Mental health services in Australia 2004–05

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Foreword

Mental health services in Australia 2004–05 is the eighth in the series of annual mental health reports produced by the Australian Institute of Health and Welfare. This report provides detailed information on mental health services in Australia, as well as information on mental health-related prescriptions and resources (namely, facilities, workforce and expenditure) that underpin the provision of mental health services in Australia.

As previously, the report includes data from the Institute's National Hospital Morbidity Database, National Community Mental Health Care Database, National Community Mental Health Establishments Database and National Public Hospital Establishments Database. These databases are compiled each year with the assistance of the state and territory health authorities.

This year, the report has been structured to increase the accessibility of the information presented, as well as its relevance to decision making and policy. It also includes newly available data sources; in particular, data are incorporated for the first time from the National Residential Mental Health Care Database, as well as information on the psychologist workforce and mental health-related services provided by emergency departments.

Another innovation this year is the inclusion of a new, and final, chapter that provides a statistical summary for each state and territory (as well as for Australia as a whole) of the data covered in the earlier chapters.

In addition, this report provides information on patients' demographics, the number and rate of services used, and the nature of these services. Where appropriate, comparisons of service use are made between jurisdictions, Indigenous and non-Indigenous populations, and areas of usual residence. Time series data are also included.

An electronic version of this report can be found on the Institute's website. It is accompanied by a suite of additional statistical information which includes an interactive cube of data from the National Hospital Morbidity Database on mental health-related hospital separations.

The Institute will continue to work with data providers and other stakeholders to maintain timeliness and to improve the quality and usefulness of this report. Comments from readers are always welcome.

Penny Allbon
Director
April 2007

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Acknowledgments

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Within the AIHW, the key contributors to this report were Jacqueline Rek, Fatima Ghani Gonzalo, Adriana Vanden Heuvel, Anne Broadbent and Jenny Hargreaves, with assistance from Bin Tong, Paul Meyer, Katrina Burgess, Alex Peng, Cid Riley, Cherie Du, Kirrily Pollock and Bev Paterson. The publication process was coordinated by Cecilia Burke.

Summary

Mental health is a matter of national importance. Previous studies have estimated that one in five Australians will experience mental illness at some stage in their lives and that over 1 million people have a psychiatric disabling condition. Its importance has recently been highlighted through the Council of Australian Governments' mental health initiatives.

This report describes the mental health-related services and goods provided in Australia, where they were accessed, and the resources used in their delivery.

Ambulatory mental health care

Ambulatory services are those that do not involve overnight admission to a hospital or residential mental health facility.

It was estimated that, in 2003–04, there were 10.2 million general practitioner (GP) encounters involving mental health-related problems—an equivalent of 505 encounters per 1,000 population. Most (60.5%) were for females and over one-third (33.7%) were for management of *Depression*. *Anxiety* (15.8%) and *Sleep disturbance* (14.9%) were other common problems managed by GPs.

There were just over 2 million psychiatrist services funded under Medicare in 2005–06 (an average of 98.6 for each 1,000 population). The number of such services decreased over time—from 2.1 million (110.3 services per 1,000 population) in 2000–01. During 2005–06, the Australian Government spent $221 million in Medicare benefits for psychiatrist services.

Based on available data from public hospitals, the Institute estimated that 190,000 occasions of service related to mental health conditions occurred in Emergency Departments (EDs) during 2004–05; this represents approximately 3.2% of all ED occasions of service. More than one in four ED mental health-related occasions of service were for *Neurotic, stress-related and somatoform disorders* (28.8%), while 20.9% were for *Mental and behavioural disorders due to psychoactive substance use*.

In 2004–05, there were 116,787 'ambulatory-equivalent' mental health-related hospital separations (essentially, day only non-procedural hospitalisations) in Australia. Of these, 22.7% were in public hospitals and 77.2% in private hospitals. More than three quarters (79.1%) of these separations involved specialised psychiatric care. *Depressive episode* was the most common principal diagnosis, accounting for 19.9% in 2004–05.

There were 5.1 million mental health service contacts provided in public community mental health services and hospital outpatient services in 2004–05. More than half (53.5%) were for males. The most common principal diagnosis reported was *Schizophrenia* (35.9%).

Admitted patient and residential mental health care

During 2004–05 there were an estimated 199,353 mental health-related separations for admitted patients from hospitals in Australia. The majority (80.8%) were from public hospitals and 19.2% from private hospitals. Most separations (58.6%) involved specialised psychiatric care. The most common principal diagnosis for separations involving specialised care was *Schizophrenia* (18.8% of separations). For separations not involving specialised psychiatric care, the most common principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (17.6%).

These separations are essentially for overnight stays in hospitals and do not include the 'ambulatory-equivalent' separations described above.

In 2004–05, there were 2,194 episodes of residential mental health care in Australia. Almost two-thirds (61.2%) of these were for males. *Schizophrenia* was the most common principal diagnosis (60.1%).

Mental health-related prescriptions

In 2005–06, 20.7 million claims processed under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) were for mental health-related medications. This represents 11.3% of all claims processed in that year. Most of the claims were for prescriptions written by GPs (87.2%). Between 2000–01 and 2005–06, the number of scripts processed increased at an average of 2.2% per year. The greatest increase was for antipsychotics and antidepressants (6.8% and 4.6% per year, respectively). Prescriptions for hypnotics and sedatives decreased 4.7% annually over the same period. During 2005–06, the Australian Government spent about $639 million on PBS/RPBS benefits for mental health-related medications.

Mental health resources

The mental health specific workforce examined in this report comprised three categories: psychiatrists, psychologists, and mental health nurses.

In 2004, an estimated 3,151 psychiatrists were employed in Australia, about a quarter of whom (23.5%) were trainees. Taking into account hours worked, this translates to a full time equivalent (FTE) workforce of 3,392, or 17 FTE psychiatrists per 100,000 population. Almost two-thirds of the psychiatrists (64.1%) were males and they were concentrated in major cities (22 FTE per 100,000 population).

The latest Australian Bureau of Statistics data indicate that there were 13,900 employed psychologists in Australia in 2005 (11,900 FTE psychologists or 58 FTE per 100,000 population). A separate study by the Institute in 2003 found that 70.8% of employed psychologists were female.

There were an estimated 14,123 employed mental health nurses in 2004, and 13,714 FTE nurses (68 FTE per 100,000 population). Most of these were registered nurses (73.7%), with the remainder being enrolled nurses. Just under two-thirds (66.3%) were females, compared with 91.3% for all areas of nursing.

In 2004–05, 20 public psychiatric hospitals provided an average of 2,487 beds per day at an estimated expenditure of $528 million. There were 122 public acute hospitals with psychiatric wards or units providing an average of 3,450 beds, and 26 private hospitals provided 1,512 beds (estimated expenditure of $168 million). There were also 234 government community and residential mental health facilities providing a further 1,226 beds at a total expenditure of $985 million.

Overview of chapters

The aim of this report is to provide information on a wide range of mental health-related services provided in Australia, as well as the resources associated with those services. The latest year for which information is presented in this report is, for the most part, 2004–05 but, where possible, more recent data are presented.

The key findings of this report are summarised below. Note that specific definitions and other concepts of relevance to these findings can be found in each of the relevant chapters and the appendixes in this report.

Chapter 2: Mental health-related care in general practice

- In 2004–05, 10.8% of the general practice encounters reported to the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity involved the management of a mental health-related problem. An extrapolation based on the 94.7 million non-specialist attendances claimed from Medicare for 2004–05 suggests that there were an estimated 10.2 million mental health-related general practice encounters for 2004–05. This corresponds to an estimated 505 encounters per 1,000 population.
- The detailed data available for 2003–04 indicate that female patients accounted for 60.5% of mental health-related general practice encounters, consistent with all general practice encounters.
- Of the mental health-related problems managed by general practitioners (GPs) in 2003–04, *Depression* was the most commonly reported (33.7% of reported mental health-related problems managed and 2.5% of all reported problems managed), followed by *Anxiety* (15.8% and 1.2%) and *Sleep disturbance* (14.9% and 1.1%).

Chapter 3: Mental health-related care in emergency departments

- In 2004–05, emergency departments in public hospitals in Australia reported 133,403 mental health-related occasions of service (based on available diagnosis information). Taking into account under-coverage issues associated with the collection of the data, it is estimated that the actual number of such occasions of service would be closer to 190,000. This estimated number represents 3.2% of the total number of occasions of service in emergency departments in public hospitals in 2004–05 (almost 6 million).
- The most common principal diagnoses associated with these mental health-related occasions of service were *Neurotic, stress-related and somatoform disorders* (28.8%), *Mental and behavioural disorders due to psychoactive substance use* (20.9%), *Mood (affective) disorders* (18.9%) and *Schizophrenia, schizotypal and delusional disorders* (16.9%).

Chapter 4: Community mental health and hospital outpatient services

- In 2004–05, there were just over 5.1 million mental health service contacts provided by public community mental health services and hospital outpatient services. This equated to 254.6 service contacts per 1,000 population.
- Male patients accounted for 53.5% of mental health service contacts while females accounted for 46.5%; this equated to 265.4 and 226.0 service contacts per 1,000 population, respectively. The largest number of service contacts was for patients aged 25

to 34 years (23.0%; 396.5 per 1,000 population), followed by those aged 35 to 44 years (19.7%; 324.9 per 1,000 population).

- The most common principal diagnosis reported for mental health service contacts was *Schizophrenia* (F20), reported for over one in three service contacts (35.9%). The next most common principal diagnosis was *Depressive episode* (F32, reported for 12.6% of service contacts), followed by *Bipolar affective disorder* (F31, 7.7%) and *Schizoaffective disorder* (F25, 6.5%).

Chapter 5: Ambulatory-equivalent mental health-related admitted patient care

- In 2004–05, there were 116,787 ambulatory-equivalent mental health-related hospital separations. Private hospitals accounted for 77.2% of these separations, with public acute hospitals accounting for 21.2% and public psychiatric hospitals accounting for 1.5%.
- Just over three-quarters (79.1%) of ambulatory-equivalent mental health-related separations during 2004–05 involved specialised psychiatric care. Of these, 86.7% were from private hospitals. For the 24,418 separations that did not involve specialised psychiatric care, the majority (58.3%) were from public acute hospitals.
- The most common principal diagnosis for ambulatory-equivalent mental health-related separations was *Depressive episode* (19.9% of separations), followed by *Mental and behavioural disorders due to use of alcohol* (13.9%) and *Recurrent depressive disorders* (13.7%).

Chapter 6: Medicare-subsidised psychiatrist services

- In 2005–06, there were 2,015,941 Medicare-funded psychiatrist services provided to 272,259 patients, which is equivalent to 7.4 services per patient, or 98.6 services per 1,000 population. There was an average annual decline of 1.1% from the 2,126,363 (or 110.3 services per 1,000 population) Medicare-funded psychiatrist services provided in 2000–01.
- Most (84.8%) of the services provided during 2005–06 were attendances in consulting rooms, with 11.2% being attendances in hospitals. Almost half (47.5%) of all services provided were to patients aged 35 to 54 years.

Chapter 7: Admitted patient mental health-related care

- In 2004–05, there were 199,353 mental health-related separations for admitted patients. Public acute hospitals accounted for 73.8% of these separations, with private hospitals accounting for 19.2% and public psychiatric hospitals accounting for 7.0%.
- More than half (58.6%) of the mental health-related separations for admitted patients included specialised psychiatric care. Of these, 65.2% were from public acute hospitals, 23.8% from private hospitals and 11.0% from public psychiatric hospitals. Of the 82,501 mental health-related separations without specialised psychiatric care, 86.0% were from public acute hospitals, 12.6% from private hospitals and 1.4% from public psychiatric hospitals.
- For those mental health-related separations that included specialised psychiatric care, the most commonly reported principal diagnosis was *Schizophrenia*, accounting for 18.8% of separations with specialised psychiatric care. For those separations that did not include specialised psychiatric care *Mental and behavioural disorders due to use of alcohol* were the most common, accounting for 17.6% of separations without specialised psychiatric care.

Chapter 8: Residential mental health care

- In 2004–05, there were 2,194 episodes of residential mental health care. This equated to 1.1 episodes per 10,000 population.
- Male patients accounted for a greater proportion (61.2%) of episodes of residential mental health care than females (38.8%). The largest number of episodes of residential care was for persons aged 25 to 34 years (31.3%; 2.4 episodes per 10,000 population), followed by those aged 35 to 44 years (23.0%; 1.7 per 10,000 population).
- The most common principal diagnosis was *Schizophrenia*, which was reported for more than half of the episodes (60.2%). The next most common principal diagnosis was *Schizoaffective disorder*, which accounted for 11.1% of the episodes, followed by *Depressive episode* (6.5%) and *Bipolar affective disorder* (5.0%).

Chapter 9: Mental health-related supported accommodation services

- In 2004–05, mental health-related closed support periods were provided to 8,959 people by Supported Accommodation and Assistance Program (SAAP) agencies in Australia. This represents approximately 11.4% of all SAAP clients in that year.
- These clients were provided with a total of 12,227 mental health-related closed support periods. This is equivalent to 60.5 support periods per 100,000 population.
- Over half (55.5%) of the mental health-related closed support periods were provided to clients aged 25 to 44 years.
- Mental health-related SAAP closed support periods were most commonly provided to unaccompanied males aged 25 years and over (39.6% of closed support periods) and to unaccompanied females aged 25 years and over (19.1%).

Chapter 10: Support services for people with psychiatric disability

- A total of 25,922 people with a psychiatric disability were provided with a Commonwealth State/Territory Disability Agreement (CSTDA) funded service in 2004–05. Of these service users, 61.8% had the psychiatric disability as their primary disability.
- The number of non-residential service users (25,156, or 1,245 users per 1,000,000 population) outweighed the number of residential service users (3,007 or 149 per 1,000,000 population).
- Between 2003–04 and 2004–0500, there was an overall increase in the number of people with a psychiatric disability using CSTDA services, particularly in relation to those using non-residential services (with the latter increasing by 4.3%).

Chapter 11: Mental health-related prescriptions

- In 2005–06, 182.7 million claims were processed by Medicare Australia for prescriptions dispensed by approved pharmacists and subsidised under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Of these, 20.7 million (11.3%) were for mental health-related medications. This is equivalent to 1,009.8 mental health-related prescriptions per 1,000 population.
- Of the 20.7 million prescriptions, 87.2% were prescribed by general practitioners, 9.4% by psychiatrists and 3.4% by non-psychiatrist specialists.
- The number of mental health-related prescriptions increased at an annual average rate of 2.2% from 2000–01 to 2005–06. The largest increases were in the number of

antipsychotics and antidepressants prescribed (which increased on average by 6.8% and 4.6% per year, respectively). Prescriptions for hypnotics and sedatives, and for anxiolytics decreased on average by 4.7% and 0.9% per year, respectively.

Chapter 12: Mental health facilities

- In 2004–05, there were 20 public psychiatric hospitals, 122 public acute hospitals with a psychiatric ward or unit, 26 private psychiatric hospitals and 234 government-operated community and residential mental health facilities reported nationally.
- The number of available beds increased between 2000–01 and 2004–05 for public psychiatric hospitals, public acute hospitals and private psychiatric hospitals, but decreased for government-operated residential mental health facilities.
- The majority of full-time-equivalent (FTE) staff in public and private psychiatric hospitals, and government-operated community and residential mental health facilities were nursing staff.

Chapter 13: Mental health workforce

- Information on three groups of health professionals, namely psychiatrists, psychologists and mental health nurses, is provided in this report.

Psychiatrists

- An estimated 3,151 psychiatrists (including psychiatrists-in-training) were employed in Australia in 2004; psychiatrists-in-training made up 23.5% of these psychiatrists. Taking into account average hours worked, there were 3,392 full-time-equivalent (FTE) psychiatrists, or 17 FTE psychiatrists per 100,000 population.
- In 2004, psychiatrists were mainly male (64.1%), had an average age of 47.8 years and were concentrated in Major cities (22 FTE per 100,000 population based on the location of their main job).
- Over the period from 2000 to 2004, the number of FTE psychiatrists increased from 3,089 to 3,392, the average hours worked per week by psychiatrists declined from 43.1 to 40.9 hours, and the proportion of employed psychiatrists who were female increased from 31.2% to 35.9%.

Psychologists

- According to ABS estimates, there were 13,900 employed psychologists in Australia in 2005. Taking average hours worked into account, there were 11,900 FTE psychologists, or 58 FTE psychologists per 100,000 population.
- AIHW survey data for five jurisdictions in 2003 found that employed psychologists had an average age of 44.2 years and were predominantly female (70.8%).

Mental health nurses

- There were an estimated 14,123 mental health nurses employed in Australia in 2004, and 13,714 FTE nurses (68 FTE nurses per 100,000 population).
- Employed mental health nurses were mainly registered (73.7%) rather than enrolled, mainly female (66.3%) and their average age was 44.9 years. The percentage of mental health nurses who were female was lower than for nurses employed across all areas of nursing in Australia (91.3%).

- Over the period from 1999 to 2004, the number of employed FTE mental health nurses increased from 13,010 to 13,714, the average age increased from 42.8 to 44.9 years, the proportion of males increased from 28.4% to 33.7%, and the average hours worked per week by mental health nurses increased from 34.1 to 36.9.

Chapter 14: Expenditure and funding for mental health services

- From 1993–94 to 2000–01, health system expenditure on mental disorders in Australia rose by 38.7% from $2,697 million (in 2000–01 dollars) to $3,741 million. On a per capita basis, expenditure on mental disorders rose by 27.6% over the period.
- In 2004–05, recurrent expenditure by public psychiatric hospitals was estimated at $527 million. Real growth in expenditure by public psychiatric hospitals averaged 2.5% annually between 2000–01 and 2004–05.
- In 2005–06, the Australian Government paid $221 million for Medicare-subsidised psychiatrist services, which is equivalent to 2.0% of total Medicare benefits expenditure and 17.4% of expenditure for specialist services provided through Medicare, and $10.79 on average per person.
- In 2005–06, 10.6% of Australian Government expenditure on PBS/RPBS medications ($639 million out of $6,053 million) was spent on mental health-related medications. Prescriptions for antidepressants and antipsychotics accounted for most of the mental health-related PBS/RPBS expenditure (47.3% and 46.3% respectively).

1 Introduction

Mental health services in Australia 2004–05 is the eighth in the AIHW's series of annual reports that describe the activity and characteristics of Australia's mental health care services. As well as providing information on a wide range of mental health care services provided in Australia in a centralised and accessible form, these reports make publicly available the data collected as specified in the National Minimum Data Sets (NMDSs) for Mental Health Care. These NMDSs cover specialised community and residential mental health care, specialised mental health care for patients admitted to public and private hospitals, and data on the facilities providing these services (Chapters 4, 5, 7, 8, 12 and 14).

The focus of this report is on the provision of mental health-related services and the resources that underpin those services. The latest year reported for most information in this report is 2004–05, with more recent data provided when available. Where appropriate and possible, time series data are also provided. More detailed data on mental health services in the years prior to 2004–05 are available in previous reports in this series.

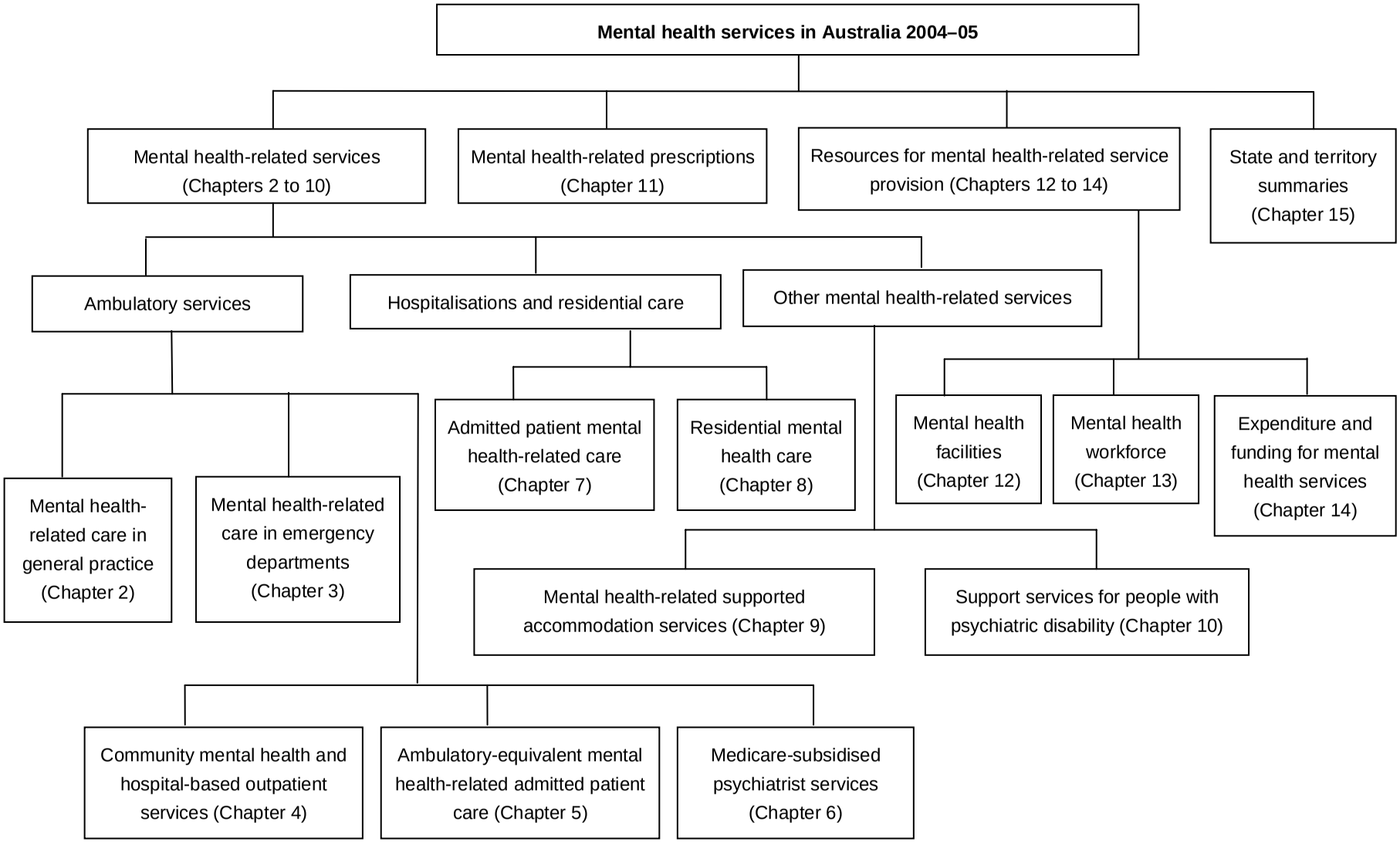
1.1 Report structure

Compared with previous reports in this series, this report has been restructured in order to increase the accessibility of the information presented, as well as its relevance to decision making and policy. Moreover, a more complete picture of mental health services and resources in Australia is provided. For example, mental health services provided by emergency departments and information on the psychologist workforce are included for the first time. Another new feature is the inclusion of summary tables that present, in one place, information on the topics covered in this report for each state and territory, as well as for Australia as a whole.

The report is structured into the following broad areas.

- This introductory chapter provides a brief discussion on the definition of mental health-related services, presents background information on the prevalence of mental illness in Australia, and outlines the current policy framework and government initiatives in relation to the provision of mental health services.
- The main body of the report consists of four main sections, as shown in Figure 1.1. The first, and main, section (which consists of Chapters 2 to 10) describes the activities and characteristics of the wide range of services involved in providing treatment and care for people with mental health problems in Australia. This includes mental health-related services provided by specialist mental health services and general health services in both residential and ambulatory settings. Many are government services, but private hospitals, non-government organisations and private medical practitioners responsible for providing mental health care are also included in the range of services covered.

Figure 1.1: Report outline



The second section (Chapter 11) provides information on prescriptions dispensed for mental health-related conditions. The third section (Chapters 12 to 14) looks at the resources utilised and/or involved in the provision of mental health services—namely facilities, the specialist mental health workforce and expenditure. The fourth section provides state and territory profiles, as well as a national profile, in tabular form (Chapter 15).

- The appendixes provide: information on the data sources used in this report (Appendix 1); technical notes on data presentation and the calculation of population rates (Appendix 2); information on the classifications used in this report (Appendix 3); and the specific codes used to define 'mental health-related' encounters and separations in particular chapters of this report (Appendix 4).

In addition to the information published in this report, detailed data on some mental health services are provided by the AIHW in the form of internet tables and data cubes. These can be found on the AIHW website (see Section 1.5 for further details).

Note that while the aim of this report is to provide a view of the broad range of mental health-related services provided in Australia, the ability to achieve this aim is driven to a large extent by the availability of quality and comparable national data. For this reason, there are some overlaps and gaps in the information on services covered in this report.

1.2 Definition of mental health-related services

There is no standard definitive means of identifying the broad range and type of services provided to people who have poor mental health. In order to compile information on mental health services for this report, it was necessary to develop definitions of 'mental health-related services' that were applicable to each individual data source. The specifics of how 'mental health-related services' are defined in relation to each data source are detailed in the relevant chapters and in the appendixes.

This report focuses on mental health services and, as result, most of the information presented relates to episodes of service, hospital separations, service contacts, encounters, support periods or prescriptions. However, information on the number and characteristics of people receiving these services is also provided where possible. In addition, some information on the prevalence of mental health problems is provided as contextual information in the next section.

1.3 Background

Mental health is described by the World Health Organization (WHO) as:

> "... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO 2001:1).

Mental health is included as one of Australia's National Health Priority Areas. As outlined below, mental health-related problems have a considerable impact on the health of the Australian population.

Prevalence

Prevalence is a measure of how commonly a condition or illness occurs within a population. There is a range of measures of its prevalence in the Australian population. The following section looks at a number of measures of the prevalence of mental health conditions or illnesses and presents available data. The estimates of prevalence vary due to several reasons, including differences in survey methodologies, and the definition of mental illness, condition, disability or wellbeing used.

Prevalence estimates from the National Survey of Mental Health and Wellbeing of Adults 1997

The most frequently quoted figure for mental illness in Australia is that one in five adults will experience a mental illness at some stage in their lives. This figure was derived from the National Survey of Mental Health and Wellbeing of Adults (NSMHW) conducted in 1997 by the Australian Bureau of Statistics (ABS 1998). This survey used a computerised version of the Composite International Diagnostic Interview to identify a range of mental disorders in people aged 18 years and over. Note that some of the people who were identified as having a mental illness would not have had a mental illness diagnosed or treated by a professional.

The NSMHW found that an estimated 17.7% of Australian adults had experienced a mental illness in the preceding 12 months (ABS 1998). It also found that the prevalence of mental illness decreased with age. That is, the highest percentage of mental illness was reported for those aged 18 to 24 years (26.6%), reflecting a relatively high rate of substance use disorders in that age group. The prevalence was lowest for those aged 65 years and over (6.1%).

The child and adolescent component of the 1997 NSMHW found that the most frequently reported disorder for children aged 6 to 17 years was Attention deficit hyperactivity disorder (11%, or an estimated 355,000 children and adolescents). Less prevalent were depressive disorders (4%) and conduct disorders (3%) (AIHW 2005d).

As part of the NSMHW, a study coordinated by the University of Western Australia examined the prevalence of psychotic disorders among Australian adults aged 18 to 64 years (Jablensky et al. 1999). The survey was based on a census of 3,800 people with psychotic illness who attended a pubic or private mental health service within defined areas of Brisbane and surrounds, Melbourne, Perth and the Australian Capital Territory. This study found that between 39 and 69 persons per every 10,000 adults residing in urban areas (a weighted mean of 47) were in contact with mental health services each month due to symptoms of a psychotic disorder. Schizophrenia and schizoaffective disorder accounted for over 60% of the prevalence of psychotic disorders.

Self-reported mental or behavioural problems

More recent measures of the prevalence of mental or behavioural problems in the Australian population are available from the ABS's 2004–05 National Health Survey (NHS) (ABS 2006c). A brief description of the scope and methodology of this survey is provided in Appendix 1.

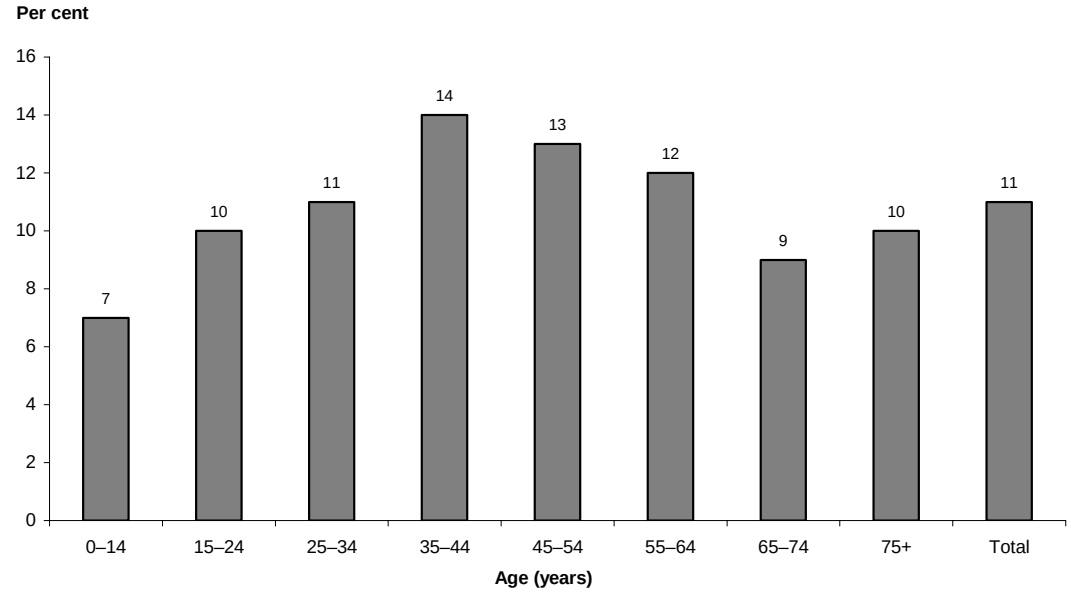
The NHS collected self-reported information on long-term medical conditions (that is, conditions current at the time of the survey that had lasted or were expected to last for 6 months or more) for adults and children. In 2004–05, an estimated 2.1 million Australians (10.7% of the population) had a long-term mental or behavioural problem. In comparison, 14.9% reported long-term arthritis and 10.2% indicated having long-term asthma. It should be noted, however, that the prevalence estimates for mental and behavioural problems are

considered to be less reliable than prevalence estimates for other conditions derived from the 2004–05 NHS since respondents were not asked to report whether a diagnosis of mental or behavioural problems had been made by a health professional.

Results from the NHS conducted in previous years indicate that the prevalence of long-term mental or behavioural problems in the population was 5.9% in 1995 and 9.6% in 2001 (ABS 2006c).

The prevalence of long-term mental or behavioural problems in 2004–05 varied with age. It was highest in the 35 to 44 year age group (13.6% of the population) and the 45 to 54 year age group (13.1%), while it was lowest for children aged under 15 years (6.7%) (Figure 1.2).

The most commonly reported mental health problems were anxiety related problems (5.3% of the population) and mood (affective) problems (4.9%).



Source: National Health Survey 2004–05 (ABS 2006c).

Figure 1.2: Prevalence of long-term mental and behavioural problems in the Australian population, 2004–05

Use of medication for mental wellbeing

As well as collecting information about long-term medical conditions, the 2004–05 NHS also collected data on the use of medication for mental wellbeing. The results indicated that approximately 2.9 million people aged 18 years and over (19.2% of the population) reported the use of medication for mental wellbeing in the 2 weeks before being surveyed (ABS 2006c). Use of antidepressants was reported by 5.2% of respondents, while 4.5% reported the use of sleeping tablets or capsules. Use of medication for mental wellbeing was more common among females (23.9% of the population) than males (14.3%). Use also varied with age, with use of medication most frequent among respondents aged 65 years and over (24.1%), and least frequent among those aged 18 to 34 years (15.0%).

Prevalence of psychological distress

The prevalence of reported psychological distress is another indicator of the mental health of Australians. The following surveys have collected information on the psychological distress of respondents aged 18 years and over using the Kessler 10 Scale of Psychological Distress (K10): the NSMHW conducted in 1997 by the ABS; the NHS conducted by the ABS in 2001 and 2004–05; the 2004 National Drug Strategy Household Survey (NDSHS) (ABS 1998, 2002b, 2003a, 2003b, 2006c; AIHW 2005e). The K10 scale consists of ten questions about non-specific psychological distress and seeks to measure the level of anxiety and depressive symptoms a person experienced in the 4 weeks before the interview. The scale contains low through to high threshold items and, for each item, there is a five-level response scale based on the amount of time the respondent experienced the particular problem (with the options ranging from 'All of the time' to 'None of the time'). Various cut-off scores can be used to define low, moderate, high and very high levels of psychological distress. K10 scores at the very high level (that is, a score between 30 and 50) may indicate a need for professional help (ABS 2003a).

While the same K10 module and method of scoring was used in the four surveys listed above, there are differences between aspects of each survey that relate to, for example, the sample design and coverage, survey methodology and content. Care should therefore be taken when comparing the prevalence of psychological distress in Australia across time, using results from these four surveys (Table 1.1).

Estimates from the 2004–05 NHS indicate that 3.8% of the population aged 18 years and over had a very high level of psychological distress (Table 1.1). People aged 45 to 54 years had the highest level of very high psychological distress (4.8%). Females had a higher prevalence of very high psychological distress than males within most age groups in 2004–05.

Overall, the 2004 NDSHS found that 2.3% of the population aged 18 years and over had very high levels of psychological distress and a further 7.6% had high levels of psychological distress. Data from this survey can also be used to examine levels of psychological distress according to reported drug use. These data show that, compared with those who had not used drugs in the previous month, a greater proportion of people aged 18 years and over who had used drugs reported high and very high levels of psychological distress (AIHW 2005e). Specifically, 14.0% of those who used any illicit drug in the previous month reported a high level of psychological distress, compared with 6.9% of those who had not. Similarly, 5.6% of those who had used and 1.9% of those who had not used illicit drugs reported a very high level of psychological stress. Almost a third (32.7%) of heroin users reported very high levels of psychological distress.

In addition to the surveys mentioned above, the 2004–05 National Aboriginal and Torres Strait Islander Health Survey collected data on the social and emotional wellbeing of Indigenous Australians (aged 18 years and over) using five questions from the K10 scale. Responses to these selected questions provided the following estimates: 9% of Indigenous adults reported feeling nervous all or most of the time; 7% reported feeling without hope all or most of the time; 12% reported feeling restless or jumpy all of most of the time; 17% reported feeling that everything was an effort all or most of the time; and 7% reported feeling so sad that nothing could cheer them up (ABS 2006b).

Table 1.1: Estimated proportion of the Australian population aged 18 years and over with very high psychological distress scores, by age, 1997, 2001, 2004 and 2004–05 (per cent)

Year[a]	Age group (years)						
	18–24	25–34	35–44	45–54	55–64	≥ 65	Total
				Males			
1997	[b]0.6	[b]1.3	2.2	3.0	2.7	[b]1.9	1.9
2001	2.7	2.1	2.5	3.7	3.6	1.9	2.7
2004	2.5	2.9	1.5	2.0	1.9	1.0	2.0
2004–05	3.3	2.3	3.4	4.0	4.6	2.9	3.3
				Females			
1997	[b]2.1	2.8	2.4	3.8	[b]1.5	[b]1.3	2.4
2001	5.4	4.6	4.2	5.5	3.6	3.2	4.4
2004	4.5	3.2	2.9	2.0	1.7	1.4	2.6
2004–05	3.5	3.5	5.1	5.5	4.3	3.5	4.3
				Total			
1997	1.3	2.1	2.3	3.4	2.1	1.6	2.2
2001	4.0	3.4	3.4	4.6	3.6	2.6	3.6
2004	3.5	3.0	2.2	2.0	1.8	1.2	2.3
2004–05	3.4	2.9	4.3	4.8	4.4	3.2	3.8

(a) Care should be taken in interpreting change over time as results are based on different surveys and therefore are not strictly comparable.
(b) Estimate has a standard error of between 25% and 50% and should be used with caution.
Sources: National Survey of Mental Health and Wellbeing of Adults 1997 (ABS 1998); National Health Survey 2001 and 2004–05 (ABS 2002b, 2006c); 2004 National Drug Strategy Household Survey (AIHW 2005e).

Psychiatric disability

Based on data collected in the 2003 Survey of Disability, Ageing and Carers, the prevalence of psychiatric disabling conditions in the Australian population is estimated to be 5.2% (Table 1.2), which represents just over 1.0 million people. The presence of a disabling condition (defined as a limitation, restriction or impairment which has lasted, or is likely to last, for at least 6 months and restricts everyday activities) was self-reported by respondents in this survey.

Over half (56.0%) of the people who reported a psychiatric disability in 2003 were women; in turn, a higher prevalence of a psychiatric disability for females than for males was observed (5.8% of the female population and 4.6% of the male population in Australia).

Almost half (48.4%) of the people reporting a psychiatric disability had severe or profound core activity limitations (that is, they sometimes or always needed help with self-care, mobility and/or communication). This is equivalent to 2.5% of the Australian population (or 493,000 people) in 2003. The prevalence of a psychiatric disability with severe or profound core activity limitations was higher for females than for males (3.0% and 2.0% for the population, respectively).

Psychiatric disability was also found to be associated with other disabling conditions. For those for whom psychiatric disability was reported as the main or other disabling condition, 36.7% also reported a sensory/speech disability and 36.2% also indicated physical or other disability (AIHW 2005d).

Table 1.2: Prevalence of a psychiatric disability[a], by core activity limitation, 2003

	Males		Females		Total	
Core activity limitation	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Profound	109.6	1.1	187.4	1.9	297.0	1.5
Severe	89.6	0.9	106.2	1.1	195.8	1.0
Moderate	65.6	0.7	91.1	0.9	156.6	0.8
Mild	87.9	0.9	96.9	1.0	184.8	0.9
Total[b]	**447.4**	**4.6**	**570.5**	**5.8**	**1,017.9**	**5.2**

(a) Includes persons with a psychiatric disability as the main or other disabling condition.

(b) Includes persons with no core activity limitation but who are restricted in schooling or employment only, and persons without specific limitations or restrictions.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

Mortality

A mental or behavioural disorder was recorded as the underlying cause of death for 574 people who died in 2004. This equates to an age standardised rate of 2.7 per 100,000 people in Australia. Most of these deaths were due to abuse of psychoactive substances such as alcohol and heroin. An additional 2,098 deaths in 2004 were attributed to suicide (AIHW 2006a).

1.4 National policies for mental health

State and territory governments and the Australian government have committed to improving the mental health of the Australian population through the National Mental Health Strategy and the recent Council of Australian Governments (COAG) initiatives on mental health care. These two major government initiatives set the broad agenda for mental health service provision in Australia. A brief outline of the main aims and objectives of these two initiatives is given below.

National Mental Health Strategy

The National Mental Health Strategy was established to provide a framework to guide the reform agenda for mental health in Australia in a coordinated manner across the whole of government. It was endorsed by the Australian and state and territory governments in 1992 (DoHA 2006c).

This strategy consists of the National Mental Health Policy and the National Mental Health Plan, and is underpinned by the Mental Health Statement of Rights and Responsibilities.

The broad aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental disorders.

The broad aims and objectives of the Strategy are described in the National Mental Health Policy. The Policy has 38 objectives, including objectives that relate to the shift from institutional to community-based case, and the delivery of services in mainstream settings.

The approach to be taken in implementing the aims and objectives of the Policy is described in the National Mental Health Plan. The current plan (2003–2008) was endorsed by all Australian Health Ministers in July 2003 (Australian Health Ministers 2003). This plan is the third National Mental Health Plan, and it consolidates reforms begun under the first two plans. It has four priority themes: promoting mental health and preventing mental health problems; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

COAG initiatives

In early 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006). This plan involves a joint package of measures and new investments by all governments over a 5-year period that is aimed at promoting better mental health and providing additional support to people with mental illness, their families and their carers. In particular, the plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia;
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Through the National Action Plan, the Australian, state and territory governments have committed to undertaking actions that emphasise coordination and collaboration between government, private and non-government providers to achieve the stated outcomes.

COAG has agreed to establish a COAG Mental Health Group in each state and territory to implement this plan. These groups will involve the Commonwealth and the states and territories working together to coordinate the implementation of their commitments. Progress on the plan will be monitored against nationally agreed progress measures over a 5-year period and will be subject to an independent review after 5 years.

1.5 Additional information

An electronic version of this report is available from the AIHW's website at <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2004–05)*. Additional tables, containing more detailed data from the National Hospital Morbidity Database, the National Community Mental Health Care Database and the National Residential Mental Health Care Database, are also available on the website. As well, data from the National Hospital Morbidity Database are available in interactive data cubes on the AIHW website <www.aihw.gov.au/mentalhealth/datacubes/index.cfm>. These data cubes allow users to choose and manipulate variables in order to create tables of data to suit their needs.

2 Mental health-related care in general practice

2.1 Introduction

Non-specialised ambulatory services can be provided to persons with mental health problems by general practitioners (GPs). This chapter presents information on mental health services provided by GPs using data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity.

2.2 BEACH survey data

The BEACH program is a survey of general practice activity across Australia. The data described in this chapter mainly relate to 100,000 GP ***encounters*** from a sample of 1,000 GPs over the period from April 2003 to March 2004. The 100,000 encounters represent about 0.11% of all GP encounters over that time. After post-stratification weighting of the data (to ensure that the data reflect national general practice activity patterns), the data include 98,877 encounters (Britt et al. 2004). The survey provides information on the reason that patients visited the GP, the ***problems managed***, and the treatments that were provided.

Note that while the focus of this report is on the detailed data that are available for 2003–04, some summary data on mental health-related encounters are available for 2004–05. These 2004-05 data, along with data for 2002–01 to 2002–03, are shown in Table 2.1.

Further information about this survey and the data can be found in Appendix 1.

Key concepts

Encounter refers to any professional interchange between a patient and a GP; it includes both face-to-face encounters and indirect encounters where there is no face-to-face meeting but where a service is provided (for example, prescription, referral) (Britt et al. 2004).

Problem managed is a statement of the provider's understanding of a health problem presented by a patient, family or community. GPs are instructed to record at the most specific level possible from the information available at the time. It may be limited to the level of symptoms. Up to four problems managed can be recorded per encounter (Britt et al. 2004).

Mental health-related encounters are those encounters during which at least one mental health-related problem was managed.

Mental health-related problems managed, for the purposes of this chapter, are those that are classified in the psychological chapter (that is, the 'P' chapter) of the *International Classification of Primary Care, version 2* (ICPC–2). A list of the 'P' chapter codes for problems, which includes alcohol and drug-related problems, is provided in Appendix 4.

Table 2.1: Mental health-related encounters, BEACH, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Annual average change (%)[a]
Per cent of total GP encounters that are mental health-related	10.1	10.2	9.8	10.4	10.8	1.7
Estimated number of mental health-related encounters[b]	10,111,000	10,004,000	9,335,000	9,828,000	10,221,000	0.3
Lower 95% confidence limit	9,937,000	9,843,000	9,175,000	9,689,000	9,995,000	. .
Upper 95% confidence limit	10,273,000	10,154,000	9,484,000	9,957,000	10,431,000	. .
Estimated number of mental health-related encounters per 1,000 population[b][c]	525	512	473	492	505	–1.0
Lower 95% confidence limit	516	504	464	485	494	. .
Upper 95% confidence limit	533	520	480	498	516	. .

(a) The confidence intervals suggest that the difference between some of the years is not statistically significant.

(b) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by the Department of Health and Ageing (DoHA). *Source:* Britt et al. 2004.

(c) Crude rate based on the Australian estimated resident population as at 31 December of the reference year.

. . Not applicable.

Source: BEACH survey of general practice activity.

2.3 Mental health-related encounters

In 2004–05, 10.8% of all general practice encounters reported for the BEACH data were considered to be ***mental health-related encounters*** (Table 2.1). These encounters are defined as those encounters at which a mental health-related problem was managed.

A simple extrapolation based on the 94.7 million non-specialist attendances claimed from Medicare for 2004–05 suggests that there were an estimated 10.2 million mental health-related general practice encounters for 2004–05. This corresponds to an estimated 505 encounters per 1,000 population.

The proportion of encounters considered to be mental health-related has shown an average annual increase of 1.7% between 2000–01 and 2004–05. Over the same period, the estimated number of mental health-related encounters showed an average annual increase of 0.3%. The estimated number of mental health-related encounters per 1,000 population showed an average annual decrease of 1.0%.

Patient demographics

Table 2.2 presents information on mental health-related encounters according to the characteristics of those receiving care. The table shows the percentage of mental health-related encounters for each demographic characteristic, as well as the number of mental health-related encounters per 100 total encounters (that is, both mental health-related and non-mental health-related encounters). In addition, in order to account for differences in the relative size of the respective populations, a rate (per 100,000 population) is provided in the last column of the table. Since the data relate to encounters (rather than persons), the rates provide information on the number of mental health-related encounters relative to the size of the population subgroup.

In 2003–04, more than one in four (27.4%) mental health-related encounters were for patients aged 65 years and over. The data also indicate that when relative population sizes of the age groups are taken into account, this older age group is relatively more likely (that is, 13.2 per 100,000 population) than those in other age groups to have had a mental health-related GP encounter.

There were more mental health-related encounters for female patients than there were for male patients (60.5% and 39.5%, respectively). Similarly, when relative age structures and population sizes are taken into account, there were more mental health-related encounters among the female population than among the male population (58.3 per 100,000 and 40.0 per 100,000, respectively).

The majority of mental health-related encounters were for non-Indigenous Australians (97.9%). However, when relative population sizes and age structures are considered, the rate of mental health-related GP encounters appears to be higher for Indigenous Australians than for non-Indigenous Australians (56.9 and 46.0 per 100,000 population, respectively).

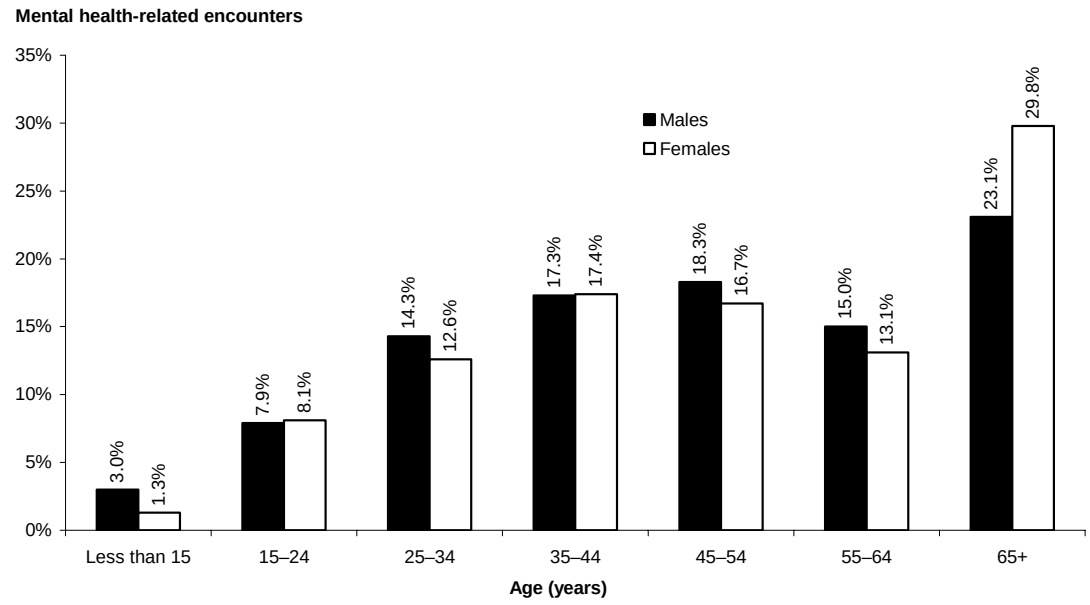
Mental health-related encounters were more common per 100,000 population among people living in Inner regional areas (52.9), followed by those living in Outer regional areas (49.8).

Table 2.2: Patient demographics for mental health-related encounters, BEACH, 2003–04

Patient demographics	Per cent total mental health-related encounters[a]	Rate (per 100 encounters)	95% LCL	95% UCL	Encounters (per 100,000 population)[b]
Age					
Less than 15 years	2.0	0.2	0.2	0.2	1.0
15–24 years	8.1	0.8	0.7	0.9	4.0
25–34 years	13.4	1.4	1.2	1.5	7.0
35–44 years	17.6	1.8	1.7	1.9	9.1
45–54 years	17.5	1.8	1.7	1.9	8.8
55–64 years	14.0	1.4	1.3	1.5	6.2
65 years and over	27.4	2.8	2.6	3.0	13.2
Sex					
Male	39.5	4.1	3.8	4.3	40.0
Female	60.5	6.2	5.9	6.5	58.3
Indigenous status[c]					
Indigenous Australians	2.1	0.2	0.1	0.3	56.9
Other Australians	97.9	9.4	8.9	9.9	46.0
Remoteness area					
Major city	65.1	6.6	6.1	7.1	47.8
Inner regional	22.9	2.3	2.0	2.7	52.9
Outer regional	10.3	1.0	0.8	1.3	49.8
Remote and Very remote	1.7	0.2	0.1	0.4	38.1
Total	**100.0**	**10.4**	**9.8**	**10.9**	**49.9**

(a) The percentages shown do not include those encounters for which the demographic information was missing and/or not reported.
(b) Rates were directly age-standardised, with the exception of age, which is a crude rate, as detailed in Appendix 2.
(c) Information on this data element was missing or not reported for more than 5 per cent of encounters.
Note: LCL—lower confidence limit; UCL—upper confidence limit.
Source: BEACH survey of general practice activity.

Figure 2.1 shows the age-sex distribution of patients at mental health-related encounters. The largest proportion of mental health-related encounters for both males and females were for those aged 65 years and over.



Source: BEACH survey of general practice activity.

Figure 2.1: The age-sex distribution of patients at mental health-related encounters, BEACH, 2003–04

Mental health-related problems managed

In 2003–04, there were 10,716 ***mental health-related problems managed*** at a rate of 10.8 per 100 encounters. Table 2.3 presents data on the 10 most frequently reported mental health-related problems managed. *Depression* (ICPC-2 codes P03, P76) was the most frequently managed mental health-related problem in 2003–04, accounting for 33.7% of all mental health-related problems managed and 2.5% of all problems managed.

Anxiety (P01, P74) was the next most frequently reported mental health-related problem managed (15.8% of all mental health-related problems managed and 1.2% of all problems managed), followed by *sleep disturbance* (P06; 14.9% of all mental health-related problems managed and 1.1% of all problems managed).

Table 2.3: The 10 most frequently mental health-related problems managed, BEACH, 2003–04

ICPC-2 code	Problem managed	Per cent total mental health-related problems	Per cent total problems	Rate (per 100 encounters)	95% LCL	95% UCL
P03, P76	Depression	33.7	2.5	3.6	3.4	3.9
P01, P74	Anxiety	15.8	1.2	1.7	1.6	1.9
P06	Sleep disturbance	14.9	1.1	1.6	1.5	1.7
P02	Acute stress reaction	4.8	0.3	0.4	0.3	0.6
P70	Dementia	4.4	0.3	0.5	0.4	0.5
P19	Drug abuse	4.3	0.2	0.3	0.3	0.4
P72	Schizophrenia	3.9	0.4	0.5	0.5	0.6
P15, P16	Alcohol abuse	2.9	0.2	0.3	0.2	0.3
P17	Tobacco abuse	2.6	0.3	0.5	0.4	0.6
P50	Prescription request/renewal	1.8	0.1	0.1	0.1	0.2
	Other	10.9	0.9	1.2	1.1	1.4
	Total	**100.0**	**7.4**	**10.8**	**10.3**	**11.4**

Note: LCL—lower confidence limit; UCL—upper confidence limit.
Source: BEACH survey of general practice activity.

Management of mental health-related problems

Table 2.4 presents the most common types of management reported for mental health-related problems. The most common way in which a mental health-related problem was managed was through a medication being prescribed, supplied or recommended by the GP. Over two-thirds (69.4%) of mental health-related problems managed involved a medication being prescribed, recommended or supplied. Antidepressants were the most commonly prescribed, recommended or supplied medication (27.8 per 100 mental health-related problems managed), followed by anti-anxiety medication (14.2) and sedative hypnotics (13.7).

The second most common form of management was the GP providing a clinical treatment (47.3 per 100 mental health-related problems managed). The most common types of clinical treatments were psychological counselling (25.2 per 100 mental health-related problems managed), the review, change and/or administering of medication (3.4) and psychological advice/education/observation and/or wait (3.0).

A referral was given at a rate of 10.2 per 100 mental health-related problems managed. The most common referrals given were to psychiatrists (2.3 per 100 mental health-related problems managed) and to psychologists (1.6).

Pathology was ordered at a rate of 8.2 tests per 100 mental health-related problems managed. The most common pathology tests ordered were for full blood count (1.7 per 100 mental health-related problems managed), liver function tests (0.9) and thyroid-stimulating hormone tests (0.6).

Table 2.4: Most common types of management of mental health-related problems, BEACH, 2003–04

Type of management		Rate (per 100 mental health-related problems managed)	95% LCL	95% UCL
Medication prescribed, recommended or supplied[(a)]		**69.4**	**65.2**	**73.5**
N06A	Antidepressants	27.8	26.0	29.6
N05B	Anti-anxiety	14.2	12.8	15.5
N05C	Sedative hypnotics	13.7	12.6	14.9
N05A	Antipsychotic	5.4	4.8	6.1
	Other	8.3	6.7	9.8
Clinical treatment[(b)]		**47.3**	**44.1**	**50.4**
P58001, P58002, P58004–P58007, P58013–P58015, P58018, P58019	Counselling—psychological	25.2	23.2	27.1
A45015, A48003, A48005–A48011	Review/change/administer—medication	3.4	2.8	3.9
P45001, P45002	Advice/education/observe/wait—psychological	3.0	2.5	3.5
P45004, P58008	Counselling/advice/education—smoking	2.1	1.6	2.5
P45005, P58009	Counselling/advice/education—alcohol	1.8	1.5	2.2
	Other	11.8	10.8	12.8
Referral[(b)]		**10.2**	**9.1**	**11.3**
P67002	Referral to psychiatrist	2.3	2.0	2.7
P66003	Referral to psychologist	1.6	1.3	2.0
P66006	Referral to drug and alcohol professional	0.7	0.4	0.9
P66005	Referral to mental health team	0.6	0.4	0.8
P66004	Referral to counsellor	0.5	0.3	0.6
	Other	4.5	4.0	5.0
Pathology[(b)]		**8.2**	**7.3**	**9.1**
A34011	Test—full blood count	1.7	1.4	1.9
D34008	Test—liver function	0.9	0.7	0.9
T34028	Test—thyroid-stimulating hormone	0.6	0.5	0.8
T34015	Test—thyroid function	0.4	0.3	0.6
A34021	Test—electrolytes and liver function	0.4	0.3	0.5
	Other	4.2	3.7	4.7

(a) Pharmaceuticals prescribed, recommended or supplied by GPs are grouped into Anatomical Therapeutic Chemical (ATC) categories.
(b) Grouped according to ICPC-2 PLUS codes.
Note: LCL—lower confidence limit; UCL—upper confidence limit.
Source: BEACH survey of general practice activity.

2.4 Additional general practice activity

There were 2,253 other general practice encounters which did not involve a mental health-related problem but where:

- a clinical treatment and/or referral that was classified in the psychological chapter of the ICPC–2; and/or
- a medication classified as psychological in the Anatomical Therapeutic Chemical (ATC) classification was prescribed, recommended or supplied (Table 2.5).

A list of the 'P' chapter codes for treatments, referrals and prescriptions is provided in Appendix 4. As these encounters did not include a mental health-related problem managed, they were not classified as mental health-related encounters, as defined earlier in this chapter.

An extrapolation based on the 94.9 million non-specialist attendances claimed from Medicare for 2003–04 suggests that the 2,253 additional encounters in the BEACH data set equate to an estimated 2.1 million additional encounters for 2003–04. In turn, this corresponds to an estimated 109.8 encounters per 1,000 population. Note that the proportion of these additional encounters that would have been related to mental health is unknown; for example, a patient may have been reported as being prescribed a medication classified as 'psychological' for a problem not classified in the psychological ('P') chapter of the ICPC-2.

