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Australian Institute of Health and Welfare

2013

MENTAL HEALTH SERVICES

In brief

2013

MENTAL**HEALTH**SERVICES

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The Australian Institute of Health and Welfare is a major national agency which provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's mission is *authoritative information and statistics to promote better health and wellbeing.*

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Four elements of freedom

Michael Taylor

I have worked for many years as a freelance graphic artist. In 2012, I was introduced to the Belconnen Arts Centre and encouraged to pursue my interest in art. I began painting on canvas and participated in a community art exhibition as part of the Arts AbiliTEA group.

Four elements of freedom is all about colour. Creating this artwork has enabled me to explore a different aspect of painting using blue, green, orange and purple as compositional elements. I have been surprised by the sense of joy and freedom I have found in exploring purples and pinks, in particular, as part of a more extensive palette. Allowing colour into my artwork has been like bringing more light into my life. The act of creating gives my life a sense of fulfilment and meaning. I am committed to continuing this journey through my art, enriching my life in ways 'yet to be discovered'.

Contents

Introduction

Mental health services in Australia <**http://mhsa.aihw.gov.au**> is an interactive website that provides national data about how the health and welfare system responds to the needs of Australians affected by mental illness. The website is updated regularly as new data become available.

This companion document, *Mental health services—in brief 2013*, provides an overview of key findings from *Mental health services in Australia* presented online each year. The most recent data from a number of data sources inform this report. As such, the reference year reported in this companion document may vary between data sources.

What do we mean by mental illness?

Mental illness refers to a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities (DoHA 2009a). The term comprises a spectrum of disorders that vary in severity. Mental illness can have damaging effects on the individuals and families concerned, 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 2003).

The terms mental illness and mental disorder are used interchangeably throughout this document.

How many people receive mental health-related services?

About 1.9 million Australians (9% of the population) received public or private mental health services in 2010–11.

There were an estimated 15 million mental health-related general practitioner (GP) encounters, or visits, in 2011–12.

How many people are affected?

An estimated 7.3 million Australians aged between 16 and 85 (45%) will experience a common mental health-related disorder over their lifetime, according to the 2007 National Survey of Mental Health and Wellbeing (DoHA 2009b).

Each year, 1 in 5 Australians in this age range, or 3 million Australians, are estimated to experience symptoms of a mental disorder (DoHA 2009b).

The most common mental illnesses are affective (mood) disorders such as depression, anxiety disorders and substance use disorders.

Mental illness also includes 'low prevalence' conditions. This group includes psychotic illnesses and a range of other conditions such as eating disorders and severe personality disorder (DoHA 2010).

Psychotic illnesses are characterised by fundamental distortions of thinking, perception and emotional response. An estimated 64,000 people in Australia have a psychotic illness and are in contact with public specialised mental health services each year. Schizophrenia is the most common psychotic illness (Morgan et al. 2011).

How much money is spent on mental health-related services?

Almost $6.9 billion, or $309 per Australian, was spent on mental health-related services in Australia during 2010–11.

What services are provided to those affected by mental illness?

This section describes the activities and characteristics of a broad range of health care and treatment services provided for people with mental health problems in Australia.

Mental health-related services are provided in a variety of ways—from hospitalisation and other residential care, hospital-based outpatient services and community mental health care services, to consultations with specialists and GPs.

Information in this section covers government service providers, private hospitals, non-government organisations and private medical practitioners.

Mental health-related services provided by general practitioners

The first professional encounter for many people seeking help for a mental illness is usually their GP. Medicare data on mental health-related Medicare Benefits Schedule (MBS) items provide a picture about mental health-related services provided by GPs. Data from the Bettering the Evaluation And Care of Health (BEACH) survey of GPs (Britt et al. 2012) supplements this information.

Key facts

- There were an estimated 15 million mental health-related GP encounters in 2011–12.
- The proportion of all GP encounters that are mental health-related increased from 10.8% in 2007–08 to 12.1% in 2011–12.

Who uses these services?

It is estimated that there were nearly 15 million mental health-related GP encounters in 2011–12. This corresponds to 665 encounters per 1,000 population.

One-quarter of these encounters were for patients aged 65 and over and nearly 3 in 5 were for females.

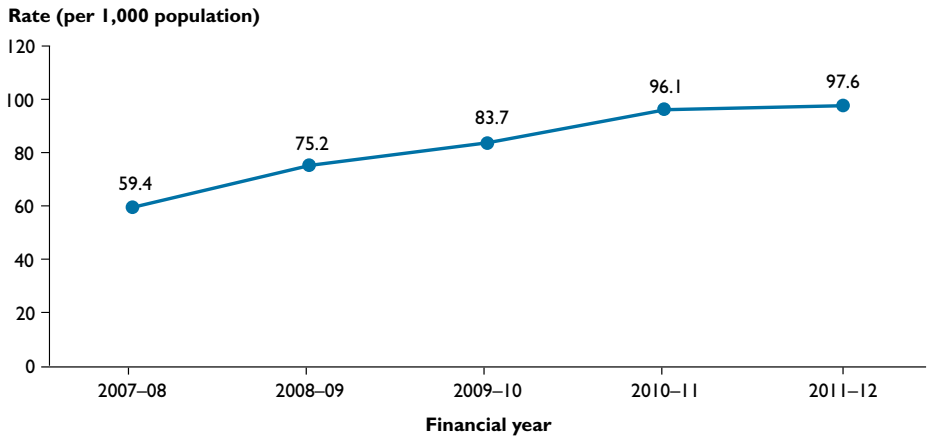
BEACH survey data suggest that the rate of encounters for Aboriginal and Torres Strait Islander people is increasing over time.

How is this changing over time?

The estimated rate of mental health-related GP encounters per 1,000 population increased by an annual average of 4.4% between 2007–08 and 2011–12. The proportion of all GP encounters that were mental health-related increased from 10.8% in 2007–08 to 12.1% in 2011–12.

Medicare data show GPs provided 2.2 million Medicare-subsidised mental health-related services to 1.2 million patients in 2011–12. Growth in rates of Medicare-subsidised mental health-related GP services between 2010–11 and 2011–12 was slower than in previous years (figure below).

Medicare-subsidised mental health-related GP service rates, over time



Why are people receiving this care?

Depression, anxiety and sleep disturbance were the 3 mental health-related problems most frequently managed by GPs in 2011–12 according to the BEACH survey. These 3 problems accounted for over 60% of all mental health-related problems managed.

What are the characteristics of the care provided?

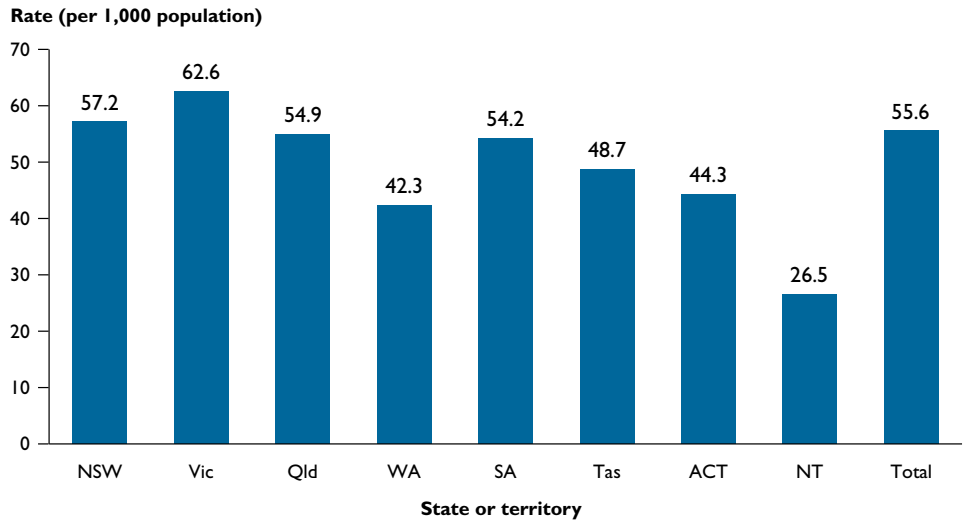
A GP was most likely to prescribe, supply or recommend a medication for the management of mental health-related problems. Antidepressants were the most commonly prescribed medication, followed by anxiolytics (anti-anxiety medications), hypnotics and sedatives.

The next most common form of management provided by GPs was counselling, advice or other treatments, with psychological counselling the most frequently provided service.

How do rates differ between states and territories?

Medicare data show variation in mental health-related GP activity across the states and territories. Victoria and New South Wales had higher rates of patients (62.6 and 57.2 per 1,000 population, respectively) receiving Medicare-subsidised GP mental health-related services than the national average (55.6). The lowest patient rate was for the Northern Territory at 26.5 per 1,000 population (figure below).

Medicare-subsidised mental health-related GP patient rates, states and territories, 2011–12



Medicare-subsidised mental health-related services

Medicare-subsidised mental health-related 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 a range of settings—in hospitals, consulting rooms, home visits and over the phone.

Key facts

- Over 7.9 million Medicare-subsidised mental health-related services were provided by psychiatrists, GPs, psychologists and other allied health professionals to over 1.6 million patients in 2011–12.
- There has been an average annual increase of 11.2% in the number of services recorded for the 5-year period between 2007–08 and 2011–12.

Who uses these services?

Over 7.9 million Medicare-subsidised mental health-related services were provided to over 1.6 million patients in 2011–12.

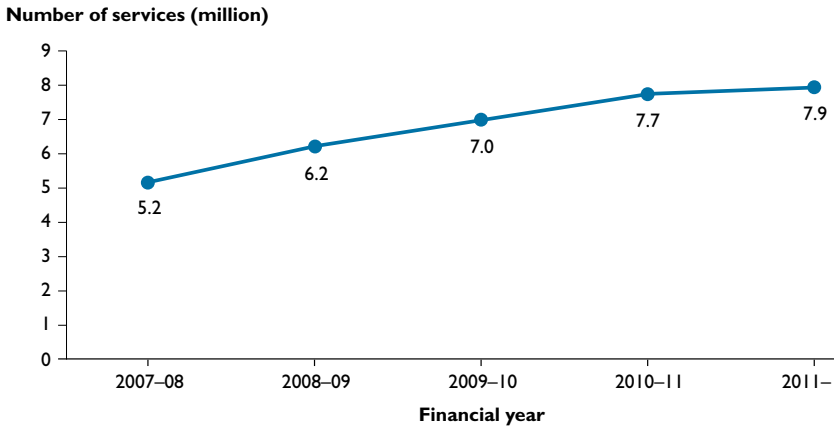
For those accessing services, the rate (per 1,000 population) was highest for those aged 35–44. This was true for all provider types except psychiatrists.

