

AUDITOR-GENERAL'S REPORT

PERFORMANCE AUDIT

Emergency Mental Health Services

NSW Department of Health



The Legislative Assembly
Parliament House
SYDNEY NSW 2000

The Legislative Council
Parliament House
SYDNEY NSW 2000

In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled **Emergency Mental Health Services: NSW Department of Health**.

A handwritten signature in black ink, appearing to read 'R J Sendt'.

R J Sendt
Auditor-General

Sydney
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Foreword

It is estimated that one in five people will be affected at some stage by a mental health problem or illness. The increasing prevalence of mental illness means that at some point in time most of us will either be affected or we will know of someone who is.

Although most people with mental illness can be treated in the community, at times some may require emergency treatment or admission to hospital for short-term intensive therapy.

Not only are more mental health patients presenting to an emergency department for treatment than ever before, they are reportedly sicker and a greater number require admission to a hospital bed for further treatment. And, because of its very nature, those suffering from acute mental illness may not understand what is wrong or be able to communicate their problems clearly.

This makes access to emergency mental health services a significant issue for government that requires continuing attention.

The focus of this report is on the provision of 24-hour crisis services to adults. Emergency mental health services play a vital role in providing timely and appropriate care. Without proper treatment the severity of the illness may escalate, increasing the risk of self-harm or harm to others.

There have been many changes to mental health services over the last decade to deal with increasing demand. Much has been done to improve access to, and the quality of emergency services through significant increases in funding, the opening of new beds and the employment of more mental health staff.

Yet recent reviews have highlighted problems with accessing mental health beds and inadequate levels of psychiatric support in rural areas.

I believe that our report will provide valuable assistance to area health services on alternative models of emergency mental health care that better manage patient risk and further improve service quality.

R J Sendt
Auditor-General

May 2005

Executive summary

Executive summary

Timely access to emergency mental health services is essential for appropriate patient care and to minimise the risk of harm to self or harm to others.

Emergency mental health services are provided by the Department of Health and Area Health Services through community-based mental health teams and public hospitals (emergency departments and psychiatric units) in metropolitan and rural areas.

This audit examines the adequacy of adult emergency mental health services in NSW from triage to assessment and whether patients face difficulties gaining access to an acute bed.

The audit does not examine the quality of clinical diagnoses or treatments but rather the practices in place to ensure patient risk is well managed.

Audit opinion

This report recognises and documents that much has been done over the last decade to improve access to, and the quality of emergency mental health services.

We believe increases in mental health funding, increases in the number of mental health beds and improvements in clinical practice have contributed significantly to better services.

However, developments in data collection and reporting have not always kept pace with service enhancements, making it difficult to quantify these improvements.

What we do know is that more mental health patients are presenting to emergency departments than ever before, these patients are often sicker and a greater number require admission.

The increase in demand for emergency mental health services has offset many (and perhaps all) of the gains from funding increases. The system is under considerable pressure, and patients can face lengthy delays before being admitted to a bed.

It is important that services work together to share resources at times of peak demand. Yet, there are times when the availability of mental health beds means that some patients face being transferred very long distances to access an acute mental health bed.

There is also evidence that some patients spend inappropriately long periods in emergency departments while awaiting acute mental health beds or are discharged from the emergency department prior to a bed becoming available.

We also consider the variation in the way Area Health Services provide access to after-hours services was not always the best for patients.

The central intake model provides a higher level of assurance that a patient will be treated according to need and will be appropriately followed up compared to the multiple entry point model where patients face a greater risk of falling through the cracks.

Summary of recommendations

We recommend that the Department of Health:

Improve service quality and better manage patient risk

- establish minimum requirements for emergency mental health telephone services (page 19)
- introduce standard response times for the completion of a mental health assessment for patients presenting to an emergency department (page 25)
- establish minimum requirements for reviewing diagnoses and documenting the results (page 26)
- include a private and secure space for conducting mental health assessments in any new or refurbished emergency department (page 26)
- establish a benchmark for access block for mental health patients and report performance in annual reports (page 33).

Collect more comprehensive data on demand for services

We recommend that the Department of Health and Area Health Services collect data and report on the performance of mental health services using the indicators in the proposed Report Card (page 33).

We recommend that Area Health Services:

Improve service quality

- adopt a central intake model for entry to mental health services (page 18)
- implement procedures to follow up mental health patients judged at risk who leave an emergency department before receiving treatment (page 20)
- enhance access to specialist support in emergency departments (page 24)
- monitor and report performance against response times in all service settings (page 25)
- monitor and report on patient transfers that arise from bed shortages (page 34)
- develop local protocols with NSW Police and the Ambulance Service for transporting mental health patients (page 34).

Audit findings

Chapter 1 Mental health services in NSW

Mental health services in NSW are provided through a diverse range of public, private and non-government organisations. People with a mental illness can seek treatment from a general practitioner, a private psychiatrist or psychologist or from community or hospital based government or private service.

Most people with a mental illness can be managed in the community. It is only during a severe or acute phase of the illness that a patient requires emergency treatment or admission to hospital for short-term intensive therapy.

Over 200,000 people receive community mental health services each year with around 35,000 presenting to an emergency department for treatment.

**Chapter 2
Gaining access to
emergency care**

The Department of Health has provided some guidance to Area Health Services on how and when emergency mental health services should be available.

All Area Health Services have adopted common guidelines for mental health triage and since 1998 have been required to provide a 24 hour 1800 telephone number for mental health problems requiring urgent attention.

However, not all telephone services are the same. Although all conduct triage and provide advice or referrals, some Area Health Services have established sophisticated call centres that act as a central intake for all providers.

The centralised intake model presents a number of advantages. More accurate and complete data on patients and service demand, standardisation of assessment and referral processes, better quality assurance mechanisms and established performance standards are some of the benefits.

Performance standards have not been established for mental health telephone services such as: time to answer calls, the use of voicemail messaging or abandonment rates.

**Chapter 3
Improving mental
health assessments**

The Department of Health introduced a systematic process for documenting mental health assessments in 2001.

This process has standardised practice ensuring consistent triage, assessment, management and the recording of patient outcomes.

The process also establishes timeframes for intervention, based on patient risk. Response times range from immediate for clients at extreme risk to an assessment within two weeks for non-urgent cases.

These timeframes generally apply to assessments completed in the community. In emergency departments, where a person has been assessed by an emergency department medical officer and referred for a mental health assessment, these timeframes are not applied by the Mental Health Service.

In emergency department settings, patients may undergo a medical assessment in a timely manner but may wait, sometimes overnight for a mental health assessment.

This is often due to the limited availability of specialist mental health services after hours and on weekends especially in rural areas.

The review of clinical decisions by a senior mental health professional plays a major role in assuring assessment quality. There are no minimum requirements for what constitutes clinical review and on the patient files we reviewed there was generally nothing to indicate a review had taken place.

Chapter 4 Gaining access to a beds

There were over 24,000 acute admissions in 2003-04 representing an 11 per cent increase over the last three years. Over the same period the Government opened an additional 122 acute mental health beds bringing the statewide total to 1,136 or 22 beds per 100,000 adults.

Despite these increases, bed numbers remain well below the Department of Health target of 31 beds per 100,000 adults. In addition, resources are not equitably distributed across the state.

Any problems with gaining access to a mental health bed will quickly become apparent in an emergency department.

We found patients may wait for very long periods in the emergency department before being admitted to a bed. In one rural hospital we visited we found that some mental health patients completed their intensive treatment in the emergency department without accessing a mental health bed.

This is neither ideal for patients nor the department.

An emergency department is extremely busy. Mental health patients awaiting admission to a bed prevent others from accessing treatment. Mental health patients may also require one-on-one supervision redirecting nursing resources.

One of the main difficulties faced in determining the extent of problems with access to acute mental health beds is the absence of data on unmet need.

Response from the NSW Department of Health

Thank you for the copy of the Performance Audit report Emergency Mental Health Services and the opportunity to comment on the findings.

The report highlights the increasing demand for emergency mental health services. Throughout the developed world this issue is testing mental health and emergency medicine services, their expertise, their resources and their models of care.

The report also emphasises that access to acute emergency and inpatient mental health care should only be considered as one component of a balanced mental health system; one which includes a proper mix of community, emergency, acute inpatient, non-acute inpatient and community support services. In the last few years we have invested many hundreds of millions of dollars in expanding and enhancing all stages of care in the NSW mental health system.

Effective community care is essential to reduce the frequency of emergency presentations. Recent enhancements have included an additional \$4.6 million for community mental health staff, \$2.5 million for enhanced acute and community services for children and adolescents, and \$1.5 million for the expansion of court liaison and community forensic services.

Emergency Departments are a central component of an emergency mental health system. They are usually the safest and most appropriate location for the assessment of complex medical and psychiatric problems. Providing safe and effective care in emergency department settings requires suitable physical facilities, training and support for emergency department staff, reliable access to specialised mental health assessment, and prompt transfer to inpatient care where required.