Table 2.5: Psychological-related activity in other general practice encounters[(a)], BEACH, 2003–04

Type of psychological-related activity	Per cent of other encounters
Psychological-related medication prescribed, recommended or supplied only	53.3
Psychological-related clinical treatment only	42.2
Psychological-related referral only	2.5
Psychological-related medication prescribed, recommended or supplied and psychological-related clinical treatment only	1.7
Psychological-related medication prescribed, recommended or supplied and psychological-related referral only	0.1
Psychological-related clinical treatment and referral only	0.1
Psychological-related medication prescribed, recommended or supplied and psychological-related clinical treatment and referral	0.1
Total	**100.0**
Total (number)	**2,253**

(a) These encounters did not involve a mental health-related problem managed (i.e., a problem managed that was classified in the psychological chapter of the ICPC-2) but did include either a clinical treatment and/or referral which was classified in the psychological chapter of the ICPC-2, and/or a prescription for medication classified as psychological in the ATC classification.

Source: BEACH survey of general practice activity.

More than half of these additional encounters (1,200 or 53.3%) consisted of a medication being prescribed, recommended or supplied that was classified as psychological in the ATC classification, without the reporting of a psychological problem managed, referral or clinical treatment (as classified according to the ICPC–2). The most common of these medications that were prescribed, recommended or supplied were anti-anxiety medications (37.0%), followed by antidepressants (32.1%). The medications were most commonly prescribed, recommended or supplied for general and unspecified prescription requests and renewals (23.6% of the problems managed), and back symptoms and complaints (13.3%).

For 951 (42.2%) of these additional encounters, a clinical treatment classified as psychological was reported while no psychological problem was managed, no psychological medication

was prescribed, recommended or supplied and no psychological referral was reported. The most common of these clinical treatments were psychological counselling (57.7%) and counselling, advice or education with regards to smoking (12.8%). The clinical treatments were most commonly given for hypertension (12.4% of the problems managed) and bronchitis (7.0%).

For 57 (2.5%) of these encounters, a referral classified as psychological was provided while no psychological problem managed, medication or clinical treatment were reported. The most common of these referrals were referral to a psychologist (34.4%) and referral to a psychiatrist (27.4%). At these encounters, the referrals were most commonly given for relationship problems (13.2% of the problems managed), and general and unspecified pain (9.2%).

At the remaining 45 (2.0%) of these additional encounters, a combination of medications, clinical treatments and/or referrals that were classified as psychological were reported.

3 Mental health-related care in emergency departments

3.1 Introduction

In previous editions of this report, no information was included on mental health-related care provided in emergency departments. However, along with other mental health care providers, hospital emergency departments play a role in providing treatment to people with mental health problems. For example, a 2004 study of mental health presentations to Victorian emergency departments found that emergency departments were used as an initial point of care for those seeking mental health-related services for the first time, as well as an additional point of care for people seeking 'after-hours' mental health care (Victorian Government Department of Human Services 2005). Furthermore, the Victorian study found that emergency departments played a role in caring for those who: presented involuntarily with the police for a mental health assessment; were brought in by ambulance after a self-harm attempt; required containment and treatment in situations where no beds in specialist psychiatric wards were readily available; and presented with high prevalence disorders, such as anxiety and depression.

With the aim of providing a more complete picture of mental health-related services in Australia, this report includes, for the first time, information on selected ***mental health-related emergency department occasions of service***.

All state and territory health authorities collect a core set of nationally comparable information on most ***emergency department occasions of service*** in public hospitals within their jurisdiction. This episode-level data are compiled annually by the AIHW into the National Non-admitted Patient Emergency Department Care Database (NAPEDCD). In addition, although not compiled as part of the NAPEDCD, all jurisdictions collect information (in some form) on the ***principal diagnosis*** for many of those emergency department occasions of service that they report to the NAPEDCD. For the purposes of this chapter, this diagnosis information is used to identify those emergency department occasions of service that were mental health-related. Data on these 'mental health-related occasions of service' were provided by the states and territories from the same sources as those used to provide data on all emergency department occasions of service to the NAPEDCD.

3.2 Mental health-related emergency department occasions of service

For the purposes of compiling information for this report, mental health-related emergency department occasions of service are defined as occasions of service in public hospital emergency departments that have a principal diagnosis of 'Mental and behavioural disorders' (that is, codes F00–F99) in the *International Classification of Diseases, 10th revision, Australian Modification* (ICD-10-AM) or the equivalent codes in the *International Classification of Diseases, 9th revision, Clinical Modification* (ICD-9-CM).

A list of the relevant diagnosis codes for both ICD-10-AM and ICD-9-CM are provided in Appendix Table A1.1. For the purposes of this data compilation, state and territory health

authorities were asked to provide emergency department data according to this definition for 2004–05. Specifically, aggregate information was requested on the demographic characteristics, triage category and departure status of the patients for whom mental health-related occasions of service were reported, and on the principal diagnosis according to the 11 diagnosis blocks that make up the 'Mental and behavioural disorders' chapter (Chapter 5) in the ICD-10-AM.

Key concepts

Emergency department occasion of service refers to the period of treatment or care between when a patient presents at an emergency department and when the non-admitted emergency department treatment ends. It includes presentations of patients who do not wait for treatment once registered or triaged in the emergency department, those who are dead on arrival and those who are subsequently admitted to hospital or to beds or units in the emergency department. An individual may have multiple occasions of service in a year. For further information, see definition of *Non-admitted patient emergency department service episode* in the *National health data dictionary*, Version 13 (HDSC 2006).

Mental health-related emergency department occasion of service refers to an emergency department occasion of service that has a principal diagnosis that falls within the 'Mental and behavioural disorders' chapter (Chapter 5) of ICD-10-AM (that is, codes F00–F99) or the equivalent ICD-9-CM codes. It should be noted that this definition does not encompass all mental health-related presentations to emergency departments, as detailed below. Additional information with regards to this and applicable caveats can be found in Appendix 1.

Principal diagnosis: currently, there is no national standard definition of principal diagnosis in relation to emergency department data. Thus, for the purposes of the data presented in this chapter, states and territories provided data on 'principal diagnosis' based on local definitions used within their jurisdiction or emergency departments.

The definition of 'mental health-related emergency department occasions of service' in this chapter does not include all possible occasions of service for the following reasons.

- Not all occasions of service in emergency departments within a state or territory are reported with detailed episode-level data. In 2004–05, nationally, an estimated 24% of all public hospital emergency department occasions of service were not reported with episode-level data and thus not included in the NAPEDCD (Appendix Table A1.2). In addition, non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals are not included. Based on ABS estimates, there were 451,700 non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals in 2004–05 (ABS 2006d).
- Not all of the emergency department occasions of service that are reported with detailed episode-level data include a diagnosis. It is estimated that in 2004–05, the proportion of reported occasions of service with a diagnosis was 93% (Appendix Table A1.2).
- Not all conditions and problems that could be considered 'mental health-related' are captured by the 'mental health-related' definition used in this chapter. For example, emergency department occasions of service for which the principal diagnosis did not fall within the 'mental and behavioural disorders' chapter but for which an external cause of morbidity or mortality was identified as 'intentional self-harm' are not included.

- The definition is based on a single diagnosis only. As a result, if a mental health-related condition was reported as a second or other diagnosis and not as the 'principal diagnosis', the occasion of service will not be included as mental health-related.
- A patient may have a mental health-related condition that is not recognised or diagnosed (and thus not recorded) during the emergency department occasion of service.

For these reasons (and as detailed further in Appendix 1), the data presented in this chapter represent an undercount of the actual number of mental health-related emergency department occasions of service. However, because there are no means currently available to identify all mental health-related occasions of service in emergency departments in a nationally comparable and agreed-upon manner, the data present a picture of the minimum number of such occasions of service.

In an attempt to collect additional information on mental health-related emergency department care for this report, states and territories were also requested to provide data using two other definitions of 'mental health-related emergency department occasions of service' (see Appendix 1). As only half of the jurisdictions could report this additional data and because the data provided for one of these additional definitions were not comparable across the jurisdictions, these data are not presented. However, in order to provide readers with an indication of the extent to which other care in emergency departments may be mental health-related, data for Victoria that is based on the two additional definitions are presented in Appendix 1.

3.3 Mental health-related emergency department care

In 2004–05, emergency departments in public hospitals in Australia reported 133,403 mental health-related occasions of service (Table 3.1). Taking into account the undercoverage issues discussed in Section 3.2, the estimated number of total mental health-related occasions of service is approximately 190,000 (Appendix Table A1.2). This estimated number represents 3.2% of the total number of occasions of service in emergency departments in public hospitals in 2004–05 (which is reported to be almost 6 million) (AIHW 2006b).

Patient demographics

The demographic characteristics reported for mental health-related emergency department occasions of service in 2004–05 are shown in Table 3.1. For comparative purposes, the characteristics reported for all emergency department occasions of service in that year (as sourced from the NAPEDCD) are also provided in Table 3.1.

Mental health-related occasions of service were more likely than all emergency department occasions of service to involve a person in the middle age groups and less likely to involve a person in the very young or older age groups. That is, in 2004–05, 2.9% of mental health-related occasions of service were for persons under 15 years of age and 66.6% were for persons aged between 15 and 44 years. In comparison, 22.8% of all emergency department occasions of service involved persons under 15 years of age and 42.0% related to those aged 15 to 44 years.

Table 3.1: Mental health-related emergency department occasions of service[a] in public hospitals, by patient demographic characteristics, 2004–05

Patient demographics	Number of occasions of service[b]	Per cent of total mental health-related occasions of service[c]	Per cent of all emergency department occasions of service reported in the NAPEDCD[c][d]
Age			
Less than 15 years	3,844	2.9	22.8
15–24 years	28,943	21.7	15.4
25–34 years	33,024	24.8	14.7
35–44 years	26,855	20.1	11.9
45–54 years	17,619	13.2	9.6
55–64 years	9,550	7.2	7.9
65–74 years	5,105	3.8	7.0
75 years and over	8,426	6.3	10.7
Sex			
Male	68,558	51.4	52.5
Female	64,734	48.6	47.5
Indigenous status			
Indigenous Australians	6,533	5.0	4.4
Other Australians	123,606	95.0	95.6
Total	**133,403**	**100.0**	**100.0**

(a) Includes those emergency department occasions of service that had a principal diagnosis that fell within the 'Mental and behavioural disorders' chapter (Chapter 5) of ICD-10-AM (i.e., codes F00–F99) or the equivalent ICD-9-CM codes.

(b) The number of occasions of service for each demographic variable may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those occasions of service for which the demographic information was missing and/or not reported.

(d) Occasions of service with episode-level data reported by state and territory health authorities to the Non-admitted Patient Emergency Department Care Database 2004–05 (AIHW 2006b).

Source: Data provided by state and territory health authorities.

In 2004–05, males made up a higher proportion of the mental health-related emergency department occasions of service than females (51.4% compared with 48.6%). This was similar to the distribution for all emergency department occasions of service (52.5% male).

Indigenous people accounted for 5.0% of the mental health-related emergency department occasions of service; this compares with 4.4% of all emergency department occasions of service. It should be noted that most of the data on emergency department occasions of service relate to emergency departments in hospitals within Major cities (see Appendix Table A1.2). Consequently, the coverage may not include areas where the proportion of Indigenous people (compared with other Australians) may be higher than average. Therefore, these data may not be indicative of the rate of usage of emergency department services by Indigenous Australians nationally. In addition, when reporting data to the NAPEDCD, most states and territories cautioned that information on Indigenous status collected in an emergency department setting could be less accurate than the corresponding information collected on admitted patients. Furthermore, the data are also of variable quality across jurisdictions (AIHW 2006b:95–96).

Principal diagnosis

States and territories were asked to provide the data on mental health-related occasions of services by principal diagnosis according to the 11 blocks within the 'Mental and behavioural

disorders' chapter in the ICD-10-AM (Table 3.2). Those jurisdictions who had recorded diagnoses using ICD-9-CM codes were asked to map their data according to the specifications provided in Appendix Table A1.1.

In 2004–05, four main principal diagnosis blocks accounted for the majority of mental health-related occasions of service. These were *Neurotic, stress-related and somatoform disorders* (F40–F48, 28.8%), *Mental and behavioural disorders due to psychoactive substance use* (F10–F19, 20.9%), *Mood (affective) disorders* (F30–F39, 18.9%) and *Schizophrenia, schizotypal and delusional disorders* (F20–F29, 16.9%). To varying degrees, these four diagnoses blocks were the largest contributors to the mental health-related emergency department occasions of service in all states and territories. However, the variations in the distribution of diagnoses across states and territories should be interpreted carefully, due to the lack of national standards for the coding and collection of principal diagnosis information in emergency departments. In addition, differences in the data scope and coverage (for example, in some jurisdictions only occasions of service from emergency departments in metropolitan hospitals are included) may contribute to variations in principal diagnosis across states and territories.

Triage category

'Triage category' is recorded according to the urgency of the patient's need for medical and nursing care, as assessed when a patient is triaged in the emergency department. For example, patients triaged to the 'emergency' category are assessed as requiring care within 10 minutes. They may or may not actually receive care within that time, however.

In 2004–05, 6.1% of mental health-related occasions of service in emergency departments were considered 'non-urgent' (requiring care within 120 minutes), 37.7% were recorded as 'semi-urgent' (within 60 minutes) and 44.8% as 'urgent' (within 30 minutes). A further 10.7% were classified as 'emergency' (requiring care within 10 minutes) and 0.7% as 'resuscitation' (within seconds) (Table 3.3). Mental health-related occasions of service were more likely than all emergency department occasions of service to be assessed as 'urgent' (44.8% and 30.7%, respectively) and as 'emergency' (10.7% and 7.9%, respectively) (AIHW 2006b). The proportion of all emergency department occasions of service assessed as 'resuscitation' (that is, requiring care within seconds) was similar for both (0.7% for mental health-related occasions of service and 0.8% for all emergency department occasions of service).

Table 3.2: Mental health-related emergency department occasions of service[(a)] in public hospitals, by principal diagnosis, states and territories, 2004–05

Principal diagnosis (ICD-10-AM)	NSW[(b)]	Vic	Qld	WA	SA[(b)]	Tas	ACT	NT	Total	Per cent
F00–F09: Organic, including symptomatic, mental disorders	1,324	1,181	724	1,016	767	194	63	80	5,349	4.0
F10–F19: Mental and behavioural disorders due to psychoactive substance use	9,343	6,973	4,229	2,379	2,781	794	483	859	27,841	20.9
F20–F29: Schizophrenia, schizotypal and delusional disorders	9,434	4,367	3,001	1,059	2,718	1,007	393	524	22,503	16.9
F30–F39: Mood (affective) disorders	9,039	5,990	4,265	1,524	2,640	1,013	412	350	25,233	18.9
F40–F48: Neurotic, stress-related and somatoform disorders	15,158	7,941	4,433	3,429	5,106	758	806	796	38,427	28.8
F50–F59: Behavioural syndromes associated with physiological disturbances and physical factors	203	129	669	47	116	25	8	11	1,208	0.9
F60–F69: Disorders of adult personality and behaviour	582	907	1,531	266	756	267	32	32	4,373	3.3
F70–F79: Mental retardation	11	6	65	0	16	1	0	1	100	0.1
F80–F89: Disorders of psychological development	55	0	76	5	10	2	1	0	149	0.1
F90–F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3,036	481	459	261	516	71	32	50	4,906	3.7
F99: Unspecified mental disorder	38	782	1,941	128	0	407	18	0	3,314	2.5
Total	**48,223**	**28,757**	**21,393**	**10,114**	**15,426**	**4,539**	**2,248**	**2,703**	**133,403**	**100.0**

(a) Includes those emergency department occasions of service that had a principal diagnosis that fell within the 'Mental and behavioural disorders' chapter (Chapter 5) of ICD-10-AM (that is, codes F00–F99) or the equivalent ICD-9-CM codes.

(b) South Australia used ICD-9-CM to code principal diagnosis for emergency department occasions of service in 2004–05. New South Wales used a combination of ICD-9-CM and ICD-10-AM. A mapping of the relevant ICD-9-CM codes to the ICD-10-AM code blocks is provided in Appendix Table A1.1.

Source: Data provided by state and territory health authorities.

Table 3.3: Mental health-related emergency department occasions of service[a] in public hospitals, by triage category, states and territories, 2004–05

Triage categories	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Resuscitation	275	299	127	96	124	16	31	29	997
Emergency	4,775	2,579	2,251	1,191	2,228	580	358	263	14,225
Urgent	22,831	10,938	9,922	4,358	7,315	2,062	969	1,341	59,736
Semi-urgent	17,511	12,455	7,952	4,120	4,808	1,779	762	907	50,294
Non-urgent	2,830	2,486	1,140	338	951	102	128	163	8,138
Total[b]	**48,223**	**28,757**	**21,393**	**10,114**	**15,426**	**4,539**	**2,248**	**2,703**	**133,403**

(a) Includes those emergency department occasions of service that had a principal diagnosis that fell within the 'Mental and behavioural disorders' chapter (Chapter 5) of ICD-10-AM (that is, codes F00–F99) or the equivalent ICD-9-CM codes.

(b) The numbers of occasions of service may not sum to the total due to missing and/or not reported data.

Source: Data provided by state and territory health authorities.

Departure status

In 2004–05, the departure status for over half of the mental health-related emergency department occasions of service was recorded as 'completed'; that is, 58.8% of these occasions of service were completed without admission or referral to another hospital (Table 3.4). Just over one-third (33.9%) of mental health-related occasions of service were closed with the patient being admitted to the hospital to which they presented, and for a further 4.3% the patient was referred to another hospital. This is slightly higher than for all emergency department occasions of service, with 27.2% of those ending in admission and 1.7% being referred (AIHW 2006b:110).

Table 3.4: Mental health-related emergency department occasions of service[a] in public hospitals, by departure status, states and territories, 2004–05

Departure status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Admitted to this hospital[b]	19,743	6,071	5,635	3,142	5,096	2,366	561	906	43,520
Non-admitted patient ED occasion of service completed[c]	24,646	20,778	10,805	6,115	7,701	2,063	1,590	1,714	75,412
Referred to another hospital for admission	2,220	1,188	273	569	1,147	54	43	5	5,499
Did not wait to be attended by a health care professional	211	0	869	36	46	13	25	11	1,211
Left at own risk[d]	1,095	717	306	192	121	37	29	67	2,564
Not reported[e]	308	3	3,505	60	1,315	6	0	0	5,197
Total	**48,223**	**28,757**	**21,393**	**10,114**	**15,426**	**4,539**	**2,248**	**2,703**	**133,403**

(a) Includes those emergency department occasions of service that had a principal diagnosis that fell within the 'Mental and behavioural disorders' chapter (Chapter 5) of ICD-10-AM (that is, codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Including to beds or units within the emergency department.

(c) Patient departed without being admitted or referred to another hospital.

(d) Patient left at own risk after being attended by a health care professional but before the non-admitted patient emergency department occasion of service was completed.

(e) Included in this category are 9 occasions of service with a departure status of 'Died in ED as a non-admitted patient' and 1 occasion of service with a departure status of 'Dead on arrival, not treated in ED'.

Note: ED—Emergency Department.

Source: Data provided by state and territory health authorities.

4 Community mental health and hospital outpatient services

4.1 Introduction

In this chapter, information for 2004–05 is presented on specialised ambulatory mental health care provided by community mental health services and hospital outpatient services (which are often referred to simply as ***community mental health care*** in this publication). The information has been derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on specialised mental health services provided to non-admitted patients in both community and hospital-based ambulatory care services that are government-operated. The NCMHCD presents information on ***service contacts*** between patients (or clients) and specialised mental health service providers; Appendix 1 provides information about the coverage and data quality of this collection.

Key concepts

Community mental health care refers to specialised mental health care provided by community mental health services and hospital-based ambulatory care services, such as outpatient clinics and day clinics, which are government-operated.

Service contacts**,** in the NCMHCD, are defined as the provision of a clinically significant service by a specialised mental health service provider(s) for patient/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the relevant period (that is, 2004–05). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also either be with the patient, or with a third party such as a carer or family member, and/or other professional or mental health worker or other service provider.

4.2 Service contacts

In 2004–05, there were 5,108,524 community mental health care service contacts nationally. Victoria reported the highest number of service contacts (1,778,559) (Table 4.1). However, the age-standardised data indicate that, relative to its population size and age structure, the Australian Capital Territory had the highest number of service contacts per 1,000 population (601.2).

Four of the states and territories—namely Victoria, Western Australia, the Australian Capital Territory and the Northern Territory—were able to provide data on the actual number of patients who had had service contacts. Of these four jurisdictions, the Northern Territory reported the highest number of patients per 1,000 population (22.8), while the Australian Capital Territory had the highest number of service contacts per patient (31.3), followed closely by Victoria (30.6).

Table 4.1: Community mental health care service contacts, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service contacts	1,363,770	1,778,559	901,706	466,670	298,459	64,317	198,666	36,377	5,108,524
Patients[(a)]	n.a.	58,195	n.a.	33,994	n.a.	n.a.	6,338	4,716	n.a.
Average service contacts per patient[(a)]	n.a.	30.6	n.a.	13.7	n.a.	n.a.	31.3	7.7	n.a.
Estimated number of patients[(b)]	236,458	99,680	83,028	41,657	29,406	13,007	13,214	6,444	522,894
Average service contacts per estimated number of patients[(b)]	5.8	17.8	10.9	11.2	10.1	4.9	15.0	5.6	9.8
	Rate (per 1,000 population)[(c)]								
Service contacts	204.0	353.9	230.8	234.4	195.9	131.4	601.2	176.2	254.6
Patients[(a)]	n.a.	11.6	n.a.	18.1	n.a.	n.a.	19.2	22.8	n.a.
Estimated number of patients[(b)]	35.0	20.0	21.1	20.9	19.1	26.9	40.8	32.1	25.9

(a) This refers to the actual number of patients involved in community mental health care service contacts. Supply of these data was optional for states and territories.

(b) This is an estimated number of patients based on the calculation of the number of unique person identifiers for each establishment. The number of patients may be overestimated as patients registered with more than one establishment are counted separately each time. See Appendix 1 for more information.

(c) Rates were directly age-standardised as detailed in Appendix 2.

n.a. Not available.

Source: National Community Mental Health Care Database.

The remaining four states and territories (that is, New South Wales, Queensland, South Australia and Tasmania) were not able to provide data on the number of patients who had community mental health care service contacts. An estimate of the number of such patients was derived from the number of unique patient identifiers for each individual service provider reporting to the database. Note that because these patient identifier data were related to individual service providers and because there is no means within the database to determine if any one person made use of services from multiple providers, the number of estimated patients may be an overestimate (see Appendix 1 for more information on how the estimated number of patients was derived). Table 4.1 presents data on the estimated number of patients who had service contacts for all states and territories. These data indicate that in 2004–05 the estimated number of patients was 522,894, and there was an average of 9.8 service contacts per patient.

Table 4.2 presents data on the number of service contacts for each jurisdiction and according to mental health legal status and jurisdiction. Nationally, for 14.9% of service contacts, the patient's mental health legal status was classed as 'involuntary'. There were different patterns across jurisdictions, with the Australian Capital Territory and Victoria having the higher proportions of service contacts for which mental health legal status was 'involuntary' (26.2% and 24.3%, respectively). These jurisdictional differences may reflect differences in legislative arrangements.

Table 4.2: Community mental health care service contacts by mental health legal status, states and territories, 2004–05

Mental health legal status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Involuntary	162,063	431,884	71,897	11,917	29,106	987	52,054	2,397	762,305
Voluntary	1,201,707	1,346,675	829,809	454,753	263,493	54,352	146,612	33,977	4,331,378
Total[(a)]	**1,363,770**	**1,778,559**	**901,706**	**466,670**	**298,459**	**64,317**	**198,666**	**36,377**	**5,108,524**

(a) Includes service contacts where mental health legal status was not reported.

Source: National Community Mental Health Care Database.

The number of service contacts reported to the NCMHCD has increased over the past few years of collection. In 2002–03, the number of reported service contacts stood at 4,672,423. It increased to 4,911,735 in 2003–04 and then to 5,108,524 in 2004–05. Note that these increases may reflect increases in the actual number of community mental health care services and/or improvements in coverage, as many jurisdictions estimated their coverage to be higher for 2004–05 than for previous years. State and territory estimates of coverage are included in Appendix 1.

4.3 Patient demographics

Table 4.3 presents information on the number of service contacts in 2004–05 according to the demographic characteristics of those receiving care. The number of service contacts does not account for differences in the relative size and age structure of the respective populations; thus, in addition, a rate per 1,000 population is provided. As these are reports of service contacts (rather than persons), the rates cannot be interpreted as the number of people with specific characteristics per 1,000 population who received this type of mental health care. Instead, they provide information on the number of service contacts relative to the size of the population subgroup.

Table 4.3: Community mental health care service contacts by patient demographic characteristics, 2004–05

Patient demographics	Number of service contacts[a]	Per cent of service contacts[b]	Rate (per 1,000 population)[c]
Age			
Less than 15 years	385,845	7.8	96.9
15–24 years	864,736	17.5	310.4
25–34 years	1,140,822	23.0	396.5
35–44 years	977,183	19.7	324.9
45–54 years	678,552	13.7	244.5
55–64 years	369,607	7.5	171.9
65 years and over	537,063	10.8	203.9
Sex			
Male	2,651,514	53.5	265.4
Female	2,306,501	46.5	226.0
Indigenous status[d][e]			
Indigenous Australians	224,213	4.9	507.2
Other Australians	4,333,399	95.1	220.0
Country of birth[e]			
Australia	4,022,493	84.3	268.9
Overseas	749,551	15.7	137.6
Remoteness area of usual residence			
Major city	3,169,677	65.3	235.0
Inner regional	1,127,585	23.2	280.6
Outer regional	474,054	9.8	239.8
Remote and Very remote	83,756	1.7	167.9
Marital status[e]			
Never married	2,757,207	60.3	. .
Widowed	214,338	4.7	. .
Divorced	442,913	9.7	. .
Separated	286,601	6.3	. .
Married	871,986	19.1	. .
Total	**5,108,524**	**100.0**	**254.6**

(a) The numbers of service contacts for each demographic variable may not sum to the total due to missing and/or not reported data.
(b) The percentages shown do not include those service contacts for which the demographic information was missing and/or not reported.
(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.
(d) These data should be interpreted with caution due to likely underidentification of Indigenous Australians.
(e) Information on this data element was missing or not reported for more than 5 per cent of service contacts.
. . Not applicable.
Source: National Community Mental Health Care Database.

The largest number of service contacts was for patients aged 25 to 34 years (23.0%; 396.5 per 1,000 population), followed by those aged 35 to 44 years (19.7%; 324.9 per 1,000 population).

Male patients accounted for 53.5% of service contacts while females accounted for 46.5%; relative to their population size and age structure, males still had more service contacts than females (265.4 and 226.0 per 1,000 population, respectively).

The data on service contacts for Indigenous Australians compared with other Australians must be interpreted with caution due to uncertainty about the quality of Indigenous identification among the jurisdictions. Table 4.3 presents national data on Indigenous status but note that data for only Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory were reported by these jurisdictions to be of acceptable quality (see Appendix 1 for more information). As a consequence, it is likely that the number of service contacts for Indigenous Australians is underestimated. Indigenous Australians accounted for a smaller number of service contacts than other Australians but, when the size and age structure of the two populations were taken into account, there was a higher number of service contacts per 1,000 population for Indigenous Australians than for other Australians (507.2 and 220.0 respectively).

The number of service contacts per 1,000 population for Australian-born persons was almost double the rate for those born overseas (268.9 and 137.6 respectively).

The highest number of service contacts per 1,000 population were for patients living in Inner regional areas (280.6), followed by Outer regional areas (239.8) and Major cities (235.0).

The most frequently reported marital status was 'never married' (60.3%), followed by 'married' (19.1%) and 'divorced' (9.7%).

4.4 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for occasioning the service contact. Table 4.4 presents the number of service contacts for principal diagnosis groups for 2004–05. Diagnoses are classified according to the *International Classification of Diseases, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3. Note that these data should be interpreted with caution due to variability in the data collection and coding practices in relation to principal diagnosis across Australia (for more information, see Appendix 1).

The most common principal diagnosis reported was *Schizophrenia* (F20), reported for over one in three service contacts (35.9%). The next most common principal diagnoses were *Depressive episode* (F32, reported for 12.6% of the service contacts), followed by *Bipolar affective disorder* (F31, 7.7%) and *Schizoaffective disorder* (F25, 6.5%). All of the remaining principal diagnoses each represented less than 5% of service contacts.

Almost one in four of all service contacts did not have a specified diagnosis; that is, 17.0% of service contacts had a principal diagnosis of F99 *Mental disorder not otherwise specified*, while the principal diagnosis was not stated or not reported for 7.6% of service contacts. The majority of service contacts that did not have a specified principal diagnosis were reported by New South Wales (44.1% of these service contacts) and Queensland (28.7%).

4.5 Additional data

Additional tables containing data on community mental health care service contacts are available from the AIHW's website (see Section 1.5 for details).

Table 4.4: Community mental health care service contacts by principal diagnosis in ICD-10-AM groupings, 2004–05

Principal diagnosis		Number of service contacts	Per cent of specified principal diagnoses
F00–F03	Dementia	91,773	2.4
F04–F09	Other organic mental disorders	29,148	0.8
F10	Mental and behavioural disorders due to use of alcohol	43,251	1.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	93,943	2.4
F20	Schizophrenia	1,381,780	35.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	58,416	1.5
F22	Persistent delusional disorders	34,195	0.9
F23	Acute and transient psychotic disorders	65,386	1.7
F25	Schizoaffective disorders	251,460	6.5
F30	Manic episode	16,827	0.4
F31	Bipolar affective disorders	295,513	7.7
F32	Depressive episode	483,587	12.6
F33	Recurrent depressive disorders	88,936	2.3
F34	Persistent mood (affective) disorders	39,695	1.0
F38, F39	Other and unspecified mood (affective) disorders	6,009	0.2
F40	Phobic anxiety disorders	23,774	0.6
F41	Other anxiety disorders	118,134	3.1
F42	Obsessive-compulsive disorders	28,983	0.8
F43	Reaction to severe stress and adjustment disorders	188,066	4.9
F44	Dissociative (conversion) disorders	5,048	0.1
F45, F48	Somatoform and other neurotic disorders	6,117	0.2
F50	Eating disorders	27,972	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	7,288	0.2
F60	Specific personality disorders	141,994	3.7
F61–F69	Disorders of adult personality and behaviour	19,614	0.5
F70–F79	Mental retardation	18,311	0.5
F80–F89	Disorders of psychological development	31,060	0.8
F90	Hyperkinetic disorders	24,101	0.6
F91	Conduct disorders	35,039	0.9
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	55,691	1.4
	Other[(a)]	141,188	3.7
Total with specified principal diagnosis		*3,852,299*	*100.0*
F99	Mental disorder not otherwise specified	868,346	
	Not reported	387,879	
Total with unspecified principal diagnosis		*1,256,225*	
Total		**5,108,524**	

(a) Includes all reported diagnoses that are not in the 'Mental and behavioural disorders' chapter of ICD-10-AM (codes F00 to F99).
Source: National Community Mental Health Care Database.

5 Ambulatory-equivalent mental health-related admitted patient care

5.1 Introduction

In addition to ambulatory (or non-admitted) care provided by community services and hospital-based ambulatory care services (as discussed in the previous chapter), mental health care that could be considered to be equivalent to ambulatory care can be provided to patients admitted to hospital. In this chapter, information is presented on this form of care—that is, on ***mental health-related*** hospital ***separations*** that could be considered to be ***ambulatory-equivalent*** admitted patient care.

The data presented in this chapter are from the National Hospital Morbidity Database (NHMD). Information on the NHMD is available in Appendix 1.

Key concepts

A ***separation*** is defined as the process by which an episode of care for an admitted patient in hospital ceases. For more information, see Chapter 7.

A separation is classified as ***ambulatory-equivalent*** for this report if each of the following apply:

- the separation was a same day separation (that is, admission and separation occurred on the same day);
- no procedure or other intervention was recorded, or any procedure recorded was identified as probably able to be provided in ambulatory mental health care; and
- the mode of admission did not include a care type change or transfer, and the mode of separation did not include a transfer (to another facility), a care type change, the patient leaving against medical advice, or death.

A separation is classified as ***mental health-related*** if:

- it had a mental health-related principal diagnosis which, for admitted patient care in this report, is defined as a principal diagnosis that is either a diagnosis that falls within the chapter on 'Mental and behavioural disorders' (Chapter 5) in the ICD-10-AM classification (i.e., codes F00 to F99) or a number of other selected diagnoses (see Appendix 4 for the full list of applicable diagnoses); and/or
- it included any specialised psychiatric care.

A separation is classified as having ***specialised psychiatric care*** if the patient was reported as having spent one or more days in a specialised psychiatric unit or ward.

5.2 Ambulatory-equivalent mental health-related separations

In 2004–05, there were 116,787 ambulatory-equivalent mental health-related separations. These accounted for 1.7% of all hospital separations reported to the NHMD in 2004–05 and 36.9% of all separations considered to be mental health-related (that is, ambulatory-

equivalent and admitted patient separations combined (see Chapter 7 of this report for more information on admitted patient mental health care in hospitals)).

Table 5.1 shows the number of ambulatory-equivalent mental health-related separations for each state and territory by hospital type (that is, public acute, public psychiatric and private hospitals). To account for differences in population between jurisdictions, the number of separations per 1,000 population has also been provided.

Table 5.1: Ambulatory-equivalent mental health-related separations[(a)] with and without specialised psychiatric care, by hospital type, states and territories, 2004–05

Hospital type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	With specialised psychiatric care								
Public acute hospitals	5,408	729	3,923	84	253	56	32	25	10,510
Public psychiatric hospitals	1,747	0	n.p.	16	10	n.p.	. .	. .	1,775
Private hospitals	20,938	32,796	15,819	7,130	31	n.p.	n.p.	n.p.	80,084
All hospitals	*28,093*	*33,525*	*n.p.*	*7,230*	*294*	*n.p.*	*n.p.*	*n.p.*	*92,369*
	Without specialised psychiatric care								
Public acute hospitals	4,607	5,593	1,499	959	1,085	285	113	97	14,238
Public psychiatric hospitals	10	0	0	0	0	0	. .	. .	10
Private hospitals	240	4,047	3,568	783	10	n.p.	n.p.	n.p.	10,170
All hospitals	*4,857*	*9,640*	*5,067*	*1,742*	*1,095*	*n.p.*	*n.p.*	*n.p.*	*24,418*
	Total								
Public acute hospitals	10,015	6,322	5,422	1,043	1,338	341	145	122	24,748
Public psychiatric hospitals	1,757	0	n.p.	16	10	n.p.	. .	. .	1,785
Private hospitals	21,178	36,843	19,387	7,913	41	n.p.	n.p.	n.p.	90,254
All hospitals	**32,950**	**43,165**	**n.p.**	**8,972**	**1,389**	**n.p.**	**n.p.**	**n.p.**	**116,787**
	Rate (per 1,000 population)[(b)]								
Public acute hospitals	1.5	1.3	1.4	0.5	0.9	0.8	0.4	0.6	1.2
Public psychiatric hospitals	0.3	0.0	0.0	0.0	0.0	0.0	. .	. .	0.1
Private hospitals	3.1	7.3	4.9	3.9	0.0	n.p.	n.p.	n.p.	4.4
All hospitals	**4.8**	**8.6**	**6.3**	**4.5**	**0.9**	**n.p.**	**n.p.**	**n.p.**	**5.7**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable.

n.p. Not published.

Source: National Hospital Morbidity Database.

Of the 116,787 ambulatory-equivalent mental health-related separations, 90,254 (77.3%) were from private hospitals, 24,748 (21.2%) from public acute hospitals and 1,785 (1.5%) from private psychiatric hospitals.

Just over three-quarters (79.1%) of ambulatory-equivalent mental health-related separations during 2004–05 involved ***specialised psychiatric care***. Of these, 80,084 (86.7%) were from

private hospitals. For the 24,418 separations that did not involve specialised psychiatric care, the majority (14,238 or 58.3%) were from public acute hospitals.

Considering all hospital types, Victoria reported the highest number of ambulatory-equivalent mental health-related separations (43,165) and the highest number of such separations per 1,000 population (8.6). Victoria also had the highest rate of ambulatory-equivalent mental health-related separations from private hospitals (7.3).

Due to confidentiality reasons, the numbers and rates of separations for private hospitals cannot be published for Tasmania, the Australian Capital Territory and the Northern Territory. With the exception of South Australia, the remaining four states reported more separations from private hospitals than public hospitals. Public psychiatric hospitals reported 1,785 separations, with 98.4% of these separations being reported by New South Wales. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

Table 5.2 shows the number of ambulatory-equivalent mental health-related separations by hospital type and the patient's mental health legal status. For 98.0% of these separations the patient's mental health legal status was 'voluntary'. There were 1,633 ambulatory-equivalent mental health-related separations where the patient's mental health legal status was 'involuntary'. Public acute hospitals had the highest proportion of separations where the patient's mental health legal status was 'involuntary' (12.6%), compared with public psychiatric hospitals (3.5%) and private hospitals (0.3%).

Table 5.2: Ambulatory-equivalent mental health-related separations[(a)] with specialised psychiatric care by mental health legal status and hospital type, 2004–05

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	1,326	63	244	1,633
Voluntary	9,131	1,712	79,703	90,546
Total[(b)]	**10,510**	**1,775**	**80,084**	**92,369**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Includes separations for which mental health legal status was not reported.

Source: National Hospital Morbidity Database.

5.3 Patient demographics

Table 5.3 presents information on the number of ambulatory-equivalent mental health-related separations and the corresponding percentage of such separations for a number of demographic groups. In addition, a rate (per 1,000 population) has been provided. As the data relate to separations (rather than persons), the rates provide a means by which to compare numbers of ambulatory-equivalent mental health-related hospital separations relative to the size of the respective population.

Since the database contains data on hospital separations, not on individual people, it is not possible to determine how many separations an individual person had.

The highest percentage of ambulatory-equivalent mental health-related separations was for patients aged 35 to 44 years and 45 to 54 years (19.5% and 19.4%, respectively). However, the highest number of separations per 1,000 population was for patients aged 55 to 64 years (8.9). The lowest proportion of separations was for patients aged less than 15 years (6.1%).

Table 5.3: Ambulatory-equivalent mental health-related separations[a] by patient demographic characteristics, 2004–05

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate (Per 1,000 population)[d]
Age			
Less than 15 years	7,175	6.1	1.8
15–24 years	17,213	14.7	6.2
25–34 years	17,016	14.6	5.9
35–44 years	22,760	19.5	7.6
45–54 years	22,678	19.4	8.2
55–64 years	19,149	16.4	8.9
65 years and over	10,793	9.2	4.1
Sex			
Male	45,868	39.3	4.5
Female	70,919	60.7	7.0
Indigenous status[e]			
Indigenous Australians	783	2.3	1.8
Other Australians[f]	34,511	97.7	4.7
Country of birth[g]			
Australia	92,366	84.6	6.2
Overseas	16,794	15.4	2.9
Remoteness area of usual residence			
Major cities	98,058	84.8	7.3
Inner regional	13,941	12.1	3.3
Outer regional	2,990	2.6	1.5
Remote	386	0.3	1.2
Very remote	229	0.2	1.2
Marital status[g]			
Never married	39,533	42.3	. .
Widowed	4,973	5.3	. .
Divorced	6,268	6.7	. .
Separated	4,102	4.4	. .
Married	38,556	41.3	. .
Total	**116,787**	**100.0**	**5.7**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The numbers of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those separations for which the demographic information was missing and/or not reported.

(d) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(e) Only includes data for Queensland, Western Australia, South Australia and public hospitals in the Northern Territory since the quality of Indigenous identification for those jurisdictions is considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data due to jurisdictional differences in data quality (see AIHW 2005c).

(f) Includes separations where Indigenous status was missing or not reported (see AIHW 2005c).

(g) Information on this data element was missing or not reported for more than 5 per cent of separations.

. . Not applicable.

Source: National Hospital Morbidity Database.

There were more separations for female patients than for male patients (60.7% and 39.3%, respectively).

Since data on Indigenous status in the National Hospital Morbidity Database are considered to be of acceptable quality for analytical purposes for only certain states and territories—namely Queensland, Western Australia, South Australia and public hospitals in the Northern Territory (AIHW 2005c)—only data on Indigenous status for those jurisdictions have been included in this chapter. Note that ambulatory-equivalent mental health-related separations for those four jurisdictions are not necessarily representative of those in the other four jurisdictions and that caution should be used in the interpretation of these data due to jurisdictional differences in data quality. Data on the number of ambulatory-equivalent mental health-related separations per 1,000 population indicated that there were fewer separations reported for Indigenous Australians than for other Australians (1.8 per 1,000 population for Indigenous Australians and 4.7 for other Australians).

The number of separations per 1,000 population for Australian-born patients was more than double the rate for those born overseas (6.2 and 2.9, respectively).

Almost 85% of ambulatory-equivalent mental health-related separations were for patients living in Major cities. This was followed by those living in Inner regional areas (12.1%). This pattern was reflected when taking into account variations in population size and age structure in the different areas (7.3 per 1,000 population for Major cities and 3.3 for Inner regional areas). The most frequently reported types of marital status were 'never married' (42.3%) and 'married' (41.3%).

5.4 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care. Table 5.4 shows the distribution of ambulatory-equivalent mental health-related separations by principal diagnosis, disaggregated by hospital type and whether they involved specialised psychiatric care. Diagnoses are classified according to the *International Classification of Diseases, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3.

Overall, in 2004–05, the principal diagnosis of *Depressive episode* (F32) accounted for the largest number of separations (23,280 or 19.9%), followed by *Mental and behavioural disorders due to use of alcohol* (F10; 16,239 or 13.9%) and *Recurrent depressive disorders* (F33; 16,017 or 13.7%).

For separations that involved specialised psychiatric care, *Depressive episode* (F32) was the most commonly reported principal diagnosis (20,466 or 22.2%). This was followed by *Recurrent depressive disorders* (F33; 15,389 or 16.7%) and *Reaction to severe stress and adjustment disorders* (F43; 10,423 or 11.3%).

For those separations that did not involve specialised psychiatric care, the most frequently reported principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (F10; 9,261 or 37.9%).

Table 5.4: Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2004–05

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		With specialised psychiatric care				
F00–F03	Dementia	5	n.p.	319	n.p.	0.4
F04–F09	Other organic mental disorders	15	n.p.	243	n.p.	0.3
F10	Mental and behavioural disorders due to use of alcohol	511	42	6,425	6,978	7.6
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	241	9	1,196	1,446	1.6
F20	Schizophrenia	773	25	3,179	3,977	4.3
F21, F24, F28, F29	Schizotypal and other delusional disorders	81	n.p.	299	n.p.	0.4
F22	Persistent delusional disorders	21	n.p.	254	n.p.	0.3
F23	Acute and transient psychotic disorders	54	n.p.	172	n.p.	0.2
F25	Schizoaffective disorders	323	n.p.	2,869	n.p.	3.5
F30	Manic episode	15	0	34	49	0.1
F31	Bipolar affective disorders	167	0	4,489	4,656	5.0
F32	Depressive episode	2,675	63	17,728	20,466	22.2
F33	Recurrent depressive disorders	318	n.p.	15,069	n.p.	16.7
F34	Persistent mood (affective) disorders	115	n.p.	1,147	n.p.	1.4
F38–F39	Other and unspecified mood (affective) disorders	89	0	51	140	0.2
F40	Phobic anxiety disorders	70	0	953	1,023	1.1
F41	Other anxiety disorders	668	114	6,012	6,794	7.4
F42	Obsessive-compulsive disorders	69	0	848	917	1.0
F43	Reaction to severe stress and adjustment disorders	1,277	53	9,093	10,423	11.3
F44	Dissociative (conversion) disorders	13	0	663	676	0.7
F45, F48	Somatoform and other neurotic disorders	88	0	245	333	0.4
F50	Eating disorders	502	11	2,522	3,035	3.3
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	5	0	82	87	0.1
F60	Specific personality disorders	416	16	2,771	3,203	3.5
F61–F69	Disorders of adult personality and behaviour	6	n.p.	192	n.p.	0.2
F70–F79	Mental retardation	18	n.p.	n.p.	n.p.	0.0
F80–F89	Disorders of psychological development	151	106	116	373	0.4
F90	Hyperkinetic disorders	210	306	46	562	0.6
F91	Conduct disorders	591	606	75	1,272	1.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	136	220	37	393	0.4
F99	Mental disorder not otherwise specified	9	n.p.	837	n.p.	0.9
G30	Alzheimer's disease	0	0	91	91	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	130	94	6	230	0.2
	Other specified mental health-related principal diagnosis[c]	34	0	108	142	0.2
	Other[d]	714	92	1,912	2,718	2.9
Total		**10,510**	**1,775**	**80,084**	**92,369**	**100.0**

(continued)

Table 5.4 (continued): Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2004–05

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		Without specialised psychiatric care				
F00–F03	Dementia	95	0	23	118	0.5
F04–F09	Other organic mental disorders	76	0	n.p.	n.p.	0.3
F10	Mental and behavioural disorders due to use of alcohol	4,244	n.p.	5,016	n.p.	37.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	920	n.p.	543	n.p.	6.0
F20	Schizophrenia	491	0	40	531	2.2
F21, F24, F28, F29	Schizotypal and other delusional disorders	158	0	0	158	0.6
F22	Persistent delusional disorders	98	0	n.p.	n.p.	0.4
F23	Acute and transient psychotic disorders	123	0	n.p.	n.p.	0.5
F25	Schizoaffective disorders	53	0	33	86	0.4
F30	Manic episode	36	0	11	47	0.2
F31	Bipolar affective disorders	172	0	244	416	1.7
F32	Depressive episode	1,198	n.p.	1,615	n.p.	11.5
F33	Recurrent depressive disorders	102	0	526	628	2.6
F34	Persistent mood (affective) disorders	53	0	32	85	0.3
F38–F39	Other and unspecified mood (affective) disorders	17	0	25	42	0.2
F40	Phobic anxiety disorders	7	0	12	19	0.1
F41	Other anxiety disorders	1,451	0	612	2,063	8.4
F42	Obsessive-compulsive disorders	11	0	0	11	0.0
F43	Reaction to severe stress and adjustment disorders	882	n.p.	318	n.p.	4.9
F44	Dissociative (conversion) disorders	105	0	0	105	0.4
F45, F48	Somatoform and other neurotic disorders	87	0	n.p.	n.p.	0.4
F50	Eating disorders	481	0	77	558	2.3
F51–F59	Other behavioural syndromes associated with physiolological disturbances and physical factors	43	0	55	98	0.4
F60	Specific personality disorders	296	0	31	327	1.3
F61–F69	Disorders of adult personality and behaviour	30	0	n.p.	n.p.	0.1
F70–F79	Mental retardation	17	0	n.p.	n.p.	0.1
F80–F89	Disorders of psychological development	22	0	n.p.	n.p.	0.1
F90	Hyperkinetic disorders	36	0	0	36	0.1
F91	Conduct disorders	321	0	0	321	1.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	49	0	0	49	0.2
F99	Mental disorder not otherwise specified	49	0	0	49	0.2
G30	Alzheimer's disease	33	0	0	33	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	115	n.p.	n.p.	n.p.	0.5
	Other specified mental health-related principal diagnosis[c]	2,367	0	946	3,313	13.6
Total		**14,238**	**10**	**10,170**	**24,418**	**100.0**

(continued)

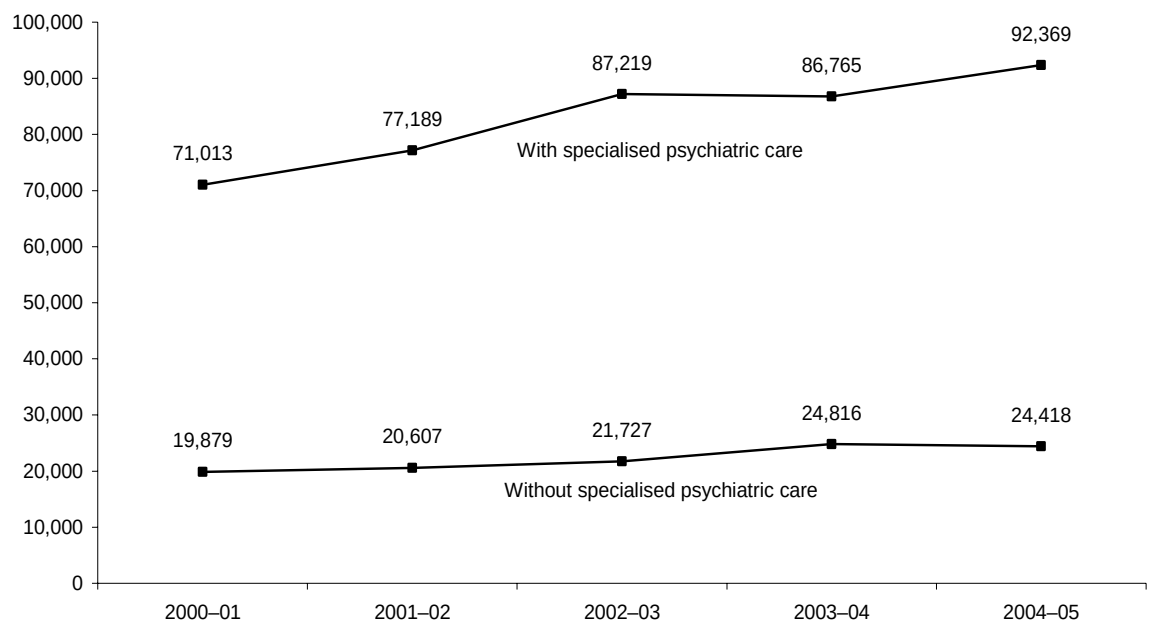
Table 5.4 (continued): Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2004–05

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		Total				
F00–F03	Dementia	100	n.p.	342	n.p.	0.4
F04–F09	Other organic mental disorders	91	n.p.	244	n.p.	0.3
F10	Mental and behavioural disorders due to use of alcohol	4,755	43	11,441	16,239	13.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,161	13	1,739	2,913	2.5
F20	Schizophrenia	1,264	25	3,219	4,508	3.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	239	n.p.	299	n.p.	0.5
F22	Persistent delusional disorders	119	n.p.	256	n.p.	0.3
F23	Acute and transient psychotic disorders	177	n.p.	173	n.p.	0.3
F25	Schizoaffective disorders	376	n.p.	2,902	n.p.	2.8
F30	Manic episode	51	0	45	96	0.1
F31	Bipolar affective disorders	339	0	4,733	5,072	4.3
F32	Depressive episode	3,873	64	19,343	23,280	19.9
F33	Recurrent depressive disorders	420	n.p.	15,595	n.p.	13.7
F34	Persistent mood (affective) disorders	168	n.p.	1,179	n.p.	1.2
F38–F39	Other and unspecified mood (affective) disorders	106	0	76	182	0.2
F40	Phobic anxiety disorders	77	0	965	1,042	0.9
F41	Other anxiety disorders	2,119	114	6,624	8,857	7.6
F42	Obsessive-compulsive disorders	80	0	848	928	0.8
F43	Reaction to severe stress and adjustment disorders	2,159	56	9,411	11,626	10.0
F44	Dissociative (conversion) disorders	118	0	663	781	0.7
F45, F48	Somatoform and other neurotic disorders	175	0	247	422	0.4
F50	Eating disorders	983	11	2,599	3,593	3.1
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	48	0	137	185	0.2
F60	Specific personality disorders	712	16	2,802	3,530	3.0
F61–F69	Disorders of adult personality and behaviour	36	n.p.	193	n.p.	0.2
F70–F79	Mental retardation	35	n.p.	n.p.	n.p.	0.0
F80–F89	Disorders of psychological development	173	106	117	396	0.3
F90	Hyperkinetic disorders	246	306	46	598	0.5
F91	Conduct disorders	912	606	75	1,593	1.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	185	220	37	442	0.4
F99	Mental disorder not otherwise specified	58	n.p.	837	n.p.	0.8
G30	Alzheimer's disease	33	0	91	124	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	245	95	8	348	0.3
	Other specified mental health-related principal diagnosis[c]	2,401	0	1,054	3,455	3.0
	Other[d]	714	92	1,912	2,718	2.3
Total		**24,748**	**1,785**	**90,254**	**116,787**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.
(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.
(d) Includes all other codes not included as a mental health principal diagnosis as listed in Appendix 4.
n.p. Not published.
Source: National Hospital Morbidity Database.

5.5 Ambulatory-equivalent mental health-related separations, 2000–01 to 2004–05

The total number of ambulatory-equivalent mental health-related separations increased by 28.5% from 2000–01 (90,892) to 2004–05 (116,787). Those separations that involved specialised psychiatric care increased by 30.1% in that period, while those separations that did not involve specialised psychiatric care increased by 22.8% (Figure 5.1).



Note: Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 5.1: Ambulatory-equivalent mental health-related separations, with and without specialised psychiatric care, 2000–01 to 2004–05

5.6 Procedures

Table 5.5 details the number of separations relating to the 10 procedures (or interventions) most frequently reported for ambulatory-equivalent mental health-related hospital separations. Procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on the classification is included in Appendix 3.

A total of 50,486 procedures were reported in relation to 45,278 separations; this reflects the fact that more than one procedure can be reported for each separation. No procedure was reported for 71,509 separations. The most frequently reported procedures were *Cognitive behaviour therapy* (14,185 procedures for 14,185 separations), *Psychological skills training* (5,786 procedures for 5,784 separations) and *Allied health intervention, psychology* (4,994 procedures for 4,994 separations).

Table 5.5: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations[a], 2004–05

Procedure	Procedures[b]		Separations	
	Number	Per cent	Number	Per cent
96101–00 Cognitive behaviour therapy	14,185	28.1	14,185	12.1
96001–00 Psychological skills training	5,786	11.5	5,784	5.0
95550–10 Allied health intervention, psychology	4,994	9.9	4,994	4.3
96180–00 Other psychotherapies or psychosocial therapies	4,977	9.9	4,970	4.3
96073–00 Substance addiction counselling or education	3,641	7.2	3,641	3.1
96090–00 Other counselling or education	3,596	7.1	3,596	3.1
92002–00 Alcohol rehabilitation	2,718	5.4	2,718	2.3
95550–02 Allied health intervention, occupational therapy	1,809	3.6	1,809	1.5
96185–00 Supportive psychotherapy, not elsewhere classified	1,734	3.4	1,732	1.5
96177–00 Interpersonal psychotherapy	1,376	2.7	1,373	1.2
Other reported procedures	5,652	11.2	5,293	4.5
No procedure reported	. .	. .	71,509	61.2
Total	**50,468**	**100.0**	**116,787[c]**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations since the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total since multiple procedures can be reported for each separation.

. . Not applicable.

Source: National Hospital Morbidity Database.

5.7 Additional data

Additional tables containing data on ambulatory-equivalent mental health-related separations are available from the AIHW's website. As well, additional data on ambulatory-equivalent mental health-related separations from the NHMD can be accessed via interactive data cubes on the AIHW's website. The data cubes allow users to create customised tables based on the number of separations by age group, sex, sector, mental health legal status and year and type of separation, for each principal diagnosis. See Section 1.5 for details on how to access these additional resources.

6 Medicare-subsidised psychiatrist services

6.1 Introduction

This chapter presents information on ***Medicare-subsidised psychiatrist services***. It includes the number and types of services provided and the characteristics of people who received these services. Note that a person may access more than one type of Medicare-subsidised psychiatrist service during the reporting period; each service is counted separately in the counts of services presented in this chapter.

The benefits paid by Medicare are based on the Medicare Benefits Schedule (MBS) (DoHA 2006b). The schedule allocates a unique item number to each medical service, as well as indicating the scheduled payment.

The data presented in this chapter refer to Medicare-subsidised psychiatrist services processed in the 2005–06 financial year; for comparison purposes, data are also presented from 2000–01 to 2004–05. More detailed information on the scope and coverage of the data presented in this chapter is provided in Appendix 1.

Key concepts

Medicare-subsidised psychiatrist services: services provided by a psychiatrist (or, for electroconvulsive therapy, by either a psychiatrist or another medical practitioner) on a fee-for-service basis that are partially or fully funded under the Australian Government's Medicare program and as listed in Table 6.2.

People who access Medicare-subsidised psychiatrist services may have been referred to a psychiatrist by a general practitioner for the specialised management of mental health-related conditions. As described in Chapter 2, 10.2 of every 100 mental health-related problems managed by general practitioners in 2003–04 were managed by a referral being provided, with the most common referral being to a psychiatrist (2.3 per 100 mental health-related problems managed).

