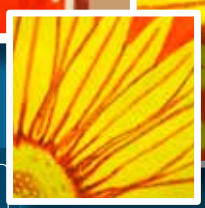
Australian Government
Australian Institute of Health and Welfare

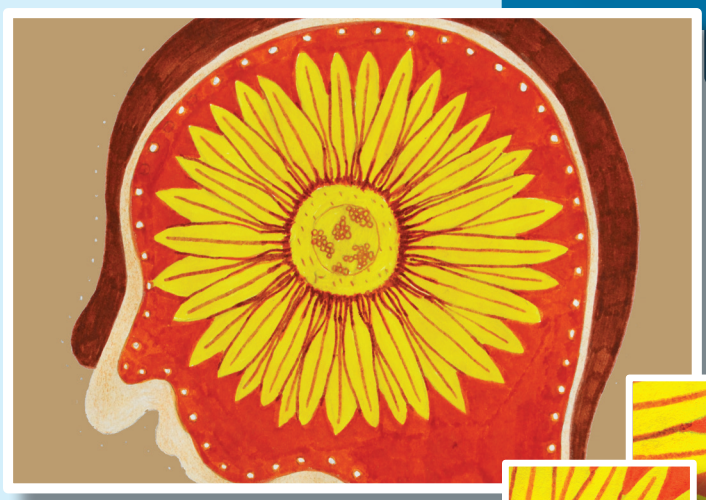
2014

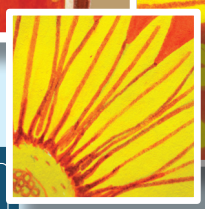


MENTAL HEALTH SERVICES

In brief

2014





MENTAL**HEALTH**SERVICES

In brief

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.*

ISBN 978-1-74249-661-0

Suggested citation

Australian Institute of Health and Welfare 2014. Mental health services—in brief 2014. Cat. no. HSE 154. Canberra: AIHW.

Australian Institute of Health and Welfare

Board Chair
Dr Mukesh C Haikerwal AO

Director
David Kalisch

Any enquiries about or comments on this publication should be directed to:

Digital and Media Communications Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Tel: (02) 6244 1000

Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare

Cover art by Ceretha Skinner

Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

Therapy by flowers

Ceretha Skinner—contemporary Indigenous artist and textile designer

Ceretha Skinner is a Gumbaynggirr woman born in Grafton, New South Wales. She has had a lifelong dream to produce graphic designs related to her Aboriginal culture and heritage. Her early childhood environment in northern New South Wales has influenced her designs. She has created images representing big rivers and creeks, fishing and a range of flora and fauna.

Ceretha creates 'new age' traditional Aboriginal designs and reproduces the images on limited edition screen prints and fabrics.

'Art has been a medicine to me—a form of therapy', Ceretha says. 'It helped me build my self-esteem. Art saved my life.'

In 2013 Ceretha was named Artist of the Year during NAIDOC week.

Ceretha was Craft ACT's first Indigenous artist-in-residence. She has displayed her textile designs at several art exhibitions.

Contents

Introduction

This *Mental health services—in brief 2014* report has been produced as a companion publication to the *Mental health services in Australia* website. The report provides an annual overview of key statistics and related information on mental health services, while incorporating updates made to the website over the 12 months to November 2014.

The next section of this report provides a brief description of mental illness in Australia in terms of its prevalence and impact. This is followed by an overview section on services accessed by people with mental illness, and expenditure on mental health services. Subsequent sections provide more detailed insights into mental health care services and support, medications, and resources, respectively. The report concludes with a 2014 special focus section on involuntary care and seclusion, and a section reporting 3 Key Performance Indicators (KPIs) for Australian Public Mental Health Services.

For readers interested in further information, the *Mental health services in Australia* website (www.mhsa.aihw.gov.au) provides detailed data on the national response of the health and welfare system to the mental health care needs of Australians.

Mental illness in Australia—prevalence and impact

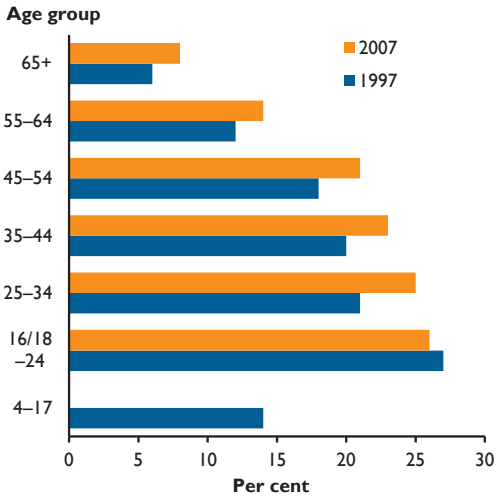
Prevalence of mental illness

In this report the terms 'mental illness' and 'mental disorder' are both used to describe a wide spectrum of mental health and behavioural disorders, which can vary in both severity and duration. The most prevalent mental illnesses are depression, anxiety and substance use disorders. Less prevalent, and often more severe, illnesses include schizophrenia, schizoaffective disorder and bipolar disorder (Slade et al. 2009).

From the 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (aged 16–85) it is estimated that 45% of Australians in this age range (7.3 million people) experienced a mental disorder sometime in their lifetime, and that an estimated 20% (3.2 million people) had experienced a common mental disorder in the previous 12 months (ABS 2008).

Of these, anxiety disorders (such as social phobia) were the most common, afflicting 14.4% of the population, followed by affective disorders such as depression (6.2%) and substance-use disorders such as alcohol dependence (5.1%). These 3 groups of common mental disorders were most prevalent in people aged 16–24 and decreased as age increased. Prevalence was higher for females than males across all ages.

The age distribution of common mental disorders in 2007 was similar to that found 10 years earlier from the same survey conducted over 1997 or 1998 (depending on age group) (Figure 1).



Note: For the 4–17 age group the data are for 1998 (rather than 1997). For the 16/18–24 age group, the 1997 data relate to people aged 18–24 and the 2007 data to people aged 16–24.

Figure 1: Prevalence of common mental disorders in the Australian population, 1997/1998 and 2007

The 1998 component of the NSMHWB was for children and adolescents (this component is currently being repeated and scheduled to be published in 2015).

The 1998 survey found that 14% of children and adolescents aged 4–17 had a clinically significant mental health problem (Sawyer et al. 2000). This equates to about 500,000 children and adolescents, including 93,000 with anxiety or depression, 200,000 with aggressive behaviours, and 93,000 with attention deficit disorders (DoHA 2013).

In terms of more severe mental illnesses, which includes psychotic disorders such as schizophrenia, estimates from the 2010 NSMHWB Survey of People Living with Psychotic Illness indicated that 0.45% of the population aged 18–64 (64,000 people) accessed treatment annually from public sector mental health services for a psychotic disorder, with schizophrenia being the most common disorder (Morgan et al. 2011). About two-thirds of these individuals experienced their initial episode of psychotic illness before they turned 25.

Impact of mental illness

Mental disorders can vary in severity and be episodic in nature. A recent review estimated that 2–3% of Australians (600,000 people) have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability (DoHA 2013). This group is not confined to those with psychotic disorders, who represent about one-third of those with severe mental disorders; it also includes people with severe and disabling forms of depression and anxiety. Another 4–6% of the population (around 1 million people) have a moderate disorder and a further 9–12% (approximately 2 million people) a mild disorder (DoHA 2013).

In 2011, mental disorders were responsible for 754 deaths, excluding suicide and dementia, with most deaths due to substance abuse, particularly alcohol (AIHW analysis of National Mortality Database).

Mental and behavioural disorders such as depression, anxiety and drug use, are important drivers of disability. For example, mental and behavioural disorders were estimated to be responsible for 13% of the total burden of disease in Australia in 2003, placing it third as a broad disease group after cancers and cardiovascular disease (Begg et al. 2007). In addition, in 2013, 31.2% of people in receipt of the Disability Support Pension had a primary medical condition of 'psychological/psychiatric' (DSS 2014).

The 2003 Burden of Disease and Injury in Australia study (currently being repeated and scheduled to be published in 2015) examined the health loss due to disease and injury that is not improved by current treatment, rehabilitative and preventative efforts of the health system and society (Begg et al. 2007). It was found that depression and anxiety disorders were associated with an increased risk of ischaemic heart disease and suicide. In terms of the non-fatal burden of disease, which is a measure of the number of years of 'healthy' life lost due to living with a disability, mental and behavioural disorders were the largest contributor (24% of the non-fatal burden of disease) (Begg et al. 2007).

