Australian Government
Australian Institute of Health and Welfare

Mental health services

In brief 2017

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2017

The Australian Institute of Health and Welfare is a major national agency whose purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

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Cover art by Donna Murray.

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About the cover artwork

My hand of hope, by Donna Murray

Donna Murray was 12 when she began what was to be her life work, and a passion for helping others like her use self-help techniques to draw on their strength and creativity to achieve mental health recovery. She began her pioneering journey by participating in a beginners' night course in pottery to express her pain, and the trauma in her life, as she could not find the words to describe what was happening, and how she felt.

Donna found a way to release the suffering and emotional turmoil, moving forward one step at a time, drawing on creativity to give her strength to deal with at times insurmountable odds.

For well over 25 years Donna has expressed herself through numerous artistic avenues. She learned the crafts of ceramics, leather-work, recycled art, and mosaics, and gained her trade certificate in painting and decorating, a tool she has carried all her life.

She is currently working as a Peer Support Worker, and a Self-help Group Facilitator, sharing the creative recovery approach and her lived experience to help and support others with mental distress—her peers. For Donna, her art is a self-care tool in her journey of recovery.

In 2012, Donna submitted one of her paintings to the Open Minds Open Doors exhibition, supported by Disability in the Arts Disadvantages in the Arts and Fremantle Hospital. Donna's painting depicting past traumas as part of her recovery, titled the *Burning winds of change*, won a major award. Her artwork is on permanent display at Fremantle Hospital.

The painting on the cover of this publication is one of many of Donna's works. It represents the confidence and self-worth she has gained, and, by seeing it—as in her hand, her perspective—'you have to find what works in personal recovery. It's not a program you can do'.

Importantly, Donna strongly advocates that creativity and strength are something all people have within, and that everyone can use to believe in themselves, and in their journey of recovery and wellbeing.

Contents

Mental health services—in brief 2017 is the companion publication to online report *Mental health services in Australia*, which provides detailed data on the national response of the health and welfare system to the mental health care needs of Australians.

This report provides an overview of key statistics and related information on mental health services, incorporating updates made to the online report over the 12 months to October 2017. The report draws on data from various sources. As such, the data reference year reported might vary between topic areas.

Mental health services: at a glance

Services provided 2015–16

2.3 million people	received Medicare-subsidised mental health-specific services
273,439 presentations	to emergency departments were mental health-related
414,176 people	received 9.4 million community mental health care service contacts
244,934 hospitalisations	were for overnight mental health-related hospital care, amounting to nearly 4.0 million patient care days
59,364 days	were same-day mental health-related hospital care days provided by public hospitals
242,563 days	were same-day mental health-related hospital care days provided by private hospitals
5,840 people	received 7,727 episodes of residential mental health care, amounting to 307,000 care days
96,330 people	with a psychiatric disability received disability support services
72,364 clients	with a mental health issue received specialist homelessness services
4.0 million patients	received mental health-related prescriptions

Mental health system 2014–15

$8.5 billion	was spent on mental health-related services
7.8%	of total health expenditure was spent on mental health-related services and programs
9,577 hospital beds	were specialised mental health-care beds in public and private hospitals
2,471 beds	were provided in residential mental health-care services
3,131 psychiatrists 20,834 mental health nurses 24,522 registered psychologists	Worked in Australia in 2015

The prevalence of mental illness in Australia

45% of Australians will have a common mental disorder in their lifetime

1 in 7 young people (4–17 years) had mental disorders in the previous 12 months in 2013–14

64,000 people aged 18–64 accessed treatment for a psychotic disorder in 2010

What is mental illness?

Mental illness refers to a clinically diagnosable disorder(s) that significantly interferes with an individual's cognitive, emotional, or social abilities (Slade et al. 2009).

The term covers a spectrum of disorders that vary in severity and duration. Mental illness can have damaging effects on individuals and families affected, and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity, and homelessness.

Those with mental illness often experience problems such as isolation, discrimination, and stigma (WHO 2016). The terms mental illness and mental disorder are often used interchangeably.

Mental illness in adults

Data from the 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (aged 16–85) showed that almost half (45.5%) of Australian adults (about 8.5 million people based on the estimated 2015 population) will experience a common mental disorder in their lifetime (ABS 2008). Each year, 1 in 5 Australians in this age range (20% or about 3.8 million Australians in 2015) are estimated to experience a mental disorder.

Anxiety disorders (for example, *Post-Traumatic Stress Disorder* and *Social phobia*) were the most common types of disorder reported in the National Survey of Mental Health and Wellbeing, with 14.4% of Australian adults experiencing an *Anxiety disorder* in the previous 12 months. This was followed by *Affective disorders* (for example, *Depression*, 6.2%), and *Substance-use disorders* (for example, *Alcohol dependence*, 5.1%) (ABS 2008).

The 2007 survey also showed that women experienced higher prevalence of 12-month mental disorders than men (22.3% compared with 17.6%) (Figure 1).

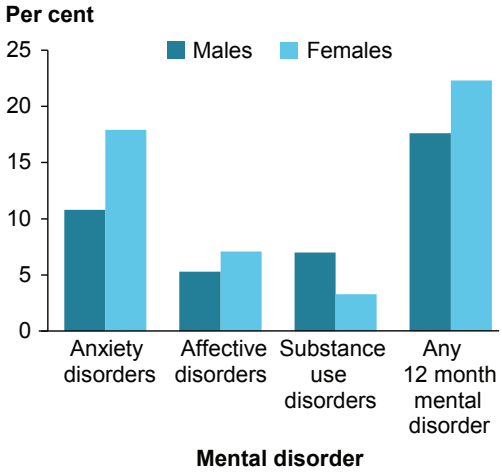


Figure 1: Prevalence of common mental disorders in Australian adults, by sex, 2007

Mental illness in young people

The most recent Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as the Young Minds Matter Survey) was undertaken in 2013–14 (Lawrence et al. 2015).

Data showed that almost 1 in 7 young people aged 4–17 (13.9% or just over 575,000 people based on the estimated 2015 population) met the clinical criteria for 1 or more mental disorders in the previous 12 months.

Attention deficit hyperactivity disorder (ADHD) was the most common mental disorder (7.4% or 307,000 children and adolescents based on the estimated 2015 population), followed by *Anxiety disorders* (6.9% or about 286,000), *Major depressive disorder* (2.8% or about 116,000), and *Conduct disorder* (2.1% or about 87,000).

A comparison of prevalence data from the *Young Minds Matter* survey with the first national Child and Adolescent Survey of Mental Health and Wellbeing (conducted in 1998) suggests that overall prevalence has remained relatively stable for common mental disorders over time, with modest declines in prevalence of ADHD and conduct disorders and a modest increase in the prevalence of major depressive disorders (Lawrence et al. 2015).

Psychotic disorders

The National Survey of Psychotic Illness 2010, conducted in 2009–10, estimated that 64,000 people aged 18–64 with a psychotic disorder accessed treatment from public specialised mental health services each year (Morgan et al. 2011). More people had a diagnosis of *Schizophrenia* (47.0%) than any other type of psychotic illness. About two-thirds (64.8%) of these people had their first episode of psychotic illness before the age of 25.

The impact of mental illness in Australia

2–3% of Australians have a severe mental disorder

1 in 4 of all years lived with a disability were due to mental and substance use disorders

1 in 10 adults with a mental disorder also had a physical disorder

Mental disorders can vary in severity and duration, and may be episodic. About 3% of Australians (equivalent to about 720,000 people based on the estimated 2015 population) have severe mental disorders, as judged by diagnosis, intensity of symptoms, duration of symptoms, and degree of disability (not limited to severe psychotic disorders) (DoHA 2013). About 4–6% of the Australian population (about 1.2 million people) have moderate disorders, and a further 9–12% (about 2.5 million people) have a mild disorder.

The contribution of mental illness to the burden of disease in Australia

The 2011 Australian Burden of Disease Study looked at the fatal (years of life lost) and non-fatal (years of life lived with a disability) impact of different diseases, conditions, or injuries on Australians (AIHW 2016).

In 2011, mental and substance use disorders were responsible for an estimated 12.1% of the total disease burden in Australia, making it the third highest group of diseases behind cancer and cardiovascular diseases (Figure 2).

It was also the leading cause of non-fatal burden, accounting for almost one-quarter (23.6%) of all years lived with a disability.

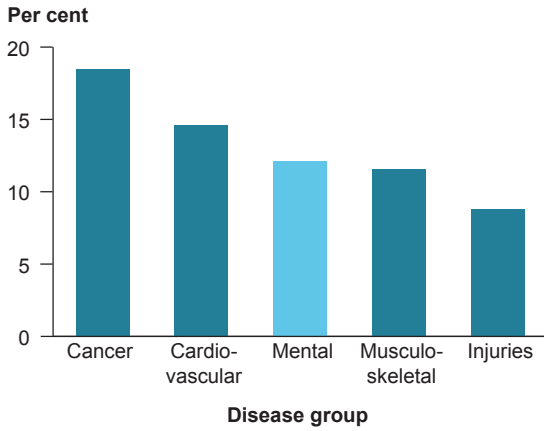


Figure 2: Australia's top 5 burden of disease groups, 2011

Close to one-quarter of the burden from *Mental and substance use disorders* was attributed to *Anxiety disorders* (26.0%), and *Depressive disorders* (23.5%). A further 12.2% was attributed to alcohol use disorders.

Coexisting illnesses

People with mental illness often have 1 or more physical disorders (referred to as a 'comorbid' disorder). The 2007 NSMHWB, found that 11.7% of adults with a mental disorder in the previous 12 months also reported a physical disorder, with 5.3% reporting 2 or more mental disorders, and 1 or more comorbid physical conditions (ABS 2008).

