Healthcare in Focus

People's use and experiences of mental health care in NSW

bureau of health information

BUREAU OF HEALTH INFORMATION
Level 11, 67 Albert Avenue
Chatswood NSW 2067
Australia
Telephone: +61 2 9464 4444
bhi.nsw.gov.au

State Health Publication Number: (BHI) 190337
ISSN: 1838-6989

Suggested citation:
Bureau of Health Information. Healthcare in Focus – People's use and experiences of mental health care in NSW. Sydney (NSW): BHI; 2019.

Published August 2019
Please note that there is the potential for minor revisions of data in this report.
Please check the online version at **bhi.nsw.gov.au** for any amendments.

Table of contents

Foreword

Many Australians will experience a mental health issue at some stage of their lives, and almost every Australian will experience their effects through a family member, friend or work colleague.

Caring for people who experience mental health issues is a major focus of health services in New South Wales (NSW). Mental health services are currently undergoing major reform and improving care for people with mental health issues is the subject of significant investment.

In previous years, *Healthcare in Focus* has taken the form of a compendium-style report that endeavoured to provide a broad overview of healthcare performance in NSW.

For this ninth edition, the Bureau of Health Information (BHI) is proud to use its unique position and expertise to support a growing public interest in mental health services. For the first time, we are looking at the performance of the NSW health system through a specific lens – the use and experiences of health services by people with lived experience of mental health issues.

Mental health issues are complex. Likewise, the mental health care system in NSW is complex and involves a variety of providers delivering services across a range of settings. While this report cannot be a comprehensive analysis of whole-system performance, it represents an important first step in BHI's performance reporting in this space.

We have structured the report to reflect key service settings in which a person may receive mental health care in NSW. They include care in the community, emergency department care and inpatient care settings.

We hope the insights into how NSW mental health services are currently performing contained in this report enhance transparency for the public and accountability of the system itself. Where possible, we have highlighted areas that can inform current efforts to improve people's healthcare experiences and outcomes.

I would like to recognise and thank those people with lived experience of mental health issues who took the time to share their insights with us, particularly by participating in BHI patient surveys.

Compiling this report about mental health services has proved a challenging task. I would like to thank the BHI Healthcare in Focus Mental Health Advisory Group, whose invaluable advice and guidance has ensured a careful and thorough treatment of the issues at hand.

On behalf of BHI's Board and staff, we hope this *Healthcare in Focus* report will make a meaningful contribution to improving care for people with lived experience of mental health issues.

Dr Diane Watson
Chief Executive, Bureau of Health Information

Summary

Mental health issues can affect anyone and many Australians will experience a mental health issue at some stage of their lives. Almost every Australian will experience the effects of mental health issues in a family member, friend or work colleague.

Mental health is a major focus of health services in NSW. Depending on the complexity of their mental health issues and associated care needs, a person may use some or all of the following public services as part of their journey of care:

- Care in the community
- Emergency department (ED) care
- Inpatient care.

These care settings are the focus of this report, with each chapter including measures intended to reflect the use and experiences of health services in NSW by people with lived experience of mental health issues.

Care in the community

Care provided in the community can help people with lived experience of mental health issues to stay well, often close to home.

Primary care providers, such as general practitioners (GPs), are often the first point of contact for people seeking help for mental health issues. Across NSW, almost 800,000 people received more than 3.5 million Medicare-subsidised mental health services in 2017–18.

Specialised community mental health services, funded by state and territory governments, provide treatment in community and outpatient care settings. In 2016–17, there were more than 3.2 million publicly-funded specialised community mental health services delivered in NSW.

Key findings include:

- Nearly one in 12 people in NSW received mental health services from GPs in 2017–18.
- Use of specialised community mental health services was higher among Aboriginal patients and in very remote communities.
- Almost all adults with a mental health issue in NSW had a regular care provider, and the majority reported positive experiences.
- Adults in NSW with a mental health issue were more likely than those in comparator countries to discuss their worries and stresses with their regular care provider.
- Accessing out-of-hours care was more challenging for NSW adults with a mental health issue than those without.

Emergency department care

An ED can be an important place of care for someone who is experiencing their first symptoms of a health issue or needing immediate treatment for exacerbating symptoms of an existing issue. An ED can also be an alternative – or only – source of after-hours care. EDs may fulfil these roles for people with lived experience of mental health issues.

In 2017–18 there were more than 2.8 million ED attendances in NSW and more than 81,000 (3%) of these were mental health-related.

Key findings include:

- Mental health-related presentations grew at a faster rate than overall ED presentations, particularly among young adults.
- About one-quarter of mental health-related presentations were among patients aged 15–24 years.
- Patients who reported having a longstanding mental health condition were more likely to make multiple visits to EDs for any health issue and have less positive experiences.
- Patients with mental health-related presentations were more likely to spend more than four hours in an ED compared with patients presenting without a mental health-related issue.
- The timeliness of care and length of time spent in an ED for mental health-related presentations varied across NSW local health districts (LHDs).

Inpatient care

Some patients who require intensive support are admitted to specialised mental health inpatient units in NSW. They may receive same-day or overnight care in an acute or non-acute unit, depending on the severity of their condition and other circumstances.

In 2017–18 there were approximately 43,000 episodes of care in NSW specialised mental health inpatient units.

Key findings include:

- Mental health episodes of care in specialised inpatient units grew at a faster rate than overall admitted patient episodes, particularly among young adults.
- Almost one-quarter of overnight acute mental health-related episodes of care were experienced by patients aged 0–25 years.
- Mothers who reported a longstanding mental health condition gave less positive ratings for their experiences of maternity care.
- More than half of the episodes of care for intentional self-harm were for patients aged 15–34 years and a majority had a mental health diagnosis.
- Three-quarters of patients received community mental health services within a week of discharge.

About this report

This report contains material that may be confronting and cause sadness or distress for some readers, particularly those with lived experience of mental health issues. If you need to talk to someone, support is available.

Lifeline: Call **13 11 14** for confidential crisis support 24/7.

Beyond Blue Support Service: Call **1300 22 46 36** for advice and support 24/7.

Kids Helpline: Call **1800 55 1800** for 24/7 counselling for young people aged 5–25 years.

For the first time, the Bureau of Health Information (BHI) has made mental health care the focus of our annual report to the Minister for Health and Medical Research, the Minister for Mental Health, Regional Youth and Women and NSW Parliament on the performance of the public health system. In this *Healthcare in Focus* report we have examined people's use and experiences of mental health services to identify where NSW is performing well and where there may be opportunities to improve care.

The report looks at people's use and experiences of care with their general practitioners (GPs) and other regular care providers. It considers access to publicly-funded specialised community mental health services. It also examines people's use and experiences of care in emergency departments (EDs) and public hospitals, including specialised mental health inpatient units, across the state.

We compare people with mental health issues' use and experiences of GPs and regular care providers with international comparator countries. For other service settings we compare patients with mental health issues' use and experiences of services with patients with other health conditions and across local areas in NSW.

Where possible, and to show where differences exist, we have highlighted the following priority groups:

- children and youth
- older people (aged 65+ years)
- Aboriginal people
- people living in rural and remote locations.

Structure of the report

This report is structured around a person's journey of care through NSW's mental health care system. A person with lived experience of mental health issues may use none, some or all of the following services, depending on the complexity of their health issues and associated care needs.

Care in the community – this chapter looks at people's use and experiences of GPs and other regular care providers, and access to publicly-funded specialised community mental health services. See pages 23–39.

Emergency department care – using data from EDs in NSW public hospitals and BHI patient survey data, this chapter looks at patterns of use and experiences of care in EDs, including wait times, for people presenting with mental health issues or who report they have a longstanding mental health condition. See pages 41–59.

Inpatient care – using data from NSW public hospitals, this chapter explores patients' use and experiences of care in specialised mental health inpatient units, use of general wards for mental health care and experiences of maternity and cancer health care for people who have a current or recent mental health condition. See pages 61–79.

Our terminology

There are many ways that people interact with and experience mental health and ill health, and there is continued stigma associated with mental health issues and those who experience them.

We understand that language is a key enabler in communicating the messages and findings of this report and we have tried to use language that is inclusive and empathetic, though also precise, when using data to refer to specific population groups.

People with lived experience of mental health issues

When speaking generally about people with mental health issues – or their carers, families, kinship groups and supporting friends – who may or may not use public health services, we have used the term 'people with lived experience of mental health issues'. This is in line with language used in NSW Health's *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022* and the Mental Health Commission of NSW's *Lived Experience Framework for NSW.*

Patient

We recognise that in contemporary, recovery-oriented mental health services, the term 'patient' is no longer used. However in this report, we have used the term 'patient' when speaking about certain data to specifically reflect the population referred to in the analysis.

The term 'patient' is used if this was the data label used to describe the cohort in data collection. For example, 'publicly-funded specialised community mental health care services per 10,000 population by patient demographics'. Likewise, we use the term 'patient' to refer to people with lived experience of mental health issues who are receiving or attending a specialised mental health service, for example, a specialised mental health inpatient unit.

We also use the term 'patient' when referring to a person's legal status as a voluntary or involuntary patient under the *NSW Mental Health Act 2007* and *NSW Mental Health (Forensic Provisions) Act 1990*.

Data cohorts

When speaking about data, we use language that specifically reflects the population referred to in the analysis. For example, we say 'adults' when discussing the Commonwealth Fund International Health Policy Survey as it surveyed people aged 18+ years. We say 'adults and children' when referring to the BHI Emergency Department Patient Survey as this survey was distributed to patients of all ages.

Mental health issues

The spectrum of mental health issues is broad and complex. Some people with lived experience of mental health issues may never receive a formal diagnosis or interact with mental health care providers, while others may be diagnosed with mental health issues early in life and receive ongoing care.

In this report, we use the term 'mental health issues' to refer to a health issue that significantly affects how a person feels, thinks, behaves, and interacts with other people. We use 'mental health diagnosis' to refer to a particular mental health issue or group of issues that have been diagnosed according to standardised criteria. Following the Mental Health Commission of NSW, we have generally avoided using the terms 'mental illness' and 'mental health disorder' or 'condition', unless the instance refers to a particular report, policy, diagnostic manual or study in which these terms were used.

Measures used in the report

The measures used in this report are intended to portray patients' use and experiences of health services in the community, EDs, general wards and specialised mental health inpatient units. We have selected a broad set of measures, including descriptive statistics, key performance indicators defined by government and patient experience measures. We did not limit the report to key performance indicators defined by government, as both the national and NSW mental health commissions are reviewing those indicators to ensure their suitability for the future.

Indicator selection for this report was based on the following criteria:

meaningful – reflect NSW Health system priorities, are clinically relevant, evidence-based and cover what matters to people

comparable – with services in NSW and international comparators, or change over time

feasible – based on data that are available, timely and of sufficiently good quality

balanced – taken together, the measures are coherent and achieve balance across sectors and aspects of care

actionable – measure aspects that are amenable to change and have potential to drive health system improvement and inform decision-making

attributable – where relevant.

Data sources

To produce this report, BHI has used the following sources of data:

- The Commonwealth Fund International Health Policy Survey 2016
- Your Experience of Service (YES) Inpatient Survey 2017–18
- BHI's NSW Patient Survey Program 2017–2018, including surveys collected from patients who received care in EDs, maternity wards and outpatient cancer clinics
- NSW Health Admitted Patient Data Collection, accessed via the Health Information Exchange (HIE) and the Secure Analytics for Population Health Research and Intelligence (SAPHaRI)
- NSW Health Emergency Department Data Collection, accessed via the Health Information Exchange (HIE)
- Health and healthcare performance data already published by governments or journals. The sources of these data are indicated where appropriate.

For the statistical analyses of data published in the report, BHI used SAS/STATTM software. More information on the methods used to calculate indicators in this report is available in the Technical Supplement.

Parameters of this report

There is an enormous depth, breadth and variance in mental health issues. Not only is there a diverse range of conditions, but people's experiences of them vary within this range. It would be unwise to attempt to represent the enormous diversity of people's lived experience of mental health issues and their use of the mental health care system in a single report.

Likewise, the mental health care system in NSW is complex and involves a variety of providers delivering services across a range of settings. Any effort to compile a complete account of the performance of the mental health care system in NSW would be overwhelmed by the sheer volume of information. As such, there are several aspects of the mental health care system, and people's experiences of it, that are not included in this report.

Specific populations

The co-occurrence of mental health issues and substance misuse disorders is common. The management of co-occuring mental health issues and substance misuse requires input from both the mental health system and drug and alcohol services. People who have a diagnosed mental health issue, who may also have a substance misuse disorder, and are receiving specialised mental health services are included in our analyses. Data on people with mental health issues receiving treatment from specialised drug and alcohol services is excluded from this report.

A significant number of people with organic mental health issues, such as dementia and intellectual disability, also experience co-occuring mental health issues and access mental health services. In this report, we have included people with organic mental health issues such as dementia and intellectual disability in our data on care in the community. We have excluded these cohorts from our detailed emergency department and inpatient analyses if the organic issue was the primary reason for presentation or admission.

Australia is culturally and linguistically diverse with many residents born overseas and originating from non-English speaking countries. People from culturally and linguistically diverse (CALD) backgrounds are less likely to access mental health services. There are challenges in current data collection, such as small sample sizes, that impact the quality of information on mental health outcomes for CALD communities.[1]

Lesbian, gay, bisexual, trans, intersex and queer (LGBTIQ) Australians are at higher risk of suicidal behaviours and poorer mental health outcomes than their peers. There are gaps in the data on mental health outcomes for the LGBTIQ community. Information on sexual orientation, gender identity and intersex status, for example, may not be collected in population research and data on service provision.[2]

These specific populations have been recognised as priority populations in a number of key national and state mental health strategies. In this report, CALD and LGBTIQ people are included in our performance data however a detailed analysis of these groups is not included.

We have not focused on analysis of some populations – for example, forensic patients – accessing mental health services due to limitations in providing useful comparative analysis.

A forensic patient is a person who has: been found unfit to be tried for an offence and ordered to be detained in a correctional centre, mental health facility or other place or; been found not guilty by reason of mental illness and ordered to be detained in a correctional centre, mental health facility or other place or released into the community subject to conditions.

Forensic patients progress through the forensic mental health system at a different rate to people in the general mental health system. Admission length in the forensic system tends to be measured in months and years rather than days or weeks. Given this different model of care, Justice Health and Forensic Mental Health Network – the principal service provider and coordinating agency for forensic mental health services in NSW – has been excluded from charts that compare local health district (LHD) results in this report. Forensic patients have, however, been counted in our totals for the care in the community and inpatient care chapters. Correctional patients – that is, inmates (adult) or detainees (juvenile) who have been admitted to a mental health facility after being transferred from a correctional or detention centre – are also included in the inpatient totals.

Available data

The data landscape in health can be challenging. There are gaps in data collection and availability for parts of the health sector which prevent comprehensive monitoring and reporting on certain programs and initiatives, and determining whether desirable outcomes are being achieved. For example, there is currently no readily available, nationally consistent data on mental health care provided by healthcare professionals funded by the Commonwealth Government.

Mental health services in NSW collect and report comprehensive data for many key issues. For example, mental health services in NSW have implemented a State Unique Patient Identifier (SUPI) for mental health care, allowing measures of continuity of care between hospital and community services and between LHDs. There is also ongoing work to further develop data collection within the mental health sector. The NSW Ministry of Health, for example, is continuing its efforts to reach more people using specialised community mental health services through its Your Experience of Service (YES) survey.[3]

Private sector

The private health sector provides professional fee-based mental health services. These services include primary care, acute management, rehabilitation, psychological interventions and other allied health-based supports. There are numerous private mental health inpatient units across NSW that are licensed under the *NSW Private Health Facilities Act 2007* and *Private Health Facilities Regulation 2017.* The NSW Ministry of Health monitors these facilities to ensure compliance with these licensing standards. Data on private mental health inpatient facilities are not included in this report but are available through the Australian Private Hospitals Association (APHA)'s Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS).

Current public reporting

There are a number of established measures and reports focusing on elements of the mental health system that are not covered in this report. The Australian Institute of Health and Welfare (AIHW), for instance, publishes a wide range of indicators of activity and performance including Pharmaceutical Benefits Scheme (PBS) data related to mental health that is not reproduced in this report.

We have endeavoured to select indicators that encompass different perspectives, such as patient experience, to allow for the measurement of the mental health system's processes, outcomes and structures. In the future, and with the development of more sophisticated and comprehensive data collections, BHI will re-assess the mental health indicators included in our regular reporting.

Context

There are many different types of mental health issues and they can affect anyone. It is estimated that almost half of the Australian population aged 16–85 years (45%) will experience a mental health issue at some time in their life. One in five Australians aged 16–85 years (20%) are estimated to have experienced a common mental health issue in the past 12 months.[4]

Almost every Australian will experience the effects of mental health issues in a family member, friend or work colleague. It is a major focus of health services in Australia.

There is enormous variation in the complexity and severity of mental health issues. They can include: psychotic disorders such as schizophrenia; mood disorders such as depression and bipolar disorder; and anxiety disorders such as obsessive-compulsive disorder.

People of all ages and backgrounds can experience mental health issues but studies show there is an increased prevalence among some groups. In around half of all cases, symptoms begin by 14 years of age and in three-quarters of cases, by 24 years of age.[5] Some groups of children and young people are at increased risk of mental health issues including those who: have a parent with a mental health issue; are Aboriginal; or have experienced abuse or neglect.[6]

Treatment for people with severe mental health issues, such as schizophrenia and extreme cases of depression and anxiety disorders, account for about 80% of expenditure on mental health in Australia.[7] While nearly 20% of people will experience a mental health issue in any 12-month period, it is estimated that around 3% of adults will experience a severe mental illness.[8]

Delivery of mental health care services in NSW

Mental health clinical and community support services are delivered by a range of providers across a number of settings in NSW. The Commonwealth and NSW governments, public sector agencies, private sector and community-managed organisations (CMOs) all contribute to the delivery of care and support for people with lived experience of mental health issues across the state. Funding for mental health services comes from a combination of national, state, insurance and out-of-pocket sources.

The Commonwealth Government funds the Medicare Benefits Schedule (MBS) and the Better Access initiative, which provide people with mild and moderate mental health issues access to mental health professionals. The Commonwealth also funds 10 primary health networks (PHNs) in NSW. PHNs plan and coordinate Commonwealth-funded mental health services and commission some primary health, suicide prevention and aftercare services from other providers.

The NSW Health mental health system is largely oriented towards people who experience severe and complex mental health issues. NSW Health provides specialised mental health services through its 15 local health districts (LHDs) and three specialty health networks – Justice Health and Forensic Mental Health Network, Sydney Children's Hospitals Network and St Vincent's Health Network. It also delivers these services through funding for the community-managed sector.

Some of the key specialised mental health clinical services NSW Health provides include acute assessment and treatment services, and continuing care and rehabilitation services. These can be provided in hospital and community settings. There are also specialised clinical services for particular cohorts, such as children and young people, mothers and babies, older people, and forensic patients.

People with lived experience of mental health issues may also require support through housing and employment services, disability, drug and alcohol services and physical healthcare services. NSW Health funds CMOs to deliver a range of targeted treatment, psychosocial rehabilitation, accommodation and housing support, and recovery and disability support programs.

Specialised clinical and community mental health services may also partner with primary care and CMO services to prevent relapse and support people as they move to lower intensity care.

The mental health sector is linked with other healthcare providers such as general hospital and drug and alcohol services and Aboriginal Community Controlled Health Organisations (ACCHOs). ACCHOs are not-for-profit organisations that deliver a range of services and programs within culturally appropriate models of care and under Aboriginal and Torres Strait Islander governance structures. Services are also delivered through collaboration with a range of government agencies responsible for housing, education, family services and the criminal justice system.

Together, these services assist the efforts people with lived experience of mental health issues make in their recovery. Family, carers, kinship groups, support people and communities also provide significant support.

Principles of mental health care in NSW

Recovery-oriented and trauma-informed mental health practices are recognised by NSW Health as a key philosophy for the delivery of mental health services.[9] Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.[10] Trauma-informed practice is also person-centred and sensitive to people's particular needs, preferences, safety, vulnerabilities and wellbeing. Recovery-oriented and trauma-informed mental health practices respect the experience, expertise and strengths people contribute, empowering them to participate in decision-making.[11]

The principle of care in the least restrictive environment is also an important element in the delivery of mental health services in NSW. The *NSW Mental Health Act 2007* requires that people with mental health issues receive the best care and treatment in the least restrictive environment possible. For the majority of people with lived experience of mental health issues, treatment is best provided in the community.

In situations where there is no less restrictive way to protect a person's health and safety, involuntary treatment may be required. Involuntary treatment is where a person is treated for their mental health issues without their consent and under mental health legislation, either in hospital or the community. Involuntary treatment may still be recovery-oriented when a person is supported to regain their capacity to make informed decisions.[10]

The principle of integrated service delivery is a key aim of mental health service planning in NSW. Integrated care endeavours to improve the experience of care for people with lived experience of mental health issues and their families and carers. It aims to support links between hospitals, primary care and community services, as well as those between mental health and generalist health and community services. An integrated system of care helps people with lived experience of mental health issues move between care settings, providing the appropriate care based on the individual's needs. Integrated service delivery also fosters joint planning and delivery of mental health services across levels of government, for example, between PHNs and LHDs and with community-managed sectors.[12]

These principles of mental health practice and service delivery are recognised in a number of key national and state mental health strategies and programs for reform. These include the:

- *Equally Well Consensus Statement*
- *Fifth National Mental Health Plan and Suicide Prevention Plan*
- NSW Government's Mental Health Reform agenda
- NSW Health's *NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022*
- NSW Government's *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*
- Mental Health Commission of NSW's *Living Well: A Strategic Plan for Mental Health in NSW 2014–2024.*

Settings for mental health service delivery

This report is structured around the services accessed by people with mental health issues and their experiences of care. Every person has their own diverse experience within the mental health care system, but some key areas of service delivery can be identified.

Care in the community

Care provided in the community can help people with lived experience of mental health issues to stay well, often close to home.

Primary care is an important care location for the prevention, diagnosis and ongoing management of mental health issues. Early diagnosis of a mental health issue and subsequent treatment can reduce the impact of the issue and support recovery.

Primary care providers, such as general practitioners (GPs), are often the first point of contact for people seeking help for mental health issues. Primary care providers deliver a variety of mental health care services to people in need, and may refer patients on to specialised services.

Primary care mental health services are often funded by the Commonwealth Government MBS and the Better Access initiative and are commissioned by PHNs. PHNs plan and coordinate Commonwealth funded mental health services and are responsible for supporting service integration with LHDs across Australia. Primary care may also be delivered through community-managed organisations such as ACCHOs.

Specialised community mental health services provide services to people with lived experience of mental health issues who are not currently admitted to a mental health inpatient or residential service. Specialised community mental health services are delivered by health professionals with specialist mental health qualifications or training.[13]

Specialised community mental health services primarily provide treatment, rehabilitation or community health support. Specialised community mental health services range, for example, from 24/7 emergency ‘acute support’ for immediate intervention and triage to an appropriate care setting, to regularly scheduled social and living skills programs in the community.

Specialised community mental health services may be delivered at a community centre, a person's home or an outpatient clinic on a hospital campus. They may be conducted either with an individual person or a group and can involve carers and family members. Services can be delivered face-to-face, via telephone or through video link.

For some people with lived experience of mental health issues who are leaving inpatient care or, in some cases, care in the ED, specialised community mental health services are arranged by the LHD as part of an ongoing care plan. Primary care providers may also refer a person to a specialised community mental health service. Not all people with lived experience of mental health issues who access specialised community mental health services will have been admitted for inpatient mental health care.

In addition to these specialised services, community-based mental health support services are delivered by the community-managed sector. Community-managed organisations (CMOs) are not-for-profit, non-government organisations that are governed by a board. Services delivered by CMOs include supported accommodation, daily living support, recovery programs, community connection, and suicide prevention or aftercare to help people with mental health issues to recover and live in the community. Many of these CMO services are partially or fully funded by NSW Health.

Emergency department care

People with mental health issues may also go to an emergency department (ED) for treatment, for example, if they require care outside of regular working hours. This could be due to mental health issues or the often higher risk of physical illness that people with mental health issues face.

EDs provide assessment and triage of people with mental health issues and can help stabilise someone who is acutely unwell. EDs also assess physical health conditions or injuries that may be associated with mental health issues. They provide health assessments for patients who are under the care of the Justice Health and Forensic Mental Health Network. Patients can be assessed for alternative causes of mental health symptoms, such as a neurological event – for example, a stroke.

Depending on the ED, staffing and models of care may vary. Most major EDs have specialised mental health clinicians on site or visiting. They provide risk assessments, treatment and manage interventions for patients presenting with mental health issues.

Some hospitals have co-located Psychiatric Emergency Care Centres (PECCs) that operate alongside the ED to provide targeted specialised care for those with lived experience of mental health issues. People with more severe mental health issues who require more extensive care can be referred from the ED to inpatient units, including specialised mental health inpatient units.

Inpatient care

Acute and non-acute inpatient services are available to people with mental health issues depending on the severity of their issue and other circumstances. Admissions to specialised mental health inpatient units in NSW are subject to the *NSW Mental Health Act 2007.* The Act aims to ensure that people receive the best possible care and treatment in the least restrictive way.

A person can be admitted to a specialised mental health inpatient unit voluntarily or involuntarily. A person can be admitted voluntarily if an authorised medical officer is satisfied that they are likely to benefit from care and treatment at the facility and the person agrees to be admitted. A person can also be admitted involuntarily, or against their will, to a specialised mental health inpatient unit. The Act sets out strict criteria that must be met to admit someone involuntarily.

A person can only undergo involuntary assessment for admission, or be admitted involuntarily, to a declared mental health facility. Declared facilities are categorised into three classes: mental health emergency assessment class, mental health assessment and inpatient treatment class, and community or healthcare agency class.

Hospitals can have different types of specialised mental health inpatient units to treat people with varying severity of symptoms. Across the state, there are specific units to support the needs of children and adolescents, adults, people aged 65+ years and forensic patients.

Mental Health Intensive Care Units (MHICUs) provide treatment for people with the most severe and complex issues who have been referred by other specialised mental health inpatient units across NSW. MHICUs provide specialised, intensive multidisciplinary care to people with high levels of clinical complexity and risk that cannot be safely and effectively managed in other specialised mental health acute inpatient units.

Non-acute inpatient services provide voluntary and involuntary care. There are a small number of specialised mental health non-acute inpatient units that are used by forensic patients. These services provide rehabilitation programs for people who have improved symptoms but are either still unwell, or cannot go home as they do not have the necessary supports in their community. People can be referred to a specialised mental health non-acute inpatient unit from a specialised mental health acute inpatient unit or via their specialised community mental health team. LHDs manage specialised mental health non-acute inpatient units for children and adolescents, adults, older people and forensic patients.


Care in the community
Emergency department care
Inpatient care

Care in the community

Care provided in the community can help people with lived experience of mental health issues to stay well, often close to home.

