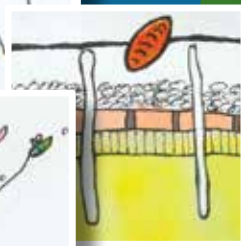
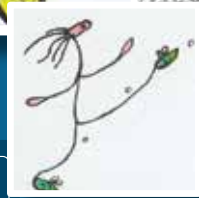
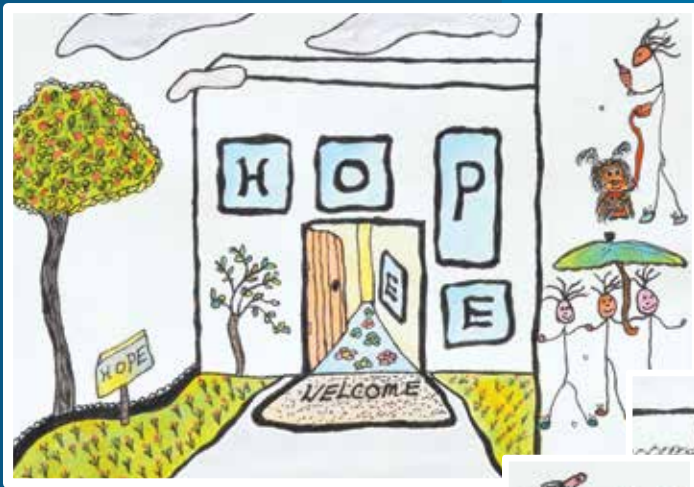




Australian Government

Australian Institute of
Health and Welfare

2015



MENTALHEALTHSERVICES

In brief

2015



MENTAL **HEALTH** SERVICES

In brief

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

© Australian Institute of Health and Welfare 2015 

This product, excluding the AIHW logo, Commonwealth Coat of Arms and any material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC-BY 3.0) licence. Excluded material owned by third parties may include, for example, design and layout, images obtained under licence from third parties and signatures. We have made all reasonable efforts to identify and label material owned by third parties.

You may distribute, remix and build upon this work. However, you must attribute the AIHW as the copyright holder of the work in compliance with our attribution policy available at <www.aihw.gov.au/copyright/>. The full terms and conditions of this licence are available at <<http://creativecommons.org/licenses/by/3.0/au/>>.

ISBN 978-1-74249-859-1 (PDF)

ISBN 978-1-74249-860-7 (Print)

Suggested citation

Australian Institute of Health and Welfare 2015. Mental health services—in brief 2015. Cat. no. HSE 169 Canberra: AIHW.

Australian Institute of Health and Welfare

Board Chair

Dr Mukesh C Haikerwal AO

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

Digital and Media Communications Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Tel: (02) 6244 1000
Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare.

Cover art by Pauline Miles.

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

Contents

Introduction.....	1
Mental illness in Australia—prevalence and impact.....	1
Australia’s mental health care system—an overview.....	4
Mental health care services and support.....	6
Mental health care resources	17
In focus 2015—mental health of children and adolescents.....	21
Key Performance Indicators for Australian Public Mental Health Services.....	24
Glossary.....	27
References.....	28

Introduction

This *Mental health services—In brief 2015* report is a companion publication to the *Mental health services in Australia* website. The report provides an annual overview of mental health services, incorporating updates made to the website over the 12 months to September 2015.

This report starts by briefly describing mental illness in Australia in terms of its prevalence and impact. This is followed by an overview of services accessed by people with mental illness, and expenditure on mental health services. Later sections provide more detailed insights into mental health care services and support, medications, and resources. The report concludes with a focus on the mental health of children and adolescents, and by reporting on three Key Performance Indicators (KPIs) for Australian Public Mental Health Services.