There can be an association between diagnosis of mental health disorders and a physical disorder, often referred to as a 'comorbid' disorder. From the 2007 NSMHWB of adults, 11.7% of people with a mental disorder of at least 12 months duration also reported a physical disorder; 5.3% reported 2 or more physical conditions.

According to the 2010 National Survey of People Living with Psychotic Illness, people with psychotic illness also frequently experience poor physical health outcomes and comorbidities (Morgan et al. 2011). For example, over one-quarter (26.8%) of survey participants had heart or circulatory conditions and one-fifth (20.5%) had diabetes (compared with 16.3% and 6.2% respectively in the general population). The prevalence of diabetes found in the National Survey of People Living with Psychotic Illness is more than 3 times the rate seen in the general population. Other comorbidities included epilepsy (7.3% compared with 0.8% in the general population) and severe headaches/migraines (25.4% compared with 8.9% in the general population).

Australia's mental health care system—an overview

This section provides a high level summary of the mental health care provided in Australia. Later sections provide more in-depth analyses of selected components of the Australian mental health care system.

Mental health care can be broadly divided into *specialised mental health services*, and *general healthcare services where mental health-related care may be delivered.*

State and territory governments fund and deliver public sector mental health services that provide specialised care for people with severe mental illness. These include admitted patient services delivered in hospital settings and services delivered in community settings.

The Australian Government funds a range of mental health-related services. These include the Medicare Benefits Schedule (MBS), and the Pharmaceutical Benefits Scheme (PBS)/Repatriation Pharmaceutical Benefits Scheme (RPBS).

The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

Who receives mental health care?

From the 2007 NSMHWB, the estimated population treatment rate for people with a mental disorder of at least 12 months duration was 34.9% (1.1 million people) (Slade et al. 2009). Of these:

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

Of people with a mental disorder of at least 12 months duration who did not receive any mental health care, 86% reported that they perceived having no need for any mental health care.

However, more recent evidence suggests that the relatively low treatment rates found in 2007 have increased significantly (to an estimated 46% in 2009–10), due primarily to the introduction of government-subsidised mental health treatment items to the Medicare Benefits Schedule in November 2006 (Whiteford et al. 2014).

Who provides mental health care?

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

Health care professions providing mental health care include: general practitioners, psychologists, psychiatrists, nurses, occupational therapists and social workers.

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

A summary of the volume of mental health-related services delivered by health practitioners can be found in Table 1.

Table 1: Selected mental health-related services provided annually (latest available data)

Service type	Volume
Community mental health care service contacts	5.5 million
Residential mental health care service episodes	6,535
Emergency department services	188,739
Admitted patient hospitalisations	234,008
MBS-subsidised mental health services provided by GPs	2.4 million
MBS-subsidised mental health services provided by psychiatrists	2.1 million
MBS-subsidised mental health services provided by psychologists	3.7 million
PBS-subsidised mental health-related medications by GPs	20.3 million
PBS-subsidised mental health-related medications by psychiatrists	1.9 million

Where is specialised mental health care provided?

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

Hospital emergency departments also play a role in treating mental illness, and may be the initial point of access to the healthcare system for an individual with mental illness.

Nationally, there were 1,514 specialised mental health care facilities providing care in 2011–12. There were more than 11,100 specialised mental health beds available nationally during 2011–12 (Table 2).

Table 2: Specialised mental health care facilities, Australia, 2011–12

Service type	Number	Number of beds
Public hospitals	161	6,709
Residential mental health services	165	2,352
Community mental health care services	1,133	n.a.
Private psychiatric hospitals	55	2,072

n.a.: not applicable

How much does mental health care cost?

In 2011–12, national recurrent expenditure on mental health-related services was estimated to be about $7.2 billion.

About $4.5 billion was spent on state and territory specialised mental health services, including some funding provided by the Australian Government. The largest proportion of this expenditure was for public hospital services for admitted patients ($1.9 billion) (Table 3).

Table 3: Recurrent expenditure, state and territory specialised mental health care services, 2011–12

Service type	Expenditure
Public hospitals	$1.9 billion
Residential mental health services	$249 million
Community mental health services	$1.8 billion

The Australian Government spent $2.5 billion on mental health-related services in 2011–12. Expenditure on MBS-subsidised mental health services and medications provided through the PBS and RPBS accounted for 66.4% of the total (Table 4).

Table 4: Australian Government recurrent expenditure on mental health-related services, 2011–12

Service type	Expenditure
MBS mental health services	$851 million
PBS/RPBS mental health medications	$854 million

Around $333 million was spent on private hospital mental health-related services in 2011–12, with the majority of this funding from private health insurance funds ($299 million). Over the 5 years to 2011–12, the average annual increase in expenditure on private hospital services was 6.0% (adjusted for inflation).

Mental health care services and support

Mental health care provided by general practitioners

This section covers mental health care provided by GPs using Medicare Benefits Schedule (MBS) items and data from the Bettering the Evaluation and Care of Health (BEACH) survey of GPs.

Key facts

- Nationally, it was estimated that there were almost 16 million mental health-related GP encounters in 2012–13.
- GPs provided about 2.4 million MBS-subsidised mental health services to almost 1.4 million patients in 2012–13.

How many services were provided?

Data from the BEACH survey estimates that 12.3% of all GP encounters in 2012–13 were mental health-related (15.8 million GP encounters nationally). In addition, there were an estimated 3.3 million GP encounters without a specific mental health-related problem recorded, but where psychologically-related management was initiated. These estimates are much higher than the total number of MBS-subsidised mental health services provided by GPs in the same year, which suggests that most mental health-related GP activity is billed as general MBS items.

GPs provided 28.2% of all MBS-subsidised mental health services, a total of 2.4 million services in 2012–13, or a rate of 105.2 services per 1,000 population. These were provided to 1.4 million patients, which equates to an average of 1.7 services per patient.

Victoria had the highest rate of MBS-subsidised GP mental health services per 1,000 population followed by New South Wales (122.2 and 108.8 respectively). The Northern Territory had the lowest rate (47.2) (Figure 2).

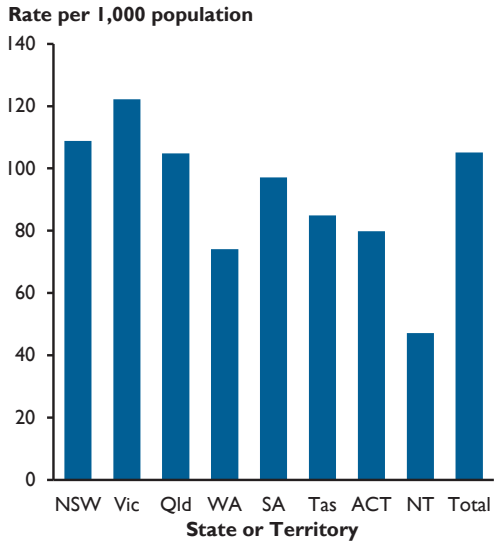


Figure 2: MBS-subsidised GP mental health services per 1,000 population, 2012–13

Over the 5 years to 2012–13, the rate of MBS-subsidised GP mental health services increased by an annual average of 8.6%.

Why are people receiving services?

Depression, anxiety and sleep disturbance were the 3 mental health-related problems most frequently managed by GPs in 2012–13 (from the BEACH survey); these 3 problems accounted for 60% of all mental health-related problems managed.

What services were provided?

Prescribing, recommending or supplying a mental health-related medication was the most frequent type of management provided by GPs in 2012–13 for mental health-related encounters (BEACH survey),

followed by counselling services (63.3 and 47.3 of every 100 mental health-related problems respectively). Referrals to either a psychiatrist or psychologist were provided at rates of 1.9 and 7.4 per 100 mental health-related encounters respectively.

Nationally, *GP Mental Health Treatment Services* (such as the development of a GP Mental Health Treatment Plan) was the most frequently provided mental-health-specific service type subsidised by the MBS, comprising 96.9% of all MBS-subsidised GP mental health services.

Mental health-related services provided by psychologists

This section covers psychological services delivered by either *Clinical psychologists* or *Other psychologists* as specified in the Medicare Benefits Schedule (MBS). Statistics are drawn from Medicare data on mental health-related MBS items.

