Mental health services in Australia 2005–06

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Mental health services in Australia 2005–06

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Foreword

Mental health services in Australia 2005–06, the tenth in the Australian Institute of Health and Welfare's Mental health series, provides a detailed overview of Australia's mental health services in 2005–06. It brings together a diverse range of data on the services used by Australian mental health consumers, and provides information on patient demographics and comparisons of service use between state and territories.

For the first time, the report includes data from the Institute's new National Mental Health Establishments Database, providing detailed information on specialised mental health expenditure, beds and staffing. The Institute acknowledges the assistance of the Australian Government and the states and territories in commissioning this new data collection and their perseverance in populating and subsequently validating the 2005–06 data it contains. It is anticipated that, as the database matures, it will enable more timely and precise reporting on mental health expenditure nationally. Also included for the first time are comprehensive data on mental health-related expenditure by the Australian Government and information on the number of patients dispensed with subsidised mental health-related prescriptions under the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme.

The report also includes mental health data from other Institute databases: the National Hospital Morbidity Database, the National Community Mental Health Care Database and the National Residential Mental Health Care Database. Mental health-related data are also provided on emergency department occasions of service, pharmaceuticals, Medicare services and mental health-related services funded under the Commonwealth, State/Territory Disability Agreement and the Supported Accommodation Assistance Program.

Interested readers are invited to visit the Institute's website where a suite of supplementary statistical information on mental health services, not included in the hard-copy form of the report, is available.

Ensuring that all Australians have access to appropriate levels of mental health care services when they need them, is a continuing focus at both levels of government in Australia. The Institute is committed to providing a national overview of mental health services via this annual report and will work with the Australian Government, state and territory governments and other stakeholders to better support their mental health reform information needs.

Penny Allbon
Director
July 2008

Contents

Acknowledgments

This report would not have been possible without the valued cooperation and effort of the data providers in the health authorities of the states and territories. The Australian Institute of Health and Welfare (AIHW) would like to express its appreciation for their timely supply of the data and their assistance with data validation. The AIHW also wishes to thank the members of the Mental Health Standing Committee's Mental Health Information Strategy Subcommittee, who provided input and advice on the report's structure and content. In addition, the AIHW would like to acknowledge the funding, assistance and data provided by the Australian Government Department of Health and Ageing and their consultants Buckingham and Associates Pty Ltd and Strategic Data Pty Ltd.

Within the AIHW, the key contributors to this report were Lyle Baker, Kirrily Pollock, Michelle Shek and Jason Thomson with assistance from Gary Hanson, Chaye Hosie and Jenny Hargreaves.

Summary

Mental health is an issue that affects many Australians either directly or indirectly in their daily lives. It is estimated that one in five Australians will experience a mental illness at some time in their lives and 11% of respondents to the 2004–05 National Health Survey reported that they had a long-term mental or behavioural problem (ABS 2006). Through the National Mental Health Strategy and the Council of Australian Governments National Action Plan on Mental Health, the Australian and state and territory governments are working to improve both the range and quality of mental health care and ensure that all Australians have access to appropriate levels of mental health care services when they need them.

This report aims to provide detailed information on the range of mental health-related services currently 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, 2005–06 but, where possible, more recent data (2006–07) are presented.

Ambulatory mental health care

Ambulatory mental health care services are provided by general practitioners (GPs), psychiatrists, hospital emergency departments, outpatient services and community mental health services. They are services that do not involve overnight admission to a hospital or mental health residential facility.

GPs are often the first health professionals to be consulted about mental health concerns. Estimates from the BEACH survey of GPs suggest that in 2006–07, one in ten encounters with GPs involved the management of a mental health-related problem, equivalent to an estimated 10.7 million GP encounters nationwide. The estimated number of mental health related GP encounters showed an average annual increase of 3% between 2002–03 and 2006–07. Depression (34%) was the most common problem managed in 2006–07, followed by anxiety (16%) and sleep disturbance (14%).

Community mental health services and hospital-based outpatient care services across Australia also provide a range of services to mental health consumers. They provided just over 5.6 million mental health service contacts in 2005–06.

In 2006–07, nearly 2 million Medicare-funded psychiatrist services were provided to 272,000 patients. This was an average annual decrease of 1% from the 2.1 million psychiatrist services provided in 2001–02. Psychiatrist services were accessed at a rate of 96 services per 1,000 population. This figure varied substantially when split into area of residence; from a high of 113 services per 1,000 in major cities, down to 19 services per 1,000 population in very remote regions.

In 2006–07, 669,000 Medicare-funded allied health services (for psychologists, social workers and occupational therapists) were provided to 165,000 patients. Most of these services were provided after 1 November 2006 when new psychologist and allied health items became available through the Medicare Benefits Schedule. Access for allied health services was similar in major cities and inner regional areas (33 and 34 services per 1,000 population, respectively). Rates were lower in outer regional and remote areas (25 and 22 services per 1,000 population, respectively), while rates in very remote areas were substantially lower, at 5 services per 1,000 population.

Admitted patient and residential mental health care

Public acute, public psychiatric and private hospitals provide admitted patient mental health care. In 2005–06, there were 204,000 mental health-related separations for admitted patients, the majority (151,000; 74%) from public acute hospitals. For separations involving specialised psychiatric care, the most commonly reported principal diagnosis was schizophrenia (18%).

In 2005–06, there were 2,345 episodes of residential mental health care. The most common principal diagnosis was schizophrenia (59%), followed by schizoaffective disorder (10%) and bipolar affective disorder (6%).

Mental health-related prescriptions

Mental health-related medications comprised 11% of the 183.4 million claims processed by Medicare Australia for pharmaceutical benefits in 2006–07. The 20.6 million mental health-related claims equate to 990 prescriptions per 1,000 population, 86% by general practitioners, 9% by psychiatrists and 4% by non-psychiatrist specialists. Mental health-related prescriptions increased at an annual average rate of 1% from 2002–03 to 2006–07.

State and territory mental health facilities

Nationally in 2005–06, there were 2,263 beds in public psychiatric hospitals, 4,008 beds in specialised psychiatric wards of public acute hospitals and 2,093 beds in government and non-government-operated residential mental health facilities. Total FTE staff increased by 3% over the 2001–02 to 2005–06 period.

Mental health workforce

Estimates from the AIHW Medical Labour Force Survey indicate that 3,180 psychiatrists were employed in Australia in 2005. Taking into account average hours worked, this equated to 3,398 FTE psychiatrists and 17 FTE psychiatrists per 100,000 population. In 2005, psychiatrists were mainly male (63%), had an average age of 47.6 years and were concentrated in major cities.

The AIHW Nursing and Midwifery Labour Force Survey found that there were an estimated 13,472 mental health nurses employed in Australia in 2005, equivalent to 13,188 FTE nurses (65 FTE nurses per 100,000 population). Mental health nurses (65%) had a substantially lower percentage of FTE based in major cities than psychiatrists (86%).

Expenditure on mental health services

Expenditure on state and territory mental health services increased on average by 5.2% per year over the 2001–02 to 2005–06 period to $2,742 million. Specialised psychiatric wards in public acute hospitals and community mental health services both experienced annual average increases in expenditure of 10%, while public psychiatric hospital expenditure had an average annual increase of 4%.

In 2006–07, $351 million was paid in benefits for Medicare-subsidised mental health services provided by consultant psychiatrists, general practitioners, psychologists and other allied health professionals. Medicare benefits paid for these services averaged $16.80 per capita.

In 2006–07, $670 million was spent on mental health-related medications under the Pharmaceutical Benefit Scheme (PBS). Prescriptions for antipsychotics and antidepressants accounted for the majority (49% and 45%, respectively).

1 Introduction

Mental health services in Australia 2005–06 is the latest in the Australian Institute of Health and Welfare's series of annual reports that describe the activity and characteristics of Australia's mental health care services. As well as giving 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 latest year reported for most information in this report is 2005–06, 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 before 2005–06 are available in previous reports in this series.

1.1 Report structure

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 major features of the current policy framework and government initiatives in relation to mental health service provision.
- The main body of the report consists of three main sections, as shown in Figure 1.1. The first section (chapters 2–10) describes the activities and characteristics of the wide range of treatment and care services provided 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 service providers, but private hospitals, non-government organisations and private medical practitioners responsible for providing mental health care are also included in the range of service providers covered. Services that cater to the wider needs of clients with psychiatric illnesses or mental health issues, such as the Supported Accommodation Assistance Program (Chapter 9), and services that cater to a wider range of disabilities, but including psychiatric disabilities, such as those provided under the Commonwealth State/Territory Disability Agreement (Chapter 10), are also covered.
- The second section (Chapter 11) provides information on prescriptions dispensed for mental health-related conditions.
- The third section (chapters 12–14) looks at the resources used and/or involved in the provision of mental health services—namely, facilities, the specialist mental health workforce and expenditure.
- The summary tables provide state/territory and national profiles (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 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 comparison to the 2004–05 report, most of the elements have been retained but there have been some additions and deletions of content within chapters:

- The *Mental health-related care in general practice* chapter, in addition to presenting analysis of the Bettering the Evaluation and Care of Health (BEACH) survey data, now includes analysis of data on the use of mental health-specific items included in the Medicare Benefits Schedule (MBS) since 2002 to provide support to general practitioners coordinating the treatment needs of patients with mental health-related problems.
- The chapter on *Medicare-subsidised psychiatrist services* appearing in the previous report has been renamed *Medicare-subsidised psychiatrist and allied health services*. It has been expanded from the previous presentation of data on MBS-subsidised psychiatrist services to include analysis of data about items recently added to the MBS, which provide consumer access to a range of allied health services, including psychologists and other mental health workers.
- The *Mental health-related prescriptions* chapter includes analysis of data on patients obtaining mental health-related prescriptions, as well as on the number of prescriptions.
- Estimates of the psychologist workforce have been omitted from the *Mental health workforce* chapter, as there has been no update of these estimates since the previous report.

In addition to the information published in this report, detailed data on some mental health-related 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 this report aims 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, comparable national data. Consequently, there are some overlaps and gaps in the information on services provided in this report.

1.2 Definition of mental health-related services

Mental health-related services are provided in Australia in a variety of ways—from hospitalisation and other residential care, hospital-based outpatient services and community mental health services, through to consultations with both specialists and general practitioners. The Australian Government assists in this service provision by subsidising consultations, other medical and certain allied health services, and prescribed medications through the Medicare and Pharmaceutical Benefits Schemes. Government assistance is also provided for broader needs such as housing. This report presents data on this diverse range of services and support.

There is no standard way of defining mental health-related services. 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.

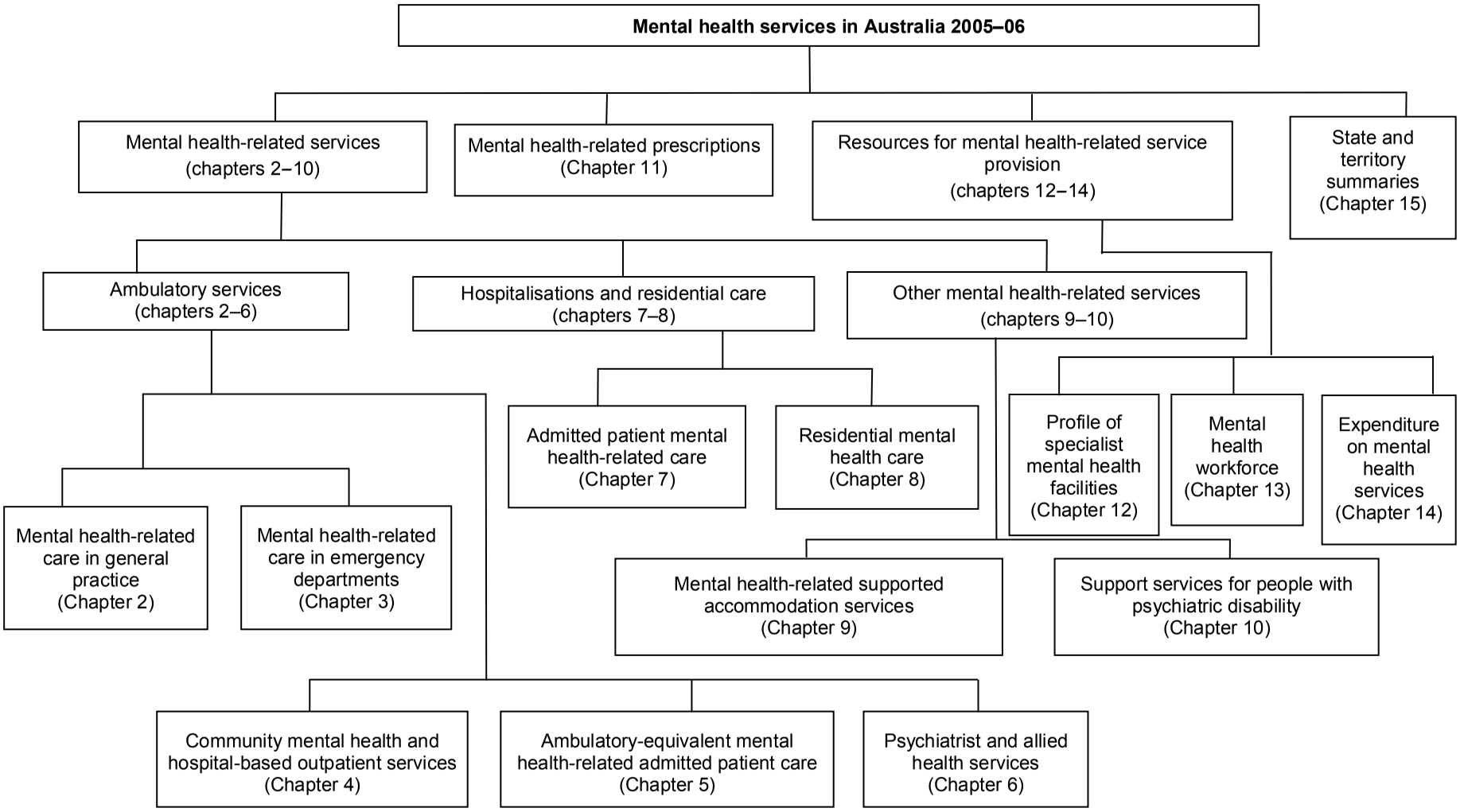


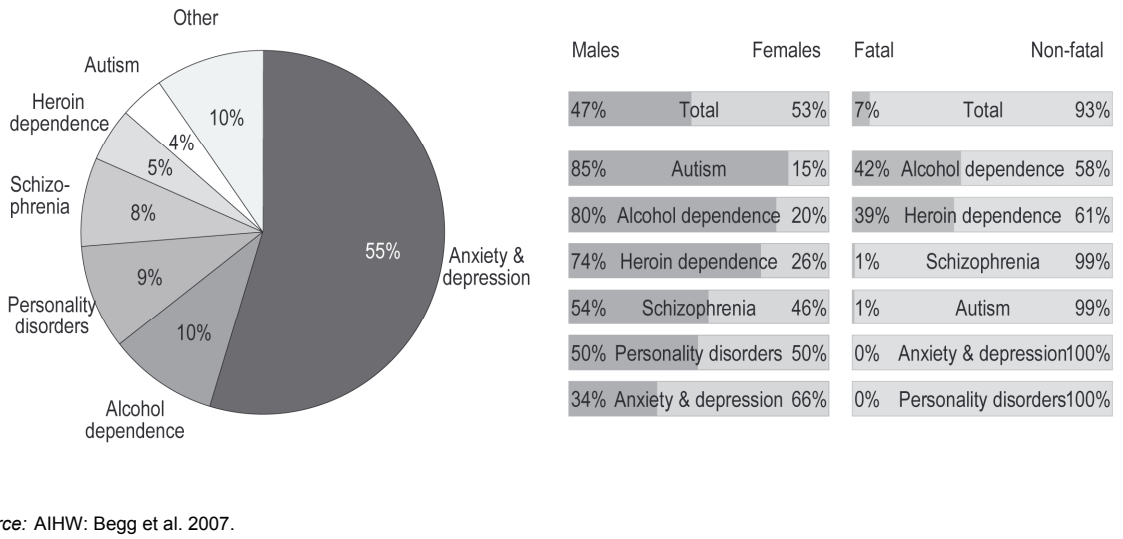
Figure 1.1: Report outline

1.3 Background

Mental health is one of Australia's National Health Priority Areas. Mental illness is one of the more prevalent conditions affecting the Australian population. According to the National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics (ABS) in 1997, almost one in five Australian adults will experience a mental illness at some time in their life. Overall, an estimated 18% of Australian adults had experienced a mental illness in the 12 months preceding the survey (ABS 1998). Another National Survey of Mental Health and Wellbeing was conducted in 2007, with results not available at the time of preparation of this publication.

Data from the AIHW National Mortality Database show that a mental or behavioural disorder was recorded as the underlying cause for 579 deaths in Australia in calendar year 2005, at a rate of 2.7 deaths per 100,000 population. Most of the deaths with a mental or behavioural disorder as the underlying cause were due to abuse of psychoactive substances such as alcohol and heroin. Suicides are not included in these figures.

More detail on the prevalence of mental illness in Australia was provided in the 2004–05 edition of this publication.



Source: AIHW: Begg et al. 2007.

Figure 1.2: Mental disorder burden, by specific cause expressed as: (a) proportions of total, (b) proportions by sex, and (c) proportions due to fatal and non-fatal outcomes, 2003

The burden of mental illnesses

According to *The burden of disease and injury in Australia 2003*, mental illnesses were estimated to be responsible for 13.3% of the total burden of disease in Australia in 2003. The total burden of disease and injury is derived from adding fatal burden (years of life lost due to premature mortality) to non-fatal burden (years of healthy life lost due to non-fatal health conditions, which is estimated by combining the average duration of new cases of a condition with a severity weight quantifying the impact of the condition). Non-fatal burden

accounted for 51% of the total burden, and mental illnesses were the leading cause (24%) (AIHW: Begg et al. 2007).

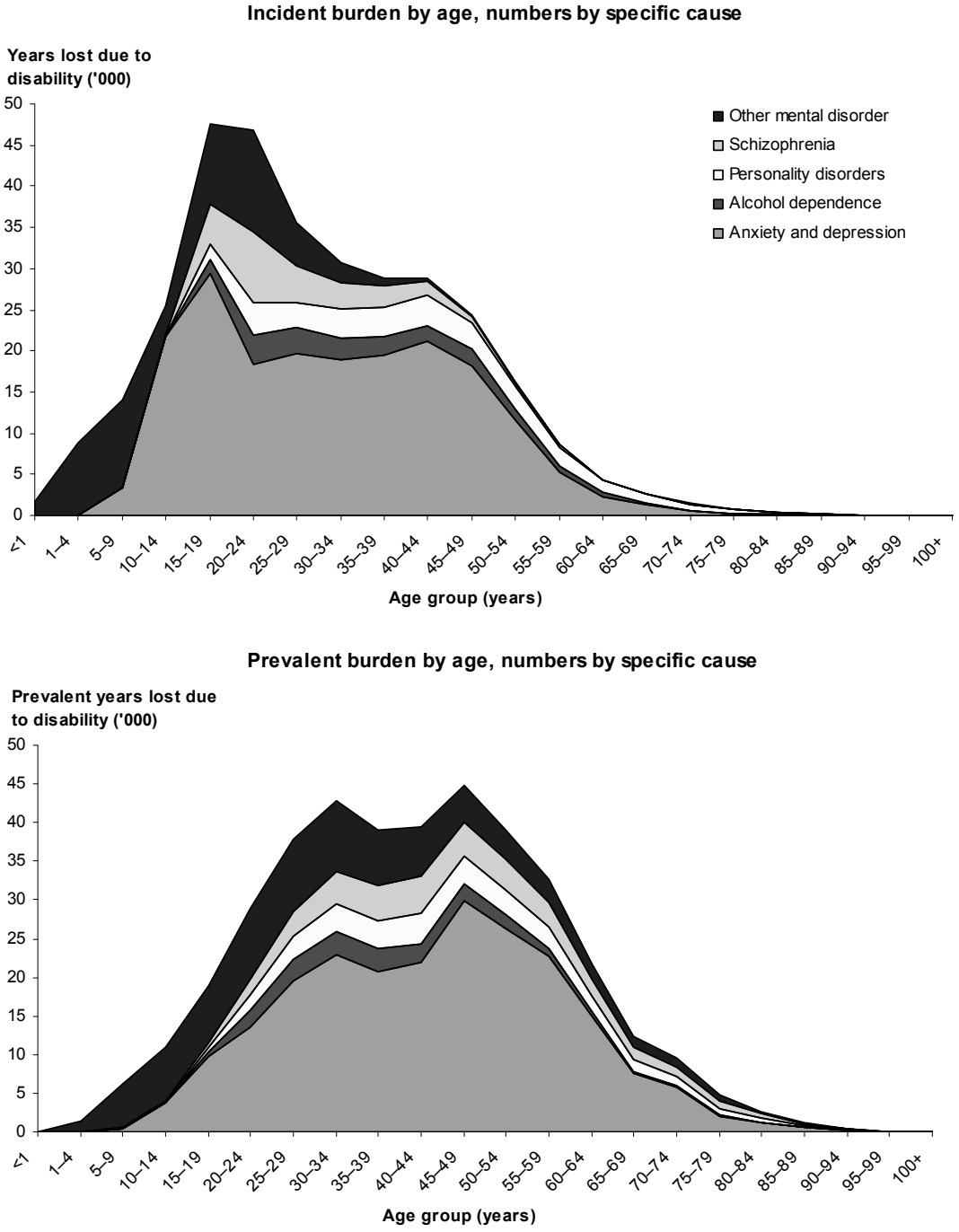
The distribution of the mental disorders burden was 93% non-fatal and 7% fatal, most of the latter caused by substance abuse. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of the total burden attributable to mental illnesses (Figure 1.2).

Mental illnesses affect both sexes and all ages. Females accounted for 53% of the burden attributed to mental illness and males 47% in 2003. In females, anxiety and depression were the foremost causes, accounting for 10% of the overall female burden of disease, and ranked third (at 4.8%) in the overall male burden.

There were marked sex differences in the mental illness burden for particular disorders. The burden from anxiety and depression combined was twice as high for females as for males. Conversely, the burden from substance abuse was more than three times as high in males as in females and autism spectrum disorders were much more common in males. On the other hand, eating disorders occurred mainly in females.

The analysis surrounding Figure 1.2 relates to an incidence-based measure of the burden of disease where healthy years lost due to disability are estimated by multiplying the number of new cases of a disorder by the average duration of that disorder as well as by a severity weight. It is also possible to calculate a prevalence-based measure of the burden of disease, the prevalent years lost due to disability, by multiplying the number of cases prevailing in the population at a point of time by the severity weight. Incident burden is most useful in the planning of health services while prevalent burden is most useful in estimating service use or expenditure on health services. The two methods produce different but complementary pictures as shown in Figure 1.3.

Incident burden peaks in the late teenage years, with the anxiety and depression burden, the largest identified category, being greatest in this age group. Incident burden is also very high in the 20–24 year age group, with schizophrenia being at a maximum in terms of burden for this group. The overall incident burden then tapers off with increasing age, apart from a small peak in the 40–44 year age group due mainly to anxiety and depression, as well as personality disorders. This second peak at the 40-44 year age group is more evident in the prevalent burden chart where the burden attributable to new cases is added to the burden cumulated in that age group from previous years. The peak in the incident anxiety and depression burden in younger age groups is not nearly as evident for anxiety and depression in the prevalent burden chart as there the burden is spread across the life span rather than being attributed to the point of incidence.



Source: AIHW, unpublished data.

Figure 1.3: Mental illnesses burden, by age, incidence and prevalence measures, 2003

1.4 National policies for mental health

State and territory governments and the Australian Government have committed to improve the mental health of the Australian population through the ongoing National Mental Health Strategy and the Council of Australian Governments (COAG) National Action Plan on Mental Health. 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 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 2006).

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 care, and the delivery of services in mainstream settings.

The approach to be taken in applying 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. This plan consolidates reforms begun under the first two plans and has four priority themes:

- promoting mental health and preventing mental health problems;
- increasing service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.

COAG National Action Plan on Mental Health

In early 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006b). This plan involves a joint package of measures and new investment by all governments over a five-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 aims to achieve 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 Government and 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.

State and territory-based COAG Mental Health Groups have been established to carry out this plan. These groups involve the Australian Government and the states and territories working together to coordinate the implementation of their commitments. Progress on the plan is being monitored against nationally-agreed progress measures over the five-year period and will be subject to an independent review at the end of the period.

1.5 Additional information

An electronic version of this report is available on the AIHW website at <www.aihw.gov.au/mentalhealth/> (follow the link to Mental health services in Australia 2005–06). 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 to create tables of data to suit their needs.

The *National Mental Health Report* (DoHA 2008b) provides a statistical report on progress made under the National Mental Health Strategy to 2004–05. Statistical indicators to provide comparisons of the performance of government mental health services by jurisdiction are provided in the *Report on Government Services* (SCRGSP 2008).

2 Mental health-related care in general practice

2.1 Introduction

This chapter presents information on mental health-related services provided by general practitioners (GPs) using data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity and Medicare Benefits Schedule (MBS) processing data.

2.2 Bettering the Evaluation and Care of Health survey data

The BEACH program is a survey of general practice activity across Australia. The data described in this chapter mainly relate to 93,000 GP ***encounters*** from a sample of 930 GPs between April 2006 and March 2007, as this is the most recent data period available. This is described as BEACH, 2006–07 in the remainder of this chapter. Note that this differs from the majority of chapters in this publication which focus on 2005–06 data.

The GP encounters covered by the survey represent about 0.1% of all GP encounters over that time. After post-stratification weighting (to ensure that national general practice activity patterns are reflected) the data include 91,805 encounters (Britt et al. 2008). The survey provides information on the reasons that patients visited the GP, the ***problems managed,*** and the types of management that were provided for each problem.

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

Key concepts

General practitioners (GPs) are those medical practitioners who are vocationally registered with Medicare Australia or Fellows of the Royal Australian College of General Practitioners or trainees for vocational registration.

Other medical practitioners are primary care practitioners who are not vocationally registered or training to become vocationally registered.

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 or referral) (AIHW: Britt et al. 2008).

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 (AIHW: Britt et al. 2008).

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, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Annual average change (per cent)[a]
Per cent of total GP encounters that are mental health-related	9.8	10.4	10.8	10.5	10.4	1.2
Estimated number of mental health-related encounters[b]	9,467,000	9,974,000	10,591,000	10,624,000	10,713,000	2.5
95% lower confidence limit	9,024,000	9,516,000	10,067,000	10,074,000	10,261,000	. .
95% upper confidence limit	9,909,000	10,433,000	11,117,000	11,174,000	11,165,000	. .
Estimated number of mental health-related encounters per 1,000 population[b][c]	479	498	523	517	514	1.4
95% lower confidence limit	456	475	497	490	492	. .
95% upper confidence limit	501	521	549	553	535	. .

(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 Medicare services for non-referred (GP) attendances (excluding practice nurse items), as reported by the Department of Health and Ageing (DoHA 2007b).

(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 2006–07, 10.4% of all GP encounters reported for the BEACH data were ***mental health-related encounters*** (Table 2.1). These are defined as those encounters at which a mental health-related problem was managed. Note that in terms of the MBS these encounters were most often recorded as surgery consultations (over 90% of all encounters for which an MBS item was recorded). The MBS mental health items claimable by GPs introduced on 1 November 2006 as part of the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative (item nos. 2710, 2712, 2713) represented 2% of MBS items recorded for mental health-related encounters in the 2006–07 BEACH survey. A further 0.2% were other mental health-specific MBS items. Section 2.5 includes a discussion of the encounters where these new MBS mental health items were recorded compared with other mental health-related encounters.

A simple extrapolation based on the 103.4 million unreferred (that is, non-specialist) attendances claimed from Medicare for 2006–07 suggests that there were an estimated 10.7 million mental health-related GP encounters for 2006–07. This corresponds to an estimated 514 encounters per 1,000 population (Table 2.1).

The proportion of encounters that were mental health-related from the BEACH data has shown an average annual increase of 1.2% between 2002–03 and 2006–07. Over the same period, the estimated total number of mental health-related GP encounters in Australia showed an average annual increase of 2.5% and the number per 1,000 population showed an average annual increase of 1.4%.

Patient demographics

Table 2.2 presents information on mental health-related encounters according to the characteristics of those receiving care. The table shows the proportion 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) for that demographic subgroup. In addition, to account for differences in the relative size of the respective populations, a rate (per 1,000 population) is provided in the last column of the table. As 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 2006–07, more than one in four (26.8%) mental health-related encounters were for patients aged 65 years and over. This age group had an estimated 1,071 mental health-related encounters per 1,000 population during the 2006–07 survey period, a much higher rate than any other age group. However, as a proportion of all GP encounters for the age group, those aged 65 years and over had fewer mental health-related GP encounters than other age groups between 25 and 65 years.

There were more mental health-related encounters for female patients than there were for male patients (60.2% and 39.8%, respectively). However, allowing for the higher rate of GP attendances for females, the difference between the genders was not as marked—an estimated 11.1% of all female encounters with GPs were mental health-related compared with 9.4% for males.

The great majority of mental health-related encounters were for non-Indigenous Australians (98.4%). However, when relative population sizes and age structures are considered, the rate

of mental health-related GP encounters for Aboriginal and Torres Strait Islander peoples (479 per 1,000 population) was about the same as that for non-Indigenous Australians (468 per 1,000 population). Indigenous Australians had a higher proportion of mental health-related GP encounters than non-Indigenous Australians (17.6% versus 10.6%).

Similarly, while mental health-related encounters were more numerous among people living in major cities, once population sizes and age structures were taken into account the differences between the remoteness areas were less pronounced.

Table 2.2: Patient demographics for mental health-related encounters, BEACH, 2006–07

Patient demographics	Per cent of total mental health-related encounters[(a)]	Rate (per 100 demographic group-specific encounters)	95% lower confidence limit	95% upper confidence limit	Estimated encounters per 1,000 population[(b)]
Age (years)					
Less than 15	2.6	2.4	2.0	2.7	69
15–24	7.0	8.0	7.3	8.8	263
25–34	13.5	12.8	11.8	13.8	496
35–44	17.4	14.7	13.7	15.6	606
45–54	18.0	13.5	12.6	14.3	677
55–64	14.6	10.6	9.9	11.3	698
65+	26.8	9.9	9.4	10.5	1,071
Sex					
Male	39.8	9.4	8.9	9.9	414
Female	60.2	11.1	10.6	11.6	587
Indigenous status[(c)]					
Indigenous Australians	1.6	17.6	13.5	21.6	479
Non-Indigenous	98.4	10.6	10.1	11.1	468
Remoteness area					
Major cities	68.3	10.1	9.6	10.7	515
Inner regional	21.0	11.2	10.4	11.9	491
Outer regional	9.3	10.6	9.6	11.7	456
Remote and Very remote	1.4	9.9	7.9	11.8	315
Total	**100.0**	**10.4**	**9.9**	**10.8**	**514**

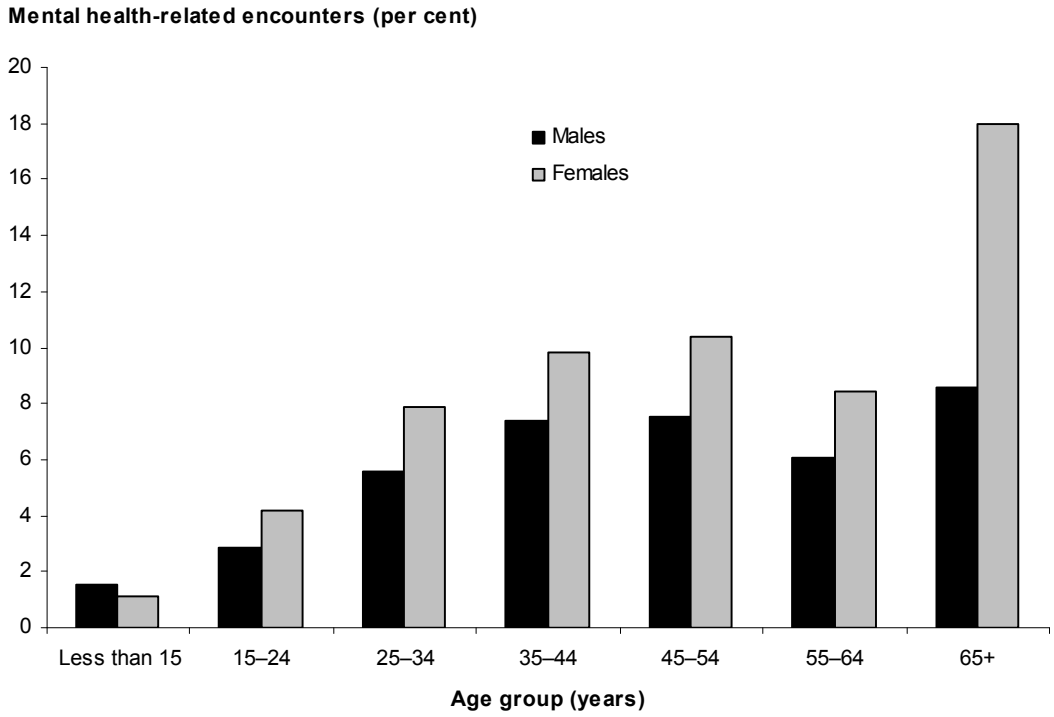
(a) The percentages shown do not include those encounters for which the demographic information was missing and/or not reported.

(b) Estimated encounter 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% of encounters.

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, especially for females. Consideration of the data in this chart should take into account the larger population of females compared with males in those aged 65 years and over, and the predominance of female patients in GP encounters. The rates presented in Table 2.2 take into account these factors.



Source: BEACH survey of general practice activity.

Figure 2.1: The age-sex distribution of patients at mental health-related encounters, BEACH, 2006–07

Mental health-related problems managed

In the 2006–07 BEACH survey, ***mental health-related problems*** were managed at a rate of 10.9 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 2006–07, accounting for 33.6% of all mental health-related problems managed, and 2.5% of all health problems managed.

Anxiety (P01, P74) was the next most frequently reported mental health-related problem managed (15.9% of all mental health-related problems managed and 1.2% of all problems managed), followed by *Sleep disturbance* (P06; 14.3% of all mental health-related problems managed and 1.1% of all problems managed).

Table 2.3: The 10 most frequent mental health-related problems managed, BEACH, 2006–07

ICPC-2 code	Problem managed	Per cent of total mental health-related problems	Per cent of total problems	Rate (per 100 encounters)	95% lower confidence limit	95% upper confidence limit
P03, P76	Depression	33.6	2.5	3.7	3.5	3.8
P01, P74	Anxiety	15.9	1.2	1.7	1.6	1.8
P06	Sleep disturbance	14.3	1.1	1.6	1.4	1.7
P02	Acute stress reaction	5.5	0.4	0.6	0.5	0.7
P70	Dementia	4.2	0.3	0.5	0.4	0.5
P72	Schizophrenia	3.9	0.3	0.4	0.4	0.5
P19	Drug abuse	3.4	0.3	0.4	0.3	0.5
P17	Tobacco abuse	3.2	0.2	0.3	0.3	0.4
P15, P16	Alcohol abuse	2.7	0.2	0.3	0.3	0.3
P73	Affective psychosis	1.7	0.1	0.2	0.2	0.2
	Other	11.7	0.9	1.3	1.2	1.4
	Total	**100.0**	**7.4**	**10.9**	**10.5**	**11.4**

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: two-thirds were handled in this way. Antidepressants were the most commonly prescribed, recommended or supplied medication (26.9 per 100 mental health-related problems managed), followed by anxiolytics (13.7) and hypnotics and sedatives (13.0).

The second most common form of management was the GP providing a procedure, other treatment or counselling (42.8 per 100 mental health-related problems managed). By far the most common of these was psychological counselling (24.7 per 100 mental health-related problems managed).

Pathology was ordered at a rate of 15.2 tests per 100 mental health-related problems managed. The most common pathology tests ordered were for full blood count (3.1 per 100 mental health-related problems managed), liver function tests (1.4) and thyroid-stimulating hormone tests (1.3).

A referral was given at a rate of 10.9 per 100 mental health-related problems managed. The most common referrals given were to psychologists (3.6 per 100 mental health-related problems managed) and to psychiatrists (1.9). This pattern of referrals has reversed since data from the 2003–04 survey were analysed (AIHW 2007e). Previously, the rate of referrals to psychiatrists was 2.3 per 100 (lower confidence limit 2.0, upper confidence limit 2.7) compared with 1.6 per 100 (lower confidence limit 1.3, upper confidence limit 2.0) referred to psychologists. This turnaround may have been influenced by the introduction of new Medicare items in November 2006 covering attendances by psychologists, part of the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative.

Table 2.4: Most common types of management of mental health-related problems, BEACH, 2006–07

Type of management		Rate (per 100 mental health-related problems)	95% lower confidence limit	95% upper confidence limit	Rate for 2003–04 BEACH survey
Medication prescribed, recommended or supplied[(a)]		66.7	64.6	68.8	69.4
N06A	Antidepressants	26.9	25.5	28.3	27.8
N05B	Anxiolytics	13.7	12.5	14.9	14.2
N05C	Hypnotics and sedatives	13.0	12.0	13.9	13.7
N05A	Antipsychotics	5.0	4.4	5.6	5.4
	Other	8.1	7.1	9.2	8.3
Procedures, other treatment, counselling[(b)]		**42.8**	**40.4**	**45.2**	**47.3**
P58001, P58002, P58004–P58007, P58013–P58015, P58018, P58019	Counselling – psychological	24.7	23.1	26.4	25.2
P45004, P58008	Counselling/advice/education – smoking	2.6	2.1	3.1	2.1
P45001, P45002	Advice/education/observe/wait – psychological	2.5	1.9	3.0	3.0
P45007, P58011, P58017	Counselling/advice/education – stress management, relaxation	2.2	1.7	2.6	. .
P45005, P58009	Counselling/advice/education – alcohol	1.7	1.4	2.0	1.8
A45015, A48003, A48005–A48011	Review/change/administer – medication	. .	. .	. .	3.4
	Other	9.2	8.3	10	11.8
Pathology[(b)]		**15.2**	**13.4**	**17**	**8.2**
A34011	Test – full blood count	3.1	2.7	3.5	1.7
D34008	Test – liver function	1.4	1.2	1.7	0.9
T34028	Test – thyroid-stimulating hormone	1.3	1.1	1.6	0.6
T34015	Test – thyroid function	0.7	0.5	1	0.4
A34010	Test – electrolytes/urea/creatinine	0.7	0.5	0.9	. .
A34021	Test – electrolytes and liver function	. .	. .	. .	0.4
	Other	7.9	6.9	8.8	4.2
Referral[(b)]		**10.9**	**9.9**	**11.8**	**10.2**
P66003	Referral to psychologist	3.6	3.1	4.1	1.6
P67002	Referral to psychiatrist	1.9	1.6	2.3	2.3
A67004	Referral to paediatrician	0.6	0.4	0.8	. .
A68011	Referral (unspecified)	0.5	0.3	0.7	. .
P67006	Referral to sleep clinic	0.5	0.3	0.7	. .
P66006	Referral to drug and alcohol professional	. .	. .	. .	0.7
P66005	Referral to mental health team	. .	. .	. .	0.6
P66004	Referral to counsellor	. .	. .	. .	0.5
	Other	3.7	3.2	4.2	4.2

(a) Pharmaceuticals prescribed, recommended or supplied by GPs are grouped into Anatomical Therapeutic Chemical (ATC) categories.

(b) Grouped according to ICPC-2 PLUS codes (see Appendix 3 for more information).

. . Not applicable.

Source: BEACH survey of general practice activity.

2.4 Additional general practice activity

In addition to the 10.9 per 100 GP encounters where a mental health-related problem was managed, there were 2.3 per 100 total GP encounters in the 2006–07 BEACH survey which did not involve a specific mental health-related problem but where:

- a management procedure, treatment, counselling and/or referral classified in the psychological chapter of the ICPC–2 was provided; and/or,
- a medication classified in the main psychological groups in the Anatomical Therapeutic Chemical (ATC) classification was prescribed, recommended or supplied (Table 2.5).

A list of the 'P' chapter codes for procedures, treatments, counselling and referrals and the ATC group codes for medications is provided in Appendix 4. As these encounters did not involve a specific mental health-related problem managed, they were not classified as mental health-related encounters, as defined earlier in this chapter. Often, however, these encounters involved a generic request for a prescription or a referral. Sometimes they related to problems with relationships or other life issues which resulted in psychological management by the GP. Almost invariably the encounter was recorded simply as a surgery consultation in terms of MBS items; in only three encounters was a new mental health-specific MBS item recorded.

An extrapolation based on the 103.4 million non-specialist attendances claimed from Medicare for 2006–07 suggests that these additional encounters in the BEACH data set equate to an estimated 2.3 million additional encounters for 2006–07. In turn, this corresponds to an estimated 112 encounters per 1,000 population. Note that how much these additional encounters are related to mental health is unknown.

Table 2.5: Psychologically-related activity in other[(a)] general practice encounters, BEACH, 2006–07

Type of psychologically-related activity			Per cent of other encounters with psychologically-related activity
Psychologically-related medication	**Psychologically-related management[(b)]**	**Psychologically-related referral**	
✓			57.3
	✓		37.8
		✓	2.8
✓	✓		1.4
✓		✓	0.3
	✓	✓	0.3
✓	✓	✓	0.0
Subtotal medications			*59.1*
	Subtotal management		*39.5*
		Subtotal referrals	*3.4*
Total psychologically-related activity in other[(a)] general practice encounters[(c)]			**100.0**

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

(b) Management covers procedures, other treatments and counselling.

(c) The subtotals do not add to the total due to row counts appearing in more than one subtotal.

Source: BEACH survey of general practice activity.

More than half of these additional encounters (59.1%) consisted of a medication being prescribed, recommended or supplied that was classified in the main psychological groups in the ATC classification, without the reporting of a specific psychological problem managed. The most common of these medications were antidepressants (35.4%), followed by anxiolytics (33.5%). The medications were most commonly prescribed, recommended or supplied for general and unspecified prescription requests and renewals (30.7% of the problems managed for this group of additional encounters) and back symptoms and complaints (7%).

For 39.5% of these additional encounters, a procedure, treatment or counselling classified as psychological was reported. The most common type of management was counselling, advice or education with regard to lifestyle (35.2%) and counselling, advice or education with regard to smoking (26.2%). This management was most commonly provided for hypertension (11.9% of the problems managed for this group of additional encounters).

For 3.4% of the additional encounters, a referral classified as psychological was provided. The most common of these referrals were referral to a psychologist (46.9%), a psychiatrist (19.5%) and a sleep clinic (14.8%). At these encounters, the referrals were most commonly given for marital and relationship problems (17.8% of the problems managed for this group of additional encounters).

2.5 Mental health-specific Medicare Benefits Schedule items for general practice

Since 2002 several additional items have been included on the MBS to support GPs coordinating the treatment needs of patients with mental health-related problems:

- The 2002 Better Outcomes in Mental Health Care initiative, designed to improve community access to quality primary mental health services by providing better education and training for GPs and more support from allied health professionals and psychiatrists, introduced new MBS items for eligible GPs under the headings 3 Step Mental Health Process and Focussed Psychological Strategies.
- The 2006 Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative, designed to improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals, introduced GP Mental Health Care Plans as well as psychiatrist and allied health worker items which are linked to these plans.

The MBS groups, subgroups and item numbers associated with these initiatives are detailed in Appendix 1.

This section reviews the use of these MBS items by GPs through analysis of both MBS data and BEACH survey data. The tables in this section show the numbers of patients and/or services for each of the main groups of MBS-subsidised specific mental health services provided by GPs and other medical practitioners (OMPs). These are MBS items that 'define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders' (DoHA 2007a) as distinct from general surgery consultations where a mental health-related problem is managed (see Key concepts).

There were 599,337 MBS-subsidised mental health services provided by GPs and OMPs in 2006–07 (Table 2.6). The great majority (91%) of these services were for the preparation or review of GP Mental Health Care Plans. This group of items was only introduced on

1 November 2006 so the 546,515 claims do not relate to a full year. The other GP/OMP MBS items shown in Table 2.6 are all for the full financial year 2006–07.

Table 2.6: MBS-subsidised specific GP/OMP mental health services, by item group of service provided, 2002–03 to 2006–07

Item group[(a)]	2002–03	2003–04	2004–05	2005–06	2006–07
GP Mental Health Care Plans	. .	. .	. .	. .	546,515
Focussed Psychological Strategies	2,779	17,523	25,450	30,261	36,779
3 Step Mental Health – GPs	7,479	13,411	16,099	25,005	15,535
3 Step Mental Health – OMPs	406	958	1,049	917	508
Total	**10,664**	**31,892**	**42,598**	**56,183**	**599,337**

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

. . Not applicable.

Source: Medicare Benefits Schedule data (DoHA).

The BEACH survey asks GPs to record an MBS item for each encounter. Analysis of the data collected for encounters where a mental health-related problem was managed (or a psychologically-related management procedure, treatment, counselling, referral or medication was provided, even though another type of problem was managed) showed that in over 90% of these encounters the MBS item recorded was for some form of surgery consultation (Table 2.7). For 2.2% of these encounters an MBS item designated specifically as a mental health service was recorded.

The mental health-specific GP items introduced on 1 November 2006 as part of the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative (items 2710, 2712 and 2713) accounted for 0.3% of MBS items recorded for BEACH, 2006–07 across all encounters. Converted to a population estimate, this suggests that these items were billed for around 244,000 GP encounters from November 2006 to March 2007 when the BEACH survey year concluded. The 95% confidence interval on this estimate ranges from 178,000 to 310,000. Medicare Australia data indicate that 301,000 claims for these items were processed in this period, so the BEACH estimate is consistent with the MBS administrative data.

The analysis of BEACH survey data earlier in this chapter showed that GPs had an estimated 10.7 million encounters in 2006–07 where at least one mental health-related problem was managed, plus another 2.3 million (estimated) additional encounters where a psychologically-related management procedure, treatment, counselling, referral or medication was provided. Given the compatibility of the BEACH estimates with the MBS administrative data demonstrated above, the 0.6 million MBS-subsidised specific mental health services provided by GPs and OMPs in 2006–07 (Table 2.6) can be subtracted from these estimates, to indicate that there were over 12 million estimated GP mental health-related encounters that did not result in claims for mental health-specific MBS items.

Table 2.7: Selected[(a)] MBS items recorded for mental health-related encounters, BEACH, 2006–07

Rank	MBS item number	Item description	Per cent of total MBS items for mental health-related encounters	
			Item	Cumulative
1	23	Surgery consultation – level 'B' (standard)	67.9	67.9
2	36	Surgery consultation – level 'C' (long)	20	87.9
3	35	Consultation at a residential aged care facility – level 'B'	2.5	90.4
4	44	Surgery consultation – level 'D' (prolonged)	2.2	92.6
5	2710	GP mental health care plan – preparation	1.2	93.8
6	24	Home visit – level 'B'	0.9	94.6
7	3	Surgery consultation – level 'A' (short)	0.8	95.5
8	2713	GP mental health care plan – surgery consultation	0.7	96.2
9	5020	Surgery consultation – after hours – level 'B'	0.6	96.8
10	721	GP management plan – preparation	0.4	97.1
11	25	Consultation at an institution other than a hospital or residential aged care facility – level 'B'	0.3	97.5
12	33	Consultation at a hospital – level 'B'	0.2	97.7
17	2574	Completion of the 3 Step Mental Health Process – surgery consultation – level 'C'	0.1	98.5
21	2712	GP mental health care plan – review	0.1	98.9
32	2721	Focussed psychological strategies – surgery consultation	0.04	99.5
35	2725	Focussed psychological strategies – surgery consultation (extended)	0.03	99.6
41	2577	Completion of the 3 Step Mental Health Process – surgery consultation – level 'D'	0.02	99.8
Subtotal – Better Access items introduced 1 November 2006[(b)]			**2**	**. .**
Subtotal – Better Outcomes in Mental Health Care items introduced in 2002[(b)]			**0.2**	**. .**

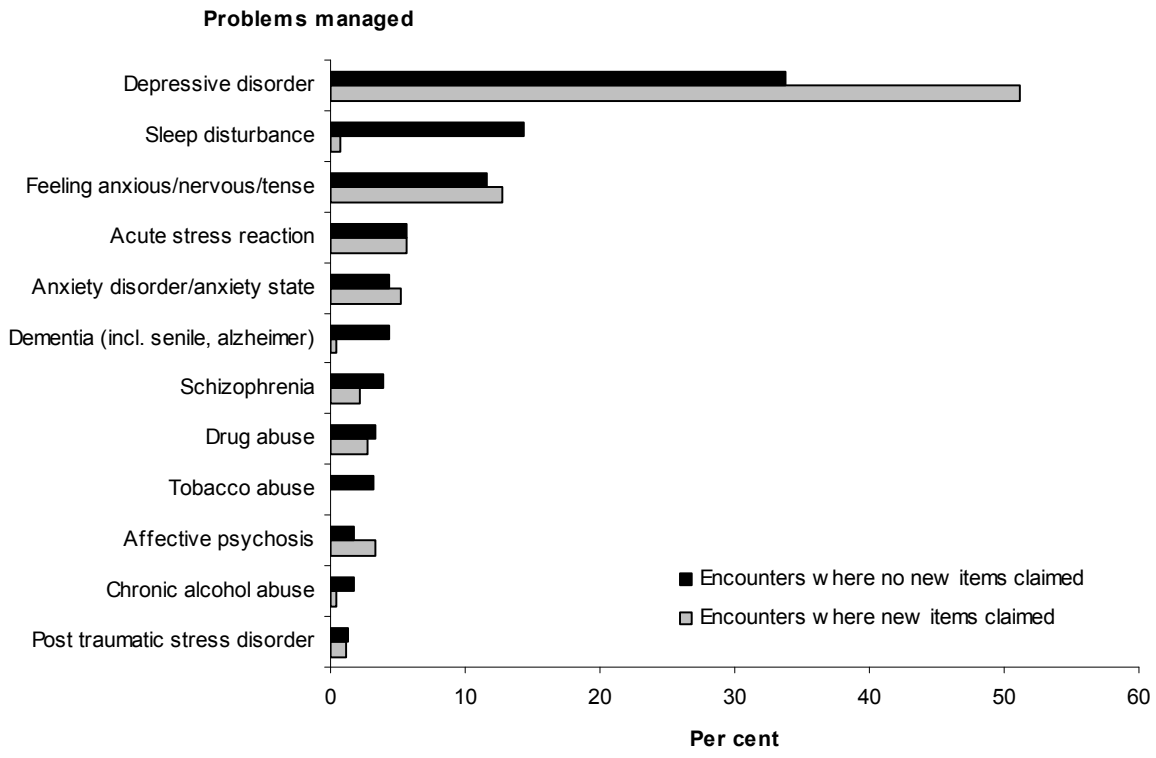
(a) Top 12, plus items which were part of the 2002 and 2006 initiatives.

(b) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these items.

. . Not applicable.

Source: BEACH survey of general practice activity.

For those GP encounters where the new Better Access to Psychiatrists, Psychologists and GPs through the MBS items were recorded, the 'P' code problems managed were distributed as shown in Figure 2.2. For comparison, Figure 2.2 also shows the distribution of 'P' code problems managed where an MBS item other than one of the new mental health-specific items was recorded. The new items tended to be recorded comparatively more for depressive and anxiety disorders and affective psychosis, and comparatively less for conditions such as sleep disturbance, dementia and tobacco abuse.



(a) GP Mental Health Care Plan items which were part of the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative introduced on 1 November 2006.

Source: BEACH survey of general practice activity.

Figure 2.2: Distribution of psychological problems managed in GP encounters where new mental health-specific MBS items[(a)] were recorded, BEACH, 2006–07

Table 2.8 shows the demographic and geographic distribution of patients in receipt of mental health-specific GP and OMP MBS items. In terms of both absolute numbers and population-adjusted rates, females and people aged 35–44 years were the biggest consumers of these services. Females received nearly twice as many of these services as males. The majority of consumers of these services were resident in major cities, however once population size was taken into account, residents of inner regional, outer regional and remote areas all had higher rates of usage.

The geographical distribution for each of the component item groups making up the mental health-specific GP and OMP MBS items can be seen in Table 2.9. While the number of patients and services is greatest in major cities for each item group, the rate of usage by residents of major cities is actually lower than that for the other regions (except for very remote in the case of GP Mental Health Care Plans which is well below all other regions).

Table 2.10 shows that allowing for state/territory population size, the rate of MBS-subsidised specific mental health services provided by GPs and OMPs was highest in Victoria (33.4 per 1,000) and lowest in the Northern Territory (12.1 per 1,000). New South Wales also has a relatively high rate (30.7 per 1000) and there is a significant positive correlation between these rates and the state/territory population size.

Table 2.8: People receiving MBS-subsidised GP/OMP services: patient demographic characteristics and services received, 2006–07(a)

Patient demographics	Number of patients[(b)]	Per cent of patients	Rate (per 1,000 population)[(c)]	Number of services[(b)]	Per cent of services	Services per patient
Age (years)						
Less than 15	17,325	4.4	4.3	20,071	3.3	1.2
15–24	58,534	14.9	20.2	85,096	14.2	1.5
25–34	85,967	21.8	29.6	130,393	21.8	1.5
35–44	91,856	23.3	29.9	142,875	23.8	1.6
45–54	71,945	18.3	24.9	113,982	19	1.6
55–64	42,743	10.9	18.6	67,536	11.3	1.6
65+	25,146	6.4	9.2	39,384	6.6	1.6
Sex						
Male	135,515	34.4	13.1	206,361	34.4	1.5
Female	258,001	65.6	24.6	392,976	65.6	1.5
Remoteness area						
Major cities	248,953	63.3	17.6	380,159	63.4	1.5
Inner regional	92,330	23.5	22.6	141,801	23.7	1.5
Outer regional	41,376	10.5	21.1	61,734	10.3	1.5
Remote	6,701	1.7	21	9,506	1.6	1.4
Very remote	1,752	0.4	10.3	2,594	0.4	1.5
Total GP/OMP items[(b)]	**393,516**	**100**	**19**	**599,337**	**100**	**1.5**

(a) GP Mental Health Care Plan items were introduced on 1 November 2006 so data are not for a full year.

(b) The numbers of patients and services for each demographic variable may not sum to the total due to omitted unknown/migratory data.

(c) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

Source: Medicare Benefits Schedule data (DoHA).