More females than males used Medicare-subsidised mental health-related services. For psychologists and other allied health services, females comprised almost two-thirds of the patients and used services at a rate nearly double that for males.

How is this changing over time?

There has been an average annual increase of 11.2% in the number of Medicare-subsidised mental health-related services per 1,000 population over the 5 years to 2011–12 (figure below). This growth is largely attributable to the implementation of the Better Access initiative (implemented in November 2006) that gave patients Medicare-subsidised access to psychologists and other allied health providers after the preparation of a Mental Health Treatment Plan by a GP.

Medicare-subsidised mental health-related services, over time



What are the characteristics of the care provided?

The largest proportion of Medicare-subsidised mental health-related services were provided by psychologists (43.5%). These services comprised mostly Focussed Psychological Strategies and Psychological Therapy Services.

GPs provided 27.7% of the services, mainly for the provision of GP Mental Health Treatment items.

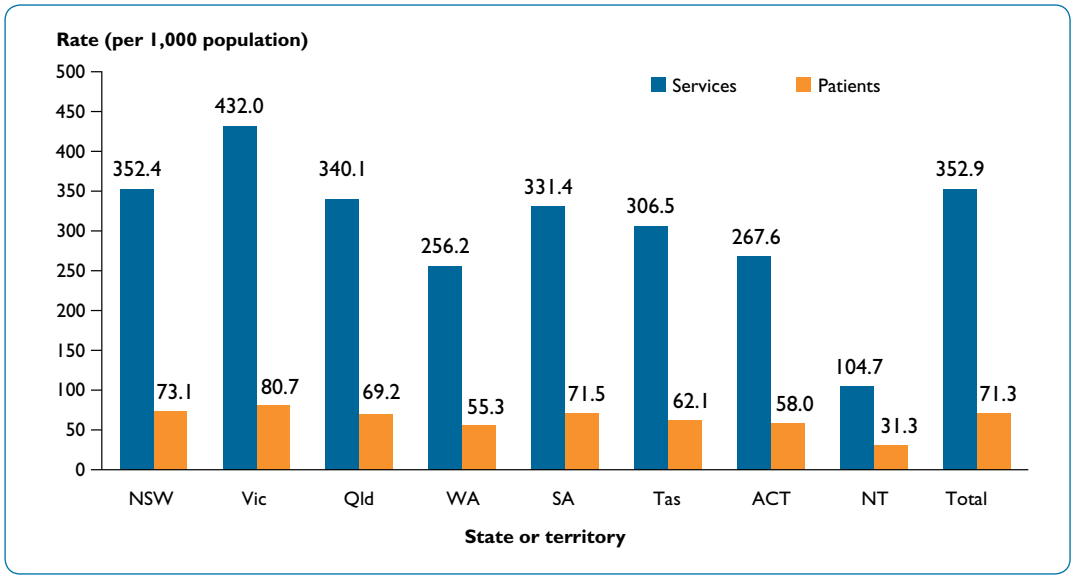
The majority of the psychiatrist services were provided in consulting rooms, followed by consultations in hospitals. Social workers provided the majority of the other allied mental health services.

How do rates differ between states and territories?

Among states and territories, Victoria had the highest number of patients and services per 1,000 population (80.7 and 432.0, respectively) for Medicare-subsidised mental health-related services, substantially higher than the national average of 71.3 patients and 352.9 services per 1,000 population (figure below).

The Northern Territory had the lowest rate for both patients (31.3) and services (104.7).

Medicare-subsidised mental health-related service and patient rates, states and territories, 2011–12



State and territory community mental health care services

State and territory governments provide specialised mental health care services to people in the community and in hospital-based ambulatory care settings.

Key facts

- The number of community mental health care service contacts has continued to increase, with over 7.1 million contacts reported for about 350,000 patients in 2010–11.
- About 1 in 7 contacts were provided on an involuntary basis; that is, the consumer was compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Who uses these services?

About 350,000 people in Australia accessed services in 2010–11, receiving over 7.1 million service contacts.

Males accessed services at a higher rate than females, with differences in rates particularly evident in the 25–44 age group.

People aged 35–44 accessed services at the highest rate, as did those living in *Inner regional* areas of Australia.

The service contact rate for Indigenous Australians was over 3 times that for non-Indigenous Australians.

How are rates changing over time?

The community mental health care service contact rate has increased by an annual average of 3.2% over the 5 years to 2010–11.

Males in the 25–44 age group have been consistently the highest users of services over the 5 years to 2010–11.

Why are people receiving this care?

The most common principal diagnosis of patients accessing community mental health care services was schizophrenia, accounting for about one-quarter of all contacts (26.6%), followed by depressive episode (10.1%), bipolar affective disorders (5.8%) and schizoaffective disorders (5.5%).

What is a typical contact?

Community mental health care service contacts are conducted with either one patient or a group of patients. Contacts may be conducted with either the patient present or absent; for example, with a third party such as a carer or family member or other professional (case conferencing). Service contacts may be conducted with a patient in either a voluntary or involuntary capacity; for example, under a community treatment order.

The most common community mental health care service contact was with an individual patient, and just over half of these contacts lasted between 15 and 60 minutes.

Involuntary contacts accounted for about 1 in 7 contacts. Contacts with people diagnosed with schizoaffective disorders and schizophrenia had the highest proportion of involuntary contacts—35.8% and 31.4%, respectively.

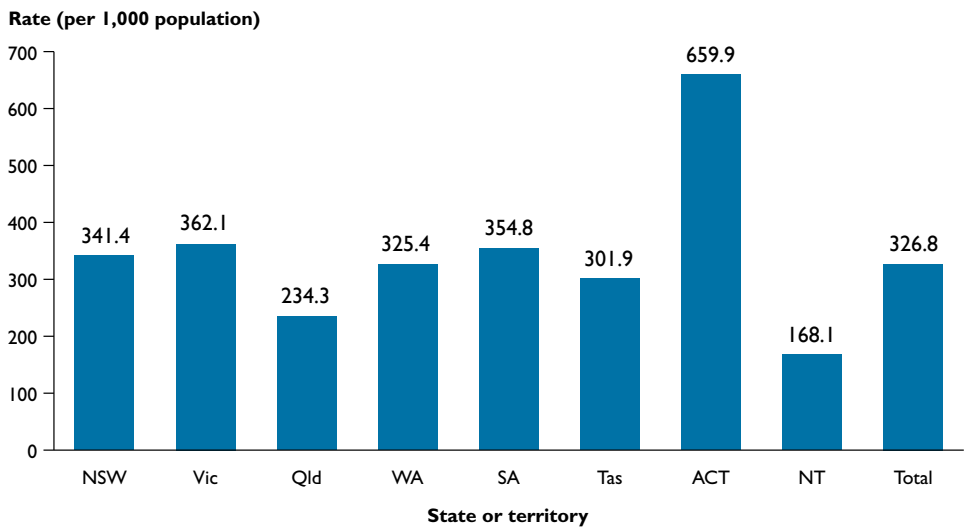
How do rates differ between states and territories?

The Northern Territory had the lowest rate of community mental health care service contacts per 1,000 population (168.1), while the Australian Capital Territory had the highest rate (659.9), compared with the national average of 326.8 (figure below).

The Northern Territory saw the highest number of patients per 1,000 population (24.2) and Victoria reported the lowest (10.9), compared with the national average of 16.0.

Some caution is required when making comparisons between jurisdictions as differences in data reporting systems for community mental health care services may contribute to varying service contact and patient rates.

Community mental health care service contact rates, states and territories, 2010–11



Mental health services provided in emergency departments

Hospital emergency departments (EDs) provide care for patients who may have an urgent need for medical care, including care for people presenting with a mental health-related problem.

Key facts

- There were an estimated 243,444 ED occasions of service with a mental health-related principal diagnosis in 2010–11.
- The total number of mental health-related ED occasions of service has remained relatively stable between 2006–07 and 2010–11.

Who uses these services?

There were 177,400 public hospital ED visits with a mental health-related principal diagnosis reported in 2010–11. After taking into account coverage limitations of this reporting, it is estimated that there were around 243,444 mental health-related public hospital emergency department occasions of service in 2010–11.

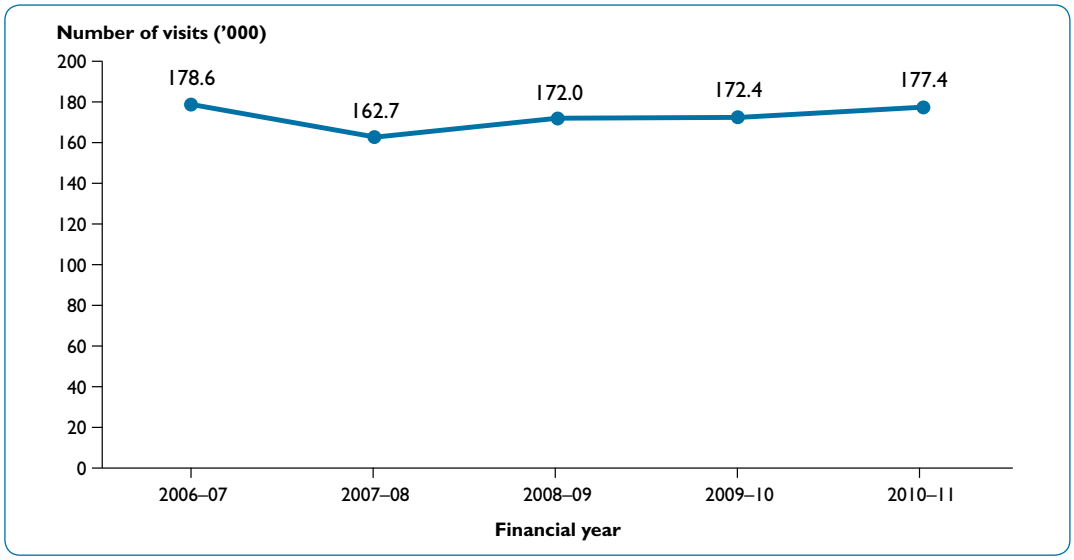
Over 2 in 5 (44.0%) of visits were for people aged 15–34, with slightly more visits for males than females.

Indigenous Australians accounted for 6.6% of the mental health-related visits to EDs.

How is this care changing over time?

