Sustainable Health Review

Interim Report: Feedback

Following the Sustainable Health Review Interim Report feedback was sought. Open feedback provided by the organisation or individual is detailed below.

Your Personal Details	
1. **Title**	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐
2. First Name(s)	
3. Surname	
4. Contact Details	
5. Organisation	Australasian College for Emergency Medicine (ACEM)
6. Location	☐ Metropolitan ☐ Regional WA ☐ Outside WA
7. Are you providing a response on behalf of your group/organisation or as an individual? **(Required)**	☒ Group/organisation ☐ Individual ☐ Other, please specify_____
Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)	
☒ I consent to my feedback being published ☐ I consent to my feedback being published anonymously ☐ I do not consent to my feedback being published	

AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

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17 May 2018

Robyn Kruk AM
Independent Panel Chair
Sustainable Health Review

Via email: SHR@health.wa.gov.au

Dear Ms Kruk

Re: Response to the Sustainable Health Review Panel's Interim Report

Thank you for the opportunity to respond to the Sustainable Health Review Panel's Interim Report on developing a more sustainable health system for Western Australia (WA). As you know, in October 2017 the Australasian College of Emergency Medicine (ACEM) provided a detailed submission describing the pressures on the health system and made recommendations for evidence based strategies and initiatives to address these issues.

Addressing the Increase in Emergency Department presentations

Major increases in acute care demand are occurring across every state and territory of Australia and are a challenge for all health systems to manage. Each year, ACEM conducts snapshot surveys to monitor access block in public hospitals[1]. Results from December 2017 show that approximately 30% of ED work is caring for patients waiting for an inpatient bed. With a forecast population growth rate of at least 2% per annum for the next eight years, WA's demand management strategies need to include growth in hospital beds and the associated workforce.

Some patients may be attending EDs due to inadequate access to community based care options, poor management of chronic disease or lack of resources for end of life care. We support the development of diversion strategies, including the proposed telehealth pilots and alternative care pathways, where these strategies are properly funded, evaluated, sustainable and effective. However, these diversion strategies are not of sufficient timeliness, size and impact to manage continued growth in demand for emergency care and inpatient services.

We therefore reiterate the need to improve the capacity and efficiency of WA's hospitals by;

- increasing the availability of inpatient beds and ED facilities to match population growth,
- implementing demand management protocols, so that pressure on care teams is shared across the whole hospital,
- investing in system wide improvements that improve patient flow, for example through after-hours access to general surgery, access to next day clinics, minor procedure day centres and possibly less reliance on visiting medical officers where other workforce options are feasible,

[1] ACEM *2017 – 2 Access Block Point Prevalence Survey Summary*

- using the evidence regarding optimal patient outcomes to set more realistic access targets across the different types of hospitals in Western Australia and report on results.

Please note that ACEM's 2017 survey of access block prevalence showed the number of patients waiting 24 hours or more for admission to be worse in WA than Victoria, which has mandatory reporting of these delays to the Minister for Health.

It is essential that the Department of Health engages with ACEM and clinical leaders on the design, implementation and monitoring of both capacity building and diversion strategies.

Addressing Mental Health Access Block

We note in the Interim Report the recommendations for immediate action in relation to new models of care to improve interaction between acute and community based mental health services. We also note some investments in increased mental health capacity announced in the recent state budget but no significant changes in system management. Another review of mental health governance by Professor Bryant Stokes has also been announced.

The pressures on inpatient capacity are particularly acute for people needing mental health care. ACEM's December 2017 snapshot of mental health access block in public EDs across Australia and New Zealand highlighted major problems in WA's mental health system[2]. This survey found that mental health patients accounted for 28% of all the patients waiting in EDs for a bed and 67% of those who had waited for over eight hours, despite mental health patients accounting for less than 5% of all ED attendances. The longest reported wait (using unpublished data) for admission for a bed was eight days or 192 hours. We note that Western Australia had the worst mental health access block measurements in Australasia.

Although often the first point of access, EDs are highly unsuitable environments for people with acute mental health conditions to wait for inpatient beds. Prolonged delays are associated with increased agitation, distress and behavioural disturbance, and poorer health outcomes. These delays increase the safety risks, and reduce the wellbeing of both patients and their treating ED staff. For these reasons ACEM recommends that delays longer than 12 hours in admitting a patient to a psychiatric facility should be reported to the Minister for Health. We advocate for rapidly improved access to mental health beds, crisis care units, increased after-hours care and well-resourced 24/7 step down care in the community. We believe early implementation of these reforms would markedly improve the quality of care provided to some of the most vulnerable people accessing EDs.

Supporting Sustainable Reforms

ACEM is committed to working with stakeholders and the community to ensure that all people have access to equitable, high quality and safe health care. Efficient emergency care is essential to ensuring that patients get timely quality care and that emergency physicians enjoy long sustainable careers contributing their unique skills and expertise to improving patient outcomes. We welcome the opportunity to contribute further to your review.

[2] ACEM *Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions*

If you have further questions or requests of ACEM, please do not hesitate to contact the Executive Director Policy, Research and Advocacy, Ms Nicola Ballenden, on (03) 9320 0444 or via email at Nicola.Ballenden@acem.org.au.

Yours sincerely,

Dr Simon Judkins
President

Associate Professor David Mountain
Chair, Western Australia Faculty

Attachments:
Australasian College of Emergency Medicine, *2017–2 Access Block Point Prevalence Survey Summary*
Australasian College of Emergency Medicine, *Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions*

2017–2 Access Block Point Prevalence Survey Summary

Key points

Demand for emergency department (ED) services in Australia is at a record high.

Australian EDs are approximately 30% over-capacity.