Table 2.9: People receiving MBS-subsidised GP/OMP mental health services: patient area of residence and services received, by remoteness area and by item group[a], 2006–07[b]

Patient area of residence	Number of patients[c]	Per cent of patients	Rate (per 1,000 population)[d]	Number of services[c]	Per cent of services	Services per patient
GP Mental Health Care Plans						
Major cities	237,987	63.5	16.8	347,535	63.6	1.5
Inner regional	87,897	23.4	21.5	129,277	23.7	1.5
Outer regional	38,793	10.3	19.8	55,580	10.2	1.4
Remote	6,294	1.7	19.7	8,545	1.6	1.4
Very remote	1,584	0.4	9.3	2,296	0.4	1.4
Total[c]	**372,709**	**100**	**18.1**	**546,515**	**100**	**1.5**
Focussed Psychological Strategies						
Major cities	9,567	62.8	0.7	23,310	63.4	2.4
Inner regional	3,422	22.5	0.8	8,408	22.9	2.5
Outer regional	1,751	11.5	0.9	4,003	10.9	2.3
Remote	338	2.2	1.1	717	1.9	2.1
Very remote	82	0.5	0.5	160	0.4	2
Total[c]	**15,112**	**100**	**0.7**	**36,779**	**100**	**2.4**
3 Step Mental Health – GPs						
Major cities	9,013	58	0.6	9,016	58	1
Inner regional	3,972	25.6	1	3,972	25.6	1
Outer regional	2,088	13.4	1.1	2,088	13.4	1
Remote	244	1.6	0.8	244	1.6	1
Very remote	135	0.9	0.8	135	0.9	1
Total[c]	**15,535**	**100**	**0.8**	**15,535**	**100**	**1**
3 Step Mental Health – OMPs						
Major cities	323	63.6	0	323	63.6	1
Inner regional	130	25.6	0	130	25.6	1
Outer regional	45	8.9	0	45	8.9	1
Remote	8	1.6	0	8	1.6	1
Very remote	1	0.2	0	1	0.2	1
Total[c]	**508**	**100**	**0**	**508**	**100**	**1**

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

(b) GP Mental Health Care Plan items were introduced on 1 November 2006 so data are not for a full year.

(c) The numbers of patients and services may not sum to the total due to omitted unknown/migratory data.

(d) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

Source: Medicare Benefits Schedule data (DoHA).

Table 2.10: MBS-subsidised specific GP/OMP mental health services, numbers of patients and services provided, by item group[a], states and territories[b], 2006–07

Provider	Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of patients					
General Practitioners	GP Mental Health Care Plans	130,499	107,212	65,309	31,820	23,673	8,035	5,199	1,535	372,709
	Focussed Psychological Strategies	5,653	4,015	2,991	903	1,174	271	94	48	15,112
	3 Step Mental Health – GPs	5,968	3,979	2,368	1,449	1,226	253	202	93	15,535
Other Medical Practitioners	3 Step Mental Health – OMPs	150	221	74	24	34	5	0	0	508
Total GP/OMP patients[c]		**138,313**	**112,382**	**68,726**	**33,476**	**25,293**	**8,369**	**5,352**	**1,605**	**393,516**
Rate (per 1,000 population)[c][d]		20.2	21.8	16.6	16.1	16.1	17	15.9	7.6	18.9
					Number of services					
General Practitioners	GP Mental Health Care Plans	190,522	158,775	93,489	48,171	34,973	11,232	6,965	2,388	546,515
	Focussed Psychological Strategies	13,892	9,442	7,637	1,750	3,262	557	151	88	36,779
	3 Step Mental Health – GPs	5,973	3,977	2,367	1,445	1,225	253	202	93	15,535
Other Medical Practitioners	3 Step Mental Health – OMPs	150	221	74	24	34	5	0	0	508
Total GP/OMP services[c]		**210,537**	**172,415**	**103,567**	**51,390**	**39,494**	**12,047**	**7,318**	**2,569**	**599,337**
Rate (per 1,000 population)[c][d]		30.7	33.4	25.1	24.7	25.1	24.5	21.8	12.1	28.7

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

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

(c) The numbers of patients may not sum to the total, as a patient may receive services from more than one item group in more than one state or territory and therefore may be counted in more than one MBS item group and state or territory.

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

Source: Medicare Benefits Schedule data (DoHA).

3 Mental health-related care in emergency departments

3.1 Introduction

Hospital emergency departments play a role in treating mental illness. The emergency department can be the initial point of care for a multitude of reasons. 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 another 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.

Information on selected ***mental health-related emergency department occasions of service*** was included in this report for the first time in 2004–05, with the aim of providing a more complete picture of mental health-related services in Australia.

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. The AIHW compiles this episode-level data annually 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, which 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

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 (codes F00–F99) in the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification (ICD-10-AM) or the equivalent codes in the International Statistical 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 A1.2.

State and territory health authorities provided aggregate 2005–06 information on the demographic characteristics, triage category, departure status and principal diagnosis of patients for whom mental health-related occasions of service were reported. Principal

diagnosis was reported on the basis of 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 (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 about 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 has limitations:

- **Not all occasions of service in emergency departments within a state or territory are reported with detailed episode-level data.**

  Nationally, in 2005–06, an estimated 22% of the 4.9 million public hospital emergency department occasions of service were not reported with episode-level data and thus not included in the NAPEDCD (Appendix Table A1.3). In addition, non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals are not included.

  The ABS estimates there were 423,300 non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals in 2005–06 (ABS 2007b).

- **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 2005–06, the proportion of reported occasions of service with a diagnosis was 92% (Appendix Table A1.3).

- **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.**

As a consequence, the data presented in this chapter is likely to under-report the actual number of mental health-related emergency department occasions of service. Further information on data collection limitations can be found in Appendix 1.

3.3 Mental health-related emergency department care

State and territories reported a total 144,006 emergency department occasions of service with a mental health-related principal diagnosis in 2005–06. However, taking into account state and territory estimates of the coverage of their emergency department data collections and the total proportion (72%) of all occasions of service with a principal diagnosis reported, it is estimated that there were 200,000 mental health-related emergency department occasions of service in public hospitals in 2005–06. This represents an increase of 5% on the estimated number of mental health-related emergency department occasions of service reported in 2004–05 (190,000). Further information on estimated and reported emergency department occasions of service is available in Appendix 1.

Patient demographics

The demographic characteristics reported for mental health-related emergency department occasions of service in 2005–06 are contained 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.

Mental health-related emergency department occasions of service differ markedly in their age distribution when compared with all emergency occasions of service, featuring a higher percentage in the 15–54 year age bracket (79.9% and 51.6%, respectively) and significantly lower rates of those aged less than 15 years (3.0% and 23.0%, respectively).

In 2005–06, males made up a slightly higher proportion of mental health-related emergency department occasions of service than females (51.6% compared with 48.4%). This was in line with the distribution for all emergency department occasions of service (52.1% male).

Aboriginal and Torres Strait Islander peoples accounted for 5.0% of the mental health-related emergency department occasions of service. This compares with 4.3% 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 A1.3). Consequently, the coverage may not include areas where the proportion of Indigenous Australians (compared with other Australians) may be higher than average. Therefore, these data may not be indicative of the rate of use of emergency department services by Indigenous Australians on a national level. In addition, when reporting data to the NAPEDCD, most states and territories cautioned that information on Indigenous status collected in emergency departments could be less accurate than the

corresponding information collected on admitted patients. Furthermore, the data are also of variable quality across jurisdictions (AIHW 2007a).

Table 3.1: Mental health-related emergency department occasions of service[a] in public hospitals, by patient demographic characteristics, 2005–06

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 (years)			
Less than 15	4,357	3.0	23.0
15–24	31,736	22.0	15.6
25–34	34,843	24.2	14.5
35–44	29,243	20.3	11.9
45–54	19,220	13.3	9.6
55–64	10,283	7.1	7.9
65–74	5,572	3.9	6.7
75+	8,744	6.1	10.7
Sex			
Male	74,257	51.6	52.1
Female	69,740	48.4	47.9
Indigenous status			
Indigenous Australians	7,220	5.0	4.3
Other Australians[e]	136,786	96.5	95.7
Total	**144,006**	**100**	**100**

(a) Includes 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 (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 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 NAPEDCD 2005–06.

(e) Other Australians includes 'not reported' Indigenous status.

Source: Data provided by state and territory health authorities.

Principal diagnosis

States and territories provided data on mental health-related occasions of services by principal diagnosis, based on the broad categories 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 A1.3.

In 2005–06, four diagnosis categories accounted for the majority (86.0%) of mental health-related occasions of service (Table 3.2). These were *Neurotic, stress-related and somatoform disorders* (F40–F48, 28.3%), *Mental and behavioural disorders due to psychoactive substance use* (F10–F19, 22.1%), *Mood (affective) disorders* (F30–F39, 18.7%) and *Schizophrenia, schizotypal and delusional disorders* (F20–F29, 16.9%). These proportions are very similar to the 2004–05 breakdown, where the top four diagnoses accounted for 85.5% of the total.

The extent to which these four diagnosis categories contributed to the mental health-related emergency department occasions of service varied substantially across states and territories (Table 3.2). However, these variations should be interpreted carefully, as they may change year to year 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.

Table 3.2: Mental health-related emergency department occasions of service[(a)] in public hospitals, by principal diagnosis, states and territories, 2005–06

Principal diagnosis (ICD-10-AM)	NSW[(b)]	Vic	Qld	WA	SA[(b)]	Tas	ACT	NT	Total	Per cent of total
F00-F09: Organic, including symptomatic, mental disorders	1,558	1,329	990	998	726	254	99	75	6,029	4.2
F10-F19: Mental and behavioural disorders due to psychoactive substance use	10,827	7,491	5,588	2,766	2,694	882	606	982	31,836	22.1
F20-F29: Schizophrenia, schizotypal and delusional disorders	10,061	5,053	3,800	1,241	2,092	874	551	648	24,320	16.9
F30-F39: Mood (affective) disorders	9,864	6,501	5,146	1,642	1,739	1,067	640	343	26,942	18.7
F40-F48: Neurotic, stress-related and somatoform disorders	16,998	8,546	4,655	3,880	4,449	771	706	727	40,732	28.3
F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors	240	198	1,552	48	90	28	15	9	2,180	1.5
F60-F69: Disorders of adult personality and behaviour	643	928	1,894	300	674	231	75	24	4,769	3.3
F70-F79: Mental retardation	22	13	84	0	5	0	1	0	125	0.1
F80-F89: Disorders of psychological development	73	0	90	11	21	1	22	1	219	0.2
F90-F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3,002	510	472	287	319	47	22	72	4,731	3.3
F99: Unspecified mental disorder	72	760	35	106	187	362	0	601	2,123	1.5
Total	**53,360**	**31,329**	**24,306**	**11,279**	**12,996**	**4,517**	**2,737**	**3,482**	**144,006**	**100.0**

(a) Includes 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 (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 2005–06. 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 A1.2.

Source: Data provided by state and territory health authorities.

Triage category

Triage category is related to the urgency of the patient's need for medical and nursing care, 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. However, they may or may not actually receive care within that time frame.

In 2005–06, 5.8% of mental health-related occasions of service in emergency departments were considered non-urgent (requiring care within 120 minutes), 36.4% were recorded as semi-urgent (within 60 minutes) and 45.9% as urgent (within 30 minutes). A further 11.0% were classified as emergency (requiring care within 10 minutes) and 0.8% as resuscitation (within seconds) (Table 3.3). These proportions are similar to 2004–05 data. Mental health-related occasions of service (56.9%) were more likely than all emergency department occasions of service (40.0%) to be assessed as urgent and as emergency (AIHW 2007a).

Table 3.3: Mental health-related emergency department occasions of service[(a)] in public hospitals, by triage category, states and territories, 2005–06

Triage category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]	Per cent of total[(c)]
Resuscitation	294	362	259	78	137	28	25	29	1,212	0.8
Emergency	5,372	3,191	2,860	1,268	1,896	536	374	347	15,844	11.0
Urgent	26,040	12,585	11,466	5,023	5,936	2,169	1,192	1,657	66,068	45.9
Semi-urgent	18,396	12,897	8,553	4,455	4,231	1,696	1,029	1,192	52,449	36.4
Non-urgent	3,250	2,294	1,168	441	796	88	117	257	8,411	5.8
Total	**53,360**	**31,329**	**24,306**	**11,279**	**12,996**	**4,517**	**2,737**	**3,482**	**144,006**	**100**

(a) Includes 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 (codes F00–F99) or the equivalent ICD-9-CM codes.

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

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

Source: Data provided by state and territory health authorities.

Departure status

In 2005–06, the departure status for over half of the mental health-related emergency department occasions of service was recorded as completed (Table 3.4). That is, 58.8% of these occasions of service were completed without admission or referral to another hospital. Just over one-third (34.4%) of mental health-related occasions of service were closed with the patient being admitted to the hospital to which he or she presented, which is slightly higher than the 27.5% for all emergency department occasions of service (AIHW 2007a). A further 4.3% of mental health-related patients were referred to another hospital.

Table 3.4: Mental health-related emergency department occasions of service[a] in public hospitals, by departure status, states and territories, 2005–06

Departure status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Per cent of total
Admitted to this hospital[b]	22,490	7,315	7,580	3,611	4,007	2,262	941	1,327	49,533	34.4
Non-admitted patient emergency department service episode completed[c]	26,639	21,861	15,693	6,821	7,698	2,136	1,710	2,058	84,616	58.8
Referred to another hospital for admission	2,635	1,341	477	586	1,029	63	47	11	6,189	4.3
Did not wait to be attended by a health care professional	277	0	247	55	52	12	6	2	651	0.5
Left at own risk[d]	1,211	811	308	200	114	37	33	82	2,796	1.9
Not reported[e]	108	1	1	6	96	7	0	2	221	0.2
Total	**53,360**	**31,329**	**24,306**	**11,279**	**12,996**	**4,517**	**2,737**	**3,482**	**144,006**	**100.0**

(a) Includes 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 (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 4 occasions of service with a departure status of 'Died in emergency department as a non-admitted patient' and 3 occasions of service with a departure status of 'Dead on arrival, not treated in emergency department'.

Source: Data provided by state and territory health authorities.

4 Community mental health and hospital outpatient services

4.1 Introduction

This chapter presents information on mental health care provided by community mental health services and hospital outpatient services. The data are derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on government-operated specialised mental health services provided to non-admitted patients in community-based and hospital-based ambulatory care settings. These types of services are generally referred to as ***community mental health care***. The statistical unit for the NCMHCD is a ***service contact*** between a client and a specialised mental health service provider. Appendix 1 provides information about the coverage and data quality of this collection.

Key concepts

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

Service contacts 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, 2005–06). 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 States and territories

In 2005–06, there were 5,665,408 community mental health care service contacts reported nationally. The number of patients accessing community service contacts was estimated to be 594,436. In general, a patient is allocated a unique identifier by the service provider. The estimated figure was derived from counting the number of unique patient identifiers for each individual provider reporting to the database. This means that patients who used services from multiple providers will be counted more than once, which will inflate the overall patient count.

Table 4.1 presents data on the number of service contacts and estimated number of patients for all states and territories. As outlined above, the estimated jurisdiction counts of patients are of limited reliability and cannot be used for comparative purposes to derive estimates of relative access to community mental health care in each jurisdiction. However, six of the jurisdictions – namely Victoria, Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory – were able to provide an actual count of patients which were also presented in the table. Of these jurisdictions, the Australian Capital Territory had the highest number of service contacts per patient (36.3).

Table 4.1: Community mental health care service contacts, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service contacts	1,832,177	1,833,205	892,393	492,468	302,400	65,576	210,833	36,356	5,665,408
Patients[(a)]	n.a.	58,063	69,158	35,965	n.a.	5,997	5,812	4,562	n.a.
Average service contacts per patient[(a)]	n.a.	31.6	12.9	13.7	n.a.	10.9	36.3	8.0	n.a.
Estimated number of patients[(b)]	300,603	102,893	84,459	46,215	34,056	5,992	13,441	6,777	594,436
Average service contacts per estimated number of patients[(b)]	6.1	17.8	10.6	10.7	8.9	10.9	15.7	5.4	9.5
				Rate (per 1,000 population)[(c)]					
Service contacts	265.1	357.3	221.5	242.2	195.6	130.5	616.3	170.8	274.9
Patients[(a)]	n.a	11.3	17.2	17.7	n.a	n.a	17.2	n.a	n.a
Estimated number of patients[(b)]	42.6	20.1	21.0	22.8	22.5	12.7	39.1	31.8	28.7

(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.

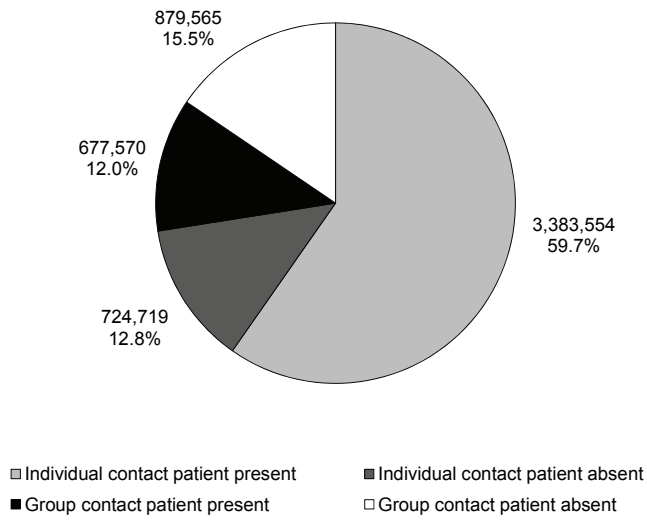
(c) Rates were directly age-standardised as detailed in Appendix 2.

n.a. Not available

Source: National Community Mental Health Care Database.

4.3 Type of service contacts

Community mental health care service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. These contacts can be conducted in the presence or the absence of the patient. Figure 4.1 shows the numbers of service contacts by contact type and patient presence status. The majority (72.5%) of contacts reported were individual contacts. Of these, 82.4% were conducted in the presence of the patients. The pattern differed for group contacts where there were more group contacts conducted without the patient being present (56.5%) than those attended by the patients (43.5%).

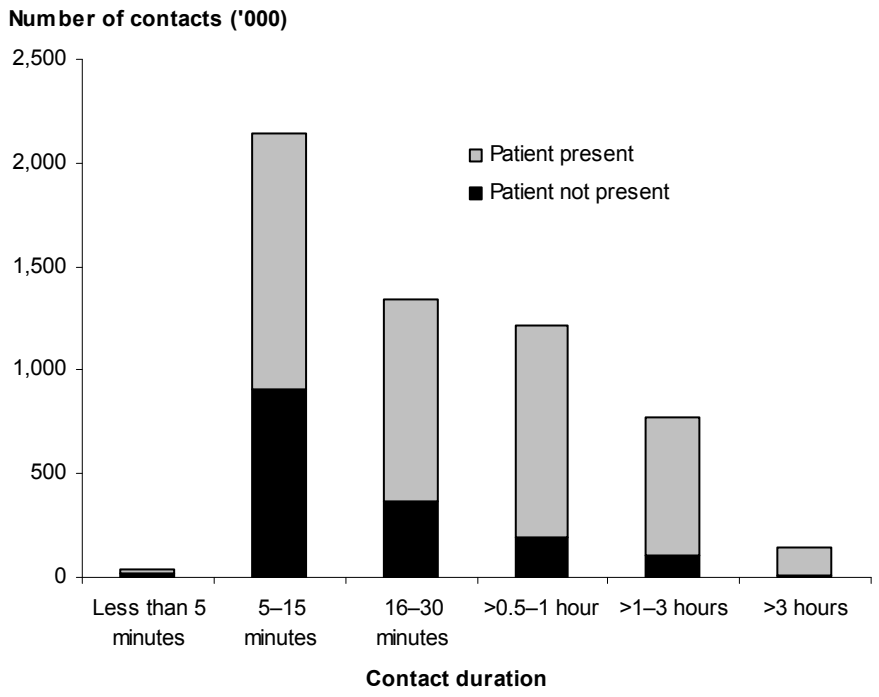


Source: National Community Mental Health Care Database.

Figure 4.1: Community mental health service contacts, by contact type and patient presence status, 2005–06

4.4 Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to more than 8 hours (Figure 4.2). The most common duration of service contacts was 5–15 minutes, with 37.9% of contacts in this category. However, 2,833 contacts (0.1%) were recorded with a duration of 999 minutes, which is the maximum length for the duration of a contact in the NCMHCD, and may simply result from open ended contacts being recorded with no end date. When these open ended contacts are excluded, 147,772 contacts (2.6%) were reported to have lasted more than 3 hours. The majority of these contacts were group sessions attended by the patients (139,784 or 94.6%).



Source: National Community Mental Health Care Database.

Figure 4.2: Duration of community mental health care service contacts, 2005–06

4.5 Mental health legal status

Broadly speaking, the state and territory mental health acts provide the legislative cover that safeguards the rights and governs the treatment of patients with mental illness in hospitals and the community. The legislation varies between the state and territory jurisdictions but all contain provisions for the assessment, admission and treatment of patients on an involuntary basis. A patient's mental health legal status refers to whether the patient is receiving treatment on a voluntary or involuntary basis. Patients with involuntary mental health legal status are defined as 'persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care'.

Table 4.2 presents the number of service contacts by jurisdiction and the patient's mental health legal status. Nationally, 16.5% of all service contacts were classified as involuntary. Different patterns appear across the jurisdictions. The Australian Capital Territory and Victoria both reported higher proportions of service contacts for which mental health legal status was involuntary (30.2% and 25.9%, respectively). The Australian Capital Territory also had the highest proportion of service contacts for which the mental health legal status was not reported (66.3%). Western Australia reported the lowest proportion of involuntary contacts (2.1%). These jurisdictional differences may be a reflection of the different legislative arrangements in place in the jurisdictions.

Table 4.2: Community mental health care service contacts, by mental health legal status, states and territories, 2005–06

Mental health legal status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Involuntary	260,704	474,613	79,268	10,245	44,094	2,099	63,633	1,874	936,530
Voluntary	1,571,473	1,358,592	813,125	482,223	254,502	50,649	7,364	34,421	4,572,349
Not reported	0	0	0	0	3,804	12,828	139,836	61	156,529
Total	**1,832,177**	**1,833,205**	**892,393**	**492,468**	**302,400**	**65,576**	**210,833**	**36,356**	**5,665,408**

Source: National Community Mental Health Care Database.

4.6 Patient demographics

Table 4.3 presents information on the number of service contacts in 2005–06 for various demographic groups. A rate (per 1,000 population) has also been provided to account for differences in the relative size and age structure of the respective populations. 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. Rather they provide information on the number of service contacts relative to the size of the population subgroup.

The highest number of contacts per 1,000 population were for patients aged 25–34 years (412.1) followed by those aged 35–44 years (341.1). The youngest age group (less than 15 years) was the least represented in both proportions of contacts (6.9%) and contacts per 1,000 population (96.3).

The data on contacts for Aboriginal and Torres Strait Islander peoples compared with non-Indigenous Australians should be interpreted with caution due to uncertainty about the quality of Indigenous identification in the data. Table 4.3 presents national data on Indigenous status, but note that only data from Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory were reported to be of acceptable quality (see Appendix 1 for more information). As a consequence, it is likely that the number of contacts for Indigenous Australians is underestimated. Although there were fewer contacts reported for Indigenous Australians compared with other Australians, when the size and age structure of the two populations were taken into account, there was a higher number of contacts per 1,000 population for Indigenous Australians than for non-Indigenous Australians (531.7 and 270.3, respectively).

More than half of the service contacts were reported by patients who were never married (71.3%) while those who were widowed were least represented (3.5%).

The data show that the typical service contact involves a patient who is an Australian-born non-Indigenous male aged 20–34 years who has never been married and lives in a major city.

Table 4.3: Community mental health care service contacts, by patient demographic characteristics, 2005–06

Patient demographics	Number of service contacts[a]	Per cent of service contacts[b]	Rate (per 1,000 population)[c]
Age (years)			
Less than 15	388,972	7.5	96.3
15–24	902,030	17.3	316.7
25–34	1,196,758	23.0	412.1
35–44	1,040,166	19.9	341.1
45–54	734,274	14.1	259.0
55–64	404,951	7.8	182.2
65+	547,043	10.5	205.8
Sex			
Male	2,780,275	53.2	274.1
Female	2,444,066	46.8	235.4
Indigenous status[d]			
Indigenous Australians	247,263	5.1	531.7
Other Australians	4,593,776	94.9	270.3
Country of birth			
Australia	4,670,717	84.9	312.7
Overseas	832,713	15.1	151.6
Remoteness area of usual residence			
Major cities	3,511,071	67.0	256.9
Inner regional	1,188,551	22.7	289.1
Outer regional	466,436	8.9	233.2
Remote and Very remote	78,084	1.5	155.7
Marital status			
Never married	3,686,330	71.3	. .
Widowed	178,384	3.5	. .
Divorced	380,022	7.3	. .
Separated	233,768	4.5	. .
Married	691,951	13.4	. .
Total	**5,665,408**	**100.0**	**274.9**

(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 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 3.

(d) These data should be interpreted with caution due to likely under-identification of Indigenous Australians.

. . Not applicable.

Source: National Community Mental Health Care Database.

4.7 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for the service contact. Table 4.4 presents the number of service contacts for principal diagnosis groups for 2005–06. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 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).

In 2005–06, a principal diagnosis was specified for 89.2% (5,051,999) of community mental health care service contacts. For those contacts:

- The most common principal diagnosis reported was *Schizophrenia* (F20) which was reported for 31.7% of all contacts. This was followed by *Depressive episode* (F32; 10.8%) and *Bipolar affective disorder* (F31; 6.6%).
- There were 45,796 contacts (0.9%) with diagnoses classified as other medical conditions from ICD-10-AM often associated with mental and behavioural disorders.
- A further 826,287 (16.4%) contacts were recorded with diagnoses classified as contextual factors that are considered to contribute significantly to the occurrence, presentation, course, outcome or treatment of a mental disorder.

Figure 4.3 shows the characteristics of community mental health care service contacts for the five most commonly reported principal diagnoses classified as mental and behavioural disorders. The proportion of contacts with duration lasting more than one hour was highest for *Depressive episode* (F32; 21.4%), which also recorded the lowest percentage of contacts lasting less than 15 minutes (32.7%). Over 90% of the contacts for *Schizoaffective disorders* (F25) lasted less than one hour. For *Reaction to severe stress and adjustment disorders* (F43), contacts lasting more than 15 minutes and up to one hour were the most common.

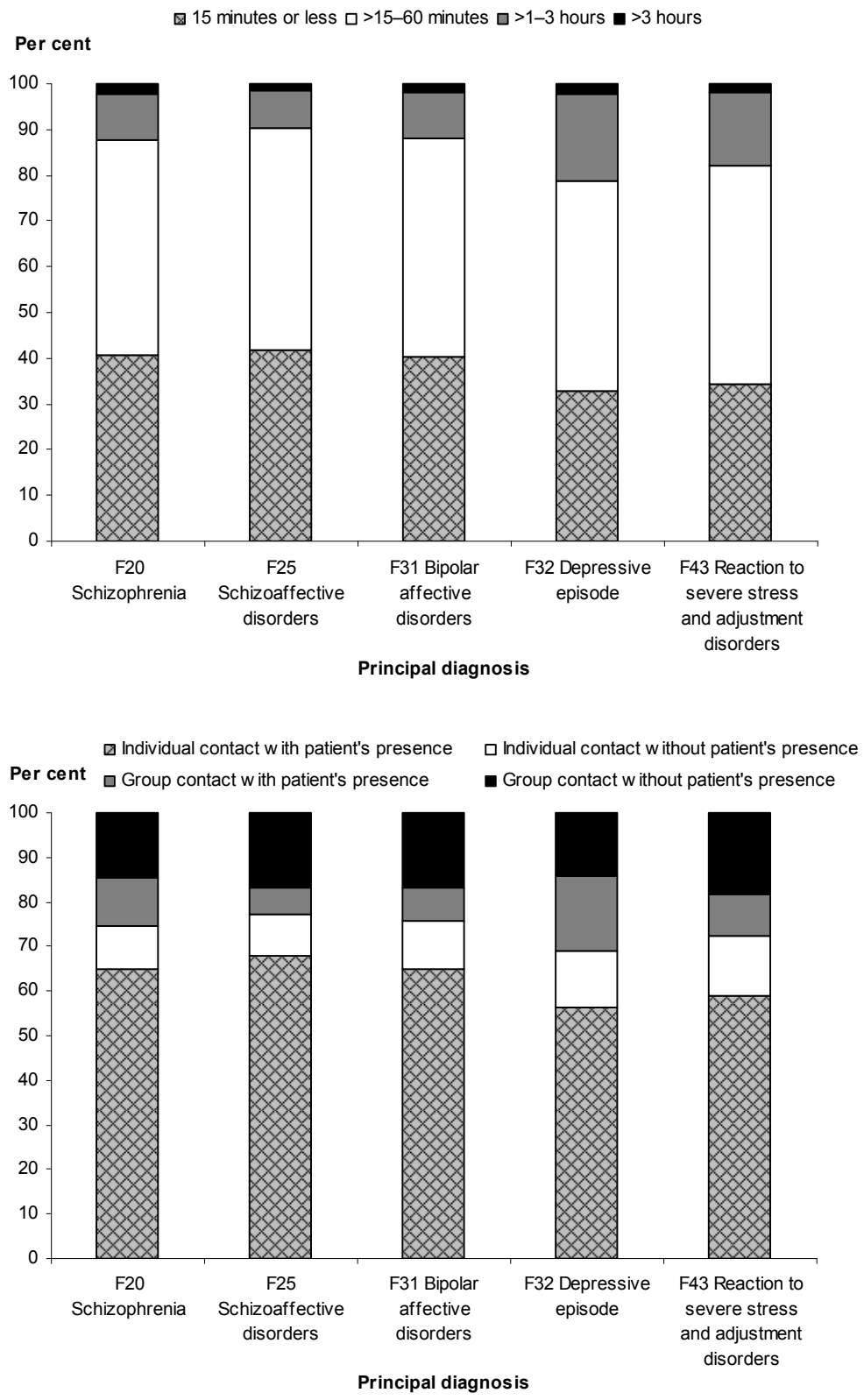
There were more group contacts for the diagnosis of *Depressive episode* (F32; 31.0%) and *Reaction to severe stress and adjustment disorders* (F43; 27.7%). The latter diagnosis was also the one with the highest percentage of service contacts in the absence of the patient (31.4%). The majority (74.7%) of group contacts with the diagnosis of *Schizoaffective disorders* (F25) were conducted in the absence of the patient.

Table 4.4: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, 2005–06

Principal diagnosis		Number of service contacts	Per cent of specified principal diagnoses
F00–F03	Dementia	84,868	1.7
F04–F09	Other organic mental disorders	30,206	0.6
F10	Mental and behavioural disorders due to use of alcohol	41,252	0.8
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	95,582	1.9
F20	Schizophrenia	1,601,984	31.7
F21, F24, F28, F29	Schizotypal and other delusional disorders	68,273	1.4
F22	Persistent delusional disorders	37,492	0.7
F23	Acute and transient psychotic disorders	80,174	1.6
F25	Schizoaffective disorders	276,271	5.5
F30	Manic episode	17,766	0.4
F31	Bipolar affective disorders	332,408	6.6
F32	Depressive episode	546,591	10.8
F33	Recurrent depressive disorders	93,600	1.9
F34	Persistent mood (affective) disorders	41,292	0.8
F38, F39	Other and unspecified mood (affective) disorders	7,145	0.1
F40	Phobic anxiety disorders	26,210	0.5
F41	Other anxiety disorders	137,686	2.7
F42	Obsessive-compulsive disorders	33,726	0.7
F43	Reaction to severe stress and adjustment disorders	206,037	4.1
F44	Dissociative (conversion) disorders	4,512	0.1
F45, F48	Somatoform and other neurotic disorders	6,053	0.1
F50	Eating disorders	40,146	0.8
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	6,973	0.1
F60	Specific personality disorders	164,060	3.2
F61–F69	Disorders of adult personality and behaviour	18,686	0.4
F70–F79	Mental retardation	19,608	0.4
F80–F89	Disorders of psychological development	34,666	0.7
F90	Hyperkinetic disorders	25,293	0.5
F91	Conduct disorders	39,069	0.8
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	62,287	1.2
	Other[(a)]	872,083	17.3
Total with specified principal diagnosis		*5,051,999*	*100.0*
F99	Mental disorder, not otherwise specified	285,681	
	Not reported	327,728	
Total with unspecified principal diagnosis		613,409	
Total		**5,665,408**	

(a) Includes all reported diagnoses that are not in the Mental and behavioural disorders chapter of ICD-10-AM (codes F00–F99).

Source: National Community Mental Health Care Database.



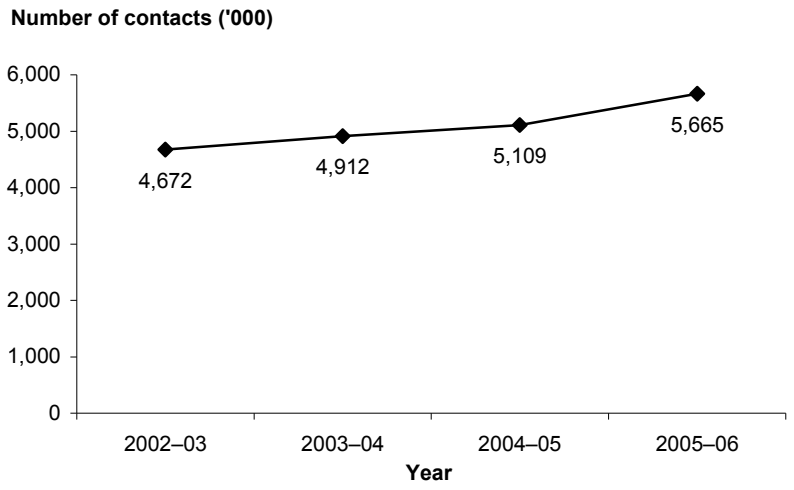
Source: National Community Mental Health Care Database.

Figure 4.3: Characteristics of community mental health service contacts for the five most commonly reported principal diagnoses, 2005–06

4.8 Change over time, 2002–03 to 2005–06

The number of service contacts reported to the NCMHCD has increased over the past few years of collection (Figure 4.4). In 2005–06, there was a 10.9% increase in the number of contacts reported compared with 2004–05. Note that these increases may reflect increases in the actual number of community mental health care services and/or improvements in data coverage. However, not all jurisdictions were able to provide estimates of data coverage for the 2005–06 data. Consequently, it is not possible to determine conclusively what contribution the expanded data coverage may have made to the observed increase in the total number of service contacts being reported. State and territory estimates of coverage for 2005–06 as a proportion of full coverage are listed below:

- New South Wales estimated that their coverage for 2005–06 was similar to 2004–05, which was around 70% of full coverage;
- Victoria did not provide estimates of their coverage for 2005–06. In 2004–05, the estimated data coverage was 83%–85%;
- Queensland estimated their compliance rate to be 50%–60%, which was based on the number of full-time-equivalent staff employed. In 2004–05, the estimated compliance rate was 50%–55%;
- Western Australia did not provide estimates of their data coverage for 2005–06. In 2004–05, it was estimated to be 98%;
- South Australia estimated their coverage to be 91%, with the figure derived as the number of organisations with incomplete or no patient level data for this NMDS divided by the number of organisations reporting community services via the national survey of mental health services for 2005–06. In 2004–05, South Australia estimated their coverage to be 88%;
- Tasmania stated that all service units that were in scope for the collection provided service contact data. However, a significant number of clinicians in some community teams were not providing consistent service contact data. No estimated coverage was provided for 2005–06. In 2004–05, Tasmania estimated that approximately 55% of potential service contacts were recorded;
- the Australian Capital Territory reported their coverage to be 99.2% in 2005–06 compared with 98.9% in 2004–05; and
- the Northern Territory estimated 90% coverage for 2005–06 which was the same as 2004–05. The estimate was based on all in-scope services reporting but there may be some missing data due to non-compliance of some clinicians.



Source: National Community Mental Health Care Database.

Figure 4.4 Community mental health service contacts, 2002–03 to 2005–06

4.9 Additional data

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

5 Ambulatory-equivalent mental health-related admitted patient care

5.1 Introduction

In addition to ambulatory (or non-admitted) care provided by community mental health 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). More detailed 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 applies:

- 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 (codes F00–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 States and territories and hospital type

In 2005–06, a total of 7,311,983 separations were reported from public and private acute and psychiatric hospitals (AIHW 2007a). Of these, 4.4% (322,110) were mental health-related comprising ambulatory-equivalent and admitted patient separations (admitted patient separations are presented in Chapter 7).

There were 117,924 ambulatory-equivalent mental health-related separations reported in 2005–06, accounting for 1.6% of all separations and 36.6% (117,924 out of 322,110) of all mental health-related separations.

Table 5.1 shows the number of separations for each state and territory by hospital type. The number of separations per 1,000 population is provided to account for differences in population size between jurisdictions.

Table 5.1: Ambulatory-equivalent mental health-related separations[(a)] with and without specialised psychiatric care, by hospital type, states and territories, 2005–06

Hospital type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	With specialised psychiatric care								
Public acute hospitals	5,687	237	1,324	61	191	46	33	27	7,606
Public psychiatric hospitals	1,373	0	0	9	6	0	. .	. .	1,388
Private hospitals	22,091	33,200	18,630	6,851	19	n.p.	n.p.	n.p.	84,208
All hospitals	*29,151*	*33,437*	*19,954*	*6,921*	*216*	*n.p.*	*n.p.*	*n.p.*	*93,202*
	Without specialised psychiatric care								
Public acute hospitals	4,599	5,721	2,179	1,177	1,003	370	183	142	15,374
Public psychiatric hospitals	5	0	0	0	0	0	. .	. .	5
Private hospitals	275	3,697	3,232	546	13	n.p.	n.p.	n.p.	9,343
All hospitals	*4,879*	*9,418*	*5,411*	*1,723*	*1,016*	*n.p.*	*n.p.*	*n.p.*	*24,722*
	Total								
Public acute hospitals	10,286	5,958	3,503	1,238	1,194	416	216	169	22,980
Public psychiatric hospitals	1,378	0	0	9	6	0	. .	. .	1,393
Private hospitals	22,366	36,897	21,862	7,397	32	n.p.	n.p.	n.p.	93,551
All hospitals	**34,030**	**42,855**	**25,365**	**8,644**	**1,232**	**n.p.**	**n.p.**	**n.p.**	**117,924**
	Rate (per 1,000 population)[(b)]								
Public acute hospitals	1.5	1.2	0.9	0.6	0.8	0.9	0.6	0.8	1.1
Public psychiatric hospitals	0.2	0.0	0.0	0.0	0.0	0.0	. .	. .	0.1
Private hospitals	3.3	7.2	5.4	3.6	0.0	n.p.	n.p.	n.p.	4.6
All hospitals	**5.0**	**8.4**	**6.3**	**4.2**	**0.8**	**n.p.**	**n.p.**	**n.p.**	**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) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

n.p. Not published. Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published due to confidentiality reasons. However, the figures are included in the national totals.

Source: National Hospital Morbidity Database.

The data show that private hospitals were the predominant providers (79.3%, 93,551 out of 117,924) of ambulatory-equivalent mental health-related admitted patient care. The number of separations reported by public psychiatric hospitals constituted 1.2% (1,393 out of 117,924) with New South Wales being the major provider (98.9%).

Specialised psychiatric care was provided in 79% of all separations (93,202 out of 117,924) primarily by private hospitals (90.3%). This was particularly significant in Victoria where private hospital separations constituted 99.3% of all separations (33,200 out of 33,437).

Public acute hospitals played a more significant role in separations without specialised psychiatric care (15,374 out of 24,722 or 62.2%).

Victoria reported the highest number of separations per 1,000 population (8.4) while South Australia has the lowest (0.8). South Australia was also the only state where public acute hospitals were the major providers of ambulatory-equivalent admitted patient care.

5.3 Mental health legal status

Table 5.2 shows the number of ambulatory-equivalent mental health-related separations with specialised psychiatric care by hospital type and the patient's mental health legal status. The mental health legal status of about 36% of the separations was not reported, and the majority of these separations were reported by private hospitals. Among the separations for which mental health legal status was reported, 1.7% were involuntary and 77.3% of those (799 out of 1,034) were public acute hospital separations.

Table 5.2: Ambulatory-equivalent mental health-related separations[(a)] with specialised psychiatric care, by mental health legal status and hospital type, 2005–06

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	799	90	145	1,034
Voluntary	6,761	1,298	50,511	58,570
Not reported	46	0	33,552	33,598
Total	**7,606**	**1,388**	**84,208**	**93,202**

(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.

Source: National Hospital Morbidity Database.

5.4 Patient demographics

Table 5.3 presents information on the number of ambulatory-equivalent mental health-related separations and the corresponding percentage of these separations for a number of demographic groups. A rate (per 1,000 population) has been provided to compare numbers of separations relative to the size of the respective population. As the data report on the number of separations rather than the number of patients, it is not possible to determine how many separations an individual patient had.

The highest proportions of ambulatory-equivalent mental health-related separations were for patients aged 35–44 years and 45–54 years (19.2% and 20.4%, respectively). However, the highest number of separations per 1,000 population was for patients aged 55–64 years (9.4).

Table 5.3: Ambulatory-equivalent mental health-related separations[a], by patient demographic characteristics, 2005–06

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate (per 1,000 population)[d]
Age (years)			
Less than 15	6,861	5.8	1.7
15–24	15,643	13.3	5.5
25–34	16,748	14.2	5.8
35–44	22,674	19.2	7.4
45–54	23,998	20.4	8.5
55–64	20,836	17.7	9.4
65+	11,164	9.5	4.2
Sex			
Male	45,057	38.2	4.3
Female	72,867	61.8	7.0
Indigenous status[e]			
Indigenous Australians	1,477	1.3	3.4
Other Australians[f]	110,818	98.7	5.7
Country of birth			
Australia	93,284	84.2	6.3
Overseas	17,509	15.8	3.0
Remoteness area of usual residence			
Major cities	97,728	84.7	7.1
Inner regional	13,718	11.9	3.2
Outer regional	3,229	2.8	1.6
Remote	467	0.4	1.5
Very remote	215	0.2	1.2
Marital status[g]			
Never married	37,689	41.0	. .
Widowed	4,353	4.7	. .
Divorced	6,244	6.8	. .
Separated	4,146	4.5	. .
Married	39,486	43.0	. .
Total	**117,924**	**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 service contacts 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 Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions which consider the data to be of sufficient quality for analysis. However, caution should be used in the interpretation of these data due to jurisdictional data quality differences. The data does not necessarily represent the national trend.

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

(g) Information on this data element was missing or not reported for more than 20% of separations.

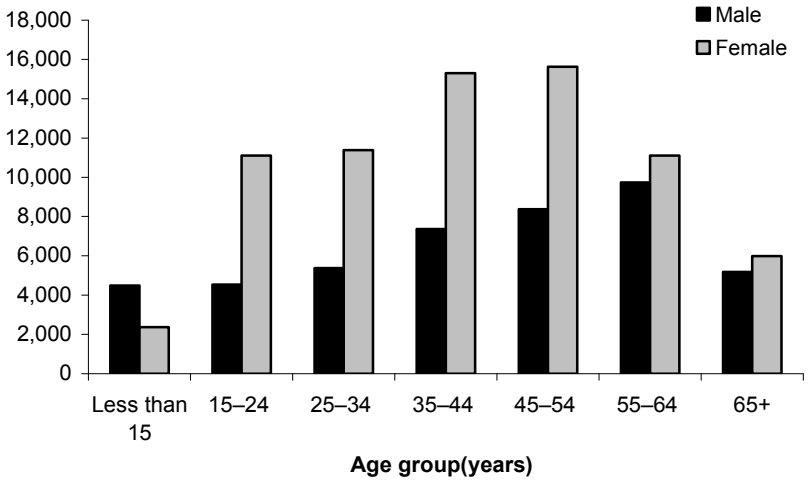
. . Not applicable.

Source: National Hospital Morbidity Database.

The separation rate for females (7.0 per 1,000 population) was nearly double that of males (4.3). Likewise, the rate of separations of Australian-born patients (6.3) was more than twice that of those born overseas (3.0).

The data show that the typical separation involves a patient who is an Australian-born non-Indigenous female, aged 35–54 years, who is or was married at some stage of her life and lives in a major city.

Figure 5.1 shows the number of ambulatory-equivalent mental health-related separations by age and sex. The dominance of female separations was noticeable in those aged 15–54 years. The differences evened out in separations involving people aged 55 and older. The situation was reversed in the less than 15 years age group, where male separations were dominant.



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.

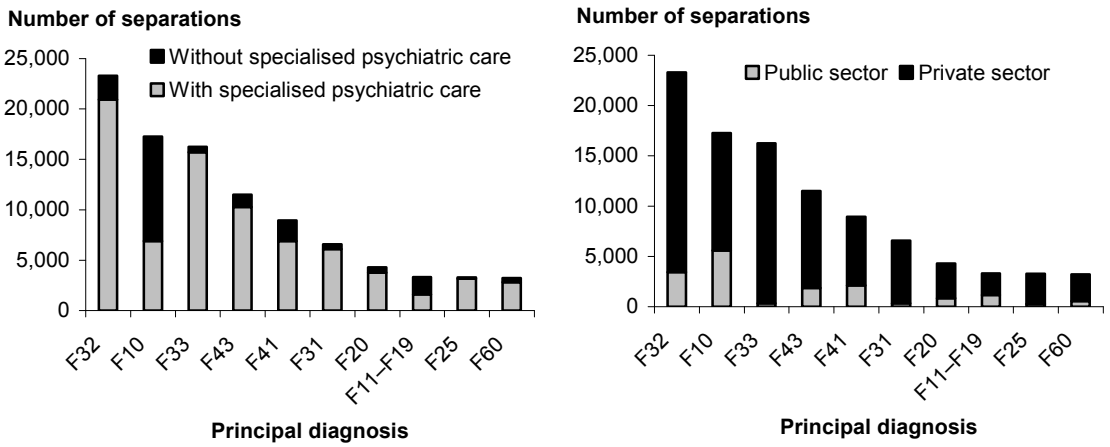
Source: National Hospital Morbidity Database.

Figure 5.1: Ambulatory-equivalent mental health-related separations, by age and sex, 2005–06

5.5 Principal diagnosis

Principal diagnosis refers to the diagnosis deemed to be chiefly responsible for the patient's episode of admitted patient care. Table 5.4 shows the distribution of ambulatory-equivalent mental health-related separations by principal diagnosis, broken down by hospital type and whether they involved specialised psychiatric care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM), 4th edition. Further information on this classification is included in Appendix 3.

In 2005–06, the principal diagnosis of *Depressive episode* (F32) accounted for the largest number of separations (23,296 or 19.8%) across all hospitals and all separations with and without specialised psychiatric care. However, for separations that did not involve specialised care, *Mental and behavioural disorders due to use of alcohol* (F10) was the leading principal diagnosis.



Key to principal diagnosis codes:

F32	Depressive episode
F10	Mental and behavioural disorders due to use of alcohol
F33	Recurrent depressive disorders
F43	Reaction to severe stress and adjustment disorders
F41	Other anxiety disorders
F31	Bipolar affective disorders
F20	Schizophrenia
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F25	Schizoaffective disorders
F60	Specific personality disorders

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 5.2: Ambulatory-equivalent mental health-related separations for the 10 most commonly reported principal diagnoses by specialised care and sector, 2005–06

The majority of separations reported by public psychiatric hospitals involved the diagnoses of *Conduct disorders* (F91) and *Other and unspecified disorders with onset in childhood or adolescence* (F92–F98).

Figure 5.2 shows the 10 most commonly reported principal diagnoses by specialised care and sector. Mental disorders with an affective component featured prominently with *Depressive disorders* (F32 and F33) among the top three diagnoses. For most of the commonly reported diagnoses, the majority of separations involved specialised psychiatric care. *Recurrent depressive disorders* (F33) was the principal diagnosis with the highest proportion of separations with specialised psychiatric care (96.6%). *Mental and behavioural disorders due to use of alcohol or other psychoactive substance use* (F10 and F11–F19) were the only commonly reported principal diagnoses having a markedly higher proportion of separations that did not involve specialised psychiatric care (60% and 51%, respectively). These were also the two principal diagnoses with higher proportions of separations reported by the public sector (more than 30%). The private sector accounted for the majority of separations for all the commonly reported diagnoses.

Table 5.4: Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2005–06

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		With specialised psychiatric care				
F00–F03	Dementia	1	0	80	81	0.1
F04–F09	Other organic mental disorders	8	0	203	211	0.2
F10	Mental and behavioural disorders due to use of alcohol	214	52	6,634	6,900	7.4
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	92	7	1,508	1,607	1.7
F20	Schizophrenia	362	14	3,398	3,774	4.0
F21, F24, F28, F29	Schizotypal and other delusional disorders	37	0	335	372	0.4
F22	Persistent delusional disorders	18	1	244	263	0.3
F23	Acute and transient psychotic disorders	19	6	149	174	0.2
F25	Schizoaffective disorders	224	6	2,937	3,167	3.4
F30	Manic episode	8	0	69	77	0.1
F31	Bipolar affective disorders	149	4	5,956	6,109	6.6
F32	Depressive episode	2,252	5	18,661	20,918	22.4
F33	Recurrent depressive disorders	264	2	15,446	15,712	16.9
F34	Persistent mood (affective) disorders	79	2	1,261	1,342	1.4
F38–F39	Other and unspecified mood (affective) disorders	43	2	118	163	0.2
F40	Phobic anxiety disorders	153	0	457	610	0.7
F41	Other anxiety disorders	560	23	6,315	6,898	7.4
F42	Obsessive-compulsive disorders	76	0	843	919	1.0
F43	Reaction to severe stress and adjustment disorders	825	38	9,402	10,265	11.0
F44	Dissociative (conversion) disorders	20	0	807	827	0.9
F45, F48	Somatoform and other neurotic disorders	81	0	144	225	0.2
F50	Eating disorders	8	0	2,286	2,294	2.5
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	9	0	266	275	0.3
F60	Specific personality disorders	209	14	2,575	2,798	3.0
F61–F69	Disorders of adult personality and behaviour	10	2	174	186	0.2
F70–F79	Mental retardation	8	1	0	9	0.0
F80–F89	Disorders of psychological development	149	20	70	239	0.3
F90	Hyperkinetic disorders	257	82	13	352	0.4
F91	Conduct disorders	685	717	31	1,433	1.5
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	304	336	31	671	0.7
F99	Mental disorder not otherwise specified	9	2	31	42	0.0
G30	Alzheimer's disease	0	0	107	107	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	149	43	18	210	0.2
	Other specified mental health-related principal diagnosis[c]	15	2	1	18	0.0
	Other[d]	309	7	3,638	3,954	4.2
Total		**7,606**	**1,388**	**84,208**	**93,202**	**100**

(continued)

Table 5.4 (continued): Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2005–06

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		Without specialised psychiatric care				
F00–F03	Dementia	97	0	2	99	0.4
F04–F09	Other organic mental disorders	85	1	2	88	0.4
F10	Mental and behavioural disorders due to use of alcohol	5,322	1	5,042	10,365	41.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,061	1	634	1,696	6.9
F20	Schizophrenia	471	0	45	516	2.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	129	0	0	129	0.5
F22	Persistent delusional disorders	93	0	1	94	0.4
F23	Acute and transient psychotic disorders	111	0	0	111	0.4
F25	Schizoaffective disorders	66	0	63	129	0.5
F30	Manic episode	24	0	3	27	0.1
F31	Bipolar affective disorders	196	0	258	454	1.8
F32	Depressive episode	1,180	1	1,197	2,378	9.6
F33	Recurrent depressive disorders	78	0	471	549	2.2
F34	Persistent mood (affective) disorders	51	0	26	77	0.3
F38–F39	Other and unspecified mood (affective) disorders	13	0	13	26	0.1
F40	Phobic anxiety disorders	7	0	57	64	0.3
F41	Other anxiety disorders	1,527	0	505	2,032	8.2
F42	Obsessive-compulsive disorders	21	0	25	46	0.2
F43	Reaction to severe stress and adjustment disorders	999	0	240	1,239	5.0
F44	Dissociative (conversion) disorders	138	0	1	139	0.6
F45, F48	Somatoform and other neurotic disorders	74	0	3	77	0.3
F50	Eating disorders	327	0	53	380	1.5
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	54	0	53	107	0.4
F60	Specific personality disorders	332	0	81	413	1.7
F61–F69	Disorders of adult personality and behaviour	28	0	15	43	0.2
F70–F79	Mental retardation	30	0	0	30	0.1
F80–F89	Disorders of psychological development	33	0	1	34	0.1
F90	Hyperkinetic disorders	12	0	0	12	0.0
F91	Conduct disorders	94	0	0	94	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	47	0	0	47	0.2
F99	Mental disorder not otherwise specified	36	0	0	36	0.1
G30	Alzheimer's disease	27	0	1	28	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	106	1	1	108	0.4
	Other specified mental health-related principal diagnosis[c]	2,505	0	550	3,055	12.4
Total		**15,374**	**5**	**9,343**	**24,722**	**100**

(continued)

Table 5.4 (continued): Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2005–06

Principal diagnosis		Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
		Total				
F00–F03	Dementia	98	0	82	180	0.2
F04–F09	Other organic mental disorders	93	1	205	299	0.3
F10	Mental and behavioural disorders due to use of alcohol	5,536	53	11,676	17,265	14.6
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,153	8	2,142	3,303	2.8
F20	Schizophrenia	833	14	3,443	4,290	3.6
F21, F24, F28, F29	Schizotypal and other delusional disorders	166	0	335	501	0.4
F22	Persistent delusional disorders	111	1	245	357	0.3
F23	Acute and transient psychotic disorders	130	6	149	285	0.2
F25	Schizoaffective disorders	290	6	3,000	3,296	2.8
F30	Manic episode	32	0	72	104	0.1
F31	Bipolar affective disorders	345	4	6,214	6,563	5.6
F32	Depressive episode	3,432	6	19,858	23,296	19.8
F33	Recurrent depressive disorders	342	2	15,917	16,261	13.8
F34	Persistent mood (affective) disorders	130	2	1,287	1,419	1.2
F38–F39	Other and unspecified mood (affective) disorders	56	2	131	189	0.2
F40	Phobic anxiety disorders	160	0	514	674	0.6
F41	Other anxiety disorders	2,087	23	6,820	8,930	7.6
F42	Obsessive-compulsive disorders	97	0	868	965	0.8
F43	Reaction to severe stress and adjustment disorders	1,824	38	9,642	11,504	9.8
F44	Dissociative (conversion) disorders	158	0	808	966	0.8
F45, F48	Somatoform and other neurotic disorders	155	0	147	302	0.3
F50	Eating disorders	335	0	2,339	2,674	2.3
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	63	0	319	382	0.3
F60	Specific personality disorders	541	14	2,656	3,211	2.7
F61–F69	Disorders of adult personality and behaviour	38	2	189	229	0.2
F70–F79	Mental retardation	38	1	0	39	0.0
F80–F89	Disorders of psychological development	182	20	71	273	0.2
F90	Hyperkinetic disorders	269	82	13	364	0.3
F91	Conduct disorders	779	717	31	1,527	1.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	351	336	31	718	0.6
F99	Mental disorder not otherwise specified	45	2	31	78	0.1
G30	Alzheimer's disease	27	0	108	135	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	255	44	19	318	0.3
	Other specified mental health-related principal diagnosis[c]	2,520	2	551	3,073	2.6
	Other[d]	309	7	3,638	3,954	3.4
Total		**22,980**	**1,393**	**93,551**	**117,924**	**100**

(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.
Source: National Hospital Morbidity Database.