The number of mental health-related visits to EDs over the 5 years to 2010–11 has remained relatively stable (figure below). The decrease observed between 2006–07 and 2007–08 is attributed to a change in the data reporting system in one state.

Mental health-related emergency department visits in public hospitals, over time



Why are people receiving this care?

The most frequently recorded principal diagnoses for ED mental health-related visits were neurotic, stress-related and somatoform disorders (28.1%), followed by mental and behavioural disorders due to psychoactive substance use (24.9%), affective (mood) disorders (15.1%) and schizophrenia spectrum disorders (12.6%).

How does this compare to all emergency department visits?

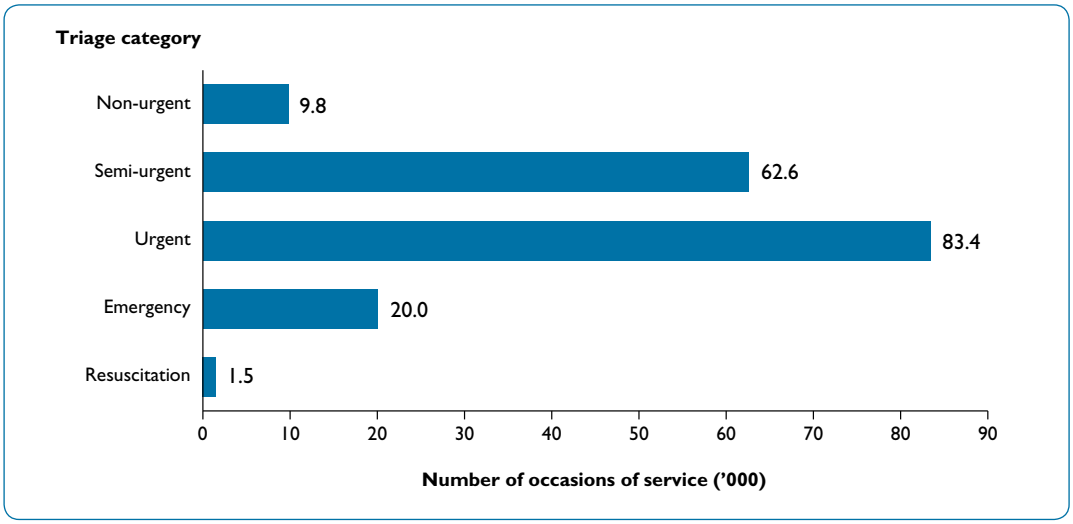
Mental health-related ED visits had a higher proportion of patients aged 15–54 compared with all ED occasions of service (78.3% compared with 51.0%, respectively) in 2010–11.

What are the characteristics of the visits?

Over 80% (146,029) of mental health-related ED visits were classified as urgent (requiring care within 30 minutes) or semi-urgent (requiring care within 60 minutes) in 2010–11. A further 11.3% (20,047) were classified as emergency (within 10 minutes) (figure below).

Over 60% of the mental health-related visits were resolved without the need for admission or referral to another hospital. A further 34.6% resulted in an admission.

Mental health-related emergency department visits in public hospitals, by triage category, 2010–11



Admitted patient mental health-related care

Admitted patient mental health-related hospitalisations, or separations, occur in public acute, public psychiatric or private hospitals and can be classified as being with or without specialised psychiatric care.

Key facts

- Of the 223,261 non-ambulatory admitted patient mental health-related separations, specialised psychiatric care was provided for 59.5% of these separations (132,917) in 2010–11.
- About one-third of mental health-related separations with specialised psychiatric care were from involuntary admissions.

Who uses these services?

There were 223,261 admitted patient mental health-related separations reported in 2010–11, accounting for 2.5% of all hospital separations.

For separations with specialised psychiatric care, the rate was higher for females (6.3 per 1,000) than males (5.7), and the highest rates were for patients aged 35–44.

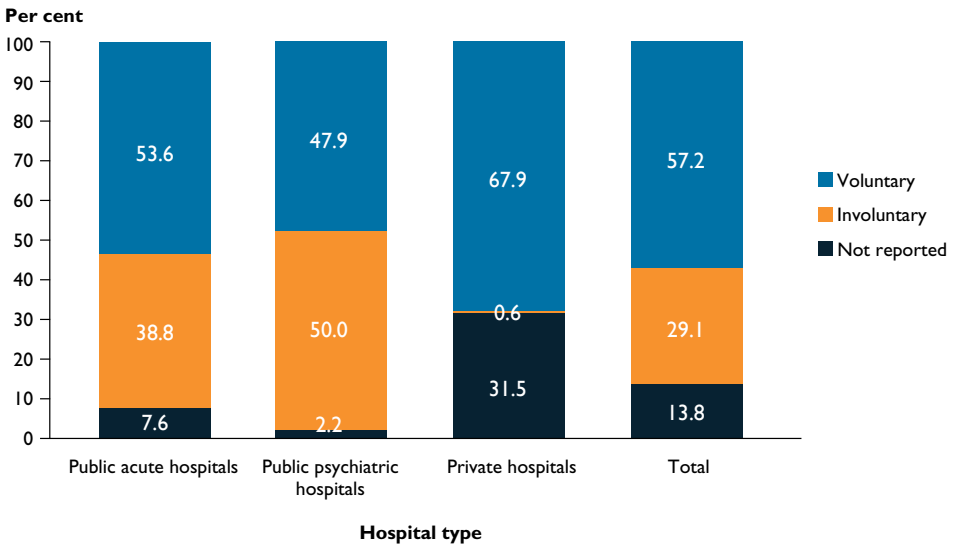
For separations without specialised care, the rate was higher for females (4.2 per 1,000) than males (3.9), and the highest rates occurred for those aged 65 and over.

About one-third (29%) of all separations with specialised psychiatric care were for patients who had an involuntary admission, while only 0.6% of private hospital separations were involuntary admissions (figure overleaf).

Why are people receiving this care?

People with a primary diagnosis of either depressive episode or schizophrenia accounted for just under one-third of separations with specialised care in 2010–11. The most commonly reported diagnosis for separations without specialised care was mental and behavioural disorders due to use of alcohol, followed by depressive episode.

Admitted patient separations with specialised psychiatric care, by mental health legal status and hospital type, 2010–11



What are the characteristics of the care provided?

About 42% of all mental health-related separations did not have a procedure recorded. It is likely that the procedures provided to admitted patients during these mental health-related separations were not able to be coded using the existing procedure classification system. The administration of mental health-related medications, for example, is not explicitly defined in the classification system.

From the data available, a commonly reported procedure for all mental health-related separations was an allied health service intervention, including services provided by social workers and occupational therapists. A common procedure for separations with specialised care was non-emergency general anaesthesia. This was most likely associated with the administration of electroconvulsive therapy, for the treatment for depression—a commonly reported principal diagnosis.

How does length of stay differ between states and territories?

The average length of stay in public acute hospitals for separations providing specialised care varied across jurisdictions in 2010–11, with Tasmania reporting the lowest average (12.6 days) and Western Australia reporting the highest average (18.0 days).

How are rates changing over time?

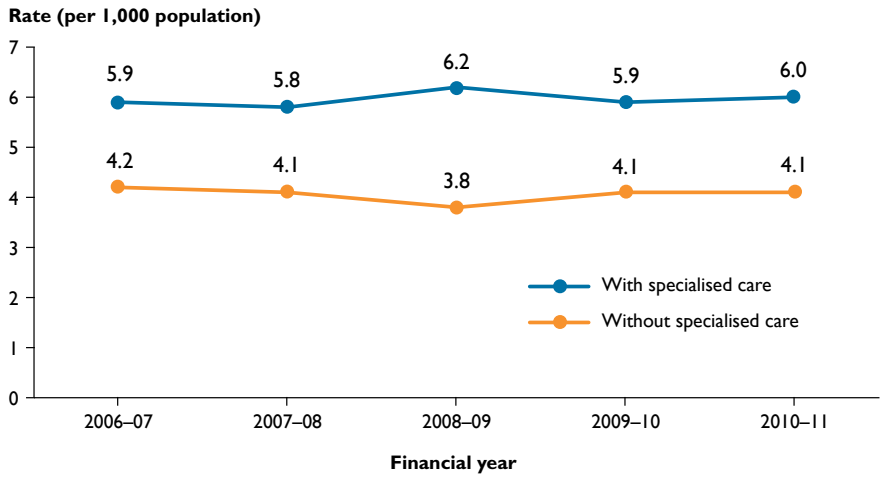
The rate of separations for patients both with and without specialised psychiatric care has remained relatively stable over the 5 years to 2010–11 (figure below).

Ambulatory-equivalent mental health-related admitted patient care

In some circumstances, patients admitted to hospital are provided with care comparable to that which could be provided by community mental health care services in that it does not involve an overnight stay and, if any procedure is recorded, it is of the nature of counselling, skills training or some similar form of therapy.

There were over 142,200 ambulatory-equivalent mental health-related separations in 2009–10, accounting for 1.7% of all hospital separations and 39.0% of all mental health-related separations.

Admitted patient mental health-related separation rates, by care type, over time



Use of restrictive practices

Reducing the use of seclusion, a form of restrictive practices, is a national priority for mental health, and has been formally endorsed by health ministers in the *National safety priorities in mental health: a national plan for reducing harm* (DoHA 2005).

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

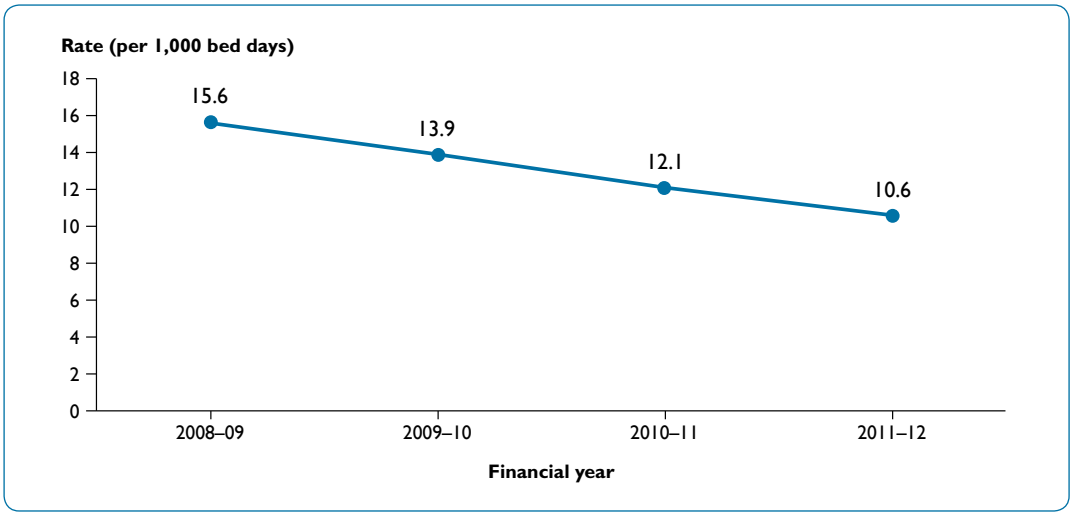
Australian mental health pilot sites implemented initiatives to progress this priority through the National Mental Health Seclusion and Restraint (Beacon Site) Project 2007 to 2009. The project informed positive change for reducing the use of seclusion and restraint in mental health services.

