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# Response to the Productivity Commission's Mental Health Draft Report

24 January 2020

## Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the Productivity Commission's Draft Report into the role of improving mental health to support economic participation and enhancing productivity and economic growth (hereafter referred to as the Draft Report). Our response to this Draft Report focuses on the draft recommendations relating to emergency departments (EDs).

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an ED.

## Overview of the reform areas

The College is pleased that the Productivity Commission recognises EDs as an integral component of Australia's mental health system. We actively support *Reform Area 2: close critical gaps in healthcare services* to improve access to quality care for people experiencing mental health crises, whether that is provided within an ED, via mobile crisis services or other alternatives. Under this reform area our submission reiterates the Commission's call for equity of access to mental health services across the stepped care model. This would ensure that EDs are no longer the only front door to mental healthcare and are accessed only for acute care needs.

Similarly, while measures should be taken to improve the physical ED environment and create alternatives for emergency mental healthcare, the experience of emergency mental healthcare could be substantially improved through a combination of measures addressing the ED workforce, reducing lengthy waits in the ED and resourcing EDs to reduce the need for restrictive practices. The role of mental health peer workers in the ED and the broader healthcare system should be further explored to improve the patient experience. Alongside this, targets should be set to ensure that there are an appropriate number of mental health inpatient beds and community mental health services for children, adolescents and adults to reduce the increased reliance on EDs in the delivery of mental healthcare.

In addition, our submission draws attention to the need to integrate mental health services with that of alcohol and other drug services as well as services which address the chronic medical conditions and housing needs of people who are homeless. Each mental health related ED presentation should also require appropriate follow-up support to ensure that patients are connected to services that address their needs and prevent re-presentation to the ED.

ACEM also supports *Reform Area 5: fundamental reform to care coordination, governance and funding arrangements*, and believes that this is a critical area for reform to improve the state of Australia's mental healthcare system. We support a National Mental Health and Suicide Prevention agreement that clearly articulates the roles and responsibilities of governments in the delivery of mental health services. Similarly, ACEM supports the commissioning of services based on their ability to deliver person-centred outcomes. Establishing targets (including time-based ones) in the ED, inpatient mental health units and community mental health services and reporting against these will enable transparent oversight in the delivery of mental healthcare. In addition, data linkage involving ED data will support such measurements and capture the prevalence of mental health related ED patient presentations, and thus play a key role in examining the effectiveness of patient-centred care alternatives for people with mental illness.

Lastly, ACEM supports the preventative and early intervention focus of the Draft Report so as to prevent mental health crises in the first instance, however our response is limited to the two reform areas described above.

## Response to specific draft recommendations

# 1 Reform area 2: Close critical gaps in healthcare services

### 1.1 Equity of access to mental health services

It is ACEM's position that all Australians have the right to access mental healthcare across the care continuum and as such we support draft recommendation 5.9 to "reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate."

Improving mental health care across the care continuum (in accordance with the stepped care model) will reduce potentially avoidable or inappropriate attendances to Australian EDs. ACEM considers that a well-functioning mental healthcare system that is clear and easy to navigate with multiple entry points will mean that EDs are accessed only for acute care rather than as the front door to mental healthcare.

### 1.2 Experience of emergency mental health services

#### 1.2.1 Emergency department alternatives

ACEM welcomes the Productivity Commission's recommendation for alternatives to EDs for people experiencing mental health crises (draft recommendation 8.1) as part of the Commission's call to improve emergency mental health service experiences. The benefits of such models are clear in improving the patient experience and ensuring that appropriate care is delivered. State and Territory Governments should be incentivised to fund and trial such models (where they do not already exist) which, as indicated by economic modelling, would elicit beneficial results. For example, in addition to reduced patient length of stay and reduced use of restrictive practices, in the first year of its operation the Behavioural Assessment Unit at the Royal Melbourne Hospital was

able to cover the costs of the initial outlay of funds and generate a small surplus.[1] Cost-effectiveness studies should be conducted to demonstrate the return on investment to further incentivise governments.

Recommendation 1: State and Territory Governments should be incentivised to fund and trial alternative models of care for people experiencing mental health crises (where they do not already exist).