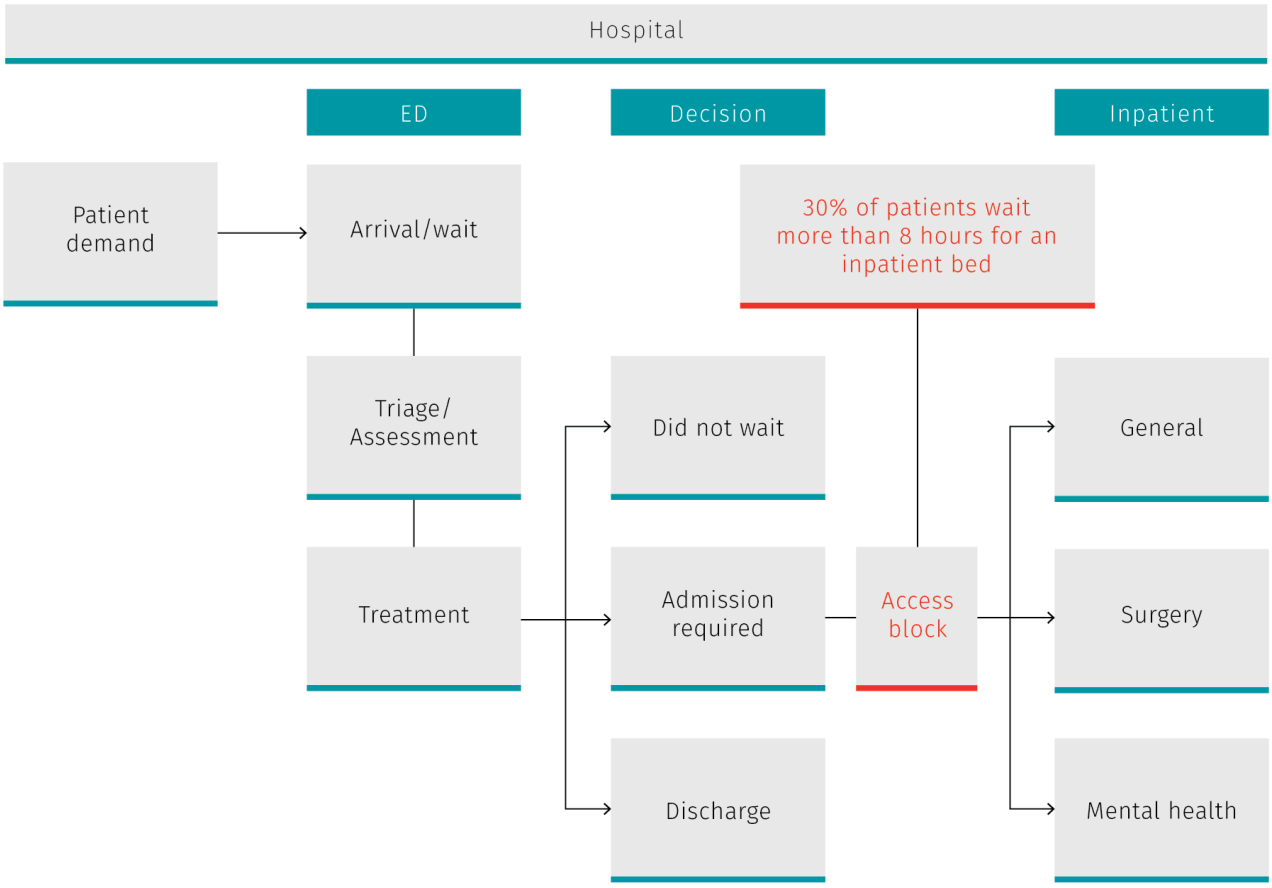
Around one-third of the workload of a typical ED involves caring for patients who have already received emergency care and are waiting for an inpatient bed elsewhere in the hospital.

Around 21% of ED patients who need to be admitted to hospital have to wait over eight hours for a bed, with some patients waiting more than 24 hours.

When EDs operate at this level of over-capacity, patient care is compromised and hospital resources are not used efficiently.

Increased resources, realistic targets and the implementation of evidence-based protocols for dealing with over-capacity are required in order to reduce the pressure on EDs and improve patient outcomes.

Access block: the delay in inpatient admission from the ED is a whole-of-hospital issue



Survey details

The Access Block Point Prevelance Survey is carried out by the Road Trauma and Emergency Medicine Unit and Australian National University on behalf of the Australasian College for Emergency Medicine (ACEM). The survey, which has been running since 2011, is undertaken twice a year (May/June and August/September). Poorer results are typical of the second survey due to the impact of seasonal demands for ED care.

Participating Australian EDs accredited by ACEM responded to the latest round of the survey by telephone, fax and email, with the data obtained providing a snapshot of Australian EDs at 10:00 local time on 28 August 2017.

Survey findings

120 of 123 (97.5%) Australian accredited EDs responded to the survey. A record number of 17 848 people were attending an Australian hospital ED at the time of the survey.

3 805 (21%) of the 17 848 patients attending EDs required admission to the hospital after receiving emergency treatment.

The survey reported a total of 817 patients waiting for inpatient beds after their emergency care was finished. Some of these patients had been waiting longer than eight hours for a bed. For example, 106 patients from 31 hospitals were classified as having a dangerously long ED time of more than 24 hours, with the worst performing hospital having nine such cases. This is worse than the findings of previous surveys.

Waiting in an ED for a hospital bed for more than eight hours is defined as 'access block'. At the time of the survey, around 30% of patients waiting for beds in EDs were experiencing access block. High levels of access block occurred in hospitals in all state and territories and across all types of hospitals, although children's hospitals had lower levels than adult/mixed hospitals.

Each ED was asked to identify their longest staying patient waiting for a hospital bed. Eight hospitals reported patients who had been in the ED for more than 48 hours and five reported patients staying more than 60 hours.

EDs operating at this level of are unlikely to provide optimum patient care and do not represent an efficient use of resources.

Patients who have finished their ED treatment and who need to be admitted to hospital require the specialised care and resources available in a hospital ward. While they remain in the ED they are taking up the time and attention of ED doctors and nurses who could be treating new ED patients.

The average hospital ED

On the day of the survey, the average Australian hospital ED had 22 patients undergoing treatment and a further seven waiting to be seen. Eight out of the 22 people being treated had already received emergency care and were waiting for a bed in other areas of the hospital. These people represented one-third of the ED workload.