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

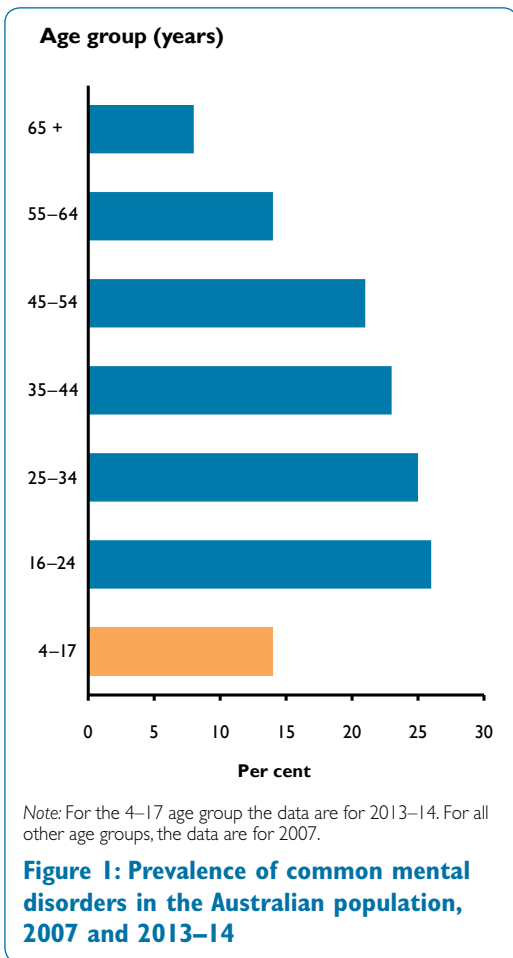
Mental illness in Australia—prevalence and impact

How many people have mental illness?

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

The 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (ages 16–85) estimated that 45% of Australians in this age range (7.3 million people) experienced a mental disorder sometime in their lifetime, and that an estimated 20% (3.2 million people) had experienced a common mental disorder in the previous 12 months (ABS 2008). The age distribution of prevalence of common mental health disorders from the 2007 survey is shown in Figure 1.





Anxiety disorders (such as social phobia) were the most common conditions reported for the 12-month period, afflicting 14% of the population, followed by affective disorders such as depression (6%) and substance-use disorders (for example, alcohol dependence [5%]). These three groups of common mental disorders were most prevalent in people aged 16-24 and decreased as age increased. Women experienced higher rates than men of anxiety (18% and 11%, respectively) and affective disorders (7% and 5%, respectively). Men, however, had twice the rate of substance use disorders (7%) compared with women (3%).

The most recent national survey of the mental health and wellbeing of Australian children and adolescents (*Young Minds Matter* survey) was for 2013-14 (Lawrence et al. 2015). It showed that almost 1 in 7 (14%) young people aged 4-17 years was assessed as having mental health disorders in the previous 12 months, corresponding to about 560,000 children and adolescents. Attention Deficit Hyperactivity Disorder (ADHD) was the most common mental disorder (just over 7% or 298,000 children and adolescents), followed by anxiety disorders (just under 7% or 278,000), major depressive disorder (3% or 112,000) and conduct disorder (2% or 83,600). A comparison of prevalence data from the *Young Minds Matter* survey and the first survey of mental health and wellbeing of children and adolescents (conducted in 1998) reveals changes in the prevalence of major depressive disorder, ADHD and conduct disorder— see the *In Focus* section for more detail.

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

Impact of mental illness

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

Mental and behavioural disorders such as depression, anxiety and drug use are important drivers of disability. For example, the Global Burden of Diseases, Injuries, and Risk Factors Study 2013 estimated that mental and behavioural disorders was responsible for 13% of the total burden of disease in Australasia (including Australia and New Zealand), placing it third as a broad disease group after cancers and musculoskeletal disease (IHME 2013). In addition, in 2013, 31% of people receiving the Disability Support Pension had a primary medical condition of 'psychological/psychiatric' (DSS 2014).

The 2003 Burden of Disease and Injury in Australia study (currently being repeated and scheduled to be published in 2016) examined the health loss due to disease and injury that is not ameliorated by current treatment, rehabilitative and preventive efforts of the health system and society generally (Begg et al. 2007). In terms of the non-fatal burden of disease—which is a measure of the number of years of 'healthy'

life lost due to living with a disability—mental and behavioural disorders were the second largest contributor (24% of the non-fatal burden of disease) in Australia (Begg et al. 2007).

In 2013, mental disorders were responsible for 597 deaths, excluding suicide and dementia, with most deaths due to substance abuse, particularly alcohol (AIHW analysis of National Mortality Database).

There can be an association between diagnosis of mental health disorders and a physical disorder, often referred to as a 'comorbid' disorder. From the 2007 NSMHWB of adults, 12% of people with a mental disorder of at least 12 months duration also reported a physical disorder; 5% reported two or more physical conditions.