### 1.2.2 Enhancing the experience of emergency departments

As ACEM has previously highlighted, EDs are often inappropriate environments for people experiencing mental health crises due to the high stimulus environment in the ED, frequent lack of appropriate physical space combined with excessively long waits. Furthermore, a greater proportion of people with mental health needs prematurely leave the ED against medical advice and at their own risk.[2] ACEM supports measures to improve the experience of people with mental illness when accessing the ED (draft recommendation 8.1).

While ACEM supports reforms to enhance the physical ED environment, EDs should be resourced to improve clinical care for people with mental illness. Such resourcing should include dedicated mental health specialists in ED staffing. In addition, there should be a focus on the education and training needs and professional development of non-mental health professionals in the ED to conduct initial assessment, behavioural stabilisation and referral to an expert for patients with mental illness. There is also a role for mental health peer workers in the ED (see section 1.7). In addition, a key consideration is that people with mental health issues frequently have concurrent medical issues such as AOD use and medication overdose as well as medical conditions that may be unstable. As a result, such presentations are not always purely attributed to mental health.

Recommendation 2: ACEM recommends that EDs are resourced to include appropriate mental health expertise in ED staffing. as well as mental health education and training and professional development for all ED staff.

### 1.2.3 Length of stay

In addition to the above recommendations, the experience of mental health patients could be substantially improved by reducing their length of stay (LOS) and experience of exceptionally long waits definitive care and disposition. The Productivity Commission in its final report must recommend that all State and Territory health departments adopt a maximum 12-hour LOS in the ED and ensure the provision of accessible, appropriate and resourced facilities to allow for ongoing care beyond the ED. The 12-hour LOS policy should include mandatory notification and review of all cases (over 12 hours in the ED) and be embedded in key performance indicators of public hospital CEOs. In addition, all episodes of a ≥24-hour LOS in an ED should be reported to the relevant Health Minister regularly, along with any CEO interventions and mechanisms for incident review.

Recommendation 3: ACEM recommends that all State and Territory health departments adopt a maximum 12-hour length of stay in the ED. Any breaches of this should require a mandatory notification and review of all cases (over 12 hours in the ED) by public hospital CEOs.

Recommendation 4: ACEM recommends that all episodes of ≥24-hour length of stays in EDs are reported to the Health Minister regularly, along with any CEO interventions and mechanisms for incident review.

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1 Braitberg G, Gerdtz M, Harding S, Pincus S, Thompson M, Knott J. (2018) A Behavioural Assessment Unit improves outcomes for patients with complex psychosocial needs, Emerg Med Aust. .30(3):353-8.

2 Australasian College for Emergency Medicine. The long wait: An analysis of mental health presentations to Australian emergency departments. ACEM: Melbourne; 2018.

### 1.2.4 Restrictive practices

Reducing the use of restrictive practices is another aspect to improving the patient experience of emergency mental health services. Restrictive practices (including sedation or physical restraint) may be needed to manage agitated or violent patients who pose a risk to themselves, staff or other patients and when all other de-escalation techniques have been unsuccessful.[3] Evidence also suggests that patients who are intoxicated with alcohol or other drugs are less likely to respond to verbal forms of de-escalation and are more likely to require sedation compared to patients with a principle diagnosis of mental illness.[4] [5] Access block and excessively long waits for definitive care and disposition can further aggravate patient distress, necessitating the use of restrictive practices where EDs are not staffed and resourced to provide clinical supervision of patients over prolonged periods of time.[6]

Restrictive practices can be traumatic and may discourage people from accessing care in the future.[7,8] Therefore, measures should be taken to reduce their use in the ED and other settings. Furthermore, a recent study from Victoria found that less than one in six patients were admitted to an inpatient bed following a Code Grey call for a behavioural emergency, indicating that such emergencies could have potentially been prevented through the provision of alternative and adequate community and crisis services.[9]

EDs require both adequate resourcing and clear reporting requirements for the use of restrictive practices to be reduced. Audits of restrictive practices (sedation and physical restraint) in the ED are needed to identify and monitor the impact on patient outcomes and the relationship to the availability and accessibility of acute or community-based services and support. Similarly, funding arrangements should support emergency management capacity to provide appropriate clinical care to reduce reliance on restrictive practices. Reducing the incidence of 12 and 24 hour waits in the ED would also reduce the need for prolonged use of restrictive practices. Alternative models of emergency and crisis care have similarly demonstrated a reduction in the number of security calls, use of restrictive practices, and patient length of stay.[10]

Recommendation 5: ACEM recommends that all EDs have clear reporting requirements for the use of restrictive practices. Audits of restrictive practices should be conducted to identify and monitor the impact on patient outcomes and the relationship the availability and accessibility of community and inpatient mental health services.