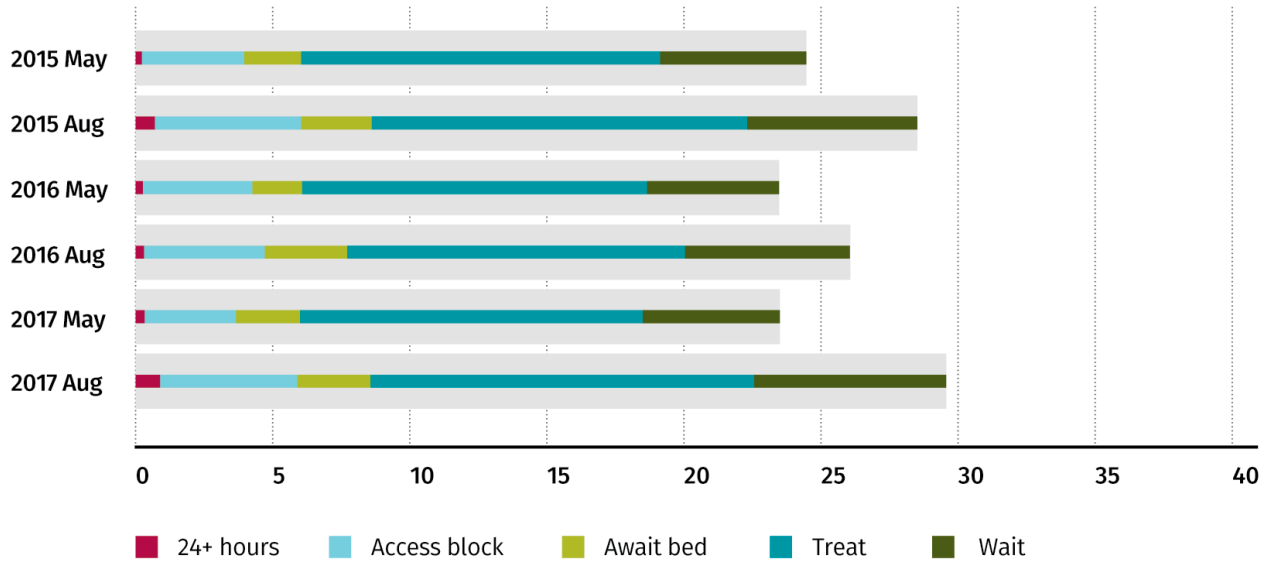
Average number of patients by ED status

	24+ hours	Access block	Await bed	Treat	Wait
NSW	1.5	6.5	2.8	13.2	8.7
VIC	0	5.0	3.4	12.5	5.4
QLD	0.3	2.6	1.6	17.3	6.9
WA	0.8	4.0	2.3	12.0	5.6
SA	0.6	3.0	2.1	17.4	6.1
ACT-TAS-NT	3.4	6.4	3.2	14.0	9.0
All	0.9	5.0	2.7	13.9	7.1
	24+ hours	**Access block**	**Await bed**	**Treat**	**Wait**
Major Referral	1.8	8.2	4.3	20.7	8.0
Major Referral Children	0	3.3	8.3	12.3	9.0
Urban District	0.4	3.7	2.2	11.8	6.0
Regional Referral	0.9	4.3	2.3	10.8	7.6

The average hospital ED over time

Although comparison between results from different years is difficult to make due to the opening and closing of hospitals, 89 hospitals answered the last six surveys, with their data showing that nationwide access block remains an issue, with the situation a little worse for patients waiting 24 hours or more this time, compared to the same time in 2015.

Average number of patients by ED status from May 2015 to August 2017



Solutions

Access block and overcrowding in hospital EDs can be reduced through a combination of increased resources, realistic targets and improved hospital management.

The following strategies would together significantly reduce the current pressure on EDs and improve both patient care and the efficiency of resource use:

1 Increase public hospital funding and capacity by increasing the number of available beds, to keep better pace with population growth and the growing demand for public hospital services.

2 Implement evidence-based, over-capacity protocols, in line with international best practice, to spread any excess demand more evenly throughout the hospital. Work with hospital staff to support the implementation of these to ensure their effectiveness.

3 Hospitals should identify system-wide process solutions that are tailored to their local needs. These should consider how patients travel through a hospital, and address factors preventing a timely and clinically appropriate patient journey e.g. inpatient discharge processes, extending service availability beyond traditional business hours, a better balance of full-time versus visiting medical officer specialists.

4 Set realistic targets for hospital performance developed by State Governments in conjunction with hospitals, clinicians and consumers. These targets should promote optimum patient care and minimise the potential for unintended consequences.

5 Increase funding for EDs to meet growing demand for care and allow flexibility in finding arrangements to accommodate unexpected increases in demand, for example, due to an unusually severe flu season.

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Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions