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. The 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 59,252 procedures were reported in relation to 48,875 separations. This reflects the fact that more than one procedure can be reported for each separation, with an average of 1.2 procedures being reported. No procedures were reported for 58.6% (69,049 out of 117,924) of the separations. The most frequently reported procedures were *Cognitive behaviour therapy* (15,827 procedures for 15,820 separations). Psychotherapies of various forms were often reported among the other procedures.

Table 5.5: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations[a], 2005–06

	Procedures[b]		Separations[b] [c]	
Procedure	**Number**	**Per cent**	**Number**	**Per cent**
96101–00 Cognitive behaviour therapy	15,827	26.7	15,820	13.4
96001–00 Psychological skills training	6,483	10.9	6,476	5.5
95550–10 Allied health intervention, psychology	5,279	8.9	5,279	4.5
96180–00 Other psychotherapies or psychosocial therapies	4,090	6.9	4,085	3.5
96073–00 Substance addiction counselling or education	3,883	6.6	3,875	3.3
96090–00 Other counselling or education	3,385	5.7	3,385	2.9
92002–00 Alcohol rehabilitation	3,364	5.7	3,360	2.8
95550–02 Allied health intervention, occupational therapy	2,957	5.0	2,957	2.5
96185–00 Supportive psychotherapy, not elsewhere classified	2,087	3.5	2,084	1.8
96177–00 Interpersonal psychotherapy	1,619	2.7	1,617	1.4
Other reported procedures	10,278	17.3	10,256	8.7
		Totals		
Number of separations with at least one procedure	. .	. .	48,875	41.4
No procedure reported	. .	. .	69,049	58.6
Total	**59,252**	**100.0**	**117,924**	**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, as 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.

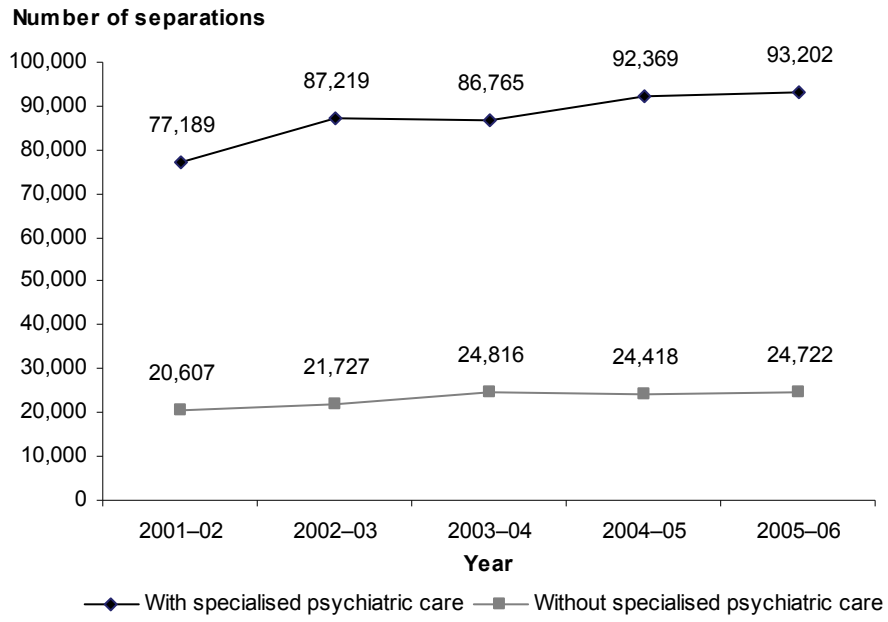
. . Not applicable.

Source: National Hospital Morbidity Database.

5.7 Change over time, 2001–02 to 2005–06

Figure 5.3 depicts the number of ambulatory-equivalent mental health-related separations, with and without specialised care from 2001–02 to 2005–06. It should be noted that the scope of the data collection and the actual definitions used by the data providers may vary from year to year. Consequently, caution should be exercised when making comparisons between reporting years.

The total number of ambulatory-equivalent mental health-related separations increased by 20.6% between 2001–02 (97,796) and 2005–06 (117,924). Separations involving specialised psychiatric care increased by 20.7% during the same period. A similar increase (20.0%) was observed for separations without specialised psychiatric care.



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 5.3: Ambulatory-equivalent mental health-related separations, with and without specialised psychiatric care, 2001–02 to 2005–06

5.8 Additional data

Additional tables containing data on ambulatory-equivalent mental health-related separations are available from the AIHW website. Additional data on ambulatory-equivalent mental health-related separations from the NHMD can also be accessed via interactive data cubes on the AIHW 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. Section 1.5 details how to access these additional resources.

6 Medicare-subsidised psychiatrist and allied health services

6.1 Introduction

This chapter presents information on ***Medicare Benefits Schedule-subsidised mental health-related services*** provided by psychiatrists and allied health professionals — psychologists, social workers and occupational therapists.

Australia's universal health care system, Medicare, comprises three main elements designed to provide access to different types of health services. The Medicare Benefits Schedule (MBS) provides access to medical, including diagnostic, services; the Pharmaceutical Benefits Scheme (PBS) provides access to medicines; while through the Australian Health Care Agreements (AHCAs) with the states and territories, the Australian Government contributes to public hospital services. MBS-subsidised mental health-related services provided by general practitioners are covered in Chapter 2. PBS-subsidised mental health-related prescriptions are covered in chapters 9 and 11, and hospital services are covered in a number of other chapters.

This chapter includes the number and types of services provided by psychiatrists and allied health professionals under the MBS and the characteristics of people who received these services. Note that a person may access more than one type of MBS-subsidised mental health service during the reporting period; each service is counted separately in the counts of services presented in this chapter.

The benefits paid by Medicare Australia are based on the MBS (DoHA 2007a). The schedule allocates a unique item number to each service, and indicates the scheduled payment.

The scope of this chapter has been expanded from the 2004–05 edition to encompass the new allied health MBS items introduced on 1 November 2006 as part of the Australian Government contribution to the COAG National Action Plan on Mental Health (COAG 2006b). This package, entitled ***Better Access to Psychiatrists, Psychologists and GPs through the MBS***, was designed to improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals, including occupational therapists and social workers. (The GP items in this package are covered in Chapter 2.) Also covered are relevant MBS items introduced on 1 July 2004 as part of the ***Enhanced Primary Care Program*** which extended Medicare to a range of allied health services, including psychologists and other mental health workers, for patients with chronic conditions and complex care needs.

The data presented in this chapter refer to MBS-subsidised mental health services processed in the 2006–07 financial year. For comparison purposes, data are also presented from 2001–02 to 2005–06. More detailed information on the scope and coverage of the data presented in this chapter is provided in Appendix 1.

People who access MBS-subsidised psychiatrist services may have been referred to a psychiatrist or allied health professional by a GP for the specialised management of mental health-related conditions. As described in Chapter 2, 10.9 of every 100 mental health-related problems managed by general practitioners in 2006–07 were managed by a referral being provided, with the most common referral being to a psychologist (3.6 per 100 mental health-related problems managed) or to a psychiatrist (1.9 per 100). Prior to the introduction of the Better Access to Psychiatrists, Psychologists and GPs through the MBS package the

trend of referrals was the reverse, with referrals to psychiatrists outnumbering referrals to psychologists.

Key concepts

MBS-subsidised mental health-related services are services provided by a psychiatrist or an allied health professional (psychologists, social workers and occupational therapists) on a fee-for-service basis that are partially or fully funded under Medicare and as listed in Table 6.3. Note that electroconvulsive therapy can be provided by either a psychiatrist or another medical practitioner.

Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS is a package of new MBS items introduced on 1 November 2006 to improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals. Comprises three subgroups:

- GP Mental Health Care Plans (covered in Chapter 2)
- Psychological Therapy Services (claimable by clinical psychologists)
- Focussed Psychological Strategies (Allied Mental Health) (covering general psychologists, occupational therapists and social workers).

The ***Enhanced Primary Care Program*** is a program introduced on 1 July 2004 to provide access to specific allied health services for patients with chronic conditions and complex care needs being managed by their GP under an Enhanced Primary Care plan. The two MBS items listed under this program which relate specifically to mental health are:

- item 10956 – services provided by a mental health worker (includes psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers)
- item 10968 – services provided by a psychologist.

The MBS-subsidised mental health services cover patient attendances (or consultations) provided in different settings as well as other services, such as preparation and review of mental health care plans, group psychotherapy, case conferencing and electroconvulsive therapy. The types of services covered in this chapter relate to specific MBS item codes (as shown in Table 6.3) and as described below:

- **Attendances:** in this chapter, the data on patient attendances have been presented according to provider type (psychiatrist, psychologist, occupational therapist and social worker) 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 the MBS:
  - 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;
  - electroconvulsive therapy;
  - psychological therapy services; and,
  - focussed psychological strategies (allied health).

More details on the specific MBS items can be found in the *Medicare Benefits Schedule book* (DoHA 2007a). Note that for items 300–370 (MBS Group A8) and 855–866 (Case Conference – Consultant Psychiatrist), only medical practitioners who are recognised as psychiatrists for the purposes of the Health Insurance Act are eligible to provide services attracting an MBS subsidy. For Medicare payments to be made on items in MBS Group M6 (Psychological Therapy Services) and MBS Group M7 (Focussed Psychological Strategies (Allied Mental Health)) the provider (psychologist, occupational therapist or social worker, as appropriate) must be registered with Medicare Australia as meeting the credential requirements for provision of the service.

In addition to the information on the MBS-subsidised psychiatrist and allied mental health services presented in this chapter, other information about psychiatrists and allied mental health providers is included in this report as follows:

- mental health-related medications prescribed by psychiatrists and subsidised under the PBS/RPBS are outlined in Chapter 11;
- information on the psychiatrist and mental health nurse workforce is presented in Chapter 13; and,
- data on expenditure on both MBS-subsidised psychiatrist and allied mental health services, and PBS/RPBS subsidised mental health-related prescriptions are detailed in Chapter 14.

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

MBS-subsidised mental health-specific services provided by GPs are covered in Chapter 2.

6.2 People accessing MBS-subsidised mental health services

Overall, in 2006–07, an estimated 272,228 people (or 1.3% of the Australian population) received MBS-subsidised psychiatrist services. Thus, on average, around one in every 77 Australians was provided with one or more of these MBS-subsidised psychiatrist services in 2006–07.

During this period, 1,986,533 MBS-subsidised psychiatrist services were provided, an average of 7.3 services per patient (Table 6.1).

During 2006–07, and mainly between November 2006 and June 2007, an estimated 164,912 people (or 0.8% of the population) received MBS-subsidised allied health services, covering both the Enhanced Primary Care items and the Better Access to Psychiatrists, Psychologists and GPs through the MBS items. As the latter items were only introduced on 1 November 2006, the data for 2006–07 do not comprise a full year's operation of these allied health items.

The number of MBS-subsidised allied health services provided was 668,902, an average of 4.1 services per patient.

Females used the psychiatrist services subsidised through the MBS to a greater extent than males, making up more than half (54.6%) of the patients and averaging 8.1 services each (compared with 6.3 services per male). The number of female patients per 1,000 population (14.2) was also higher than that for males (11.9).

In 2006–07, 42.7% of patients were aged 35–54 years and accounted for almost half (47.0%) of all MBS-subsidised psychiatrist services.

Table 6.1: People receiving MBS-subsidised psychiatrist and allied health services: patient demographic characteristics and services received, 2006–07[a]

Patient demographics	Number of patients	Per cent of patients	Patients per 1,000 population[b]	Number of services	Per cent of services	Services per patient
			Psychiatrist services			
Age (years)						
Less than 15	10,046	3.7	2.5	37,721	1.9	3.8
15–24	34,321	12.6	11.8	209,656	10.6	6.1
25–34	46,272	17.0	15.9	332,546	16.7	7.2
35–44	58,182	21.4	18.9	454,689	22.9	7.8
45–54	58,052	21.3	20.1	478,204	24.1	8.2
55–64	39,922	14.7	17.4	310,914	15.7	7.8
65+	25,433	9.3	9.3	162,803	8.2	6.4
Sex						
Male	123,560	45.4	11.9	781,998	39.4	6.3
Female	148,668	54.6	14.2	1,204,535	60.6	8.1
Total psychiatrist items	**272,228**	**100.0**	**13.1**	**1,986,533**	**100.0**	**7.3**
			Allied health services			
Age (years)						
Less than 15	12,474	7.6	3.1	46,468	6.9	3.7
15–24	23,101	14.0	8.0	91,120	13.6	3.9
25–34	35,482	21.5	12.2	147,007	22.0	4.1
35–44	38,740	23.5	12.6	161,059	24.1	4.2
45–54	29,984	18.2	10.4	124,460	18.6	4.2
55–64	17,587	10.7	7.7	71,232	10.6	4.1
65+	7,544	4.6	2.8	27,556	4.1	3.7
Sex						
Male	54,355	33.0	5.2	214,975	32.1	4.0
Female	110,557	67.0	10.5	453,927	67.9	4.1
Total allied health items	**164,912**	**100.0**	**7.9**	**668,902**	**100.0**	**4.1**

(a) Allied Health items were introduced on 1 November 2006 so data are not for a full year.

(b) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

Source: Medicare Benefits Schedule data (DoHA).

Psychiatrist services were accessed at a rate of 96 services per 1,000 population (Table 6.2). This figure varied substantially when analysed by area of residence; from a high of 113.2 services per 1,000 in major cities, down to 18.8 services per 1,000 population in very remote areas. There were 66.7 psychiatrist services per 1,000 in inner regional areas, while rates in outer regional and remote areas were similar (40.5 and 43.8 services per 1,000 population, respectively.

Access for allied health services as a whole was similar in major cities and inner regional areas (33.2 and 33.6 services per 1,000 population, respectively). Rates were lower in outer regional and remote areas (25.0 and 22.4 services per 1,000 population, respectively), while service utilisation rates in very remote areas were substantially lower, at 5.3 services per 1,000 population (Table 6.2).

Table 6.2: People receiving MBS-subsidised psychiatrist and allied health services: patient area of residence and item group[a] of services received by remoteness area, 2006–07[b]

	Patients			Services			
Patient area of residence	Number of patients	Per cent of patients	Rate (patients per 1,000 population)[c]	Number of services	Per cent of services	Rate (services per 1,000 population)[c]	Services per patient
				Psychiatrist services			
Major cities	204,970	75.3	14.5	1,604,281	80.8	113.2	7.8
Inner regional	45,330	16.7	11.1	272,340	13.7	66.7	6.0
Outer regional	16,044	5.9	8.2	79,493	4.0	40.5	5.0
Remote	3,000	1.1	9.4	13,959	0.7	43.8	4.7
Very remote	847	0.3	5.0	3,208	0.2	18.8	3.8
Unknown/Migratory	2,037	0.7	. .	13,252	0.7	. .	6.5
Total	**272,228**	**100.0**	**13.2**	**1,986,533**	**100.0**	**96.0**	**7.3**
				Allied health services			
Psychological Therapy Services—clinical psychologists							
Major cities	34,908	75.1	2.5	146,561	77.2	10.3	4.2
Inner regional	8,296	17.9	2.0	31,734	16.7	7.8	3.8
Outer regional	2,451	5.3	1.2	8,740	4.6	4.5	3.6
Remote	294	0.6	0.9	958	0.5	3.0	3.3
Very remote	72	0.2	0.4	216	0.1	1.3	3.0
Unknown/Migratory	431	0.9	. .	1,737	0.9	. .	4.0
Total	**46,452**	**100.0**	**2.2**	**189,946**	**100.0**	**9.2**	**4.1**
Enhanced primary care—registered psychologists							
Major cities	10,993	64.6	0.8	32,061	65.2	2.3	2.9
Inner regional	3,994	23.5	1.0	11,501	23.4	2.8	2.9
Outer regional	1,698	10.0	0.9	4,723	9.6	2.4	2.8
Remote	271	1.6	0.9	707	1.4	2.2	2.6
Very remote	14	0.1	0.1	33	0.1	0.2	2.4
Unknown/Migratory	55	0.3	. .	165	0.3	. .	3.0
Total	**17,025**	**100.0**	**0.8**	**49,190**	**100.0**	**2.4**	**2.9**
Enhanced primary care—mental health workers[d]							
Major cities	958	66.9	0.1	2,543	65.2	0.2	2.7
Inner regional	340	23.7	0.1	999	25.6	0.2	2.9
Outer regional	107	7.5	0.1	288	7.4	0.1	2.7
Remote	21	1.5	0.1	51	1.3	0.2	2.4
Very remote	0	0.0	0.0	0	0.0	0.0	. .
Unknown/Migratory	7	0.5	. .	22	0.6	. .	3.1
Total	**1,433**	**100.0**	**0.1**	**3,903**	**100.0**	**0.2**	**2.7**

(continued)

Table 6.2 (continued): People receiving MBS-subsidised psychiatrist and allied health services: patient area of residence and item group[a] of services received by remoteness area, 2006–07[b]

Patient area of residence	Number of patients	Per cent of patients	Rate (patients per 1,000 population)[c]	Number of services	Per cent of services	Rate (services per 1,000 population)[c]	Services per patient
Focussed Psychological Strategies (Allied Health)—registered psychologists							
Major cities	68,159	65.0	4.8	277,168	68.1	19.6	4.1
Inner regional	24,697	23.5	6.1	88,085	21.6	21.6	3.6
Outer regional	9,800	9.3	5.0	33,795	8.3	17.2	3.4
Remote	1,515	1.4	4.8	5,337	1.3	16.7	3.5
Very remote	232	0.2	1.4	636	0.2	3.7	2.7
Unknown/Migratory	524	0.5	. .	2,096	0.5		4.0
Total	**104,927**	**100.0**	**5.1**	**407,117**	**100.0**	**19.7**	**3.9**
Focussed Psychological Strategies (Allied Health)—occupational therapists							
Major cities	408	61.8	0.0	1,626	65.0	0.1	4.0
Inner regional	150	22.7	0.0	540	21.6	0.1	3.6
Outer regional	90	13.6	0.0	301	12.0	0.2	3.3
Remote	5	0.8	0.0	9	0.4	0.0	1.8
Very remote	0	0.0	0.0	0	0.0	0.0	. .
Unknown/Migratory	7	1.1	. .	26	1.0		3.7
Total	**660**	**100.0**	**0.0**	**2,502**	**100.0**	**0.1**	**3.8**
Focussed Psychological Strategies (Allied Health)—social workers							
Major cities	2,402	60.8	0.2	10,632	65.5	0.8	4.4
Inner regional	1,086	27.5	0.3	4,096	25.2	1.0	3.8
Outer regional	397	10.1	0.2	1,287	7.9	0.7	3.2
Remote	27	0.7	0.1	89	0.5	0.3	3.3
Very remote	4	0.1	0.0	14	0.1	0.1	3.5
Unknown/Migratory	34	0.9	. .	126	0.8		3.7
Total	**3,950**	**100.0**	**0.2**	**16,244**	**100.0**	**0.8**	**4.1**
Allied health services—total							
Major cities	110,697	67.1	7.8	470,587	70.4	33.2	4.3
Inner regional	36,498	22.1	8.9	136,978	20.5	33.6	3.8
Outer regional	13,952	8.5	7.1	49,122	7.3	25.0	3.5
Remote	2,041	1.2	6.4	7,139	1.1	22.4	3.5
Very remote	318	0.2	1.9	904	0.1	5.3	2.8
Unknown/Migratory	1,406	0.9	. .	4,172	0.6		3.0
Total	**164,912**	**100.0**	**8.0**	**668,902**	**100.0**	**32.3**	**4.1**

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

(b) Focussed Psychological Strategies (Allied health) items were introduced on 1 November 2006 so data are not for a full year.

(c) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

(d) Covers psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.

. . Not applicable.

Source: Medicare Benefits Schedule data (DoHA).

New South Wales had the highest number of patients for both psychiatrists and allied health professionals but South Australia had the highest number per 1,000 population for psychiatrist items and Victoria for allied health items (Table 6.3). The Northern Territory had a considerably lower number per 1,000 population for patients of both psychiatrists and allied health professionals.

Table 6.3: People receiving MBS-subsidised psychiatrist and allied health services, by item group[a] of service provided, states and territories[b], 2006–07[c]

Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[e]
Psychiatrist									
Patient attendances – consulting room	84,978	74,254	48,227	20,487	24,234	4,519	3,496	764	260,959
Patient attendances – hospital	5,069	4,512	3,739	1,680	1,031	664	183	21	16,899
Patient attendances – other	2,419	929	212	97	288	26	20	1	3,992
Group psychotherapy	2,327	3,884	562	186	342	294	. .	. .	7,614
Interview with non-patient	1,174	1,236	1,030	452	337	96	37	7	4,369
Telepsychiatry	156	42	88	13	7	. .	. .	3	312
Case conferencing	73	235	15	17	37	29	. .	. .	414
Electroconvulsive therapy[d]	483	512	473	191	133	70	. .	. .	1,876
Total psychiatrist items[e]	**90,312**	**78,072**	**49,610**	**20,865**	**24,643**	**4,583**	**3,421**	**722**	**272,228**
Rate (per 1,000 population)[f]	13.2	15.1	12.0	10.0	15.6	9.3	10.2	3.4	13.1
Allied health									
Psychological Therapy Services—clinical psychologists	15,001	12,743	4,774	8,378	2,841	1,418	708	124	45,987
Enhanced primary care—registered psychologists	6,553	5,095	3,376	558	913	472	150	17	17,134
Enhanced primary care—mental health workers[g]	538	379	259	58	191	9	5	1	1,440
Focussed Psychological Strategies—registered psychologists	33,591	35,750	21,644	4,199	4,883	2,206	1,467	304	104,044
Focussed Psychological Strategies—occupational therapists	149	148	110	131	76	38	4	1	657
Focussed Psychological Strategies—social workers	1,383	937	880	289	326	49	35	12	3,911
Total allied health items[e]	**54,213**	**52,690**	**29,706**	**13,073**	**8,684**	**3,923**	**2,194**	**429**	**164,912**
Rate (per 1,000 population)[f]	7.9	10.2	7.2	6.3	5.5	8.0	6.5	2.0	7.9

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

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

(c) Psychological Therapy Services and Focussed Psychological Strategies (Allied Health) items were introduced on 1 November 2006 so data are not for a full year.

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

(e) The numbers of patients will not sum to the total, as 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 MBS item group and state or territory.

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

(g) Covers psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.

. . Not applicable.

Source: Medicare Benefits Schedule data (DoHA).

6.3 MBS-subsidised psychiatrist and allied health services

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

In 2006–07, there were 1,986,533 services provided by psychiatrists and 668,902 services provided by allied health professionals that were subsidised through the MBS. Thus the MBS subsidised a total of 2,655,435 psychiatrist and allied health services. This is equivalent to 127.3 services per 1,000 population (Table 6.4). These services represented 1% of all MBS-subsidised services (257.9 million). The services provided by psychiatrists represented 9.2% of all the MBS-subsidised specialist attendances (21.7 million) provided in that year and were equivalent to a rate of 95.3 services per 1,000 population.

Most of the MBS-subsidised psychiatrist services (84.5%) were attendances provided in consulting rooms, followed by attendances in hospitals (11.4%). Group psychotherapy accounted for most of the other services provided (2.1%).

Victoria accounted for the highest proportion of MBS-subsidised psychiatrist and allied health services provided (33.2%), as well as the highest rate (170.8 per 1,000 population) among the states and territories (Table 6.4). New South Wales had the second highest proportion of services provided (31.1%). However, when population size is taken into account, there were more MBS-subsidised psychiatrist and allied health services provided in South Australia than in New South Wales (131.9 and 120.3 per 1,000 population, respectively). The Northern Territory had the lowest rate, with 27.8 MBS-subsidised psychiatrist and allied health services provided per 1,000 population.

There was a decline in the number of MBS-subsidised psychiatrist services from 2001–02 to 2006–07 at an average annual rate of 1.1% (Table 6.5). However, the introduction of MBS allied health items for people with chronic conditions and complex care needs in July 2004, followed by the uptake of the new MBS items provided by psychologists, occupational therapists and social workers from November 2006, resulted in an increase in the overall number of services subsidised by Medicare for both psychiatrists and allied health professionals to 2,655,435 in 2006–07.

Table 6.4: MBS-subsidised psychiatrist and allied health services, by item group[a] of service provided, states and territories[b], 2006–07[c]

Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Psychiatrist					
Patient attendances – consulting room	527,866	555,617	286,468	93,853	160,850	30,985	18,968	4,130	1,678,737
Patient attendances – hospital	51,239	69,328	59,579	21,928	13,180	9,172	1,539	202	226,167
Patient Attendances – other	8,637	3,780	755	470	787	59	74	1	14,563
Group psychotherapy	13,764	20,382	3,669	1,151	670	1,908	138	7	41,689
Interview with non-patient	1,671	1,823	1,444	527	446	131	44	7	6,093
Telepsychiatry	347	71	196	23	11	3	1	13	665
Case conferencing	89	412	18	24	49	37	1	7	637
Electroconvulsive therapy[d]	4,590	4,648	5,037	1,478	1,444	670	112	3	17,982
Total psychiatrist items	**608,203**	**656,061**	**357,166**	**119,454**	**177,437**	**42,965**	**20,877**	**4,370**	**1,986,533**
Rate (per 1,000 population)[e]	88.7	127.0	86.4	57.4	112.6	87.4	62.1	20.6	95.3
				Allied health					
Psychological Therapy Services—clinical psychologists	60,306	56,251	17,920	36,114	10,110	5979	2875	391	189,946
Enhanced primary care — registered psychologists	18,718	15,249	9,825	1,631	2,048	1,237	447	35	49,190
Enhanced primary care— mental health workers[f]	1,658	1,052	732	152	274	24	10	1	3,903
Focussed Psychological Strategies—registered psychologists	129,114	148,889	81,404	16,783	16,511	8,078	5,236	1,102	407,117
Focussed Psychological Strategies—occupational therapists	574	654	366	409	324	161	13	1	2,502
Focussed Psychological Strategies—social workers	6,179	4,268	3,216	1,177	1,133	158	97	16	16,244
Total allied health items	**216,549**	**226,363**	**113,463**	**56,266**	**30,400**	**15,637**	**8,678**	**1,546**	**668,902**
Rate (per 1,000 population)[e]	31.6	43.8	27.5	27.0	19.3	31.8	25.8	7.3	32.1
Total psychiatrist and allied health items	**824,752**	**882,424**	**470,629**	**175,720**	**207,837**	**58,602**	**29,555**	**5,916**	**2,655,435**
Rate (per 1,000 population)[e]	120.3	170.8	113.9	84.4	131.9	119.2	87.8	27.8	127.3

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

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

(c) Psychological Therapy Services and Focussed Psychological Strategies (Allied Health) items were introduced on 1 November 2006 so data are not for a full year.

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

(e) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

(f) Covers psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.

Source: Medicare Benefits Schedule data (Medicare Australia 2007b and DoHA).

Table 6.5: MBS-subsidised psychiatrist and allied health services, by item group[a] of service provided, 2001–02 to 2006–07[b]

Item group[a]	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Psychiatrist							
Patient attendances – consulting room	1,821,404	1,781,337	1,745,472	1,723,598	1,708,878	1,678,737	–1.6
Patient attendances – Hospital	197,899	205,045	208,996	209,294	225,918	226,167	2.7
Patient Attendances – Other	12,350	12,828	12,128	12,419	13,355	14,563	3.4
Group psychotherapy	49,138	45,078	41,641	40,611	43,797	41,689	–3.2
Interview with non-patient	4,304	4,294	4,301	4,670	4,845	6,093	7.2
Telepsychiatry	. .	19	177	228	369	665	n.p.
Case conferencing	. .	62	274	545	696	637	n.p.
Electroconvulsive therapy[c]	14,937	16,412	15,469	15,853	18,083	17,982	3.8
Total psychiatrist items	**2,100,032**	**2,065,075**	**2,028,458**	**2,007,218**	**2,015,941**	**1,986,533**	**–1.1**
Rate (per 1,000 population)[d]	107.5	104.4	101.3	99.0	98.1	95.3	–2.4
Allied health							
Psychological Therapy Services—clinical psychologists	. .	. .	. .	. .	. .	189,946	. .
Enhanced primary care — registered psychologists	. .	. .	. .	23,092	45,541	49,190	n.p.
Enhanced primary care— mental health workers[e]	. .	. .	. .	748	2,730	3,903	n.p.
Focussed Psychological Strategies—registered psychologists	. .	. .	. .	. .	. .	407,117	. .
Focussed Psychological Strategies—occupational therapists	. .	. .	. .	. .	. .	2,502	. .
Focussed Psychological Strategies—social workers	. .	. .	. .	. .	. .	16,244	. .
Total allied health items	**. .**	**. .**	**. .**	**23,840**	**48,271**	**668,902**	**n.p.**
Rate (per 1,000 population)[d]	. .	. .	. .	1.2	2.3	32.1	n.p.
Total psychiatrist and allied health items	**2,100,032**	**2,065,075**	**2,028,458**	**2,031,058**	**2,064,212**	**2,655,435**	**n.p.**
Rate (per 1,000 population)[d]	107.5	104.4	101.3	100.2	100.4	127.3	n.p.

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

(b) Psychological Therapy Services and Focussed Psychological Strategies (Allied Health) items were introduced on 1 November 2006 so data are not for a full year.

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

(d) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006.

(e) Covers psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.

n.p. not published.

. . Not applicable.

Source: Medicare Benefits Schedule data (Medicare Australia 2007b and DoHA)

7 Admitted patient mental health-related care

7.1 Introduction

Mental health-related ***separations*** can be classified as ambulatory or non-ambulatory. In this chapter, information on non-ambulatory ***admitted patient*** mental health-related care is presented. 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). The statistical unit for the NHMD is the separation (see Key concepts). Data are not available on the number of separations accrued by an individual, so all the tabulations in this chapter are in terms of separation events, not patients. Ambulatory-equivalent admitted patient care is discussed in Chapter 5.

Admitted patient ***mental health-related*** separations can be divided into those that involved ***specialised psychiatric care*** (which are presented in Section 7.3 of this chapter) and those that did not (Section 7.4). Section 7.5 provides an overview 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, but 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 International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification (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.

(continued)

Key concepts

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.

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. The patient day data presented in this report include days within hospital stays that occurred before 1 July 2005 provided that the separation from hospital occurred during 2005–06. 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 2005–06 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.

7.2 Change over time, 2001–02 to 2005–06

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 2001–02 to 2005–06. It should be noted that the scope of the data collection and the actual definitions used by the data providers may vary from year to year, so comparisons between reporting years and hospital types should be made with caution.

As mentioned in Chapter 5, a total of 7,311,983 separations were reported from public and private acute and psychiatric hospitals in 2005–06. Approximately 4.4% (322,110) of these separations were mental health-related, comprising both ambulatory-equivalent and non-ambulatory-equivalent admitted patient separations.

A total of 204,186 separations for admitted patient mental health-related care were reported in 2005–06, accounting for 2.8% of all hospital separations and 63.4% (204,186 out of 322,110) of mental health-related separations. Of these, 118,733 (58.1% of 204,186) were separations with specialised psychiatric care.

Over the 5 years to 2005–06, the average annual rate of change for all mental health-related separations was 2.2%. The proportions of separations by specialised care remained fairly constant at approximately 59% for separations with specialised psychiatric care and 41% for those without. Public acute hospitals reported average annual increases in all separations. Private hospitals reported a decline in separations without specialised care (–4.8%) but an increase in those with specialised care (4.0%). For separations with specialised psychiatric care, the average length of stay has increased for public acute hospitals only.

Table 7.1: Admitted patient mental health-related separations[a] with and without specialised psychiatric care, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
			Separations			
Separations with specialised psychiatric care						
Public acute hospitals	71,891	73,972	76,042	76,172	76,019	1.4
Public psychiatric hospitals[b]	13,877	13,371	14,188	12,887	13,255	–1.1
Private hospitals	25,201	25,702	26,495	27,793	29,459	4.0
Total	*110,969*	*113,045*	*116,725*	*116,852*	*118,733*	*1.7*
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	63,755	66,607	68,087	70,975	75,195	4.2
Public psychiatric hospitals[b][c]	787	1,055	1,048	1,136	770	–0.5
Private hospitals	11,532	11,462	11,852	10,390	9,488	–4.8
Total	*76,074*	*79,124*	*80,987*	*82,501*	*85,453*	*2.9*
Total mental health-related separations						
Public acute hospitals	135,646	140,579	144,129	147,147	151,214	2.8
Public psychiatric hospitals[b]	14,664	14,426	15,236	14,023	14,025	–1.1
Private hospitals	36,733	37,164	38,347	38,183	38,947	1.5
Total	**187,043**	**192,169**	**197,712**	**199,353**	**204,186**	**2.2**
			Patient days			
Patient days for separations with specialised psychiatric care[d]						
Public acute hospitals	1,021,348	1,078,122	1,118,512	1,208,422	1,215,274	4.4
Public psychiatric hospitals[b]	1,005,918	885,541	666,275	757,916	652,375	–10.3
Private hospitals	431,217	420,496	424,787	441,617	456,146	1.4
Total	*2,458,483*	*2,384,159*	*2,209,574*	*2,407,955*	*2,323,795*	*–1.4*
Patient days for mental health-related separations without specialised psychiatric care						
Public acute hospitals	480,587	427,315	399,342	384,160	419,669	–3.3
Public psychiatric hospitals[b][c]	4,860	9,758	8,341	19,753	5,547	3.4
Private hospitals	134,021	125,438	120,186	96,120	93,266	–8.7
Total	*619,468*	*562,511*	*527,869*	*500,033*	*518,482*	*–4.4*
Total mental health-related patient days						
Public acute hospitals	1,501,935	1,505,437	1,517,854	1,592,582	1,634,943	2.1
Public psychiatric hospitals[b]	1,010,778	895,299	674,616	777,669	657,922	–10.2
Private hospitals	565,238	545,934	544,973	537,737	549,412	–0.7
Total	**3,077,951**	**2,946,670**	**2,737,443**	**2,907,988**	**2,842,277**	**–2.0**
			Psychiatric care days			
Public acute hospitals	1,003,727	1,061,681	1,099,446	1,183,862	1,190,652	4.4
Public psychiatric hospitals[b]	989,327	866,761	663,541	753,328	644,104	–10.2
Private hospitals	428,232	417,560	423,507	440,663	454,719	1.5
Total	**2,421,286**	**2,346,002**	**2,186,494**	**2,377,853**	**2,289,475**	**–1.4**

(continued)

Table 7.1 (continued): Admitted patient mental health-related separations[a] with and without specialised psychiatric care, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
			Average length of stay			
Separations with specialised psychiatric care						
Public acute hospitals	14.2	14.6	14.7	15.9	16.0	3.0
Public psychiatric hospitals[b]	72.5	66.2	47.0	58.8	49.2	–9.2
Private hospitals	17.1	16.4	16.0	15.9	15.5	–2.5
Total	*22.2*	*21.1*	*18.9*	*20.6*	*19.6*	*–3.1*
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	7.5	6.4	5.9	5.4	5.6	–7.2
Public psychiatric hospitals[b][c]	6.2	9.2	8.0	17.4	7.2	3.9
Private hospitals	11.6	10.9	10.1	9.3	9.8	–4.1
Total	*8.1*	*7.1*	*6.5*	*6.1*	*6.1*	*–7.1*
Total mental health-related separations						
Public acute hospitals	11.1	10.7	10.5	10.8	10.8	–0.6
Public psychiatric hospitals[b]	68.9	62.1	44.3	55.5	46.9	–9.2
Private hospitals	15.4	14.7	14.2	14.1	14.1	–2.1
Total	**16.5**	**15.3**	**13.8**	**14.6**	**13.9**	**–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) In Tasmania, some long-stay patients in public psychiatric hospitals were integrated into community mental health care services during 2001–02. Consequently the number of separations and length of stay for public psychiatric hospitals may be inflated for the year.

(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, as some separations will include days of specialised psychiatric care and days of other care.

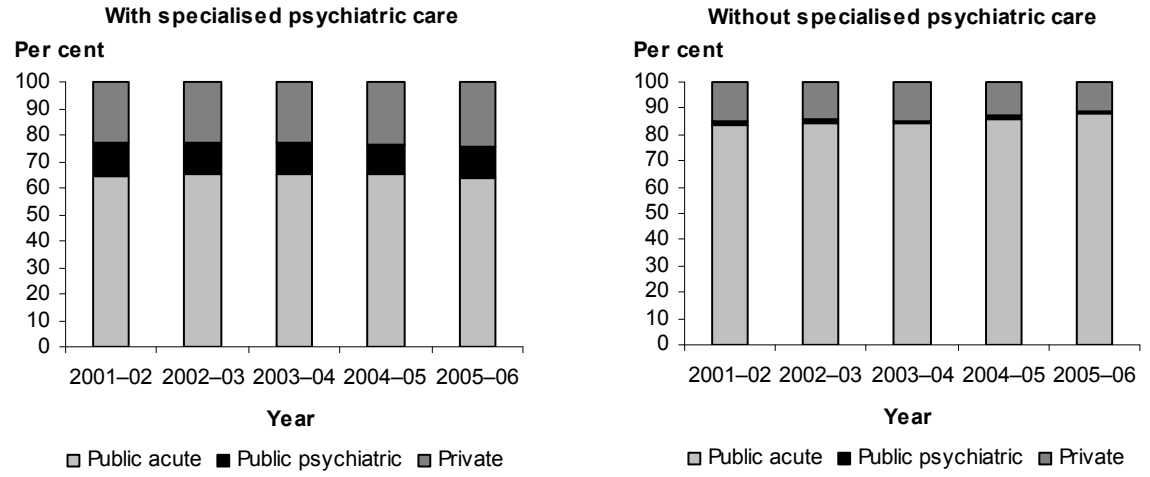
Source: National Hospital Morbidity Database.

Figure 7.1 shows the percentage of separations with and without specialised psychiatric care by hospital type. For separations with specialised psychiatric care, public acute hospitals maintained their dominance as providers (over 60%) of admitted patient services over the 5 years to 2005–06. In 2005–06, there was a slight reduction (1.2%) in the overall percentage of public acute hospital separations and a corresponding increase in private hospital (1%) and public psychiatric hospital (0.2%) separations. The dominance of public acute hospitals was even more pronounced (over 80%) in mental health-related separations without specialised psychiatric care. This is partly explained by the smaller role of public psychiatric hospitals in providing non-specialised psychiatric care, although private hospitals also played a lesser role in this type of care. In 2005–06, there was a 2% overall increase in the number of separations reported by public acute hospitals. In general, the proportion of separations reported by each hospital type remained fairly constant over the 5 years.

Figure 7.2 shows the average length of stay for separations with and without specialised psychiatric care by hospital type. As outlined in the key concepts, public psychiatric hospitals tend to provide for longer stays and report fewer separations, which explains the noticeably higher average length of stay for separations with specialised psychiatric care.

Public psychiatric hospitals also have a higher percentage of separations with involuntary mental health legal status (Table 7.3).

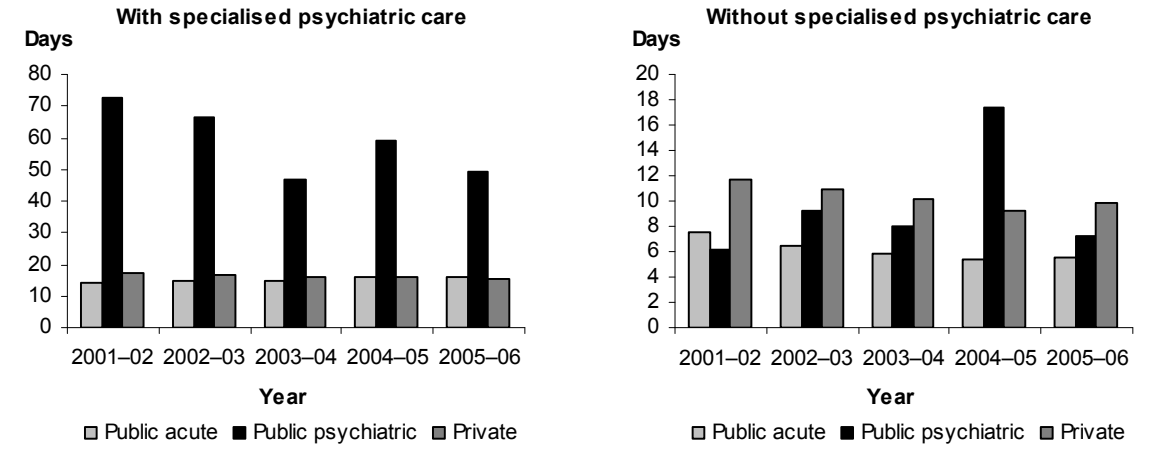
A different picture is apparent for mental health-related separations without specialised psychiatric care. The average length of stay was noticeably higher for private hospital separations across all years except in 2004–05 when there was a longer average length of stay for public psychiatric hospitals.



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 7.1: Mental health–related separations with and without specialised psychiatric care, by hospital type, 2005–06



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 7.2: Average length of stay for mental health–related separations with and without specialised psychiatric care, by hospital type, 2005–06

7.3 Specialised admitted patient mental health care

Specialised admitted patient mental health care refers to separations involving one or more days of specialised psychiatric care in a psychiatric unit or ward.

Of the 204,186 mental health-related separations for admitted patient care, 118,733 (58.1%) involved specialised psychiatric care (Table 7.1).

States and territories and hospital type

Table 7.2 shows the number of separations with specialised psychiatric care for each state and territory by hospital type. Confidentiality reasons prevent the publication of private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory, but the figures are included in the national total. The number of separations and patient days per 1,000 population are provided to account for differences in population between jurisdictions. It should be noted that jurisdictional data differences may reflect differences in service delivery practices, admission practices and/or the types of establishments categorised as hospitals. Caution should be used in the interpretation and comparison of data between jurisdictions.

The data indicates that of the five jurisdictions with fully reported figures, Queensland had the highest percentage of public acute hospitals separations (73.8%), while New South Wales had the lowest (55.3%). For private hospital separations, Victoria had the highest percentage (32.9%), which was nearly twice that of South Australia. Public psychiatric hospital separations constituted 11.2% (13,255 out of 118,733) of all separations with New South Wales being the major provider (65.8%). Public psychiatric hospital separations in Victoria and Queensland constituted less than 2% of the total number of separations in each jurisdiction.

The number of separations per 1,000 population, referred to as the separation rate in the following discussion, varied greatly in each jurisdiction. For public acute hospitals, Tasmania has the highest separation rate (6.2) which was 67.6% higher than the national average of 3.7. Public hospital separation rates were higher compared with other hospital types across all jurisdictions.

Queensland was the jurisdiction with the highest number of public hospital patient days (66.8) per 1,000 population. The number of public psychiatric hospital patient days per 1,000 population varied greatly from 6.2 days in Victoria to 69.8 days in South Australia. South Australia reported the lowest number of patient days in private hospitals per 1,000 population (15.4).

All the public acute hospitals separations reported by South Australia and Tasmania involved specialised psychiatric care (100%). The lowest percentage of psychiatric care days compared with the total number of patient days was reported by public acute hospitals in the Australian Capital Territory (93.3%).

Table 7.2: Admitted patient separations[(a)] with specialised psychiatric care, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	21,258	16,850	19,526	6,629	6,505	2,927	1,178	1,146	76,019
Public psychiatric hospitals	8,725	380	351	1,491	2,060	248	. .	. .	13,255
Private hospitals	8,430	8,466	6,568	3,479	1,753	n.p.	n.p.	n.p.	29,459
Total	**38,413**	**25,696**	**26,445**	**11,599**	**10,318**	**n.p.**	**n.p.**	**n.p.**	**118,733**
					Separations per 1,000 population[(b)]				
Public acute hospitals	3.2	3.3	4.9	3.3	4.2	6.2	3.4	5.3	3.7
Public psychiatric hospitals	1.3	0.1	0.1	0.7	1.3	0.5	. .	. .	0.7
Private hospitals	1.2	1.6	1.6	1.7	1.1	n.p.	n.p.	n.p.	1.4
Total	**5.7**	**5.0**	**6.6**	**5.7**	**6.6**	**n.p.**	**n.p.**	**n.p.**	**5.8**
					Patient days				
Public acute hospitals	353,564	317,754	268,290	119,948	102,545	25,989	16,340	10,844	1,215,274
Public psychiatric hospitals	321,373	31,388	111,251	50,041	113,621	24,701	. .	. .	652,375
Private hospitals	145,262	121,717	100,975	49,955	24,969	n.p.	n.p.	n.p.	456,146
Total	**820,199**	**470,859**	**480,516**	**219,944**	**241,135**	**n.p.**	**n.p.**	**n.p.**	**2,323,795**
					Patient days per 1,000 population[(b)]				
Public acute hospitals	52.0	61.6	66.8	59.7	62.8	55.6	47.1	51.4	58.9
Public psychiatric hospitals	47.1	6.2	27.6	24.5	69.8	48.9	. .	. .	31.6
Private hospitals	21.0	23.5	24.7	24.2	15.4	n.p.	n.p.	n.p.	21.8
Total	**120.1**	**91.3**	**119.1**	**108.5**	**147.9**	**n.p.**	**n.p.**	**n.p.**	**112.3**
					Psychiatric care days				
Public acute hospitals	337,596	317,017	264,150	117,343	102,545	25,989	15,238	10,774	1,190,652
Public psychiatric hospitals	313,102	31,388	111,251	50,041	113,621	24,701	. .	. .	644,104
Private hospitals	144,400	121,611	100,931	49,648	24,969	n.p.	n.p.	n.p.	454,719
Total	**795,098**	**470,016**	**476,332**	**217,032**	**241,135**	**n.p.**	**n.p.**	**n.p.**	**2,289,475**

(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.

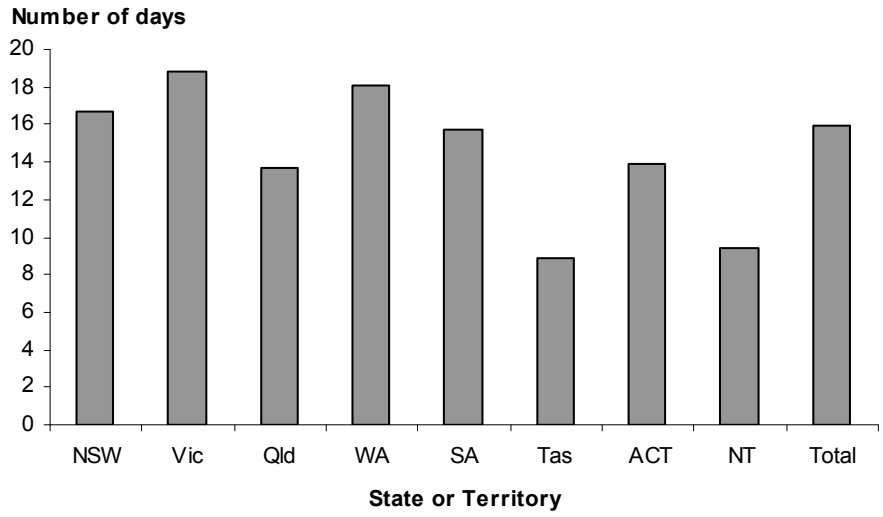
(b) Rates were directly age-standardised as detailed in Appendix 2.

. . Not applicable. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

n.p. Not published. Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published due to confidentiality reasons. However, the figures are included in the national total.

Source: National Hospital Morbidity Database.

Figure 7.3 shows that the average length of stay in public acute hospitals was highest for Victoria, which was nearly twice the average length of stay for the Northern Territory and Tasmania. The average lengths of stay for New South Wales, Victoria and Western Australia were also higher than the national average (16 days).



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 7.3: Average length of stay for separations with specialised psychiatric care in public acute hospitals, 2005–06

Mental health legal status

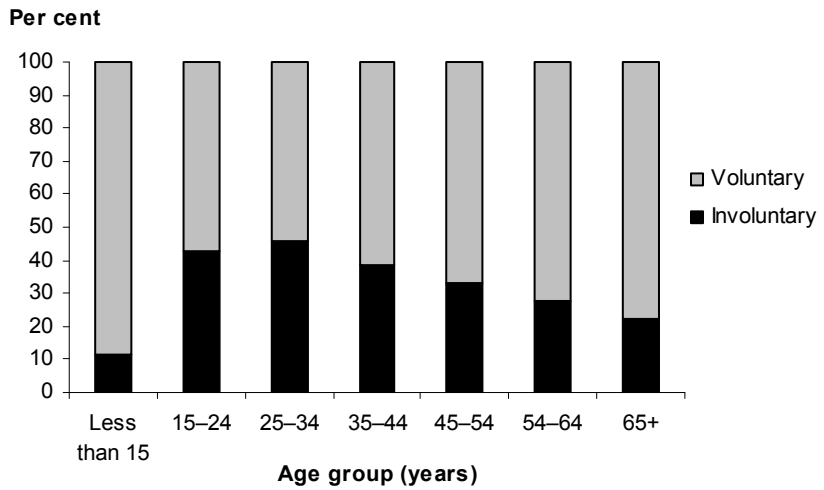
Table 7.3 shows the number of separations with specialised psychiatric care by hospital type and the patient's mental health legal status. Voluntary separations comprised 57.9% of all separations. Public acute hospitals reported the highest number of involuntary separations (79.0%). The majority (69.6%) of private hospital separations were voluntary but there was a relatively high number of private hospital separations with no mental health legal status reported(8,666 or 29.4%). Public psychiatric hospitals have a higher proportion (61.2%) of separations with involuntary status compared with the other hospital types.

Table 7.3: Admitted patient separations[(a)] with specialised psychiatric care, by mental health legal status and hospital type, 2005–06

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	31,509	8,110	276	39,895
Voluntary	43,072	5,145	20,517	68,734
Not reported	1,438	0	8,666	10,104
Total	**76,019**	**13,255**	**29,459**	**118,733**

(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.

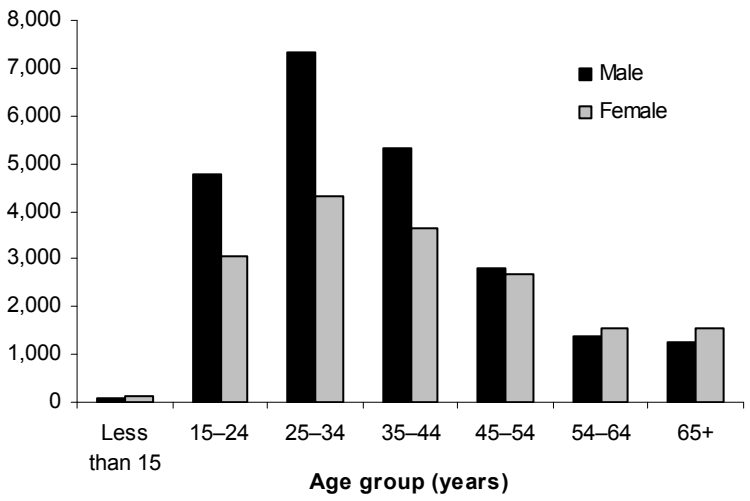
Source: National Hospital Morbidity Database.



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 7.4: Separations with specialised psychiatric care, by mental health legal status and age group, 2005–06



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 7.5: Involuntary separations with specialised psychiatric care, by age group and sex , 2005–06

Figures 7.4 and 7.5 show the relationship between mental health legal status and demographic characteristics. A higher proportion of involuntary separations is evident for the younger age groups (except for those aged less than 15 years). The highest proportion of separations with involuntary status was for those aged 25–34 years.

A high number of males aged 15–44 years had involuntary separations. However, there were noticeably more involuntary separations for females in those aged less than 15 years. These apparent sex differences tend to be less pronounced in the older age groups.

Patient demographics

Table 7.4 provides a summary of the demographics of patients receiving specialised psychiatric care in 2005–06. In addition, a rate (per 1,000 population) is reported to adjust for relative population sizes and age structures. As these are reports of separations (rather than patients), the rates should not be interpreted as the number of patients with specific characteristics per 1,000 population. Instead, they provide information on the number of separations relative to the size of the population subgroup.

Table 7.4: Admitted patient separations[(a)] with specialised psychiatric care, by patient demographic characteristics, 2005–06

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate (per 1,000 population)[(d)]
Age (years)			
Less than 15	1,975	1.7	0.5
15–24	19,300	16.3	6.8
25–34	27,081	22.8	9.3
35–44	25,296	21.3	8.3
45–54	18,712	15.8	6.6
55–64	12,118	10.2	5.5
65+	14,251	12.0	5.4
Sex			
Male	56,799	47.8	5.6
Female	61,934	52.2	5.9
Indigenous status[(e)]			
Indigenous Australians	4,478	3.9	10.4
Other Australians[(f)]	109,139	96.1	5.7
Country of birth			
Australia	92,759	81.1	6.3
Overseas	21,566	18.9	3.8
Area of usual residence			
Major cities	82,043	70.9	6.0
Inner regional	23,253	20.1	5.7
Outer regional	8,856	7.6	4.5
Remote	948	0.8	3.0
Very remote	680	0.6	3.7
Marital status			
Never married	58,222	52.4	. .
Widowed	5,187	4.7	. .
Divorced	9,011	8.1	. .
Separated	6,182	5.6	. .
Married	32,595	29.3	. .
Total	**118,733**	**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 service contacts 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 Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions which consider the data to be of sufficient quality for further analysis. However, caution should be used in the interpretation of these data due to jurisdictional data collection differences; the data does not necessarily represent the national trend.