According to the Australian National Survey of People Living with Psychotic Illness 2010, people being treated for psychotic illness often had poor physical health outcomes and comorbidities (Morgan et al. 2011). People being treated for psychotic illness were more likely to experience a number of physical health conditions compared to the general population; for example, they were more than 3 times as likely to have diabetes, and more than 1.5 times as likely to have a heart or circulatory condition (Morgan et al. 2011).

Australia's mental healthcare system—an overview

Mental health care can be broadly divided into specialised mental health services, and health services where mental health-related care might be delivered (Table 1).

State and territory governments fund and deliver public sector specialised mental health care services, including admitted patient services delivered in hospitals, and services delivered in community settings. They may also fund additional programs and support services, often delivered by the non-government sector.

The Australian Government funds various mental health services through the Medicare Benefits Scheme (Medicare), as well as prescriptions through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS).

The Australian Government also funds various essential support programs and services, some of which are managed by Primary Health Networks. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

Table 1: Overview of Australia's mental health care system

Medicare-subsidised services		
General practitioners	Psychiatrists	Psychologists
Specialised mental health care settings		
Public and private hospitals	Community mental health care	Residential mental health care services
Support services		
Disability support services	Homelessness support services	Mental health programs

Estimates of people with mental illness receiving mental health care

The 2007 NSMHWB of adults (aged 16–85) estimated that about one-third of people with a mental disorder in the previous 12 months accessed mental health services (ABS 2008). Of these:

- 70.8% consulted a general practitioner (GP)
- 37.7% consulted a psychologist
- 22.7% consulted a psychiatrist.

Since the 2007 survey, the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS Initiative (Better Access) was introduced to 'provide better access to mental health practitioners through Medicare' (DoHA 2006). An updated estimate of treatment rates for people with mental illness showed a rise from about one-third in 2007 to about 46% 2009–10 (Whiteford et al. 2014).

Since 2009–10, the rate of people accessing Medicare-subsidised mental health-specific services has continued to rise (see 'Medicare-subsidised mental health-related services' in this document).

For young people, more recent survey results are available. Based on the 2013–14 *Young Minds Matter* survey, about 1 in 6 (17.0%) young people aged 4–17 had used services for emotional or behavioural problems in the previous 12 months, with 56.0% of those having at least 1 mental disorder. Service use was found to increase with severity of the disorder, with almost 9 in 10 (87.6%) of those with severe disorders accessing services.

Services used by those aged 4–17 with a mental disorder were provided by GPs (35.0%), psychologists (23.9%), paediatricians (21.0%), or counsellors or family therapists (20.7%), noting that people may receive services from more than one provider.

Types of mental health care services and providers of care

In Australia, people with mental illness have access to a variety of mental health care services provided by various health care professionals in different care settings.

Mental health care service types include specialised hospital services (both public and private), specialised residential services, specialised community services, private practices (such as GPs and psychiatrists), and support services delivered by non-government organisations (such as telephone counselling services).

Specialised mental health care is delivered in various facilities designed to support people with mental illness. These facilities include public and private psychiatric hospitals, psychiatric units/wards in public acute hospitals, community mental health care services, and government or non-government-operated residential mental health services.

Hospital emergency departments (EDs) also play a role in treating people with mental illness, and might be the initial point of access to the health care system for an individual with mental illness.

Health care professionals providing mental health care and support include GPs, psychologists, psychiatrists, nurses, occupational therapists, social workers, and peer workers.

The remainder of this publication details the number of services provided by various service providers, summarises the system providing these services and the total cost of mental health-related care in Australia.

Mental health care services and support

Mental health care provided by general practitioners

12.4% of GP care was estimated to be mental health-related in 2015–16

18.0 million estimated GP encounters were mental health-related

3.2 million mental health MBS-specific GP services were provided to 1.8 million patients

The first professional encounter for many people seeking help for a mental illness is their General Practitioner. The Bettering the Evaluation and Care of Health (BEACH) survey of GPs provides a picture of the estimated number of GP encounters that are mental health-related. Medicare data describing GP activity for mental health-specific MBS items are also available.

Services provided

Data from the BEACH survey estimated that 12.4% of all GP encounters in 2015–16 were mental health-related (18.0 million estimated GP encounters). These estimates are much higher than the number of mental health-specific Medicare-subsidised GP services provided (3.2 million services in 2015–16). This means that only about 1 in 6 (18.1%) estimated GP encounters that were mental health-related were billed using mental health-specific MBS items numbers in 2015–16 with the remainder likely billed as general MBS items. This is a rise from about 1 in 7 (14.7%) in 2011–12.

GPs provided 30.6% (3.2 million) of all Medicare-subsidised mental health-specific services in 2015–16, at a rate of 135.5 services per 1,000 population. These services were provided to about 1.8 million patients, an average of 1.8 services per patient. Victoria (156.1 service per 1,000 population) had the highest rate of services, while the Northern Territory (61.3) had the lowest.

Changes over time

Between 2011–12 and 2015–16, the number of estimated GP encounters that were mental health-related, according to the BEACH data, increased by an annual average of 4.7%. The proportion of all GP encounters that were mental health-related increased from 12.1% to 12.4% over the same time period.

Profile of people who received services

From the BEACH data source, about 1 in 4 estimated mental health-related GP encounters were for patients aged 65 and over (24.4%). Almost 3 in 5 encounters were provided to females (58.1%).

Mental health-related problems managed

In 2015–16, the most frequent mental health-related problems managed by GPs were, *Depression* (32.1%), *Anxiety* (16.6%), and *Sleep disturbance* (12.1%), according to the BEACH data source (Figure 3).

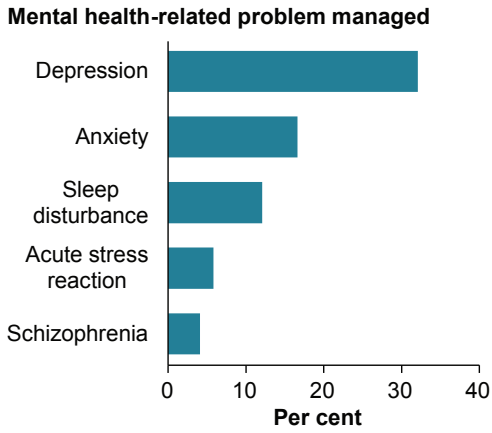


Figure 3: The 5 most common problems managed during mental health-related GP encounters, 2015–16

Management provided

In 2015–16, *Prescribing, recommending, or supplying a mental health-related medication* was the most frequent type of management provided by GPs (61.6 per 100 mental health-related problems), according to the BEACH survey, noting that more than one management type can be provided during each encounter. Counselling services (49.6 per 100 mental health-related problems) was the next most common type of management. Referrals were most commonly provided to psychologists (9.3 per 100 mental health-related problems).

Medicare-subsidised mental health-related services

2.3 million people (9.4% of the population) received Medicare-subsidised mental health-specific services in 2015–16

10.6 million Medicare-subsidised mental health-specific services were provided

GPs provided more services than other provider types

7.6% was the average annual increase in the number of services provided (2011–12 to 2015–16)

Medicare-subsidised mental health-specific services are provided by psychiatrists, GPs, psychologists, and other allied health professionals (in particular, social workers, mental health nurses, and occupational therapists). The services are provided in various settings, such as in consulting rooms, in hospitals, by home visits, over the phone, and by video link.

Profile of people who received services

According to Medicare Benefits Schedule data, the proportion of people receiving mental health-specific services in 2015–16 was highest for those aged 35–44 (129.9 people per 1,000 population). More females (113.0 per 1,000 population) received services than males (75.8 per 1,000 population).

Victoria had the highest rates of patients (105.1 per 1,000 population) and services (525.4 per 1,000 population). The Northern Territory had the lowest rates for both patients (44.7) and services (132.3). Nationally, the rates were 94.5 patients and 443.6 services per 1,000 population.

People who usually live in *Inner regional* areas were most likely to receive services, followed closely by those living in *Major cities*. For the remaining areas, the rate of people receiving services decreased as remoteness increased; that is, *Outer regional*, *Remote* and *Very remote* areas.

Changes over time

The number of patients receiving Medicare-subsidised mental health-specific services, and the number of services provided increased over the 5 years to 2015–16. The number of patients receiving services increased from 1.6 million to 2.3 million (Figure 4), while the number of services provided increased from 7.9 million to 10.6 million, an annual average increase of 7.6%.

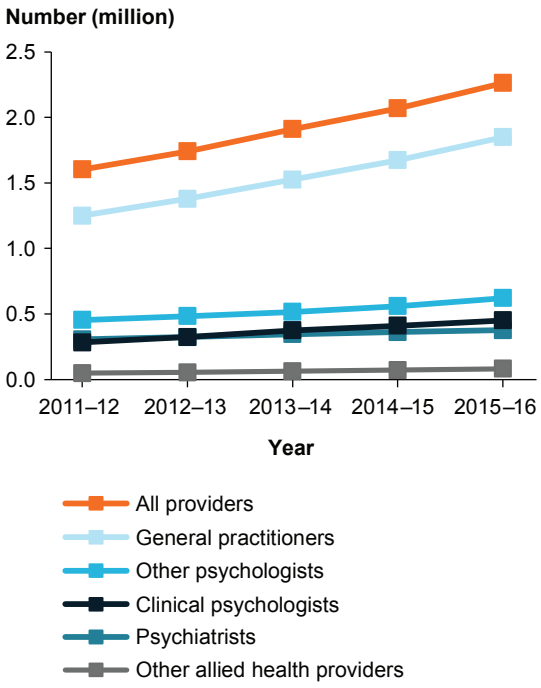


Figure 4: Number of people receiving Medicare-subsidised mental health-specific services, by provider type, 2011–12 to 2015–16

From 2011–12 to 2015–16, services provided by GPs and clinical psychologists made up almost two-thirds of the total growth in services.