Primary care assists in the prevention, diagnosis and ongoing management of mental health issues. Specialised community mental health services provide essential treatment, rehabilitation or community health support for people with lived experience of mental health issues.

Mental health services provided in the community help to keep people well and reduce presentations to emergency departments (EDs) and admissions to hospital. They also support people to remain in the community after discharge and re-engage with work, training and education, community and family life. Hospitals are important, but they are primarily for urgent, complex cases that require intensive treatment.

This chapter describes Medicare-subsidised mental health-specific services funded by the Commonwealth Government and specialised community mental health care services funded by NSW Health. It also includes people's experiences with regular care providers.

Key findings of this chapter

- Nearly one in 12 people in NSW received mental health services from general practitioners (GPs) in 2017–18.
- Use of specialised community mental health services was higher among Aboriginal patients and in very remote communities.
- Almost all adults with a mental health issue in NSW had a regular care provider, and the majority reported positive experiences.
- Adults in NSW with a mental health issue were more likely than those in comparator countries to discuss their worries and stresses with their regular care provider.
- Accessing out-of-hours care was more challenging for NSW adults with a mental health issue than those without.

Use of Medicare-subsidised mental health services

Nearly one in 12 people in NSW received mental health services from general practitioners in 2017–18

When first experiencing symptoms of a mental health issue, people often seek help from their general practitioner (GP) or health professional. These services can provide early diagnosis and treatment to help people manage their mental health, while referring those who need more specialised treatment to other service providers.

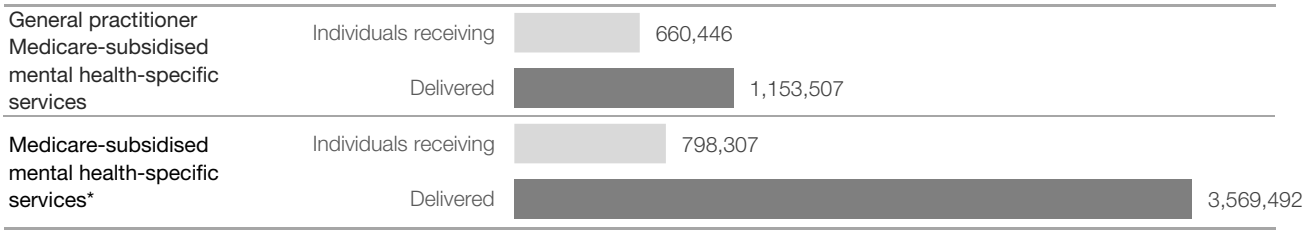
In 2017–18, 660,446 people received Medicare-subsidised mental health-specific services from GPs – more than 8%, or nearly one in 12 of the NSW population. They received almost 1.2 million services, or almost two per person (Figure 1). These services include, for example, an appointment with a GP for a mental health-related prescription.

Across NSW, 798,307 people received a total of 3,569,492 Medicare-subsidised mental health-specific services in 2017–18. This included services provided by GPs, psychiatrists, psychologists and other health professionals (Figure 1).

The majority of mental health issues arise before the age of 25[5], so access to mental health services is particularly important for young people.

More than 196,000 people in NSW aged 0–24 years received Medicare-subsidised mental health-specific services, excluding psychiatrists, in 2017–18 – or 8% of all NSW children and young people aged 0–24 (Figure 2). Young people who used the services were more likely to be female, Aboriginal, and come from inner regional areas (Figure 3).

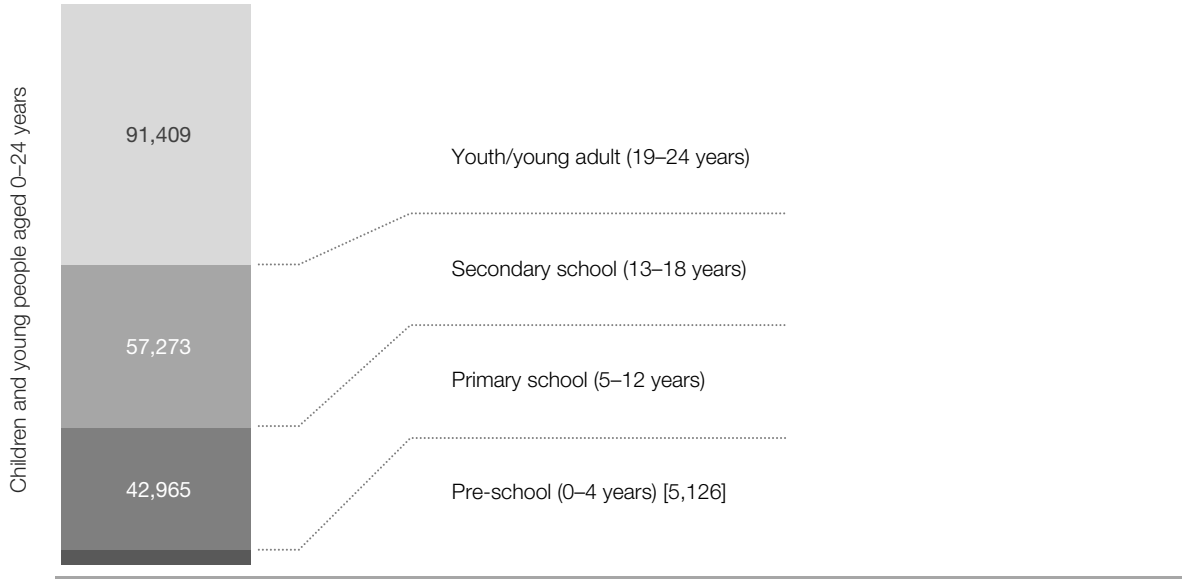
Figure 1 **Number of Medicare-subsidised mental health-specific services received by individuals and number of services delivered, NSW, 2017–18**



*Medicare-subsidised mental health-specific services include psychiatrists, GPs, psychologists and other health professionals.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Medicare-subsidised mental health-specific services.

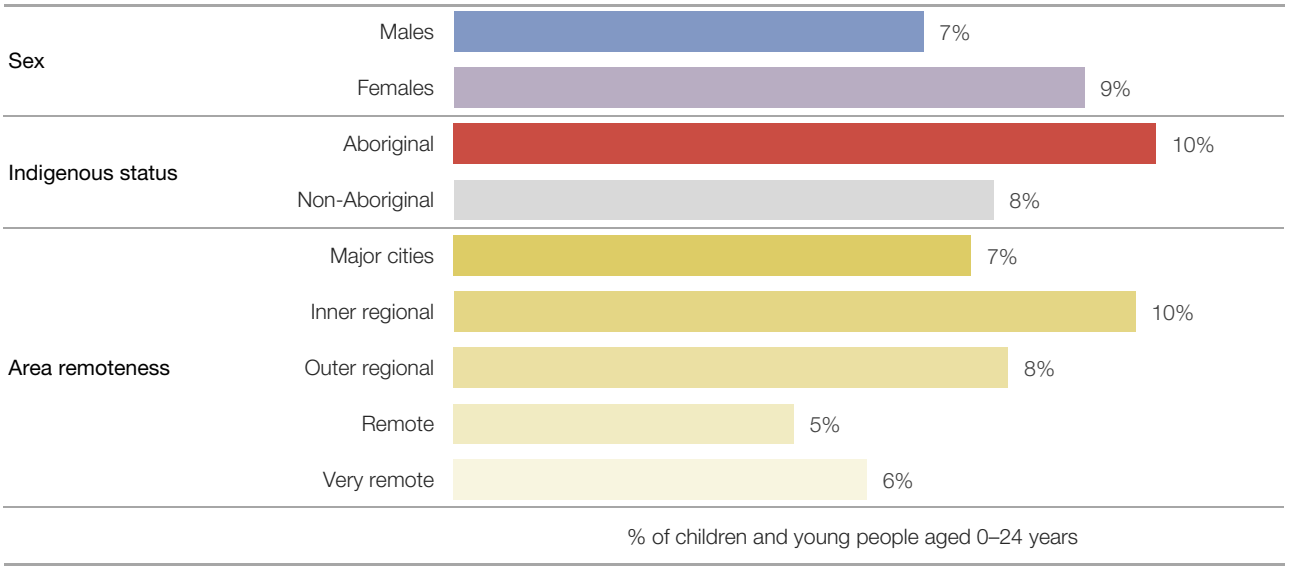
Figure 2 **Number of individuals aged 0–24 years who received Medicare-subsidised mental health-specific services, excluding psychiatrists, NSW, 2017–18**



Note: This figure includes Medicare Benefits Schedule funded services only and does not include Commonwealth services funded through other schemes.

Source: Productivity Commission Report on Government Services 2019, Part E, Chapter 13: Mental health management.

Figure 3 **Percentage of individuals aged 0–24 years who received Medicare-subsidised mental health-specific services, excluding psychiatrists, by patient characteristics, NSW, 2017–18**



Note: This figure includes Medicare Benefits Schedule funded services only and does not include Commonwealth services funded through other schemes. Geographical classifications are based on the Australian Statistical Geography Standard (ASGS) 2011. The ASGS classifies Australia into large regions that share common characteristics of remoteness. It is based on calculated road distances to the nearest service centres in five categories of population size.

Source: Productivity Commission Report on Government Services 2019, Part E, Chapter 13: Mental health management

Use of specialised community mental health services over time

More than 3.2 million publicly-funded specialised community mental health services were delivered in NSW in 2016–17

In NSW, people with lived experience of mental health issues have access to a variety of specialised community mental health services provided by the state that aim to keep people well.

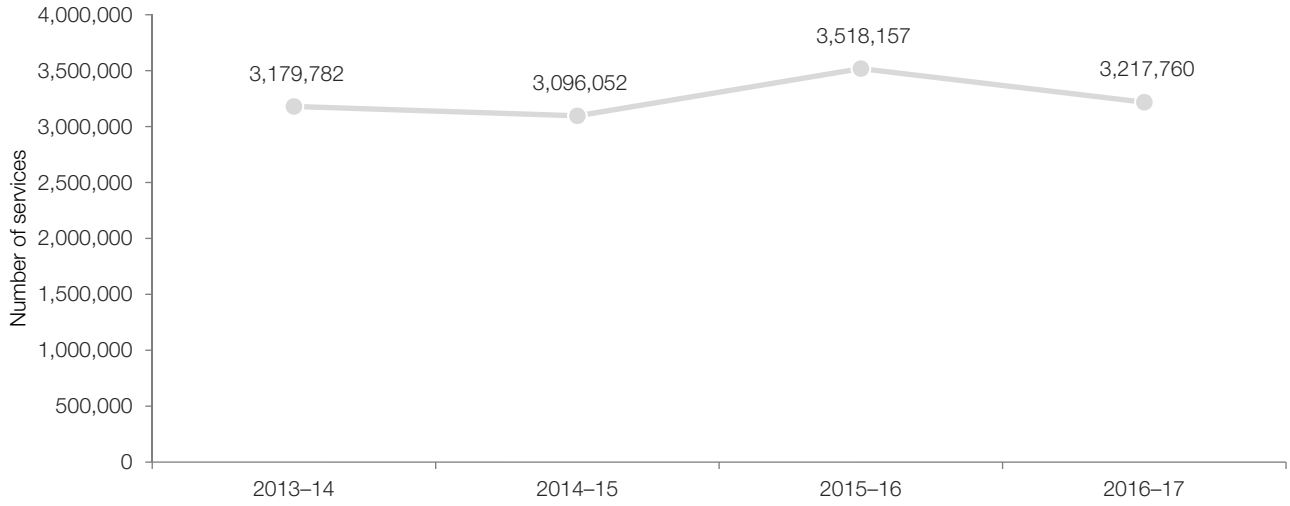
These services may include crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services. They may be delivered in community health centres, a person's home or an outpatient clinic.

In 2016–17, there were more than 3.2 million publicly-funded specialised community mental health services delivered in NSW. These include services delivered by a specialised mental health service provider, for example, an appointment with a mental health nurse. Between 2013–14 and 2016–17, the number of services delivered shifted each year (Figure 4).

The average number of services per patient was 25 in 2016–17, broadly similar to the 26 services per patient in 2013–14. The average number of treatment days per patient in 2016–17 was also similar to the number in 2013–14 (Figure 4).

The Mental Health Review Tribunal can authorise involuntary care for patients with mental health issues who are living in the community. The percentage of services for these involuntary patients, out of all services, has remained relatively stable. From 2013–14 to 2016–17, 8–9% of services were for involuntary patients, while the total number of services for both involuntary and voluntary patients increased by 3% (Figure 5).

Figure 4 **Number of publicly-funded specialised community mental health care services, NSW, 2013–14 to 2016–17**

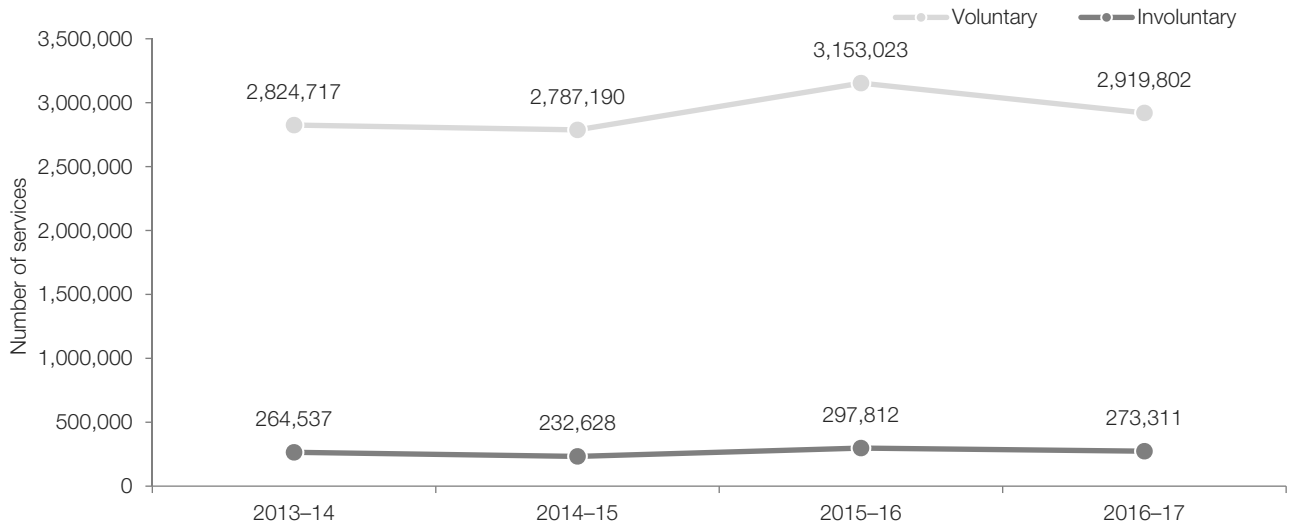


	2013–14	2014–15	2015–16	2016–17
Average services per patient	26.1	25	27.6	25.1
Average treatment days per patient	18.6	18.4	19.6	18

Note: In 2016–17, NSW reported reduced data coverage. The observed reductions in both services and patient numbers are considered to be primarily due to these missing data. This data includes specialised community (also termed 'ambulatory') mental health services that deliver clinical care and are administered or funded by the State Government. It does not include: admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services), and services provided by community-managed organisations and residential care services.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Community mental health care services.

Figure 5 **Number of publicly-funded specialised community mental health care services, by legal status, NSW, 2013–14 to 2016–17**



Note: Not included in this chart are the number where the 'treatment status' was missing, this means that the total number of services in this chart will not equal the total in Figure 4. In 2016–17, NSW reported reduced data coverage. The observed reductions in both services and patient numbers are considered to be primarily due to these missing data. This data includes specialised community (also termed 'ambulatory') mental health services that deliver clinical care and are administered or funded by the State Government. It does not include: admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services), and services provided by community-managed organisations and residential care services.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Community mental health care services.

Use of specialised community mental health services by demographic

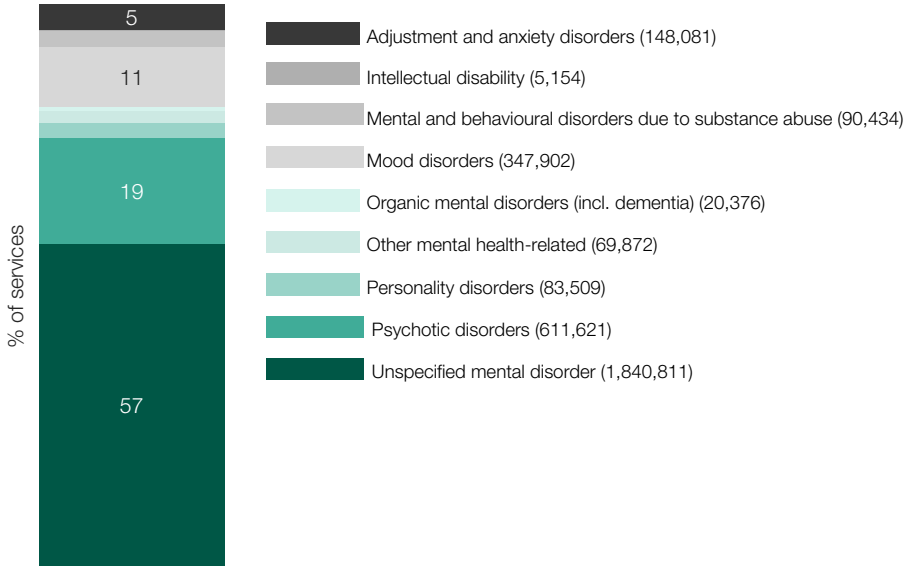
Use of specialised community mental health services was higher among Aboriginal patients and in very remote communities.

In 2016–17 more than half of publicly-funded specialised community mental health care services in NSW (57%) were provided to patients recorded as having an unspecified mental disorder.

An additional 38% of publicly-funded specialised community mental health care services were provided to patients diagnosed with psychotic disorders, mood disorders, adjustment and anxiety disorders, and personality disorders (Figure 6).

In 2016–17 specialised community mental health care service usage rates per 10,000 population were higher for men than women (Figure 7) and disproportionately high for Aboriginal patients and those in very remote areas (Figure 8).

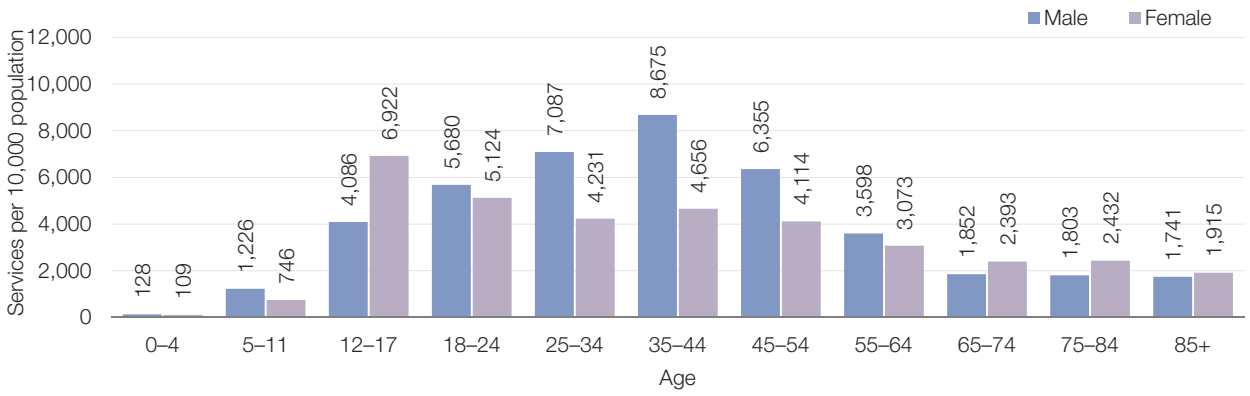
Figure 6 **Percentage of publicly-funded specialised community mental health care services by principal diagnosis, NSW, 2016–17**



Note: The quality of principal diagnosis data may be affected by the variability in collection and coding practices. This may include differences according to the size of the facility (for example, large versus small) and differences in the availability of appropriately qualified clinicians to assign principal diagnoses (diagnoses are generally to be made by psychiatrists, whereas service contacts are mainly provided by non-psychiatrists). Information on the diagnostic grouping is specified in the Technical Supplement to this report. Specialised community mental health services provide brief or crises contacts and patients receiving these may not have a diagnosis recorded. It does not include: admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services), and services provided by community-managed organisations and residential care services.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Community mental health care services.

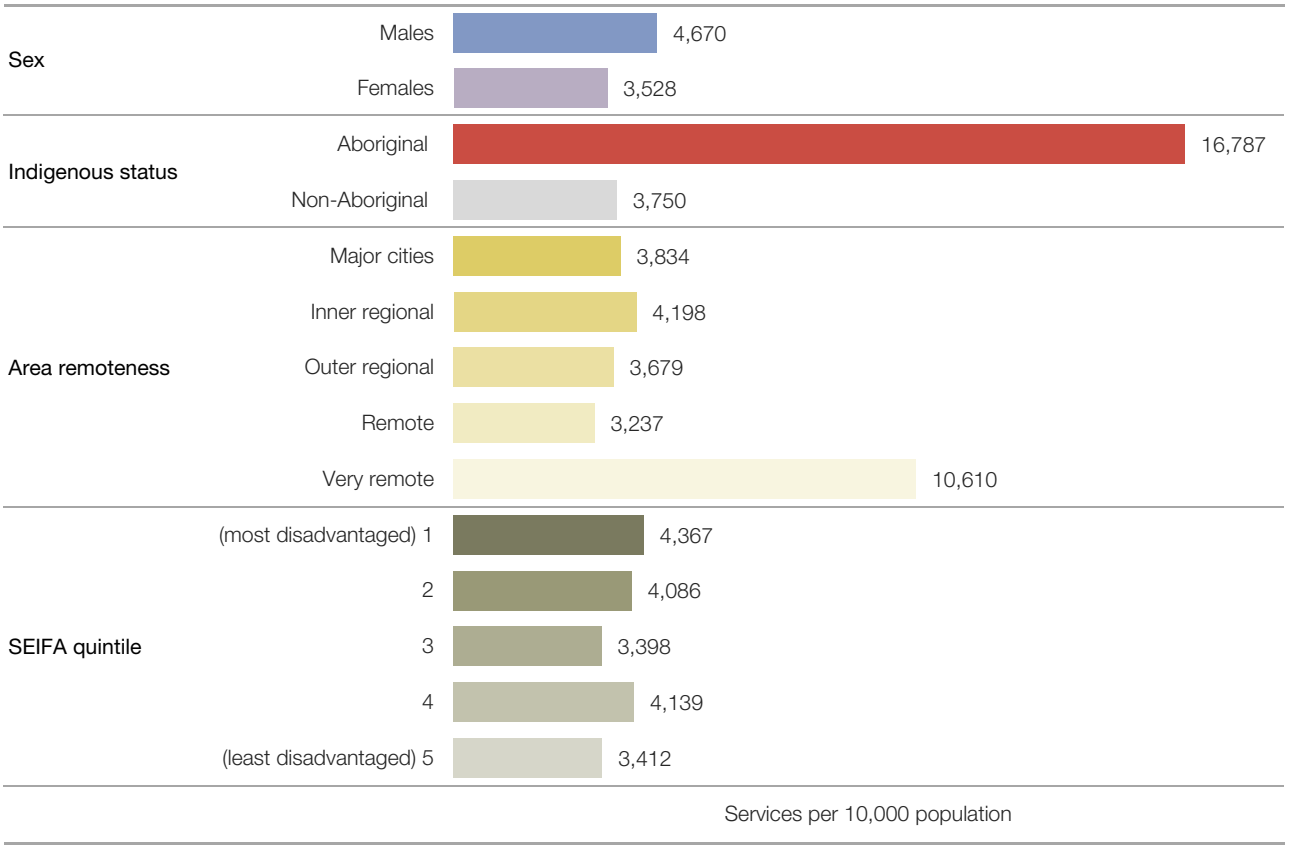
Figure 7 **Publicly-funded specialised community mental health care services per 10,000 population, by age and sex, NSW, 2016–17**



Note: This data includes specialised community (also termed 'ambulatory') mental health services that deliver clinical care and are administered or funded by the State Government. It does not include: admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services), and services provided by community-managed organisations and residential care services.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Community mental health care services.

Figure 8 **Publicly-funded specialised community mental health care services per 10,000 population, by patient demographic, NSW, 2016–17**



Note: Please refer to the Australian Bureau of Statistics (ABS) for more information on Socio-Economic Indexes for Areas (SEIFA). Please refer to the community mental health care, National Community Mental Health Care Database 2016–2017 Quality Statement 2018, for information on Indigenous status data. This data includes specialised community (also termed 'ambulatory') mental health services that deliver clinical care and are administered or funded by the State Government. It does not include: admitted patient mental health care services, support services that are not specialised mental health care services (e.g. accommodation support services), and services provided by community-managed organisations and residential care services.

Source: Australian Institute of Health and Welfare, Mental health services in Australia: Community mental health care services.

Experiences with regular care providers

Almost all adults with a mental health issue had a regular care provider

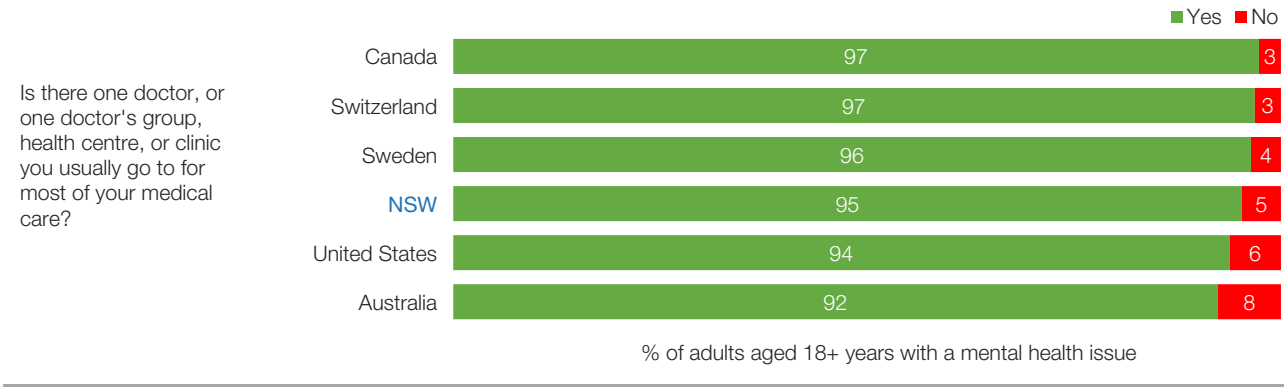
Having a regular GP or other care provider can help people access the mental health care system. A longer history with the same care provider improves opportunities to benefit from continuity of care. Almost all adults with a mental health issue in NSW (95%) report having a regular doctor or place of care (Figure 9).

When asked how they would rate the overall care provided by their GP, almost half of NSW adults with a mental health issue said 'excellent'. This was the highest rating among comparator countries (Figure 10).