(f) Includes separations where Indigenous status was missing or not reported (AIHW2005b).

. . Not applicable.

Source: National Hospital Morbidity Database.

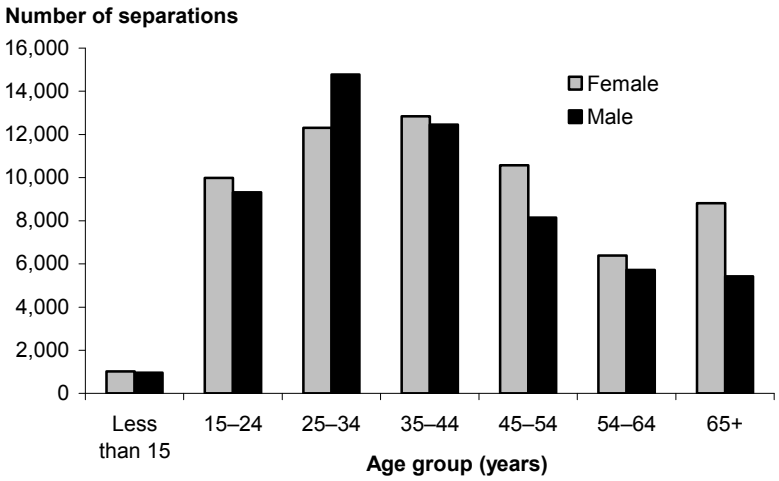
The highest proportion of separations was for patients aged 25–34 years and 35–44 years (22.8% and 21.3%, respectively). The 25–34 age group also had the highest number of separations per 1,000 population (9.3). The lowest proportion of separations was for patients aged less than 15 years (1.7%).

There was no major difference between male and female separations per 1,000 population (5.6 and 5.9, respectively), but there were differences in distributions of separations when age was taken into consideration (Figure 7.6). There were more female separations in all age groups apart from the 25–34 years age group. The biggest difference between the number of male and female separations was in the 65 years and over age group, followed by those aged 45–54 years. Separations were evenly distributed for those aged less than 15 years.

The rate of separation for Australian-born patients was noticeably higher than that of those born overseas (6.3 and 3.8, respectively). Those living in major cities had double the rate of separations of those in remote areas (6.0 and 3.0, respectively).

More than half of the separations (52.4%) involved those who were never married.

The data show that the typical separation involves an Australian-born, non-Indigenous male aged 15–34 years who has never been married and lives in a major city.



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 7.6: Admitted patient mental health–related separations with specialised psychiatric care by age and sex, 2005–06

Principal diagnosis

Principal diagnosis refers to the diagnosis deemed to be chiefly responsible for the patient's episode of admitted patient care. Table 7.5 shows the distribution of separations with psychiatric care by principal diagnosis and hospital type. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3.

In 2005–06, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of separations (21,842 or 18.4%). It was the most commonly reported diagnosis for public acute and psychiatric hospitals. *Depressive episode* (F32) ranked second and was the most commonly reported diagnosis for private hospitals. In fact, depressive disorders (F32 and F33) constituted 44.8% of the total number of private hospital separations.

Figures 7.7 and 7.8 show the 10 most commonly reported principal diagnoses by age and sex. For separations involving those aged less than 15 years, *Reaction to severe stress and adjustment disorder* were the most commonly reported diagnoses. Other common diagnoses for the less than 15 years age group included *Conduct disorders* (F91) and *Other specified problems related to psychosocial circumstances* (Z658).

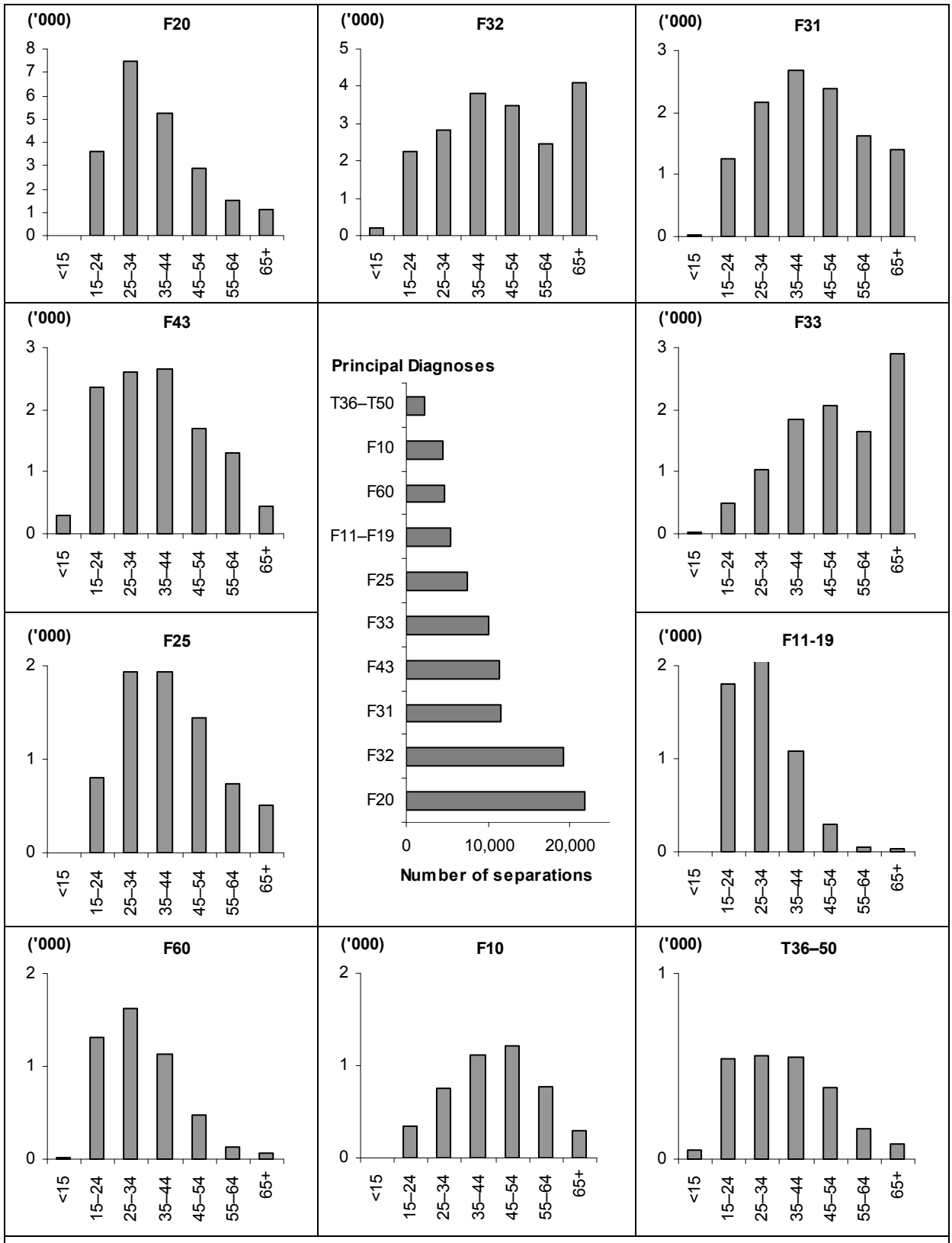
The 15–24 years age group featured prominently in separations with the principal diagnosis of *Mental and behavioural disorders due to other psychoactive substance use* (F11–19) and *Specific personality disorders* (F60). These two diagnoses were also commonly reported for the 25–34 years age group, which had the highest percentage of separations with *Schizophrenia* (F20) as the principal diagnosis. *Eating disorders* (F50) also appeared in the top 10 for separations for the 15–24 year old group. Separations involving the 35–44 years age group were evenly represented in the 10 most commonly reported principal diagnoses. For the 45–54 years age group, there was a higher percentage of separations involving *Mental and behavioural disorders due to use of alcohol* (F10) compared with other commonly reported principal diagnoses. Depressive disorders (F32 and F33) were the most common principal diagnoses reported in separations involving those aged 65 years and over.

There were marked sex differences in the number of separations for the 10 most commonly reported diagnoses (Figure 7.8). For the most commonly reported diagnosis of *Schizophrenia* (F20), the number of male separations was more than twice that of female separations. The diagnoses of *Mental and behavioural disorders due to use of alcohol and other psychoactive substance use* (F10 and F11–F19) also displayed a similar pattern with noticeably more male separations than female separations. Female separations, though, were noticeably higher for the principal diagnoses of *Recurrent depressive disorders* (F33) and *Specific personality disorders* (F60).

Table 7.5: Admitted patient separations[a] with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type, 2005–06

Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	609	188	162	959	0.8
F04–F09	Other organic mental disorders	599	146	139	884	0.7
F10	Mental and behavioural disorders due to use of alcohol	1,623	542	2,331	4,496	3.8
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	3,464	878	1,038	5,380	4.5
F20	Schizophrenia	17,402	3,231	1,209	21,842	18.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,505	260	89	1,854	1.6
F22	Persistent delusional disorders	787	163	89	1,039	0.9
F23	Acute and transient psychotic disorders	1,309	217	137	1,663	1.4
F25	Schizoaffective disorders	5,078	1,028	1,268	7,374	6.2
F30	Manic episode	449	71	54	574	0.5
F31	Bipolar affective disorders	7,331	1,157	3,072	11,560	9.7
F32	Depressive episode	10,844	1,068	7,226	19,138	16.1
F33	Recurrent depressive disorders	3,761	251	5,977	9,989	8.4
F34	Persistent mood (affective) disorders	910	109	341	1,360	1.1
F38–F39	Other and unspecified mood (affective) disorders	143	41	41	225	0.2
F40	Phobic anxiety disorders	62	14	45	121	0.1
F41	Other anxiety disorders	994	57	1,032	2,083	1.8
F42	Obsessive-compulsive disorders	239	22	216	477	0.4
F43	Reaction to severe stress and adjustment disorders	7,232	1,402	2,742	11,376	9.6
F44	Dissociative (conversion) disorders	124	13	269	406	0.3
F45, F48	Somatoform and other neurotic disorders	79	10	50	139	0.1
F50	Eating disorders	604	15	695	1,314	1.1
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	169	24	120	313	0.3
F60	Specific personality disorders	3,642	542	542	4,726	4.0
F61–F69	Disorders of adult personality and behaviour	189	45	103	337	0.3
F70–F79	Mental retardation	139	53	2	194	0.2
F80–F89	Disorders of psychological development	168	31	3	202	0.2
F90	Hyperkinetic disorders	114	11	9	134	0.1
F91	Conduct disorders	291	53	3	347	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	170	61	7	238	0.2
F99	Mental disorder not otherwise specified	251	22	3	276	0.2
G30	Alzheimer's disease	509	134	52	695	0.6
	Other factors related to mental and behavioural disorders and substance use[b]	224	357	2	583	0.5
	Other specified mental health-related principal diagnosis[c]	209	17	29	255	0.2
	Other[d]	4,796	1,022	362	6,180	5.2
Total		**76,019**	**13,255**	**29,459**	**118,733**	**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.
Source: National Hospital Morbidity Databas

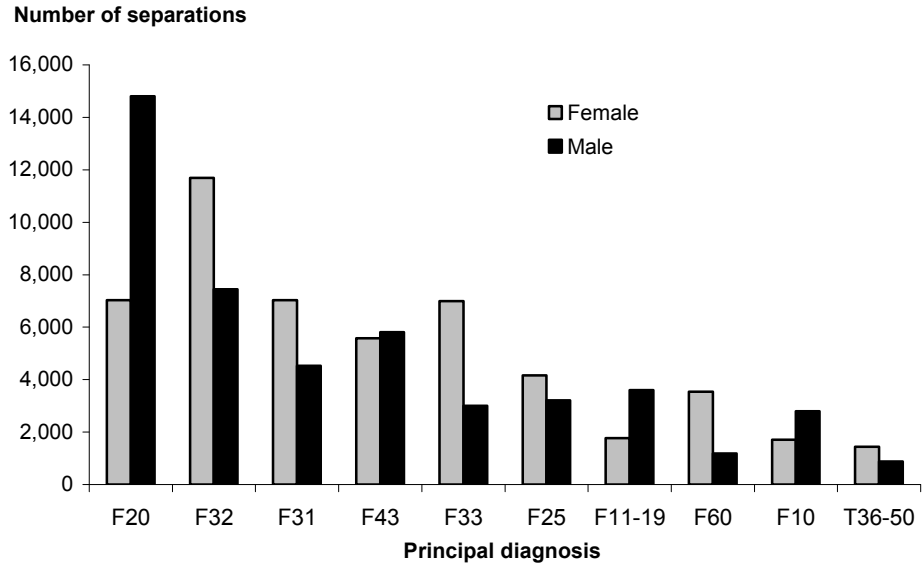


Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital borders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 7.7: Admitted patient mental health-related separations with specialised psychiatric care, by the 10 most commonly reported principal diagnoses and age group, 2005–06

Key to the principal diagnosis codes in Figures 7.7 and 7.8	
F10	Mental and behavioural disorders due to use of alcohol
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F20	Schizophrenia
F25	Schizoaffective disorders
F31	Bipolar affective disorders
F32	Depressive episode
F33	Recurrent depressive disorders
F43	Reaction to severe stress and adjustment disorders
F60	Specific personality disorders
T36–50	Poisoning by drugs, medicaments and biological substances



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 7.8: Admitted patient mental health–related separations with specialised psychiatric care, by the 10 most commonly reported principal diagnoses and sex, 2005–06

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.

A total of 157,922 procedures were reported in relation to 63,786 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 46.3% of the separations (54,947 out of 118,733). The most frequently reported procedure was *General anaesthesia, American Society of Anaesthesiologists (ASA) 99.* This procedure was most likely associated with the administration of electroconvulsive therapy (93340-02), a form of treatment for depression which was a commonly reported principal diagnosis. Allied health interventions from a number of different health disciplines also featured prominently in the 10 most frequently reported procedures.

Table 7.6: The 10 most frequently reported procedures for admitted patient separations[a] with specialised psychiatric care, 2005–06

Procedure	Procedures[b]		Separations[b][c]	
	Number	Per cent	Number	Per cent
92514–99 General anaesthesia, ASA 99	28,499	18	11,183	9.4
95550–01 Allied health intervention, social work	22,406	14.2	22,378	18.8
93340–02 Electroconvulsive therapy ≤ 12 treatments	14,495	9.2	14,370	12.1
95550–02 Allied health intervention, occupational therapy	13,610	8.6	13,594	11.4
95550–10 Allied health intervention, psychology	7,420	4.7	7,414	6.2
92514–29 General anaesthesia, ASA 29	5,236	3.3	1,797	1.5
56001–00 Computerised tomography of brain	5,002	3.2	4,983	4.2
95550–11 Allied health intervention, other	4,454	2.8	4,422	3.7
96175–00 Mental/behavioural assessment	4,234	2.7	4,185	3.5
95550–00 Allied health intervention, dietetics	4,219	2.7	4,208	3.5
Other reported procedures	48,347	30.6	41,987	35.4
		Totals		
Number of separations with at least one procedure	. .	. .	63,786	53.7
No procedure reported	. .	. .	54,947	46.3
Total	**157,922**	**100**	**118,733**	**100**

(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, as 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.

7.4 Non-specialised admitted patient mental health 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). 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–F99) or is one of a number of other selected diagnoses (see Appendix 4).

There were 85,453 mental health-related separations without specialised psychiatric care, accounting for 41.9% of all mental health-related separations for admitted patient care.

States and territories and hospital type

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

Table 7.7: Admitted patient separations[(a)] and patient days for mental health-related separations without specialised psychiatric care, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	27,329	22,799	9,221	6,631	7,063	1,364	335	453	75,195
Public psychiatric hospitals[(b)]	768	2	0	0	0	0	0	0	770
Private hospitals	1,263	2,483	2,796	1,373	660	n.p.	n.p.	n.p.	9,488
Total	**29,360**	**25,284**	**12,017**	**8,004**	**7,723**	**n.p.**	**n.p.**	**n.p.**	**85,453**
					Separations per 1,000 population[(c)]				
Public acute hospitals	4.0	4.4	2.3	3.3	4.5	2.8	1.1	2.6	3.7
Public psychiatric hospitals[(b)]	0.1	0.0	0.0	0.0	0.0	0.0	. .	. .	0.0
Private hospitals	0.2	0.5	0.7	0.7	0.4	n.p.	n.p.	n.p.	0.5
Total	**4.3**	**4.9**	**3.0**	**4.0**	**4.9**	**n.p.**	**n.p.**	**n.p.**	**4.2**
					Patient days				
Public acute hospitals	180,325	107,465	45,492	31,395	39,313	10,968	2,294	2,417	419,669
Public psychiatric hospitals[(b)]	5,545	2	0	0	0	0	. .	. .	5,547
Private hospitals	13,089	23,217	32,242	8,056	4,726	n.p.	n.p.	n.p.	93,266
Total	**198,959**	**130,684**	**77,734**	**39,451**	**44,039**	**n.p.**	**n.p.**	**n.p.**	**518,482**
					Patient days per 1,000 population[(c)]				
Public acute hospitals	25.8	20.5	11.4	15.7	23.6	21.9	8.0	19.2	20.2
Public psychiatric hospitals[(b)]	0.8	0.0	0.0	0.0	0.0	0.0	. .	. .	0.3
Private hospitals	1.9	4.5	8.0	4.1	2.7	n.p.	n.p.	n.p.	4.5
Total	**28.5**	**25.0**	**19.4**	**19.9**	**26.3**	**n.p.**	**n.p.**	**n.p.**	**24.9**

(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 New South Wales public psychiatric hospitals were mainly for alcohol and drug treatment episodes.

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

. . Not applicable.

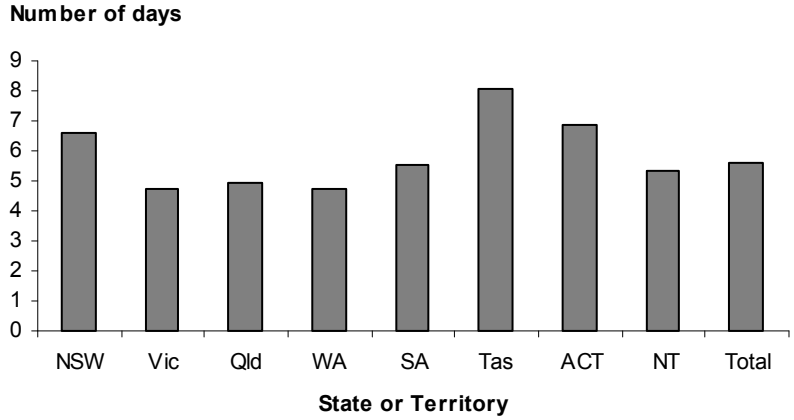
n.p. Not published. Private hospital figures for Tasmania, the Australian Capital Territory and the Northern Territory are not published due to confidentiality reasons. However, the figures are included in the national total.

Source: National Hospital Morbidity Database.

Mental health-related separations without specialised psychiatric care were predominantly provided by public acute hospitals (88% of 85,453). The percentage for this type of separation was lowest for Australian Capital Territory (0.4%). South Australia reported the highest rate of public acute hospital separations per 1,000 population (4.5). The overall separation rates for Victoria and South Australia across all hospital types were also the highest rate among the jurisdictions that fully reported their figures (4.9).

Private hospital separations constituted 11.1% of all mental health-related separations without specialised psychiatric care. Of the five jurisdictions with published private hospital figures, Queensland reported the highest number of patient days per 1,000 population.

Figure 7.9 shows the average length of stay in public acute hospitals for separations without specialised psychiatric care. The average length of stay across all jurisdictions was 5.6 days, which was much lower than the national average of 16 days for separations with specialised care (see Figure 7.3). Tasmania reported the highest average length of stay in public acute hospitals. Tasmania, New South Wales and Australian Capital Territory all reported higher average length of stay figures than the national average.



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 7.9: Average length of stay for separations without specialised psychiatric care in public acute hospitals, 2005–06

Patient demographics

Table 7.8 presents information on the number of separations without specialised psychiatric care in 2005–06 according to the characteristics of those receiving care. In addition, a rate (per 1,000 population) is reported to take into account relative population sizes and age structures. Again, the number of distinct individuals receiving care cannot be derived from the figures presented.

The highest proportion of separations without specialised psychiatric care was for patients aged 65 years and over (23.9%). This age group also has the highest number of separations per 1,000 population (7.7). The lowest proportion of separations without specialised care was for patients aged less than 15 years (6.9%).

Table 7.8: Mental health-related admitted patient separations[a] without specialised psychiatric care, by patient demographic characteristics, 2005–06

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate (per 1,000 population)[d]
Age (years)			
Less than 15	5,880	6.9	1.5
15–24	9,722	11.4	3.4
25–34	16,430	19.2	5.7
35–44	15,375	18.0	5.0
45–54	10,874	12.7	3.8
55–64	6,754	7.9	3.0
65+	20,399	23.9	7.7
Sex			
Male	40,335	47.2	4.0
Female	45,098	52.8	4.3
Indigenous status[e]			
Indigenous Australians	5,103	6.2	13.5
Other Australians[f]	77,738	93.8	4.0
Country of birth			
Australia	67,299	81.8	4.5
Overseas	14,961	18.2	2.6
Area of usual residence			
Major cities	49,401	58.9	3.6
Inner regional	18,633	22.2	4.4
Outer regional	12,161	14.5	6.0
Remote	2,386	2.8	7.6
Very remote	1,250	1.5	7.4
Total	**85,453**	**100**	**4.2**

(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) 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 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 Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions which consider the data to be of sufficient quality for further analysis. However, caution should be used in the interpretation of these data due to jurisdictional data collection differences; the data does not necessarily represent the national trend.

(f) Includes separations where Indigenous status was missing or not reported (see AIHW2005b).

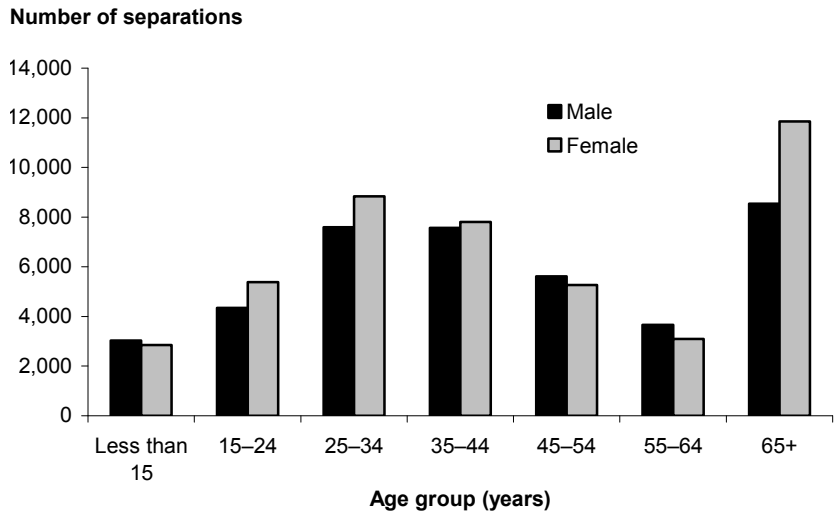
. . Not applicable.

Source: National Hospital Morbidity Database.

There was no major difference between the number of male and female separations per 1,000 population (4.0 and 4.3, respectively). However, as in the case of separations with specialised psychiatric care, there were differences in distributions of separations when age groups were taken into consideration (Figure 7.10). The biggest difference between the number of male and female separations was in the 65 years and over age group, followed by those aged 25–34 years.

The majority of mental health-related separations without specialised psychiatric care reported were for patients living in major cities (58.9%). However, the highest number of separations per 1,000 population was for patients in remote areas (7.6 per 1,000 population). The rate of separations involving Australian-born people was higher than for those born overseas (4.5 and 2.6, respectively). The reporting of marital status is not mandatory for separations without specialised psychiatric care, and is sparsely reported. Consequently, it has not been included in this report.

The data show that the typical separation without specialised care involves an Australian-born non-Indigenous female aged 15–34 years who lives in a major city.



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 7.10: Admitted patient mental health–related separations without specialised psychiatric care, by age and sex, 2005–06

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. In 2005–06, the principal diagnosis of *Mental and behavioural disorders due to use of alcohol* (F10) accounted for the largest number of separations (16,361 or 19.1%). It was the most commonly reported diagnosis for public acute and private hospitals. *Depressive episode* (F32) ranked second, constituting 14% of the total number of reported principal diagnoses.

Separations involving *Mental and behavioural disorders due to use of alcohol and other psychoactive substance use* (F10 and F11–F19) constituted the majority of separations reported by public psychiatric hospitals (76.5%).

Figures 7.11 and 7.12 show the 10 most commonly reported principal diagnoses by age and sex. For patients aged less than 15 years, the most common principal diagnoses was in the category *Other specified mental health-related principal diagnosis* which ranked third in the top 10 hierarchy. In this category, sleep-related disorders constituted 98.5% of separations for those aged less than 15 years. For the age group 15–24 years, *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) were the most common diagnoses. These diagnoses also were also common for the age group 25–34 years, followed by *Reaction to severe stress and adjustment disorders* (F43) and *Schizophrenia* (F20). Over 30%of all separations with these three diagnoses were reported by this age group. The younger age groups reported more separations associated with the use of psychoactive substances (F11–F19). More than half of separations associated with the use of alcohol (F10) were reported by those aged 35–54 years (51.8%). Alcohol-related disorders (F10) were also top of the list for those aged 55–64 years.

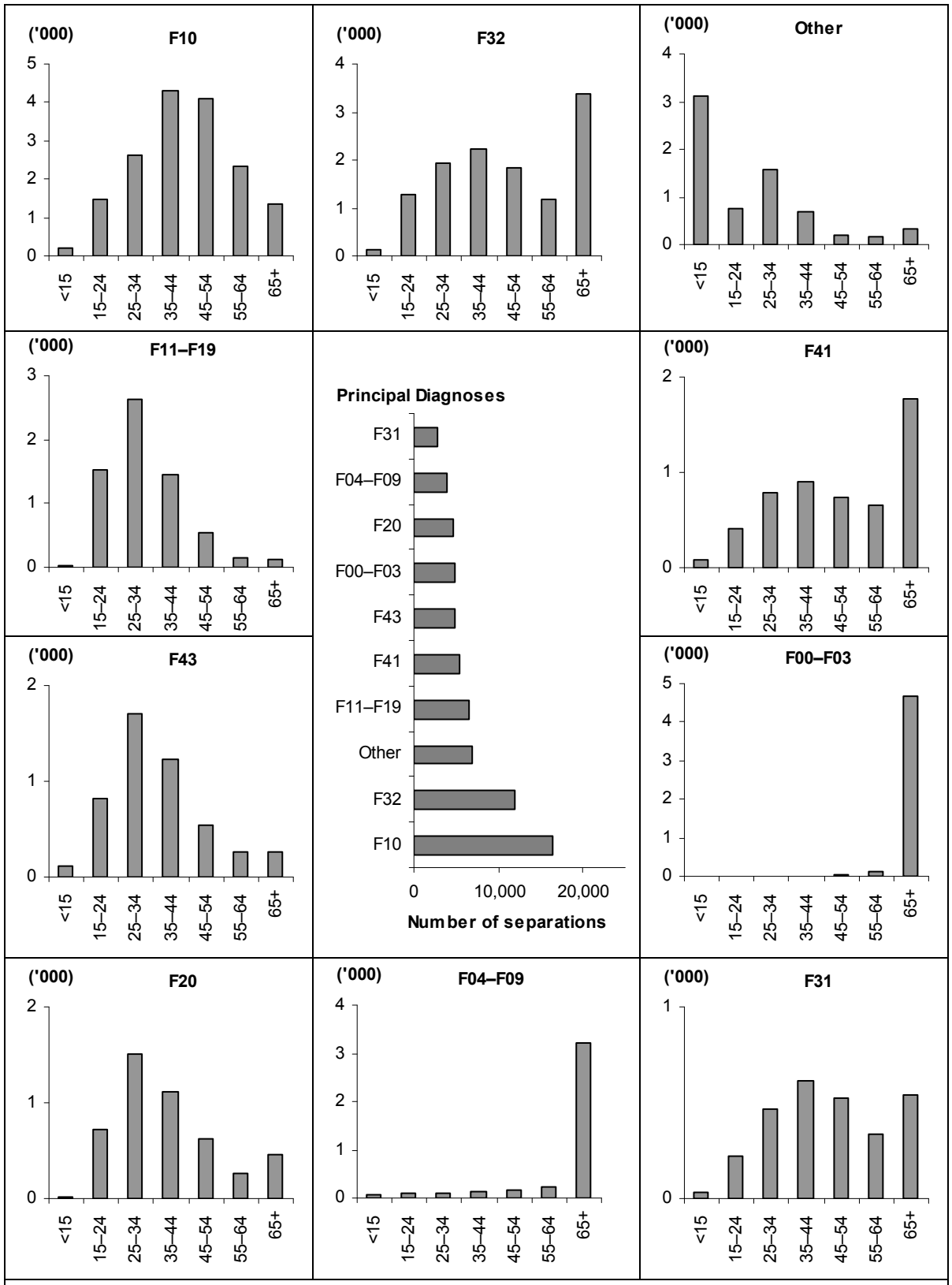
Not surprisingly, separations with the principal diagnosis of *Dementia* (F00–F03) were predominantly reported for those aged 65 years and over. This was also the case for separations with the diagnosis of *Other organic mental disorders* (F04–F09). However, there were also more separations reported for this age group for depressive and anxiety disorders (F32 and F41) compared with other age groups.

Male separations for the principal diagnoses of *Mental and behavioural disorders due to use of alcohol and other psychoactive substance use* (F10 and F11–F19) and *Schizophrenia* (F20) were markedly more than female separations (Figure 7.12).

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, 2005–06

Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	4,135	0	699	4,834	5.7
F04–F09	Other organic mental disorders	3,458	0	525	3,983	4.7
F10	Mental and behavioural disorders due to use of alcohol	14,368	244	1,749	16,361	19.1
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	5,598	345	519	6,462	7.6
F20	Schizophrenia	4,632	4	66	4,702	5.5
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,275	2	27	1,304	1.5
F22	Persistent delusional disorders	552	1	31	584	0.7
F23	Acute and transient psychotic disorders	1,074	1	22	1,097	1.3
F25	Schizoaffective disorders	1,108	4	57	1,169	1.4
F30	Manic episode	288	0	20	308	0.4
F31	Bipolar affective disorders	2,449	11	271	2,731	3.2
F32	Depressive episode	10,724	40	1,179	11,943	14.0
F33	Recurrent depressive disorders	2,249	12	301	2,562	3.0
F34	Persistent mood (affective) disorders	198	11	45	254	0.3
F38–F39	Other and unspecified mood (affective) disorders	74	0	6	80	0.1
F40	Phobic anxiety disorders	24	0	16	40	0.0
F41	Other anxiety disorders	4,567	5	767	5,339	6.2
F42	Obsessive-compulsive disorders	58	0	12	70	0.1
F43	Reaction to severe stress and adjustment disorders	4,547	11	374	4,932	5.8
F44	Dissociative (conversion) disorders	957	0	66	1,023	1.2
F45, F48	Somatoform and other neurotic disorders	375	0	211	586	0.7
F50	Eating disorders	900	0	83	983	1.2
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	1,017	0	411	1,428	1.7
F60	Specific personality disorders	1,200	3	40	1,243	1.5
F61–F69	Disorders of adult personality and behaviour	96	0	43	139	0.2
F70–F79	Mental retardation	174	0	2	176	0.2
F80–F89	Disorders of psychological development	349	0	63	412	0.5
F90	Hyperkinetic disorders	56	0	1	57	0.1
F91	Conduct disorders	368	0	4	372	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	465	2	13	480	0.6
F99	Mental disorder not otherwise specified	222	0	0	222	0.3
G30	Alzheimer's disease	1,773	0	334	2,107	2.5
	Other factors related to mental and behavioural disorders and substance use[b]	478	74	22	574	0.7
	Other specified mental health-related principal diagnosis[c]	5,387	0	1,509	6,896	8.1
Total		**75,195**	**770**	**9,488**	**85,453**	**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.

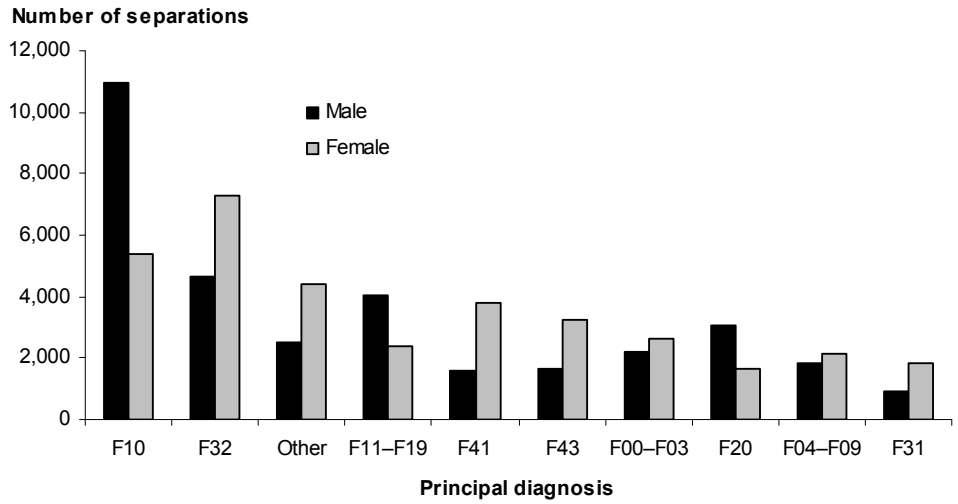


Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital borders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 7.11: Admitted patient mental health-related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and age group, 2005–06

Key to the principal diagnosis codes in Figures 7.11 and 7.12	
F00–F03	Dementia
F04–F09	Other organic mental disorders
F10	Mental and behavioural disorders due to use of alcohol
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F20	Schizophrenia
F31	Bipolar affective disorders
F32	Depressive episode
F41	Other anxiety disorders
F43	Reaction to severe stress and adjustment disorders
Other	Other specified mental health-related principal diagnosis



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 7.12: Admitted patient mental health–related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and sex, 2005–06

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.

A total of 96,047 procedures were reported in relation to 44,345 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 48.1% (41,108 out of 85,453) of the separations. The most frequently reported procedure was *Allied health intervention, social work* (12,067 procedures for 12,043 separations). Allied health interventions from other health disciplines also featured prominently in the 10 most frequently reported procedures.

Table 7.10: The 10 most frequently reported procedures for mental health-related admitted patient separations[a] without specialised psychiatric care, 2005–06

Procedure	Procedures[b]		Separations[b][c]	
	Number	Per cent	Number	Per cent
95550–01 Allied health intervention, social work	12,067	12.6	12,043	14.1
95550–03 Allied health intervention, physiotherapy	8,793	9.2	8,778	10.3
56001–00 Computerised tomography of brain	7,167	7.5	7,144	8.4
93340–02 Electroconvulsive therapy ≤ 12 treatments	6,747	7.0	6,736	7.9
92514–99 General Anaesthesia, ASA 99	6,351	6.6	5,830	6.8
95550–02 Allied health intervention, occupational therapy	5,699	5.9	5,682	6.6
95550–00 Allied health intervention, dietetics	4,133	4.3	4,127	4.8
92003–00 Alcohol detoxification	3,586	3.7	3,586	4.2
95550–10 Allied health intervention, psychology	2,747	2.9	2,747	3.2
92006–00 Drug detoxification	2,746	2.9	2,746	3.2
Other reported procedures	36,011	37.5	35,239	41.2
			Totals	
Number of separations with at least one procedure	. .	. .	44,345	51.9
No procedure reported	. .	. .	41,108	48.1
Total	**96,047**	**100**	**85,453**	**100**

(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, as 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.

7.5 Separations with mental health-related additional diagnoses

In addition to the 322,110 admitted patient mental health-related separations, 282,876 separations 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 2,759,125 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; 57,640 separations), *Unspecified dementia* (F03; 50,478 separations) and *Depressive episode* (F32; 38,678 separations).

The most commonly reported principal diagnoses for these separations were *Care involving use of rehabilitation procedures* (Z50; 17,549 separations), *Other chronic obstructive pulmonary disease* (J44; 10,743 separations) and *Pneumonia, organism unspecified* (J18; 7,200 separations).

7.6 Additional data

Additional tables containing data on mental health-related admitted patient separations are available from the AIHW website. In addition, data on mental health-related separations for admitted patient mental health care from the NHMD can be accessed via interactive data cubes on the AIHW 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

Non-ambulatory mental health-related care can be accessed via hospitals, as discussed in Chapter 7, or through facilities providing residential mental health services. This chapter presents information on this type of care funded by government. The data presented are from the National Residential Mental Health Care Database (NRMHCD), which is a collation of data on episodes of residential care. The database was inaugurated in 2004–05 and this is the second time that the data was reported. 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. Appendix 1 provides information about the coverage and data quality of this collection.

Government-funded residential mental health care can be provided by both government and non-government organisations. These organisations can be staffed 24 hours a day or less (see Appendix 1). While no data from non-government organisations were collected for financial year 2004–05, data from two non-government organisations in Tasmania were included in the 2005–06 data and reported.

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 residents to take responsibility for their daily living activities.

These services are provided by mental health-trained staff 24 hours a day, or at least 50 hours per week with at least 6 hours staffing on any single 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 2005) 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 2006)). 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. 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 States and territories

In 2005–06, there were 2,345 ***episodes of residential care*** with 222,003 ***residential care days*** provided to 1,584 ***residents*** (Table 8.1). This corresponds to an average of 1.5 episodes of care per resident and 95 residential care days per episode. The number of residents reported may be an overestimate because residents who made use of services from multiple providers were counted separately each time and there is no means to identify these residents individually.

There were noticeable differences in the data across the states and territories. These may be due to differences in service delivery practices and/or the types of establishments categorised as residential mental health care facilities. Therefore, caution should be used in the interpretation of differences between jurisdictions. Queensland and the Northern Territory do not currently report any residential mental health care service data to the collection.

Table 8.1: Episodes of residential mental health care, number of residents and residential care days, states and territories, 2005–06

	NSW	Vic	Qld[(a)]	WA	SA	Tas	ACT	NT[(a)]	Total
Episodes	436	791	. .	177	140	741	60	. .	2,345
Estimated number of residents[(b)]	316	554	. .	132	129	399	54	. .	1,584
Average episodes per resident[(b)]	1.4	1.4	. .	1.3	1.1	1.9	1.1	. .	1.5
Residential care days	50,480	88,145	. .	4,211	11,211	54,830	13,126	. .	222,003
Average residential care days per episode	116	111	. .	24	80	74	219	. .	95
				Rate (per 10,000 population)					
Episodes[(c)]	0.6	1.6	. .	0.9	1.0	14.1	1.8	. .	1.1
Estimated number of residents[(b)(c)]	0.5	1.1	. .	0.7	0.9	8.1	1.6	. .	0.8
Residential care days	73.8	174.8	. .	20.8	76.0	1,066.9	393.4	. .	108.2

(a) Queensland and the Northern Territory do not report residential mental health service data.

(b) The number of residents is likely to be overestimated, as 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.

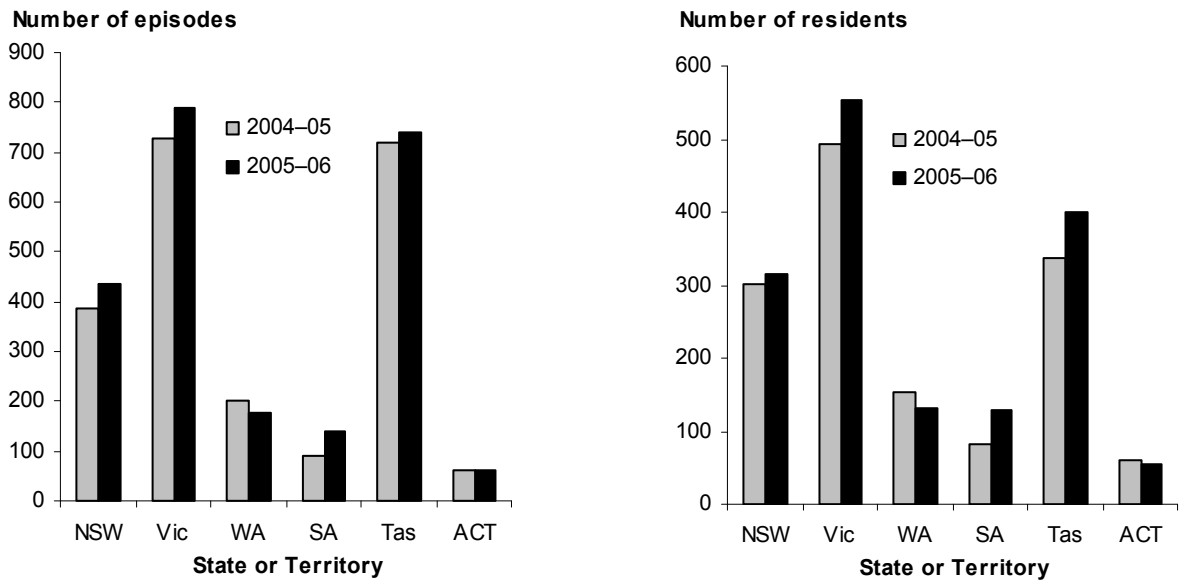
Tasmania reported the highest average number of episodes per resident compared with the national average (1.9 and 1.5, respectively). This is possibly due to the inclusion of a respite residential unit which admits patients for short stays to stabilise them. The highest average residential care days per episode was reported by the Australian Capital Territory (219 days). The incorporation of forensic patients in the Australian Capital Territory residential facility is a possible contributing factor.

Taking population size into consideration, Tasmania also reported the highest numbers per 10,000 population for the number of episodes (14.1), estimated number of residents (8.1) and residential care days (1,067). New South Wales had the lowest number of episodes (0.6) and

residents (0.5) per 10,000 population, while Western Australia reported the lowest number of residential care days (20.8).

8.3 Changes 2004–05 to 2005–06

There were noticeable changes for some jurisdictions in the number of residential care episodes and residents accessing care between 2004–05 and 2005–06 (Figure 8.1). South Australia reported the highest increase in the number of episodes (53.8%) and residents (55.4%) from 2004–05. This is possibly due to an increase in the coverage of data being reported. For 2004–05, South Australia estimated their coverage to be between 33% (based on the number of in-scope services actually reporting to the collection) and 87% (based on the estimated number of episodes). By contrast their estimate for 2005–06, is a 100% data coverage (see Appendix 1 for further information on NRMHCD data coverage). The inclusion of two Tasmanian non-government organisations in the 2005–06 data may also have contributed to an 18.4% increase in the number of residents and 2.8% increase in the number of episodes for Tasmania.



Note: The number of residents is likely to be overestimated, as residents who used services from multiple providers are counted separately each time.

Source: National Residential Mental Health Care Database.

Figure 8.1: Residential mental health care episodes and residents, states and territories, 2004–05 to 2005–06

8.4 Mental health legal status

Table 8.2 presents data on the number of episodes of residential care by mental health legal status and jurisdiction. The majority of residential care episodes were for residents with voluntary legal status (63.9%), and in the case of Western Australia, all residential care episodes were voluntary. However, this was not the case for the Australian Capital Territory, with over 50% of reported episodes being classified as involuntary. The evident jurisdictional

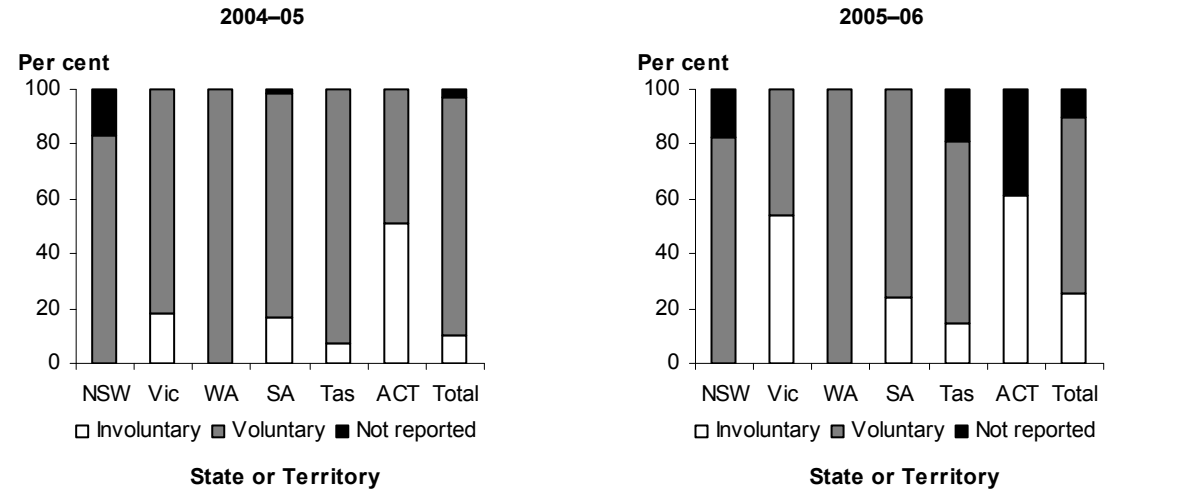
differences are likely to be a reflection of the different legal status legislative arrangements in place in the jurisdictions.

Figure 8.2 shows the jurisdictional comparison of episodes by mental health legal status between 2004–05 and 2005–06. It shows an overall increase in proportion of involuntary episodes especially for Victoria, South Australia, Tasmania and the Australian Capital Territory. There were also noticeable increases in the overall proportion of episodes with no mental health legal status reported.

Table 8.2: Episodes of residential mental health care, by mental health legal status, states and territories, 2005–06

Mental health legal status	NSW	Vic	WA	SA	Tas	ACT	Total
Involuntary	0	428	0	34	107	37	606
Voluntary	361	363	177	106	492	0	1,499
Not reported	75	0	0	0	142	23	240
Total	**436**	**791**	**177**	**140**	**741**	**60**	**2,345**

Source: National Residential Mental Health Care Database.



Source: National Residential Mental Health Care Database.

Figure 8.2: Residential mental health care episodes, by mental health legal status, states and territories, 2004–05 to 2005–06

8.5 Patient demographics

Table 8.3 provides a summary of the demographics of patients receiving residential mental health care in 2005–06. In addition, a rate (per 10,000 population) is reported to account for relative population sizes and age structure differences. As these are reports of episodes of care rather than patients, the rates cannot be interpreted as the number of patients with specific characteristics per 10,000 population. Rather, they provide information on the number of episodes relative to the size of the population subgroup.

Table 8.3: Episodes of residential mental health care, by patient demographic characteristics, 2005–06

Patient demographics	Number of episodes[a]	Per cent of episodes[b]	Rate (per 10,000 population)[c]
Age (years)			
Less than 15	21	0.9	0.1
15–24	270	11.8	0.9
25–34	693	30.3	2.4
35–44	518	22.6	1.7
45–54	342	14.9	1.2
55–64	199	8.7	0.9
65+	247	10.8	0.9
Sex			
Male	1,409	61.4	1.4
Female	885	38.6	0.8
Indigenous status[d]			
Indigenous Australians	64	97.2	1.7
Other Australians	2,226	2.8	1.1
Country of birth			
Australia	1,965	86.8	1.4
Overseas	299	13.2	0.5
Remoteness area of usual residence			
Major cities	1,049	47.0	0.8
Inner regional	1,032	46.2	2.5
Outer regional	134	6.0	0.7
Remote and Very remote	19	0.9	0.4
Marital status[e]			
Never married	1,464	71.3	. .
Widowed	97	4.7	. .
Divorced	190	9.3	. .
Separated	103	5.0	. .
Married	198	9.6	. .
Total	**2,345**	**100.0**	**1.1**

(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 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 3.

(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 12% of episodes.

. . Not applicable.

Source: National Residential Mental Health Care Database.

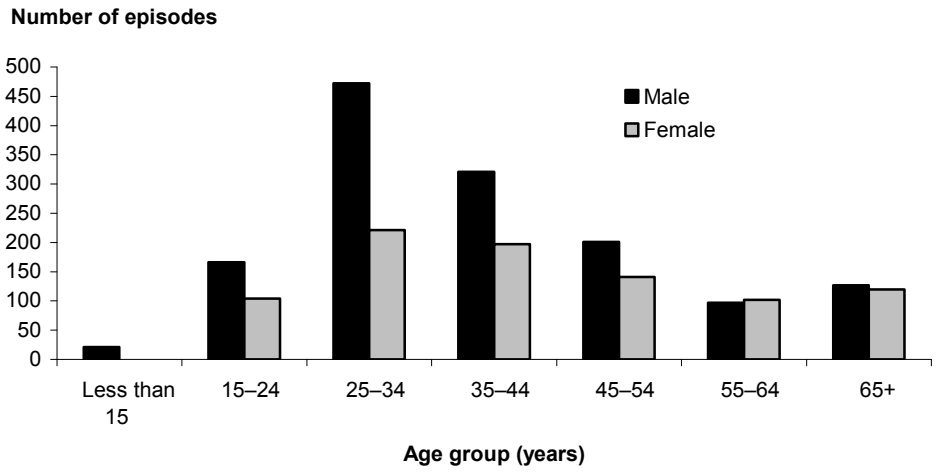
The highest proportion of residential care episodes was for patients aged 25–34 years and 35–44 years (30.3% and 22.6%, respectively). The 25–34 age group also had the highest number of episodes per 10,000 population, which was twice that of the 45–54 years age group (2.4 and 1.2, respectively). The lowest proportion of episodes was for patients aged less than 15 years (0.9%).

There were more residential care episodes involving males than females. This is particularly marked for those aged 25–44 years (Figure 8.3).

The rate of episodes for Australian-born patients was noticeably higher than the rate of those born overseas (1.4 and 0.5, respectively). Likewise, a higher rate of episodes was noted for those living in inner regional areas, which was more than three times that of those in major cities (2.5 and 0.8, respectively).

Nearly three-quarters of the episodes (71.3%) involved those who were never married. This is potentially explained by the predominance of the younger age groups in residential care.

The data show that the typical episode involves an Australian-born, non-Indigenous male aged 15–34 who has never been married and lives in a major city.



Source: National Residential Mental Health Care Database.

Figure 8.3: Residential mental health care episodes, by age and sex, 2005–06

8.6 Principal diagnosis

Principal diagnosis refers to the diagnosis deemed to be chiefly responsible for 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 2005–06. In this table, diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 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).

In 2005–06, a principal diagnosis was specified for 92.2% of episodes of residential care (2,162). For those episodes, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of residential care episodes (1,268 or 58.6%). It was also the most commonly

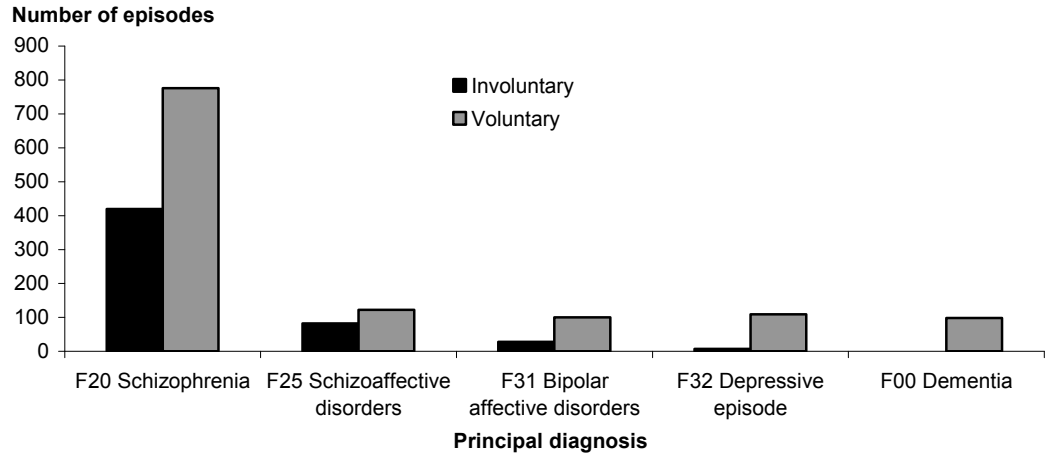
reported diagnosis for episodes with involuntary mental health legal status (419 or 69.1% out of 606) (Table 8.2; Figure 8.4). For the principal diagnosis of *Schizoaffective disorders* (F25), there was also a relatively high proportion of involuntary episodes (40.2%, excluding episodes with no mental health legal status reported).

Table 8.4: Episodes of residential mental health care, by principal diagnosis in ICD-10-AM groupings, 2005–06

Principal diagnosis		Number of episodes	Specified principal diagnoses (per cent)
F00–F03	Dementia	113	5.2
F04–F09	Other organic mental disorders	13	0.6
F10	Mental and behavioural disorders due to use of alcohol	9	0.4
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	13	0.6
F20	Schizophrenia	1,268	58.6
F21, F24, F28, F29	Schizotypal and other delusional disorders	38	1.8
F22	Persistent delusional disorders	10	0.5
F23	Acute and transient psychotic disorders	24	1.1
F25	Schizoaffective disorders	220	10.2
F30	Manic episode	7	0.3
F31	Bipolar affective disorders	134	6.2
F32	Depressive episode	122	5.6
F33	Recurrent depressive disorders	13	0.6
F34	Persistent mood (affective) disorders	2	0.1
F38, F39	Other and unspecified mood (affective) disorders	0	0.0
F40	Phobic anxiety disorders	2	0.1
F41	Other anxiety disorders	22	1.0
F42	Obsessive-compulsive disorders	6	0.3
F43	Reaction to severe stress and adjustment disorders	29	1.3
F44	Dissociative (conversion) disorders	5	0.2
F45, F48	Somatoform and other neurotic disorders	0	0.0
F50	Eating disorders	1	0.0
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	2	0.1
F60	Specific personality disorders	55	2.5
F61–F69	Disorders of adult personality and behaviour	3	0.1
F70–F79	Mental retardation	10	0.5
F80–F89	Disorders of psychological development	7	0.3
F90	Hyperkinetic disorders	0	0.0
F91	Conduct disorders	4	0.2
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	1	0.0
	Other[(a)]	29	1.3
Total with specified principal diagnosis		*2,162*	100.0
F99	Mental disorder not otherwise specified	*133*	
	Not reported	50	
Total with unspecified principal diagnosis		*183*	
Total		**2,345**	

(a) Includes all reported diagnoses that are not in the Mental and behavioural disorders chapter of ICD-10-AM (codes F00–F99).

