AUDITOR-GENERAL'S REPORT
PERFORMANCE AUDIT

Mental Health Workforce

NSW Health

The Legislative Assembly
Parliament House
SYDNEY NSW 2000

The Legislative Council
Parliament House
SYDNEY NSW 2000

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

Peter Achterstraat
Auditor-General

Sydney
December 2010

Contents

Executive summary

Background

Mental illness causes significant distress and loss and is responsible for 13 per cent of the disease burden in Australia. NSW Health allocated $1.171 billion or 8.1 per cent of the State's total health budget on mental health in 2009-10. NSW Health consists of the Department of Health, which sets policies and budgets and monitors performance, and Area Health Services which manage mental health services in hospitals and the community.

In 2006 NSW Health announced *A New Direction for Mental Health (New Directions)*, a five year plan committing $939 million to improve access to mental health. The then Minister described the initiative as 'significant in that for the first time it aims to balance hospital focused care with community care'. The plan promised more hospital beds and more community care and early intervention so that problems are identified and managed before they escalate and require hospitalisation. The plan also promised to provide greater continuity of care and more integrated services for people with mental illness.

In this audit we assessed whether NSW Health distributes the mental health frontline clinical workforce effectively.

Audit conclusion

Compared to the mental health workforce in most other Australian states and territories, the NSW workforce is more concentrated in acute hospitals for adult patients and is marginally smaller for its population.

NSW Health increased its mental health workforce between 2006 and 2009. It has improved the geographical distribution of clinicians across the state to more closely match need. It has also increased the number of staff working with younger and older mental health patients. These are positive achievements in a time of financial stringency.

However, we have three key concerns.

Firstly, the precise size of the increase in the mental health workforce is unclear because the data on mental health funding and workforce are inconsistent and in places inaccurate. This reduces NSW Health's capacity to plan its services and workforces effectively.

Secondly, although New South Wales recruited 438 clinicians to new community based positions, the community workforce increased by less than this, perhaps only half as much. As a result community based services have not grown as intended and people may not receive help early in an illness, be unable to access alternatives to hospital and get limited support after leaving hospital.

Thirdly, although mental health funding is supposed to be 'protected', and spent on mental health, poor data and management have allowed some leakage to other areas of health. This risk may increase during the impending reorganisation of Area Health Services.

Supporting findings

Is the workforce distributed according to need for services?

The audit is unable to determine the size of the mental health workforce with any certainty. Workforce information collected from payroll systems, internal reporting and the annual national survey differ by significant amounts. This is due to the lack of consistency between the data sets, a lack of standardised approaches in gathering data and non-compliance. However the various data sets all indicate the number of clinicians has increased between 2006 and 2009.

The distribution of the mental health workforce is weighted towards acute care for adults (18 to 64 years of age) in hospital beds and is spread unevenly across the state. Relatively few clinicians meet the demand for care from younger and older patients and for patients in the community.

Since *New Directions*, extra clinicians have been allocated to better meet need across regions and client age groups. But NSW Health continues to put more additional staff into hospitals than the community. Two thirds of the extra clinicians have been employed in hospitals to staff the increasing number of beds. The remainder have been employed in the community. New South Wales invested less per head of population on mental health than most other states and grew non-hospital based services more slowly.

Has NSW Health identified workforce gaps and set strategies to manage them?

NSW Health has a good understanding of the size of the workforce it needs for each Area Health Service. But it has not translated that into the mix of clinical staff required. Coupled with the lack of sound information on the size of the existing clinical workforce and its funding, this means that NSW Health cannot accurately assess gaps.

NSW Health has developed a range of strategies to manage workforce shortages but not the detailed plans to integrate new and old staffing into a coherent service locally. Nor does it yet have integrated workforce and financial management systems to manage that implementation.

Has NSW Health reduced workforce shortages?

With the addition of new mental health positions, NSW Health has reduced workforce shortages but the scale of the reductions is uncertain.

NSW Health filled 438 (81 per cent) of the 544 newly funded community positions. However, the overall community workforce only grew by between 200 and 340 clinicians, because some Area Health Services delayed or did not fill pre-existing positions when they became vacant. Mental health funding was not adequately protected from pressure in some Area Health Services to support other expenditure.

This could be partly due to 'efficiency savings' which required NSW Health to cut costs and translated into staff reductions. In mental health such savings appear to have fallen disproportionately upon community based services.

The slower than anticipated growth in community based services impairs NSW Health's ability to intervene early, support recovery and provide continuity of care. Community mental health should follow up patients leaving hospital, but at present only 52 per cent are contacted in the first week. A third of children and adolescents and two-thirds of older people stay in acute beds for long periods because there are not adequate alternatives in the community or non-acute hospitals to meet their specialised needs.

As NSW Health replaces Area Health Services with Local Area Health Networks in 2011, it will need to ensure that community based mental health is not further compromised.

Recommendations

Improve planning

1. By January 2012, NSW Health should ensure all local health services:

   1.1. improve data quality to provide reliable information on the size and profile of the current workforce for internal planning and external reporting [p18]

   1.2. determine what mental health services and workforce are being and will continue to be funded by local health services [p18]

   1.3. have consistently developed mental health workforce plans, which cover existing (including pre-2006) and planned services and are integrated into a state wide plan [p25].

Use mental health funds as intended

2. By July 2011 NSW Health should ensure:

   2.1. Mental Health Directors have direct reporting lines to their Chief Executives including authority over the budgets and delegation to recruit mental health workers (subject to CEO approval) [p25]

   2.2. overhead charges made against mental health programs by other health services are appropriate and transparent [p25]

   2.3. local health networks report against agreed benchmarks for the distribution of their workforce between community and hospital based services [p23]

   2.4. the average recruitment time to fill a position is reduced to nine weeks [p25].

Improve continuity of care

3. By January 2012 NSW Health should ensure all local health services:

   3.1. expedite action to integrate mental health services and build partnerships with non-government organisations, private clinicians, other service providers, consumers and carers [p19]

   3.2. inform a patient's private doctor of the ongoing care plan when the patient is discharged from a NSW Health facility subject to privacy legislation [p19].

Response from NSW Health

I thank you for the Report Performance Audit Mental Health Workforce NSW Health *and I welcome the Report recommendations as these are consistent with, and reinforce, actions already being taken by the NSW Department of Health to further improve mental health services for the people of New South Wales.*

You will appreciate that the Mental Health portfolio is significant in scale and complexity, with a direct clinical workforce of more than 6,800 full time equivalents (FTE) and a total budget of $1.231 billion in 2010/11, representing approximately 8% of the total Health budget. As the background to your Report points out, from the 2006 launch of A New Direction for Mental Health, *the portfolio has expanded rapidly in both scale and scope with the commitment to a $939 million program over five years. Whilst I commend your officers for their efforts to understand a complex system in a short period of time, I do not believe that they have adequately represented the complexity of the system or given a balanced representation of the significant progress that has been achieved since 2006. Your officers were provided with a 120+ page* Mental Health Achievements *Report (October 2010) detailing the significant development that has occurred. I have enclosed another copy of the Report for your reference.*

As detailed throughout the Achievements Report, there have been clear results arising from the NSW Government's mental health reform package and supported by reforms at the national level. In particular:

- *In improving inpatient responses, over 417 new acute and non-acute mental health beds have been funded since 2005/06 (762 since 2000/01), increasing the number of beds per head of population and increasing the capacity for patients to be treated within their own Area Health Service.*

- *Emergency responses and service models have been tailored to meet the differing and particular requirements of metropolitan and rural areas and more effectively ensure that people with mental health emergencies are linked to those services, leading to improved Emergency admission performance. Of particular note is the impact from the establishment of Psychiatric Emergency Care Centres (PECC).*

- *New models of care for community based care and support to avoid unnecessary admissions and help people with mental illness lead stable, quality, productive lives through access to ongoing support, housing and linkages to education and employment. Of particular note is the significant expansion of the Housing and Accommodation Support Initiative (HASI); the Vocational, Education, Training and Employment Initiative; the significant increase in the percentage of health services in NSW with consumer and carer participation in decision making at the highest level; and the increase in paid consumer and carer consultants.*

- *In terms of workforce, there has been an increase in the number of direct care positions from 93.5 per 100,000 in 2005/06 to 98.2 in 2007/08; medical staff increased from 10.9 to 11.7 per 100,000 people in 2007/08; nursing staff increased from 60.8 to 64.3 per 100,000 people in 2007/08; allied health staff increased from 21.9 to 22.2 per 100,000 people in 2007/08 (2008/09 profile currently being analysed); and in February 2009, a new NSW Chief Psychiatrist was appointed to foster excellence across the mental health workforce.*

- *NSW continues to have the lowest suicide rate nationally at 7.8 per 100,000 population in 2008, down from 14.8 per 100,000 in 1997. Suicide rates in NSW for young people are now below those of the general population with the rate for young people 15-24 years falling from 15.2 per 100,000 population in 1996/97 to 5.9 per 100,000 in 2008, the lowest in Australia.*

The Department's Mental Health and Drug and Alcohol Office continues to monitor the performance of the Area Health Services on a monthly basis through the Department's Performance Management Framework and on a six monthly basis through the Milestones Tracking Report which covers initiatives under the New Directions package and subsequent Budget enhancements

The focus of the current Performance Review was mental health workforce and, particularly, whether NSW Health distributes the mental health frontline clinical workforce effectively. When considering all of the clinical FTE contributing to the direct care of patients (adjusted FTE; includes other clinicians who provided patient services who are not directly attached to the unit level), the NSW Health system has exceeded the expected increase in total FTE based on new beds and initiatives funded across the period of review (refer the graphs below).
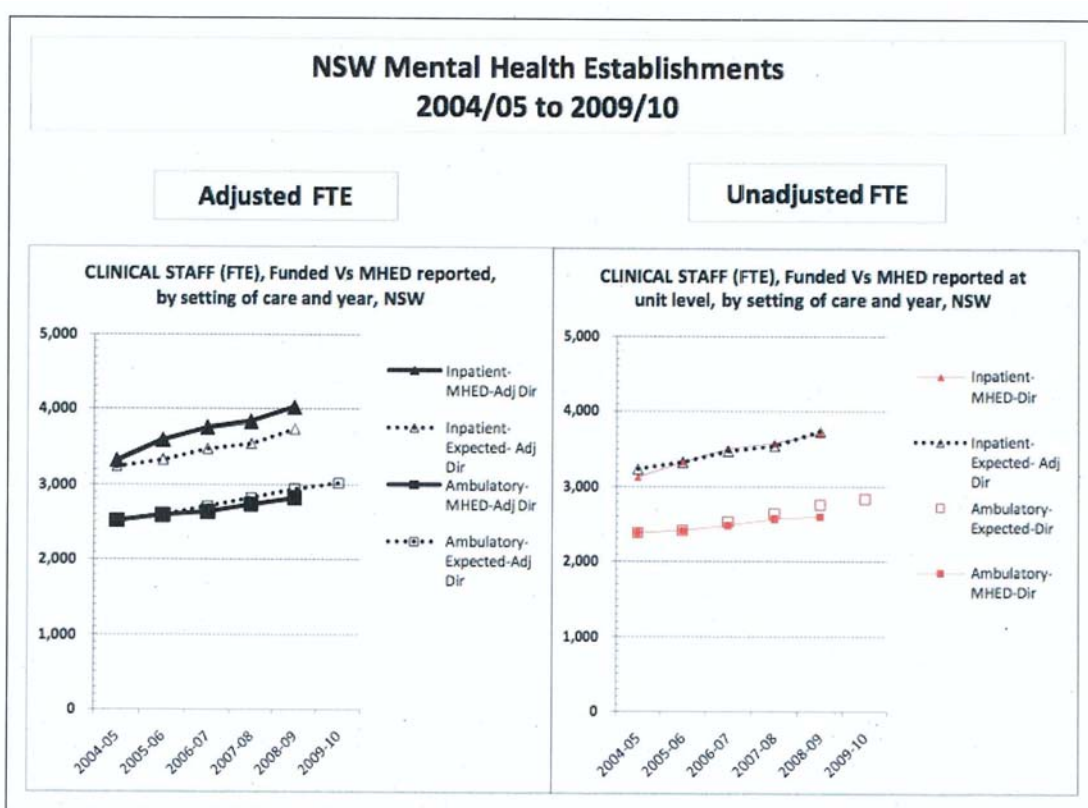
When examining the data for clinicians directly attributed to unit level (unadjusted FTE), the NSW Health system has achieved the expected increase in clinical FTE based on the roll-out of new inpatient beds and come close to achieving the expected FTE growth in the ambulatory (community) setting. Through the Milestone Tracking process, the Department monitors recruitment to these positions on an on-going basis. The limited number of Area Health Services that have experienced recruitment delays have submitted advice to the Department as to how they will address this shortfall.