Recent initiatives have addressed many of these components, including:

- *Rollout of more than 60 Clinical Nurse Consultant positions in more than 40 Emergency Departments throughout NSW.*
- *Development of Psychiatric Emergency Care centres at 8 locations, including Liverpool, Nepean, St Vincent's, and St George hospitals.*
- *Development of a Rural Critical Care pilot linking telephone access, expert clinical support and secure transport to mental health facilities in rural Areas.*
- *Revision of the NSW Health Facility Guidelines for Emergency Departments to ensure provision of a secure assessment room within all redeveloped emergency departments.*

Access to sufficient acute mental health beds is essential. Since 2001 new acute mental health beds have opened throughout NSW including additional beds at Westmead, Blacktown, Cumberland, Nepean, Liverpool, St George, Sutherland, Royal North Shore, Albury, Wagga Wagga, Lismore, Tweed Heads, Taree, Kempsey, Coffs Harbour, Wollongong, Wyong and Broken Hill hospitals. Further developments are underway or planned at Dubbo, Katoomba, Liverpool, Concord and Hornsby hospitals. Over this period the number of acute mental health beds in NSW will increase by more than 20%.

Bed numbers, while critical, cannot be considered in isolation. The Audit report compares current acute mental health bed numbers against NSW Health's Mental Health Clinical Care and Prevention (MH-CCP) model. While the MH-CCP model is a valuable planning tool, its structure and underlying assumptions are currently being revised. The restructure of NSW Area Health Services has created larger Areas, with less unequal acute mental health bed numbers.

Area Health Service	Population Aged 18+ (2003-04)	No. MH-CCP recommended beds (2003-04)	Beds March 2005	Percentage of MH-CCP estimated beds (March 2005)	Approved future beds under planning or construction (to June 2008)	Current beds + approved future beds (To June 2008)	Final percentage of MH-CCP estimated beds (2007-08)
South Eastern Sydney Illawarra	929,677	286	210	73%	23	233	81%
Northern Sydney Central Coast	862,376	266	184	69%	19	203	76%
Sydney South West	1,011,727	312	262	84%	6	268	86%
Sydney West	790,008	244	206	84%	25	231	95%
Hunter New England	563,048	173	139	80%	10	149	86%
Northern Rivers	424,871	128	120	94%	15	135	105%
Greater Southern	349,641	107	59	55%	0	59	55%
Greater Western	241,054	75	46	61%	12	58	77%
Total	5,172,402	1,591	1,226	77%	110	1,336	80%

New Areas create the opportunity to link local units into larger systems better able to share resources to manage peaks in demand. Funding has been provided to Areas to develop mental health patient access and bed management systems for these new Area Health Services. These systems are being closely linked to developments to improve patient access throughout health, such as the NSW Health Electronic Bed Board.

Appropriate use of acute mental health beds requires effective access to non-acute beds and supported accommodation. More than 70 new non-acute mental health beds have been opened since 2003. The 20 bed non-acute unit at Campbelltown Hospital is due to open later this year, and a further 80 non-acute beds are being planned in four units in St George, Shell Harbour, Coffs Harbour and Newcastle hospitals. The Housing and Accommodation Support Initiative (HASI) has rolled out 118 places of supported accommodation throughout NSW. Tenders have recently been announced for a further 460 supported accommodation places for people living in public and community housing. NSW Health's new, larger Areas are also of a sufficient scale to allow planning for a wide range of non-acute mental health needs within each Area, with a reduced reliance on access to services in other Area Health Services.

We welcome the specific recommendations contained within the report. Most are consistent with current NSW Health Policy, and action has already commenced in a number of the issues highlighted. In particular:

- *Further development of centralised intake models is supported. It is unlikely that one model will suit every community. Our initial priority is to improve access in rural Areas. The current Rural Critical Care Trial being conducted in Taree, Coffs Harbour, Port Macquarie and Kempsey is piloting an innovative model of intake and expert support. The model is being evaluated for its suitability for broader use throughout NSW.*

- *The report highlights very good use of structured medical record forms (MHOAT) in audited Areas. The use of MHOAT documentation by specialist mental health staff in Emergency Department settings is currently NSW Health Policy. We are commencing a detailed evaluation of the current MHOAT forms, to be conducted by the InforMH unit, to ensure that the forms are suitable for use in all settings.*
- *Extended hours of cover of specialist mental health staff in emergency departments has commenced in many Areas and will continue through the development of Psychiatric Emergency Care Centres and other initiatives. We feel that the speed of access to specialist mental health assessment is more important than the physical location of mental health teams. Co-location of acute and community mental health teams with general hospitals is clearly ideal. To more specifically co-locate these teams with Emergency Departments may be neither physically possible nor necessary, provided proper systems are in place for setting and monitoring mental health response times.*
- *The NSW Health Suicide Risk Assessment and Management Protocols were released in November 2004, and include requirements for clinical review and documentation. Rollout of these guidelines is occurring in all Areas in 2005.*
- *The NSW Health Facility Guidelines for Emergency Departments have been revised, and now include a requirement for securable interview space in all new Emergency Departments.*
- *A number of new data collections and systems have commenced to monitor access to acute mental health care. This data is being coordinated by the Centre for Mental Health and InforMH, and will be incorporated into the NSW Health Annual Report.*

I am very pleased with the level of co-operation that existed between NSW Health and the Audit Office in the preparation of the report, and thank the staff of both agencies for their professionalism and co-operation.

(signed)

*Robyn Kruk
Director-General*

Dated: 13 May 2005

1. Mental health services in NSW

1.1 Mental health services in NSW

Mental health problems and disorders affect at least one in five people and have a major impact on those affected, their families and the community.¹

The New South Wales *Mental Health Act* 1990 is the principal legislation governing the treatment of people with a mental health disorder. The intent of the legislation is to ensure these people receive the best possible care and treatment in the least restrictive environment.

There is a diverse range of services and providers

Mental health services in NSW are provided through a diverse range of public, private and non-government organisations. People with a mental illness can seek treatment from a general practitioner, a private psychiatrist or psychologist or from community or hospital based government or private services.

The Department of Health provides mental health services through its Area Health Service network that includes crisis teams, case managers and mental health professionals.

Service standards exist

In 1998, the Department of Health released its policy framework for the delivery of mental health care by Area Health Services.

This framework establishes minimum requirements for service delivery including the need for Areas to:

- develop appropriate service models to ensure community and inpatient services are available 24 hours, 7 days a week
- establish prevention and early intervention programs
- effectively treat and, where this is not possible, rehabilitate, support and maintain people experiencing mental health problems and disorders
- achieve fairness and equity in service provision.

1.2 Gaining access to services

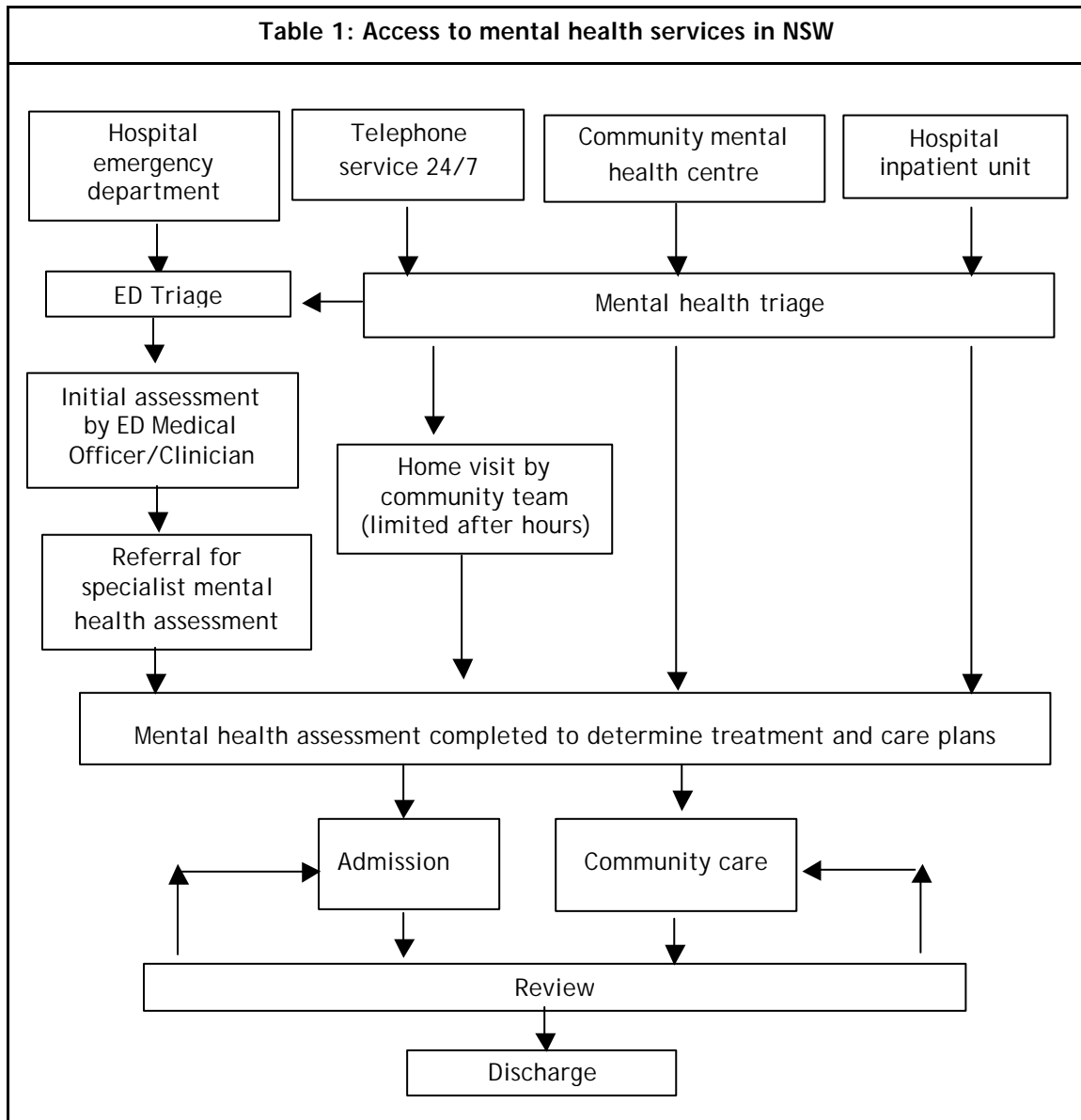
Over 200,000 people use public mental health services each year

Each year, over 200,000 people use mental health services provided by Area Health Services.² Patients can access these services through four main portals:

- hospital emergency departments
- 24 hour telephone services
- community mental health centres
- hospital inpatient units.