Recommendation 6: ACEM recommends that EDs are resourced appropriately to provide clinical care to reduce reliance on restrictive practices.

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3 Knott, j., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B. and Chapman, P. (2019) Restrictive interventions in Victorian emergency departments: A study of current clinical practice, Emergency Medicine Australasia

4 Yap CL, Taylor DMcD, Kong DCM, Knott JC, Taylor S, Graudins A, Keijzers G, Kulawickrama S, Thom O, Lawton L, Furyk J, Finucci D, Holdgate A, Watkins G, Jordan P. 2019 Management of behavioural emergencies: a prospective observational study in Australian emergency department. J Pharm & Prac

5 Braitberg et al. 2018

6 Kennedy MP. Violence in emergency departments: under-reported, unconstrained, and unconscionable. Med J Aust. 2005;183(7):362–5.

7 Frueh BC, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot JA, Cousins VC, et al. Special section on seclusion and restraint: patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatr Serv. 2005;56:1123–33.

8 Knott et al. (2019)

9 Knott et al. (2019)

10 Braitberg et al. (2018)

### 1.3 Mental health inpatient beds

There is an urgent need to increase the number of inpatient mental health beds to meet population demand as addressed in **draft recommendation 7.1**. As the Draft Report states, Australia is currently lagging behind the Organisation for Economic Development (OECD) average with 42 acute psychiatric beds per 100,000 population compared to the OECD average of 71 per 100,000.

The Draft Report explicitly states that no benchmarks for mental health inpatient beds will be set as part of the final recommendations. ACEM is concerned that this prevents stakeholders from holding States and Territory Governments to account for the prevalence of mental health access block attributed to the lack of inpatient beds. While we support regional planning to determine demand, minimum inpatient bed targets per head of population must be set for tangible change to occur. In addition to the number of inpatient beds, processes need to be timely and streamlined so that acutely unwell people can access an appropriate inpatient bed any time of day or any day of the week.

**Recommendation 7:** ACEM recommends that the Commonwealth Government set minimum targets per head of population for inpatient beds or their equivalent (for example, hospital in the home).

**Recommendation 8:** ACEM recommends that processes for inpatient admission are timely and streamlined to enable acutely unwell people access to an inpatient bed at any time of the day or week. This should be monitored and tracked by State and Territory Governments.

### 1.4 Community mental health services

In addition to increasing the number of mental health inpatient beds, there is also a need to increase non-acute or sub-acute mental health services. For example, a report by the Auditor General in Western Australia highlights the lack of such services. According to the report, 284 people between 2013 and 2017 spent at least a year in an acute hospital bed.[11] Furthermore, 125 of these patients (44%) spent more than 365 consecutive days in an acute inpatient ward, even though these beds are intended only for stays of 15 days or less to stabilise a patient.[12] This use of inpatient wards has a flow-on effect to EDs where, over the same period, 2,278 people had to visit the ED three or more times in one week before being admitted to hospital, while nine people visited the ED 10 or more times in a week before admission.[13] The length of these stays demonstrates the lack of long-term community mental health services. ACEM supports reforms that incentivise Local Hospital Networks and other funding bodies to fund such services. ACEM also notes that in the United Kingdom targets have been set for the average length of stay of inpatient units to reduce lengthy inpatient stays. Such joint actions could be taken to reduce reliance on inpatient units and direct people with long-term care needs into the most appropriate setting.[14]

**Recommendation 9:** ACEM recommends that Local Hospital Networks and other funding bodies are incentivised to fund community mental health services to meet demand.

**Recommendation 10:** ACEM recommends that the average length of stay of inpatient units is monitored by State and Territory Governments with targets set to reduce lengthy stays.