Key facts

- Nationally, psychologists provided more than 3.7 million MBS-subsidised mental health services to almost 806,000 patients in 2012–13.
- Over the 5 years to 2012–13, the rate of MBS-subsidised *Clinical psychologist* and *Other psychologist* services increased at an annual average of about 13% and 7% respectively.

There is no data source available for reporting psychologist activity that is not subsidised by the MBS.

How many mental health-related services did psychologists provide?

Nationally, psychologists provided 43.8% of all MBS-subsidised mental health services, a total of 3.7 million services in 2012–13.

These were provided to 805,706 patients (an average of 4.8 services per patient). *Clinical psychologists* provided 1.6 million of the 3.7 million services, which equates to a rate of 68.0 services per 1,000 population. *Other psychologists* provided 2.2 million services, or 95.1 services per 1,000 population.

Tasmania had the highest rate of *Clinical psychologist* services per 1,000 population followed by South Australia (88.2 and 83.9 respectively). The Northern Territory had the lowest rate (13.9). Victoria had the highest rate of *Other psychologist* services per 1,000 population followed by New South Wales (124.0 and 100.9 respectively). The Northern Territory had the lowest rate (29.4) (Figure 3).

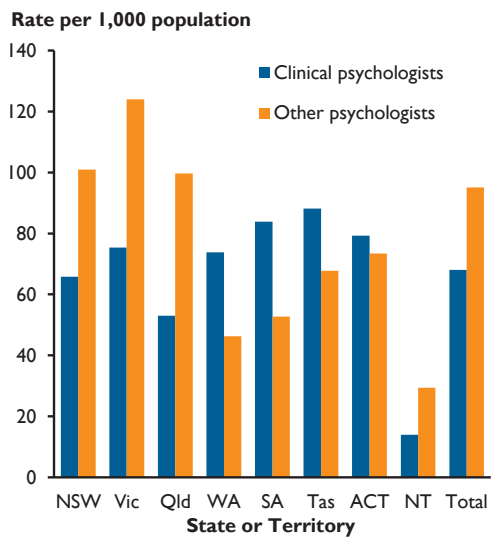


Figure 3: MBS-subsidised psychologist services per 1,000 population, 2012–13

Over the 5 years to 2012–13, the rate of MBS-subsidised *Clinical psychologist* and *Other psychologist* services increased at annual average rates of 12.7% and 6.6% respectively.

What mental health-related services were provided by psychologists?

Nationally, the MBS-subsidised service *Psychological Therapy Services* (for example, psychological assessment and therapy for a mental disorder) constituted all MBS-subsidised services provided by *Clinical psychologists*.

For *Other psychologists*, the MBS-subsidised service *Focussed Psychological Strategies* (for example, cognitive behavioural therapy) was the most frequently provided service type, making up 99.0 % of all MBS-subsidised services.

Mental health-related services provided by psychiatrists

The information in this section on mental health care provided by psychiatrists is drawn from Medicare data on mental health-related MBS items.

Key facts

- Nationally, psychiatrists provided about 2.1 million MBS-subsidised mental health services to almost 323,000 patients in 2012–13.
- Over the 5 years to 2012–13, the rate of MBS-subsidised psychiatrist services has remained relatively steady, increasing at an annual average of 0.4%.

There is no data source available that enables reporting of psychiatrist activity that is not subsidised by the MBS.

How many mental health-related services did psychiatrists provide?

Nationally, psychiatrists provided 25.0% of all MBS-subsidised mental health services in 2012–13, a total of 2.1 million services which equates to a rate of 93.3 services per 1,000 population per year. These services were provided to 322,791 patients (an average of 6.6 services per patient).

Over the 5 years to 2012–13, the rate of MBS-subsidised psychiatrist services has remained relatively steady, increasing at an annual average rate of 0.4%.

Victoria had the highest rate of services per 1,000 population followed by South Australia (115.5 and 101.0 respectively). The Northern Territory had the lowest rate (12.0) (Figure 4).

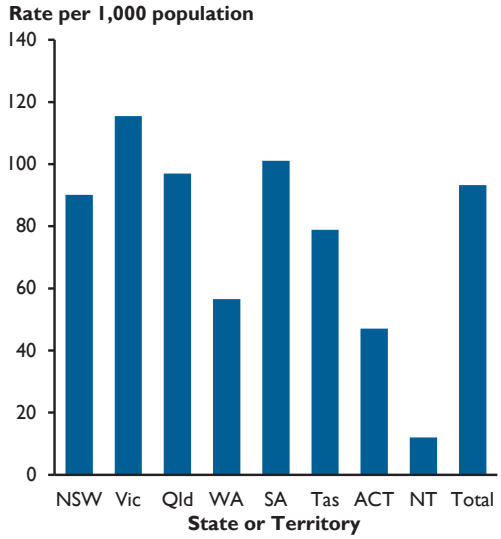


Figure 4: MBS-subsidised psychiatrist mental health services per 1,000 population, 2012–13

What mental health-related services were provided by psychiatrists?

Nationally, *Patient Attendances—Consulting Room* was the most frequently provided MBS-subsidised psychiatrist service type, making up 73.6% of all services.

Mental health-related medications

This section presents information on prescriptions for mental health-related medications, both subsidised and under co-payment (non-subsidised), from the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS).

Key facts

- There were about 31 million prescriptions dispensed for mental health-related medications during 2012–13.
- 86% of these prescriptions were provided by GPs, 8% by psychiatrists and 6% by non-psychiatrist specialists.

How many mental health-related prescriptions were provided?

There were 31.1 million prescriptions (subsidised and under co-payment) dispensed for mental health-related medications during 2012–13. These were provided to 3.6 million patients which equates to an average of 8.6 prescriptions per patient and a rate of 1,292.0 prescriptions per 1,000 population.

Tasmania had the highest rate of prescriptions (subsidised and under co-payment) per 1,000 population followed by South Australia (1,613.2 and 1,439.0 respectively). The Northern Territory had the lowest rate (666.2) (Figure 5).

Over the 5 years to 2012–13, the rate of subsidised mental health-related medications increased at an annual average of 0.8%.

GPs prescribed 85.7% of all dispensed PBS/RPBS subsidised mental health-related medications, or 20.3 million prescriptions.

Psychiatrists prescribed 8.1% of all dispensed PBS/RPBS subsidised mental health-related medications, or 1.9 million prescriptions.

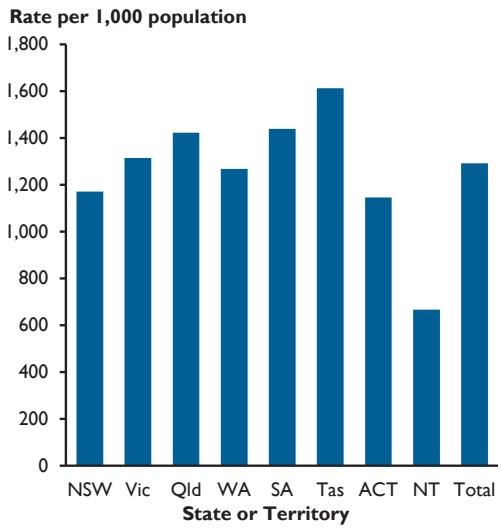


Figure 5: Mental health-related prescriptions per 1,000 population, 2012–13

What mental health-related medications were provided?

The majority of prescriptions (subsidised and under co-payment) were for antidepressant medications (65.9%, or 20.5 million), followed by anxiolytics (12.2%), antipsychotics (10.6%) and hypnotics and sedatives (8.7%). When considering subsidised prescriptions only, a similar pattern was observed.

Antidepressants were the most frequently dispensed subsidised mental health-related medications prescribed by GPs followed by anxiolytics (64.3% and 13.7% respectively). The same findings were seen for total prescriptions (subsidised and under co-payment).

Similarly, antidepressants were the most frequently dispensed subsidised mental health-related medications prescribed by psychiatrists followed by antipsychotics (51.4% and 32.5% respectively). The same findings were seen for total prescriptions (subsidised and under co-payment).

Community mental health care services provided by state and territory governments

Among the types of specialised mental health care services provided by state and territory governments are public sector services delivered in the community and in hospital-based ambulatory care settings.

Victoria did not submit data for the 2011–12 reporting period, limiting the presentation of national activity and comparisons over time.