The Medicare-subsidised psychiatrist services cover patient attendances (or consultations) provided in different settings as well as other services such as group psychotherapy, case conferencing and electroconvulsive therapy (ECT). The types of services covered in this chapter relate to specific Medicare item codes (as shown in Table 6.2) and as described below.

Attendances: in this chapter, the data on patient attendances have been aggregated according to both duration (for example, 15 minutes or less, 16 to 30 minutes) and setting, including consulting rooms, hospitals and other locations (such as for home visits).

Other services: data are also presented in this chapter on the following services funded under Medicare:

- group psychotherapy;
- interview of a person other than a patient;

- telepsychiatry (that is, use of communications technology in the provision of psychiatric services);
- case conferencing; and
- electroconvulsive therapy.

More details on the specific Medicare items can be found in the *Medicare Benefits Schedule book* (DoHA 2006b). Note that with the exception of ECT (item 14224), only medical practitioners who are recognised as psychiatrists for the purposes of the Health Insurance Act are eligible to claim the Medicare items considered in this chapter.

In addition to the information on the Medicare-subsidised psychiatrist services presented in this chapter, other information pertaining to psychiatrists is included in this report as follows:

- medications prescribed by psychiatrists and subsidised under the PBS/RPBS are outlined in Chapter 11;
- information on the psychiatrist workforce (including both clinical and non-clinical psychiatrists, and salaried and private providers) is presented in Chapter 13; and
- data on expenditure on both Medicare-subsidised psychiatrist services and PBS/RPBS subsidised prescriptions provided by psychiatrists are detailed in Chapter 14.

Note also that some of the services covered in this chapter (such as ECT and in-hospital services) are also included in other parts of this publication.

6.2 People accessing Medicare-subsidised psychiatrist services

Overall, in 2005–06, an estimated 17,920,110 people (or 87.6% of the population) were provided with Medicare-subsidised services, while an estimated 272,259 people (or 1.5% of the population) received Medicare-subsidised psychiatrist services. Thus, on average, around one in every 75 Australians was provided with one or more Medicare-subsidised psychiatrist service in 2005–06.

During this period, 2,015,941 Medicare-subsidised psychiatrist services were provided, giving an average number of services per patient of 7.4 (Table 6.1).

Females utilised the psychiatrist services subsidised through Medicare to a greater extent than males, making up more than half (54.8%) of the patients and averaging 8.2 services each (compared with 6.4 services per male). The number of female patients per 1,000 population (14.5) was also higher than that for males (12.1).

In 2005–06, 45.1% of patients were aged 35 to 54 years and accounted for almost half (47.5%) of all Medicare-subsidised psychiatrist services.

When the size of the population in each jurisdiction is taken into account, people in South Australia and Victoria were relatively more likely than those in other jurisdictions to be provided with a Medicare-subsidised psychiatrist service (16.2 and 15.5 per 1,000 population, respectively) (Table 6.2).

The number of patients that received Medicare-subsidised psychiatrist services was highest in relation to attendances in consulting rooms (261,224 patients), followed by attendances in hospitals (16,474), other services (13,446) and attendances in other locations (3,764).

Table 6.1: People receiving Medicare-subsidised psychiatrist services: patient demographic characteristics and services received, 2005–06

Patient demographics	Number of people[(a)]	Per cent of people[(b)]	Rate (per 1,000 population)[(c)]	Number of services	Per cent of services	Services per person
Age						
Less than 15 years	10,591	3.9	2.7	41,180	2.0	3.9
15–24 years	34,696	12.7	12.2	214,023	10.6	6.2
25–34 years	48,805	17.9	17.0	347,022	17.2	7.1
35–44 years	61,173	22.5	20.3	467,046	23.2	7.6
45–54 years	61,646	22.6	21.9	489,078	24.3	7.9
55–64 years	41,194	15.1	18.5	301,546	15.0	7.3
65+ years	25,487	9.4	9.4	156,046	7.7	6.1
Sex						
Male	123,198	45.3	12.1	793,688	39.4	6.4
Female	149,077	54.8	14.5	1,222,253	60.6	8.2
Total	**272,259**	**100.0**	**13.3**	**2,015,941**	**100.0**	**7.4**

(a) The numbers of patients for each demographic category may exceed the total since people who accessed more than one service in any one year can be recorded within more than one age group and sex.

(b) The percentages shown are calculated as a proportion of the total number of people and will therefore sum to more than 100% (as described in footnote 'a', people can be counted in more than one demographic category).

(c) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2005.

Source: Medicare data (DoHA).

Over the period from 2000–01 to 2005–06, the number of patients provided with Medicare-subsidised psychiatrist services declined from 284,072 to 272,259; this represents an average annual decline of 0.8%. The number of patients per 1,000 population also declined over that period, from 14.7 patients per 1,000 to 13.3 per 1000 (Table 6.3).

There was a decline in the number of patients who had attendances in consulting rooms (an annual average decline of 0.9%) from 2000–01 to 2005–06 and other services (an annual average decline of 3.1%). However, the number of patients who had attendances in hospitals and in other locations increased (0.9% and 6.8%, respectively). Persons who received group psychotherapy accounted for the biggest percentage decrease in the number of people accessing Medicare-subsidised psychiatrist services from 2000–01 to 2005–06 (5.8% average decrease per year).

Table 6.2: People receiving Medicare-subsidised psychiatrist services, by type of service provided, states and territories[a], 2005–06

MBS item	Service	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[b]
Patient attendances in consulting room										
300, 310	15 minutes or less	5,871	3,841	2,510	2,159	1,140	380	581	264	16,720
302, 312	16 to 30 minutes	25,425	21,616	17,397	6,705	6,490	1,572	1,631	291	80,954
293, 304, 314	31 to 45 minutes	39,252	37,859	26,784	10,251	12,013	2,756	1,623	323	130,528
306, 316	46 to 75 minutes	50,664	48,169	27,279	9,990	16,081	2,486	1,942	424	156,481
308, 318	Over 75 minutes	7,614	6,225	3,592	2,196	3,459	549	274	31	23,918
291, 319	Selected cases (> 45 minutes)	1,649	834	509	74	479	46	38	2	3,623
Subtotal		*86,114*	*74,725*	*48,417*	*19,740*	*24,505*	*4,507*	*3,581*	*797*	*261,224*
Patient attendances in hospital										
320	15 minutes or less	689	1,141	719	377	227	181	61	3	3,393
322	16 to 30 minutes	2,453	2,672	2,785	1,147	642	445	93	17	10,231
324	31 to 45 minutes	3,519	2,862	2,754	1,250	747	518	105	15	11,734
326	46 to 75 minutes	3,200	2,935	2,284	1,029	695	421	83	13	10,631
328	Over 75 minutes	1,125	959	572	661	211	184	38	3	3,749
Subtotal		*4,957*	*4,197*	*3,924*	*1,606*	*994*	*659*	*171*	*27*	*16,474*
Patient attendances in other locations										
330	15 minutes or less	235	110	34	32	4	1	0	1	417
332	16 to 30 minutes	600	343	52	44	34	6	1	2	1,082
334	31 to 45 minutes	1,069	367	52	40	65	9	0	1	1,603
336	46 to 75 minutes	1,089	401	78	54	98	15	10	3	1,746
338	Over 75 minutes	489	95	30	25	58	2	3	0	702
Subtotal		*2,297*	*903*	*191*	*121*	*210*	*27*	*13*	*6*	*3,764*
Other services										
342, 344, 346	Group psychotherapy	2,381	4,082	575	167	526	283	17	5	8,024
348, 350, 352	Interview with non-patient	864	968	771	527	310	76	54	10	3,578
353, 355, 356, 357, 358,364, 366, 367, 369, 370	Telepsychiatry	76	29	62	5	2	1	1	6	181
855, 857, 858, 861, 864, 866	Case conferencing	48	182	9	5	129	63	0	0	434
14224	Electroconvulsive therapy[b]	559	482	429	183	127	62	17	3	1,861
Subtotal		*3,752*	*5,518*	*1,775*	*874*	*1,042*	*392*	*88*	*23*	*13,446*
Total[c]		**90,682**	**78,227**	**50,048**	**20,238**	**25,030**	**4,779**	**3,678**	**818**	**272,259**
Rate (per 1,000 population)[d]		13.3	15.5	12.5	10.0	16.2	9.8	11.3	4.0	13.3

(a) State and territory is based on the postcode of the mailing address of the patient as recorded by Medicare.

(b) Information for electroconvulsive therapy may include data for services provided by medical practitioners other than psychiatrists.

(c) The numbers of patients will not sum to the total since a patient may receive more than one type of service in more than one state or territory and therefore may be counted in more than one Medicare item group and state or territory.

(d) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2005.

Source: Medicare data (DoHA).

Table 6.3: People receiving Medicare-subsidised psychiatrist services, by type of service provided, 2000–01 to 2005–06

MBS item	Service	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (%)
Patient attendances in consulting room								
300, 310	15 minutes or less	19,455	18,578	17,516	16,974	16,471	16,720	–3.0
302, 312	16 to 30 minutes	89,186	88,707	86,168	83,709	81,967	80,954	–1.9
293, 304, 314	31 to 45 minutes	136,141	135,472	133,831	133,375	132,160	130,528	–0.8
306, 316	46 to 75 minutes	172,934	167,023	161,699	159,593	158,274	156,481	–2.0
308, 318	Over 75 minutes	23,894	22,963	23,091	23,544	23,675	23,918	0.0
291, 319	Selected cases (> 45 minutes)	1,912	1,954	2,042	2,019	1,994	3,623	13.6
Subtotal		*272,745*	*270,071*	*264,655*	*262,706*	*261,714*	*261,224*	*–0.9*
Patient attendances in hospital								
320	15 minutes or less	4,015	4,057	3,685	3,748	3,407	3,393	–3.3
322	16 to 30 minutes	9,958	10,372	10,397	10,223	9,870	10,231	0.5
324	31 to 45 minutes	10,360	10,849	10,987	11,202	11,157	11,734	2.5
326	46 to 75 minutes	9,428	9,848	9,977	10,054	10,265	10,631	2.4
328	Over 75 minutes	2,900	2,832	2,765	3,261	3,350	3,749	5.3
Subtotal		*15,774*	*15,884*	*15,807*	*16,027*	*15,803*	*16,474*	*0.9*
Patient attendances in other locations								
330	15 minutes or less	275	322	323	360	361	417	8.7
332	16 to 30 minutes	663	833	904	818	930	1,082	10.3
334	31 to 45 minutes	927	1,099	1,184	1,273	1,401	1,603	11.6
336	46 to 75 minutes	1,212	1,312	1,282	1,496	1,653	1,746	7.6
338	Over 75 minutes	675	706	732	676	763	702	0.8
Subtotal		*2,715*	*3,011*	*3,103*	*3,281*	*3,490*	*3,764*	*6.8*
Other services								
342, 344, 346	Group psychotherapy	10,816	10,309	9,338	8,353	7,565	8,024	–5.8
348, 350, 352	Interview with non-patient	3,883	3,313	3,364	3,263	3,401	3,578	–1.6
353, 355, 356, 357, 358, 364, 366, 367, 369, 370	Telepsychiatry	0	0	17	71	115	181	. .
855, 857, 858, 861, 864, 866	Case conferencing	0	0	54	189	340	434	. .
14224	Electroconvulsive therapy[a]	1,476	1,560	1,677	1,631	1,660	1,861	4.7
Subtotal		*15,768*	*14,820*	*14,086*	*13,086*	*12,562*	*13,446*	*–3.1*
Total[b]		**284,072**	**281,518**	**275,637**	**273,416**	**272,143**	**272,259**	**–0.8**
Rate (per 1,000 population)[c]		14.7	14.4	14.0	13.7	13.5	13.3	–2.0

(a) Information for electroconvulsive therapy may include data for services provided by medical practitioners other than psychiatrists.

(b) The numbers of patients will not sum to the total since a patient may receive more than one type of service and therefore may be counted in more than one Medicare item group.

(c) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2005.

. . Not applicable.

Source: Medicare data (DoHA).

6.3 Medicare-subsidised psychiatrist services

The previous section of this chapter focused on the number of people who received Medicare-subsidised psychiatrist services. In this section, the focus is on the number of services provided.

The 2,015,941 services that were provided by psychiatrists and subsidised through Medicare in 2005-06 is equivalent to a rate of 98.6 services per 1,000 population (Table 6.4). These services represented 0.8% of all Medicare-subsidised services (247.4 million) and 9.4% of all the Medicare-subsidised specialist attendances (21.3 million) provided in that year.

Most of the Medicare-subsidised psychiatrist services (84.8%) were attendances provided in consulting rooms, followed by attendances in hospitals (11.2%). In 2005–06, 45.2% of the attendances in consulting rooms lasted between 46 and 75 minutes. While 41.1% of services located in the hospital setting lasted between 16 and 30 minutes, over half (56.4%) of the services provided in other locations lasted between 31 and 75 minutes. Group psychotherapy accounted for most of the other services provided (64.6%).

Victoria accounted for the highest proportion of Medicare-subsidised psychiatrist services provided (32.9% or 663,942), as well as the highest rate (131.4 per 1,000 population) among the states and territories (Table 6.4). New South Wales had the second highest proportion of services provided (30.5%). However, when the population size in each jurisdiction is taken into account, there were more Medicare-subsidised psychiatrist services provided in South Australia, Queensland and Tasmania (116.7, 91.5 and 91.0 per 1,000 population, respectively) than in New South Wales (90.4 per 1,000 population). The Northern Territory had the lowest rate, with 21.9 Medicare-subsidised psychiatrist services provided per 1,000 population.

Consistent with the decline in the number of patients provided with Medicare-subsidised psychiatrist services from 2000–01 to 2005–06 (as discussed earlier), the number of services also declined during this period from 2,126,363 to 2,015,941. This equates to an average annual decline of 1.1% (Table 6.5).

Between 2000–01 and 2005–06, there was an increase in patient attendances for psychiatrist services provided in locations other than consulting rooms or hospitals (6.3% increase on average per year) and in hospital (3.7%), while the number of attendances in consulting rooms decreased at an average annual rate of 1.6%. The number of other services, as a group, declined by 1.4% annually, on average, from 2000–01 to 2005–06. In contrast, the number of electroconvulsive therapy services increased over the period from 13,999 to 18,083 (an average annual increase of 5.3%).

Table 6.4: Medicare-subsidised psychiatrist services, by type of service provided, states and territories[a], 2005–06

MBS item	Service	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Patient attendances in consulting room										
300, 310	15 minutes or less	18,735	9,506	5,496	4,235	2,624	1,700	1,237	1,233	44,766
302, 312	16 to 30 minutes	88,718	79,467	59,747	17,011	19,652	6,344	5,072	1,187	277,198
293, 304, 314	31 to 45 minutes	127,145	155,596	106,836	33,846	42,299	12,852	5,054	899	484,527
306, 316	46 to 75 minutes	251,891	278,666	107,179	33,974	83,175	8,802	7,624	854	772,165
308, 318	Over 75 minutes	14,359	12,939	6,807	2,888	8,070	1,583	536	47	47,229
291, 319	Selected cases (> 45 min)	34,984	29,251	8,363	1,439	7,609	247	1,098	2	82,993
	Subtotal	*535,832*	*565,425*	*294,428*	*93,393*	*163,429*	*31,528*	*20,621*	*4,222*	*1,708,878*
Patient attendances in hospital										
320	15 minutes or less	2,031	5,555	2,112	2,939	868	658	242	5	14,410
322	16 to 30 minutes	13,682	26,901	36,688	7,669	4,322	3,297	252	92	92,903
324	31 to 45 minutes	18,059	18,852	14,564	6,729	3,977	3,774	339	51	66,345
326	46 to 75 minutes	14,293	14,186	6,651	3,823	3,299	1,684	348	23	44,307
328	Over 75 minutes	2,563	2,155	1,004	1,253	514	348	107	9	7,953
	Subtotal	*50,628*	*67,649*	*61,019*	*22,413*	*12,980*	*9,761*	*1,288*	*180*	*225,918*
Patient attendances in other locations										
330	15 minutes or less	547	335	66	132	4	1	0	1	1,086
332	16 to 30 minutes	1,575	1,049	91	146	53	19	1	2	2,936
334	31 to 45 minutes	2,268	968	145	55	110	14	0	1	3,561
336	46 to 75 minutes	2,338	940	296	96	261	26	14	3	3,974
338	Over 75 minutes	1,106	200	92	55	333	9	3	0	1,798
	Subtotal	*7,834*	*3,492*	*690*	*484*	*761*	*69*	*18*	*7*	*13,355*
Other services										
342, 344, 346	Group psychotherapy	14,008	21,625	3,244	1,245	1,209	2,294	163	9	43,797
348, 350,352	Interview with non-patient	1,169	1,353	1,103	625	413	107	65	10	4,845
353, 355, 356, 357, 358, 364, 366, 367, 369, 370	Telepsychiatry	193	39	102	7	2	4	1	21	369
855, 857, 858, 861, 864, 866	Case conferencing	51	271	10	8	258	98	0	0	696
14224	Electroconvulsive therapy[b]	5,291	4,088	5,315	1,436	1,328	455	145	25	18,083
	Subtotal	*20,712*	*27,376*	*9,774*	*3,321*	*3,210*	*2,958*	*374*	*65*	*67,790*
Total		**615,006**	**663,942**	**365,911**	**119,611**	**180,380**	**44,316**	**22,301**	**4,474**	**2,015,941**
Rate (per 1,000 population) [c]		90.4	131.4	91.5	59.0	116.7	91.0	68.3	21.9	98.6

(a) State and territory is based on the postcode of the mailing address of the patient as recorded by Medicare.

(b) Information for electroconvulsive therapy may include data for services provided by medical practitioners other than psychiatrists.

(c) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2005.

Source: Medicare data (DoHA).

Table 6.5: Medicare-subsidised psychiatrist services, by type of service provided, 2000–01 to 2005–06

MBS item	Service	2000–01	2001–02	2002–03	2003–04	2004-05	2005–06	Average annual change (%)
Patient attendances in consulting room								
300, 310	15 minutes or less	57,357	54,811	47,939	44,341	43,648	44,766	–4.8
302, 312	16 to 30 minutes	312,246	307,553	296,656	282,098	280,529	277,198	–2.4
293, 304, 314	31 to 45 minutes	485,778	483,954	487,656	492,899	488,545	484,527	–0.1
306, 316	46 to 75 minutes	869,734	842,716	816,480	793,932	779,805	772,165	–2.4
308, 318	Over 75 minutes	45,186	43,149	44,788	44,666	46,807	47,229	0.9
291, 319	Selected cases (> 45 min)	85,401	89,221	87,818	87,536	84,264	82,993	–0.6
	Subtotal	*1,855,702*	*1,821,404*	*1,781,337*	*1,745,472*	*1,723,598*	*1,708,878*	*–1.6*
Patient attendances in hospital								
320	15 minutes or less	20,364	19,635	17,510	16,480	14,669	14,410	–6.7
322	16 to 30 minutes	78,693	83,191	88,543	87,160	86,910	92,903	3.4
324	31 to 45 minutes	48,256	53,380	56,044	59,345	60,916	66,345	6.6
326	46 to 75 minutes	35,471	36,319	37,765	39,662	40,190	44,307	4.5
328	Over 75 minutes	5,421	5,374	5,183	6,349	6,609	7,953	8
	Subtotal	*188,205*	*197,899*	*205,045*	*208,996*	*209,294*	*225,918*	*3.7*
Patient attendances in other locations								
330	15 minutes or less	736	1,059	1,076	1,136	1,080	1,086	8.1
332	16 to 30 minutes	1,854	2,657	2,679	2,157	2,451	2,936	9.6
334	31 to 45 minutes	2,600	2,807	3,106	3,062	3,096	3,561	6.5
336	46 to 75 minutes	3,068	3,822	4,179	3,790	3,967	3,974	5.3
338	Over 75 minutes	1,584	2,005	1,788	1,983	1,825	1,798	2.6
	Subtotal	*9,842*	*12,350*	*12,828*	*12,128*	*12,419*	*13,355*	*6.3*
Other services								
342, 344, 346	Group psychotherapy	53,221	49,138	45,078	41,641	40,611	43,797	–3.8
348, 350, 352	Interview with non-patient	5,394	4,304	4,294	4,301	4,670	4,845	–2.1
353, 355, 356, 357, 358, 364, 366, 367, 369, 370	Telepsychiatry	0	0	19	177	228	369	. .
855, 857, 858, 861, 864, 866	Case conferencing	0	0	62	274	545	696	. .
14224	Electroconvulsive therapy[(a)]	13,999	14,937	16,412	15,469	15,853	18,083	5.3
	Subtotal	*72,614*	*68,379*	*65,865*	*61,862*	*61,907*	*67,790*	*–1.4*
Total		**2,126,363**	**2,100,032**	**2,065,075**	**2,028,458**	**2,007,218**	**2,015,941**	**–1.1**
Rate (per 1,000 population)[(b)]		110.3	107.5	104.5	101.5	99.3	98.6	–2.2

(a) Information for electroconvulsive therapy may include data for services provided by medical practitioners other than psychiatrists.

(b) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2005.

. . Not applicable.

Source: Medicare data (DoHA).

As noted earlier, the average number of Medicare-subsidised psychiatrist services per patient in 2005–06 was 7.4 (Tables 6.1 and 6.6). This average, however, varies across demographic groups (Table 6.1) and by type of service provided (Table 6.6). The highest average number of services per patient was for attendances in hospital (13.7 services per patient), followed by attendances in consulting rooms (6.5).

Table 6.6: Medicare-subsidised psychiatrist services summary, by Medicare item, 2005–06

Medicare item group	Number of patients[(a)]	Number of services	Services per patient
Patient attendances in consulting room	261,224	1,708,878	6.5
Patient attendances in hospital	16,474	225,918	13.7
Patient attendances in other locations	3,764	13,355	3.5
Other services	13,446	67,790	5.0
Total	**272,259**	**2,015,941**	**7.4**

(a) The numbers of patients will not sum to the total as a patient may receive more than one type of service and therefore may be counted in more than one Medicare item group.

Source: Medicare data (DoHA).

7 Admitted patient mental health-related care

7.1 Introduction

In this chapter, information is presented on mental health care provided to hospital ***admitted patients*** in the form of ***mental health-related separations***, excluding ambulatory-equivalent mental health-related separations (see Chapter 5). The data are from the National Hospital Morbidity Database (NHMD) which is a collation of data on admitted patient care in Australian hospitals (see Appendix 1 for more information on the database). Note that data on individual people are not available in this data collection; that is, there is no way of calculating how many ***separations*** an individual person had.

Admitted patient mental health-related separations can be divided into those that involved ***specialised psychiatric care*** (which are presented in Section 7.2 of this chapter) and those that did not involve specialised psychiatric care (Section 7.3). In Section 7.4, an overview is provided on separations that were not considered to be mental health-related but for which a mental health-related additional diagnosis was reported.

Key concepts

Separation refers to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). *Separation* also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care. Separation data provide information on the number of hospital stays completed in a designated period, typically a financial year. These data can be used as a measure of hospital activity; however, they can represent quite different types of activity. That is, some separations will occur after same day stays in hospital, some for stays of a few days, while others can be for stays of months or, rarely, years. Thus, the separations data do not allow accurate comparison of hospitals that tend to provide for longer stays and report fewer separations (for example, public psychiatric hospitals) with hospitals that concentrate on providing numerous short stays (for example, acute care hospitals).

An ***admitted patient*** is a patient who undergoes a hospital's formal admission process and completes an episode of care and 'separates' from the hospital.

A separation is classified as ***mental health-related*** for the purposes of this report if:

- it had a mental health-related principal diagnosis which, for admitted patient care in this report, is defined as a principal diagnosis that is either a diagnosis that falls within the chapter on 'Mental and behavioural disorders' (Chapter 5) in the ICD-10-AM classification (that is, codes F00 to F99) or a number of other selected diagnoses (see Appendix 4 for a full list of applicable diagnoses); and/or
- it included any specialised psychiatric care.

A separation is classified as having ***specialised psychiatric care*** if the patient was reported as having one or more days in a specialised psychiatric unit or ward.

(continued)

Patient day means the occupancy of a hospital bed (or chair in the case of some same day patients) by an admitted patient for all or part of a day. The patient day (and psychiatric care day) data measure hospital activity in a way that is not as affected by variation in length of stay, as short-stay activity is represented in the same way as long-stay activity. However, the patient day data presented in this report include days within hospital stays that occurred before 1 July 2004 provided that the separation from hospital occurred during 2004–05. This has little or no impact in private and public acute hospitals, where separations are relatively brief, throughput is relatively high and the patient days that occurred in the previous year are expected to be approximately balanced by the patient days not included in the counts because they are associated with patients yet to separate from the hospital and therefore yet to be reported. However, some public psychiatric hospitals provide very long stays for small numbers of patients and, as a result, would have comparatively large numbers of patient days recorded that occurred before 2004–05 and that may not be balanced by patient days associated with patients yet to separate from the hospital.

Psychiatric care days are the number of days or part-days the person received care as an admitted patient in a designated psychiatric unit or ward.

Average length of stay is the average number of patient days for admitted patient separations.

Table 7.1 provides a summary of admitted patient mental health-related separations both with and without specialised psychiatric care, as well as the ***patient days***, ***psychiatric care days*** and ***average length of stay*** data related to those separations by hospital type from 2000–01 to 2004–05.

In 2004–05, there were 199,353 mental health-related separations for admitted patient care. These accounted for 2.8% of all hospital separations reported to the NHMD in 2004–05 and 63.1% of all separations (that is, ambulatory-equivalent separations and others combined) considered to be mental health-related. (See Chapter 5 for more information on ambulatory-equivalent mental health-related separations.)

Between 2000–01 and 2004–05, there was an average annual increase of 2.0% in both the number of mental health-related separations for admitted patient care and in the number of patient days for these separations. Over this same period, the average annual increase in the number of psychiatric care days was 3.7%.

Of the 199,353 mental health-related separations, 147,147 (73.8%) were from public acute hospitals, 38,183 (19.2%) were from private hospitals and 14,023 (7.0%) were from public psychiatric hospitals. Of the 116,852 separations with specialised psychiatric care, 65.2% were from public acute hospitals, 23.8% from private hospitals and 11.0% from public psychiatric hospitals. Of the 82,501 mental health-related separations without specialised psychiatric care, 86.0% were from public acute hospitals, 12.6% from private hospitals and 1.4% from public psychiatric hospitals.

The total number of separations with specialised psychiatric care increased from 107,474 in 2000–01 to 116,852 in 2004–05, with an average annual increase of 2.1%. The number of separations for public acute hospitals and private hospitals increased, showing average annual increases of 3.2% and 2.9%, respectively. However, the number of separations for public psychiatric hospitals shows an average annual decrease of 4.6%.

The total number of separations without specialised psychiatric care increased from 76,507 in 2000–01 to 82,501 in 2004–05, with an average annual increase of 1.9%. The number of separations for both public acute hospitals and public psychiatric hospitals has increased since 2000–01, showing average annual increases of 3.0% and 16.1%, respectively. However, the number of separations for private hospitals shows an average annual decrease of 5.3%.

Table 7.1: Statistics for admitted patient mental health-related separations[a] with and without specialised psychiatric care, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Average annual change (%)
			Separations			
Separations with specialised psychiatric care						
Public acute hospitals	67,100	71,863	73,972	76,042	76,172	3.2
Public psychiatric hospitals[b]	15,543	13,905	13,371	14,188	12,887	–4.6
Private hospitals	24,831	25,201	25,702	26,495	27,793	2.9
Total	*107,474*	*110,969*	*113,045*	*116,725*	*116,852*	*2.1*
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	62,950	63,755	66,607	68,087	70,975	3.0
Public psychiatric hospitals[b][c]	625	787	1,055	1,048	1,136	16.1
Private hospitals	12,932	11,532	11,462	11,852	10,390	–5.3
Total	*76,507*	*76,074*	*79,124*	*80,987*	*82,501*	*1.9*
Total mental health-related separations						
Public acute hospitals	130,050	135,618	140,579	144,129	147,147	3.1
Public psychiatric hospitals[b]	16,168	14,692	14,426	15,236	14,023	–3.5
Private hospitals	37,763	36,733	37,164	38,347	38,183	0.3
Total	**183,981**	**187,043**	**192,169**	**197,712**	**199,353**	**2.0**
			Patient days			
Patient days for separations with specialised psychiatric care[d]						
Public acute hospitals	960,726	1,031,566	1,078,122	1,118,512	1,208,422	5.9
Public psychiatric hospitals[b][e]	718,943	995,700	885,541	666,275	757,916	1.3
Private hospitals	400,759	431,217	420,496	424,787	441,617	2.5
Total	*2,080,428*	*2,458,483*	*2,384,159*	*2,209,574*	*2,407,955*	*3.7*
Patient days for mental health-related separations without specialised psychiatric care						
Public acute hospitals	463,406	480,587	427,315	399,342	384,160	–4.6
Public psychiatric hospitals[b][c][e]	3,069	4,860	9,758	8,341	19,753	59.3
Private hospitals	143,467	134,021	125,438	120,186	96,120	–9.5
Total	*609,942*	*619,468*	*562,511*	*527,869*	*500,033*	*–4.8*
Total mental health-related patient days						
Public acute hospitals	1,424,132	1,512,153	1,505,437	1,517,854	1,592,582	2.8
Public psychiatric hospitals[b][e]	722,012	1,000,560	895,299	674,616	777,669	1.9
Private hospitals	544,226	565,238	545,934	544,973	537,737	–0.3
Total	**2,690,370**	**3,077,951**	**2,946,670**	**2,737,443**	**2,907,988**	**2.0**
			Psychiatric care days			
Public acute hospitals	942,727	1,013,946	1,061,681	1,099,446	1,183,862	5.9
Public psychiatric hospitals[b][e]	716,176	979,331	866,761	663,541	753,328	1.3
Private hospitals	398,189	428,232	417,560	423,507	440,663	2.6
Total	**2,057,092**	**2,421,509**	**2,346,002**	**2,186,494**	**2,377,853**	**3.7**
			Average length of stay			
Separations with specialised psychiatric care						
Public acute hospitals	14.3	14.4	14.6	14.7	15.9	2.6
Public psychiatric hospitals[b]	46.3	71.6	66.2	47.0	58.8	6.2
Private hospitals	16.1	17.1	16.4	16.0	15.9	–0.4
Total	*19.4*	*22.2*	*21.1*	*18.9*	*20.6*	*1.6*

(continued)

Table 7.1 (continued): Statistics for admitted patient mental health-related separations[(a)] with and without specialised psychiatric care, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Average annual change (%)
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	7.4	7.5	6.4	5.9	5.4	–7.4
Public psychiatric hospitals[(b)(c)]	4.9	6.2	9.2	8.0	17.4	37.2
Private hospitals	11.1	11.6	10.9	10.1	9.3	–4.4
Total	*8.0*	*8.1*	*7.1*	*6.5*	*6.1*	*–6.6*
All mental health-related separations						
Public acute hospitals	11.0	11.2	10.7	10.5	10.8	–0.3
Public psychiatric hospitals[(b)]	44.7	68.1	62.1	44.3	55.5	5.6
Private hospitals	14.4	15.4	14.7	14.2	14.1	–0.6
Total	**14.6**	**16.5**	**15.3**	**13.8**	**14.6**	**–0.1**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) In Tasmania, some long-stay patients in public psychiatric hospitals were integrated into community mental health care services during 2000–01 and 2001–02. Consequently the number of separations and lengths of stay for public psychiatric hospitals may be inflated for those years.

(c) Mental health-related separations without specialised psychiatric care reported by public psychiatric hospitals relate to the provision of alcohol and drug treatment in New South Wales public psychiatric hospitals.

(d) These data indicate the number of patient days for separations with at least some specialised psychiatric care. This figure will not necessarily be equivalent to a count of psychiatric care days since some separations will include days of specialised psychiatric care and days of other care.

(e) Statistical discharge and re-admission of long-stay patients in public psychiatric hospitals in Queensland resulted in reduced patient days and psychiatric care days for 2000–01.

Source: National Hospital Morbidity Database.

A total of 2,907,988 patient days were recorded for the 199,353 mental health-related separations. More than half of these were from public acute hospitals (1,592,582 or 54.8%), while public psychiatric hospitals reported 777,669 patient days (26.7% of total mental health-related patient days) and private hospitals reported 537,737 patient days (18.5%). Note that some public psychiatric hospitals provide very long stays for small numbers of patients. Because lengths of stay for patients of public psychiatric hospitals can very widely and separations may occur unevenly over time, the extent to which patient days that occurred before 2004–05 are balanced by patient days associated with patients yet to separate from hospital is not known. Hospital activity relating to these patients would therefore be better estimated with information on patient days in the reporting year for both patients who separated in the year and patients who did not. However, these data are not available nationally.

Of the 2,407,955 patient days for separations with specialised psychiatric care, 2,377,853 were psychiatric care days (98.7% of patient days).

The average length of stay for all mental health-related separations for admitted patient care was 14.6 days. The average length of stay was much longer for separations from public psychiatric hospitals (55.5 days) than for private hospitals (14.1) and public acute hospitals (10.8). The average length of stay for separations with specialised care was greater than that for mental health-related separations without specialised psychiatric care (20.6 and 6.1 days respectively).

7.2 Specialised admitted patient mental health care

As mentioned in the previous section, specialised admitted patient mental health care refers to those separations for which the patient is reported as having one or more days of specialised psychiatric care. This involves care in a specialised psychiatric unit or ward.

Of the 199,353 mental health-related separations for admitted patient care, 116,852 (58.6%) involved specialised psychiatric care (Table 7.1).

Separations with specialised psychiatric care

Table 7.2 presents information on separations with specialised psychiatric care for Australia as a whole, as well as for each state and territory. Numbers of separations and patient days per 1,000 population are also presented in order to account for variations in the population size and age structure of each jurisdiction. It should be noted that differences in the data presented by jurisdictions may reflect differences in service delivery practices, admission practices and/or the types of establishments categorised as hospitals. Interpretation of the differences between jurisdictions therefore needs to be done with care.

Of the 116,852 separations with specialised psychiatric care, 76,172 (65.2%) were from public acute hospitals, 27,793 (23.8%) from private hospitals and 12,887 (11.0%) from public psychiatric hospitals.

Across the jurisdictions, New South Wales reported the highest number of separations with specialised psychiatric care (36,517), followed by Queensland (27,322) and Victoria (24,858). However, Queensland had the highest number of separations with specialised care per 1,000 population (7.1), followed by South Australia (6.6) and Western Australia (5.9). Due to confidentiality reasons, data on separations and patient days for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory cannot be published, and therefore the total number of separations for these jurisdictions cannot be published. However, these separations and patient days are included in the national total.

New South Wales also reported the highest number of patient days (847,086), followed by Queensland (567,758) and Victoria (470,230). However, when differences in population size and age structure across the jurisdictions are taken into account, the data indicate that Queensland had the highest number of patient days per 1,000 population (147.0), followed by South Australia (130.1) and New South Wales (125.0).

Table 7.3 shows the number of separations with specialised psychiatric care by hospital type and the patient's mental health legal status. For 64.4% of these separations, the patient's mental health legal status was 'voluntary'. There were 39,838 separations where the patient's mental health legal status was 'involuntary'. Public psychiatric hospitals had the highest proportion of separations where the patient's mental health legal status was 'involuntary' (61.5%), compared with public acute hospitals (41.5%) and private hospitals (1.0%).

Table 7.2: Separation[(a)] statistics for admitted patient separations with specialised psychiatric care, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	Separations								
Public acute hospitals	20,444	16,966	20,327	6,818	6,356	2,948	1,139	1,174	76,172
Public psychiatric hospitals	8,018	390	524	1,586	2,125	244	. .	. .	12,887
Private hospitals	8,055	7,502	6,471	3,327	1,699	n.p.	n.p.	n.p.	27,793
Total	**36,517**	**24,858**	**27,322**	**11,731**	**10,180**	**n.p.**	**n.p.**	**n.p.**	**116,852**
	Separations per 1,000 population[(b)]								
Public acute hospitals	3.1	3.4	5.3	3.5	4.2	6.4	3.4	5.7	3.8
Public psychiatric hospitals	1.2	0.1	0.1	0.8	1.4	0.5	. .	. .	0.6
Private hospitals	1.2	1.5	1.7	1.7	1.1	n.p.	n.p.	n.p.	1.4
Total	**5.4**	**4.9**	**7.1**	**5.9**	**6.6**	**n.p.**	**n.p.**	**n.p.**	**5.8**
	Patient days								
Public acute hospitals	347,971	317,051	274,100	126,476	92,151	25,874	13,697	11,102	1,208,422
Public psychiatric hospitals	355,199	41,221	194,964	50,316	89,433	26,783	. .	. .	757,916
Private hospitals	143,916	111,958	98,694	49,972	24,040	n.p.	n.p.	n.p.	441,617
Total	**847,086**	**470,230**	**567,758**	**226,764**	**205,624**	**n.p.**	**n.p.**	**n.p.**	**2,407,955**
	Patient days per 1,000 population[(b)]								
Public acute hospitals	51.6	62.9	71.1	65.3	58.2	55.9	40.6	54.6	59.9
Public psychiatric hospitals	52.3	8.3	50.7	25.3	56.8	54.4	. .	. .	37.7
Private hospitals	21.1	22.1	25.2	25.1	15.1	n.p.	n.p.	n.p.	21.6
Total	**125.0**	**93.2**	**147.0**	**115.7**	**130.1**	**n.p.**	**n.p.**	**n.p.**	**119.2**
	Psychiatric care days								
Public acute hospitals	329,182	317,051	270,607	124,368	92,151	25,874	13,592	11,037	1,183,862
Public psychiatric hospitals	350,611	41,221	194,964	50,316	89,433	26,783	. .	. .	753,328
Private hospitals	143,376	111,958	98,607	49,648	24,040	n.p.	n.p.	n.p.	440,663
Total	**823,169**	**470,230**	**564,178**	**224,332**	**205,624**	**n.p.**	**n.p.**	**n.p.**	**2,377,853**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable.

n.p. Not published.

Source: National Hospital Morbidity Database.

Table 7.3: Admitted patient separations[(a)] with specialised psychiatric care by mental health legal status and hospital type, 2004–05

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	31,625	7,924	289	39,838
Voluntary	42,816	4,963	27,443	75,222
Total[(b)]	**76,172**	**12,887**	**27,793**	**116,852**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Includes separations where mental health legal status was not reported.

Source: National Hospital Morbidity Database.

Patient demographics

Table 7.4 presents information on the number of separations with specialised psychiatric care in 2004–05 according to the characteristics of those receiving care. In addition, a rate (per 1,000 population) is given in order to take into account relative population sizes and age structures. As these are reports of separations (rather than persons), the rates cannot be interpreted as the number of people with specific characteristics per 1,000 population who received specialised admitted patient mental health care. Instead, they provide information on the number of separations relative to the size of the population subgroup.

There were more separations with specialised psychiatric care reported for patients in the 25 to 34 and 35 to 44 years age groups (23.7% and 21.0%, respectively) than for any of the other age groups. The smallest percentage of separations was for patients aged less than 15 years (1.9%).

Female patients accounted for 52.0% of separations while males accounted for 48.0%; relative to their population size and age structure, females had more separations than males (6.0 and 5.6 per 1,000 population, respectively).

Only data on Indigenous status for selected jurisdictions—Queensland, Western Australia, South Australia and public hospitals in the Northern Territory—were considered to be of acceptable quality for analytical purposes (AIHW 2005c) and thus only data from those jurisdictions are presented in Table 7.4. Note that separations for those four jurisdictions are not necessarily representative of those in the other jurisdictions and that caution should be used in the interpretation of these data due to jurisdictional differences in data quality. The data indicate that there were fewer separations with specialised psychiatric care reported for Indigenous Australians than for other Australians (5.8 per 1,000 population and 6.7 per 1,000 population, respectively).

Australian-born patients had a higher rate of separation than those born overseas (6.3 and 3.6 separations per 1,000 population, respectively).

The majority of separations with specialised psychiatric care was for patients living in Major cities (70.3%). This was followed by those living in Inner regional areas (20.4%). However, when variations in population size and age structure of the different areas were taken into account, the rate of separations for patients who were resident in these two areas were similar (that is, 5.9 and 5.8 separations per 1,000 population, respectively).

The most frequently reported marital status was 'never married' (53.4%), followed by 'married' (28.6%).

Table 7.4: Admitted patient separations[a] with specialised psychiatric care by patient demographic characteristics, 2004–05

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate (per 1,000 population)[d]
Age			
Less than 15 years	2,230	1.9	0.6
15–24 years	20,056	17.2	7.3
25–34 years	27,646	23.7	9.6
35–44 years	24,538	21.0	8.2
45–54 years	17,801	15.2	6.5
55–64 years	11,084	9.5	5.3
65 years and over	13,496	11.5	5.2
Sex			
Male	56,094	48.0	5.6
Female	60,757	52.0	6.0
Indigenous status[e]			
Indigenous Australians	2,617	5.2	5.8
Other Australians[f]	47,790	94.8	6.7
Country of birth			
Australia	92,437	82.1	6.3
Overseas	20,097	17.9	3.6
Area of usual residence			
Major cities	80,174	70.3	5.9
Inner regional	23,261	20.4	5.8
Outer regional	9,031	7.9	4.7
Remote	911	0.8	2.9
Very remote	643	0.6	3.6
Marital status[g]			
Never married	58,382	53.4	. .
Widowed	5,107	4.7	. .
Divorced	8,749	8.0	. .
Separated	5,846	5.3	. .
Married	31,338	28.6	. .
Total	**116,852**	**100.0**	**5.8**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The numbers of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those separations for which the demographic information was missing and/or not reported.

(d) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(e) Data on Indigenous status only includes data for Queensland, Western Australia, South Australia and public hospitals in the Northern Territory since the quality of the Indigenous identification data in these jurisdictions was considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data due to jurisdictional differences in data quality (see AIHW 2005c).

(f) Includes separations where Indigenous status was missing or not reported (see AIHW 2005c).

(g) Information on this data element was missing or not reported for more than 5 per cent of separations.

. . Not applicable.

Source: National Hospital Morbidity Database.

Table 7.5: Admitted patient separations[(a)] with specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2004–05

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent
F00–F03	Dementia	720	208	109	1,037	0.9
F04–F09	Other organic mental disorders	602	144	142	888	0.8
F10	Mental and behavioural disorders due to use of alcohol	1,590	521	2,242	4,353	3.7
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	3,498	729	900	5,127	4.4
F20	Schizophrenia	17,453	3,237	1,227	21,917	18.8
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,576	291	74	1,941	1.7
F22	Persistent delusional disorders	836	148	102	1,086	0.9
F23	Acute and transient psychotic disorders	1,397	202	111	1,710	1.5
F25	Schizoaffective disorders	5,306	973	1,265	7,544	6.5
F30	Manic episode	560	56	53	669	0.6
F31	Bipolar affective disorders	7,171	1,173	2,536	10,880	9.3
F32	Depressive episode	10,781	1,102	6,978	18,861	16.1
F33	Recurrent depressive disorders	3,295	232	5,476	9,003	7.7
F34	Persistent mood (affective) disorders	1,037	138	379	1,554	1.3
F38–F39	Other and unspecified mood (affective) disorders	108	43	45	196	0.2
F40	Phobic anxiety disorders	50	11	58	119	0.1
F41	Other anxiety disorders	927	62	987	1,976	1.7
F42	Obsessive-compulsive disorders	243	13	235	491	0.4
F43	Reaction to severe stress and adjustment disorders	7,367	1,358	2,655	11,380	9.7
F44	Dissociative (conversion) disorders	134	13	265	412	0.4
F45, F48	Somatoform and other neurotic disorders	74	13	65	152	0.1
F50	Eating disorders	647	35	824	1,506	1.3
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	143	27	113	283	0.2
F60	Specific personality disorders	3,696	481	442	4,619	4.0
F61–F69	Disorders of adult personality and behaviour	159	72	46	277	0.2
F70–F79	Mental retardation	140	49	8	197	0.2
F80–F89	Disorders of psychological development	135	49	11	195	0.2
F90	Hyperkinetic disorders	96	15	8	119	0.1
F91	Conduct disorders	281	60	n.p.	n.p.	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	246	60	8	314	0.3
F99	Mental disorder not otherwise specified	287	9	12	308	0.3
G30	Alzheimer's disease	501	141	76	718	0.6
	Other factors related to mental and behavioural disorders and substance use[(b)]	251	367	n.p.	n.p.	0.5
	Other specified mental health-related principal diagnosis[(c)]	195	11	39	245	0.2
	Other[(d)]	4,670	844	293	5,807	5.0
Total		**76,172**	**12,887**	**27,793**	**116,852**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.
(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.
(d) Includes all other codes not included as a mental health principal diagnosis as listed in Appendix 4.
n.p. Not published.
Source: National Hospital Morbidity Database.

Principal diagnosis

Table 7.5 presents the principal diagnoses recorded for separations with specialised psychiatric care using various groupings of diagnosis codes from the *International Classification of Diseases, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3.

Overall, separations with the principal diagnosis *Schizophrenia* (F20) were the most common, accounting for 18.8% of separations with specialised psychiatric care. This was followed by principal diagnoses of *Depressive episode* (F32; 16.1%) and *Reaction to severe stress and adjustment disorders* (F43; 9.7%).

Of all public acute hospital separations with specialised psychiatric care, 22.9% had a principal diagnosis of *Schizophrenia* (F20). This was also the most frequently reported principal diagnosis for public psychiatric hospitals, accounting for 25.1% of separations. In contrast, for private hospitals, the most common principal diagnosis was *Depressive episode* (F32; 25.1%).

Procedures

Table 7.6 details 10 procedures (or interventions) most frequently reported for separations with specialised psychiatric care. Procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on this classification is included in Appendix 3.

For the 116,852 separations with specialised psychiatric care, there were a total of 145,872 procedures reported. No procedure was reported for almost half (48.9%) of the separations with specialised psychiatric care. The most frequently reported procedures were *General anaesthesia, American Society of Anesthesiologists (ASA) 99* (25,382 procedures for 10,659 separations), *Allied health intervention, social work* (20,155 procedures for 20,124 separations) and *Allied health intervention, occupational therapy* (13,716 procedures for 13,702 separations).

7.3 Non-specialised admitted patient mental health care

In contrast with the previous section, which focused on separations with specialised psychiatric care, this section presents information on mental health-related separations that did not involve any specialised psychiatric care (that is, the patient did not receive one or more days of care in a specialised psychiatric unit or ward).

There were 82,501 mental health-related separations without specialised psychiatric care, accounting for 41.4% of all mental health-related separations for admitted patient care (that is, including those separations with specialised psychiatric care). As described earlier, these separations are classified as mental health-related because the reported principal diagnosis for the separation is either one that falls within the chapter on mental and behavioural disorders in the ICD-10-AM classification (codes F00 to F99) or is one of a number of other selected diagnoses (see Appendix 4).

Table 7.6: The 10 most frequently reported procedures for admitted patient separations[(a)] with specialised psychiatric care, 2004–05

Procedure	Procedures[(b)]		Separations	
	Number	Per cent	Number	Per cent
92514–99 General anaesthesia, ASA 99	25,382	17.4	10,659	9.1
95550–01 Allied health intervention, social work	20,155	13.8	20,124	17.2
95550–02 Allied health intervention, occupational therapy	13,716	9.4	13,702	11.7
93340–02 Electroconvulsive therapy [ECT] ≤ 12 treatments	13,580	9.3	13,296	11.4
95550–10 Allied health intervention, psychology	6,639	4.6	6,634	5.7
92514–29 General anaesthesia, ASA 29	5,226	3.6	1,598	1.4
56001–00 Computerised tomography of brain	4,721	3.2	4,703	4.0
95550–00 Allied health intervention, dietetics	3,873	2.7	3,872	3.3
95550–11 Allied health intervention, other	3,834	2.6	3,828	3.3
96180–00 Other psychotherapies or psychosocial therapies	3,661	2.5	3,658	3.1
Other reported procedures	45,085	30.9	24,372	20.9
No procedure reported	. .	. .	57,172	48.9
Total	**145,872**	**100.0**	**116,852[(c)]**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations since the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total as multiple procedures can be reported for each separation.

. . Not applicable.

Source: National Hospital Morbidity Database.

Mental health-related separations without specialised psychiatric care

Table 7.7 presents the number of separations and patient days for mental health-related separations without specialised psychiatric care for Australia overall and for each state and territory. Numbers of separations and patient days per 1,000 population are also presented to account for variations in the population size and age structure of each jurisdiction.

Of the 82,501 mental health-related separations without specialised psychiatric care, 70,975 (86.0%) were from public acute hospitals, 10,390 (12.6%) from private hospitals and 1,136 (1.4%) from public psychiatric hospitals.

Across jurisdictions, New South Wales reported the highest number of mental health-related separations without specialised psychiatric care (27,147), followed by Victoria (24,369) and Queensland (11,083). However, South Australia had the highest number of these separations per 1,000 population (5.2), followed by Victoria (4.8) and Western Australia (4.5). Due to confidentiality reasons, data on separations and patient days cannot be published for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory. However, these separations and patient days are included in the national total.

New South Wales also reported the largest number of patient days for mental health-related separations without specialised psychiatric care (180,210), followed by Victoria (124,331) and

Queensland (77,932). New South Wales also had the highest number of patient days per 1,000 population (25.6), followed by Western Australia (24.9) and South Australia (24.3).

Table 7.7: Admitted patient separations[(a)] and patient days for mental health-related separations without specialised psychiatric care, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	Separations								
Public acute hospitals	24,859	21,968	8,422	6,349	7,438	1,303	307	329	70,975
Public psychiatric hospitals[(b)]	1,136	0	0	0	0	0	. .	. .	1,136
Private hospitals	1,152	2,401	2,661	2,460	714	n.p.	n.p.	n.p.	10,390
Total	**27,147**	**24,369**	**11,083**	**8,809**	**8,152**	**n.p.**	**n.p.**	**n.p.**	**82,501**
	Separations per 1,000 population[(c)]								
Public acute hospitals	3.7	4.4	2.2	3.2	4.8	2.7	1.0	2.0	3.5
Public psychiatric hospitals[(b)]	0.2	0.0	0.0	0.0	0.0	0.0	. .	. .	0.1
Private hospitals	0.2	0.5	0.7	1.3	0.4	n.p.	n.p.	n.p.	0.5
Total	**4.0**	**4.8**	**2.9**	**4.5**	**5.2**	**n.p.**	**n.p.**	**n.p.**	**4.1**
	Patient days								
Public acute hospitals	147,924	102,377	43,493	37,530	35,595	12,952	2,821	1,468	384,160
Public psychiatric hospitals[(b)]	19,753	0	0	0	0	0	. .	. .	19,753
Private hospitals	12,533	21,954	34,439	10,077	5,476	n.p.	n.p.	n.p.	96,120
Total	**180,210**	**124,331**	**77,932**	**47,607**	**41,071**	**n.p.**	**n.p.**	**n.p.**	**500,033**
	Patient days per 1,000 population[(c)]								
Public acute hospitals	21.0	19.6	11.4	19.6	21.2	28.1	10.2	15.4	18.6
Public psychiatric hospitals[(b)]	2.9	0.0	0.0	0.0	0.0	0.0	. .	. .	1.0
Private hospitals	1.8	4.3	8.9	5.3	3.1	n.p.	n.p.	n.p.	4.7
Total	**25.6**	**23.9**	**20.3**	**24.9**	**24.3**	**n.p.**	**n.p.**	**n.p.**	**24.2**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *posthumous organ procurement* have been excluded.

(b) Mental health-related separations without specialised psychiatric care reported by NSW public psychiatric hospitals were for alcohol and drug treatment episodes.

(c) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable.

n.p. Not published.

Source: National Hospital Morbidity Database.

Patient demographics

Table 7.8 presents information on the number and rate of mental health-related separations without specialised psychiatric care in 2004–05 according to the demographic characteristics of those receiving care.

Relative to their population size, there were more mental health-related separations without specialised psychiatric care reported for patients aged 65 years and over (7.7 per 1,000 population) than for each of the other age groups. The smallest number of separations per 1,000 population was for patients aged less than 15 years (1.7).

Female patients accounted for 52.7% of separations while males accounted for 47.3%; relative to their population size and age structure, females also had more separations per 1,000 population than males (4.2 and 4.0, respectively).

As noted previously, due to data quality issues, only Indigenous status data for Queensland, Western Australia, South Australia and public hospitals in the Northern Territory were used (AIHW 2005c), but separations for these four jurisdictions are not necessarily representative of those in the other jurisdictions and caution should be used in the interpretation of these data due to jurisdictional differences in data quality. When taking into account the population size and age distribution of the Indigenous and non-Indigenous populations of those four jurisdictions, the number of separations per 1,000 population was higher for Indigenous Australians than for other Australians (11.8 and 3.5 per 1,000 population, respectively).

The number of separations per 1,000 population shows that Australian-born patients have a higher rate of separation than those patients born overseas (4.3 and 2.6 separations per 1,000 population, respectively).

The majority of mental health-related separations without specialised psychiatric care reported were for patients living in Major cities (59.6%). However, the highest number of separations per 1,000 population was for patients in Very remote areas (7.6 per 1,000 population).

The reporting of 'marital status' is not mandatory for separations without specialised psychiatric care. These data were not reported for the majority of these separations and therefore have not been included in this report.

Principal diagnosis

Table 7.9 presents the principal diagnoses recorded for mental health-related separations without specialised psychiatric care using various groupings of diagnosis codes from ICD-10-AM. Overall, separations with the principal diagnosis of *Mental and behavioural disorders due to use of alcohol* (F10) were the most common, accounting for 17.6% of separations without specialised psychiatric care. This was followed by principal diagnoses of *Depressive episode* (F32; 14.2%) and *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19; 7.4%).

For public acute hospitals, the most commonly reported principal diagnosis was also *Mental and behavioural disorders due to use of alcohol* (F10; 18.1%), while *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) was the most common principal diagnosis for public psychiatric hospitals (39.8%). *Reaction to severe stress and adjustment disorders* (F43) was the most common principal diagnosis for private hospitals (15.3%).

Table 7.8: Mental health-related admitted patient separations[a] without specialised psychiatric care by patient demographic characteristics, 2004–05

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate (per 1,000 population)[d]
Age			
Less than 15 years	6,707	8.1	1.7
15–24 years	9,413	11.4	3.4
25–34 years	15,708	19.0	5.5
35–44 years	14,418	17.5	4.8
45–54 years	9,928	12.0	3.8
55–64 years	6,255	7.6	3.0
65 years and over	20,072	24.3	7.7
Sex			
Male	39,017	47.3	4.0
Female	43,483	52.7	4.2
Indigenous status[e]			
Indigenous Australians	2,669	9.4	11.8
Other Australians[f]	25,734	90.6	3.5
Country of birth			
Australia	64,863	81.6	4.3
Overseas	14,609	18.4	2.6
Area of usual residence			
Major cities	48,151	59.6	3.6
Inner regional	17,385	21.5	4.1
Outer regional	11,844	14.7	5.9
Remote	2,145	2.7	6.9
Very remote	1,267	1.6	7.6
Total	**82,501**	**100.0**	**4.1**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The numbers of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those separations for which the demographic information was missing and/or not reported.

(d) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(e) Data on Indigenous status only includes data for Queensland, Western Australia, South Australia and public hospitals in the Northern Territory since the quality of the Indigenous identification data in these jurisdictions was considered acceptable for the purposes of analysis. Caution should be used in the interpretation of these data due to jurisdictional differences in data quality (see AIHW 2005c).

(f) Includes separations where Indigenous status was missing or not reported (see AIHW 2005c).

Source: National Hospital Morbidity Database.