February 2018

1 Background

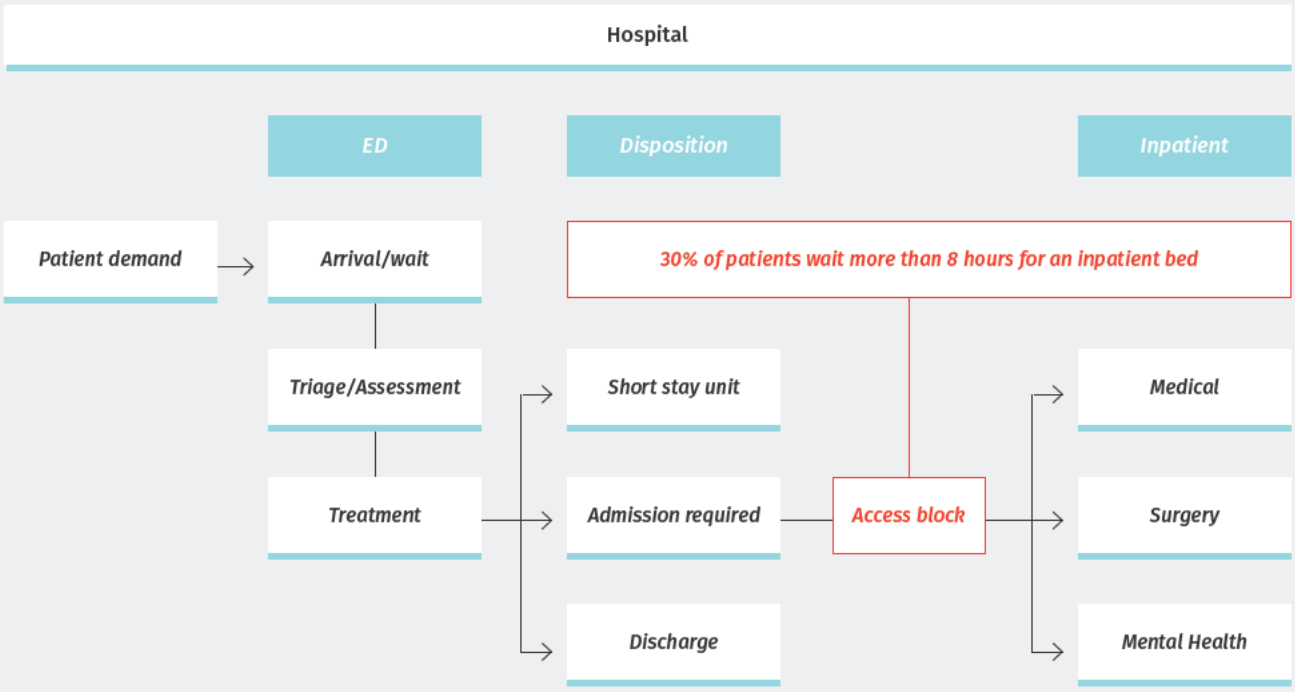
The Australasian College for Emergency Medicine (ACEM, the College) is the not-for-profit organisation in Australia and New Zealand responsible for training emergency physicians and the advancement of professional standards in emergency medicine. As the peak binational professional organisation for emergency medicine, the College has a significant interest in ensuring the highest standards of medical care for patients are maintained in emergency departments (EDs) across Australia and New Zealand.

ACEM, as the College representing specialist emergency physicians, has a long-standing interest in acute health system function, in particular, hospital ED overcrowding, long ED wait times and the management of patient flow throughout hospitals. The term 'access block' was coined by ACEM to describe the situation when patients who have been admitted to a hospital inpatient unit and require a bed are delayed from leaving the ED due to lack of capacity. [1, 2] Patient access to hospital beds should occur within a reasonable timeframe, that is, in no more than eight hours. [3] When a patient waits in the ED for eight hours or more following assessment and treatment, they are known to be experiencing 'access block'. In the United States, this phenomenon is known as boarding. [4]

Access block and ED overcrowding have implications for patient safety, and are associated with poor health outcomes and excess mortality and morbidity. People most affected by access block and ED overcrowding are those who require unplanned hospital admissions because of their medical condition. [3] Since 2011, ACEM has been carrying out twice-yearly point prevalence surveys on access block. These surveys show that across Australia and New Zealand the management of patients experiencing long waits for inpatient hospital beds represents one-third of the ED workload. [5] Rather than being an ED-only problem, access block is a whole-of-hospital and health system issue.

Anecdotal evidence from ACEM members has consistently suggested that patients with acute mental and behavioural conditions disproportionately experience unacceptably long waits in the ED for inpatient mental health care following admission to hospital. These concerns led the College to explore this issue more closely and, in December 2017, a snapshot survey of mental health presentations in Australian and New Zealand EDs accredited by ACEM was undertaken.

Figure 1 Access block: the delay in inpatient admission from the ED is a whole-of-hospital issue



2 Purpose

The purpose of this brief report is to present findings from ACEM's research exploring mental health presentations in EDs, with the hope of beginning a binational conversation about how mental illness can be better managed in the acute care context and the broader health system. Using these data, the College's goal is to advocate for a better health system response that addresses discriminatory treatment practices and improves overall health and psychosocial outcomes for this patient group.

3 Data Sources

Three data sources were triangulated to explore the issue of long ED wait times and lengths of stay among people presenting to EDs for acute mental and behavioural conditions.

3.1 Australian Institute of Health and Welfare (AIHW) emergency department care 2014/15 to 2016/17

The following data from AIHW's ED care reports are shown for the periods 2014/15, 2015/16 and 2016/17:

+ Number of ED presentations
+ Number of ED presentations classified as mental and behavioural conditions
+ Number of inpatient admissions due to mental and behavioural conditions. [6–8]

Each year, ACEM undertakes an Annual Site Census of all Australian and New Zealand EDs accredited by the College to deliver the emergency medicine specialist training program.

3.2 ACEM Annual Site Census 2016

Each year, ACEM undertakes an Annual Site Census of all Australian and New Zealand EDs accredited by the College to deliver the emergency medicine specialist training program. The Annual Site Census is distributed to approximately 140 EDs and is mandatory for Directors of Emergency Medicine Training (DEMTs) to complete.

In 2016, questions were added that asked DEMTs about their perceptions of lengths of stay for mental health presentations in their EDs. Namely, *In general, how often does your ED have mental health patients waiting for admission for more than eight hours?* Categorical response options were: daily, weekly (one to a few times a week), monthly (one to a few times a month), yearly (one to a few times a year) and never.

Data shown in this report are:

+ Perceptions from 135 DEMTs regarding ED lengths of stay of more than eight hours for mental health presentations (i.e. mental health access block).

3.3 Prevalence of Mental Health Access Block (POMAB) Snapshot Survey

On Monday 4 December 2017 at 10:00 local time, the POMAB Snapshot Survey was undertaken to estimate the point-prevalence of mental health access block in Australian and New Zealand public EDs accredited for specialist training by ACEM. Data were provided by 25 hospitals in NSW, 11 hospitals in Victoria and Queensland (respectively), seven hospitals in Western Australia, five hospitals in South Australia, and five hospitals in the Australian Capital Territory, Northern Territory and Tasmania (combined). For the purposes of the study, a mental health presentation was defined as one in which *the primary underlying reason for the consultation is a situation that mandates review by a mental health professional during the ED stay,* including self-harm and alcohol and other drug presentations.

Data presented are:

+ Percentage of mental health presentations of all ED presentations at 10:00 local time
+ Percentage of mental health presentations of all ED presentations waiting for inpatient beds at 10:00 local time
+ Percentage of mental health presentations of all ED presentations waiting for more than eight hours at 10:00 local time
+ Longest ED length of stay for mental health presentations in the past year.