Key facts

- Nationally, there were 5.5 million service contacts for community mental health care services provided to about 301,000 patients in 2011–12.
- The most frequently recorded principal diagnoses were *Schizophrenia* and *Depressive episode* (24.6% and 11.2% respectively).

How much mental health care did these services provide?

Nationally, Community Mental Health Care (CMHC) services provided 5.5 million service contacts in 2011–12. These were provided to 300,926 patients, which equates to an average of 18.4 service contacts per patient per year, and a rate of 333.2 service contacts per 1,000 population.

The Australian Capital Territory had the highest rate of service contacts per 1,000 population followed by South Australia (690.4 and 371.8 respectively). The Northern Territory had the lowest rate (198.0) (Figure 6).

Why are people receiving these services?

The most frequently recorded principal diagnoses for patients who had service contacts with specialised CMHC services were *schizophrenia* and *depressive* episode (24.6% and 11.2% respectively).

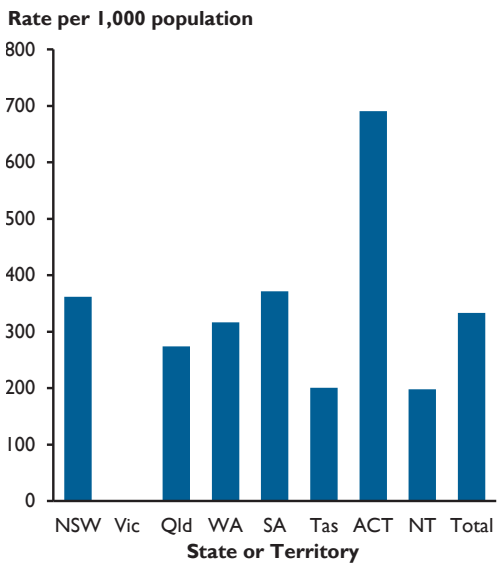


Figure 6: Community specialised mental health care service contacts per 1,000 population, states and territories, 2011–12

What services were provided?

CMHC service contacts can be conducted either with an individual or in a group session. These can be delivered face-to-face, via telephone or video link, or using other forms of direct communication. They can also be conducted either in the presence of the patient, or with a third party, such as a carer or family member, and/or other professional or mental health worker.

Nationally, 72.8% of service contacts were individual contacts and 67.3% were with the patient present. For all service contacts, the average session duration was 65 minutes, with 23.3% having session durations of up to 15 minutes and 28.3% having durations of greater than 60 minutes. The average session duration for service contacts with the patient present was about twice that of when the patient was absent (77 and 39 minutes respectively).

State and territory residential mental health care services

State and territory governments provide specialised Residential Mental Health Care (RMHC) services on an overnight basis in a domestic-like environment. RMHC services may include rehabilitation, treatment or extended care.

Queensland does not provide data on RMHC services.

Key facts

- Nationally, there were about 6,500 residential episodes of care provided to about 4,800 residents in 2012–13.
- *Schizophrenia* and *Depressive episode* were the most frequently recorded diagnoses (30.1% and 9.8% respectively).

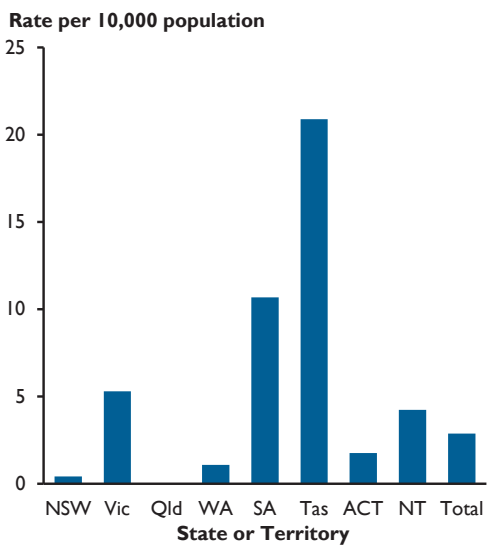


Figure 7: Specialised Residential Mental Health Care service episodes per 10,000 population, states and territories, 2012–13

How much mental health care did these services provide?

Nationally, specialised RMHC services provided 286,925 residential care days within 6,535 episodes of care, with an average of 1.4 episodes per resident and 43.9 residential care days per episode. This equates to a rate of 2.9 episodes per 10,000 population during 2012–13.

Over the 5 years to 2012–13, the rate of residential mental health episodes provided rose by an annual average of 15.3%. However, in considering this national rate it should be noted that there was variability across states and territories.

Tasmania had the highest rate of episodes of care per 10,000 population followed by South Australia (20.9 and 10.7 respectively). New South Wales had the lowest rate (0.4) (Figure 7). Tasmania also had the highest rate of residential care days per 10,000 population followed by the Australian Capital Territory (994.9 and 368.3 respectively).

Why are people receiving these services?

The most frequently recorded principal diagnoses for patients who had an episode of residential care were *Schizophrenia* and *Depressive episode* (30.1% and 9.8% respectively).

What services were provided?

Nationally, 59.5% of completed residential episodes during 2012–13 were up to 2 weeks in duration, and 24.6% were between 2 weeks and 1 month. For 2.4% of episodes the duration was greater than 1 year.

Mental health services provided in emergency departments

This section presents information on mental health-related emergency department (ED) occasions of service in public hospitals.

Key facts

- There were almost 188,000 ED occasions of service with a mental health-related principal diagnosis in 2011–12.
- The most frequently recorded principal diagnoses were *Neurotic, stress-related and somatoform disorders* and *Mental and behavioural disorders due to psychoactive substance use* (27.8% and 25.1% respectively).

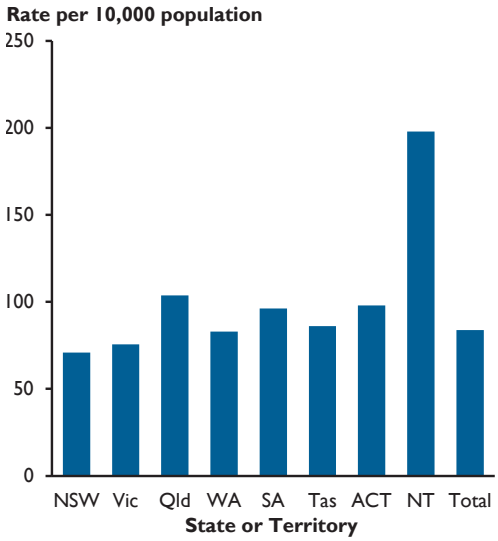


Figure 8: Public hospital emergency department mental health-related occasions of service per 10,000 population, 2011–12

How much mental health care did these services provide?

There were 188,739 ED occasions of service with a mental health-related principal diagnosis during 2011–12 (2.4% of all ED occasions of service), which equates to a rate of 83.8 occasions per 10,000 population per year. Over the 5 years to 2011–12, the rate of mental health-related ED occasions of service rose by an annual average of 3.8%.

The Northern Territory had the highest rate of mental health-related ED occasions of service per 10,000 population followed by Queensland (198.0 and 103.8 respectively). New South Wales had the lowest (70.8) (Figure 8).

Why are people receiving these services?

The most frequently recorded principal diagnoses were *Neurotic, stress-related and somatoform disorders* (such as anxiety disorders) and *Mental and behavioural disorders due to psychoactive substance use* (such as alcohol dependency disorders), which made up 27.8% and 25.1% of mental health-related ED occasions of service respectively.

What services were provided?

In 2011–12, 82.3% of mental health-related ED occasions of service were classified at triage (initial assessment) as either *urgent* (requiring care within 30 minutes) or *semi-urgent* (requiring care within 60 minutes). Occasions of service classified as *emergency* (requiring care within 10 minutes) or *resuscitation* (immediate care) made up 11.5% and 0.8% respectively.

The most frequently recorded 'mode' for ending of a mental health-related occasion of service was for the episode to have been completed, and with the patient leaving ED (37.6%). The next most recorded mode was admission of the patient to the hospital from ED (35.9%).

Admitted patient mental health care

This section presents information on mental health-related hospitalisations. These are categorised as either with or without specialised psychiatric care, and whether they occurred in public acute, public psychiatric or private psychiatric hospitals.

Key facts

- There were more than 241,000 mental health-related hospitalisations in 2012–13.
- About 60% of these hospitalisations included specialised psychiatric care.

How much mental health care did these services provide?

Of the 241,389 mental health-related hospitalisations during 2012–13, 60.9% (146,935) had specialised psychiatric care.