Table 7.9: Mental health-related admitted patient separations[(a)] without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2004–05

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent
F00–F03	Dementia	4,031	n.p.	662	n.p.	5.7
F04–F09	Other organic mental disorders	3,320	n.p.	471	n.p.	4.6
F10	Mental and behavioural disorders due to use of alcohol	12,835	258	1,467	14,560	17.6
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	5,228	452	425	6,105	7.4
F20	Schizophrenia	4,355	64	65	4,484	5.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,111	6	30	1,147	1.4
F22	Persistent delusional disorders	549	0	38	587	0.7
F23	Acute and transient psychotic disorders	1,097	18	25	1,140	1.4
F25	Schizoaffective disorders	1,090	14	39	1,143	1.4
F30	Manic episode	278	0	14	292	0.4
F31	Bipolar affective disorders	2,291	24	231	2,546	3.1
F32	Depressive episode	10,400	41	1,266	11,707	14.2
F33	Recurrent depressive disorders	2,741	20	252	3,013	3.7
F34	Persistent mood (affective) disorders	207	11	44	262	0.3
F38–F39	Other and unspecified mood (affective) disorders	58	0	7	65	0.1
F40	Phobic anxiety disorders	36	0	13	49	0.1
F41	Other anxiety disorders	4,203	n.p.	787	n.p.	6.0
F42	Obsessive-compulsive disorders	45	0	6	51	0.1
F43	Reaction to severe stress and adjustment disorders	3,605	47	1,588	5,240	6.4
F44	Dissociative (conversion) disorders	794	n.p.	56	n.p.	1.0
F45, F48	Somatoform and other neurotic disorders	428	n.p.	194	n.p.	0.8
F50	Eating disorders	862	n.p.	84	n.p.	1.1
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	678	0	332	1,010	1.2
F60	Specific personality disorders	1,028	12	40	1,080	1.3
F61–F69	Disorders of adult personality and behaviour	120	n.p.	52	n.p.	0.2
F70–F79	Mental retardation	151	0	n.p.	n.p.	0.2
F80–F89	Disorders of psychological development	397	n.p.	87	n.p.	0.6
F90	Hyperkinetic disorders	56	0	5	61	0.1
F91	Conduct disorders	393	0	n.p.	n.p.	0.5
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	468	0	n.p.	n.p.	0.6
F99	Mental disorder not otherwise specified	228	0	n.p.	n.p.	0.3
G30	Alzheimer's disease	1,660	0	390	2,050	2.5
	Other factors related to mental and behavioural disorders and substance use[(b)]	476	156	49	681	0.8
	Other specified mental health-related principal diagnosis[(c)]	5,756	0	1,660	7,416	9.0
Total		**70,975**	**1,136**	**10,390**	**82,501**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.

n.p. Not published.

Source: National Hospital Morbidity Database.

Procedures

Table 7.10 details the 10 procedures or interventions most frequently reported for mental health-related separations without specialised psychiatric care. Procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on the classification is included in Appendix 3.

For the 82,501 mental health-related separations without specialised psychiatric care, there were 94,746 procedures reported; no procedure was reported for almost half (48.4%) of the separations. The most frequently reported procedures were *Allied health intervention, social work* (11,597 procedures for 11,572 separations), *Allied health intervention, physiotherapy* (8,139 procedures for 8,121 separations) and *Electroconvulsive therapy ≤ 12 treatments* (6,552 procedures for 6,550 separations).

Table 7.10: The 10 most frequently reported procedures for mental health-related admitted patient separations[(a)] without specialised psychiatric care, 2004–05

	Procedures[(b)]		Separations	
Procedure	**Number**	**Per cent**	**Number**	**Per cent**
95550–01 Allied health intervention, social work	11,597	12.2	11,572	14.0
95550–03 Allied health intervention, physiotherapy	8,139	8.6	8,121	9.8
93340–02 Electroconvulsive therapy ≤ 12 treatments	6,552	6.9	6,550	7.9
56001–00 Computerised tomography of brain	6,345	6.7	6,309	7.6
92514–99 General anaesthesia, ASA 99	6,226	6.6	5,880	7.1
95550–02 Allied health intervention, occupational therapy	5,557	5.9	5,547	6.7
95550–00 Allied health intervention, dietetics	3,901	4.1	3,899	4.7
92003–00 Alcohol detoxification	3,401	3.6	3,401	4.1
96175–00 Mental/behavioural assessment	2,777	2.9	2,776	3.4
92006–00 Drug detoxification	2,531	2.7	2,530	3.1
Other reported procedures	37,720	39.8	20,246	24.5
No procedure reported	. .	. .	39,892	48.4
Total[(c)]	**94,746**	**100.0**	**82,501**	**100.0**

(a) Separations for which care type was reported as *Newborn* with no qualified days and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations since the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total since multiple procedures can be reported for each separation.

. . Not applicable.

Source: National Hospital Morbidity Database.

7.4 Separations with mental health-related additional diagnoses

In addition to the 199,353 admitted patient mental health-related separations, there were 297,689 separations that were not classed as mental health-related (that is, did not have a mental health-related principal diagnosis or receive specialised psychiatric care) but had at least one mental health-related additional diagnosis. These separations accounted for 2,810,018 patient days.

In relation to these separations, the most commonly reported mental health-related additional diagnoses were *Mental and behavioural disorders due to use of alcohol* (F10; 54,617 separations), *Depressive episode* (F32; 53,195 separations) and *Unspecified dementia* (F03; 51,043 separations).

The most commonly reported principal diagnoses for these separations were *Care involving use of rehabilitation procedures* (Z50; 17,694 separations), *Other chronic obstructive pulmonary disease* (J44; 10,685 separations) and *Pneumonia, organism unspecified* (J18; 7,753 separations).

7.5 Additional data

Additional tables containing data on mental health-related admitted patient separations are available from the AIHW's website. As well, additional data on mental health-related separations for admitted patient mental health care from the NHMD can be accessed via interactive data cubes found on the AIHW's website. The data cubes allow users to create customised tables based on the number of separations by age group, sex, sector, mental health legal status and year and type of separation, for each principal diagnosis. See Section 1.5 for details on how to access these additional resources.

8 Residential mental health care

8.1 Introduction

In addition to admitted patient mental health-related care provided in hospitals, another form of mental health-related non-ambulatory care is ***residential mental health care***. This chapter presents information on such care that is provided by government-funded and operated residential mental health services. Non-government operated services and services that are staffed less than 24 hours a day are not included. The data presented are from the inaugural collection of the National Residential Mental Health Care Database (NRMHCD) which is a collation of data on ***episodes of residential care***. Appendix 1 provides information about the coverage and data quality of this collection.

Key concepts

Residential mental health care refers to residential care provided by residential mental health services. A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on-site;
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of each day.

Episodes of residential care are defined as a period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period (that is, 1 July 2004)) and the end of residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period (that is, 30 June 2005)). An individual can have one or more episodes of care during the reference period.

Residential stay refers to the period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. It may involve more than one reference period (that is, more than one episode of residential care).

A ***resident*** is a person who receives residential care intended to be for a minimum of one night.

Residential care days refer to the number of days of care the resident received in the episode of residential care.

8.2 Episodes of residential care

In 2004–05, there were 2,194 episodes of residential care provided to 1,431 ***residents*** (Table 8.1). This corresponds to an average of 1.5 episodes of care per resident. The number of residents reported may be an over-estimate because there is no means to determine if any one person made use of services from multiple providers.

Victoria reported the highest number of residential mental health care episodes (728), followed by Tasmania (721). However, the age-standardised data indicate that, relative to its

population size and age structure, Tasmania had the highest number of episodes of residential mental health care per 10,000 population (15.3). New South Wales and South Australia had the lowest number of episodes per 10,000 population (both 0.6). Note that differences in the data across the states and territories may be due to differences in service delivery practices and/or the types of establishments categorised as residential mental health care facilities. Interpretation of the differences between jurisdictions therefore needs to be done with care. Queensland and the Northern Territory do not have any residential services and therefore do not provide data to the collection.

For the 2,194 episodes of residential care, there were 188,351 ***residential care days***. Tasmania had the highest number of residential care days per 10,000 population (677.0), followed by the Australian Capital Territory (377.8) and Victoria (182.9).

Table 8.1: Episodes of residential mental health care, number of residents and residential care days, states and territories, 2004–05

	NSW	Vic	Qld[(a)]	WA	SA	Tas	ACT	NT[(a)]	Total
Episodes	388	728	. .	203	91	721	63	. .	2,194
Estimated number of residents[(b)]	302	494	. .	154	83	337	61	. .	1,431
Average episodes per resident[(b)]	1.3	1.5	. .	1.3	1.1	2.1	1.0	. .	1.5
Residential care days	39,772	91,462	. .	5,509	4,555	34,434	12,619	. .	188,351
	Rate (per 10,000 population)[(c)]								
Episodes	0.6	1.5	. .	1.0	0.6	15.3	1.9	. .	1.1
Estimated number of residents[(b)]	0.4	1.0	. .	0.8	0.5	7.0	1.9	. .	0.7
Residential care days	58.3	182.9	. .	27.4	30.9	677.0	377.8	. .	93.1

(a) Queensland and the Northern Territory do not have any residential mental health services.

(b) The number of residents is likely to be overestimated since residents who made use of services from multiple providers are counted separately each time.

(c) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable.

Source: National Residential Mental Health Care Database.

Table 8.2 presents data on the number of episodes of residential care by mental health legal status and jurisdiction. Nationally, for 10.6% (or 231) of episodes of residential mental health care, the resident's mental health legal status was classed as 'involuntary'. There were different patterns across jurisdictions, with relatively higher proportions of residents with an involuntary status recorded for the Australian Capital Territory (50.8%), Victoria (18.3%) and South Australia (16.5%). At least some part of these differences may reflect differences in legislative arrangements regarding legal status among the jurisdictions.

Table 8.2: Episodes of residential mental health care by mental health legal status, states and territories, 2004–05

Mental health legal status	NSW	Vic	WA	SA	Tas	ACT	Total
Involuntary	0	133	0	15	51	32	231
Voluntary	322	595	203	75	670	31	1,896
Total[(a)]	**388**	**728**	**203**	**91**	**721**	**63**	**2,194**

(a) Includes episodes for which mental health legal status was not reported.

Source: National Residential Mental Health Care Database.

8.3 Patient demographics

Table 8.3 presents information on the number of episodes of residential care in 2004–05 according to the demographic characteristics of those receiving care. In addition, the number of episodes per 10,000 population is given in order to take into account relative population sizes and age structures. As these are reports of episodes (rather than persons), the rates provide information on the number of episodes relative to the size of the population subgroup.

The largest number of episodes of residential care was for residents aged 25 to 34 years (31.3%; 2.4 episodes per 10,000 population) followed by those aged 35 to 44 years (23.0%; 1.7 per 10,000 population).

Male residents accounted for 61.2% of episodes while females accounted for 38.8%; relative to their population size and age structure, males had more episodes than females (1.3 and 0.8 per 10,000 population, respectively).

The data on episodes of residential care for Indigenous Australians compared with other Australians must be interpreted with caution due to uncertainty about the quality of Indigenous identification among the jurisdictions. Table 8.3 presents national data on Indigenous status; however, only Western Australia, Tasmania and the Australian Capital Territory reported their data to be of acceptable quality (see Appendix 1 for more information). As a consequence, it is likely that the number of residential mental health care episodes for Indigenous Australians is underestimated. The data indicate that Indigenous Australians accounted for 3% of episodes. However, when the size and age structure of the Indigenous and other Australian populations were taken into account, there was a higher number of episodes per 10,000 population for Indigenous Australians than for other Australians (1.5 and 1.0 episodes respectively).

The number of episodes per 10,000 population for Australian-born residents was more than double the rate for those born overseas (1.3 and 0.5 respectively).

The highest number of episodes per 10,000 population was for residents living in Inner regional areas (2.7 per 10,000 population), followed by Major cities (0.7) and Outer regional areas (0.6).

The most frequently reported marital status was 'never married' (72.9%), followed by 'married' (10.4%), and 'divorced' (9.1%).

8.4 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for occasioning the resident's episode of residential mental health care. Table 8.4 presents the number of residential mental health care episodes for principal diagnosis groups for 2004–05. In this table, diagnoses are classified according to the *International Classification of Diseases, 10th revision, Australian Modification* (ICD-10-AM). Note that these data should be interpreted with caution due to variability in the data collection and coding practices in relation to principal diagnosis across Australia (for more information, see Appendix 1).

A principal diagnosis was specified for 95.0% (2,084) of episodes of residential care. For those episodes, the most common principal diagnosis was *Schizophrenia* (F20), which was reported for more than half of the episodes (60.2%). The next most common principal diagnosis was *Schizoaffective disorder* (F25), which accounted for 11.1% of the episodes, followed by *Depressive episode* (F32, 6.5%) and *Bipolar affective disorder* (F31, 5.0%).

Table 8.3: Episodes of residential mental health care by patient demographic characteristics, 2004–05

Patient demographics	Number of episodes[a]	Per cent of episodes[b]	Rate (per 10,000 population)[c]
Age			
Less than 15 years	1	0.0	0.0
15–24	290	13.2	1.0
25–34 years	687	31.3	2.4
35–44 years	504	23.0	1.7
45–54 years	386	17.6	1.4
55–64 years	207	9.4	1.0
65 years and over	119	5.4	0.5
Sex			
Male	1,342	61.2	1.3
Female	852	38.8	0.8
Indigenous status[d][e]			
Indigenous Australians	61	3.0	1.5
Other Australians	2,000	97.0	1.0
Country of birth			
Australia	1,900	87.6	1.3
Overseas	268	12.4	0.5
Remoteness area of usual residence			
Major city	912	43.2	0.7
Inner regional	1,070	50.7	2.7
Outer regional	125	5.9	0.6
Remote and Very remote	5	0.2	0.1
Marital status[e]			
Never married	1,359	72.9	. .
Widowed	54	2.9	. .
Divorced	170	9.1	. .
Separated	88	4.7	. .
Married	193	10.4	. .
Total	**2,194**	**100.0**	**1.1**

(a) The numbers of episodes for each demographic variable may not sum to the total due to missing and/or not reported data.
(b) The percentages shown do not include those episodes for which the demographic information was missing and/or not reported.
(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.
(d) These data should be interpreted with caution due to likely under identification of Indigenous Australians.
(e) Information on this data element was missing or not reported for more than 5 per cent of episodes.
. . Not applicable.
Source: National Residential Mental Health Care Database.

Table 8.4: Episodes of residential mental health care by principal diagnosis in ICD-10-AM groupings, 2004–05

Principal diagnosis		Number of episodes	Per cent of specified principal diagnoses
F00–F03	Dementia	49	2.4
F04–F09	Other organic mental disorders	7	0.3
F10	Mental and behavioural disorders due to use of alcohol	3	0.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	22	1.1
F20	Schizophrenia	1,254	60.2
F21, F24, F28, F29	Schizotypal and other delusional disorders	28	1.3
F22	Persistent delusional disorders	4	0.2
F23	Acute and transient psychotic disorders	28	1.3
F25	Schizoaffective disorders	232	11.1
F30	Manic episode	7	0.3
F31	Bipolar affective disorders	105	5.0
F32	Depressive episode	135	6.5
F33	Recurrent depressive disorders	8	0.4
F34	Persistent mood (affective) disorders	1	0.0
F38, F39	Other and unspecified mood (affective) disorders	0	0.0
F40	Phobic anxiety disorders	1	0.0
F41	Other anxiety disorders	31	1.5
F42	Obsessive-compulsive disorders	11	0.5
F43	Reaction to severe stress and adjustment disorders	25	1.2
F44	Dissociative (conversion) disorders	14	0.7
F45, F48	Somatoform and other neurotic disorders	0	0.0
F50	Eating disorders	3	0.1
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	0	0.0
F60	Specific personality disorders	86	4.1
F61–F69	Disorders of adult personality and behaviour	3	0.1
F70–F79	Mental retardation	5	0.2
F80–F89	Disorders of psychological development	2	0.1
F90	Hyperkinetic disorders	0	0.0
F91	Conduct disorders	2	0.1
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	0	0.0
	Other[(a)]	18	0.9
Total with specified principal diagnosis		*2,084*	*100.0*
F99	Mental disorder not otherwise specified	41	
	Not reported	69	
Total with unspecified principal diagnosis		*110*	
Total		**2,194**	

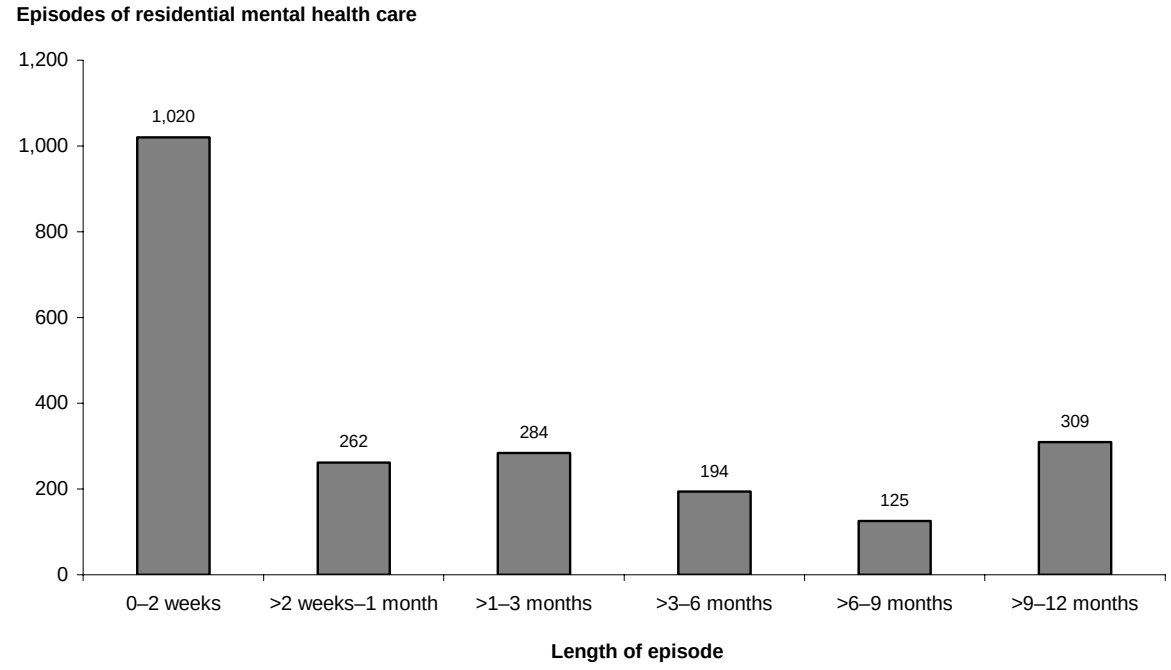
(a) Includes all reported diagnoses that are not in the 'Mental and behavioural disorders' chapter of ICD-10-AM (codes F00 to F99).
Source: National Residential Mental Health Care Database.

8.5 Length of episodes and residential stays

Episodes

The NRMHCD collects data on the episodes of residential mental health care which occurred during the collection period (that is, from 1 July 2004 to 30 June 2005). The length of episode is calculated by subtracting the date on which the episode started from the episode end date and deducting leave days. These leave days may occur for a variety of reasons including receiving treatment by a specialised or non-specialised health service or spending time in the community. Note that episodes which started and ended on the same day are allocated an episode length of one day; in 2004–05, there were 58 such episodes.

In relation to the 2,194 episodes of residential mental health care in 2004–05, there was a total of 188,351 residential mental health care days. The average length of stay was 85.8 days, the most common length of stay was 3 days and the median length of stay was 19 days (Figure 8.1). There were 258 reports of episodes longer than 326 days.



Source: National Residential Mental Health Care Database.

Figure 8.1: Episodes of residential mental health care by length of episode, 2004–05

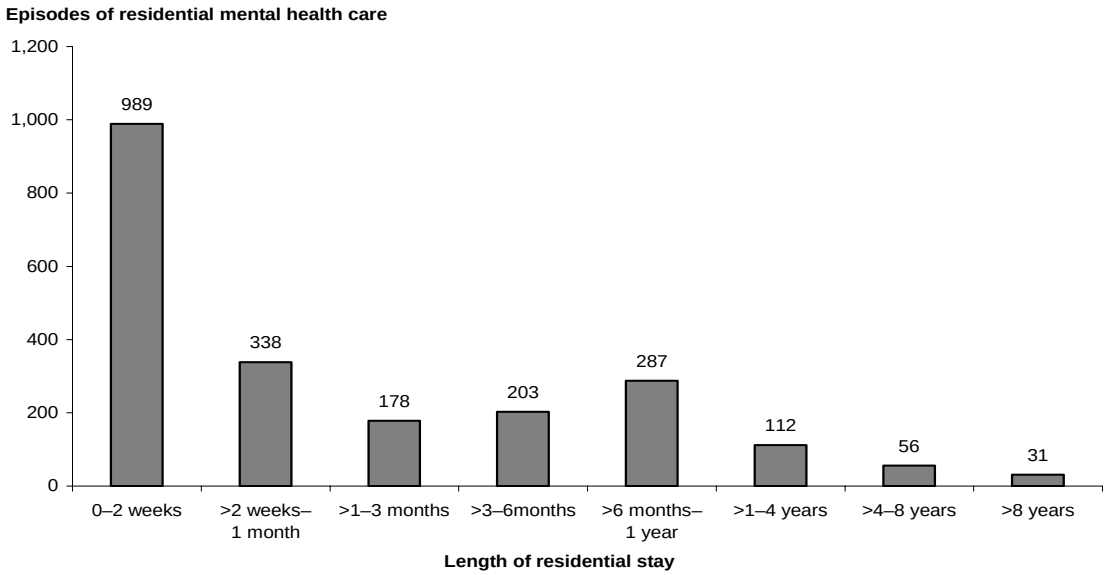
Residential stays

Of the episodes of residential mental health care in 2004–05, 76.8% started in the 2004–05 collection period (that is, between 1 July 2004 and 30 June 2005), while the remaining episodes began prior to the data collection period (that is, before 1 July 2004). The number of days the resident was in residential care before 1 July 2004 can be added to the length of the

episode within 2004–05 to provide an estimate of the length of ***residential stays***. However, the number of leave days the resident had before 1 July 2004 has not been taken into account as this information was not available from jurisdictions other than Western Australia and South Australia. (Note that for those two states, the number of leave days before 1 July 2004 totalled 5,281 days or 8.1% of residential care days; if taken into account, these would have reduced the average length of residential stays for these jurisdictions and given a more accurate calculation). Thus the number of days presented for residential stays are not strictly comparable with the data presented above for episodes of residential care as the latter take leave days into account.

When the numbers of residential care days before 1 July 2004 are taken into account, the average length of residential stay was 271.1 days. The most common length of stay was 3 days and the median length of stay was 21 days. Note that the data on residential stays includes both those episodes that formally ended during 2004–05 and those that did not.

Figure 8.2 shows the distribution of the length of residential stays for the episodes reported in 2004–05. There were 31 reports of residential stays of longer than 8 years (15 of these were for longer than 10 years).



Source: National Residential Mental Health Care Database.

Figure 8.2: Episodes of residential mental health care ending or continuing in 2004–05, by length of residential stay

8.6 Additional data

Additional tables containing data on episodes of residential mental health care are available on the AIHW website. See Section 1.5 for details on how to access these tables.

9 Mental health-related supported accommodation services

9.1 Introduction

The Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC) includes some information that provides an indication of the use of SAAP services by clients with mental health problems. This chapter presents information on these ***mental health-related closed support periods*** provided by SAAP agencies in 2004–05.

The Supported Accommodation Assistance Program

SAAP was designed to provide people who are homeless or at risk of being homeless with transitional ***supported accommodation*** and related support services in order to assist them to achieve the maximum possible degree of self-reliance and independence. The agencies that are funded through SAAP range from small stand-alone outlets to multiple outlets and they provide a range of both accommodation and non-accommodation support services. As well as being homeless or at risk of being homeless, many ***SAAP clients*** have complex needs involving mental health and/or alcohol and other drug issues (Cameron & Payton 2004).

Data presented in this chapter have been extracted from the Client Collection component of the SAAP NDC held by the AIHW. This collection contains information on clients receiving SAAP support lasting for at least 1 hour. It should be noted that, while participation and consent rates are high, not all SAAP agencies participate in the SAAP NDC and not all clients in participating agencies consent to providing of their details. For further details regarding the scope and coverage of the SAAP Client Collection, see Appendix 1.

Key concepts

SAAP client: a person aged 18 years or older or an unaccompanied child (aged under 18 years) who:

- receives support or assistance from a SAAP agency which entails generally 1 hour or more of a worker's time on a given day; or
- is accommodated by a SAAP agency; or
- enters into an ongoing support relationship with a SAAP agency.

An ***accompanying child:*** is under 18 years of age and has a parent or guardian who is a SAAP client. This means that the child accompanies a parent or guardian at any time during the parent or guardian's support period; and/or receives SAAP assistance directly as a consequence of a parent or guardian's support period.

(continued)

Supported accommodation: accommodation paid for or provided directly by a SAAP agency. This includes crisis or short-term accommodation, medium to long-term accommodation or other SAAP-funded arrangements such as accommodation in hostels, motels, hotels and caravans, or community placements. This category also includes other types of support, such as meals and/or showers, in addition to accommodation.

Other support services: the assistance, other than supported accommodation, provided as part of an ongoing support relationship between a SAAP agency and the client.

Support period: the period in which the client receives supported accommodation and/or other support services from a SAAP agency. As at 30 June each year, a support period can either be open/ongoing or closed/completed.

Accommodation period: the period in which the client was in SAAP supported accommodation. A client may have no accommodation periods or one or more accommodation periods within a support period.

Closed support period: a support period that had finished on or before 30 June of the reporting year.

Mental health-related closed support periods: closed support periods for which at least one of the following were reported:

- the source of referral to the SAAP agency was a dedicated psychiatric unit;
- the main, or other, presenting reason for seeking assistance was the client's psychiatric illness; or
- the type of support needed, provided or referred was psychological services or psychiatric services.

Mental health-related SAAP services

The SAAP Client Collection includes information on source of referral, presenting reasons and type of assistance. Information from each of these data elements have been used to indicate whether or not a SAAP ***support period*** was mental health-related (see above for definition) and, in turn, how many clients received mental health-related closed support periods.

The number of mental health-related closed support periods reported in this chapter is an underestimate of the actual number of such support periods for the following reasons:

- The data presented in this chapter are unweighted; thus, no attempt has been made to adjust for the undercount of support periods due to non-participation of some agencies and the non-consent of some SAAP clients to the provision of their data. Hence, the data are not comparable with other data published from the SAAP Client Collection. It is difficult to estimate the actual impact of using unweighted data. However, for indicative purposes, the total number of closed support periods reported to the SAAP Client Collection in 2004–05 was 142,200 (unweighted), which is 92.4% of the estimated actual (weighted) number of 153,900 (AIHW 2006e). More specifically, there were 12,227 mental health-related closed support periods reported for clients in 2004–05, which is equivalent to 8.6% of the unweighted closed support periods reported by SAAP agencies for clients in 2004–05.

- Information on presenting reasons for seeking assistance is only collected from clients that give consent. In addition, consenting clients with mental disorders may not report 'psychiatric illness' as a presenting reason. This may occur if clients with 'psychiatric illness' report other presenting reasons, such as 'usual accommodation unavailable'.
- Data are collected by workers in SAAP agencies; these workers may not be trained to assess a client's need for psychiatric or psychological services.

Note that some clients that were identified as having had mental health-related closed support periods may have had other closed support periods for which no mental health-related information was reported. These latter support periods are not included in the data presented in this chapter.

Further information on the SAAP collection, including coverage, data quality and the use of unweighted data in this chapter, is presented in Appendix 1.

9.2 SAAP clients with mental health-related closed support periods

In 2004–05, there were 8,959 SAAP clients with at least one mental health-related closed support period (Table 9.1). This represents approximately 11.4% of all SAAP clients in that year. There was an average of 1.4 mental health-related closed support periods per client.

There were slightly more male clients than female clients with mental health-related support periods in 2004–05 (51.3% compared with 48.7%). The age-standardised rate per 100,000 population was also higher for male clients (45.7 per 100,000) than for females (43.8).

Over half (54.9%) of clients were aged 25 to 44 years. The age-standardised rates per 100,000 population were highest for people aged 18 to 19 years (90.5), 20 to 24 years (86.3) and 25 to 44 years (83.4). They were lowest for those aged under 15 years and for those aged 65 years and over (2.8 and 6.5 per 100,000 population respectively).

In 2004–05, 8.6% of clients with mental health-related closed support periods for whom information on their Indigenous status was available reported that they were Indigenous Australians. This is considerably higher than the proportion of population as at 30 June 2004 that was estimated to be Indigenous (2.4% of the total Australian population (ABS 2004b)). Taking into account differences in population size and age distribution, Indigenous Australians were about 5 times as likely to have had a SAAP mental health-related closed support period in 2004–05 as other Australians (245.3 and 57.1 per 100,000 population, respectively).

Most clients (85.2%) were born in Australia. Taking into account differences in population size and age distribution, Australian-born people were twice as likely to have had a SAAP mental health-related closed support period in 2004–05 as those born overseas (70.2 and 34.2 per 100,000 population, respectively).

In the SAAP data collection, each client is allocated to a client group based on the client's sex and age group, and the mode of presentation to the SAAP agency (that is, either as an individual or as a couple, and with or without children). In 2004–05, the most commonly reported client group for those with mental health-related closed support periods was unaccompanied males aged 25 years and over (37.0%), followed by unaccompanied females aged 25 years and over (19.5%) and females with children (15.2%).

Table 9.1: SAAP clients with mental health-related closed support periods: demographic characteristics and number of support periods, 2004–05

	Clients			Closed support periods		
Client demographics	Number[a]	Per cent[b]	Rate (per 100,000 population)[c]	Number[a][d]	Per cent[b]	Rate (per 100,000 population)[c]
Age						
Less than 15 years	110	1.2	2.8	126	1.1	3.2
15–17 years	582	6.5	70.7	675	6.0	82.0
18–19 years	502	5.6	90.5	598	5.3	107.6
20–24 years	1,215	13.6	86.3	1,518	13.5	107.8
25–44 years	4,908	54.9	83.4	6,254	55.5	106.2
45–64 years	1,450	16.2	29.4	1,872	16.6	38.0
65 years and over	171	1.9	6.5	223	2.0	8.4
Sex						
Male	4,595	51.3	45.7	6,526	53.4	64.7
Female	4,364	48.7	43.8	5,687	46.6	57.0
Indigenous status						
Indigenous Australians	756	8.6	158.1	1,015	9.1	245.3
Other Australians	8,021	91.4	41.3	10,151	90.9	57.1
Country of birth						
Australia	7,526	85.2	50.2	9,627	85.8	70.2
Overseas	1,305	14.8	26.5	1,596	14.2	34.2
Client group						
Male alone, under 25	997	11.3	. .	1,253	11.1	. .
Male alone, 25 and over	3,266	37.0	. .	4,470	39.6	. .
Female alone, under 25	1,008	11.4	. .	1,206	10.7	. .
Female alone, 25 and over	1,726	19.5	. .	2,154	19.1	. .
Couple with no children	146	1.7	. .	174	1.5	. .
Couple with children	173	2.0	. .	205	1.8	. .
Male with children	82	0.9	. .	101	0.9	. .
Female with children	1,341	15.2	. .	1,593	14.1	. .
Other	97	1.1	. .	126	1.1	. .
Total	**8,959**	**100**	**44.3**	**12,227**	**100**	**60.5**

(a) The number of clients and closed support periods for each demographic characteristic may not sum to the total due to missing and/or not reported data.

(b) The percentages shown do not include those clients or closed support periods for which the demographic information was missing and/or not reported.

(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(d) For age, Indigenous status, country of birth and client group, information was missing or not reported for more than 5 per cent of the closed support periods. Because of the large number of missing values for support periods for both Indigenous status and country of birth, the missing values for these data elements have been redistributed across the age groups to calculate the age-standardised rate.

. . Not applicable.

Source: Supported Accommodation Assistance Program Client Collection.

Children accompanying clients

This section presents information on children who accompanied their parent(s) or guardian(s) to SAAP agencies or who required assistance from a SAAP agency as a result of their parent of guardian being a client of the same agency. The number of ***accompanying children*** is additional to the number of clients (that is, adults and unaccompanied children) described above.

In 2004–05, there were 2,550 children who accompanied clients that had mental health-related closed support periods (Table 9.2). The majority of these children (84.1%) were less than 13 years of age. Slightly more than half (50.8%) of the accompanying children were female.

Table 9.2: Number of children accompanying SAAP clients with mental health-related closed support periods, by age and sex of child, 2004–05 (per cent)[(a)]

Age	Males	Females	Total	Number[(b)]
0–4 years	41.2	40.4	40.8	1,032
5–12 years	43.9	42.8	43.3	1,097
13–15 years	9.6	12.0	10.8	274
16–17 years	5.3	4.9	5.1	129
Total	**100.0**	**100.0**	**100.0**	**. .**
Total % of children	*49.1*	*50.8*	*100.0*	*. .*
Number	1,244	1,288	. .	2,550

(a) The percentages shown do not include the number of children for which information was missing and/or not reported.
(b) The number of children may not sum to the total due to missing and/or not reported data.
. . Not applicable.
Source: Supported Accommodation Assistance Program Client Collection.

9.3 SAAP mental health-related closed support periods

The previous section provided details on SAAP clients who had a mental health-related closed support period in 2004–05. This section presents information on the closed support periods and the SAAP services provided to these clients. As noted earlier, there were 12,227 mental health-related closed support periods reported for clients in 2004–05 (Tables 9.1 and 9.3).

Type of support period

Of the mental health-related closed support periods provided by SAAP in 2004-05, 62.4% (or 7,634) involved supported accommodation services (which may include ***other support services***) while 37.6% (or 4,593) involved a range of other support services (which did not include accommodation) (Table 9.3).

Taking population size into account, the distribution of mental health-related closed support periods varied considerably across the states and territories. In 2004–05, the Australian Capital Territory had the highest number of mental health-related closed support periods per 100,000 population (125.8), followed by Victoria (91.7). Western Australia had the lowest (30.1).

Table 9.3: SAAP mental health-related closed support periods, by service type, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Supported accommodation	2,646	2,188	1,326	424	449	158	349	94	7,634
Other support services	923	2,391	354	177	485	163	59	41	4,593
Total	**3,569**	**4,579**	**1,680**	**601**	**934**	**321**	**408**	**135**	**12,227**
	Rate (per 100,000)[(a)]								
Supported accommodation	39.2	43.8	33.8	21.3	29.2	32.7	107.6	46.8	37.8
Other support services	13.7	47.9	9.0	8.9	31.6	33.7	18.2	20.4	22.7
Total	**52.9**	**91.7**	**42.8**	**30.1**	**60.8**	**66.3**	**125.8**	**67.2**	**60.5**

(a) Crude rate based on the Australian estimated resident population at 31 December 2004.

Source: Supported Accommodation Assistance Program Client Collection.

Supported accommodation services accounted for 85.5% of the SAAP services provided in the Australian Capital Territory, 78.9% in Queensland, 74.1% in New South Wales, 70.5% in Western Australia and 69.6% in the Northern Territory. In contrast, other support services accounted for 52.2% of the SAAP services provided in Victoria, 51.9% in South Australia and 50.8% in Tasmania.

Main reason for seeking SAAP assistance

As part of the SAAP Client Collection, SAAP agencies collect information on the main and other presenting reasons for which a client is seeking assistance for each support period. Multiple presenting reasons may be recorded for each support period.

During 2004–05, 'psychiatric illness' was reported as either the main or other presenting reason for which a client was seeking SAAP assistance in 52.4% of mental health-related closed support periods. It was reported as the main presenting reason in 18.4% of mental health-related closed support periods. Other frequently reported main reasons were domestic violence (13.8%) and substance abuse (9.6%) (Table 9.4).

Table 9.4: SAAP mental health-related closed support periods[a], by main presenting reason for seeking assistance, 2004–05

Main presenting reason for seeking assistance	Number[b]	Per cent[c]
Psychiatric illness	1,998	18.4
Domestic violence	1,500	13.8
Drug, alcohol, substance abuse	1,036	9.6
Eviction, previous accommodation ended	999	9.2
Usual accommodation unavailable	993	9.2
Relationship, family breakdown	822	7.6
Financial difficulty	555	5.1
Other	487	4.5
Recent arrival to area with no means of support	427	3.9
Time out from family, other situation	398	3.7
Recently left institution	371	3.4
Itinerant	357	3.3
Interpersonal conflicts	279	2.6
Physical, emotional abuse	247	2.3
Emergency accommodation ended	225	2.1
Sexual abuse	95	0.9
Gambling	48	0.4
Total	**12,227**	**100.0**

(a) Information by main presenting reason for seeking assistance was missing or not reported for over 5% of the mental health-related closed support periods.

(b) The number of closed support periods may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those closed support periods for which information was missing and/or not reported.

Source: Supported Accommodation Assistance Program Client Collection.

Source of referral to SAAP services

There are several ways in which prospective SAAP clients come in contact with a SAAP agency. In 2004–05, self-referral was the most common source of referral to SAAP services for mental health-related support periods (38.7%), followed by referrals from other SAAP agencies (10. 8%) and referrals from telephone/crisis referral agency (9.3%, Table 9.5).

Table 9.5: SAAP mental health-related closed support periods, by source of referral[a], 2004–05

Source of referral	Number[b]	Per cent[c]
Self	4,211	38.7
Other SAAP agency	1,175	10.8
Telephone, crisis referral agency	1,018	9.3
Other non-government organisation	784	7.2
Hospital, health/medical services	775	7.1
Psychiatric unit	753	6.9
Other government department	423	3.9
Community services department	398	3.7
Police, legal unit	391	3.6
Family	277	2.5
Friends	263	2.4
Other	263	2.4
Prison, correction institution	94	0.9
School, other educational institution	69	0.6
Total	**12,227**	**100**

(a) Information on source of referral was missing or not reported for over 5% of the mental health-related closed support periods.
(b) The number of closed support periods may not sum to the total due to missing and/or not reported data.
(c) The percentages shown do not include those closed support periods for which information was missing and/or not reported.
Source: Supported Accommodation Assistance Program Client Collection.

Of the 11,282 mental health-related closed support periods for which client group and length of support were recorded, 39.6% were provided to unaccompanied males aged 25 years and over, followed by unaccompanied females aged 25 years and over (19.1%), and females with children (14.1%) (Table 9.6).

Overall, the length of support varied from less than 1 day to over 52 weeks, with greater than 4 weeks to 13 weeks being the most frequently reported (23.8% of closed support periods), followed by 1 to 7 days (21.1%). Support periods lasting over 1 year accounted for 5.1% of all reported mental health-related closed support periods.

The length of the closed support periods varied among client groups. Clients who were accompanied by children tended to have longer periods of support than other clients. That is, while on average, 46.4% of closed support periods lasted longer than 4 weeks, over 60% of support periods provided to clients who had accompanying children lasted this long (65.2% for females with children, 64.3% for males with children and 62.0% for couples with children).

Clients who presented to the SAAP agency alone tended to have shorter support periods than other clients. In particular, 63.0% of support periods provided to unaccompanied males aged 25 years and over lasted 4 weeks or less.

Table 9.6: SAAP mental health-related closed support periods[a], by length of support and client group, 2004–05 (per cent)

Length of support	Male alone, under 25	Male alone, 25 and over	Female alone, under 25	Female alone, 25 and over	Couple, no children	Couple with children	Male with children	Female with children	Other	Total[b]	Number[c]
Less than 1 day	8	12.6	5.7	11.9	11.5	13.2	13.9	8.7	13.5	10.7	1,205
1–7 days	20.3	26.5	17.6	22.2	19.4	5.9	8	11.6	9.6	21.1	2,387
> 1–2 weeks	13.2	11.7	11	9	9.8	7.8	5	5.6	6.3	10.2	1,152
> 2–4 weeks	12.9	12.2	11.9	11.8	8	11.2	8.9	8.9	12.7	11.6	1,307
> 4–13 weeks	23.9	22	23.6	25	25.9	21	21.8	26.7	35.7	23.8	2,686
> 13–26 weeks	9.6	8.3	12.8	9.4	12.6	13.7	15.8	16.3	12.7	10.5	1,187
> 26–52 weeks	6.8	3.8	10	6.1	10.3	16.6	18.8	12.6	6.3	7	785
> 52 weeks	5.4	2.8	7.4	4.5	2.3	10.7	7.9	9.6	3.2	5.1	573
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (%)	*11.1*	*39.6*	*10.7*	*19.1*	*1.5*	*1.8*	*0.9*	*14.1*	*1.1*	*100.0*	*. .*
Number[c]	1,253	4,470	1,206	2,154	174	205	101	1,593	126	. .	12,227

(a) Information on client group was missing or not reported for over 5% of the mental health-related closed support periods.
(b) The percentages shown do not include those closed support periods for which information was missing and/or not reported.
(c) The number of closed support periods may not sum to the total due to missing and/or not reported data.
. . Not applicable.
Source: Supported Accommodation Assistance Program Client Collection.

Living situation and type of accommodation immediately before and after closed support periods

In the SAAP Client Collection, information is available on the living situation and type of accommodation of the client immediately before and after each closed support period. Note, though, that the information relating to the client's situation after they leave the SAAP services is indicative only, as it is based on information obtained by the SAAP agency at the end of the support period; thus it may or may not indicate what actually eventuates. In addition, some clients will not know where they will be going when they leave the SAAP agency and other clients leave unexpectedly without informing the SAAP agency. This results in large numbers of support periods with missing information in relation to this data element. In 2004–05, 34.8% of mental health-related closed support periods did not include information on the living situation of clients immediately after the support period and 34.0% did not include information on the type of accommodation immediately after the support period. The proportion of missing values for living situation and type of accommodation immediately before the support period were also large (16.5% and 13.6%, respectively). As a result, the following data should be treated with caution.

For those support periods for which information was recorded, the most common living situations reported for immediately before and immediately after mental health-related closed support periods were living 'alone' (over 30% for both), followed by living 'with other unrelated persons' (over 20% for both) (Table 9.7). Living 'with spouse/partner with/out child(ren)' and living 'with relatives/friends short-term' were more commonly reported as the living situation immediately before the support period (14.2% and 12.4%, respectively) than after (9.7% and 8.0%, respectively).

Table 9.7: SAAP mental health-related closed support periods, by living situation immediately before and immediately after the support period[(a)], 2004–05

	Immediately before support period		Immediately after support period	
Living situation	**Number[(b)]**	**Per cent[(c)]**	**Number[(b)]**	**Per cent[(c)]**
With parent(s)	862	8.4	561	7.0
With foster family	43	0.4	26	0.3
With relatives/friends short-term	1,261	12.4	636	8.0
With relatives/friends long-term	245	2.4	318	4.0
With spouse/partner with/out child(ren)	1,453	14.2	772	9.7
Alone with child(ren)	676	6.6	974	12.2
Alone	3,266	32.0	2,943	36.9
With other unrelated persons	2,301	22.5	1,642	20.6
Other	101	1.0	96	1.2
Total	**12,227**	**100.0**	**12,227**	**100.0**

(a) Information by living situation immediately before and immediately after the support period was missing or not reported for over 5% of the mental health-related closed support periods.

(b) The number of closed support periods may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those closed support periods for which information was missing and/or not reported.

Source: Supported Accommodation Assistance Program Client Collection.

For those mental health-related closed support periods for which information was available, the most common type of accommodation reported for both immediately before and after

was 'SAAP or other emergency housing' (over 19% for both) (Table 9.8). 'Living in a car, tent, park, street or squat' immediately before the support period was reported in 12.8% of the SAAP mental health-related support periods and living in 'institutions' (including psychiatric institutions) was reported in 12.0% of the support periods. These circumstances were reported less often in terms of the situation immediately after the SAAP support period (6.7% and 9.7%, respectively).

Table 9.8: SAAP mental health-related closed support periods, by type of accommodation immediately before and immediately after the support period[(a)], 2004–05

	Immediately before support period		Immediately after support period	
Accommodation	**Number[(b)]**	**Per cent[(c)]**	**Number[(b)]**	**Per cent[(c)]**
SAAP or other emergency housing	2,026	19.2	1,595	19.8
Living rent-free in house or flat	1,085	10.3	710	8.8
Private rental	1,301	12.3	1,136	14.1
Public or community housing	1,006	9.5	1,371	17.0
Rooming house, hostel, hotel or caravan	995	9.4	803	10.0
Boarding in a private home	1,015	9.6	697	8.6
Own home	328	3.1	242	3.0
Living in a car, tent, park, street or squat	1,349	12.8	540	6.7
Institutional	1,269	12.0	780	9.7
Other	195	1.8	196	2.4
Total	**12,227**	**100.0**	**12,227**	**100.0**

(a) Information on type of accommodation immediately before and immediately after the support period was missing or not reported for over 5% of the mental health-related closed support periods.

(b) The number of closed support periods may not sum to the total due to missing and/or not reported data.

(c) The percentages shown do not include those closed support periods for which information was missing and/or not reported.

Source: Supported Accommodation Assistance Program Client Collection.

Services needed, provided and referred

One measure of outcomes for SAAP clients is whether the client's needs (as identified by the SAAP agency) were met either by the SAAP agency itself or through a referral. Note that more that one type of service can be reported as needed, provided and/or referred for each closed support period, and not all support periods had information recorded on services needed. In 2004–05, SAAP agencies reported that 112,350 services were identified as needed by clients with mental health-related closed support periods in 11,999 support periods. Of the services needed, the most frequently provided were general support and/or advocacy (97.0%), basic support and services not elsewhere specified (96.7%), counselling (92.7%) and housing and/or accommodation (90.5%) (Table 9.9).

The most common broad groups of services that were neither provided nor referred were specialist services (9.7%) and financial/employment services (5.9%). Two types of mental health-related specialist services—psychological services and psychiatric services—were provided directly by SAAP agencies in less than half of the instances in which the services were sought (42.0% and 45.9%, respectively), and not provided but referred in 41.8% and 40.9% of cases, respectively. The need for psychological services was not met (either through provision or referral) in 16.1% of cases, while the need for psychiatric services was not met in 13.2% of cases (Table 9.9).

Table 9.9: SAAP services identified as needed in mental health-related closed support periods, by provision[(a)], 2004–05 (per cent)

	Not provided			Provided				
	Neither provided nor referred	Referred	Subtotal	Provided only	Provided and referred	Subtotal	Total	Closed support periods
Housing, accommodation	*3.1*	*6.3*	*9.4*	*78.6*	*11.9*	*90.5*	*100.0*	*9,840*
SAAP/CAP accommodation	2.4	4.3	6.7	82.9	10.4	93.3	100.0	8,158
Assistance to obtain/maintain short-term accommodation	6.2	10.8	17.0	61.9	21.1	83.0	100.0	3,534
Assistance to obtain/maintain independent housing	9.0	12.5	21.5	52.2	26.3	78.5	100.0	4,717
Financial, employment	*5.9*	*11.9*	*17.8*	*60.5*	*21.7*	*82.2*	*100.0*	*6,301*
Assistance to obtain/maintain government payment	4.3	14.0	18.3	47.4	34.3	81.7	100.0	2,365
Employment/training assistance	14.2	22.0	36.2	42.0	21.7	63.7	100.0	1,532
Financial assistance/material aid	3.3	7.0	10.3	73.1	16.6	89.7	100.0	4,962
Financial counselling	7.8	11.7	19.5	62.0	18.5	80.5	100.0	2,397
Counselling	*3.7*	*3.6*	*7.3*	*77.2*	*15.5*	*92.7*	*100.0*	*8,474*
Incest/sexual abuse counselling	14.0	28.3	42.3	32.2	25.4	57.6	100.0	826
Domestic violence counselling	7.5	10.3	17.8	61.1	21.1	82.2	100.0	2,473
Family/relationship counselling and support	9.1	10.7	19.8	56.7	23.5	80.2	100.0	3,290
Emotional support/other counselling	2.6	2.1	4.7	80.0	15.3	95.3	100.0	7,973
Assistance with problem gambling	13.6	26.9	40.5	41.8	17.7	59.5	100.0	294
General support, advocacy	*1.8*	*1.2*	*3.0*	*85.7*	*11.3*	*97.0*	*100.0*	*10,208*
Living skills/personal development	6.2	3.8	10.0	78.2	11.8	90.0	100.0	3,566
Assistance with legal issues/court support	6.0	17.2	23.2	42.8	34.0	76.8	100.0	2,446
Advice/information	0.7	0.3	1.0	87.3	11.7	99.0	100.0	8,890
Retrieval/storage/removal of personal belongings	2.0	2.7	4.7	89.6	5.8	95.4	100.0	3,946
Advocacy/liaison on behalf of the client	1.3	1.1	2.4	84.1	13.5	97.6	100.0	6,397
Brokerage services	2.6	7.6	10.2	76.0	13.8	89.8	100.0	1,450

(continued)

Table 9.9 (continued): SAAP services identified as needed in mental health-related closed support periods, by provision[(a)], 2004–05 (per cent)

	Not provided			Provided				
	Neither provided nor referred	Referred	Subtotal	Provided only	Provided and referred	Subtotal	Total	Closed support periods
Specialist services	*9.7*	*28.4*	*38.1*	*38.0*	*23.9*	*61.9*	*100.0*	*8,901*
Psychological services	16.1	41.8	57.9	23.1	18.9	42.0	100.0	3,957
Psychiatric services	13.2	40.9	54.1	23.2	22.7	45.9	100.0	4,671
Pregnancy support	9.3	20.0	29.3	36.2	34.5	70.7	100.0	290
Family planning support	17.1	20.7	37.8	38.5	23.6	62.1	100.0	275
Drug/alcohol support	12.6	16.1	28.7	38.9	32.4	71.3	100.0	3,451
Physical disability services	12.4	33.3	45.7	29.4	24.9	54.3	100.0	177
Intellectual disability services	18.3	34.9	53.2	28.9	17.9	46.8	100.0	235
Culturally appropriate support	4.0	5.9	9.9	70.5	19.6	90.1	100.0	1,042
Interpreter services	3.7	14.4	18.1	66.7	15.2	81.9	100.0	243
Assistance with migration issues	6.9	9.6	16.5	37.8	45.7	83.5	100.0	188
Health/medical services	4.0	27.4	31.4	41.1	27.6	68.7	100.0	5,135
Basic support and services n.e.s.	*1.8*	*1.6*	*3.4*	*88.8*	*7.9*	*96.7*	*100.0*	*8,589*
Meals	0.7	0.9	1.6	94.4	4.1	98.5	100.0	6,555
Laundry/shower facilities	0.7	0.4	1.1	96.5	2.5	99.0	100.0	6,002
Recreation	1.4	2.4	3.8	90.2	6.0	96.2	100.0	3,912
Transport	1.8	1.3	3.1	91.2	5.8	97.0	100.0	4,619
Other	2.1	1.6	3.7	79.8	16.5	96.3	100.0	2,382
Total number[(b)]	**5,362**	**10,743**	**16,105**	**78,418**	**17,827**	**96,245**	**. .**	**12,227**

(a) More than one type of service can be reported as needed, provided and/or referred for each closed support period, and not all support periods had information recorded on services needed.

(b) The sum of closed support periods by service type requested and/or provided to clients may not equal the total because more than one type of service for each support period can be reported as requested and/or provided to SAAP clients. There were 228 closed support periods for which type of service requested and/or provided to clients was not reported. This figure is included in the total.

CAP Crisis Accommodation Program

n.e.s. Not elsewhere specified.

. . Not applicable.

Source: Supported Accommodation Assistance Program Client Collection.

10 Support services for people with psychiatric disability

10.1 Introduction

Specialist support services are provided to persons with a disability through the Commonwealth State/Territory Disability Agreement (CSTDA), with the current agreement covering the period from 2002 to 2007 (FaCS 2002). This agreement provides the framework for the Australian and state and territory governments to work collaboratively in providing specialist services to help people with disabilities live and participate equally with others in the community. Under the CSTDA, the Australian Government has responsibility for the planning, policy setting and management of employment services, and the states and territories are responsible for all other disability support services, with the exception of advocacy, information and print disability services. Both levels of government are responsible for these latter services (AIHW 2006c:5).

Under the CSTDA, 'people with disabilities' refers to people with disabilities that are attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) and that:

- are likely to be permanent;
- result in substantially reduced capacity in at least one of the following: self-care/management, mobility or communication;
- are likely to require significant ongoing and/or long-term episodic support; and
- are evident before 65 years of age (FaCS 2002).

A person that fulfils the above criteria can receive a range of CSTDA-funded ***service types*** depending on availability and their individual needs. Services can be either ***residential*** or ***non-residential***, or a combination of the two. The data presented in this chapter covers both of these types of services. For further details on CSTDA-funded services, refer to *Disability support services 2004–05* (AIHW 2006c:118–122).

Overall, 200,493 people across Australia made use of residential and/or non-residential CSTDA-funded services during 2004–05. The most common ***primary disability*** among these clients was intellectual disability (35.2%), followed by physical disability (13.1%) (AIHW 2006c). Psychiatric disability rated as the third most commonly reported primary disability, with 8.0% (or 16,018) of service users having this disability as their primary disability.

This chapter presents information on CSTDA-funded disability support services provided to service users with a '***psychiatric disability***' either as their primary disability or as an '***other significant disability***'. The information has been extracted from the CSTDA National Minimum Data Set (NMDS), which is a collation of data on disability support services that receive CSTDA funding and the estimated number of service users. There are some jurisdictional variations in the services funded under the CSTDA and thus comparisons across the states and territories must be undertaken with caution.

Note that no data on the quantity (for example, hours) of support received is provided in this chapter. While some information is collected on the hours of support received by the service user in a reference week over the reporting period, this information only relates to selected non-residential services (such as personal care, case management, community access and

respite). Furthermore, there is an unacceptably high proportion of missing information in relation to these hours of support data.

See Appendix 1 for further information on data quality, coverage and other aspects of the CSTDA data collection.

While data on disability support services were collected before 2003, the first full financial year of data was collected in relation to 2003–04. In this report, information from the most recent data collection (pertaining to 2004–05) are presented, along with information from the 2003–04 collection for comparison purposes.

Key concepts

Disability groups are a broad categorisation of disabilities in terms of the underlying health condition, impairment, activity limitations, participation restrictions, environmental factors and support needs (NCSDC 2006). The 12 categories are: intellectual; specific learning/Attention deficit disorder; autism; physical; acquired brain injury; neurological; deafblind; vision; hearing; speech; psychiatric; and developmental delay. For the CSTDA data, the relevant disability groups are identified by the service user, carer and/or service provider.

Primary disability is the disability group that most clearly expresses the experience of disability by a person, causing the most difficulty to the person in their daily life.

Other significant disability refers to disability group(s) other than that indicated as being 'primary' that also clearly expresses the experience of disability by a person and/or causes difficulty for the person. A number of other significant disabilities may be identified for each service user from the categories mentioned above.

Psychiatric disability in the CSTDA collection includes clinically recognisable symptoms and behaviour patterns frequently associated with distress and which may impair functioning in normal social activity. The typical effects of conditions such as schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders are included but dementias, specific learning disorders (such as Attention deficit disorder) and autism are excluded.

Service type refers to the classification of services according to the support activity which the service provider has been funded to provide under the CSTDA. For the purpose of this report, service types are divided into residential and non-residential.

Residential services are services that provide accommodation to people with a disability. They include accommodation in large and small residentials/institutions; hostels; and group homes.

Non-residential services are services that support people with a disability to live in a non-institutional setting through the provision of community support, community access, accommodation support in the community, respite and/or employment services.

10.2 CSTDA services

In 2004–05, a total of 25,922 people with a psychiatric disability made use of residential and/or non-residential CSTDA–funded services. In comparison, 24,753 people did so during 2003–04. For most of the service users in 2004–05, the psychiatric disability was the service user's primary disability (61.8%, or 16,018 service users) rather than 'other significant disability' (9,904 service users).

In 2004–05, there were 25,156 users who accessed non-residential services, 3,007 who accessed residential services and 2,241 who accessed both types of service (Table 10.1).

While at the national and the state and territory levels, the number of non-residential service users outweighed the number of residential service users, the percentages differed somewhat across the states and territories. In particular, non-residential services accounted for 99.1% of service users in Queensland, compared with a lower percentage (89.9%) in the Northern Territory.

New South Wales had the largest number of residential service users, accounting for 38.0% (or 1,142) of all residential users, while non-residential users in Victoria represented over one third of the total non-residential users (35.6%, or 8,954).

Table 10.1: CSTDA-funded service users with a psychiatric disability, states and territories, 2003–04 and 2004–05

	2003–04			2004–05			Percentage change		
State or territory	Resi-dential	Non-residential	Total[a]	Resi-dential	Non-residential	Total[a]	Resi-dential	Non-residential	Total
NSW	1,072	5,993	6,217	1,142	6,172	6,492	6.5	3.0	4.4
Vic[b]	983	8,396	8,585	941	8,954	9,121	–4.3	6.6	6.2
Qld	203	4,711	4,752	166	5,157	5,204	–18.2	9.5	9.5
WA	186	1,915	1,936	208	1,675	1,711	11.8	–12.5	–11.6
SA	271	2,000	2,095	317	2,027	2,143	17.0	1.4	2.3
Tas	183	707	764	193	775	839	5.5	9.6	9.8
ACT	34	340	348	19	365	369	–44.1	7.4	6.0
NT	26	133	145	21	116	129	–19.2	–12.8	–11.0
Total[c]	**2,958**	**24,108**	**24,753**	**3,007**	**25,156**	**25,922**	**1.7**	**4.3**	**4.7**

(a) The number of the residential and non-residential service users may not sum to the total because service users may utilise both types of services.