According to the 2010 National Survey of People Living with Psychotic Illness, people with psychotic illness also frequently experience poor physical health outcomes and comorbidities (Morgan et al. 2011). For example, over one-quarter (27%) of survey participants had heart or circulatory conditions and one-fifth (21%) had diabetes (compared with 16% and 6%, respectively, in the general population). The prevalence of diabetes found in the National Survey of People Living with Psychotic Illness is more than three times the rate seen in the general population. Other comorbidities included epilepsy (7% compared with 0.8% in the general population) and severe headaches/migraines (25% compared with 9% in the general population).

Australia's mental health care system—an overview

This section summarises the mental health care provided in Australia. Later sections provide more information on selected components of the Australian mental health care system.

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

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

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

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

Who receives mental health care?

The 2007 NSMHWB estimated that 35% of people with a mental disorder of at least 12-months duration had mental health treatment (1.1 million people) (Slade et al. 2009). Of these:

- 71% consulted a general practitioner (GP)
- 38% consulted a psychologist
- 23% consulted a psychiatrist.

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

More recent evidence suggests that the treatment rates have increased since 2007 to an estimated 46% in 2009–10. Primarily, this increase is due to mental health treatment items, subsidised by the Australian Government, being introduced to the MBS in November 2006 (Whiteford et al. 2014).

How many mental health care services are provided?

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

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

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

The volume of mental health-related services is summarised in Table 1.

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

Service type	Volume
Community mental health care service contacts	8.7 million
Residential mental health care service episodes	6,957
Emergency department services	211,139
Hospitalisations	249,672
MBS-subsidised mental health-related services provided by GPs	2.7 million
MBS-subsidised mental health-related services provided by psychiatrists	2.2 million
MBS-subsidised mental health-related services provided by psychologists	3.9 million
PBS-subsidised mental health-related medications by GPs	21.4 million
PBS-subsidised mental health-related medications by psychiatrists	2.0 million

Where is specialised mental health care provided?

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

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

Nationally, there were 1,578 specialised mental health care facilities providing care in 2012–13. There were more than 11,400 specialised mental health beds available nationally during 2012–13 (Table 2).

Table 2: Specialised mental health care facilities, 2012–13

Facility	Number	Number of beds
Public hospitals	163	6,768
Residential mental health services	166	2,356
Community mental health care services	1,193	n. a.
Private psychiatric hospitals	56	2286

n.a. not applicable.

How much does mental health care cost?

In 2012–13, national recurrent expenditure on mental health-related services was estimated to be about \$7.6 billion.

About \$4.6 billion was spent on state and territory specialised mental health services, including some funding provided by the Australian Government. The largest proportion of this expenditure was for public hospital services for admitted patients (\$2 billion) (Table 3).

Table 3: Recurrent expenditure, state and territory specialised mental health care services, 2012–13

Service type	Expenditure
Public hospitals	\$2.0 billion
Residential mental health services	\$0.3 billion
Community mental health services	\$1.8 billion

The Australian Government spent \$2.8 billion on mental health-related services in 2012–13. Expenditure on MBS-subsidised mental health-related services and medications provided through the PBS and RPBS accounted for 61% of the total (Table 4).

Table 4: Australian Government recurrent expenditure on mental health-related services, 2012–13

Service type	Expenditure
MBS mental health services	\$906 million
PBS/RPBS mental health medications	\$788 million

Around \$330 million was spent on private hospital mental health-related services in 2012–13, with the majority of this funding from private health insurance funds (\$309 million). Over the 5 years to 2012–13, the average annual increase in expenditure on private hospital services was 7.2% (adjusted for inflation).

Mental health care services and support

Mental health care provided by general practitioners

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

Key facts

- Nationally, it was estimated that there were about 17 million mental health-related GP encounters in 2013–14.
- GPs provided about 2.7 million MBS-subsidised mental health-related services to just over 1.5 million patients in 2013–14.

How many services were provided?

Data from the BEACH survey estimates that 13% of all GP encounters in 2013–14 were mental health-related (17.1 million GP encounters nationally). These estimates are much higher than the total number of MBS-subsidised mental health-related services provided by GPs in the same year. This suggests that most mental health-related GP activities are billed as general MBS items.