¹ NSW Health Caring for Mental Health: A framework for Mental Health Care in NSW 1998

² National Mental Health Survey 2001-02



Source: Audit Office research.

1.3 Current trends

The number of admissions are increasing

Services in all jurisdictions report that patients are presenting with more complex mental health problems. There are now over 24,000 admissions to acute beds each year in NSW, an increase of 11 per cent since 2001-02.

Acute mental health inpatient bed numbers have also increased over the same three-year period to 1,136 beds statewide or 22 beds per 100,000 adults.

Funding has increased

In 2004-05, in response to the increased demand for mental health services, the NSW Government announced an additional \$24.6 million as the first part of a four-year, \$241 million enhancement to services.

Total government spending on mental health services in NSW in 2003-04 was \$749 million.³

1.4 Changes to mental health services

Trend is towards caring for people at home

Since the 1950's there has been an increasing trend towards treating patients in the community rather than in a freestanding institution or hospital.

The current configuration of mental health services reflects this trend. Significant reductions in inpatient bed numbers occurred during the 1960s and 1970s, and continued at a slower rate in the 1980s in line with international service trends, National Mental Health policy and recommendations from reviews such as the 1983 Richmond Report.⁴

The scope of mental health services has also expanded. Emergency mental health services today are not confined to the sorts of conditions previously treated in stand-alone psychiatric hospitals. These services deal with a much wider range of conditions and problems such as depression, anxiety, substance abuse, acts of deliberate self-harm, and reactions to family or social crises. For many such problems, a hospital emergency department is possibly the safest and most appropriate setting for assessment and the initiation of care.

Although, there have been concerns with the care received by mental health patients in emergency departments mainly concerning the recognition of mental illness at triage and delays in receiving appropriate treatment or access to an inpatient bed.⁵

Recent reviews have also highlighted problems with accessing mental health beds, inadequate levels of psychiatric support in rural areas and high levels of demand for services from community crisis teams.⁶

³ Department of Health Annual Report 2003-04

⁴ D. T. Richmond Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled 1983

⁵ Department of Health Working Group for Mental Health Care in Emergency Departments 1998

⁶ NSW Parliament Legislative Council Select Committee on Mental Health Inquiry into Mental Health in New South Wales 2002

There have been some major improvements in emergency mental health care

Internationally, there is a recognised need to develop expertise and appropriate service models for emergency psychiatry. NSW has invested in developing greater emergency mental health capacity through initiatives such as the establishment of Clinical Nurse Consultant positions in Emergency Departments, the development of the Mental Health Emergency Department Triage Guidelines and the publication of the Mental Health for Emergency Departments Reference Guide.

During the course of this audit, the Department established Psychiatric Emergency Care Centres (PECCs) at Nepean and Liverpool Hospitals. These services provide specialised mental health staff and a more suitable physical setting within the Emergency Department for patients needing short-term care or waiting transfer to a specialist mental health unit. The Department advises that these services have improved patient flows and reduced emergency department stays in those hospitals. The development of four further PECCs has been announced.

In late 2004, the Department also initiated a routine data collection for access block to mental health units from all metropolitan Emergency Departments.

1.5 The reform agenda

Mental health reforms feature on both the national and the state agendas. In 1992, Australian Health Ministers endorsed the National Mental Health Strategy as the framework to guide mental health reform over the following 5 years. The framework promoted structural reforms and a shift from institutional to community-based care.

National service standards were agreed in 1996

As part of the reform package, a set of agreed national standards for mental health services were introduced in 1996. These guide service delivery and establish minimum requirements for access to services, assessment and patient review. A second national mental health plan was agreed to in 1998 to further improve service quality and delivery.

In line with these changes, the NSW Government introduced service reforms along with increased funding and increases in acute bed numbers.

Guidelines and manuals have also been introduced in emergency departments on triage, management and supervision of mental health patients.

About the audit

This audit examines emergency mental health services provided by community-based mental health teams and public hospitals (emergency departments, co-located psychiatric units, and freestanding psychiatric hospitals) in metropolitan and rural areas.

The audit focuses on the treatment of adults presenting with an acute phase of mental illness. The audit did not examine the treatment of children or adolescents or the quality of clinical diagnoses or treatment.

The audit team visited community mental health centres in Central Sydney Area Health Service (CSAHS) and the Greater Murray Area Health Service (GMAHS) and the Central Coast Area Health Service (CCAHS).

The audit also visited emergency departments at Royal Prince Alfred Hospital (CSAHS), Gosford Hospital (CCAHS), and Wagga Wagga Base Hospital (GMAHS) and three inpatient units: Rozelle Hospital (CSAHS), Mandala Clinic (CCAHS) and Gissing House (GMAHS).

Further details of the audit methodology are provided in Appendix 1.

2. Gaining access to emergency care

At a glance

The Department of Health has provided some guidance to Area Health Services on how and when emergency mental health services should be available.

All Area Health Services have adopted a common approach to mental health triage and since 1998 have been required to provide a 24 hour 1800 telephone number for mental health problems requiring urgent attention.

However, not all telephone services are the same. Although all conduct triage and provide advice or referrals, some Area Health Services have established sophisticated call centres that act as a central intake for all providers.

The centralised intake model has a number of advantages. More accurate and complete data on patients and service demand, standardisation of assessment and referral processes, better quality assurance mechanisms and established performance standards are some of the benefits.

Overall, centralised intake provides a higher degree of assurance that patient risk is managed.

So far, the Department of Health has not established performance standards for mental health telephone services such as: time to answer calls, the use of voicemail messaging or abandonment rates. And Area Health Services are not required to report on their performance.

2.1 Gaining entry to mental health services

Timely and appropriate emergency mental health care is necessary to avoid the escalation of acute episodes of mental illness and to manage the risk of self-harm or harm to others.

Since 1998, all Area Health Services have been required to provide a 24-hour 1800 telephone number for the effective response to people with mental health problems requiring emergency attention.



Case study 1: Emergency mental health care

During normal business hours, people suffering a mental health crisis have many service options available to them and may choose between a private or public provider. After hours, there are fewer options available.

All Area Health Services provide a 24/7 toll free phone service and there are numerous non-government agencies that can provide after hours counselling.

If medical treatment is required, people calling the toll free number are generally referred to the nearest emergency department so a doctor can assess them. Some Areas also have crisis teams that will do after hours visits but these are generally restricted to patients who are known to the service.

Services approach intake in different ways

Although the Department of Health provides some guidance, Area Health Services have traditionally chosen their own methods for the delivery of emergency mental health services to best meet the needs of their client population.

The result has been variations in practice. Of the three Areas we visited, two (a rural and a metropolitan service) had adopted the central intake model via a call centre whereas the third (metropolitan) service had chosen multiple entry points.

These variations do not always mean better client service

In this context, variation is not necessarily a sign that the Service is effectively meeting needs. Although an Area Health Service may argue that its mode of delivery best suits the needs of its clients, we found variations in practice in the multiple entry point model that were absent from the more consistent central intake approach (see Table 2).

For example, not all multiple entry points had dedicated staff to answer telephones and perform triage, ie staff may be otherwise occupied with face-to-face treatment. Call waiting time and the number of people who hung up before their call was answered were not monitored.

In contrast, services that used central intake had dedicated operators to answer calls, better patient data and a more accurate picture of service demand and trends. The Department of Health advises that different approaches can be used to establish these call centres. Area Health Services may run their own call centre or contract out the service to the private sector.

Case study 2: A mental health call centre
<p>One of the rural Areas we visited contracts out its 24/7 telephone service to a private call centre located in Sydney. This specialised call centre provides central intake services for the Area as well as after hours case management.</p> <p>Each call is triaged by a mental health professional using computer driven clinical protocols to assess risk and help determine the appropriate intervention.</p> <p>Minimum service levels for the call centre are outlined in contracts and regular reports are provided to management on performance. Meetings and case conferences are also held regularly between the parties.</p> <p>Both the call centre and the Area mental health teams work closely together to ensure service delivery is seamless and that services meet the needs of clients.</p>

Table 2: Comparing approaches to intake	
Single entry point	Multiple entry points
Clients are referred to a single toll free telephone number. Call centre provides central intake	Clients may contact service outlets direct. A 24/7 number also available for emergencies
Call centre has dedicated staffing	Staff may be required to undertake other duties
Staffing levels match peaks in demand to ensure service standards are met	No data available on demand
Call centre staff have special training for dealing with telephone inquiries	Staff have no specific training in conducting phone assessments
Voicemail facilities are provided if client doesn't want to wait	Access to voicemail facilities varies
Client details are recorded in electronic database	Client details are recorded in paper-based files
Patient contact history and decision tools are available to caseworker to assist assessments	Patient details are recorded on a standard form
All contacts are recorded in central database	No central database of client contacts
Standard procedures in place to followed-up clients assessed at risk to ensure they have presented to the service	Procedures for follow up differ between sites
Performance standards established for: <ul style="list-style-type: none"> ▪ Time to answer the call ▪ Abandonment rates ▪ Time to return voicemail 	No performance standards established
Performance against standard is monitored and reported	Performance is not monitored

Source: Audit Office research

Recommendation It is recommended that Area Health Services adopt a central intake model for entry to mental health services.