Nationally, seclusion rates have fallen, from 15.6 events per 1,000 bed days in 2008–09 to 10.6 in 2011–12 (figure below).

In 2011–12, there were 10.6 seclusion events per 1,000 bed days in public acute hospital services, nationally. Jurisdictional rates ranged from 1.3 seclusion events per 1,000 bed days in the Australian Capital Territory to 25.7 in the Northern Territory.

Restraint is also a form of restrictive practice. Work is ongoing to develop a nationally consistent definition and data counting methodology to describe restraint events.

Rate of seclusion events, over time



Residential mental health care

Residential mental health care services are specialised services that assist people with a mental illness by providing rehabilitation, treatment or extended care in a domestic-like environment on an overnight basis. Data exclude aged care services subject to Commonwealth reporting arrangements.

Key facts

- There were over 4,200 residential episodes of care for over 3,200 residents in 2010–11.
- Residents with an involuntary mental health legal status accounted for about one-third of all episodes of care in 2010–11.

Who uses these services?

Males accessed residential services at a higher rate than females (2.1 and 1.7 episodes per 10,000 population, respectively).

Residents aged 35–44 accessed services at the highest rate among the various age groups.

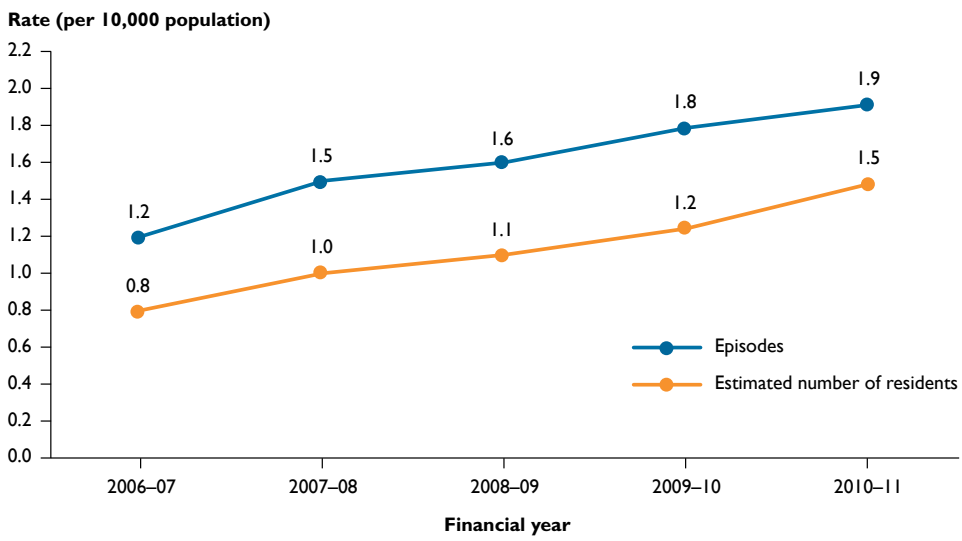
Indigenous Australians accessed residential services at a higher rate than non-Indigenous Australians (2.6 and 1.8 episodes per 10,000 population, respectively).

How is this care changing over time?

The number of residential mental health care episodes per 10,000 population has risen slightly over the 5 years to 2010–11 (figure below).

Both the average number of episodes per resident and the average number of residential care days per episode (length of stay) declined over the 5 years to 2010–11.

Residential mental health care episode and resident rates, over time



Why are people receiving this care?

The most common principal diagnosis was schizophrenia, which represented nearly half of all episodes (46.7%), followed by schizoaffective disorder (14.1%) and depressive episode (9.8%).

What is a typical episode of residential care?

The most common length of stay for a completed residential episode in 2010–11 was 2 weeks or less (50.0%), with just under 5% lasting longer than 1 year.

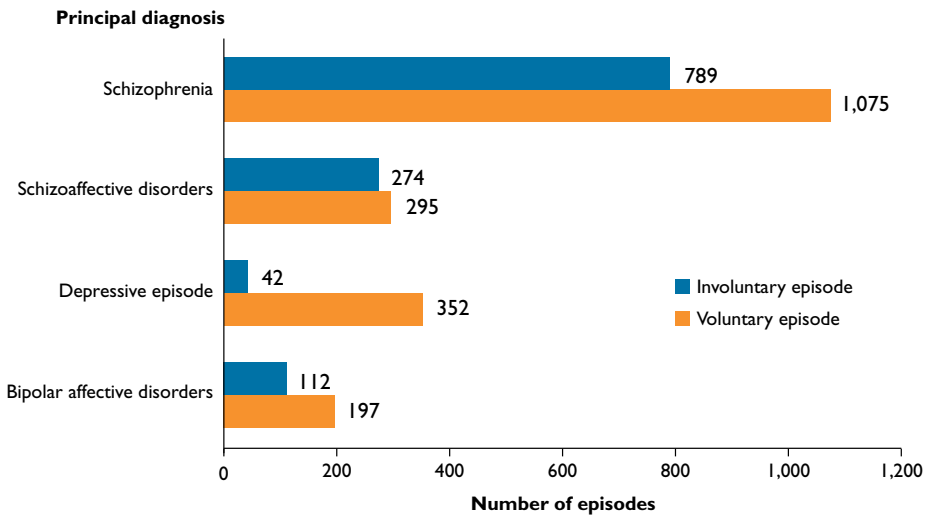
Residents admitted involuntarily accounted for about 34% of all episodes. The proportion of episodes for residents with an involuntary mental health legal status was stable between 2006–07 and 2010–11.

Residents with a principal diagnosis of schizophrenia accounted for more than half of all involuntary episodes of care (789 or 56.8% of the total number of involuntary episodes) (figure below).

How do rates differ between states and territories?

Tasmania had the highest rates of residential care use, including episodes, residents and care days (14.4, 8.3 and 878.5 per 10,000 population, respectively). This was noticeably higher than the Australian average, indicating a greater reliance on this type of care in the Tasmanian mental health system. New South Wales had the lowest rates for both residents and episodes (both 0.3 per 10,000 population). Queensland does not report residential mental health care services. These diverse rates are a reflection of the mental health service profile mix of each jurisdiction. See the Specialised mental health care facilities section (page 30) for further information.

Residential mental health care episodes for the 4 most commonly reported principal diagnoses, by mental health legal status, 2010–11



Psychiatric disability support services

Support services are available for Australians with disability, including psychiatric disability. These include both residential and non-residential services funded under the National Disability Agreement.

Key facts

- Over 87,800 people with psychiatric disability made use of both residential and non-residential disability support services in 2010–11.
- There were more psychiatric disability non-residential service users compared with psychiatric disability residential service users across all states and territories.
- Employment services were the most widely used service type.

Who accesses non-residential services?

Non-residential support services include accommodation support, community support, community access, employment services and respite services.

Over 87,200 people with psychiatric disability accessed non-residential support services in 2010–11.

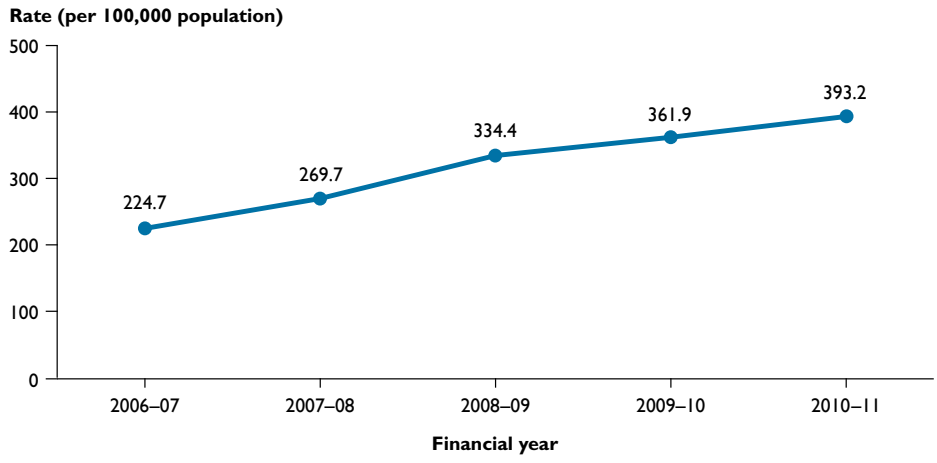
Service users were more likely to be male, aged 25–54, living alone in a private residence in a *Major city* and receiving a disability support pension.

Employment services were the most widely used service type.

How is the non-residential rate changing over time?

There has been an average annual increase of 15.0% in the rate of non-residential service users with psychiatric disability over the 5 years to 2010–11 (figure below).

Access rates to psychiatric disability non-residential support services, over time



How do rates of non-residential service use differ between states and territories?

Non-residential disability support services were most frequently used by people with psychiatric disability in Victoria, with 617.2 users per 100,000 population.

The national average was 393.2 users per 100,000 population.

The Northern Territory had the lowest rate of users (106.3 per 100,000 population).

How do rates of residential service use differ between states and territories?

In addition to non-residential disability support services, some people with psychiatric disability also access residential disability support services. People with psychiatric disability accessed residential disability support services most frequently in Tasmania, with 33.9 users per 100,000 population.

The national average was 17.6 users per 100,000 population.

The lowest rate was in the Northern Territory, with 6.1 users per 100,000 population.

Who accesses residential services?

Residential support services include large and small residential facilities/institutions, hostels and group homes.

