hr 07min	+0hr 53min
New South Wales	17hr 17min	26hr 02min	+8hr 45min	11hr 36min	20hr 30min	+8hr 54min
Northern Territory	14hr 29min	23hr 05min	+8hr 36min	16hr 10min	17hr 29min	+1hr 19min
Queensland	11hr 31min	20hr 40min	+9hr 09min	9hr 15min	16hr 11min	+6hr 56min
South Australia	19hr 05min	35hr 46min	+16hr 41min	11hr 05min	19hr 05min	+8hr 00min
Tasmania	20hr 56min	34hr 07min	+13hr 11min	17hr 59min	24hr 56min	+6hr 57min
Victoria	16hr 44min	22hr 13min	+5hr 29min	10hr 37min	17hr 43min	+7hr 06min
Western Australia	16hr 53min	21hr 37min	+4hr 44min	9hr 07min	15hr 55min	+6hr 48min
National average	**16hr 17min**	**23hr 24min**	**+7hr 07min**	**10hr 44min**	**18hr 17min**	**+7hr 33min**
Non-admitted						
Australian Capital Territory	7hr 07min	9hr 30min	+2hr 23min	4hr 52min	6hr 33min	+1hr 41min
New South Wales	7hr 42min	13hr 40min	+5hr 58min	4hr 50min	7hr 13min	+2hr 23min
Northern Territory	6hr 43min	10hr 59min	+4hr 16min	5hr 10min	7hr 00min	+1hr 50min
Queensland	7hr 26min	11hr 15min	+3hr 49min	5hr 01min	7hr 36min	+2hr 35min
South Australia	13hr 06min	14hr 24min	+1hr 18min	5hr 59min	8hr 28min	+2hr 29min
Tasmania	8hr 08min	14hr 45min	+6hr 37min	5hr 18min	7hr 34min	+2hr 16min
Victoria	9hr 40min	14hr 56min	+5hr 16min	5hr 23min	7hr 44min	+2hr 21min
Western Australia	14hr 16min	15hr 27min	+1hr 11min	5hr 07min	7hr 02min	+1hr 55min
National average	**9hr 02min**	**13hr 28min**	**+4hr 26min**	**5hr 07min**	**7hr 27min**	**+2hr 20min**

Note: Mental health-related presentations were also included in the 'all presentations' total, as exclusion was not possible with the publicly available dataset.

People presenting to the ED for mental health-related reasons are likely to experience prolonged ED lengths of stay. The most significant delays are waiting for assessment, and transfer to an appropriate inpatient area for presentations that result in admission. Wait time and length of stay in the ED is impacted by the capacity of inpatient mental health services. The number of mental health-related presentations requiring admission increased by 3.2 per cent between 2016-17 and 2023-24, while the number of public specialist mental health hospital beds has decreased by 1.3 per cent between 2016-17 and 2022-23.[22]

Other factors contributing to extended ED length of stay include limited operating hours of inpatient mental health teams and, in some circumstances, differing practices around the timing of assessments, particularly in relation to when patients are considered 'medically cleared'. ACEM recommends that medical investigations and psychological assessments occur in parallel, and that investigations are based on clinical need, as assessed by an ED physician or their delegate.

> *'Reducing stigma, improving access to specialist advice, and streamlining care pathways are essential to delivering compassionate, effective mental health care in all EDs.' – Emergency physician*

Mental health-related presentations relating to psychoactive substance use are often complex and resource-intensive to manage due to comorbidities and overlapping symptoms. These presentations can take longer to refer for psychiatric assessment, as the influence of substances may cause, or amplify, mental health symptoms such as suicidal ideation, delusional thinking or psychosis, which can subside as intoxication resolves. In some cases, psychiatrists are unable to conduct a mental health assessment while a patient's decision-making capacity is impaired by intoxication. This means that patients often remain in the ED for extended periods while 'sobering up', which further constrains the ED's capacity to provide timely treatment to new ED presentations.