Public psychiatric hospitals had the highest proportion of hospitalisations with specialised psychiatric care followed by private and public acute hospitals (100.0%, 82.9% and 52.2% respectively).

For public acute hospitals, the national hospitalisation rate with specialised psychiatric care was 4.1 per 1,000 population. Queensland had the highest rate followed by New South Wales (4.9 and 4.1 respectively). Victoria and South Australia had the lowest rate (3.7) (Figure 9). The rate without specialised psychiatric care was 4.0 per 1,000 population nationally. For public acute hospitals, the Northern Territory had the highest rate followed by South Australia (5.4 and 5.1 respectively). The Australian Capital Territory had the lowest rate (2.7).

Over the 5 years to 2012–13 the rate of hospitalisations with specialised psychiatric care rose by an annual average of 0.8%. For hospitalisations without specialised psychiatric care there was an annual average fall of 4.0%.

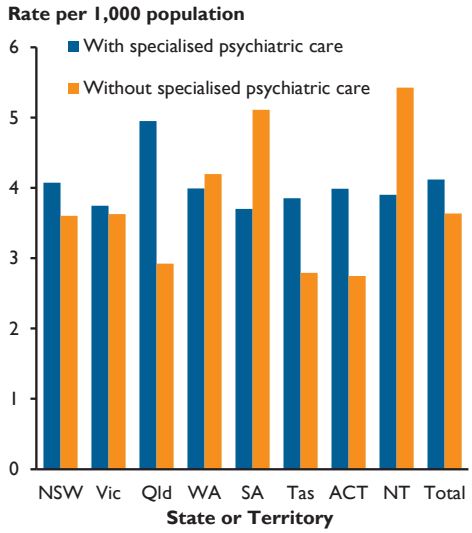


Figure 9: Public acute hospital mental health-related hospitalisations per 1,000 population, 2012–13

Why are people receiving these services?

For hospitalisations with specialised psychiatric care, *Depressive episode* and *Schizophrenia* were the most frequently recorded principal diagnoses (17.0% and 14.5% respectively).

For hospitalisations without specialised psychiatric care, the most frequently recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* followed by *Depressive episode* (19.5% and 12.2% respectively).

What services were provided?

Procedures were recorded in 60.5% of hospitalisations with specialised psychiatric care, with non-emergency anaesthesia being the most frequently reported procedure, followed by allied health services delivered by social workers and occupational therapists (15.4%, 14.2% and 8.1% of all procedures respectively).

For hospitalisations without specialised psychiatric care, 44.9% reported at least 1 procedure. The most frequently reported procedure was allied health services delivered by social workers, followed by physiotherapists and occupational therapists (14.2%, 12.5% and 8.7% respectively).

Personal Helpers and Mentors services

Personal Helpers and Mentors (PHaMs) services, funded by the Australian Government, aim to increase recovery opportunities for people whose lives are severely affected by mental illness.

Key facts

- In 2012–13 there were more than 15,000 people participating in the PHaMs program.
- More than one-third (37.5%) of PHaMs participants reported experiencing another significant disability.

PHaMs services provide links with other services such as housing support, employment and education, drug and alcohol rehabilitation, independent living skills courses, clinical services and other mental health and allied health services, while ensuring services accessed by participants are coordinated, integrated and complement other services in the community.

How much mental health care did these services provide?

Nationally, there were 15,066 PHaMs participants during 2012–13. The number of participants rose by an annual average rate of 15.1% between 2009–10 and 2012–13. New South Wales had the largest number of participants and the Australian Capital Territory the smallest (4,325 and 266 respectively) (Figure 10).

Why are people receiving these services?

The most frequently reported mental illness diagnoses for PHaMs participants, at the time of initial assessment, were mood disorders, followed by anxiety disorders and psychotic delusional disorders (66.0%, 37.6% and 26.1% respectively).

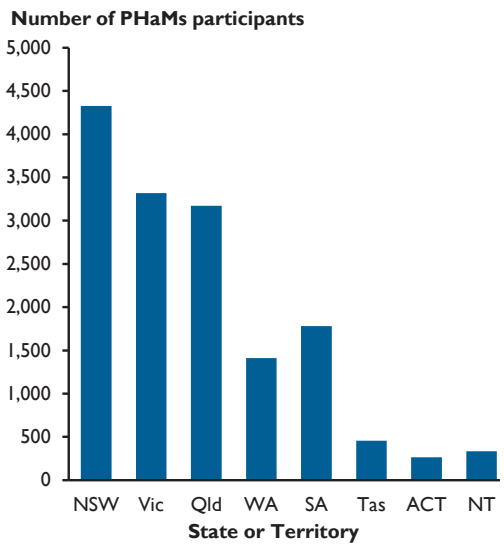


Figure 10: Number of PHaMs participants, 2012–13

More than one-third (37.5%) of PHaMs participants reported experiencing another significant disability other than their primary mental illness. Of these, 19.8% reported a co-existing physical disability.

PHaMs participants are assessed on their areas of functional limitation resulting from mental illness. The most commonly reported limitations were: *Social and community activities; Learning, applying knowledge and general demands; Interpersonal relationships*; and *Working and employment* (97.3%, 97.1%, 96.0% and 94.3% respectively).

PHaMs services identify 'special needs groups'; alcohol and/or drug issues was the most frequently reported of these groups (26.4%).

What services were provided?

A specialist mental health care service was the most frequent source of referral followed by self-referral (29.3% and 18.2% respectively).

Specialist Homelessness Services

Specialist Homelessness Services (SHS) are provided by various agencies around Australia that are funded by the Australian Government. Services provided include accommodation and non-accommodation support services (such as counselling services).

This section focuses on SHS clients with a current mental health issue.

Key facts

- There were just over 46,000 SHS clients with a current mental health issue in 2012–13.
- *Housing crisis* was the most frequently recorded main reason for seeking assistance (15%) followed by *Domestic and family violence* (14%).

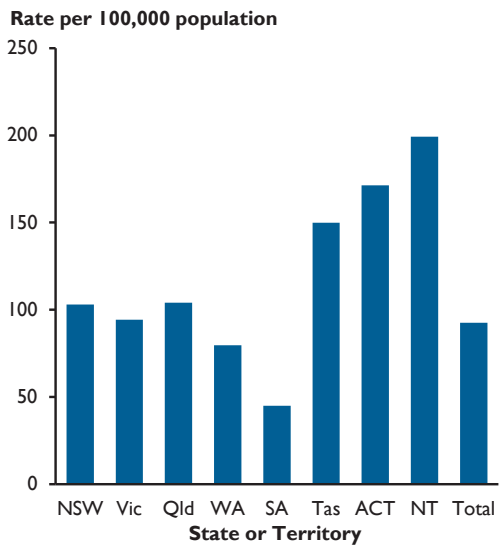


Figure 11: Specialist Homelessness Services clients with a current mental health issue accessing accommodation services, per 100,000 population, 2012–13

How much mental health care did these services provide?

Of the 193,700 SHS clients, aged 10 years and over, reported in 2012–13 (AIHW 2013b), 23.8% (46,037) had a current mental health issue. This equates to a rate of 207.1 people per 100,000 population.

Nationally, 46.0% of SHS clients with a mental health issue accessed accommodation services (21,193 clients), which equates to a rate of 92.5 per 100,000 population. The Northern Territory had the highest rate followed by the Australian Capital Territory (199.3 and 171.3 respectively). South Australia had the lowest rate (44.9) (Figure 11).

The national rate for clients accessing non-accommodation services was 102.1 per 100,000 population. The Australian Capital Territory had the highest rate followed by Victoria (194.2 and 188.0 respectively). New South Wales had the lowest rate (71.3).

Why are people receiving these services?

Of the clients with a current mental health issue presenting to an SHS agency, 42.7% reported being homeless in the previous 12 months.

For clients with a current mental health issue, *Housing crisis* was the most frequently recorded main reason for seeking assistance, followed by *Domestic and family violence* (15.2% and 13.8% respectively).

What services were provided?

Nationally, 419,786 services were provided to clients with a current mental health issue. *General assistance and support* was the most frequently provided service, followed by *Specialised services* (77.4% and 12.5% respectively). *Housing or accommodation services* made up 10% of services provided.

Psychiatric disability support services

This section presents information on the use of specialist disability support services provided under the National Disability Agreement to clients with a psychiatric disability. They include non-residential services such as employment services and community access services, as well as residential services such as group homes.