More adults in NSW with a mental health issue rated their GP's care as 'excellent' than adults without a mental health issue (49% compared with 40%). However, at the other end of the scale, they were also more likely to rate care as 'fair or poor' than adults without a mental health issue (6% compared with 2%) (Figure 11).

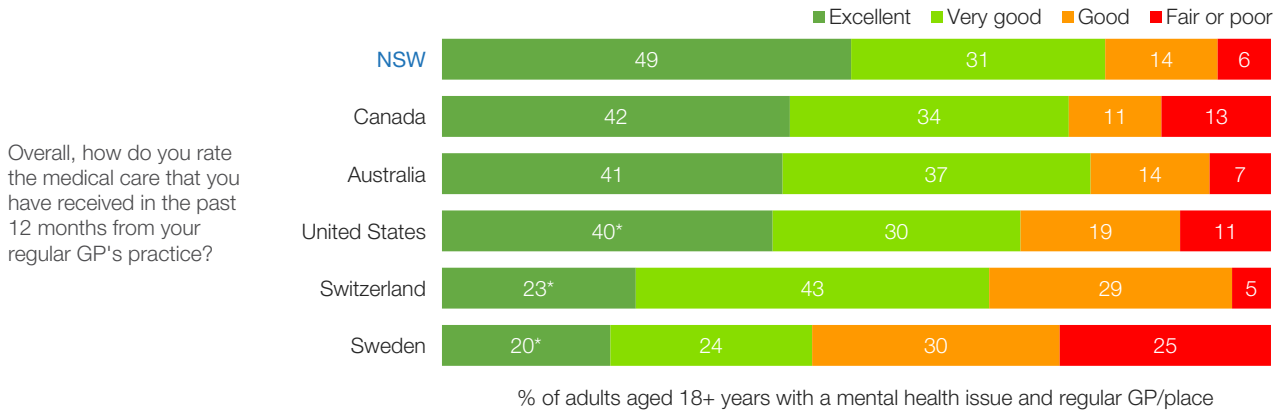
Other published evidence has shown that when adjusting the same dataset for age, sex, income, immigrant status and self-rated health, the results narrow somewhat, but the gaps remain significant in almost all cases.[14]

Figure 9 **Presence of a regular doctor or place of care, adults with a mental health issue, NSW and comparator countries, 2016**



Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.
Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 10 **Overall ratings of medical care received from regular GP practice in the past 12 months, adults with a mental health issue, NSW and comparator countries, 2016**

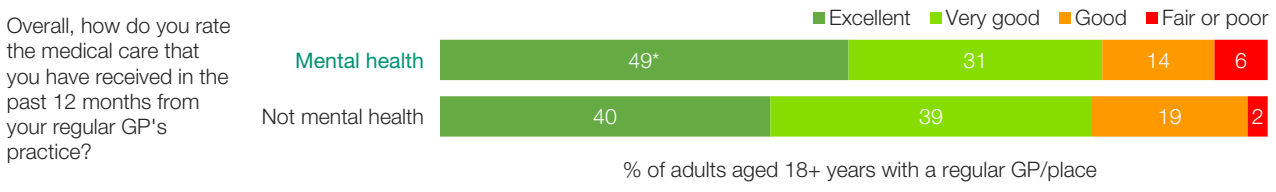


*Comparator countries significantly different from NSW.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems. Numbers may not sum to 100 due to rounding.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 11 **Overall ratings of medical care received from regular GP practice in the past 12 months, adults with and without a mental health issue, NSW, 2016**



*Significantly different result for those with a mental health issue compared with those with no mental health issue.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Support for healthy living

Adults in NSW with a mental health issue were more likely than those in comparator countries to discuss worries and stresses with their regular care provider

People with lived experience of mental health issues have significantly higher rates of physical health problems, poorer health outcomes and a lower life expectancy than the general population.[15] An important part of the support people with these experiences receive is appropriate advice, assessments and counselling about their physical health to help address potential issues associated with their mental health.

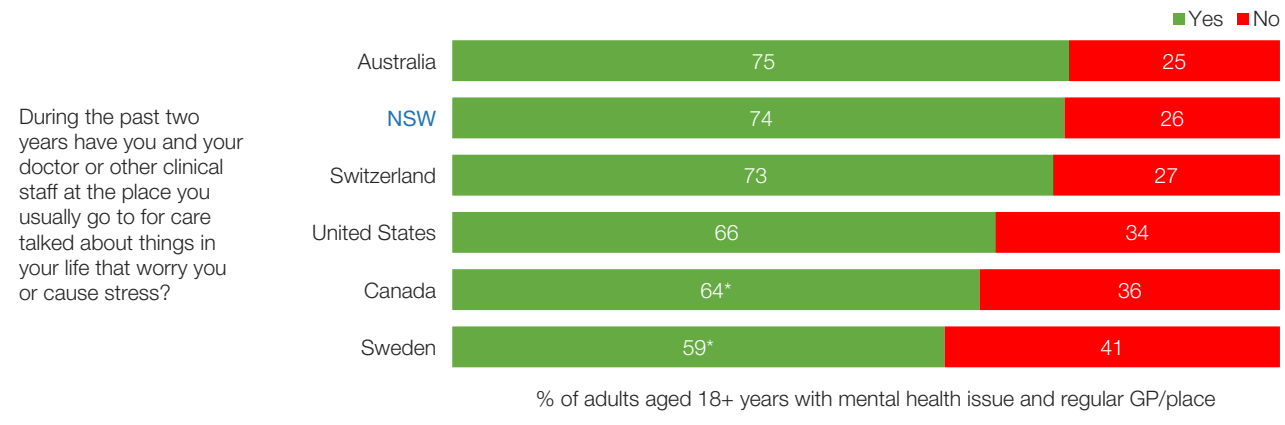
In 2016, almost three-quarters of NSW adults with a mental health issue (74%) said they had discussed things that worry them and cause them stress with their regular care provider. This was among the highest among comparator countries (Figure 12).

NSW adults with a mental health issue were almost three times as likely as those without to have discussed with their regular care provider things that worry them or cause them stress (74% compared with 27%) (Figure 13).

Around one-third of people with a mental health issue (35%) said a health professional discussed alcohol use with them; this was higher than for those without a mental health issue (24%) (Figure 13).

Prescription medication is often part of treatment for a mental health issue. Regular reviews of medication help support safe and effective use of these treatments. Almost eight in 10 NSW adults with a mental health issue who were on two or more prescription medications (78%) said they had their medications reviewed. This was similar to that reported by adults without a mental health issue (81%) (Figure 14).

Figure 12 **Discussions relating to stress with doctor or other clinical staff in regular place of care, adults with a mental health issue, NSW and comparator countries, 2016**

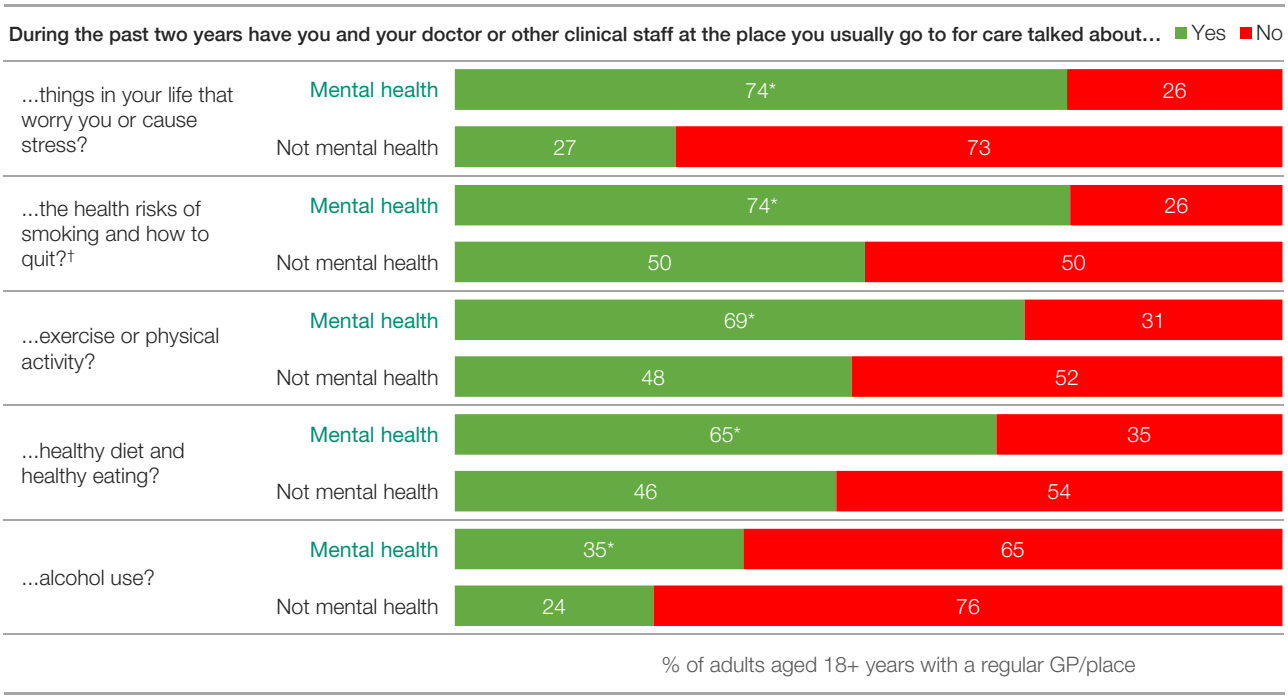


*Comparator countries significantly different from NSW.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 13 **Health promotion topics discussed with doctor or clinical staff in regular place of care, adults with and without a mental health issue, NSW, 2016**



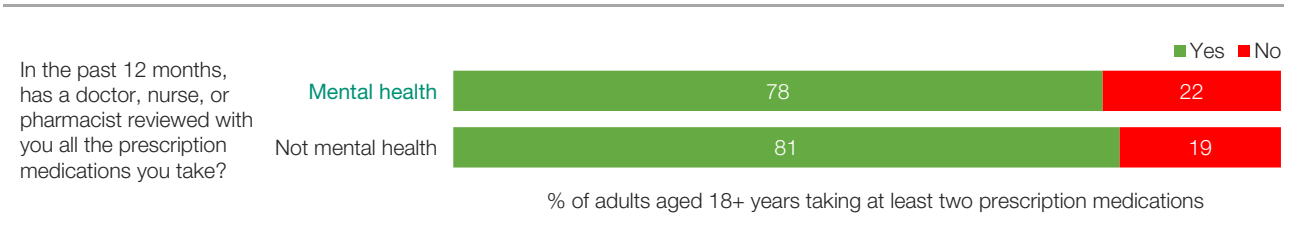
*Significantly different result for those with a mental health issue compared with those with no mental health issue.

† Asked of those who smoke.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 14 **Prescription medication reviewed within past 12 months, adults with and without a mental health issue using two or more prescription medications, NSW, 2016**



Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Seeking help for emotional distress

More than one in 10 adults in emotional distress could not get professional help when they needed it

People can experience emotional distress whether or not they have a diagnosed mental health issue. Some people may not choose to seek help. Factors behind choosing not to seek help may include: not knowing that treatment or advice is available; uncertainty about where to seek help; lack of socially and culturally appropriate services in the area; direct costs such as gap payments; and indirect costs such as transportation or loss of income.

In 2016, 16% of all adults in NSW said they experienced emotional distress, such as anxiety or sadness, and felt it was difficult to cope. This was lower than in all comparator countries.

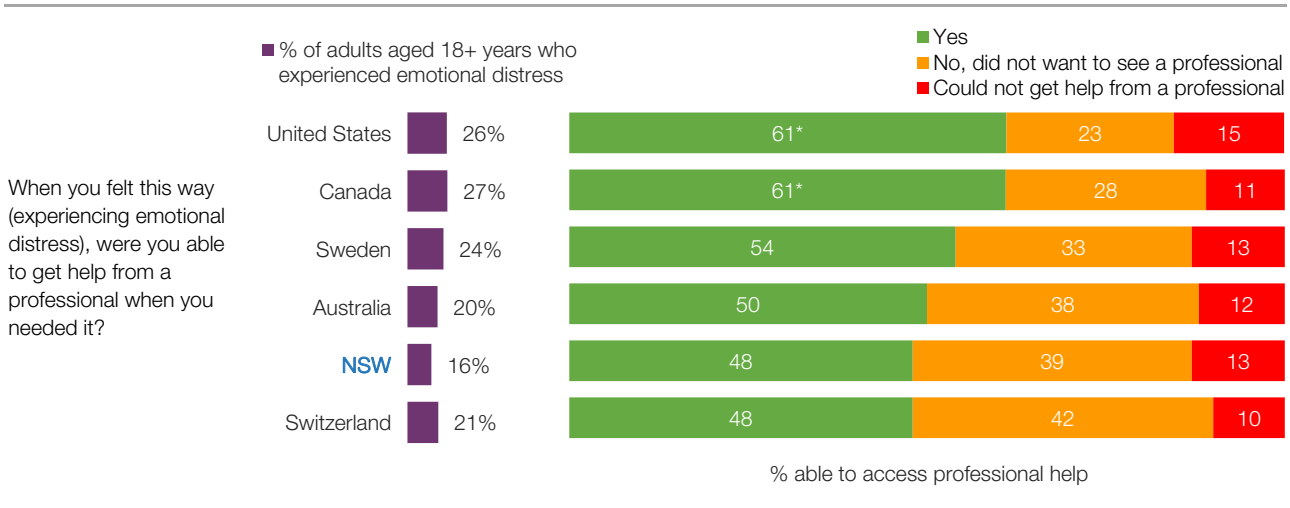
Almost half of the adults in NSW who experienced emotional distress (48%) said they were able to get help from a professional when needed. The United States and Canada had a significantly higher percentage of adults who said they could get help from a professional when needed (both 61%). In NSW and comparator countries, at least one in 10 adults who experienced emotional distress said they could not get help when needed (Figure 15).

In NSW, 64% of adults who said they had been diagnosed with a mental health issue said they experienced distress, compared with 10% of those without an issue (data not shown).

Adults with a mental health issue were significantly more likely to seek and receive help when they needed it (72% compared with 30% of those with no mental health issue). A higher percentage of NSW adults without a mental health issue said they did not want to see a professional (57% compared with 15%). Adults with a mental health issue were as likely as those without an issue to report not being able to get help from a professional when they needed it (13%) (Figure 16).

More adults in metropolitan areas than rural areas (15% compared with 11%), and more older adults aged 65+ years than those aged 18–49 years (15% compared with 12%) said they were unable to access help when experiencing emotional distress (Figure 17).

Figure 15 **Ability to access professional help when experiencing emotional distress, adults aged 18+ years, NSW and comparator countries, 2016**

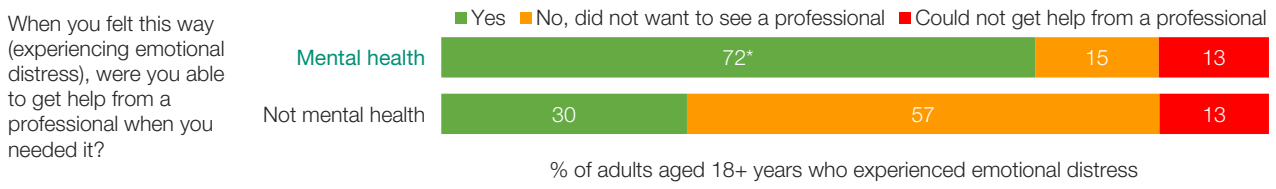


*Comparator countries significantly different from NSW.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 16 **Ability to access professional help when experiencing emotional distress, adults with and without a mental health issue, NSW, 2016**

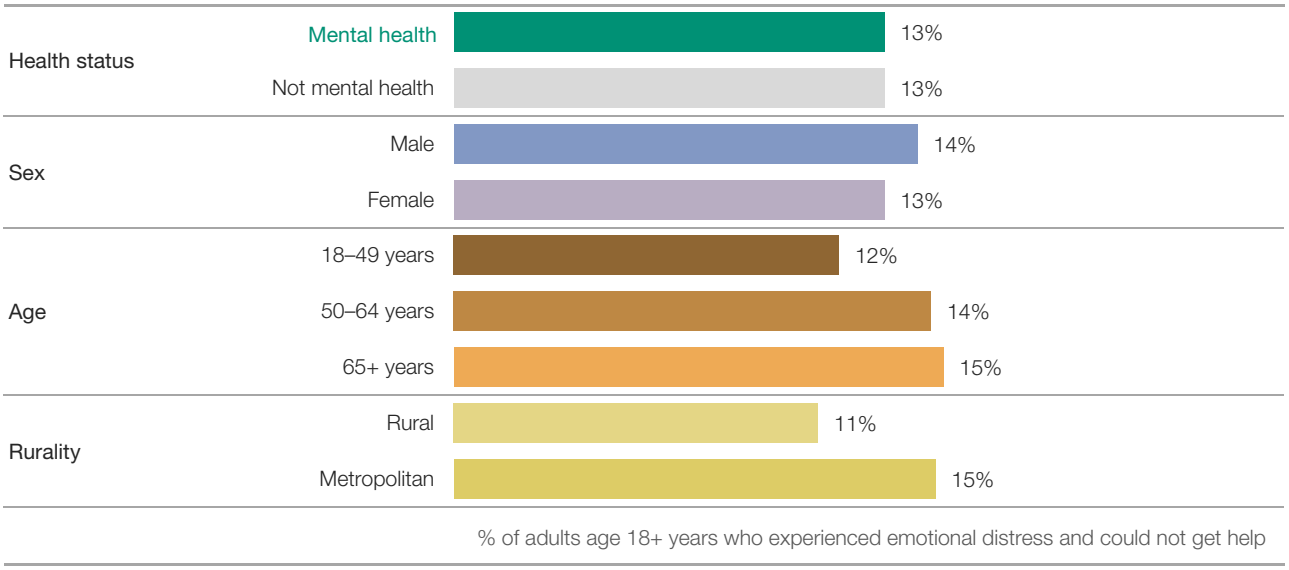


*Significantly different result for those with a mental health issue compared with those with no mental health issue.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 17 **Percentage of adults experiencing emotional distress who could not get help from a professional when needed, by patient characteristics, NSW, 2016**



Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Accessing care where and when needed

Accessing out-of-hours care was more challenging for NSW adults with a mental health issue than for those without

People are more inclined to seek healthcare when needed if timely, conveniently-located services are readily available. This also applies to people with lived experience of mental health issues, who may feel more comfortable seeking care if they do not have to face additional challenges to do so.

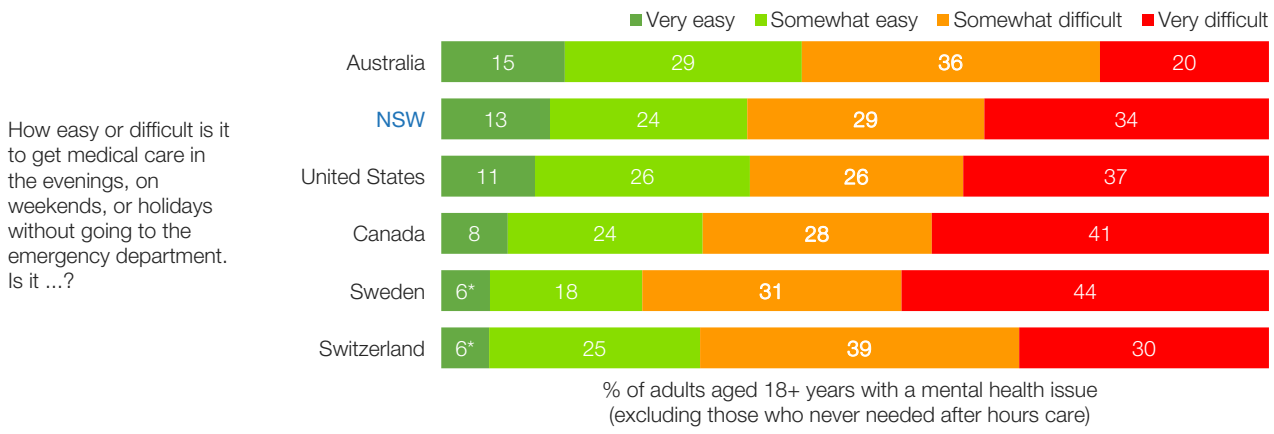
In 2016, just 13% of adults in NSW with a mental health issue said it was 'very easy' to access medical care outside of office hours. NSW (13%) and all of Australia (15%) achieved the highest results across comparator countries (Figure 18).

More than one-third of adults in NSW with a mental health issue (34%) said it was 'very difficult' to access medical care outside of office hours, compared with 20% in Australia (Figure 18).

The percentage of adults in NSW with a mental health issue who said it was 'very difficult' to access care outside of office hours was twice as high as those without an issue (34% compared with 17%) (Figure 19).

Almost one in three NSW adults with a mental health issue (29%) said the last time they had gone to an ED was for an issue they thought could have been treated at their regular place of care. This was lower than in many comparator countries (Figure 20). There was a similar result for NSW adults without a mental health issue (30%) (Figure 21).

Figure 18 **Experiences of access to medical care, other than emergency departments, during evenings, weekends, or holidays, adults with a mental health issue, NSW and comparator countries, 2016**

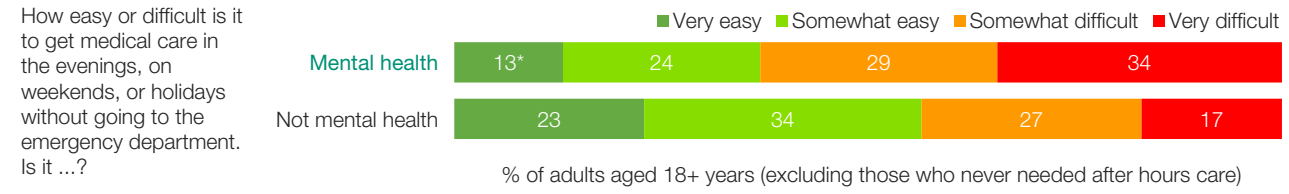


*Comparator countries significantly different from NSW.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 19 **Experiences of access to medical care, other than emergency departments, during evenings, weekends, or holidays, adults with and without a mental health issue, NSW, 2016**

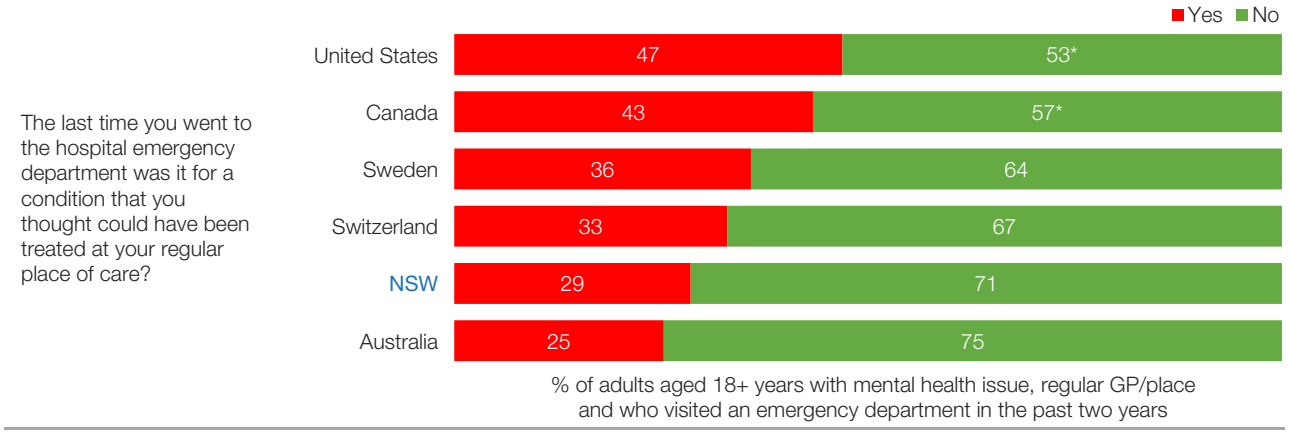


*Significantly different result for those with a mental health issue compared with those with no mental health issue.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 20 **Experiences of attending an emergency department for an issue that could have been treated at a regular place of care, adults with a mental health issue, NSW and comparator countries, 2016**

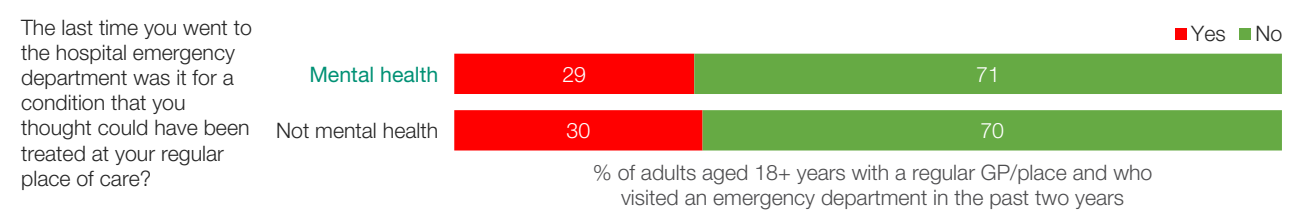


*Comparator countries significantly different from NSW.

Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.

Figure 21 **Experiences of attending an emergency department for an issue that could have been treated at a regular place of care, adults with and without a mental health issue, NSW, 2016**



Note: Mental health issue refers to those who said 'yes' when asked if they had ever been told by a doctor they have depression, anxiety or other mental health problems.

Source: 2016 Commonwealth Fund International Health Policy Survey of Adults.