GPs provided 29% of all MBS-subsidised mental health-related services, a total of approximately 2.7 million services in 2013–14, or a rate of 114 services per 1,000 population. These services were provided to 1.5 million patients, which equates to an average of 1.7 services per patient.

Victoria had the highest rate of MBS-subsidised GP mental health services per 1,000 population followed by New South Wales (132 and 117, respectively). The Northern Territory had the lowest rate (48) (Figure 2).

Over the 5 years to 2013–14, the rate of MBS-subsidised GP mental health services increased by an annual average of 8%.

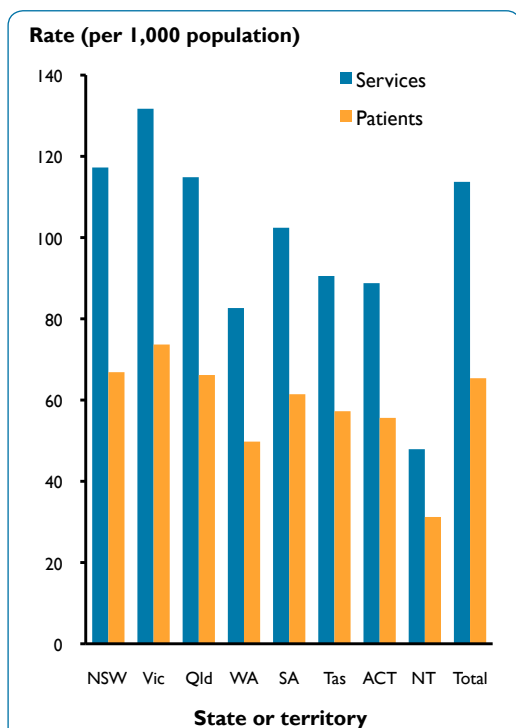


Figure 2: MBS-subsidised mental health-related GP service and patient rates, per 1,000 population, by state and territory, 2013–14

Why are people receiving services?

Depression, anxiety and sleep disturbance were the three mental health-related problems most frequently managed by GPs in 2013–14 (from the BEACH survey); together, they accounted for 59% of all mental health-related problems managed.

What services were provided?

Prescribing, recommending or supplying a mental health-related medication was the most frequent type of management provided by GPs in 2013–14 for mental health-related encounters (BEACH survey), followed by counselling services (62 and 50, respectively, of every 100 mental health-related problems). Referrals to either a psychiatrist or psychologist were provided at rates of 2 and 8, respectively, per 100 mental health-related encounters.

Nationally, *GP Mental Health Treatment Services* (such as the development of a GP Mental Health Treatment Plan) was the most frequently provided mental health-related service type subsidised by the MBS. It comprised 97% of all MBS-subsidised GP mental health-related services.

Mental health-related services provided by psychologists

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

Key facts

- Nationally, psychologists provided more than 3.9 million MBS-subsidised mental health-related services to about 889,000 patients in 2013–14.
- Over the 5 years to 2013–14, the rate of MBS-subsidised *Clinical psychologist* services increased at an annual average of about 10% while the rate of MBS-subsidised *Other psychologist* services increased at a lower annual average rate of 2%.

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

How many mental health-related services did psychologists provide?

Nationally, psychologists provided 43% of all MBS-subsidised mental health-related services, a total of 3.9 million services in 2013–14. These were provided to 889,101 patients (an average of 4 services per patient). *Clinical psychologists* provided 1.7 million of the 3.9 million services, which equates to a rate of 73 services per 1,000 population per year. *Other psychologists* provided 2.2 million services, or 94 services per 1,000 population.

Tasmania had the highest rate of *Clinical psychologist* services per 1,000 population followed by South Australia (96 and 93, respectively). The Northern Territory had the lowest rate (14). Victoria had the highest rate of *Other psychologist* services per 1,000 population followed by Queensland (119 and 105, respectively). The Northern Territory had the lowest rate (29) (Figure 3).

Over the 5 years to 2013–14, the rate of MBS-subsidised *Clinical psychologist* and *Other psychologist* services increased at annual average rates of 10% and 2%, respectively.