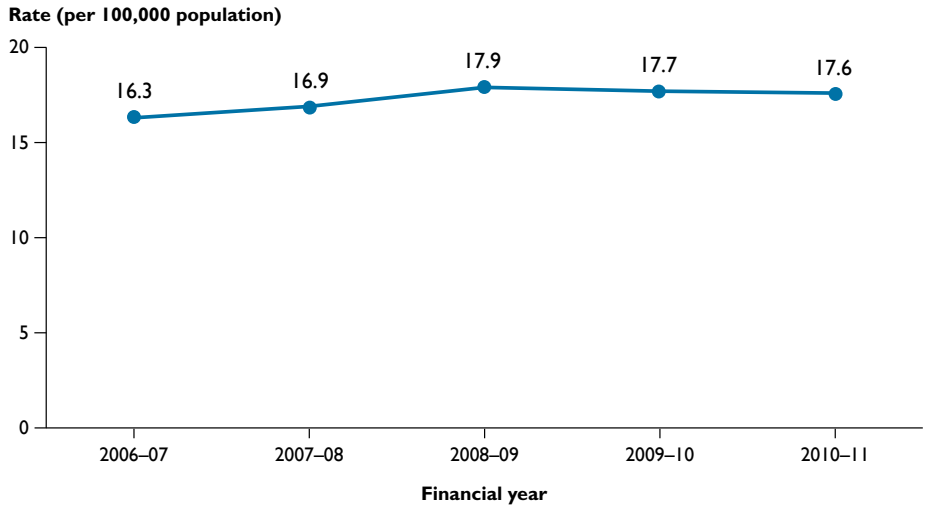
Over 3,900 people with psychiatric disability accessed residential services in 2010–11.

A typical service user was male, aged 35–64, living with others in a *Major city* in a domestic-scale supported living facility and receiving a disability support pension as a main source of income.

How is the residential rate changing over time?

There has been an average annual increase of 2.0% in the rate of residential service users with psychiatric disability over the 5 years to 2010–11 (figure below). However, since 2008–09, the rate has remained relatively stable.

Access rates to psychiatric disability residential support services, over time



Specialist homelessness services

In addition to supporting clients who are homeless, a key aim of specialist homelessness services (SHS) is to prevent homelessness occurring among those for whom the risk is high. Services provided by SHS agencies include accommodation and associated support services.

This section presents information provided by SHS agencies on clients with a current mental health issue in 2011–12.

The Specialist Homelessness Services Collection (SHSC) began on 1 July 2011, replacing the Supported Accommodation Assistance Program (SAAP) National Data Collection.

Key facts

- Clients with a current mental health issue represented 23.8% (40,405) of all SHS clients (169,989 clients).
- Clients with a current mental health issue aged 18–24 had the highest rate of use of SHS agencies (359.8 per 100,000 population).
- Domestic and family violence was the most common main reason for seeking assistance for clients with a current mental health issue.

What's new?

The SHSC replaced the SAAP National Data Collection on 1 July 2011. Data in the SHSC generally relate to the number of clients, whereas SAAP data related to the number of client support periods.

Who uses these services?

Clients with a current mental health issue represented 23.8% (40,405) of all SHS clients (169,989 clients).

For clients with a current mental health issue, those aged 18–24 had the highest rate of SHS agency use, followed by those aged 15–17 (359.8 and 340.5 per 100,000, respectively) for 2011–12.

Rates of SHS agency use were higher for females than males (207.8 and 162.1 per 100,000, respectively).

The rate of SHS clients with a current mental health issue for Indigenous Australians was about 7 times that for non-Indigenous Australians (1,040.8 and 149.2 per 100,000, respectively).

What are the characteristics of SHS clients with a current mental health issue?

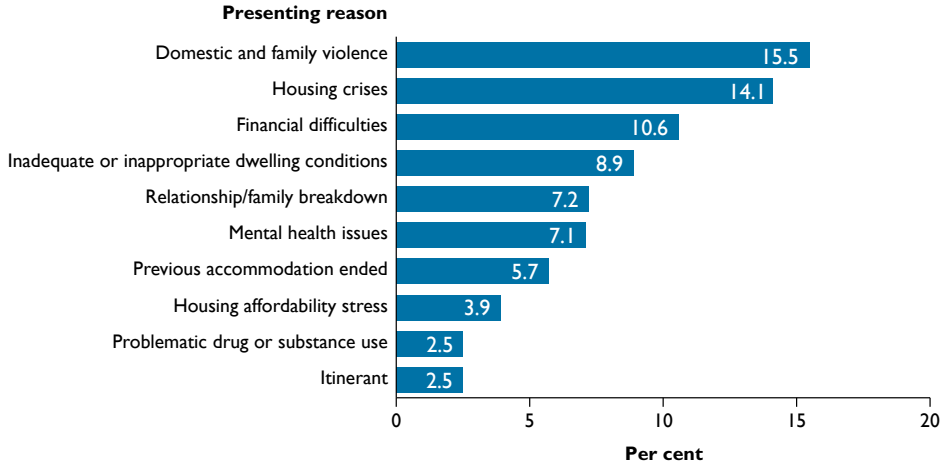
Over 2 in 5 clients (44.7%) with a current mental health issue reported an episode of homelessness in the previous 12 months before presenting, compared with about 1 in 4 of those clients (26.6%) without a current mental health issue.

About 1 in 7 SHS clients (15.5%) with a mental health issue had domestic and family violence as the main reason for seeking assistance, followed by housing crises (14.1%) and financial difficulties (10.6%) (figure overleaf).

About 423,000 services were provided to SHS clients with a current mental health issue in 2011–12. Of these, the majority (70.9%) related to general assistance and support (that is, support services not directly related to housing/accommodation services).

About half of the clients with a current mental health issue received between 6 and 45 days of support (25.1%) or over 180 days of support (25.7%) in 2011–12.

Top 10 main reasons for SHS clients with a mental health issue seeking assistance, 2011–12



How do rates differ between states and territories?

Nationally, there were 97.5 clients per 100,000 population with a current mental health issue who received accommodation services from SHS agencies in 2011–12.

Rates ranged from 42.2 per 100,000 for South Australia to 198.0 for the Australian Capital Territory.

For other types of support services provided (not including accommodation), the national average rate was 86.6 per 100,000 population. Rates ranged from 52.2 per 100,000 for Queensland to 146.2 for Victoria.

Personal Helpers and Mentors

The Personal Helpers and Mentors (PHaMs) service is an Australian Government initiative, administered by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

The program aims to increase recovery opportunities for people whose lives are severely affected by their experience of mental illness. PHaMs support participants in their recovery journey, building long term relationships and providing holistic support.

PHaMs takes a strengths-based recovery approach to helping participants better manage their daily activities and reconnect to their community.

Key facts

- About 13,200 people participated in a PHaMs service in 2011–12.
- Of the 4,024 participants that exited a PHaMs service in 2011–12, about one-third exited because they had reached their goals.

What are the functional limitations reported by PHaMs participants?

On entry into a PHaMs service, participants are assessed on their areas of functional limitation resulting from a severe mental illness.

The most commonly reported limitations were: learning, applying knowledge and general demands; social and community activities; interpersonal relationships; and working and employment (see figure overleaf).

PHaMs identifies groups of people that face additional disadvantages in their recovery as 'special needs groups'.

The most commonly reported special needs group was alcohol and/or drug comorbidity (26.7% of participants), while the least commonly reported special needs group was humanitarian entrants (2.8% of participants). However, it is important to note that participants may report belonging to more than one special needs group.

Who uses PHaMs services?

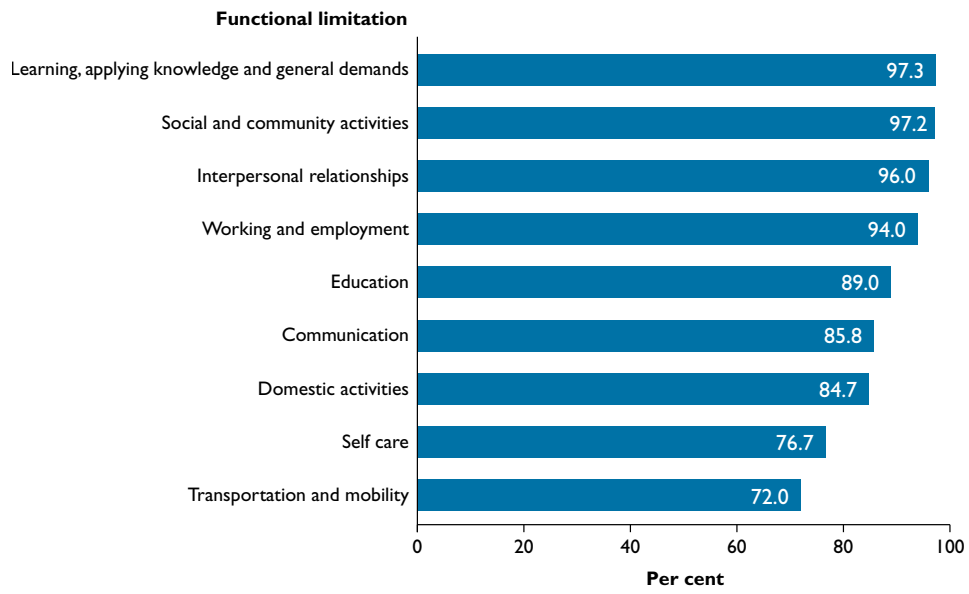
About 13,200 people participated in a PHaMs service in 2011–12; a 6.6% increase from 2010–11 and a 33.9% increase from 2009–10.

PHaMs participants were most likely to be aged 25–44, female, Australian-born and have a mental illness diagnosis at the time of initial assessment into the program.

What are the reasons for exiting the service?

Of the 4,024 participants who exited PHaMs services in 2011–12, 34.4% (1,386 participants) exited because they reached their goals, while 19.9% (802 participants) chose to leave the service and a further 12.0% (481 participants) did not return to the PHaMs service after 6 months.

Functional limitations reported by PHaMs participants, 2011–12



What resources are provided?

This section details the most recent information about the resources used in the care of people with mental health-related problems and how much is spent on these services.

Resources used or involved in the provision of mental health-related services include expenditure on mental health services, provision of facilities, mental health-related workforce and subsidised prescriptions for mental health-related medications.

Mental health workforce

Health care professionals, including GPs, psychiatrists, psychologists, nurses, social workers and occupational therapists, provide the mental health-related services described in this report. Up to date national workforce data are currently only available for psychiatrists and nurses who work principally in mental health care.

The annual Australian Institute of Health and Welfare (AIHW) Labour Force Surveys for medical practitioners and nurses and midwives were replaced from July 2010 onwards by the National Health Workforce Data Set, from data collected under the National Registration and Accreditation Scheme for health professionals.