(b) Advice was received from the Victorian Department of Human Services shortly before the publication of this report that there had been an error in the data supplied to the AIHW. In addition to those service users included in this table (and, more broadly, in this chapter), there were an additional 7,971 CSTDA-funded service users with a psychiatric disability in 2003–04 in Victoria and an additional 9,590 such service users in 2004–05. Given the late notification of this error, the information about these service users could not be incorporated into the data presented in this chapter.

(c) The number of service users may not sum to the total because service users may access services in more than one state or territory.

Source: AIHW analysis of data from the 2003–04 and 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

10.3 Residential services

A range of residential CSTDA-funded services are provided to service users as follows:

- *large residentials/institutions* provide 24-hour residential support in a setting of more than 20 beds (these are referred to as large institutions in this report);
- *small residentials/institutions* provide 24-hour residential support in a setting of 7 to 20 beds (these are referred to as small institutions in this report);
- *hostels* provide residential support in a setting of usually less than 20 beds and may or may not provide 24-hour residential support; and
- *group homes* provide combined accommodation and community-based residential support to people in a residential setting and are generally staffed 24 hours a day. Usually, no more than 6 service users are located in any one home.

Of the service users who accessed residential services during 2004–05, 2,061 (or 68.5%) accessed group homes, followed by large institutions (26.7%), small institutions (3.6%) and hostels (2.6%, Table 10.2). With one exception, the number of service users who accessed group homes was higher than for other residential service types in each of the jurisdictions

and, in particular, in the Australian Capital Territory (100%), Northern Territory (100%), and Victoria (88.8%). South Australia was the exception, with most users (62.1%) accessing large institutions in that state.

Nationally, users accessed residential services at a rate of 14.9 clients per 100,000 population. This rate was highest in South Australia (20.6) and lowest in Queensland (4.2).

Table 10.2: CSTDA-funded residential service users with a psychiatric disability, by residential service type, states and territories, 2004–05

Residential service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[a]	Total (%)
Large institution	437	87	33	28	197	21	0	0	803	26.7
Small institution	8	n.p.	56	37	n.p.	n.p.	0	0	108	3.6
Hostels	8	26	0	0	8	37	0	0	79	2.6
Group homes	714	836	79	143	115	134	19	21	2,061	68.5
Total[b]	**1,142**	**941**	**166**	**208**	**317**	**193**	**19**	**21**	**3,007**	**. .**
Rate (per 100,000 population)[c]	16.9	18.8	4.2	10.4	20.6	39.9	5.9	10.5	14.9	. .

(a) The number of service users may not sum to the total because users may have accessed services from more than one state and/or territory.

(b) The number of service users may not sum to the total because users may have accessed services from more than one residential service type.

(c) Crude rate based on the Australian estimated resident population as at 31 December 2004.

n.p. Not published.

Note: Numbers under 5 have been suppressed due to confidentiality reasons.

. . Not applicable.

Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

Profile of residential service users

As previously mentioned, there were 3,007 service users with a psychiatric disability (classified either as their 'primary' or as an 'other significant' disability) that accessed CSTDA-funded residential services during 2004–05. For 9.8% of these (or 294 service users), their psychiatric disability was reported as their primary disability, in contrast with 90.2% (or 2,713) that had it reported as 'other significant disability' (Table 10.3).

Table 10.3: CSTDA-funded residential service users with a psychiatric disability, by primary disability group, 2004–05

Primary disability group	Service users (number)	Service users (per cent)
Intellectual	2,385	79.3
Psychiatric	294	9.8
Physical	97	3.2
Acquired brain injury	95	3.2
Autism	66	2.2
Neurological	57	1.9
Other disability[a]	13	0.4
Total	**3,007**	**100.0**

(a) Includes the following disability groups: specific learning/Attention deficit disorder; sensory; speech; and developmental delay.

Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

Intellectual disability was the most prominent primary disability among those residential service users identified with psychiatric disability group; this disability was reported for 79.3% (or 2,385) of the service users.

More male users accessed the CSTDA-funded residential services than females (58.2% compared to 41.8%) and over half (53.6%) of residential users were aged 35 to 54 years (Table 10.4).

Table 10.4: Demographic characteristics of CSTDA-funded residential service users with a psychiatric disability, 2004–05

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate (per 1,000,000 population)[(c)]
Age group			
Less than 15 years	3	0.1	1
15–24 years	182	6.1	65
25–34 years	528	17.7	184
35–44 years	817	27.4	272
45–54 years	781	26.2	281
55–64 years	505	16.9	235
65 years and over	168	5.6	64
Sex			
Male	1,748	58.2	173
Female	1,258	41.8	122
Indigenous status[(d)]			
Indigenous Australians	96	3.4	264
Other Australians	2,761	96.6	139
Country of birth			
Australia	2,778	93.6	196
Overseas	191	6.4	33
Remoteness area of usual residence			
Major cities	2,110	72.0	156
Inner regional	674	23.0	162
Outer regional	139	4.7	70
Remote	9	0.3	26
Very remote	0	0.0	0
Total[(c)]	**3,007**	**100.0**	**149**

(a) The numbers of service users for each demographic variable may not sum to the total due to missing and/or not reported data.
(b) The percentages shown do not include those service users for which the demographic information was missing and/or not reported.
(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.
(d) These data should be interpreted with caution due to likely under identification of Indigenous Australians.
Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

Furthermore, 3.4% of residential service users identified as Aboriginal and/or Torres Strait Islanders. Although Indigenous peoples make up a small percentage of CSTDA-funded

residential service users, when their age structure and population size are taken into account, they were relatively more likely than other Australians to utilise these services (264 and 139 per 1,000,000 population, respectively).

The majority of residential service users were born in Australia (93.6%). When relative population sizes and age structures are considered, there is an under-representation of residential service users who were born overseas (33 per 1,000,000 population for overseas-born compared with 196 per 1,000,000 population for Australian-born).

Most residential service users accessed CSTDA-funded services in Major cities (72.0%), followed by Inner regional areas (23.0%). However, when relative population sizes and age structures are taken into account, users accessed services in Inner regional areas at a higher rate than in Major cities (162 and 156 per 1,000,000 population, respectively).

As part of CSTDA data collection activities, information on the service users' usual residential setting is collected. This refers to the type of physical accommodation in which the person resides for 4 or more days per week on average while receiving CSTDA-funded services. Among service users with a psychiatric disability who accessed CSTDA-funded residential services during 2004–05, over half (59.2% or 1,777 service users) usually lived in a 'domestic-scale supported living facility' (which provides some support by staff or volunteers), followed by 37.2% (1,118) who lived in a 'supported accommodation facility' (which provides a 24-hour care by rostered care workers). About 1.4% of residential service

Table 10.5: CSTDA-funded residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2004–05

	Service users (number)[(a)]	Service users (per cent)[(b)]
Residential setting[(c)]		
Private residence	42	1.4
Domestic-scale supported living facility	1,777	59.2
Supported accommodation facility	1,118	37.2
Psychiatric/mental health community care facility	43	1.4
Other	24	0.8
Living arrangement		
Lives alone	72	2.4
Lives with family	19	0.6
Lives with others	2,908	97.0
Income source (service users aged 16 years and over)[(d)]		
Disability Support Pension	2,884	97.5
Other pension or benefit	44	1.5
Paid employment	19	0.6
Other	11	0.4
Total	**3,007**	**100.0**

(a) The numbers of service users for each data item may not sum to the total due to missing and/or not reported data.

(b) The percentages shown do not include those services for which information was missing and/or not reported.

(c) Other residential settings are collected under the CSTDA NMDS (i.e., residence within an Aboriginal community, boarding house or private hotel, independent living within a retirement village, hospital, and public place or temporary shelter) but none of the service users with a psychiatric disability reported them.

(d) A total of 2,977 of the non-residential service users with a psychiatric disability were aged 16 years or more. Each user can have more than one income source.

Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

users lived in a 'psychiatric or mental health community care facility' (which provides temporary accommodation and non-acute care to people with mental illness or psychological disabilities) (Table 10.5).

In reference to usual living arrangements, most residential service users lived with persons other than family members (97.0%). This corresponds with the relatively high percentage of service users whose usual accommodation was in a facility rather than a private residence.

Among those residential service users aged 16 years and over who provided information on their source of income (2,958 users), 97.5% received their income from the Disability Support Pension.

10.4 Non-residential services

A range of non-residential CSTDA-funded services are provided to service users as follows:

- *in-home accommodation support* involves support with the basic needs of living. It includes personal care by an attendant, in-home living support, alternative placement (such as shared-care arrangements and host family placements), and crisis accommodation support;
- *community support* includes services such as specialised therapeutic services, early childhood intervention, behaviour and/or specialist intervention, counselling and case management;
- *community access* services are designed to provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence. They include learning and life skills development, and recreation and holiday programs;
- *respite services* provide a short-term and time-limited break for caregivers of people with a disability and includes services such as those provided in the individual's home, in centres, in respite homes and with host families;
- *employment support services* includes providing assistance in obtaining and/or retaining paid employment in both general employment as well as specialised and supported environments;
- *advocacy, information and print disability and other support* includes services such as advocacy, information, referral, mutual support, self-help groups, research, evaluation, training and development. Note that no service user counts are collected for these services.

During 2004–05, 66.4% of the non-residential service users with a psychiatric disability accessed employment support services, followed by 21.4% of users using community access services, 20.8% using community support, 11.7% using accommodation support and 6.6% using respite services (see Table 10.6).

With one exception, the number of non-residential service users who accessed employment support services was higher than for other service types in each of the jurisdictions, and in particular in New South Wales (73.1%) and the Australian Capital Territory (71.2%). Tasmania was the exception, with most users (45.9%) accessing community access services in that state.

Nationally, users accessed non-residential services at a rate of 125 clients per 100,000 population. The rate was highest in Victoria (179), and lowest in the Northern Territory (58).

Table 10.6: CSTDA-funded non-residential service users with a psychiatric disability, by non-residential service type, states and territories, 2004–05

Non-residential service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(a)]	Total (%)
Accommodation support	317	963	980	341	211	75	45	6	2,938	11.7
Community support	959	2,067	819	402	689	192	83	28	5,222	20.8
Community access	1,083	2,019	1,228	277	388	356	20	18	5,385	21.4
Respite	211	767	421	82	96	24	64	5	1,666	6.6
Employment	4,509	6,204	2,923	1,164	1,282	337	260	75	16,711	66.4
Total[(b)]	**6,172**	**8,954**	**5,157**	**1,675**	**2,027**	**775**	**365**	**116**	**25,156**	**. .**
Rate (per 100,000 population)[(c)]	91.4	179.3	131.3	84.0	131.9	160.2	112.6	57.8	124.5	. .

(a) The number of service users may not sum to the total because users may have accessed services from more than one state and/or territory.
(b) The number of service users may not sum to the total because users may have accessed services from more than one non- residential service type.
(c) Crude rate based on the Australian estimated resident population as at 31 December 2004.
. . Not applicable.
Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

Profile of non-residential service users

As noted above, there were 25,156 service users with a psychiatric disability (classified either as the 'primary' or as an 'other significant' disability) that accessed non-residential CSTDA-funded services during 2004–05. Of these, 63.1% (or 15,869 service users) reported psychiatric disability as their 'primary disability' and 36.9% (or 9,287) as an 'other significant disability' (Table 10.7). This contrasts with those clients who made use of residential services; for those service users, the psychiatric disability was the primary disability for 9.8% of service users. The next most commonly reported primary disability group of the clients with a psychiatric disability that made use of non-residential services was intellectual disability (5,675 users, or 22.6%), followed by physical disability (1,175 users, or 4.7%).

Table 10.7: CSTDA-funded non-residential service users with a psychiatric disability, by primary disability group, 2004–05

Primary disability group	Service users (number)	Service users (per cent)
Psychiatric	15,869	63.1
Intellectual	5,675	22.6
Physical	1,175	4.7
Acquired brain injury	992	3.9
Neurological	473	1.9
Autism	352	1.4
Sensory	319	1.3
Specific learning/Attention deficit disorder	285	1.1
Other disability[(a)]	16	0.1
Total	**25,156**	**100.0**

(a) Includes the following disability groups: speech and developmental delay.
Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

More male users accessed the CSTDA-funded non-residential services than females (59.9% compared with 40.1%), and over half (52.6%) of non-residential users were aged 25 to 44 years (Table 10.8).

Although Aboriginal and Torres Strait Islander Australians made up a small percentage of users (3.2%), when the relative age structures and population sizes were taken into account, Indigenous Australians were relatively more likely than other Australians to have utilised non-residential CSTDA-funded services (1,870 per 1,000,000 population and 1,146, respectively).

Table 10.8: Demographic characteristics of CSTDA-funded non-residential service users with a psychiatric disability, 2004–05

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate (per 1,000,000 population)[(c)]
Age group			
Less than 15 years	290	1.2	73
15–24 years	3,773	15.0	1,354
25–34 years	6,481	25.8	2,253
35–44 years	6,734	26.8	2,239
45–54 years	5,169	20.6	1,862
55–64 years	2,199	8.7	1,023
65 years and over	500	2.0	190
Sex			
Male	15,069	59.9	1,502
Female	10,082	40.1	1,002
Indigenous status[(d)(e)]			
Indigenous Australians	749	3.2	1,870
Other Australians	22,483	96.8	1,146
Country of birth			
Australia	21,371	88.4	1,464
Overseas	2,815	11.6	514
Remoteness area of usual residence			
Major cities	16,420	65.7	1,208
Inner regional	5,834	23.2	1,480
Outer regional	2,452	9.8	1,265
Remote	218	0.9	685
Very remote	70	0.3	371
Total	**25,156**	**100.0**	**1,245**

(a) The numbers of service users for each demographic variable may not sum to the total due to missing and/or not reported data.
(b) The percentages shown do not include those service users for which the demographic information was missing and/or not reported.
(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.
(d) These data should be interpreted with caution due to likely under identification of Indigenous Australians.
(e) Information on this data element was missing or not reported for more that 5 per cent of service users.

Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

As was the case for the residential service users, most non-residential service users were born in Australia (88.4%) and those who were born overseas were relatively less likely than their Australian-born counterparts to have used these services (1,464 per 1,000,000 population for Australian-born compared with 514 for overseas-born).

Almost two-thirds (65.7%) of non-residential service users accessed CSTDA-funded services in Major cities, followed by 23.2% of users who accessed services in Inner regional areas. However, when relative population sizes and age structures are taken into account, users accessed services in Inner regional areas and in Outer regional areas at a higher rate than in Major cities (1,480 and 1,265 per 1,000,000 population, respectively, compared with 1,208 in Major cities).

Table 10.9: CSTDA-funded non-residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2004–05

	Service users (number)[(a)]	Service users (per cent)[(b)]
Residential setting		
Private residence	18,993	76.0
Residence within an Aboriginal community	36	0.1
Domestic-scale supported living facility	1,997	8.0
Supported accommodation facility	2,070	8.3
Boarding house/private hotel	549	2.2
Independent living within a retirement village	15	0.1
Residential aged care facility	115	0.5
Psychiatric/mental health community care facility	415	1.7
Hospital	42	0.2
Short-term crisis, emergency or transitional accommodation	251	1.0
Public place/temporary shelter	22	0.1
Other	476	1.9
Living arrangement		
Lives alone	6,663	27.5
Lives with family	10,772	44.4
Lives with others	6,818	28.1
Income source (service users aged 16 years and over)[(c)]		
Disability Support Pension	16,850	71.4
Other pension or benefit	4,046	17.2
Paid employment	1,984	8.4
Compensation income	70	0.3
Other income	429	1.8
No income	207	0.9
Total	**25,156**	**100.0**

(a) The numbers of service users for each data item may not sum to the total due to missing and/or not reported data.

(b) The percentages shown do not include those services for which information was missing and/or not reported.

(c) A total of 24,739 of the non-residential service users with a psychiatric disability were aged 16 years or more. Each user can have more than one income source.

Source: AIHW analysis of data from the 2004–05 Commonwealth State/Territory Disability Agreement NMDS.

Among service users with a psychiatric disability that accessed CSTDA-funded non-residential services during 2004–05, about three in four (76.0% or 18,993 service users) usually lived in a private residence, followed by 8.3% (2,070) in a supported accommodation facility and 8.0% (1,997) in a 'domestic-scale supported living facility' such as a group home (Table 10.9).

In reference to usual living arrangements, most users lived with their family (44.4%), followed by living with others (that is, non-family members) (28.1%) and living alone (27.5%).

Among those non-residential service users aged 16 years and over who provided information on their source of income (23,586 users), 71.4% received their income from the Disability Support Pension, while 17.2% received some other type of pension or benefit, and 8.4% received income from paid employment.

11 Mental health-related prescriptions

11.1 Introduction

This chapter presents information on prescriptions for ***mental health-related medications*** that are subsidised by the Australian Government through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Under both schemes, Medicare Australia makes payments to pharmacists to subsidise pharmaceutical products that are regarded as necessary and/or life-saving and are listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2006d).

Key concepts

Mental health-related medications are defined in this chapter as:

(a) four selected medication groups as classified in the Anatomical Therapeutic Chemical (ATC) Classification System (WHO 2006)—namely antipsychotics (code N05A), anxiolytics (code N05B), hypnotics and sedatives (code N05C), and antidepressants (code N06A)—prescribed by all medical practitioners (that is, general practitioners, non-psychiatrist specialists and psychiatrists); and

(b) all other medications prescribed by psychiatrists.

Mental health-related prescriptions: are defined as prescriptions for mental health-related medications subsidised under the PBS/RPBS, which were dispensed by an approved pharmacist and for which the claim was processed by Medicare Australia in the reporting period.

Note that the intent of the definition of mental health-related medications used in this chapter is to capture, as far as possible, those medications that were dispensed for mental health-related reasons. However, it is likely that some medications are included that were prescribed for non-mental health-related reasons (for example, some medications prescribed by psychiatrists may not relate directly to the patient's mental health problems), while other medications that were related to mental health problems may have been excluded (for example, some medications prescribed by general practitioners or non-psychiatrist specialists that fall outside of the four selected medication groups may have related to mental health-related problems).

It should also be noted that over-the-counter medications (including orthodox and alternative medications) and non-subsidised medications, such as private and below copayment prescriptions (where the patient copayment covers the total costs of the prescribed medication), are not included in the PBS/RPBS data. The Pharmacy Guild of Australia estimated that slightly less than 80% of all community prescriptions were dispensed under the PBS/RPBS in 2001 (AIHW 2003). However, this proportion does not necessarily apply to mental health-related prescriptions.

This chapter first presents information on ***mental health-related prescriptions*** for 2005–06, according to the type of medication prescribed and the prescribing medical practitioner. This is followed by data that covers the period from 2000–01 to 2005–06. For further information on the PBS/RPBS and on data on medications covered by these

schemes refer to Appendix 1. Related data on *expenditure* on medications under the PBS and RPBS are presented in Chapter 14 of this publication.

In interpreting the information provided in this chapter, note that individual prescriptions will vary in the number of doses, the strength of each individual dose and the type of preparation (such as tablets or injections).

Each of the pharmaceutical products subsidised through the PBS/RPBS is listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2006d). The coding of the pharmaceutical products in this schedule is based on the Anatomical Therapeutic Chemical (ATC) Classification System, defined by the World Health Organization (WHO 2006a). This classification assigns therapeutic drugs to different groups according to the organ or system on which they act, as well as their therapeutic and chemical characteristics. In Table 11.1, the four selected medication groups that have been defined as 'mental health-related' when considering prescriptions by general practitioners and non-psychiatrist specialists are briefly described. Specific medications within these groups may also be used in the management of patients with illnesses that are not psychiatric in nature (for example, use of hypnotics and sedatives during post-operative care).

Table 11.1: Drug groups defined for this report as mental health-related medications prescribed by general practitioners and non-psychiatrist specialists in PBS/RPBS data

ATC code	Drug groups	Brief description of effects and indications
N05	**Psycholeptics**	**A group of drugs that tranquilises (CNS depressants)**
N05A	Antipsychotics	Drugs used to treat symptoms of psychosis (a severe mental disorder characterised by loss of contact with reality, delusions and hallucinations), common in conditions such as schizophrenia, mania and delusional disorder.
N05B	Anxiolytics	Drugs prescribed to treat symptoms of anxiety.
N05C	Hypnotics and sedatives	Hypnotic drugs are used to induce sleep and treat severe insomnia. Sedative drugs are prescribed to reduce excitability or anxiety.
N06	**Psychoanaleptics**	**A group of drugs that stimulates the mood (CNS stimulants)**
N06A	Antidepressants	Drugs used to treat the symptoms of clinical depression.

Note: Previous *Mental health services in Australia* editions specified that the antipsychotic drug prochlorperazine was excluded from the antipsychotic drugs group, as it is frequently prescribed as an anti-nausea medication. This exclusion is no longer relevant as prochlorperazine is now classified in the 'alimentary tract and metabolism' ATC group.

Source: World Health Organization 2006a.

11.2 Prescriptions

This section presents information on the number and type of mental health-related prescriptions that were subsidised under the PBS/RPBS during 2005–06. In interpreting this information, note that a person may have had several subsidised mental health–related prescriptions during the period covered.

Overall, 182.7 million PBS/RPBS-subsidised prescriptions for medications were provided by medical practitioners in 2005–06, of which 20.7 million (11.3%) were for mental health-related medications (Table 11.2). This is equivalent to 1,010 mental health-related prescriptions per 1,000 population (Table 11.3).

Of the 20.7 million mental health-related prescriptions, 87.2% were provided by general practitioners, 9.4% by psychiatrists and 3.4% by non-psychiatrist specialists.

General practitioners prescribed 95.0% of hypnotics and sedatives, 93.1% of anxiolytics, 88.4% of antidepressants and 73.1% of antipsychotics. Psychiatrists provided 19.6% of the prescriptions for antipsychotics in 2005–06.

Most of the 20.7 million prescriptions were for antidepressant medication (59.6%, or 12.3 million), followed by anxiolytics (15.9%), hypnotics and sedatives (13.9%) and antipsychotics (8.9%). These proportions varied according to the specialty of the prescriber. General partitioners prescribed a total of 18.0 million mental health-related medications, most of which were antidepressants (60.4%), followed by anxiolytics (17.0%) and hypnotics and sedatives (15.1%). Antidepressants accounted for 53.0% of the mental health-related medications prescribed by psychiatrists and for 56.6% of the medications prescribed by non-psychiatrist specialists.

Table 11.2: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, 2005–06

ATC group (code)	General practitioners	Non-psychiatrist specialists	Psychiatrists	Total	Total (%)
Antipsychotics (N05A)	1,343,504	135,711	359,794	1,839,009	8.9
Anxiolytics (N05B)	3,060,687	84,636	142,262	3,287,585	15.9
Hypnotics and sedatives (N05C)	2,726,700	87,301	57,594	2,871,595	13.9
Antidepressants (N06A)	10,868,984	401,442	1,029,843	12,300,269	59.6
Other ATC groups[(b)]	. .	. .	354,675	354,675	1.7
Total	**17,999,875**	**709,090**	**1,944,168**	**20,653,133**	**100.0**
Total per cent	*87.2*	*3.4*	*9.4*	*100.0*	*. .*

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) Includes other N codes as well as other ATC medication groups as presented in Table 11.4. Note that data for other ATC groups prescribed by general practitioners and non-psychiatrist specialist are not presented because they are not included in the definition of mental health-related medications.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

There was some variation in the number and type of mental health-related medications prescribed across states and territories in 2005–06 (Table 11.3). The rate of prescriptions per 1,000 population was below the national average (of 1,009.8) in the Northern Territory and the Australian Capital Territory (344 and 762 per 1,000 population, respectively). In contrast, Tasmania and South Australia had higher rates of prescriptions than the national average (1,372 and 1,211 prescriptions per 1,000 population, respectively).

Most jurisdictions showed the same relationships between the type of mental health-related medication and the medical practitioner who provided the prescription, as outlined above for Australia as a whole. Exceptions include the Northern Territory, which had a higher proportion of antipsychotic prescriptions provided by non-psychiatrist specialists than the national average (26.0% compared with 7.4% for Australia), and the Australian Capital Territory, which had a higher proportion of antipsychotic prescriptions provided by psychiatrists (31.4% compared with 19.6% for Australia).

Medications prescribed by psychiatrists

This section focuses on the PBS/RPBS prescriptions provided by psychiatrists that were dispensed by a community pharmacy in the reporting period.

In 2005–06, psychiatrists provided a total of 1.9 million PBS/RPBS subsidised prescriptions, equivalent to 95.1 prescriptions per 1,000 people (Table 11.4).

Table 11.3: Mental health-related prescriptions, by type of medication prescribed[a] and prescribing medical practitioner, states and territories[b], 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Antipsychotics (N05A)									
General practitioners	448,005	370,920	232,474	105,892	136,008	31,581	14,365	4,259	1,343,504
Non-psychiatrist specialists	30,214	54,252	26,815	14,455	5,572	1,121	1,465	1,817	135,711
Psychiatrists	123,289	109,409	60,077	19,767	32,703	6,393	7,255	901	359,794
Subtotal	*601,508*	*534,581*	*319,366*	*140,114*	*174,283*	*39,095*	*23,085*	*6,977*	*1,839,009*
Anxiolytics (N05B)									
General practitioners	864,348	862,124	625,186	244,913	292,414	139,113	25,723	6,866	3,060,687
Non-psychiatrist specialists	19,706	25,609	20,057	8,770	7,944	1,750	570	230	84,636
Psychiatrists	35,525	49,986	29,787	6,882	13,475	5,298	1,025	284	142,262
Subtotal	*919,579*	*937,719*	*675,030*	*260,565*	*313,833*	*146,161*	*27,318*	*7,380*	*3,287,585*
Hypnotics and sedatives (N05C)									
General practitioners	857,602	707,908	506,519	268,220	260,106	98,490	21,421	6,434	2,726,700
Non-psychiatrist specialists	23,518	26,637	18,454	10,026	6,222	1,418	712	314	87,301
Psychiatrists	14,625	17,616	12,392	4,018	6,557	1,599	682	105	57,594
Subtotal	*895,745*	*752,161*	*537,365*	*282,264*	*272,885*	*101,507*	*22,815*	*6,853*	*2,871,595*
Antidepressants (N06A)									
General practitioners	3,279,807	2,683,782	2,299,274	1,101,040	963,679	344,859	152,975	43,568	10,868,984
Non-psychiatrist specialists	105,522	112,234	93,300	49,107	26,103	7,966	4,597	2,613	401,442
Psychiatrists	305,734	299,159	214,036	82,591	92,208	21,582	12,627	1,906	1,029,843
Subtotal	*3,691,063*	*3,095,175*	*2,606,610*	*1,232,738*	*1,081,990*	*374,407*	*170,199*	*48,087*	*12,300,269*
Other medications prescribed by psychiatrists[c]									
Psychiatrists	101,744	91,005	67,343	51,268	29,469	7,393	5,470	983	354,675
Total	**6,209,639**	**5,410,641**	**4,205,714**	**1,966,949**	**1,872,460**	**668,563**	**248,887**	**70,280**	**20,653,133**
Rate (per 1,000 population)[d]	912.8	1,070.9	1,051.2	969.6	1,210.9	1,372.3	761.9	343.7	1,009.8

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the pharmacy supplying the item is used.

(c) Includes other N codes as well as other ATC medication groups as presented in Table 11.4. Note that data for other ATC groups prescribed by general practitioners and non-psychiatrist specialist are not presented because they are not included in the definition of mental health-related medications.

(d) Crude rate based on the preliminary Australian estimated resident population at 31 December 2005.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

Table 11.4: Mental health-related prescriptions by psychiatrists, by broad type of medication prescribed[a], states and territories[b], 2005–06

Code	ATC group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
N	Central Nervous System									
N05A	Antipsychotics	123,289	109,409	60,077	19,767	32,703	6,393	7,255	901	359,794
N05B	Anxiolytics	35,525	49,986	29,787	6,882	13,475	5,298	1,025	284	142,262
N05C	Hypnotics and sedatives	14,625	17,616	12,392	4,018	6,557	1,599	682	105	57,594
N06A	Antidepressants	305,734	299,159	214,036	82,591	92,208	21,582	12,627	1,906	1,029,843
	Subtotal	*479,173*	*476,170*	*316,292*	*113,258*	*144,943*	*34,872*	*21,589*	*3,196*	*1,589,493*
	Other N	59,944	53,571	36,091	40,976	17,377	4,734	3,583	449	216,725
	Subtotal N	*539,117*	*529,741*	*352,383*	*154,234*	*162,320*	*39,606*	*25,172*	*3,645*	*1,806,218*
A	Alimentary tract and metabolism	10,851	10,076	8,929	2,491	3,084	803	405	54	36,693
B	Blood and blood-forming organs	870	968	943	413	452	56	50	2	3,754
C	Cardiovascular system	15,220	11,926	9,573	3,276	4,553	933	647	324	46,452
D	Dermatologicals	689	650	516	300	171	30	25	2	2,383
G	Genito-urinary system and sex hormones	2,651	1,953	2,847	945	792	134	146	2	9,470
H	Systemic hormonal preparations, excl. sex hormones and insulins	1,155	1,322	1,064	437	476	98	55	4	4,611
J	Antiinfectives for systemic use	2,660	2,733	1,939	607	624	117	149	16	8,845
L	Antineoplastic and immunomodulating agents	272	154	126	48	42	10	25	3	680
M	Musculo-skeletal system	2,877	3,521	2,268	807	822	268	160	72	10,795
P	Antiparasitic products, insecticides and repellents	47	35	19	17	12	13	3	0	146
R	Respiratory system	3,128	2,941	2,090	679	787	153	173	42	9,993
S	Sensory organs	1,183	971	756	238	230	43	44	13	3,478
V	Various[c]	140	158	155	22	40	1	5	0	521
Z	Other[d]	57	26	27	12	7	0	0	0	129
	Subtotal	*41,800*	*37,434*	*31,252*	*10,292*	*12,092*	*2,659*	*1,887*	*534*	*137,950*
Total		**580,917**	**567,175**	**383,635**	**164,526**	**174,412**	**42,265**	**27,059**	**4,179**	**1,944,168**
Rate (per 1,000 population)[e]		85.4	112.3	95.9	81.1	112.8	86.8	82.8	20.4	95.1

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the pharmacy supplying the item is used.

(c) Include allergens, diagnostic agents, urine test reagents and food supplements (lactose, amino acid preparations).

(d) Refers to extemporaneously prepared items and/or PBS items with no ATC equivalent.

(e) Crude rate based on the preliminary Australian estimated resident population at 31 December 2005.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

Of these, 1.6 million (81.8%) were for the four selected mental health-related medication groups (namely antipsychotics, anxiolytics, hypnotics and sedatives, and antidepressants).

Similar to the pattern described for all medical practitioners, the rate of prescriptions provided by psychiatrists under PBS/RPBS was well below the national average in the Northern Territory (20.4 prescriptions per 1,000 people). South Australia and Victoria accounted for the highest number of prescriptions per 1,000 people (112.8 and 112.3 respectively).

In Western Australia and the Northern Territory, the percentage of prescriptions provided by psychiatrists for the four selected mental health-related medication groups was lower than average (68.8% and 76.5%, respectively). While prescriptions for antidepressants accounted for 53.0% of all medications prescribed by psychiatrists, this ranged from 45.6% in the Northern Territory to 55.8% in Queensland. Prescriptions for antipsychotics ranged from 12.0% of medications prescribed by psychiatrists in Western Australia to 26.8% in the Australian Capital Territory; this compares with an overall average of 18.5%. Anxiolytics and hypnotics and sedatives accounted for smaller percentages of medications prescribed by psychiatrists overall (7.3% and 3.0% respectively).

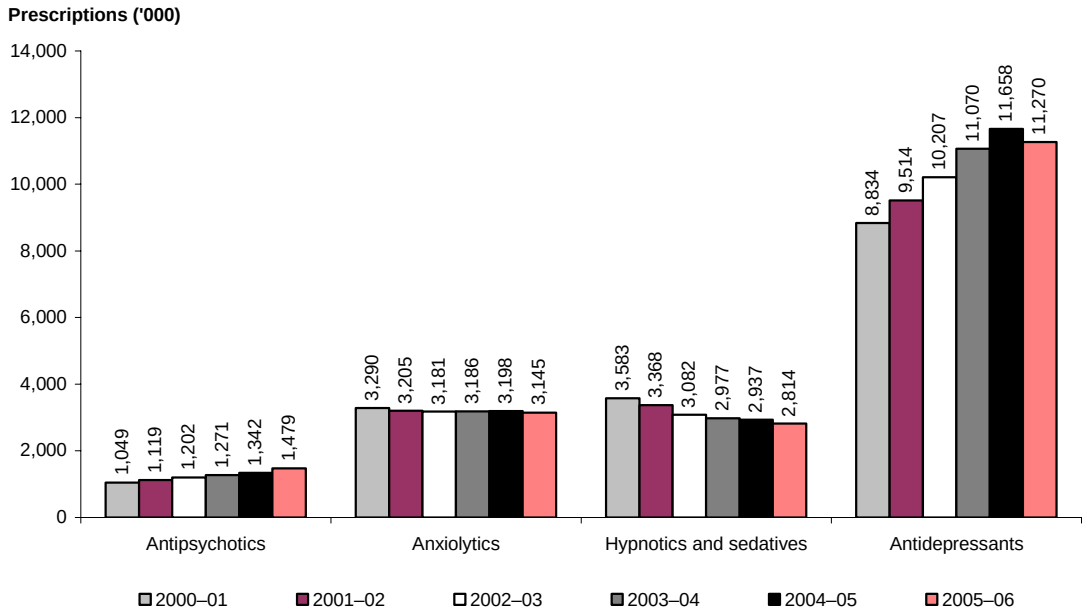
11.3 Changes in mental health-related prescriptions

This section provides data from 2000–01 to 2005–06 on the number of prescriptions issued by medical practitioners for mental health-related medications. Note that the data provided for the years before 2005–06 may not match those published in previous publications due to data revisions.

Overall, mental health-related prescriptions increased from 18.5 million in 2000–01 to 20.6 million in 2005–06, at an annual average rate of 2.2% (Figures 11.1 and 11.2). The number of antipsychotics and antidepressants prescribed both increased (on average by 6.8% and 4.6% per year, respectively) while prescriptions for hypnotics and sedatives as well as anxiolytics decreased on average by 4.7% and 0.9% per year, respectively. Other medications prescribed by psychiatrists increased (2.4% on average per year).

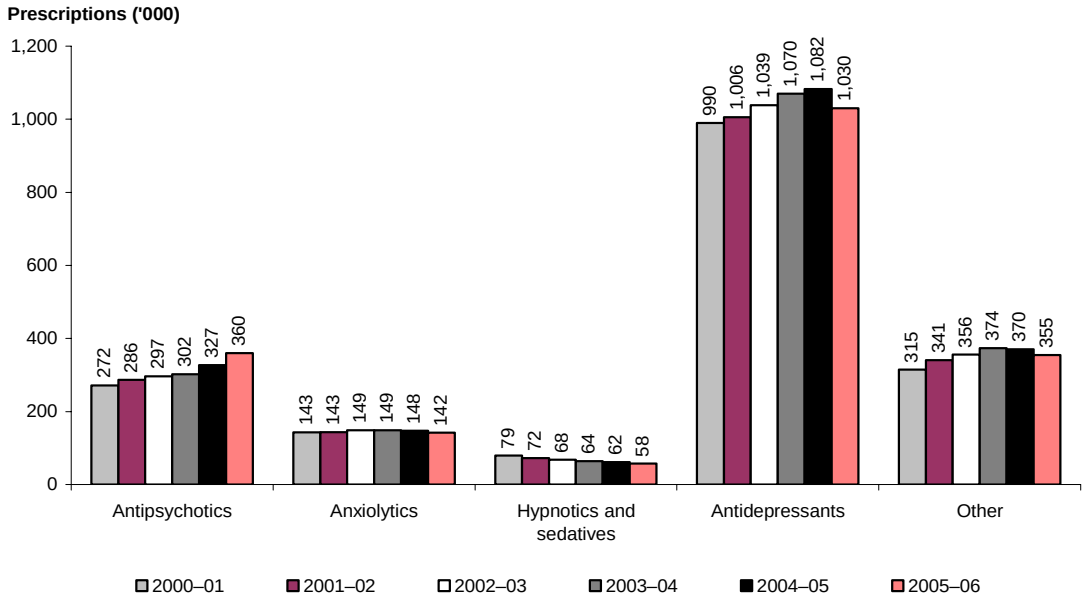
The number of prescriptions provided by general practitioners and non-psychiatrists for antipsychotics and antidepressants increased between 2000–01 and 2005–06 by 7.1% and 5.0% per year on average, respectively, while it decreased for hypnotics and sedatives, and anxiolytics at an average rate of 4.7% and 0.9% per year, respectively (Figure 11.1).

There was an annual average increase of 5.8% in the number of prescriptions provided by psychiatrists (Figure 11.2) for antipsychotics and a smaller average increase in the number of prescriptions for antidepressants (0.8% annual average increase). In contrast, the number of prescriptions for hypnotics and sedatives by psychiatrists decreased by 6.2% on average per year between 2000–01 and 2005–06.



Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

Figure 11.1: Mental health-related prescriptions provided by general practitioners and non-psychiatrist specialist, 2000–01 to 2005–06



Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

Figure 11.2: Mental health-related prescriptions provided by psychiatrists, 2000–01 to 2005–06

12 Mental health facilities

12.1 Introduction

This chapter presents an overview of available data on the characteristics of the main establishments or facilities delivering specialised mental health care in Australia. The facilities described include ***public*** and ***private psychiatric hospitals, psychiatric units or wards*** in ***public acute hospitals,*** and ***government-operated community and residential mental health services***. This chapter describes these facilities in terms of the number of facilities, number of available beds and staff employed and then presents information on facilities within ***specialised mental health service organisations***. Information on expenditure and revenue for these facilities is provided in Chapter 14.

Key concepts

A ***public psychiatric hospital*** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is controlled by a state or territory health authority and offers free diagnostic services, treatment, care and accommodation to all eligible patients.

A ***private psychiatric hospital*** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. In this report, they have been defined as those that are licensed/approved by a state or territory health authority and for which 50% of more of the total patient days were for psychiatric patients.

A ***public acute hospital*** is an establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Psychiatric units or wards are specialised units/wards, within a hospital, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.

Government-operated community mental health services are facilities that provide specialised mental health services to non-admitted patients. They can be both community and hospital-based ambulatory care services that are government-operated. They do not include psychiatric hospitals or designated psychiatric units in acute care hospitals, and 24-hour staffed specialised residential mental health services.

Community mental health service outlets are the individual units providing services within a community mental health service. The number of outlets, for the purpose of this report, are derived from the number of individual service units reporting to the National Community Mental Health Care Database.

Government-operated residential mental health services are specialised mental health services which:

- are operated by Commonwealth or state or territory government;
- employ mental health-trained staff on-site for 24 hours per day;
- provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment; and
- encourage the resident to take responsibility for their daily living activities.

(continued)

A ***specialised mental health service organisation*** is a separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care. A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres.

When the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation when they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share clinical records or, in the case where is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most states and territories, a specialised mental health service organisation is equivalent to the area/district mental health service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the term may also refer to health care organisations which provide only one type of mental health service (for example, acute admitted patient care) or which serve a specialised or state-wide function (for example, child and adolescent mental health services).

12.2 Mental health facilities

Public psychiatric hospitals

In 2004–05, there were 20 public psychiatric hospitals in Australia. They were responsible for 5.0% of all mental health-related hospital separations and 7.0% of the separations with specialised psychiatric care (Tables 5.1 and 7.1). The number of separate hospitals reported for 2004–05 was similar to that reported for the previous 4 years (Table 12.1). The majority of public psychiatric hospitals were located in Major cities (55% or 11 hospitals) (Table 12.2).

A useful indicator of public psychiatric hospital service delivery is the number of available beds. The number of available beds for 2004–05 was 2,487, compared with 2,560 in 2003–04 and 2,523 in 2002–03. For the first time since 2001–02, a decline in the number of beds was observed compared with the previous year. This observed decrease was mainly due to a decrease of 76 available beds in New South Wales between 2003-04 and 2004–05. Across jurisdictions, New South Wales reported the highest number of available beds in 2004–05 (1,161), while South Australia had the highest number of available beds per 100,000 population (30.1) (Table 12.2).

The data on full-time-equivalent (FTE) staff refer to the average available staff for the year. In 2004–05, there was 5,748 FTE staff employed in public psychiatric hospitals. The number of FTE staff remained relatively stable between 2000–01 and 2004–05, with an average annual increase of 0.6%. The majority of the FTE staff in 2004–05 were *Nursing staff* (53.3% or 3,061 FTE staff), followed by *Domestic and other staff* (17.1% or 984 FTE staff) (Table 12.3).

Table 12.1: Summary of public and private psychiatric hospitals and government-operated community and residential mental health services, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Average annual change (%)
Public psychiatric hospitals						
Number of hospitals[(a)]	22	21	19	20	20	–2.4
Available beds[(b)]	2,430	2,409	2,523	2,560	2,487	0.6
Full-time-equivalent staff	5,601	5,545	5,458	5,600	5,748	0.6
Public acute hospitals						
Number of hospitals with a specialised psychiatric unit or ward[(a)]	109	110	128	124	122	2.9
Available beds in psychiatric units or wards	n.a.	n.a.	3,281	3,458	3,450	2.5
Private psychiatric hospitals						
Number of hospitals	24	24	25	25	26	2.0
Available beds[(b)]	1,369	1,387	1,463	1,441	1,512	2.5
Full-time-equivalent staff	1,566	1,707	1,704	1,672	1,680	1.8
Government-operated community and residential mental health services						
Number of services[(c)]	233	246	242	246	234	0.1
Services providing residential care[(c)(d)]	49	53	50	52	46	–1.6
Available beds[(b)]	1,306	1,249	1,241	1,246	1,226	–1.6
Full-time-equivalent staff	8,933	9,759	10,420	10,783	10,879	5.1

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses. Some data for 2000–01 to 2003–04 have been updated since previously published.

(b) Average available beds.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(d) The number of establishments providing residential care services reported to the National Community Mental Health Establishments Database (NCMHED) is larger than the number of establishments reporting to the National Residential Mental Health Care Database (NRMHCD) because Victoria reported specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.

n.a. Not available.

Sources: National Public Hospital Establishments Database, Private Health Establishments Collection, and National Community Mental Health Establishments Database.

Public acute hospitals

In 2004–05, there were 122 public acute hospitals with a specialised psychiatric unit or ward (Table 12.1). These provided 54.4% of all mental health-related hospital separations and 41.4% of the separations with specialised psychiatric care (Tables 5.1 and 7.1).

New South Wales and Victoria had the largest number of public acute hospitals with specialised psychiatric units or wards (42 and 31 respectively) (Table 12.4). The majority of public acute hospitals with specialised psychiatric units or wards were located in Major cities (68.0% or 83 hospitals).

In these hospitals, there were on average 3,450 available beds in the specialised psychiatric units and wards (17.2 available beds per 100,000 population). This number has been increasing since 2002–03 with an average annual increase of 2.5%. The largest number of these beds per 100,000 population was also in Major cities (19.8) (Table 12.4).

Table 12.2: Public psychiatric hospitals[a] and available beds, by Remoteness Area, states[b], 2004–05

	NSW	Vic[c]	Qld	WA	SA	Tas	Total
Public psychiatric hospitals							
Major cities	7	1	1	1	1	. .	11
Inner regional	3	0	1	0	0	3	7
Outer regional	0	0	2	0	0	0	2
Remote and Very remote	0	0	0	0	0	0	0
Total all regions	**10**	**1**	**4**	**1**	**1**	**3**	**20**
Available beds							
Major cities	807	115	192	205	461	. .	1,780
Inner regional	354	0	204	0	0	69	627
Outer regional	0	0	80	0	0	0	80
Remote and Very remote	0	0	0	0	0	0	0
Total all regions	**1,161**	**115**	**476**	**205**	**461**	**69**	**2,487**
Available beds per 100,000 population							
Major cities	16.8	3.2	9.4	14.7	41.9	. .	13.4
Inner regional	25.6	0	20.1	0	0	22.4	14.9
Outer regional	0	0	11.8	0	0	0	3.9
Remote and Very remote	0	0	0	0	0	0	0
Total all regions	**17.3**	**2.3**	**12.2**	**10.4**	**30.1**	**14.3**	**12.4**

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses.
(b) There were no public psychiatric hospitals in the Australian Capital Territory or the Northern Territory.
(c) The count of hospitals in Victoria is a count of the campuses which report data separately to the National Hospital Morbidity Database.
. . Not applicable.
Source: National Public Hospital Establishments Database.

Table 12.3: Full-time-equivalent staff by staffing category[a], public psychiatric hospitals, states[b], 2004–05

Staffing category	NSW[c]	Vic[d]	Qld[e]	WA[f]	SA[c]	Tas	Total
Salaried medical officers	169	23	29	42	63	1	327
Nurses							
Registered nurses	n.a.	n.a.	477	289	392	33	n.a.
Enrolled nurses	n.a.	n.a.	114	59	120	18	n.a.
Total nurses	*1,394*	*166*	*591*	*348*	*512*	*51*	*3,061*
Other personal care staff	n.a.	n.a.	40	n.a.	n.a.	21	n.a.
Diagnostic and allied health professionals	274	12	114	70	131	0	600
Administrative and clerical staff	372	27	106	93	115	3	716
Domestic and other staff	495	22	203	112	144	8	984
Total staff	**2,703**	**249**	**1,083**	**664**	**964**	**84**	**5,748**

(a) Where average full-time-equivalent staff numbers were not available, staff numbers at 30 June 2005 were used. Staff contracted to provide products (rather than labour) are not included.
(b) There were no public psychiatric hospitals in the Australian Capital Territory or Northern Territory.
(c) *Other personal care staff* are included in *Diagnostic and allied health professionals* and *Domestic and other staff*.
(d) For Victoria, full-time-equivalent staff numbers may be slightly understated. *Other personal care staff* are included in *Domestic and other staff*.
(e) Queensland pathology services provided by staff employed by the state pathology service are not reported here.
(f) Some hospitals were unable to provide a split between nurse categories and these have been reported as *Registered nurses*.
n.a. Not available.
Source: National Public Hospital Establishments Database.

Table 12.4: Public acute hospitals with psychiatric units or wards[(a)] and available beds, by Remoteness Area, states and territories, 2004–05

	NSW	Vic[(b)]	Qld	WA	SA	Tas	ACT	NT	Total
Public acute hospitals with psychiatric units or wards									
Major cities	29	22	9	13	8	. .	2	. .	83
Inner regional	12	8	6	1	0	2	0	. .	29
Outer regional	1	1	3	2	0	1	. .	1	9
Remote and Very remote	0	0	0	0	0	0	. .	1	1
Total all regions	**42**	**31**	**18**	**16**	**8**	**3**	**2**	**2**	**122**
Available psychiatric beds									
Major cities	714	763	567	383	172	. .	44	. .	2,643
Inner regional	179	124	230	15	0	62	0	. .	610
Outer regional	2	12	111	16	0	24	. .	26	191
Remote and Very remote	0	0	0	0	0	0	. .	6	6
Total all regions	**895**	**899**	**908**	**414**	**172**	**86**	**44**	**32**	**3,450**
Available psychiatric beds per 100,000 population									
Major cities	14.9	21.0	27.6	27.4	15.6	. .	13.6	. .	19.8
Inner regional	12.9	11.7	22.7	5.8	0	20.1	0	. .	14.4
Outer regional	0.4	4.7	16.4	8.6	0	14.7	. .	23.8	9.3
Remote and Very remote	0	0	0	0	0	0	. .	6.6	1.2
Total all regions	**13.3**	**18.1**	**23.4**	**20.9**	**11.2**	**17.8**	**13.6**	**16.0**	**17.2**

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses.
(b) The count of hospitals in Victoria is a count of the campuses which report data separately to the National Hospital Morbidity Database.
. . Not applicable.
Source: National Public Hospital Establishments Database.

Private psychiatric hospitals

Data from the Private Health Establishments Collection held by the ABS suggest that there were 26 private hospitals defined as 'psychiatric' hospitals in 2004–05, with an average of 1,512 available beds (Tables 12.1 and 12.5). New South Wales reported the highest number of private psychiatric hospitals (9), followed by Victoria (6). New South Wales also reported the highest number of available beds (494). Victoria reported the highest number of beds per 100,000 population (8.5).

In 2004–05, the average number of FTE staff employed by private psychiatric hospitals was 1,680. There was an average annual increase of 1.8% between 2000–01 and 2004–05. The majority of FTE staff were in the *Nursing staff* category (55.5% or 932 FTE staff) (Table 12.6).

Table 12.5: Private psychiatric hospitals, available beds and available beds per 100,000 population, states[(a)], 2004–05

	NSW	Vic	Qld	WA	SA	Tas	Total[(b)]
Private psychiatric hospitals	9	6	4	n.a.	n.a.	n.a.	26
Available beds[(c)]	494	423	289	n.a.	n.a.	n.a.	1,512
Available beds per 100,000 population[(d)]	7.3	8.5	7.4	n.a.	n.a.	n.a.	7.5

(a) There were no private psychiatric hospitals in the Australian Capital Territory or the Northern Territory.
(b) Total includes figures not available.
(c) Average available beds.
(d) Crude rate based on the Australian estimated resident population as at 31 December 2004.
n.a. Not available.
Source: Private Health Establishments Collection.

Table 12.6: Full-time-equivalent staff by staffing category[(a)], private psychiatric hospitals, states[(b)], 2004–05

	NSW	Vic	Qld	WA	SA	Tas	Total[(c)]
Salaried medical officers	12	n.a.	n.a.	n.a.	n.a.	n.a.	21
Nurses[(d)]	287	312	176	n.a.	n.a.	n.a.	932
Diagnostic and allied health professionals	42	45	41	n.a.	n.a.	n.a.	151
Administrative and clerical staff	121	71	34	n.a.	n.a.	n.a.	281
Domestic and other staff[(e)]	110	n.a.	n.a.	n.a.	n.a.	n.a.	294
Total staff[(c)]	**572**	**517**	**294**	**n.a.**	**n.a.**	**n.a.**	**1,680**

(a) Average full-time-equivalent staff.
(b) There were no private psychiatric hospitals in the Australian Capital Territory or the Northern Territory.
(c) Includes totals for hospitals that were not able to provide data by staffing category.
(d) Includes *Nursing administrators*, *Nurse educators*, *Other registered nurses*, *Enrolled nurses*, *Student nurses*, *Trainee nurses*, *Other nursing staff* and *Other personal care staff* categories.
(e) Includes *Catering and kitchen*, *Domestic*, *Engineering and maintenance* and *Other categories*.
n.a. Not available.
Source: Private Health Establishments Collection.

Government-operated community and residential mental health services

In 2004–05, there were 234 government-operated community and residential mental health services reported to the National Community Mental Health Establishments Database, 46 of which included residential care services (Tables 12.1 and 12.7). The number of services reported does not necessarily reflect the number of physical buildings or service outlets from which mental health care was provided as there is variation across jurisdictions in the definitions of what constitutes a 'service'. For example, in Tasmania and Queensland, the services reported were equivalent to individual service units, which can include hospital-based mental health outpatient and outreach services. In other jurisdictions, such as New South Wales and Western Australia, entire area health services were defined as services.

The number of available beds decreased from 1,246 in 2003–04 to 1,226 in 2004–05, with an annual average decrease of 1.6% between 2000–01 and 2004–05. Victoria reported the highest number of available beds (907). Tasmania reported the highest number of beds per 100,000 population (23.1). Nationally, there were 6.1 of these beds per 100,000 population (Table 12.7).

There were 10,879 average FTE staff reported in 2004–05. This number increased each year from 2000–01, with an average annual increase of 5.1%. *Nursing staff* made up the largest category of staff (20.9% or 2,275 FTE staff), followed by *Diagnostic and allied health professionals* (19.1% or 2,075 FTE staff) and *Administrative and clerical staff* (9.7% or 1,054 FTE staff) (Table 12.8).

Table 12.7: Government-operated community and residential mental health services, services providing residential care, available beds and available beds per 100,000 population, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Services[(a)]	10	38	96	18	35	28	2	7	234
Services providing residential care[(a)(b)]	5	30	0	2	1	7	1	0	46
Available beds[(c)]	138	907	0	21	20	112	28	0	1,226
Available beds per 100,000 population[(d)]	2.0	18.2	0.0	1.1	1.3	23.1	8.6	0.0	6.1

(a) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(b) The number of establishments providing residential care services reported to the National Community Mental Health Establishments Database (NCMHED) is larger than the number of establishments reporting to the National Residential Mental Health Care Database (NRMHCD) because Victoria reported specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.

(c) Average available beds.

(d) Crude rate based on the Australian estimated resident population as at 31 December 2004.

Source: National Community Mental Health Establishments Database.

Table 12.8: Full-time-equivalent staff by staffing category[a], government-operated community and residential mental health services, states and territories, 2004–05

	NSW[b]	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	219	n.a.	136	n.a.	81	20	14	13	483
Nurses									
Registered nurses	n.a.	n.a.	473	n.a.	284	141	67	35	n.a.
Enrolled nurses	n.a.	n.a.	6	n.a.	16	36	14	0	n.a.
Total nurses	*1,203*	*n.a.*	*479*	*n.a.*	*300*	*177*	*81*	*35*	*2,275*
Other personal care staff	n.a.	n.a.	29	n.a.	7	53	0	2	n.a.
Diagnostic and allied health professionals	965	n.a.	633	n.a.	296	60	99	22	2,075
Administrative and clerical staff	634	n.a.	230	n.a.	110	34	24	22	1,054
Domestic and other staff	137	n.a.	10	n.a.	6	32	7	0	192
Total staff[c]	**3,157**	**3,563**	**1,517**	**1,145**	**800**	**377**	**226**	**94**	**10,879**

(a) Where average full-time-equivalent staff numbers were not available, staff numbers at 30 June 2005 were used.
(b) For New South Wales, *Other personal care staff* are not available separately and are included in the total.
(c) Includes total for services which were not able to provide data by staffing category.
n.a. Not available.
Source: National Community Mental Health Establishments Database.

12.3 Mental health service organisations

Table 12.9 presents information on public sector specialised mental health facilities and the way they are structured as the specialised mental health service organisations reported by states and territories. The table details the number of organisations, which include public acute hospitals with specialised psychiatric units or wards, public psychiatric hospitals, residential mental health care services and/or community mental health care services.

In 2004–05, there were 218 organisations reported. Just under 40% of these organisations consisted of a community mental health care service only. These contained 174 community mental health care ***service outlets*** and accounted for 507,577 (9.9%) of the total number of service contacts reported to the National Community Mental Health Care Database in 2004–05.

The next most common type of organisation was those that consisted of a public acute hospital and community mental health care service only (72 organisations; 33.0%). These organisations consisted, in total, of an average of 2,106 available beds in public acute hospitals and accounted for 52,801 (60.9%) separations with specialised psychiatric care from these hospitals. They also consisted of 500 community mental health care service outlets and accounted for 2,577,205 (50.4%) of service contacts reported.

Organisations in which they were the only specialised mental health facility were the most common type of organisation for public psychiatric hospitals.

Similarly, organisations in which there was only a residential mental health care service were the most commonly reported organisations for residential mental health care services.

Only two organisations included all four types of specialised mental health facilities (that is, a public acute hospital with a specialised psychiatric ward or unit, public psychiatric hospital, residential mental health care service and community mental health care service).