Source: National Residential Mental Health Care Database.



Source: National Residential Mental Health Care Database.

Figure 8.4: Five most commonly reported principal diagnoses, by mental health legal status, 2005–06

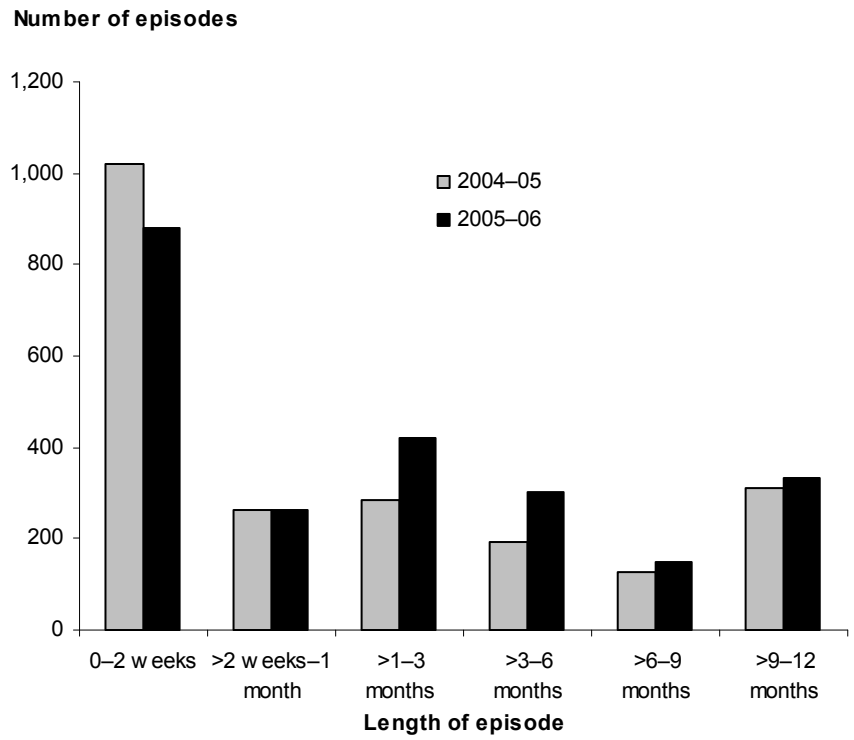
8.7 Length of episodes and residential stays

Episodes

The NRMHCD collects data on the episodes of residential mental health care that occurred during the collection period (that is, from 1 July 2005 to 30 June 2006). 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 that started and ended on the same day are allocated an episode length of one day; in 2005–06, there were 75 such episodes.

In relation to the 2,345 episodes of residential mental health care in 2005–06, there was a total of 222,003 residential mental health care days. The average length of stay per episode was 95 days, the most common length of stay was 365 days (184 episodes or 7.8%), and the median length of stay was 33 days.

Figure 8.5 compares the length of stay for episodes between 2004–05 and 2005–06. There was a general increase in the number of residential episodes with longer length of stay (more than 2 weeks) in 2005–06. The highest increase was for episodes with length of stay more than 3 to 6 months (55.2%). For episodes lasting less than 2 weeks, there was a 13.6% reduction in the total number of episodes.



Source: National Residential Mental Health Care Database.

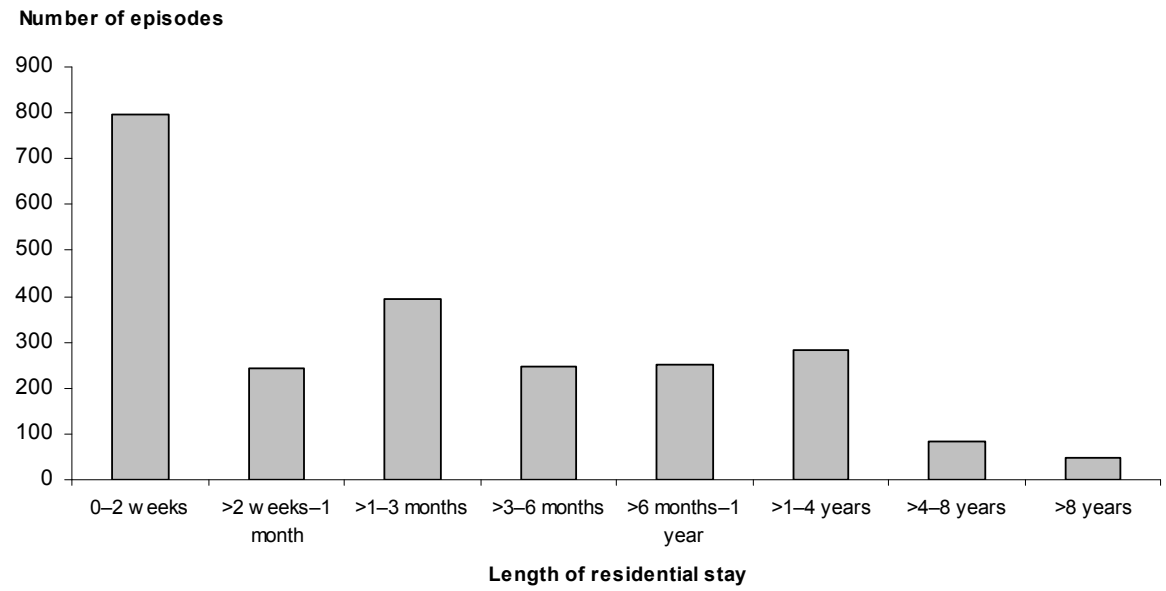
Figure 8.5: Episodes of residential mental health care, by length of episode, 2004–05 and 2005–06

Residential stays

Of the 2,345 residential mental health care episodes reported in 2005–06, 1,717 (73.2%) episodes began during the collection period (1 July 2005 to 30 June 2006), with the remainder beginning before 1 July 2005. The number of days a resident was in residential care before 1 July 2005 can be added to the length of the episode within 2005–06 to give an estimate of the length of residential stays. Figure 8.6 shows the distribution of the length of residential stays for the episodes reported in 2005–06.The figures presented are only estimates because the number of leave days before 1 July 2005 were not accounted for.

When the number of residential care days before 1 July 2005 is taken into account, the average length of residential stay was 310.5 days. The most common length of stay was 3 days and the median length of stay was 41 days. Note that the data on residential stays include both episodes that formally ended during 2005–06 and those that did not.

Episodes with residential stay longer than 1 year constituted 17.4% (407 out of 2,345) of all episodes. There were 48 reports of residential stays of longer than 8 years, with 31 of these lasting longer than 10 years. The longest length of residential stay was 39.2 years.



Source: National Residential Mental Health Care Database.

Figure 8.6: Episodes of residential mental health care ending or continuing in 2005–06, by length of residential stay

8.8 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).

9 Mental health-related Supported Accommodation Assistance Program services

9.1 Introduction

The Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC) includes data that provide information about the use of SAAP services by clients with psychiatric or other mental health problems, defined by their having mental health-related closed support periods (see Key concepts box below). This chapter presents information on these mental health-related closed support periods, provided by SAAP agencies in 2005–06.

The Supported Accommodation Assistance Program

The primary aim of SAAP is to provide people who are homeless or at risk of being homeless with transitional supported accommodation and related support services to help them achieve the maximum possible degree of self-reliance and independence. Agencies funded through SAAP provide a range of 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. However, while participation and consent rates are high, not all SAAP agencies participate in the SAAP NDC and, not all clients of participating agencies give consent to provide their details to the NDC. For further details about the scope and coverage of the SAAP Client Collection, see Appendix 1.

Key concepts

A ***SAAP client*** is 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.

Supported accommodation is 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 refers to the assistance, other than supported accommodation, provided as part of an ongoing support relationship between a SAAP agency and the client.

(continued)

An ***accommodation period*** is 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.

A ***closed support period*** is a support period that had finished on or before 30 June of the reporting year.

Mental health-related closed support periods are closed support periods for which at least one of the following were reported (*italics* indicates an expansion of the definition from previous editions of this publication):

- 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 *mental health issue*;
- *the client reported an accommodation type of psychiatric institution either before or after SAAP support*; or
- the type of support needed, provided, or referred was psychological services or psychiatric services.

An ***accompanying child*** is less than 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.

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 a SAAP support period was mental health-related and, in turn, how many clients received mental health-related closed support periods.

Due to definitional changes, the information in this publication relating to the number of mental health-related closed support periods cannot be compared with previous publications in this series. The expanded definition of what constitutes a mental health-related closed support period is in italics print, in the key concepts box above.

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:

- Data presented in this chapter are unweighted, meaning no adjustment for undercounting of support periods due to the non-participation of some agencies and the non-consent of some SAAP clients to the provision of their data has been made. The data, therefore, are not comparable with other data published from the SAAP Client Collection.
- 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.
- Information is collected by workers in SAAP agencies, and these workers may not be trained to assess a client's need for psychiatric or psychological services.

It is important to 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.

Table 9.1: SAAP clients with mental health-related closed support periods: demographic characteristics and number of support periods, 2005–06

	Clients			Closed support periods		
Client demographics	Number	Per cent of clients[(b)]	Rate[(a)] (per 100,000 population)	Number[(c)]	Per cent of support periods[(b)]	Rate[(a)] (per 100,000 population)
Age (years)						
Less than 15	275	2.0	6.8	337	1.7	8.3
15–17	1,107	8.0	131.4	1,393	6.8	165.3
18–19	774	5.6	138.5	1,003	4.9	179.5
20–24	1,783	12.9	123.2	2,345	11.5	162.0
25–44	7,230	52.4	121.4	9,923	48.7	166.7
45–64	2,086	15.1	41.2	2,985	14.6	59.0
65+	155	1.1	5.8	233	1.1	8.8
Sex						
Female	7,277	52.8	69.8	10,243	50.2	91.0
Male	6,490	47.1	62.4	10,067	49.4	88.1
Indigenous status						
Indigenous Australians	1,626	11.8	324.1	2,114	10.4	419.6
Other Australians	11,552	83.8	56.9	15,738	77.2	77.4
Country of birth						
Australia	11,721	85.0	74.8	15,997	78.4	102.3
Overseas	1,796	13.0	35.0	2,355	11.5	45.1
Overseas-born[(d)]						
EP country group 1	554	31.5	32.0	742	32.2	42.0
EP country group 2	399	22.7	32.7	535	23.3	34.3
EP country group 3	651	37.0	45.8	821	35.7	56.6
EP country group 4	155	8.8	59.6	203	8.8	71.7
Total number	**13,791**	. .	. .	**20,392**	. .	. .

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

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

(c) For age, Indigenous status, country of birth and client group, information was missing or not reported for more than 5% 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.

(d) For definition of the English Proficiency (EP) country groups see Appendix 3. The four groups sum to slightly less than the total number of overseas-born because a small number of overseas-born clients could not be allocated to an EP country group.

. . Not applicable

Source: Supported Accommodation Assistance Program Client Collection.

9.2 SAAP clients with mental health-related closed support periods

In 2005–06, there were 13,791 SAAP clients with at least one mental health-related closed support period (Table 9.1). The average number of mental health-related closed support periods per client for those with mental health-related closed support periods was 1.5.

There were more female than male clients with mental health-related support periods in 2005–06 (52.8% compared with 47.1%). The rate of access to mental health-related support, as measured by the age-standardised rate, was also higher for female clients than for males (69.8 and 62.4 per 100,000 population, respectively).

Clients aged 25-44 years represented over half of the total number for 2005–06 (52.4 %), but the number per 100,000 population was highest for clients aged 18–19 years and lowest for those aged over 65 years (138.5 and 5.8 per 100,000 population, respectively) (Table 9.1).

In 2005–06, 11.8% of clients with mental health-related closed support periods reported being Aboriginal or Torres Strait Islander. This proportion is considerably higher than the estimated Indigenous population proportion as at 30 June 2005 (2.4% of the total Australian population, ABS 2006). The age-standardised rate for Indigenous Australians was 419.6 per 100,000 population for closed support periods, which was over 5 times the rate for non-Indigenous Australians (77.4).

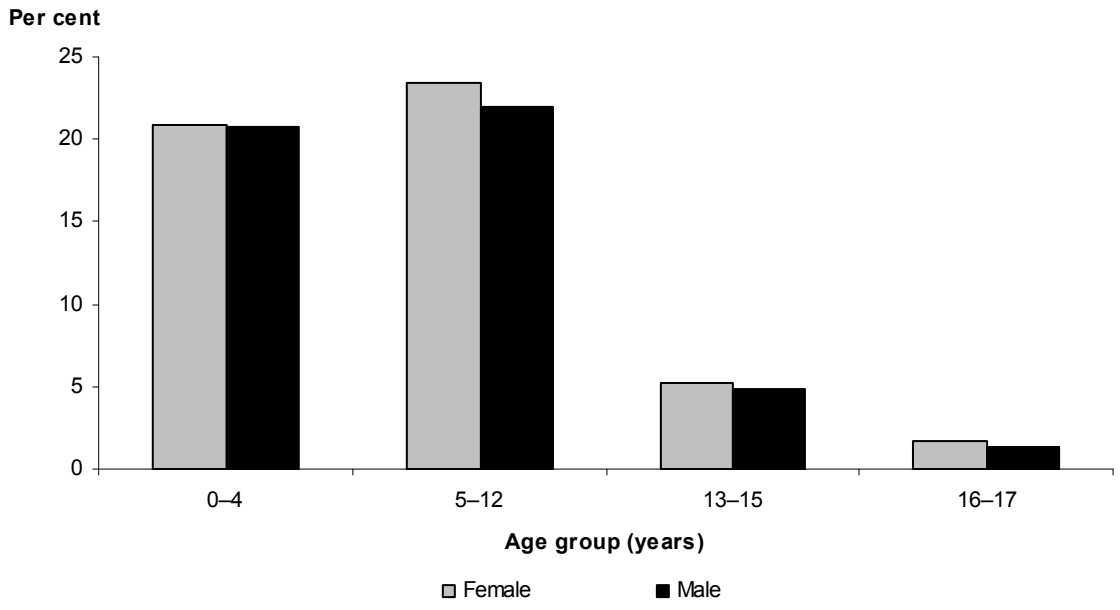
Most clients were born in Australia (85%), and the age-standardised rate for Australian-born people who had a SAAP mental health-related closed support period in 2005–06 was over twice that of those born overseas (102.3 and 45.1 per 100,000 population, respectively).

The 13.0% of clients who were born overseas in 2005–06 can be classified into English proficiency (EP) country groups (see Appendix 3 for details). There was considerable variation in rates of access between the EP country groups. For clients who were born in EP group 4 countries, the rate was almost twice that of those born in EP group 1 countries (59.6 and 32.0 per 100,000 population, respectively).

Children accompanying clients

Information is collected on children who accompany their parent(s) or guardian(s) to SAAP agencies or who require 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 2005–06, 4,563 children (unweighted data) accompanied clients who had mental health-related closed support periods (Figure 9.1). The majority of these children were aged 0–12 years (86.9%). Slightly more than half were girls (51.2%).

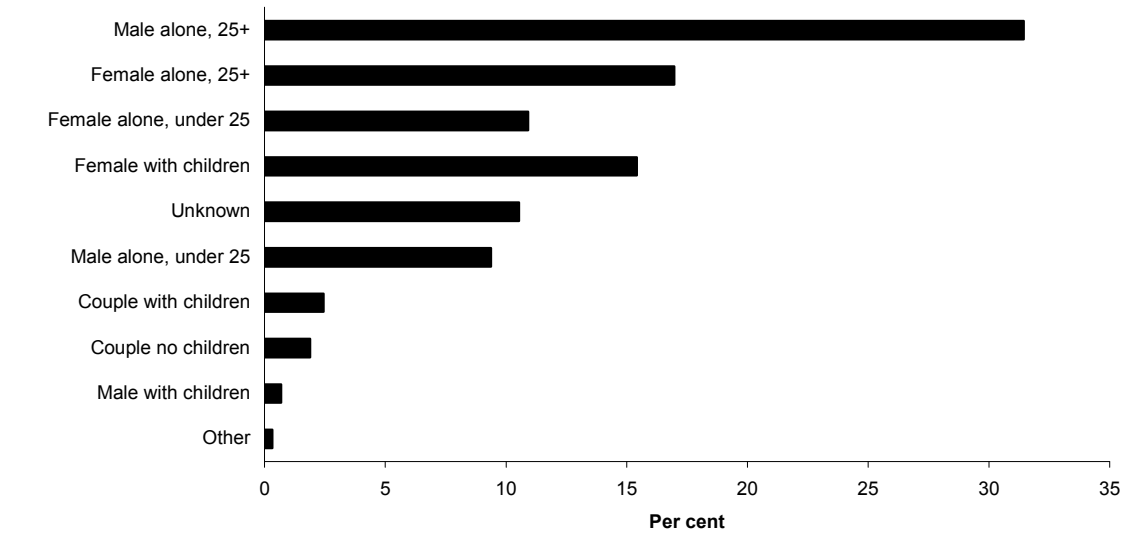


Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.1: Children accompanying SAAP clients with mental health-related closed support periods, by age and sex of child, 2005–06

Client groups

In the SAAP data collection, each client is allocated to a client group based on the client's sex, age group and the mode of presentation to the SAAP agency. In 2005–06, the most commonly reported client group with mental health-related closed support periods was unaccompanied males aged 25 years and over (31.4 %), followed by unaccompanied females aged 25 years and over (17.0%) (Figure 9.2).



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.2: SAAP clients with mental health-related closed support periods, proportion of support periods by client group type, 2005–06

9.3 SAAP mental health-related closed support periods

The previous section provides details on SAAP clients who had a mental health-related closed support period in 2005–06. This section presents information on the closed support periods and the SAAP services provided to these clients. There were 146,864 closed support periods for all SAAP support types in 2005–06 (unweighted data), and 20,392 mental health-related closed support periods reported for clients, representing 13.9% of the total (tables 9.1 and 9.2).

Type of support period

Of the mental health-related closed support periods provided by SAAP in 2005–06, 11,069 (54.3%) involved supported accommodation services, which may include other support services, while 9,323 (45.7%) involved a range of other support services, which did not include accommodation (Table 9.2).

Taking population size differences into account, the distribution of mental health-related closed support periods varied considerably across each state and territory. In 2005–06, the Northern Territory had the highest rate of mental health-related closed support periods per 100,000 population (287.4), whereas Western Australia had the lowest rate (29.3).

Supported accommodation services accounted for over 70% of the SAAP services provided in the Australian Capital Territory, Queensland, New South Wales, Western Australia and the Northern Territory, while other support services accounted for over 60% of SAAP services in Victoria and South Australia (Table 9.2).

Table 9.2: SAAP mental health-related closed support periods, by service type, states and territories, 2005–06

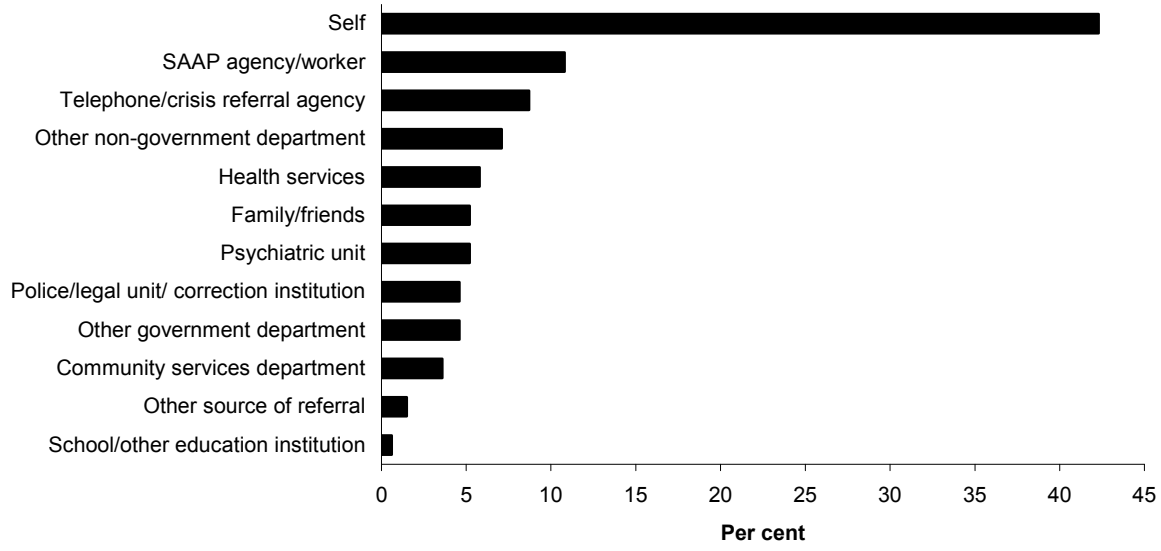
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number				
Supported accommodation	3,514	3,125	1,838	597	652	317	426	600	11,069
Other support services	1,243	5,752	425	218	1,088	294	156	147	9,323
Total	**4,757**	**8,877**	**2,263**	**815**	**1,740**	**611**	**582**	**747**	**20,392**
					Rate (per 100,000 population)[(a)]				
Supported accommodation	51.7	61.4	45.4	29.3	41.8	64.9	128.1	287.4	53.8
Other support services	18.3	113.0	10.5	10.7	69.8	60.2	46.9	70.4	45.3
Total	**70.1**	**174.5**	**55.9**	**40.0**	**111.6**	**125.1**	**175.0**	**357.8**	**99.2**

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

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 2005–06, self-referral was the most common source of referral to SAAP services for mental health-related support periods (41.3%), followed by referrals from other SAAP agencies or workers (11.2%) and referrals from telephone/crisis referral agencies (9.1%) (Figure 9.3).



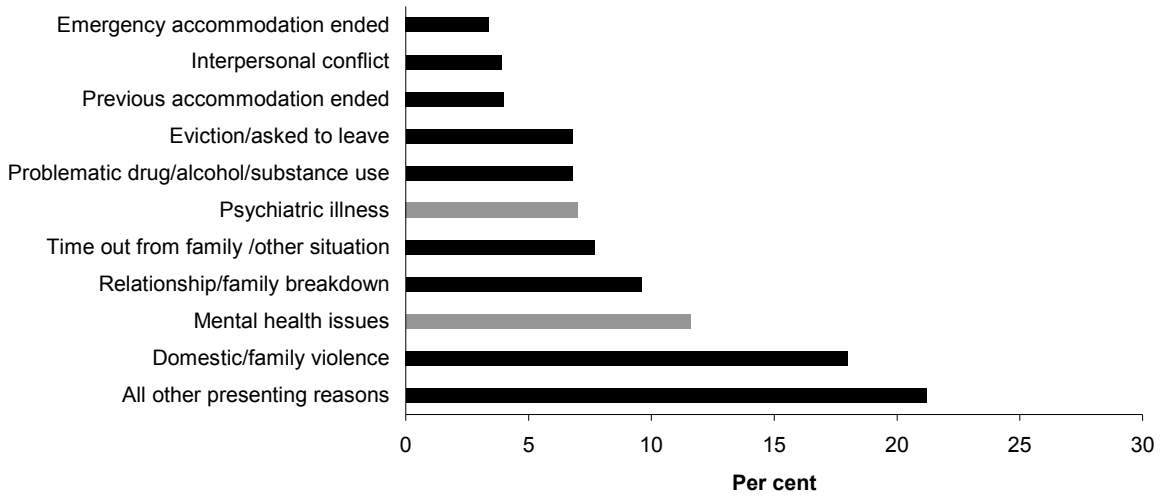
Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.3: SAAP mental health-related closed support periods, by source of referral, 2005–06

Main reason for seeking SAAP assistance

As part of the SAAP data collection, SAAP agencies collect information on the main presenting reasons for which the client is seeking assistance for each support period. Multiple presenting reasons may be recorded for each support period.

During 2005–06, psychiatric illness or mental health issues were reported as the main reasons for which a client was seeking SAAP assistance in 7.0% and 11.4% of closed support periods, respectively (Figure 9.4). Domestic/family violence was the most common reason for seeking assistance, being recorded for 18.0% of clients.



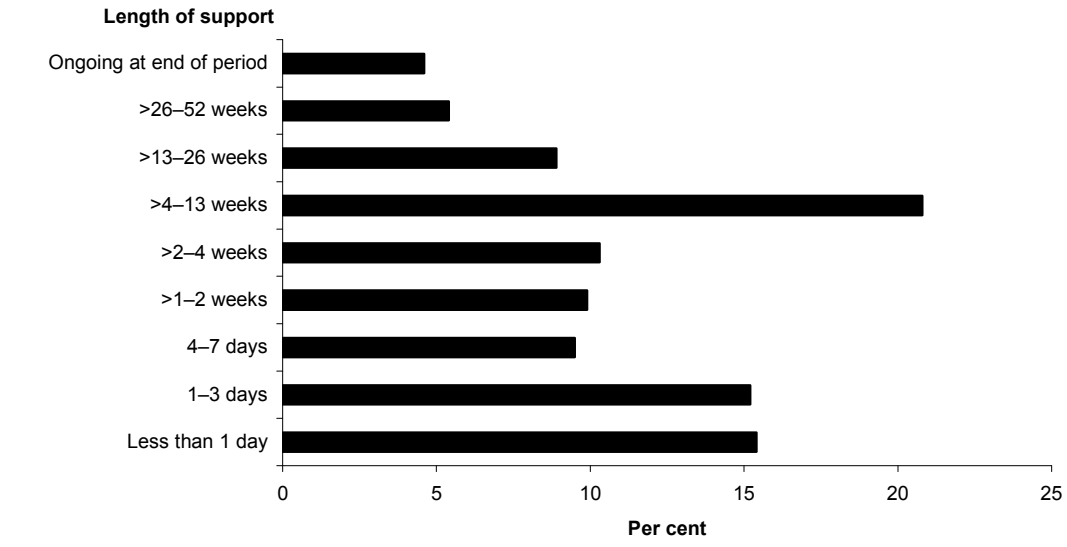
Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.4: SAAP mental health-related closed support periods, by main presenting reason for seeking assistance, 2005–06

Length of support period

The length of the closed support periods varied among client groups. For example, clients who presented to SAAP agencies alone tended to have shorter support periods, while clients who were accompanied by children tended to have longer periods.

Overall, the length of support varied from less than one day to over 52 weeks (Figure 9.5).



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.5: SAAP mental health-related closed support periods, by length of support, 2005–06

10 Support services for people with psychiatric disability

10.1 Introduction

Specialist support services are provided to people with a disability through the Commonwealth State/Territory Disability Agreement (CSTDA) (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, for which both levels of government are responsible (AIHW 2007b).

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 self-care/management, mobility or communication;
- are likely to need significant ongoing and/or long-term episodic support; and
- are evident before the age of 65 years (FaCS 2002).

A person who fulfils the above criteria can receive a range of CSTDA-funded ***service types***, depending on availability and their individual needs. Services can be ***residential*** or ***non-residential***, or a combination of the two. The data presented in this chapter cover both of these types of services. For further details on CSTDA-funded services, refer to *Disability support services 2005–06* (AIHW 2007b).

Overall, 217,143 people across Australia made use of CSTDA-funded services during 2005–06. The most common ***primary disability*** among these clients was intellectual disability (33.3%). ***Psychiatric disability*** rated as the second most commonly reported primary disability, at 13.8%, ahead of physical disability, at 11.8%.

This chapter presents information on CSTDA-funded disability support services provided to service users (that is, clients) with a psychiatric disability either as their primary disability or as ***other significant disability***. The information has been extracted from the CSTDA National Minimum Data Set (NMDS), which is a collation of data on both 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, so comparisons across the states and territories must be done with caution. Of particular note in this context is the change that occurred in the way Victoria reports psychiatric service users since the 2004–05 *Mental health services in Australia*. Previously most service users accessing specialised psychiatric disability rehabilitation and support services in Victoria were not identified as having a psychiatric disability. For 2005–06 and retrospectively for 2003–04 and 2004–05, data in the current version of the report incorporate these previously unidentified users of Victorian psychiatric services. This has doubled the number of non-residential service users

recorded for Victoria. There has been relatively little impact on the number of residential service users though, with a net increase of seven.

Note that no data on the quantity (or hours) of support received are provided in this chapter. While some information is collected on the hours of support received by CSTDA service users 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 a 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.

In this report, information from the most recent data collection (relating to 2005–06) is presented, along with data from 2004–05 for comparison. Data from the 2003–04 collection were published in the 2004–05 edition of this report (AIHW 2007e).

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 types 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 residential/institutions; hostels; and group homes.

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

10.2 CSTDA services by state and territory

In 2005–06, 38,086 people with a psychiatric disability used CSTDA–funded services, residential and/or non-residential, an increase of 7.0% from 2004–05. Non-residential services were accessed by 98.0% of clients with a psychiatric disability, residential services by 7.8%, and both types by 5.7% (2,182).

While at both the national and the state/territory levels, the number of non-residential service users far outweighed the number of residential service users, the proportions differed considerably across the states and territories (Table 10.1). In particular, 21.7% of service users in Tasmania accessed residential services and 21.4% in the Northern Territory, whereas 1.2% did so in Western Australia. This is compared with the national average of 7.8% for residential services.

There was a marked difference between residential and non-residential service users in terms of whether their primary disability was psychiatric. For non-residential service users, psychiatric disability was the primary disability in 80.1% of cases, whereas for residential service users it was the primary disability for 11.5% of cases.

Table 10.1: CSTDA-funded service users with a psychiatric disability, states and territories, 2004–05 and 2005–06

State or territory[a]	2004–05			2005–06		
	Non-residential	Residential	Total[b]	Non-residential	Residential	Total[b]
NSW	*6,175	1,142	*6,495	6,432	1,218	6,834
Vic	*18,631	[c]948	*[c]18,798	20,619	[c]963	[c]20,784
Qld	5,157	166	5,204	5,570	183	5,631
WA[d]	1,675	208	1,711	1,698	20	1,704
SA	2,027	317	2,143	1,927	335	2,004
Tas	775	193	839	797	184	846
ACT	365	19	369	317	34	320
NT	116	21	129	87	22	103
Total[e]	***34,833**	***[c]3,014**	***[c]35,599**	**37,309**	**[c]2,959**	**[c]38,086**

* Indicates where previously published data have been revised in line with corrected data submission from Victoria. New South Wales figures are also affected due to cross-border service use.

(a) State/territory is based on the location of the CSTDA-funded service. Service type outlet response rates varied across state/territory jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2007a).

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

(c) Prior to the publication of this report an issue came to light with the data compilation resulting in the count of residential service users in Victoria being substantially understated. Work will be undertaken to fix this problem with the aim of re-issuing corrected tables on the internet.

(d) Changes in the number of residential service users in 2005–06 reflect changes in coding of service users for one agency.

(e) 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 2004–05 and 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

10.3 Residential services

Nationally, service users accessed residential services at a rate of 14.4 clients per 100,000 population. This rate was highest in Tasmania and lowest in Western Australia (37.7 and 1.0, respectively) (Table 10.2).

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.
- 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 six service users are located in any one home.

Overall, group homes were the predominant residential service type. A substantial proportion of the client group resided in large institutions and only minor proportions in hostels and small institutions.

Table 10.2: CSTDA-funded residential service users with a psychiatric disability, by residential service type, states and territories[(a)], 2005–06

Residential service type	NSW	Vic[(b)]	Qld	WA	SA	Tas	ACT	NT	Total[(c)]	Total (per cent)
Large institutions	432	89	45	11	187	20	0	0	784	26.5
Small institutions	8	0	56	0	3	2	0	0	69	2.3
Hostels	12	29	0	0	8	43	0	0	92	3.1
Group homes	771	876	89	9	141	119	34	22	2,061	69.7
Total[(d)]	**1,218**	**963**	**183**	**20**	**335**	**184**	**34**	**22**	**2,959**	. .
Rate (per 100,000 population)[(e)]	17.9	18.9	4.5	1.0	21.5	37.7	10.2	10.5	14.4	. .

(a) Service type outlet response rates varied across state/territory jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2007a).

(b) Prior to the publication of this report an issue came to light with the data compilation resulting in the count of residential service users in Victoria being substantially understated. Work will be undertaken to fix this problem with the aim of re-issuing corrected tables on the internet.

(c) 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.

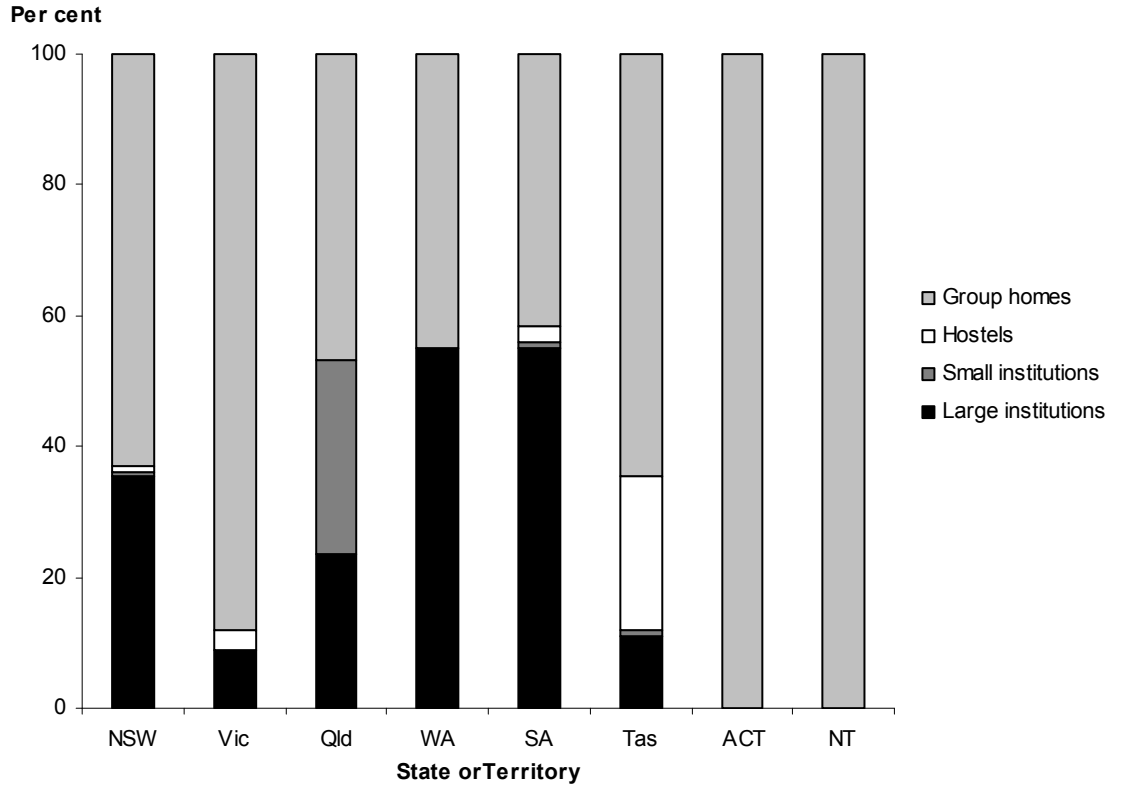
(d) The number of service users may not sum to the total because users may have accessed services from more than one residential service type.

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

. . Not applicable.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

There was considerable variation between jurisdictions in the type of residential service used for CSTDA-funded residential services in 2005–06 as illustrated in Figure 10.1. All clients resided in group homes in the two territories while in Tasmania hostels were used substantially (23.4% of clients). The majority of residential clients in Western Australia and South Australia were in large institutions.



Source: AIHW analysis of data from the 2005–06 CSTDA NMDS

Figure 10.1: Residential service type, states and territories, 2005–06

Profile of residential service users

As previously indicated, the primary disability was psychiatric in a relatively small proportion of cases for residential service users with a psychiatric disability. Intellectual disability was identified as the primary disability for the great majority of these clients (Table 10.3).

Table 10.3: CSTDA-funded residential service users[(a)] with a psychiatric disability, by primary disability group, 2005–06

Primary disability group	Service users (number)	Service users (per cent)
Intellectual	2,335	78.9
Psychiatric	341	11.5
Acquired brain injury	91	3.1
Physical	75	2.5
Autism	64	2.2
Neurological	39	1.3
Other disability[(b)]	14	0.5
Total	**2,959**	**100.0**

(a) Prior to the publication of this report an issue came to light with the data compilation resulting in the count of residential service users in Victoria being substantially understated. Work will be undertaken to fix this problem with the aim of re-issuing corrected tables on the internet.

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

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.4: Demographic characteristics of CSTDA-funded residential service users with a psychiatric disability, 2005–06

Service user demographics	Number of service users[(a) (b)]	Per cent of service users[(c)]	Rate (per 1 million population)[(d)]
Age group (years)			
Less than 15	9	0.3	2
15–24	158	5.3	55
25–34	490	16.6	169
35–44	828	28.0	271
45–54	806	27.2	284
55–64	496	16.8	223
65+	172	5.8	65
Sex			
Male	1,686	57.0	164
Female	1,272	43.0	121
Indigenous status[(e)]			
Indigenous Australians	98	3.3	273
Other Australians	2,830	95.6	140
Country of birth			
Australia	2,734	92.4	188
Overseas	180	6.1	34
Overseas-born[(f)]			
EP country group 1	58	2.0	28
EP country group 2	49	1.7	33
EP country group 3	61	2.1	42
EP country group 4	12	0.4	52
Remoteness area of usual residence			
Major cities	2,093	70.7	153
Inner regional	692	23.4	161
Outer regional	151	5.1	76
Remote and Very remote	9	0.3	16
Total[(a)]	**2,959**	**100.0**	**144**

(a) Prior to the publication of this report an issue came to light with the data compilation resulting in the count of residential service users in Victoria being substantially understated. Work will be undertaken to fix this problem with the aim of re-issuing corrected tables on the internet.

(b) The numbers of service users 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 service users for whom 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) These data should be interpreted with caution due to likely under-identification of Indigenous Australians.

(f) For definition of the English Proficiency (EP) country groups see Appendix 3.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.5: CSTDA-funded residential service users with a psychiatric disability, by usual residential setting, living arrangement and income source, 2005–06

	Service users (number)[(a) (b)]	Service users (per cent)[(c)]
Usual residential setting		
Private residence	59	2.0
Domestic-scale supported living facility	1,785	60.3
Supported accommodation facility	1,030	34.8
Psychiatric/mental health community care facility	46	1.6
Other	39	1.3
Living arrangement		
Lives alone	78	2.6
Lives with family	22	0.7
Lives with others	2,856	96.5
Income source (adult 16+ years)[(d)]		
Disability Support Pension	2,878	97.6
Other pension or benefit	36	1.2
Paid employment	10	0.3
Other income sources	7	0.2
No income	3	0.1
Total	**2,959**	**100.0**

(a) Prior to the publication of this report an issue came to light with the data compilation resulting in the count of residential service users in Victoria being substantially understated. Work will be undertaken to fix this problem with the aim of re-issuing corrected tables on the internet.

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

(c) The percentages shown do not include service users for whom information was missing and/or not reported.

(d) A total of 2,948 of the residential service users with a psychiatric disability were aged 16 years and over. Each user can have more than one income source.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.4 shows the demographic and geographic distribution of residential service users with a psychiatric disability in 2005–06.

More male users accessed CSTDA-funded residential services than females (57% compared with 43%), and the majority of residential users were aged 35–54 years (55.2%). These mid-age ranges also had the highest rates of usage.

While a small proportion of CSTDA-funded residential service users identified as Aboriginal and Torres Strait Islander peoples, when their age structure and population size are taken into account, Indigenous Australians were relatively more likely than other Australians to use these services (273 and 140 per 1 million population, respectively).

The majority of residential service users were born in Australia (92.4%). When relative population sizes and age structures are considered, there was an under-representation of residential service users who were born overseas (34 per 1 million population for overseas-born compared with 188 per 1 million population for Australian-born). Within the overseas-born population there are differences in the rates of usage of CSTDA-funded residential services, with migrants born in countries in the lower English Proficiency country groups having higher rates of usage.

Most residential service users accessed CSTDA-funded services in major cities (70.7%), followed by inner regional areas (23.4%). Outer regional and remote/very remote areas had considerably lower numbers and rates of service use.

Almost all CSTDA-funded residential service users resided in some form of supported accommodation facility and/or were on Disability Support Pensions (Table 10.5). Domestic-scale supported living facilities (which provide some support by staff or volunteers) were more common usual residential settings than supported accommodation facilities (which provide 24-hour care by rostered care workers).

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 the open labour market and 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.

There was considerable variation between jurisdictions in the type of non-residential services used by people with a psychiatric disability in 2005–06 (Table 10.6). Employment services dominated for New South Wales, Western Australia and the two territories, but community access and support services were used more in Victoria and Tasmania.

Table 10.6: CSTDA-funded non-residential disability support service users with a psychiatric disability, by service type received, states and territories[a], 2005–06

Service type received	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[b]	Total (per cent)
Accommodation support	362	5,992	1,063	86	212	73	4	7	7,798	20.9
Community support	888	2,562	1,013	223	772	186	74	6	5,706	15.3
Community access	1,062	9,380	1,436	35	427	348	28	14	12,726	34.1
Respite	254	2,951	515	16	94	22	18	3	3,869	10.4
Employment	4,751	6,216	3,049	1,492	1,126	368	246	63	17,254	46.2
Total[c]	**6,432**	**20,619**	**5,570**	**1,698**	**1,927**	**797**	**317**	**87**	**37,309**	**. .**
Rate (per 100,000 population)[d]	101.2	432.0	147.1	88.9	131.1	173.8	101.5	45.5	193.7	. .

(a) Service type outlet response rates varied across state/territory jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2007a).

(b) 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.

(d) 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.

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

. . Not applicable.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Profile of non-residential service users

In contrast to the users of residential services, the great majority of CSTDA-funded non-residential service users who had a psychiatric disability reported this psychiatric disability as their primary disability (Table 10.7).

More male users than females accessed CSTDA-funded non-residential services than females (in very similar proportions to users of residential services), and around half of non-residential users were aged 25–44 years (Table 10.8).

Table 10.7: CSTDA-funded non-residential service users with a psychiatric disability, by primary disability group, 2005–06

Primary disability group	Service users (number)	Service users (per cent)
Psychiatric	29,875	80.1
Intellectual	4,782	12.8
Acquired brain injury	908	2.4
Physical	587	1.6
Neurological	394	1.1
Autism	338	0.9
Sensory	280	0.8
Specific learning/Attention deficit disorder	126	0.3
Other disability[a]	19	0.1
Total	**37,309**	**100.0**

(a) Includes the following disability groups: speech and developmental delay.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.8: Demographic characteristics of CSTDA-funded non-residential service users with a psychiatric disability, 2005–06

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate (per 1 million population)[(c)]
Age group (years)			
Less than 15	705	1.9	174
15–24	4,839	13.0	1,699
25–34	8,945	24.0	3,080
35–44	9,642	25.8	3,162
45–54	7,905	21.2	2,788
55–64	3,644	9.8	1,640
65+	1,607	4.3	604
Sex			
Male	21,335	57.2	2,089
Female	15,905	42.6	1,536
Indigenous status[(d)(e)]			
Indigenous Australians	1,185	3.2	2,919
Other Australians	33,959	91.0	1,796
Country of birth			
Australia	29,329	78.6	1,977
Overseas	4,781	12.8	853
Overseas-born[(f)]			
EP country group 1	1,389	3.7	668
EP country group 2	1,215	3.3	816
EP country group 3	1,707	4.6	1,045
EP country group 4	470	1.3	1,287
Remoteness area of usual residence			
Major cities	24,767	66.4	1,808
Inner regional	8,787	23.6	2,169
Outer regional	3,014	8.1	1,519
Remote and Very remote	286	0.8	558
Total[(c)]	**37,309**	**100.0**	**1,937**

(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 service users for whom 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% of service users.

(f) For definition of the English Proficiency (EP) country groups see Appendix 3.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.9: CSTDA-funded non-residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2005–06

	Service users (number)[(a)]	Service users (per cent)[(b)]
Residential setting		
Private residence	25,660	68.8
Domestic-scale supported living facility	2,088	5.6
Supported accommodation facility	2,365	6.3
Psychiatric/mental health community care facility	1,172	3.1
Residence within an Aboriginal community	74	0.2
Boarding house/private hotel	837	2.2
Independent living within a retirement village	68	0.2
Residential aged care facility	178	0.5
Hospital	53	0.1
Short-term crisis, emergency or transitional accommodation	607	1.6
Public place/temporary shelter	77	0.2
Other	938	2.5
Living arrangement		
Lives alone	9,611	25.8
Lives with family	14,185	38.0
Lives with others	8,767	23.5
Income source (adult 16+ years)[(c)]		
Disability Support Pension	22,214	60.8
Other pension/benefit	4,982	13.6
Paid employment	2,734	7.5
Compensation income	114	0.3
Other income	481	1.3
No income	624	1.7
Total	**37,309**	**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 service users for whom information was missing and/or not reported.

(c) A total of 36,504 of the non-residential service users with a psychiatric disability were aged 16 years and over. Each user can have more than one income source.

Source: AIHW analysis of data from the 2005–06 Commonwealth State/Territory Disability Agreement NMDS.

Although Aboriginal and Torres Strait Islander peoples made up a small proportion of users, when the relative age structures and population sizes were taken into account, Indigenous Australians were relatively more likely than other Australians to have used non-residential CSTDA-funded services (2,919 and 1,796 per 1 million population, respectively) (Table 10.8).

As was the case for the residential service users, most non-residential service users were born in Australia (78.6%) and those who were born overseas were relatively less likely than their Australian-born counterparts to have used these services (1,977 and 853 per 1 million population, respectively). Within the overseas-born population there was variation in rates of use across English Proficiency country groups, with immigrants born in countries with

poorer English proficiency in the first five years of residence having higher rates of use than those born in countries with higher post-settlement levels of English proficiency.

Two-thirds of non-residential service users accessed CSTDA-funded services in major cities, about a quarter in inner regional areas, and much lower numbers in outer regional and remote areas. The rates of use in outer regional and remote areas were also lower.

About two-thirds of non-residential service users lived in a private residential setting and 38% lived with their family (see Table 10.9). This contrasts with users of residential services, very few of whom usually lived in private residences and with family (Table 10.5). Most (60.8%) of non-residential service users were on Disability Support Pensions, which is well below the 97.6% of residential service users who were on this type of pension.

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 2007c).

Key concepts

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

- five selected medication groups as classified in the Anatomical Therapeutic Chemical (ATC) Classification System (WHO 2008)—namely antipsychotics (code N05A), anxiolytics (code N05B), hypnotics and sedatives (code N05C), antidepressants (code N06A) and psychostimulants and nootropics (code N06B)—prescribed by all medical practitioners (that is, GPs, non-psychiatrist specialists and psychiatrists); and
- 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, 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 GPs or non-psychiatrist specialists that fall outside of the five selected medication groups may have been prescribed for 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 prescriptions and below copayment prescriptions (where the patient copayment covers the total costs of the prescribed medication), are not included in the PBS and RPBS data. Based on the Drug Utilisation Sub-Committee database, 78% of mental health-related prescriptions were dispensed under the PBS or RPBS in 2006–07 (DoHA 2008a). The remainder were privately funded due either to the ineligibility of the patient or the price being below the maximum patient contribution.

This chapter first presents information on mental health-related prescriptions for 2006–07, according to the type of medication prescribed and the prescribing medical practitioner, followed by data that covers the period from 2001–02 to 2006–07. Secondly, tables present the number of patients receiving mental health-related prescriptions for 2006–07, broken down by demographic characteristics and area of residence, as well as by

prescribing medical practitioner and type of medication prescribed. The latter is also presented in time series form for the period from 2001–02 to 2006–07.

For further information on the PBS and 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 or RPBS is listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2007c). 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 2008). 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 five selected medication groups that have been defined as mental health-related 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 in the PBS/RPBS data

ATC code	Drug groups	Brief description of effects and indications
N05	**Psycholeptics**	**A group of drugs that tranquilises (central nervous system 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 (central nervous system stimulants)**
N06A	Antidepressants	Drugs used to treat the symptoms of clinical depression.
N06B	Psychostimulants	Agents used for Attention-Deficit Hyperactivity Disorder (ADHD) and to improve impaired cognitive abilities (nootropics)

Source: WHO 2008.

11.2 Prescriptions

This section presents information on the number and type of mental health-related prescriptions that were subsidised under the PBS and RPBS. In interpreting this information, note that a person may have obtained several subsidised mental health–related prescriptions during the period covered. Information on the number of people receiving mental health-related prescriptions is presented in the following section.

In 2006–07, medical practitioners provided 183.4 million PBS/RPBS-subsidised prescriptions for medications, of which 20.6 million (11.2%) were for mental health-related medications (Table 11.2). This is equivalent to 990 mental health-related prescriptions per 1,000 population (Table 11.3).

Of the 20.6 million mental health-related prescriptions, the great majority (86.3%) were provided by GPs, with another 9.5% being prescribed by psychiatrists and 4.2% by non-psychiatrist specialists.

Most of the 20.6 million prescriptions were for antidepressant medication (58.3%, or 12 million), followed by anxiolytics (15.8%), hypnotics and sedatives (13.4%) and antipsychotics (9.7%).

Table 11.2: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner[(b)], 2006–07

ATC group (code)	General practitioners	Non-psychiatrist specialists	Psychiatrists	Total	Total (per cent)
Antipsychotics (N05A)[(c)]	1,453,905	153,690	390,425	1,998,020	9.7
Anxiolytics (N05B)	3,037,662	85,216	141,540	3,264,418	15.8
Hypnotics and sedatives (N05C)	2,632,598	85,360	54,435	2,772,393	13.4
Antidepressants (N06A)	10,642,397	391,199	1,004,580	12,038,176	58.3
Psychostimulants and nootropics (N06B)	48,906	155,341	69,984	274,231	1.3
Other ATC groups[(d)]	. .	. .	290,251	290,251	1.4
Total	**17,815,468**	**870,806**	**1,951,215**	**20,637,489**	**100.0**
Total (per cent)	86.3	4.2	9.5	100.0	. .

(a) Classified according to the ATC Classification System (WHO 2008). Includes all scripts for 2006–07 where the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements, in particular for Clozapine.

(b) Does not include 28,863 scripts where the prescriber's specialty was unknown and the ATC level 3 code was N05A, N05B, N05C, N06A or N06B.

(c) Includes Clozapine dispensed through Section 100 arrangements by private hospitals but not by public hospitals.

(d) 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 GPs 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 2006–07 (Table 11.3). The rate of prescriptions per 1,000 population was relatively low in the Australian Capital Territory (699 per 1,000 population) and New South Wales and Western Australia were also below the national average of 990 prescriptions per 1,000 population. In contrast, Tasmania and South Australia had considerably higher rates of prescriptions than the national average (1,332 and 1,172 prescriptions per 1,000 population, respectively) while Victoria and Queensland were also above average.

Regarding the distribution of mental health-related prescriptions across the ATC groups, Tasmanian providers prescribed a higher proportion of anxiolytics than the national average (21.8% compared with 15.8% for Australia) and a lower proportion of antipsychotics (6.3% compared with 9.7% for Australia) while providers in the Northern Territory and the Australian Capital Territory prescribed a higher proportions of antidepressants (around 65.4% compared with 58.3% for Australia) and Western Australian providers prescribed a higher proportion of psychostimulants and nootropics (3.3% compared with 1.3% for Australia).

Table 11.3: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner[(b)], states and territories[(c)], 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Antipsychotics including Clozapine (N05A)									
General practitioners	489,365	398,318	253,061	115,402	143,284	33,457	15,682	5,278	1,453,905
Non-psychiatrist specialists	32,024	64,083	29,384	16,701	6,651	1,947	1,317	1,570	153,690
Psychiatrists	133,455	117,218	67,426	21,958	35,900	6,158	7,282	1,026	390,425
Total	*654,844*	*579,619*	*349,871*	*154,061*	*185,835*	*41,562*	*24,281*	*7,874*	*1,998,020*
Anxiolytics (N05B)									
General practitioners	851,439	863,865	621,977	240,547	290,937	136,231	25,611	7,008	3,037,662
Non-psychiatrist specialists	20,663	26,529	18,871	8,189	8,388	1,726	599	249	85,216
Psychiatrists	35,303	49,227	30,053	7,367	13,296	4,775	1,152	367	141,540
Total	*907,405*	*939,621*	*670,901*	*256,103*	*312,621*	*142,732*	*27,362*	*7,624*	*3,264,418*
Hypnotics and sedatives (N05C)									
General practitioners	827,298	682,586	496,025	257,957	249,594	92,004	21,061	6,001	2,632,598
Non-psychiatrist specialists	23,491	26,468	17,529	9,589	6,232	1,147	632	266	85,360
Psychiatrists	13,608	16,761	12,125	4,115	5,803	1,315	649	56	54,435
Total	*864,397*	*725,815*	*525,679*	*271,661*	*261,629*	*94,466*	*22,342*	*6,323*	*2,772,393*
Antidepressants (N06A)									
General practitioners	3,248,693	2,603,935	2,263,408	1,085,409	930,648	331,153	138,834	40,179	10,642,397
Non-psychiatrist specialists	102,842	115,188	86,159	48,134	25,223	7,913	3,759	1,974	391,199
Psychiatrists	297,197	287,460	213,770	83,877	88,415	21,024	11,221	1,597	1,004,580
Total	*3,648,732*	*3,006,583*	*2,563,337*	*1,217,420*	*1,044,286*	*360,090*	*153,814*	*43,750*	*12,038,176*
Psychostimulants and nootropics (N06B)									
General practitioners	7,701	3,286	20,775	9,452	5,090	1,520	567	515	48,906
Non-psychiatrist specialists	57,312	32,906	21,471	24,654	9,094	7,524	1,569	811	155,341
Psychiatrists	16,849	8,032	6,347	30,530	5,168	1,349	1,644	65	69,984
Total	*81,862*	*44,224*	*48,593*	*64,636*	*19,352*	*10,393*	*3,780*	*1,391*	*274,231*
Other medications prescribed by psychiatrists[(d)]									
Psychiatrists	84,887	83,521	65,425	22,608	23,483	5,799	3,553	968	290,251
Total	**6,242,127**	**5,379,383**	**4,223,806**	**1,986,489**	**1,847,206**	**655,042**	**235,132**	**67,930**	**20,637,489**
Rate (per 1,000 population)[(e)]	911	1,041	1,022	955	1,172	1,332	699	320[(f)]	990

(a) Classified according to the ATC Classification System (WHO 2008). Includes all scripts for 2006–07 where the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements, in particular for Clozapine.