Key facts

- An estimated 2,813 psychiatrists worked in Australia in 2011.
- An estimated 17,916 mental health nurses worked in Australia in 2011.

Who comprises the mental health workforce?

An estimated 2,813 psychiatrists worked in Australia in 2011, representing 1 in 9 (11.5%) of specialist medical practitioners; the majority of whom (87.6%) worked in *Major cities*.

The average age of psychiatrists was 52, and about two-thirds were male.

For the same period, there were an estimated 17,916 mental health nurses, representing about 1 in 16 (6.3%) of all employed nurses in Australia.

About three-quarters of mental health nurses were working in *Major cities*, with an average age of 47.

About one-third of these nurses were male, which is in contrast to the roughly 1 in 10 reported for the general nursing population (AIHW 2012).

Community managed mental health workforce

Mental health non-government organisations (NGOs) 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 (CMOs) reflecting their governance structure.

National data about the activities of mental health NGOs are not currently collected on a routine basis.

What hours are worked?

Psychiatrists worked an average of 38.9 hours per week in 2011. On average, males worked more hours than females.

Mental health nurses worked an average of 36.5 hours per week, with males again working more hours than females on average.

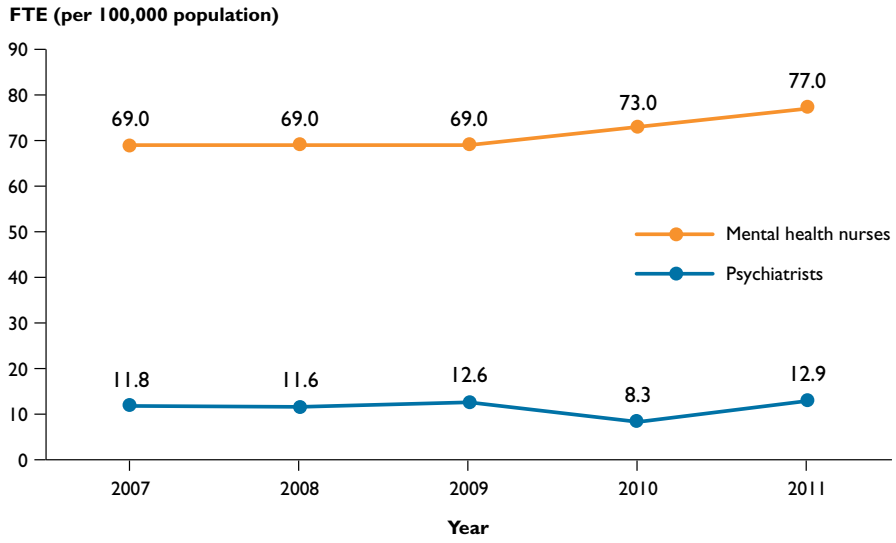
How is the workforce changing over time?

There were an estimated 12.9 full-time-equivalent (FTE) psychiatrists per 100,000 population employed in 2011 (figure below).

For mental health nurses, there was an increase between 2007 and 2011 in the supply of mental health nurses, from 69.0 to 77.0 FTE per 100,000 population.

Caution should be used when interpreting changes over time due to changes in data collection methodology.

Full-time-equivalent psychiatrist and mental health nurse rates, over time



Notes:

1. The Nursing and Midwifery Workforce Survey was not reported in 2010.
2. Data before 2010 are derived from AIHW Labour Force Surveys, and 2010 onwards from the National Health Workforce Data Set under the National Registration and Accreditation System. Comparison between data sources should be made with caution due to differing methodologies, scope and response rates.

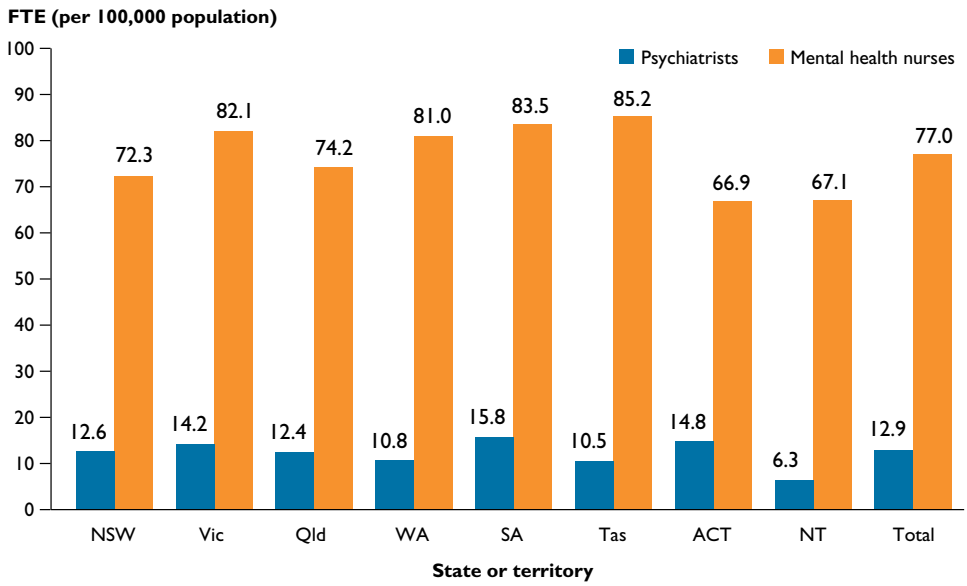
How do rates differ between states and territories?

The estimated number of FTE psychiatrists and mental health nurses per 100,000 population varied between states and territories.

Psychiatrists ranged from 6.3 FTE per 100,000 population for the Northern Territory to 15.8 for South Australia, compared with a national average of 12.9 (figure below).

For mental health nurses, the national FTE was 77.0 per 100,000 population and ranged from 66.9 for the Australian Capital Territory to 85.2 for Tasmania.

Full-time-equivalent psychiatrist and mental health nurse rates, states and territories, 2011



Expenditure on mental health services

Mental health services are funded by a combination of state and territory governments, the Australian Government and private health insurance funds.

Key facts

- Almost $6.9 billion, or $309 per Australian, was spent on mental health-related services in Australia during 2010–11.
- Expenditure on mental health services has increased by 5.7% per Australian over the 5 years to 2010–11.

How much is spent on state and territory specialised mental health services?

Over $4.2 billion was spent on state and territory specialised mental health services in 2010–11 (running costs only). The largest proportion was spent on public hospital services for admitted mental health care ($1.8 billion), equating to an average cost of $842 per patient day (figure overleaf).

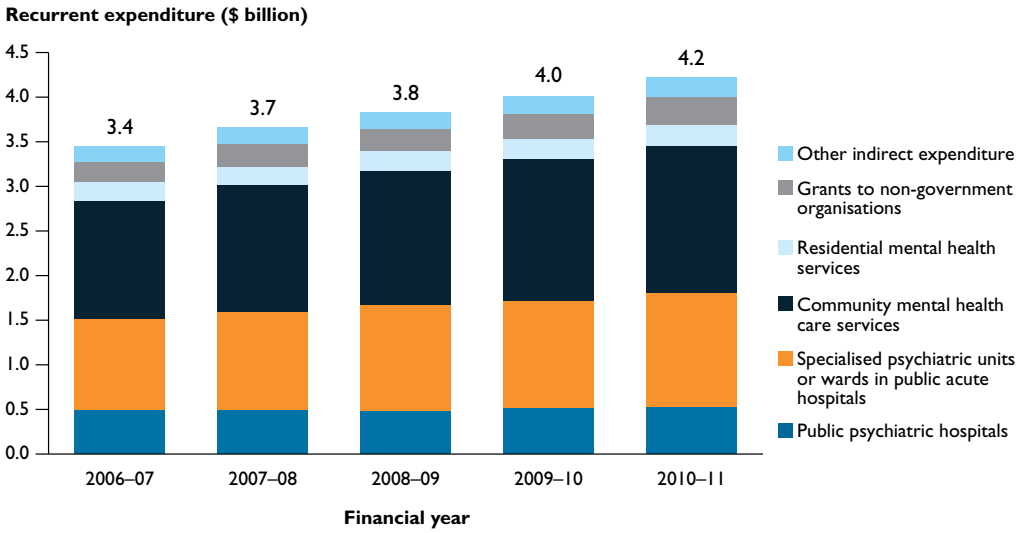
Community mental health care spending accounted for $1.6 billion in 2010–11. A further $238 million was spent on residential mental health services, with the majority spent on 24-hour staffed services.

Expenditure on state and territory specialised mental health services has increased from $165 per Australian to $190 between 2006–07 and 2010–11, an average annual increase of 3.6%.

What is Australian Government expenditure on mental health-related services used for?

The Australian Government spent $2.4 billion or $109 per Australian on mental health-related services in 2010–11, an average annual increase of 8.2% per Australian between 2006–07 and 2010–11. The majority ($1.7 billion) was spent on Medicare-subsidised mental health-related services and Pharmaceutical Benefits Scheme- (PBS) and Repatriation Pharmaceutical Benefits Scheme- (RPBS) subsidised prescriptions. Spending on these items has continued to increase, which is evident in the most recently available 2011–12 data.

Recurrent expenditure on state and territory specialised mental health services, over time



How much is spent on Medicare-subsidised services?

In 2011–12, $851 million ($38 per Australian) was paid in benefits for Medicare-subsidised mental health-related services, which was 4.8% of total Medicare expenditure. Adjusted for inflation, mental health-related Medicare costs increased by an average annual rate of 8.5% per Australian between 2007–08 and 2011–12. The largest portion of 2011–12 spending was for services provided by psychologists (41.3%), followed by psychiatrists (33.3%) and GPs (23.3%).

How much is spent on PBS/RPBS-subsidised prescriptions?

In 2011–12, $854 million ($38 per Australian) was spent on mental health-related subsidised prescriptions, equating to 8.8% of all subsidised prescriptions. Adjusted for inflation, expenditure on mental health-related PBS/RPBS prescriptions increased by an average annual rate of 2.1% per Australian between 2007–08 and 2011–12. Over 70% of the expenditure on prescriptions was for prescriptions issued by GPs, followed by psychiatrists and non-psychiatrist specialists. Antipsychotics and antidepressants accounted for the majority of expenditure—54.6% and 39.5%, respectively.