Providers of Medicare-subsidised mental health-related services

In 2015–16, the largest proportion of Medicare-subsidised mental health-specific services were provided by GPs (30.6%), followed by other psychologists (psychologists not classified as clinical psychologists) (24.8%), and psychiatrists (22.2%). Psychiatrists provided the highest number of services per patient (6.3 services per patient).

Mental health services provided in public hospital emergency departments

273,439 mental health-related ED presentations in 2015–16

78.5% of mental health-related emergency department presentations were for people aged 15–54

35.9% of mental health-related presentations resulted in a hospital admission

Public hospital emergency departments (EDs) play an important role in treating mental illness. They can be the initial point of care for those seeking mental health-related services for the first time, as well as an alternative point of care for people seeking after-hours mental health care.

Data for the Australian Capital Territory were unavailable for the 2015–16 reporting period. This limits the presentation of national activity and comparisons over time.

Services provided

Nationally, there were an estimated 273,439 ED presentations with a mental health-related principal diagnosis during 2015–16 (3.7% of all ED occasions of service)(excluding the ACT).

More than three-quarters (77.5%) of mental health-related ED presentations were classified on initial assessment as being either *Urgent* (requiring care within 30 minutes) or *Semi-urgent* (requiring care within 60 minutes). Another 12.8% of presentations were classified as *Emergency* (requiring care within 10 minutes), and 0.9% as *Resuscitation* (requiring immediate care).

The most frequently recorded end mode for a mental health-related ED presentation was *Completed without admission or referral to another hospital* (60.8%).

About one-third (35.9%) of presentations resulted in *Admission to hospital*, either to the hospital where the emergency service was provided (32.0%), or *Referred to another hospital for admission* (3.9%).

Changes over time

Time series analysis of mental health-related emergency department presentations cannot be calculated, due to a data source change between the 2013–14 and 2014–15 collection periods.

Profile of people who received services

More than three-quarters (78.5%) of mental health-related ED presentations were for people aged 15–54. Males (52.1%) received more services than females (47.9%).

The most frequently recorded principal diagnosis groups were *Mental and behavioural disorders due to psychoactive substance use* (such as alcohol dependency disorders) (28.6%) and *Neurotic, stress-related and somatoform disorders* (such as anxiety disorders (25.6%).

ED mental health-related care compared with all ED visits

Mental health-related ED presentations had a higher proportion of patients aged 15–54 (78.5%) compared with all ED presentations (48.9%), and a lower proportion of patients aged less than 15 (3.8% and 21.7%, respectively) and 65 and over (10.3% and 20.3%, respectively) (Figure 5).

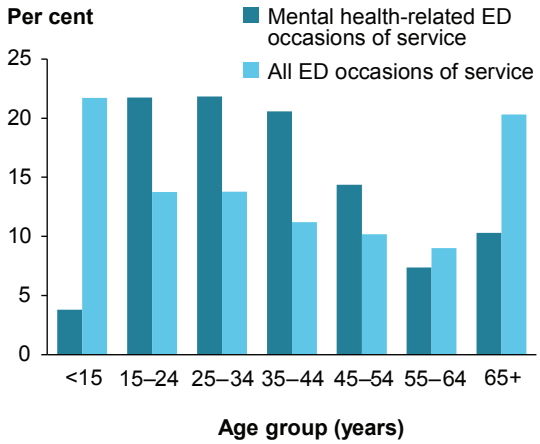


Figure 5: ED occasions of service in public hospitals, by age group (years), 2015–16

State and territory community mental health care services

9.4 million community mental health care service contacts were provided to more than 410,000 people in 2015–16

40.8% of patients (just under 170,000 people) had a medium to long term treatment length (92 days or more)

Schizophrenia was the most common principal diagnosis recorded during a service contact

Mental illness is often treated in community and hospital-based outpatient care settings. Collectively, these services are referred to as specialised Community Mental Health Care (CMHC) services.

Services provided

Nationally, CMHC services provided 9.4 million service contacts in 2015–16. These were provided to 414,176 clients; equating to an average of 23 service contacts per client. The rate of clients receiving services was highest in the Northern Territory (29.9 clients per 1,000 population) and lowest in Victoria (11.3). The national average was 17.3.

Nationally, about 1 in 7 (13.5%) service contacts were provided to people with an *Involuntary* mental health legal status in 2015–16. The Australian Capital Territory (37.6%) had the highest proportion of service contacts provided to people with an *Involuntary* mental health legal status, while Western Australia (1.7%) had the lowest.

Changes over time

After taking population changes into account, service contact rates increased in most states and territories between 2011–12 and 2015–16. Data coverage problems in 2011–12 mean that the change at the national level cannot be calculated.

Profile of people who received services

Males (417.0 per 1,000 population) had a higher rate of service contacts than females (352.3) in 2015–16. The service contact rate for Indigenous Australians (1,271.9) was nearly 4 times the rate for Non-Indigenous Australians (347.2).

In 2015–16, about 2 in 5 clients (40.8%) had a length of treatment of 92 days or more (that is, the time between their first and last service contact during the reporting period). These patients received more than 4 in 5 treatment days (83.3%) from CMHC services (Figure 6).

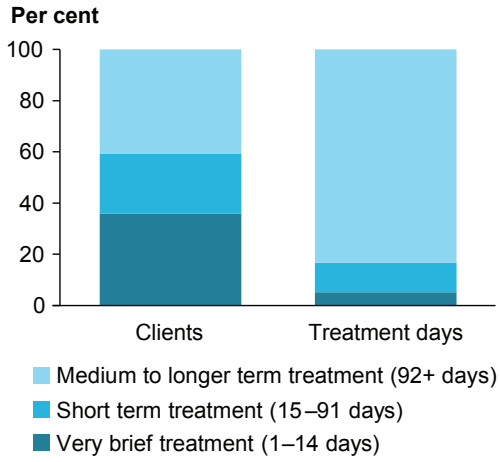


Figure 6: Community mental health care clients and treatment days, by length of treatment period, 2015–16

The most frequently recorded principal diagnoses for patients receiving service contacts were *Schizophrenia* (21.5% of all contacts), *Depressive episode* (9.7%), and *Bipolar affective disorders* (5.0%).

Profile of service contacts

CMHC service contacts can be conducted individually or in a group session. Service contacts can also be delivered with the patient present, such as face to face, via telephone or video link, or by using other forms of direct communication. They can also be conducted without the patient present, such as with a carer or family member, and/or other professional or mental health worker.

Nationally, in 2015–16, 88.0% of service contacts (or 8.3 million contacts) were individual contacts. About two-thirds (60.7%) of all service contacts took place with the patient present.

In 2015–16, the average service contact length was 36 minutes. Service contacts with the patient present (42 minutes) were on average longer than contacts without the patient present (25 minutes).

Overnight mental health-related hospital care

244,934 overnight mental health-related hospitalisations occurred in public and private hospitals in 2015–16

16 days was the average length of mental health-related hospitalisations

63.7% of overnight mental health-related hospitalisations involved specialised care

Depressive episode was the most common principal diagnosis for hospitalisations with specialised care

Overnight mental health-related hospitalisations (also referred to as separations) occur in public acute, public psychiatric, or private hospitals, and can be classified as being with or without specialised psychiatric care.

Services provided

Nationally, there were 244,934 overnight mental health-related separations in public and private hospitals in 2015–16, equating to nearly 4.0 million patient care days, and an average length of stay of 16 days.

Almost two-thirds (63.7%) of all overnight mental health-related separations involved specialised psychiatric care. For public hospitals around 3 in 5 (59.2%) involved specialised psychiatric care, compared with about 4 in 5 (82.0%) for private hospitals.

Changes over time

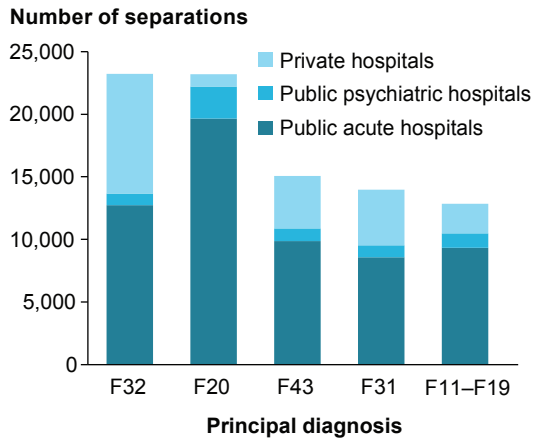
The number of overnight mental health-related separations increased by an annual average of 5.1% in the 5 years to 2015–16, whereas non-mental health overnight separations increased by an annual average of 2.2% over the same period.

Profile of people who received services

With specialised care

For overnight mental health-related separations with specialised psychiatric care, females (6.7 per 1,000 population) had a higher rate of separations than males (6.3). The highest rate among the age groups was for people aged 35–44 (10.6). The rate for Indigenous Australians (13.6) was twice the rate for Other Australians (6.8).

The most common principal diagnosis recorded for overnight mental health-related separations with specialised psychiatric care was *Depressive episode* (F32; 23,228 separations or 14.9%), followed closely by *Schizophrenia* (F20; 23,182 or 14.8%). The profile of principal diagnoses for patients receiving care varied between hospital types (Figure 7).