2.2 Ensuring effective triage

Standard approach to triage and risk assessment has been established In 2001, the Department of Health released the Mental Health Outcomes Assessment Tools (MH-OAT) to provide systematic mental health triage and assessment for the development of care plans. The tools also standardise patient documentation.

Emergency departments across the State had already developed a sound approach to triage mental health patients in the emergency department.

The three Area Health Services we visited used MH-OAT to document patient outcomes except in the emergency department where the outcomes of specialist mental health assessments were generally documented in patient notes.

Recommendation It is recommended that MH-OAT be used for documenting mental health assessments conducted by mental health professionals in the emergency department.

2.3 Setting service standards

National standards require an initial mental health assessment of an urgent referral to commence within one hour of contact with the service and within 24 hours if the client is assessed as non-urgent. These assessments can be conducted over the phone.

As indicated earlier all Area Health Services provide a 24-hour telephone service. Following triage, patients requiring urgent assistance are generally referred to the closest emergency department. Less urgent clients have their details sent to a community team for follow-up the next working day.

There are risks regarding the time taken to answer a call. If call waiting times are long, a caller is more likely to hang up. There are also no standards for when voicemail messages should be returned to ensure patients are followed up.

Without standards or data on call waiting times and abandonment rates we were unable to judge the quality of services or if services were effective in meeting demand.

Recommendation It is recommended that the Department of Health establish minimum requirements for emergency mental health telephone services including:

- time to answer the call
- call abandonment rates
- time to return a voicemail message.

The Department and Area Health Services should monitor performance against these standards and report performance in annual reports.

2.4 Entry through the emergency department

Emergency departments see about 35,000 cases each year

At least 2.5 per cent of all emergency department patients each year are treated for a mental illness (around 35,000 presentations). About a third of these are admitted to a mental health bed.

Common presentations to emergency departments include patients with depression, psychosis, disturbed behaviour, anxiety disorders, organic brain disorders, substance abuse, suicide attempts and other episodes of self-harm.

Patients arriving at emergency departments are triaged as a category 1 to 5, according to their condition, and are seen by a medical officer in order of priority.



In 1998, the Working Group for Mental Health Care in Emergency Departments recommended the use of specific triage guidelines for patients presenting with a mental illness. All three emergency departments we visited had adopted these guidelines.

Training is provided to staff on how to use the guidelines to assess mental health patients and most conduct audits to test triage outcomes.

Case study 3: Improving the skills of emergency department staff

All three emergency departments we visited provided some training in conducting mental health triage as part of the in-service program for nursing staff.

One emergency department had established an eight-week rotation program between emergency department nurses and nurses in the Hospital's psychiatric unit.

The program is intended to improve the skills of emergency department staff in managing patients who present with a mental health problem. The program also heightens the awareness of how a delay in accessing a bed impacts on patients.

Patients who do not wait are not always followed up

Between four and nine per cent of all patients who present to an emergency department and are triaged leave prior to seeing a doctor.⁷

Only one of the three emergency departments we visited had procedures to follow up mental health patients to check if they were still in need of treatment. None of the three emergency departments checked to see if these protocols had been followed when patients left prior to treatment.

Controls were better in community services where protocols were in place to follow-up a patient who fails to attend an appointment. Yet, only one service had actually reviewed files to check if appropriate action had been taken.

Recommendation

It is recommended that hospitals implement procedures to follow up mental health patients who are judged at risk and who leave an emergency department before receiving treatment. These procedures should include checks to ensure timely and appropriate action is taken.

⁷ The Audit Office of NSW Transporting and Treating Emergency Patients: NSW Department of Health Ambulance Service of NSW 2004

3. Improving mental health assessments

At a glance

The Department of Health introduced a systematic process for conducting mental health assessments in 2001.

This process has standardised practice ensuring consistent triage, assessment, management and the recording of patient outcomes.

The process also establishes timeframes for intervention based on patient risk. Response times range from immediate for clients at extreme risk to an assessment within two weeks for non-urgent cases.

None of the three Area Health Services we visited monitored performance against these response times. We are unable to judge whether or not the time taken to respond, matched assessed urgency.

These timeframes generally apply to assessments completed in the community. In contrast, there are no timeframes for specialist mental health assessments conducted in an emergency department.

As a result, patients may undergo a medical assessment in a timely manner but will wait, sometimes overnight for a mental health assessment.

The review of clinical decisions by a senior mental health professional plays a major role in assuring assessment quality. There are no minimum requirements for what constitutes clinical review and on the patient files we reviewed there was generally nothing to indicate a review had taken place.

3.1 What is a mental health assessment?

A doctor, psychologist, nurse, occupational therapist, or social worker that has received specialist and recognised training in mental health assessment and treatment may conduct a mental health assessment. These assessments may be completed in a community health centre, a patient's home, a hospital inpatient unit or an emergency department.

A mental health assessment involves a comprehensive review of a patient's mental health state at the time of presentation and is used to develop appropriate interventions and inform care plans.



The Department's Mental Health Outcomes Assessment Tools (MH-OAT) establish a standard approach to the conduct of a comprehensive mental health assessment through standard protocols for recording patient triage, assessment and treatment plans.

These protocols and modules have been developed in accordance with the requirements of the National Standards for Mental Health Services (1997) to improve service quality and ensure that services meet the requirements of the standards.

The MH-OAT tools were introduced to Areas in 2001.

3.2 Providing specialist support

Over 200,000 people use mental health services each year and around 35,000 people present to an emergency department for crisis services.

Access to community-based mental health services after hours can be problematic as these services generally only operate 9:00am to 5:00pm Monday to Friday.

Beyond these times only limited staff cover is available. In the rural locations we found there may be no out of hours cover at all.

Alternate crisis and acute services are available at hospital emergency departments and inpatient units. One emergency department we visited indicated that at least 52 per cent of all mental health presentations occurred after 5:00pm on weekdays or at weekends.

Increased focus on treating patients in emergency departments

In 1998, in response to an increasing number of mental health presentations to emergency departments, the Department of Health recommended that emergency departments have:

- 24 hour access to specialist mental health consultations
- where possible, mental health staff available to provide consultation services and work collaboratively with other clinicians.

A number of reforms have been put in place to improve access such as 24-hour telephone consultations and telemedicine facilities. There have also been two trials involving the employment of mental health nurses (referred to as mental health consultation liaison nurses) in large emergency departments in both metropolitan and rural areas.

The role of these nurses is to assess patients and provide clinical assistance, staff support and conduct training sessions to improve staff skills. The Department reports that over 80 per cent of large emergency departments currently employ mental health nurses.

Specialists improve patient flow

Where a mental health nurse is employed, emergency department staff report reductions in waiting times, streamlined transfer of patients to inpatient units, and improved follow-up of mental health patients following discharge.

In most cases, these nurses are employed during business hours and not necessarily to match presentation patterns.



Case study 4: Matching services to meet demand

One of the metropolitan emergency departments we visited employs mental health nurses from 8:00 am to 4:30 pm seven days a week with extended cover on Fridays to 10:00 pm to more closely reflect presentation patterns.

Emergency department staff report improvements in patient flow with 75 per cent of patients requiring a mental health assessment being seen by the mental health nurse within one hour of arrival. Patients also receive a more streamlined and timely discharge from the department.

In one Area we visited, rather than have a mental health nurse on site, the community mental health crisis team was physically located in the emergency department providing 24 hour cover to facilitate mental health presentations and conduct assessments.

There are some obvious advantages in this approach. Firstly, it increased access to mental health professionals in the emergency department. Secondly, as the teams are part of the community-based mental health service they have a better knowledge of the type and availability of out-patient services and can facilitate patient follow-up.

Recommendation

It is recommended that Area Health Services enhance access to specialist support in emergency departments by:

- extending the cover provided by mental health nurses or other professionals to match demand better, or
- locating acute community mental health teams in emergency departments where possible.

Some Areas face significant problems recruiting mental health professionals

The Department advises that Areas face significant difficulty recruiting mental health professionals. Experienced mental health nurses, psychiatrists and psychiatry trainees are in limited supply in most Areas, and in particular in rural and outer metropolitan regions. These difficulties may impose a practical limit on the model(s) of care that can be established and the rate at which some service expansions can be implemented.

3.3 Assuring a timely response

Response time established for community-based services

The Department of Health has established timeframes for clinical intervention based on assessed patient risk for people requiring mental health services in the community.

Response times vary from immediate to two hours, twelve hours, two days or two weeks depending on assessed risk of harm to self or others.

But we don't know how well services are performing

Yet none of the three Area Health Services we visited monitored performance against these response times. We are unable to judge whether or not the time taken for clinical intervention to occur matched the assessed urgency.