Table 12.9: Specialised mental health organisations (public sector), 2004–05

		Public acute hospitals with a specialised psychiatric ward or unit		Public psychiatric hospitals		Residential mental health care services		Community mental health care services	
	Number of organisations	Available beds	Separations[a]	Available beds	Separations[a]	Available beds[b]	Episodes of care	Service outlets[c]	Service contacts
Public acute hospital(s) only	16	348	10,200	. .	. .	. .	. .	. .	. .
Public psychiatric hospital(s) only	7	. .	. .	1,248	7,235	. .	. .	. .	. .
Residential mental health care service(s) only	1	. .	. .	. .	. .	33	21	. .	. .
Community mental health care service(s) only	85	. .	. .	. .	. .	. .	. .	174	507,577
Public acute hospital(s) and public psychiatric hospital(s) only	0	0	0	0	0	. .	. .	. .	. .
Public acute hospital(s) and residential mental health care service(s) only	0	0	0	. .	. .	0	0	. .	. .
Public acute hospital(s) and community mental health care service(s) only	72	2,106	52,801	. .	. .	. .	. .	500	2,577,205
Public psychiatric hospital(s) and residential mental health care service(s) only	0	. .	. .	0	0	0	0	. .	. .
Public psychiatric hospital(s) and community mental health care service(s) only	3	. .	. .	171	2,356	. .	. .	8	29,454
Residential mental health care service(s) and community mental health care service(s) only	6	. .	. .	. .	. .	192	212	80	240,068
Public acute hospital(s), public psychiatric hospital(s) and residential mental health care service(s) only	0	0	0	0	0	0	0	. .	. .
Public acute hospital(s), public psychiatric hospital(s) and community mental health care service(s) only	4	204	4,086	587	2,061	. .	. .	16	209,995
Public acute hospital(s), residential mental health care service(s) and community mental health care service(s) only	21	726	16,876	. .	. .	633	1,059	294	1,438,293
Public psychiatric hospital(s), residential mental health care service(s) and community mental health care service(s) only	1	. .	. .	168	1,414	34	157	19	67,945
Public acute hospital(s), public psychiatric hospital(s) and residential mental health care service(s) and community mental health care service(s)	2	66	2,719	313	1,596	334	745	17	37,987
Total	**218**	**3,450**	**86,682**	**2,487**	**14,662**	**1,226**	**2,194**	**1,108**	**5,108,524**

(a) Separations with specialised psychiatric care only.
(b) The number of available beds for residential mental health care services reported to the National Community Mental Health Establishments Database (NCMHED) may not directly correspond to the number of services reporting to the National Residential Mental Health Care Database (NRMHCD) due to Victoria reporting specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.
(c) The number of service outlets reporting data to the National Community Mental Health Care Database.
. . Not applicable.
Sources: National Hospital Morbidity Database, National Public Hospital Establishments Database, National Community Mental Health Care Database, National Residential Mental Health Care Database, National Community Mental Health Establishments Database, and information provided by state and territory health authorities.

13 Mental health workforce

13.1 Introduction

Information is presented in this chapter on the size and characteristics of three groups of specialised health professionals: psychiatrists, psychologists and mental health nurses.

Other health care professionals and workers who can provide mental health-related services, such as GPs, counsellors, social workers, general nurses, and unpaid carers are not covered since equivalent workforce data are not available.

Key concepts

Employed: In this report, an employed health professional is defined as one who:

- worked for a total of 1 hour or more, principally in the relevant profession, for pay, commission, payment in kind or profit; mainly or only in a particular state or territory during a specified period (that is, for psychiatrists, at the time of the survey; for psychologists enumerated in the AIHW survey, in the 4 weeks before the survey; for psychologists enumerated in the ABS survey, 1 week before the survey; and for nurses, in the week before the survey); or
- usually worked but was away on leave (with some pay) for less than 3 months, on strike or locked out, or rostered off.

This includes those involved in both clinical and non-clinical roles (such as education, research, and administration). 'Employed' people are also referred to as the 'workforce' in this chapter.

Full-time-equivalent (FTE): The number of 38-hour-week workloads worked by professionals. FTE is calculated by multiplying the number of employed professionals in a particular category by the average total hours worked by employed people in the category, and dividing by 38 (with 38 hours being considered, for this report, a standard working week). The FTE per 100,000 population figures provide a standardised measure of supply of the number of FTE professionals per relevant 100,000 population.

The standard of 38 hours was used in this report to provide comparable figures across the three professions covered. This differs from the approach used in previous reports of *Mental health services in Australia*, and with data on the medical, nursing and psychology labour force published by the AIHW (AIHW 2006f, 2006g, 2006h). FTE numbers presented in this chapter will, therefore, not be comparable with those published elsewhere.

Total hours: Total hours worked per week in the profession, including paid and unpaid work. Average total weekly hours are calculated only for those people who reported their hours (that is, those who did not report them are excluded).

It should be noted that the numbers presented in this chapter are estimates, based on responses to the AIHW and ABS labour force surveys, as outlined in Appendix 1. While the data are weighted to population benchmarks (which are based on professional registration numbers for the AIHW survey data and population estimates for the ABS survey data), not all possible non-response bias can be accounted for or measured. In addition, the survey questionnaires, while generally consistent in content and design, have been modified over time and can vary by jurisdiction. As a result, some care should be taken in interpreting changes in numbers and rates, and variations across states and territories.

13.2 Psychiatrists

Estimates on the number of psychiatrists (including psychiatrists-in-training) practising in Australia are available from the AIHW Medical Labour Force Survey. As described more fully in the description of the AIHW surveys in Appendix 1, the state and territory health departments, in consultation with the AIHW and in cooperation with the medical registration boards in each jurisdiction, conduct this survey of all registered medical practitioners on an annual basis.

Psychiatrists and psychiatrists-in-training 'self-identify' in the AIHW survey. Subsequent weighting of responses, using registration data as benchmarks, provides estimates of the total number of psychiatrists and psychiatrists-in-training at the state and territory and national levels.

For the purposes of this report, estimates of the psychiatrist workforce are based on those psychiatrists and psychiatrists-in-training who stated that they were ***employed*** as a medical practitioner at the time of the survey. This includes those working predominantly in non-clinical areas, such as research, education and administration, as well as clinicians. However, medical practitioners practising psychiatry as a second or third speciality are excluded, as are those who were on extended leave for more than 3 months or who were not employed (including those looking for work).

To enable meaningful comparisons in the supply of psychiatrists across Australia, over time and with the psychologist and nursing workforce data in this chapter, ***full-time-equivalent (FTE)*** figures are provided in addition to the number of psychiatrists. The FTE measures the number of 38-hour-week workloads worked by psychiatrists, regardless of how many worked full-time or part-time. Population standardised FTE figures (FTE per 100,000 population) are also reported as these take into account differences in the size of the relevant populations between regions and over time.

Characteristics of the psychiatrist workforce

Psychiatrists (including psychiatrists-in-training) made up 5.4% of all employed medical practitioners in Australia, with an estimated 3,151 working in Australia in 2004 (Table 13.1). Psychiatrists-in-training made up 23.5% (or 742) of these psychiatrists. The average age of psychiatrists in 2004 was 47.8 years, with female psychiatrists being younger, on average, than their male counterparts. In 2004, 64.1% of employed psychiatrists were male and almost one-quarter (23.5%) were psychiatrists-in-training.

Including clinical and non-clinical hours, psychiatrists worked an average of 40.9 ***total hours*** per week in 2004 (Table 13.2). The hours worked per week were, on average, lower for females than males (36.6 hours compared with 43.3 hours) and higher for psychiatrists-in-training than for those not in training (43.8 hours compared with 40.0 hours).

Table 13.1: Employed psychiatrists and psychiatrists-in-training, demographic characteristics, 2000 to 2004

	2000	2001	2002	2003	2004	Distribution 2004 (%)	Average annual change (%)
Psychiatrists	2,149	2,097	2,367	2,395	2,409	76.5	2.9
Psychiatrists-in-training	575	632	587	631	742	23.5	6.6
Sex							
Males	1,875	1,797	1,946	1,972	2,020	64.1	1.9
Females	849	931	1,008	1,054	1,131	35.9	7.5
Age and sex							
Males							
Less than 35 years	266	233	227	196	274	13.6	0.7
35–44 years	503	469	450	505	469	23.2	–1.7
45–54 years	520	488	537	546	543	26.9	1.1
55–64 years	388	400	471	453	463	22.9	4.5
65 years and over	200	207	262	272	272	13.5	8.0
Females							
Less than 35 years	174	250	197	227	268	23.7	11.5
35–44 years	287	296	291	323	353	31.2	5.3
45–54 years	233	203	308	289	304	26.9	6.9
55–64 years	117	136	171	161	159	14.1	8.0
65 years and over	41	49	40	53	48	4.2	3.6
Average age (years)							
Males	48.9	49.8	50.7	50.5	49.9	. .	0.5
Females	44.5	44.1	45.5	45.0	44.0	. .	–0.3
Total	*47.5*	*47.9*	*48.9*	*48.6*	*47.8*	. .	0.2
Total number	**2,724**	**2,729**	**2,954**	**3,026**	**3,152**	**100.0**	**3.7**
All employed medical practitioners	51,106	53,384	53,991	56,207	58,211	. .	3.3

. . Not applicable.

Source: AIHW Medical Labour Force Surveys, 2000 to 2004.

Table 13.2: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, type and sex, 2000 to 2004

	2000	2001	2002	2003	2004	Average annual change (%)
Psychiatrists	42.6	42.0	41.4	40.8	40.0	–1.6
Psychiatrists-in-training	45.1	45.1	44.0	45.4	43.8	–0.7
Sex						
Males	45.3	44.5	44.2	44.3	43.3	–1.1
Females	38.3	39.2	37.5	36.9	36.6	–1.1
Total	**43.1**	**42.7**	**41.9**	**41.8**	**40.9**	**–1.3**

Source: AIHW Medical Labour Force Surveys, 2000 to 2004.

Size and distribution of the psychiatrist workforce

Psychiatrists are not evenly spread across Australia either by state and territory or by geographic region. This is best illustrated by examining the ratio of FTE psychiatrists working in the state or territory (or region) to the population of that state or territory (or region). In 2004, there were 17 FTE psychiatrists per 100,000 population in Australia (Table 13.3). The rate ranged from 10 FTE per 100,000 in the Northern Territory to 22 per 100,000 in Victoria and South Australia. Queensland and Western Australia had relatively low rates of 12 FTE psychiatrists per 100,000 population (Table 13.3).

Table 13.3: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, states and territories, 2004

	Number of psychiatrists	Number of psychiatrists-in-training	Total number	Average total hours worked per week	FTE	FTE per 100,000 population[(a)]
NSW	752	274	1,026	41.8	1,129	17
Vic	782	225	1,008	40.6	1,076	22
Qld	361	78	439	41.1	474	12
WA	186	53	240	39.2	247	12
SA	214	95	310	41.1	335	22
Tas	61	5	66	39.0	68	14
ACT	41	6	47	35.1	44	14
NT	11	6	17	44.4	20	10
Total	**2,409**	**742**	**3,152**	**40.9**	**3,392**	**17**

(a) Crude rate based on the Australian estimated resident population as at 30 June 2004.

Source: AIHW Medical Labour Force Survey, 2004.

Table 13.4: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, by region[(a)], 2004

Region[(a)]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(b)]
Major cities	2,758	41.1	2,983	22
Inner regional	247	39.9	259	6
Outer regional	54	40.4	57	3
Remote and Very remote	12	40.0	13	3
Not reported	81	37.8	80	. .
Total	**3,152**	**40.9**	**3,392**	**17**

(a) Region is derived from the postcode of the respondent's main job and is classified according to the Remoteness Area Structure within the Australian Standard Geographical Classification (ABS 2002a). This data should be treated with caution due to the large number of 'Not reported' values for region, relative to the number in 'Outer regional' and 'Remote and Very remote' regions.

(b) Crude rate based on the Australian estimated resident population as at 30 June 2004.

. . Not applicable.

Source: AIHW Medical Labour Force Survey, 2004.

In 2004, 90.1% of FTE psychiatrists (for whom region was reported) worked mainly in the Major cities, while less than half of a per cent worked mainly in Remote and Very remote regions (Table 13.4). In comparison, 66.3% of Australia's population resided in Major cities and 2.5% in Remote and Very remote regions. As a result, the number of FTE psychiatrists

per 100,000 population was higher in Major cities (22 FTE psychiatrists per 100,000 population) than in the other regions. In 2004, the Inner regional areas had 6 FTE psychiatrists per 100,000 population and both the Outer regional and Remote and Very remote regions had 3 FTE psychiatrists per 100,000 population.

Changes in the psychiatrist workforce

The size and characteristics of the psychiatrist workforce, including the hours worked, changed in the period from 2000 to 2004. Over that period, the number of employed psychiatrists (and psychiatrists-in-training) increased by 15.7% (which equates to an average annual increase of 3.7%) (Table 13.1). This is slightly higher than the 13.9% increase in the total number of all employed medical practitioners (AIHW 2006f).

Table 13.5: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, 2000 to 2004

	2000	2001	2002	2003	2004	Average annual change (%)
FTE						
Psychiatrists	2,408	2,316	2,578	2,571	2,535	1.3
Psychiatrists-in-training	682	749	680	754	856	5.8
Total FTE	**3,089**	**3,066**	**3,257**	**3,328**	**3,392**	**2.4**
FTE per 100,000 population[(a)]	16	16	17	17	17	1.2

(a) Crude rate based on the Australian estimated resident population as at 30 June 2004.

Source: AIHW Medical Labour Force Survey, 2000 to 2004.

The supply of psychiatrists, measured as FTE and FTE per 100,000 population, also increased between 2000 and 2004 but to a lesser extent than the number of employed psychiatrists (Tables 13.5 and 13.6). The smaller increase in supply was due to a fall in the average hours worked by psychiatrists, from 43.1 hours in 2000 to 40.9 hours in 2004 (Table 13.2) combined with a 4.9% growth in the Australian population between 2000 and 2004. The supply of psychiatrists increased in some, but not all, jurisdictions in the period from 2000 to 2004 (Table 13.6).

The proportion of psychiatrists in the workforce who were female increased over the period from 31.2% in 2000 to 35.9% in 2004 (Table 13.1). Given that female psychiatrists are generally younger than their male counterparts (as noted earlier) and that females made up 56.0% of psychiatrists-in-training in 2004, this trend may continue. Over the same period, the average age for males increased from 48.9 to 49.9 years and the proportion of males aged over 54 years increased by 5.0 percentage points. In comparison, the average age for female psychiatrists declined by 1.1% and the proportion aged over 54 also declined slightly.

Female psychiatrists, whilst increasing their share of the psychiatry workforce, worked fewer hours per week on average than their male counterparts over the 5-year period (Table 13.2). In addition, both male and female psychiatrists were working somewhat fewer average hours in 2004 than they were in 2000, with an average annual drop in average total working hours of 1.1% for both sexes (Table 13.2).

Table 13.6: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, states and territories, 2000 to 2004

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					FTE				
2000	973	902	457	308	311	49	56	32	3,089
2001	922	991	437	274	318	57	45	20	3,066
2002	1,094	1,047	434	233	302	63	56	29	3,257
2003	1,063	1,049	463	271	319	71	50	36	3,328
2004	1,129	1,076	474	247	335	68	44	20	3,392
Average annual change (%)	3.8	4.5	0.9	–5.3	1.8	8.3	–5.9	–11.1	2.4
					Rate (per 100,000 population)[(a)]				
2000	15	19	13	16	21	10	18	17	16
2001	14	21	12	14	21	12	14	10	16
2002	16	22	12	12	20	13	18	15	17
2003	16	21	12	14	21	15	16	18	17
2004	17	22	12	12	22	14	14	10	17
Average annual change (%)	2.9	3.3	–1.2	–6.6	1.4	7.7	–6.6	–11.9	1.2

(a) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.
Source: AIHW Medical Labour Force Survey, 2000 to 2004.

13.3 Psychologists

Two sources of information on the psychology workforce in Australia are presented in this chapter. One source is the quarterly ABS Labour Force Survey. As outlined in Appendix 1, this is a household-based sample survey that is intended to provide broad-level, national estimates of the Australian labour force. As psychologists are relatively small in number compared with all employed people, the estimates of employed psychologists are subject to high sampling variability at a state and territory level, and when age and sex are considered. As a result only national-level data are presented from this source.

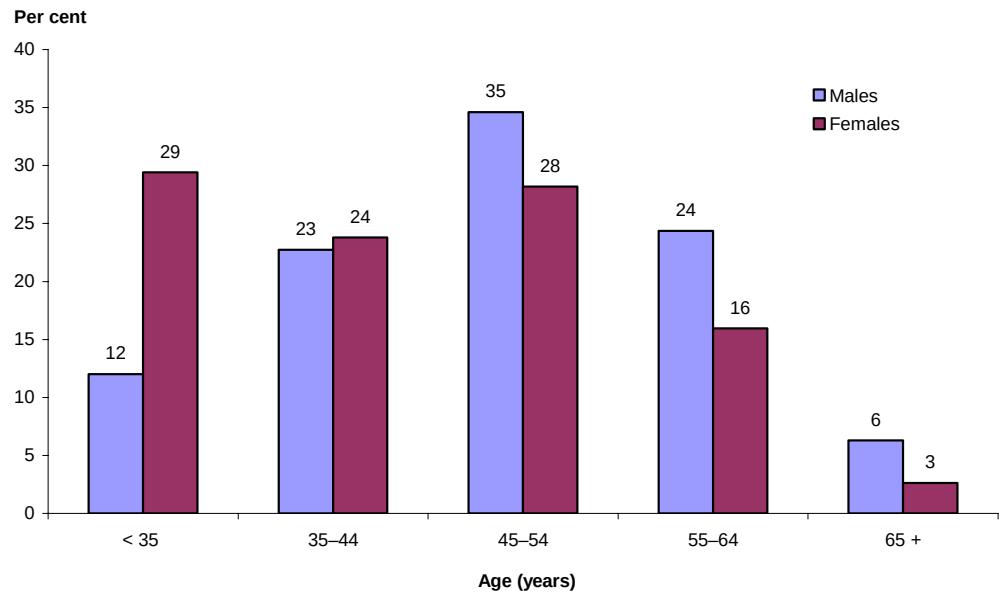
The other source of workforce information is the survey of all registered psychologists in New South Wales, Victoria, Queensland, South Australia and the Australian Capital Territory. This survey was conducted in 2003 by the state and territory health departments with the cooperation of the registration boards and in consultation with the AIHW. This survey (referred to as the 'AIHW survey' to distinguish it from the ABS Labour Force Survey) was conducted as a census of registered psychologists within each participating jurisdiction. Responses to the survey were weighted to benchmark psychologist registration figures by the AIHW in order to provide estimates of the psychology workforce at the state and territory level for the five jurisdictions.

Data presented from both surveys include both clinical and non-clinical psychologists. It should be noted that estimates of clinical psychologists from these surveys are based on respondent's self-reported role in psychology. This differs from definitions of a 'clinical psychologist' based on the membership requirements of the Australian Psychological Society's College of Clinical Psychologists (APS 2006).

Data from the ABS survey have been used to describe the size of the psychology workforce in Australia since this data source provides more recent data, includes all states and territories and can provide a time series. Data from the AIHW survey supplements this information by providing a demographic profile of psychologists.

Characteristics of the psychologist workforce

In 2005, the ABS's national estimate of the number of employed psychologists was 13,900. This figure differs from the AIHW estimates from the five states surveyed in 2003 (Table 13.7). While the AIHW estimates are derived from a census of all registered psychologists within each jurisdiction, the ABS estimates are derived from a sample of households across Australia (see Appendix 1).



Source: AIHW Psychology Labour Force Survey, 2003.

Figure 13.1: Employed psychologists in New South Wales, Victoria, South Australia and the Australian Capital Territory, distribution by age and sex, 2003

Psychologists are predominantly female. The AIHW survey found that for the states surveyed in 2003, 70.8% of all employed psychologists and 71.9% of employed clinical psychologists were females (AIHW 2006h). The average age of psychologists in 2003 was 44.2 years. Female psychologists were younger than their male counterparts (with average ages of 43.2 years and 48.5 years, respectively). A higher proportion of female than male psychologists were aged 34 years and younger (29% and 12%, respectively), while a lower proportion of female than male psychologists were aged 55 years and over (Figure 13.1).

In 2003, for the jurisdictions that participated in the AIHW survey, psychologists worked an average of 35.7 total hours per week (Table 13.7). On average, male psychologists worked longer hours than females (39.5 hours compared with 34.5 hours) and non-clinicians worked longer hours than clinicians (38.4 hours compared with 34.5 hours).

Table 13.7: Employed psychologists in New South Wales, Victoria, Queensland, South Australia and the Australian Capital Territory, main field of work and average total hours worked per week, 2003

	Number of employed psychologists			Average total hours worked per week		
	Males	Females	Total[(b)]	Males	Females	Total[(b)]
Clinical psychologist[(a)]	2,529	6,486	9,694	38.3	33.3	34.5
Non-clinical psychologist	1,298	2,801	4,379	41.8	37.4	38.4
Total	**3,828**	**9,288**	**14,073**	**39.5**	**34.5**	**35.7**

(a) Psychologist's self-reported main field of work.

(b) Includes psychologists whose sex was not reported. Queensland did not report on the sex of respondents.

Source: AIHW Psychology Labour Force Survey, 2004.

Further details on the characteristics of employed psychologists for the five jurisdictions that participated in the AIHW survey in 2003 are available from *Psychology labour force 2003* (AIHW 2006h).

Size of the psychologist workforce

Estimates derived from the ABS Labour Force Survey indicate that there was growth in both the absolute number of employed psychologists and the number of employed FTE psychologists between 2000 and 2005 (Table 13.8). The number increased, on average, 8.5% per year over the period, from 9,300 psychologists in 2000 to 13,900 in 2005. The average hours worked by psychologists, however, declined from 35 hours in 2000 to 32 hours in 2005; this led to a slightly lower increase in FTE psychologists (6.9% per year, on average) than in numbers. FTE psychologists per 100,000 population also increased (by 5.7% per year, on average) from 44 in 2000 to 58 in 2005.

Table 13.8: Employed psychologists, average total hours worked per week, FTE and FTE per 100,000 population, 2000 to 2005

	2000	2001	2002	2003	2004	2005	Average annual change (%)
Number	9,300	11,100	12,300	13,100	12,700	13,900	8.5
Average total hours worked per week	35	33	31	31	33	32	–1.5
FTE	8,500	9,500	10,200	10,800	11,000	11,900	6.9
FTE per 100,000[(a)]	44	49	52	55	55	58	5.7

(a) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

Source: ABS Labour Force Survey, 2000 to 2005.

13.4 Mental health nurses

Mental health nurses are another group of professionals who can provide specialist health-related care to people with mental health problems. In this report, the definition of 'mental health nursing' is based on the principal area of nursing activity, rather than the qualification of the nurse. An employed registered or enrolled nurse whose principal area of activity in their main nursing job is self-identified as 'mental health nursing' is considered to be a 'mental health nurse'. Nurses working principally with alcohol and other substance use are not included.

Information on the mental health nursing workforce is derived from responses to the AIHW Nursing and Midwifery Labour Force Survey, with these responses weighted to available nursing registration data from each state and territory. As described in Appendix 1, this is a survey of all enrolled and registered nurses in Australia conducted by the state and territory departments of health, in conjunction with nursing registration boards and the AIHW. The survey collects information on the demographic characteristics of nurses, the hours they worked, their qualifications, their place of work and their main area of nursing activity in the week before the survey.

In this section of the chapter, some comparisons are made between employed mental health nurses and all employed nurses. Detailed data on the total nursing labour force are available from *Nursing and midwifery labour force 2004* (AIHW 2006g).

Characteristics of the mental health nursing workforce

Out of a total of 249,458 nurses employed in Australia in 2004, an estimated 14,123 (5.7%) worked principally in the area of mental health nursing (Table 13.9). Of these, 29.3% reported that they had completed a post-registration or post-enrolment course of more than 6 months' duration in mental health.

Nurses working in mental health are less likely to be a registered nurse, slightly older on average, and much more likely to be male than nurses in the general workforce (AIHW 2006g).

The minimum educational requirement for a newly registered nurse is a 3-year degree or equivalent. Enrolled nurses, whose minimum educational requirement is a 1-year diploma or equivalent, usually work under the direction of registered nurses to provide basic care (AIHW 2006g). In 2004, 73.7% of nurses working principally in mental health and 80.4% of all employed nurses in Australia were registered nurses, with the remainder being enrolled nurses.

The average age of employed mental health nurses in 2004 was 44.9 years, which is slightly older than the 43.3 years for all employed nurses (Table 13.9). Female nurses working in mental health nursing were younger, on average, than their male counterparts (44.3 years compared with 46.2 years).

In general, nursing is a very female-dominated profession, with 8.7% of all nurses employed in Australia in 2004 being male. In contrast, male nurses made up over a third (33.7%) of employed mental health nurses in 2004 (Table 13.9).

Mental health nurses worked an average of 36.9 total hours per week in 2004 (Table 13.10). The hours worked per week were, on average, lower for females than males (35.8 hours compared with 39.2 hours) and higher for registered nurses than for enrolled nurses (37.3 hours compared with 35.9 hours).

Table 13.9: Employed mental health nurses, demographic characteristics, 1999 to 2004

	1999	2001	2003	2004	Distribution 2004 (%)	Change 2003–2004 (%)	Average annual change 1999–2004 (%)
Registered nurses	10,848	11,353	10,315	10,408	73.7	0.9	–4.1
Enrolled nurses	3,649	2,002	3,463	3,715	26.3	7.3	1.8
Sex							
Males	4,120	4,353	4,469	4,766	33.7	6.6	15.7
Females	10,377	9,002	9,308	9,357	66.3	0.5	–9.8
Age and sex							
Males							
Less than 25 years	68	52	72	53	1.1	–25.9	–21.5
25–34 years	605	611	533	563	11.8	5.7	–6.9
35–44 years	1,544	1,396	1,255	1,189	25.0	–5.2	–23.0
45–54 years	1,463	1,738	1,875	2,072	43.5	10.5	41.6
55–64 years	398	508	668	805	16.9	20.5	102.1
65 years and over	42	48	67	83	1.7	24.9	99.7
Females							
Less than 25 years	284	222	285	355	3.8	24.3	24.8
25–34 years	1,874	1,539	1,483	1,475	15.8	–0.5	–21.3
35–44 years	3,886	2,998	2,767	2,483	26.5	–10.3	–36.1
45–54 years	3,282	3,139	3,402	3,535	37.8	3.9	7.7
55–64 years	941	1,005	1,214	1,341	14.3	10.4	42.5
65 years and over	110	100	157	169	1.8	7.5	53.4
Average age (years)							
Males	43.6	44.9	45.6	46.2	. .	1.3	6.0
Females	42.4	43.5	44.2	44.3	. .	0.3	4.4
Total	*42.8*	*43.9*	*44.6*	*44.9*	. .	*0.7*	*5.1*
Total number	**14,497**	**13,355**	**13,777**	**14,123**	**100.0**	**2.5**	**–2.6**
All employed nurses	224,822	228,230	236,645	249,458	. .	5.4	11.0

. . Not applicable.

Source: AIHW Nursing and Midwifery Labour Force Surveys, 1999 to 2004.

Table 13.10: Employed mental health nurses, average total hours worked per week, by sex, 1999 to 2004

	1999	2001	2003	2004	Change 2003–2004 (%)	Average annual change 1999–2004 (%)
Registered nurses	34.8	34.9	37.0	37.3	0.8	7.2
Enrolled nurses	31.8	34.0	36.0	35.9	–0.3	12.9
Sex						
Males	37.2	37.2	39.1	39.2	0.3	5.4
Females	32.9	33.6	35.6	35.8	0.6	8.8
Total	**34.1**	**34.7**	**36.7**	**36.9**	**0.5**	**8.2**

Source: AIHW Nursing and Midwifery Labour Force Surveys, 1999 to 2004.

Size and distribution of the mental health nursing workforce

As with psychiatrists, nurses working in mental health areas are not evenly distributed across the states and territories or the regions of Australia. Their distribution also does not mirror that of the distribution of all employed nurses in Australia (AIHW 2006g). In 2004, there were 68 FTE mental health nurses per 100,000 population in Australia (Tables 13.11 and 13.12). The supply of mental health nurses ranged from 80 FTE per 100,000 population in Victoria to 38 FTE per 100,000 population in the Northern Territory.

Table 13.11: Employed mental health nurses, average total hours worked per week and FTE, states and territories, 2004

	Mental health nurses				All nurses
	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(a)]	FTE per 100,000 population[(a)]
NSW	4,394	37.5	4,336	65	1,099
Vic	4,095	36.7	3,955	80	1,249
Qld	2,473	36.4	2,369	61	998
WA[(b)]	1,494	37.0	1,455	74	1,325
SA	1,122	36.3	1,072	70	1,374
Tas	301	37.3	295	61	1,212
ACT	170	37.0	165	51	1,173
NT[(b)]	74	39.5	77	38	1,262
Total	**14,123**	**36.9**	**13,714**	**68**	**1,164**

(a) Crude rate based on the Australian estimated resident population as at 30 June 2004.

(b) Due to low response rates (38% for WA and 35% for the NT) the data for these jurisdictions should be treated with some caution.

Source: AIHW Nursing and Midwifery Labour Force Survey 2004.

Information on the supply of mental health nurses by geographic region (as derived from the location of the respondent's main nursing job as reported in the survey) is provided in Table 13.12. The figures are underestimates for each individual region as nurses who did not provide information on the location of their main job could not be allocated to a region. The figure for total FTE per 100,000 population is calculated based on all employed nurses.

For those nurses who reported information on the location of their main job, the number of FTE mental health nurses per 100,000 population was highest in the Inner regional areas of Australia (74 FTE per 100,000 population in 2004) and in Major cities (69 FTE per 100,000). Remote and Very remote regions had a lower rate of 20 FTE per 100,000 population in 2004.

Table 13.12: Employed mental health nurses, average total hours worked per week and FTE, by region[(a)], 2004

	Mental health nurses				All nurses
Region[(a)]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(b)]	FTE per 100,000 population[(b)]
Major cities	9,441	37.2	9,242	69	1,122
Inner regional	3,245	36.4	3,109	74	1,102
Outer regional	777	37.9	775	38	1,090
Remote and Very remote	98	38.3	99	20	1,164
Not reported	562	34.0	502	. .	. .
Total	**14,123**	**36.9**	**13,714**	**68**	**1,164**

(a) Region is derived from the postcode of the respondent's main job and is classified according to the Remoteness Area Structure within the Australian Standard Geographical Classification (ABS 2002a). This data should be treated with caution due to the large number of 'Not reported' values for region, relative to the number in 'Outer regional' and 'Remote and Very remote' regions.

(b) Crude rate based on the Australian estimated resident population as at 30 June 2004.

. . Not applicable.

Source: AIHW Nursing and Midwifery Labour Force Survey 2004.

Changes in the mental health nursing workforce

An overall 11.0% increase in the total number of employed nurses in Australia between 1999 and 2004 was not reflected in the number working in mental health nursing, which declined by 2.6% over the same period (Table 13.9). While the total number of employed nurses increased by 5.4% between 2003 and 2004, the number of mental health nurses increased by 2.5% (Table 13.9).

The decline in the number of mental health nurses between 1999 and 2004 was offset by an increase of 8.2% in the average total weekly hours worked, from 34.1 to 36.9 hours per week (Table 13.10). As a result, the number of FTE mental health nurses increased from 13,010 in 1999 to 13,714 in 2004 (an increase of 5.4%). The growth in FTE was greater for enrolled nurses (14.9%) than for registered nurses (2.8%) (Table 13.13). The number of FTE mental health nurses per 100,000 population was similar in 2004 (68) to that in 1999 (69).

Table 13.13: Employed mental health nurses, FTE, 1999 to 2004

	1999	2001	2003	2004	Change 2003–2004 (%)	Change 1999–2004 (%)
FTE						
Registered nurses	9,935	10,427	10,043	10,216	1.7	2.8
Enrolled nurses	3,054	1,791	3,281	3,510	7.0	14.9
Total FTE	**13,010**	**12,195**	**13,306**	**13,714**	**3.1**	**5.4**
FTE per 100,000 population[(a)]	69	63	67	68	1.9	–0.7

(a) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

Source: AIHW Nursing and Midwifery Labour Force Survey 1999 to 2004.

Table 13.14: Employed mental health nurses, FTE, states and territories, 1999 to 2004

	NSW	Vic	Qld	WA[(a)]	SA	Tas	ACT	NT[(a)]	Total
					FTE				
1999	4,374	3,240	2,382	1,289	1,187	265	161	115	13,010
2001	4,257	3,475	1,831	950	1,115	282	212	93	12,195
2003	4,846	3,659	2,254	916	1,098	320	167	54	13,306
2004	4,336	3,955	2,369	1,455	1,072	295	166	77	13,714
Change 2003–2004 (%)	–10.5	8.1	5.1	58.8	–2.4	–7.7	–0.6	42.8	3.1
Change 1999–2004 (%)	–0.9	22.1	–0.6	12.9	–9.7	11.4	3.3	–32.9	5.4
					FTE per 100,000 population[(b)]				
1999	68	69	68	70	79	56	52	59	69
2001	65	72	50	50	74	60	66	47	63
2003	73	75	59	47	72	67	52	27	67
2004	65	80	61	74	70	61	51	38	68
Change 2003–2004 (%)	–11.0	6.9	2.7	56.5	–2.8	–8.7	–0.8	41.9	1.9
Change 1999–2004 (%)	–5.4	15.3	–10.4	5.6	–11.8	8.9	–0.5	–35.3	–0.7

(a) Due to low response rates (19% in 2003 and 38% in 2004 for WA and 31% and 35%, respectively, for the NT) the data for these jurisdictions should be treated with some caution.

(b) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

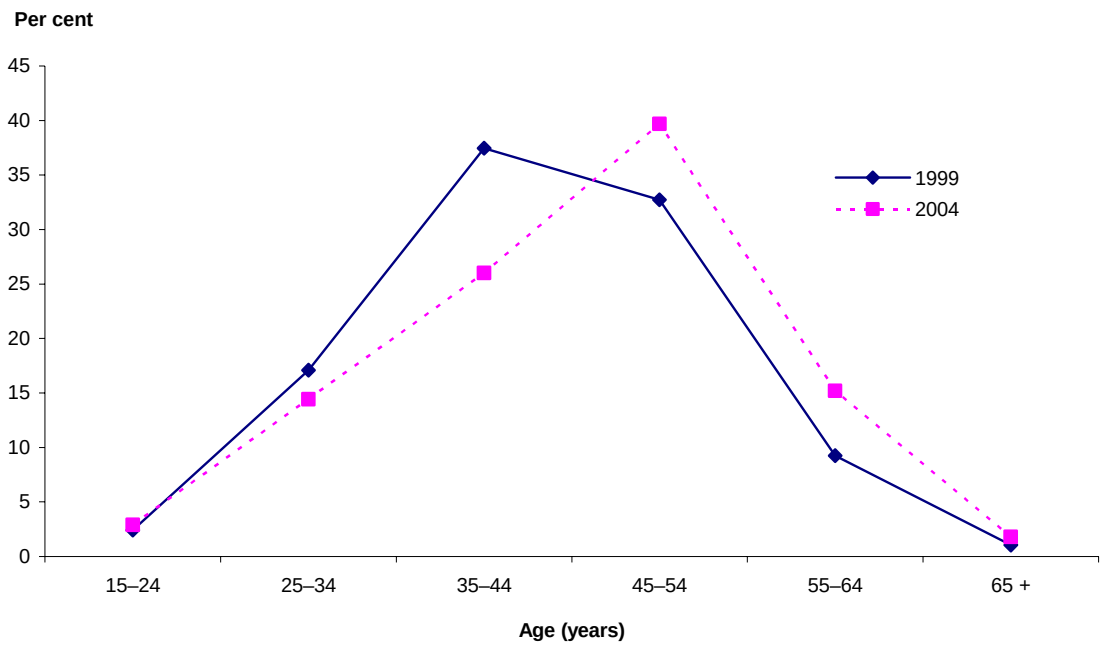
Source: AIHW Nursing and Midwifery Labour Force Surveys, 1999 to 2004.

There is considerable variability in the state and territory estimates of FTE mental health nurses and FTE per 100,000 population in the period from 1999 to 2004 (Table 13.14). As outlined in Appendix 1, at least part of this variation may be due to changes in the survey methodology and variations in response rates, and thus jurisdictional differences should be interpreted with caution.

The demographic characteristics of the mental health nursing workforce are also changing over time. The proportion of males in this workforce increased from 28.4% in 1999 to 33.7% in 2004 (Table 13.9). The proportion of mental health nurses who were registered nurses (rather than enrolled nurses) declined slightly over the period, from 74.8% in 1999 to 73.7% in 2004 (Table 13.9).

As with the general nursing population, the mental health nursing workforce is ageing, with the average age increasing from 42.8 in 1999 to 44.9 years in 2004 (Table 13.9 and Figure 13.2). The proportion of mental health nurses aged 55 years and over also increased, from 10.3% in 1999 to 17.0% in 2004.

As noted above, the average hours worked by nurses in mental health nursing increased in the period from 1999 to 2004 (Table 13.10). While this is the case for both males and females, the increase has been higher for females (8.8%) than for males (5.4%).



Source: AIHW Nursing and Midwifery Labour Force Survey, 1999 and 2004.

Figure 13.2: Employed mental health nurses, by age, 1999 and 2004

14 Expenditure and funding for mental health services

14.1 Introduction

Health expenditure and ***health funding*** are distinct but related concepts, with information on both needed to understand the financial resources used by the health system. Expenditure information relates to who incurs the expenditure, while funding information relates to the provider of the financial resources (as detailed further in the Key Concepts box below).

Key concepts

Health expenditure is reported in terms of who incurs the expenditure rather than who ultimately provides the funding for that expenditure. In the case of public hospital care, for example, all expenditures (that is, expenditure on medical and surgical supplies, drugs, salaries of doctors and nurses, etc.) are incurred by the states and territories, but a considerable proportion of those expenditures are funded by transfers from the Australian Government (AIHW 2006d).

Health funding is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospital care, for example, the Australian Government and the states and territories together provide over 90% of the funding; these funds are derived ultimately from taxation and other sources of government revenue. Some other funding comes from private health insurers and from individuals who choose to be treated as private patients and pay hospital fees out of their own pockets (AIHW 2006d).

Recurrent expenditure refers to expenditure that does not result in the acquisition or enhancement of an asset—for example, salaries and wages expenditure and non-salary expenditure such as payments to visiting medical officers (AIHW 2006a).

Current prices refer to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditures reflect changes in both price and volume (AIHW 2006a).

Constant price estimates are derived by adjusting the current prices to remove the effects of inflation. This allows for expenditures in different years to be compared and for changes in expenditure to reflect changes in the volume of health goods and services. Generally, the constant price estimates have been derived using annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS). In some cases, such indexes are not available, and ABS implicit price deflators have been used instead (AIHW 2006a).

For definitions of key concepts related to *Medicare-subsidised psychiatric services* refer to Chapter 6; *mental health-related prescriptions* refer to Chapter 11; and various types of mental health facilities (for example, *public psychiatric hospital* or *public psychiatric hospital*) refer to Chapter 12.

The expenditure and funding reported here relate mainly to specialised mental health services, as detailed in the chapter. This information can be disaggregated in a number of ways, including by disease, facility type, inputs (for example, salaries) or outputs (for instance, products).

Funding for health goods and services comes from a mixture of government and non-government sources, which changes depending on the type of good or service being provided. The Australian Government, for example, provides most of the funding for

Medicare services, which are provided by: general practitioners, medical specialists and other professionals, usually in private practices; high-level residential care; and pharmaceuticals, for which benefits were paid under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). As well as these direct forms of expenditure, the Australian Government provides subsidies for private health insurance and Special Purpose Payments to the states and territories for health purposes. Responsibility for funding public hospitals and public health activities are shared by the Australian Government and the states and territories, while the state and territory governments provide the main funding for health services, such as ambulance and community health services. The main non-government funding sources are out-of-pocket payments by individuals, benefits paid by health insurance companies, and payments by injury compensation insurers. These non-government sources provide the bulk of funding for such things as over-the-counter pharmaceuticals, dental and other professional services and private hospital services.

This chapter covers the available information on expenditure for mental health services, beginning with broad estimates of health system expenditure on mental disorders. Information is then provided on expenditure on mental health facilities, Medicare expenditure for services provided by psychiatrists and mental health-related expenditure under the PBS/RPBS. Finally, the sources of funding for specialised mental health services are presented. Data are presented, where available, for the previous 5 years to provide some indication of the trends in expenditure and funding.

Data on expenditure and funding come from a variety of sources and these are outlined in Appendix 1. Further information on health expenditure is available in two other AIHW publications, *Australia's health 2006* (AIHW 2006a) and *Health expenditure Australia 2004–05* (AIHW 2006d).

14.2 Health system expenditure on mental disorders

The AIHW produces estimates of expenditure on the goods and services provided by the health system. These estimates are based on the satellite national accounts in which non-monetary data sources are linked to the monetary accounting system (AIHW 2005b). The methodology provides estimates for the various goods and services produced by the health system (hospitals, high-level residential aged care, medical services, other professional services, pharmaceuticals, research and community, or public health programs) and allows the allocation of much of that expenditure to specific diseases.

The AIHW has estimated that total health expenditure in 2000–01 was $60,897 million, of which $50,146 million (82.3%) has been able to be allocated, as ***recurrent expenditure***, to specific diseases and conditions. In 2000–01, expenditure on all mental disorders was estimated at $3,741 million (Table 14.1), or 7.5% of total allocated health system expenditure in that year. Other disease groups with high proportions of allocated health expenditure in that year were cardiovascular diseases (10.9%), nervous system disorders (9.9%), musculoskeletal diseases (9.2%), injuries (8.0%), respiratory diseases (7.5%) and oral health (6.9%).

Expenditure on depression was $1,107 million, which represents 29.6% of allocated expenditure on mental disorders and 2.2% of all allocated health expenditure in 2000–01.

For depression, the bulk of expenditure was in respect of pharmaceuticals (30.7%), out-of-hospital medical care—mainly general practitioner services—(24.9%) and hospital

services (21.7%). In contrast, hospital services comprised over one-third (36.3%) of expenditure for other mental disorders, with expenditure on pharmaceuticals and residential aged care accounting for 10.5% each. Community mental health services accounted for 9.4% of expenditure on depression, and over one-quarter (27.2%) of expenditure on other mental disorders.

The $3,741 million expenditure on mental disorders in 2000–01 was an increase of 38.7% on the comparable figure ($2,697 million in 2000–01 prices) in 1993–94. On a per capita basis, expenditure on mental disorders rose by 27.6% over the period. Much of this growth was due to large increases in mental health expenditure for pharmaceuticals (especially for those treating depression), research and community mental health services, all of which more than doubled between 1993–94 and 2000–01.

Table 14.1: Health system expenditure on mental disorders, 1993–94[(a)] and 2000–01 ($ million)

Year	Hospitals[(b)]	Aged care homes	Out-of-hospital medical[(c)]	Pharma-ceuticals	Other health professional services[(d)]	Research	Community mental health services	Total
				Depression				
1993–94[(a)]	223	103	166	78	15	9	26	619
2000–01	240	89	276	340	21	37	104	1,107
				Other mental disorders				
1993–94[(a)]	869	213	346	159	84	25	382	2,078
2000–01	956	277	223	276	113	72	717	2,634
				All mental disorders[(e)] [(f)]				
1993–94[(a)]	1,091	316	512	237	99	34	408	2,697
2000–01	1,196	366	499	616	134	109	821	3,741

(a) Expenditures for 1993–94 have been converted to 2000–01 prices by adjusting for health price inflation between 1993–94 and 2000–01.

(b) Includes admitted and non-admitted patients and in-hospital private medical services.

(c) Includes unreferred attendances, imaging, pathology and other medical.

(d) Includes services delivered by physiotherapists, chiropractors, occupational therapists, audiologists, speech therapists, hydropaths, podiatrists, therapeutic and clinical massage therapists, clinical psychologists, dietitians and osteopaths.

(e) Includes ICD-10-AM codes F04–F99 (i.e., all mental and behavioural disorders *excluding* dementia in Alzheimer's disease, vascular dementia, dementia in other diseases classified elsewhere and unspecified dementia) and G31.2 (degeneration of nervous system due to alcohol) for 2000–01. Includes ICD-9 chapter V (mental disorders), excluding 290 (senile and presenile organic psychotic conditions) and 330–331 (cerebral degenerations usually manifest in childhood and other cerebral degenerations) for 1993–94.

(f) The total expenditure for all mental disorders in 2000–01 includes $310 million for treating drug and alcohol dependence and $47 million for intellectual disability.

Source: AIHW Disease Expenditure Database.

In this analysis, expenditures on mental health-related care provided to patients who have been admitted to hospitals with dementias have been included with the estimates of expenditure on mental health disorders. This is because dementias are included in the definition of mental health-related separations from hospitals used elsewhere in this report (Table 14.2). Expenditures on care provided to patients with dementias in other settings (such as aged care homes) are not necessarily regarded as mental health-related and are not included in these estimates.

Between 1993–94 and 2000–01, real expenditure on Alzheimer's disease and other dementias (not including community mental health services, for which 1993–94 figures are not available), nearly trebled.

Table 14.2: Health system expenditure on Alzheimer's disease and other dementias[a], 1993–94 and 2000–01 ($ million)

Year	Hospitals[b]	Aged care homes	Out-of-hospital medical[c]	Pharma-ceuticals	Other health professional services[d]	Research	Community mental health services	Total
1993–94[e]	132	647	13	2	5	14	n.a.	814
2000–01	160	1,902	18	27	9	94	21	2,230

(a) Includes ICD–10–AM codes F01–F03 (i.e., vascular dementia, dementia in other diseases classified elsewhere and unspecified dementia) and G30–G31 (Alzheimer's disease and other degenerative disease of the nervous system not elsewhere classified), excluding G31.2 (degeneration of nervous system due to alcohol) for 2000–01. Includes ICD–9–CM codes 290 (senile and presenile organic psychotic conditions) and 330–331 (cerebral degenerations usually manifest in childhood and other cerebral degenerations) for 1993–94.

(b) Includes admitted and non-admitted patients and in-hospital private medical services.

(c) Includes unreferred attendances, imaging, pathology and other medical.

(d) Includes services delivered by physiotherapists, chiropractors, occupational therapists, audiologists, speech therapists, hydropaths, podiatrists, therapeutic and clinical massage therapists, clinical psychologists, dietitians and osteopaths.

(e) Expenditures for 1993–94 have been converted to 2000–01 prices by adjusting for health price inflation between 1993–94 and 2000–01.

Source: AIHW Disease Expenditure Database.

14.3 Expenditure on mental health facilities

Expenditure data for public psychiatric hospitals, private psychiatric hospitals and government-operated community and residential mental health services are reported in this section, with the data for 2000–01 to 2004–05 summarised in Table 14.3. The data are presented in both ***current*** and ***constant prices***. Unless otherwise stated, ***constant*** prices estimates are expressed in 2003–04 prices. For other information on these mental health facilities, such as the number of establishments, available beds and staffing, refer to Chapter 12 of this report.

This section draws on data from the National Public Hospital Establishments Database, the ABS's Private Health Establishments Collection and the National Community Mental Health Establishments Database. For further information on these data sources see Appendix 1.

In 2004–05, recurrent expenditure by public psychiatric hospitals was estimated at $527 million (Table 14.3). Expenditure on salaries and wages was the major component and ranged from 67.6% of the total in 2000–01 to 70.9% in 2003–04. In 2004–05 it was 69.9% of the total. Depreciation was 4.2% of expenditure in 2004–05 and all other non-salary expenditure was 25.8% of the total in that year. Estimated revenue was $27 million in 2004–05 and represented 5.1% of expenditure. Real growth in expenditure on these facilities averaged 2.5% annually between 2000–01 and 2004–05.

Only total expenditure information is available from private psychiatric hospitals (which are defined by the ABS as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients). In 2004–05, total recurrent expenditure for these facilities was $168 million (Table 14.3).

Real growth in expenditure for private psychiatric hospitals, over the period 2000–01 to 2004–05, averaged 2.4% per year, which is nearly the same as for the public psychiatric hospitals group.

Expenditure for government-operated community and residential mental health facilities in 2004–05 was estimated at $987 million. It grew at an average of 5.6% per year from 2000–01 to 2004–05 (Table 14.3).

Table 14.3: Recurrent health expenditure ($'000) for public and private psychiatric hospitals, and government-operated community and residential mental health services, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Average annual change (%)
Public psychiatric hospitals						
Current prices[a]						
Salaries and wages expenditure	281,494	303,693	309,931	346,078	369,118	6.1
Non-salary expenditure[c]	115,295	119,576	115,199	122,408	136,276	4.3
Depreciation[b]	19,899	21,955	21,958	19,869	22,299	2.9
Total recurrent expenditure	416,688	445,224	447,088	488,355	527,693	6.1
Revenue	21,978	19,260	19,578	23,709	26,781	5.1
Constant prices[a]						
Salaries and wages expenditure	311,197	325,345	321,181	346,078	356,024	3.4
Non-salary expenditure[c]	127,461	128,101	119,380	122,408	131,442	0.8
Depreciation[b]	21,999	23,520	22,755	19,869	21,508	–0.6
Total recurrent expenditure	460,656	476,966	463,316	488,355	508,974	2.5
Revenue	24,297	20,633	20,289	23,709	25,831	1.5
Public acute hospitals with a specialised psychiatric unit or ward						
Total recurrent expenditure	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Private psychiatric hospitals[d]						
Current prices[a]						
Total recurrent expenditure	133,491	143,653	158,529	162,066	168,490	6.0
Constant prices[a]						
Total recurrent expenditure	147,577	153,895	164,283	162,066	162,513	2.4
Government-operated community and residential mental health services[e]						
Current prices[a]						
Salaries and wages expenditure	505,310	563,495	624,680	675,809	724,617	9.4
Non-salary expenditure[f]	187,887	214,636	247,052	249,149	262,616	8.7
Total recurrent expenditure	695,709	778,131	871,751	922,079	987,233	9.1
Constant prices[a]						
Salaries and wages expenditure	555,897	596,923	640,697	675,809	692,089	5.6
Non-salary expenditure[f]	206,696	227,369	253,387	249,149	250,827	5.0
Total recurrent expenditure	765,356	824,291	894,104	922,079	942,916	5.4

(a) Expenditure and revenue data are listed in both current and constant prices. Constant price values are referenced to 2003–04 and are adjusted for inflation and expressed in terms of prices for the reference year.

(b) Data on *Depreciation* for public psychiatric hospitals were not supplied: in 2004–05 by Tasmania; in 2003–04 by South Australia and Tasmania; in 2002–03 by Victoria, South Australia and Tasmania; in 2001–02 by South Australia and Tasmania; and in 2000–01 by Victoria, South Australia and Tasmania.

(c) Excludes depreciation.

(d) The ABS defined private psychiatric hospitals as those that are licensed/approved by each state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(e) Victoria has included expenditure data for specialised aged care residential services in the National Mental Health Establishments Database that are not in-scope for the National Residential Mental Health Care Database.

(f) Includes depreciation.

n.a. Not available.

Sources: National Public Hospital Establishments Database, Private Health Establishments Collection, and National Community Mental Health Establishments Database.

Expenditure on salaries and wages ($725 million) represented 73.4% of expenditure on community and residential mental health facilities in 2004–05. This was slightly higher than the comparable figure (69.9%) for public psychiatric hospitals.

Specialised psychiatric wards or units in public acute hospitals are also considered to be mental health facilities (see Chapter 12); however, separate expenditure data for these facilities were not available. Additional information on expenditure on these mental health facilities can be found in the *National Mental Health Report 2005* (DoHA 2005).

14.4 Expenditure on Medicare-subsidised psychiatrist services

This section presents information on the Australian Government's funding through Medicare for psychiatrist services (see Chapter 6) for the financial years 2000–01 to 2005–06 (Appendix 1 provides further information on data quality, coverage and other aspects of the Medicare data).

In 2005–06, $221 million was paid in benefits for Medicare-subsidised psychiatrist services (Table 14.4); this represents 2.0% of total Medicare benefits expenditure ($10,976 million) and 17.4% of expenditure for specialist services funded through Medicare ($1,271 million).

For Australia as a whole, benefits paid for these services averaged $10.79 per capita in 2005–06. The average benefits paid per capita in Victoria and South Australia were above the national average, while those paid in Western Australia and the Northern Territory were below the national average.

Most of the $221 million ($198 million or 89.8%) was spent on patient attendances in consulting rooms, followed by $17 million (or 7.7%) spent on patient attendances in hospital. Smaller amounts were spent on patient attendances in other locations ($2 million, or 0.8%) and on other services ($4 million, or 1.7%). Of this latter amount, $2.5 million (66.7%) was for group psychotherapy.

Over half (55.3% or $109 million) of the expenditure on patient attendances in consulting rooms was for consultations that lasted between 46 and 75 minutes.

Expenditure on Medicare-subsidised psychiatric services decreased, at an average of 2.1% annually, between 2000–01 and 2005–06 (Table 14.5). This was greater than the rates of decline in both the number of such services (1.1% per year) and the number of people provided with them (0.8% per year) over the same period (see Chapter 6).

Consistent with changes in the number of services and the number of patients receiving these services, expenditure on attendances in 'other locations' had the highest average annual nominal increase at 8.5%. There were also nominal increases in Medicare expenditure on attendances in hospital (6.6% per year), other services (2.2%) and attendances in consulting rooms (2.0%).

Table 14.4: Medicare expenditure ($'000) on services provided by psychiatrists, by schedule item, states and territories, 2005–06

MBS item		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[a]
Patient attendances in consulting room										
300, 310	15 minutes or less	626	318	187	146	85	54	43	39	1,499
302, 312	16 to 30 minutes	5,803	5,189	3,993	1,141	1,261	408	353	75	18,223
293, 304, 314	31 to 45 minutes	12,527	15,075	10,551	3,510	3,971	1,215	559	87	47,495
306, 316	46 to 75 minutes	36,878	39,619	14,810	4,814	10,954	1,157	1,130	112	109,474
308, 318	Over 75 minutes	2,326	2,121	1,086	479	1,278	260	107	7	7,664
291, 319	Selected cases (> 45 min)	6,032	4,830	1,305	207	1,101	36	190	0	13,702
	Subtotal	*64,193*	*67,154*	*31,932*	*10,297*	*18,650*	*3,130*	*2,382*	*320*	*198,057*
Patient attendances in hospital										
320	15 minutes or less	57	155	59	82	24	18	7	0	402
322	16 to 30 minutes	761	1,495	2,040	426	240	183	14	5	5,165
324	31 to 45 minutes	1,471	1,536	1,187	549	324	307	28	4	5,406
326	46 to 75 minutes	1,607	1,596	748	430	371	189	39	3	4,983
328	Over 75 minutes	351	295	138	172	70	48	15	1	1,089
	Subtotal	*4,247*	*5,076*	*4,172*	*1,659*	*1,030*	*746*	*102*	*13*	*17,046*
Patient attendances in other locations										
330	15 minutes or less	32	20	4	8	0	0	0	0	63
332	16 to 30 minutes	143	97	8	13	5	2	0	0	269
334	31 to 45 minutes	286	124	18	7	14	2	0	0	452
336	46 to 75 minutes	358	147	46	15	40	4	2	0	612
338	Over 75 minutes	247	39	17	10	61	2	1	0	376
	Subtotal	*1,067*	*426*	*93*	*53*	*120*	*9*	*3*	*1*	*1,772*
Other services										
342, 344, 346	Group psychotherapy	759	1,311	185	62	70	77	5	0	2,470
348, 350, 352	Interview with non-patient	67	84	63	39	25	7	5	0	290
353, 355, 356, 357, 358, 364, 366, 367, 369, 370	Telepsychiatry	26	2	1	1	26	9	0	0	85
855, 857, 858, 861, 864, 866	Case conferencing	7	41	7	1	0	1	0	3	41
14224	Electroconvulsive therapy[b]	239	186	241	65	60	21	7	1	819
	Subtotal	*1,097*	*1,624*	*497*	*168*	*182*	*114*	*17*	*5*	*3,705*
Total expenditure in current prices ($'000)		**70,604**	**74,280**	**36,695**	**12,177**	**19,982**	**3,999**	**2,503**	**340**	**220,579**
Per capita ($)[c]		10.38	14.70	9.17	6.00	12.92	8.21	7.66	1.66	10.79

(a) Includes expenditure for services for which the state or territory was not reported.

(b) Information for electroconvulsive therapy may include data for medical practitioners other than psychiatrists.

(c) Crude rate based on the preliminary Australian estimated resident population at 31 December 2005.

Source: Medicare data (DoHA).