Key

F32:	Depressive episode
F20:	Schizophrenia
F43:	Reaction to severe stress and adjustment disorders
F31:	Bipolar affective disorders
F11–19:	Mental and behavioural disorders due to other psychoactive substance use

Figure 7: Mental health-related hospitalisations with specialised psychiatric care, 5 most common mental health principal diagnoses, by hospital type, 2015–16

Without specialised care

For overnight mental health-related separations without specialised care, the rate for females (3.8 per 1,000 population) was higher than males (3.6). The highest rate among the age groups occurred for people aged 65 and over (8.7). The rate for Indigenous Australians (11.2) was almost 3.5 times the rate for Non-Indigenous (3.3).

The most frequently recorded principal diagnoses for overnight mental health-related separations without specialised care were *Mental and behavioural disorders due to use of alcohol* (21.1%), and *Other organic mental disorders* (16.8%).

Interventions provided

Generalised allied health interventions was the most commonly reported procedure for hospitalisations both with and without specialised psychiatric care (49.4% and 46.2% of separations, respectively).

Same-day mental health-related hospital care

59,364 same-day mental health-related separations were provided by public hospitals in 2015–16

32.6% of public hospital same-day separations involved specialised mental health care

242,563 same-day mental health-related care days were provided by private hospitals in 2015–16

In some cases, patients need to be admitted to hospital briefly for the day that they receive care due to various factors, such as the hospital's model of care, or the type of intervention provided. Models of care differ between the states and territories, and between public and private hospitals, and this has an impact on the reported volume of same-day admitted care, and the inclusion/omission of some types of hospital-based care.

Public hospitals

Services provided

In 2015–16, public acute and public psychiatric hospitals provided 59,364 mental health-related same-day separations; a rate of 2.5 separations per 1,000 population. About one-third (32.6%) of same-day separations involved specialised psychiatric care.

Changes over time

In contrast to overnight separations, the number of public hospital same-day admitted mental health separations and non-mental health separations increased by similar amounts in the 5 years to 2015–16, with annual average increases of 4.0% and 4.1%, respectively.

Profile of people who received services

With specialised care

The rate of same-day mental health-related separations with specialised psychiatric care in public hospitals was highest for patients aged 65 and over (1.4 per 1,000 population), and lowest for those aged less than 15 (0.4) (Figure 8).

Females were more likely to receive services than males, accounting for 55.4% of the separations. The most commonly recorded principal diagnosis was *Depressive episode* (5,007 separations or 25.9%).

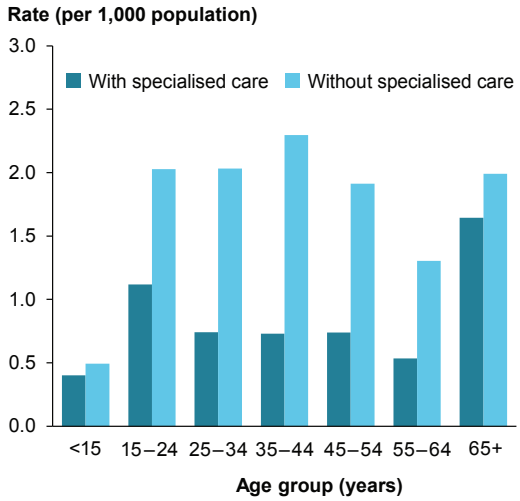


Figure 8: Same-day mental health-related separations with and without specialised psychiatric care in public hospitals, by age group (years), 2015–16

Without specialised care

Males and females had similar rates of sameday mental health-related separations without specialised care (1.7 per 1,000 population) in public hospitals.

The highest rate was for people aged 35–44 (2.3 per 1,000 population) (Figure 8), and lowest for those aged under 15 (0.5).

The most commonly recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (9,122 separations or 22.8%).

Interventions provided

Almost half (45.5%) of same-day mental health-related separations with specialised psychiatric care included at least 1 procedure. The most frequently recorded procedure for these separations was for *Electroconvulsive therapy* (26.9%). For same-day mental health separations without specialised psychiatric care, more than one-third (36.6%) included at least 1 procedure. The most frequently recorded procedure for these separations was for *Cerebral anaesthesia* (22.5%).

Private hospitals

For private hospitals, same-day care may be provided at the hospital or as a home-based service.

Services provided

In 2015–16, private hospitals provided 242,563 same-day admitted patient mental health care days to 18,585 patients.

Changes over time

The data source for same-day private admitted mental health care is limited to 2012–13 to 2015–16. Over that period, the number of patients increased by almost 3,000 people, while the number of care days provided increased by about 38,000.

Profile of people who received services

The rate of private hospital same-day admitted mental health care was highest for patients aged 45–54 (12.1 per 10,000 population), and lowest for those aged under 15 (Figure 9). Almost two-thirds (64.2%) of patients were female. The rate of female patients (9.9 patients per 10,000 population) was more than 1.5 times the rate of male patients (5.6).

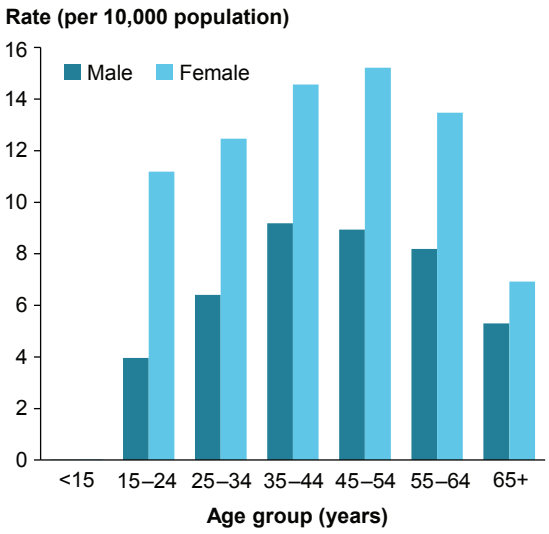


Figure 9: Same-day private hospital admitted mental health care patients, by sex and age group (years), 2015–16

On average 13.1 care days were provided per patient. The average number of care days was higher for patients who usually lived in urban areas (13.4 care days) than for people in non-urban areas (10.9).

In 2015–16, *Major affective and other mood disorders* (47.2% of episodes) was the most common principal diagnosis associated with a same-day private admitted mental health care episode, followed by *Alcohol or other substance use disorders* (17.4% of episodes) and *Anxiety disorders* (11.3%).

State and territory residential mental health care

5,840 people received residential mental health care during 2015–16

7,727 episodes were provided, amounting to more than 307,000 care days

Schizophrenia was the most common specified principal diagnosis

19.4% of episodes were provided to people with an *Involuntary* mental health legal status

Residential mental health care (RMHC) services provide overnight specialised mental health care in a domestic-like environment. These services may include rehabilitation, treatment, or extended care. RMHC services are not reported by Queensland.

Services provided

RMHC services provided 307,447 residential care days during 7,727 episodes of care to 5,840 residents in 2015–16. This equates to an average of 40 residential care days per episode, and 1.3 episodes of care per patient.

The provision of RMHC services differed among states and territories in 2015–16, with Tasmania reporting the highest rate of episodes of care (20.3 per 10,000 population) and residents (11.5), and New South Wales reporting the lowest (0.4 and 0.3 respectively). Rates are related to the number of services in each state or territory. See the Facilities section for further information.

Changes over time

There was an annual average increase of 7.8% in the number of residential mental health care episodes provided between 2011–12 and 2015–16. The number of residents (7.6%) increased by a similar amount over the same time period, but the total number of care days (0.8%) remained relatively stable.

Data are available back to 2005–06, when 2,345 episodes were provided to 1,584 residents. The rate of episodes has increased from 1.2 episodes per 10,000 population in 2005–06 to 3.2 in 2015–16.

Profile of people who received services

In 2015–16, the rate of episodes for males and females was the same (3.2 episodes per 10,000 population). People aged 35–44 (6.1) had the highest rate of episodes while people aged 65 and over had the lowest (0.8).

The rate of episodes was highest for those who usually lived in *Inner regional* areas (5.3 episodes per 10,000 population), and for those living in areas with the lowest socioeconomic status (4.7).

The two most common principal diagnoses recorded for an episode of care were *Schizophrenia* (27.1%) and *Specific personality disorders* (10.4%).

About 1 in 5 episodes (19.4%) were provided to patients with an *Involuntary* mental health legal status.

Typical completed episode of residential care

More than half (54.7%) of all completed residential episodes lasted 2 weeks or less. About 1 in 20 episodes lasted 3 to 12 months (5.4%). Longer term episodes have reduced over the decade to 2015–16—6.6% of completed episodes lasted more than 1 year in 2006–07, decreasing to 2.3% in 2015–16 (Figure 10).

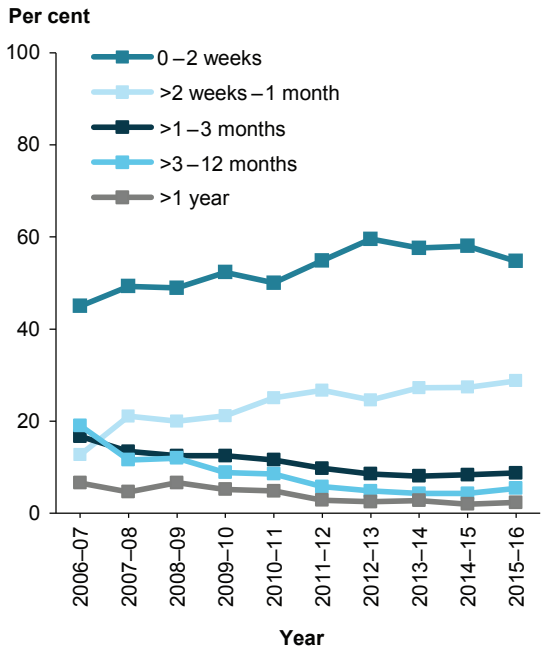


Figure 10: Residential mental health care episodes, by length of completed residential stay, 2006–07 to 2015–16

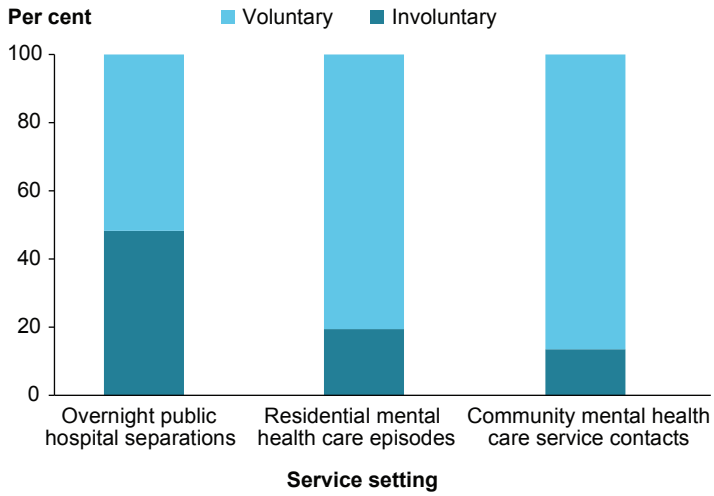
More than 4 in 5 (83.6%) residential mental health care episodes ended as a result of formal discharge.