In regard to emergency departments, triage protocols establish timeframes for medical review, but unlike community-based services, there are no recommended response times for undertaking a mental health assessment in this setting.

Patients can face significant delays waiting for treatment

At one site, patients who presented to the emergency department after 5:00pm requiring a mental health assessment were routinely kept in the emergency department overnight until a mental health professional was available the next day to conduct the assessment.

Overnight stays in the emergency department can have adverse consequences for the patient and the health system. Neither emergency department facilities nor staff are appropriate for providing longer term patient care. In addition, mental health patients often require one-on-one supervision, which redirects scarce nursing resources.

A mental health patient waiting to be assessed ties up a bed in the emergency department. This may increase the waiting times for other patients seeking treatment and may lead to overcrowding in the emergency department.

The common reported causes of patient delays in an emergency department were workload issues including conflicting priorities faced by community mental health team members having to serve clients in different settings, excessive patient numbers especially mornings and weekends and access to mental health professionals especially in rural areas.

Service models should reflect local resources and geography, and be appropriate to the role delineation of the emergency department. Immediate, face-to-face access to a specialist mental health professional would be ideal but may not be possible in all settings. Yet, this should not prevent the establishment of minimum standards appropriate to various settings. All emergency departments should have a clear line of access to immediate specialist mental health consultation, even if in some settings this may be by use of telephone or videoconferencing.

More timely, specialist intervention would facilitate early discharge from the department or transfer of the patient to a ward.

Recommendation

It is recommended that:

- the Department of Health establish standard response times for the completion of a mental health assessment for patients presenting to an emergency department
- Area Health Services monitor and report performance against response times in all service settings.

3.4 Strengthening clinical review and documentation

Clinical review helps assure quality

The National Mental Health Standards recommend assessments be subject to review by a more senior mental health professional or peer review as part of routine clinical supervision to assure quality.

Only one of the Area Health Services we visited had developed a policy that outlined minimum requirements for clinical review. None of the patient files we reviewed clearly noted when an assessment had been subject to clinical review.

Recommendations It is recommended that the Department establish minimum requirements for conducting clinical review and the documentation of outcomes.

3.5 Providing appropriate facilities for assessments

Urgent assessments of clients in the community were usually done in a patient's home or the local community health centre.

Emergency departments are increasingly becoming the after hours provider of mental health services. Department of Health guidelines recommend emergency departments have adequate facilities for the safe reception, assessment, stabilisation and initial treatment of acute mental health patients.

The facilities in the three emergency departments we visited were not always ideal to ensure the safety of patients or staff. None had a secure room for conducting mental health assessments to minimise the risk of self-harm or harm to others. All had multiple exits and could not prevent a patient from absconding.

Recommendation It is recommended that the Department consider including a private and secure space for conducting mental health assessments in any new or refurbished emergency departments.

4. Gaining access to a bed

At a glance

Most people with a mental illness can be effectively managed in the community. It is only during a severe or acute phase of the illness that a patient requires admission to hospital for short-term intensive therapy.

There were over 24,000 acute admissions in 2003-04 representing an increase of 11 per cent over the last three years. Over the same period the Government opened an additional 122 acute mental health beds bringing the statewide total to 1,136 or 22 beds per 100,000 adults.

Despite these increases, bed numbers remain well below the Department of Health target of 31 beds per 100,000 adults. In addition, resources are not equitably distributed across the state.

Any problems with gaining access to a mental health bed will quickly become apparent in an emergency department.

We found patients may wait for very long periods in the emergency department before being admitted to a bed. In one rural hospital we found that some mental health patients completed their intensive treatment in the emergency department without ever accessing a mental health bed.

This is neither ideal for the patient nor the department.

Emergency departments are extremely busy. Mental health patients awaiting admission to a bed prevent other patients' access to treatment. Mental health patients may also require one-on-one supervision redirecting nursing resources.

Problems with access may also influence clinical behaviour. We found significant increases in admission rates following the opening of new beds.

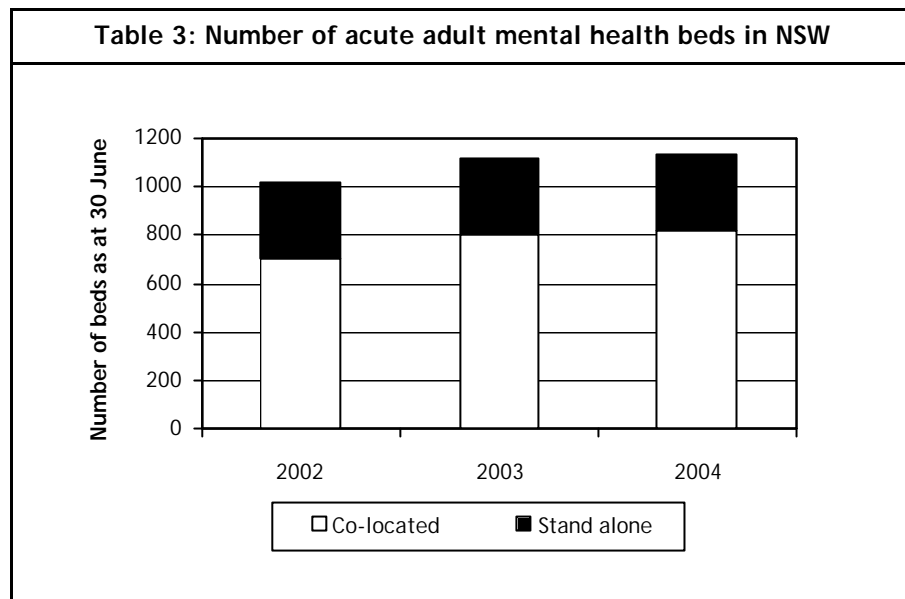
And access may influence clinical outcomes. Because of the chronic nature of most mental illnesses, there is a need for continuity of care across community and hospital settings for treatment to be effective. The transfer of patients out of their local area in order to access a bed may disrupt this continuum.

4.1 How many mental health beds are there?

Resources have shifted from non acute to acute units

NSW has seen a significant decrease in the total number of psychiatric beds over the last 20 years to around 2,100 beds (acute and non acute) mainly as a result of the closure of stand-alone institutions.

Most people with a mental illness are effectively treated in the community except during an acute or severe phase of illness, when inpatient care is required. Co-located psychiatric units in general hospitals are now the preferred inpatient model although acute mental health beds remain in stand-alone psychiatric hospitals.



Source: Department of Health

There are currently 1,136 acute adult beds in NSW or 22 beds per 100,000 adults.⁸

More recent increases have been the 50-bed acute facility at Wyong in May 2004 and an additional 43 beds are planned for Cumberland, Westmead, Liverpool and Nepean in 2004-05.



Since 2001, the Department of Health's Mental Health Clinical Care and Prevention Model (MH-CCP) has provided a guide to Area Health Services for determining the level and mix of clinical resources needed to adequately meet its population requirements.

Although the model provides a broad guide to Areas, the Department acknowledges that the model contains limitations that are currently being addressed. In particular, the Department advises that the next version of MH-CCP will be more sensitive to differences in need related to geography or local social disadvantage. It will also reflect better the range of possible service models including provision for alternatives to inpatient care such as supported accommodation and assertive community care. According to the Department, it is likely that acute and non-acute mental health bed numbers provided by the model will be revised, yet the extent and direction of this revision is not known.

⁸ Centre for Mental Health 2004. Additional adult beds have been provided at Coffs Harbour, Kempsey, Sutherland, St George, Tamworth, Taree, Tweed Heads, Westmead, Wollongong and Wyong Hospitals.

4.2 Are there sufficient beds to meet demand?

Demand for mental health services has changed in recent years. Services in all jurisdictions report increasing levels of patient acuity and subsequent increases in admission rates.

Over the last three years there has been increasing demand for mental health beds in NSW:

- a 11.3 per cent increase in acute admissions to 24,157
- a 16 per cent increase in involuntary admissions to 13,608
- a 3 per cent increase in bed occupancy rates to 93 per cent
- an increase in average length of stay for adults from 15 days to 15.5 days.⁹

During this period there has also been a 12 per cent increase in the number of acute beds to 1,136.



**GOOD
PRACTICE**

Case study 5: Managing the demand for beds

A mental health patient may need to be transferred to another hospital if there are no free beds.

To help clinicians locate spare capacity in the system, the Department of Health introduced the Mental Health Bed Monitoring System in 2002. The system provides real-time information about the location of available mental health beds across the state and encourages the sharing of resources both within and across Areas.

All three Areas we visited used the system to monitor and report bed availability. The Areas also employed other bed management strategies such as :

- accepting transfer patients only when occupancy rates were less than 85 per cent
- using “leave” beds where patients are at home overnight or for the weekend for new admissions
- using home-based care teams to support early discharge.



**GOOD
PRACTICE**

During this audit, the Department is developing a Mental Health Report Card as part of its Mental Health Performance Agreements with Areas in order to monitor demands for services and performance. The Report Card includes a number of mandatory indicators that Areas must collect data and report on such as the:

- gap between MH-CCP estimates and actual resources
- access block for mental health patients (see also 4.4).

⁹ Department of Health (DOHRS)

New accountability framework will improve Area performance monitoring

In addition, the Report Card includes indicators required under the National Mental Health Strategy such as:

- unplanned readmissions
- admissions out-of-catchment that arise from bed shortages (see also 4.5)
- lengths of stay for acute admissions.