Reforms are needed to improve the acute service response to patients with co-occurring alcohol and other drug (AOD) and mental health conditions, including the establishment of dual diagnosis units to manage these complex emergency presentations. These patients often exhibit volatile behaviours associated with intoxication, increasing safety risks for patients and staff and placing additional demands on ED resources for security, risk management and observation. ACEM's *Breaking Point: An Urgent Call to Action on Emergency Department Safety* report highlighted the link between such presentations and violence in EDs.[23]

> *'Managing patients who present to the ED with acute behavioural disturbance is likely the most dangerous thing that we will do in our day.' – Emergency physician*

Ideally, a dedicated Behavioural Assessment Unit (BAU) within the ED, supported by a multidisciplinary team spanning emergency medicine, psychiatry, addiction medicine and toxicology. Purpose-built BAUs offer low-stimulus environments that reduce behavioural escalation, enhance patient privacy and dignity, and minimise disruption to others, with evidence showing improved time to psychiatric assessment and reduced overall ED length of stay.[24]

Departure from the emergency department

Departure from the ED refers to how patients leave the ED, including whether presentations resulted in admission to the same hospital, were discharged, transferred to another hospital for admission, or where the patient left before the commencement or completion of their treatment.

- Between 2016-17 and 2023-24 the proportion of mental health-related presentations resulting in admission increased by 3.7 per cent (38.1 per cent vs 34.4 per cent).
- Mental health-related presentations resulting in transfer to another hospital for admission were more likely compared with non-mental health presentations resulting in transfer to another hospital for admission (3.7 per cent vs 1.7 per cent) in 2023-24.

Table 4. The proportion of mental health-related presentations and non-mental health presentations by departure status between 2016-17 and 2023-24.

	Mental health-related presentations			Non-mental health presentations		
	2016-17	2023-24	Change	2016-17	2023-24	Change
Admitted to this hospital	34.4%	38.1%	+3.7%	30.5%	29.6%	-0.9%
Discharged without being admitted or referred	57.3%	51.9%	-5.4%	61.5%	59.3%	-2.2%
Transferred to another hospital for admission	4.2%	3.7%	-0.5%	1.8%	1.7%	-0.1%
Left before treatment concluded	2.5%	4.8%	+2.3%	1.7%	3.8%	+2.1%
Left before treatment commenced*	1.6%	1.4%	-0.2%	4.4%	5.4%	+1.0%

*Note: *The category 'Left before treatment commenced' included those categorised as 'Did not wait to be attended by a health care professional' and 'Registered, advised of another health service, and left without being attended by a health care professional'.*

The higher rate of mental health-related presentations requiring transfer to another hospital for admission indicates a lack of available and/or suitable beds in some hospitals. Likewise, the proportion of mental health-related presentations resulting in discharge without being admitted or referred indicates that there is a considerable need for community-based mental health services and more affordable Medicare-funded or subsidised services, to ensure people can access the care and support they need.

> *'In EDs without on-site mental health services or inpatient units, both patients and clinicians face significant challenges, often resulting in long waits and unmet care expectations.' – EM physician*

Patients, families and carers seeking mental health care at the ED may feel disempowered and let down by the ED experience when the presenting condition has been assessed as non-urgent or not requiring admission. Such circumstances highlight the challenges associated with service gaps in community-based mental healthcare availability. ACEM has long advocated for increased investment and access to pre-hospital and community-based mental health services, recognising that they better align with consumer preferences as well as the inherent benefits of receiving treatment and support in environments that are more therapeutic than EDs.

It is worth noting that admitted-to-hospital data includes patients placed in short-stay units (SSUs), obscuring the ability to track patient pathways and skewing data on system performance. ACEM does not support the use of SSUs or other ED areas solely to meet length-of-stay key performance indicators. Patients requiring brief admissions would often benefit from greater access to sub-acute or community-based mental health services – however, limited bed availability frequently results in entire treatment episodes occurring in the ED. This reflects systemic gaps in care that delay recovery and increase the likelihood of re-presentation.

> *'Improved care environments, providing timely assessment and appropriate support are essential to ensuring patient safety and promoting recovery.' – Emergency physician*

Recommendations

1. Strengthen emergency department and hospital-based care

- **Equip EDs with the necessary infrastructure to create clinically safe and therapeutic environments for mental health care:** State and territory governments should undertake an audit of all EDs to ensure that every facility has purpose-built assessment rooms (or preferably entire units) to manage patients experiencing acute distress, agitation, confusion, delirium or intoxication, who typically wait longer for psychiatric assessment. Staffing and resources must also be prioritised to safely manage these patients.
- **Embed cultural safety in EDs:** State and territory governments must resource EDs with Aboriginal and Torres Strait Islander Liaison Officers and staff to provide culturally safe care to Aboriginal and Torres Strait Islander peoples presenting with mental health needs.
- **Increase mental health inpatient service capacity:** State and territory governments must begin to address years of underinvestment in hospital capacity by increasing the number of inpatient beds to meet the need for admitted care. This will reduce access block in the ED and avoid unnecessary delays to hospital admission for patients whose treatment cannot commence due to a lack of bed capacity. International best-practice recommends publicly funded psychiatric beds are 60 per 100,000 population.[25]