This recruitment difficulty must also be viewed from the perspective that the entire national health system is experiencing shortages across a range of clinical disciplines, contributed to in no small way by the historical shortfall in Commonwealth-funded training places. Significant efforts are required to attract appropriately skilled staff, particularly in rural and remote parts of the State.

There is a strong inference in the Performance Audit Report that NSW Health funds additional staff for hospitals at the expense of services in the community setting. The Report focuses on FTE data from the Mental Health Establishments Data Set which does not include FTE employed in the Non-Government Organisation (NGO) sector. The Report, therefore, does not adequately communicate the impact of expanded services in the NGO sector, which, in the mental health portfolio, has had funding increase from $17.119 million in 2005/06 to $56.996 million in 2010/11, an increase of 233%. Of particular importance in this space is the state-wide roll-out of the Housing and Accommodation Support Initiative (HASI) with 1,102 places now funded across the sector. Using the latest nationally validated data, in 2007/08, community expenditure represented 46.2% of total expenditure on mental health services in NSW.

Therefore, I strongly argue that there has been considerable parallel investment in both inpatient and community services. The Performance Audit Report acknowledges the strong growth in new beds for children and adolescents, new older peoples mental health units, new specialist mental health rehabilitation units in general hospitals and innovative units for psychiatric emergency care; as well as the greater distribution of beds to rural and regional areas. Coupled with substantial investments in Supported Accommodation (HASI) this represented a comprehensive expansion and modernisation of NSW mental health patient services across the whole spectrum of care.

Some of the findings in the Performance Audit are consistent with the Service Profile and Performance Review of Mental Health and Drug and Alcohol Programs *(SPF Review) undertaken by IAB Services at the instigation of the Department's Mental Health and Drug and Alcohol Office and as reported to the Department in July 2009. Your officers used the SPF Review Report to inform the current Performance Audit and have referenced it in the current Report. Following from the SPF Review the Department instituted numerous actions oversighted by an Implementation Committee, chaired by the Deputy Director-General, Strategic Development, Richard Matthews, with membership including but not limited to the Chief Financial Officer, John Roach, and the Director, Mental Health and Drug and Alcohol Programs, David McGrath. Some of those actions are included in the Department's response to the specific recommendations in Table 1 on the following pages.*

You will appreciate that our considerable ramped efforts to expand and enhance mental health services over recent years have not been without their difficulties. We welcome the opportunity presented by this Performance Audit to continue our focus on improvement of mental health services for the people of New South Wales.

(signed)

Professor Debora Picone AM
Director-General

Dated: 6 December 2010

Table 1: NSW Department of Health response to the Recommendations of the Performance Audit of Mental Health Workforce

Recommendation	Response
<u>Recommendation 1.1</u> By January 2012, NSW Health should ensure all local health services: improve data quality to provide reliable information on the size and profile of the current workforce for internal planning and external reporting.	<u>Supported</u>. The implementation of the State-wide Management Reporting Tool (SMRT) project, as referenced in the Performance Audit Report, will considerably improve data quality in relation to human resource and financial management across the NSW Health system. The financial side of the project is advanced. Training has been provided across the state to key finance staff in Area Health Services. Net Cost of Service (NCOS) reporting is currently being piloted and we are targeting January 2011 (reporting in February 2011) as the 'go live' for NCOS and capital reporting. Functionality for the recurrent and capital budget management will be tested in the first quarter of calendar 2011. The timeline for the Human Resource side of the project is still being developed. It is likely that human resource reporting tools will not be fully implemented across all health networks until 2013. In the interim period, the Department will continue to use the Mental Health Establishments National Minimum Data Set reported annually, supported by Mental Health KPI reporting processes monthly, and reconciled 6-monthly ('Attachment C' Reports). Following from the IAB Services SPF Review, the Mental Health and Drug and Alcohol Office has done considerable work to improve the integration and integrity of the data sources, and has worked closely with Area Health Services in improving data quality. This work will continue and be enhanced by the current processes to map cost centres for the transition to the new Local Health Networks, and the current project of the Mental Health and Drug and Alcohol Office to develop a state-wide mental health project code structure.
<u>Recommendation 1.2</u> By January 2012, NSW Health should ensure all local health services: determine what mental health services and workforce are being and will continue to be funded by local health services.	<u>Supported</u>. Local Health Networks (LHNs) are currently being established in response to national health reform agenda. As part of the due diligence processes for the LHN transition, Area Health Services have been mapping all existing services, including Mental Health, and their corresponding cost centre structures. The Mental Health program will be clearly identifiable in the General Ledger structure of the new Health financial system.
<u>Recommendation 1.3</u> By January 2012, NSW Health should ensure all local health services: have consistently developed mental health workforce plans, which cover existing (including pre-2006) and planned services and are integrated into a state wide plan.	<u>Supported</u>. In 2006, the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006 – 2011 was agreed, to help drive ongoing reforms within the National Mental Health Strategy and bolster the diverse specialist mental health service sector. This included an 'Action Area' to increase workforce capacity with workforce also a priority area for the new Fourth National Mental Health Plan that was agreed in September 2009. A new National Mental Health Workforce Strategy is currently being developed under the Fourth Plan with participation by all jurisdictions. It is focussed on five outcomes areas: ▪ developing, supporting and securing the current workforce; ▪ building capacity for workforce innovation and reform; ▪ building supply of the mental health workforce; ▪ building the capacity of all health and community service providers; ▪ collecting accurate, timely and quality data on Australia's mental health workforce with well designed and integrated data collection systems. The draft Strategy is currently be considered by relevant advisory committees to the Australian Health Ministers' Conference. Once finalised, NSW Health will incorporate its principles into a state wide plan.

| Recommendation	Response
	NSW Health has already developed a Planning Toolkit to facilitate development of Workforce Plans. The toolkit provides a systematic and consistent approach to workforce planning linked with service planning, across all workforce categories. In their responses to the Performance Audit Report, all Area Health Services have indicated they have already Area-based workforce plans.
Recommendation 2.1 By July 2011 NSW Health should ensure: Mental Health Directors have direct reporting lines to their Chief Executives including authority over the budgets and delegation to recruit mental health workers (subject to CEO approval).	Supported with qualification. On 21 April 2005 the former Director-General gave direction to Area Health Service Chief Executives to this effect. In responses to this Performance Audit Report, most Area Health Services have indicated that Mental Health Directors are closely involved in the various transition processes as Areas move toward LHN structures. Mental health requirements in regard to budget authority and recruitment delegation in relation to mental health service networks will be clearly articulated as part of the transition to the new structure. Guidance will be provided by the Department.
Recommendation 2.2 By July 2011 NSW Health should ensure: overhead charges made against mental health programs by other health services are appropriate and transparent.	Supported. This was a key recommendation and action from the IAB Services SPF Review. The Department is developing guidelines on cost allocations which will describe overhead charges and other administrative and corporate charges and how they should be attributed to programs. Once full functionality is established, SMRT will provide capability to closely monitor charges attributed to Mental Health Programs .In addition, as part of the transition to Local Health Networks, NSW Health is reconfiguring its accounting systems to enable discrete reporting for Mental Health services.
Recommendation 2.3 By July 2011 NSW Health should ensure: local health networks report against agreed benchmarks for the distribution of their workforce between community and hospital based services.	Supported with qualification. 'Benchmarks' are not the most appropriate tools to promote a flexible workforce geared to meet the operational needs of the local health setting. The Department already has an internationally recognised population-based service planning tool, the Mental Health Clinical Care and Prevention (MH-CCP) Model, which covers the full spectrum of mental health care services in NSW. The Department will continue to use the MH-CCP Model as a guide for service planning and to assist on decisions of future investment; however, workforce distribution should be determined based on the particular circumstances of the particular LHN. It is the expectation that, once workforce targets are agreed, the LHNs will report against those targets through the established performance reporting processes.
Recommendation 2.4 By July 2011 NSW Health should ensure: the average recruitment time to fill a position is reduced to nine weeks.	Supported with qualification. Whilst the nine week recommendation is desirable, it is not necessarily achievable, particularly when recruitment time is considered to be the time from the decision to advertise the position to the letter of offer being provided to the successful candidate. Time to recruit is also greatly reliant on the availability of appropriately skilled workforce (particularly vexing for rural locations) and the additional recruitment and credentialing processes required for certain positions such as staff specialists. The e-recruitment system currently being implemented throughout NSW Health will assist with monitoring timelines for recruitment.
Recommendation 3.1 By January 2012 NSW Health should ensure all local health services: expedite action to integrate mental health services and build partnerships with non-government organisations, private	Supported. There has been a considerable body of work done with partner services across the State and at Area Health Service level. This includes but is not limited to Departments of Housing, Education, Community Services, Aging Disability and Home Care, Residential Aged Care Facilities, Divisions of General Practice, Police, Ambulance, local Councils and Aboriginal Community Controlled Health Services. Specific examples follow:

Recommendation	Response
clinicians, other service providers, consumers and carers.	• The Housing and Accommodation support Initiative is a model example of what can be achieved when Departments such as Health and Housing and the NGO sector can work together • Three Ts Project (Training, Treatment, Transferring knowledge) is a project to bring together the Department of Health and Ageing, NSW Health and General Practice NSW to work in partnership to improve the clinical management and treatment of people with mental illness and drug and alcohol disorders. • NSW Health has also undertaken a number of initiatives to enhance GP's knowledge and skills in mental health and to promote improved communication between Area mental health workers and GPs for the benefit of mental health consumers in the community. • In addition to local Area mental health / GP activities, NSW Health funds the Institute of Psychiatry for the only post graduate Mental Health qualification for GPs in Australia. The training program offers day workshops, scholarships and education courses to Certificate, Diploma and Masters level. • A review of Shared Care has been recently commissioned by MHDAO to provide recommendations for improving collaboration, communication and coordination among services for people with mental health problems. This review is currently being finalised and will be considered by the Mental Health Clinical Advisory Council. • The '*Linking physical and mental health…it makes sense*' initiative was launched in 2009 to improve the physical health of mental health consumers. One of its key goals is to encourage greater collaboration between health care providers, in particular between GPs and mental health services. The Policy and Guidelines associated with this initiative are currently being implemented by AMHS and include the requirement for services to develop a strategy to better engage with local GPs to ensure that mental health consumers receive regular physical health care assessments and ongoing care for physical health issues. As part of this initiative, local workshops are planned for the first half of 2011 to bring together GPs and mental health staff to look at existing processes and how they could be improved, or what others have already implemented that is working. • The development of special care units and supported discharge programs in residential aged care facilities for older people with severe behavioural and psychological symptoms of dementia and/or mental illness, delivered by residential aged care providers in partnership with NSW Health mental health services, and • The development of specialist community based assessment and intervention services that work in partnership with residential and community aged care providers, GPs and carers to support better mental health care for older people. • The Mental Health NGO Learning and Development Unit is a key initiative aimed at creating a skilled and progressive workforce to help people in their recovery from mental illness. The Unit has already achieved a number of outcomes across the areas of Workforce Development, Quality and Outcomes and Promoting Partnerships. • MHDAO meets on a quarterly basis with GP NSW and DoHA to take a tripartite approach to policy development, issues and problem solving in relation to the interface between general practice and mental health services.