Care in the community
Emergency department care
Inpatient care

Emergency department care

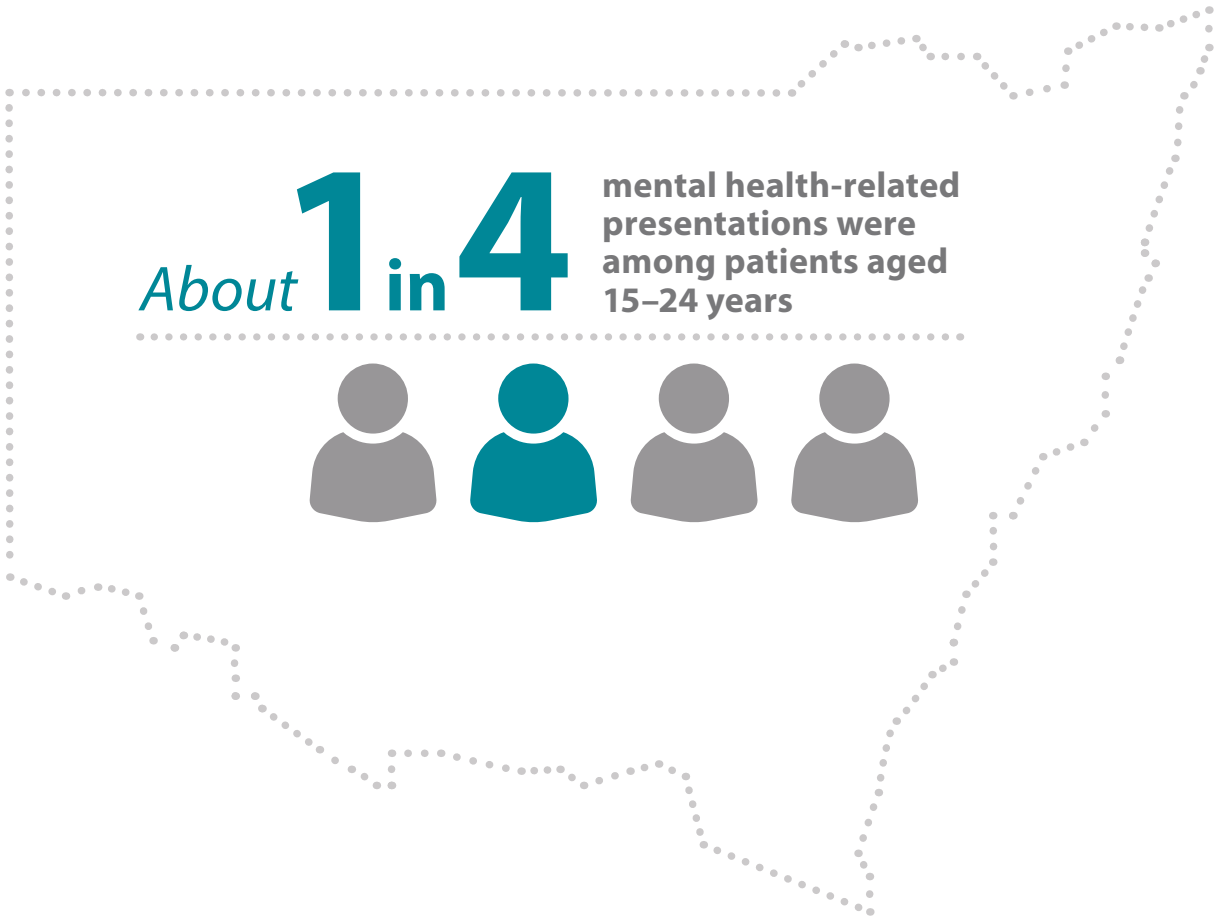
People with lived experience of mental health issues may use emergency departments (EDs) for a number of reasons.

An ED can be an important place of care for someone who is experiencing their first symptoms of a mental health issue or needing immediate treatment for exacerbating symptoms of an existing issue. An ED can also be an alternative – or only – source of after-hours care.

This chapter focuses on patients' use and experiences of ED care. The measures show who used EDs, the types of mental health issues they presented with, and their experiences receiving care in EDs for any health issue, including physical health conditions.

For many of the measures in this chapter, the experiences of patients with mental health issues who presented to the ED for any health condition are compared with the experiences of patients without mental health issues.

Key findings of this chapter



- Mental health-related presentations grew at a faster rate than overall ED presentations, particularly among young adults.
- About one-quarter of mental health-related presentations were for patients aged 15–24 years.
- Patients who reported having a longstanding mental health condition were more likely to make multiple visits to EDs for any health issue and have less positive experiences.
- Patients with mental health-related presentations were more likely to spend more than four hours in an ED compared with patients presenting without a mental health-related issue.
- The timeliness of care and length of time spent in an ED for mental health-related presentations varied across NSW local health districts (LHDs).

Use of emergency departments over time

Mental health-related presentations grew at a faster rate than overall emergency department presentations, particularly among young adults

In 2017–18 there were 77,329 mental health-related ED presentations to 115 NSW public hospitals, representing 2.8% of all ED presentations in those hospitals (Figure 1).

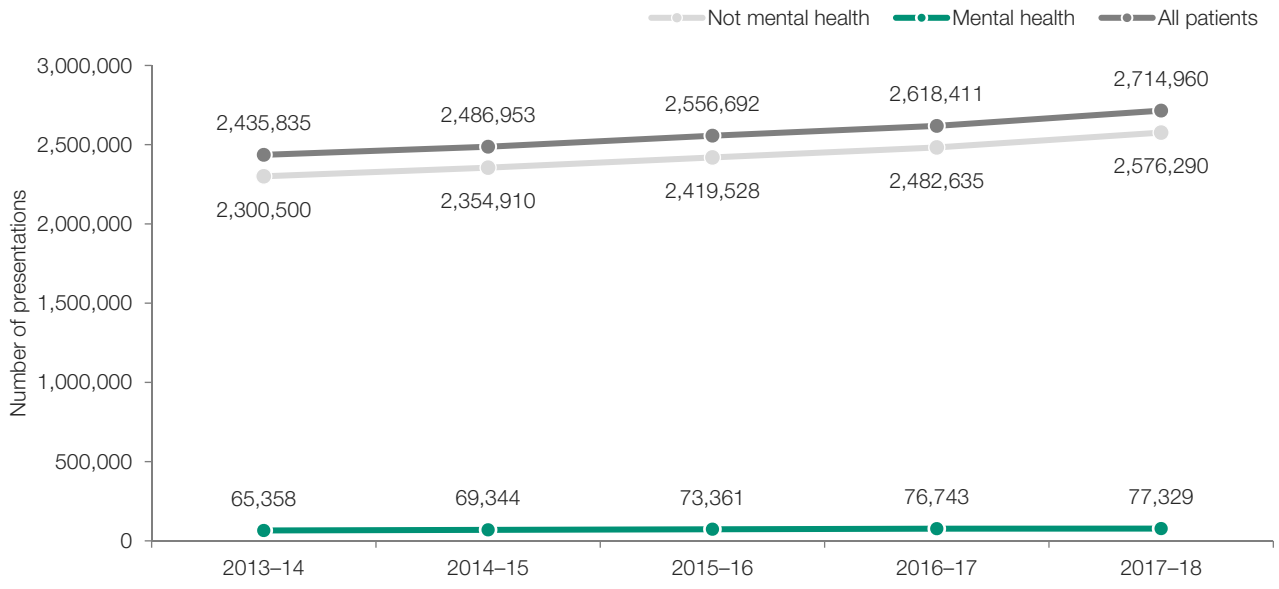
Between 2013–14 and 2017–18, the number of mental health-related ED presentations in these public hospitals grew by 18% (an additional 11,971 presentations), a faster rate than the overall growth in ED presentations (11%) (Figure 1).

Over time, this increase in presentations resulted in an increase in the rate per 10,000 population in most age groups. The largest increase was among patients aged 15–24 years, which grew from 167 to 206 presentations per 10,000 people between 2013–14 and 2017–18. The rate among patients aged 65+ years remained stable at 42 presentations per 10,000 population across the period (Figure 2).

For Aboriginal people, the prevalence of mental health-related ED presentations in 2017–18, at 299 per 10,000 people, was around three times higher than for non-Aboriginal people across all age groups (98 per 10,000 people) (Figures 2–3).

The way in which mental health-related presentations are coded in some EDs may mean that the number of mental health-related presentations across the state are underestimated.

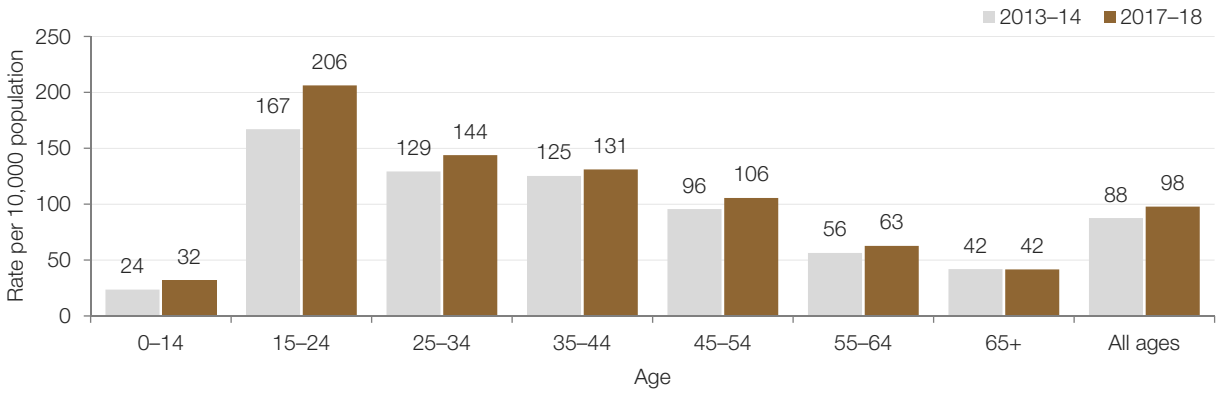
Figure 1 **Number of emergency department presentations for all patients, by mental health-related presentation or other reasons, NSW, 2013–14 to 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 115 public hospitals in each period, since this was the number of facilities that had electronic information systems across the period. Totals for the cohort of all patients include presentations without a diagnosis code.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

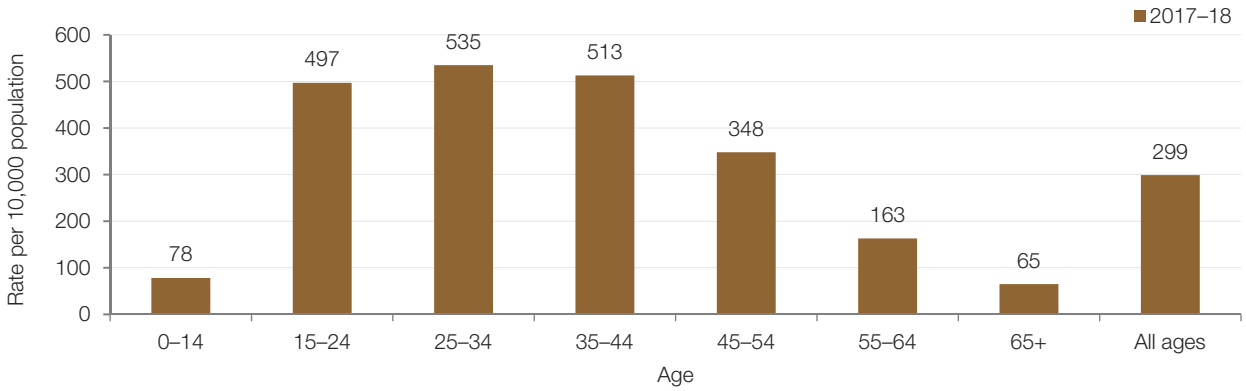
Figure 2 **Mental health-related emergency department presentations per 10,000 population, by age group, NSW, 2013–14 to 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 115 public hospitals in each period, since this was the number of facilities that had electronic information systems across the period.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019. Population file extracted from Secure Analytics for Population Health Research and Intelligence (SAPHaRI) on 9 April 2019.

Figure 3 **Aboriginal mental health-related emergency department presentations per 10,000 Aboriginal population, by age group, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 115 public hospitals in each period, since this was the number of facilities that had electronic information systems across the period. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 82%. See the Technical Supplement for more information.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019. Population file extracted from Secure Analytics for Population Health Research and Intelligence (SAPHaRI) on 9 April 2019.

Mental health-related presentations

Adjustment and anxiety disorders were the most common mental health-related emergency department presentations in 2017–18

In 2017–18 there were more than 2.8 million presentations across all 175 NSW EDs with an electronic information system that year. Of these presentations, 81,174 were mental health-related. These presentations are the focus of this chapter. An additional 23,797 presentations were for patients with substance abuse disorders and 7,531 were for those with organic mental disorders, such as dementia (Figure 4).

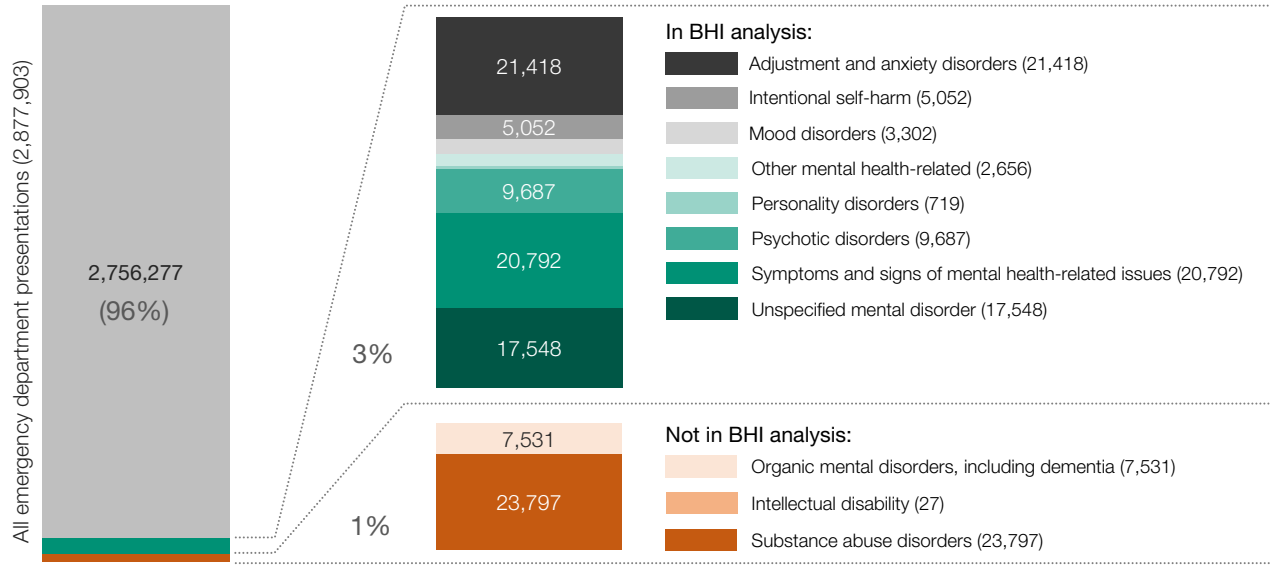
About half of patients presenting with mental health-related issues in 2017–18 (48%) did not receive a specific diagnosis while in an ED (i.e. they were coded as leaving the ED with either 'Unspecified mental disorder' or 'Symptoms and signs of mental health-related issues').

Of those who received a specific diagnosis, the most common conditions were:

- adjustment and anxiety disorders (26%)
- psychotic disorders (12%)
- intentional self-harm (6%) and
- mood disorders (4%) (Figures 4–5).

Similarly, about half of Aboriginal patients presenting with a mental health-related issue in 2017–18 did not receive a specific diagnosis while in an ED (52%). Of those who received a specific diagnosis, 21% were diagnosed with adjustment and anxiety disorders and 13% with a psychotic disorder (Figure 6).

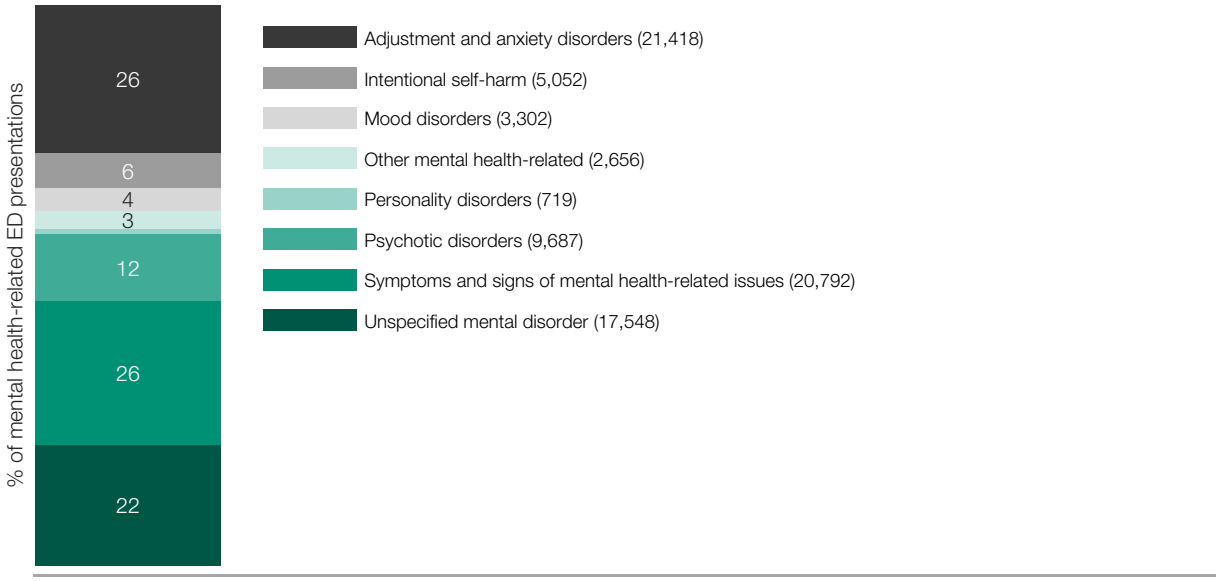
Figure 4 **Number of mental health-related emergency department presentations by presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

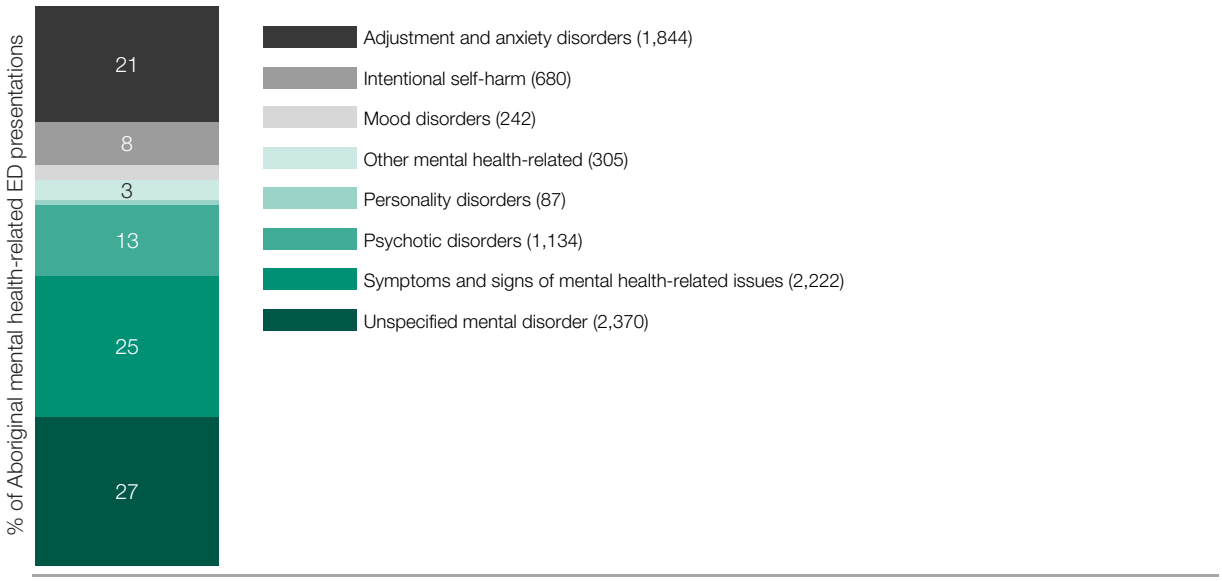
Figure 5 **Percentage of mental health-related emergency department presentations, by presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Figure 6 **Percentage of Aboriginal mental health-related emergency department presentations, by presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 82%. See the Technical Supplement for more information.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Use of emergency departments by age

About one-quarter of mental health-related presentations were for patients aged 15–24 years

In 2017–18 patients presenting to EDs with mental health-related issues were younger than those who presented for other reasons.

About one-third of presentations (32%) were for patients aged 0–24 years (6% aged 0–14 years and 26% aged 15–24 years). An additional 21% of presentations were for those aged 25–34 years (Figure 7).

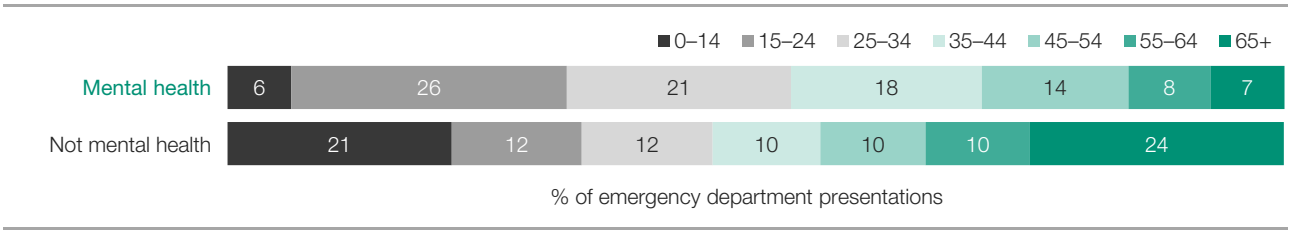
In 2017–18 only 7% of presentations for mental health-related issues were for patients aged 65+ years, whereas patients aged 65+ years made up 24% of presentations for other reasons (Figure 7).

Of those aged 0–14 years, 17% presented with adjustment and anxiety disorders, while of those aged 15–24 years, 23% presented with the same condition. By comparison, 43% of adults aged 65+ years presented with adjustment and anxiety disorders (Figure 8).

ED presentations for intentional self-harm were more common in younger age groups, with 14% of patients aged 0–14 years and 11% of those aged 15–24 years having self-harmed. This compared with less than 5% of presentations for all other age groups (Figure 8).

Among Aboriginal patients the types of mental health-related presentations in each age group were similar to the broader population (Figure 9).

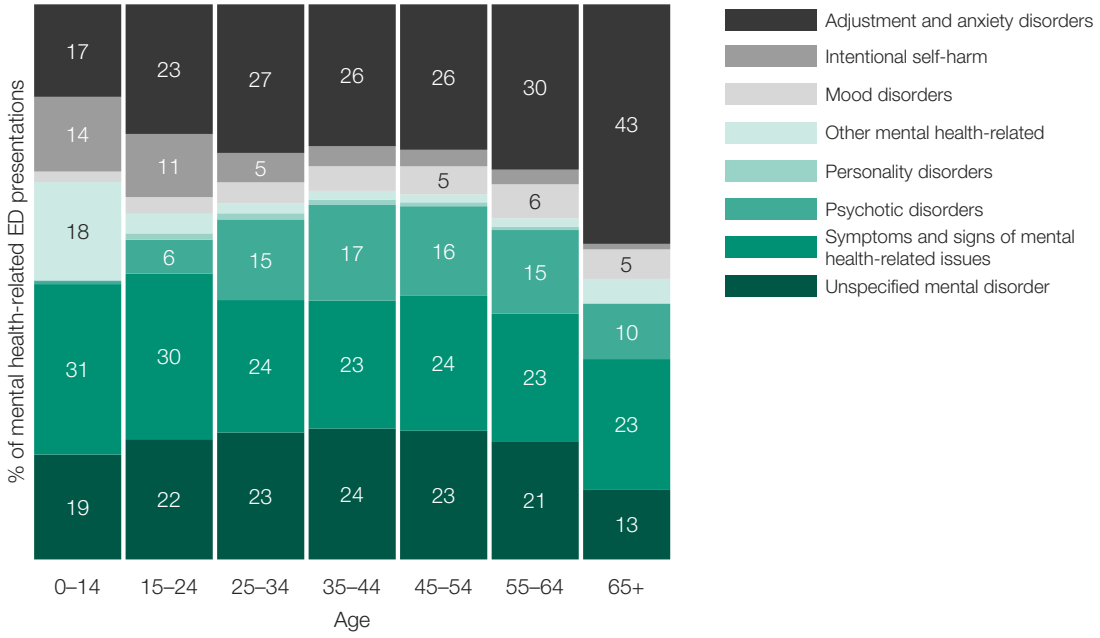
Figure 7 **Percentage of emergency department presentations, by presentation for mental health-related or other reasons and age, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals. Numbers may not sum to 100 due to rounding.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

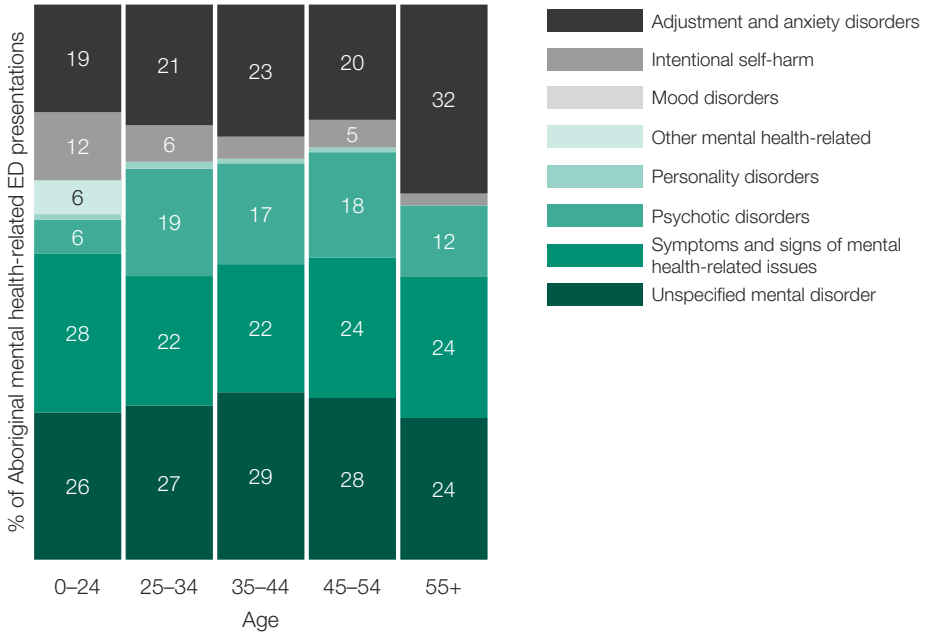
Figure 8 **Percentage of mental health-related emergency department presentations, by age and presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Figure 9 **Percentage of Aboriginal mental health-related emergency department presentations, by age and presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 175 public hospitals. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 82%. See the Technical Supplement for more information.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Experiences in emergency departments

Patients with a longstanding mental health condition were more likely to make multiple visits to emergency departments for any health issue and have less positive experiences

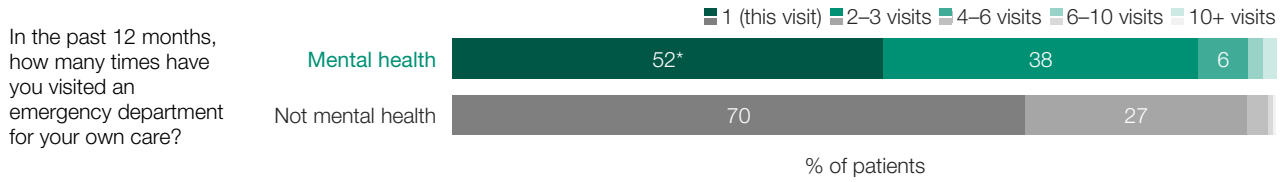
In 2017, 15,995 adults participated in the BHI Emergency Department Survey, with 10% reporting they had a longstanding mental health condition. Almost half of patients who said they had a longstanding mental health condition (48%) went to an ED more than once for any health issue in 2017–18. By comparison, of those who did not have a longstanding mental health condition or had another condition unrelated to mental health, 30% went to an ED more than once (Figure 10).