Key facts

- More than 87,600 people with psychiatric disability made use of disability support services in 2011–12.
- Employment services were the most frequently provided service group for non-residential service users with psychiatric disability.

How much mental health care did these services provide?

Of all specialist disability services clients nationally in 2011–12, 27.6% (87,649) were people with a psychiatric disability (this refers to all recorded disabilities, not just primary disability). This equates to a rate of 389.3 service users per 100,000 population. The rate of service users was highest in Victoria followed by South Australia (597.8 and 422.3 respectively). The Northern Territory had the lowest rate (121.6) (Figure 12).

Nationally, there were 87,092 clients with a psychiatric disability who accessed non-residential specialist disability services, and 3,732 who accessed residential services.

Why are people receiving these services?

Of the non-residential service users who identified as having psychiatric disability, almost two-thirds (64.9%) reported this as their primary disability.

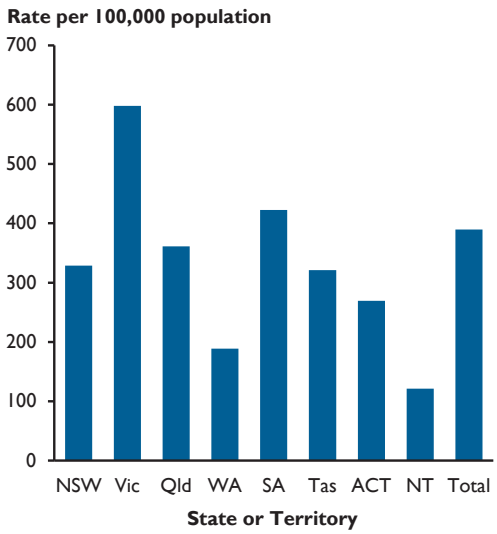


Figure 12: Specialist disability service clients with a psychiatric disability, per 100,000 population, 2011–12

Of all residential service users with psychiatric disability, the most frequently reported primary disability was intellectual disability (70.4%). Only a relatively small proportion of residential service users had a primary psychiatric disability compared with users of non-residential services (14.8% and 64.9% respectively).

What services were provided?

The largest number of non-residential specialist disability service users accessed employment services followed by community access services (60,743 and 14,435 service users respectively).

Group homes were the most widely reported residential service type nationally, with 12.8 service users per 100,000 population.

Mental health care resources

Mental health workforce

A range of health care professionals including general practitioners, psychiatrists, psychologists, nurses, social workers and occupational therapists provide mental health-related services.

This section focuses on the number of employed psychiatrists, psychologists and mental health nurses.

Key facts

- In 2012 there were about 2,900 psychiatrists, 22,400 psychologists and 19,000 mental health nurses employed in Australia.
- Nationally, there were 13.1 full-time equivalent (FTE) psychiatrists per 100,000 population, 80.3 FTE mental health nurses and 84.6 FTE psychologists.

To provide more meaningful comparisons, full-time equivalent (FTE) figures have been reported in addition to numbers of employed psychiatrists, nurses and psychologists, and the average total hours worked. 'FTE' measures the number of 38-hour-week workloads completed, regardless of number of people employed and their full-time or part-time working hours.

Psychiatrists

In 2012 there were 2,913 psychiatrists employed in Australia, with an FTE rate of 13.1 per 100,000 population. South Australia had the highest rate per 100,000 population followed by Victoria (15.1 and 14.3 respectively). The Northern Territory had the lowest rate (8.2) (Figure 13).

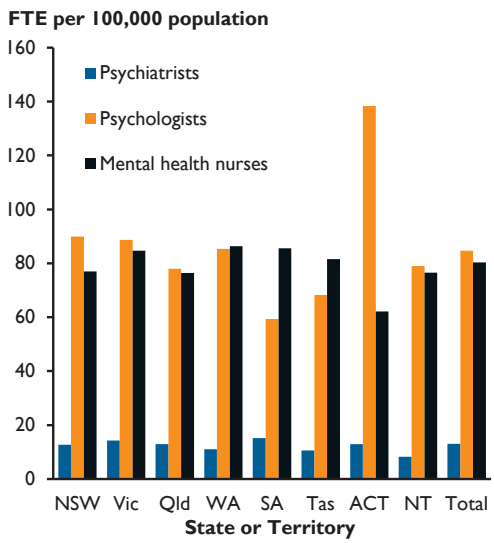


Figure 13: Employed psychiatrists, psychologists and mental health nurses, FTE per 100,000 population

Psychologists

In 2012 there were 22,404 registered psychologists employed in Australia, with an FTE rate of 84.6 per 100,000 population. The Australian Capital Territory had the highest rate per 100,000 population followed by New South Wales (138.4 and 89.9 respectively). South Australia had the lowest rate (59.3) (Figure 13).

Mental health nurses

In 2012 there were 19,048 mental health nurses employed in Australia, with an FTE rate of 80.3 per 100,000 population. Western Australia had the highest rate per 100,000 population followed by South Australia (86.3 and 85.5 respectively). The Australian Capital Territory had the lowest rate (62.1) (Figure 13).

Mental health services expenditure

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

Key facts

- Over $7.2 billion was spent on mental health-related services in Australia during 2011–12.
- The Australian government spent $851 million in benefits for Medicare-subsidised mental health-related services and $854 million on subsidised mental health-related prescriptions during 2011–12.
- About $4.5 billion was spent on state and territory specialised mental health services and $333 million on specialised mental health services in private hospitals.

Expenditure on state and territory specialised mental health services

Recurrent expenditure (running costs only) for state and territory specialised mental health services was about $4.5 billion in 2011–12, which equates to $198 per person.

Western Australia had the highest per person expenditure followed by the Australian Capital Territory ($243.32 and $213.51 respectively). Victoria had the lowest per person expenditure ($181.65) (Figure 14).

The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients ($1.9 billion), comprising public acute hospitals with a specialist psychiatric unit or ward ($1.4 billion) and public psychiatric hospitals ($0.5 billion). This was closely followed by expenditure on community mental health care services totalling $1.8 billion.

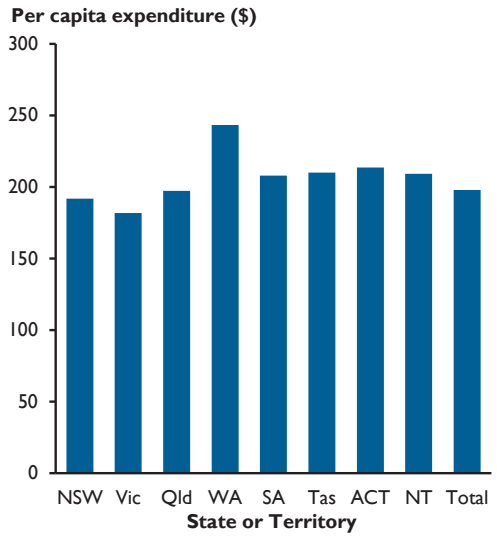


Figure 14: Recurrent expenditure on state and territory specialised mental health services per person, 2011–12

Australian Government expenditure

In 2011–12 the Australian Government spent $2.5 billion or $112.48 per person on mental health-related services.

About $851 million was paid in benefits for Medicare-subsidised mental health-related services, which equates to $37.79 per person nationally. Victoria had the highest per person expenditure on Medicare-subsidised mental health-related services, followed by New South Wales ($46.54 and $38.24 respectively).

Nationally, $854 million was paid on mental health-related subsidised prescriptions under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS). This equates to $37.95 per person. Tasmania had the highest per person expenditure for mental health-related subsidised prescriptions under the PBS/RPBS followed by South Australia ($45.00 and $44.08 respectively). The Northern Territory had the lowest per person expenditure ($14.61).

State and territory specialised mental health care facilities and workforce

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.

Key facts

- There were about 1,500 facilities (public and private) across Australia providing specialised mental health services during 2011–12.
- Specialised mental health services for admitted patients were provided by 161 public hospitals and 55 private hospitals.
- There were about 6,700 specialised mental health hospital beds and 2,100 beds available in residential mental health services.

State and territory specialised mental health care facilities

Nationally, there were 1,514 specialised mental health care facilities providing care in 2011–12. These included:

- 16 public psychiatric hospitals and 145 public acute hospitals with a psychiatric unit or ward
- 55 private psychiatric hospitals
- 81 government operated and 84 non-government operated residential mental health services
- 1,133 community mental health services.