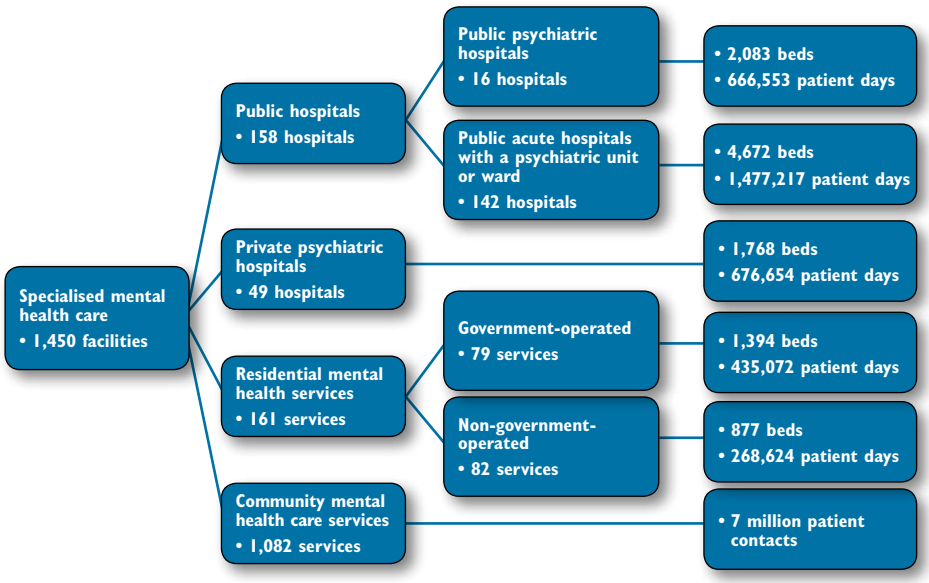
Specialised mental health care facilities

Specialised mental health care in Australia is delivered in a range of facilities including public and private psychiatric hospitals, psychiatric units or wards in public and private acute hospitals, community mental health care services and residential mental health services (figure below).

Key facts

- There were 1,450 specialised mental health care facilities nationwide in 2010–11.
- There were 8,523 specialised mental health hospital beds and 2,271 beds available in residential mental health services in 2010–11.
- Over 29,000 FTE staff were employed by state and territory specialised mental health care services in 2010–11.

State and territory specialised mental health care facilities, beds and activity, 2010–11



How many mental health care facilities are available?

There were 1,450 specialised mental health care facilities nationwide in 2010–11.

There were 1,401 state and territory specialised mental health facilities, including hospital, residential and community mental health services.

These state and territory facilities were administered by 208 health service organisations, equivalent to the area health services or district mental health services in most states and territories.

The most common of these organisations comprised a specialised mental health public hospital service and a community mental health service.

In addition, there were 49 private psychiatric hospitals and about 440 non-government organisations (data not shown) funded by state and territory governments to provide mental health services.

The Australian Government also directly funded a range of services which are not represented in the figure on the previous page. Work is ongoing to collect and report data relating to these services.

How many specialised mental health beds are available?

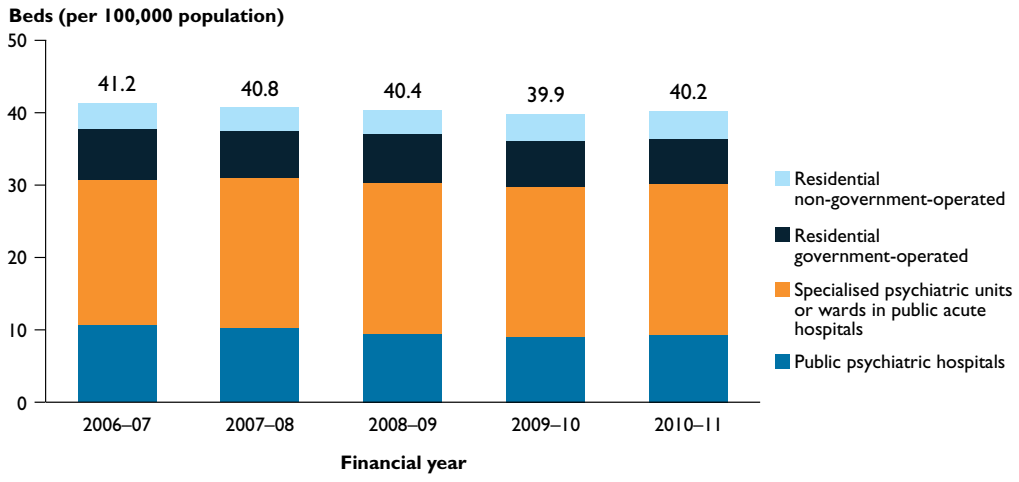
There were 8,523 specialised mental health hospital beds available during 2010–11, with 6,755 beds provided by public hospital services and 1,768 beds in private hospitals. In addition, there were 2,271 beds available in residential mental health services.

Over two-thirds (4,672) of the 6,755 public sector hospital beds available in 2010–11 were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals.

About two-thirds of all residential mental health beds were in services that were government-operated, however the number of beds in non-government-operated services increased from 743 beds in 2006–07 to 877 beds in 2010–11, an annual average increase of 4.2%.

While the actual number of available state and territory specialised mental health beds increased from 8,602 beds in 2006–07 to 9,027 in 2010–11, the rate of beds per 100,000 population has remained relatively constant (figure below).

State and territory specialised mental health beds, over time



24-hour staffed public-sector care

Mental health services with staff employed in active shifts for 24 hours a day are provided through either public-sector specialised mental health hospital services or 24-hour staffed residential mental health services. Comparison between states and territories can be made when different types of 24-hour care are combined.

Tasmania had the highest number of 24-hour care beds per 100,000 population (43.2), while the Northern Territory had the lowest (21.0), compared with a national average rate of 36.9 in 2010–11 (figure below).

How are consumers and carers involved in service planning and delivery?

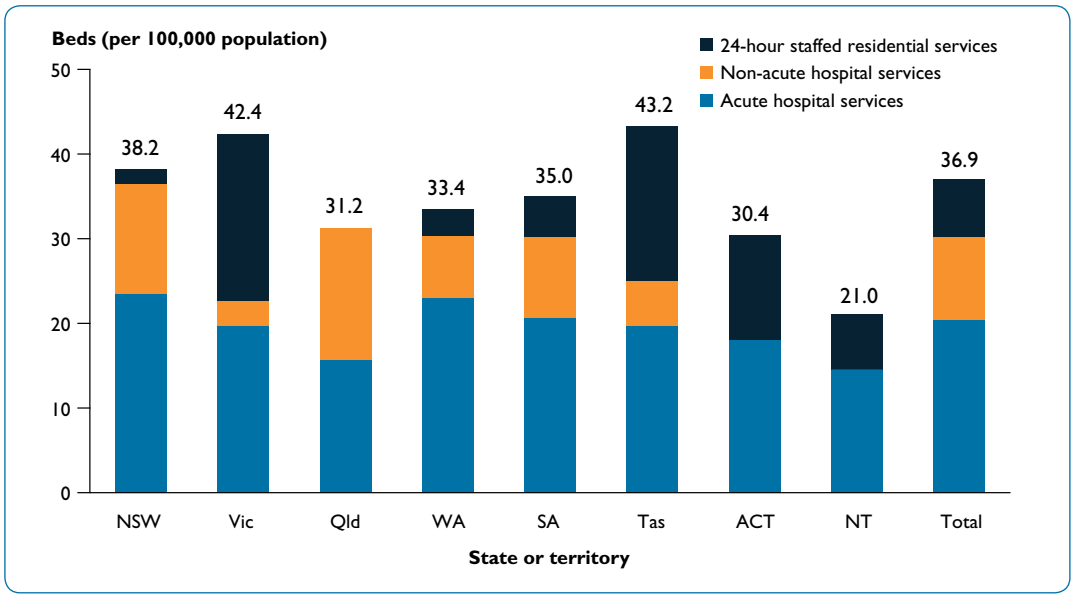
Specialised mental health organisations employ consumer and carer workers to contribute to mental health service planning and delivery.

The proportion of specialised mental health organisations employing consumer workers increased from 32.6% in 2006–07 to 46.6% in 2010–11, with a similar increase in the employment of carer workers over the same time period (from 18.3% to 33.2%, respectively).

The number of mental health consumer and carer workers employed, as a proportion of mental health care FTE staff, provides a further indicator of the involvement of consumers and carers in the planning and delivery of mental health services.

There were 28.1 consumer worker FTE staff per 10,000 mental health care staff in 2010–11. This rate has remained relatively stable over the 5 years to 2010–11. Over the same period, the number of carer workers has risen from 10.8 to 18.1 FTE staff per 10,000 mental health care staff.

24-hour care specialised mental health beds, states and territories, 2010–11



How many staff are employed in state and territory services?

Over 29,000 FTE staff were employed by state and territory specialised mental health care services in 2010–11. There was an average annual increase of 3.0% in the number of these FTE staff over the 5 years to 2010–11.

The majority of staff were nurses (50.6%), followed by diagnostic and allied health professionals (19.0%) and salaried medical officers (9.9%).

Tasmania had the highest rate (per 100,000 population) of FTE staff (157.4), while the Northern Territory had the lowest (101.7), compared with the national rate of 130.0 in 2010–11 (figure below).

When only direct care staff are considered, specialised mental health hospital admitted patient services employed the highest rate of staff with 53.1 direct care FTE staff per 100,000 population during 2010–11. Community mental health care services employed 47.1 direct care FTE staff per 100,000 population and residential mental health services employed 7.8 direct care FTE staff per 100,000.

Community mental health care services have seen the greatest average annual increase (2.9%) in the rate of direct care FTE staff from 42.0 FTE staff per 100,000 population in 2006–07 to 47.1 in 2010–11.

How many staff are employed in private hospital services?

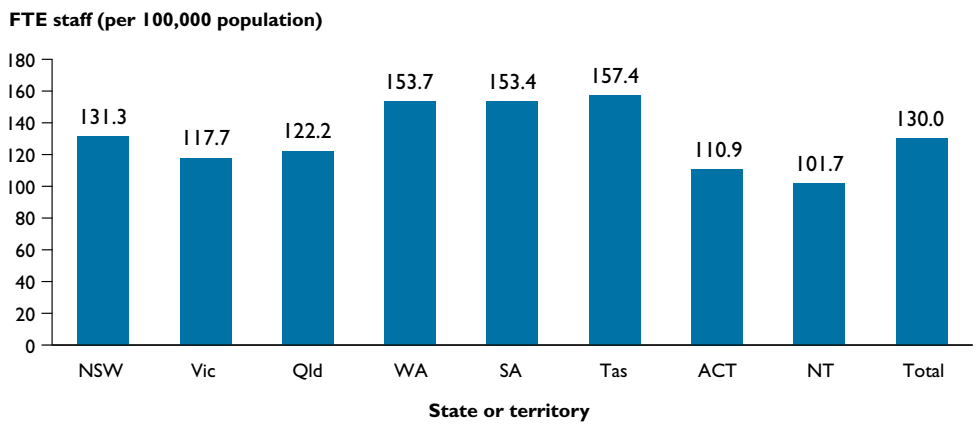
In addition to state and territory specialised mental health care services, there were just under 2,300 FTE staff or 10.2 FTE staff per 100,000 population employed by private hospitals providing specialised mental health services in 2010–11.