4 Findings

4.1 AIHW emergency department care 2014/15 to 2016/17

Over the three periods, in Australia mental health presentations accounted for between 3.5% and 3.7% of all ED presentations (Table 1).

Table 1 Mental health ED presentations, 2014/15 to 2016/17

	2014/15	2015/16	2016/17
All ED presentations	7,366,442	7,465,869	7,755,606
Presentations due to mental and behavioural conditions	254,901	273,438	276,954
% of presentations due to mental and behavioural conditions	**3.46**	**3.66**	**3.57**

From 2014/15 to 2016/17, annual mental health presentations to Australian EDs were reasonably consistent over time. Across jurisdictions, the percentage of presentations was highest in South Australia and the Northern Territory. The annual percentage of mental health presentations slightly increased in Western Australia, South Australia and Tasmania, while slightly decreasing in Queensland (Table 2).

Table 2 Mental health presentations by jurisdiction, 2014/15 to 2016/17

	NSW %	VIC %	QLD %	WA %	SA %	TAS %	ACT %	NT %	Total %
2014/15	3.30	3.03	3.98	3.25	4.50	3.65	3.05	4.26	3.46
2015/16	3.59	3.17	3.96	3.60	4.77	3.86	–	4.37	3.66
2016/17	3.39	3.13	3.85	3.76	4.78	3.92	3.30	4.19	3.57

– No data available

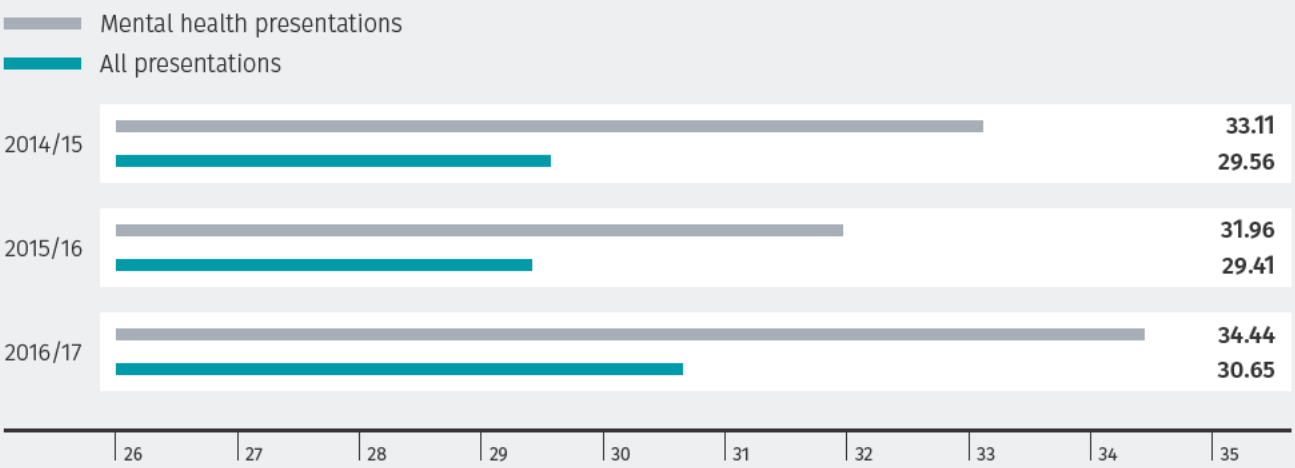
From 2014/15 to 2016/17, annual mental health inpatient hospital admissions comprised about 4% of all ED inpatient admissions, with a slight yet gradual increased observed over the three periods (Table 3).

Table 3 Mental health inpatient hospital admissions, 2014/15 to 2016/17

	2014/15	2015/16	2016/17
All ED inpatient admissions	2,177,759	2,195,838	2,376,774
Admissions due to mental and behavioural conditions	84,406	87,383	95,384
% of admissions due to mental and behavioural conditions	**3.87**	**3.98**	**4.04**

Mental health inpatient hospital admission rates via EDs were significantly higher than general inpatient hospital admission rates via EDs (Figure 2).

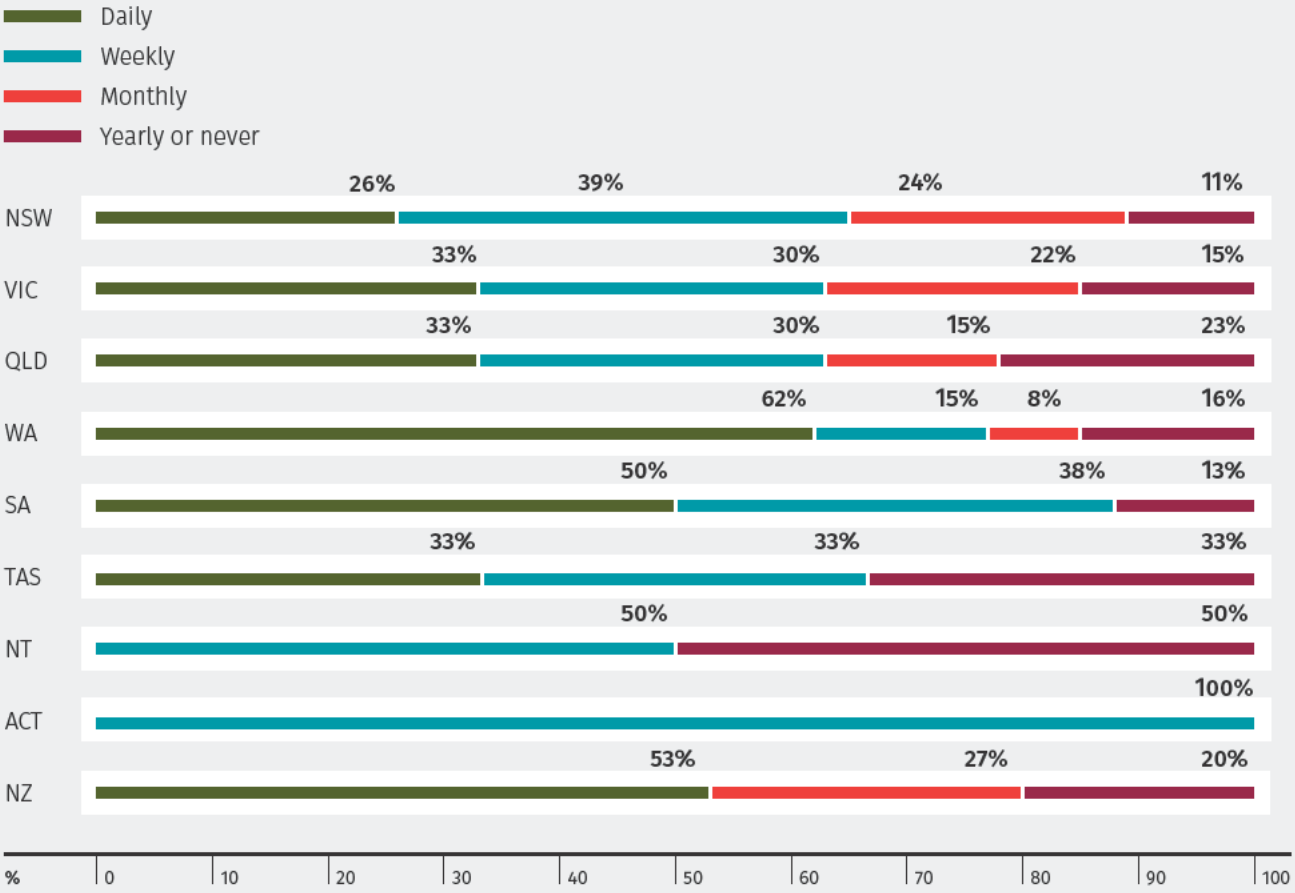
Figure 2 Mental health inpatient hospital admission rates, 2014/15 to 2016/17