The Department currently reports demand for acute mental health beds in collocated units in its annual report in terms of:

- the number of admissions
- occupancy rates.

Recommendation

It is recommended that the Department of Health and Areas collect and report on the performance of mental health services using the indicators in the proposed Report Card. The Department should also expand its reporting on mental health services in its annual report to include a discussion on unplanned readmissions, lengths of stay and out-of-catchment transfers affecting acute mental health patients.

Demand for beds exceeds current supply

There are days when patients cannot access a mental health bed in their local area or anywhere nearby requiring patients to be kept for long periods in emergency departments waiting for a bed to become available (see also 4.3).

According to the Department's resource model (MH-CCP), Areas should allow on average, 31 acute beds for every 100,000 adults. In NSW there are currently 22 beds per 100,000 adults and gaps between actual and model bed numbers at Area level range from 83 per cent below target to 21 per cent above as at June 2004 (see Appendix 2: Tables 6 and 7).

These variations may result in the patient spending long periods in the emergency department waiting for a bed or being transferred to another hospital.

Some mental health patients are treated in the emergency department

Case study 6: The effect of access block on patients
<p>During July to December 2003, at one of the hospitals we visited, 19 mental health patients who were assessed by the consulting psychiatrist as requiring admission had been discharged from the emergency department.</p> <p>During the patients' stay, no beds became available in the hospital and there were no beds nearby that the patients could be transferred to. As a result, these patients remained in the emergency department until their treatment was complete and they could be discharged and sent home.</p>

An additional 90 beds have been added to the system since June 2004 and another 110 beds have been approved for opening by June 2008 (see Appendix 2: Table 7).

4.3 Monitoring patient flow

Access block is the percentage of patients waiting longer than the benchmark eight hours to be admitted to a hospital bed from an emergency department.

Access block is not monitored

Although hospitals routinely monitor and report on access block for general admissions, we found the three emergency departments we visited did not routinely monitor these delays for mental health patients.

	Area 1	Area 2	Area 3
Do you monitor the proportion of mental health admissions delayed >8 or >24 hours?	No	No	No
Do you routinely monitor access block to mental health beds?	No	No	No
What is the proportion of mental health admissions from the ED where the delay is > 8 hours?	No data	No data	30.9% ¹
What is the proportion of mental health admissions from the ED where the delay is > 24 hours?	No data	No data	6.7% ¹

Source: Audit Office research 2004

Note 1: Based on sample data collected by the Area in response to the survey.

Access block has adverse consequences for patients and the health system. Neither emergency department facilities nor staff are appropriate for providing longer term patient care. And for patients, studies indicate these delays are associated with poorer clinical outcomes and increased lengths of stay.¹⁰

In addition, the benchmark eight hours may not be appropriate for mental health patients. For example, mental health patients waiting in the emergency department for a bed may need one-on-one supervision. This is generally achieved by engaging agency nurses and, in some cases, by redeploying staff or working overtime.

According to data provided by the Department, access block of greater than 8 hours is reported for 30-40 per cent of emergency department patients of all types. For patients with mental health problems, this proportion is lower at 23 per cent.¹¹ Even though the proportion of mental health patients affected is less than the total population the issue remains as to what is an appropriate benchmark for this group of patients.

¹⁰ NSW Audit Office Transporting and Treating Patients 2004

¹¹ Department of Health Emergency Department Information System (EDIS) 2004

4.4 Does access influence decisions?

Although it is not possible to conclude that a decision to admit a patient will be influenced by whether or not a bed can be easily accessed, we did find a difference in the number of admissions following the opening of new beds.

For example, the number of admissions to mental health beds at Tweed Heads District and Manning River Base Hospitals more than doubled following the opening of new beds in 2002.

Hospital	2001	2002	2003
Tweed Heads District Hospital			
▪ Presentations	906	922	1,125
▪ Admissions	93	234	433
▪ Admission rate	10%	25%	38%
Manning River Base Hospital			
▪ Presentations	547	632	712
▪ Admissions	154	226	356
▪ Admission rate	27%	36%	50%

Source: Department of Health

Overall, where a hospital has a co-located inpatient unit, the admission rate is 35 per cent. For hospitals that do not have these facilities the admission rate (to the nearest facility) is less than half at 16 per cent.

Factors that may contribute to this outcome are patient choice of hospital, referral practices and Police transporting involuntary patients to larger hospitals.

Yet there is a risk that access to beds may influence a clinician's decision to admit a patient and may lead to a less than optimal outcome.

Recommendation

It is recommended that:

- the Department of Health establish a benchmark for access block for mental health patients
- that emergency departments routinely monitor performance against this benchmark
- that the Department of Health and Areas collect data and report performance as part of the Mental Health Report Card
- the Department of Health consider including data on access block for mental health patients in its annual report.

4.5 Patient transfers

Due to the chronic nature of most mental illnesses there is a need for continuity of care across community and hospital settings for treatment to be effective. The transfer of patients out of their local area in order to access a bed may disrupt this continuity.

Transfers to other hospitals are not monitored

These are referred to as out-of-catchment transfers. The Department does not monitor these transfers. However, based on sample data collected by the Department, it predicts that each year 806 out-of-catchment transfers will be due to bed shortages, representing around three per cent of all mental health admissions.

Three per cent does not represent a significant proportion of admissions. However, these transfers have the potential to impact on patient outcomes and should be monitored.

Recommendation

It is recommended that Area Health Services monitor and report on out-of-catchment transfers that arise from bed shortages.

4.6 Transporting patients



There is a statewide memorandum of understanding (MOU) between the Department of Health, the Ambulance Service and NSW Police, which establishes the roles and responsibilities of each agency in the transport and treatment of mental health patients. An interdepartmental committee has also been established to deal with any problems arising from the MOU.

Not all Areas have established local protocols

Areas are encouraged to develop local protocols in line with the MOU and to indicate where patients should be taken for treatment. Two of the Areas we visited had protocols in place. One Area had not developed local protocols.

Staff reported that the process of developing these protocols was valuable in gaining an understanding of the impact delays in the emergency department have on all parties and to develop ways to fast track patients.

Trials using outreach clinical support are reducing the need for Police to be involved in patient transport

The Department has advised that a recent pilot project by the Mid North Coast Area Health Service has reduced the need for police assistance in inter-hospital transport apart from in situations of extreme risk. The project has trialled a more integrated system of clinical support and transport suitable for rural areas, in which specialist mental health staff are accessed via a call centre, and provide urgent outreach support to assist local staff and ambulance services in stabilising and transporting patients to a suitable mental health bed.

Recommendation

It is recommended that Area Health Services ensure local protocols with NSW Police and the Ambulance Service are in place under the statewide memorandum of understanding for transporting mental health patients.

Appendices

Appendix 1 About the audit

The audit Our performance audit examined how people suffering an acute episode of mental illness access appropriate emergency care. Acute episodes are characterised by a recent onset of severe clinical symptoms.

Audit objectives The objective of the audit was to determine whether emergency mental health services for people in crisis are provided by the Department of Health in a timely and appropriate manner.

Audit scope The audit scope was based on the premise that any delays in accessing emergency mental health services may lead to an escalation in the severity of an episode of mental illness and an increase in risk of self harm or harm to the community.

The audit examined emergency mental health services provided by community mental health teams and public hospitals (emergency departments) as well as stand-alone psychiatric hospitals in both metropolitan and rural settings.

The audit focused on the management of adults (aged 18-64 years) requiring acute mental health care. The audit did not examine the quality of diagnosis or treatment or services for children, adolescents or older persons.

The audit did not examine private sector services, non-acute services or mental health services delivered within the correctional system.

Audit criteria Our audit examined performance against the following criteria:

- Triage and intake services provided by community-based mental health services are conducted in a timely manner and in accordance with standards, policies and procedures
- Triage and assessment of patients presenting to an emergency department with a mental illness are conducted in a timely manner and in accordance with standards, policies and procedures
- Clinical assessments are completed in a timely manner and in accordance with standards, policies and procedures
- Where a clinical decision is made to admit a patient to an acute inpatient bed, admission occurs in a timely and safe manner.

What we did The audit team visited community mental health centres in Central Sydney Area Health Service (CSAHS), the Greater Murray Area Health Service (GMAHS) and the Central Coast Area Health Service (CCAHS).

We also visited emergency departments at Royal Prince Alfred Hospital (CSAHS), Gosford Hospital (CCAHS), and Wagga Wagga Base Hospital (GMAHS) and three inpatient units: Rozelle Hospital (CSAHS), Mandala Clinic (CCAHS) and Gissing House (GMAHS).

Service profile	Area 1	Area 2	Area 3 (rural)
Population (aged 18+) (1)	409,175	232,908	196,165
MH non-inpatient services (\$m) (2)	21.28	15.13	7.92
MH non-inpatient staffing (FTE) (2)	237.0	195.1	86.9
MH acute beds at 30.6.04 (1)	152	40	38
MH presentations to EDs (3)	2,319	2,402	2,384
MH admissions from EDs (3)	522 (4)	606	773
Note: MH = Mental Health; ED = Emergency Department; FTE = Full Time Equivalent Sources: 1) Centre for Mental Health 2003-04; 2) National Survey of Mental Health Services 2003-04 provisional data; 3) Department of Health EDIS data; 4) Patients in area also present direct to the stand alone facility.			

Audit cost Including printing and all overheads, the estimated cost of this audit is \$519,735.