(b) Does not include 28,863 scripts where the prescriber's specialty was unknown.

(c) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the supplying pharmacy is used. Australia includes data where the state is unknown.

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

(e) Crude rate based on the preliminary Australian estimated resident population at 31 December 2006.

(f) A substantial proportion of the Australian Government subsidy of pharmaceuticals in the Northern Territory is funded through the Aboriginal Health Services program, which is processed on the basis of boxes supplied to Aboriginal Health Services and not through the usual PBS systems.

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

Table 11.4: Mental health-related prescriptions, by type of medication prescribed[a] and prescribing medical practitioner[b], 2002–03 to 2006–07

Medication prescribed/ prescriber	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Antipsychotics including Clozapine (N05A)						
General practitioners	1,118,971	1,169,958	1,231,005	1,344,013	1,453,905	6.8
Non-psychiatrist specialists	83,166	101,136	111,568	135,723	153,690	16.6
Psychiatrists	303,210	309,435	334,897	368,840	390,425	6.5
Subtotal	*1,505,347*	*1,580,529*	*1,677,470*	*1,848,576*	*1,998,020*	*7.3*
Anxiolytics (N05B)						
General practitioners	3,107,695	3,110,660	3,117,091	3,060,719	3,037,662	–0.6
Non-psychiatrist specialists	73,568	75,753	80,868	84,636	85,216	3.7
Psychiatrists	149,202	149,124	147,707	142,263	141,540	–1.3
Subtotal	*3,330,465*	*3,335,537*	*3,345,666*	*3,287,618*	*3,264,418*	*–0.5*
Hypnotics and sedatives (N05C)						
General practitioners	2,993,573	2,888,136	2,848,365	2,726,783	2,632,598	–3.2
Non-psychiatrist specialists	88,321	88,786	88,245	87,303	85,360	–0.8
Psychiatrists	68,267	64,380	61,629	57,594	54,435	–5.5
Subtotal	*3,150,161*	*3,041,302*	*2,998,239*	*2,871,680*	*2,772,393*	*–3.1*
Antidepressants (N06A)						
General practitioners	9,841,838	10,666,972	11,249,261	10,869,136	10,642,397	2.0
Non-psychiatrist specialists	365,854	403,139	408,700	401,446	391,199	1.7
Psychiatrists	1,038,628	1,070,005	1,082,196	1,029,864	1,004,580	–0.8
Subtotal	*11,246,320*	*12,140,116*	*12,740,157*	*12,300,446*	*12,038,176*	*1.7*
Psychostimulants and nootropics (N06B)						
General practitioners	38,166	37,453	38,688	44,293	48,906	6.4
Non-psychiatrist specialists	141,855	134,319	122,732	144,145	155,341	2.3
Psychiatrists	70,440	76,809	71,623	66,180	69,984	–0.2
Subtotal	*250,461*	*248,581*	*233,043*	*254,618*	*274,231*	*2.3*
Other medications prescribed by psychiatrists[c]						
Psychiatrists	338,840	298,834	300,845	291,507	290,251	–3.8
Total	**19,821,594**	**20,644,899**	**21,295,420**	**20,854,445**	**20,637,489**	**1.0**
Rate (per 1,000 population)[d]	1,002	1,031	1,051	1,014	990	–0.3

(a) Classified according to the ATC Classification System (WHO 2008). Includes all scripts for 2006–07 where the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements, in particular for Clozapine.

(b) Does not include scripts where the prescriber's specialty was unknown.

(c) Includes other N codes as well as other ATC medication groups as presented in Table 11.5. Note that data for other ATC groups prescribed by GPs 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 2006.

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

Most jurisdictions showed the same relationships between the type of mental health-related medication and the medical practitioner who provided the prescription. Exceptions include the Northern Territory, which had a higher proportion of antipsychotic prescriptions provided by non-psychiatrist specialists than the national average (19.9% compared with 7.7% for Australia), and the Australian Capital Territory, which had a higher proportion of antipsychotic prescriptions provided by psychiatrists (30.0% compared with 19.5% for Australia). Queensland and the Northern Territory also had higher proportions of psychostimulant and nootropic prescriptions provided by GPs than the national average (42.8% and 37.0%, respectively, compared with 17.8% for Australia) and a lower proportion provided by psychiatrists (13.1% and 4.7%, respectively, compared with 25.5% for Australia). New South Wales, Victoria and Tasmania had a higher proportion of psychostimulant and nootropic prescriptions provided by non-psychiatrist specialists than the national average (over 70% compared with 56.6% for Australia).

Table 11.4 shows the trends in the prescription of mental health-related medications over the five years from 2002–03 to 2006–07.

Overall, mental health-related prescriptions increased from 19.8 million in 2002–03 to 20.6 million in 2006–07, at an annual average rate of 1.0%. There were increases in the number of antipsychotics, psychostimulants and nootropics, and antidepressants prescribed (on average by 7.3%, 2.3% and 1.7% per year, respectively). However, prescriptions for hypnotics and sedatives, as well as anxiolytics decreased on average by 3.1% and 0.5% per year, respectively. Other medications prescribed by psychiatrists also decreased (by 3.8% on average per year).

The biggest increase in prescription of a particular ATC group by a provider type was for the prescription of antipsychotics by non-psychiatrist specialists, which rose steadily by an average annual rate of change of 16.6%. The prescription of psychostimulants and nootropics by GPs also saw a substantial increase, especially since 2004–05 where it has increased by 12.4% per year. Non-psychiatrist specialists also increased their prescribing of this group, which covers attention deficit hyperactivity disorder (ADHD) medications, over this two-year period by 12.5% per year, whereas prescribing by psychiatrists declined slightly.

11.3 Patients

In 2006–07, 20.4 million PBS/RPBS-subsidised prescriptions for mental health-related medications were provided to 2.3 million patients (Table 11.5). (There were a further 0.3 million prescriptions for which patient identification was not available.) This represents an average of 8.7 prescriptions per patient.

There was very little variation in the number of prescriptions per patient across sex, age and area of residence groups, with lower average rates for young people and those in Remote and Very Remote areas being the only marked differences. There was more marked variation in the number of people obtaining mental health-related prescriptions per 1,000 population (rather than prescriptions per patient). Females, people aged 55 and over, and people living in Inner and Outer Regional areas had higher rates of receipt of mental health-related prescriptions than the national average of 112 patients per 1,000 population.

Table 11.5: Patients dispensed with mental health-related prescriptions: patient demographic characteristics and services received, 2006–07

Patient demographics	Number of patients	Per cent of patients	Rate (per 1,000 population)[(a)]	Number of scripts[(b)]	Per cent of scripts	Scripts per patient
Age (years)						
Less than 15	45,145	1.9	11	228,272	1.1	5.1
15–24	132,582	5.7	46	777,763	3.8	5.9
25–34	229,561	9.9	79	1,843,165	9.0	8.0
35–44	321,656	13.8	105	2,892,759	14.2	9.0
45–54	344,313	14.8	119	3,245,168	15.9	9.4
55–64	375,012	16.1	163	3,468,202	17.0	9.2
65+	878,500	37.7	323	7,901,887	38.8	9.0
Sex						
Male	888,880	38.1	86	7,640,997	37.5	8.6
Female	1,437,897	61.7	137	12,716,305	62.4	8.8
Area of residence						
Major cities	1,471,837	63.2	104	12,863,794	63.2	8.7
Inner regional	560,153	24.0	137	4,942,983	24.3	8.8
Outer regional	237,991	10.2	121	2,039,400	10.0	8.6
Remote	25,588	1.1	80	206,946	1.0	8.1
Very remote	6,734	0.3	40	48,927	0.2	7.3
Total	**2,330,561**	**100.0**	**112**	**20,368,152**	**100.0**	**8.7**

(a) Crude rate based on the preliminary Australian estimated resident population as at 31 December 2006, except for area of residence where 30 June 2006 preliminary estimates of resident population by Australian Standard Geographical Classification remoteness area used.

(b) Includes all scripts for 2006–07 where the prescriber was a psychiatrist or the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements. Excludes 298,200 scripts for which no identifying information exists.

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

Commensurate with the rates of mental health-related medications prescribed across states and territories, the rate of patients obtaining mental health-related prescriptions per 1,000 population in 2006–07 was very low in the Northern Territory and the Australian Capital Territory (45 and 87 per 1,000 population, respectively, while Tasmania and South Australia had very high patient rates (143 and 130 patients per 1,000 population, respectively) compared with the national average of 112 (Table 11.6).

Tasmania and the Northern Territory had very low rates of patients obtaining mental health-related prescriptions from psychiatrists (5.4% and 5.3%, respectively, of patients compared with 9.7% in the Australian Capital Territory and 8.6% nationally). Tasmania had a higher rate of patients obtaining mental health-related prescriptions from GPs than other jurisdictions (94.6% compared with 92.2% nationally), while a higher proportion of patients in the Northern Territory obtained mental health-related prescriptions from non-psychiatric specialists (12.5% compared with 11.0% nationally). Victoria also had a high proportion (12.9%) of patients obtaining mental health-related prescriptions from non-psychiatric specialists.

A high proportion of patients of psychiatrists in Western Australia obtained prescriptions for psychostimulant and nootropic medications (24.1% compared with a national average of only 5.5%). A similar proportion (24.5%) of the patients of non-psychiatric specialists receiving mental health-related medications in Tasmania obtained prescriptions for psychostimulants and nootropics compared with a national average of 13.5%.

The number of patients obtaining mental health-related prescriptions per 1,000 population declined over the five years to 2006–07 by an average annual rate of 1.5% per year (Table 11.7). The fall in the last two years of the period in particular was over 4% per year. The number of patients obtaining mental health-related prescriptions from psychiatrists fell by 1.1% per year over the five year period, and by 3.4% per year over the last two years of the period. The number of patients obtaining mental health-related prescriptions from GPs also fell slightly over the five years while those obtaining mental health-related prescriptions from non-psychiatric specialists rose by 2.8% per year and by 12.8% per year for antipsychotics in particular. Antipsychotics (including Clozapine) and psychostimulants and nootropics were the mental health-related medication groups with the greatest increase in patient numbers over the five year period across all prescriber types.

Table 11.6: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner[a] and type of medication prescribed[b], states and territories[c][d], 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
General practitioners									
N05A	73,676	57,557	38,893	17,682	21,359	5,271	2,432	958	217,837
N05B	158,342	147,469	115,062	41,691	50,831	21,436	4,476	1,405	540,725
N05C	168,648	141,539	103,061	53,372	51,926	17,245	4,883	1,399	542,087
N06A	461,562	361,759	314,965	149,514	129,701	45,015	20,544	6,743	1,489,824
N06B	1,583	695	4,576	1,576	825	238	103	96	9,692
Total patients[e]	*674,198*	*535,509*	*442,318*	*204,362*	*190,789*	*66,426*	*26,895*	*8,804*	*2,149,344*
Non-psychiatrist specialists									
N05A	9,254	15,017	9,085	4,087	1,916	484	379	340	40,565
N05B	10,171	13,968	10,508	3,760	3,148	938	306	131	42,930
N05C	12,535	15,203	10,065	5,195	3,598	742	341	137	47,818
N06A	35,142	38,781	30,122	14,557	8,869	2,706	1,260	593	132,033
N06B	13,675	7,013	5,666	4,591	1,741	1,333	382	178	34,579
Total patients[e]	*71,835*	*75,305*	*55,463*	*27,373*	*16,840*	*5,449*	*2,399*	*1,202*	*255,872*
Psychiatrists									
N05A	22,771	18,768	11,667	3,649	5,860	1,042	1,166	229	65,152
N05B	7,877	9,924	6,531	1,637	2,675	889	259	91	29,883
N05C	3,991	4,428	3,395	1,078	1,530	325	218	30	14,997
N06A	48,203	42,102	31,768	11,815	13,150	3,020	1,866	320	152,247
N06B	3,047	1,390	1,294	4,004	778	162	308	10	10,993
Total patients[e]	*64,367*	*54,561*	*39,896*	*16,647*	*17,287*	*3,795*	*2,831*	*511*	*199,898*
All prescribers									
N05A	89,642	73,871	48,637	21,941	25,462	6,030	3,325	1,217	270,136
N05B	166,754	157,736	121,677	44,051	53,178	22,144	4,761	1,528	571,843
N05C	175,802	149,513	108,597	55,933	54,053	17,680	5,184	1,506	568,284
N06A	497,549	395,734	338,149	160,302	139,609	47,342	21,904	7,144	1,607,757
N06B	17,439	8,647	9,969	9,226	3,016	1,655	748	257	50,957
Total [e]	**732,944**	**585,469**	**475,320**	**223,335**	**204,333**	**70,240**	**29,288**	**9,587**	**2,330,561**
Rate (per 1,000 population)[f]	107	113	115	107	130	143	87	45	112

(a) Does not include counts for 24,577 patients where the prescriber's specialty was unknown. Data for these patients may also be in other categories so they may be included elsewhere in the above table.

(b) Classified according to the ATC Classification System (WHO 2008). Includes all scripts for 2006–07 where the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements, in particular for Clozapine. See Table 11.1 for a key to the ATC codes.

(c) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the supplying pharmacy is used. There remains a small number of records for which state/territory is unknown and which appear only in the total Australia column.

(d) Excludes scripts where the patient identity is unknown.

(e) Total patients may be less than the sum of the numbers of patients for each of the ATC groups, as the same patient may obtain prescriptions for medications in more than one group.

(f) Crude rate based on the preliminary Australian estimated resident population at 31 December 2006.

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

Table 11.7: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner[a] and type of medication prescribed[b][c], 2002–03 to 2006–07

Prescriber/ medication prescribed	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
General practitioners						
N05A	182,166	188,255	195,758	208,963	217,837	4.6
N05B	568,140	565,574	561,061	549,147	540,725	–1.2
N05C	608,415	590,619	581,576	558,701	542,087	–2.8
N06A	1,453,475	1,539,759	1,587,354	1,546,274	1,489,824	0.6
N06B	7,686	7,570	7,738	8,951	9,692	6.0
Total patients[d]	*2,174,439*	*2,243,081*	*2,283,437*	*2,225,916*	*2,149,344*	*–0.3*
Non-psychiatrist specialists						
N05A	25,017	30,168	33,240	37,321	40,565	12.8
N05B	37,159	38,413	39,478	42,270	42,930	3.7
N05C	49,071	49,595	48,829	48,606	47,818	–0.6
N06A	123,897	135,443	135,902	135,909	132,033	1.6
N06B	27,332	26,334	24,601	31,437	34,579	6.1
Total patients[d]	*228,706*	*242,732*	*244,527*	*255,045*	*255,872*	*2.8*
Psychiatrists						
N05A	56,025	57,178	59,900	63,650	65,152	3.8
N05B	31,729	31,915	31,635	30,452	29,883	–1.5
N05C	18,682	17,798	17,230	15,737	14,997	–5.3
N06A	166,311	169,248	168,666	160,068	152,247	–2.2
N06B	10,619	11,305	11,101	10,413	10,993	0.9
Total patients[d]	*209,165*	*213,313*	*214,408*	*206,774*	*199,898*	*–1.1*
All prescribers						
N05A	225,480	234,093	243,336	259,398	270,136	4.6
N05B	598,476	596,296	592,075	580,449	571,843	–1.1
N05C	636,432	618,929	609,269	585,358	568,284	–2.8
N06A	1,580,179	1,668,225	1,713,919	1,669,815	1,607,757	0.4
N06B	42,362	41,854	40,194	47,169	50,957	4.7
Total patients[d]	**2,355,599**	**2,425,843**	**2,463,760**	**2,408,690**	**2,330,561**	**–0.3**
Rate (per 1,000 population)[e]	119	121	122	117	112	–1.5

(a) Does not include counts for patients where the prescriber's specialty was unknown. Data for these patients may also be in other categories so they may be included elsewhere in the above table.

(b) Classified according to the ATC Classification System (WHO 2008). Includes all scripts for 2006–07 where the ATC level 3 code was N05A, N05B, N05C, N06A or N06B. Does not include public hospital scripts dispensed through Section 100 arrangements, in particular for Clozapine. See Table 11.1 for a key to the ATC codes.

(c) Excludes scripts where the patient identity is unknown.

(d) Total patients may be less than the sum of the numbers of patients for each of the ATC groups as the same patient may obtain prescriptions for medications in more than one group.

(e) Crude rate based on the preliminary Australian estimated resident population at 31 December 2006.

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

12 Profile of specialised mental health facilities

12.1 Introduction

This chapter presents an overview of available data on the facilities delivering specialised mental health care in Australia. These facilities include ***public*** and ***private psychiatric hospitals***, ***psychiatric units or wards in public acute hospitals***, ***community mental health services*** and ***government*** and ***non-government-operated residential mental health services***. Information is presented on the number of facilities, number of available beds and staff employed. 2005–06 data are sourced from the National Mental Health Establishments Database, while historical information is taken from the National Survey of Mental Health Services, previously undertaken by the Australian Government Department of Health and Ageing. Private hospital information is sourced from the Private Health Establishments Collection (ABS). For information relating to the scope of the National Mental Health Establishments Database, see Appendix 1.

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 which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2007b). 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 hospitals, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.

Community mental health services include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.

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

- are operated by a state or territory government;
- employ mental health-trained staff on-site;
- 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)

Non-government-operated residential mental health services are specialised residential mental health services which meet the same criteria as government-operated residential mental health services. These services while funded by governments, are operated by non-government agencies. Only non-government operated residential mental health services in receipt of government funding are reported in this chapter.

12.2 Mental health facilities

There are six key types of specialised mental health facilities involved in the provision of mental health-related services. Their distribution is detailed in Table 12.1. Nationally, in 2005–06 there were 15 stand alone public psychiatric hospitals and 26 stand alone private psychiatric hospitals, with a further 136 public acute hospitals providing a dedicated psychiatric unit or ward.

Table 12.1: Number of specialised mental health facilities[(a)], states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	8	2	3	1	1	0	0	0	15
Public acute hospitals with a specialised psychiatric unit or ward	46	34	27	11	8	6	2	2	136
Government-operated residential mental health services[(b)]	19	47	0	2	3	5	1	0	77
Non-government-operated residential mental health services[(b)]	5	29	0	8	1	4	6	2	55
Community mental health services	384	223	134	45	92	23	13	13	927
Private psychiatric hospitals[(c)]	9	6	4	n.a.	n.a.	n.a.	0	0	26
Total facilities	**471**	**341**	**168**	**n.a.**	**n.a.**	**n.a.**	**22**	**17**	**1,236**

(a) These figures differ from *Australian hospital statistics 2005–06* (AIHW 2007a) due to differences in definitions and jurisdictional reporting.

(b) 'Services' refers to the number of actual residential mental health service units, not the number of organisations providing the services.

(c) Excludes two publicly funded private hospitals reported by WA as being out of scope of the ABS definition of a private psychiatric hospital.

n.a. Individual state values are not available for publication but have been included in totals.

Source: National Mental Health Establishments Database and Private Health Establishments Collection (ABS).

Table 12.2: Number of specialised mental health facilities[(a)], 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
Public psychiatric hospitals	21	19	20	20	15	–8.1
Public acute hospitals with a specialised psychiatric unit or ward	110	128	124	122	136	5.4
Government-operated residential mental health services	53	50	52	46	77	9.8
Private psychiatric hospitals	24	25	25	26	26	2.0
Total facilities	**208**	**222**	**221**	**214**	**254**	**5.1**

(a) Historical data for public hospitals and government operated residential services were sourced from the National Public Hospitals Establishments and Community Mental Health Establishments databases and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

Source: National Mental Health Establishments Database, National Public Hospitals Establishments Database, Community Mental Health Establishments Database and Private Health Establishments Collection (ABS).

While there has been an annual average decline of 8.1% in the number of public psychiatric hospitals (Table 12.2), there has been an increase in the number of specialised psychiatric units or wards in public acute hospitals (5.4% average annual change).

12.3 State and territory mental health services

Mental health hospital beds

The number of available mental health beds refers to the average number of beds that are immediately available for use by an admitted patient within the mental health establishment over the financial year and is estimated using monthly figures (METeOR identifier 270133). Nationally, there were 6,271 mental health-related hospital beds. Almost two thirds of these beds (63.9% or 4,008 beds) were in specialised psychiatric units or wards within public acute hospitals, while the remaining 2,263 beds were in public psychiatric hospitals (Table 12.3).

The total number of available specialised mental health beds increased over the past five years with an average annual rate of change of 1.5%, with some of the increase in specialised psychiatric unit or ward beds numbers being offset by a decline in public psychiatric hospitals beds (Table 12.4).

Table 12.3: Public sector specialised mental health hospital beds, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	1,072	116	375	245	455	0	0	0	2,263
Public acute hospitals with a specialised psychiatric unit or ward	1,151	1,045	1,014	403	188	125	50	32	4,008
Total beds	**2,223**	**1,161**	**1,389**	**648**	**643**	**125**	**50**	**32**	**6,271**

Source: National Mental Health Establishments Database.

Table 12.4: Public sector specialised mental health hospital beds, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
Public psychiatric hospitals	2,328	2,360	2,335	2,339	2,263	–0.7
Public acute hospitals with a specialised psychiatric unit or ward	3,580	3,713	3,753	3,863	4,008	2.9
Total beds	**5,908**	**6,073**	**6,088**	**6,202**	**6,271**	**1.5**

Source: National Mental Health Establishments Database and National Mental Health Report (DoHA 2005 and 2008b).

Target population

Public sector specialised mental health services are categorised into four target population groups. *Child and Adolescent* services focus on those aged under 18 years, while *Older Person* programs focus on those aged over 65 years. *Forensic* health services concentrate on clients whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component. The remaining category, *General*, targets the adult population, aged 18 to 64. General mental

health services may also provide assistance to children, adolescents or older people (METeOR identifier 288957).

In some states, specialist mental health beds for aged persons are jointly funded by the Australian and state and territory governments under the *Aged Care Act 1997*. However, not all states or territories report such jointly-funded beds through the Mental Health Establishments Database.

Table 12.5 outlines the number of hospital beds by target population group. Approximately 29.8% of the total 6,271 beds are for the target population groups of Child and Adolescent, Older Persons and Forensic. Not all target populations are specifically catered for in each state and territory.

Table 12.5: Public sector specialised mental health hospital beds, by target population, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Child and adolescent	82	64	70	28	12	0	0	0	256
Older persons	289	213	185	143	205	0	0	0	1,035
Forensic	190	116	170	38	40	17	0	8	579
General adult	1,662	768	964	439	386	108	50	24	4,401
Total	**2,223**	**1,161**	**1,389**	**648**	**643**	**125**	**50**	**32**	**6,271**

Source: National Mental Health Establishments Database.

South Australia had the highest number of specialised mental health beds per 100,000 population, at 41.2 (Table 12.6). New South Wales, Queensland and Western Australia were similar to the national average of 30.5 beds. Victoria (22.8) was a little below the national average, with the Northern and Australian Capital Territories having approximately half the national number of beds per 100,000 population.

Table 12.6: Public sector specialised mental health hospital beds per 100,000 population, by target population, states and territories, 2005–06[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Child and adolescent	4.6	4.9	6.3	5.1	3.1	0.0	0.0	0.0	4.7
Older persons	31.7	31.5	38.0	60.0	87.4	0.0	0.0	0.0	38.9
Forensic	3.8	3.1	5.8	2.6	3.4	4.7	0.0	5.6	3.8
General adult	40.6	24.8	39.3	35.2	41.3	37.6	23.3	18.1	35.3
Total	**32.7**	**22.8**	**34.3**	**31.8**	**41.2**	**25.6**	**15.0**	**15.3**	**30.5**

(a) Crude rate based on state and territory estimated resident population by targeted age groups, at 31 December 2005.

Source: National Mental Health Establishments Database.

While there were small declines in the number of beds targeted for children and adolescents and older persons (–1.8% average annual change) over the 2001–02 to 2005–06 period, there was a similar increase in the general adult beds and a larger increase in forensic beds (1.8% and 8.1%, respectively). This led to a small overall increase of 1.5% annually in total beds from 5,908 in 2001–02 to 6,271 in 2005–06 (Table 12.7).

Table 12.7: Public sector specialised mental health hospital beds, by target population, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
Child and adolescent	275	270	282	284	256	–1.8
Older persons	1,113	1,083	1,058	1,037	1,035	–1.8
Forensic	424	486	538	541	579	8.1
General adult	4,096	4,234	4,210	4,340	4,401	1.8
Total	**5,908**	**6,073**	**6,088**	**6,202**	**6,271**	**1.5**

Source: National Mental Health Establishments Database and National Mental Health Report (DoHA 2005 and 2008b).

Program type

The provision of public sector specialised mental health care is typically characterised as being either acute or non-acute, based on the principal purpose(s) of the program rather than the classification of the individual patients. Acute care admitted patient programs involve short-term treatment, characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. Non-acute care refers to all other admitted patient programs, including rehabilitation and extended care services (METeOR identifier 288889).

Table 12.8: Public sector specialised mental health hospital beds, by target population and program, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Child and adolescent									
Acute	42	64	55	28	12	0	0	0	201
Non-acute	40	0	15	0	0	0	0	0	55
Older persons									
Acute	162	213	47	119	78	0	0	0	619
Non-acute	127	0	138	24	127	0	0	0	416
Forensic									
Acute	78	56	0	19	8	17	0	8	186
Non-acute	112	60	170	19	32	0	0	0	393
General adult									
Acute	1,116	668	574	348	263	81	50	24	3,124
Non-acute	546	100	390	91	123	27	0	0	1,277
Total	**2,223**	**1,161**	**1,389**	**648**	**643**	**125**	**50**	**32**	**6,271**

Source: National Mental Health Establishments Database.

The split between acute and non-acute hospital beds varies substantially, depending on the target population. At the national level, child and adolescent (256 beds) and general adult programs (4,401 beds) are orientated towards the provision of acute services, with 78.5% and 71.0%, respectively, of those total program beds allocated as acute (Table 12.8). Older person program beds are slightly more evenly allocated, with acute beds accounting for 59.8% of the total 1,035 beds. However, forensic programs differ markedly from the other specialist program types, with the majority of their 579 beds being classified as non-acute (67.9%).

On a per capita basis, Western Australia (49.9) had the highest number of acute older person beds per 100,000, while South Australia (54.2) had the highest number of non-acute older person beds per 100,000 (Table 12.9).

Table 12.9: Public sector specialised mental health hospital beds per 100,000 population, by target population and program, states and territories, 2005–06[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Child and adolescent									
Acute	2.3	4.9	5.0	5.1	3.1	0.0	0.0	0.0	3.7
Non-acute	2.2	0.0	1.4	0.0	0.0	0.0	0.0	0.0	1.0
Older persons									
Acute	17.8	31.5	9.7	49.9	33.3	0.0	0.0	0.0	23.3
Non-acute	13.9	0.0	28.4	10.1	54.2	0.0	0.0	0.0	15.6
Forensic									
Acute	1.6	1.5	0.0	1.3	0.7	4.7	0.0	5.6	1.2
Non-acute	2.2	1.6	5.8	1.3	2.7	0.0	0.0	0.0	2.6
General adult									
Acute	27.3	21.6	23.4	27.9	28.2	28.2	23.3	18.1	25.1
Non-acute	13.3	3.2	15.9	7.3	13.2	9.4	0.0	0.0	10.4
Total	**32.7**	**22.8**	**34.3**	**31.8**	**41.2**	**25.6**	**15.0**	**15.3**	**30.5**

(a) Crude rate based on state and territory estimated resident population at 31 December 2005.

Source: National Mental Health Establishments Database.

Residential mental health service beds

There were 126 services involved in the provision of 2,093 mental health-related residential care beds (Table 12.10). The majority (1,430 or 68.3%) of these beds were provided by government-operated services. There were 1,496 residential beds operating with mental health-trained staffed on the premises for the entire 24-hour period, with the remaining 597 beds provided by residential facilities with mental health-trained staff on site for between 6 and 24 hours per day, totalling at least 50 hours per week. Tasmania (35.6), Victoria (24.9) and the Australian Capital Territory (24.1) have the highest rates of residential beds per 100,000 population (Table 12.11).

Table 12.10: Number of residential mental health services beds, states and territories, 2005–06[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Government-operated	296	962	0	18	33	91	30	0	1,430
Non-government-operated	144	304	0	62	10	83	50	10	663
24-hour staffing	249	967	0	36	30	174	40	0	1,496
Non-24-hour staffing	191	299	0	44	13	0	40	10	597
Older persons	141	621	0	0	0	42	10	0	814
General adult[(a)]	299	645	0	80	43	132	70	10	1,279
Total	**440**	**1,266**	**0**	**80**	**43**	**174**	**80**	**10**	**2,093**

(a) A small number of residential beds reported by NSW as *Child and adolescent* residential services beds were included in General Adult at the request of NSW Health.

Source: National Mental Health Establishments Database.

Table 12.11: Residential mental health services beds per 100,000 population, by program type, states and territories, 2005–06[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Older persons	15.5	91.9	0.0	0.0	0.0	59.4	32.0	0.0	30.6
General adult	7.3	20.8	0.0	6.4	4.6	45.9	32.7	7.5	10.3
Total	**6.5**	**24.9**	**0.0**	**3.9**	**2.8**	**35.6**	**24.1**	**4.8**	**10.2**

(a) Crude rate based on state and territory estimated resident population at 31 December 2005.

Source: National Mental Health Establishments Database.

Program type

With the exception of New South Wales, which has a small number of children and adolescent beds (see footnote (a) in Table 12.10), there are only older person and general adult programs provided in residential services. General adult beds account for the majority (61.1%) of these beds, a figure which has been increasing on average by 2.0% per annum since 2001–02 (Table 12.12).

Table 12.12: Residential mental health services beds, by hours staffed and program type, 2001–02 to 2005–06[(a)]

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
24-hour staffing	1,387	1,407	1,439	1,427	1,496	1.9
Non-24-hour staffing	545	598	596	563	597	2.3
Older persons	782	794	808	784	814	1.0
General adult[(a)]	1,150	1,211	1,227	1,206	1,279	2.7
Total	**1,932**	**2,005**	**2,035**	**1,990**	**2,093**	**2.0**

(a) A small number of residential beds reported by NSW as Child and Adolescent residential services beds were included in General Adult at the request of NSW Health.

Source: National Mental Health Establishments Database and National Mental Health Report (DoHA 2005 and 2008b).

Community mental health services

In 2005–06, there were 927 community mental health care services throughout Australia. Of these 21.4% (198 service units) were specialised child and adolescent facilities, 9.6% (89) were targeted at older persons, 2.2% (20) were forensic services, with the remaining 66.8% (620) servicing the general adult population (Table 12.13).

Table 12.13: Community mental health care services, by program type, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Child and adolescent	83	30	44	15	20	3	1	2	198
Older persons	27	25	15	12	4	5	1		89
Forensic	4	1	6	1	4	1	1	2	20
General adult	270	167	69	17	64	14	10	9	620
Total	**384**	**223**	**134**	**45**	**92**	**23**	**13**	**13**	**927**

Source: National Mental Health Establishments Database.

Staffing of state and territory specialist mental health facilities

The staff numbers reported in the following tables refer to the average number of full-time-equivalent (FTE) staff reported for the financial year in public psychiatric hospitals, specialised psychiatric units or wards in public acute hospitals, ambulatory mental health services, and government and non-government-operated residential mental health services.

Nurses account for the majority of the national workforce in mental health facilities, totalling 12,754 FTE or 51.6% (Tables 12.14 and 12.15), with registered nurses accounting for the larger proportion (10,826 FTE). However, when viewed from a state basis, the Australian Capital Territory had a lower overall percentage of nurses in their mental health-related workforce.

Rates per 100,000 population of salaried medical officers range from 8.8 in Tasmania to 12.3 in South Australia, while the rates for nurses varies substantially with differences of 26.7 FTE per 100,000 population across the states and territories (Table 12.16).

From a historical perspective, all staffing categories have seen increases in their total FTE numbers over the 2001–02 to 2005–06 period. Notably, salaried medical officers increased at an average annual rate of 4.2% per annum, diagnostic and allied health professionals increase by an average 3.8%, while nurses increased by approximately 3.5% per year (Table 12.17).

Table 12.14: Full-time-equivalent staff by staffing category, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers									
Consultant psychiatrists and psychiatrists	366.5	231.1	170.8	99.7	78.2	24.5	10.8	7.7	989.3
Psychiatry registrars and trainees	315.0	235.6	199.8	88.9	88.4	14.4	17.0	6.4	965.5
Other medical officers	55.0	96.5	31.1	58.8	25.0	4.0	4.5	5.6	280.5
Total salaried medical officers	*736.5*	*563.2*	*401.7*	*247.4*	*191.6*	*42.9*	*32.3*	*19.7*	*2,235.3*
Nurses									
Registered	3,567.1	2,697.5	1,894.2	1,283.0	878.7	294.8	126.1	84.1	10,825.5
Enrolled	557.3	601.2	302.9	160.7	224.4	50.2	23.3	8.0	1,928.0
Total nurses	*4,124.4*	*3,298.7*	*2,197.1*	*1,443.7*	*1,103.1*	*345.0*	*149.4*	*92.1*	*12,753.5*
Diagnostic and allied health professionals	1,483.2	1,209.8	837.1	552.1	379.4	84.6	112.1	35.1	4,693.4
Other personal care	120.3	157.0	187.7	88.6	14.4	150.7	13.2	5.0	736.9
Carer consultants	2.7	11.7	0.4	0.0	0.0	0.0	0.0	0.0	14.8
Consumer consultants	27.3	19.6	9.8	0.5	2.8	0.0	1.3	0.0	62.6
Other staff[(a)]	1,593.8	755.5	651.5	590.8	442.3	99.3	41.7	26.9	4,201.8
Total staff	**8,088.2**	**6,015.5**	**4,285.3**	**2,923.1**	**2,133.6**	**722.5**	**350.0**	**178.8**	**24,698.3**

(a) Other staff includes 'Administrative and clerical' and 'domestic and other staff' categories.

Source: National Mental Health Establishments Database.

Table 12.15: Full-time-equivalent staff by staffing category, states and territories, 2005–06 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	9.1	9.4	9.4	8.5	9.0	5.9	9.2	11.0	9.1
Nurses									
Registered	44.1	44.8	44.2	43.9	41.2	40.8	36.0	47.0	43.8
Enrolled	6.9	10.0	7.1	5.5	10.5	6.9	6.7	4.5	7.8
Total nurses	*51.0*	*54.8*	*51.3*	*49.4*	*51.7*	*47.8*	*42.7*	*51.5*	*51.6*
Diagnostic and allied health professionals	18.3	20.1	19.5	18.9	17.8	11.7	32.0	19.6	19.0
Other personal care	1.5	2.6	4.4	3.0	0.7	20.9	3.8	2.8	3.0
Carer consultants	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Consumer consultants	0.3	0.3	0.2	0.0	0.1	0.0	0.4	0.0	0.3
Other staff[(a)]	19.7	12.6	15.2	20.2	20.7	13.7	11.9	15.0	17.0
Total staff	**100**	**100**	**100**	**100**	**100**	**100**	100	100	100

(a) Other staff includes 'administrative and clerical' and 'domestic and other staff' categories.

Source: National Mental Health Establishments Database.

Table 12.16: Full-time-equivalent staff per 100,000 population by staffing category[(a)], states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	10.8	11.1	9.9	12.1	12.3	8.8	9.7	9.4	10.9
Nurses									
Registered	52.5	53.0	46.8	62.9	56.3	60.3	37.9	40.3	52.7
Enrolled	8.2	11.8	7.5	7.9	14.4	10.3	7.0	3.8	9.4
Total nurses	*60.7*	*64.8*	*54.3*	*70.8*	*70.7*	*70.6*	*44.9*	*44.1*	*62.0*
Diagnostic and allied health professionals	21.8	23.8	20.7	27.1	24.3	17.3	33.7	16.8	22.8
Other personal care	1.8	3.1	4.6	4.3	0.9	30.8	4.0	2.4	3.6
Carer consultants	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Consumer consultants	0.4	0.4	0.2	0.0	0.2	0.0	0.4	0.0	0.3
Total staff	**119.1**	**118.2**	**105.8**	**143.4**	**136.8**	**147.9**	**105.3**	**85.6**	**120.1**

(a) Crude rate based on state and territory estimated resident population at 31 December 2005.

Source: National Mental Health Establishments Database.

Table 12.17: Full-time-equivalent staff by staffing category, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
Salaried medical officers	1,895.3	1,920.8	1,976.0	1,970.9	2,235.3	4.2
Nurses	11,125.2	11,323.2	11,770.3	12,022.8	12,753.5	3.5
Diagnostic and allied health	4,038.1	4,127.3	4,286.9	4,269.3	4,693.4	3.8
Other staff[(a)]	4,883.2	5,154.7	5,090.8	4,680.1	5,016.1	0.7
Total staff	**21,941.8**	**22,525.9**	**23,124.1**	**22,943.1**	**24,698.3**	3.0

(a) Other staff includes 'carer consultants, 'consumer consultants', 'other personal care staff', 'administrative and clerical' and 'domestic and other staff' categories.

Source: National Mental Health Establishments Database and National Mental Health Report (DoHA 2005 and 2008b).

12.4 Private psychiatric hospitals

The Private Health Establishments Collection held by the ABS defines private psychiatric hospitals as those 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 2005–06, there were 26 private hospitals defined as psychiatric, with an average available beds total of 1,573. Based on data reported in the National Mental Health Report 2007, it is estimated that these beds comprise approximately 90% of total private hospital psychiatric beds (with the remaining 10% not satisfying the 50% total psychiatric patient days criterion specified by the ABS).

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 (512), while Victoria reported the highest number of beds per 100,000 population (8.6; Table 12.18).

In 2005–06, the average number of FTE staff employed by private psychiatric hospitals was 1,711.1 (Table 12.19). While the total number of FTE staff have remained relatively constant over the five years to 2005–06 (an average annual change of 0.1%), there have been some changes within staffing categories, with a 2.4% average annual decline over the 2002–03 to 2005–06 period in the number of FTE nurses and a 7.4% annual increase in the number of diagnostic and allied health professionals.

Table 12.18: Private psychiatric hospitals, available beds and available beds per 100,000 population, states[a], 2005–06

	NSW	Vic	Qld	WA	SA	Tas	Total[b]
Private psychiatric hospitals	9	6	4	n.a.	n.a.	n.a.	26
Available beds[c]	512	437	278	n.a.	n.a.	n.a.	1,573
Available beds per 100,000 population[d]	7.5	8.6	6.9	n.a.	n.a.	n.a.	7.7

(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 2005.

n.a. Not available.

Source: Private Health Establishments Collection (ABS).

Table 12.19: Full-time-equivalent staff by staffing category[a], private psychiatric hospitals, states[b], 2005–06

	NSW	Vic	Qld	WA	SA	Tas	Total[c]
Salaried medical officers	11.0	n.a.	n.a.	n.a.	n.a.	n.a.	19.30
Nurses[d]	298.2	237.6	186.1	n.a.	n.a.	n.a.	878.9
Diagnostic and allied health	68.5	n.a.	n.a.	n.a.	n.a.	n.a.	179.6
Administrative and clerical staff	118.1	94.9	33.0	n.a.	n.a.	n.a.	310.9
Domestic and other staff[e]	95.0	89.8	73.4	n.a.	n.a.	n.a.	322.4
Total staff[c]	**590.8**	**481.8**	**324.8**	**n.a.**	**n.a.**	**n.a.**	**1,711.1**

(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 (ABS).

13 Mental health workforce

13.1 Introduction

Information is presented in this chapter on the size and characteristics of the workforces of professionals specialised in mental health care, which include psychiatrists and mental health nurses. For information on psychologists, please refer to the previous publication *Mental health services in Australia 2004–05,* as there have been no new data available.

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, as equivalent workforce data are not available.

Key concepts

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 (for psychiatrists, at the time of 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) is 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 between the professions covered. This differs from the approach used in *Mental health services in Australia* reports published before 2004–05, and with data on the medical and nursing labour force published by the AIHW (AIHW 2008a, 2008b). FTE numbers presented in this chapter will, therefore, not be comparable with those reports.

Total hours are the 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 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), 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, care needs to be taken in interpreting changes in numbers and rates, and variations across states and territories.

13.2 Psychiatrists and psychiatrists-in-training

Estimates on the number of psychiatrists and 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 annually.

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 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 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 5.3% of all employed medical practitioners in Australia, with an estimated 3,180 working in Australia in 2005 (Table 13.1). Psychiatrists-in-training made up 22.8% (or 726) of these psychiatrists. The average age of psychiatrists in 2005 was 47.6 years, with female psychiatrists being younger, on average, than their male counterparts. In 2005, 62.6% of employed psychiatrists were male, and, of all male practitioners, 15.2% were trainee psychiatrists.

Including clinical and non-clinical hours, psychiatrists worked an average of 40.6 ***total hours*** per week in 2005 (Table 13.2). The hours worked per week were, on average, lower for females than males (36.9 hours compared with 42.8 hours) and higher for psychiatrists-in-training than for those not in training (43.4 hours compared with 39.8 hours).

Table 13.1: Employed psychiatrists and psychiatrists-in-training, demographic characteristics, 2001–2005

	2001	2002	2003	2004	2005	Distribution 2005 (per cent)	Average annual change (per cent)
Psychiatrists	2,097	2,367	2,395	2,409	2,454	77.2	4.0
Psychiatrists-in-training	632	587	631	742	726	22.8	3.5
Sex							
Males	1,797	1,946	1,972	2,020	1,991	62.6	2.6
Females	931	1,008	1,054	1,131	1,189	37.4	6.3
Sex and age (years)							
Males							
Less than 35	233	227	196	274	266	8.4	3.4
35–44	469	450	505	469	489	15.4	1.0
45–54	488	537	546	543	505	15.9	0.9
55–64	400	471	453	463	464	14.6	3.8
65+	207	262	272	272	267	8.4	6.6
Females							
Less than 35	250	197	227	268	285	9.0	3.3
35–44	293	291	323	353	380	11.9	6.7
45–54	203	308	289	304	323	10.2	12.3
55–64	136	171	161	159	152	4.8	2.8
65+	49	40	53	48	49	1.5	0.0
Average age (years)							
Males	49.8	50.7	50.5	49.9	49.9	. .	0.1
Females	44.1	45.5	45.0	44.0	43.7	. .	–0.2
Total	*47.9*	*48.9*	*48.6*	*47.8*	*47.6*	. .	*–0.2*
Total number[(a)]	**2,729**	**2,954**	**3,026**	**3,152**	**3,180**	**100.0**	**3.9**
All employed medical practitioners	53,384	53,991	56,207	58,211	60,252	. .	3.1

(a) The number for each variable may not sum to the total due to the estimation process and rounding.

. . Not applicable.

Source: AIHW Medical Labour Force Survey, 2001–2005.

Table 13.2: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, by type and sex, 2001–2005

	2001	2002	2003	2004	2005	Average annual change (per cent)
Psychiatrists	42.0	41.4	40.8	40.0	39.8	–1.3
Psychiatrists-in-training	45.0	44.0	45.4	43.8	43.4	–0.9
Sex						
Males	44.5	44.2	44.3	43.3	42.8	–1.0
Females	39.2	37.5	36.9	36.6	36.9	–1.5
Total	**42.7**	**41.9**	**41.8**	**40.9**	**40.6**	**–1.3**

Source: AIHW Medical Labour Force Survey, 2001–2005.

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 2005, there were 17 FTE psychiatrists per 100,000 population in Australia (Table 13.3). The rate ranged from 11 FTE per 100,000 in Western Australia to 20 per 100,000 in Victoria and South Australia.

Table 13.3: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, and FTE and FTE per 100,000 population, states and territories, 2005

	Number of psychiatrists	Number of psychiatrists-in-training	Total number	Average total hours worked per week	FTE	FTE per 100,000 population[(a)]
NSW	774	282	1,056	41.2	1,144	17
Vic	743	222	965	40.5	1,028	20
Qld	404	93	497	41.4	541	14
WA	185	36	221	38.3	223	11
SA	219	71	289	41.1	313	20
Tas	61	6	68	35.6	63	13
ACT	55	9	64	37.6	63	19
NT	14	7	21	44.4	25	12
Total[(b)]	**2,454**	**726**	**3,180**	**40.6**	**3,398**	**17**

(a) Crude rate based on the Australian estimated resident population as at 30 June 2005.

(b) The number for each variable may not sum to the total due to the estimation process and rounding.

Note: FTE is based on 38-hour standard working week.

Source: AIHW Medical Labour Force Survey, 2005.

In 2005, 88.9% of FTE psychiatrists (for whom region was reported) worked mainly in the major cities, while less than 0.5% worked mainly in remote and very remote regions (Table 13.4). By comparison, 66.2% 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 2005, the inner regional areas had 6 FTE psychiatrists per 100,000 population and the remote and very remote regions had 3 FTE psychiatrists per 100,000 population.

Table 13.4: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, and FTE and FTE per 100,000 population, by region[(a)],2005

Region[(a)]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(b)]
Major cities	2,733	40.8	2,934	22
Inner regional	255	39.7	267	6
Outer regional	85	38.5	86	4
Remote and Very remote	12	43.9	14	3
Not reported	95	40.1	101	. .
Total[(c)]	**3,180**	**40.6**	**3,398**	**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 2002). 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 31 December 2005.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

. . Not applicable.

Note: FTE is based on 38-hour standard working week

Source: AIHW Medical Labour Force Survey, 2005.

Changes in the psychiatrist workforce

The size and characteristics of the psychiatrist workforce, including the hours worked, changed in the period from 2001 to 2005. Over that period, the number of employed psychiatrists (and psychiatrists-in-training) increased by 16.5% (which equates to an average annual increase of 3.9%) (Table 13.1). This is slightly higher than the 12.9% increase in the total number of all employed medical practitioners (AIHW 2008a).

The supply of psychiatrists, measured as FTE and FTE per 100,000 population, also increased between 2001 and 2005 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 42.7 hours in 2001 to 40.6 hours in 2005 (Table 13.2) combined with a 5.1% growth in the Australian population between 2001 and 2005. The supply of psychiatrists increased in some, but not all, jurisdictions in the period from 2001 to 2005 (Table 13.6).

The proportion of female psychiatrists in the workforce increased over the period from 34.1% in 2001 to 37.4% in 2005 (Table 13.1). Given that female psychiatrists are generally younger than their male counterparts (as noted earlier) and that females made up 58.2% of psychiatrists-in-training in 2005, this trend may continue.

Female psychiatrists, while 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 2005 than they were in 2001, with an average annual drop in average total working hours of 1.3% for the sexes combined.

Table 13.5: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, 2001–2005

	2001	2002	2003	2004	2005	Average annual change (per cent)
Psychiatrists	2,317	2,579	2,571	2,536	2,570	2.6
Psychiatrists-in-training	748	680	754	856	830	2.6
Total FTE[(a)]	**3,066**	**3,257**	**3,328**	**3,392**	**3,398**	**2.6**
FTE per 100,000 population[(b)]	16	17	17	17	17	1.5

(a) The number for each variable may not sum to the total due to the estimation process and rounding.

(b) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

Note: FTE is based on 38-hour standard working week.

Source: AIHW Medical Labour Force Survey, 2001–2005.

Table 13.6: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population[(a)], states and territories, 2001–2005

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT[(b)]	Total[(c)]
					FTE				
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
2005	1,144	1,028	541	223	313	63	63	25	3,398
Average annual change (per cent)	5.5	0.9	5.5	–5.0	–0.4	2.5	8.8	5.7	2.6
					FTE per 100,000 population[(a)]				
2001	14	21	12	14	21	12	14	10	16
2002	17	22	12	12	20	13	17	14	17
2003	16	21	12	14	21	15	15	18	17
2004	17	22	12	12	22	14	13	10	17
2005	17	20	14	11	20	13	19	12	17
Average annual change (per cent)	5.0	–1.2	3.9	–5.9	–1.2	2.0	7.9	4.7	1.5

(a) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

(b) Northern Territory estimates for 2005 are based on responses to the 2004 Medical Labour Force Survey weighted to 2005 benchmark figures, giving an estimated response rate of 31.8%. Care should be taken when interpreting these figures.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

Note: FTE is based on 38-hour standard working week.

Source: AIHW Medical Labour Force Survey, 2001–2005.

13.3 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 2005* (AIHW 2008b).

Characteristics of the mental health nursing workforce

Out of 244,360 nurses employed in Australia in 2005, an estimated 13,472 (5.5%) worked principally in the area of mental health nursing (Table 13.7). Of these, 22.8% reported that they had completed a post-registration or post-enrolment course in mental health lasting more than 6 months.

Nurses working in mental health are more likely to work full time, are slightly older on average, and much more likely to be male than nurses in the general workforce (AIHW 2008b).

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 2008b). In 2005, 82.1% of nurses working principally in mental health and 81.2% of all employed nurses in Australia were registered nurses, with the remainder being enrolled nurses.

There has been a 1.4% average annual increase in the average age of mental health nurses since 2001.The average age of employed mental health nurses in 2005 was 46.4 years, which is slightly older than the 45.1 years for all employed nurses (Table 13.7). Female nurses working in mental health nursing were younger, on average, than their male counterparts (45.8 years compared with 47.7 years).

In general, nursing is a very female-dominated profession, with only 7.9% of all nurses employed in Australia in 2005 being male (AIHW 2008b). By contrast, male nurses made up over a third (31.3%) of employed mental health nurses in 2005 (Table 13.7).

Mental health nurses worked an average of 37.2 total hours per week in 2005 (Table 13.8). The hours worked per week were, on average, lower for females than males (36.1 hours

compared with 39.5 hours) and higher for registered nurses than for enrolled nurses (37.5 hours compared with 35.8 hours).

Table 13.7: Employed mental health nurses, demographic characteristics, 2001–2005

	2001	2003[a]	2004[b]	2005	Distribution 2005 (per cent)	Average annual change 2003–2005 (per cent)	Average annual change 2001–2005 (per cent)
Registered nurses	11,353	10,315	10,134	11,066	82.1	3.6	–0.6
Enrolled nurses	2,002	3,463	3,702	2,406	17.9	–16.6	4.7
Sex							
Males	4,353	4,469	4,676	4,211	31.3	–2.9	–0.8
Females	9,002	9,308	9,160	9,261	68.7	–0.3	0.7
Sex and age (years)							
Males							
Less than 25	52	72	52	38	0.3	–27.4	–7.5
25–34	611	533	557	407	3.0	–12.6	–9.7
35–44	1,396	1,255	1,172	901	6.7	–15.3	–10.4
45–54	1,738	1,875	2,035	1,917	14.2	1.1	2.5
55–64	508	668	779	862	6.4	13.6	14.1
65+	48	67	81	86	0.6	13.3	15.7
Females							
Less than 25	222	285	349	204	1.5	–15.4	–2.1
25–34	1,539	1,483	1,445	1,215	9.0	–9.5	–5.7
35–44	2,998	2,767	2,425	2,289	17.0	–9.0	–6.5
45–54	3,139	3,402	3,465	3,852	28.6	6.4	5.3
55–64	1,005	1,214	1,309	1,523	11.3	12.0	11.0
65+	100	157	166	177	1.3	6.2	15.3
Average age (years)							
Males	44.9	45.6	46.2	47.7	. .	2.3	1.5
Females	43.5	44.1	44.3	45.8	. .	1.9	1.3
Total	*43.9*	*44.6*	*44.9*	*46.4*	. .	2.0	1.4
Total number[c]	**13,355**	**13,777**	**13,836**	**13,472**	**100.0**	**–1.1**	**0.2**
All employed nurses	228,230	236,645	243,916	244,360	. .	1.6	1.7

(a) The Nursing and Midwifery Labour Force Survey was conducted every two years from 1995 to 2003, which explains the missing data for 2002. The survey has been conducted annually since 2003.

(b) 2004 data have been revised since the publication of *Mental health services in Australia 2004–05*.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

. . Not applicable.

Source: AIHW Nursing and Midwifery Labour Force Survey, 2003–2005.

Table 13.8: Employed mental health nurses, average total hours worked per week, by sex, 2001–2005

	2001	2003	2004	2005	Average annual change 2003–2005 (per cent)	Average annual change 2001–2005 (per cent)
Registered nurses	34.9	37.0	37.3	37.5	0.7	1.8
Enrolled nurses	34.0	36.0	35.9	35.8	–0.3	1.3
Sex						
Males	37.2	39.1	39.2	39.5	0.5	1.5
Females	33.6	35.6	35.8	36.1	0.7	1.8
Total	**34.7**	**36.7**	**36.9**	**37.2**	**0.7**	**1.8**

Source: AIHW Nursing and Midwifery Labour Force Survey, 2001–2005.

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 the distribution of all employed nurses in Australia (AIHW 2008b). In 2005, there were 65 FTE mental health nurses per 100,000 population in Australia, with Victoria reporting the highest rate of 73 FTE per 100,000 population (Table 13.9).

Table 13.9: Employed mental health nurses, average total hours worked per week, and FTE and FTE per 100,000 population, states and territories, 2005

	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	4,315	37.8	4,293	64	975
Vic[(b)]	3,869	36.4	3,706	73	1,144
Qld	2,317	37.0	2,256	56	911
WA[(c)]	1,037	36.5	996	49	950
SA	1,153	36.8	1,116	72	1,279
Tas	343	37.6	339	70	1,190
ACT	221	37.1	215	65	1,126
NT[(d)]	n.p.	n.p.	n.p.	n.p.	n.p.
Total[(d)]	**13,472**	**37.2**	**13,188**	**65**	**1,040**

(a) Crude rate based on the Australian estimated resident population as at 30 June 2005.

(b) Estimates for Victoria for 2005 are derived from survey results of 2006 AIHW Nursing and Midwifery Labour Force Survey, weighted to 2005 benchmarks.

(c) Estimates for Western Australia for 2005 should be treated with caution due to the low response rate (26.9%) in the 2005 survey.

(d) Estimates for the Northern Territory are not separately published due to the very low response rate to the survey in that jurisdiction (13.7%). However, the total includes Northern Territory estimates. The number for each variable may not sum to the total due to the estimation process and rounding.

n.p. Not published.

Note: FTE based on 38-hour standard working week. Note FTE rates differ from those published in *Nursing and midwifery labour force 2005* (AIHW 2008b) due to revised population estimates.