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[11] Beeley, J., Charlton, A., Payne, K. and Lindberg, R. (2019) Access to State-Managed Adult Mental health Services, Office of the Auditor General Western Australia, available online at: https://audit.wa.gov.au/wp-content/uploads/2019/08/Access-to-State-Managed-Adult-Mental-Health-Services.pdf, accessed 15 January 2020.

[12] Beeley et al. (2019)

[13] Beeley et al. (2019)

[14] https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/adult-mental-health-services/

## 1.5 Referral to services

### 1.5.1 Alcohol and other drug services

As the Commission highlights in the Draft Report (**chapter 9.2**) alcohol and other drug (AOD) use is a common co-occurring issue for many people with mental illness. So much so, that the Alfred Hospital reported to the Royal Commission into Mental Health that 47% of inpatient mental health bed days are due to AOD use.[15]

It is imperative that alcohol and other drug services are considered an integral part of the mental healthcare system. However, at present the lack of service integration and community assistance means that people requiring support for AOD use often seek support from EDs in crisis. Appropriate community provision of such services would likely prevent many of these ED presentations. In addition, for those who do present to EDs there is a need for integrated care pathways into specialist treatment programs.

Models such as the Behavioural Assessment Unit in Melbourne and the Psychiatric Alcohol and Non-Prescription Assessment (PANDA) Unit at St Vincent's Hospital in Sydney co-locate AOD patients and emergency mental health clinicians, enabling timely referral and access to services.[16] Such integrated models of care should be central to any reforms of the mental healthcare system.

**Recommendation 11:** ACEM recommends that alcohol and other drug services are considered an integral part of the mental healthcare system. These services should also be integrated to allow for timely referral and access to a range of services to meet a person's needs.

### 1.5.2 Homelessness services

The Draft Report recognises the importance of tenancy support for people with mental illness through **draft recommendation 15.1 and 15.2**. However, ACEM considers that homelessness services should equally be considered a part of the mental healthcare system given the interconnections between mental illness, AOD use and homelessness.[17] This population are frequent attenders of EDs, often due to the lack of affordable and appropriate services, combined with social isolation.[18] As a result, this cohort often requires tailored services to address their complex needs.

The Royal Perth Hospital has been running services that offer GP outreach, referral and discharge support to people who are homeless to provide continuity of care. This service has been able to reduce ED presentations and inpatient admissions amongst this vulnerable cohort.[19] ACEM believes that State and Territory governments should similarly be incentivised to deliver proactive and targeted primary care services to reduce costly ED presentations and lengthy inpatient admissions.

**Recommendation 12**: ACEM recommends that homelessness services are considered a part of the mental healthcare system given the interconnections between mental illness, alcohol and other drug use and homelessness.

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15 Armytage, P., Fels, A., Cockram, A. and McSherry, B. (2019) Royal Commission into Victoria's Mental Health System, Interim Report November 2019, available online at, https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/9415/7489/4426/Interim_Report.pdf, accessed 9 January 2020, p177.

16 Braitberg et al. (2018)

17 Davies, A. and Wood, L. (2018) Homeless healthcare: meeting the challenges of providing primary care, MJA, 209(5):230-234.

18 Salhi, B., White, M. Pitts, S. and Wright, D. (2017) Homelessness and Emergency Medicine: A Review of the Literature, 25(5):577-593; Davies and Wood (2018)

19 Gazey, A., Wood, L., Cumming, C., Chapple, N. and Vallesi, S. (2019) Royal Perth Hospital Homeless Team. A Report on the First Two and a Half Years of Operation. School of Population and Global Health: University of Western Australia, Perth, Western Australia.

### 1.6 Children and adolescents

ACEM supports the Productivity Commission's call for the provision of child and adolescent inpatient beds that are separate to adult mental health wards (**draft recommendation 8.2**). While this is much needed, there is also a need for mental health services across the stepped care model to be dedicated to the needs of children and adolescents.