Rate (per 1,000 population)

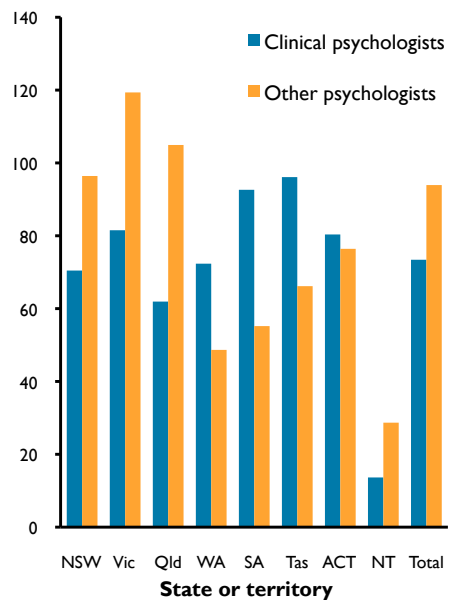


Figure 3: MBS-subsidised psychologist services per 1,000 population, 2013–14

What mental health-related services were provided by psychologists?

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

For *Other psychologists*, the MBS-subsidised service *Focussed Psychological Strategies* (for example, cognitive behavioural therapy) was the most frequently provided service type, making up 99% of all MBS-subsidised services.

Mental health-related services provided by psychiatrists

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

Key facts

- Nationally, psychiatrists provided about 2.2 million MBS-subsidised mental health-related services to about 345,000 patients in 2013–14.
- Over the 5 years to 2013–14, the rate of MBS-subsidised psychiatrist services has remained relatively steady, increasing at an annual average of 1%.

How many services did psychiatrists provide?

Nationally, psychiatrists provided approximately 25% of all MBS-subsidised mental health-related services in 2013–14, a total of 2.2 million services. This equates to a rate of 95 services per 1,000 population per year. These services were provided to 345,154 patients (an average of 6 services per patient).

Over the 5 years to 2013–14, the rate of MBS-subsidised psychiatrist services has remained relatively steady, increasing at an annual average rate of 1%.

Victoria had the highest rate of services per 1,000 population, followed by Queensland (117 and 103, respectively). The Northern Territory had the lowest rate (12) (Figure 4).

Rate (per 1,000 population)

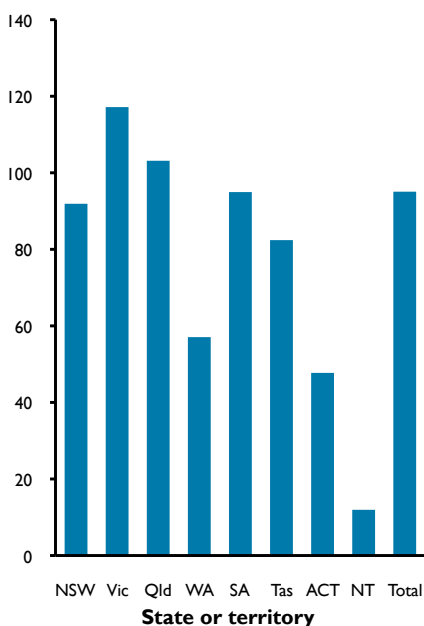


Figure 4: MBS-subsidised psychiatrist mental health services per 1,000 population, 2013–14

What mental health-related services were provided by psychiatrists?

Nationally, *Patient Attendances—Consulting Room* was the most frequently provided MBS-subsidised psychiatrist service, making up 73% of all services.

Mental health-related medications

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

Key facts

- There were about 34 million prescriptions filled for mental health-related medications during 2013–14.
- A total of 86% of these prescriptions were provided by GPs, 8% by psychiatrists and 6% by non-psychiatrist specialists.

How many mental health-related prescriptions were provided?

There were 34.3 million prescriptions (subsidised and under co-payment) filled for mental health-related medications during 2013–14. These were provided to 3.8 million patients, which equates to an average of 9 prescriptions per patient and a rate of 1,469 prescriptions per 1,000 population.

Tasmania had the highest rate of prescriptions (subsidised and under co-payment) per 1,000 population followed by South Australia (1,902 and 1,697, respectively). The Northern Territory had the lowest rate (725) (Figure 5).

Over the 5 years to 2013–14, the rate of subsidised mental health-related medications increased at an annual average of 2%.

GPs prescribed 86% of all dispensed PBS/RPBS subsidised mental health-related medications, or 21 million prescriptions.