Source: AIHW Nursing and Midwifery Labour Force Census 2005.

Information on the supply of mental health nurses by geographic region (derived from the location of the respondent's main nursing job as reported in the survey) is provided in Table 13.10. 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 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 inner regional areas (69 FTE per 100,000 population in 2005) and in major cities (64 FTE per 100,000). Remote and very remote regions had a lower rate of 32 FTE per 100,000 population in 2005.

Table 13.10: Employed mental health nurses, average total hours worked per week, and FTE and FTE per 100,000 population, by region[(a)], 2005

	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	8,818	37.1	8,609	64	989
Inner regional	3,058	37.0	2,977	69	1,019
Outer regional	865	38.2	870	42	1,049
Remote and Very remote	143	43.3	163	32	1,026
Not reported	588	34.8	538	. .	. .
Total[(c)]	**13,472**	**37.2**	**13,188**	**65**	**1,040**

(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 relatively 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 2005.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

. . Not applicable.

Note: FTE based on 38-hour standard working week. Note FTE rates differ from those published in *Nursing and midwifery labour force 2005* (AIHW 2008b) due to revised population estimates.

Source: AIHW Nursing and Midwifery Labour Force Census 2005.

Changes in the mental health nursing workforce

An overall 7.1% increase in the total number of employed nurses in Australia between 2001 and 2005 was not reflected in the number working in mental health nursing, which increased by 0.9% over the same period (Table 13.7). While the total number of employed nurses increased by 0.2% between 2004 and 2005, the number of mental health nurses actually decreased by 2.6% which was largely due to the 35.0% drop in the number of enrolled mental health nurses.

There was an increase of 7.2% in the average total weekly hours worked, from 34.7 to 37.2 hours per week, which is likely to have contributed to the 8.1% increase in the number of FTE mental health nurses over the 5-year period (tables 13.8 and 13.11). The number of FTE mental health nurses per 100,000 population was similar in 2005 to that in 2001 (65 and 63, respectively).

Table 13.11: Employed mental health nurses, FTE and FTE per 100,000 population, 2001–2005

	2001	2003	2004[a]	2005	Average annual change 2003–2005 (per cent)	Average annual change 2001–2005 (per cent)
Registered nurses	10,427	10,043	9,947	10,920	4.3	1.2
Enrolled nurses	1,791	3,281	3,497	2,267	–16.9	6.1
Total FTE[b]	**12,195**	**13,306**	**13,435**	**13,188**	**–0.4**	**2.0**
FTE per 100,000 population[c]	63	67	67	65	–1.5	0.8

(a) 2004 data have been revised since the publication of *Mental health services in Australia 2004–05*.

(b) The number for each variable may not sum to the total due to the estimation process and rounding.

(c) Crude rate based on the Australian estimated resident population as at 30 June.

Note: FTE based on 38-hour standard working week. Note FTE rates differ from those published in *Nursing and midwifery labour force 2005* (AIHW 2008b) due to revised population estimates.

Source: AIHW Nursing Labour Force survey, 2001; AIHW Nursing and Midwifery Labour Force Census, 2003–2005.

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 2001 to 2005 (Table 13.12). 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 decreased from 32.6% in 2001 to 31.3% in 2005 (Table 13.7). The proportion of mental health nurses who were registered nurses (rather than enrolled nurses) declined slightly over the period, from 85.0% in 2001 to 82.1% in 2005.

As with the general nursing population, the mental health nursing workforce is ageing, with the average age increasing from 43.9 in 2001 to 46.4 years in 2005 (Table 13.7 and Figure 13.1). The proportion of mental health nurses aged 55 years and over also increased, from 12.4% in 2001 to 19.7% in 2005.

As noted above, the average hours worked by nurses in mental health nursing increased in the period from 2001 to 2005 (Table 13.8). While this is the case for both males and females, the increase has been higher for females (7.4%) than for males (6.2%).

Table 13.12: Employed mental health nurses, FTE and FTE per 100,000 population, states and territories, 2001–2005

	NSW	Vic[(b)]	Qld	WA[(c)]	SA	Tas	ACT	NT[(d)]	Total[(d)]
					FTE				
2001	4,257	3,475	1,831	950	1,115	282	212	93	12,195
2003	4,846	3,660	2,254	916	1,098	320	167	54	13,306
2004[(e)]	4,336	3,955	2,369	1,175	1,072	295	166	77	13,435
2005	4,293	3,706	2,256	996	1,116	339	215	n.p.	13,188
Average annual change 2003–2005 (per cent)	–5.9	0.6	0.0	4.3	0.8	2.9	13.5	. .	–0.4
Average annual change 2001–2005 (per cent)	0.2	1.6	5.4	1.2	0.0	4.7	0.4	. .	2.0
					FTE per 100,000 population[(a)]				
2001	65	72	50	50	74	60	66	47	63
2003	73	74	59	47	72	67	51	27	67
2004[(e)]	65	79	61	59	70	61	51	38	67
2005	64	73	56	49	72	70	65	n.p.	65
Average annual change 2003–2005 (per cent)	–6.4	–0.7	–2.6	2.1	0.0	2.2	12.9	. .	–1.5
Average annual change 2001–2005 (per cent)	–0.4	0.3	2.9	–0.5	–0.7	3.9	–0.4	. .	0.8

(a) Crude rate based on the Australian estimated resident population as at 30 June.

(b) Estimates for Victoria for 2005 are derived from survey results of 2006 AIHW Nursing and Midwifery Labour Force Survey, weighted to 2005 benchmarks.

(c) Estimates for Western Australia for 2005 should be treated with caution due to the low response rate (26.9%) in the 2005 survey. Estimates for Western Australia for 2003 and 2004 should also be treated with caution as they are based on a response rate of 19.0% and 37.7%, respectively.

(d) Estimates for the Northern Territory are not separately published for 2005 due to the very low response rate to the survey in that jurisdiction (13.7%). Estimates for the Northern Territory for 2003 and 2004 should be treated cautiously due to the low response rate (31.1% and 35.1%, respectively. Total includes Northern Territory estimates. The number for each variable may not sum to the total due to the estimation process and rounding.

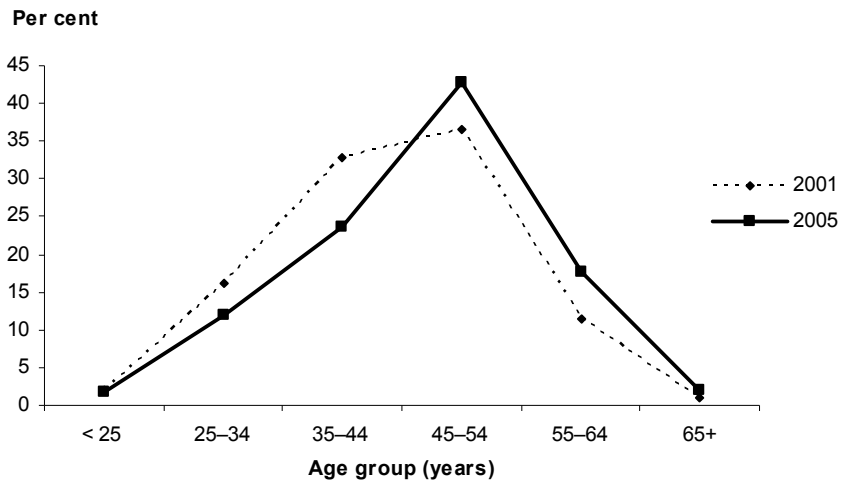
(e) 2004 data have been revised since the publication of *Mental health services in Australia 2004–05*.

. . Not applicable.

n.p. Not published.

Note: FTE based on 38-hour standard working week. Note FTE rates differ from those published in *Nursing and midwifery labour force 2005* (AIHW 2008b) due to revised population estimates.

Source: AIHW Nursing Labour Force Survey, 2001; AIHW Nursing and Midwifery Labour Force Census, 2003–2005.



Source: AIHW Nursing and Midwifery Labour Force Survey, 2001 and 2005.

Figure 13.1: Employed mental health nurses, by age, 2001 and 2005

14 Expenditure on mental health services

14.1 Introduction

This chapter reviews the available information on expenditure for mental health services, commencing with expenditure on state and territory government-operated mental health facilities. Information is then provided on expenditure for mental health-related services under the Medicare Benefits Schedule (MBS) and mental health-related expenditure under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) and grants and expenditure by the Australian Government. Data on expenditure and funding are derived from a variety of sources, as outlined in Appendix 1. Further information on health expenditure is available in *Health expenditure Australia 2005–06* (AIHW 2007c).

Health expenditure and ***health funding*** are distinct but related concepts, essential to understanding the financial resources utilised 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 2007c).

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 2007c).

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 2007c).

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 2007c).

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 2007c).

Funding for health products and services is derived from both government and non-government sources, depending on the type of good or service provided. The Australian Government, for example, funds the majority of Medicare services. These services include those provided by general practitioners, medical specialists and other professionals (usually in private practices), aged residential care and pharmaceuticals, for which benefits were paid under the PBS and 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.

Responsibility for funding public hospitals and public health activities is shared by the Australian Government and the states and territories, while state and territory governments provide the main funding for other health services, including 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 majority of funding for incidentals, including over-the-counter pharmaceuticals, dental and other professional services and private hospital services.

14.2 Recurrent expenditure on state and territory specialised mental health services

Expenditure data for public psychiatric hospitals, public acute hospitals with a specialised psychiatric unit or ward, community mental health services, government and non-government-operated residential mental health services are reported in this section, with the data for 2001–02 to 2005–06 summarised in Table 14.2. Expenditure for non-government-operated residential mental health services refers only to the funding provided by state and territory governments, not to the total expenditure of the non-government-operated organisation. The data are presented in both ***current*** and ***constant prices***. Unless otherwise stated, constant price estimates are expressed in 2005–06 prices. For information on the scope of facilities included in this chapter and details on the number of services, available beds and staffing, refer to Chapter 12 of this report.

This section draws on data from the National Mental Health Establishments Database and for historical data, the National Mental Health Reports, published by the Australian Government Department of Health and Ageing. For further information on these data sources see Appendix 1.

Total expenditure on state and territory specialised mental health services across all jurisdictions increased on average by 5.2% per year over the 2001–02 to 2005–06 period to $2,742 million (Table 14.1). A breakdown of total expenditure reveals that in 2005–06, recurrent expenditure by public psychiatric hospitals was estimated at $434 million, increasing on average by 4.3% per year over the 2001–02 to 2005–06 period. Public acute hospitals with a specialised psychiatric unit or ward and community mental health services experienced considerable annual average increases in expenditure of 10.2% and 9.6%, respectively. Expenditure for residential mental health facilities (including non-government-organisations in receipt of government funding) in 2005–06 was estimated at $177 million, an average annual increase of 7.1% (Table 14.2).

Table 14.1: Recurrent expenditure ($'000) for state and territory public sector mental health services, 2005–06[a]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals									
Salaries and wages expenditure	135,387	20,834	46,523	46,259	58,246	. .	. .	. .	307,248
Non-salary expenditure	41,586	9,326	17,070	12,449	20,771	. .	. .	. .	101,202
Indirect expenditure share[c]	12,507	1,959	3,711	3,009	4,041	. .	. .	. .	25,227
Total recurrent expenditure	*189,480*	*32,119*	*67,303*	*61,716*	*83,058*	. .	. .	. .	*433,677*
Specialised psychiatric units or wards in public acute hospitals									
Salaries and wages expenditure	190,171	134,442	128,580	72,939	26,968	12,565	4,716	6,417	576,797
Non-salary expenditure	63,205	45,624	36,657	14,262	7,856	6,611	2,856	1,616	178,685
Indirect expenditure share[c]	17,907	11,693	9,642	4,469	1,781	2,012	1,314	2,295	51,112
Total recurrent expenditure	*271,282*	*191,759*	*174,879*	*91,670*	*36,604*	*21,188*	*8,885*	*10,327*	*806,594*
Community mental health services									
Salaries and wages expenditure	223,332	185,583	116,043	103,530	55,571	14,399	14,687	7,247	720,391
Non-salary expenditure	66,081	66,864	35,471	33,310	18,341	6,831	5,577	2,411	234,887
Indirect expenditure share[c]	20,454	16,394	8,841	7,014	3,780	2,228	3,516	2,759	64,984
Total recurrent expenditure	*309,866*	*268,841*	*160,355*	*143,853*	*77,692*	*23,458*	*23,780*	*12,417*	*1,020,261*
Residential mental health services[d]									
Salaries and wages expenditure	18,806	83,569	. .	3,620	1,961	7,856	2,952	153	118,916
Non-salary expenditure	4,419	30,586	. .	1,277	621	6,526	2,302	115	45,847
Indirect expenditure share[c]	1,641	7,413	. .	251	132	1,509	911	77	11,934
Total recurrent expenditure	*24,866*	*121,569*	. .	*5,148*	*2,714*	*15,890*	*6,165*	*344*	*176,697*
Other expenditure									
Grants to non-government organisations[e]	31,744	62,107	25,347	16,474	14,686	1,690	5,136	3,088	160,272
Other indirect expenditure	64,155	32,200	26,764	7,234	5,140	4,971	2,219	2,048	144,731
Total state/territory expenditure	**891,394**	**708,596**	**454,648**	**326,096**	**219,894**	**67,197**	**46,185**	**28,223**	**2,742,232**

(a) Data may differ from previous years as a consequence of changes to jurisdictional reporting and definitions.

(b) Public psychiatric hospital expenditure in WA includes two public funded private hospitals.

(c) Indirect expenditure was apportioned based on the proportion of total expenditure at the service setting level (the categories in bold).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Non-government-operated expenditure excludes staffed residential services managed by non-government organisations in receipt of government funding. These are included in residential.

NB: Total recurrent expenditure excludes depreciation. Totals may not add due to rounding.

. . Not applicable.

Source: National Mental Health Establishments Database.

Table 14.2: Recurrent expenditure ($'000) for state and territory public sector mental health services, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06[b]	Average annual change (per cent)
Public psychiatric hospitals	366,651	380,409	412,884	429,667	433,677	4.3
Public acute hospitals with a specialised psychiatric unit or ward	546,041	605,687	661,106	737,352	806,594	10.2
Community mental health services	706,853	774,960	836,113	922,187	1,020,261	9.6
Residential mental health services[c]	134,452	146,955	150,802	157,800	176,697	7.1
Grants to non-government-organisations[d]	100,001	103,405	111,351	129,524	160,272	12.5
Other indirect expenditure	89,656	103,361	116,262	126,113	144,731	12.7
Total state/territory expenditure (current prices)	**1,943,654**	**2,114,777**	**2,288,517**	**2,502,644**	**2,742,232**	**9.0**
Total state/territory expenditure (constant prices)[e]	2,239,863	2,358,504	2,466,788	2,606,862	2,742,232	5.2

(a) Expenditure excludes depreciation.

(b) 2005–06 public psychiatric hospital expenditure in WA includes two publicly funded private hospitals.

(c) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(d) Grants to non-government-organisations expenditure excludes staffed residential services managed by non-government organisations in receipt of government funding. These are included in residential.

(e) Constant prices are referenced to 2005–06 and are adjusted for inflation.

Source: National Mental Health Establishments Database and National Mental Health Report (DoHA 2005 and 2008b).

Table 14.3 includes a more detailed analysis of source of funds for public sector specialised mental health services. This breakdown includes:

- State and territory funds;
- Australian Government funding, including:
- National Mental Health Strategy grants made under the Australian Health Care Agreements;
- other health care grants provided under the Australian Health Care Agreements;
- funds allocated under the Commonwealth/State-Territory Disability Agreement;
- nursing home and hostel subsidies;
- grants and payments made by the Department of Veterans' Affairs for mental health care of veterans made as part of the transfer of previously owned Australian Government repatriation hospitals to state ownership;
- other Australian Government grants for specific mental health purposes; and
- other and patient revenue and recoveries (DoHA 2007).

In 2005–06, 93.4% ($2,560 million) of funds for specialised mental health services were provided by state or territory governments, a further 4.4% ($121 million) was from the Australian Government, with the remaining 2.2% ($60 million) sourced from patient and other revenues and recoveries (Table 14.2). State and territory funding increased by 11.5% on 2004–05 figures (up from $2,296 million) and Australian Government funding increased by 12.6%, up from $108 million in 2004–05.

Table 14.3: Source of funding for specialised mental health service ($'000), states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[a]
State/Territory funds[b]	836,151	648,679	426,130	311,978	205,204	61,913	43,808	26,400	2,560,262
Australian Government funds									
National Mental Health Strategy[c]	21,619	17,104	13,290	7,251	5,056	1,861	1,396	1,466	69,042
Department of Veterans' Affairs[d]	8,759	8,462	893	1,655	3,113	156	151	0	23,188
Other Australian Government funds	265	18,605	4,434	2,085	2,520	824	212	304	29,250
Total Australian Government funds	*30,643*	*44,171*	*18,617*	*10,991*	*10,689*	*2,841*	*1,759*	*1,770*	*121,480*
Other revenue[e]	24,599	15,746	9,901	3,126	4,002	2,443	618	54	60,490
Total funds	**891,394**	**708,596**	**454,648**	**326,096**	**219,894**	**67,197**	**46,185**	**28,223**	**2,742,232**

(a) Totals may not add due to rounding.

(b) Excludes depreciation and specified Australian Government funding sources. Values are derived by subtracting Total Australian Government funds and Other revenue from Total funds.

(c) Actual payments to states and territories by the Australian Government for mental health reform under the Australian Health Care Agreements.

(d) Actual payments to states and territories, as estimated by the Department of Veterans' Affairs.

(e) Other and patient revenue and recoveries.

Source: National Mental Health Establishments Database (State/Territory funds, other Australian Government funds and other revenue) and unpublished Department of Health and Ageing data (National Mental Health Strategy and Department of Veterans' Affairs).

14.3 Private psychiatric hospital expenditure

Expenditure information is available for private psychiatric hospitals, 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. It must be emphasised that these figures do not include expenditure on psychiatric units co-located in private hospitals.

In 2005–06, total recurrent expenditure for these facilities was $177 million (Table 14.4). Real growth in expenditure for private psychiatric hospitals, over the period 2001–02 to 2005–06, averaged 1.5% per year (Table 14.5).

Table 14.4: Private psychiatric hospital expenditure ($'000), states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	Total
Salaries and wages expenditure	34,173	30,563	20,380	n.a.	n.a.	n.a.	99,413
Non-salary expenditure	23,189	21,260	11,333	n.a.	n.a.	n.a.	69,899
Total recurrent expenditure[a]	**58,099**	**52,379**	**31,972**	**n.a.**	**n.a.**	**n.a.**	**176,781**

(a) The recurrent expenditure totals may not add due to rounding.

n.a. Not available, but included in totals.

Source: Private Health Establishments Collection (ABS).

Table 14.5: Private psychiatric hospital expenditure ($'000), 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
Total expenditure (current prices)	143,653	158,529	162,066	168,490	176,781	5.3
Total expenditure (constant prices)[(e)]	166,402	177,489	175,209	175,870	176,781	1.5

Source: Private Health Establishments Collection (ABS).

14.4 Australian Government expenditure on Medicare-subsidised mental health-related services

Prior to November 2006, specific mental health-related Medicare items were limited to services provided by psychiatrists. However, changes to the Medicare system under the *Better Access* initiative resulted in new item numbers aimed at improving the early intervention, assessment and management of patients with mental disorders, as well as to provide new referral pathways to clinical psychologist and allied mental health service providers (Council of Australian Governments 2006a).

This section outlines the Australian Government's funding through the MBS for mental health services provided by consultant psychiatrists, general practitioners, psychologists and other allied health professionals for the financial years 2001–02 to 2006–07 (Appendix 1 provides further information on data quality, coverage and other aspects of the Medicare data).

In 2006–07, $351 million was paid in benefits for MBS-subsidised mental health-related services (Table 14.6); this represents 3.0% of total Medicare benefits expenditure ($11,735 million). For Australia as a whole, benefits paid for these services averaged $16.83 per capita in 2006–07. The average benefits paid per capita in Victoria and South Australia were above the national average, while those in the Northern Territory were substantially lower, at $3.72 per capita.

The majority of the $351 million was spent on patient attendances in consulting rooms ($207 million or 58.9%). The new Medicare items associated with the GP Mental Health Care Plans accounted for 17.8% of total mental health-related benefits expenditure, followed by services provided by psychologists (14.8%). Expenditure on the new MBS items, particularly through General Practitioners and Psychologists, is illustrated in Table 14.7.

Prior to 2006–07, the average annual rate of change for total MBS expenditure in current prices was 4.3% (2002–03 to 2005–06). However, expenditure in 2006–07 increased 56.0% on the previous year, reflecting the introduction of the new items. It should be noted that the only item numbers experiencing a decline in expenditure relate to the 3 Step Mental Health Process, which was replaced by GP Mental Health Care Plans in November 2006.

It is important to note that analysis of BEACH data reveals an estimated 90% of mental health-related General Practitioner items were billed as *surgery consultations* and not as mental health-related items under the Medicare *Better Access* program. For further information on this issue, see Section 2.3 of this report.

Table 14.6: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[a], states and territories, 2006–07[b]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Consultant psychiatrists									
Patient attendances – Consulting room	67,251	69,937	33,080	11,016	19,515	3,226	2,291	357	206,674
Patient attendances – Hospital	4,550	5,597	4,280	1,697	1,093	747	124	19	18,109
Patient Attendances – Other locations	1,198	480	113	53	119	9	7	4	1,984
Group psychotherapy	756	1,253	201	56	42	66	5	0	2,378
Interview with non-patient	164	196	146	53	46	13	5	1	623
Telepsychiatry	38	6	18	3	1	0	2	0	68
Case conferencing	12	55	3	6	8	3	1	0	88
Electroconvulsive therapy[c]	212	215	233	68	67	31	0	5	831
Subtotal	*74,180*	*77,739*	*38,072*	*12,953*	*20,892*	*4,097*	*2,435*	*387*	*230,755*
General practitioners									
GP Metal Health Care Plans[d]	21,763	18,343	10,649	9,190	9,190	1,296	829	253	62,323
Focused Psychological Strategies	1,377	937	748	162	338	54	15	9	3,639
3 Step Mental Health Process	406	268	158	92	83	16	14	7	1,044
Subtotal	*23,546*	*19,548*	*11,556*	*9,445*	*9,610*	*1,366*	*858*	*269*	*67,006*
Psychologists									
Psychological Therapy[d]	6,714	6,168	1,974	3,989	1,110	658	318	43	20,974
Focused Psychological Strategies[d]	9,905	11,263	6,176	1,274	1,245	607	406	84	30,961
Subtotal	*16,619*	*17,431*	*8,150*	*5,263*	*2,356*	*1,265*	*724*	*128*	*51,936*
Other providers									
3 Step Mental Health Process (Other Medical Providers)	6	12	3	1	1	0	0	0	24
Focused Psychological Strategies (Occupational Therapists)[d]	37	46	25	28	22	11	1	0	170
Focused Psychological Strategies (Social Workers)[d]	423	285	216	74	77	10	1	7	1,093
Subtotal	*467*	*343*	*244*	*102*	*101*	*21*	*2*	*7*	*1,287*
Total expenditure in current prices ($'000)	**114,805**	**115,049**	**58,019**	**23,976**	**27,553**	**6,748**	**4,019**	**790**	**350,984**
Per capita ($)[e]	16.75	22.27	14.04	11.52	17.49	13.73	11.94	3.72	16.83

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

(b) Any apparent discrepancies in totals are due to rounding to nearest $'000.

(c) Information for electroconvulsive therapy may include data for medical practitioners other than psychiatrists.

(d) New mental health-related MBS items commenced November 2006.

(e) Crude rate based on the preliminary Australian estimated resident population at 31 December 2006.

Source: Medicare data (DoHA).

Table 14.7: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[a], 2002–03 to 2006–07 [b]

Description	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Consultant psychiatrists						
Patient attendances – Consulting room	178,867	181,868	193,820	198,057	206,674	3.7
Patient attendances -- Hospital	13,964	14,826	15,321	17,046	18,109	6.7
Patient Attendances – Other locations	1,571	1,538	1,601	1,772	1,984	6
Group psychotherapy	2,185	2,120	2,325	2,470	2,378	2.1
Interview with non-patient	199	208	250	290	623	33.1
Telepsychiatry	2	19	24	41	68	144.6
Case conferencing	9	39	62	85	88	74.5
Electroconvulsive therapy[c]	695	671	704	819	831	4.6
Subtotal	*197,492*	*201,290*	*214,106*	*220,579*	*230,755*	*4*
General practitioners						
GP Metal Health Care Plans[d]	. .	. .	. .	. .	62,323	. .
Focused Psychological Strategies	210	1,328	2,131	2,828	3,639	103.9
3 Step Mental Health Process	397	725	962	1,658	1,044	27.4
Subtotal	*607*	*2,053*	*3,093*	*4,486*	*67,006*	. .
Psychologists						
Psychological Therapy[d]	. .	. .	. .	. .	20,974	. .
Focused Psychological Strategies[d]	. .	. .	. .	. .	30,961	. .
Subtotal	*0*	*0*	*0*	*0*	*51,936*	. .
Other providers						
3 Step Mental Health Process (Other Medical Providers)	16	37	43	43	24	10.1
Focused Psychological Strategies (Occupational Therapists) [c]	. .	. .	. .	. .	170	. .
Focused Psychological Strategies (Social Workers) [c]	. .	. .	. .	. .	1,093	. .
Subtotal	*16*	*37*	*43*	*43*	*1,287*	. .
Total expenditure in current prices ($'000)	**198,100**	**203,343**	**217,199**	**225,065**	**350,984**	**15.4**
Total expenditure in constant prices ($'000) [e]	225,509	220,626	225,767	225,065	334,609	10.4
Per capita (constant prices) ($)[f]	11.40	11.02	11.14	10.95	16.05	8.90

(a) See the Medicare Benefits Schedule data section of Appendix 1 for a listing of these item groups.

(b) Any apparent discrepancies in totals are due to rounding to nearest $'000.

(c) Information for electroconvulsive therapy may include data for medical practitioners other than psychiatrists.

(d) New mental health-related MBS items commenced November 2006.

(e) Constant prices are referenced to the 2005–06 and are adjusted for inflation.

(f) Crude rate based on the preliminary Australian estimated resident population at 31 December 2006.

.. Not applicable.

Source: Medicare data (DoHA).

14.5 Australian Government expenditure on mental health-related medications

In 2006–07, 183 million claims were processed under the PBS and RPBS for prescribed medications. The total benefits paid for these claims, excluding patient contributions, were $6,194 million (Medicare Australia 2007a). Of this, 10.8% ($670 million) was spent on mental health-related medications. For further information on data quality, coverage and other aspects of the PBS/RPBS database refer to Appendix 1.

Almost three-quarters (74.0%) of the expenditure on mental health-related medications was for prescriptions issued by general practitioners. This was followed by prescriptions written by psychiatrists (19.9%), with non-psychiatrist specialists' prescriptions accounting for the remaining 6.1% (Table 14.8).

In 2006–07, prescriptions for antipsychotics and antidepressants accounted for the majority of mental health-related PBS/RPBS expenditure (48.6% and 44.7%, respectively), followed by prescriptions for anxiolytics (2.4%), hypnotics and sedatives (1.6%) and psychostimulants (0.8%) (Table 14.8). Other medications prescribed by psychiatrists accounted for 1.9% of the expenditure on mental health-related prescriptions. For further information on mental health-related medications, see Section 11.1 of this report.

Table 14.8: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[(a)] and medical practitioner, 2006–07

	Anti-psychotics (N05A)	Anxiolytics (N05B)	Hypnotics and sedatives (N05C)	Anti-depressants (N06A)	Psychostimulants (N06B)	Other[(b)]	Total	Total (per cent)
General practitioners	213,505	14,507	10,065	255,153	891	. .	494,120	74.0
Non-psychiatrist specialists	31,835	348	299	7,947	3,052	. .	43,481	6.1
Psychiatrists	80,813	1,177	264	36,775	1,213	12,567	132,810	19.9
Total	**326,153**	**16,031**	**10,628**	**299,876**	**5,156**	**12,567**	**670,411**	
Total (per cent)	48.6	2.4	1.6	44.7	0.8	1.9		100

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

(b) Other medications prescribed by psychiatrists and subsidised through PBS/RPBS.

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

From a benefits paid perspective, the cost to the Australian Government of subsidising mental health-related prescriptions under the PBS/RPBS in 2006–07 ($670 million) was equivalent to $32.15 per capita (Table 14.9). The average benefits paid in South Australia, Victoria and Tasmania were above the national average, while those paid in the Northern Territory and the Australian Capital Territory were markedly below the national average. This is consistent with the distribution of prescriptions outlined in more detail in Chapter 9.

Table 14.9: Australian Government 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, 2006–07[b]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Antipsychotics (N05A)									
General practitioners	72,931	59,844	36,075	16,855	19,809	4,678	2,501	812	213,505
Non-psychiatrist specialists	6,315	13,395	6,149	3,420	1,432	438	270	415	31,835
Psychiatrists	27,665	24,067	13,960	4,461	7,560	1,394	1,508	198	80,813
Subtotal	*106,911*	*97,306*	*56,185*	*24,736*	*28,801*	*6,510*	*4,279*	*1,425*	*326,153*
Anxiolytics (N05B)									
General practitioners	3,926	4,389	2,906	1,062	1,376	702	116	31	14,507
Non-psychiatrist specialists	88	111	70	31	35	8	3	1	348
Psychiatrists	266	444	249	66	109	32	8	2	1177
Subtotal	*4,280*	*4,945*	*3,225*	*1,159*	*1,520*	*742*	*127*	*34*	*16,031*
Hypnotics and sedatives (N05C)									
General practitioners	3,159	2,545	1,974	963	958	365	78	23	10,065
Non-psychiatrist specialists	85	90	62	33	21	4	2	1	299
Psychiatrists	60	61	68	28	36	5	5	0	264
Subtotal	*3,304*	*2,696*	*2,104*	*1,025*	*1,015*	*373*	*86*	*24*	*10,628*
Antidepressants (N06A)									
General practitioners	75,827	64,343	54,119	26,839	22,224	7,942	3,056	803	255,153
Non-psychiatrist specialists	1,947	2,421	1,772	1,103	460	134	73	38	7,947
Psychiatrists	10,164	10,622	8,065	3,417	3,211	874	375	47	36,775
Subtotal	*87,938*	*77,386*	*63,956*	*31,359*	*25,894*	*8,950*	*3,504*	*888*	*299,876*
Psychostimulants, agents used for ADHD and nootropics (N06B)									
General practitioners	179	72	334	172	89	22	14	8	891
Non-psychiatrist specialists	1,179	689	389	462	155	128	32	17	3,052
Psychiatrists	285	143	119	516	95	23	30	1	1,213
Subtotal	*1,644*	*904*	*842*	*1,150*	*340*	*173*	*77*	*26*	*5,156*
Other medications prescribed by psychiatrists[c]									
Psychiatrists	3,691	3,892	2,799	910	912	187	139	37	12,567
Total expenditure									
Expenditure in current prices ($'000)	**207,769**	**187,128**	**129,111**	**60,339**	**58,483**	**16,935**	**8,211**	**2,435**	**670,411**
Per capita ($)[d]	30.31	36.23	31.25	29.00	37.12	34.44	24.41	11.45	32.15
Total cost of Clozapine (Government cost plus patient contribution)									
Clozapine ($'000)[e]	11,100	11,148	6,544	2,764	2,509	779	424	202	35,470

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

(b) Any apparent discrepancies in totals are due to rounding to nearest $'000.

(c) Includes other N codes as well as other ATC medication as presented in Table 14.8. Data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(d) Total expenditure excludes Clozapine. Crude rate based on the Australian estimated resident population at 31 December 2006.

(e) Clozapine is a Section 100, atypical antipsychotic. Total cost equals Government cost plus patient contribution. A component of this usage data may relate to drugs distributed in earlier claim periods for which details were submitted late.

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

PBS/RPBS expenditure for medications prescribed by psychiatrists accounted for $133 million in 2006–07. About 97.0% ($129 million) of this was for medications pertaining to the central nervous system (including antipsychotics, anxiolytics, hypnotics and sedatives, antidepressants and psychostimulants), while the remainder (3.0%, or $4 million) was for other medications (Table 14.10).

Table 14.10: Australian Government expenditure ($'000) on medications prescribed by psychiatrists subsidised under the PBS/RPBS, by type of medication prescribed,[(a)] states and territories, 2006–07

ATC code		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
N	**Central nervous system**									
N05A	Antipsychotics	27,665	24,067	13,960	4,461	7,560	1,394	1,508	198	80,814
N05B	Anxiolytics	266	444	249	66	109	32	8	2	1,177
N05C	Hypnotics and sedatives	60	61	68	28	36	5	5	0	264
N06A	Antidepressants	10,164	10,622	8,065	3,417	3,211	874	375	47	36,776
N06B	Psychostimulants, agents for ADHD and nootropics	285	143	119	516	95	23	30	1	1,213
	Subtotal	*38,440*	*35,337*	*22,462*	*8,488*	*11,011*	*2,328*	*1,927*	*249*	*120,244*
	Other N Code	2,444	2,880	1,807	591	608	121	83	26	8,559
Total N Code		**40,884**	**38,217**	**24,269**	**9,079**	**11,619**	**2,449**	**2,010**	**275**	**128,803**
Other Codes										
A	Alimentary tract and metabolism	296	259	238	68	69	21	11	2	963
B	Blood and blood-forming organs	20	23	26	10	11	2	1	1	95
C	Cardiovascular system	438	328	319	105	108	23	20	5	1,347
D	Dermatologicals	8	5	6	4	1	0	0	0	25
G	Genitourinary system and sex hormones	160	104	186	50	36	4	7	1	548
H	Systemic hormonal preparations, excluding sex hormones	21	21	22	8	9	2	0	0	84
J	General anti-infectives for systematic use	48	54	52	16	14	2	6	1	192
L	Antineoplastic and immunomodulating agents	70	30	20	9	16	0	1	0	147
M	Musculoskeletal system	60	80	48	15	12	5	3	1	226
P	Antiparasitic products	0	0	0	0	0	0	0	0	0
R	Respiratory system	102	86	62	27	24	5	5	1	312
S	Sensory organs	13	12	8	4	3	0	0	0	42
	Other[(b)]	10	9	6	3	1	0	0	0	29
	Subtotal	*1,247*	*1,012*	*993*	*320*	*305*	*65*	*56*	*11*	*4,009*
Total expenditure ($'000)		**42,132**	**39,229**	**25,261**	**9,399**	**11,924**	**2,514**	**2,065**	**286**	**132,812**
Per capita ($)[(c)]		6.15	7.59	6.11	4.52	7.57	5.11	6.14	1.35	6.37

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

(b) Other refers to extemporaneously prepared items and/or PBS items with no ATC equivalent.

(c) Crude rate based on the Australian estimated resident population at 31 December 2006.

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

Table 14.11: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[a] and type of medical practitioner, 2002–03 to 2006–07

ATC group (code)	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Antipsychotics (N05A)						
General practitioners	140,041	154,954	170,418	194,903	213,505	11.1
Non-psychiatrist specialists	13,272	16,777	20,057	27,670	31,835	24.4
Psychiatrists	54,313	57,327	65,483	75,987	80,813	10.4
Subtotal	*207,626*	*229,058*	*255,958*	*298,559*	*326,153*	*12.0*
Anxiolytics (N05B)						
General practitioners	15,199	15,296	14,845	14,329	14,507	–1.2
Non-psychiatrist specialists	328	333	335	342	348	1.5
Psychiatrists	1,248	1,229	1,205	1,167	1,177	–1.4
Subtotal	*16,775*	*16,858*	*16,385*	*15,838*	*16,031*	*–1.1*
Hypnotics and sedatives (N05C)						
General practitioners	12,430	12,000	11,185	10,353	10,065	–5.1
Non-psychiatrist specialists	348	347	322	305	299	–3.8
Psychiatrists	308	311	290	269	264	–3.7
Subtotal	*13,086*	*12,658*	*11,797*	*10,927*	*10,628*	*–5.1*
Antidepressants (N06A)						
General practitioners	253,546	279,733	285,731	255,732	255,153	0.2
Non-psychiatrist specialists	7,859	8,922	8,826	8,123	7,947	0.3
Psychiatrists	40,046	42,081	41,559	38,052	36,775	–2.1
Subtotal	*301,451*	*330,736*	*336,116*	*301,907*	*299,876*	*–0.1*
Psychostimulants, agents used for ADHD and nootropics (N06B)						
General practitioners	621	611	639	735	891	9.4
Non-psychiatrist specialists	2,173	2,057	1,886	2,268	3,052	8.9
Psychiatrists	1,248	1,354	1,308	1,208	1,213	–0.7
Subtotal	*4,042*	*4,022*	*3,833*	*4,211*	*5,156*	*6.3*
Other[b]						
Psychiatrists	11,600	12,553	13,131	12,977	12,567	2.0
Total expenditure in current prices ($'000)[c]	**554,579**	**605,885**	**637,219**	**644,420**	**670,411**	**4.9**
Total expenditure in constant prices ($'000)[c]	557,068	608,094	638,557	644,420	668,908	4.7
Per capita (constant prices, $)[d]	**28.17**	**30.37**	**31.51**	**31.35**	**32.08**	**3.3**
			Clozapine			
Clozapine ($'000)[e]	26,276	28,663	30,091	33,462	35,470	7.8

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

(b) Includes other N codes as well as other ATC medication, as presented in Table 14.8. Data for other ATC groups prescribed by GPs and non-psychiatrist specialists 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 2005–06 and are adjusted for inflation.

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

(e) Clozapine is a Section 100, atypical antipsychotic. Total cost equals Government cost plus patient contribution. A component of these data may relate to drugs distributed in earlier claim periods for which details were submitted late.

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

Overall, expenditure on medications prescribed by psychiatrists under the PBS/RPBS averaged $6.37 per capita in 2006–07. The average benefits paid per capita for mental health 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.

Real growth in expenditure (constant prices) averaged 4.7% per year between 2002–03 and 2006–07 (Table 14.11). Per capita, this represents an average growth rate of 3.3% per year over the period. These rises can be largely attributed to the increase in expenditure on antipsychotics, which has seen an average annual rate of change of 12.0% over 2002–03 to 2006–07.

Expenditure on antidepressants saw an initial increase of 11.3% over the 2002–03 to 2004–05 period, followed by a marked decline of 9.0% in 2005–06. The number of antidepressant prescriptions decreased by 3.5% in 2005–06 (see Chapter 11, Table 11.4). Their levels in 2006–07 remained similar to previous years.

Expenditure on psychostimulants had an average annual rate of change of 6.3% over the past five years, though the values remain relatively small ($5.2 million in 2006–07), while expenditure on prescriptions for hypnotics and sedatives, anxiolytics and other medications remained stable.

For the first time in this report, data have been included on the cost of Clozapine, an atypical antipsychotic, which is a highly specialised drug provided under *Section 100* of the *National Health Act 1953*. Due to the nature of reporting Section 100 medications, the values in Tables 14.7 and 14.9 reflect government cost plus patient contributions, so they are therefore not directly comparable with the PBS-listed medications.

The expenditure on Clozapine has been increasing steadily over the 2002–03 to 2006–07 period, from $26.3 to $35.5 million, respectively, with an average annual rate of change of 7.8%.

14.6 Australian Government expenditure

Expenditure on Medicare-subsidised mental health services and medications provided through the PBS, described in the preceding sections, accounted for 74% of the total $1,474 million spending on mental health by the Australian Government in 2005–06. In addition to the MBS and PBS outlays, the Australian Government provided funding for mental health services and programs through a number of channels. These included:

- Australian Health Care Agreements (AHCA). AHCA mental health funding provided to states and territories by the Australian Government is to assist with ongoing service reform. Mental health grants provided to states and territories through the AHCAs in 2005–06 accounted for approximately $69 million (see Table 14.3).
- Other National Mental Health Strategy. In addition to providing mental health specific grants to states and territories under the AHCAs, the Australian Government funds a range of national activities and projects that aim to facilitate service reform.
- Department of Veterans' Affairs. Funding is provided through DVA to meet the mental health care needs of veterans and their families.

Table 14.12 details Australian Government mental health-related expenditure over the past five years. During this time, the total expenditure has seen an average annual increase of 6.2%. The reported expenditure does not include contributions to running of state and territory hospital-based psychiatric units provided through the non specific 'base grants' of

the AHCAs (see Table 14.3) and that 2005–06 data precedes the introduction of the Medicare-subsidised *Better Access* initiative described in Section 14.4 and Chapter 9.

Table 14.12: Australian Government expenditure ($'000) on mental health-related services, 2001–02 to 2005–06

	2001–02	2002–03	2003–04	2004–05	2005–06	Average annual change (per cent)
PBS – Psychiatric drugs	497,759	543,995	594,428	625,992	637,503	6.4
MBS – General Practitioners	167,272	168,740	173,556	201,021	232,739	8.6
MBS – Consultant Psychiatrist services	196,928	197,663	201,604	214,356	220,879	2.9
National Mental Health Strategy[(a)]	94,172	94,829	92,635	108,951	140,981	10.6
Department of Veterans' Affairs	126,793	129,420	126,069	123,715	125,505	–3.0
Private Hospital Insurance Premium Rebates	44,618	46,791	49,007	58,698	63,920	9.4
Research	14,543	18,511	19,439	27,289	35,200	24.7
National Suicide Prevention Strategy	9,809	10,106	9,846	12,080	8,648	–1.3
Other	9,207	8,208	8,742	8,782	9,243	0.1
Total Expenditure in current prices ($'000)[(b)]	**1,161,101**	**1,218,263**	**1,275,325**	**1,380,883**	**1,474,618**	**6.2**
Total Expenditure in constant prices ($'000)	1,341,802	1,365,655	1,388,010	1,445,784	1,474,618	2.4
Per capita ($)[(c)]	68.68	69.05	69.33	71.34	71.73	1.1

(a) Includes specific grants to states and territories.

(b) Constant prices are referenced to 2005–06 and are adjusted for inflation.

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

Source: Department of Health and Ageing 2007.

14.7 Sources of funding for specialised mental health services

The Department of Health and Ageing (DoHA) *National Mental Health Report* provides 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 2008b).

Using this definition of mental health services, the 2007 report estimates that recurrent expenditure on mental health services in 2004–05 was $3,920 million. Of this total, 60.6% came from state and territory governments, 35.2% from the Australian government and 4.2% from private health funds (Table 14.13).

Over the period 1997–98 to 2005–06, total expenditure on mental health by state and territory governments increased on average by 6.7% per year to $2.65 billion, with funding by the Australian Government increasing on average by 7.4% per year to $1.48 billion.

Table 14.13: Expenditure ($ million) on public sector specialised mental health services[(a)], by source of funding, 1997–98 to 2005–06

Source of funding[(c)]	1997–98	2002–03	2004–05	2005–06	Average annual change (per cent)
State and territory governments	1,574	1,976	2,376	2,650	6.7
Australian Government	835	1208	1,381	1,475	7.4
Private health funds	139	148	163	n.a.	. .
Total	**2,548**	**3,332**	**3,920**	**n.a.**	**. .**

(a) Some mental health services (for example, mental health services in aged care facilities) are not included.

(b) Some sources of funding are not included, for example private out-of-pocket funds.

Source: Department of Health and Ageing 2007.

15 State and territory 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 2, 6 and 11).
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	Mental Health Establishments Database (Chapters 12 and 14).
xi	Private Health Establishments Collection (Chapter 12 and 14).
xii	AIHW Medical Labour Force Survey (Chapter 13).
xiii	AIHW Nursing and Midwifery 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, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	3,375,000	3,158,925*	3,061,082*	3,576,947	3,431,919	3,461,510
95% lower confidence limit	3,059,000	2,920,602*	2,851,222*	3,252,254	3,184,730	3,199,179
95% upper confidence limit	3,691,000	3,397,256*	3,270,956*	3,901,674	3,679,130	3,723,878
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	48,223	53,360	n.a.
Community mental health care service contacts[(iii)]	942,307	1,301,233	1,431,729	1,363,770	1,832,177	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	31,677	32,579	32,026	32,950	34,030	n.a.
With specialised psychiatric care	25,528	26,473	26,752	28,093	29,151	n.a.
Public hospitals	8,749	8,893	8,310	7,155	7,060	n.a.
Private hospitals	16,779	17,580	18,442	20,938	22,091	n.a.
Without specialised psychiatric care	6,149	6,106	5,274	4,857	4,879	n.a.
Public hospitals	3,707	3,782	3,830	4,617	4,604	n.a.
Private hospitals	2,442	2,324	1,444	240	275	n.a.
Medicare-subsidised psychiatrist services[(v)]	693,192	666,357	637,448	627,107	615,006	608,203
Mental health-related hospital separations[(iv)]	59,631	60,703	62,864	63,664	67,773	n.a.
With specialised psychiatric care	34,529	34,948	36,070	36,517	38,413	n.a.
Public hospitals	26,938	27,815	29,103	28,462	29,983	n.a.
Private hospitals	7,591	7,133	6,967	8,055	8,430	n.a.
Without specialised psychiatric care	25,102	25,755	26,794	27,147	29,360	n.a.
Public hospitals	22,373	23,165	24,305	25,995	28,097	n.a.
Private hospitals	2,729	2,590	2,489	1,152	1,263	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	388	436	n.a.
SAAP mental health-related closed support periods[(vii)]	3,377	3,001	3,276	3,569	4,757	n.a.
Accommodated	2,798	2,443	2,521	2,646	3,514	n.a.
Supported	579	558	755	923	1,243	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	6,217	6,495*	6,834	n.a.
Residential care	n.a.	n.a.	1,072	1,142	1,218	n.a.
Non-residential care	n.a.	n.a.	5,993	6,175*	6,432	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.2: Mental health-related prescriptions, New South Wales, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	582,034	599,089	605,458	603,368	580,917	581,299
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	5,302,678	5,392,792	5,621,316	5,759,600	5,628,722	5,660,828

(ix) See page 167 for data source.

Table 15.3: Mental health facilities, New South Wales, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	9	9	10	10	8
Average available beds	1,075	1,166	1,237	1,161	1,072
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	34	42	44	42	46
Average available beds	n.a.	810	911	895	1,151
Private psychiatric hospitals[b][xi]					
Number of hospitals	8	9	9	9	9
Average available beds	444	531	316	494	512
Government-operated residential mental health services[x]					
Number of services[c]	9	6	7	5	19
Average available beds	161	138	137	138	296

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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.

(x-xi) See page 167 for data sources.

Table 15.4: Workforce: psychiatrists and mental health nurses, New South Wales, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	973	922	1,094	1,063	1,129	1,144
Full-time-equivalent employed mental health nurses[xiii]	n.a.	4,257	n.a.	4,846	4,336	4,293

n.a. Not available.

(xii–xiii) See page 167 for data sources.

Table 15.5: Recurrent mental health expenditure for public sector mental health services ($'000), New South Wales, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	189,480	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	271,282	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	309,866	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	24,866	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	53,504	58,519	57,518	56,228	28,099	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	65,674	64,809	64,937	69,831	70,604	74,180
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	23,546	n.a.
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	16,619	n.a.
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	32,720	35,135	36,939	38,685	40,036	42,132
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	121,343	133,912	147,926	154,736	155,988	165,637

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

15.2 Victoria

Table 15.6: Mental health services, Victoria, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	2,714,000	2,825,914*	2,665,939*	2,823,060	3,242,467	2,756,515
95% lower confidence limit	2,429,000	2,477,470*	2,426,857*	2,543,588	2,813,312	2,511,151
95% upper confidence limit	2,999,000	3,174,347*	2,905,008*	3,102,549	3,671,599	3,001,882
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	28,757	31,329	n.a.
Community mental health care service contacts[(iii)]	1,645,974	1,610,674	1,599,800	1,778,559	1,833,205	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	29,289	38,985	41,250	43,165	42,855	n.a.
With specialised psychiatric care	22,440	31,483	32,568	33,525	33,437	n.a.
Public hospitals	1,068	1,099	624	729	237	n.a.
Private hospitals	21,372	30,384	31,944	32,796	33,200	n.a.
Without specialised psychiatric care	6,849	7,502	8,682	9,640	9,418	n.a.
Public hospitals	5,050	5,129	5,758	5,593	5,721	n.a.
Private hospitals	1,799	2,373	2,924	4,047	3,697	n.a.
Medicare-subsidised psychiatrist services[(v)]	673,637	667,309	658,145	650,089	663,942	656,061
Mental health-related hospital separations[(iv)]	45,177	47,913	48,558	49,227	50,980	n.a.
With specialised psychiatric care	23,377	24,341	25,097	24,858	25,696	n.a.
Public hospitals	17,776	17,712	18,192	17,356	17,230	n.a.
Private hospitals	5,601	6,629	6,905	7,502	8,466	n.a.
Without specialised psychiatric care	21,800	23,572	23,461	24,369	25,284	n.a.
Public hospitals	19,048	20,045	20,486	21,968	22,801	n.a.
Private hospitals	2,752	3,527	2,975	2,401	2,483	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	728	791	n.a.
SAAP mental health-related closed support periods[(vii)]	3,491	4,019	5,071	4,579	8,877	n.a.
Accommodated	1,514	1,689	1,872	2,188	3,125	n.a.
Supported	1,977	2,330	3,199	2,391	5,752	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	16,556*	18,798*	20,784	n.a.
Residential care	n.a.	n.a.	983	948*	963	n.a.
Non-residential care	n.a.	n.a.	8,396	18,631*	20,619	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.7: Mental health-related prescriptions, Victoria, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	532,700	547,564	560,968	578,440	567,175	562,219
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	4,402,151	4,496,990	4,713,821	4,891,159	4,843,466	4,817,164

(ix) See page 167 for data source.

Table 15.8: Mental health facilities, Victoria, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	2
Average available beds	95	95	115	115	116
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	32	37	31	31	34
Average available beds	879	870	916	899	1,045
Private psychiatric hospitals[b][xi]					
Number of hospitals	6	6	6	6	6
Average available beds	359	358	378	423	437
Government-operated residential mental health services[d][x]					
Number of services[c]	31	31	31	30	47
Average available beds	883	893	891	907	962

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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 Mental Health Establishments Database (NMHED) 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 NMHED that are not in scope for the NRMHCD.

n.a. Not available.

(x–xi) See page 167 for data sources.

Table 15.9: Workforce: psychiatrists and mental health nurses, Victoria, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	902	991	1,047	1,049	1,076	1,028
Full-time-equivalent employed mental health nurses[xiii]	n.a.	3,475	n.a.	3,660*	3,955	3,706

n.a. Not available.

* indicates where previously published data have been revised.

(xii–xiii) See page 167 for data sources.

Table 15.10: Recurrent mental health expenditure for public sector mental health services ($'000), Victoria, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	32,119	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	191,759	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	268,841	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	121,569	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	38,695	43,779	47,031	49,105	52,379	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	64,733	65,487	66,869	71,070	74,280	77,739
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	19,548
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	17,431
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	29,133	31,457	32,942	35,920	38,002	39,229
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	107,227	118,646	131,571	138,331	141,085	147,899

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

15.3 Queensland

Table 15.11: Mental health services, Queensland, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	1,807,000	1,641,617*	1,950,654*	2,002,270	2,148,140	2,093,580
95% lower confidence limit	1,598,000	1,499,723*	1,695,439*	1,807,137	1,870,799	1,896,617
95% upper confidence limit	2,016,000	1,783,502*	2,205,860*	2,197,415	2,425,495	2,290,551
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	21,393	24,306	n.a.
Community mental health care service contacts[(iii)]	705,895	779,527	889,011	901,706	892,393	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	23,593	23,386	23,813	24,810	25,365	n.a.
With specialised psychiatric care	19,135	19,256	19,233	19,743	19,954	n.a.
Public hospitals	3,571	3,405	3,930	3,924	1,324	n.a.
Private hospitals	15,564	15,851	15,303	15,819	18,630	n.a.
Without specialised psychiatric care	4,458	4,130	4,580	5,067	5,411	n.a.
Public hospitals	1,135	1,173	1,345	1,499	2,179	n.a.
Private hospitals	3,323	2,957	3,235	3,568	3,232	n.a.
Medicare-subsidised psychiatrist services[(v)]	349,352	344,217	344,548	352,380	365,911	357,166
Mental health-related hospital separations[(iv)]	36,687	36,310	37,503	38,405	38,462	n.a.
With specialised psychiatric care	24,915	25,597	26,922	27,322	26,445	n.a.
Public hospitals	18,787	19,618	20,384	20,851	19,877	n.a.
Private hospitals	6,128	5,979	6,538	6,471	6,568	n.a.
Without specialised psychiatric care	11,772	10,713	10,581	11,083	12,017	n.a.
Public hospitals	8,596	8,024	8,083	8,422	9,221	n.a.
Private hospitals	3,176	2,689	2,498	2,661	2,796	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	. .	. .	. .
SAAP mental health-related closed support periods[(vii)]	1,554	1,251	1,238	1,680	2,263	n.a.
Accommodated	1,331	991	910	1,326	1,838	n.a.
Supported	223	260	328	354	425	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	4,752	5,204	5,631	n.a.
Residential care	n.a.	n.a.	203	166	183	n.a.
Non-residential care	n.a.	n.a.	4,711	5,157	5,570	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

. . Not applicable.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.12: Mental health-related prescriptions, Queensland, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	329,959	338,085	356,732	377,935	383,635	395,146
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	3,420,918	3,551,955	3,761,071	3,968,779	3,822,079	3,828,660

(ix) See page 167 for data source.

Table 15.13: Mental health facilities, Queensland, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	6	4	4	4	3
Average available beds	504	503	476	476	375
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	18	18	18	18	27
Average available beds	795	887	904	908	1,014
Private psychiatric hospitals[b][xi]					
Number of hospitals	4	4	4	4	4
Average available beds	288	290	288	289	278
Government-operated residential mental health services[x]					
Number of services[c]	0	0	0	0	0
Average available beds	0	0	0	0	0

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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–xi) See page 167 for data sources.

Table 15.14: Workforce: psychiatrists and mental health nurses, Queensland, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	457	437	434	463	474	541
Full-time-equivalent employed mental health nurses[xiii]	n.a.	1,831	n.a.	2,254	2,369	2,256

n.a. Not available.

(xii–xiii) See page 167 for data sources.

Table 15.15: Recurrent mental health expenditure for public sector mental health services ($'000), Queensland, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	67,303	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	174,879	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	160,355	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	. .	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	25,596	28,931	30,231	30,359	31,972	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	30,807	30,886	31,830	34,632	36,695	38,072
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	11,556
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	8,150
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	17,250	18,172	19,842	22,036	23,579	25,261
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	79,299	87,228	96,150	102,103	99,493	103,850

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 167 for data sources.