4.2 ACEM Annual Site Census 2016

Thirty per cent (n=41) of DEMTs reported perceiving that, on a daily basis, mental health presentations spend eight or more hours in the ED waiting for inpatient beds. There were no DEMTs from New Zealand EDs who reported lengths of stay for more than eight hours (on a daily basis), compared with 34% of Australian DEMTs (Figure 2). Stays in the ED of eight hours or more are representative of mental health access block.

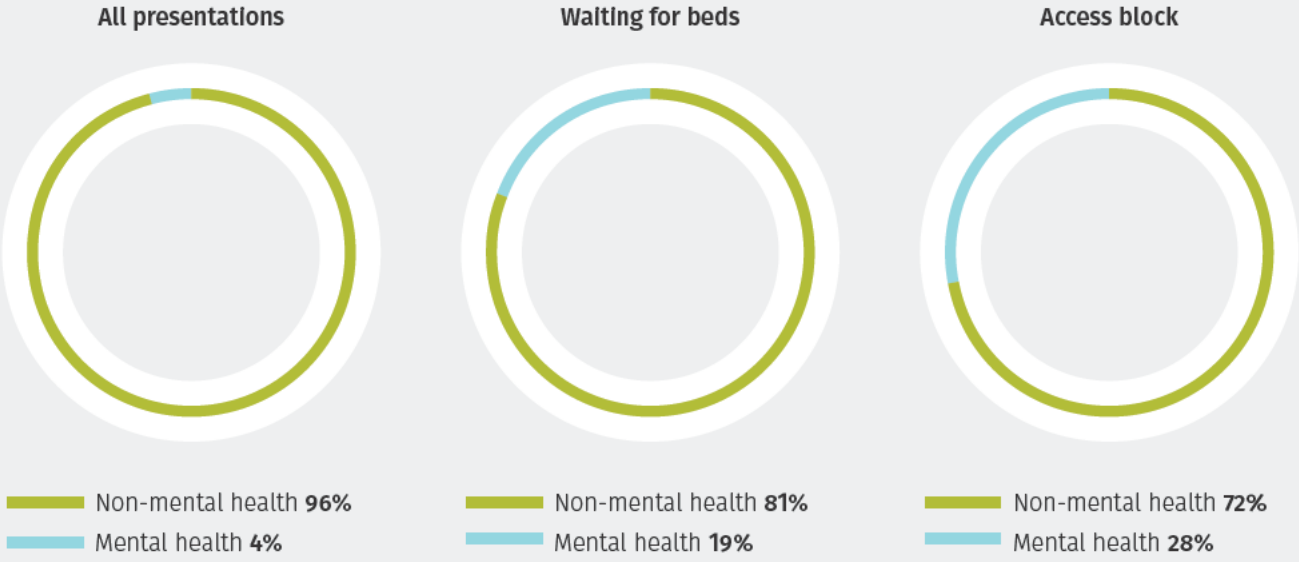
Figure 3 DEMTs' perceptions of the frequency of mental health access block, Australia and New Zealand, 2016



4.3 POMAB Snapshot Survey

For the POMAB Snapshot Survey, 72 of 135 eligible ED sites participated across Australia and New Zealand, a response rate of 53%. At 10:00 on Monday 4 December 2017, a total of 1,473 patients were identified as being in treatment, with a further 411 patients waiting to be seen. While only 4% of all ED presentations were due to mental and behavioural conditions, this group comprised 19% of patients waiting for beds and 28% of patients experiencing access block (Figure 4).