In 2017-18 11,609 people aged 5-14 presented to public EDs for mental or behavioural disorders in Australia.[20] An ED visit provides a key opportunity to address acute risk and provide early intervention, with the potential to alter the trajectory of mental illness and subsequent disability and disease burden in later life.[21] However, the provision of adequate care is often difficult. The dramatic increase in paediatric and adolescent mental health presentations is challenging to ED staff, with this population requiring separation not just from adults but from other unwell children. Ensuring children are able to be assessed in a suitable, calming, child-friendly environment is rarely possible. Any investment in new models of mental health care must also consider the needs of this vulnerable population. Similarly, the workforce should be appropriately skilled to deliver emergency mental health care to children and adolescents.

**Recommendation 13:** ACEM recommends that the specific needs of children and adolescents are incorporated into the planning of mental health services across the stepped care model including in service design and workforce expertise.

### 1.7 Mental health workforce

While ACEM supports reforms to strengthen the existing mental health workforce **(draft recommendation 11.1 and 11.4)**, there is also a need to upskill non-mental health professionals and clinicians working within the ED to conduct initial assessment, behavioural stabilisation and referral of patients with mental illness, noting that this does not replace the role of a mental health specialist.

ACEM is also supportive of draft recommendation 11.4 to strengthen the peer workforce. Consumers who have interacted with peer workers have reported positive outcomes achieved through shared lived experience. Research is currently underway to explore how peer workers can be best integrated into ED teams to improve the quality of care delivered in EDs and improve the overall ED environment.[22] ACEM welcomes opportunities to strengthen the peer workforce and their opportunities throughout the healthcare system, particularly in EDs.

**Recommendation 14**: ACEM recommends that measures are taken to up-skill non-mental health professionals and clinicians in order to equip them with the appropriate skills and knowledge to deliver high quality mental health care.

**Recommendation 15:** ACEM recommends that opportunities are explored to strengthen the peer workforce and their role within EDs and the broader mental healthcare system.

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[20] AIHW (2018) Emergency department care 2017-18: Australian hospital statistics, available online at: https://www.aihw.gov.au/reports/hospitals/emergency-department-care-2017-18/data, accessed 9 January 2020.

[21] Perera J, Wand T, Bein KJ, et al. (2018) 'Presentations to NSW emergency departments with self-harm, suicidal ideation, or intentional poisoning, 2010-2014', *The Medical Journal of Australia* 2018; vol. 208, no. 8, pp. 348-53.

[22] Melbourne Social Equity Institute (2020) *Developing a model for peer support in emergency departments*; available online at: https://socialequity.unimelb.edu.au/projects/developing-a-model-for-peer-support-in-emergency-departments; Chavulak, J., Buckley, L. and Petrakis, M. (2018) Recovery co-design and peer workforce development in the acute inpatient setting, New Paradigm, vol. 2017/18, pp. 34-39.

### 1.8 Discharge and follow up support

ACEM supports draft recommendation 21.1 regarding universal access to aftercare for anyone who presents to an ED following an attempt on their life. ACEM would extend this aftercare to all mental health patients who present to the ED, particularly where people have presented due to AOD use. All jurisdictions should implement a centralised follow up service and within 24 hours of discharge from the ED, all patients should receive a phone call from a Mental Health Liaison Office or Social Worker working within the ED to offer advice on available services, and check on referrals or other actions as required.

Recommendation 16: All jurisdictions should implement a centralised follow up service and within 24 hours of discharge from an ED, a patient should receive a follow up phone call to ensure appropriate linkage to the service system.

## 2 Reform area 5: Fundamental reform to care coordination, governance and funding arrangements

ACEM agrees with draft recommendation 23.3 that the mental healthcare system requires structural reform. It is ACEM's position that the roles and responsibilities of all levels of government should be clearly articulated and reported against as stated in draft recommendation 22.1. ACEM is agnostic regarding the model that this reform takes (renovate or rebuild). However, we would caution against a model that separates physical health from mental health as this risks fragmenting the system further and entrenching an already existing dichotomy between physical and mental health. As noted earlier, people with mental illness presenting to the ED frequently have comorbid medical conditions and thus require integrated care which treat the whole person.

We recognise that a structure is needed to integrate services and support an approach that requires Primary Health Networks and Local Hospital Networks to form area steering bodies to be accountable to governments and monitor and report on mental health services. ACEM maintains that whichever structure is agreed upon, there must be clear clinical governance, reporting, monitoring, and evaluation and accountability measures for service providers and governments.