Recommendation	Response
Recommendation 3.2 By January 2012 NSW Health should ensure all local health services: Inform a patient's private doctor of the ongoing care plan when the patient is discharged from a NSW Health facility subject to privacy legislation.	Supported. As a requirement under the current policy for Discharge Planning from Adult Mental Health Units and under the revised policy now in development it is a standard practice to provide the patient's GP and /or other health professionals involved in ongoing care with the Transfer/Discharge documentation, care plan and other relevant information. It is also a requirement that during the discharge planning process, Area mental health clinicians involve General Practitioners (GPs), private health professionals and others who will be supporting the patient in the community. At the time of discharge, all NSW health inpatient and community mental health services complete and send standardised transfer/discharge documentation to the GP or other community based clinicians involved in the consumer's ongoing care. The transfer/discharge summary includes advice about the care provided, medication and dosage information, current risks and safety issues, suggested follow-up treatment/action and provides contact details of relevant persons including Area mental health clinicians. Under policy, Area mental health services are expected to conduct regular audits of clinical documentation and discharge planning practices to ensure standards are maintained. The Policy and Guidelines released as part of the '*Linking physical and mental health...it makes sense*' initiative require AMHS to work more collaboratively with the consumer's GP, if they have one, or to link the consumer with a local GP, to ensure they receive care for their physical as well as mental health issues. Additionally, the Policy specifically documents the responsibility of services to ensure the consumer's GP is consulted, with the consumer's consent, when developing the care plan and receives a copy of the care plan on discharge to ensure they are aware of any physical health concerns or medications. These documents are currently being implemented within AMHS and the requirements for services are being promoted through a recently launched dedicated website (www.cadre.com.au/nsw_health/index.html) and through workshops planned for GPs and mental health staff in the first half of 2011. NSW Health is currently promoting service self-audit and quality improvement in this area in older people's mental health services across NSW through the SMHSOP benchmarking project. A number of standards in the Self-Audit Tool that are relevant to this recommendation: • A system is in place to ensure that contact with the GP and any other follow-up providers has occurred, and been documented, prior to discharge • A NSW Mental Health Discharge Summary is completed for all consumers on the day of discharge • A system is in place to ensure that the above discharge summary is despatched to the consumer's GP on the day of discharge • A system is in place to ensure that verbal communication occurs with, and the above discharge summary is despatched to, the primary follow-up provider on the day of discharge The Self-Audit Tool is currently being implemented annually in SMHSOP units and teams across NSW to promote service self-review and quality improvement, as part of the NSW Health-led SMHSOP benchmarking project.

Key findings

1. Introduction – Overview of mental health system

Mental illness covers a wide spectrum of disorders that significantly interfere with a person's life. These range from illness that causes disruption such as mild anxiety and depression to illness that can be severely disabling such as psychosis and schizophrenia. The following table indicates the mental health of the NSW population and the providers who help care for the different levels of illness.

Exhibit 1: NSW population, mental illness and health services
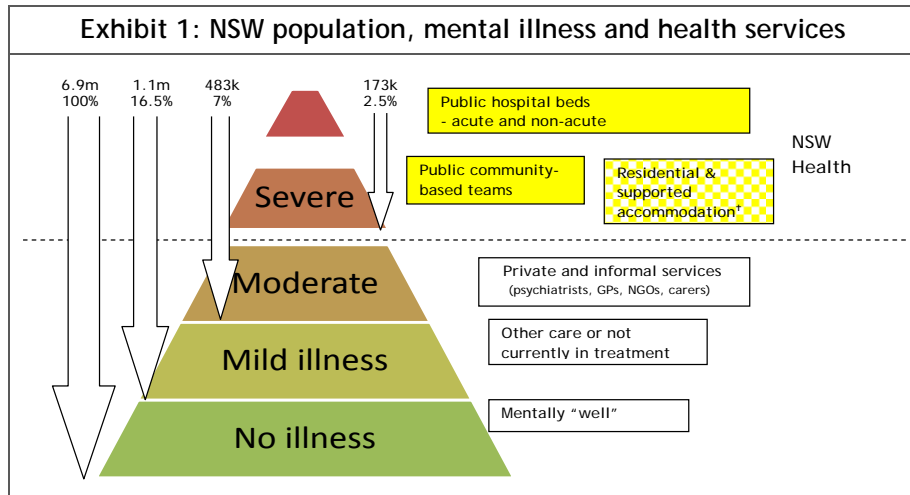
Source: NSW Health 2007.

† NSW Health community teams provide clinical support to clients in residential and supported accommodation. Generally NGOs provide housing and other services with funding from government agencies including NSW Health.

While NSW Health estimates that 16.5 per cent of the population has some form of mental illness, it deals predominantly with the more severe cases (2.5 per cent) in hospital and community settings.

Mental health service types

Typically, a person undergoing an episode of severe mental illness is assessed in the community or taken to an emergency department and assessed there. If necessary, he or she is admitted to an acute hospital bed. The **acute** unit stabilises the patient over 10 to 17 days before discharging them back into the community or into a non-acute bed. **Non-acute** units provide ongoing stabilisation and rehabilitation for patients who require further hospitalisation for several months.

After patients leave hospital, they should receive ongoing support in the community. **Community** clinicians provide treatment, case management, counselling and therapy to clients at less acute stages of their illness. These patients may also receive accommodation and other support from non government organisations (NGOs) and the private sector.

Because mental illness is often a chronic condition, patients need to be able to step-up or step-down to appropriate services as their need changes. This requires providers to work together to provide an integrated array of services to people with mental illness.

Identifying the required workforce	NSW Health estimates the size of the workforce needed now and in the future by modelling the population, the incidence of mental illness and treatment packages. The required workforce is measured in terms of the number of full time clinicians needed by different age groups in different settings. NSW Health's target is to meet 80 per cent of demand. This would have required 7,590 clinicians in 2008-09.

2. What was promised?

NSW Health strategies to address workforce shortages	In the early years of this century, New South Wales recognised that it had fallen behind the rest of Australia in the treatment of mental illness. We invested less than most states in mental health per person and concentrated on hospital-based treatment for patients aged between 18 and 64 years (adults).

The Government increased spending on mental health in the years following 2005 under a number of strategies including the State Plan (2006), *New Directions* (2006) and the Community Mental Health Strategy (2008) that set the direction for workforce growth.

Exhibit 2: Foreword of *New Directions* (extract)

New South Wales: A New Direction for Mental Health is a plan to transform and uplift the State's mental health services.

We're also backing this plan with a revolution in the way mental health services are delivered.

We will provide more community care and early intervention so that problems are identified and managed earlier instead of escalating into acute episodes that require hospitalisation.

People with a mental illness deserve continuity of care and a more seamless delivery of services, and that is what we are committed to provide.

We will therefore build stronger links between the public, private and community sectors, between hospitals and GPs, and between the State and Federal Governments.

We will also invest in attracting and retaining our mental health workforce.

Our investment over the next five years will deliver more services, earlier, and provide better support for families.

New Directions and subsequent commitments provided NSW Health with additional recurrent funding to employ more clinicians. By June 2009 this was intended to provide an additional 952 clinicians increasing the overall workforce by 15 per cent and:

- the community based workforce by 21 per cent with 544 extra clinicians including 60 nurse practitioners
- the hospital workforce by 12 per cent with 408 extra clinicians.

Further funding was provided to attract, train and support the professional development of psychiatrists, GPs, nurses and allied health staff. In addition, Area Health Services developed local strategies and workforce plans to:

- attract and retain clinicians, partner with universities, develop competencies and provide continuing development
- deliver psychiatric and clinical expertise to remote clients and health workers through tele-conferencing.
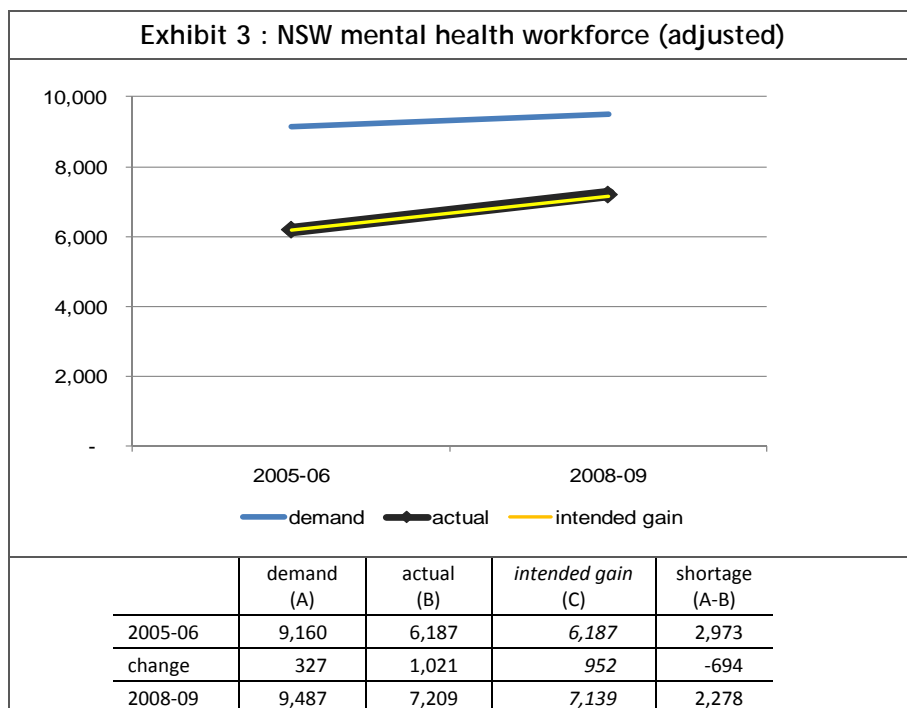
3.   What was achieved?

| Key finding | The audit is unable to determine the 'true' size of the mental health workforce. Workforce information collected from payroll systems, internal reporting and the annual national survey differ by significant amounts. This is due to the lack of consistency between the data sets, a lack of standardised approaches in gathering data and non-compliance.