Specialised mental health care beds

Nationally, in 2011–12 there were 6,709 specialised mental health hospital beds in public hospitals, 2,072 in private hospitals and 2,352 in residential mental health services. These included:

- 1,873 beds in public psychiatric hospitals and 4,836 beds in public acute hospitals with a psychiatric unit or ward
- 2,072 beds in private psychiatric hospitals
- 1,439 beds in government operated and 931 beds in non-government operated residential mental health services.

State and territory specialised mental health care workforce

Of the 30,154 FTE staff employed in state and territory specialised mental health care services in 2011–12, 50.9% were nurses, with most being registered nurses. Diagnostic and allied health professionals made up 18.8%, comprising mostly social workers and psychologists. Salaried medical officers made up 9.8%, comprising consultant psychiatrists and psychiatrists, and psychiatry registrars and trainees.

Nationally there were 111.5 FTE direct care staff per 100,000 population employed in state and territory specialised mental health care services in 2011–12. Western Australia had the highest rate per 100,000 population followed by South Australia (126.1 and 123.5 respectively). The Northern Territory had the lowest rate (92.9) (Figure 15).

There were 2,446 FTE staff employed by specialised psychiatric services in private hospitals during 2011–12, equating to 10.9 FTE staff employed per 100,000 population.

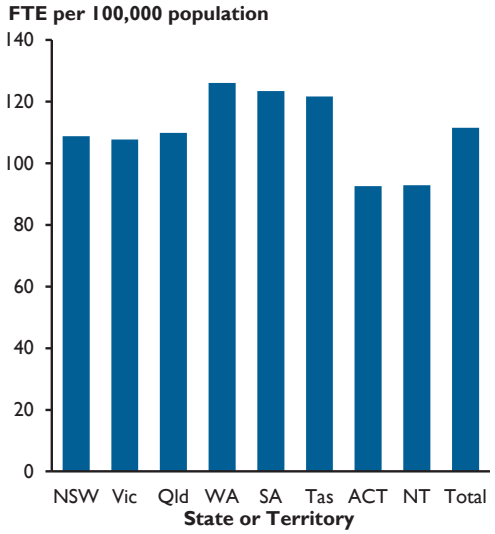


Figure 15: State and territory specialised mental health care services, full-time equivalent direct care staff per 100,000 population, 2011–12

In focus 2014—involuntary care and seclusion

Involuntary mental health care and seclusion events occurring in care settings were topics of particular interest in the mental health care sector in 2014.

Involuntary mental health care

The mental health legal status of a patient determines whether the care provided to a patient is considered voluntary or involuntary. An involuntary patient is someone who is detained in hospital or compulsorily treated in the community under state and territory mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Involuntary care is provided by the range of state and territory mental health care services described in previous sections of this publication. Although general trends in involuntary care can be observed in available data, direct comparisons between service settings should be made with caution due to differences among data collection standards and methods.

How many people received involuntary mental health care?

Nationally, 13.4% of community mental health care (CMHC) contacts were for clients recorded as having an involuntary mental health legal status in 2011–12.

For people receiving residential mental health care (RMHC) in 2012–13, 22.8% of episodes were for clients with an involuntary status.

For public hospital admissions with specialised psychiatric care in 2011–12, 29.0% had an involuntary admission, while only 0.3% of private hospital admissions had involuntary status.

Who received involuntary mental health care?

CMHC contacts for people diagnosed with *Schizoaffective disorders* and *Schizophrenia* had the highest proportions of contacts with an involuntary mental health legal status in 2011–12 (28.3% and 33.7% respectively).

People receiving RMHC and who were diagnosed with *Schizophrenia* and *Schizoaffective disorders* had the highest proportions of episodes with an involuntary mental health legal status in 2012–13 (40.9% and 39.6% respectively).

Does involuntary mental health care differ between jurisdictions?

Western Australia had the lowest proportion of CMHC contacts with an involuntary mental health legal status and the Australian Capital Territory the highest (3.4% and 38.4% respectively) in 2011–12.

Western Australia had the lowest proportion of RMHC episodes with an involuntary mental health legal status and the Australian Capital Territory the highest (0% and 91.3% respectively) in 2012–13 (Figure 16).

However, it should be noted that these jurisdictional differences may be a reflection of different legislative arrangements in place among the jurisdictions.

Is the provision of involuntary mental health care changing over time?

The proportion of involuntary community mental health care contacts fell from 16.6% in 2007–08 to 13.4% in 2011–12.

Similarly, the proportion of involuntary residential episodes fell from 31.9% in 2008–09 to 22.8% in 2012–13.

The proportion of involuntary mental health-related admissions with specialised psychiatric care has remained relatively stable in the 5 years to 2011–12.

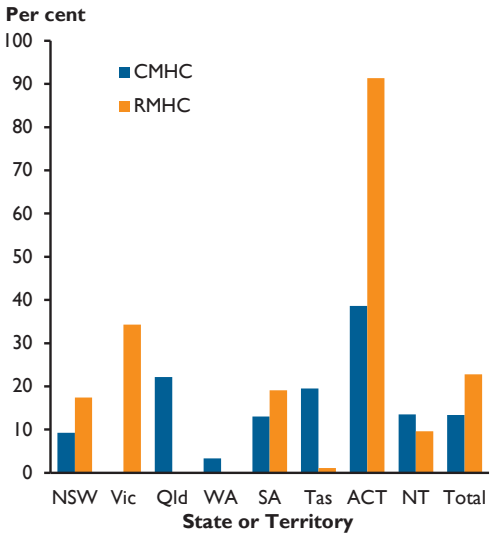


Figure 16: Public sector CMHC and RMHC activity with involuntary mental health legal status, per cent, 2011–12 (CMHC) and 2012–13 (RMHC)

Use of seclusion as a restrictive practice in mental health care services

Patients admitted to mental health hospital services may experience restrictive practices, such as seclusion on the basis of protecting the patient and others from harm.

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.

Reducing the use of seclusion is a national priority for mental health services, and has been formally endorsed by Health Ministers.

Seclusion data are currently collected at the national level via an interim collection, with restraint data expected to be available for the 2013–14 collection period.

This section presents information on the use of seclusion in public sector acute mental health care services for the 2012–13 reporting period.

How many people were secluded?

Nationally, there were 9.6 seclusion events per 1,000 bed days in public acute specialised mental health hospital services in 2012–13. Tasmania had the highest rate of seclusion events per 1,000 bed days in public acute specialised mental health hospital services, followed by the Northern Territory (19.7 and 15.8 respectively). The Australian Capital Territory had the lowest rate (0.9) (Figure 17).

Has the number of people secluded changed over time?

The national seclusion rate has fallen since 2008–09, from 15.5 seclusion events per 1,000 bed days in 2008–09 to 9.6 in 2012–13, an average annual reduction of 11.3% over the 5-year period.

Do seclusion rates differ between the target populations for services?

Some specialised mental health services primarily target specific population groups, including:

- child and adolescent services
- older person programs
- forensic health services (services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence)
- youth services
- general services.

Nationally, child and adolescent services had a higher rate of seclusion events (14.5 per 1,000 bed days) compared with general services (10.3) in 2012–13.

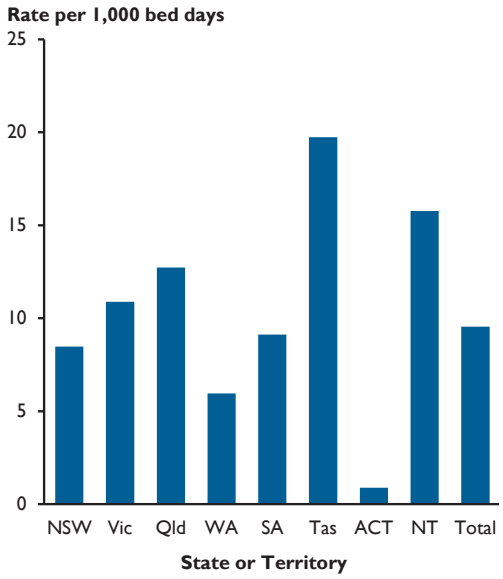


Figure 17: Public acute specialised mental health hospital services, seclusion events per 1,000 bed days, 2012–13

Key Performance Indicators for Australian Public Mental Health Services

The Key Performance Indicators (KPIs) for Australian Public Mental Health Services define a common framework and a standardised set of indicators to measure mental health sector performance across state and territories. First released in 2005, the Mental Health Services KPIs (MHS KPIs) are published on the AIHW's *Mental health services in Australia* website in interactive form.