Psychiatrists prescribed 8% of all dispensed PBS/RPBS subsidised mental health-related medications, or 2 million prescriptions.

Rate (per 1,000 population)

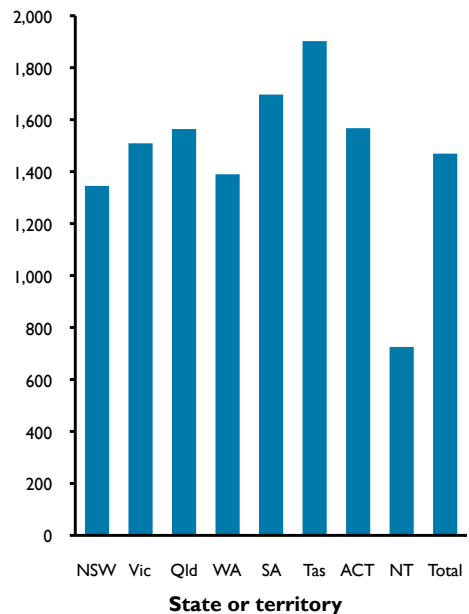


Figure 5: Mental health-related prescriptions per 1,000 population, 2013–14

What mental health-related medications were provided?

The majority of prescriptions (subsidised and under co-payment) were for antidepressant medications (67%, or 23 million), followed by anxiolytics (12%), antipsychotics (11%) and hypnotics and sedatives (8%). A similar pattern was seen for subsidised prescriptions only.

Antidepressants were the most frequently dispensed subsidised mental health-related medications prescribed by GPs followed by anxiolytics (64% and 13%, respectively). The same findings were seen for total prescriptions (subsidised and under co-payment).

Similarly, antidepressants were the most frequently dispensed subsidised mental health-related medications prescribed by psychiatrists followed by antipsychotics (50% and 34%, respectively). The same findings were seen for total prescriptions (subsidised and under co-payment).

Community mental health care services provided by state and territory governments

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

Key facts

- Nationally, there were 8.7 million service contacts for community mental health care services provided to about 390,000 patients in 2013–14.
- The most frequently recorded principal diagnoses were *Schizophrenia* and *Depressive episode* (23% and 11%, respectively).

How much mental health care did these services provide?

Nationally, Community Mental Health Care (CMHC) services provided 8.7 million service contacts in 2013–14. These were provided to 389,464 patients, which equates to an average of 22 service contacts per patient per year, and a rate of 374 service contacts per 1,000 population.

The Australian Capital Territory had the highest rate of service contacts per 1,000 population followed by South Australia (775 and 395, respectively). Tasmania had the lowest rate (293) (Figure 6).

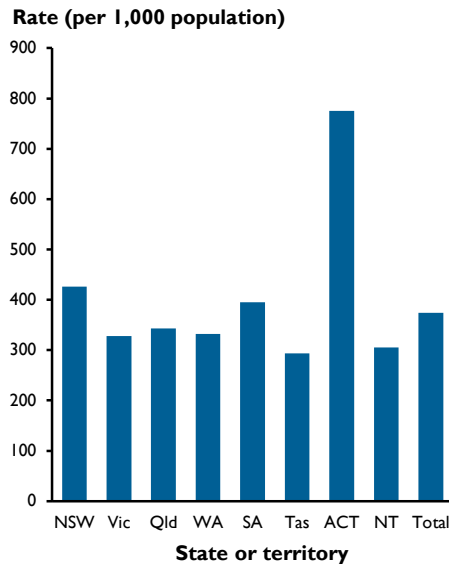


Figure 6: Community specialised mental health care service contacts per 1,000 population, by states and territories, 2013–14

Why are people receiving these services?

The most frequently recorded principal diagnoses for patients who had service contacts with specialised CMHC services were *Schizophrenia* and *Depressive episode* (23% and 11%, respectively).

What services were provided?

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

Nationally, 82% of service contacts were individual contacts and 54% were with the patient present. For all service contacts, the average session duration was 47 minutes, with 34% having session durations of up to 15 minutes and 18% having session durations of more than 60 minutes. The average session duration for service contacts with the patient present was longer than when the patient was absent (55 and 34 minutes, respectively).

State and territory residential mental health care services

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

Queensland does not provide RMHC services.