The various data sets all indicate workforce growth between 2006 and 2009. However, they differ in extent of the increase from a low of 580 to a high of 1,021 extra clinicians. |

NSW reports 17 per cent more clinicians

NSW Health has reported to the Federal Government that its <u>**adjusted**</u> mental health workforce grew by 1,021 clinicians or 17 per cent between 2005-06 and 2008-09. This would have more than compensated for the increased demand, as the following table illustrates, and reduced the staff shortages by 694 (23 per cent), which was on par with the expectations of *New Directions* and subsequent enhancements.

Exhibit 3 : NSW mental health workforce (adjusted)

	demand (A)	actual (B)	*intended gain (C)*	shortage (A-B)
2005-06	9,160	6,187	*6,187*	2,973
change	327	1,021	*952*	-694
2008-09	9,487	7,209	*7,139*	2,278

Source: NSW Health.
Note: The current target is to meet 80 per cent of the required workforce (A).
        This equates to 7,590 clinicians in 2008-09.
        (B) represents the adjusted workforce reported to the Commonwealth.
        (C) represents the intended gain based on the increased level of funding.

The Area Health Services also report the '<u>**unadjusted**</u>' workforce which provides the smaller workforce estimate quoted earlier. The unadjusted workforce aligns more closely to payroll information but is incomplete because it omits some clinicians who work across or support several units. Between 2005-06 and 2008-09 the unadjusted workforce grew by 580 (10 per cent).

Exhibit 4 compares how the capacity of the clinical workforce to meet demand in hospital and community settings has changed according to the different data sets.

Exhibit 4: Proportion of demand met by the clinical workforce in hospitals and community settings	
Adjusted Workforce	Unadjusted workforce
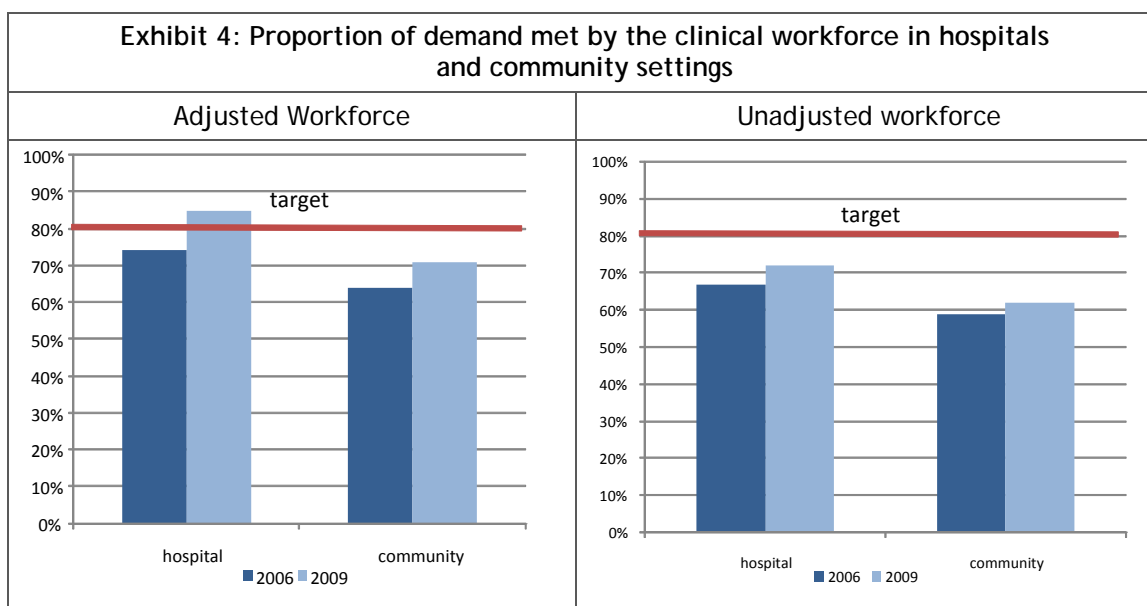
Source: NSW Health demand and adjusted and unadjusted workforce data.

See Appendix Two for a more detailed comparison of unadjusted and adjusted figures. The table excludes the workforce in residential settings.

Some AHS overstate their adjusted mental health clinical workforce
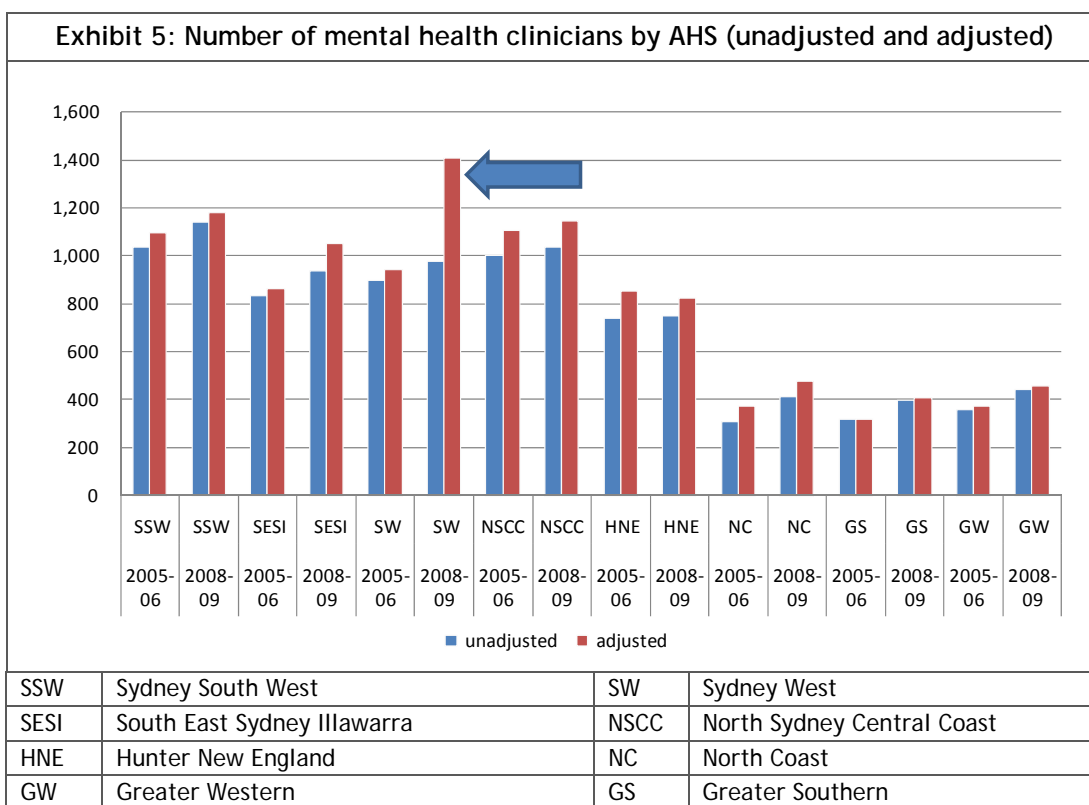
The adjusted workforce which is reported nationally has grown more rapidly particularly in hospitals. In 2009 the Department of Health was concerned about the accuracy of the adjusted data and engaged external consultants to review mental health staffing and expenditure across the Area Health Services. The reviewers found some of the Area Health Services went to great lengths to maximise the adjusted workforce numbers reported.

For example Sydney South West AHS included 63 'staff' in its adjusted 2007-08 return who were not staff at all but rather facility costs such as food, security, linen and IT services. The same service also included 34 non-clinical area administrators in its adjusted clinical workforce.

The problem persists in the latest round of national reporting for 2008-09. For example, the Mental Health Service at Sydney West AHS reported an increase of 198 mental health staff in the previous year, including 75 additional psychiatrists. This does not seem plausible as 75 staff represents around half the national annual growth in the psychiatrist workforce. When queried, the Service responded that changed AHS reporting practices …

> has led to this mental health inpatient unit being assigned large hospital costs that could not be removed. This included larger than expected share of medical, allied health, clerical and domestic costs and [staff] assigned by the hospital to mental health.

Exhibit 5 shows that with the exception of Sydney West AHS, the individual Area Health Service's adjusted and unadjusted workforce moved in tandem between 2005-06 and 2008-09.

Exhibit 5: Number of mental health clinicians by AHS (unadjusted and adjusted)

SSW	Sydney South West	SW	Sydney West
SESI	South East Sydney Illawarra	NSCC	North Sydney Central Coast
HNE	Hunter New England	NC	North Coast
GW	Greater Western	GS	Greater Southern

Source: Audit Office analysis of NSW Health data.

See Appendix One for map and population of Area Health Services.

Lack of reliable information

Like the external reviewers engaged by the Department of Health in 2009, this audit is unable to determine the precise size of the mental health workforce. Workforce information collected from payroll systems, internal reporting and the annual national survey differ by significant amounts.

New information systems planned

NSW Health plans to address these shortcomings with the implementation of new financial and human resource information systems, but these will not all be operational before 2012. In the meantime, NSW Health needs to inform the allocation of resources to the new Local Health Networks in 2011 with more reliable data.

Recommendation

By January 2012, NSW Health should ensure all local health services:

- improve data quality to provide reliable information on the size and profile of the current workforce for internal planning and external reporting
- determine what mental health services and workforce are being, and will continue to be, funded in each local health service.

Local action to increase the pool of recruits

Area Health Services have implemented local 'grow your own' strategies to attract new graduates and establish local training options in partnership with universities. They have started to develop competencies and have employed some patients in recovery as consumer workers so that a broader pool of potential recruits is available.

Sharing the care with the private and non-government providers	Some progress has been made by NSW Health to engage with and fund training of the private and NGO sectors. However, continuity of care is impeded by poor communication and a lack of agreement over responsibilities. Representatives from two Divisions of General Practice told us that their members found it difficult to speak directly to NSW Health clinicians about care plans for their patients. They were sometimes required to communicate through the NSW Health's public mental health access line which did not always have the relevant information. For example, one doctor interviewed only found out that his patient had been released from an acute bed hundreds of miles away when they met on the street of their small country town.

Conversely, NSW Health staff told us private clinicians sometimes fail to provide information that would facilitate improved care for their patients who had entered public care.

NSW Health advises that there are legal, cultural and technological barriers to the more efficient exchange of information necessary to improve the continuity of care. Recent Federal legislation around electronic health records and national health identifiers may facilitate reform. Complementary action is needed at the State level.

Recommendation	By January 2012 NSW Health should ensure all local health services:

- expedite action to integrate mental health services and build partnerships with non-government organisations, private clinicians, other service providers, consumers and carers

- inform a patient's private doctor of the ongoing care plan when the patient is discharged from a NSW Health facility subject to privacy legislation.

4. Is the workforce distributed on the basis of demand for services?

Key finding	The legacy of the past means that the distribution of the mental health workforce remains weighted towards acute care for adults in hospital beds and it is spread unevenly across the State. Relatively few clinicians meet the demand for care from young and old patients and from patients in the community.
	The more conservative unadjusted data indicates that, between 2006 and 2009, NSW Health better aligned the workforce with need across regions and client age groups. However, NSW Health continues to put most of the extra resources into acute hospitals rather than community care. New South Wales invests less per capita than most other states in community based services and is growing this sector more slowly than other states.

Distribution by Area Health Service	NSW Health seeks as far as possible to provide mental health services to people in the Area Health Service in which they live.

Exhibit 6 shows that there are more clinicians per head of population in places that have a history of large mental health hospitals such as Northern Sydney Central Coast AHS and Orange in Greater Western AHS.

It also shows that since 2005-06, NSW Health is redressing the geographic imbalance by allocating additional clinicians to areas with disproportionately small workforces. Apart from Greater Western, the largest staff increases occurred where they were most needed: North Coast, Greater Southern, and South-East Sydney Illawarra AHS.