<http://mhsa.aihw.gov.au/indicators/nkpi/>

This section summarises the results for 3 of the 13 indicators, which are related to different aspects of continuity of care in mental health services:

- 28 day readmission rate
- Rate of pre-admission community care
- Rate of post-discharge community care.

MHS KPI 2: 28 day readmission rate

Readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. Rapid readmissions may point to deficiencies in the functioning of the mental health care system and place pressure on beds, thereby reducing access for other consumers in need (NMHPSC 2011).

This indicator represents the proportion of separations from acute psychiatric inpatient units that are followed by readmission to the same or another public sector acute psychiatric inpatient unit within 28 days of discharge.

28 day readmission rate: states and territories

In 2011–12, of the 79,427 separations from a psychiatric facility, 11,427 (14.4%) were followed by readmission within 28 days of discharge. New South Wales had the highest rate (15.7%) followed by Queensland (15.1%). South Australia had the lowest rate (9.3%) (Figure 18).

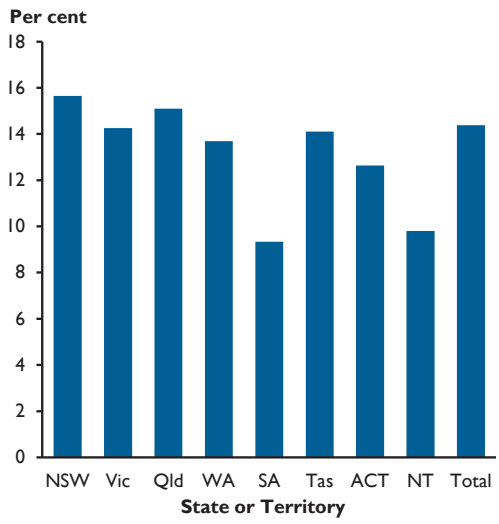


Figure 18: Proportion of separations from public sector acute psychiatric inpatient units who were readmitted within 28 days of discharge, 2011–12

MHS KPI 11: Rate of pre-admission community care

The rate of pre-admission community care indicator is designed to monitor the continuity and accessibility of care by measuring the extent to which public sector community mental health services are involved with consumers prior to their admission to hospital.

Pre-admission care aims to support and alleviate patient distress, relieve carer burden, prevent hospital admission where possible, ensure that admission is appropriate, and to begin treatment as soon as possible when admission is required. The majority of consumers admitted to public sector acute psychiatric inpatient units have had prior contact with public sector community mental health services, and it is reasonable to expect that community mental health services teams should be involved in pre-admission care (NMHPSC 2011).

This indicator represents the proportion of admissions to acute psychiatric inpatient units for which a community mental health service contact was recorded in the 7 days immediately preceding that admission.

Rate of pre-admission community care: states and territories

In 2011–12, of the 69,540 admissions to a public sector acute psychiatric inpatient unit, 21,386 (30.8%) involved pre-admission community care. The Australian Capital Territory had the highest rate (73.5%), followed by Western Australia (52.5%). Tasmania had the lowest rate (14.2%) (Figure 19).

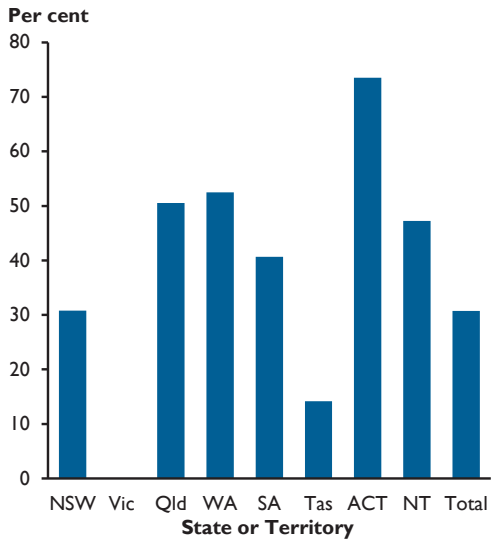


Figure 19: Proportion of admissions to public sector acute psychiatric inpatient units who received community care in the 7 days prior to admission, 2011–12

MHS KPI 12: Rate of post-discharge community care

An effective community support system for those who have experienced an acute psychiatric episode requiring admission to hospital is essential for supporting patients, and minimises the likelihood of hospital readmission. Consumers who leave hospital after a psychiatric admission with a formal discharge plan, which includes links with community services and supports, are less likely to need early readmission. Consumers are most vulnerable immediately following discharge from hospital and are at higher risk of suicide (NMHPSC 2011).

This indicator represents the proportion of separations from public sector acute psychiatric inpatient units for which a community mental health service contact was recorded in the 7 days following the separation.

Rate of post-discharge community care: states and territories

In 2011–12, of the 60,777 separations from an acute psychiatric inpatient unit, 33,205 (54.6%) involved post-discharge community care. The Australian Capital Territory had the highest rate (77.7%) followed by Queensland (64.4%). Tasmania had the lowest rate (27.4%) (Figure 20).

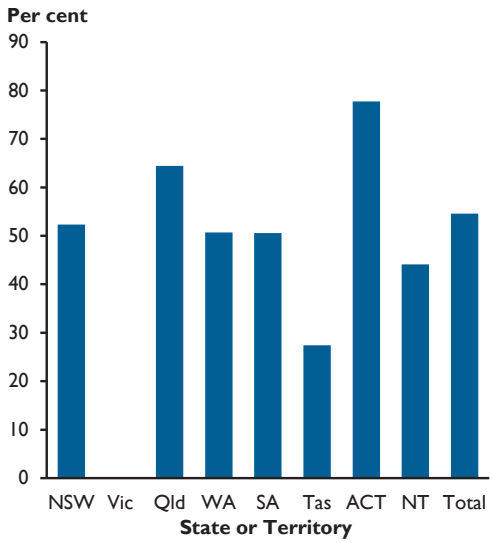


Figure 20: Proportion of separations from public sector acute psychiatric inpatient units which received post-discharge community care in the 7 days following discharge, 2011–12

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).

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 workloads (usually 38 hours) worked by professionals.

Medicare-subsidised 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 concessional 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: Refers 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. Examples of localities in different remoteness categories are:

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.

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.

References

ABS (Australian Bureau of Statistics) 2006. Australian and New Zealand Standard Classification of Occupations. 1st ed. ABS cat. no. 1220.0. Canberra: ABS.

ABS 2008. National Survey of Mental Health and Wellbeing 2007: summary of results. ABS cat. no. 4326.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2014. Medical workforce 2012. National health workforce series no. 8. Cat. no. HWL 54. Canberra: AIHW.

AIHW 2013a. Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW.

AIHW 2013b. Specialist homelessness services 2012–2013. Cat. no. HOU 27. Canberra: AIHW.

AIHW 2013c. Disability support services: services provided under the National Disability Agreement 2011–12. Bulletin no. 118. Cat. no. AUS 173. Canberra: AIHW.

APS (Australian Psychological Society) 2014. About psychologists. Viewed 18 July 2014, <http://www.psychology.org.au/community/about/>.

Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD 2007. The burden of disease and injury in Australia. Cat. no. PHE 82. Canberra: AIHW.

DoHA (Department of Health and Ageing) 2013. National mental health report 2013: tracking progress of mental health reform in Australia 1993–2011. Canberra: Commonwealth of Australia.

DSS (Department of Social Services) 2014. Characteristics of disability support pension recipients, June 2013. Canberra: DSS.

Morgan VA, Waterreus A, Jablensky A, Mackinnon A, McGrath JJ, Carr V et al. 2011. People living with psychotic illness 2010. Canberra: DoHA.

NMHPSC (National Mental Health Performance Subcommittee) 2011. Key performance indicators for Australian public mental health services. 2nd edn. Canberra: NMHPSC.

Sawyer MG, Arney FM, Baghurst PA, Graetz BW, Kosky RJ, Nurcombe B et al. 2000. The mental health of young people in Australia. Canberra: Commonwealth Department of Health and Aged Care.

Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J et al. 2009. The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: Department of Health and Ageing.

Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ et al. 2014. Estimating treatment rates for mental disorders in Australia. Australian Health Review 38:80-5.

Mental health services—in brief 2014 **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>.**