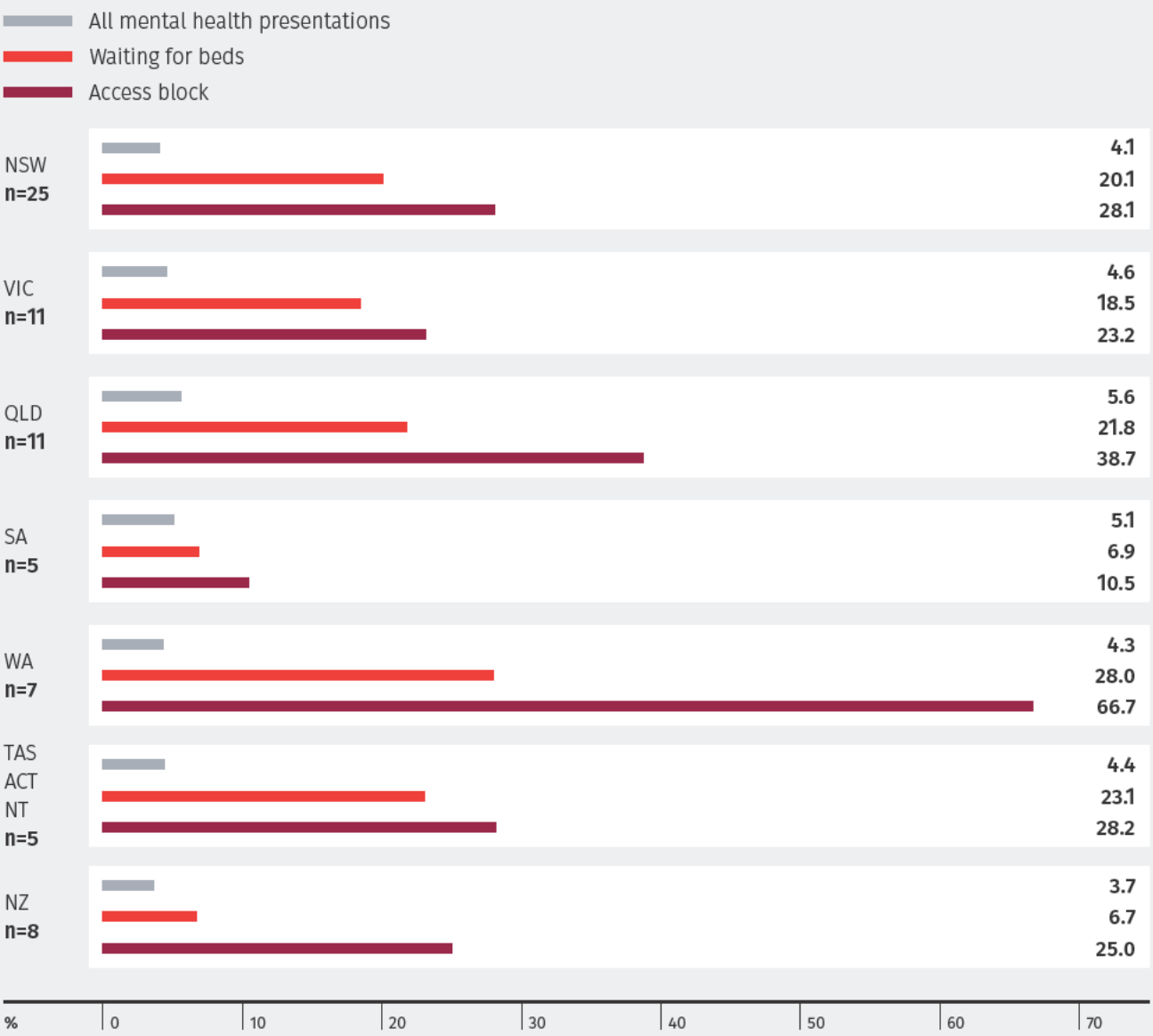
Figure 4 Overall ED occupancy at 10:00 in Australian and New Zealand EDs



Across jurisdictions, a similar prevalence of mental health presentations was observed (4% to 6%), with high percentages of patients waiting for inpatient beds and experiencing mental health access block. Mental health access block appears to be of most concern in Western Australia (67%) and Queensland (39%). While there appears to be less of an issue in South Australia and New Zealand, admission rates were lower in both jurisdictions. Compared with paediatric hospitals, mental health access block was generally worse in adult and mixed Australian hospitals (Figure 5).

Across jurisdictions, a similar prevalence of mental health presentations was observed (4% to 6%), with high percentages of patients waiting for inpatient beds and experiencing mental health access block.

Figure 5 Overall ED occupancy at 10:00 by jurisdiction



The inpatient admission rate for mental health presentations was much lower in New Zealand compared with Australia (7% vs. 20%). However, there was only a small difference in the percentage of patients experiencing mental health access block in Australia and New Zealand (29% vs. 25%) (Table 4).

The inpatient admission rate for mental health presentations was much lower in New Zealand compared with Australia (7% vs. 20%).

Table 4 Overall ED occupancy at 10:00 in Australian and New Zealand EDs

Australian

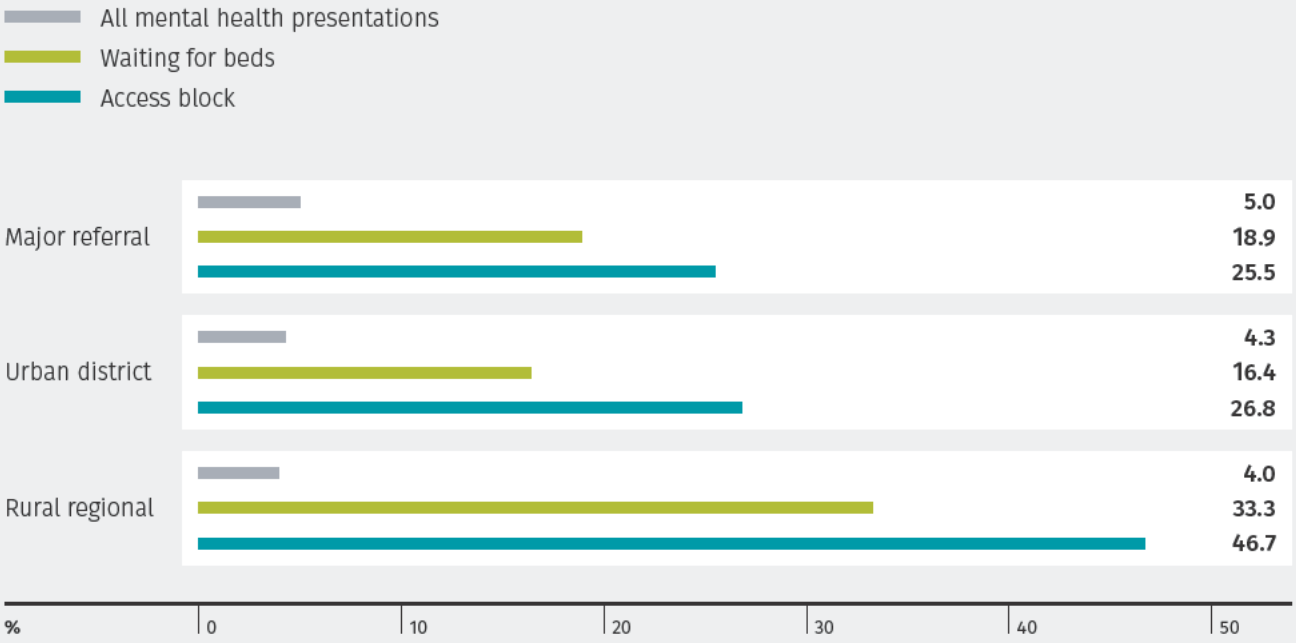
All presentations	Waiting for beds	Access block
		