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.

How many staff are employed in other private-sector services?

In addition to state and territory services and private hospitals, there were a substantial number of health professionals employed in the private sector, funded through Medicare and via other Australian Government sources. Work is ongoing to report data on these professionals in future years.

Full-time-equivalent staff rates, states and territories, 2010–11



Mental health-related prescriptions

Mental health-related medications are provided through non-subsidised prescriptions as well as prescriptions subsidised by the Australian Government through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). This section uses data from these schemes as well as estimates of the number of non-subsidised prescriptions, including private prescriptions and those for which the price is below the required patient contribution (under co-payment), obtained from the Drug Utilisation Sub-Committee database.

Key facts

- There were over 23 million PBS- and RPBS-subsidised prescriptions for mental health-related medications in 2011–12, accounting for 11.2% of all subsidised prescriptions.
- There was an average annual increase of 3.0% in the rate of community-dispensed prescriptions for mental health-related medications from 2007–08 to 2011–12.

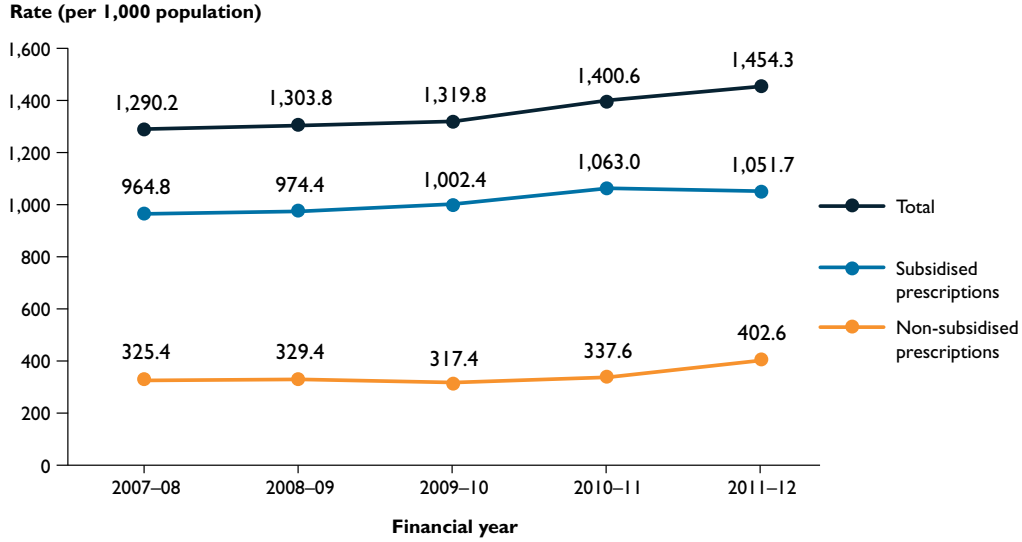
How many prescriptions?

There were an estimated 32.7 million prescriptions for mental health-related medications dispensed in 2011–12, of which 72.3% (23.4 million) were subsidised by the Australian Government under the PBS and RPBS. Subsidised prescriptions for mental health-related medications accounted for 11.2% of all subsidised prescriptions dispensed in Australia in 2011–12.

How is this changing over time?

There was an increase in the rate (per 1,000 population) of mental health-related prescriptions dispensed, averaging 3.0% per year over the 5 years to 2011–12 (figure below). This change includes an annual increase of 2.2% in subsidised prescriptions and 5.5% in non-subsidised prescriptions over the same period.

Mental health-related prescription rates, by subsidy type, over time



What is prescribed and by whom?

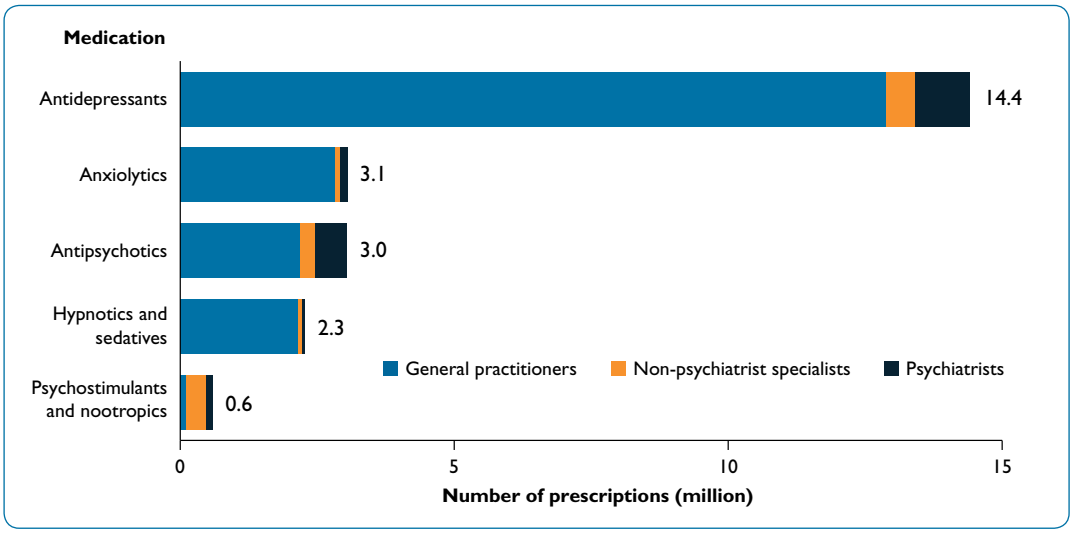
Antidepressant medication accounted for over 60% (14.4 million) of all subsidised mental health-related prescriptions dispensed in 2011–12 (figure below).

GPs provided the majority of the subsidised prescriptions (86.1%), with 8.1% prescribed by psychiatrists and 5.8% by non-psychiatrist specialists.

How do rates differ between states and territories?

The rate of mental health-related prescriptions per 1,000 population was relatively low in the Australian Capital Territory (731.4), compared with the national average (982.3). Tasmania had a considerably higher rate of prescriptions than the national average (1,307.6 prescriptions per 1,000 population) as did South Australia (1,103.5).

Mental health-related prescriptions, by medication and prescriber type, 2011–12



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** and can be classified as:

- **ambulatory-equivalent**—when the care provided is comparable to that which could be provided by community mental health care services in that it does not involve an overnight stay and, if any procedure is recorded, it is of the nature of counselling, skills training or some similar form of therapy.
- **admitted patient care**—when the care provided is specific to 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).
- **seclusion**—confinement at any time of the day or night alone in a room or area from which free exit is prevented.
- **separation**—the process by which an episode of care for an admitted patient ceases.

Average annual rate: Indicates the extent of 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 ambulatory care 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.

Direct care: Refers to the staffing categories of medical staff, nurses, diagnostic and allied health professionals and other personal care staff.

FTE: Stands for full-time-equivalent, which is a measure of the number of standard week (usually 38 hours) workloads worked by professionals.

Medicare-subsided services: Medicare Benefits Schedule-subsidised mental health-related services are provided by psychiatrists, general practitioners, psychologists and other allied health professionals.

Mental health problem: 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 (DSM) or the International Classification of Diseases (ICD).

PBS: Stands for Pharmaceutical Benefits Scheme; subsidises the cost of prescription medicine.

RPBS: Stands for Repatriation Pharmaceutical Benefits Scheme; provides a wide range of pharmaceuticals and dressings at a concession rate for the treatment of eligible veterans, war widows/widowers, and their dependants.

Psychiatric disability: Refers to 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.

Remoteness areas: Refer to categories within the Australian Standard Geographical Classification, which is based on an index that measures the remoteness of a point according to the physical road distance to the nearest urban centre. Some examples of localities in different remoteness categories include:

Major cities, which include most capital cities, as well as major urban areas such as Newcastle, Geelong and the Gold Coast.

Inner regional, which includes cities such as Hobart, Launceston, Mackay and Tamworth.

Outer regional, which includes cities and towns such as Darwin, Whyalla, Cairns and Gunnedah.

Remote, which includes cities and towns such as Alice Springs, Mount Isa and Esperance.

Very remote, which 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.

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Data sources

Mental health services—in brief 2013 draws on a wide range of health and welfare data sources to provide an overview of the national response to the mental health needs of Australians. Data included in the national databases are collected according to national data dictionaries published online in the AIHW Metadata Online Registry (METeOR).

Current data sources for this publication can be found at the *Mental health services in Australia* website and include the following:

- Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity (Mental health-related services provided by general practitioners section)
- Data provided by state and territory health authorities (Mental health services provided in emergency departments section; Admitted patient mental health-related care section)
- Disability Services National Minimum Data Set, National Disability Agreement (NDA) (Psychiatric disability support services section)
- Medicare data (DoHA) (Mental health-related services provided by general practitioners section; Medicare-subsidised mental health-related services section; Expenditure on mental health services section)
- National Community Mental Health Care Database (State and territory community mental health care services section)
- National Health Workforce Data Set: medical practitioners and National Health Workforce Data Set: nurses and midwives (Mental health workforce section)
- National Hospital Morbidity Database (Admitted patient mental health-related care section)
- National Mental Health Establishments Database (Specialised mental health care facilities section; Expenditure on mental health services section)
- National Residential Mental Health Care Database (Residential mental health care section)
- Personal Helpers and Mentors Eligibility and Reporting System (Personal Helpers and Mentors section)
- Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA) (Mental health-related prescriptions section; Expenditure on mental health services section)
- Private Health Establishments Collection (Specialised mental health care facilities section; Expenditure on mental health services section)
- Private Mental Health Alliance Centralised Data Management Service (Admitted patient mental health-related care section)
- Specialist Homelessness Services Collection (Specialist homelessness services section).

Mental health services—in brief 2013 provides an overview of data about the national response of the health and welfare system to the mental health care needs of Australians.

It is designed to accompany the more comprehensive data on Australia's mental health services available online at <http://mhsa.aihw.gov.au>.