Special focus: use of restrictive practices

People with mental illness and their carers advocate that the use of restrictive practices in Australian mental health care settings do not benefit the patient, infringe on human rights, and compromise the therapeutic relationship between the patient and the clinician (Melbourne Social Equity Institute 2014). The Royal Australian and New Zealand College of Psychiatrists (RANZCP 2016) position statement, *Minimising the use of seclusion and restraint in people with mental illness*, recognises that there are certain circumstances where the use of restrictive practices is supported, as a safety measure to protect the patient, staff and/or others when all other interventions have been exhausted.

Involuntary mental health care

States and territories each have legislation on the treatment of people with mental illness, including provisions to treat people in an involuntary capacity. The mental health legal status of people receiving care is presented here for 3 mental health care settings. Calculations exclude separations, episodes or contacts that did not have a legal status recorded. Public hospital overnight separations with specialised care (48.2% of separations) had the highest proportion of involuntary treatment, compared with residential mental health care (19.4% of episodes) and community mental health care (13.5% of service contacts) settings in 2015–16 (Figure 11).



The mental health legal status of a person is whether the person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during the period of care. Involuntary patient status can only be reported by facilities approved to treat involuntary patients.

Figure 11: Mental health care, by setting and mental health legal status, 2015–16

In response to the *National safety priorities in mental health: a national plan for reducing harm* (DoHA 2005), various initiatives have aimed to reduce seclusion and restraint use in public mental health facilities. National routine data collections were developed to enable monitoring of the initiatives. As evidence suggested that seclusion and restraint was mostly occurring in the acute specialised mental health hospital service setting, quality improvement initiatives, and data collection and reporting were initially focused on that setting. As a result, seclusion and restraint data presented in this report are limited to specialised public acute mental health hospital services.

Seclusion

Seclusion is the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

8.1 seclusion events per 1,000 bed days occurred in 2015–16

5.0% of mental health episodes of care include a seclusion event

5.3 hours was the average time patients spent in seclusion

Nationally, there were 8.1 seclusion events per 1,000 bed days in 2015–16. The Northern Territory (23.9 seclusion events per 1,000 bed days) had the highest rate of seclusion and the Australian Capital Territory had the lowest (1.6) (Figure 12).

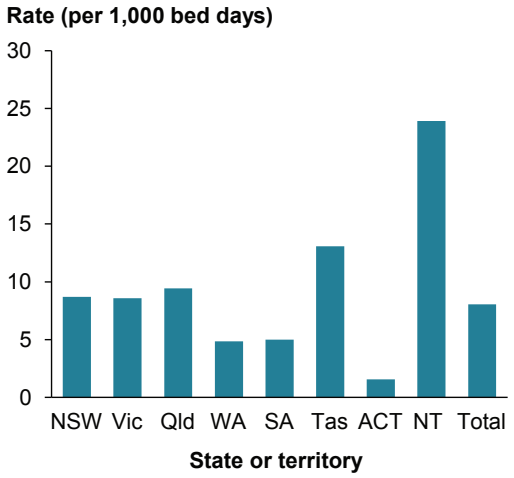


Figure 12: Rate of seclusion events, public sector acute mental health hospital services, by state or territory, 2015–16

The national seclusion rate fell from 10.6 events per 1,000 bed days in 2011–12 to 8.1 in 2015–16, with rates falling in 5 of the 8 states and territories over that period.

Restraint

Restraint is the restriction of an individual's freedom of movement by physical or mechanical means.

Mechanical restraint is the application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement.

Physical restraint is the application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.

9.2 physical restraint events per 1,000 bed days occurred in 2015–16

1.7 mechanical restraint events per 1,000 bed days occurred in 2015–16

In 2017, AIHW published national restraint data for the first time. Caution should be used in interpreting these data, especially the comparability between states and territories—each have different policy and legislative requirements on the use of restraint, so have different definitions of restraint, and different processes and systems for collecting relevant data.

Nationally, 9.2 physical restraint and 1.7 mechanical restraint events were recorded per 1,000 bed days in 2015–16.

In 2015–16, the use of restraint (both physical and mechanical) was more common in *Forensic services* than other types of services.

Psychiatric disability support services

96,330 people with a psychiatric disability used disability support services in 2015–16

Employment services were the most common type of non-residential service provided

Group homes was the most frequently provided residential service

Specialist disability support services are provided under the National Disability Agreement to support people with psychiatric disability, either as their primary disability or as another significant disability. Residential service types include large and small facilities/institutions, hostels, and group homes. Non-residential support services include accommodation support, community support, community access, respite services, and employment services.

Services provided

Across Australia, about 331,800 people used specialist disability support services during 2015–16 (AIHW 2017). Of these, 96,330 clients had a psychiatric disability (primary or other significant disability), with about two-thirds of these (61,566) reporting their psychiatric disability as their primary disability.

The rate of clients accessing psychiatric disability services was highest in Victoria (498.0 per 100,000 population), and lowest in the Northern Territory (132.4). The national rate was 402.4 (Figure 13).

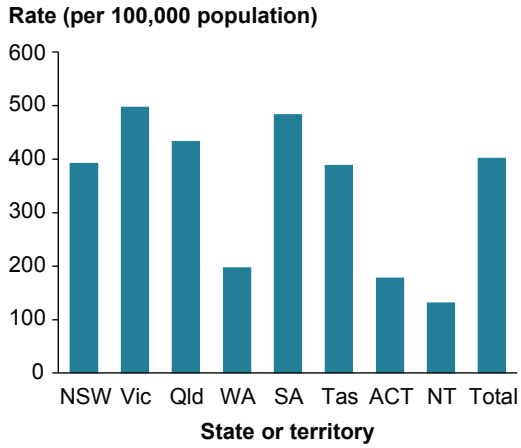


Figure 13: Specialist disability support service users with a psychiatric disability, by state and territory, 2015–16

Non-residential service users

In 2015–16, 95,835 people with a psychiatric disability (primary or other significant disability) accessed non-residential disability support services. Almost two-thirds of those (61,376 or 64.0%) reported psychiatric disability as their primary disability.

The highest rates (per 100,000 population) of non-residential service users with a psychiatric disability (primary or other significant disability) among the demographic groups were:

- Indigenous Australians (786.0)
- those aged 45–54 (701.9)
- those from Inner regional areas (504.5)
- males (431.7).

Employment services were the most commonly provided non-residential support service type, followed by *Community support*, and *Community access*.

Residential service users

In 2015–16, 3,584 people with a psychiatric disability (primary or other significant disability) accessed residential support services. About 1 in 7 of those (499 people or 13.9%) reported psychiatric disability as their primary disability.

While there were fewer users of residential services than non-residential services, the profile of service users was similar, with the highest rates among the demographic groups (per 100,000 population) seen for:

- Indigenous Australians (29.5)
- those aged 45–54 (32.2)
- those from Inner regional areas (17.8)
- males (17.7).

Residential support provided in group homes was the most common residential service type provided.

Specialist homelessness services

72,364 clients of Specialist Homelessness Services (SHS) had a current mental health issue in 2015–16

47.6% of SHS clients with a current mental health issue had been homeless at some point in the 12 months before presenting to an agency

Governments fund various agencies across Australia to provide Specialist Homelessness Services (SHS) including accommodation and non-accommodation services (such as counselling).

Data in this section describe SHS clients with a current mental health issue, broadly:

- they indicated they were receiving services or assistance for their mental health issues or reported 'mental health issues' as a reason for seeking assistance
- their formal referral source to the agency was a mental health service
- their recent dwelling type was a psychiatric hospital or unit, or had been in a psychiatric hospital or unit in the last 12 months
- at some stage during their support period, a need was identified for psychological services, psychiatric services, or mental health services.

Services provided

Nationally, in 2015–16, of the 233,400 SHS clients aged 10 and over, about one-third (72,364 clients or 346.7 clients per 100,000 population) had a current mental health issue.

More than half of SHS clients with a mental health issue (50.7% or 36,691 clients) accessed accommodation services, at a rate of 175.8 clients per 100,000 population.

A further 47.4% (34,336 or 164.5 clients per 100,000 population) received other support services, while 1.8% (1,337 clients) did not receive a service or referral to a service.

Changes over time

Nationally, the rate of clients with a current mental health issue increased by 14.9% between 2011–12 and 2015–16. The rate of support periods increased by an average of 16.8% per year over the same period.