2. Improve system coordination, flow and transitions

- **Prioritise whole-of-hospital patient flow:** Hospitals must benchmark hospital patient flow performance against ACEM's Hospital Access Targets. This will require hospitals to adapt a series of localised hospital flow measures, with the goal of ensuring that the maximum length of stay for any patient should not exceed 12 hours.
- **Strengthen collaboration between the ED and mental health services:** Hospital management must work with ED and psychiatric and mental health services to create local service agreements that prevent unnecessary delays in the patient journey. This includes addressing delays to psychiatric assessment of patients while awaiting medical clearance.
- **Improve specialist aged care capabilities:** The Federal Government must address service gaps in the management of older persons with dementia and delirium. Greater investment in specialised dementia aged care facilities is needed to prevent further deterioration and ensure access to therapeutic care in the community.

3. Enhance crisis response outside the emergency department

- **Provide ED alternatives for people experiencing crises:** State and territory governments must invest in ED alternatives that provide a more therapeutic space for people who are experiencing a mental health crisis. There are a range of models, such as the Safe Haven Cafés, which provide after-hours, trauma-informed care, tailored to respond to the spectrum of mental health support needs.
- **Expand Police, Ambulance and Clinician Early Response (PACER) models:** State and territory governments must continue to increase investment in the PACER (or equivalent) model. This tri-response model for mental health crisis in the community has effectively demonstrated the ability to reduce the number of ED presentations.

4. Build a comprehensive community mental health system that supports prevention, early intervention and recovery

- **Expand community-based mental health services:** All governments must commit to funding the expansion of mental health services to match community needs, ensuring support is available across the full spectrum of care. This includes increasing primary care capacity, access to affordable psychology services and better access to specialist community mental health services.

- Improve referral pathways from ED to community-based mental health services: All governments must undertake regular audits of local services to ensure individual hospital sites have clear referral pathways and local service agreements in place that link both non-admitted lower-acuity patients and higher-acuity admitted patients to community-based services post-discharge.
- Expand access to culturally appropriate mental health and social and emotional wellbeing therapies: The Federal Government must fund states and territories to expand access to therapies, healing, mental health and social and emotional wellbeing programs that reflect Aboriginal and Torres Strait Islander cultural values and needs for recovery.

5. Support better planning and system design

- Improved data capture to strengthen planning: The Federal Government, via the Australian Institute of Health and Welfare, must prioritise improving data collection and reporting so that the exact prevalence of mental health-related presentations and suicidality is accurately quantified. This will assist all governments with determining resourcing and service planning requirements.

Conclusion

Still Waiting shines a light on a mental health system facing sustained and system-wide pressure, falling short of meeting the community's needs.

As a result, EDs are increasingly serving as the community's only point of access to mental health services, with mental health presentations rising in acuity and complexity. This means an increasing number of people are coming to the ED with mental health needs and a larger proportion require care that is more urgent and more intensive. Yet patients are waiting longer to be seen, spending extended periods in EDs and facing significant delays to inpatient admission. These trends are not isolated – they reflect systemic underinvestment in community-based services, inadequate inpatient capacity and fragmented care pathways. EDs will always respond to people in crisis, but the growing demand reflects a system that is failing people with mental health needs by not providing the right care, or enough care, to prevent their condition from worsening.

Additionally, despite growing awareness and help-seeking behaviour, particularly among young people and Aboriginal and Torres Strait Islander communities, the system continues to fall short in delivering timely, therapeutic and culturally safe care.

This report underscores the urgent need for whole-of-system reform. Expanding community mental health services, increasing inpatient bed capacity, embedding cultural safety, and scaling up tri-response models such as PACER are critical steps toward a more responsive and equitable mental health system. Without decisive action, Australia risks perpetuating a reactive model that fails to meet the needs of its most vulnerable populations.

The data is clear. The solutions are known. The time for reform is now.

Glossary of terms

Terminology, as defined in this report has been informed by ACEM's P02 *Policy on Standard Terminology*.[26]

Access block
Access block refers to the situation where patients requiring admission to hospital from the emergency department (ED) have an ED length of stay greater than eight hours. This includes patients who were referred for admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital, or who died in the ED.