Audit team Neil Avery, Rachel Hibbard and Chris Yates. Direction and quality assurance was provided by Jane Tebbatt.

Acknowledgment We gratefully acknowledge the co-operation and assistance from officers of the Centre for Mental Health and the Department of Health. We also appreciate the assistance and co-operation of the staff employed in the three Area Health Services we visited and particularly those engaged in providing services at the sites we visited as part of the audit.

Previous audits This audit follows on from earlier performance audits into the NSW public health system.

Hospital Emergency Departments: Delivering Services to Patients (March 2000):

Although waiting times for seriously ill patients have decreased, waiting times for around 95 per cent of emergency department patients have increased or remain unchanged and performance against benchmarks for access block has declined each year.

Ambulance Service: Readiness to Respond (March 2001):

This performance audit indicates that the Service has considerable work to do to reach its aspirations of being recognised amongst leading examples of best practice services.

Waiting Times for Elective Surgery in Public Hospitals (September 2003):

By all measures used by NSW Health, patients are waiting longer for elective treatment today than six or seven years ago.

Code Red: Hospital Emergency Departments (December 2003):

The Emergency Department Network Access Scheme (EDNA) was introduced by the Ambulance Service and the Department of Health to improve ambulance patients' access to hospital services by reducing ambulance delays at emergency departments. Since EDNA was introduced, there has not been an overall reduction in ambulance delays at hospitals. EDNA has had some impact on sharing demand but it is limited by the fact that there is very little spare capacity available in the network. Under these conditions, EDNA cannot markedly improve patient access. More fundamental changes to hospital practices are required.

Transporting and Treating Emergency Patients (July 2004):

Despite increases in expenditure, metropolitan hospitals have been unable to cope with the growth in the number of emergency patients requiring overnight admission. This has been compounded by increases in the proportion of aged patients seeking treatment and in the complexity of conditions with which patients are presenting.

Reductions in bed numbers and high occupancy levels have led to a long-term increase in access block. Shortages of medical, nursing and allied health staff restrict the ability to increase the capacity of the public health system.

The increasing number of emergency patients requiring inpatient admission has also reduced the ability of public hospitals to provide booked surgery.

Appendix 2 Acute mental health beds

Table 6: Actual acute beds versus MH-CCP recommendations at June 2004				
Area Health Service	Population Aged 18+	No. beds	No. MH-CCP recommended beds	Percentage of recommended beds
South Eastern Sydney	647,584	141	200	71%
Northern Sydney	629,468	109	195	56%
South Western Sydney	602,552	92	186	49%
Western Sydney	555,890	150	171	88%
Hunter	429,575	106	132	80%
Central Sydney	409,175	152	126	121%
Illawarra	282,093	69	86	80%
Wentworth	234,118	30	73	41%
Central Coast	232,908	40	71	56%
Mid-North Coast	213,992	70	64	109%
Northern Rivers	210,878	50	64	78%
Greater Murray	196,165	38	60	63%
Southern	153,476	22	47	47%
New England	133,473	33	41	80%
Mid-Western	128,451	28	40	70%
Macquarie	76,860	4	24	17%
Far West	35,743	2	11	18%
Total	5,172,402	1,136	1,591	71%

Source: Centre for Mental Health 2004

Area Health Service	Population Aged 18+ (2003-04)	No.beds March 2005	Percentage of MH-CCP estimated beds at March 2005	Approved future beds to June 2008*	Total beds at June 2008	Percentage of MH-CCP estimated beds (2007-08)
South Eastern Sydney	647,584	141	70%	8	149	72%
Northern Sydney	629,468	109	56%	19	128	64%
South Western Sydney	602,552	110	58%	6	116	59%
Western Sydney	555,890	163	94%	10	173	94%
Hunter	429,575	106	80%	10	116	85%
Central Sydney	409,175	152	119%	0	152	115%
Illawarra	282,093	69	79%	15	84	92%
Wentworth	234,118	43	58%	15	58	76%
Central Coast	232,908	75	104%	0	75	100%
Mid-North Coast	213,992	70	106%	0	70	101%
Northern Rivers	210,878	50	77%	15	65	96%
Greater Murray	196,165	39	64%	0	39	63%
Southern	153,476	20	43%	0	20	40%
New England	133,473	33	80%	0	33	79%
Mid-Western	128,451	32	80%	0	32	78%
Macquarie	76,860	8	33%	12	20	83%
Far West	35,743	6	55%	0	6	55%
Total	5,172,402	1,226	76%	110	1,336	80%

Source: Centre for Mental Health April 2005

* Planned or under construction for completion by June 2009

Appendix 3 Terms used in this report

Access block	Access block is the proportion of admitted patients not moved to a hospital ward within 8 hours from commencement of active treatment. ¹²
Acute episode	Acute episodes are those characterised by a recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self or others.
Admitted patients	Patients accepted by a hospital for inpatient care. ¹³
Area Health Service (Area)	An Area Health Service is the administering authority for public health activities within a designated geographic area. From 1 July 2004 the number of Area Health Services across NSW was reduced from 17 to 8 through amalgamation.
Average length of stay (ALOS)	The average number of days each admitted patient stays in hospital. This is calculated by dividing the total number of occupied bed days for the period by the number of actual separations in the period. ¹⁴
Bed occupancy rate	The percentage of available beds which have been occupied over the year. It is a measure of the intensity of the use of hospital resources by inpatients. ¹⁵
Inpatient	Patients who are formally admitted to a hospital or health service facility. Admitted patients can be same-day or overnight. ¹⁶
Mental health assessment	A mental health assessment involves a comprehensive review of a patient's mental health state at the time of presentation and is used to develop appropriate interventions and inform care plans.
Mental health professional	A doctor, psychologist, nurse, occupational therapist, or social worker who has received specialist and recognised training in mental health assessment and treatment.
Mental Illness	A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is usually made according to recognised classification systems such as DSM-IV or ICD-10, but not all illnesses in these classification systems are within the ambit of the National Mental Health Plan. In Australia, specialist mental health services do not usually have primary responsibility for drug and alcohol problems or dementia. ¹⁷
Psychiatrist	A medically qualified physician who specialises in the study and treatment of mental disorders. ¹⁸

¹² NSW Department of Health Annual Report 2002-03; p111

¹³ NSW Health Waiting Times Information: General Waiting Times Definitions

¹⁴ NSW Department of Health Annual Report 2002-03; p194

¹⁵ *ibid*

¹⁶ *Performance Reports Health: Glossary*; Council on the Cost and Quality of Government

¹⁷ *National Mental Health Plan 2003-2008*. Australian Government, 2003

¹⁸ *Concise Medical Dictionary*, Oxford University Press, 1994

Separations	Separations are episodes of care from admission to discharge, transfer or death.
Triage	Triage aims to ensure that patients are treated in the order of their clinical priority and that their treatment is timely. ¹⁹

¹⁹ NSW Department of Health Annual Report 2002-03

Performance Audits by the Audit Office of New South Wales

Performance Auditing

What are performance audits?

Performance audits are reviews designed to determine how efficiently and effectively an agency is carrying out its functions.

Performance audits may review a government program, all or part of a government agency or consider particular issues which affect the whole public sector.

Where appropriate, performance audits make recommendations for improvements relating to those functions.

Why do we conduct performance audits?

Performance audits provide independent assurance to Parliament and the public that government funds are being spent efficiently and effectively, and in accordance with the law.

They seek to improve the efficiency and effectiveness of government agencies and ensure that the community receives value for money from government services.

Performance audits also assist the accountability process by holding agencies accountable for their performance.

What is the legislative basis for Performance Audits?

The legislative basis for performance audits is contained within the *Public Finance and Audit Act 1983, Part 3 Division 2A*, (the Act) which differentiates such work from the Office's financial statements audit function.

Performance audits are not entitled to question the merits of policy objectives of the Government.

What conducts performance audits?

Performance audits are conducted by specialist performance auditors who are drawn from a wide range of professional disciplines.

How do we choose our topics?

Topics for performance audits are chosen from a variety of sources including:

- our own research on emerging issues
- suggestions from Parliamentarians, agency Chief Executive Officers (CEO) and members of the public
- complaints about waste of public money
- referrals from Parliament.

Each potential audit topic is considered and evaluated in terms of possible benefits including cost savings, impact and improvements in public administration.

The Audit Office has no jurisdiction over local government and cannot review issues relating to council activities.

If you wish to find out what performance audits are currently in progress just visit our website at www.audit.nsw.gov.au.

How do we conduct performance audits?

Performance audits are conducted in compliance with relevant Australian standards for performance auditing and operate under a quality management system certified under international quality standard ISO 9001.

Our policy is to conduct these audits on a "no surprise" basis.

Operational managers, and where necessary executive officers, are informed of the progress with the audit on a continuous basis.

What are the phases in performance auditing?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team will develop audit criteria and define the audit field work.

At the completion of field work an exit interview is held with agency management to discuss all significant matters arising out of the audit. The basis for the exit interview is generally a draft performance audit report.

The exit interview serves to ensure that facts presented in the report are accurate and that recommendations are appropriate. Following the exit interview, a format draft report is provided to the CEO for comment. The relevant Minister is also provided with a copy of the draft report. The final report, which is tabled in Parliament, includes any comment made by the CEO on the conclusion and the recommendations of the audit.

Depending on the scope of an audit, performance audits can take from several months to a year to complete.

Copies of our performance audit reports can be obtained from our website or by contacting our publications unit.