Profile of people who received services

Clients with a current mental health issue aged 18–24 had the highest rate of SHS agency use (635.0 clients per 100,000 population), followed by those aged 15–17 (586.3). Female clients (400.1) sought services at a greater rate than males (292.1). The rate of Indigenous SHS clients with a current mental health issue (1,688.5) was more than 6 times the rate of non-Indigenous Australians (257.1).

SHS clients with a current mental health issue most often reported *Housing crisis* (26.6%) as the main reason for seeking assistance, followed by *Domestic and family violence* (16.8%).

Length of support period

In 2015–16, more than half of clients (58.1%) with a current mental health issue received more than 45 days of support. In contrast, about two-thirds of clients (36.6%) without a current mental health issue received more than 45 days of support (Figure 14).

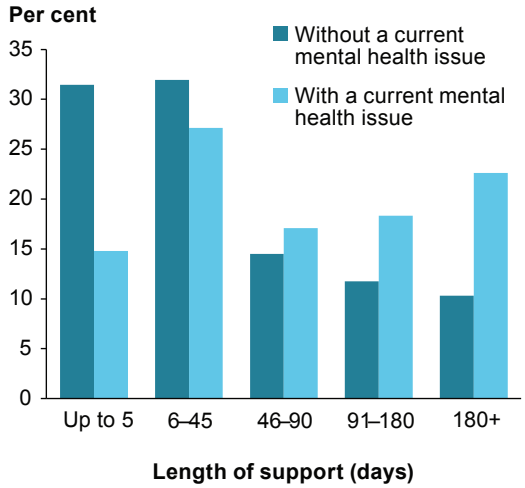


Figure 14: SHS clients with and without a current mental health issue, by total length of support provided, 2015–16

Personal Helpers and Mentors

20,337 people used Personal Helpers and Mentors services during 2014–15

67.5% of participants had a mental illness diagnosis category of *Mood disorder*

2 in 5 participants who exited the service reported having reached their goals

Personal Helpers and Mentors service (PHaMs) is an Australian Government initiative designed to increase recovery opportunities for people whose lives are severely affected by mental illness. Since 1 July 2016, PHaMs clients have been progressively moving to the National Disability Insurance Scheme. As a result, data for 2015–16 onwards are not available, and have not been updated since *Mental health services: in brief 2016*.

Services provided

Nationally, 20,337 people participated in the PHaMs during 2014–15. New South Wales had the largest number of participants (5,889), and the Australian Capital Territory had the smallest (360).

Profile of people who received services

PHaMs participants were most commonly:

- Australian born (83.5% of participants)
- living in a *Major city* (58.9%)
- female (56.9%)
- aged 25–44 (46.3%).

Nine in 10 (91.4%) of participants had a formal mental illness diagnosis at the time of initial assessment for the program.

The most commonly recorded mental illness diagnosis categories for PHaMs participants were *Mood disorders* (67.5%), *Anxiety disorders* (42.9%), and *Schizophrenia and psychotic delusional disorders* (21.8%) noting that people can have more than one recorded category.

Almost 2 in 5 (37.5%) PHaMs participants also reported having another significant disability (comorbidity) in addition to a mental illness. The most commonly reported comorbid disability category was *Physical* (20.2% of participants) followed by *Specific learning/Attention Deficit Disorder* (4.6%) and *Intellectual disabilities* (3.7%), noting that participants may have more than one additional comorbid disability category.

PHaMs participants are assessed on their areas of functional limitation resulting from mental illness, noting they may have more than one. The most commonly reported limitations were *Learning, applying knowledge and general demands* (97.4%), *Social and community activities* (96.9%), *Interpersonal relationships* (96.3%), and *Working and employment* (95.0%).

Reasons for exiting the service

Of the 6,730 participants who exited a PHaMs service in 2014–15, almost 2 in 5 (37.5%) exited because they reached their goals, 1 in 5 (21.3%) because they chose to, and about 1 in 9 (11.1%) not returning to the service after 6 months.

Access to Allied Psychological Services

71,830 people accessed services via the Access to Allied Psychological Services program in 2014–15

386,669 Access to Allied Psychological Services sessions were delivered

46–60 minutes was the most common session length (87.1%)

The Access to Allied Psychological Services (ATAPS) program enables various health, social welfare, and other professionals to refer consumers who have been diagnosed with a mild or moderate mental disorder to a mental health professional to provide short-term focused psychological strategies and services.

ATAPS is designed for people who have difficulty accessing Medicare-subsidised mental health services for various reasons, such as the lack of services in some geographical locations. Management of services previously delivered under the ATAPS program has transitioned to Primary Health Networks.

Services provided

In 2014–15, 71,830 consumers accessed ATAPS, equating to 304.2 consumers per 100,000 population. The Northern Territory (423.5) had the highest rate of consumers, while the Australian Capital Territory had the lowest (277.2).

There were 386,669 ATAPS sessions provided in 2014–15. The majority of sessions:

- were individual sessions (84.0%)
- lasted 46–60 minutes (87.1%)
- occurred face to face (96.7%).

Consumers are entitled to 12 sessions under the ATAPS program, and may receive another 6 sessions in exceptional circumstances. About 1 in 30 consumers (2,503 or 3.5%) received additional sessions after the completion of the initial 12 sessions.

GPs (93.6%) were the most common source of referral for ATAPS consumers.

Over the 5 years to 2014–15, the number of ATAPS consumers increased from about 39,000 to just over 71,800. The number of sessions provided more than doubled over the same period.

Profile of people who received services

Females (378.7 per 100,000 population) were more likely to use ATAPS than males (227.4). People aged 15–24 had the highest rate of ATAPS access (421.1). Indigenous Australians (848.0) accessed ATAPS at a rate more than 4 times that of non-Indigenous Australians (210.6).

Depression (42.7%) was the most commonly reported diagnostic category among ATAPS consumers, followed by *Anxiety disorders* (36.2%), noting that consumers may have more than one diagnosis (Figure 15).

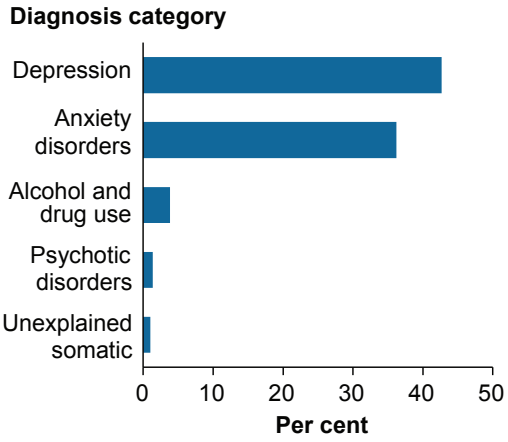


Figure 15: Top 5 specific diagnosis categories for ATAPS consumers, 2014–15

Mental health-related prescriptions

4.0 million patients received mental health-related medications in 2015–16

36.0 million prescriptions for mental health-related medications were provided, amounting to 9.0 prescriptions per patient

Antidepressants were the most commonly prescribed medication type

Mental health-related medications supplied to patients are either non-subsidised prescriptions (under co-payment) or subsidised by the Australian Government through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). As some medications classified as mental health-related may be prescribed for non-mental health conditions, data are likely an overcount of prescriptions dispensed for mental illness. The proportion of prescriptions for non-mental health conditions cannot be accurately removed from the data presented in this section.

Patients and prescriptions

In 2015–16, 36.0 million prescriptions (subsidised and under co-payment) for mental health-related medications were provided to 4.0 million patients. Of these, two-thirds (67.2% or 24.2 million) were subsidised by the Australian Government under the PBS or RPBS.

The rate of patients receiving mental health-related prescriptions was highest for people 65 years and over (327.1 people per 1,000 population). Females (200.3) received medications at a higher rate than males (134.5).

Tasmania had the highest rate of patients (210.2 patients per 1,000 population) receiving mental health-related prescriptions and prescriptions dispensed (1,957.5 prescriptions per 1,000), while the Northern Territory had the lowest (97.2 patients, and 733.5 prescriptions).

The rate of patients receiving mental health-related prescriptions, and the rate of prescriptions dispensed varied depending on the patient's usual area of residence. *Inner regional* areas had the highest rate of patients receiving mental health-related prescriptions (211.8 patients per 1,000 population), and prescriptions dispensed (1,964.3 prescriptions per 1,000), while *Very remote* areas had the lowest (57.1 patients, and 433.6 prescriptions per 1,000).

Over time

Time series data is limited to the number of patients receiving PBS/RPBS-subsidised medications.

Since 2011–12, the rate of patients receiving subsidised mental health-related prescriptions fell by an average of 1.9% per year—from 109.7 patients per 1,000 population in 2011–12 to 101.6 in 2015–16. Of the 5 mental health-related prescription types, the number of patients receiving prescriptions for *Hypnotics and sedatives* and *Antidepressants* fell over the period.

Type of mental health-related medications provided

Antidepressants were the most frequently dispensed mental health-related medications, in 2015–16 (68.7% or 24.7 million prescriptions), prescribed to 2.9 million patients. About 970,000 people received *Anxiolytics*, 805,000 received *Hypnotics and sedatives*, and 457,000 received *Antipsychotics*, noting that individuals may receive more than one medication type.

Prescriber type

GPs prescribed the most mental health-related prescriptions (subsidised and under co-payment) (87.6% or 31.5 million prescriptions) in 2015–16. Psychiatrists prescribed 2.9 million prescriptions (8.0%), and non-psychiatrist specialists prescribed 1.6 million prescriptions (4.4%).

Mental health resources

Mental health workforce

3,131 psychiatrists

20,834 mental health nurses

24,522 registered psychologists worked in Australia in 2015

Various health-care professionals—including GPs, psychiatrists, psychologists, nurses, social workers, occupational therapists, and peer workers—provide mental health-related services and support. Detailed data on the size and characteristics of the mental health workforce presented in this section are limited to psychiatrists, nurses, and registered psychologists who worked principally in mental health care. For the first time, data are available on the amount of time spent working as a clinician—that is, working in a direct clinical role.