Acute behavioural disturbance
Acute behavioural disturbance (ABD) has been defined as any manner in which a person conducts themselves that (i) does not respond to normal verbal intervention, (ii) interrupts the normal activities of the ED and (iii) has the potential to place the individual and/or others at risk.

Admission
An admission is determined by the need for interventions, investigations, monitoring or other management that would not be considered part of an ED attendance. An admission should only be determined and designated on clinical grounds. Admission occurs when a medical decision for the need for inpatient care is made by an appropriately qualified decision maker, a patient is accepted by a hospital inpatients specialty service for ongoing management, and the patient is administratively admitted to the hospital.

Behavioural disturbance
Behavioural disturbance is defined as the combined physical actions made by an individual which are in excess of those considered contextually appropriate and are judged to have the potential to result in significant harm to the individual themselves, other individuals or property. Acute behavioural disturbance is characterised by a rapid onset and severe intensity. The aetiology is commonly a mental disorder, physical illness or intoxication with alcohol and/or other substances. Often the behaviour is considered to be under the voluntary or legally competent control of the individual.

Cultural safety
ACEM Supports the Australian Health Practitioner Regulation Agency (Ahpra) definition of cultural safety: 'Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviour and power differentials in delivering safe, accessible, and responsive healthcare free of racism.'

ED length of stay
The ED length of stay is the time difference between the arrival time and departure time. A recording with accuracy to within the nearest minute is appropriate.

Emergency department overcrowding
Emergency department overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical and/or staffing capacity of the ED, whether they are waiting to be seen, undergoing assessment and treatment, or waiting for departure.

Mental and behavioural disorders
Mental and behavioural disorders is a term used by the World Health Organization (WHO) in its classification system to describe the clinical features of a wide range of groups of psychiatric conditions measured using International Classification of Diseases and Related Health Problems (ICD-10) criteria. Mental and behavioural disorders are classified in the ICD-10 codes F01 to F79.

Patient
A patient refers to all people seeking treatment.

Patient transfer
Patient transfer refers to the transition of care of a patient from one area of a health facility to another area within that facility, or from and between health care facilities. For example, from an ED to an inpatient bed within the same hospital, or from an ED to an inpatient bed in another hospital.

Restrictive practices
Restrictive practices are by their very nature involuntary. The involuntary treatment of patients can involve complex medical and ethical decision-making and has a different legal framework across jurisdictions. Restrictive practices can include:

a. **Restraint:** the restriction of an individual's movement both physical/manual (hands-on immobilisation techniques) or mechanical (using devices such as belt or straps). Restraint may also involve the use of medication when administered to a person without their explicit, free, informed consent with the purpose of reducing the movement of a patient or activity that is otherwise preventing their safe care. The choice of agent may also have a role in providing treatment for the distressing symptoms of the underlying illness.

b. **Seclusion:** the involuntary confinement of a patient at any time alone in an enclosed environment which free exit is prevented.

The term clinical restraint refers to the administration of medication for the primary aim of controlling behaviour, rather than providing safe care. Chemical restraint should not be occurring in the ED. The use of medication to allow safe assessment and treatment of the patient in the ED is not considered chemical restraint.

Self-harm
Self-harm includes self-injury (an intentional act to cause self-harm without intending death), suicide attempt and self-poisoning or self-injury, irrespective of the apparent purpose of the act. Self-harm is classified in the ICD-10 codes X60 to X84.

Short stay unit
An ED short stay unit (SSU) is designed and designated for the short-term treatment, observation, assessment, and reassessment of patients following triage and assessment in the ED. SSUs have specific admission and discharge criteria and policies. They are physically separated areas from the ED acute assessment area and are designed for lengths of stay of up to 24 hours. A SSU should provide a 24-hour seven days per week service to provide a consistent standard of patient care.

Triage
A triage system is a standard method of rapidly determining the clinical urgency of all incoming patients to assist staff to identify and prioritise those who are critically ill or injured.

Violence
The World Health Organization defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has the likelihood to result in, injury, death, psychological harm, mal-development or deprivation.

More specifically, physical violence is described as the use of physical force against another person or group that results in physical, sexual or psychological harm and includes (among others) beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching. Psychological violence is described as the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development and includes (among others) verbal abuse, bullying, harassment and threats.

Waiting time
Waiting time is the difference between arrival time and time of initial medical assessment and treatment. A recording with accuracy to within the nearest minute is appropriate.

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