In 2017–18, about half of patients in NSW with a longstanding mental health condition (52%) rated their care in ED for any health issue as 'very good'. This was significantly lower than for those who did not have a longstanding mental health condition (60%) (Figure 11).

Among patients with a mental health condition, those aged 0–24 years were least positive about their experiences of care in the ED (data not shown).

Patients with a longstanding mental health condition reported less positive experiences across a wide range of topics. For example, there were gaps of 10 percentage points or more for survey questions about experiences in EDs in relation to respect and dignity, patient engagement, being given enough information to manage their condition at home and whether care helped them (Figure 12).

Figure 10 **Use of emergency departments in the past year, adults and children with and without a longstanding mental health condition, NSW, 2017–18**

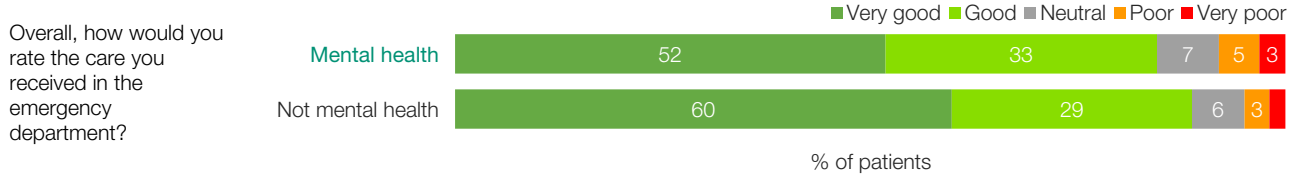


*Significantly different result for those with a longstanding mental health condition compared with those with no longstanding mental health condition after adjusting for age, sex, and language spoken at home.

Note: In 2017, a survey was mailed to adults that attended an ED at one of 82 public hospitals about three months after their visit and 15,995 people responded, representing a 24% response rate. Results are weighted to represent the age, sex structure of patients at each hospital. Adults with a longstanding mental health condition (n=1,596) include those who report 'yes' to a question on a survey as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding.

Source: Bureau of Health Information, NSW Patient Survey: Emergency Department, 2017–18.

Figure 11 **Overall ratings of care in emergency department, adults and children with and without a longstanding mental health condition, NSW, 2017–18**



*Significantly different result for those with a longstanding mental health condition compared with those with no longstanding mental health condition after adjusting for age, sex, and language spoken at home.

Note: In 2017, a survey was mailed to adults who attended an ED at one of 82 public hospitals about three months after their visit and 15,995 people responded, representing a 24% response rate. Results are weighted to represent the age-sex structure of patients at each hospital. Adults with a longstanding mental health condition (n=1,596) included those who responded 'yes' to a question on a survey as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding.

Source: Bureau of Health Information, NSW Emergency Department Patient Survey 2017–18.

Figure 12 **Patient-reported experiences in emergency departments, adults and children with and without a longstanding mental health condition, NSW, 2017–18**

Note: In 2017, a survey was mailed to adults who attended an ED at one of 82 public hospitals about three months after their visit and 15,995 people responded, representing a 24% response rate. Results are weighted to represent the age-sex structure of patients at each hospital. Adults with a longstanding mental health condition (n=1,596) included those who responded 'yes' to a question on a survey as specified in the Technical Supplement to this report.

Source: Bureau of Health Information, NSW Emergency Department Patient Survey 2017–18.

Timeliness of care and length of time spent in emergency departments

Patients who presented with mental health-related issues waited longer for care

In 2017–18, twice as many patients presenting at EDs with a mental health-related issue (43%) arrived by ambulance compared with other patients (22%). Almost half of patients presenting with a mental health-related issue (48%) arrived by ambulance, police or correctional services (Figure 13).

More patients presenting with a mental health-related issue (66%) were triaged to the categories of emergency and urgent compared with those who presented for other reasons (47%) (Figure 13).

Looking at whether patients started their treatment on time, across all triage categories, in 2017–18 the majority of patients presenting with a mental health-related issue (70%) started their treatment on time, but this was lower than other patients (75%) (Figure 13).

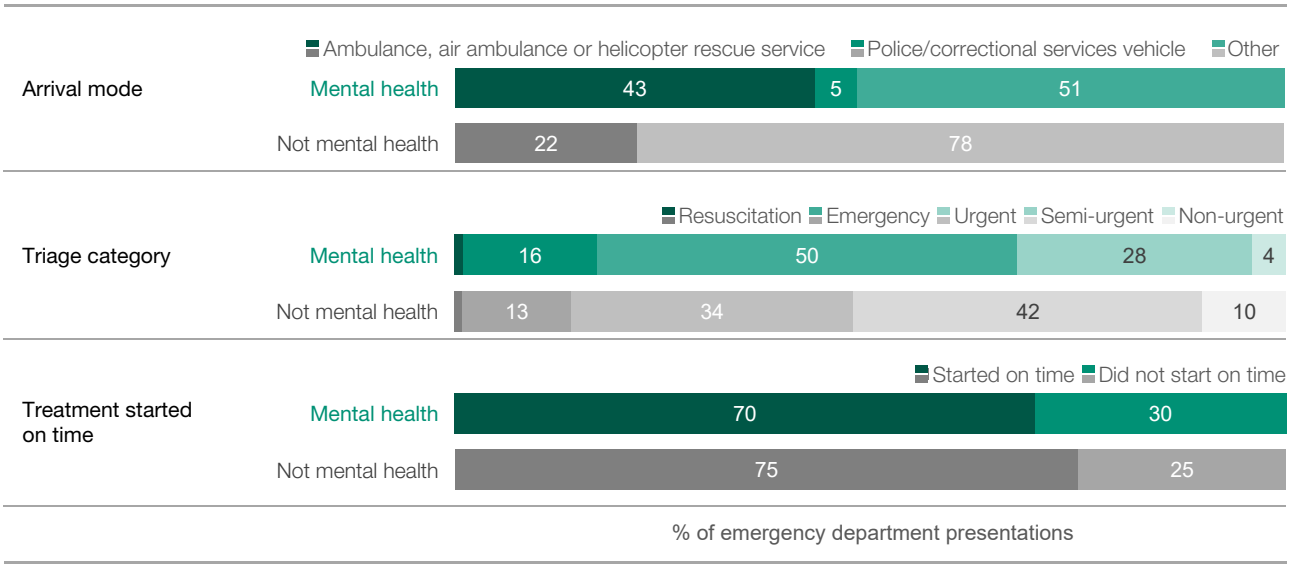
Looking at the length of time patients spent in EDs and shifts over time across 115 NSW hospitals, in 2017–18 the median* time patients presenting with a mental health-related issue spent in the ED was more than three and a half hours (three hours, 32 minutes). This was longer than other patients, for whom the median time spent in the ED was under three hours (two hours, 53 minutes) (Figure 14).

In 2017–18, 90% of patients presenting with a mental health-related issue left the ED within 12 and a half hours (90th percentile:† 12 hours, 33 minutes) and the remaining 10% waited longer. The 90th percentile for time spent in the ED for these patients has increased from 10 hours 48 minutes in 2013–14 to 12 hours 33 minutes in 2017–18, but it has decreased slightly for other presentations (Figure 14).

*The median time describes the time by which half of patients were discharged, admitted to hospital, left without or before completing treatment or were transferred to another hospital. The other half took equal to or longer than this time.

†The 90th percentile describes the time from presentation by which 90% of patients started treatment. The final 10% of patients took equal to or longer than this time.

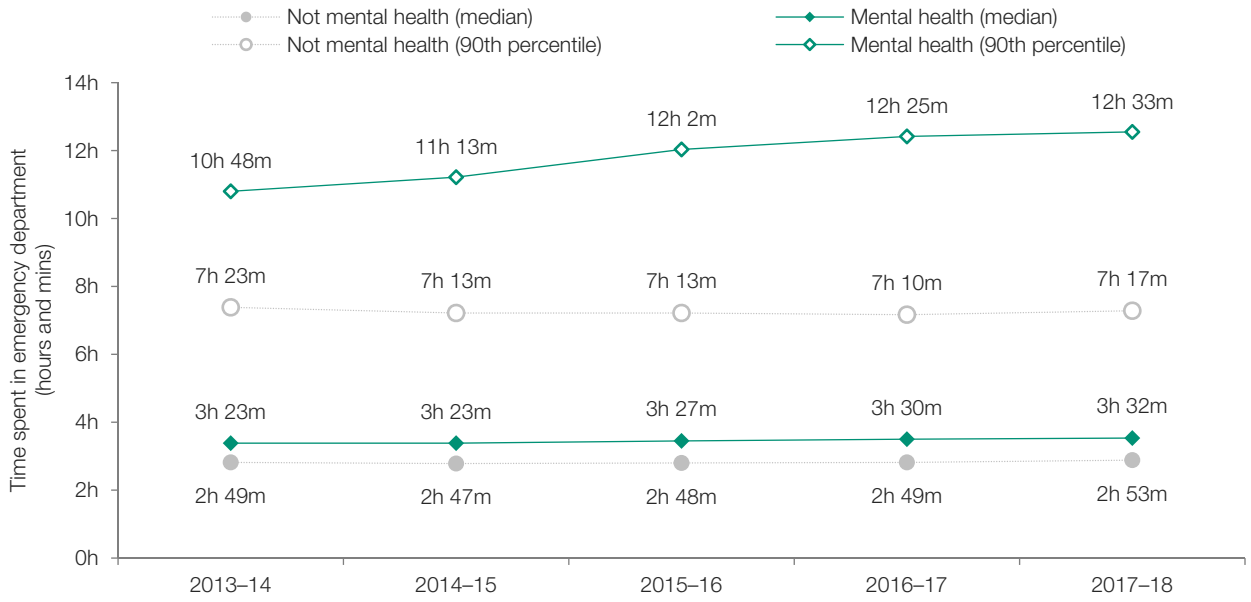
Figure 13 **Percentage of emergency department presentations for mental health-related or other reasons, by arrival mode, triage category and patients whose treatment started within clinically recommended time, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Time to treatment is calculated as the difference between presentation time and start of treatment time. The Australian College for Emergency Medicine recommends maximum waiting times within which treatment should occur, including: resuscitation (within two minutes), emergency (within 10 minutes), urgent (within 30 minutes), semi-urgent (within 60 minutes) and non-urgent (within 120 minutes). Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Figure 14 **Median and 90th percentile time spent in the emergency department, by presentations for mental health-related and other reasons, NSW, 2013–14 to 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Number of presentations based on 115 public hospitals in each period, since this was the number of facilities that had electronic information systems across the period.

The median time describes the time by which half of patients were discharged, admitted to hospital, left without or before completing treatment or were transferred to another hospital. The other half took equal to or longer than this time. The 90th percentile describes the time from presentation by which 90% of patients started treatment. The final 10% of patients took equal to or longer than this time.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Length of time spent in emergency departments

Patients with mental health-related issues were more likely to spend longer than four hours in the emergency department

The percentage of patients who spent four hours or less in the ED is measured from the time the patient presents to the time they depart.

In 2017–18, 60% of patients presenting with a mental health-related issue spent four hours or less in the ED. By comparison, 73% of patients presenting without a mental health-related issue spent four hours or less in an ED (Figure 15).

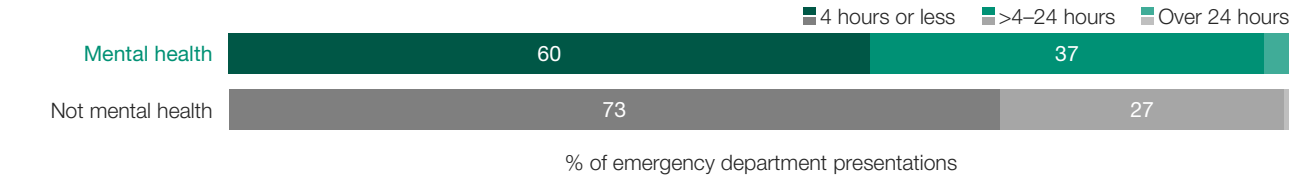
A similar percentage of Aboriginal patients presenting with a mental health-related issue spent four hours or less in the ED (64%). By comparison, 79% of Aboriginal patients who presented at EDs for other reasons spent four hours or less in the ED (Figure 16).

For patients presenting with mental health-related issues, the likelihood of spending more than four hours in an ED was similar across age groups.

However, patients aged 0–24 years presenting with a mental health-related issue were twice as likely to spend longer than four hours in the ED compared with patients of the same age who presented for other reasons.

For example, 37% of patients aged 0–14 years presenting with a mental health-related issue spent four or more hours in the ED compared with 17% of their peers who presented for other reasons (Figure 17).

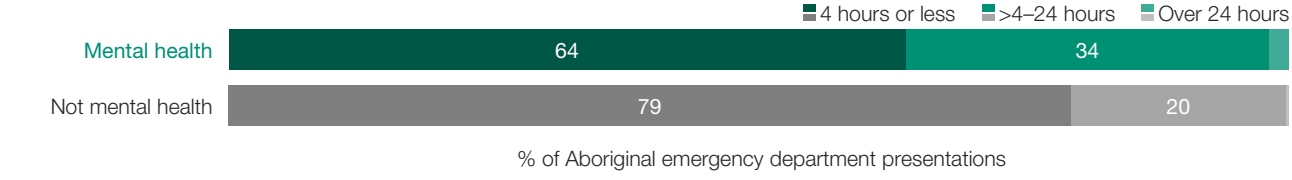
Figure 15 **Percentage of presentations for mental health-related and other reasons, by length of time spent in emergency department, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

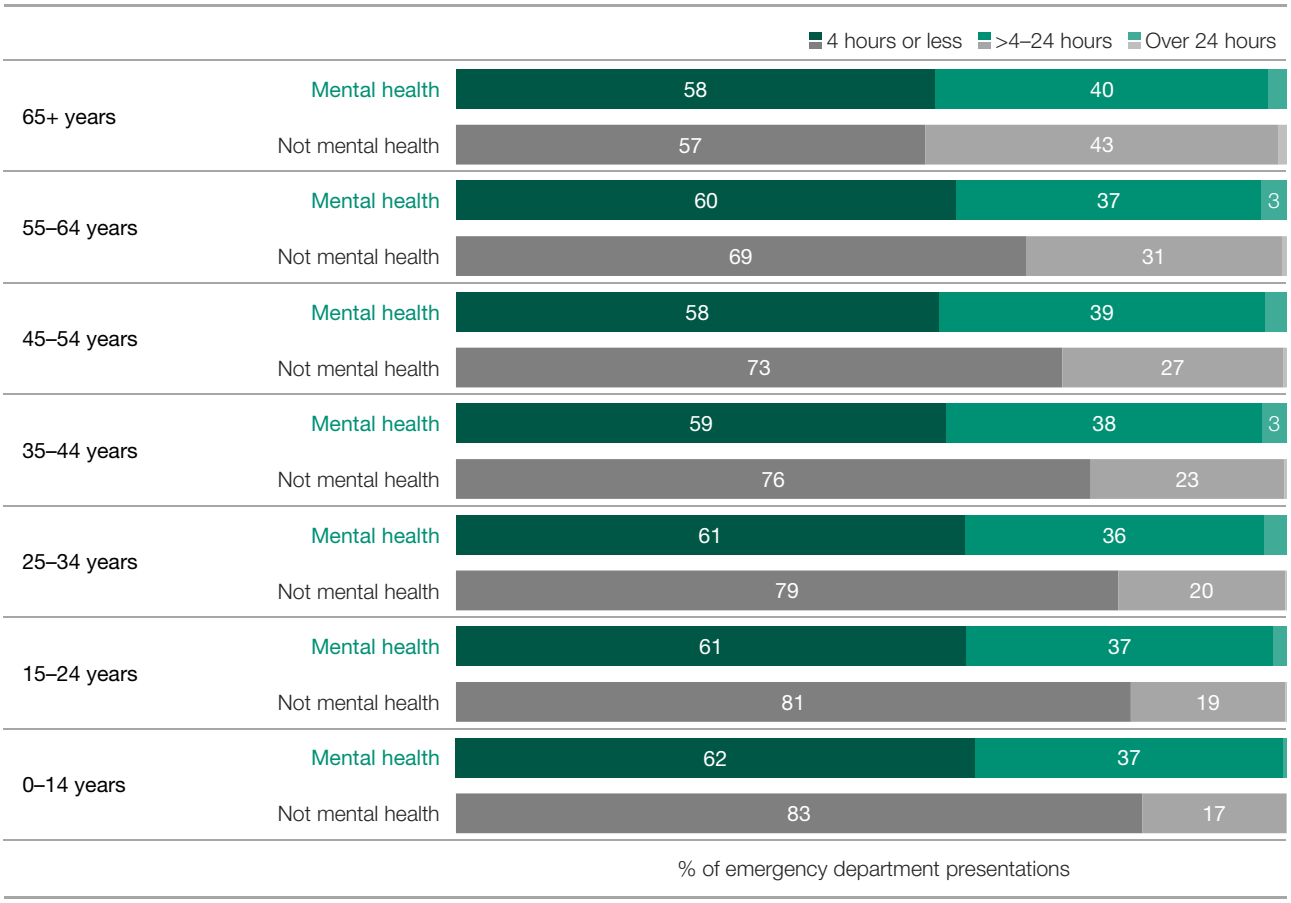
Figure 16 **Percentage of Aboriginal presentations for mental health-related and other reasons, by length of time spent in emergency department, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 82%. See the Technical Supplement for more information.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Figure 17 **Percentage of presentations for mental health-related and other reasons, by length of time spent in emergency department and age, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Time in emergency departments by region

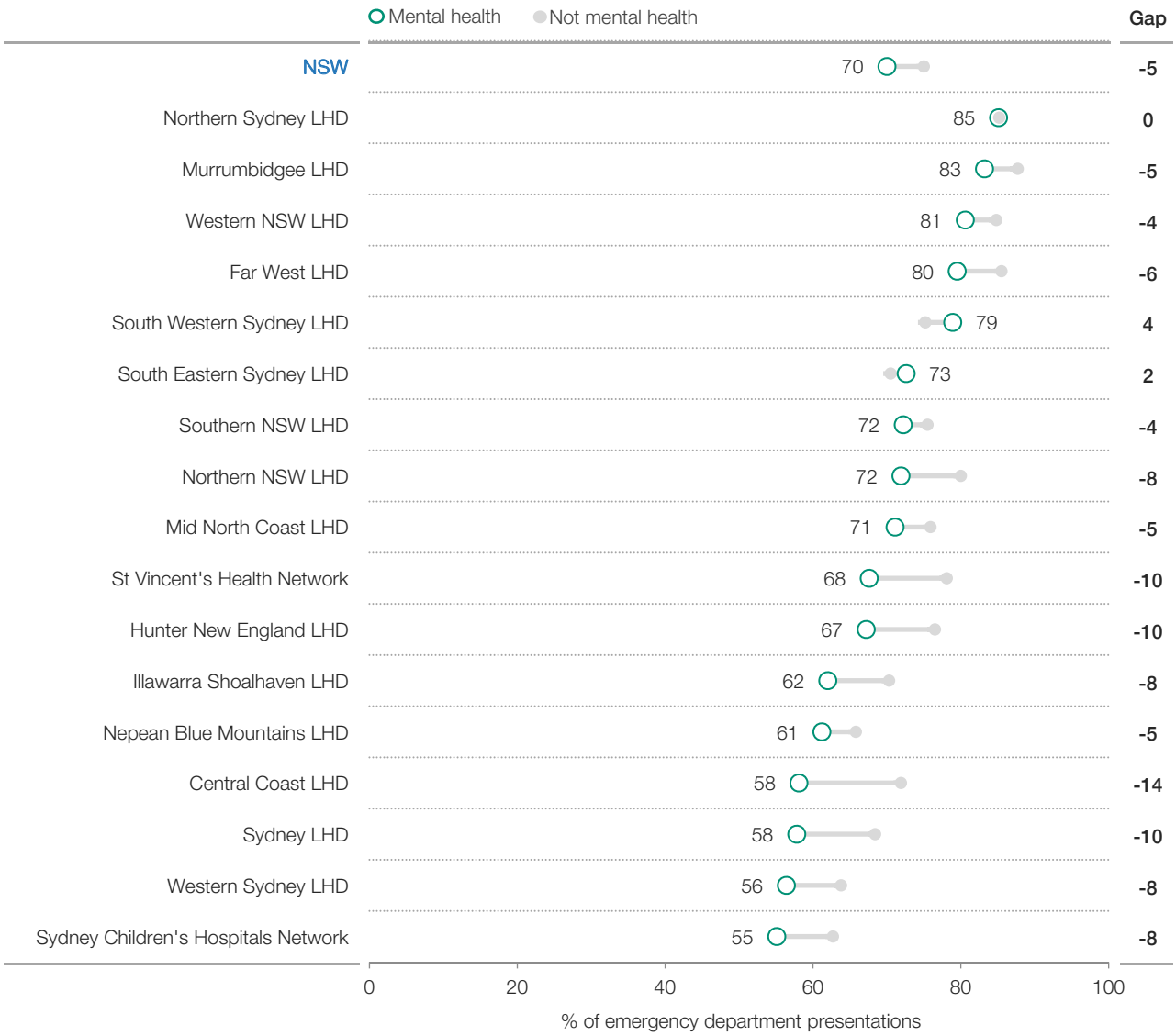
The timeliness of care and length of time spent in the emergency department for patients with mental health-related issues varied across NSW local health districts

Local health districts (LHDs) and specialty networks provide ED services to patients within their geographical area, or defined patient population for specialty networks.

There are 15 LHDs in NSW. In addition there are three speciality networks: Sydney Children's Hospitals Network, Justice Health and Forensic Mental Health Network, and St Vincent's Health Network.

In 2017–18 there was large variation in the percentage of patients whose treatment started within clinically recommended times. The majority of patients with a mental health-related presentation to Northern Sydney LHD (85%) were treated on time, similar to patients presenting for other reasons (85%). In Western Sydney LHD, 56% of patients with a mental health-related presentation were treated on time, compared with 64% of patients presenting for other reasons (Figure 18).

Figure 18 **Percentage of patients whose treatment started within the clinically recommended time, by presentations for mental health-related and other reasons, NSW and local health districts, 2017–18**



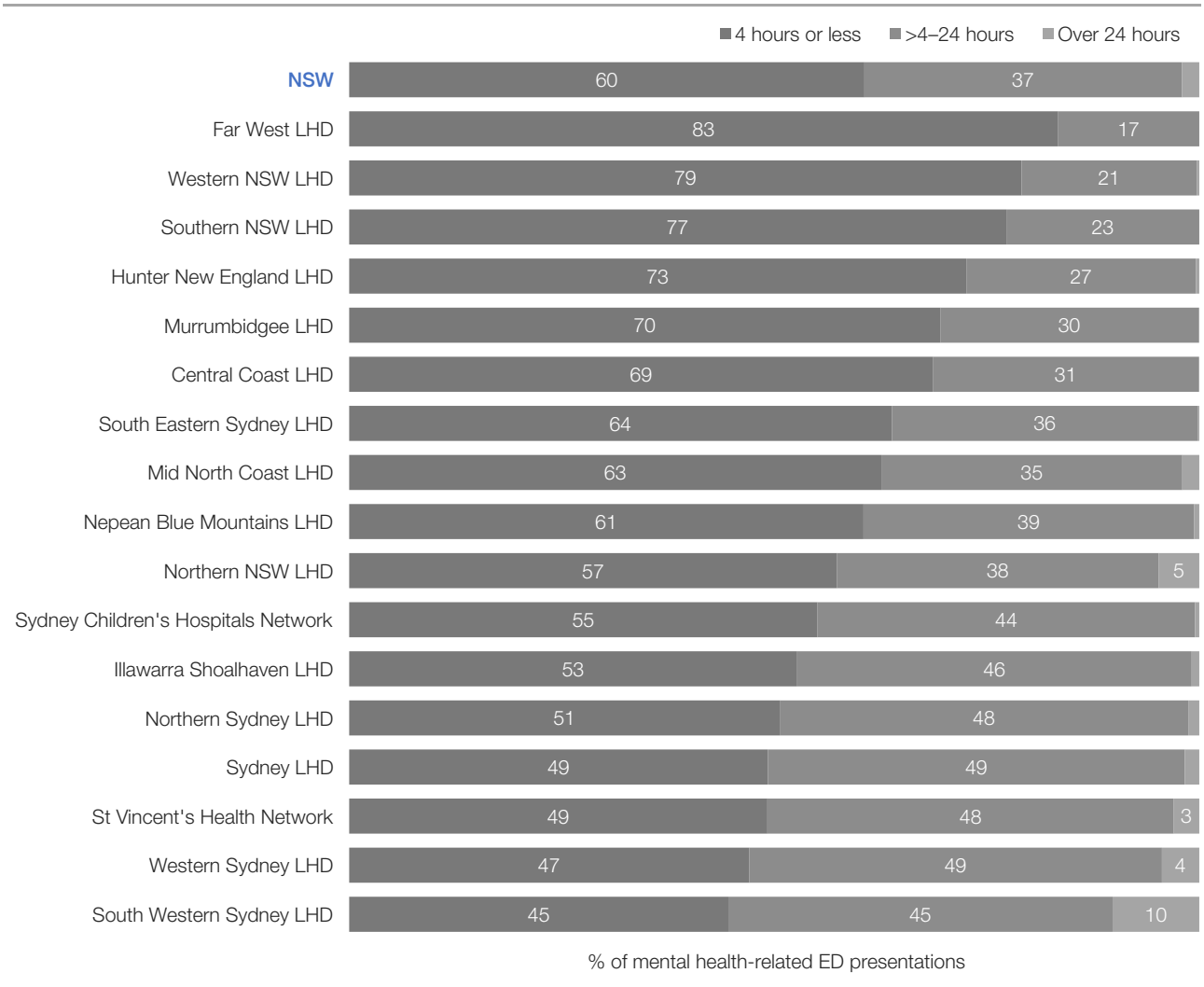
Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Time to treatment is calculated as the difference between presentation time and start of treatment time. The Australian College for Emergency Medicine recommends maximum waiting times within which treatment should occur, including: resuscitation (within two minutes), emergency (within 10 minutes), urgent (within 30 minutes), semi-urgent (within 60 minutes) and non-urgent (within 120 minutes). Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

The percentage of patients who spent four hours or less in the ED is measured from the time the patient presents to the time they depart. In 2017–18, 83% of patients who presented with a mental health-related issue left the ED in Far West LHD in four hours or less, compared with 45% in South Western Sydney LHD (Figure 19).

No patients who presented with a mental health-related issue spent more than 24 hours in the ED in Far West LHD and Southern NSW LHD, compared with 10% in South Western Sydney LHD (Figure 19).

Figure 19 **Percentage of mental health-related emergency department presentations, by hours spent in ED, NSW and local health districts, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Discharge from the emergency department

Fewer patients presenting with mental health-related issues were treated and discharged

Following the completion of treatment in the ED patients can be: discharged – usually to go home or to their usual place of care; admitted to an inpatient unit for further treatment; or transferred to a more appropriate location for the continuation of their care. Some patients choose to leave the ED before they are seen or before their treatment has been completed.