Exhibit 6: Mental health clinicians per 100,000 population

	SSW	SW	SESI	NSCC	HNE	NC	GW	GS	All
2006	74	81	71	92	87	64	129	69	84.0
2009	78	87	78	92	87	82	155	77	89.4
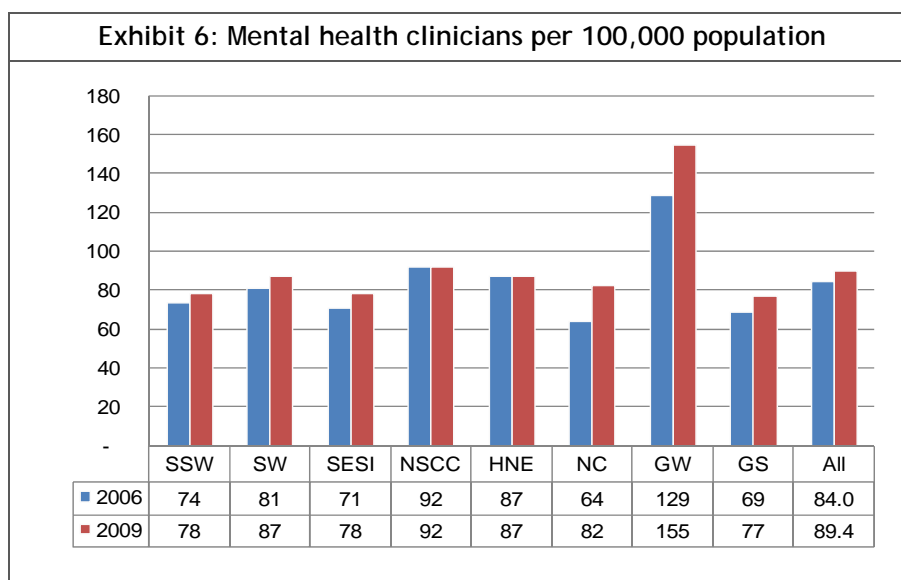
Source – AO analysis of NSW Health demand and unadjusted workforce data

Note: All represents all AHS plus Justice Health and Westmead Children's Hospital which employ 163 and 63 clinicians respectively and met five per cent of state demand.
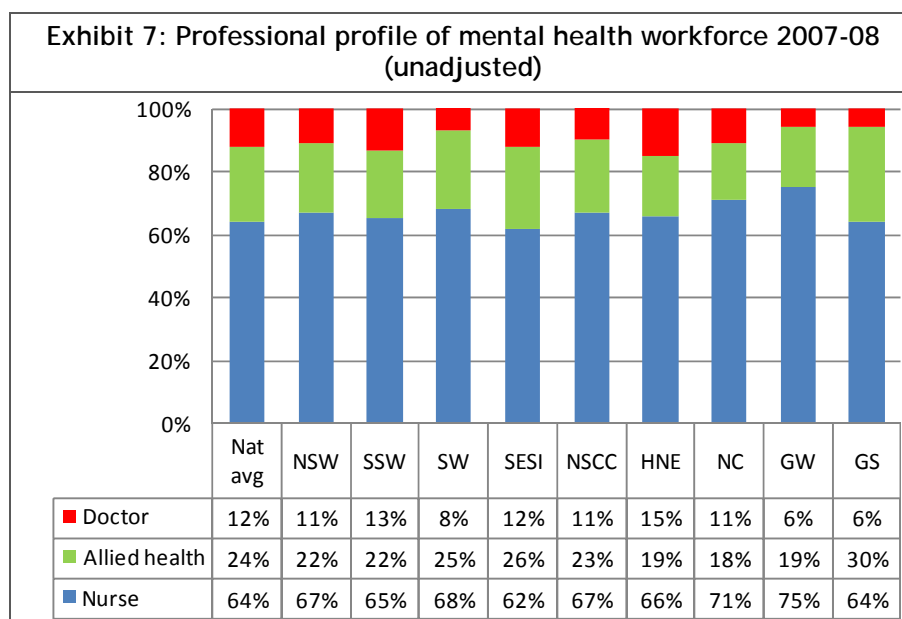
Greater Western AHS is a special case. It has the smallest population with around 300,000 residents, but it contains Bloomfield, a large facility in Orange, that takes mental health patients from across the State particularly other rural centres. Bloomfield gives this Area Health Service a high rate of clinicians for its population.

Distribution of doctors, nurses and allied health

The audit cannot conclude whether the distribution of resources across clinical professions is based on demand because NSW Health has not quantified the professional profile of the workforce it needs.

In 2007-08 NSW's overall mental health workforce profile had a similar profile to the nations. In every 100 mental health workers, New South Wales had 11 psychiatrists, 22 allied health professionals (psychologists, therapists and social workers) and 67 nurses.

But the profile of the workforce varied significantly across the State and NSW Health has not set benchmarks or guidelines to indicate the right professional mix.

Exhibit 7: Professional profile of mental health workforce 2007-08 (unadjusted)

	Nat avg	NSW	SSW	SW	SESI	NSCC	HNE	NC	GW	GS
■ Doctor	12%	11%	13%	8%	12%	11%	15%	11%	6%	6%
■ Allied health	24%	22%	22%	25%	26%	23%	19%	18%	19%	30%
■ Nurse	64%	67%	65%	68%	62%	67%	66%	71%	75%	64%

Source: National average uses adjusted EMH NMDS. NSW & AHS – unadjusted EMH NMDS.

Over one in seven clinicians was a doctor in Hunter New England, but less than one in 14 was a doctor in Greater Western and Greater Southern AHS. Remote Area Health Services rely more on nurses to provide mental health care.
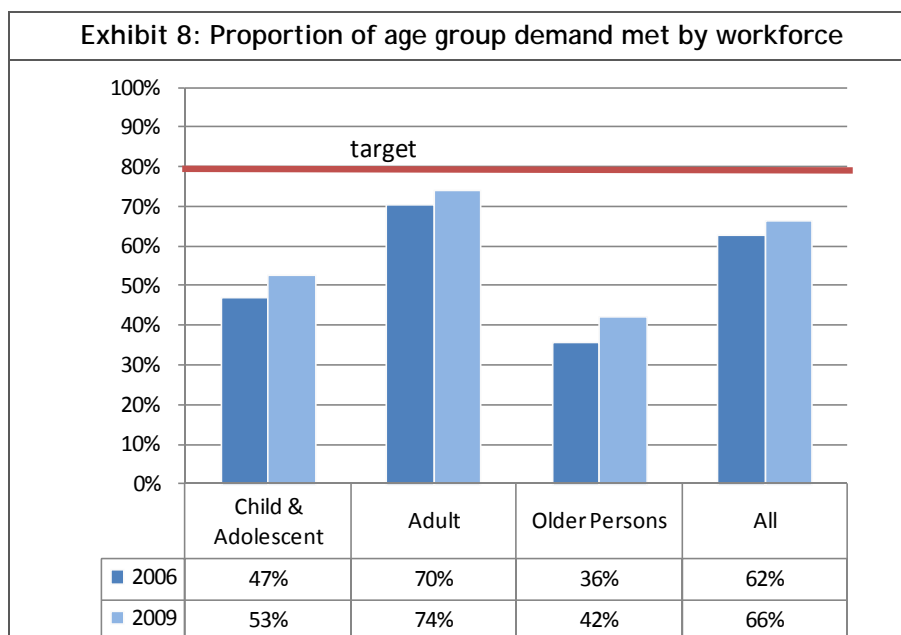
We found significant variation in composition of community mental health teams in some of the Area Health Services visited. These teams should contain a multi-disciplinary mix appropriate for their specific function, but some consist almost exclusively of nurses and a few almost exclusively of psychologists. NSW Health advises that sometimes this is the best available mix because remote Area Health Services find it difficult to attract some clinical disciplines.

Rural Area Health Services have partially mitigated the lack of medical resources by introducing tele-conferencing to provide psychiatric advice and assessment to remote hospitals. In Greater Western AHS, for example, this has reduced the occurrence of unnecessary, stressful and costly transfers of patients to major psychiatric hospitals many hours away.

Distribution across client age groups

NSW Health has a legacy of focusing on services for adults (18 to 65 years) and only meets 53 per cent of demand from children and adolescents (under 18 years) and 42 per cent from older persons (over 65 years) with specialist clinicians.
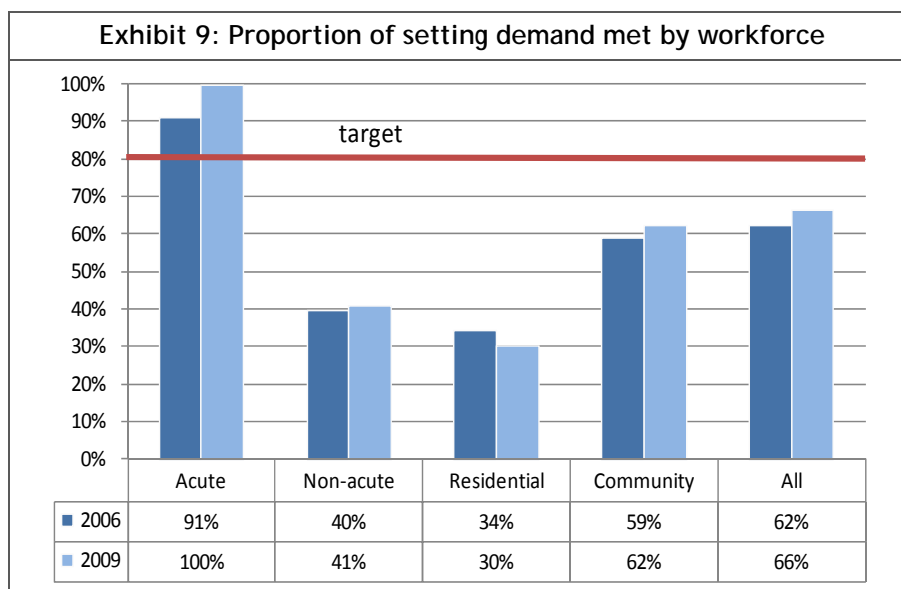
However, there has been a marked improvement since 2005-06 because NSW Health has allocated proportionally more of the additional clinicians to services for people under 18 and over 65 years of age. Some of these positions have been established to provide early intervention and assessment before mental illness escalates.

Exhibit 8: Proportion of age group demand met by workforce

	Child & Adolescent	Adult	Older Persons	All
■ 2006	47%	70%	36%	62%
■ 2009	53%	74%	42%	66%

Source – AO analysis of NSW Health demand and unadjusted workforce data.

Distribution between hospital and community

NSW Health has a legacy of concentrating its workforce to provide acute mental health care in hospitals. It has continued this focus between 2006-07 and 2008-09. The acute workforce grew by 13 per cent and attracted 54 per cent of the 580 new positions.

Exhibit 9: Proportion of setting demand met by workforce

	Acute	Non-acute	Residential	Community	All
■ 2006	91%	40%	34%	59%	62%
■ 2009	100%	41%	30%	62%	66%

Source – AO analysis of NSW Health demand and unadjusted workforce data

This enabled NSW Health to establish acute services for children, young adults and in emergency departments in more locations.

But there are still local gaps. There are no child and adolescent or older person acute beds in Greater Western or Greater Southern AHS. North Coast AHS also has no older person beds. In the absence of specialist beds these clients may be treated in general (adult) acute beds with appropriate protocols and safeguards.