Non-mental health **95.4%**	Non-mental health **79 9%**	Non-mental health **71.5%**
Mental health **4.6%**	Mental health **20.1%**	Mental health **28.5%**

New Zealand

		
Non-mental health **96.3%**	Non-mental health **92.9%**	Non-mental health **75.0%**
Mental health **3.7%**	Mental health **7.1%**	Mental health **25.0%**

Significant differences were found between metropolitan, urban and rural/regional hospital settings. The percentages of mental health ED presentations were comparable. However, in rural/regional settings significantly higher percentages of presentations were waiting for inpatient beds and experiencing mental health access block (Figure 6).

Figure 6 Overall ED occupancy at 10:00 by hospital role delineation



In rural/regional settings significantly higher percentages of presentations were waiting for inpatient beds and experiencing mental health access block.

4.3.1 Longest ED length of stay

For the POMAB Snapshot, hospital EDs also reported the longest time in the past year that a patient with a mental health presentation waited in the ED for an inpatient hospital bed. Fifty-six EDs in Australia and New Zealand provided data, with 62% reporting ED lengths of stay for more than 24 hours and 23% reporting lengths of stay for more than 72 hours. The maximum reported ED length of stay for a mental health presentation was 145 hours, translating to a wait of more than six days for an inpatient bed.

5 Limitations

There are some limitations to the data presented in this brief report:

- The impact of mental and behavioural conditions in the ED is significantly underestimated in AIHW ED care data collections, e.g. presentations involving self-harm are currently excluded and those involving multiple comorbidities may be classified under other primary causes. [9]
- ACEM Annual Site Census data are based on subjective perceptions of DEMTs.
- The findings for New Zealand and Western Australia should be interpreted with caution due to the relatively small numbers of patients in EDs at the time of the POMAB Snapshot Survey.
- Data for the Australian Capital Territory, Northern Territory and Tasmania are combined so that individual hospitals cannot be identified.

While mental health presentations account for only around 4% of ED presentations, this patient population disproportionately experiences access block compared with patients presenting with other emergency conditions.

6 Conclusions

While mental health presentations account for only around 4% of ED presentations, this patient population disproportionately experiences access block compared with patients presenting with other emergency conditions. The phenomenon of mental health access block is potentially worse in adult and mixed Australian hospital EDs and in rural and regional hospital EDs.

ACEM believes that all community members have the right to timely, high quality emergency medical care delivered in a respectful environment, free from discrimination and regardless of predisposing factors. Long waits in the ED experienced by patients presenting with acute mental and behavioural conditions are unacceptable and likely to lead to serious deterioration in wellbeing.

To address this long-standing issue, ACEM proposes the following solutions.

- Strategies should be taken to ensure that long ED waiting times and lengths of stay are minimised for this patient population. To achieve this, appropriate measures might include:
  - Reporting access block exceeding 12 hours for mental health presentations to the relevant health minister, human rights and/or health rights commissioner
  - Piloting alternative models of care for this cohort, particularly after-hours mental health support models, that might reduce mental health presentations to EDs (e.g. the Safe Haven Café model being trialled at St Vincent's Hospital Melbourne) [10]
  - Increasing mental health expertise in EDs.
- Improvements to ED design to ensure settings support the wellbeing of patients experiencing acute mental and behavioural conditions, particularly for patients who are agitated and in distress (e.g. access to quiet, low-stimulus private spaces)
- Increases to funding for community-based and inpatient mental health and alcohol and other drug services. It is likely that many mental health presentations to EDs occur as a result of chronic underfunding in community treatment settings. ACEM believes that funding to mental health services should occur as a matter of urgency.

7 References

1 Australasian College for Emergency Medicine, *Access block and overcrowding in emergency departments.* 2004, ACEM: Melbourne.

2 Australasian College for Emergency Medicine, *Statement on access block (S127).* 2014, ACEM: Melbourne.

3 Forero, R., et al., *Access block and ED overcrowding.* Emerg Med Australas, 2010. 22: p. 119-135.

4 American College of Emergency Physicians. Definition of boarded patient. 2017 [2 Feb 2018]; Available from: www.acep.org/content.aspx?id=75791#sm.0001xg6bui110qfssw1vh8lgn4w57.

5 Australasian College for Emergency Medicine, *Access block point prevalence survey.* 2016, Melbourne: ACEM.

6 Australian Institute of Health and Welfare, *Emergency department care 2014/15: Australian hospital statistics. Health services series no. 65. Cat. no. HSE 168.* 2015, AIHW: Canberra.

7 Australian Institute of Health and Welfare, *Emergency department care 2015/16: Australian hospital statistics. Health services no. 72. Cat. no. HSE 182.* 2016, AIHW: Canberra.

8 Australian Institute of Health and Welfare, *Emergency department care 2016/17: Australian hospital statistics. Health services series no. 80. Cat. no. HSE 194.* 2017, AIHW: Canberra.

9 Australian Institute of Health and Welfare. *Mental health services provided in emergency departments [Internet].* 2016 [8 Feb 2017]; Available from: www.mhsa.aihw.gov.au/services/emergency-departments/.

10 Better Care Victoria. *A Safe Haven Cafe for mental health consumers.* 2016 [2 Feb 2018]; Available from: www.bettercare.vic.gov.au/innovation-projects/browse-all-projects-listing/safe-haven-cafe-for-mental-health.

8 Suggested Citation

Australasian College for Emergency Medicine, Waiting times in emergency departments for people presenting with acute mental and behavioural conditions. 2018, ACEM: Melbourne.

9 Contact For Further Information

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