### 2.1 National Mental Health and Suicide Prevention Agreement

ACEM agrees that the 5th Mental Health Plan and the broader National Mental Health Strategy have been limited in their ability to effect tangible change. As a result, ACEM supports the development of the National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) to ensure that there are clear responsibilities for clinical governance arrangements and reporting requirements across all levels of government.

However, ACEM is concerned that separating funding and governance arrangements by physical and mental health risks fragmenting the system further. For example, EDs are often not considered to be a part of the mental health system, however, as the Productivity Commission has identified many people with mental illness may also have a comorbid physical health condition(s). In addition, mental health patients commonly present with medication overdose requiring medical management prior to fully addressing mental health issues. Similarly, in the absence of alternatives for people experiencing mental health crises, the ED will continue to provide acute care for people with mental illness, despite not always being the most appropriate environment for this to be delivered. Funding reforms should focus on the delivery of integrated and multidisciplinary teams that offer tailored expertise (chronic health issues, alcohol and addiction, mental health and allied health) in the most appropriate setting as health, according to the World Health Organization, is a complete state of physical, mental and social wellbeing.

In addition to this, the next Mental Health Plan (or Strategy) must also address the roles, skills and training needs of both specialist and non-specialist health professionals. As stated previously, all healthcare professionals require appropriate skills and knowledge to respond to the needs of people with mental illness and enable consumers and their carers to effectively navigate the system.

**Recommendation 17**: ACEM recommends that funding reforms focus on the delivery of integrated and multidisciplinary teams that offer tailored expertise (chronic health issues, alcohol and addiction, mental health, physical health and allied health) in the most appropriate setting.

**Recommendation 18:** ACEM recommends that the next Mental Health Plan (or Strategy) address the roles, skills and training needs of both specialist and non-specialist health professionals.

### 2.2 Commissioning of services

ACEM supports an approach requiring services to be funded by commissioning bodies based on their ability to deliver outcomes and meet the needs of people with mental illness rather than based on the historical funding of particular service providers (such as headspace centres) as outlined in **draft recommendation 24.2**. Similarly, as a condition of funding, government-funded mental health services should be required to adjust their hours of operation to provide flexible service times, including after hours and weekend services.

**Recommendation 19:** ACEM recommends that as a condition of funding, government-funded mental health services should be required to adjust their hours to operation to provide flexible service times, including after hours and weekend services.

### 2.3 Targets and reporting

ACEM supports the setting of targets for services to achieve over a defined period of time (**draft recommendation 22.4**) and reporting against these measures.

Local Hospital Networks should be required to report on:

- 12- and 24-hour length of stays for all patients and mental health patients
- patient experience within the ED
- use of restrictive practices (and whether they were applied under Mental Health legislation or Duty of Care)
- walk outs (left at own risk or against medical advice)

Primary Health Networks should monitor and report on primary care service use both pre- and post- ED presentations and hospital admissions for all individuals requiring continuing mental health services (appropriate data linkage would support this recommendation).

The goal of this system and governments should be to improve the integration and coordination of the system and the quality of care people receive. Reduced ED presentations should be an indirect outcome of reforms and should be measured over a longer time period. For this to be achieved, Primary Health Networks and Local Hospital Networks should be required to form area mental health service steering bodies to align, coordinate and monitor their respective mental health services to ensure all individuals have access to the appropriate level of care.

In addition, the Commonwealth should establish a robust mechanism for monitoring system performance against the national standards for mental health services established by the Australian Commission on Safety & Quality in Health Care.

**Recommendation 20:** ACEM recommends that Local Hospital Networks and Primary Health Networks are required to report on targets to measure any improvements in the delivery of care to mental health patients.

## 2.4 Data linkage

ACEM supports **draft recommendation 25.1** to improve data linkage for mental health data. ED presentation data should form an integral component to such data linkage and would support any monitoring and evaluation of specific reforms and initiatives.

**Recommendation 21:** ACEM recommends that data linkage involves ED data to monitor and evaluate the effectiveness of mental health reforms and initiatives.

Thank you for the opportunity to provide a response to the Draft Report. If you have any questions please do not hesitate to contact Freya Saich, Policy Officer

Yours sincerely

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