Table 14.5: Medicare expenditure ($'000) on services provided by psychiatrists (current prices), by schedule item, 2000–01 to 2005–06

MBS item		2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (%)
Patient attendances in consulting room								
300, 310	15 minutes or less	1,637	1,587	1,418	1,348	1,417	1,499	–1.7
302, 312	16 to 30 minutes	17,819	17,806	17,546	17,160	17,963	18,223	0.4
293, 304, 314	31 to 45 minutes	40,765	41,186	42,409	44,191	46,580	47,495	3.1
306, 316	46 to 75 minutes	101,943	100,215	99,212	100,158	107,081	109,474	1.4
308, 318	Over 75 minutes	6,404	6,183	6,549	6,723	7,404	7,664	3.7
291, 319	Selected cases (> 45 min)	11,072	11,685	11,733	12,287	13,373	13,702	4.4
	Subtotal	*179,639*	*178,660*	*178,867*	*181,868*	*193,820*	*198,057*	*2.0*
Patient attendances in hospital								
320	15 minutes or less	515	501	456	439	400	402	–4.8
322	16 to 30 minutes	3,966	4,239	4,605	4,646	4,737	5,165	5.4
324	31 to 45 minutes	3,568	3,985	4,269	4,633	4,866	5,406	8.7
326	46 to 75 minutes	3,631	3,742	3,971	4,275	4,431	4,983	6.5
328	Over 75 minutes	676	674	663	833	887	1,089	10.0
	Subtotal	*12,355*	*13,141*	*13,964*	*14,826*	*15,321*	*17,046*	*6.6*
Patient attendances in other locations								
330	15 minutes or less	39	56	58	63	61	63	10.1
332	16 to 30 minutes	152	222	228	188	219	269	12.1
334	31 to 45 minutes	296	325	367	371	385	452	8.8
336	46 to 75 minutes	427	540	608	559	600	612	7.5
338	Over 75 minutes	263	344	309	357	336	376	7.4
	Subtotal	*1,178*	*1,487*	*1,571*	*1,538*	*1,601*	*1,772*	*8.5*
Other services								
342, 344, 346	Group psychotherapy	2,495	2,358	2,185	2,120	2,325	2,470	–0.2
348, 350, 352	Interview with non-patient	250	199	199	208	250	290	3.0
353, 355, 356, 357, 358, 364, 366, 367, 369, 370	Telepsychiatry	0	0	2	19	24	41	. .
855, 857, 858, 861, 864, 866	Case conferencing	0	0	9	39	62	85	. .
14224	Electroconvulsive therapy[a]	575	620	695	671	704	819	7.3
	Subtotal	*3,320*	*3,178*	*3,090*	*3,058*	*3,364*	*3,705*	*2.2*
Total expenditure in current prices ($'000)		**196,492**	**196,465**	**197,492**	**201,290**	**214,106**	**220,579**	**2.3**
Total expenditure in constant prices ($'000)[b]		**235,679**	**227,113**	**216,285**	**210,109**	**214,106**	**212,207**	**–2.1**
Per capita (constant prices) ($)[c]		12.23	11.63	10.95	10.51	10.59	10.38	–3.2

(a) Information for electroconvulsive therapy may include data for medical practitioners other than psychiatrists.
(b) Constant prices are referenced to 2004–05 and are adjusted for inflation.
(c) Crude rate based on the Australian estimated resident population at 31 December of the reference year.
. . Not applicable.
Source: Medicare data (DoHA).

14.5 Expenditure on mental health-related medications

This section presents information on Australian Government expenditure on prescribed mental health-related medications subsidised under the PBS and the RPBS for 2005–06. Some additional information on expenditure in earlier years is also provided. (For information on the numbers and types of medications prescribed, see Chapter 11. Appendix 1 has further information on data quality, coverage and other aspects of the PBS/RPBS database).

In 2005–06, 183 million claims were processed under the PBS and RPBS in respect of prescribed medications. The total benefits paid for these claims were $6,053 million (Medicare Australia 2006). Of this, 10.6% (or $639 million) was spent on mental health-related medications (see Chapter 11).

Almost three-quarters (74.4%) of the expenditure on mental health-related medications was for medications prescribed by general practitioners. Prescriptions written by psychiatrists was the next highest (19.9%), with non-psychiatrist specialists' prescriptions accounting for the remaining 5.7%) (Table 14.6).

In 2005–06, prescriptions for antidepressants and antipsychotics accounted for most of the mental health-related PBS/RPBS expenditure (47.3% and 46.3% respectively), followed by prescriptions for anxiolytics (2.5%) and hypnotics and sedatives (1.7%) (Table 14.6). Other medications prescribed by psychiatrists accounted for 2.2% of the expenditure on mental health-related prescriptions.

Table 14.6: Expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[(a)] and type of medical practitioner, 2005–06

Type of medical practitioner	Antipsychotics (N05A)	Anxiolytics (N05B)	Hypnotics and sedatives (N05C)	Antidepressants (N06A)	Other[(b)]	Total	Total (per cent)
General practitioners	194,782	14,329	10,353	255,732	. .	475,196	74.4
Non-psychiatrist specialists	27,668	342	305	8,123	. .	36,438	5.7
Psychiatrists	73,293	1,167	269	38,052	14,147	126,928	19.9
Total	**295,743**	**15,838**	**10,927**	**301,907**	**14,147**	**638,562**	**100**
Total (%)	*46.3*	*2.5*	*1.7*	*47.3*	*2.2*	*100*	*. .*

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) Other medications prescribed by psychiatrists and subsidised through PBS/RPBS.

. . Not applicable.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

In terms of benefits paid, the cost to the Australian Government of subsidising mental health-related prescriptions under the PBS/RBPS in 2005–06 ($639 million) was equivalent to $31.22 per capita (Table 14.7). The average benefits paid in South Australia and Victoria were above the national average, while those paid in the Northern Territory and the Australian Capital Territory were below the national average. This is consistent with the distribution of prescriptions (see Chapter 11).

Table 14.7: Expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[a] and type of medical practitioner, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	Antipsychotics (N05A)								
General practitioners	66,039	55,248	32,974	15,071	18,165	4,316	2,342	628	194,782
Non-psychiatrist specialists	5,783	11,533	5,463	2,900	1,046	205	270	467	27,668
Psychiatrists	24,947	22,337	12,246	4,035	6,754	1,383	1,425	168	73,293
Subtotal	*96,769*	*89,118*	*50,683*	*22,006*	*25,965*	*5,903*	*4,037*	*1,263*	*295,743*
	Anxiolytics (N05B)								
General practitioners	3,923	4,289	2,866	1,056	1,355	698	113	31	14,329
Non-psychiatrist specialists	81	108	76	33	32	8	3	1	342
Psychiatrists	267	444	241	62	108	37	7	1	1,167
Subtotal	*4,270*	*4,841*	*3,183*	*1,151*	*1,495*	*743*	*123*	*33*	*15,838*
	Hypnotics and sedatives (N05C)								
General practitioners	3,262	2,623	1,990	1,001	987	389	79	23	10,353
Non-psychiatrist specialists	83	92	64	36	21	5	3	1	305
Psychiatrists	63	64	67	27	38	5	5	1	269
Subtotal	*3,408*	*2,778*	*2,120*	*1,064*	*1,046*	*399*	*86*	*25*	*10,927*
	Antidepressants (N06A)								
General practitioners	74,824	64,833	54,128	26,994	22,744	8,197	3,207	805	255,732
Non-psychiatrist specialists	1,993	2,360	1,932	1,105	469	136	76	53	8,123
Psychiatrists	10,574	11,117	8,137	3,475	3,393	896	399	60	38,052
Subtotal	*87,392*	*78,310*	*64,197*	*31,574*	*26,606*	*9,228*	*3,681*	*919*	*301,907*
	Other medications prescribed by psychiatrists[b]								
Psychiatrists	4,185	4,039	2,888	1,519	1,052	228	202	32	14,147
	Total expenditure								
Expenditure in current prices ($'000)	**196,024**	**179,086**	**123,071**	**57,314**	**56,164**	**16,501**	**8,129**	**2,272**	**638,562**
Per capita ($)[c]	28.81	35.45	30.76	28.25	36.32	33.87	24.88	11.11	31.22

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) Includes other N codes as well as other ATC medication groups as presented in Table 14.8. Note that data for other ATC groups prescribed by general practitioners and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(c) Crude rate based on the preliminary Australian estimated resident population at 31 December 2005.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

PBS/RPBS expenditure for medications prescribed by psychiatrists accounted for $127 million in 2005–06. About 96.7% ($123 million) of this was for medications pertaining to the Central Nervous System (including antipsychotics, anxiolytics, hypnotics and sedatives, and antidepressants), while the remainder (3.3%, or $4 million) was for other medications (Table 14.8).

Overall, expenditure on medications prescribed by psychiatrists under the PBS/RPBS averaged $6.21 per capita in 2005–06 (Table 14.8). The average benefits paid per capita for mental health-related medications prescribed by psychiatrists were below the national average in the Northern Territory and Western Australia, and above the average in Victoria and South Australia.

Aggregate expenditure on PBS/RPBS-subsidised mental health-related medications was estimated at $639 million in 2005–06. Real growth in expenditure averaged 7.5% per year between 2000–01 and 2005–06. On a per capita basis, this represents a growth rate of 6.3% per year over the period (Table 14.9). The increase is mainly explained by the rise in expenditure on antipsychotics and antidepressants. However, while expenditure for antipsychotic prescriptions has experienced annual increases over the 5 years, expenditure for antidepressants increased by 3.3% yearly to $336 million in 2004–05, and then decreased by 10.2% to $302 million in 2005–06. In contrast, expenditure on prescriptions for hypnotics and sedatives decreased by 5.5% per year between 2000–01 and 2005–06, while expenditure for anxiolytics experienced a smaller decrease (0.8% per year).

Table 14.8: Expenditure ($'000) on medications prescribed by psychiatrists subsidised under the PBS/RPBS, by type of medication prescribed[a], 2005–06

ATC Code		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
N	**Central Nervous System**									
N05A	Antipsychotics	24,947	22,337	12,246	4,035	6,754	1,383	1,425	168	73,293
N05B	Anxiolytics	267	444	241	62	108	37	7	1	1,167
N05C	Hypnotics and sedatives	63	64	67	27	38	5	5	1	269
N06A	Antidepressants	10,574	11,117	8,137	3,475	3,393	896	399	60	38,052
	Subtotal	*35,851*	*33,962*	*20,691*	*7,599*	*10,293*	*2,321*	*1,836*	*230*	*112,781*
	Other N	2,868	2,987	1,896	1,209	706	157	129	24	9,976
	Total N	*38,718*	*36,950*	*22,587*	*8,807*	*10,999*	*2,478*	*1,964*	*254*	*122,757*
A	Alimentary tract and metabolism	326	295	268	72	92	26	14	2	1,095
B	Blood and blood-forming organs	24	20	24	11	13	1	1	0	94
C	Cardiovascular system	433	322	298	91	131	23	20	3	1,321
D	Dermatologicals	10	7	7	5	2	0	0	0	31
G	Genito-urinary system and sex hormones	157	106	164	48	36	5	11	0	527
H	Systemic hormonal preparations, excl. sex hormones and insulins	17	25	18	7	9	1	1	0	78
J	Antiinfectives for systemic use	64	55	53	22	15	4	4	0	218
L	Antineoplastic and immunomodulating agents	107	22	27	12	7	1	13	0	188
M	Musculo-skeletal system	63	83	48	15	15	4	3	1	232
P	Antiparasitic products, insecticides and repellents	0	0	0	0	0	0	0	0	1
R	Respiratory system	95	95	68	23	20	5	5	2	314
S	Sensory organs	14	13	11	3	3	1	1	0	44
V	Various[b]	7	9	6	1	3	0	0	0	27
Z	Other[c]	0	0	0	0	0	0	0	0	1
	Subtotal (excluding N)	*1,317*	*1,052*	*992*	*310*	*346*	*71*	*73*	*8*	*4,171*
Total expenditure ($'000)		**40,035**	**38,002**	**23,579**	**9,117**	**11,345**	**2,549**	**2,037**	**262**	**126,928**
Per capita ($)[d]		5.88	7.52	5.89	4.49	7.34	5.23	6.24	1.28	6.21

(a) Classified according to the ATC Classification System (WHO 2006a).
(b) Various include allergens, diagnostic agents, urine test reagents and food supplements (lactose, amino acid preparations).
(c) Other refers to extemporaneously prepared items and/or PBS items with no ATC equivalent.
(d) Crude rate based on the preliminary Australian estimated resident population at 31 December 2005.
Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

Table 14.9: Expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[a] and type of medical practitioner, 2000–01 to 2005–06

ATC group (code)		2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (%)
Antipsychotics (N05A)	General practitioners	92,258	119,870	139,958	154,858	170,309	194,782	16.1
	Non-psychiatrist specialists	8,306	10,572	13,272	16,777	20,055	27,668	27.2
	Psychiatrists	43,705	48,660	52,451	55,240	63,188	73,293	10.9
	Subtotal	*144,269*	*179,101*	*205,680*	*226,874*	*253,553*	*295,743*	*15.4*
Anxiolytics (N05B)	General practitioners	14,960	15,156	15,199	15,296	14,845	14,329	–0.9
	Non-psychiatrist specialists	322	319	328	333	335	342	1.2
	Psychiatrists	1,186	1,199	1,248	1,229	1,205	1,167	–0.3
	Subtotal	*16,469*	*16,674*	*16,775*	*16,858*	*16,385*	*15,838*	*–0.8*
Hypnotics and sedatives (N05C)	General practitioners	13,793	13,384	12,430	12,000	11,185	10,353	–5.6
	Non-psychiatrist specialists	378	369	348	347	322	305	–4.2
	Psychiatrists	321	310	308	311	290	269	–3.5
	Subtotal	*14,492*	*14,064*	*13,086*	*12,658*	*11,797*	*10,927*	*–5.5*
Antidepressants (N06A)	General practitioners	213,481	234,749	253,546	279,733	285,731	255,732	3.7
	Non-psychiatrist specialists	6,424	7,024	7,859	8,922	8,826	8,123	4.8
	Psychiatrists	36,751	38,247	40,046	42,081	41,559	38,052	0.7
	Subtotal	*256,656*	*280,020*	*301,451*	*330,736*	*336,116*	*301,907*	*3.3*
Other[b]	Psychiatrists	9,345	11,663	12,842	13,903	14,410	14,147	8.6
Total expenditure in current prices ($'000)		**441,231**	**501,522**	**549,833**	**601,029**	**632,261**	**638,562**	**7.7**
Total expenditure in constant prices ($'000)[c]		442,942	503,150	551,144	601,956	632,261	637,225	7.5
Per capita (constant prices) ($)[d]		22.98	25.76	27.90	30.12	31.28	31.16	6.3

(a) Classified according to the ATC Classification System (WHO 2006a).

(b) Includes other N codes as well as other ATC medication groups as presented in Table 14.8. Note that data for other ATC groups prescribed by general practitioners and non-psychiatrist specialist are not presented because they are not included in the definition of mental health-related medications.

(c) Expenditure data are listed in both current and constant prices. Constant prices are referenced to 2004–05 and are adjusted for inflation.

(d) Crude rate based on the Australian estimated resident population at 31 December of the reference year.

Source: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA).

14.6 Sources of funding for specialised mental health services

The national mental health reports from the Department of Health and Ageing (DoHA) provide estimates of expenditure on specialised mental health services by three main funding sources: Australian Government; state and territory governments; and private health insurance funds. Specialised mental health services are defined as 'those which have as their primary function the provision of treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability' (DoHA 2005:16).

Using this definition of mental health services, the 2005 report estimates that recurrent expenditure on mental health services in 2002–03 was $3,332 million. Of this total, 59.3% came from state and territory governments, 36.3% from the Australian government and 4.4% from private health funds (Table 14.10).

Over the first 10-year period of the National Mental Health Strategy (1993–2003), total expenditure on mental health services increased by 68.9%, with funding by the Australian government increasing the most (133.7%, or more than doubling).

Table 14.10: Expenditure on mental health services[(a)] by source of funding, constant prices[(b)], 1992–93 to 2002–03 ($ million)

Source of funding[(c)]	1992–93	1997–98	2002–03	% change 1992–93 to 2002–03
State and territory governments	1327	1574	1976	49
Australian government	517	835	1208	134
Private health funds	128	139	148	16
Total	**1,972**	**2,548**	**3,332**	**69**

(a) Some mental health services (for example, mental health services in aged care facilities) are not included.

(b) Expenditures for 1993–94 and 1997–98 have been converted to 2002–03 prices by adjusting for health price inflation.

(c) Some sources of funding are not included, for example private out-of-pocket funds.

Source: Department of Health and Ageing 2005.

15 Summary tables

This section presents a summary of mental health services data for each state and territory, and for Australia as a whole.

Listed below are the data sources from which the summary information was derived, as well as the corresponding chapter in this report in which the data and related analyses were described. Roman numerals are used in each summary table in this chapter to provide a link between the statistics shown with the data sources, as listed below.

i Bettering the Evaluation and Care of Health survey of general practitioners (Chapter 2)
ii Data provided by state and territory health authorities (Chapter 3)
iii National Community Mental Health Care Database (Chapter 4)
iv National Hospital Morbidity Database (Chapters 5 and 7)
v Medicare data (DoHA) (Chapters 6 and 14)
vi National Residential Mental Health Care Database (Chapter 8)
vii Supported Accommodation Assistance Program Client Collection (Chapter 9)
viii Commonwealth State/Territory Disability Agreement National Minimum Data Set (Chapter 10)
ix Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA) (Chapters 11 and 14)
x National Public Hospital Establishments Database (Chapters 12 and 14)
xi Private Health Establishments Collection (Chapters 12 and 14)
xii National Community Mental Health Establishments Database (Chapters 12 and 14)
xiii AIHW Medical Labour Force Survey (Chapter 13)
xiv AIHW Nursing and Midwifery Labour Force Survey (Chapter 13)
xv ABS Labour Force Survey (Chapter 13).

For further information on the scope and coverage of each of these data sources, refer to Appendix 1.

15.1 New South Wales

Table 15.1: Mental health services, New South Wales, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	3,375,000	3,375,000	3,405,000	3,013,000	n.a.	n.a.
95% LCL	3,059,000	3,059,000	3,204,000	2,975,000	n.a.	n.a.
95% UCL	3,691,000	3,691,000	3,606,000	3,043,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	48,223	n.a.
Community mental health care service contacts[(iii)]	620,469	942,307	1,301,233	1,431,729	1,363,770	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	27,950	31,677	32,579	32,026	32,950	n.a.
With specialised psychiatric care	22,084	25,528	26,473	26,752	28,093	n.a.
Public hospitals	8,078	8,749	8,893	8,310	7,155	n.a.
Private hospitals	14,006	16,779	17,580	18,442	20,938	n.a.
Without specialised psychiatric care	5,866	6,149	6,106	5,274	4,857	n.a.
Public hospitals	3,739	3,707	3,782	3,830	4,617	n.a.
Private hospitals	2,127	2,442	2,324	1,444	240	n.a.
Medicare-subsidised psychiatrist services[(v)]	686,572	693,192	666,357	637,448	627,107	615,006
Admitted patient mental health-related hospital separations[(iv)]	56,725	59,631	60,703	62,864	63,664	n.a.
With specialised psychiatric care	31,185	34,529	34,948	36,070	36,517	n.a.
Public hospitals	24,587	26,938	27,815	29,103	28,462	n.a.
Private hospitals	6,598	7,591	7,133	6,967	8,055	n.a.
Without specialised psychiatric care	25,540	25,102	25,755	26,794	27,147	n.a.
Public hospitals	22,779	22,373	23,165	24,305	25,995	n.a.
Private hospitals	2,761	2,729	2,590	2,489	1,152	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	388	n.a.
SAAP mental health-related closed support periods[(vii)]	3,516	3,377	3,001	3,276	3,569	n.a.
Accommodated	3,144	2,798	2,443	2,521	2,646	n.a.
Supported	372	579	558	755	923	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	6,217	6,492	n.a.
Residential care	n.a.	n.a.	n.a.	1,072	1,142	n.a.
Non-residential care	n.a.	n.a.	n.a.	5,993	6,172	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source:* Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

(i–viii) See page 144 for data sources.

Table 15.2: Mental health-related prescriptions, New South Wales, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	552,170	582,034	599,089	605,458	603,368	580,917
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	5,240,408	5,302,678	5,392,792	5,621,316	5,759,600	5,628,722

(ix) See page 144 for data source.

Table 15.3: Mental health facilities, New South Wales, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	9	9	9	10	10
Average available beds	1,046	1,075	1,166	1,237	1,161
Full-time-equivalent staff	2,468	2,462	2,534	2,693	2,703
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	35	34	42	44	42
Average available beds in specialised psychiatric units	n.a.	n.a.	810	911	895
Private psychiatric hospitals[b][xi]					
Number of hospitals	9	8	9	9	9
Average available beds	471	444	531	316	494
Full-time-equivalent staff	555	607	571	592	572
Government-operated community and residential mental health services[xii]					
Number of services[c]	19	19	19	19	10
Services providing residential care	7	9	6	7	5
Average available beds	206	161	138	137	138
Full-time-equivalent staff	2,593	2,937	3,305	3,304	3,157

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.4: Workforce: psychiatrists and mental health nurses, New South Wales, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xiii]	973	922	1,094	1,063	1,129	n.a.
Full-time-equivalent employed mental health nurses[xiv]	n.a.	4,257	n.a.	4,846	4,336	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.5: Mental health expenditure, current prices ($'000), New South Wales, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[x]	181,545	192,933	211,142	241,246	252,163	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[x]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[a] [xi]	55,314	53,504	58,519	57,518	56,228	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[xii]	201,436	243,788	297,624	314,728	311,718	n.a.
Medicare expenditure on services provided by psychiatrists[v]	64,190	65,674	64,809	64,937	69,831	70,604
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	28,762	32,720	35,135	36,939	38,685	40,036
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	106,613	121,343	133,912	147,926	154,736	155,988

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.2 Victoria

Table 15.6: Mental health services, Victoria, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	2,721,000	2,714,000	3,088,000	2,627,000	n.a.	n.a.
95% LCL	2,421,000	2,429,000	2,761,000	2,580,000	n.a.	n.a.
95% UCL	2,996,000	2,999,000	3,414,000	2,663,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	28,757	n.a.
Community mental health care service contacts[(iii)]	1,491,600	1,645,974	1,610,674	1,599,800	1,778,559	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	28,108	29,289	38,985	41,250	43,165	n.a.
With specialised psychiatric care	21,250	22,440	31,483	32,568	33,525	n.a.
Public hospitals	1,243	1,068	1,099	624	729	n.a.
Private hospitals	20,007	21,372	30,384	31,944	32,796	n.a.
Without specialised psychiatric care	6,858	6,849	7,502	8,682	9,640	n.a.
Public hospitals	4,368	5,050	5,129	5,758	5,593	n.a.
Private hospitals	2,490	1,799	2,373	2,924	4,047	n.a.
Medicare-subsidised psychiatrist services[(v)]	682,758	673,637	667,309	658,145	650,089	663,942
Admitted patient mental health-related hospital separations[(iv)]	44,768	45,177	47,913	48,558	49,227	n.a.
With specialised psychiatric care	23,798	23,377	24,341	25,097	24,858	n.a.
Public hospitals	17,938	17,776	17,712	18,192	17,356	n.a.
Private hospitals	5,860	5,601	6,629	6,905	7,502	n.a.
Without specialised psychiatric care	20,970	21,800	23,572	23,461	24,369	n.a.
Public hospitals	17,531	19,048	20,045	20,486	21,968	n.a.
Private hospitals	20,970	2,752	3,527	2,975	2,401	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	728	n.a.
SAAP mental health-related closed support periods[(vii)]	3,383	3,491	4,019	5,071	4,579	n.a.
Accommodated	1,529	1,514	1,689	1,872	2,188	n.a.
Supported	1,854	1,977	2,330	3,199	2,391	n.a.
CSTDA-funded service users with a psychiatric disability[(b)(viii)]	n.a.	n.a.	n.a.	8,585	9,121	n.a.
Residential care	n.a.	n.a.	n.a.	983	941	n.a.
Non-residential care	n.a.	n.a.	n.a.	8,396	8,954	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

(b) Advice was received from the Victorian Department of Human Services shortly before the publication of this report that there had been an error in the data supplied to the AIHW. In addition to those service users included in this table (and, more broadly, in this chapter), there were an additional 7,971 CSTDA-funded service users with a psychiatric disability in 2003–04 in Victoria and an additional 9,590 such service users in 2004–05. Given the late notification of this error, the information about these service users could not be incorporated into the data presented in this chapter.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

(i–viii) See page 144 for data sources.

Table 15.7: Mental health-related prescriptions, Victoria, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	527,532	532,700	547,564	560,968	578,440	567,175
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	4,327,830	4,402,151	4,496,990	4,713,821	4,891,159	4,843,466

(ix) See page 144 for data source.

Table 15.8: Mental health facilities, Victoria, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	1
Average available beds	95	95	95	115	115
Full-time-equivalent staff	186	216	237	245	249
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	32	32	37	31	31
Average available beds in specialised psychiatric units	n.a.	879	870	916	899
Private psychiatric hospitals[b][xi]					
Number of hospitals	7	6	6	6	6
Average available beds	304	359	358	378	423
Full-time-equivalent staff	363	463	525	508	517
Government-operated community and residential mental health services[xii]					
Number of services[c]	38	39	39	39	38
Services providing residential care[d]	30	31	31	31	30
Average available beds	906	883	893	891	907
Full-time-equivalent staff	2,982	3,142	3,522	3,255	3,563

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(d) The number of establishments providing residential care services reported to the National Community Mental Health Establishments Database (NCMHED) is larger than the number of establishments reporting to the National Residential Mental Health Care Database (NRMHCD) due to Victoria reporting specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.9: Workforce: psychiatrists and mental health nurses, Victoria, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	902	991	1,047	1,049	1,076	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	3,475	n.a.	3,659	3,955	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.10 Mental health expenditure, current prices ($'000), Victoria, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	24,958	n.a.	30,686	32,541	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	30,302	38,695	43,779	47,031	49,105	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(b)(xii)]	245,055	256,829	275,629	281,980	305,898	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	64,754	64,733	65,487	66,869	71,070	74,280
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	26,904	29,133	31,457	32,942	35,920	38,002
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	93,760	107,227	118,646	131,571	138,331	141,085

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(b) Victoria has included expenditure data for specialised aged care residential services in the National Mental Health Establishments Database that are not in-scope for the National Residential Mental Health Care Database.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.3 Queensland

Table 15.11: Mental health services, Queensland, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	1,803,000	1,807,000	1,787,000	1,925,000	n.a.	n.a.
95% LCL	1,601,000	1,598,000	1,653,000	1,860,000	n.a.	n.a.
95% UCL	2,024,000	2,016,000	1,922,000	1,971,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	21,393	n.a.
Community mental health care service contacts[(iii)]	619,068	705,895	779,527	889,011	901,706	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	18,213	23,593	23,386	23,813	24,810	n.a.
With specialised psychiatric care	14,303	19,135	19,256	19,233	19,743	n.a.
Public hospitals	3,228	3,571	3,405	3,930	3,924	n.a.
Private hospitals	11,075	15,564	15,851	15,303	15,819	n.a.
Without specialised psychiatric care	3,910	4,458	4,130	4,580	5,067	n.a.
Public hospitals	1,053	1,135	1,173	1,345	1,499	n.a.
Private hospitals	2,857	3,323	2,957	3,235	3,568	n.a.
Medicare-subsidised psychiatrist services[(v)]	359,679	349,352	344,217	344,548	352,380	365,911
Admitted patient mental health-related hospital separations[(iv)]	36,875	36,687	36,310	37,503	38,405	n.a.
With specialised psychiatric care	24,405	24,915	25,597	26,922	27,322	n.a.
Public hospitals	18,538	18,787	19,618	20,384	20,851	n.a.
Private hospitals	5,867	6,128	5,979	6,538	6,471	n.a.
Without specialised psychiatric care	12,470	11,772	10,713	10,581	11,083	n.a.
Public hospitals	8,905	8,596	8,024	8,083	8,422	n.a.
Private hospitals	3,565	3,176	2,689	2,498	2,661	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	. .	n.a.
SAAP mental health-related closed support periods[(vii)]	1,478	1,554	1,251	1,238	1,680	n.a.
Accommodated	1,267	1,331	991	910	1,326	n.a.
Supported	211	223	260	328	354	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	4,752	5,204	n.a.
Residential care	n.a.	n.a.	n.a.	203	166	n.a.
Non-residential care	n.a.	n.a.	n.a.	4,711	5,157	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

. . Not applicable.

(i–viii) See page 144 for data sources.

Table 15.12: Mental health-related prescriptions, Queensland, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	326,787	329,959	338,085	356,732	377,935	383,635
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	3,293,143	3,420,918	3,551,955	3,761,071	3,968,779	3,822,079

(ix) See page 144 for data source.

Table 15.13: Mental health facilities, Queensland, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	6	6	4	4	4
Average available beds	549	504	503	476	476
Full-time-equivalent staff	1,207	1,144	1,106	1,081	1,083
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	16	18	18	18	18
Average available beds in specialised psychiatric units	n.a.	795	887	904	908
Private psychiatric hospitals[b][xi]					
Number of hospitals	4	4	4	4	4
Average available beds	289	288	290	288	289
Full-time-equivalent staff	331	323	315	303	294
Government-operated community and residential mental health services[xii]					
Number of services[c]	90	101	95	97	96
Services providing residential care	0	0	0	0	0
Average available beds	0	0	0	0	0
Full-time-equivalent staff	1,221	1,293	1,374	1,443	1,517

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.14: Workforce: psychiatrists and mental health nurses, Queensland, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xiii]	457	437	434	463	474	n.a.
Full-time-equivalent employed mental health nurses[xiv]	n.a.	1,831	n.a.	2,254	2,369	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.15: Mental health expenditure, current prices ($'000), Queensland, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[x]	96,983	89,414	88,513	88,371	92,133	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[x]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[a] [xi]	24,129	25,596	28,931	30,231	30,359	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[xii]	90,764	96,473	105,761	113,950	129,001	n.a.
Medicare expenditure on services provided by psychiatrists[v]	31,331	30,807	30,886	31,830	34,632	36,695
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	16,364	17,250	18,172	19,842	22,036	23,579
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	69,365	79,299	87,228	96,150	102,103	99,493

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.4 Western Australia

Table 15.16: Mental health services, Western Australia, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	919,000	919,000	812,000	872,000	n.a.	n.a.
95% LCL	763,000	759,000	727,000	845,000	n.a.	n.a.
95% UCL	1,084,000	1,080,000	897,000	889,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	10,114	n.a.
Community mental health care service contacts[(iii)]	393,312	395,513	414,183	418,484	466,670	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	12,539	8,529	7,791	7,437	8,972	n.a.
With specialised psychiatric care	10,620	7,504	6,749	5,659	7,230	n.a.
Public hospitals	3,805	416	194	121	100	n.a.
Private hospitals	6,815	7,088	6,555	5,538	7,130	n.a.
Without specialised psychiatric care	1,919	1025	1,042	1,778	1,742	n.a.
Public hospitals	784	849	892	862	959	n.a.
Private hospitals	1,135	176	150	916	783	n.a.
Medicare-subsidised psychiatrist services[(v)]	118,919	115,039	111,539	121,962	121,072	119,611
Admitted patient mental health-related hospital separations[(iv)]	19,527	19,012	19,125	20,107	20,540	n.a.
With specialised psychiatric care	11,981	11,802	11,547	11,901	11,731	n.a.
Public hospitals	8,976	8,938	8,561	8,525	8,404	n.a.
Private hospitals	3,005	2,864	2,986	3,376	3,327	n.a.
Without specialised psychiatric care	7,546	7,210	7,578	8,206	8,809	n.a.
Public hospitals	6,237	6,149	6,621	6,299	6,349	n.a.
Private hospitals	1,309	1,061	957	1,907	2,460	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	203	n.a.
SAAP mental health-related closed support periods[(vii)]	1,030	1,242	809	590	601	n.a.
Accommodated	896	1,061	660	468	424	n.a.
Supported	134	181	149	122	177	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	1,936	1,711	n.a.
Residential care	n.a.	n.a.	n.a.	186	208	n.a.
Non-residential care	n.a.	n.a.	n.a.	1,915	1,675	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

(i–viii) See page 144 for data sources.

Table 15.17: Mental health-related prescriptions, Western Australia, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	137,503	147,528	155,695	170,534	174,534	164,526
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,583,940	1,661,063	1,715,581	1,808,835	1,860,899	1,802,423

(ix) See page 144 for data source.

Table 15.18: Mental health facilities, Western Australia, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	1
Average available beds	225	209	201	203	205
Full-time-equivalent staff	710	681	565	591	664
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	11	11	16	16	16
Average available beds in specialised psychiatric units	n.a.	391	391	393	414
Private psychiatric hospitals[b][xi]					
Number of hospitals	n.a.	3	3	n.a.	n.a.
Average available beds	n.a.	149	155	n.a.	n.a.
Full-time-equivalent staff	n.a.	140	148	n.a.	n.a.
Government-operated community and residential mental health services[xii]					
Number of services[c]	20	18	18	18	18
Services providing residential care	2	2	3	2	2
Average available beds	18	22	22	21	21
Full-time-equivalent staff	985	1,021	1,071	1,083	1,145

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.19: Workforce: psychiatrists and mental health nurses, Western Australia, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	308	274	233	271	247	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	950	n.a.	916	1,455	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.20: Mental health expenditure, current prices ($'000), Western Australia, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	48,452	51,765	46,280	48,957	53,132	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	n.a.	11,809	13,863	n.a.	n.a.	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(xii)]	74,371	82,697	85,216	97,265	110,670	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	10,379	9,976	9,759	11,077	11,972	12,177
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	6,536	7,230	7,664	8,385	9,032	9,117
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	32,517	38,410	42,783	47,802	49,685	48,197

(a) The ABS defined private psychiatric hospitals as those that are licensed/approved by each state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

(v–xv) See page 144 for data sources.

15.5 South Australia

Table 15.21: Mental health services, South Australia, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	946,000	948,000	1,030,000	1,078,000	n.a.	n.a.
95% LCL	787,000	788,000	882,000	1,040,000	n.a.	n.a.
95% UCL	1,105,000	1,108,000	1,178,000	1,102,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	15,426	n.a.
Community mental health care service contacts[(iii)]	241,080	280,056	314,085	311,535	298,459	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	1,817	1,656	2,409	1,749	1,389	n.a.
With specialised psychiatric care	1,055	788	1,443	689	294	n.a.
Public hospitals	1,043	646	242	268	263	n.a.
Private hospitals	12	142	1,201	421	31	n.a.
Without specialised psychiatric care	762	868	966	1,060	1,095	n.a.
Public hospitals	740	854	942	1,048	1,085	n.a.
Private hospitals	22	14	24	12	10	n.a.
Medicare-subsidised psychiatrist services[(v)]	209,764	201,371	202,988	192,073	182,959	180,380
Admitted patient mental health-related hospital separations[(iv)]	17,855	18,041	19,388	19,716	18,332	n.a.
With specialised psychiatric care	10,691	10,317	10,617	10,945	10,180	n.a.
Public hospitals	7,902	7,939	8,393	8,985	8,481	n.a.
Private hospitals	2,789	2,378	2,224	1,960	1,699	n.a.
Without specialised psychiatric care	7,164	7,724	8,771	8,771	8,152	n.a.
Public hospitals	6,264	6,926	7,958	7,949	7,438	n.a.
Private hospitals	900	798	813	822	714	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	91	n.a.
SAAP mental health-related closed support periods[(vii)]	718	762	649	830	934	n.a.
Accommodated	475	520	413	445	449	n.a.
Supported	243	242	236	385	485	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	2,095	2,143	n.a.
Residential care	n.a.	n.a.	n.a.	271	317	n.a.
Non-residential care	n.a.	n.a.	n.a.	2,000	2,027	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

(i–viii) See page 144 for data sources.

Table 15.22: Mental health-related prescriptions, South Australia, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	184,659	184,085	187,667	185,330	179,028	174,412
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,508,334	1,574,003	1,620,414	1,685,643	1,719,197	1,698,048

(ix) See page 144 for data source.

Table 15.23: Mental health facilities, South Australia, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	1
Average available beds	488	486	478	461	461
Full-time-equivalent staff	859	1,043	967	940	964
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	8	8	8	8	8
Average available beds in specialised psychiatric units	n.a.	176	172	172	172
Private psychiatric hospitals[b][xi]					
Number of hospitals	n.a.	n.a.	n.a.	n.a.	n.a.
Average available beds	n.a.	n.a.	n.a.	n.a.	n.a.
Full-time-equivalent staff	n.a.	n.a.	n.a.	n.a.	n.a.
Government-operated community and residential mental health services[xii]					
Number of services[c]	30	31	33	35	35
Services providing residential care	1	1	1	2	1
Average available beds	24	20	20	27	20
Full-time-equivalent staff	652	737	715	756	800

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.24: Workforce: psychiatrists and mental health nurses, South Australia, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	311	318	302	319	335	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	1,115	n.a.	1,098	1,072	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data source.

Table 15.25: Mental health expenditure, current prices ($'000), South Australia, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	90,517	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(xii)]	42,440	45,124	52,634	55,903	64,867	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	20,090	19,604	20,218	19,901	19,636	19,982
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	9,361	10,062	10,321	10,544	10,749	11,346
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	31,436	36,755	39,811	42,887	44,324	44,819

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.6 Tasmania

Table 15.26: Mental health services, Tasmania, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	247,000	246,000	279,000	329,000	n.a.	n.a.
95% LCL	153,000	153,000	235,000	281,000	n.a.	n.a.
95% UCL	339,000	340,000	321,000	346,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	4,539	n.a.
Community mental health care service contacts[(iii)]	44,715	48,286	51,314	67,581	64,317	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	67	76	75	65	56	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	111	184	176	233	285	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	43,868	43,387	46,653	48,115	46,190	44,316
Admitted patient mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	2,497	3,267	3,104	2,979	3,192	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	1,414	1,009	1,315	1,351	1,303	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	721	n.a.
SAAP mental health-related closed support periods[(vii)]	321	343	279	317	321	n.a.
Accommodated	236	202	165	160	158	n.a.
Supported	85	141	114	157	163	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	764	839	n.a.
Residential care	n.a.	n.a.	n.a.	183	193	n.a.
Non-residential care	n.a.	n.a.	n.a.	707	775	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

n.p. Not published.

(i–viii) See page 144 for data sources.

Table 15.27: Mental health-related prescriptions, Tasmania, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	42,943	43,484	45,126	47,361	43,356	42,265
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	536,473	560,909	576,194	604,037	618,098	626,298

(ix) See page 144 for data sources.

Table 15.28: Mental health facilities, Tasmania, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	4	3	3	3	3
Average available beds	27	40	80	69	69
Full-time-equivalent staff	173	n.a.	49	50	84
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	3	3	3	3	3
Average available beds in specialised psychiatric units	n.a.	74	74	86	86
Private psychiatric hospitals[b][xi]					
Number of hospitals	n.a.	n.a.	n.a.	n.a.	n.a.
Average available beds	n.a.	n.a.	n.a.	n.a.	n.a.
Full-time-equivalent staff	n.a.	n.a.	n.a.	n.a.	n.a.
Government-operated community and residential mental health services[xii]					
Number of services[c]	28	30	30	30	28
Services providing residential care	8	9	9	9	7
Average available beds	132	140	140	140	112
Full-time-equivalent staff	239	368	369	375	377

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.29: Workforce: psychiatrists and mental health nurses, Tasmania, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	49	57	63	71	68	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	282	n.a.	320	295	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.30: Mental health expenditure, current prices ($'000), Tasmania, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a) (xi)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(xii)]	18,328	27,483	26,381	27,604	31,105	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	3,643	3,615	3,974	4,209	4,122	3,999
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	1,701	1,846	2,018	2,148	2,191	2,549
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	9,812	11,090	12,005	13,354	13,821	13,952

(a) The ABS defined private psychiatric hospitals as those that are licensed/approved by each state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.7 Australian Capital Territory

Table 15.31: Mental health services, Australian Capital Territory, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[(a)(i)]	127,000	127,000	153,000	86,000	n.a.	n.a.
95% LCL	77,000	76,000	100,000	86,000	n.a.	n.a.
95% UCL	178,000	177,000	205,000	86,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	n.a.	2,248	n.a.
Community mental health care service contacts[(iii)]	137,529	156,108	178,751	167,541	198,666	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	70	53	30	4	32	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	22	38	40	102	113	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	19,442	19,595	21,305	21,454	22,534	22,301
Admitted patient mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	1,422	1,376	1,314	1,136	1,139	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	180	178	222	341	307	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	n.a.	63	n.a.
SAAP mental health-related closed support periods[(vii)]	448	470	531	523	408	n.a.
Accommodated	422	431	490	481	349	n.a.
Supported	26	39	41	42	59	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	n.a.	348	369	n.a.
Residential care	n.a.	n.a.	n.a.	34	19	n.a.
Non-residential care	n.a.	n.a.	n.a.	340	365	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

n.p. Not published.

(i–viii) See page 144 for data sources.

Table 15.32: Mental health-related prescriptions, Australian Capital Territory, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	23,637	23,880	30,492	27,815	27,327	27,059
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	208,035	226,314	258,968	246,843	249,254	221,828

(ix) See page 144 for data source.

Table 15.33: Mental health facilities, Australian Capital Territory, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a](x)					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Full-time-equivalent staff	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[a](x)					
Number of hospitals	2	2	2	2	2
Average available beds in specialised psychiatric units	n.a.	47	45	45	44
Private psychiatric hospitals[b](xi)					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Full-time-equivalent staff	. .	. .	. .	. .	. .
Government-operated community and residential mental health services[xii]					
Number of services[c]	2	2	2	2	2
Services providing residential care	1	1	1	1	1
Average available beds	20	23	30	28	28
Full-time-equivalent staff	181	207	249	220	226

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

. . Not applicable.

(x–xii) See page 144 for data sources.

Table 15.34: Workforce: psychiatrists and mental health nurses, Australian Capital Territory, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	56	45	56	50	44	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	212	n.a.	167	166	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.35: Mental health expenditure, current prices ($'000), Australian Capital Territory, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(xii)]	15,487	18,108	19,846	21,535	22,301	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	1,709	1,726	1,989	2,072	2,429	2,503
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	1,502	1,566	1,864	1,690	1,775	2,038
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	5,063	5,870	6,959	6,851	6,710	6,091

(a) ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

n.a. Not available.

. . Not applicable.

(v–xii) See page 144 for data sources.

Table 15.44: Workforce: psychiatrists, mental health nurses and psychologists, Australia, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	3,089	3,066	3,257	3,328	3,392	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	12,195	n.a.	13,306	13,714	n.a.
Full-time-equivalent employed psychologists[(a)(xv)]	8,500	9,500	10,200	10,800	11,000	11,900

(a) Information on full-time-equivalent employed psychologists is only reported at the national level only due to relative large standard errors for smaller states and territories in the ABS Labour Force survey data.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.45: Mental health expenditure, current prices ($'000), Australia, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	416,688	445,224	447,088	488,355	527,693	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	133,491	143,653	158,529	162,066	168,490	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(b)(xii)]	695,709	778,131	871,751	922,079	987,233	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	196,492	196,465	197,492	201,290	214,106	220,579
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	91,309	100,079	106,893	112,764	120,652	126,928
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	349,923	401,443	442,939	488,265	511,609	511,634

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(b) Victoria has included expenditure data for specialised aged care residential services in the National Mental Health Establishments Database that are not in-scope for the National Residential Mental Health Care Database.

n.a. Not available.

(v–xii) See page 144 for data sources.

Table 15.37: Mental health-related prescriptions, Northern Territory, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	4,163	5,013	4,881	4,972	4,841	4,179
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	57,577	58,385	59,276	62,174	67,339	66,101

(ix) See page 144 for data source.

Table 15.38: Mental health facilities, Northern Territory, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Full-time-equivalent staff	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	2	2	2	2	2
Average available beds in specialised psychiatric units	n.a.	31	32	31	32
Private psychiatric hospitals[b][xi]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Full-time-equivalent staff	. .	. .	. .	. .	. .
Government-operated community and residential mental health services[xii]					
Number of services[c]	6	6	6	6	7
Services providing residential care	0	0	0	0	0
Average available beds	0	0	0	0	0
Full-time-equivalent staff	80	80	82	80	94

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

. . Not applicable.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.39: Workforce: psychiatrists and mental health nurses, Northern Territory, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	32	20	29	36	20	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	93	n.a.	54	77	n.a.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.40: Mental health expenditure, current prices ($'000), Northern Territory, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(xii)]	7,829	7,629	8,660	9,114	11,673	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	414	341	371	396	413	340
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	180	272	262	274	266	262
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	1,356	1,450	1,595	1,724	1,898	2,009

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

. . Not applicable.

n.a. Not available.

(v–xii) See page 144 for data sources.

15.9 Australia

Table 15.41: Mental health services, Australia, 2000–01 to 2005–06

Mental health services	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Estimated number of mental health-related general practice encounters[a][i]	10,192,000	10,143,000	9,986,000	9,828,000	n.a.	n.a.
95% LCL	9,592,000	9,612,000	9,607,000	9,689,000	n.a.	n.a.
95% UCL	10,692,000	10,674,000	10,366,000	9,956,000	n.a.	n.a.
Mental health-related occasions of service in emergency departments in public hospitals[ii]	n.a.	n.a.	n.a.	n.a.	133,403	n.a.
Community mental health care service contacts[iii]	3,584,469	4,203,731	4,672,423	4,911,735	5,108,524	n.a.
Ambulatory-equivalent mental health-related hospital separations[iv]	90,892	97,796	108,946	111,581	116,787	n.a.
With specialised psychiatric care	71,013	77,189	87,219	86,765	92,369	n.a.
Public hospitals	17,580	14,620	13,966	13,349	12,285	n.a.
Private hospitals	53,433	62,569	73,253	73,416	80,084	n.a.
Without specialised psychiatric care	19,879	20,607	21,727	24,816	24,418	n.a.
Public hospitals	10,857	11,878	12,222	13,249	14,248	n.a.
Private hospitals	9,022	8,729	9,505	11,567	10,170	n.a.
Medicare-subsidised psychiatrist services[v]	2,126,538	2,100,126	2,065,090	2,028,467	2,007,218	2,015,941
Admitted patient mental health-related hospital separations[iv]	183,981	187,043	192,169	197,712	199,353	n.a.
With specialised psychiatric care	107,474	110,969	113,045	116,725	116,852	n.a.
Public hospitals	82,643	85,768	87,343	90,230	89,059	n.a.
Private hospitals	24,831	25,201	25,702	26,495	27,793	n.a.
Without specialised psychiatric care	76,507	76,074	79,124	80,987	82,501	n.a.
Public hospitals	63,575	64,542	67,662	69,135	72,111	n.a.
Private hospitals	12,932	11,532	11,462	11,852	10,390	n.a.
Episodes of residential mental health care[vi]	n.a.	n.a.	n.a.	n.a.	2,194	n.a.
SAAP mental health-related closed support periods[vii]	11,176	11,426	10,754	12,024	12,227	n.a.
Accommodated	8,137	7,976	7,017	7,003	7,634	n.a.
Supported	3,039	3,450	3,737	5,021	4,593	n.a.
CSTDA-funded service users with a psychiatric disability[viii]	n.a.	n.a.	n.a.	24,753	25,922	n.a.
Residential care	n.a.	n.a.	n.a.	2,958	3,007	n.a.
Non-residential care	n.a.	n.a.	n.a.	24,108	25,156	n.a.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of GP Medicare services reported by DoHA. *Source*: Britt et al. 2004.

Note: LCL – lower confidence limit; UCL – upper confidence limit.

n.a. Not available.

(i–viii) See page 144 for data sources.

Table 15.42: Mental health-related prescriptions, Australia, 2000–01 to 2005–06[ix]

Mental health-related prescriptions	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
PBS and RPBS-subsidised prescriptions by psychiatrists	1,799,394	1,848,683	1,908,599	1,959,170	1,988,829	1,944,168
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	16,755,740	17,206,421	17,672,170	18,503,740	19,134,325	18,708,965

(ix) See page 144 for data source.

Table 15.43: Mental health facilities, Australia, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[a][x]					
Number of hospitals	22	21	19	20	20
Average available beds	2,430	2,409	2,523	2,560	2,487
Full-time-equivalent staff	5,601	5,545	5,458	5,600	5,748
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	109	110	128	124	122
Average available beds in specialised psychiatric units	n.a.	n.a.	3,281	3,458	3,450
Private psychiatric hospitals[b][xi]					
Number of hospitals	24	24	25	25	26
Average available beds	1,369	1,387	1,463	1,441	1,512
Full-time-equivalent staff	1,566	1,707	1,704	1,672	1,680
Government-operated community and residential mental health services[xii]					
Number of services[c]	233	246	242	246	234
Services providing residential care[d]	49	53	50	52	46
Average available beds	1,306	1,249	1,241	1,246	1,226
Full-time-equivalent staff	8,933	9,785	10,420	10,783	10,879

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(d) The number of establishments providing residential care services reported to the National Community Mental Health Establishments Database (NCMHED) is larger than the number of establishments reporting to the National Residential Mental Health Care Database (NRMHCD) due to Victoria reporting specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.

n.a. Not available.

(x–xii) See page 144 for data sources.

Table 15.44: Workforce: psychiatrists, mental health nurses and psychologists, Australia, 2000 to 2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[(xiii)]	3,089	3,066	3,257	3,328	3,392	n.a.
Full-time-equivalent employed mental health nurses[(xiv)]	n.a.	12,195	n.a.	13,306	13,714	n.a.
Full-time-equivalent employed psychologists[(a)(xv)]	8,500	9,500	10,200	10,800	11,000	11,900

(a) Information on full-time-equivalent employed psychologists is only reported at the national level only due to relative large standard errors for smaller states and territories in the ABS Labour Force survey data.

n.a. Not available.

(xiii–xiv) See page 144 for data sources.

Table 15.45: Mental health expenditure, current prices ($'000), Australia, 2000–01 to 2005–06

Mental health expenditure	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06
Total recurrent expenditure for public psychiatric hospitals[(x)]	416,688	445,224	447,088	488,355	527,693	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total recurrent expenditure for private psychiatric hospitals[(a)(xi)]	133,491	143,653	158,529	162,066	168,490	n.a.
Total recurrent expenditure for government-operated community and residential mental health services[(b)(xii)]	695,709	778,131	871,751	922,079	984,976	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	196,492	196,465	197,492	201,290	214,106	220,579
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	91,309	100,079	106,893	112,764	120,652	126,928
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	349,923	401,443	442,939	488,265	511,609	511,634

(a) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(b) Victoria has included expenditure data for specialised aged care residential services in the National Mental Health Establishments Database that are not in-scope for the National Residential Mental Health Care Database.

n.a. Not available.

(v–xii) See page 144 for data sources.

Appendix 1: Data sources

In order to present a broad picture of mental health-related care in Australia, this report uses data drawn from a variety of sources. These data sources include AIHW databases such as the National Hospital Morbidity Database (NHMD), the National Public Hospital Establishments Database (NPHED) and the National Community Mental Health Establishments Database (NCMHED), for which data were supplied under the National Health Information Agreement and specified in the National Minimum Data Sets (NMDSs) for Mental Health Care in the *National health data dictionary*, Version 13 (HDSC 2006).

This report also presents data from other AIHW data collections such as the AIHW labour force surveys, the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity, the Supported Accommodation Assistance Program (SAAP) National Data Collection and the Commonwealth State/Territory Disability Agreement (CSTDA) National Minimum Data Set collection.

Data from collections external to the AIHW were also used, including the Australian Bureau of Statistics' Private Health Establishments Collection (PHEC) and the Department of Health and Ageing's Medicare, Pharmaceutical and Repatriation Pharmaceutical Benefits Schemes (MBS, PBS and RPBS) data collections.

The characteristics of each of the data sources used in this report should to be considered when interpreting the data. The data sources used in this report are briefly described below.

AIHW labour force surveys: Medical Labour Force Survey, Nursing and Midwifery Labour Force Survey and Psychology Labour Force Survey (Chapter 13)

The AIHW Medical Labour Force Survey and the Nursing and Midwifery Labour Force Survey are conducted by the state and territory departments of health with the cooperation of the medical and nursing registration boards in each jurisdiction, and in consultation with the AIHW. The AIHW is the data custodian for these national collections and is responsible for collating, editing and weighting the survey data.

The Medical Labour Force Survey is a census of all registered medical practitioners in each state and territory in Australia. The Nursing and Midwifery Labour Force Survey is a census of all registered nurses and midwives in each state and territory in Australia. The surveys are a mail-out survey conducted in association with the annual registration renewal process. The Medical Labour Force Survey has been conducted annually since 1993. The Nursing and Midwifery Labour Force Survey was conducted every 2 years from 1995 to 2003, and annually since then.

In the surveys, information on demographic details, main areas and specialty of work, qualifications and hours worked are collected from registered professionals. The data collected generally relate to the 4 weeks before the survey for medical practitioners and to the week before the survey for nurses. Average weekly hours worked refers to average total hours worked per week in the main, second and third medical job for medical practitioners, and the main and second nursing jobs for nurses.

Survey responses are weighted by state, age and sex (and the number of registered and enrolled nurses for nursing) to produce state and territory and national estimates of the total

medical and nursing and midwifery labour force. Benchmarks for weighting come from registration information provided by state and territory registration boards.

The response rates to these surveys vary from year to year and across jurisdictions. While the response rate for the Medical Labour Force Survey has stayed fairly stable over the 5 years to 2004, there has been a decline in the response rate for the Nursing and Midwifery Labour Force Survey from 78.1% in 1999 to 59.8% in 2004. In 2004, the estimated national response rate for the Medical Labour Force Survey was 71.4%, and it ranged from 43.8% in the Northern Territory to 87.5% in Queensland. For the Nursing and Midwifery Labour Force Survey, in 2004 the overall response rate was 59.8%, ranging from 35.1% in the Northern Territory and 37.7% in Western Australia to 71.2% in South Australia and 71.1% in the Australian Capital Territory.

It should also be noted that, for both surveys (although more so for the nursing than for the medical survey), the questionnaires have varied over time and across jurisdictions. Mapping of data items has been undertaken to provide time series data. However, because of this and the variation in response rates, some caution should be used in interpreting change over time and differences across jurisdictions. This is particularly the case for mental health nurses, as the definition of these is reliant on the responses to one particular question within the questionnaire.

More detailed information about how these surveys were conducted is available from the *Medical labour force 2004* (AIHW 2006f) and *Nursing and midwifery labour force 2004* (AIHW 2006g).

The AIHW Psychology Labour Force Survey was conducted in 2003 using a similar methodology to the Medical and Nursing and Midwifery Labour Force Surveys. However, only five jurisdictions participated in the AIHW Psychology Labour Force Survey (namely, New South Wales, Victoria, Queensland, South Australia and the Australian Capital Territory). Registered psychologists in each of the participating states and territory were surveyed at the time of registration renewal. The data generally relate to the week before the survey. Average weekly hours worked refers to average total hours worked per week in the main and second psychology job.

The overall response rate for the five jurisdictions was 55.7%, although it ranged from a low of 29.5% in Victoria to 76.1% in New South Wales. Queensland did not report on the sex of respondents. Survey data have been weighted, using registration data, to produce estimates of the total psychology labour force in participating jurisdictions. The latest information on this survey is published in *Psychology labour force 2003* (AIHW 2006h).

The AIHW labour force survey data presented in this report are estimates, based on weighted responses. As a result, row and column numbers may not add to totals due to rounding.

Australian Bureau of Statistics Labour Force Survey (Chapter 13)

The ABS Labour Force Survey was first run in 1960 and is the basis for official estimates of employment and unemployment in Australia. It is based on a multi-stage area sample of private dwellings (currently about 30,000 houses and flats) and a list sample of non-private dwellings (for example, hotels and motels), and covers about 0.45% of the population of Australia. Information is obtained from the occupants of selected dwellings by trained interviewers. The ABS Labour Force Survey collects a wide range of information on both employed and unemployed people. All information, including occupation, is self-reported by respondents. The information about employment relates to the week before the interview.

ABS Labour Force Survey estimates are calculated in such a way as to add up to independent estimates of the civilian population aged 15 years and over (that is, population benchmarks).

The ABS Labour Force Survey is based on a sample of households and, as a result, is subject to sampling variability and relatively large standard errors for small populations and occupations. As this limitation applies to psychologists, the level of disaggregation possible with these data is limited.

Descriptions of the sources and methods used in compiling the estimates from the ABS Labour Force Survey are available from *Labour Statistics: Concepts, Sources and Methods* (ABS 2006a).