In 2017–18, fewer patients presenting with a mental health-related issue (59%) were treated and discharged compared with those presenting for other reasons (66%). Both groups were admitted at a similar rate (26%), and more patients with a mental health-related issue (7%) were transferred compared with those presenting for other reasons (2%) (Figure 20).

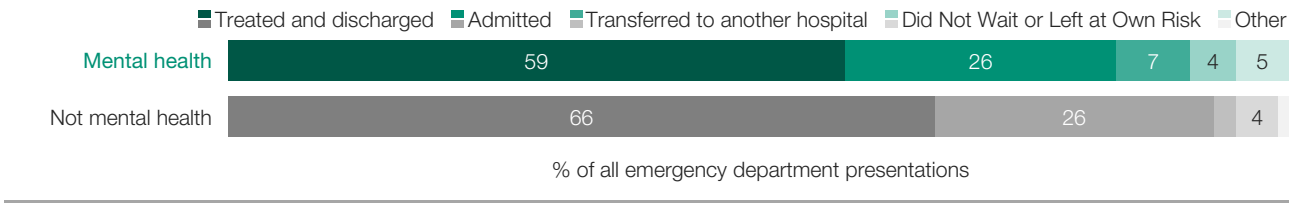
In 2017–18 more young patients were treated and discharged compared with older patients, irrespective of whether they had presented with a mental health issue.

Across most age groups, patients who presented with mental health-related issues were less likely to be treated and discharged and more likely to be admitted. For example, 65% of those aged 15–24 years who presented with a mental health-related issue were treated and discharged compared with 77% of patients of the same age who presented for other reasons.

The exception was adults aged 65+ years who presented with a mental health-related issue, with 54% treated and discharged. This was higher than the percentage of their peers who presented for other reasons (45%) (Figure 21).

In 2017–18 most patients presenting with mental health-related issues were treated and discharged from an ED, except those with a mood or psychotic disorder. For example, 83% of patients who presented with adjustment and anxiety disorders were treated and discharged compared with 29% of those presenting with a psychotic disorder (Figure 22).

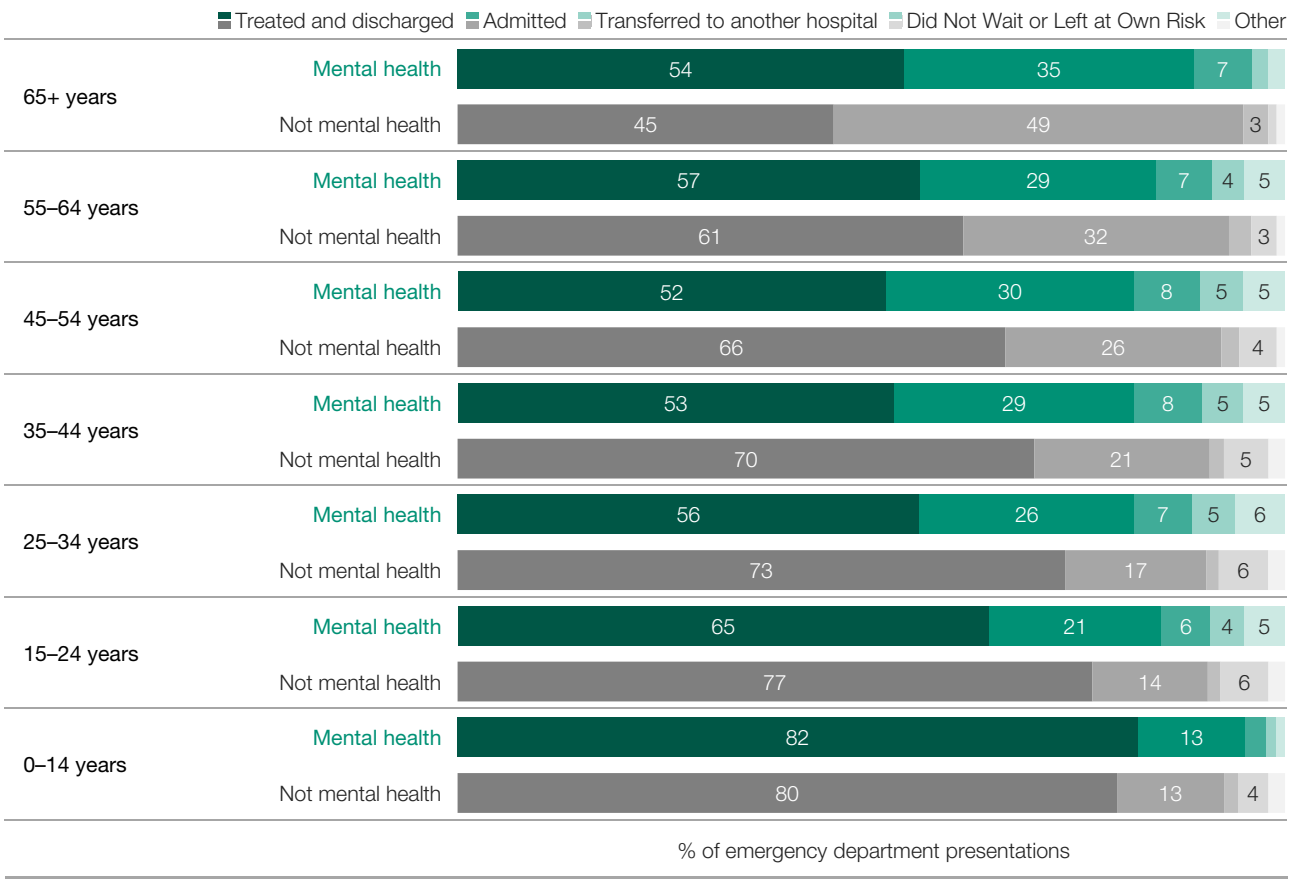
Figure 20 **Percentage of emergency department presentations, by mode of separation and presentations for mental health-related and other reasons, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

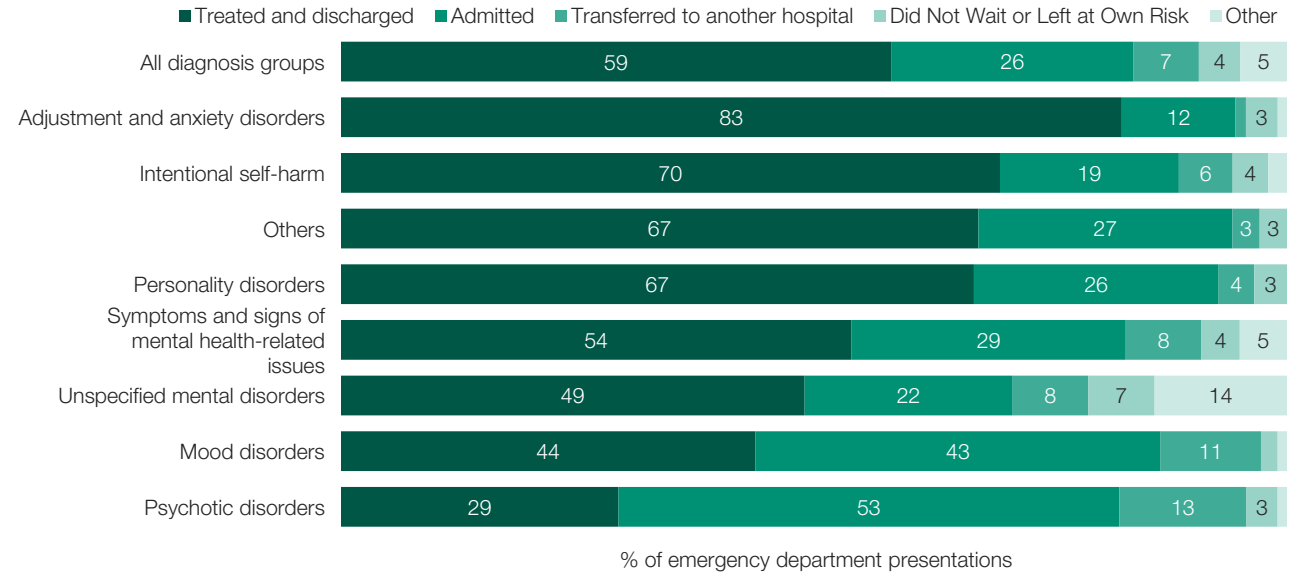
Figure 21 **Percentage of emergency department presentations, by mode of separation and presentations for mental health-related and other reasons, and age, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

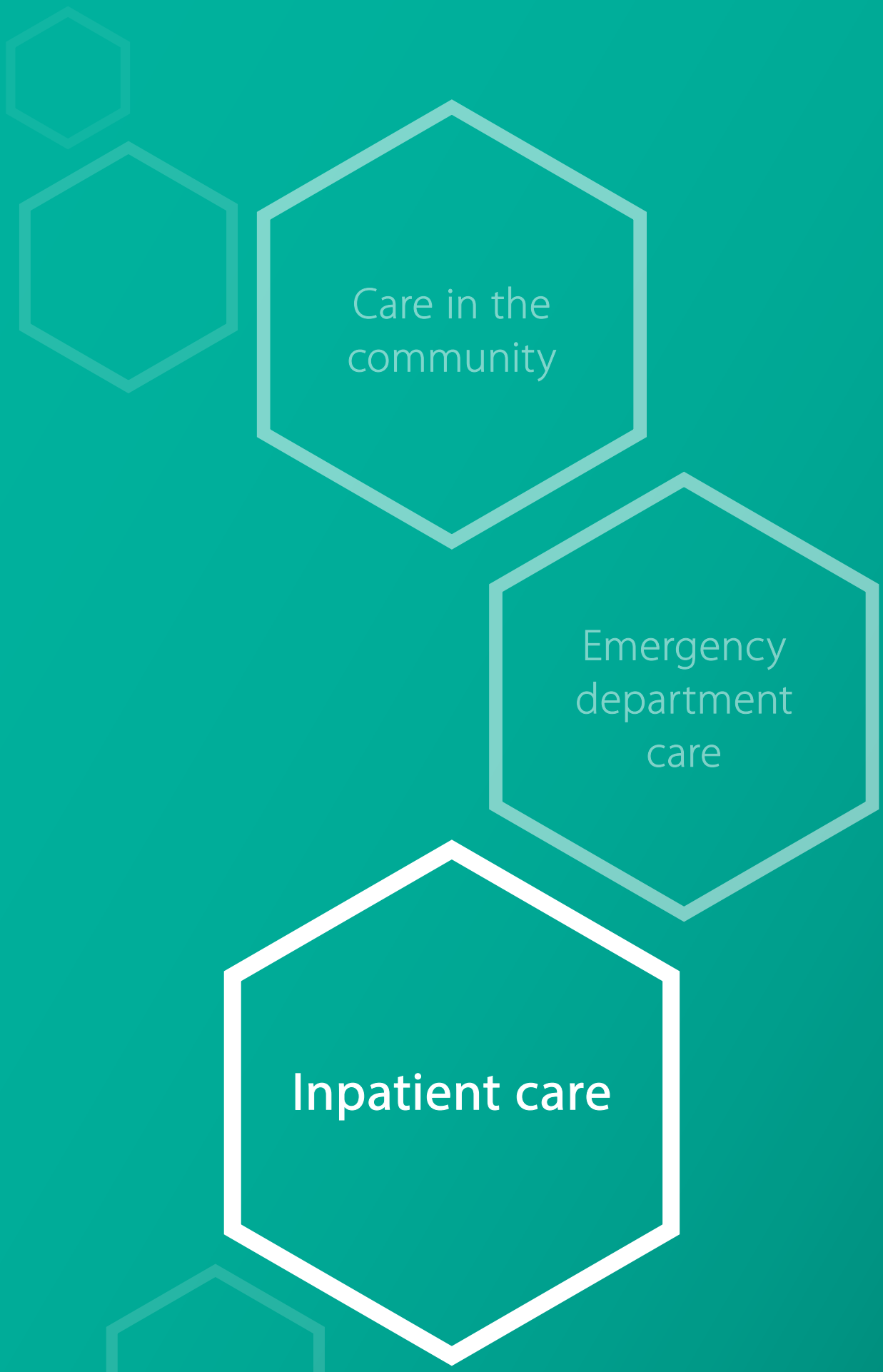
Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.

Figure 22 **Percentage of emergency department presentations, by mode of separation and mental health-related presenting condition, NSW, 2017–18**



Note: Mental health-related presentations include patients diagnosed or presenting with symptoms associated with a mental health issue, as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding. Number of presentations based on 175 public hospitals.

Source: BHI analysis of Emergency Department Data Collection, Health Information Exchange, NSW Health, data extracted 28 February 2019.


Care in the community
Emergency department care
Inpatient care

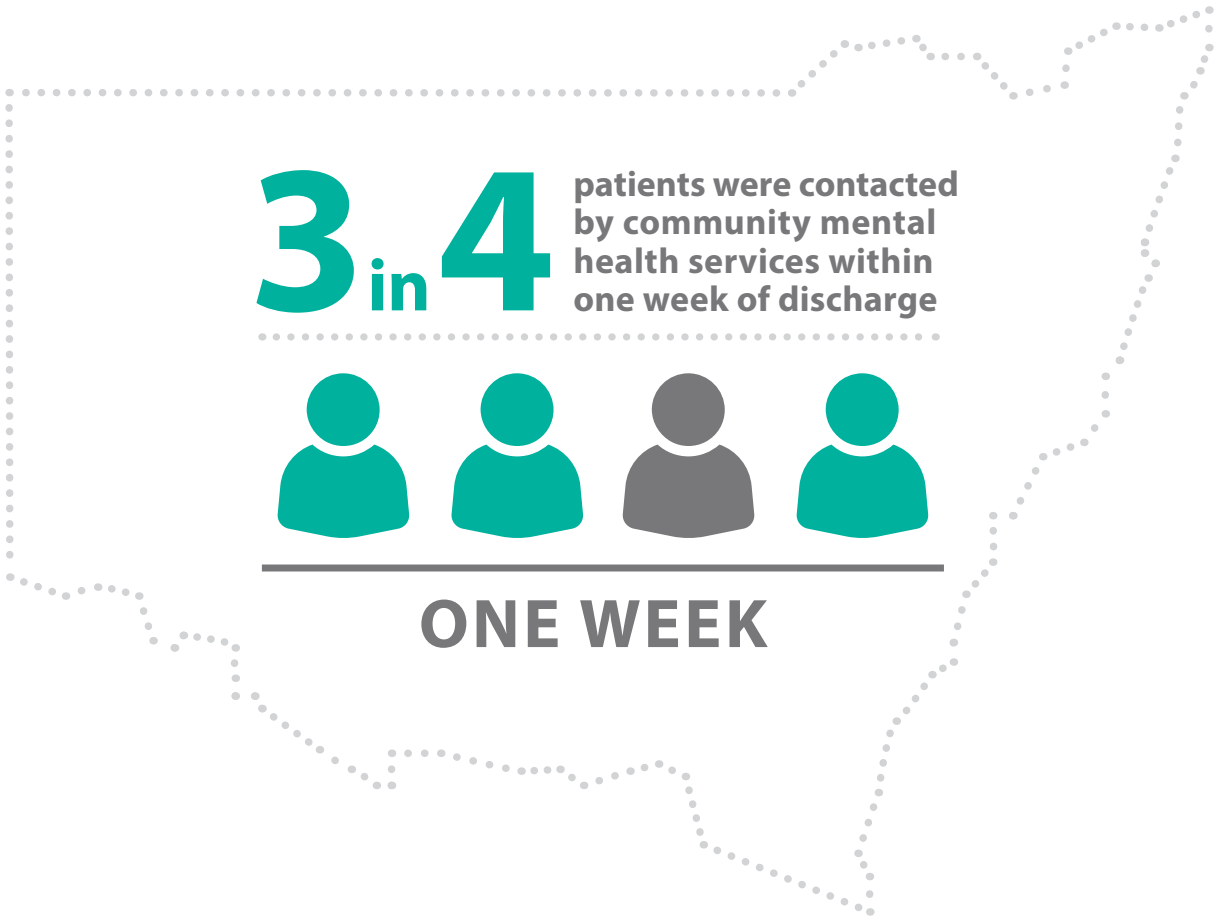
Inpatient care

Hospital care can be an important part of the journey of care for people with lived experience of mental health issues in NSW. People with mental health issues or symptoms may be admitted one or more times in their lifetime, for conditions that are episodic or persistent in nature.

People with lived experience of mental health issues may receive treatment on a general ward. Those who require intensive support may be admitted to an acute or non-acute specialised mental health inpatient unit, where they may receive same-day or overnight care depending on the severity of their condition and other personal and social circumstances.

Acute services vary, including specific units to support the needs of adults, children and adolescents, patients aged 65+ years and those who have been through the criminal justice system (forensic patients). In this chapter we focus on the patients who had a stay in a specialised mental health inpatient unit in NSW in 2017–18.

Key findings of this chapter



- Mental health episodes of care in specialised inpatient units grew at a faster rate than overall admitted patient episodes, particularly among young adults.
- Almost one-quarter of overnight acute mental health-related episodes of care were experienced by patients aged 0–25 years.
- Mothers who reported a longstanding mental health condition gave less positive ratings for their experiences of maternity care.
- More than half of the episodes of care for intentional self-harm were for patients aged 15–34 years and a majority had a mental health diagnosis.
- Three-quarters of patients were contacted by community mental health services within one week of discharge.

Admissions for mental health-related issues

Admitted patients experienced 69,732 mental health-related episodes of care in 2017–18

In 2017–18, admitted patients in NSW hospitals experienced more than 1.9 million episodes of care. Among these, 69,732 episodes of care were for patients with a primary or subsequent diagnosis of a mental health-related condition, representing 3.6% of all episodes of care.

Of the 69,732 episodes of care, 26,740 (38%) were for patients in general wards with a primary diagnosis of a mental health-related issue. Three-quarters (75%) were overnight episodes, 90% had a length of stay of around one week or less and 80% were in major metropolitan hospitals. Of these patients in general wards, 63% were discharged and 23% were transferred into a specialised mental health inpatient unit.

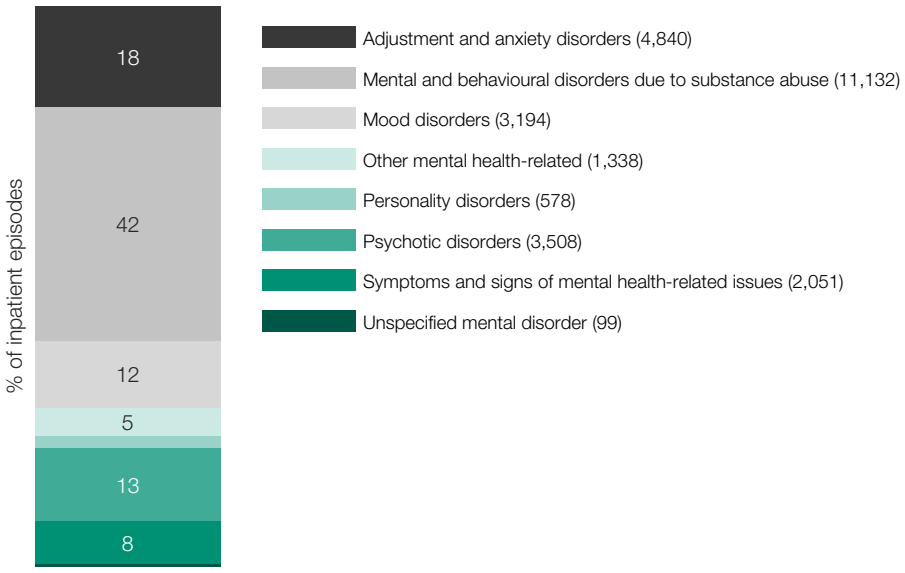
The most prevalent primary diagnoses for mental health-related episodes of care in general wards were: mental and behavioural disorders due to substance abuse (42%), adjustment and anxiety disorders (18%), psychotic disorders (13%) and mood disorders (12%) (Figure 1).

In 2017–18 there were 42,992 episodes of care for patients with a primary or subsequent diagnosis of a mental health-related condition in specialised mental health inpatient units. Patients in these units form the foundation for most of the analyses in this chapter.

The most prevalent primary or subsequent diagnoses for episodes of care in specialised mental health inpatient units were psychotic disorders (35%), mood disorders (21%) and adjustment and anxiety disorders (16%) (Figure 2). The majority of patients who received care in specialised mental health inpatient units (91%) stayed overnight (Figure 3), and 57% had a length of stay of around one week or less.

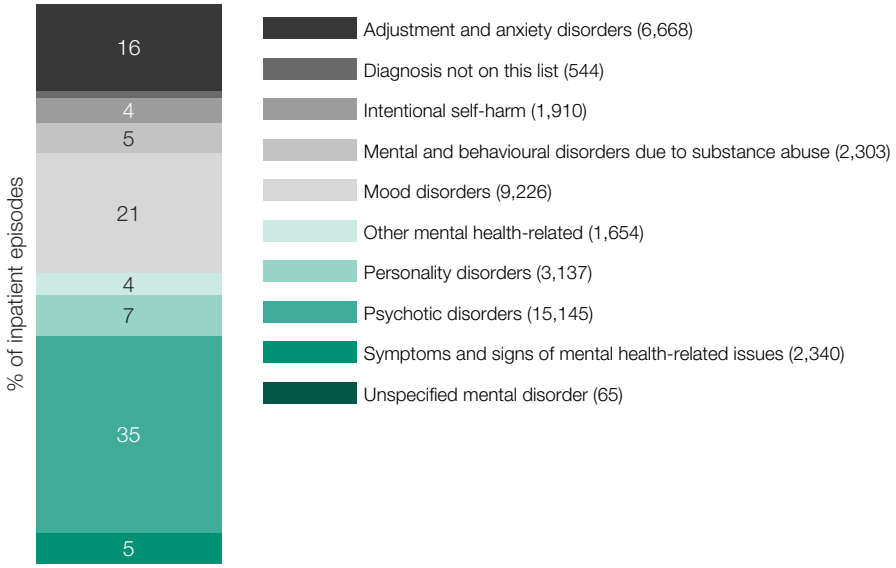
Aboriginal patients accounted for 10% of all episodes of care in these specialised inpatient units (4,209 episodes), and the most common primary or subsequent diagnoses among Aboriginal patients were psychotic disorders (42%), adjustment and anxiety disorders (15%) and mood disorders (12%).

Figure 1 **Percentage of mental health-related admitted patient episodes of care on general wards in NSW public hospitals, by primary diagnoses, 2017–18 (n=26,740)**



Note: These figures include acute, non-acute, same-day and overnight care, and do not include patients who have a subsequent mental health-related diagnosis.
Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

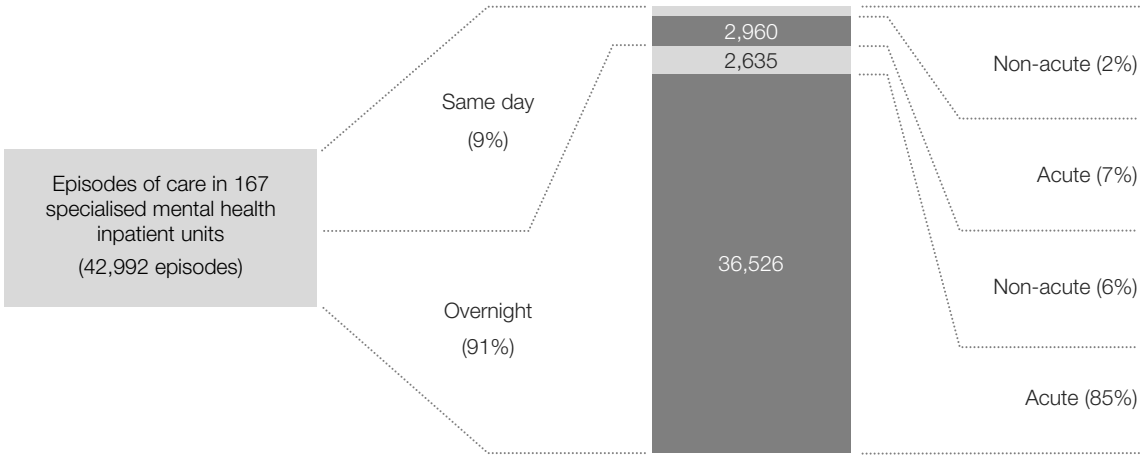
Figure 2 **Percentage of mental health-related admitted patient episodes of care in specialised mental health inpatient units in NSW public hospitals where there is a primary or subsequent diagnosis of a mental health condition, or a secondary diagnosis of intentional self-harm, 2017–18 (n=42,992)**



Note: These figures include acute, non-acute, same-day and overnight care in 167 specialised mental health inpatient units. Episodes of care in small specialist mental health inpatients units that focus on older adults who have organic mental disorders are excluded (i.e. seven T-BASIS and OPMH non-acute units which included 293 episodes of care in 2017–18). Same-day admitted episodes of care in mental health social day programs and ECT clinics have also been excluded (i.e. eight social day programs and ECT clinics which included 3962 episodes of care in 2017–18).

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Figure 3 **Number of mental health-related admitted patient episodes of care in specialised mental health inpatient units in NSW public hospitals where there is a primary or subsequent diagnosis of a mental health condition, or a secondary diagnosis of intentional self-harm, by care type, 2017–18 (n=42,992)**



Note: These figures include acute, non-acute, same-day and overnight care in 167 specialised mental health inpatient units. Episodes of care in small specialist mental health inpatient units that focus on older adults who have organic mental disorders are excluded (i.e. seven T-BASIS and OPMH non-acute units which included 293 episodes of care in 2017–18). Same-day admitted episodes of care in mental health social day programs and ECT clinics have also been excluded (i.e. eight social day programs and ECT clinics which included 3962 episodes of care in 2017–18.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Admissions for mental health issues over time

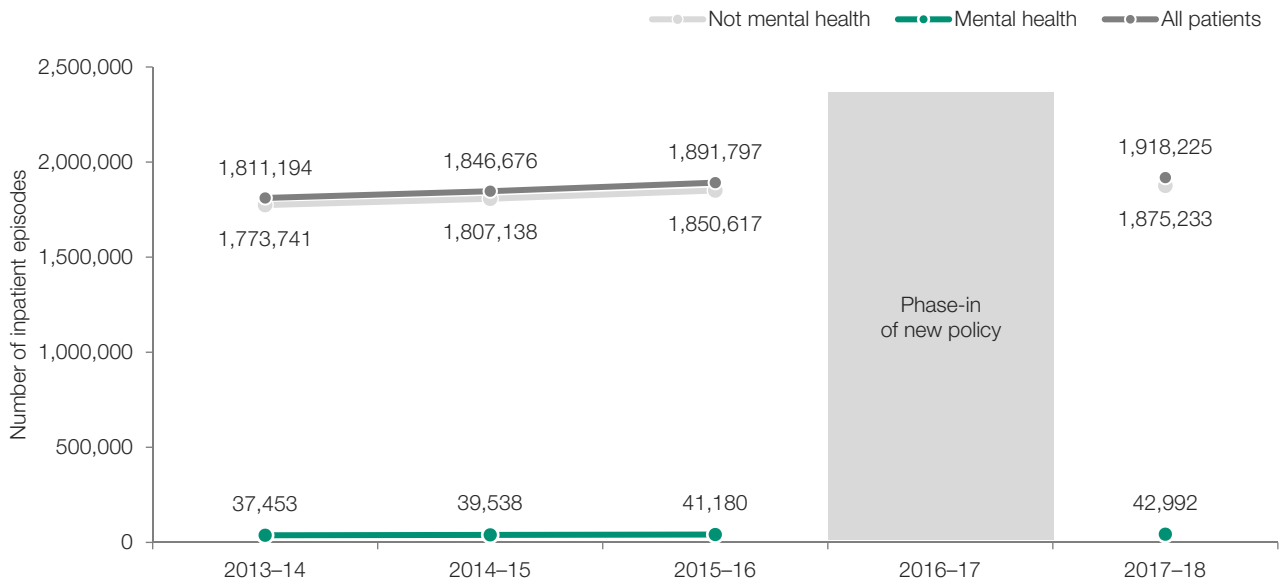
Episodes of care in specialised mental health inpatient units grew at a faster rate than overall episodes of care for admitted patients, particularly among young adults

Between 2013–14 and 2017–18, the number of overnight, same-day, acute and non-acute episodes of care in specialised mental health inpatient units grew by 15%, a faster rate than overall growth in episodes of care for admitted patients (6%) (Figure 4).