In contrast the community and non-acute workforces grew by less than ten per cent. The residential workforce reduced in size as NSW Health devolved responsibility to NGOs with significant investments in supported accommodation. Between 2005-06 and 2008-09 an additional 1,003 places were funded under the Housing and Accommodation Support Initiative.

How NSW compares to the rest of Australia

The latest comparative data for Australian jurisdictions is the higher adjusted workforce data for 2007-08. This shows that by the second year of *New Directions,* NSW Health reported that its mental health workforce was growing faster than, and approaching the national average. Even this data shows that New South Wales spent less per head of population on mental health overall. It also grew community based care more slowly.

Exhibit 10: National comparison of mental health workforces (adjusted)			
	2003-04	**2007-08**	**change**
Staff per 100,000 population			
NSW	85.4	98.2	15%
Australian average	91.2	100.8	11%
Recurrent mental health expenditure per person			
NSW	$120	$145	21%
Australian average	$124	$152	23%
Proportion of mental health budget spent on community based care			
NSW	44%	46%	4%
Australian average	49%	52%	7%

Source: Report on Government Services 2010. This is based on the adjusted data reported in the Establishment Mental Health National Minimum Data Set.

The Government has announced that as part of the National Health Reform, it would replace Area Health Services with Local Area Health Networks in 2011. During the audit many stakeholders and NSW Health staff expressed concern that community mental health services are likely to be further compromised if the Boards running the new Networks focus too much on hospital based care.

Recommendation

By July 2011 NSW Health should ensure local health networks report against agreed benchmarks for the distribution of their workforce between community and hospital based services.

5. Barriers to achieving what was promised

Key finding

> By June 2009, NSW Health had filled around 80 per cent of the 544 new community positions funded by *New Directions* and subsequent enhancements. This resulted in a net increase in the range of 200 to 340 community clinicians because, as Area Health Services created new positions, they delayed or refused permission to fill older positions when they became vacant. The mental health budget was not adequately protected from the pressure from Area Health Services to support other areas of health.

Expected community gains not achieved

Although NSW Health created and filled new community clinician positions, only 38 to 62 per cent of the intended workforce growth was achieved. The audit concludes that in the range of 100 to 230 older community based positions that pre-date *New Directions* were lost.

Mental health funding is meant to be protected	In its annual allocation of the mental health budget to Area Health Services, NSW Health states:

> … the Mental Health Program Budget is a protected budget source. … the mental health budget should not be used as a basis for assisting with broader budgetary pressures …

But the roll out of *New Directions* and subsequent enhancements has occurred in a difficult financial environment.

Expanding mental health in a time of budgetary constraint

Between 2002-03 and 2007-08 New South Wales increased overall health funding each year by an average 8.2 per cent and NSW Health exceeded these budgets each year by an average of 3.3 per cent. Prior to 2007-08 part of these overruns was covered by supplementary funding from Treasury due to strong economic conditions and Government's desire to fund additional health services.

One of the reasons for the overruns was that health services were recruiting more staff than they could afford to meet waiting list reductions and other clinical targets. By 2007-08 some Area Health Services had 400 to 600 staff over budget across their units, including mental health.

In 2008 NSW Health tightened its internal controls to restrict the growth in spending. It did so in part by leaving positions, which were not specifically budget funded, vacant. This included mental health positions.

While Area Health Services filled newly-funded mental health positions, they often left pre-existing positions vacant when the current occupant left or moved into a *New Directions* position. This reduced the net increase in clinicians delivered by the additional mental health funding.

Only one of the four Mental Health Directors in the Area Health Services visited had control of the mental health budget and was able to approve the recruitment of staff. The other Mental Health Directors had to get approval from Operational, Finance or HR Directors to recruit, even for positions for which the Area Health Service had received *New Directions* funding. Notwithstanding the protected status of this funding, approval to recruit was not always forthcoming or was substantially delayed.

Through such mechanisms, one Mental Health Directorate estimated that its Area Health Service had underspent the mental health budget for the last five years by between four and seven per cent. This translated to a shortfall of 40 to 60 clinicians per year at that Area Health Service. We estimate that less than half of this underspend could be explained by efficiency savings, if those savings were applied proportionally across the entire Area Health Service workforce.

Mental health funding at risk	In addition, external reviewers commissioned by the Department in 2009 found:

> … significant risks to the mental health funding systems. These risks, exacerbated by the current budgetary environment, related to overheads applied, revenue sources and the lack transparency in Health Service's financial systems …

> … determining the exact 'leakage' of funds from the Mental Health program was problematic … we believe that the total leakage (i.e. unjustified movements) is likely to be in the range of $20m per annum.

The audit estimates that $20 million could employ at least another 150 clinicians.

The external reviewers also questioned the legitimacy of various overheads that Area Health Services charged mental health. These charges ranged from 13 to 34 per cent of program funding, well in excess of the 7.5 per cent cap that the Department set for overheads charged to mental health programs. We agree that the allocation of overheads lacks transparency and puts protected mental health funding at risk.

Delays in recruitment

Once recruitment action is approved, NSW Health typically takes three to six months to fill mental health positions even when there is no difficulty attracting candidates. This delay exacerbates staff shortages. It also impedes effective care because it prevents outgoing staff from handing over cases and clients to their replacements.

Lack of integrated workforce plan

While NSW Health has planned the roll-out of individual *New Directions* initiatives, it is not clear how these fit with pre-existing services.

New South Wales has committed to contribute to a national workforce strategy as part of the Fourth National Mental Health Plan. The NSW Mental Health Workforce Development sub-committee has undertaken to:

> … develop a NSW mental health workforce data story including defining the workforce and mapping current workforce supply … and promote the uptake across all AHS, a uniform method of data collection for MH workforce planning … consistent with the Australian Standards of workforce planning …

But as yet there is no consolidated workforce plan at the State level to ensure the distribution of clinicians matches need. Workforce planning within Area Health Services also varied in depth and approach.

Many NSW Health staff and external stakeholders suggested there is a need to reassess mental health services in terms of 'what we do, how we do it and why'. This is essential because demand cannot be met using existing approaches. The pool of potential recruits is limited and in short supply around the world, and the demand for mental health services rose by four per cent overall and eight per cent for older person services between 2005-06 and 2008-09.

Recommendation

By July 2011 NSW Health should ensure:

- Mental Health Directors have direct reporting lines to their Chief Executives including authority over budgets and direct delegation to recruit (subject to CEO approval)
- overhead charges made against mental health programs by other health services are appropriate and transparent
- the average recruitment time to fill a position is reduced to nine weeks.

Recommendation

By January 2012, NSW Health should ensure all local health services have consistently developed mental health workforce plans, which cover existing (including pre-2006) and planned services and are integrated into a state wide plan.

6. What has been the impact of staff shortages and the current workforce distribution?

Key findings

> The slower than anticipated growth in community care impairs NSW Health's ability to support ongoing recovery and continuity of care in appropriate settings. Community mental health should follow-up patients who are discharged from an acute bed. Its target is to contact 70 per cent of patients within a week of discharge. However, community clinicians record making contact with 52 per cent. A third of children and two-thirds of older people stay in acute beds for long periods because there are not adequate alternatives in the community or non-acute hospitals to meet their specialised needs.

Vacancies in hospitals

Area Health Services generally monitor and manage vacancies at hospitals well. Once a bed is open, there is pressure to maintain a safe level of staffing to ensure patient and employee safety and well-being. Vacancies amongst hospital clinicians are reported to be less than five per cent. During June 2010, only 55 (two per cent of 2,549) mental health beds across New South Wales were unavailable because of staff shortages.

While bed closure is usually avoided, hospitals incur increased costs from covering staff shortages with overtime, casual and agency staff and contractors. Visiting Medical Officers (VMOs) are physicians in private practice who are contracted to work in the public health system. VMOs provide a higher proportion of the medical workforce in areas where it is hard to attract staff doctors. While VMOs represented 13 per cent (104 of 790) of the psychiatrist workforce across the State in 2008-09, they represented almost 60 per cent of doctors in Greater Western, North Coast and in Greater Southern AHS. Compared to resident staff doctors, VMOs from distant centres can spend more of their paid time travelling, leaving less time for patient consultation and for supervision of other mental health clinicians.

Vacancies in community services

NSW Health monitors the community based positions funded under *New Directions* and subsequent enhancements. In June 2009, 81 per cent of these positions were filled across the State. Greater Southern AHS filled 96 per cent (90 of 94) of positions, while Sydney West filled 62 per cent (50 of 81 positions).
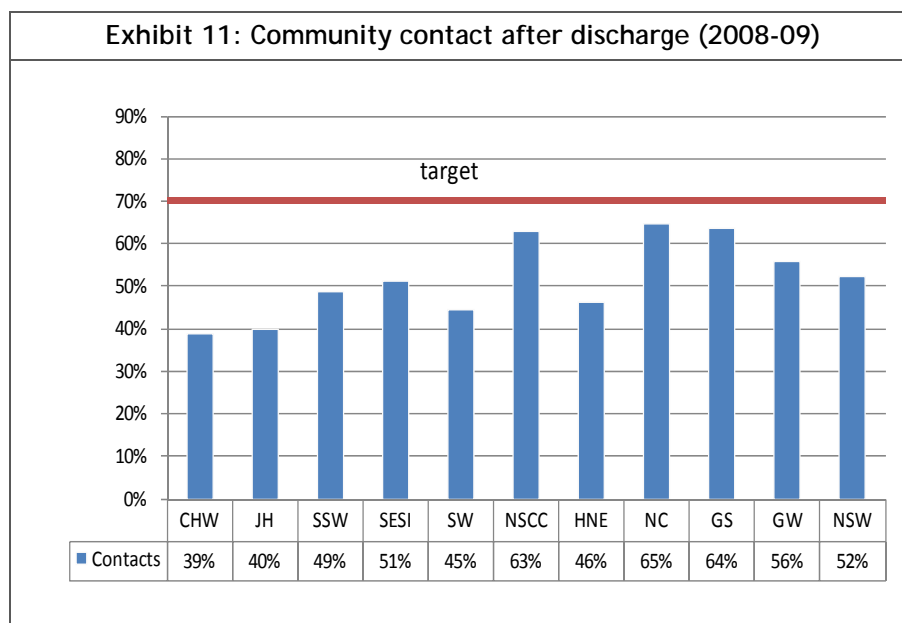
However, NSW Health does not monitor vacancies amongst pre-*New Directions* community positions, basically because there is no commitment that they will be maintained.

NSW Health staff advised that up to 40 per cent of some pre-*New Directions* community health teams are vacant at any point of time. To reduce expenditure, some Area Health Services did not replace community based staff who were on maternity or other extended leave, or working on other duties.

Staff and other stakeholders expressed concern that unfilled vacancies and staff shortages disrupted ongoing care and case management. This leads to a focus on monitoring and managing clients at greatest risk of self harm or harming others.

Lack of community follow-up	Community mental health should follow-up patients leaving hospital. NSW Health's target is to contact 70 per cent of patients within a week of their discharge from hospital. During 2008-09 community clinicians record making contact with 52 per cent (14,936 of 28,554).