Psychiatrists

There were an estimated 3,131 psychiatrists, or 12.7 full-time-equivalent (FTE) psychiatrists per 100,000 population in Australia in 2015.

When considering time spent as a clinician, there were 10.5 clinical FTE psychiatrists per 100,000 population, with rates ranging from 5.8 in the Northern Territory to 12.0 in South Australia (Figure 16). The majority of FTE psychiatrists were in *Major cities* (88.1% or 15.8 FTE per 100,000 population), while *Very remote* areas had the least (0.1% or 2.1 FTE per 100,000 population).

Psychiatrists worked an average of 38.5 total hours, and 31.8 clinical hours per week in 2015. On average, male psychiatrists worked 6.9 total hours, and 6.1 clinical hours more per week than female psychiatrists.

Nurses

In 2015, about 1 in 15 employed nurses (20,834 or 6.9% of nurses) indicated they were working principally in mental health. This equates to 84.2 FTE mental health nurses per 100,000 population. The national rate of clinical FTE mental health nurses was 77.2 per 100,000 population, ranging from 61.7 in the Australian Capital Territory to 88.0 in Western Australia (Figure 16).

More than three-quarters of FTE mental health nurses (76.2% or 90.4 per 100,000 population) worked in *Major cities*. Rates mostly decreased with increasing remoteness, with 31.6 FTE mental health nurses per 100,000 population working in *Very remote* areas.

Mental health nurses worked an average of 36.5 total hours, and 33.5 clinical hours per week, with male nurses (34.9 hours) working more clinical hours on average than women (32.9 hours).

Registered psychologists

In 2015, an estimated 24,522 fully registered psychologists were working in Australia, equating to 88.0 FTE registered psychologists per 100,000 population.

When considering time spent as a clinician, there were 63.9 clinical FTE psychologists per 100,000 population, with rates ranging from 47.7 in South Australia to 101.2 in the Australian Capital Territory (Figure 16).

More than 8 in 10 FTE registered psychologists (82.7%) worked in *Major cities*. Rates decreased with increasing remoteness, with to 23.2 FTE per 100,000 population registered psychologists working in *Very remote* areas.

Registered psychologists worked an average of 32.4 total hours, and 23.5 clinical hours per week. The average clinical hours ranged

from 22.6 hours for Victorian psychologists to 25.4 hours for Northern Territory psychologists. Male psychologists (25.2 hours) worked on average more clinical hours than female psychologists (23.1 hours).

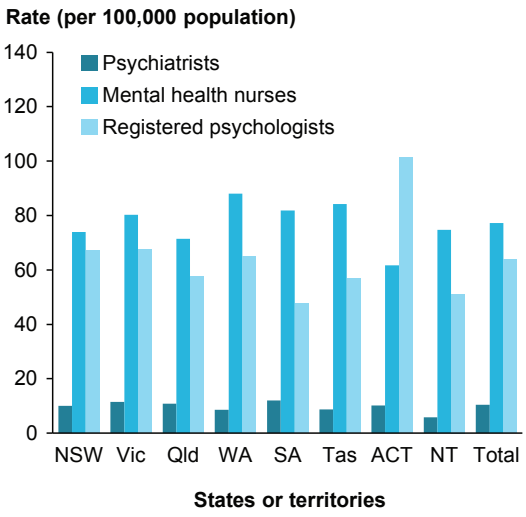


Figure 16: Employed psychiatrists, registered psychologists, and mental health nurses, clinical FTE per 100,000 population, by state and territory, 2015

Community-managed mental health workforce

Mental health non-government organisations also play an important role in Australia's mental health system. These organisations are typically not-for-profit and values-driven. Not-for-profit organisations are also referred to as community-managed organisations, reflecting their governance structure. National data about the activities of mental health non-government organisations and their workforce are not currently collected on a routine basis in Australia.

Expenditure on mental health services

$8.5 billion was spent on mental health-related services in 2014–15

7.8% of total health expenditure was spent on mental health in 2014–15

$1.1 billion was paid in benefits for Medicare-subsidised mental health-specific services in 2015–16

$564 million was paid on subsidised prescriptions under the PBS/RPBS in 2015–16

A total of $8.5 billion was spent on mental health-related services in 2014–15. A combination of state and territory governments, the Australian Government, and private health insurance companies fund mental health-related services.

Combined Australian and state and territory government spending on mental health services was estimated to be 7.8% of total health spending in 2014–15.

Spending on state and territory specialised mental health services

In 2014–15, $5.2 billion was spent on state and territory specialised mental health services (running costs only), equating to $219 per person. Over $2.2 billion was spent on public hospital services for admitted patients, and $1.9 billion on community mental health care services. After adjusting for inflation, spending on state and territory specialised mental health services increased by an average 2.3% per year over the 5 years to 2014–15.

Detailed expenditure data are available for the 20 years to 2014–15. Spending on community mental health care services has seen the largest per capita rise over this time—from $27 per person in 1992–93 to $82 in 2014–15 (Figure 17; constant prices).

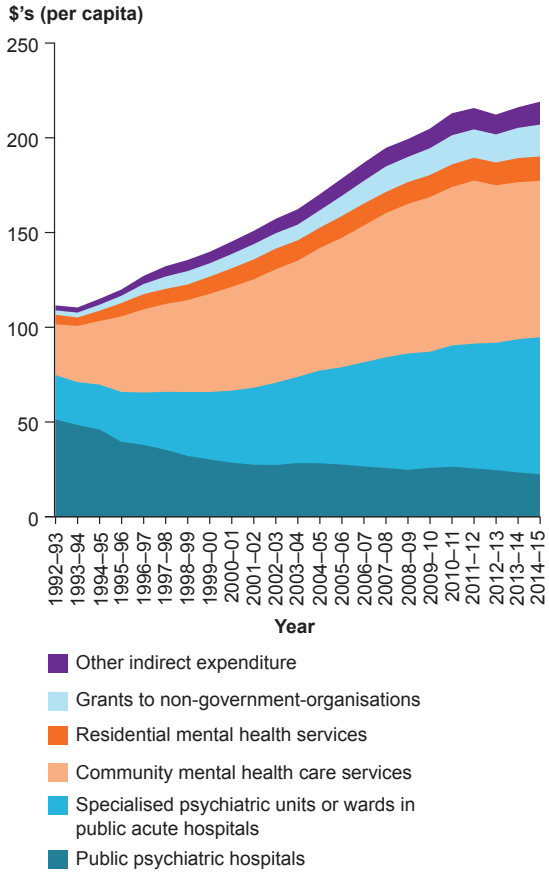


Figure 17: Recurrent expenditure per capita on state and territory specialised mental health services, constant prices, 1992–93 to 2014–15

Australian Government spending on mental health-related services

In 2014–15, the Australian Government spent an estimated $3.0 billion on mental health-related services, equating to $129 per person. About one-third (34.6%) was spent on Medicare-subsidised mental health-specific services, with a further 19.4% spent on prescriptions subsidised under the PBS and RPBS.

Other areas of expenditure included:

- Department of Health programs and initiatives (18.8%)
- Department of Social Services programs and initiatives (7.4%)
- Department of Veterans' Affairs programs and initiatives (5.9%)
- private health insurance premium rebates (4.3%).

Australian Government spending, after adjusting for inflation, increased by an average of 3.6% per year over the 5 years to 2014–15. This rise was mostly due to increased spending on national programs and initiatives managed by the Australian Government Department of Health, and on Medicare-subsidised mental health-specific services.

Medicare-subsidised mental health-specific services

More recent data for Medicare services show that $1.1 billion was paid in benefits for Medicare-subsidised mental health-specific services in 2015–16, equating to $47 per person nationally.

The largest proportion of spending was for services provided by psychologists (43.3%), followed by psychiatrists (30.3%), and GPs (23.8%). After adjusting for inflation, spending on Medicare-subsidised mental health-specific services increased by an average of 3.9% per year per Australian in the 5 years to 2015–16.

PBS and RPBS-subsidised prescriptions

A total of $564 million was spent on mental health-related subsidised prescriptions under the PBS and RPBS in 2015–16, equating to $24 per Australian.

About three-quarters (75.8%) of total spending was for prescriptions issued by GPs, followed by psychiatrists (17.6%), and non-psychiatrist specialists (6.6%). After adjusting for inflation, spending on mental health-related PBS and RPBS prescriptions per Australian fell by an average of 9.8% per year in the 5 years to 2015–16. This was likely the result of a decrease in the subsidised cost of some

medications, and a decrease in the number of people receiving subsidised mental health-related prescriptions.

Specialised mental health care facilities

9,577 mental health hospital beds were available in 2014–15 (public and private hospitals)

2,471 residential mental health care beds were available (government and non-government operated services)

31,395 full-time-equivalent staff were employed by state and territory mental health services

Specialised mental health care is delivered by a variety of facilities in Australia. This section excludes services subsidised by the Medicare Benefits Scheme.

Specialised mental health care facilities

Nationally, 1,607 specialised mental health care facilities provided specialised mental health care in 2014–15. Of these, 401 provided overnight care, with 12,048 specialised mental health care beds available in public and private hospitals, and in residential mental health care services (Table 2). There were 1,206 state and territory community mental health care facilities.

Table 2: Specialised mental health care beds, 2014–15

Facility type	Beds
Public hospitals	6,895
Acute beds	*4,806*
Non-acute beds	*2,089*
Private hospitals	2,682
Residential services	2,471
24-hour staffed	*1,824*
Non-24-hour staffed	*647*

Consumer and carer involvement

The employment of mental health consumer and carer workers is an indicator of the engagement of consumers and carers in the delivery of mental health services.