Over this period, the highest rate of growth for overnight, acute episodes of care in specialised mental health inpatient units was for patients aged 15–24 years, which increased by 23% (from 64 to 79 episodes per 10,000 population). Care in specialised mental health inpatient units for those aged 65+ years remained unchanged at 21 episodes per 10,000 population across the period (Figure 5).

Among Aboriginal patients, the prevalence of episodes of care in specialised mental health inpatient units in 2017–18 (136 per 10,000) was higher than for all patients (46 per 10,000) and for each age group (Figures 5–6).

Figure 4 **Number of episodes of care in specialised mental health inpatient units and general wards in NSW public hospitals, 2013–14 to 2017–18**



Percentage of episodes of care in specialised mental health inpatient units

2013–14	2014–15	2015–16	2016–17	2017–18
2.1%	2.1%	2.2%	–	2.2%

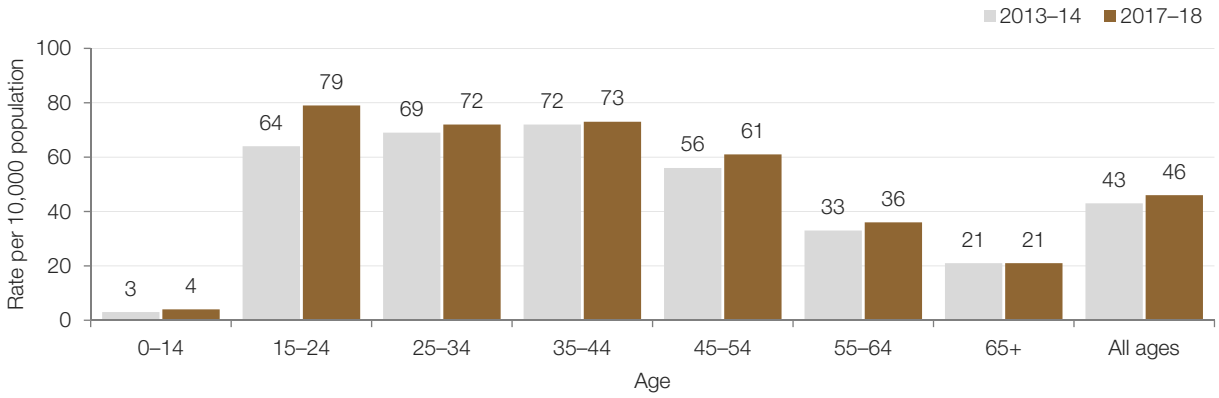
Note: These figures include acute, non-acute, same-day and overnight care in 167 specialised mental health inpatient units. Episodes of care in small specialist mental health inpatient units that focus on older adults who have organic mental disorders are excluded (i.e. seven T-BASIS and OPMH non-acute units which included 293 episodes of care in 2017–18). Same-day admitted episodes of care in mental health social day programs and ECT clinics have also been excluded (i.e. eight social day programs and ECT clinics which included 3962 episodes of care in 2017–18.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019

Phase-in of new policy

Between 1 July 2016 and 30 June 2017, all LHDs and health networks introduced a mental health care type when classifying newly admitted or long standing mental health patients. This was part of the Independent Hospital Pricing Authority's (IHPA) implementation of the Australian Mental Health Care Classification collection. Fair comparisons cannot be made with results from the policy phase-in period due to staggered implementation across LHDs that affected activity counts in the acute, non-acute and mental health categories and comparisons between pre- and post-policy period should be made with caution.

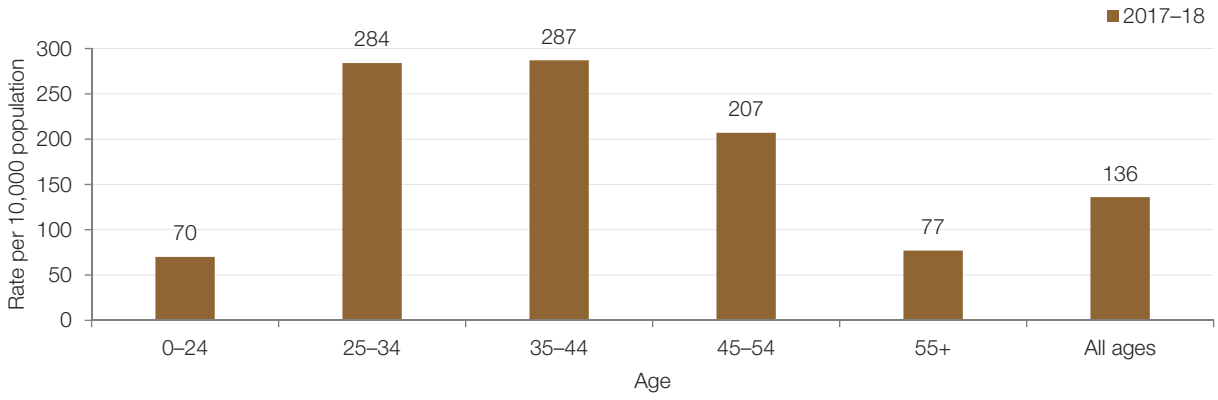
Figure 5 **Overnight acute episodes of care per 10,000 population in specialised mental health inpatient units in NSW public hospitals, by age, 2013–14 and 2017–18**



Note: These figures include overnight acute episodes of care in the number of specialised mental health inpatient units relevant to each year.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019. Population file extracted from Secure Analytics for Population Health Research and Intelligence (SAPHaRI) on 9 April 2019.

Figure 6 **Overnight acute episodes of care among Aboriginal patients per 10,000 Aboriginal population in specialised mental health inpatient units in NSW public hospitals, by age, 2017–18**



Note: These figures include overnight acute episodes of care (N=3,604) in specialised mental health inpatient units. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 85%. See the Technical Supplement for more information.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019. Population file: Estimates of Aboriginal and Torres Strait Islander Australians, June 2016, extracted from Australian Bureau of Statistics (ABS) on 16 April 2019.

Mental health episodes of care by age

Almost one-quarter of overnight acute mental health-related episodes of care were experienced by patients aged 0–25 years

In 2017–18, patients admitted with mental health-related issues were younger than those admitted to NSW public hospitals for other reasons. Almost one-quarter of overnight acute episodes of care in specialised mental health inpatient units (23%) were experienced by patients aged 0–25 years (2% aged 0–14 years, 21% aged 15–24 years). An additional 23% were aged 25–34 years (Figure 7).

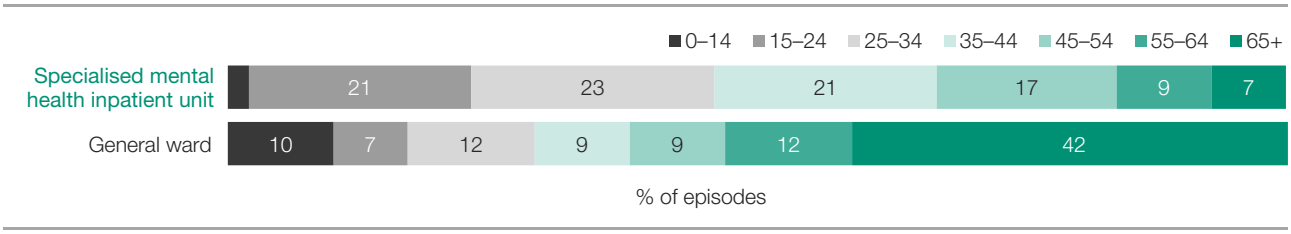
Among those aged 0–14 years, the most prevalent primary diagnoses for overnight acute episodes of care in specialised mental health inpatient units were adjustment and anxiety disorders (28%) and mood disorders (25%) (Figure 8).

Among those aged 15–24 years, the most prevalent primary diagnoses included psychotic disorders (24%), adjustment and anxiety disorders (19%) and mood disorders (18%) (Figure 8).

Among those aged 25–64 years, the most prevalent primary diagnoses included psychotic disorders (approximately 40% of episodes), mood disorders (approximately 15–30% of episodes), and adjustment and anxiety disorders (approximately 14% of episodes) (Figure 8).

For Aboriginal patients, the most prevalent primary diagnoses among those aged 0–25 years in 2017–18 included psychotic disorders (30%), adjustment and anxiety disorders (19%) and personality disorders (14%) (Figure 9).

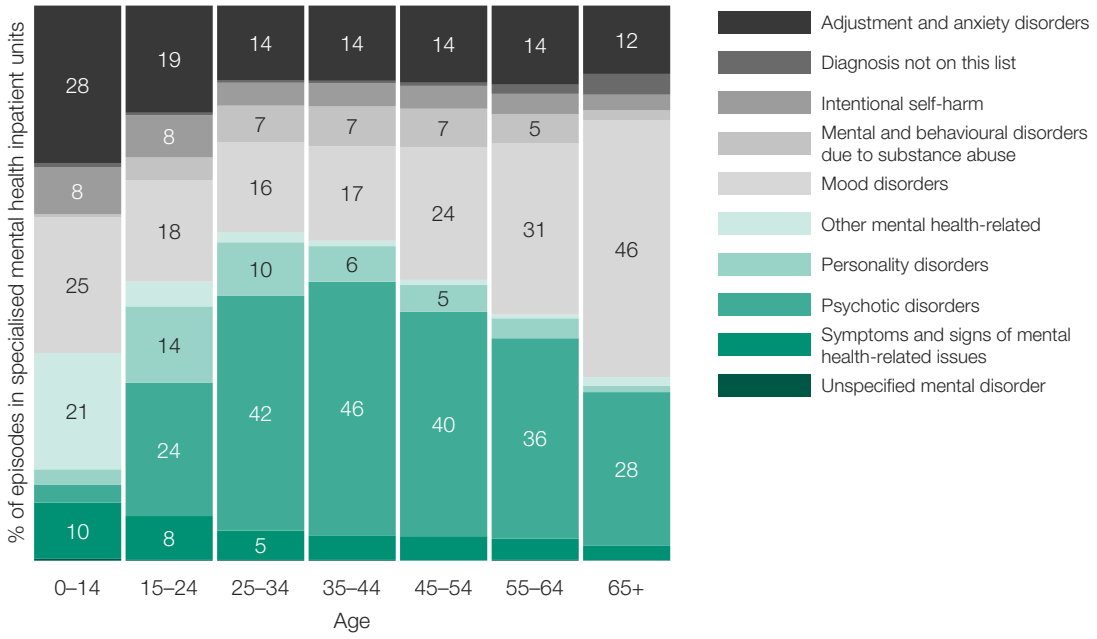
Figure 7 **Percentage of overnight acute episodes of care in specialised mental health inpatient units and general wards in NSW public hospitals, by mental health-related episodes and others, and age, 2017–18**



Note: Figures for mental health-related episodes include overnight acute episodes of care (n=36,526) in 118 specialised mental health inpatient units. Numbers may not sum to 100 due to rounding.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

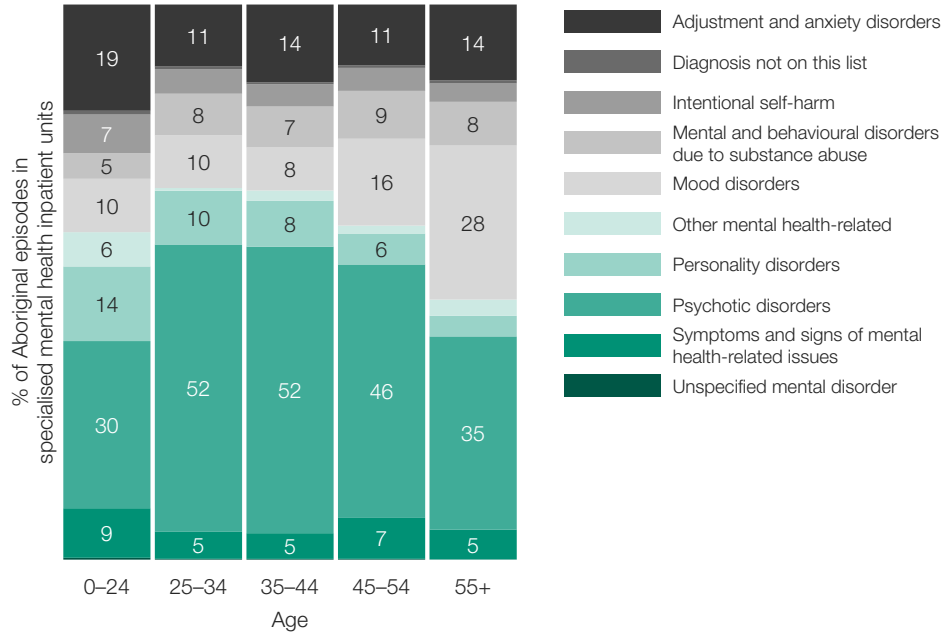
Figure 8 **Percentage of overnight acute episodes of care in specialised mental health inpatient units in NSW public hospitals where there is a primary, secondary or subsequent diagnosis of a mental health-related condition or a secondary diagnosis of intentional self-harm, by mental health diagnosis and age, 2017–18**



Note: These figures include overnight acute episodes of care (n=36,526) in 118 specialised mental health inpatient units.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Figure 9 **Percentage of overnight acute episodes of care among Aboriginal patients in specialised mental health inpatient units in NSW public hospitals where there is a primary, secondary or subsequent diagnosis of a mental health-related condition, or a secondary diagnosis of intentional self-harm, by mental health diagnosis and age, 2017–18**



Note: These figures include overnight acute episodes of care (n=3,604) in 110 specialised mental health inpatient units. The completeness and accuracy of the Aboriginal identifier in 2017 is estimated to be 85%. See the Technical Supplement for more information.

Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Experiences and overall ratings of care

Patients' experiences in specialised mental health inpatient units varied across NSW local health districts (LHDs)

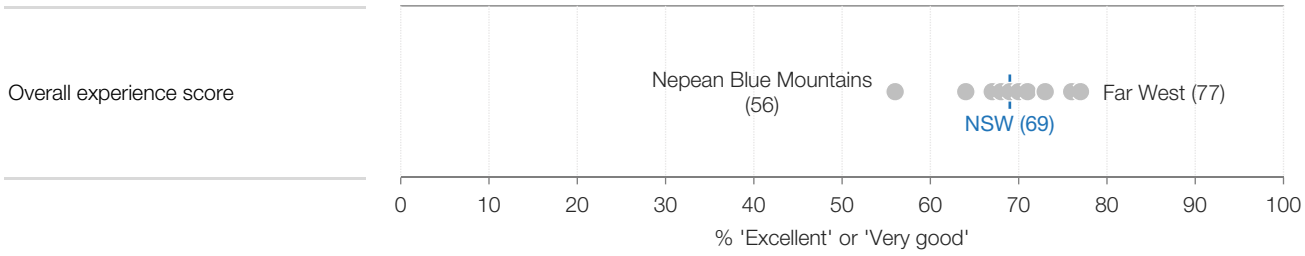
Understanding how experiences of care may differ between patients in specialised mental health inpatient units across NSW can help inform efforts to improve mental health care. In 2017–18, 69% of adults and children aged 11+ years who received care in one of 163 specialised mental health inpatient units in NSW rated their overall experiences of care as 'very good' or 'excellent' (Figure 10).

Adults and children gave higher ratings for certain aspects of care, measured by frequency scales, including: being recognised, valued and treated with dignity; being provided with a physically and emotionally safe environment and treated reasonably and fairly; sensitivity to culture, gender, personal values and beliefs; and opportunities for engagement, choice and involvement in care (Figure 11).

By comparison, adults and children gave lower ratings for aspects of care measured by other performance scales, including: whether they were provided with resources such as written information, a care plan and access to peer support; and whether the service made a difference to their social and emotional wellbeing and physical health (Figure 11).

For all measures, adults and children's ratings of their experiences of care in specialised mental health inpatient units varied widely across NSW LHDs (Figures 10 and 11).

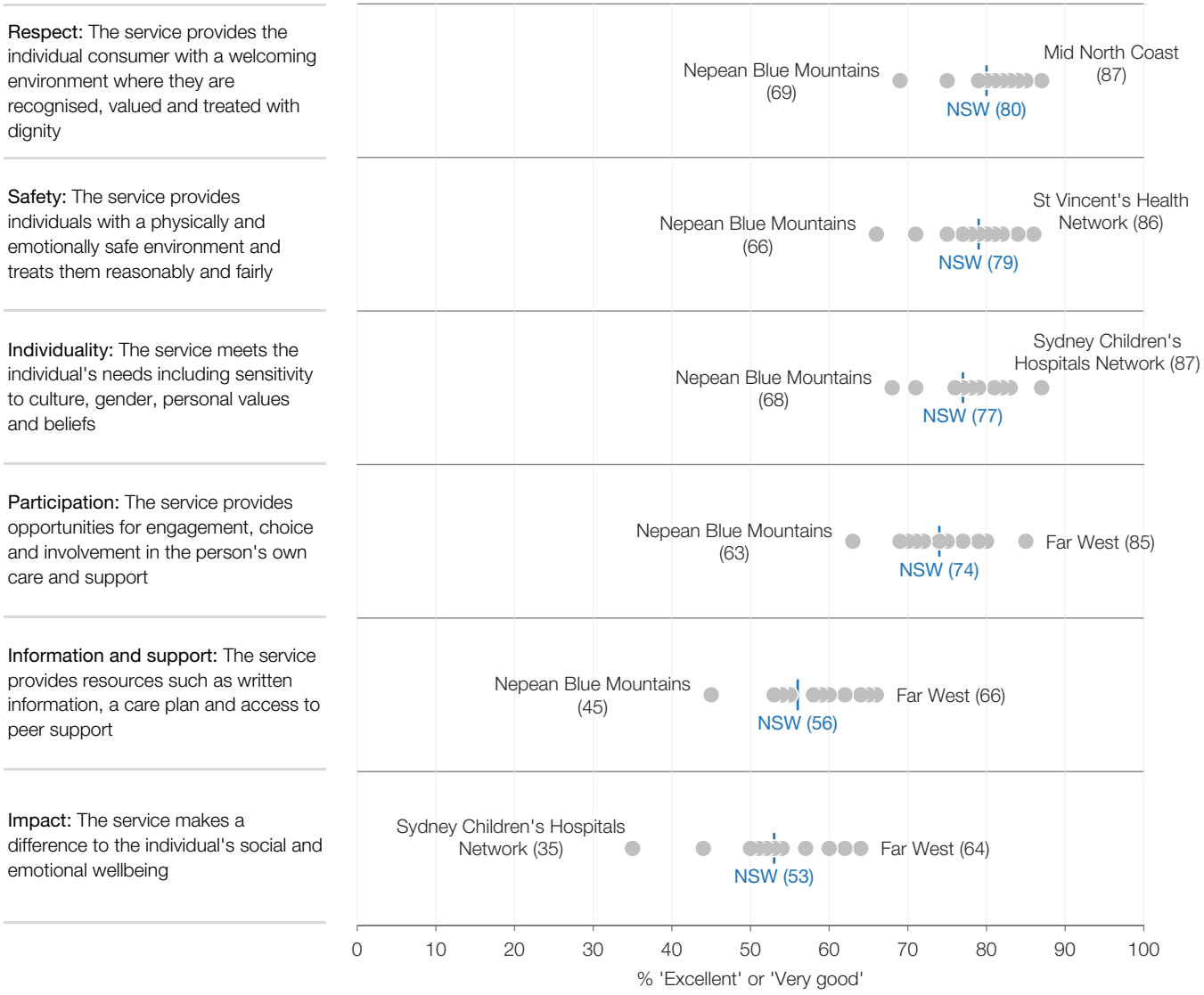
Figure 10 **Overall ratings of care index in public specialised mental health inpatient units, adults and children aged 11+ years, NSW and by NSW local health district, 2017–18**



Note: In 2017–18, 15,123 YES surveys were completed by patients in 163 specialised mental health inpatient units upon discharge, representing a 34% response rate. Charts do not include Justice Health and Forensic Mental Health Network. Results are crude and not weighted to reflect the demographic structure of the population of patients who receive care in specialised mental health inpatient units. The overall experience score represents a composite of questions.

Source: NSW Ministry of Health, Your Experience of Service survey, 2017–18.

Figure 11 **Patient-reported experiences in public specialised mental health inpatient units, adults and children aged 11+ years, NSW and by NSW local health district, 2017–18**



Note: In 2017–18, 15,123 YES surveys were completed by patients in 163 specialised mental health inpatient units upon discharge, representing a 34% response rate. Charts do not include Justice Health and Forensic Mental Health Network. Results are crude and not weighted to reflect the demographic structure of the population of patients who receive care in specialised mental health inpatient units. Each result represents a composite of relevant questions.

Source: NSW Ministry of Health, Your Experience of Service survey, 2017–18.

Women's experiences and ratings of maternity care

Women who reported a longstanding mental health condition had less positive experiences of maternity care

Understanding how experiences of hospital care differ between mothers with lived experience of mental health issues and those without helps inform efforts to improve maternity care.

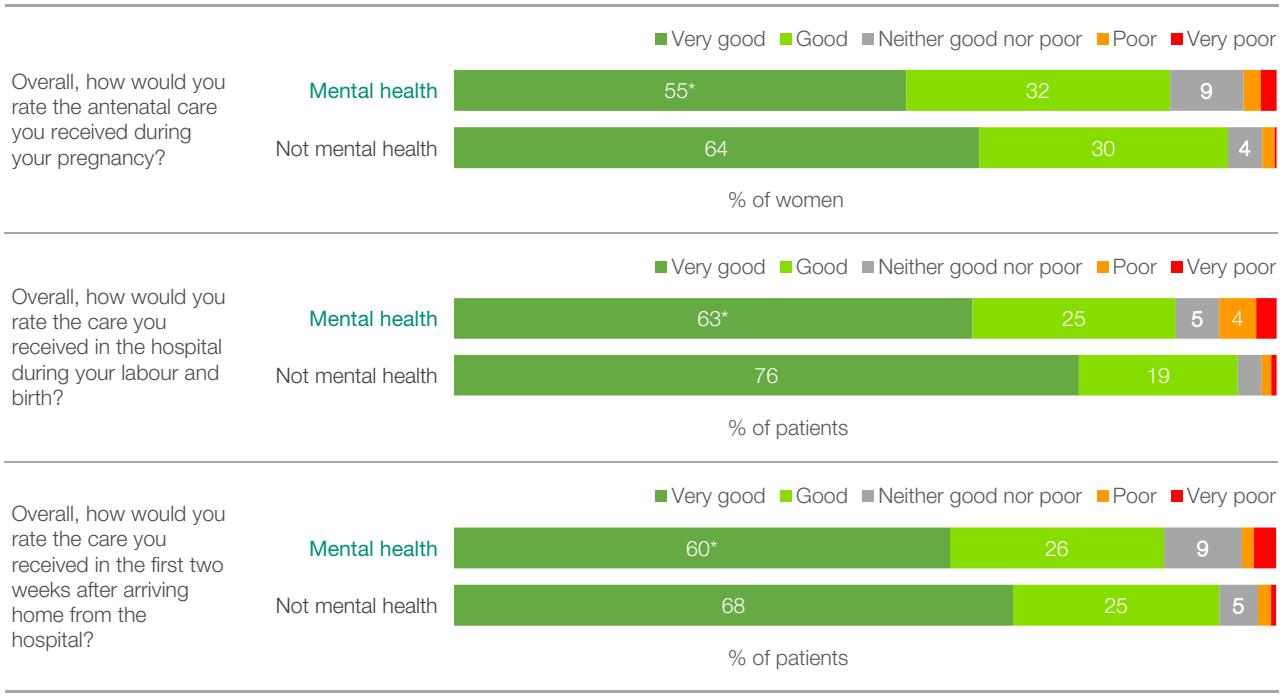
In 2017, almost 62,000 women gave birth in NSW public hospitals. Among the 5,000 women who participated in the BHI Maternity Care Survey, 7% reported they had a longstanding mental health condition, which was the most common longstanding condition reported. The percentage of women who said they had a longstanding mental health condition was more than double for mothers aged 18–24 years (15%) compared with all other age groups (7%).

Overall ratings of antenatal care, care during labour and birth, and follow-up care were less positive for women who had a longstanding mental health condition.

Among those with a longstanding mental health condition, 63% rated their care during labour and birth as 'very good' compared with 76% of women with no mental health condition (Figure 12).

Mothers with a longstanding mental health condition gave lower ratings for care across a wide range of topics. There were gaps of 10 percentage points or more for survey questions regarding their experiences in relation to respect and dignity, patient engagement and being given enough information (Figure 13).