15.4 Western Australia

Table 15.16: Mental health services, Western Australia, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	919,000	747,376*	964,322*	905,815	843,099	977,016
95% lower confidence limit	759,000	671,206*	830,455*	771,124	723,024	859,898
95% upper confidence limit	1,080,000	823,540*	1,098,185*	1,040,505	963,177	1,094,130
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	10,114	11,279	n.a.
Community mental health care service contacts[(iii)]	395,513	414,183	418,484	466,670	492,468	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	8,529	7,791	7,437	8,972	8,644	n.a.
With specialised psychiatric care	7,504	6,749	5,659	7,230	6,921	n.a.
Public hospitals	416	194	121	100	70	n.a.
Private hospitals	7,088	6,555	5,538	7,130	6,851	n.a.
Without specialised psychiatric care	1025	1,042	1,778	1,742	1,723	n.a.
Public hospitals	849	892	862	959	1,177	n.a.
Private hospitals	176	150	916	783	546	n.a.
Medicare-subsidised psychiatrist services[(v)]	115,039	111,539	121,962	121,072	119,611	119,454
Mental health-related hospital separations[(iv)]	19,012	19,125	20,107	20,540	19,603	n.a.
With specialised psychiatric care	11,802	11,547	11,901	11,731	11,599	n.a.
Public hospitals	8,938	8,561	8,525	8,404	8,120	n.a.
Private hospitals	2,864	2,986	3,376	3,327	3,479	n.a.
Without specialised psychiatric care	7,210	7,578	8,206	8,809	8,004	n.a.
Public hospitals	6,149	6,621	6,299	6,349	6,631	n.a.
Private hospitals	1,061	957	1,907	2,460	1,373	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	203	177	n.a.
SAAP mental health-related closed support periods[(vii)]	1,242	809	590	601	815	n.a.
Accommodated	1,061	660	468	424	597	n.a.
Supported	181	149	122	177	218	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	1,936	1,711	1,704	n.a.
Residential care	n.a.	n.a.	186	208	20	n.a.
Non-residential care	n.a.	n.a.	1,915	1,675	1,698	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.17: Mental health-related prescriptions, Western Australia, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	147,528	155,695	170,534	174,534	164,526	170,455
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,661,063	1,715,581	1,808,835	1,860,899	1,802,423	1,816,034

(ix) See page 167 for data source.

Table 15.18: Mental health facilities, Western Australia, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	1
Average available beds	209	201	203	205	245
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	11	16	16	16	11
Average available beds	391	391	393	414	403
Private psychiatric hospitals[b][xi]					
Number of hospitals	3	3	n.p.	n.p.	n.p.
Average available beds	149	155	n.p.	n.p.	n.p.
Government-operated residential mental health services[x]					
Number of services[c]	2	3	2	2	2
Average available beds	22	22	21	21	18

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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.p. Not published.

(x–xi) See page 167 for data sources.

Table 15.19: Workforce: psychiatrists and mental health nurses, Western Australia, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	308	274	233	271	247	223
Full-time-equivalent employed mental health nurses[xiii]	n.a.	950	n.a.	916	1,175*	996

n.a. Not available.

* indicates where previously published data have been revised.

(xii–xiii) See page 167 for data sources.

Table 15.20: Recurrent mental health expenditure for public sector mental health services ($'000), Western Australia, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	61,716	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	91,670	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	143,853	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	5,148	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	11,809	13,863	n.p.	n.p.	n.p	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	9,976	9,759	11,077	11,972	12,177	12,953
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	9,445
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	5,263
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	7,230	7,664	8,385	9,032	9,117	9,399
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	38,410	42,783	47,802	49,685	48,197	50,940

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

15.5 South Australia

Table 15.21: Mental health services, South Australia, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	948,000	933,310*	1,003,211*	899,267	871,919	983,515
95% lower confidence limit	788,000	743,684*	873,798*	718,860	737,541	847,235
95% upper confidence limit	1,108,000	1,122,933*	1,132,616*	1,079,670	1,006,303	1,119,794
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	15,426	12,996	n.a.
Community mental health care service contacts[(iii)]	280,056	314,085	311,535	298,459	302,400	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	1,656	2,409	1,749	1,389	1,232	n.a.
With specialised psychiatric care	788	1,443	689	294	216	n.a.
Public hospitals	646	242	268	263	197	n.a.
Private hospitals	142	1,201	421	31	19	n.a.
Without specialised psychiatric care	868	966	1,060	1,095	1,016	n.a.
Public hospitals	854	942	1,048	1,085	1,003	n.a.
Private hospitals	14	24	12	10	13	n.a.
Medicare-subsidised psychiatrist services[(v)]	201,371	202,988	192,073	182,959	180,380	177,437
Mental health-related hospital separations[(iv)]	18,041	19,388	19,716	18,332	18,041	n.a.
With specialised psychiatric care	10,317	10,617	10,945	10,180	10,318	n.a.
Public hospitals	7,939	8,393	8,985	8,481	8,565	n.a.
Private hospitals	2,378	2,224	1,960	1,699	1,753	n.a.
Without specialised psychiatric care	7,724	8,771	8,771	8,152	7,723	n.a.
Public hospitals	6,926	7,958	7,949	7,438	7,063	n.a.
Private hospitals	798	813	822	714	660	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	91	140	n.a.
SAAP mental health-related closed support periods[(vii)]	762	649	830	934	1,740	n.a.
Accommodated	520	413	445	449	652	n.a.
Supported	242	236	385	485	1,088	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	2,095	2,143	2,004	n.a.
Residential care	n.a.	n.a.	271	317	335	n.a.
Non-residential care	n.a.	n.a.	2,000	2,027	1,927	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.22: Mental health-related prescriptions, South Australia, 2000–01 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	184,085	187,667	185,330	179,028	174,412	172,065
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,574,003	1,620,414	1,685,643	1,719,197	1,698,048	1,675,141

(ix) See page 167 for data source.

Table 15.23: Mental health facilities, South Australia, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	1	1	1	1	1
Average available beds	486	478	461	461	455
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	8	8	8	8	8
Average available beds	176	172	172	172	188
Private psychiatric hospitals[b][xi]					
Number of hospitals	n.p.	n.p.	n.p.	n.p.	n.p.
Average available beds	n.p.	n.p.	n.p.	n.p.	n.p.
Government-operated residential mental health services[x]					
Number of services[c]	1	1	2	1	3
Average available beds	20	20	27	20	33

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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.

n.p. Not published.

(x–xi) See page 167 for data sources.

Table 15.24: Workforce: psychiatrists and mental health nurses, South Australia, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	311	318	302	319	335	313
Full-time-equivalent employed mental health nurses[xiii]	n.a.	1,115	n.a.	1,098	1,072	1,116

n.a. Not available.

(xii–xiii) See page 167 for data source.

Table 15.25: Recurrent mental health expenditure for public sector mental health services ($'000), South Australia, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	83,058	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	36,604	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	77,692	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	2,714	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	45,124	52,634	55,903	64,867	n.p	n.a
Medicare expenditure on services provided by psychiatrists[(v)]	19,604	20,218	19,901	19,636	19,982	20,892
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	9,610
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	2,356
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	10,062	10,321	10,544	10,749	11,346	11,924
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	36,755	39,811	42,887	44,324	44,819	46,559

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

15.6 Tasmania

Table 15.26: Mental health services, Tasmania, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	246,000	253,520*	332,791*	307,156	243,229	281,930
95% lower confidence limit	153,000	213,041*	248,072*	237,845	194,003	234,692
95% upper confidence limit	340,000	294,000*	417,509*	376,467	292,457	329,166
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	4,539	4,517	n.a.
Community mental health care service contacts[(iii)]	48,286	51,314	67,581	64,317	65,576	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	76	75	65	56	46	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	184	176	233	285	370	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	43,387	46,653	48,115	46,190	44,316	42,965
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	3,267	3,104	2,979	3,192	3,175	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	1,009	1,315	1,351	1,303	1,364	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.	721	741	n.a.
SAAP mental health-related closed support periods[(vii)]	343	279	317	321	611	n.a.
Accommodated	202	165	160	158	317	n.a.
Supported	141	114	157	163	294	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	764	839	846	n.a.
Residential care	n.a.	n.a.	183	193	184	n.a.
Non-residential care	n.a.	n.a.	707	775	797	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

n.p. Not published.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.27: Mental health-related prescriptions, Tasmania, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	43,484	45,126	47,361	43,356	42,265	40,420
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	560,909	576,194	604,037	618,098	626,298	614,622

(ix) See page 167 for data sources.

Table 15.28: Mental health facilities, Tasmania, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	3	3	3	3	0
Average available beds	40	80	69	69	0
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	3	3	3	3	6
Average available beds	74	74	86	86	125
Private psychiatric hospitals[b][xi]					
Number of hospitals	n.p.	n.p.	n.p.	n.p.	n.p.
Average available beds	n.p.	n.p.	n.p.	n.p.	n.p.
Government-operated residential mental health services[x]					
Number of services[c]	9	9	9	7	5
Average available beds	140	140	140	112	91

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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.

n.p. Not published.

(x–xi) See page 167 for data sources.

Table 15.29: Workforce: psychiatrists and mental health nurses, Tasmania, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	49	57	63	71	68	63
Full-time-equivalent employed mental health nurses[xiii]	n.a.	282	n.a.	320	295	339

n.a. Not available.

(xii–xiii) See page 167 for data sources.

Table 15.30: Recurrent mental health expenditure for public sector mental health services ($'000), Tasmania, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	0	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	21,188	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	23,458	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	15,890	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	n.a.	n.a.	n.a.	n.a.	n.p.	n.a
Medicare expenditure on services provided by psychiatrists[(v)]	3,615	3,974	4,209	4,122	3,999	4,097
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	1,366
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	1,265
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	1,846	2,018	2,148	2,191	2,549	2,514
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	11,090	12,005	13,354	13,821	13,952	14,421

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

15.7 Australian Capital Territory

Table 15.31: Mental health services, Australian Capital Territory, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	127,000	143,804*	87,966*	120,213	103,178	118,128
95% lower confidence limit	76,000	104,792*	63,242*	79,767	64,199	82,991
95% upper confidence limit	177,000	182,815*	112,690*	160,660	142,156	153,266
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	2,248	2,737	n.a.
Community mental health care service contacts[(iii)]	156,108	178,751	167,541	198,666	210,833	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	53	30	4	32	33	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	38	40	102	113	183	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	19,595	21,305	21,454	22,534	22,301	20,877
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	1,376	1,314	1,136	1,139	1,178	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	178	222	341	307	335	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.	63	60	n.a.
SAAP mental health-related closed support periods[(vii)]	470	531	523	408	582	n.a.
Accommodated	431	490	481	349	426	n.a.
Supported	39	41	42	59	156	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	348	369	320	n.a.
Residential care	n.a.	n.a.	34	19	34	n.a.
Non-residential care	n.a.	n.a.	340	365	317	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

n.p. Not published.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.32: Mental health-related prescriptions, Australian Capital Territory, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	23,880	30,492	27,815	27,327	27,059	25,501
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	226,314	258,968	246,843	249,254	221,828	209,631

(ix) See page 167 for data source.

Table 15.33: Mental health facilities, Australian Capital Territory, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	2	2	2	2	2
Average available beds	47	45	45	44	50
Private psychiatric hospitals[b][xi]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Government-operated residential mental health services[x]					
Number of services[c]	1	1	1	1	1
Average available beds	23	30	28	28	30

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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–xi) See page 167 for data sources.

Table 15.34: Workforce: psychiatrists and mental health nurses, Australian Capital Territory, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	56	45	56	50	44	63
Full-time-equivalent employed mental health nurses[xiii]	n.a.	212	n.a.	167	166	215

n.a. Not available.

(xii–xiii) See page 167 for data sources.

Table 15.35: Recurrent mental health expenditure for public sector mental health services ($'000), Australian Capital Territory, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	8,885	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	23,780	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	6,165	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	. .	. .	. .	. .	. .	n.a
Medicare expenditure on services provided by psychiatrists[(v)]	1,726	1,989	2,072	2,429	2,503	2,435
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	858
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	724
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	1,566	1,864	1,690	1,775	2,038	2,065
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	5,870	6,959	6,851	6,710	6,091	6,146

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 167 for data sources.

15.8 Northern Territory

Table 15.36: Mental health services, Northern Territory, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	50,000	60,364*	38,128*	39,302	55,625	44,957
95% lower confidence limit	29,000	36,689*	17,097*	26,406	25,235	24,320
95% upper confidence limit	71,000	84,039*	59,158*	52,198	86,015	65,594
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	2,703	3,482	n.a.
Community mental health care service contacts[(iii)]	29,592	22,656	26,054	36,377	36,356	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	41	28	27	25	27	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	61	88	71	97	142	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	4,553	4,722	4,722	4,887	4,474	4,370
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	747	826	926	1,174	1,146	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	263	312	321	329	453	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.
SAAP mental health-related closed support periods[(vii)]	187	215	179	135	747	n.a.
Accommodated	119	166	146	94	600	n.a.
Supported	68	49	33	41	147	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	145	129	103	n.a.
Residential care	n.a.	n.a.	26	21	22	n.a.
Non-residential care	n.a.	n.a.	133	116	87	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

n.p. Not published.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.37: Mental health-related prescriptions, Northern Territory, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	5,013	4,881	4,972	4,841	4,179	4,079
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	58,385	59,276	62,174	67,339	66,101	63,851

(ix) See page 167 for data source.

Table 15.38: Mental health facilities, Northern Territory, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	2	2	2	2	2
Average available beds	31	32	31	32	32
Private psychiatric hospitals[b][xi]					
Number of hospitals	0	0	0	0	0
Average available beds	. .	. .	. .	. .	. .
Government-operated residential mental health services[x]					
Number of services[c]	0	0	0	0	0
Average available beds	0	0	0	0	0

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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–xi) See page 167 for data sources.

Table 15.39: Workforce: psychiatrists and mental health nurses, Northern Territory, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	32	20	29	36	20	25
Full-time-equivalent employed mental health nurses[xiii]	n.a.	93	n.a.	54	77	n.p.

n.a. Not available.

n.p. Not published.

(xii–xiii) See page 167 for data sources.

Table 15.40: Recurrent mental health expenditure for public sector mental health services ($'000), Northern Territory, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	10,327	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	12,417	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	344	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	. .	. .	. .	. .	. .	n.a
Medicare expenditure on services provided by psychiatrists[(v)]	341	371	396	413	340	387
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	269
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	128
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	272	262	274	266	262	286
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	1,450	1,595	1,724	1,898	2,009	2,149

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 167 for data sources.

15.9 Australia

Table 15.41: Mental health services, Australia, 2001–02 to 2006–07

Mental health services	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Estimated number of mental health-related general practice encounters[(a)(i)]	10,143,000	9,467,000*	9,974,000*	10,591,000	10,624,000	10,713,000
95% lower confidence limit	9,612,000	9,024000*	9,516,000*	10,067,000	10,074,000	10,261,000
95% upper confidence limit	10,674,000	9,909,000*	10,433,000*	11,117,000	11,174,000	11,165,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	n.a.	133,403	144,006	n.a.
Community mental health care service contacts[(iii)]	4,203,731	4,672,423	4,911,735	5,108,524	5,665,408	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	97,796	108,946	111,581	116,787	117,924	n.a.
With specialised psychiatric care	77,189	87,219	86,765	92,369	93,202	n.a.
Public hospitals	14,620	13,966	13,349	12,285	8,994	n.a.
Private hospitals	62,569	73,253	73,416	80,084	84,208	n.a.
Without specialised psychiatric care	20,607	21,727	24,816	24,418	24,722	n.a.
Public hospitals	11,878	12,222	13,249	14,248	15,379	n.a.
Private hospitals	8,729	9,505	11,567	10,170	9,343	n.a.
Medicare-subsidised psychiatrist services[(v)]	2,100,232*	2,065,075*	2,028,458*	2,007,218	2,015,941	1,986,533
Mental health-related hospital separations[(iv)]	187,043	192,169	197,712	199,353	204,186	n.a.
With specialised psychiatric care	110,969	113,045	116,725	116,852	118,733	n.a.
Public hospitals	85,768	87,343	90,230	89,059	89,274	n.a.
Private hospitals	25,201	25,702	26,495	27,793	29,459	n.a.
Without specialised psychiatric care	76,074	79,124	80,987	82,501	85,453	n.a.
Public hospitals	64,542	67,662	69,135	72,111	75,965	n.a.
Private hospitals	11,532	11,462	11,852	10,390	9,488	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	n.a.	2,194	2,345	n.a.
SAAP mental health-related closed support periods[(vii)]	11,426	10,754	12,024	12,227	20,392	n.a.
Accommodated	7,976	7,017	7,003	7,634	11,069	n.a.
Supported	3,450	3,737	5,021	4,593	9,323	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	n.a.	24,753	35,599*	38,086	n.a.
Residential care	n.a.	n.a.	2,958	3,014*	2,959	n.a.
Non-residential care	n.a.	n.a.	24,108	34,833*	37,309	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 Medicare services for Non-Referred (GP) Attendances (excluding Practice Nurse Items) as reported by the Department of Health and Ageing (DoHA 2007b). Note that this method of calculation differs slightly from that used to produce the equivalent table in the previous edition of this publication (AIHW 2007e). Confidence intervals have also been recalculated.

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 167 for data sources.

Table 15.42: Mental health-related prescriptions, Australia, 2001–02 to 2006–07[ix]

Mental health-related prescriptions	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
PBS and RPBS-subsidised prescriptions by psychiatrists	1,848,683	1,968,587*	1,968,587*	1,998,897*	1,956,248*	1,951,215
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	17,206,421	17,853,007*	18,676,312*	19,296,523*	18,898,197*	18,686,274

(ix) See page 167 for data source.

Table 15.43: Mental health facilities, Australia, 2001–02 to 2005–06

Mental health facilities	2001–02	2002–03	2003–04	2004–05	2005–06
Public psychiatric hospitals[a][x]					
Number of hospitals	21	19	20	20	15
Average available beds	2,409	2,523	2,560	2,487	2,263
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	110	128	124	122	136
Average available beds	n.a.	3,281	3,458	3,450	4,008
Private psychiatric hospitals[b][xi]					
Number of hospitals	24	25	25	26	26
Average available beds	1,387	1,463	1,441	1,512	1,573
Government-operated residential mental health services[d][x]					
Number of services[c]	53	50	52	46	77
Average available beds	1,249	1,241	1,246	1,226	1,430

(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. Historical data were sourced from the National Public Hospitals Establishments Database and therefore there may differ from 2005–06 data due to definitions and reporting requirements.

(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 Mental Health Establishments Database (NMHED) 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 NMHED that are not in scope for the NRMHCD.

n.a. Not available.

(x–xi) See page 167 for data sources.

Table 15.44: Workforce: psychiatrists and mental health nurses, Australia, 2000–2005

Workforce	2000	2001	2002	2003	2004	2005
Full-time-equivalent employed psychiatrists and psychiatrists in training[xii]	3,089	3,066	3,257	3,328	3,392	3,398
Full-time-equivalent employed mental health nurses[xiii]	n.a.	12,195	n.a.	13,306	13,435*	13,188

n.a. Not available.

* Indicates where previously published data have been revised.

(xii–xiii) See page 167 for data sources.

Table 15.45: Recurrent mental health expenditure for public sector mental health services ($'000), Australia, 2001–02 to 2006–07

Mental health expenditure	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Total recurrent expenditure for public psychiatric hospitals[(x)]	n.a.	n.a.	n.a.	n.a.	433,677	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(x)]	n.a.	n.a.	n.a.	n.a.	807,708	n.a.
Total recurrent expenditure for community mental health services[(x)]	n.a.	n.a.	n.a.	n.a.	1,019,450	n.a.
Total recurrent expenditure for residential mental health services[(a)(x)]	n.a.	n.a.	n.a.	n.a.	175,012	n.a.
Total recurrent expenditure for private psychiatric hospitals[(b)(xi)]	143,653	158,529	162,066	168,490	175,054	n.a
Medicare expenditure on services provided by psychiatrists[(v)]	196,465	197,492	201,290	214,106	220,579	230,755
Medicare expenditure on services provided by general practitioners[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	67,006
Medicare expenditure on services provided by psychologists[(v)]	n.a.	n.a.	n.a.	n.a.	n.a.	51,936
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	100,079	106,893	112,764	120,652	126,928	132,812
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	401,443	442,939	488,265	511,609	511,634	537,601

(a) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

(v–xi) See page 167 for data sources.

Appendix 1: Data sources

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) and the National Mental Health Establishments Database (NMHED), 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 DoHA'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 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 and Nursing and Midwifery 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 has been 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. In 2005, the estimated national response rate for the Medical Labour Force Survey was 71.3%, and it ranged from 63.0 for Tasmania to 83.8% for Queensland. Estimates for the Northern Territory should be treated with caution as they are derived from responses to the 2004 Medical labour force survey, weighted to 2005 benchmark figures. The estimated 'response rate' for Northern Territory in 2005 is 31.8%.

There has been a decline in the response rate for the Nursing and Midwifery Labour Force Survey from 77.2% in 2001 to 55.0% in 2005 (excluding Victoria due to the manner in which Victorian estimates were derived). In 2005, response rates in the Northern Territory (13.7%) and Western Australia (26.9%) were particularly low. As a result, no estimates have been published for the Northern Territory. Estimates for Western Australia have been included in this report, but should be treated with care. The national estimates are based on census results from all jurisdictions, as the impact of any bias in responses from Western Australia and the Northern Territory is likely to be relatively small at the national level. As Victoria could not provide data for 2005, estimates for that year are based on responses to the 2006 AIHW Nursing and Midwifery Labour Force Census, weighted to registration/enrolment benchmark figures for 2005.

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 2005* (AIHW 2008a) and *Nursing and midwifery labour force 2005* (AIHW 2008b).

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 2006–07 BEACH survey can be obtained from *General practice activity in Australia 2006–07* (AIHW: Britt et al. 2008).

Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (Chapter 10)

Data pertaining to the Commonwealth State/Territory Disability Agreement (CSTDA) are collected through the CSTDA National Minimum Data Set (NMDS). This NMDS, which is managed by the AIHW, enables 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 or to apportion the number of service users against the amount of funding provided (that is, if 50% of funding is from CSTDA then services are asked to report 50% of their 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 2005–06 collection period, and were released in *Disability support services 2005–06* (AIHW 2007a). For the 2005–06 collection, there was an overall service type outlet response rate of 94%.

The collection includes 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 and all service users accessing these services are identified as having a psychiatric disability.
- 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 Benefits Schedule data (Chapters 2, 6 and 14)

Medicare Australia collects data on the activity of all providers making claims through the Medicare Benefits Schedule (MBS), and provides this information to DoHA. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare Australia for the service. The item number and benefits paid by Medicare Australia are based on the *Medicare Benefits Schedule book* (DoHA 2007a). Services that are not included in the MBS are not included in the data.

The MBS items included in the 2002 *Better Outcomes in Mental Health Care,* the 2004 *Enhanced Primary Care* and 2006 *Better Access to Psychiatrists, Psychologists and GPs through the MBS initiatives*, as well as existing psychiatrist items are at Table A1.1.

Table A1.1: MBS items (2002 Better Outcomes in Mental Health Care, 2004 Enhanced Primary Care and 2006 Better Access to Psychiatrists, Psychologists and GPs)

Initiative and item group	MBS Group and Subgroup	MBS item numbers
Better Outcomes in Mental Health Care, 2002		
3 Step Mental Health Process—GPs	Group A18 Subgroup 4	2574, 2575, 2577, 2578
3 Step Mental Health Process—OMPs	Group A19 Subgroup 4	2704, 2705, 2707, 2708
Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
Case conferencing—psychiatrists		855, 857, 858, 861, 864, 866
Enhanced Primary Care, 2004		
Enhanced Primary Care—mental health workers	Group M3	10956
Enhanced Primary Care—registered psychologists	Group M3	10968
Better Access to Psychiatrists, Psychologists and GPs through the MBS, 2006		
GP Mental Health Care Plans	Group A20 Subgroup 1	2710, 2712, 2713
Psychological Therapy Services—clinical psychologists	Group M6	80000, 80005, 80010, 80015, 80020
Focussed Psychological Strategies (Allied Mental Health)	Group M7	
—registered psychologists		80100, 80105, 80110, 80115, 80120
—occupational therapists		80125, 80130, 80135, 80140, 80145
—social workers		80150, 80155, 80160, 80165, 80170
Initial consultation for a new patient—psychiatrists	Group A8	296, 297, 299
Existing psychiatrist items		
Patient attendances—consulting room	Group A8	291, 293, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319
Patient attendances—hospital	Group A8	320, 322, 324, 326, 328
Patient Attendances—other locations	Group A8	330, 332, 334, 336, 338
Group psychotherapy	Group A8	342, 344, 346
Interview with non-patient	Group A8	348, 350,352
Telepsychiatry	Group A8	353, 355, 356, 357, 358, 364, 366, 367, 369, 370
Case conferencing	Group A15 Subgroup 2	855, 857, 858, 861, 864, 866
Electroconvulsive therapy	Group T1 Subgroup 13	14224

The MBS data presented in this report relate to services provided on a fee-for-service basis for which MBS benefits were paid. The year is determined from the date the service was processed by Medicare Australia, rather than the date the service was provided. 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.

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. The AIHW compiles these episode-level data annually 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 2005–06, 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 2005–06 was 6.3 million. Episode-level data were collected by state and territory health authorities departments for 78% of these occasions of service (a total of 4.9 million occasions of service) (AIHW 2006b). Episode-level data were available for 100% of all emergency department occasions of service for public hospitals in peer groups A and B, and approximately 30% of emergency department occasions of service for other public hospitals.

Definition of mental health-related emergency department occasions of service

While there is a national data compilation of episode-level data on emergency department occasions of service (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) 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 2005–06, all jurisdictions did collect some information on the principal diagnosis of an estimated 91% 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.

Table A1.2: 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 (excluding 305.8 and 305.9)
F20–F29: Schizophrenia, schizotypal and delusional disorders	295, 297, 298 (excluding 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 (excluding 300.4, 300.19), 306 (excluding 306.3, 306.51, 306.6), 307.53, 307.80, 307.89, 308, 309 (excluding 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 (excluding 307.53), 316, 648.44
F60–F69: Disorders of adult personality and behaviour	300.19, 301 (excluding 301.1, 301.22), 302 (excluding 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 (excluding 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.

Most jurisdictions had coded the principal diagnosis of emergency department occasions of service in 2005–06 using ICD-10-AM. However, for those using ICD-9-CM, mapping of the relevant ICD-10-AM codes to ICD-9-CM codes was undertaken (Table A1.2).

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.

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.
- 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.
- 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 78% of public hospital emergency department occasions of service for public hospitals in 2005–06, and these data are mainly from the larger metropolitan hospitals (Table A1.3). Of the data available on emergency department occasions of service, it is estimated that 92% 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 72% 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 just over 200,000 rather than the reported 144,006 (Table A1.3).

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 A1.3: Emergency department occasions of service in public hospitals, estimated coverage and estimated actual number, states and territories, 2005–06

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Estimated per cent of total public hospital emergency department occasions of service with episode-level data for the following hospital groups:[(a)]									
Peer group A and B[(b)]	*100*	*100*	*99*	*100*	*100*	*99*	*100*	*100*	*100*
Other hospitals	*45*	*36*	*n.a.*	*32*	*22*	*n.a.*	*n.a.*	*100*	*30*
Total estimated per cent	**81**	**89**	**65**	**68**	**68**	**86**	**100**	**100**	**78**
Estimated per cent of occasions of service reported at episode-level that have a principal diagnosis code[(c)]	95	90	100	74	91	100	100	94	92
Estimated per cent of total emergency department occasions of service with a principal diagnosis[(d)]	77	80	65	50	62	86	100	94	72
Number of emergency department occasions of service with a mental health-related principal diagnosis[(e)]	53,360	31,329	24,306	11,279	12,996	4,517	2,737	3,482	144,006
Estimated actual number of emergency department occasions of service with a mental health-related principal diagnosis[(f)]	69,344	39,112	37,394	22,415	21,002	5,252	2,737	3,704	200,438

(a) The proportion of all occasions of service in emergency departments in public hospitals in 2005–06 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 per cent of all occasions of service in emergency departments in public hospitals in 2005–06 that are reported at episode-level to the NAPEDCD by the per cent 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 2007.

National Community Mental Health Care Database (Chapter 4)

Scope

The National Community Mental Health Care Database (NCMHCD) contains data on all ambulatory mental health service contacts provided by government-operated community mental health services as specified by the Community Mental Health Care National Minimum Data Set (CMHC NMDS). Data collated include information relating to each individual service contact provided by the relevant mental health services. Examples of data elements are demographic information of patients such as age and sex and clinical information like principal diagnosis and mental health legal status. Detailed data specifications for the CMHC NMDS can be found in METeOR, the AIHW's online metadata registry, at <www.aihw.gov.au>.

The scope for this collection is all services mentioned above that are included in the newly established Mental Health Establishments National Minimum Data Set. A list of the government-operated community mental health services that contribute 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 2005–06*).

A mental health service contact for the purposes of this collection is 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, 2005–06). 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 are variations across jurisdictions on the scope and definition of a service contact. For example, New South Wales, Queensland, South Australia and Tasmania may include written correspondences as service contacts while others do not. Data on contacts with unregistered clients are not included by all jurisdictions.

Coverage

Data collection for the NCMHCD began in July 2000. 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 comments or estimates of their coverage for 2005–06 as a proportion of full coverage:

- New South Wales estimated their coverage for 2005–06 to be around 70% of full coverage;
- Victoria and Western Australia did not provide estimates of their coverage for 2005–06;
- Queensland estimated that 100% of in-scope services have reported service contact data. In early 2006, an estimation of the level of compliance was conducted based on the number of full-time-equivalent staff employed over the year. The process revealed a compliance rate between 50–60% across the State;
- South Australia estimated their coverage to be 91%, with the figure derived as the number of organisations with incomplete or no patient level data for this NMDS divided by the number of organisations reporting community services via the National Survey of Mental Health Services for 2005–06;
- Tasmania stated that all service units that were in scope for the collection provided service contact data. However, a significant number of clinicians in some community teams were found not to be providing consistent service contact data. No estimated coverage was provided;
- the Australian Capital Territory reported their coverage to be 99.2%; and
- the Northern Territory estimated 90% coverage based on all in-scope services reporting, but there may be 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 2005–06 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 is acceptable at the broad level, that is, in distinguishing Aboriginal and Torres Strait Islander peoples and other Australians. However, they believed that there were quality issues in the coding of more specific details (that is, Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander). Queensland reported that several strategies have been carried out 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 2005–06 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 is 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

The quality of principal diagnosis data in the NCMHCD may also be affected by the variability in collection and coding practices across jurisdictions. 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, International Statistical Classification of Diseases and Related Health Problems, 10th revision, Primary Care (ICD-10-PC), and local codes where there are no ICD-10-PC equivalents. 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 mainly reported the current diagnosis for each service contact rather than a principal diagnosis for a longer

period of care. The remaining jurisdictions mainly reported 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 people who used services in more than one establishment will be counted more than once; therefore, the number of patients may be overestimated.

National Hospital Morbidity Database (chapters 5 and 7)

The National Hospital Morbidity Database (NHMD) is a compilation of electronic summary separation records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone, external causes of injury and poisoning and the Australian Refined Diagnosis Related Group information are also recorded.

The 2005–06 collection contains data for hospital separations that occurred between 1 July 2005 and 30 June 2006. Data on separations that occurred before 1 July 2005 are included, provided that the discharge dates fell within the collection period (2005–06). A record is generated for each separation rather than each patient. Therefore, patients who separated more than once in the reference 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 2005–06* (AIHW 2007a).

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. Therefore, caution should be used in the interpretation of the differences between jurisdictions. 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 Residential Mental Health Care Database (Chapter 8)

Scope

The National Residential Mental Health Care Database (NRMHCD) contains data on episodes of residential care provided by government-funded residential mental health services as specified by the Residential Mental Health Care National Minimum Data Set (RMHC NMDS). Data collated include information relating to each episode of residential care provided by the relevant mental health services. Examples of data elements are demographic information of residents, such as age and sex, and clinical information, such as principal diagnosis and mental health legal status. Detailed data specifications for the RMHC NMDS can be found in METeOR, the AIHW's online metadata registry, at <www.aihw.gov.au>.

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). Government-funded, non-government-operated services and non-24-hour staffed services could be included optionally. For the 2005–06 data collection, all the data providers have mental health-trained staff on site 24 hours a day except for one South Australian facility which was staffed for 8 hours a day. Data from two Tasmanian non-government organisations staffed 24 hours a day were also included in the 2005–06 collection. 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 2005–06*).

Queensland and the Northern Territory do not have any in-scope government-operated residential mental health services and therefore do not report to this collection.

Coverage

States and territories provided estimates of their coverage for 2005–06 as a proportion of full coverage:

- New South Wales, Victoria and Western Australia did not report any undercounting of residential care from service units within scope;
- South Australia, the Australian Capital Territory and Tasmania estimated their data coverage to be 100%.

Indigenous data quality

Data from the NRMHCD on Indigenous status should be interpreted with caution due to the varying quality and completeness of Indigenous identification across all jurisdictions. Only Western Australia, Tasmania and the Australian Capital Territory considered their Indigenous status data of acceptable quality. New South Wales have not evaluated the quality of their Indigenous data. Likewise, limited analysis was done on the quality of Indigenous data in South Australia. Victoria considered the quality of Indigenous data not acceptable due to the lack of consistency in data entry across their services.

Principal diagnosis coding

All but one jurisdiction used the complete ICD-10-AM classification to code principal diagnosis. New South Wales used a combination of ICD-10-AM, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Primary Care (ICD-10-PC) and some local codes.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (Chapters 11 and 14)

Medicare Australia collects data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (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 to the number of mental health-related prescriptions processed by Medicare Australia in the reporting period, the number of the persons provided with the prescriptions and their characteristics, as well as the prescription costs funded by the PBS and RPBS.

Although the PBS and 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 and RPBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions (DoHA 2006d). 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.
- There are a number of programs paid for using payment mechanisms other than Medicare Australia processed payments, including:
  - most section 100 drugs funded through public hospitals (though the pharmaceutical reform measures for public hospitals under the Australian Health Care Agreement and the Chemotherapy Pharmaceutical Access Program are paid for through Medicare Australia);
  - Aboriginal health services;
  - Opiate Dependence Treatment Program;
  - Special Authority Program;
  - Botox (including Dysport);
  - in vitro fertilisation; and
  - human growth hormones

  The only one of these that has a significant bearing on the data published in Chapters 11 and 14 is the Aboriginal health services program. Most affected are the data for remote and very remote areas and the data for the Northern Territory, which will not fully

reflect government expenditure. The total expenditure for the Aboriginal Health Services program in 2006–07 was $27.5 million and most of this is in remote areas. Around one-third of PBS total expenditure for the Northern Territory is through the Aboriginal health services program.

The number of prescriptions issued through community pharmacies that are not covered by the PBS and 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 2007). These survey data are combined with PBS and RPBS data from Medicare Australia in the Drug Utilisation Sub-Committee (DUSC) database. Tabulation of the data from this database shows the number and proportion of scripts covered by the PBS and RPBS within each of the mental health-related Anatomical Therapeutic Chemical (ATC) groups (Table A1.4).

Table A1.4: Community dispensed scripts by patient category group for mental health-related ATC groups

	PBS	RPBS	*Subtotal (PBS + RPBS)*	Under co-payment	Private	Total
Number of scripts						
N05A	1,927,541	88,683	*2,016,224*	28,659	82,495	**2,127,378**
N05B	3,064,220	212,393	*3,276,613*	491,130	461,367	**4,229,110**
N05C	2,411,965	363,803	*2,775,768*	380,670	1,170,977	**4,327,415**
N06A	11,365,317	677,271	*12,042,588*	2,574,051	163,616	**14,780,255**
N06B	279,438	1,088	*280,526*	115,961	198,407	**594,894**
Total	**19,048,481**	**1,343,238**	***20,391,719***	**3,590,471**	**2,076,862**	**26,059,052**
Percent of scripts						
N05A	90.6	4.2	*94.8*	1.3	3.9	100.0
N05B	72.5	5.0	*77.5*	11.6	10.9	100.0
N05C	55.7	8.4	*64.1*	8.8	27.1	100.0
N06A	76.9	4.6	*81.5*	17.4	1.1	100.0
N06B	47.0	0.2	*47.2*	19.5	33.4	100.0
Total	**73.1**	**5.2**	***78.3***	**13.8**	**8.0**	**100.0**
Per cent (excluding private)						
N05A						
N05B	94.3	4.3	*98.6*	1.4	. .	100.0
N05C	81.3	5.6	*87.0*	13.0	. .	100.0
N06A	76.4	11.5	*87.9*	12.1	. .	100.0
N06B	77.8	4.6	*82.4*	17.6	. .	100.0
Total	**70.5**	**0.3**	***70.8***	**29.2**	**. .**	**100.0**

. . Not applicable.

Source: Drug Utilisation Sub-Committee database. Date of service basis. PBS Schedule ATC used except for some private scripts where the item does not exist in the PBS schedule and WHO ATC was used.

The ATC classification version used is the primary classification as it appears in the Schedule of Pharmaceutical Benefits. This can differ slightly from the WHO version. There are two differences between the WHO ATC classification and the PBS Schedule classification that

have a bearing on Mental health data. Prochlorperazine is regarded as an *Other antiemetics* (A04AD) in the PBS Schedule while it is an *Antipsychotic* according to the WHO classification. Lithium carbonate on the other hand is classified as an *Antidepressant* in the PBS Schedule while it is an *Antipsychotic* according to the WHO classification (Table A1.5).

Table A1.5: Differences between the WHO ATC classification and the PBS Schedule Classification

Drug Name	WHO ATC Code	PBS Schedule Code	Scripts dispensed in 2006–07
Prochlorperazine	N05AB04	A04AD	623,859
Lithium carbonate	N05AN01	N06AX	91,257

Source: Date of service basis from Drug Utilisation Sub-Committee database.

The data published in Chapters 11 and 14 are slightly different from that published in earlier editions of *Mental Health Services in Australia*. Private hospital Clozapine Section 100 data and N06B Psychostimulants and nootropics have been included which were not previously included. This makes the data in this publication more comparable with that published by DoHA in the annual *National Mental Health Report* (DoHA 2005).

There has also been a slight methodological change compared with previous editions to include records with unknown state/territory or unknown provider specialty (though in tables 11. 2 and 11.3 the data for unknown specialty is only recorded in the footnote).

To avoid double counting in the demographic tabulations, patients are allocated to the last category in which they appear. The category most affected by this will be the age group data as the age is calculated at the time of supply, and patients ages will be one year greater for scripts supplied after their birthday than before it.

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.

Mental Health Establishments Database (Chapter 12)

Collection for the National Minimum Data Set for Mental Health Establishments (MHE NMDS) commenced on 1 July 2005, replacing the Community Mental Health Establishments NMDS (CMHE NMDS) and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the CMHE NMDS and replicate the data previously collected by the National Survey of Mental Health Services. The Mental Health Establishments Database is compiled as specified by the MHE NMDS.

The scope of the MHE NMDS includes all specialised mental health services managed or funded by state or territory health authorities. Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget nor is it defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability. Services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (for example, designated psychiatric units and wards, outpatient clinics etc).

The AIHW validates the data provided by states and territories using a series of anomaly, exceptional and historical edit checks. As 2005–06 is the first year of the MHE NMDS, these checks are continually being refined and improved. Consequently, there may be changes to state and territory data following the release of this report.

Private Health Establishments Collection (Chapters 12 and 14)

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.

The data definitions used in the Private Health Establishments Collection 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 Private Health Establishments Collection can be obtained from the annual ABS publication *Private Hospitals, Australia* (ABS 2007b).

Supported Accommodation Assistance Program National Data Collection (Chapter 9)

The Supported Accommodation Assistance Program (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 2005–06, 1,300 non-government, community and local government agencies were funded nationally under the program. Of the agencies required to participate in the collection, 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 accommodation or support that is of an ongoing nature or that generally lasts for more that 1 hour on a given day. 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 (30 June of each year). Data collected include basic socio-demographic information and information on the services needed by,

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 2005–06, valid consent was obtained from clients in 82% 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 146,864 closed support periods reported in the SAAP Client Collection for 2005–06. For the same period, the number of closed support periods using weighted data is estimated to be 158,600.

For further information on the SAAP collection, refer to the *Homeless people in SAAP: SAAP National Data Collection annual report 2005–06 Australia* (AIHW 2007e).

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 2005–06 data were calculated using ERP at 31 December 2005, while rates for 2005 calendar year data were calculated using ERP at 30 June 2005). Rates for 2006–07 data were calculated using preliminary ERP at 31 December 2006.

Rates for Indigenous status, country of birth and remoteness area data were calculated using ERP at 30 June of the relevant year.

Age-standardised rates

Rates are adjusted for age to facilitate comparisons between populations that have different age structures, e.g. between youthful and ageing communities. In this publication we use direct standardisation in which age-specific rates are multiplied against a standard population (the Australian Estimated Resident Population as at 30 June 2001 unless otherwise specified). This effectively removes the influence of age structure on the calculated rate that is described as the age-standardised rate. The method used for this calculation comprises three steps.

Step 1 Calculate the crude age-specific rate for each age group.

Step 2 Calculate the expected number of cases in each 5-year age group by multiplying the age-specific rates by the corresponding standard population and dividing by the base number for the rate calculation (say 100,000), giving the expected number of cases.

Step 3 Sum the expected number of cases in each age group to give the age-standardised total expected number. Divide this sum by the total of the standard population and multiply by 100,000.

In some instances in this publication where the numbers in particular 5-year age groups are very small (less than 5), neighbouring age groups have been combined to enable calculation of a meaningful crude rate.

Average annual rates of change

Average annual rates of change or growth rates have been calculated as geometric rates:

$$\text{Average rate of change} = ((P_n/P_o)^{1/N} - 1) \times 100$$

where P_n = value in the later time period

P_o = value in the earlier time period

N = number of years between the two time periods.

Confidence intervals

Where indicators based on survey data include a comparison of rates (or comparable numbers) between time periods, between demographic groups or between other categories, a 95% confidence interval is often presented with the rates. This is because the observed value of a rate may vary due to chance even where there is no variation in the underlying value of the rate. The 95% confidence interval represents a range over which variation in the observed rate is consistent with this chance variation.

These confidence intervals can be used as an approximate test of whether changes in a particular rate are consistent with chance variation. Where the confidence intervals do not overlap, the change in a rate is greater than that which could be explained by chance. Where the intervals do overlap, then changes in the rate may be taken as approximately consistent with variability due to chance.

It is important to note that this result does not imply that the difference between the two rates is definitely due to chance. Instead, an overlapping confidence interval represents a difference in rates which is too small to differentiate between a real difference and one which is due to chance variation.

Appendix 3: Classifications used

Health-related classifications have multiple purposes, including the facilitation of data collection and management in the clinical setting, the analysis of data to inform public policy and the allocation of financial and other resources. This section provides a short description of the classification systems referenced 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.

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://nis-web.fhs.usyd.edu.au/ncch_new/2.15.aspx >.

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. This 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 2007a).

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 WHO website <http://www.whocc.no/atcddd/>.

English Proficiency Country Groups

The English Proficiency Country Groups were developed by the (then) Bureau of Immigration, Multicultural and Population Research, based on the 1991 Census. It is a classification of countries of birth to enable the analysis and presentation of data on immigrants to Australia. Countries are classified to one of four groups depending on the proportion of immigrants in the five years prior to the Census who spoke good English (the EP index).

The latest published version of the English Proficiency Country Groups (often abbreviated to EP groups) was based on the 2001 Census (DIMIA 2003). They are:

- EP1 – All countries rating 98.5% or higher on the EP index with at least 10,000 residents in Australia
- EP2 – Countries rating 84.5% or higher on the EP index, other than those in EP1
- EP3 – Countries rating 57.5% to less than 84.5%
- EP4 – Countries rating less than 57.5%

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 2006).

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 use 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, version 2, 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). While in the great majority of cases the codes appearing in the diagnosis/problem fields of the BEACH survey form are those listed in this Appendix under the *Problems Managed* heading, occasionally, a code more relevant to procedures, other treatments, counselling or referrals has appeared. These cases (accounting for 2.8% of total problems managed) are still counted as mental health-related general practice encounters for the purpose of the report, in particular the estimates of Table 2.1.

For procedures, other treatments, counselling and referrals, codes that are classified in the psychological chapter of the ICPC-2 PLUS have been used, as these enable greater specificity in coding.

For medications prescribed, recommended or supplied, Anatomical Therapeutical Chemical (ATC) Classification System codes have been used, where the medication falls into one of four groups (WHO 2008).

Table A4.1 presents a list of the ICPC-2, ICPC-2 PLUS and ATC codes classed as 'psychological' for problems managed, procedures, other treatments, counselling, referrals and medications.

Table A4.1: ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2006–07

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC 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 ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2006–07

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC 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
Procedures, other treatments, counselling			
Check-ups			
	P30001		Exploration; psychological; complete
	P30002		Check up; complete; psychological
	P30003		Exam; complete; psychological
	P31001		Exploration; psychological; partial
	P31002		Check up; partial; psychological
	P31003		Exam; partial; psychological
	P31004		Exam; mental state
	P31005		Monitoring; drug rehab
Tests and investigations			
	P34001		Test; blood; psychological
	P34002		Test; lithium
	P34003		Test; methadone
	P35001		Test; urine; psychological
	P38001		Test; other lab; psychological
	P39001		Test; physical function; psychological
	P41001		Radiology; diagnostic; psychological
	P43001		Test; psychological
	P43003		Procedures; diagnostic; psychological
Advice/counselling			
	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
	P58001		Counselling; psychiatric

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2006–07

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Procedures, other treatments, counselling (continued)			
	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
	P58017		Counselling; stress management
	P58018		Therapy; group
Therapeutic procedures			
	P59001		Therapeutic procedure; psychological
	P59002		Therapy; electroconvulsive
	P59003		Hypnosis/hypnotherapy
	P59005		Therapy; relaxation
Other management			
	P42001		Electrical tracings; psychological
	P46001		Consultation; other general practitioner/allied health professional; psychological
	P46002		Consultation; primary care provided; psychological
	P46003		Consultation; psychiatrist
	P47003		Consultation; psychiatrist
	P48002		Discuss; patients reason for encounter; psychological
	P49001		Prevent procedure; psychological
	P49002		Exchange; needle/syringe
	P50001		Medications; psychological
	P50002		Medication; request; psychological
	P50003		Medication; renew; psychological
	P50004		Prescription; psychological
	P50006		Injection; psychological
	P60001		Test; result(s); psychological

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2006–07

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Procedures, other treatments, counselling (continued)			
	P60002		Results; procedures; psychological
	P62001		Administrative; psychological
	P63001		Encounter; follow-up; psychological
	P64002		Encounter; provider-initiated; psychological
	P69001		Encounter; other; psychological
	P69002		Assist at operation; psychological
Referrals			
	P66003		Referral; psychologist
	P66004		Referral; counsellor
	P66005		Referral; mental health team
	P66006		Referral; drug and alcohol
	P66007		Referral; hypnotherapy
	P67002		Referral; psychiatrist
	P67004		Referral; clinic; psychiatrist
	P67005		Referral; hospital; psychiatrist
	P67006		Referral; sleep clinic
	P68003		Referral; needle/syringe exchange
Medications			
		N05A	Antipsychotics
		N05B	Anxiolytics
		N05C	Hypnotics and sedatives
		N06A	Antidepressants

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 Australian Refined Diagnosis Related Group 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 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	✓		✓	

(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
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	✓			
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			✓	

(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
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				✓
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	✓			

(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
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 with parents and in-laws			✓	
Z63.8	Other specified problems related to primary 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
ASA	American Society of Anaesthesiologists
ASGC	Australian Standard Geographical Classification
ATC	Anatomical Therapeutic Chemical
BEACH	Bettering the Evaluation and Care of Health
CNS	Central Nervous System
COAG	Council of Australian Governments
CSTDA	Commonwealth State/Territory Disability Agreement
DoHA	Department of Health and Ageing
ED	emergency department
EP	English proficiency
ERP	estimated resident population
FTE	full-time-equivalent
HDSC	Health Data Standards Committee
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, version 2
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
NMHED	National Mental Health Establishments Database
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

References

ABS (Australian Bureau of Statistics) 1998. Mental health and wellbeing: profile of adults, Australia, 1997. ABS cat. no. 4326.0. Canberra: ABS.

ABS 2002. Australian Standard Geographical Classification. ABS cat. no. 1216.0 Canberra: ABS. Viewed December 2007, <http://www.abs.gov.au>.

ABS 2007a. Australian Standard Geographical Classification (ASGC), July 2007. ABS cat. no. 1216.0. Canberra: ABS. Viewed February 2008, <http://www.abs.gov.au>.

ABS 2007b. Private hospitals, Australia, 2005–06. ABS cat. no. 4390.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2005a. Disability support services 2003–04: national data on services provided under the Commonwealth State/Territory Disability Agreement. Disability series. Cat. no. DIS 40. Canberra: AIHW

AIHW 2005b. Improving the quality of Indigenous identification in hospital separations data. Health services series no. 25. Cat. no. HSE 101. Canberra: AIHW.

AIHW 2006a. Australia's health 2006. Cat. no. AUS 73. Canberra: AIHW.

AIHW 2007a. Australian hospital statistics 2005–06. Health services series no. 30. Cat. no. HSE 50. Canberra: AIHW.

AIHW 2007b. Disability support services 2005–06: national data on services provided under the Commonwealth State/Territory Disability Agreement. Disability series. Cat. no. DIS 51. Canberra: AIHW.

AIHW 2007c. Health expenditure Australia 2005–06. Health and welfare expenditure series no. 30. Cat no. HWE 37. Canberra: AIHW.

AIHW 2007d. Homeless people in SAAP: SAAP National Data Collection annual report 2005–06 Australia. SAAP NDCA report. Series 11. Cat. no. HOU 156. Canberra: AIHW.

AIHW 2007e. Mental Health Services in Australia 2004–05. Mental health series no. 9. Cat. no. HSE 47. Canberra: AIHW.

AIHW 2008a. Medical labour force 2005. National health labour force series no. 40. Cat. no. HWL 41. Canberra: AIHW.

AIHW 2008b. Nursing and midwifery labour force 2005. National health labour force series no. 39. Cat. no. HWL 40. Canberra: AIHW.

AIHW: Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A 2007. The burden of disease and injury in Australia, 2003. Cat. no. PHE 82. Canberra: AIHW.

Britt H, Miller GC, Charles J, Bayram C, Pan Y, Henderson J, Valenti L, O'Halloran J, Harrison C, Fahridin S 2008. General practice activity in Australia 2006–07. General Practice Series No. 21. Cat. no. GEP 21. Canberra: AIHW.

Cameron J & Payton J 2004. Report on exclusion practice in SAAP: identification of the mental health, alcohol and other drugs issues impacting on current practice in SAAP services. Viewed April 2008, <http://www.community.wa.gov.au/NR/rdonlyres/AB3781C1-D177-4074-A48F-2D527B0092FB/0/DCDRPTReportOnExclusionPracticeInSAAP2004.pdf>.

COAG (Council of Australian Governments) 2006a. Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS). Viewed December 2007, <http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm>.

COAG (Council of Australian Governments) 2006b. National Action Plan on Mental Health 2006–2011. Viewed January 2008, <http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.rtf>.

DIMIA (Department of Immigration, Multicultural and Indigenous Affairs) 2003. Statistical Focus - 2001 Classification of Countries into English Proficiency Groups. Canberra. Viewed April 2008, <http://www.immi.gov.au/media/publications/statistics/ep-groups/index.htm>.

DoHA (Department of Health and Ageing) 2005. National mental health report 2005: summary of ten years of reform in Australia's mental health services under the National Mental Health Strategy 1993–2003. Canberra: Commonwealth of Australia.

DoHA 2006. National Mental Health Strategy. Viewed April 2008, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-strategy>.

DoHA 2007a. Medicare Benefits Schedule book, effective 1 November 2007. Canberra: Commonwealth of Australia.

DoHA 2007b. Medicare Statistics – June Quarter 2007. Viewed 20 December 2007, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/medstat-jun07-tables-g>.

DoHA 2007c. PBS Portal. Viewed January 2008<http://www.pbs.gov.au/html/home>.

DoHA 2008a. Drug Utilisation Sub-Committee (DUSC) database as at 28 February 2008.

DoHA 2008b. National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005. Canberra: Commonwealth of Australia.

FaCS (Commonwealth Department of Families and Community Services) 2002. Commonwealth State/Territory Disability Agreement (CSTDA) 2002-2007. Viewed January 2007, <http://www.facsia.gov.au/internet/facsinternet.nsf/disabilities/policy-cstda.htm>.

HDSC (Health Data Standards Committee) 2006. National health data dictionary, Version 13. Canberra: AIHW.

Medicare Australia 2007a. Australian Government. Viewed November 2007, <http://www.medicareaustralia.gov.au>.

Medicare Australia 2007b. Medicare Benefits Schedule (MBS) Item Statistics Reports. Viewed January 2008, <http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml>

METeOR (Metadata Online Registry) 2007. Viewed November 2007, <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>.

National Centre for Classification in Health (NCCH) 2006. The international statistical classification of diseases and related health problems, 10th revision, Australian modification. Sydney: NCCH.

National Coding Centre (NCC) 1996. The Australian version of the international classification of diseases, 9th revision, clinical modification. Sydney: NCC.

NCSDC (National Community Services Data Committee) 2006. National Community Services Data Dictionary. AIHW cat. no. HWI 91. Version 4. Canberra: AIHW.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2008. Report on Government Services 2008. Canberra: Productivity Commission.

Victorian Government Department of Human Services 2005. Mental health presentations to the emergency department. Melbourne: Victorian Government. Viewed December 2007, <http://www.health.vic.gov.au/mentalhealth/publications/mh-presentations.pdf>.

WHO 2006. International Classification of Diseases (ICD). Viewed February 2008, <http://www.who.int/classifications/icd/en/>.

WHO 2008. The Anatomical, Therapeutic, Chemical Classification System with Defined Daily Doses(ATC/DDD), Viewed January 2008, <http://www.whocc.no/atcddd/>.

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