Exhibit 11: Community contact after discharge (2008-09)

	CHW	JH	SSW	SESI	SW	NSCC	HNE	NC	GS	GW	NSW
■ Contacts	39%	40%	49%	51%	45%	63%	46%	65%	64%	56%	52%

Source: NSW Health 2010

CHW: Children's Hospital Westmead   JH: Justice Health

Despite the low rate of community contact after discharge, only 15 per cent (2,107 of 13,915) were readmitted to hospital within 28 days in the first six months of 2009. The national readmission rate in 2007-08 was 13.8 per cent.

Nevertheless, clinicians and stakeholders told us that the lack of community based staff to support recovery and maintenance contributed to worsening mental health and rehospitalisation in some cases. Despite staff increases they were concerned that the mental health system resembled a revolving door for these people.

Interviewees also told us some patients were discharged without plans for recovery. At least 3.7 per cent of acute patients discharged in 2008-09 were homeless which made the implementation of an effective recovery plan difficult.

Lack of step-down services	Other people with mental illness remain in hospital for longer periods of time. The following exhibit shows the time patients occupied mental health hospital beds between July and December 2009 and how this relates to the recommended lengths of stay. One-third of children and adolescents and two-thirds of older persons stay in acute beds for four weeks or more.

Exhibit 12: Length of hospital stay (percentage of patients) by bed-type									
	1-3 days	4-7 days	8-14 days	15-21 days	4-6 weeks	7-12 weeks	4-6 month	7-12 month	> 1 year	Long stayers
PECC-Emergency Departments	74.4%	15.8%	4.4%	1.9%	2.4%	0.8%	0.3%	0.0%	0.0%	3.5%
Adult acute	24.0%	18.8%	18.7%	12.5%	16.7%	7.6%	1.5%	0.2%	0.1%	26.0%
Child & adolescent Acute	14.2%	15.5%	18.7%	16.5%	24.6%	9.6%	0.9%	0.0%	0.0%	35.1%
Older person Acute	8.8%	5.8%	10.2%	10.1%	27.0%	22.2%	6.3%	1.3%	8.4%	65.1%
Child & adolescent non-acute	13.7%	54.3%	24.2%	1.9%	3.3%	1.3%	0.6%	0.6%	0.0%	-
Adult non-acute	2.7%	3.8%	4.2%	3.7%	4.9%	19.2%	17.4%	22.3%	21.9%	See note
Legend	Recommended length of stay						Potential; overstay			

Source: NSW Health InforMH Benchmarking Data July 2009 – Dec 2009.

Note: There is great variation in the expected length of stay in non-acute wards. Newer wards with a rehabilitation focus expect to discharge patients after six months, but some wards in older institutions have patients stay far longer.

During our fieldwork we learnt of two patients who had stayed in a Psychiatric Emergency Care bed in a busy Emergency Department for over seven weeks and an 82 year old woman who had occupied an acute bed for over a year.

NSW Health advises that it may be clinically appropriate for individuals to stay for longer than recommended, but it also acknowledges that people with mental illness find it difficult to access appropriate services when their needs change. This is due in part to the lack of community based services and clinicians to support these groups and a lack of integration with private sector providers.

Remaining gaps Despite the growth in clinician numbers, the workforce is not adequate to meet demand. Exhibit 13 indicates the size of the gap in real and relative terms between the unadjusted workforce and the workforce needed to meet demand by age group and setting. The numbers represent the number of additional clinicians needed to meet 100 per cent of demand. The shading indicates the relative size of the gap.

Actual workforce equal to or greater than required workforce
Actual workforce at least 90% of required workforce
Actual workforce at least 75% of required workforce
Actual workforce at least 50% of required workforce
Actual workforce at least 25% of required workforce
Actual workforce less than 25% of required workforce

Exhibit 13: Workforce gaps in 2005-06 and 2008-09					
The workforce gap in 2005-06					
	hospital		non-hospital		
	acute	non-acute	residential	community	Total
Children & Adolescent 0-17 years	13	-48	-	678	**643**
Adult 18 - 64 years	50	1,130	175	618	**1,972**
Older Person 65 + years	167	285	20	348	**820**
Total	230	**1,367**	**194**	**1,644**	**3,435**
The workforce gap in 2008-09					
	hospital		non-hospital		
	acute	Non-acute	Residential	Community	Total
Children & Adolescent 0-17 years	-10	-56	-	653	**587**
Adult 18 - 64 years	-162	1,152	191	620	**1,801**
Older Person 65 + years	182	295	23	295	**794**
Total	**10**	**1,390**	**214**	**1,568**	**3,182**

Source: NSW Health demand and unadjusted workforce data.

Note: NSW demand modelling does not provide for non-acute or residential care for children and adolescents.

NSW Health's target for the medium term is to meet 80 per cent of demand. On a state wide basis it has achieved this in respect of acute services for adults and children but not for older persons. There are still local gaps. For example Greater Western and Greater Southern AHS have no acute hospital beds for children and adolescents.

While NSW Health has reduced the workforce gap in community mental health there is still a significant way to go, particularly for older persons services.

NSW Health advises that it is reviewing the demand modelling to modelling to better account for supported accommodation, non-government providers and alternatives for non-acute hospital care.

Appendices

Appendix 1:   Boundaries of current Area Health Services

Regional AHS

Sydney AHS	AHS Population
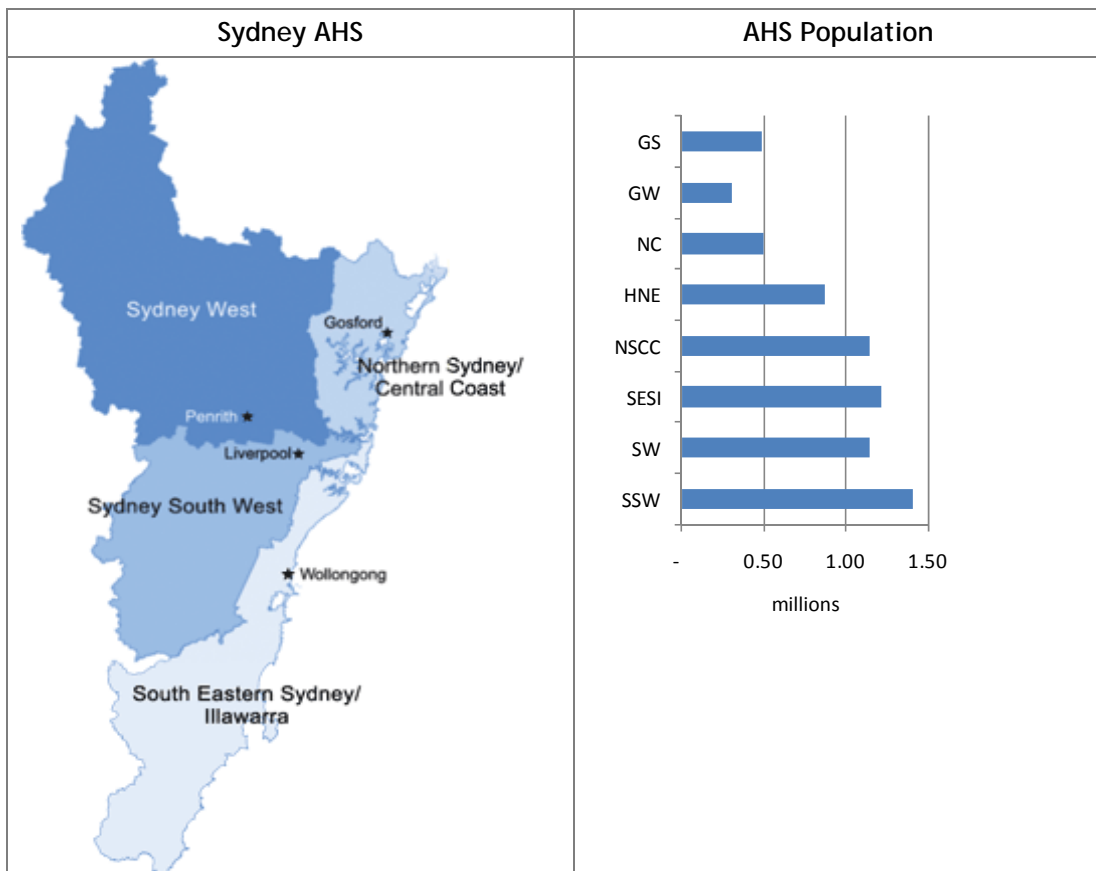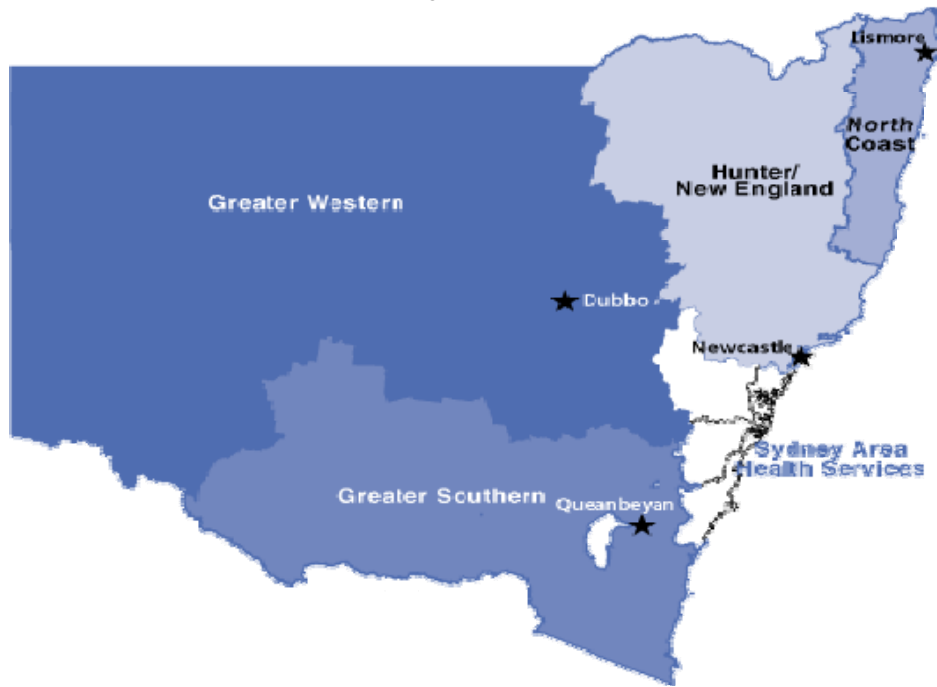
Source: NSW Health 2010 Note: The stars show the location of the AHS head offices. They do not indicate the location of mental health services.