How do we measure an agency's performance?

During the planning stage of an audit the team develops the audit criteria. These are standards of performance against which an agency is assessed. Criteria may be based on government targets or benchmarks, comparative data, published guidelines, agencies corporate objectives or examples of best practice.

Performance audits look at:

- processes
- results
- costs
- due process and accountability.

Do we check to see if recommendations have been implemented?

Every few years we conduct a follow-up audit of past performance audit reports. These follow-up audits look at the extent to which recommendations have been implemented and whether problems have been addressed.

The Public Accounts Committee (PAC) may also conduct reviews or hold inquiries into matters raised in performance audit reports. Agencies are also required to report actions taken against each recommendation in their annual report.

To assist agencies to monitor and report on the implementation of recommendations, the Audit Office has prepared a Guide for that purpose. The Guide, *Monitoring and Reporting on Performance Audits Recommendations*, is on the Internet at <www.audit.nsw.gov.au/guides-bp/bpqlist.htm>

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards. This includes ongoing independent certification of our ISO 9001 quality management system.

The PAC is also responsible for overseeing the activities of the Audit Office and conducts reviews of our operations every three years.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament and from internal sources.

For further information relating to performance auditing contact:

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Performance Audit Reports

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
65	Attorney General's Department	<i>Management of Court Waiting Times</i>	3 September 1999
66	Office of the Protective Commissioner Office of the Public Guardian	<i>Complaints and Review Processes</i>	28 September 1999
67	University of Western Sydney	<i>Administrative Arrangements</i>	17 November 1999
68	NSW Police Service	<i>Enforcement of Street Parking</i>	24 November 1999
69	Roads and Traffic Authority of NSW	<i>Planning for Road Maintenance</i>	1 December 1999
70	NSW Police Service	<i>Staff Rostering, Tasking and Allocation</i>	31 January 2000
71*	Academics' Paid Outside Work	<i>Administrative Procedures Protection of Intellectual Property Minimum Standard Checklists Better Practice Examples</i>	7 February 2000
72	Hospital Emergency Departments	<i>Delivering Services to Patients</i>	15 March 2000
73	Department of Education and Training	<i>Using Computers in Schools for Teaching and Learning</i>	7 June 2000
74	Ageing and Disability Department	<i>Group Homes for People with Disabilities in NSW</i>	27 June 2000
75	NSW Department of Transport	<i>Management of Road Passenger Transport Regulation</i>	6 September 2000
76	Judging Performance from Annual Reports	<i>Review of Eight Agencies' Annual Reports</i>	29 November 2000
77*	Reporting Performance	<i>Better Practice Guide A guide to preparing performance information for annual reports</i>	29 November 2000
78	State Rail Authority (CityRail) State Transit Authority	<i>Fare Evasion on Public Transport</i>	6 December 2000
79	TAFE NSW	<i>Review of Administration</i>	6 February 2001
80	Ambulance Service of New South Wales	<i>Readiness to Respond</i>	7 March 2001
81	Department of Housing	<i>Maintenance of Public Housing</i>	11 April 2001
82	Environment Protection Authority	<i>Controlling and Reducing Pollution from Industry</i>	18 April 2001
83	Department of Corrective Services	<i>NSW Correctional Industries</i>	13 June 2001
84	Follow-up of Performance Audits	<i>Police Response to Calls for Assistance The Levying and Collection of Land Tax Coordination of Bushfire Fighting Activities</i>	20 June 2001

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
85*	Internal Financial Reporting	<i>Internal Financial Reporting including a Better Practice Guide</i>	27 June 2001
86	Follow-up of Performance Audits	<i>The School Accountability and Improvement Model (May 1999)</i> <i>The Management of Court Waiting Times (September 1999)</i>	14 September 2001
87	E-government	<i>Use of the Internet and Related Technologies to Improve Public Sector Performance</i>	19 September 2001
88*	E-government	<i>e-ready, e-steady, e-government: e-government readiness assessment guide</i>	19 September 2001
89	Intellectual Property	<i>Management of Intellectual Property</i>	17 October 2001
90*	Intellectual Property	<i>Better Practice Guide Management of Intellectual Property</i>	17 October 2001
91	University of New South Wales	<i>Educational Testing Centre</i>	21 November 2001
92	Department of Urban Affairs and Planning	<i>Environmental Impact Assessment of Major Projects</i>	28 November 2001
93	Department of Information Technology and Management	<i>Government Property Register</i>	31 January 2002
94	State Debt Recovery Office	<i>Collecting Outstanding Fines and Penalties</i>	17 April 2002
95	Roads and Traffic Authority	<i>Managing Environmental Issues</i>	29 April 2002
96	NSW Agriculture	<i>Managing Animal Disease Emergencies</i>	8 May 2002
97	State Transit Authority Department of Transport	<i>Bus Maintenance and Bus Contracts</i>	29 May 2002
98	Risk Management	<i>Managing Risk in the NSW Public Sector</i>	19 June 2002
99	E-Government	<i>User-friendliness of Websites</i>	26 June 2002
100	NSW Police Department of Corrective Services	<i>Managing Sick Leave</i>	23 July 2002
101	Department of Land and Water Conservation	<i>Regulating the Clearing of Native Vegetation</i>	20 August 2002
102	E-government	<i>Electronic Procurement of Hospital Supplies</i>	25 September 2002
103	NSW Public Sector	<i>Outsourcing Information Technology</i>	23 October 2002
104	Ministry for the Arts Department of Community Services Department of Sport and Recreation	<i>Managing Grants</i>	4 December 2002

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
105	Department of Health Including Area Health Services and Hospitals	<i>Managing Hospital Waste</i>	10 December 2002
106	State Rail Authority	<i>CityRail Passenger Security</i>	12 February 2003
107	NSW Agriculture	<i>Implementing the Ovine Johne's Disease Program</i>	26 February 2003
108	Department of Sustainable Natural Resources Environment Protection Authority	<i>Protecting Our Rivers</i>	7 May 2003
109	Department of Education and Training	<i>Managing Teacher Performance</i>	14 May 2003
110	NSW Police	<i>The Police Assistance Line</i>	5 June 2003
111	E-Government	<i>Roads and Traffic Authority Delivering Services Online</i>	11 June 2003
112	State Rail Authority	<i>The Millennium Train Project</i>	17 June 2003
113	Sydney Water Corporation	<i>Northside Storage Tunnel Project</i>	24 July 2003
114	Ministry of Transport Premier's Department Department of Education and Training	<i>Freedom of Information</i>	28 August 2003
115	NSW Police NSW Roads and Traffic Authority	<i>Dealing with Unlicensed and Unregistered Driving</i>	4 September 2003
116	NSW Department of Health	<i>Waiting Times for Elective Surgery in Public Hospitals</i>	18 September 2003
117	Follow-up of Performance Audits	<i>Complaints and Review Processes (September 1999) Provision of Industry Assistance (December 1998)</i>	24 September 2003
118	Judging Performance from Annual Reports	<i>Review of Eight Agencies' Annual Reports</i>	1 October 2003
119	Asset Disposal	<i>Disposal of Sydney Harbour Foreshore Land</i>	26 November 2003
120	Follow-up of Performance Audits NSW Police	<i>Enforcement of Street Parking (1999) Staff Rostering, Tasking and Allocation (2000)</i>	10 December 2003
121	Department of Health NSW Ambulance Service	<i>Code Red: Hospital Emergency Departments</i>	15 December 2003
122	Follow-up of Performance Audit	<i>Controlling and Reducing Pollution from Industry (April 2001)</i>	12 May 2004
123	National Parks and Wildlife Service	<i>Managing Natural and Cultural Heritage in Parks and Reserves</i>	16 June 2004
124	Fleet Management	<i>Meeting Business Needs</i>	30 June 2004

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
125	Department of Health NSW Ambulance Service	<i>Transporting and Treating Emergency Patients</i>	28 July 2004
126	Department of Education and Training	<i>School Annual Reports</i>	15 September 2004
127	Department of Ageing, Disability and Home Care	<i>Home Care Service</i>	13 October 2004
128*	Department of Commerce	<i>Shared Corporate Services: Realising the Benefit including guidance on better practice</i>	3 November 2004
129	Follow-up of Performance Audit	<i>Environmental Impact Assessment of Major Projects (2001)</i>	1 February 2005
130*	Fraud Control	<i>Current Progress and Future Directions including guidance on better practice</i>	9 February 2005
131	Follow-up of Performance Audit Department of Housing	<i>Maintenance of Public Housing (2001)</i>	2 March 2005
132	Follow-up of Performance Audit State Debt Recovery Office	<i>Collecting Outstanding Fines and Penalties (2002)</i>	17 March 2005
133	Follow-up of Performance Audit Premier's Department	<i>Management of Intellectual Property (2001)</i>	March 2005
134	Department of Environment and Conservation	<i>Managing Air Quality</i>	6 April 2005
135	Department of Infrastructure, Planning and Natural Resources Sydney Water Corporation Sydney Catchment Authority	<i>Planning for Sydney's Water Needs</i>	4 May 2005
136	Department of Health	<i>Emergency Mental Health Services</i>	May 2005

* Better Practice Guides

Performance Audits on our website

A list of performance audits tabled or published since March 1997, as well as those currently in progress, can be found on our website <www.audit.nsw.gov.au>

If you have any problems accessing these Reports, or are seeking older Reports, please contact our Executive Officer on 9275 7220.