Figure 12 **Overall ratings of care among women with and without a longstanding mental health condition in NSW public hospitals, 2017**

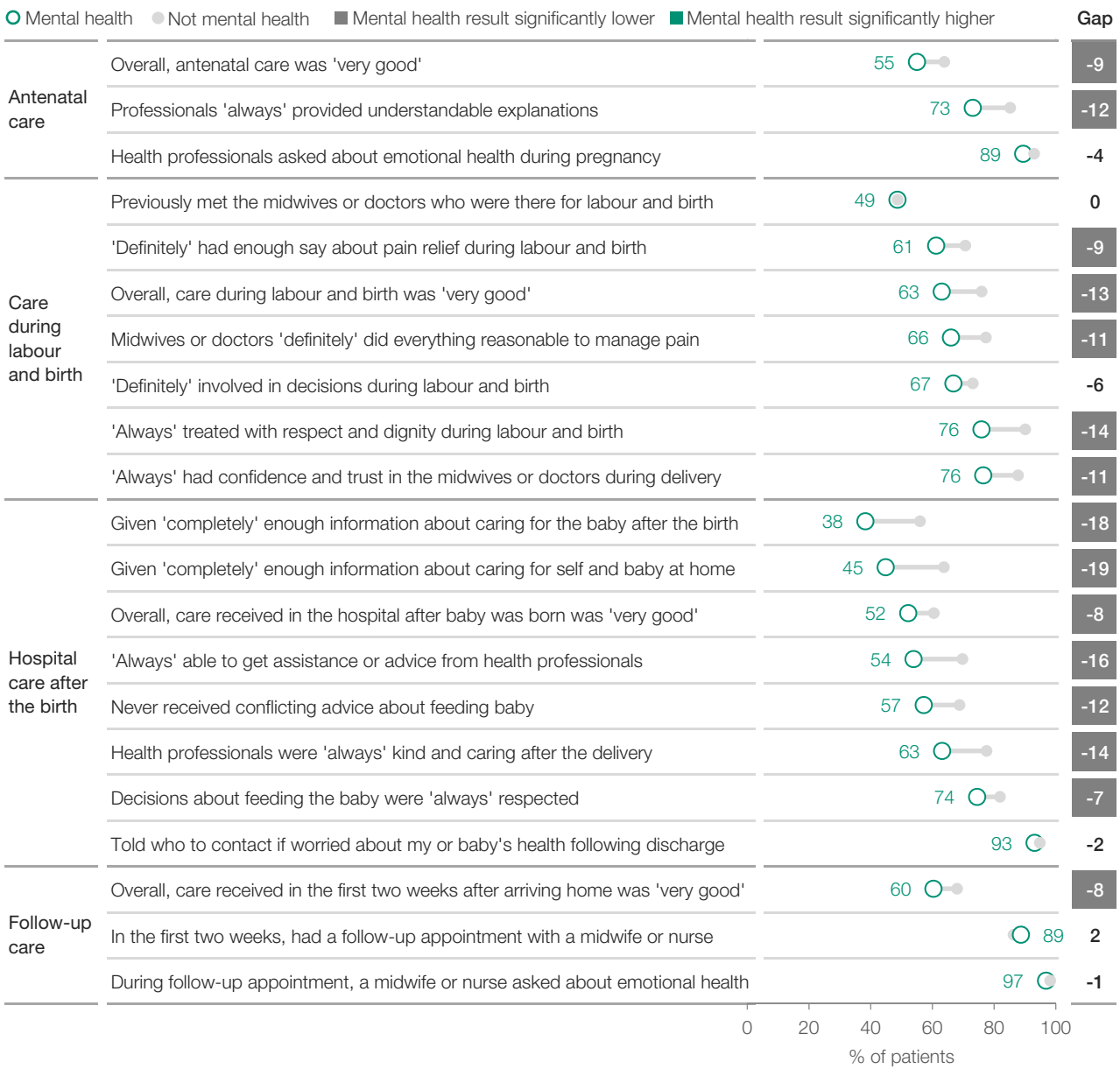


*Significantly different result for those with a longstanding mental health condition compared with those with no longstanding mental health condition after adjusting for mothers' age and language spoken at home.

Note: In 2017, a survey was mailed to women who attended one of 71 NSW public hospitals about three months after labour and delivery, and 4,787 people responded, representing a 35% response rate. Results are weighted to represent the NSW age structure of new mothers. Women with a longstanding mental health condition include those who report 'yes' to this question on a survey as specified in the Technical Supplement to this report (n=353). Numbers may not sum to 100 due to rounding.

Source: Bureau of Health Information, NSW Maternity Care Survey 2017.

Figure 13 **Patient-reported experiences of maternity care in NSW public hospitals, mothers with and without a longstanding mental health condition, 2017**



Note: In 2017, a survey was mailed to women who attended one of 71 NSW public hospitals about three months after labour and delivery, and 4,787 people responded, representing a 35% response rate. Results are weighted to represent the NSW age structure of new mothers. Women with a longstanding mental health condition include those who report 'yes' to this question on a survey as specified in the Technical Supplement to this report (n=353).

The distribution of patient characteristics in the survey closely reflect the same age, immigrant status and geographic distribution characteristics of the new mothers in the hospital records. Since women self-report their mental health condition, there is no way to determine what proportion of women had mental health conditions of all those who gave birth. Therefore, the sample was not selected to be representative of people with mental health conditions. The survey likely under-represents mothers with serious mental health conditions as the sample excludes women who spent any time in a psychiatric unit, had a history of self-harm or expressed suicidal ideation.

Source: Bureau of Health Information, NSW Maternity Care Survey 2017.

Experiences and ratings of cancer care

Patients with and without a longstanding mental health condition reported positive experiences of outpatient cancer care

Patients who attend outpatient cancer centres for diagnoses and treatment are likely to face psychological and emotional stress. Therefore, understanding how experiences of cancer care differ between patients with lived experience of mental health issues and those without helps inform efforts to improve care.

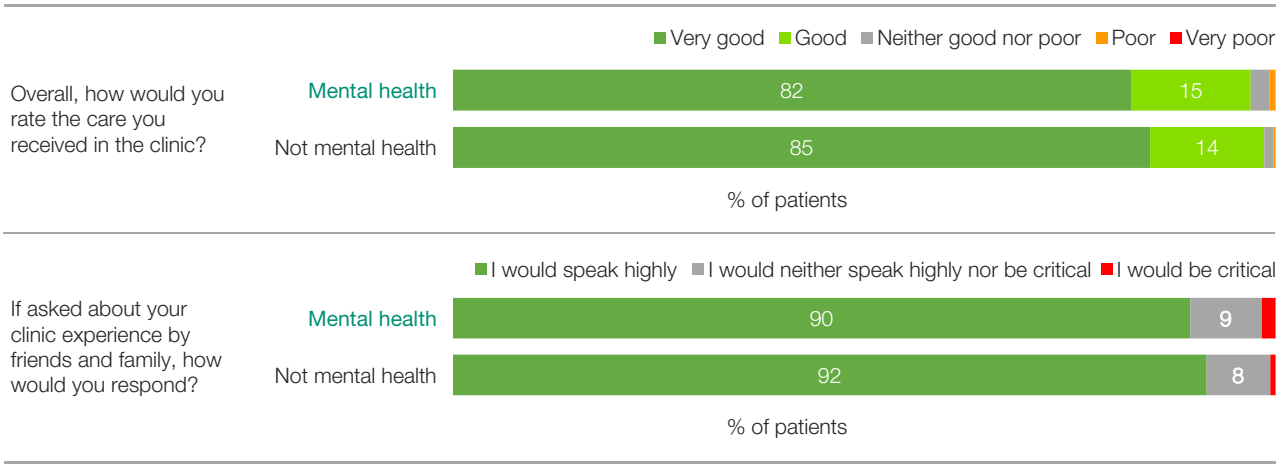
In November 2017, more than 11,000 adults attended one of 50 clinics and participated in the BHI Outpatient Cancer Clinics Survey, with 7% reporting they had a longstanding mental health condition.

Overall ratings of care in outpatient cancer clinics were positive for most patients. This included those with a longstanding mental health condition, with 82% rating care as 'very good' compared with 85% of those with no condition (Figure 14).

Patients with a longstanding mental health condition gave lower ratings for some types of experiences, though there were no large gaps of 10 percentage points or more as there were for maternity care (see pages 72–73).

For example, patients with a longstanding mental health condition were less likely to say professionals 'always' explained things in a way they could understand (84% compared with 91% of those with no mental health condition) (Figure 15).

Figure 14 **Overall ratings of outpatient cancer care across NSW public and two private hospitals, adults with and without a longstanding mental health condition, 2017**

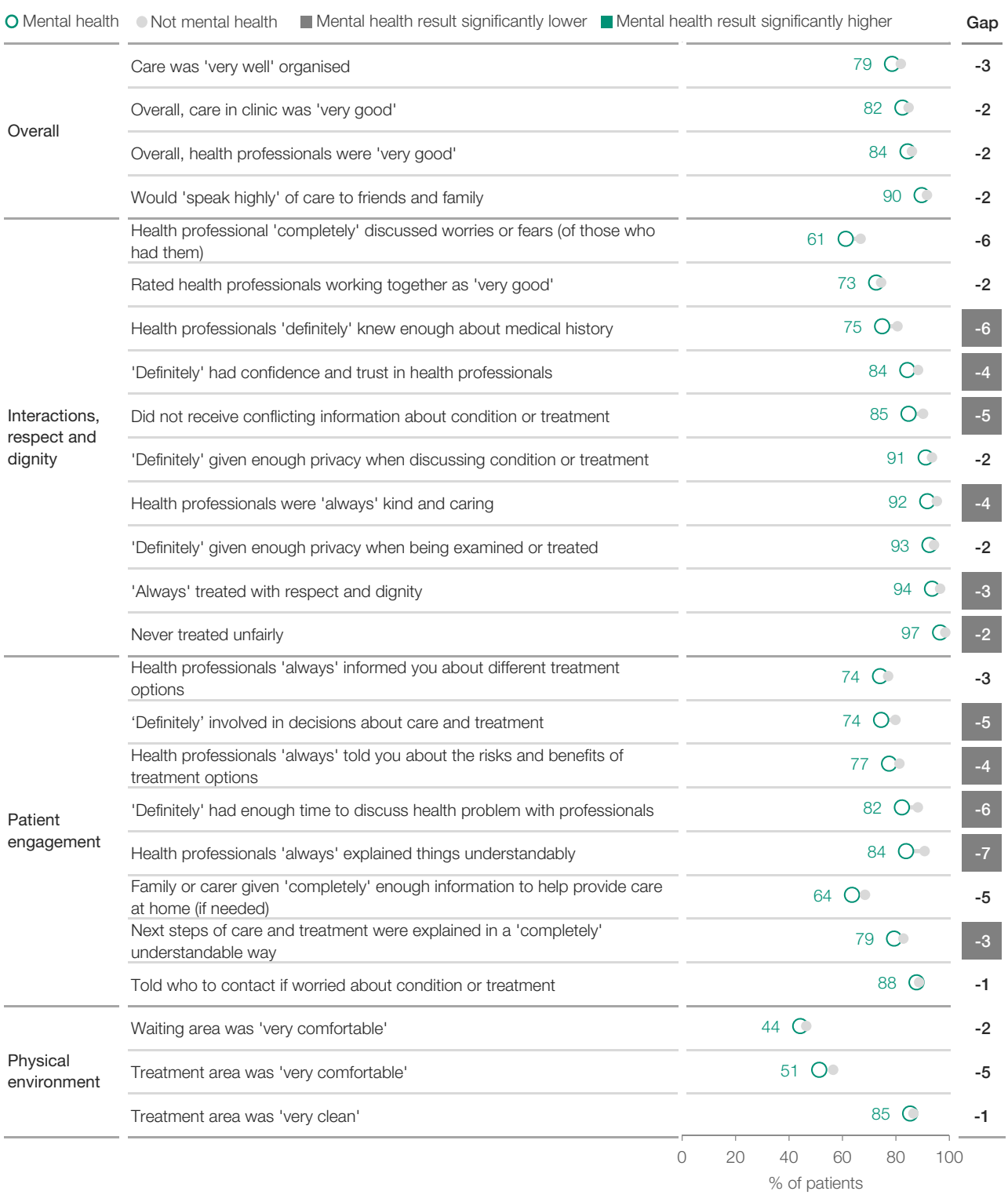


*Significantly different result for those with a longstanding mental health condition compared with those with no longstanding mental health condition after adjusting for age, sex, and language spoken at home.

Note: In 2017, a survey was mailed to adults who attended an outpatient cancer clinic in one of 48 public and two private hospitals, about three months after their visit, and 11,301 people responded, representing a 49% response rate. Results are weighted to represent the age-sex structure of patients who attend these clinics. Adults with a longstanding mental health condition (n=799) include those who report 'yes' to this question on a survey as specified in the Technical Supplement to this report. Numbers may not sum to 100 due to rounding.

Source: Bureau of Health Information, NSW Outpatient Cancer Clinics Survey 2017.

Figure 15 **Patient-reported experiences of care in cancer outpatient clinics across NSW public and two private hospitals, adults with and without a longstanding mental health condition, NSW, 2017**



Note: In 2017, a survey was mailed to adults who attended an outpatient cancer clinic in one of 48 public and two private hospitals, about three months after their visit, and 11,301 people responded, representing a 49% response rate. Results are weighted to represent the age-sex structure of patients who attend these clinics. Adults with a longstanding mental health condition (n=799) include those who report 'yes' to this question on a survey as specified in the Technical Supplement to this report.

Source: Bureau of Health Information, NSW Outpatient Cancer Clinics Survey 2017.

Involuntary care, seclusion and restraint

Almost half of patients in specialised mental health inpatient units were admitted involuntarily

A person can be admitted to a specialised mental health inpatient unit voluntarily or involuntarily. The *NSW Mental Health Act 2007* sets out strict criteria that must be met for someone to be admitted involuntarily.

In 2017–18, less than half of the episodes of care among overnight acute episodes of care in specialised mental health inpatient units (47%), but more than half of acute bed days (59%), were experienced by patients admitted involuntarily (Figure 16).

Restrictive interventions, including seclusion and restraint, are not therapeutic. Whenever possible, the least restrictive approaches to protecting patients and staff are optimal. Seclusion means a patient is placed in a room or an area alone at any time of the day or night with no freedom of exit. It is not determined by the duration of the confinement or the size and type of area in which a patient is confined.

In 2017–18, the rate of seclusion in specialised acute mental health inpatient units in NSW was 6.0 per 1,000 bed days, which was lower than the rate in 2016–17 (6.9 per 1,000 bed days) and the national rate in 2017–18 (6.9 per 1,000 bed days).[16]

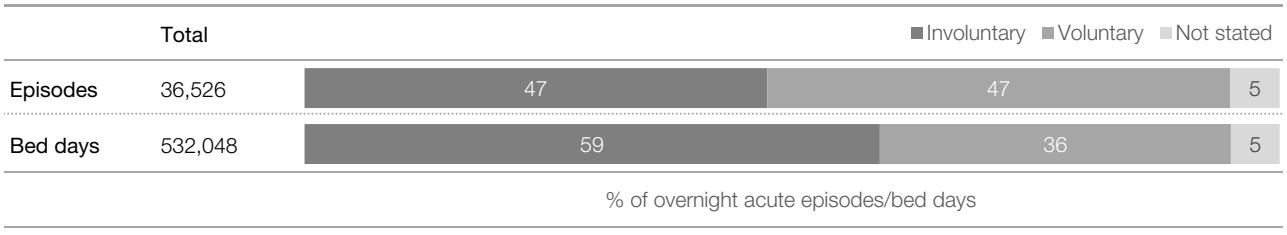
The average number of hours per seclusion event in specialised acute mental health units in NSW, excluding forensic services, was 4.7 hours, which was lower than in 2016–17 (5.5 hours) and nationally in 2017–18 (5.1 hours).[16]

Restraint means a patient's freedom of movement is restricted by physical means (i.e. the hands-on immobilisation by healthcare staff), or mechanical means (i.e. application of devices).

In 2017–18, the rate of physical restraint in specialised acute mental health units in NSW was 8.0 per 1,000 bed days which was lower than the national rate (10.3 per 1,000 bed days). The rate of mechanical restraint was 0.3 per 1,000 bed days which was also lower than the national rate (0.5 per 1,000 bed days).[16]

There was variation across hospitals in the use of seclusion and restraint.[16] BHI will commence routine reporting on the prevalence, rate, volume and duration of seclusion and restraint across NSW public hospitals in *Healthcare Quarterly* reports in 2019.

Figure 16 **Percentage of overnight acute episodes of care and bed days in specialised acute mental health inpatient units by legal status in NSW public hospitals, 2017–18**



Note: These figures include overnight acute episodes of care (n=36,526) in specialised acute mental health inpatient units. Numbers may not sum to 100 due to rounding.
Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Intentional self-harm

More than half of episodes of care for intentional self-harm were for patients aged 15–34 years and the majority had a mental health diagnosis

'Intentional self-harm' is deliberate self-injury or self-poisoning, irrespective of motive or the extent of suicidal intent. Methods of self-harm are varied and may include self-cutting, jumping from heights and self-exposure by ingesting or inhaling potentially harmful substances.[17] The way in which people self-harm, and their reasons for it, influence whether they are hospitalised.

Patients admitted due to intentional self-harm may be admitted directly to a specialised mental health inpatient unit if their physical and mental health needs can be addressed in this setting, or they may be admitted to a general ward if they have high physical needs.

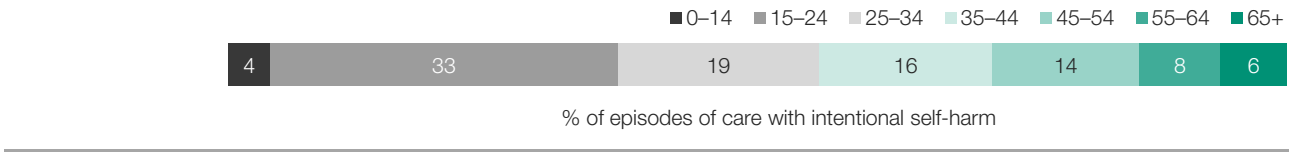
In 2017–18, there were 9,739 episodes of care for patients admitted for intentional self-harm in NSW public hospitals. More than two-thirds (69%) were treated on general wards, while the remainder (31%) received care in a specialised mental health inpatient unit. In total, 18% of episodes of care were experienced by patients admitted involuntarily.

Among all episodes of care for patients who intentionally self-harmed, the majority stayed overnight (87%) and stayed in hospital three days or fewer (72%).

In 2017–18 almost 80% of patients who experienced episodes of care in NSW following intentional self-harm (79%) had a mental health-related diagnosis. On general wards 73% of intentional self-harm episodes were experienced by patients who had one or more mental health-related diagnoses, and on specialist inpatient units 95% of self-harm episodes had one or more mental health-related diagnoses.

A majority of patients who experienced episodes of care following intentional self-harm (62%) were females, and almost 11% were Aboriginal. More than half of the episodes of care (52%) were experienced by patients aged 15–34 years (Figure 17).

Figure 17 **Percentage of episodes of care with intentional self-harm in general wards and specialised mental health inpatient units in NSW public hospitals, by age, 2017–18**



Note: Episodes of care with a diagnosis of intentional self harm (n=9,739) across 145 NSW public hospitals.
Source: BHI analysis of Admitted Patient Data Collection, Health Information Exchange, NSW Health, data extracted 2 April 2019.

Care in the community following discharge from mental health inpatient units

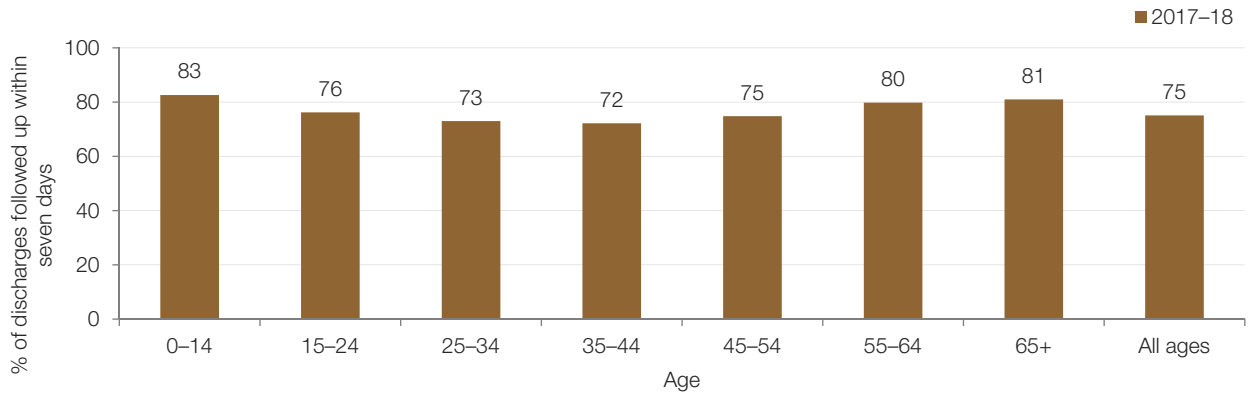
Three-quarters of patients were contacted by community mental health services within a week of discharge

Discharge from hospital is a critical transition point for people with lived experience of mental health issues. Patients leaving hospital after being admitted for a mental health-related issue have heightened levels of vulnerability and, without adequate follow-up, may relapse or be readmitted. The post-discharge period is also a time of great stress and uncertainty for families and carers.[18]

In 2017–18 the rate of community follow-up within seven days of discharge from a specialised acute mental health inpatient unit in NSW was 75%. There was variation in the rates of follow-up by age group. Patients aged 0–14 years were contacted within seven days on 83% of occasions, whereas patients aged 35–44 years were contacted on 72% of occasions (Figure 18).

There was similar variation in the rate of community follow-up within seven days of discharge from a specialised acute mental health inpatient unit across NSW LHDs. The majority of Aboriginal (88%) and non-Aboriginal (82%) patients in Murrumbidgee LHD were contacted within seven days of discharge. In Nepean Blue Mountains LHD 59% of Aboriginal and 66% of non-Aboriginal patients were contacted within seven days (Figure 19).

Figure 18 **Percentage of discharges from a specialised acute mental health inpatient unit contacted by community mental health services within seven days of discharge, by age, NSW, 2017–18**



Notes: This performance measure was calculated by the NSW Ministry of Health.
Source: NSW Ministry of Health, System Information and Analytics Branch, InforMH.

Figure 19 **Percentage of discharges from a specialised acute mental health inpatient unit contacted by community mental health services within seven days, by Aboriginality, NSW and by NSW local health district, 2017–18**

Notes: This performance measure was calculated by the NSW Ministry of Health. Local health districts with fewer than 50 discharges for Aboriginal people and fewer than 50 discharges for non-Aboriginal people are suppressed.

Source: NSW Ministry of Health, System Information and Analytics Branch, InforMH.

References

About this report

1. Minas H, et al. Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. Brisbane: Mental Health in Multicultural Australia. 2013.
2. The National LGBTI Health Alliance. Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People. Sydney: The National LGBTI Health Alliance. 2016.
3. NSW Ministry of Health. Your Experience of Service: What consumers say about NSW Mental Health Services, 2017–2018. Sydney: NSW Ministry of Health, 2018.

Context

4. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: summary of results, Australia, 2007. Cat. no. 4326.0. Canberra: ABS, 2008.
5. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry 2007;20(4):359.
6. The Royal Australian and New Zealand College of Psychiatrists. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand. Melbourne: RANZCP, 2010.
7. NSW Ministry of Health. NSW Health Addendum to Submission No 13. PAC Inquiry into the Management of Healthcare Delivery in NSW. Sydney: PAC, 2017.
8. Whiteford H, Buckingham B, Harris M, Diminic S, Stockings E, Degenhardt L. Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. Aust N Z J Psychiatry 2017;51(8):799–809.
9. NSW Ministry of Health. NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022: A Framework and Workforce Plan for NSW Health Services. Sydney: NSW Ministry of Health, 2018.
10. Australian Health Ministers' Advisory Council. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Canberra: Commonwealth of Australia, 2013.
11. Department of Health and Human Services, Recovery-oriented practice: Literature review. Melbourne: State of Victoria, 2011.
12. Commonwealth Department of Health. Joint regional planning for integrated mental health and suicide prevention services: A guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs). Canberra: Commonwealth of Australia, 2018.
13. Australian Institute of Health and Welfare. Ambulatory mental health care service. METeOR Glossary Item 699980. Canberra: Commonwealth of Australia. 2018.

Care in the community

14. Corscadden L, Callander E, Topp S. Who experiences unmet need for mental health services and what other barriers to accessing health care do they face? Findings from Australia and Canada. Int J Health Plann Manage 2019;1–12.
15. Rodgers M, et al. Integrated care to address the physical health needs of people with severe mental illness: a mapping review of the recent evidence on barriers, facilitators and evaluations. In J Integr Care 2018;18(1).

Inpatient Care

16. Australian Institute of Health and Welfare. Mental health services in Australia, Restrictive Practices. Sydney, Commonwealth Government of Australia.
17. Hawton K, Saunders KE, O'Connor RC. Self-harm and suicide in adolescents. Lancet 2012;379(9834):2373–82.
18. Department of Health and Ageing. National Mental Health Report 2013: Tracking progress of mental health reform in Australia 1993–2011. Canberra: Commonwealth of Australia, 2013.

Acknowledgements

The Bureau of Health Information (BHI) is the main source of information for the people of NSW about the performance of their public healthcare system. A board-governed organisation, BHI is led by Chairperson Professor Carol Pollock and Chief Executive Dr Diane Watson.

We would like to recognise and thank those people with lived experience of mental health issues and their families, friends, carers and kinship groups, particularly those who took the time to participate in BHI patient surveys.

We would also like to thank members of the BHI Healthcare in Focus Mental Health Advisory Group and the NSW Ministry of Health.

We acknowledge BHI's dedicated teams of analytics, research, corporate, design and communications professionals whose expertise made this report possible.

BHI Healthcare in Focus Mental Health Advisory Group

Amanda Mulcahy	(formerly) NSW Ministry of Health
Ashleigh Mills	Mental Health Commission of NSW
Bè Aadam	Consumer representative
Associate Professor Beth Kotze	Western Sydney Local Health District
Catherine Lourey	Mental Health Commission of NSW
Cathy Baker	(formerly) Mental Health Commission of NSW
Cherie Puckett	Southern NSW Local Health District
Christine Flynn	Mental Health Commission of NSW
David McGrath	External Expert Advisor
Fayez Nour	Carer representative
Associate Professor Grant Sara	Information for Mental Health (InforMH)
Doctor Karin Lines	(formerly) NSW Ministry of Health
Kath Schelling	(formerly) Agency for Clinical Innovation
Paul De Carlo	NSW Ministry of Health
Robyn Manzie	Murrumbidgee Local Health District
Sanjeewanie Kariyawasam	(formerly) Mental Health Commission of NSW
Sharon Jones	NSW Ministry of Health
Tania Skippen	(formerly) Mental Health Commission of NSW
Victoria Hirst	Mental Health Commission of NSW

About the Bureau of Health Information

The Bureau of Health Information (BHI) is a board-governed organisation that provides independent information about the performance of the NSW healthcare system.

BHI was established in 2009 and supports the accountability of the healthcare system by providing regular and detailed information to the community, government and healthcare professionals. This in turn supports quality improvement by highlighting how well the healthcare system is functioning and where there are opportunities to improve.

BHI manages the NSW Patient Survey Program, gathering information from patients about their experiences and outcomes of care in public hospitals and other healthcare facilities.

BHI publishes a range of reports and information products, including interactive tools, that provide objective, accurate and meaningful information about how the health system is performing.

BHI's work relies on the efforts of a wide range of healthcare, data and policy experts. All of our assessment efforts leverage the work of hospital coders, analysts, technicians and healthcare providers who gather, codify and supply data. Our public reporting of performance information is enabled and enhanced by the infrastructure, expertise and stewardship provided by colleagues from NSW Health and its pillar organisations.

bhi.nsw.gov.au

bureau of health information