Appendix 2: Comparison of NSW adjusted and non-adjusted mental workforces and their capacity to meet estimated demand

Exhibit 13:Proportion of need met by adjusted and unadjusted workforce	
Adjusted Workforce	**Unadjusted workforce**
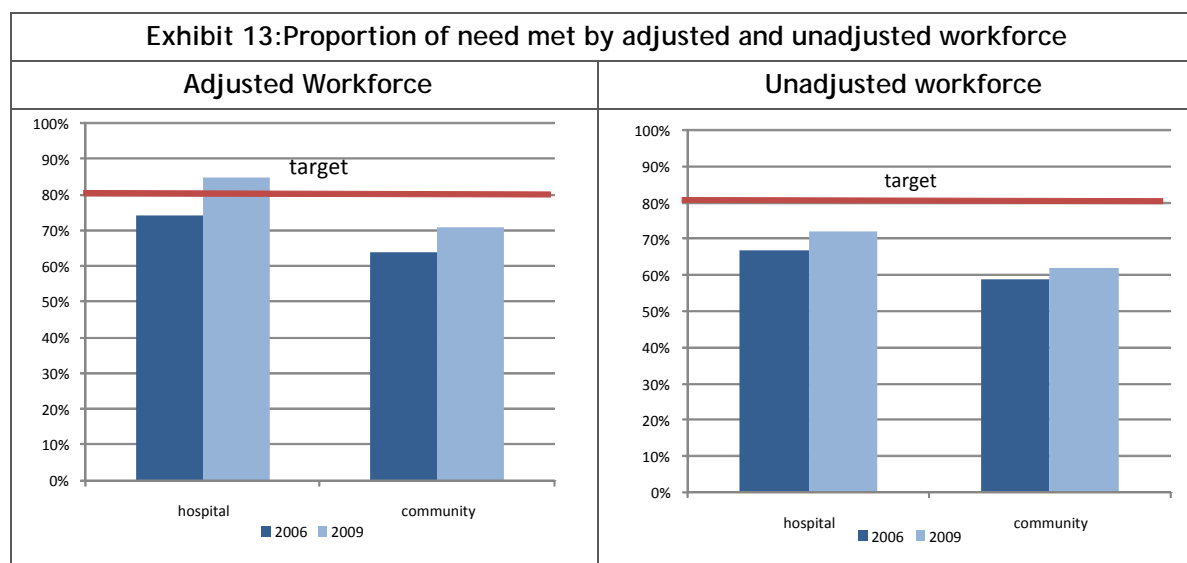
Source: Audit Office analysis of NSW Health data.

Note: In this table 'hospital' includes acute and non-acute settings. The table excludes the workforce in residential settings.

	Adjusted		Unadjusted	
	Hospital	Community	Hospital	Community
Workforce 2006	3596	2591	3256	2367
Workforce Demand 2006	4853	4012	4853	4012
Staff Shortage 2006	1257	1421	1597	1644
Proportion of need met 2006	74%	64%	67%	59%
Workforce 2009	4278	2931	3637	2576
Workforce Demand 2009	5037	4144	5037	4144
Staff shortage in 2009	759	1213	1400	1568
Proportion of need met 2009	85%	71%	72%	62%
Growth in workforce 2006-2009	682	340	381	209
Workforce Growth as %	19%	13%	12%	9%
Growth in demand 2006-2009	4%	3%	4%	3%
Share of workforce growth 2006-2009	67%	33%	65%	35%

Appendix 3:   About the audit

Audit Objective

The objective of the audit was to assess whether the public mental health workforce, and its distribution, supports the effective and efficient delivery of services.

Audit Criteria

In reaching our opinion against the audit objective, we used the following audit criteria (the 'what should be') to judge performance. We based these standards on our research of current thinking and guidance on better practice and agreed them with NSW Health. The criteria used were:

- is the distribution and mix of the mental health workforce based on need for services?
- has NSW Health identified workforce gaps and set strategies to manage them?
- are NSW Health initiatives to address mental health workforce gaps and manage their impacts adequate?

Audit scope

The audit focused on the clinical workforce providing mental health care in the eight Area Health Services, the Children's Hospital Westmead and Justice Health. It included Visiting Medical Officers, contractors and agency staff engaged by these services.

The audit did not review:

- domestic, administrative, security and other non-clinical workforces
- clinical practice models
- arrangements for engaging the workforce (employee, contractor, etc)
- shortages at particular hospitals except as case studies
- quality of care
- merits of Government policy objectives.

Audit approach

We acquired subject matter expertise through:

- interviews and examination of relevant documents including policies, guidelines, reports, studies, reviews relating to mental health care and workforce management
- discussions with relevant staff of NSW Health
- discussions with representatives of key stakeholders
- comparisons where appropriate with other states and countries
- government and best practice guidelines relevant to the above.

Audit selection

We use a strategic approach to selecting performance audits which balances our performance audit program to reflect issues of interest to Parliament and the community. Details of our approach to selecting topics and our forward program are available on our website.

Audit methodology   Our performance audit methodology is designed to satisfy Australian Standards on Assurance Engagements, ASAE3500 on performance engagements, and to reflect current thinking on performance auditing practices.

Audits are produced under the Office's quality control policies and practices, including a quality management system certified to International Standard ISO 9001. Our processes have also been designed to comply with the *Public Finance and Audit Act 1983*.

Acknowledgements   We gratefully acknowledge the cooperation and assistance provided by NSW Health. In particular we wish to thank our liaison officers and staff who participated in interviews and provided material relevant to the audit.

We were also assisted by discussions with a number of government agencies and external bodies including the Mental Health Priority Taskforce, NSW Carers Advisory Group, Mental Health Coordinating Council, NSW Nurses Association, Divisions of General Practice, Department of Corrective Services, Ombudsman, Mr Peter Draper MP, Queensland Health, and Australian Institute of Health and Welfare.

Audit team   Our team for the performance audit was led by Michael Johnston who was assisted by Andrew Chan and Gordon Eastwood. Giulia Vitetta and Rob Mathie provided direction and quality assurance.

Audit cost   Including staff costs, printing costs and overheads the estimated cost of the audit is $196,000.

Performance Audits by the
Audit Office of New South Wales

Performance Auditing

What are performance audits?

Performance audits determine whether an agency is carrying out its activities effectively, and doing so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of a government agency or consider particular issues which affect the whole public sector. They cannot question the merits of Government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in the *Public Finance and Audit Act 1983.*

Why do we conduct performance audits?

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

Through their recommendations, performance audits seek to improve the efficiency and effectiveness of government agencies so that the community receives value for money from government services.

Performance audits also focus on assisting accountability processes by holding managers to account for agency performance.

Performance audits are selected at the discretion of the Auditor-General who seeks input from Parliamentarians, the public, agencies and Audit Office research.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing. They can take up to nine months to complete, depending on the audit's scope.

During the planning phase the audit team develops an understanding of agency activities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the agency or program activities are assessed. Criteria may be based on best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork the audit team meets with agency management to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with agency management to check that facts presented in the draft report are accurate and that recommendations are practical and appropriate.

A final report is then provided to the CEO for comment. The relevant Minister and the Treasurer are also provided with a copy of the final report. The report tabled in Parliament includes a response from the CEO on the report's conclusion and recommendations. In multiple agency performance audits there may be responses from more than one agency or from a nominated coordinating agency.

Do we check to see if recommendations have been implemented?

Following the tabling of the report in Parliament, agencies are requested to advise the Audit Office on action taken, or proposed, against each of the report's recommendations. It is usual for agency audit committees to monitor progress with the implementation of recommendations.

In addition, it is the practice of Parliament's Public Accounts Committee (PAC) to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report is tabled. These reports are available on the Parliamentary website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

Internal quality control review of each audit ensures compliance with Australian assurance standards. Periodic review by other Audit Offices tests our activities against best practice. We are also subject to independent audits of our quality management system to maintain certification under ISO 9001.

The PAC is also responsible for overseeing the performance of the Audit Office and conducts a review of our operations every three years. The review's report is tabled in Parliament and available on its website.

Who pays for performance audits?

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

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

Performance Audit Reports

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
210	NSW Health	*Mental Health Workforce*	December 2010
209	Department of Premier and Cabinet	*Sick leave*	8 December 2010
208	Department of Industry and Investment	*Coal Mining Royalties*	30 November 2010
207	Whole of Government electronic information security	*Electronic Information Security*	20 October 2010
206	NSW Health NSW Ambulance Service	*Helicopter Emergency Medical Service Contract*	22 September 2010
205	Department of Environment, Climate Change and Water	*Protecting the Environment: Pollution Incidents*	15 September 2010
204	Corrective Services NSW	*Home Detention*	8 September 2010
203	Australian Museum	*Knowing the Collections*	1 September 2010
202	Industry & Investment NSW Homebush Motor Racing Authority Events NSW	*Government Investment in V8 Supercar Races at Sydney Olympic Park*	23 June 2010
201	Department of Premier and Cabinet	*Severance Payments to Special Temporary Employees*	16 June 2010
200	Department of Human Services - Ageing, Disability and Home Care	*Access to Overnight Centre-Based Disability Respite*	5 May 2010
199	Department of Premier and Cabinet NSW Treasury WorkCover NSW	*Injury Management in the NSW Public Sector*	31 March 2010
198	NSW Transport and Infrastructure	*Improving the Performance of Metropolitan Bus Services*	10 March 2010
197	Roads and Traffic Authority of NSW	*Improving Road Safety: School Zones*	25 February 2010
196	NSW Commission for Children and Young People	*Working with Children Check*	24 February 2010
195	NSW Police Force NSW Department of Health	*Managing Forensic Analysis – Fingerprints and DNA*	10 February 2010
194	Department of Premier and Cabinet Department of Services, Technology and Administration NSW Treasury	*Government Advertising*	10 December 2009
193	Roads and Traffic Authority of NSW	*Handback of the M4 Tollway*	27 October 2009
192	Department of Services, Technology and Administration	*Government Licensing Project*	7 October 2009
191	Land and Property Management Authority Maritime Authority of NSW	*Administering Domestic Waterfront Tenancies*	23 September 2009
190	Department of Environment, Climate Change and Water NSW Environmental Trust	*Environmental Grants Administration*	26 August 2009

No	Agency or Issues Examined	Title of Performance Audit Report or Publication	Date Tabled in Parliament or Published
189	NSW Attorney General's Department NSW Department of Health NSW Police Force	*Helping Aboriginal Defendants through MERIT*	5 August 2009
188	NSW Department of Health	*Tackling Cancer with Radiotherapy*	23 June 2009
187	Roads and Traffic Authority of NSW	*Improving Road Safety – Heavy Vehicles*	13 May 2009
186	Grants	*Grants Administration*	6 May 2009
185	Forests NSW	*Sustaining Native Forest Operations*	29 April 2009
184	NSW Police Force	*Managing Injured Police*	10 December 2008
183	Department of Education and Training	*Improving Literacy and Numeracy in NSW Public Schools*	22 October 2008
182	Department of Health	*Delivering Health Care out of Hospitals*	24 September 2008
181	Department of Environment and Climate Change	*Recycling and Reuse of Waste in the NSW Public Sector*	11 June 2008
180	Follow-up of 2003 Performance Audit	*Protecting Our Rivers*	21 May 2008
179	NSW Office of Liquor, Gaming and Racing; NSW Police Force	*Working with Hotels and Clubs to reduce alcohol-related crime*	23 April 2008
178	Greyhound and Harness Racing Regulatory Authority	*Managing the Amalgamation of the Greyhound and Harness Racing Regulatory Authority*	3 April 2008
177	Office of the Director of Public Prosecutions	*Efficiency of the Office of the Director of Public Prosecutions*	26 March 2008
176*	Better Practice Guide	*Implementing Successful Amalgamations*	5 March 2008
175	Department of Commerce Department of Primary Industries	*Managing Departmental Amalgamations*	5 March 2008
174	Department of Education and Training	*Ageing workforce – Teachers*	13 February 2008
173	NSW Police Force	*Police Rostering*	5 December 2007
172	Department of Primary Industries	*Improving Efficiency of Irrigation Water Use on Farms*	21 November 2007
171	Department of Premier and Cabinet Department of Commerce	*Government Advertising*	29 August 2007
170	RailCorp	*Signal Failures on the Metropolitan Rail Network*	15 August 2007

* Better Practice Guides

Performance audits on our website

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

If you have any problems accessing these reports, or are seeking older reports, please contact our Office Services Manager on (02) 9275 7116.