Of the 171 state and territory specialised mental health service organisations in 2014–15, 73 organisations (42.7%) employed mental health consumer workers, and 37 organisations (21.6%) employed mental health carer workers.

Staffing of specialised mental health care services

In 2014–15, state and territory specialised mental health care services employed 31,395 full-time equivalent (FTE) staff. About half were nurses (51.0%, or 16,025 FTE staff), with most of those being registered nurses (13,788).

Diagnostic and allied health professionals were the next largest staffing group (18.7% or 5,876 FTE staff), comprising mostly social workers (2,026) and psychologists (1,786). Since 1993–94, the number of FTE staff employed in admitted patient hospital services has remained relatively stable (about 13,000), while those employed by community mental health services has almost tripled (from about 4,000 in 1993–94, to more than 12,000 in 2014–15).

Specialised psychiatric services in private hospitals employed a further 3,121 FTE staff in 2014–15.

These figures do not include Medicare-subsidised medical practitioners and other health professionals, who also provide services to people admitted to private hospitals for mental health care.

Key Performance Indicators for Australian Public Mental Health Services

The *Key Performance Indicators for Australian Public Mental Health Services* (MHS KPIs) are standardised measures used to monitor the performance of the states' and territories' mental health services. Data are available for 13 out of the 15 nationally agreed MHS KPIs, and can be broken down by service type or patient demographic variables. The following summarises the available data, arranged according to the National Mental Health Performance Framework. More detailed interactive data is available on the *Mental health services in Australia* website.

Effectiveness of care, 2014–15

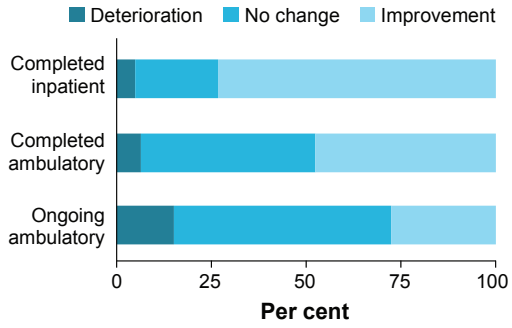
Change in consumers' clinical outcomes (MHS KPI 1)

73.2% of completed hospital stays saw a significant improvement in the mental health of the consumer

28-day readmission rate (MHS KPI 2)

14.4% of hospital stays had a readmission to hospital within 28 days

Outcomes from mental health care



Appropriateness of care, 2014–15

National services standards compliance (MHS KPI 3)

78.3% of services met the national mental health standards

Accessibility of care, 2014–15

Proportion of people receiving clinical mental health care (MHS KPI 8)

1.8% of people received state and territory clinical mental health care

New client index (MHS KPI 9)

42.6% were new state and territory clients, within the previous 12 months

Continuity of care, 2014–15

Rate of pre-admission community care (MHS KPI 11)

41.4% of hospital stays involved community mental health care prior to the hospital stay

Rate of post-discharge community care (MHS KPI 12)

67.0% of hospitals stays involved community mental health care after discharge from the hospital

Efficiency of care, 2014–15

Average length of acute admitted patient stay (MHS KPI 4)

14.0 days was the average length of a stay in an acute inpatient mental health unit

Average cost per acute admitted patient day (MHS KPI 5)

$1,094 was the average cost per day for an general acute inpatient mental health unit

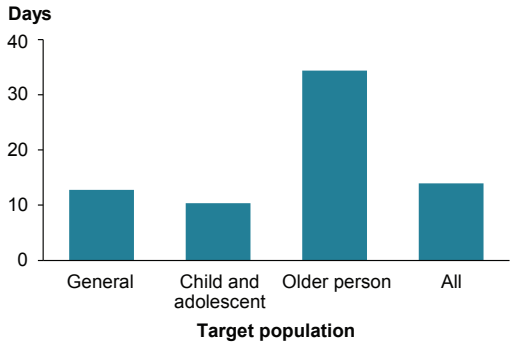
Average treatment days per 3-month community care period (MHS KPI 6)

6.9 days was the average number of treatment days provided per 3-month community care period

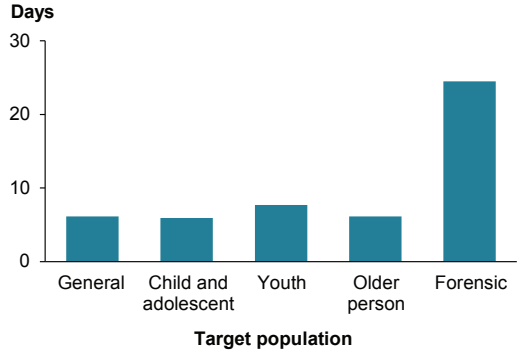
Average cost per community treatment day (MHS KPI 7)

$319 was the average cost per community treatment day

Inpatient average length of stay



Average community treatment days



Capability of services, 2014–15

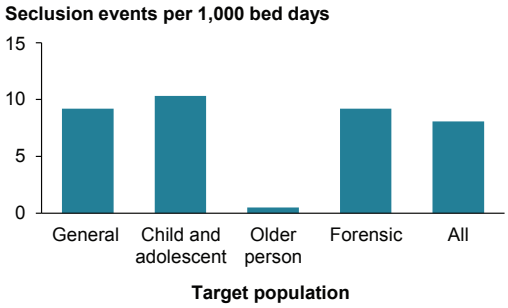
Outcomes readiness (MHS KPI 14)

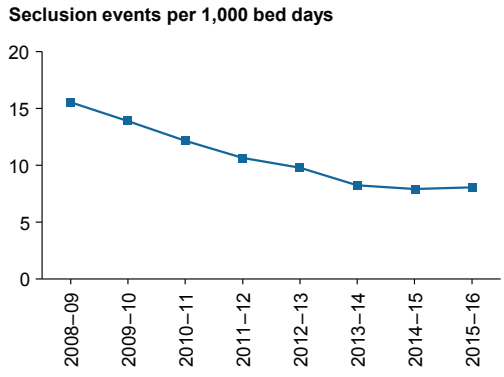
35.4% of completed inpatient episodes had a valid outcome measurement

Safety of services, 2015–16

Rate of seclusion (MHS KPI 15)

8.1 seclusion events per 1,000 bed days was the rate of seclusion for public acute inpatient services in 2015–16





Glossary

admitted patient mental health-related care: Mental health care provided to a patient who has been admitted to hospital. Episodes of care are described as 'separations' or 'hospitalisations' and can be classified as:

- **same day:** Care provided during a single day, and the patient does not stay in hospital overnight.
- **overnight:** When the care provided included an overnight stay in the hospital setting. Patients can have separations with specialised psychiatric care (within a specialised psychiatric unit or ward) or without specialised psychiatric care (no care within a specialised psychiatric unit or ward).

average annual rate: The annual change for a particular measure (such as number of service contacts per 100,000 population) over time.

community mental health care: Government-operated specialised mental health care provided by community mental health care services and hospital-based services, such as outpatient and day clinics. The statistical counting unit used is a service contact between a patient and a specialised community mental health care service provider.

diagnostic and allied health professional: Includes professions such as psychologists, social workers, occupational therapists, and other qualified allied health staff (other than medical or nursing staff) engaged in duties of a diagnostic, professional, or technical nature.

full-time equivalent: A measure of the number of standard week workloads (usually 38 hours) that professionals work.

Medicare-subsidised mental health-specific services: Services provided by psychiatrists, GPs, psychologists, and other allied health professionals subsidised according to the 'item numbers' listed in the Medicare Benefits Schedule (MBS).

mental health issue: A health issue where cognitive, emotional, or social abilities are diminished but not to the extent that the criteria for a mental illness are met.

mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional, or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.

prevalence: The number or proportion of cases or instances of a disease or illness present in a population at a given time.

Pharmaceutical Benefits Scheme: An Australian Government scheme that subsidises the cost of prescription medicine.

Repatriation Pharmaceutical Benefits Scheme: An Australian Government scheme that provides a wide variety of pharmaceuticals and dressings at a concessional rate for the treatment of eligible veterans, war widows/widowers, and their dependants.

psychiatric disability: The impact of a mental illness on a person's functioning in different aspects of their life, such as the ability to live independently, maintain friendships and employment, and participate meaningfully in the community.

psychiatrist: A medical doctor who has completed a medical degree followed by further study to specialise in the diagnosis, treatment, and prevention of mental illness.

psychologist: A mental health professional who has studied the brain, memory, learning, human development, and the processes determining how people think, feel, behave, and react, and who is registered with the Psychology Board of Australia.

remoteness areas: Categories within the Australian Statistical Geographical Standard, which is based on an index that measures the remoteness of a point according to the physical road distance to the nearest urban centre. Examples of localities in different remoteness categories are:

- ***Major cities:*** Includes most capital cities, as well as major urban areas, such as Newcastle, Geelong, and the Gold Coast.
- ***Inner regional:*** Includes cities such as Hobart, Launceston, Mackay and Tamworth.
- ***Outer regional:*** Includes cities and towns such as Darwin, Whyalla, Cairns, and Gunnedah.
- ***Remote:*** Includes cities and towns such as Alice Springs, Mount Isa, and Esperance.
- ***Very remote:*** Includes towns such as Tennant Creek, Longreach, and Coober Pedy.

residential mental health care: Specialised mental health care, on an overnight basis, in a domestic-like environment. Periods of care are described as episodes of residential care.

separation: The process by which an episode of care for an admitted patient ceases.

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Mental health services: in brief 2017 provides an overview of data about the national response of the health and welfare system to the mental health care needs of Australians.

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