Bettering the Evaluation and Care of Health survey (Chapter 2)

The BEACH survey of general practice activity is a collaborative study between the AIHW and the University of Sydney. For each year's data collection, a random sample of about 1,000 general practitioners each report details of 100 consecutive general practice encounters of all types on structured encounter forms. Each form collects information about the consultations (for example, date and type of consultation), the patient (for example, date of birth, sex, and reasons for encounter), the problems managed and the management of each problem (for example, treatment provided, prescriptions and referrals). Data on patient risk factors, health status and general practitioner characteristics are also collected.

Additional information on the 2003–04 BEACH survey can be obtained from *General practice activity in Australia 2003–04* (Britt et al. 2004).

Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (Chapter 10)

Data pertaining to the CSTDA are collected through the CSTDA National Minimum Data Set (NMDS). This NMDS, which is managed by the AIHW, facilitates the annual collation of nationally comparable data about CSTDA-funded services. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA. A funded agency may receive funding from multiple sources. Where a funded agency is unable to differentiate service users according to funding source (that is, CSTDA or other), they are asked to provide details of all service users.

With the exceptions noted below, agencies funded under the CSTDA are asked to provide information about:

- each of the service types they are funded to provide (that is, service type outlets they operate);
- all service users who received support over a specified period; and
- the CSTDA NMDS service type(s) the service users received.

However, certain service type outlets—such as those providing advocacy or information and referral services—are not requested to provide any service user details while other service type outlets (such as recreation and holiday programs) are only asked to provide minimal service user details.

The 2003–04 collection was the first full financial year of data available, with an overall service type outlet response rate of 93%. The data were reported in *Disability support services 2003–04* (AIHW 2005a). The most recent data available is for the 2004–05 collection period

were released in *Disability support services 2004–05* (AIHW 2006c). For the 2004–05 collection, there was an overall service type outlet response rate of 94%.

The collection includes those disability support service providers that receive funding under the CSTDA, including psychiatric-specific disability service providers, as well as other disability service providers that may be accessed by persons with a psychiatric disability. It should be noted that the CSTDA does not apply to the provision of services with a specialist clinical focus. In addition, the collection does not include psychiatric-specific disability support services that are not funded through the CSTDA.

There is some variation between jurisdictions in the services included under the CSTDA as follows:

- In New South Wales, psychiatric-specific disability services are provided by the New South Wales Department of Health and are not included in the CSTDA NMDS collection.
- In Victoria, psychiatric-specific disability services are included in the CSTDA NMDS collection.
- In Queensland, psychiatric-specific disability services that receive CSTDA funding through Disability Services Queensland are included in the CSTDA NMDS collection.
- In Western Australia, only some psychiatric disability services are included in the CSTDA NMDS collection. The health department is the main provider of services for people with a psychiatric disability and these services are not included.
- Tasmania, the Australian Capital Territory and the Northern Territory do not include any services classified as 'psychiatric disability services'. However, these jurisdictions do provide 'mental health services'. There appears to be no sharp distinction between what is classified as a 'psychiatric disability service' and a 'mental health service', with some mental health services providing support to people with psychiatric disability.

Medicare data (Chapter 6)

Medicare Australia (formerly known as the Health Insurance Commission) collects data on the activity of all providers that make claims through the Medicare Scheme and it provides this information to DoHA. Information collected includes the type of service provided (Medicare item number) and the benefit paid by Medicare for the service. The item number and benefits paid by Medicare are based on the *Medicare Benefits Schedule Book* (DoHA 2006b).

The Medicare data presented in this report refer only to services that were performed by a recognised psychiatrist (with the exception of ECT, which can be claimed by medical practitioners other than psychiatrists) qualified for a Medicare benefit, and for which a claim was processed by Medicare Australia in the reporting period. They relate to services provided on a 'fee-for-service' basis for which Medicare benefits were paid.

Services that are not included in Medicare are not included in the data.

Under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative announced by the Commonwealth Government in 2006, new mental health-related Medicare items were introduced to the MBS (items 296–299) in November 2006 (DoHA 2006a). These are not included in this report as the latest time period for which data are reported is 2005–06.

In the Medicare data, the state or territory is determined according to the postcode of the patient's mailing address at the time of making the claim. In some cases, this will not be the same as the postcode of the patient's residential address. The year is determined from the

date the service was processed by Medicare Australia, rather than the date the service was provided.

Mental health-related emergency department data (Chapter 3)

While there is no national agreement on the collection of information on mental health-related services provided by emergency departments in hospitals in Australia, states and territories agreed to provide the AIHW with aggregate data to compile national information on mental health-related occasions of service provided by emergency departments in public hospitals.

All state and territory health authorities collect a core set of nationally comparable information on most of the emergency department occasions of service in public hospitals within their jurisdiction. This episode-level data are compiled annually by the AIHW to form the National Non-admitted Patient Emergency Department Care Database (NAPEDCD) (AIHW 2006b). The data are collected by state and territory health authorities according to definitions in the NAPEDC National Minimum Data Set (NMDS) and cover occasions of service provided in emergency departments of public hospitals categorised in the previous financial year as peer groups A (that is, principal referral and specialist women's and children's hospitals) and B (large hospitals). For 2004–05, data were also collected by some states and territories for hospitals in peer groups other than A and B.

The total number of emergency department occasions of service for all public hospitals in 2004–05 was 5,993,248. Episode-level data were collected by state and territory health authorities departments for 76% of these occasions of service (a total of 4,529,412 occasions of service) (AIHW 2006b:99). Episode-level data were available for 99% of all emergency department occasions of service for public hospitals in peer groups A and B, and approximately 26% of emergency department occasions of service for other public hospitals.

Definition of mental health-related emergency department occasions of service

While, as noted above, there is a national data compilation of episode-level data on emergency department occasions of service (the NAPEDCD), there is currently no national agreement to collect information on the principal diagnosis for emergency department occasions of service. In addition, there is no standard or agreed classification for diagnoses in use across emergency departments that could be used uniformly to identify mental health-related care, or any other data item (such as, based on referral, reason for the occasion of service, intentional self-harm codes, mental health flags) that is collected in a nationally consistent manner that would allow for the identification of mental health-related occasions of service in emergency departments. Thus, it is difficult to identify and report on mental health-related emergency department occasions of service in a comparable manner across jurisdictions.

However, in 2004–05, all jurisdictions did collect some information on the principal diagnosis of an estimated 93% of emergency service department occasions of service for which they reported episode-level data to the NAPEDCD. As a result, it was determined that a definition of 'mental health-related' based on the collected diagnosis information could be applied nationally, for the purposes of compiling data for this publication.

Data on mental health-related emergency department occasions of service reported in Chapter 3 of this report have been provided by the state and territory health authorities according to the following definition: 'occasions of service in public hospital emergency

departments that have a principal diagnosis of 'Mental and behavioural disorders' (i.e., codes F00–F99) in ICD-10-AM or the equivalent codes in ICD-9-CM'.

This definition does not capture all mental health-related presentation to emergency departments and the caveats listed below should be taken into consideration when interpreting the data presented on mental health-related emergency department occasions of service.

Most jurisdictions had coded the principal diagnosis of emergency department occasions of service in 2004–05 using ICD-10-AM. However, ICD-9-CM was used for emergency department occasions of service reported in South Australia, and for some of those in New South Wales. A mapping of the relevant ICD-10-AM codes to ICD-9-CM codes was undertaken to assist those states using ICD-9-CM to provide data (Table A1.1).

Aggregate data on the demographic characteristics of the patients, the triage category, departure status and the diagnosis category were provided by all states and territories to AIHW for occasions of service that met the definition of a mental health-related occasion of service.

Table A1.1: Mental health-related emergency department occasions of service, principal diagnosis codes included, ICD-10-AM and ICD-9-CM

ICD–10–AM[(a)] codes	ICD–9-CM[(b)] codes
F00–F09: Organic, including symptomatic, mental disorders	290, 293, 294, 310
F10–F19: Mental and behavioural disorders due to psychoactive substance use	291, 292, 303, 304, 305 (excl. 305.8 and 305.9)
F20–F29: Schizophrenia, schizotypal and delusional disorders	295, 297, 298 (excl. 298.0, 298.1, 298.2), 301.22
F30–F39: Mood (affective) disorders	296, 298.0, 298.1, 300.4, 301.1, 311
F40–F48: Neurotic, stress-related and somatoform disorders	2982, 300 (excl. 300.4, 300.19), 306 (excl. 306.3, 306.51, 306.6), 307.53, 307.80, 307.89, 308, 309 (excl. 309.21, 309.22)
F50–F59: Behavioural syndromes associated with physiological disturbances and physical factors	302.7, 305.8, 305.9, 306.3, 306.51, 306.6, 307.1, 307.4, 307.5 (excl. 307.53), 316, 648.44
F60–F69: Disorders of adult personality and behaviour	300.19, 301 (excl. 301.1, 301.22), 302 (excl. 302.7), 312.3
F70–F79: Mental retardation	317, 318, 319
F80–F89: Disorders of psychological development	299, 315, 330.8
F90–F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	307.0, 307.2, 307.3, 307.6, 307.7, 307.9, 309.21, 309.22, 312 (excl. 312.3), 313, 314
F99: Unspecified mental disorder	—

(a) International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification.

(b) International Classification of Diseases, 9th revision, Clinical Modification.

Caveats

To ensure that the data on emergency department mental health-related occasions of service are interpreted correctly, the following should be noted:

- there is no nationally agreed-upon method of identifying mental health-related occasions of service in emergency departments;
- there is no standard diagnosis classification in use across states and territories in relation to emergency department data;

- there is no standard way to disaggregate those occasions of service identified as mental health-related into subcategories of mental health conditions; and
- not all potential mental health-related emergency department occasions of service are represented in the data, for the following reasons:
  - not all emergency department occasions of service are collected by state and territory authorities at the episode-level;
  - not all occasions of service episode-level data collected by state and territory authorities include diagnosis information;
  - the principal diagnosis codes included in the definition do not cover all mental health-related conditions; and
  - the mental health-related condition or illness may not have been coded as the diagnosis, if it was either not diagnosed by the emergency department or was not recognised as a reason for presentation at an emergency department.
  - The definition is based on a single diagnosis only. As a result, if a mental health-related condition was reported as a second or other diagnosis and not as the 'principal diagnosis', the occasion of service will not be included as mental health-related.

It should also be noted that the data refer to occasions of service and not to individuals. An individual may have had multiple occasions of service within the same year.

Coverage

As noted above, episode-level data were available for 76% of public hospital emergency department occasions of service for public hospitals in 2004–05, and that these data are mainly from the larger metropolitan hospitals (Table A1.2). Of the data available on emergency department occasions of service, it is estimated that 93% had a diagnosis code.

Using these figures, and assuming that mental health-related occasions of service are evenly distributed, it can be roughly estimated that the number of mental health-related occasions of service reported in this publication represents around 70% of all public hospital emergency department mental health-related occasions of service as defined above. Taking this into account, the actual number of such occasions of service would be closer to 190,000 than the reported 133,403 (Table A1.2).

In addition, it should be noted that coverage of the data are biased toward the larger metropolitan emergency departments; mental health-related occasions of service in smaller rural hospitals may differ from those in the larger metropolitan hospitals.

Table A1.2: Emergency department occasions of service in public hospitals, estimated coverage and estimated actual number, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Estimated % of total public hospital emergency department occasions of service with episode-level data for the following hospital groups:[a]									
Peer group A&B[b]	*100*	*100*	*98*	*97*	*100*	*99*	*100*	*100*	*99*
Other hospitals	*32*	*40*	*0*	*32*	*22*	*0*	*n.a.*	*100*	*26*
Total estimated %	**76**	**88**	**64**	**68**	**68**	**84**	**100**	**100**	**76**
Estimated % of occasions of service reported at episode-level that have a principal diagnosis code[c]	95	95	100	71	86	100	83	92	93
Estimated % of total emergency department occasions of service with a principal diagnosis[d]	72	83	64	48	58	84	83	92	70
Number of emergency department occasions of service with a 'mental health-related' principal diagnosis[e]	48,223	28,757	21,393	10,114	15,426	4,539	2,248	2,703	133,403
Estimated actual number of emergency department occasions of service with a 'mental health-related' principal diagnosis[f]	67,000	34,000	33,000	21,000	26,000	5,000	3,000	3,000	190,000

(a) The proportion of all occasions of service in emergency departments in public hospitals in 2004-05 that are reported at episode-level to the NAPEDCD.

(b) Peer group A: Principal referral and specialist women's and children's hospitals; Peer group B: Large hospitals.

(c) The proportion of emergency department occasions of service reported at episode-level to the NAPEDCD that had a diagnosis. Total is estimated based on state and territory proportions and numbers.

(d) Calculated by multiplying the total % of all occasions of service in emergency departments in public hospitals in 2004–05 that are reported at episode-level to the NAPEDCD by the % of emergency department occasions of service reported at episode-level to the NAPEDCD that had a diagnosis (divided by 100).

(e) Number of 'mental health-related emergency department occasions of service' as defined for the purposes of this publication, and provided by state and territory health authorities.

(f) Estimate of the actual number of 'mental health-related emergency department occasions of service', as defined for the purposes of this publication, if coverage were 100 per cent.

n.a. Not available.

Source: Data provided by state and territory health authorities, AIHW 2006.

Additional data on mental health-related emergency department occasions of service

Because the above definition does not identify all possible mental health-related occasions of service in emergency departments, jurisdictions were asked to provide additional data, if possible, according to the following two definitions:

> Definition 2: Other emergency department occasions of service that were coded as related to intentional self-harm (or attempted suicide), excluding those captured under the main definition and those that only had a flag for previous intentional self-harm.
>
> Definition 3: Other emergency department occasions of service that could be considered to be mental health-related, excluding those captured under the main or second definition.

As only one-half of the jurisdictions could provide data under definition 2 or 3, and the actual specifications used to extract the data varied across those jurisdictions, the additional data are not published in the main body of this report. However, the following information provided by Victoria is presented as an indication of the relative number of emergency

department occasions of service that could be considered 'mental health-related' under these broader definitions. These are in addition to the 28,757 occasions of service reported by Victoria under the main definition.

Definition 2: Victoria reported 6,517 occasions of service in 2004–05 based on the most likely role of human intent in the occurrence of an injury or poisoning being self-harm (as assessed by a clinician).These were in addition to any self-harm occasions of service that also had a principal diagnosis of 'Mental and behavioural disorders' (ICD-10-AM codes F00–F99) and thus already included under the main definition.

Definition 3: Victoria reported 5,153 occasions of service identified as those that had a diagnosis of 'Mental and behavioural disorders' (ICD-10-AM codes F00–F99) in the second or third diagnosis, or had a diagnosis code of 'General psychiatric examination requested by authority' (ICD-10-AM code Z04.6) or 'Personal history of self-harm' (ICD-10-AM code Z91.5) recorded. These occasions of service were in addition to those captured under the main and second definitions.

National Aboriginal and Torres Strait Islander Health Survey (Chapter 1)

The 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) is a health survey of Indigenous Australians conducted by the ABS on a sample of 10,439 persons (or about one in 45 of the total Indigenous population). The survey was conducted in remote and non-remote areas throughout Australia, with the purpose of collecting a range of information from Indigenous Australians about health-related issues.

The 2004–05 NATSIHS collected data on the social and emotional wellbeing of Indigenous adults for the first time. The module included selected questions from the Kessler 10 Scale of Psychological Distress (K10) and the Medical Outcome Short Form (SF–36) Health Survey, as well as questions related to feelings of anger, the impact of psychological distress, cultural identification and stressors (ABS 2006b).

National Community Mental Health Care Database (Chapter 4)

Scope

The National Community Mental Health Care Database (NCMHCD) includes data on service contacts provided by government-operated community mental health services. The data collated in the NCMHCD are specified by the NMDS for Community Mental Health Care. The NCMHCD contains data on client demographics, including information such as age and sex, and data on each individual service contact, such as principal diagnosis and mental health legal status. Detailed specifications for the NMDS for Community Mental Health Care can be found in METeOR, the AIHW's online metadata registry, at <www.aihw.gov.au>.

The scope for this collection is all ambulatory mental health service contacts provided by the government-operated community mental health services that are included in the NMDS for Community Mental Health Establishments.

A list of the government-operated community mental health services contributing this patient-level data to NCMHCD can be found online in the 'Internet only tables' section that accompanies this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2004–05*).

A mental health service contact for the purposes of this collection was defined as the provision of a clinically significant service by a specialised mental health service provider(s) for patient/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24-hour staffed specialised residential mental health services where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the relevant period (that is, 2004-05). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also either be with the patient or with a third party, such as a carer or family member, and/or other professional or mental health workers or other service providers.

It should be noted that there is some variation across jurisdictions as to what is classified as a service contact. For example, New South Wales, Queensland, South Australia and Tasmania may include written correspondence as service contacts, while others do not.

Coverage

The NCMHCD was agreed to be collected from 1 July 2000 and collated for the first year during 2002. Each year of the collection has seen an increase in the number of service contacts, probably reflecting, to some degree, improved coverage of the data collection.

States and territories provided estimates of their coverage for 2004–05 as a proportion of full coverage:

- New South Wales estimated their coverage for 2004–05 to be around 70% of full coverage;
- Victoria estimated their coverage for 2004–05 to be 83–85%;
- Queensland stated that all in-scope services are currently recording service contact data; however, within these services it is estimated that only 50–55% of the expected number of service contacts are being recorded. Queensland based these estimates on duration of the service contacts and full-time-equivalent staff numbers for the services;
- Western Australia estimated 98% coverage for 2004–05 based on compliance from services within the jurisdiction;
- South Australia estimated their coverage to be from 88% to 92%, depending on methods used when estimating;
- Tasmania estimated that they collected approximately 55% of potential service contacts for 2004–05. This is based on assumptions regarding service delivery models;
- the Australian Capital Territory report their coverage to be 98.9%; and
- the Northern Territory estimated 90% coverage based on all in-scope services reporting, but there being some missing data due to non-compliance of some clinicians.

Quality of Indigenous identification

Data from the NCMHCD on Indigenous status should be interpreted with caution. Across the jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown.

All states and territories provided information on the quality of the Indigenous data for the NCMHCD 2004–05 as follows:

- New South Wales stated that the quality of Indigenous data has not been evaluated;

- Victoria considered the quality of Indigenous data was not acceptable due to lack of consistency in data entry across its services;
- Queensland reported that the quality of Indigenous data are acceptable at a broad level, that is, in distinguishing Indigenous Australians and other Australians. However, they believe that there are quality issues regarding the coding of more specific details (that is, 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander'). Queensland reported that several strategies have been implemented to improve the quality of Indigenous data and noted that a replacement for the existing collection system with in-built validation checks would further improve the quality of this data;
- Western Australia reported that the quality of Indigenous status data for 2004–05 was acceptable. However, the data could be improved with the appropriate resources, training and reporting standards;
- South Australia indicated that there has been limited analysis of the quality of Indigenous status data. Therefore, the quality of the data are uncertain at this stage;
- Tasmania reported the quality of its data to be acceptable;
- the Australian Capital Territory considered the quality of its Indigenous status data to be acceptable, noting that there is some room for improvement regarding the reporting of the 'Not stated' category; and
- the Northern Territory indicated its Indigenous status data to be of acceptable quality.

Principal diagnosis data quality

It should also be noted that there is variability across the states and territories in the data collection and coding practices in relation to principal diagnosis in the NCMHCD; this may also affect data quality. In particular, there are:

- differences among states and territories in the classification used. Six of the state and territory health authorities used the complete ICD-10-AM classification to code principal diagnosis. However, New South Wales used a combination of ICD-10-AM and the International Classification of Diseases, 10th revision, Primary Care (ICD-10-PC), and the Northern Territory used only the 'Mental and behavioural disorders' chapter of the ICD-10-AM classification;
- differences according to the size of the facility (for example, large versus small) in the ability to accurately code principal diagnosis;
- differences in the availability of appropriate clinicians to assign principal diagnoses (diagnoses are generally to be made by psychiatrists, whereas service contacts are mainly provided by non-psychiatrists); and
- differences according to whether the principal diagnosis is applied to an individual service contact or to a period of care. New South Wales and the Australian Capital Territory mainly report the current diagnosis for each service contact rather than a principal diagnosis for a longer period of care. The remaining jurisdictions mainly report principal diagnosis as applying to a longer period of care.

Estimating the number of patients

The estimated number of patients in the NCMHCD has been calculated by counting the number of unique person identifier–establishment identifier combinations. Within each establishment or facility, a patient is allocated a unique identifier. However, this means that

persons who utilised services in more than one establishment will be counted more than once; therefore the number of patients may be overestimated.

National Community Mental Health Establishments Database (Chapter 12)

The NCMHED includes data on government-operated community mental health establishments and their expenditure and staffing. For residential facilities, data on beds and episodes of residential care are also collected. The data collated in the NCMHED are specified by the NMDS for Community Mental Health Establishments.

For this NMDS, 'community mental health care' refers to all specialised government-operated mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted patients. The scope is both residential and ambulatory public community mental health care establishments, including adult, aged, and adolescent and child community mental health services, and non-admitted services in hospitals such as specialised psychiatric outpatient services. The scope excludes admitted patient mental health care services, support services that are not specialised mental health care services (such as accommodation support services) and services provided by non-government organisations. Only residential services that were staffed 24 hours a day were included. A list of the public community mental health establishments contributing to this report can be found online in the 'Internet only tables' section that accompanies this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2004–05*).

Data collected in 2004–05 is the last that will be collated in the NCMHED. From 2005–06, the NCMHED will be replaced by a new database specified by the NMDS for Mental Health Establishments, and incorporating a wider range of facilities and data items.

National Drug Strategy Household Survey (Chapter 1)

The most recent National Drug Strategy Household Survey was conducted by the AIHW in 2004. Previous surveys were conducted in 1985, 1988, 1991, 1993, 1995, 1998 and 2001.

The 2004 survey collected information from 29,445 respondents, using a household-based sample. Homeless and institutionalised people were not included in the sample. People aged 12 years and older were included in the sample (although not all questions were asked of 12 and 13 year olds). Survey responses were weighted to the Australian population aged 12 years or older, or 14 years and older, as appropriate.

In addition to information of licit and illicit drug use and perceptions and attitudes associated with these drugs, the survey collected information on the level of psychological distress of respondents aged 18 years and over, as measured by the Kessler 10 scale, and self-reported mental illness (AIHW 2005e).

National Hospital Morbidity Database (Chapter 5 and 8)

The National Hospital Morbidity Database (NHMD) is a compilation of electronic summary records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data, as well as data on the diagnoses of patients, the procedures they underwent in hospital, external causes of injury and poisoning, and the AR-DRG for each hospital separation.

Records in relation to 2004–05 are for hospital separations that occurred between 1 July 2004 and 30 June 2005. Data on patients admitted before 1 July 2004 are included, provided they separated between 1 July 2004 and 30 June 2005. A record is included for each separation, not for each patient; thus, patients who separated more than once in the year have more than one record in the database.

Data relating to admitted patients in almost all hospitals are included. The coverage is described in greater detail in *Australian hospital statistics 2004–05* (AIHW 2006b).

Specialised mental health care is identified through the fact that a patient had one or more psychiatric care days recorded —that is, care was received in a specialised psychiatric unit or ward. In acute care hospitals, a 'specialised' episode of care or separation may comprise some psychiatric care days and some days in general care or psychiatric care days only. An episode of care from a public psychiatric hospital is deemed to comprise psychiatric care days only and to be 'specialised', unless some care was given in a unit other than a psychiatric unit, such as a drug and alcohol unit.

Before interpreting any NHMD data presented in this report, note that mental health care for admitted patients in Australia is provided in a large and complex system, and there are state and territory differences in the scope of services provided for admitted patients. Differences in the data presented by jurisdiction may reflect different service delivery practices, differences in admission practices and/or differences in the types of establishments categorised as hospitals. Interpretation of the differences between jurisdictions therefore needs to be done with care. For example, there are some differences in the approach that states and territories and the public and private sectors take to the formal admission and separation of people attending hospital on a same-day basis (such as for group therapy sessions or day programs). In Tasmania and the territories, these attendances are recorded as non-admitted patient occasions of service. In other jurisdictions, patients are formally admitted for this care and therefore this care is reported as same-day separations.

National Health Survey (Chapter 1)

The National Health Survey (NHS) was conducted in Australia by the ABS in 1977–78, 1983, 1989–90, 1995, 2001 and 2004–05. This survey collects information on the health status of the population, including: long-term medical conditions and recent injuries; health-related aspects of people's lifestyles, such as smoking, diet, exercise and alcohol consumption; use of health services such as consultations with health practitioners; and demographic and socioeconomic characteristics.

The 2004–05 survey was conducted on a sample of 19,501 private dwellings across Australia (covering 25,900 respondents). Very remote areas of Australia and non-private dwellings, such as hotels, hospitals, nursing homes and short-stay caravan parks, were not included. Within each selected dwelling, one adult (aged 18 years and over) and one child were randomly selected for inclusion in the survey. Children under 15 years were not interviewed personally (an adult within the house provided details about the selected child). Responses to the survey were weighted by sex, age and area of usual residence to infer results for the total population at 31 December 2004. As with any sample survey, estimates are subject to sampling and non-sampling error.

In the NHS, long-term medical conditions were described using the ICD-10-AM classification. The prevalence estimates for long-term mental or behavioural problems are considered to be less reliable than prevalence estimates for other conditions derived from the

2004–05 NHS as responses could be based on self-diagnosis rather than diagnosis by a health professional.

Pharmaceuticals were classified by generic type, based on the WHO Anatomical Therapeutic Chemical Classification System (WHO 2006a).

The NHS also collected information on the level of psychological distress of persons aged 18 years and over, as measured by the Kessler 10 scale.

National Public Hospital Establishments Database (Chapter 12)

The AIHW is the custodian of the National Public Hospital Establishments Database (NPHED), which holds a record for each public hospital in Australia. The data are collected by state and territory health authorities from routine administrative collections of public acute hospitals, psychiatric hospitals, drug and alcohol hospitals, and dental hospitals in all states and territories.

The collection covers only hospitals within the jurisdiction of the state and territory health authorities. Public hospitals not administered by the state and territory health authorities (such as some hospitals run by correctional authorities in some jurisdictions and those in offshore territories) are not included.

Information is included on hospitals resources (beds, staff and specialised services), recurrent expenditure, non-appropriation revenue and summary information on services to admitted and non-admitted patients. Limitations have been identified in the financial data reported to the NPHED. In particular, some states and territories have not yet fully implemented accrual accounting procedures and systems, which means the expenditure and revenue data are a mixture of expenditure/payments and revenue/receipts, respectively. A need for further development has been identified in the areas of capital expenditure, expenditure at the area health service administration level and group services expenditure (for example, central laundry and pathology services).

The NPHED includes the data for *Full-time-equivalent staff*, *Salaries and wages* and the *Non-salary operating costs* subcategory data elements (types of staff and types of non-salary expenditure). The public acute hospital establishments that contain one or more specialised psychiatric units or wards are flagged in NPHED. However, no financial or staffing data are available for these specialised psychiatric wards.

For greater detail on the scope, definitions and quality of data obtained from the NPHED, see *Australian hospital statistics 2004–05* (AIHW 2006b).

A list of the public psychiatric hospitals contributing to this report can be found online in the 'Internet only tables' section that accompanies this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2004–05*).

National Residential Mental Health Care Database (Chapter 8)

Scope

The National Residential Mental Health Care Database (NRMHCD) includes data on episodes of residential care provided by government-funded and operated residential mental health services as specified by the NMDS for Residential Mental Health Care. The NRMHCD contains data that pertain to the resident, such as demographic information (for

example, age and sex), and data that pertain to each individual episode the resident has, such as principal diagnosis and mental health legal status.

The scope for this collection is all episodes of residential care for residents in all government-funded and operated residential mental health services in Australia, except those residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (that is, they report to the System for the Payment of Aged Residential Care collection). For 2004–05, government-operated services that employ mental health trained staff on-site 24 hours per day are included. Government-funded, non-government operated services and non-24-hour staffed services could be included optionally; however, none such service was reported for 2004–05. A list of the residential mental health services contributing data to the NRMHCD can be found online in the 'Internet only tables' section that accompanies this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2004–05*).

Queensland and the Northern Territory do not have any in-scope residential mental health services and therefore do not report to this collection.

Coverage

The NRMHCD was agreed for collection from 1 July 2004; therefore, 2004–05 marks the first compilation of the data. States and territories provided estimates of their coverage for 2004–05 as a proportion of full coverage:

- New South Wales estimated their coverage to be close to 100% with all in-scope service units reporting close to 100% of episodes;
- Victoria reported that their data included 100% of the in-scope residential services;
- Western Australia, Tasmania and the Australian Capital Territory all reported 100% coverage; and
- South Australia estimated their coverage to be from 33% (based on the number of in-scope services actually reporting to the collection) to 87% (based on the estimated number of episodes).

Indigenous data quality

Data from the NRMHCD on Indigenous status should be interpreted with caution. Across the jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown.

All states and territories provided information on the quality of the Indigenous data for the NRMHCD 2004–05 as follows:

- New South Wales stated that the quality of Indigenous data had not been evaluated;
- Victoria indicated that the quality of Indigenous data was not acceptable due to a lack of consistency in data entry across its services;
- Western Australia reported that, while that the data could be improved with the appropriate resources, training and reporting standards, the quality of Indigenous status data was acceptable;
- South Australia indicated that there has been limited analysis of the quality of Indigenous status data and thus the quality of their data was uncertain;
- Tasmania reported that the quality of their data was acceptable; and

- the Australian Capital Territory considered the quality of its Indigenous status data to be acceptable.

Principal diagnosis data quality

There is some variability across the states and territories in the data collection in relation to the classification used to code principal diagnosis. With one exception, the state and territory health authorities used the complete ICD-10-AM classification to code principal diagnosis. The one exception is New South Wales; they used a combination of ICD-10-AM and the International Classification of Diseases, 10th revision, Primary Care (ICD-10-PC).

National Survey of Mental Health and Wellbeing of Adults (Chapter 1)

The National Survey of Mental Health and Wellbeing of Adults (NSMHW) was conducted by the ABS in 1997 to provide information on the prevalence of a range of mental disorders, the level of disability associated with these disorders, and the health services used and needed as a consequence of a mental health problem for Australians aged 18 years or older. A computerised version of the Composite International Diagnostic Interview was used to identify mental illness in the adult component. The survey also collected information on the level of psychological distress of respondents aged 18 years and over, as measured by the Kessler 10 scale. Other scales and measures (such as the General Health Questionnaire 12 and SF-12), related to the respondent's general health and wellbeing, were also included in the NSMHW.

The survey was conducted on a sample of 15,500 private dwellings across Australia, with one person aged 18 years and over selected from each household. Very remote areas of Australia and non-private dwellings, such as hotels, hospitals, nursing homes and short-stay caravan parks, were not included. Estimates are based on the 10,600 responses to the survey, weighted to the 1997 Australian population aged 18 years and over.

Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data (Chapter 11)

Medicare Australia (formerly known as the Health Insurance Commission) collects data on prescriptions funded through the PBS and RPBS and provides the data to DoHA. Information collected includes the characteristics of the person who is provided with the prescription, the medication prescribed (for example, type and cost), the prescribing practitioner and the supplying pharmacy (for example, location). The figures reported in this publication relate the number of mental health-related prescriptions processed by Medicare Australia in the reporting period, as well as the prescription costs funded by the PBS/RPBS.

Although the PBS/RPBS data capture the majority of prescribed medicines dispensed in Australia, it has the following limitations:

- It refers only to prescriptions scripted by registered medical practitioners who are approved to work within the PBS/RPBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions (DoHA 2006d:38). It excludes adjustments made against pharmacists' claims, any manually paid claims, or any benefits paid as a result of retrospective entitlement or refund of patient contributions.

- It excludes non-subsidised medications, such as private and below copayment prescriptions (where the patient copayment covers the total costs of the prescribed medication) and over-the-counter medications.
- The level of the copayment increases annually, which means that some medicines that were captured in previous years might be below the copayment level and thus, excluded in following years.

The number of prescriptions issued through community pharmacies that are not covered by the PBS/RPBS is estimated through the Pharmacy Guild Survey, which is an ongoing survey of 250 community pharmacies that provide records of all dispensed prescriptions for medicines listed on the PBS/RPBS (AIHW 2003). In 2001, it was estimated that slightly less than 80% of all community prescriptions were dispensed under the PBS/RPBS.

State and territory are determined by DoHA according to the patient's residential address. If the patient's state/territory is unknown, then the state or territory of the pharmacy supplying the item is reported. If the pharmacy's state/territory details are also missing then the data are not included by DoHA. The data are also excluded by DoHA when the specialty of the prescribing provider is not known. These exclusions accounted for about 0.2% of all the mental health-related prescriptions reported for 2005–06.

The year was determined from the date the service was processed by Medicare Australia, rather than the date of prescribing or the date of supply by the pharmacy.

Private Health Establishments Collection (Chapter 12)

The ABS conducts an annual census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by DoHA. As part of that census, data on the staffing, finances and activity of these establishments are collected and compiled in the Private Health Establishments Collection (PHEC).

The data definitions used in the PHEC are largely based on definitions in the *National health data dictionary*, Version 13 (HDSC 2006). The ABS definition for private psychiatric hospitals is 'those establishments that are licensed or approved by a state or territory health authority and cater primarily for admitted patients with psychiatric or behavioural disorders'. The term 'cater primarily' applies when 50% or more of total patient days are for psychiatric patients.

Additional information on the PHEC can be obtained from the annual ABS publication *Private Hospitals, Australia* (ABS 2006d).

Supported Accommodation Assistance Program National Data Collection (Chapter 9)

The SAAP National Data Collection (NDC) is a nationally consistent information system that combines information from SAAP agencies state and territory and Australian government funding departments. The AIHW manages the collection.

The scope of the SAAP NDC includes all agencies that receive funding through the national SAAP agreement and/or state and territory SAAP funds. In 2004–05, 1,294 non-government, community and local government agencies were funded nationally under the program. Of these, 93% participated in the data collection.

The data presented in this report were extracted from the Client Collection component of the SAAP NDC, which includes information about all clients receiving SAAP support lasting at

least 1 hour. Data are recorded by service providers during or immediately following contact with clients and are then forwarded to the AIHW after the clients' support periods have ended or, for ongoing clients, at the end of the reporting period (31 December and 30 June of each year). Data collected include basic sociodemographic information and information on the services needed, and provided to, each client. Information about each client's situation before and after receiving SAAP services is also collected.

There are high levels of non-response to particular questions in the data collection forms received by the AIHW. This means that caution should be exercised when interpreting the data because the results may not fully reflect the entire population of interest.

Furthermore, the protocols established for the NDC require that SAAP clients provide information in a climate of informed consent. If a client's consent is not obtained, only a limited number of questions can be completed on data collection forms. In 2004–05, valid consent was obtained from clients in 87% of support periods in participating agencies.

While data reported from the SAAP Client Collection are generally weighted to take non-participation of agencies and non-consent of clients into account, unweighted data are presented in this report. Based on unweighted responses, there were a total of 142,232 closed support periods reported in the SAAP Client Collection for 2004–05. For the same period, the number of closed support periods using weighted data is estimated to be 153,900.

For further information on the SAAP collection, refer to the *Homeless people in SAAP: SAAP National Data Collection annual report 2004–05 Australia* (AIHW 2006e).

Survey of Disability, Ageing and Carers (Chapter 1)

This survey was conducted by the ABS throughout Australia from June to November 2003, as well as in 1998. The primary objective of the survey was to collect information on people with a disability, older people (aged 60 years and over) and carers. Disability was defined as any limitation, restriction or impairment which has lasted, or is likely to last, for at least 6 months and restricts everyday activities.

The scope of the survey included people in both private and non-private dwellings (including people in cared accommodation establishments, but excluding correctional facilities). The survey covered all areas of Australia except remote and sparsely settled areas. The survey target population was identified by screening questions asked of a responsible adult within households, and selected by a nominated contact officer within cared-accommodation establishments. The 2003 survey results were benchmarked to the estimated population living in non-sparsely settled areas at 30 June 2003.

For further information on this survey, refer to *Disability, Ageing and Carers: summary of findings, Australia 2003* (ABS 2004a).

Appendix 2: Technical notes

Data presentation

Throughout this publication, data may not sum to the totals shown due to missing and/or not stated values, as well as rounding. Totals reported include missing and/or not stated values. The percentages shown within the tables are calculated excluding the missing and/or not stated figures, unless indicated otherwise. Percentage distributions may not sum to 100 due to rounding.

Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Population rates

Crude (or observed) rates were calculated using the ABS estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2004–05 data were calculated using ERP at 31 December 2004, while rates for 2004 calendar year data were calculated using ERP at 30 June 2004). Rates for 2005–06 data were calculated using preliminary ERP at 31 December 2005.

Rates for Indigenous, country of birth and Remoteness Areas data were calculated using ERP at 30 June of the relevant year.

The direct method of age standardisation was used for the calculation of age-standardised rates using 5-year age groups. The total Australian population for 30 June 2001 was used as the population for which expected rates were calculated.

Appendix 3: Classifications used

Health-related classifications have multiples purposes, including the facilitation of data collection and management in the clinical setting, the analysis of the data to inform public policy, and the allocation of financial and other resources. This section provides a short description of the classification systems mentioned in this report.

Australian Classification of Health Interventions

The Australian Classification of Health Interventions (ACHI) is the Australian national standard for procedure and intervention coding in Australian hospitals.

The National Centre for Classification in Health (NCCH) developed ACHI based on the *Medicare Benefits Schedule* (MBS). The MBS is a fee schedule for Medicare services including general practice consultations, specialist consultations, operations and other medical services such as diagnostic investigations and optometric services. DoHA updates the MBS at least twice each year and these code changes are either incorporated into ACHI or the MBS codes are mapped to existing ACHI codes.

ACHI captures procedures and interventions performed in public and private Australian hospitals, day centres and ambulatory settings, as well as allied health interventions, dentistry and imaging. The structure of ACHI is anatomically based, rather than based on the surgical specialty.

In order to maintain parity with disease classification, ACHI chapters resemble the chapter headings of the ICD-10. ACHI is updated biennially by the NCCH in line with the disease section of ICD-10-AM. Use of the codes is guided by the *Australian Coding Standards*, volume 5 of ICD-10-AM.

Further information on ACHI is available from the NCCH website: <http://www3.fhs.usyd.edu.au/ncch/4.1.3.htm>.

Australian Standard Geographical Classification

The Australian Standard Geographical Classification (ASGC) was developed by the ABS for the collection and dissemination of geographically classified statistics. It is an essential reference for understanding and interpreting the geographical context of statistics in Australia.

In this report the ASGC applies to the data presented by remoteness area, which is based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre.

This report uses the ASGC to present data in the following categories:

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote

For further information on this classification system, refer to *Australian Standard Geographical Classification* (ABS 2002a).

Anatomical Therapeutic Chemical Classification System

The Anatomical Therapeutic Chemical (ATC) Classification System, developed by the WHO, assigns therapeutic drugs to different groups according to the organ or system on which they act, as well as their therapeutic and chemical characteristics.

The coding of pharmaceutical products within the *Schedule of Pharmaceutical Benefits* is based on the ATC Classification System.

For further information on this classification system, refer to the World Health Organization website <http://www.whocc.no/atcddd/>.

International Classification of Diseases

The International Classification of Diseases (ICD), which was developed by the WHO, is the international standard for coding morbidity and mortality statistics. It was designed to promote international comparability in the collection, processing, classification and presentation of these statistics. The ICD is periodically reviewed to reflect changes in clinical and research settings (WHO 2006b).

Although the ICD is primarily designed for the classification of diseases and injuries with a formal diagnosis, it also classifies a wide variety of signs, symptoms, abnormal findings, complaints and social circumstances that may stand in place of a diagnosis.

Further information on the ICD is available from the WHO website <http://www.who.int/classifications/icd/en/>.

International Statistical Classification of Diseases, 9th revision, Clinical Modification

The International Statistical Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) is based on the ninth revision of the ICD (NCC 1996). The ICD-9-CM was the official system of assigning codes to diagnoses and procedures associated with hospital utilisation in Australia before it was superseded by the ICD-10-AM.

International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification

The Australian Modification of ICD-10 (called ICD-10-AM) is used to classify diseases in the acute health sector in Australia. The ICD-10-AM was developed in Australia by the National Centre for Classification in Health with the purpose of making it more relevant to Australian clinical practice (NCCH 2006).

International Classification of Primary Care, 2nd edition, and ICPC-2 PLUS

The International Classification of Primary Care, version 2 (ICPC-2) is a classification method for primary care (that is, general practice) encounters; this method has been adopted by the WHO. It allows for the classification of three elements of a health care encounter in relation to the patient: reasons for encounter; diagnoses or problems; and process of care.

The ICPC-2 PLUS (which is also known as the BEACH coding system) is an extended vocabulary of terms classified according to the ICPC-2, which enables greater specificity in coding. The ICPC-2 PLUS is primarily used in the context of the Australian general practice.

The ICPC-2 is currently being used in electronic health records within the clinical general practice, as well as in the research of general practice (that is, BEACH) and other statistical collections such as the ABS National Health Survey.

Further information on ICPC-2 is available from the WHO website <www.who.int/en/> and information on ICPC-2 PLUS is available from the BEACH website: <http://www.fmrc.org.au/icpc2plus/>.

Appendix 4: Codes used to define mental health-related general practice encounters and mental health-related hospital separations

This Appendix provides a list of codes used to define 'mental health-related' general practice encounters from the BEACH database (as used in Chapter 2) and 'mental health-related' hospital separations from the National Hospital Morbidity Database (as used in Chapters 5 and 7).

BEACH survey of general practice activity data

For the purpose of this report, 'mental health-related' general practice encounters are defined as those encounters where a mental health-related problem was managed. Mental health-related problems are those that are classified in the psychological chapter (that is, the 'P' chapter) of the *International Classification of Primary Care, version 2* (ICPC-2). In addition, codes that are classified in the psychological chapter of the ICPC-2 (note that ICPC-2 PLUS codes have been used as these enable greater specificity in coding) for clinical treatments and referrals, and medications prescribed, recommended or supplied that are classed in the psychological chapter of the Coding Atlas for Pharmaceutical Substances (CAPS) were used in additional analysis of general practice activity.

Table A4.1 presents a list of the ICPC-2, ICPC-2 PLUS and CAPS codes classed as 'psychological' for problems managed, clinical treatments, referrals and medications. (CAPS codes can be grouped into Anatomical Therapeutical Chemical (ATC) groups and these have also been listed.)

Table A4.1: ICPC-2, ICPC-2 PLUS and CAPS codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2003–04

ICPC-2 code	ICPC-2 PLUS code	CAPS code	ICPC-2/ICPC-2 PLUS/CAPS label
PROBLEMS MANAGED			
P01			Feeling anxious/nervous/tense
P02			Acute stress reaction
P03			Feeling depressed
P04			Feeling/behaving irritable/angry
P05			Senility, feeling/behaving old
P06			Sleep disturbance
P07			Sexual desire reduced
P08			Sexual fulfilment reduced
P09			Concern about sexual preference
P10			Stammering, stuttering, tics
P11			Eating problems in children
P12			Bed-wetting, enuresis
P13			Encopresis/bowel training problem
P15			Chronic alcohol abuse
P16			Acute alcohol abuse
P17			Tobacco abuse
P18			Medication abuse
P19			Drug abuse
P20			Memory disturbance
P22			Child behaviour symptom/complaint
P23			Adolescent symptom/complaint
P24			Specific learning problem
P25			Phase of life problem in adult
P27			Fear of mental disorder
P28			Limited function/disability psychological
P29			Psychological symptom/complaint, other
P70			Dementia (including senile, Alzheimer's)
P71			Organic psychoses, other
P72			Schizophrenia
P73			Affective psychoses
P74			Anxiety disorder/anxiety state
P75			Somatisation disorder
P76			Depressive disorder
P77			Suicide/suicide attempt
P78			Neurasthenia
P79			Phobia, compulsive disorder
P80			Personality disorder

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and CAPS codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2003–04

ICPC-2 code	ICPC-2 PLUS code	CAPS code	ICPC-2/ICPC-2 PLUS/CAPS label
PROBLEMS MANAGED (continued)			
P81			Hyperkinetic disorder
P82			Post-traumatic stress disorder
P85			Mental retardation
P86			Anorexia nervosa, bulimia
P98			Psychoses not otherwise specified, other
P99			Psychological disorders, other
CLINCIAL TREATMENTS			
	P43001		Test; psychological
	P43003		Procedures; diagnostic; psychological
	P45001		Advice/education; psychological
	P45002		Observe/wait; psychological
	P45004		Advice/education; smoking
	P45005		Advice/education; alcohol
	P45006		Advice/education; illicit drugs
	P45007		Advice/education; relaxation
	P45008		Advice/education; lifestyle
	P45009		Advice/education; sexuality
	P45010		Advice/education; life stage
	P46001		Consultation; other general practitioner/allied health professional; psychological
	P46002		Consultation; primary care provided; psychological
	P46003		Consultation; psychiatrist
	P47003		Consultation; psychiatrist
	P58001		Counselling; psychiatric
	P58002		Psychotherapy
	P58004		Counselling; psychological
	P58005		Counselling; sexual; psychological
	P58006		Counselling; individual; psychological
	P58007		Counselling; bereavement
	P58008		Counselling; smoking
	P58009		Counselling; alcohol
	P58010		Counselling; drug abuse
	P58011		Counselling; relaxation
	P58012		Counselling; life style
	P58013		Counselling; anger
	P58014		Counselling; self-esteem
	P58015		Counselling; assertiveness
	P58016		Counselling; life stage

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and CAPS codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2003–04

ICPC-2 code	ICPC-2 PLUS code	CAPS code	ICPC-2/ICPC-2 PLUS/CAPS label
CLINCIAL TREATMENTS (continued)			
	P58017		Counselling; stress management
	P58018		Therapy; group
	P59001		Therapeutic procedure; psychological
	P59002		Therapy; electroconvulsive
	P59003		Hypnosis/hypnotherapy
	P59005		Therapy; relaxation
	P60001		Test; result(s); psychological
	P60002		Results; procedures; psychological
	P62001		Administrative; psychological
REFERRALS			
	P66003		Referral; psychologist
	P66004		Referral; counsellor
	P66005		Referral; mental health team
	P66006		Referral; drug & alcohol
	P66007		Referral; hypnotherapy
	P67002		Referral; psychiatrist
	P67004		Referral; clinic; psychiatrist
	P67005		Referral; hospital; psychiatrist
	P68003		Referral; needle/syringe exchange
MEDICATIONS			
		P10–P12	Sedative hypnotics (ATC code: N05C)
		P20–P21	Anti-anxiety (ATC code: N05B)
		P30–P32	Antipsychotic (ATC code: N05A)
		P40–P42	Antidepressants (ATC code: N06A)

National Hospital Morbidity Database data

During the preparation of *Mental health services in Australia 1999–00*, attention was given to ensuring that for data on hospital separations from the National Hospital Morbidity Database (NHMD) the definition of a 'mental health-related diagnosis' included all codes which were either clinically or statistically relevant to mental health. This definition was revised for *Mental health services in Australia 2000–01* to increase the accuracy of the data. More specifically, for the analyses of the 2000–01 National Hospital Morbidity data, a diagnosis was considered clinically relevant to mental health if:

- it was included as a principal diagnosis defining AR-DRG Version 4.2 Major Diagnostic Categories 19 (*Mental diseases and disorders)* and 20 (*Alcohol/drug use and alcohol/drug induced organic mental disorders*); or
- it appeared to be specific for a mental health-related condition based on expert advice.

A diagnosis was defined as being statistically relevant to mental health if:

- during 2000–01 there were more than 20 separations with specialised psychiatric care for that principal diagnosis at the 3-character level of ICD-10-AM or more than 10 at the 4-character level; or
- over 50% of separations with that principal diagnosis included specialised psychiatric care.

This method was developed in consultation with the National Mental Health Working Group Information Strategy Committee (which is now called the Mental Health Information Strategy Subcommittee) and the Clinical Casemix Committee of Australia.

Certain codes were statistically relevant during 1999–00 but not in 2000–01; these were examined and included if over 50% of total separations over the 2 years included specialised psychiatric care.

For this edition of *Mental health services of Australia*, the same codes as used for the analysis of the 2000–01 data have been used to define 'mental health-related' hospital separations in Chapters 5 and 7. However, updates have been made to incorporate changes in codes that have occurred as new editions of ICD-10-AM have been released.

Thus, the full list of codes used to define mental health-related hospital separations is shown in Table A4.2.

Table A4.2: ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F00	Dementia in Alzheimer's disease				✓
F01	Vascular dementia				✓
F02	Dementia in other diseases classified elsewhere			✓	
F03	Unspecified dementia				✓
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances				✓
F05	Delirium, not induced by alcohol and other psychoactive substances				✓
F06	Other mental disorders due to brain damage and dysfunction and to physical disease			✓	✓
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction			✓	✓
F09	Unspecified organic or symptomatic mental disorder			✓	
F10	Mental and behavioural disorders due to use of alcohol		✓		
F11	Mental and behavioural disorders due to use of opioids		✓		
F12	Mental and behavioural disorders due to use of cannabinoids		✓	✓	
F13	Mental and behavioural disorders due to use of sedatives or hypnotics		✓		
F14	Mental and behavioural disorders due to use of cocaine		✓		
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine		✓	✓	
F16	Mental and behavioural disorders due to use of hallucinogens		✓		
F17	Mental and behavioural disorders due to use of tobacco		✓		
F18	Mental and behavioural disorders due to use of volatile solvents		✓		
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances		✓	✓	
F20	Schizophrenia	✓		✓	
F21	Schizotypal disorder	✓		✓	
F22	Persistent delusional disorders	✓		✓	
F24	Induced delusional disorder	✓		✓	
F25	Schizoaffective disorders	✓		✓	
F28	Other non-organic psychotic disorders	✓		✓	
F29	Unspecified non-organic psychosis	✓		✓	
F30	Manic episode	✓		✓	
F31	Bipolar affective disorder	✓		✓	
F32	Depressive episode	✓		✓	
F33	Recurrent depressive disorder	✓		✓	
F34	Persistent mood (affective) disorders	✓		✓	
F38	Other mood (affective) disorders	✓		✓	
F39	Unspecified mood (affective) disorder	✓		✓	
F40	Phobic anxiety disorders	✓		✓	
F41	Other anxiety disorders	✓			
F42	Obsessive–compulsive disorder	✓		✓	
F43	Reaction to severe stress, and adjustment disorders	✓		✓	
F44	Dissociative (conversion) disorders	✓			
F45	Somatoform disorders	✓			
F48	Other neurotic disorders	✓			

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F50	Eating disorders	✓		✓	
F51	Non-organic sleep disorders	✓			
F52	Sexual dysfunction, not caused by organic disorder or disease	✓(a)		✓	✓
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified				✓
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere	✓			
F55	Harmful use of non-dependence-producing substances		✓		✓
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors	✓			
F60	Specific personality disorders	✓		✓	
F61	Mixed and other personality disorders	✓		✓	
F62	Enduring personality changes, not attributable to brain damage and disease	✓		✓	
F63	Habit and impulse disorders	✓		✓	
F64	Gender identity disorders	✓			
F65	Disorders of sexual preference	✓		✓	
F66	Psychological and behavioural disorders associated with sexual development and orientation	✓		✓	
F68	Other disorders of adult personality and behaviour	✓		✓	
F69	Unspecified disorder of adult personality and behaviour	✓			
F70	Mild mental retardation			✓	
F71	Moderate mental retardation				✓
F72	Severe mental retardation				✓
F73	Profound mental retardation				✓
F78	Other mental retardation				✓
F79	Unspecified mental retardation			✓	
F80	Specific developmental disorders of speech and language	✓			
F81	Specific developmental disorders of scholastic skills	✓			
F82	Specific developmental disorder of motor function	✓			
F83	Mixed specific developmental disorders	✓			
F84	Pervasive developmental disorders	✓(b)		✓	
F88	Other disorders of psychological development	✓			
F89	Unspecified disorder of psychological development	✓			
F90	Hyperkinetic disorders	✓		✓	
F91	Conduct disorders	✓		✓	
F92	Mixed disorders of conduct and emotions	✓		✓	
F93	Emotional disorders with onset specific to childhood	✓		✓	
F94	Disorders of social functioning with onset specific to childhood and adolescence	✓			
F95	Tic disorders	✓		✓	
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence	✓(c)		✓	
F99	Mental disorder, not otherwise specified	✓			
G30.0	Alzheimer's disease with early onset			✓	
G30.1	Alzheimer's disease with late onset			✓	
G30.8	Other Alzheimer's disease				✓
G30.9	Alzheimer's disease, unspecified				✓

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
G47.0	Disorders initiating and maintaining sleep	✓			
G47.1	Disorders excessive somnolence	✓			
G47.2	Disorders of the sleep–wake schedule	✓			
G47.8	Other sleep disorders	✓			
G47.9	Sleep disorder, unspecified	✓			
O99.3	Mental disorder nervous system pregnancy and birth				✓
R44.0	Auditory hallucinations	✓			
R44.1	Visual hallucinations				✓
R44.2	Other hallucination	✓			
R44.3	Hallucinations, unspecified	✓			
R44.8	Other/not otherwise specified symptom involving general sensation perception	✓			
R45.0	Nervousness	✓			
R45.1	Restlessness and agitation	✓			
R45.4	Irritability and anger	✓			
R48.0	Dyslexia and alexia	✓			
R48.1	Agnosia	✓			
R48.2	Apraxia	✓			
R48.8	Other and unspecified symbolic dysfunctions	✓			
Z00.4	General psychiatric examination, not elsewhere classified			✓	
Z03.2	Observation for suspected mental and behavioural disorder	✓		✓	
Z04.6	General psychiatric examination, requested by authority			✓	
Z09.3	Follow-up examination after psychotherapy				✓
Z13.3	Special screening examination for mental and behavioural disorders				✓
Z50.2	Alcohol rehabilitation				✓
Z50.3	Drug rehabilitation				✓
Z54.3	Convalescence following psychotherapy				✓
Z61.9	Negative life event in childhood, unspecified			✓	
Z63.1	Problems relationship w parents & in-laws			✓	
Z63.8	Other spec problems related to prim support group			✓	
Z63.9	Problem related to primary support group, unspecified			✓	
Z65.8	Other specified problems related to psychosocial circumstances			✓	
Z65.9	Problem related to unspecified psychosocial circumstances				✓
Z71.4	Counselling and surveillance for alcohol use disorder				✓
Z71.5	Counselling and surveillance for drug use disorder				✓
Z76.0	Issue of repeat prescription			✓	

(a) Excluding F52.5.
(b) Excluding F84.2.
(c) Excluding F98.5 and F98.6.

Abbreviations

ABS	Australian Bureau of Statistics
ACHI	Australian Classification of Health Interventions
AIHW	Australian Institute of Health and Welfare
AR-DRG	Australian Refined Diagnosis Related Group
ASA	American Society of Anesthesiologists
ASGC	Australian Standard Geographical Classification
ATC	Anatomical Therapeutic Chemical classification
BEACH	Bettering the Evaluation and Care of Health
CAPS	Coding Atlas for Pharmaceutical Substances
CNS	Central Nervous System
COAG	Council of Australian Governments
CSTDA	Commonwealth State/Territory Disability Agreement
DoHA	Department of Health and Ageing
ED	Emergency Department
ECT	electroconvulsive therapy
ERP	Estimated resident population
FaCSIA	Department of Families, Community Services and Indigenous Affairs
FTE	full-time-equivalent
GP	general practitioner
ICD	International Classification of Diseases
ICD-9-CM	International Statistical Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICD-10 PC	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Primary Care
ICPC-2	International Classification of Primary Care, 2nd edition
K10	Kessler 10 Scale of Psychological Distress
LCL	lower confidence limit
NAPEDCD	National Non-admitted Patient Emergency Department Care Database
MBS	Medicare Benefits Schedule
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NCCH	National Centre for Classification in Health
NCMHCD	National Community Mental Health Care Database
NCMHED	National Community Mental Health Establishments Database

NDC	National Data Collection
NDSHS	National Drug Strategy Household Survey
NHMD	National Hospital Morbidity Database
NHS	National Health Survey
NMDS	National Minimum Data Set
NPHED	National Public Hospital Establishments Database
NRMHCD	National Residential Mental Health Care Database
NSMHW	National Survey of Mental Health and Wellbeing
PBS	Pharmaceutical Benefits Scheme
PHEC	Private Health Establishments Collection
RPBS	Repatriation Pharmaceutical Benefits Scheme
SAAP	Supported Accommodation Assistance Program
UCL	upper confidence limit
WHO	World Health Organization

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