Key facts

- Nationally, there were about 7,000 residential episodes of care provided to about 5,200 residents in 2013–14.
- *Schizophrenia* and *Depressive episode* were the most frequently recorded diagnoses (32% and 12%, respectively).

How much mental health care did these services provide?

Nationally, specialised RMHC services provided 285,701 residential care days within 6,957 episodes of care, with an average of 1.3 episodes per resident and 41 residential care days per episode. This equates to a rate of 3 episodes per 10,000 population during 2013–14.

Over the 5 years to 2013–14, the rate of residential mental health episodes provided rose by an annual average of 13%. However, in considering this national rate, it should be noted that there was variability across states and territories.

Tasmania had the highest rate of episodes of care per 10,000 population, followed by South Australia (15 and 11, respectively). New South Wales had the lowest rate (0.3) (Figure 7). Tasmania also had the highest rate of residential care days per 10,000 population, followed by the Australian Capital Territory (799 and 314, respectively).

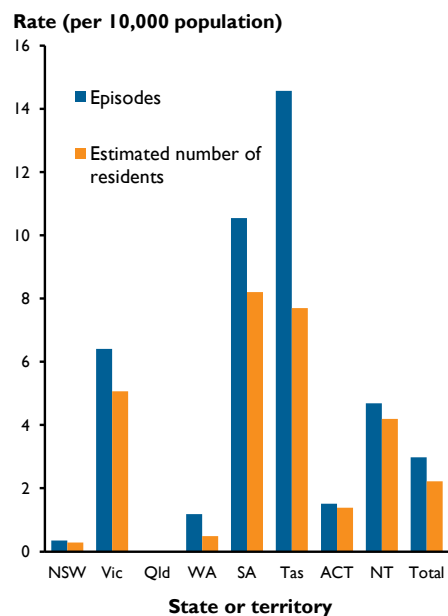


Figure 7: Specialised residential mental health care service episodes and residents per 10,000 population, states and territories, 2013–14

Why are people receiving these services?

The most frequently recorded principal diagnoses for patients who had an episode of residential care were *Schizophrenia* and *Depressive episode* (32% and 12%, respectively).

What services were provided?

Nationally, 58% of completed residential episodes during 2013–14 were up to 2 weeks in duration, and 27% were between 2 weeks and 1 month. For 3% of episodes, the duration was more than 1 year.

Mental health services provided in emergency departments

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

Key facts

- In 2012–13, about 211,000 ED occasions of service with a mental health-related principal diagnosis were reported.
- The most frequently recorded principal diagnoses were *Neurotic, stress-related and somatoform disorders* and *Mental and behavioural disorders due to psychoactive substance use* (28% and 26%, respectively).

How much mental health care did these services provide?

There were 211,139 ED occasions of service with a mental health-related principal diagnosis during 2012–13 (3% of all ED occasions of service), which equates to a rate of 92 occasions per 10,000 population per year. Over the 5 years to 2012–13, the rate of mental health-related ED occasions of service rose by an annual average of 5.3%.

The Northern Territory had the highest rate of mental health-related ED occasions of service per 10,000 population, followed by Queensland (282 and 109, respectively). Victoria had the lowest (75) (Figure 8).

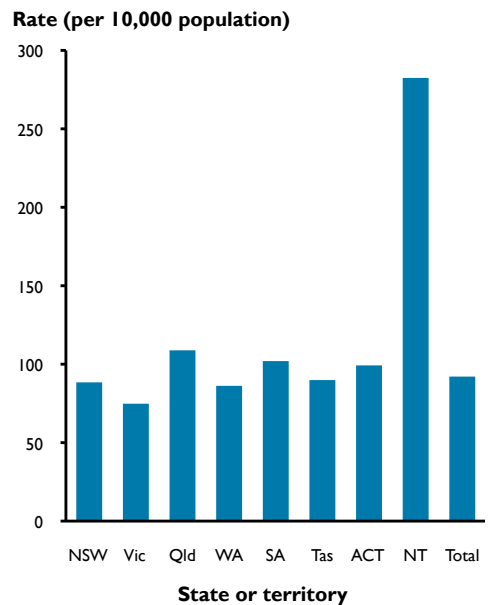


Figure 8: Public hospital emergency department mental health-related occasions of service per 10,000 population, 2012–13

Why are people receiving these services?

The most frequently recorded principal diagnoses were *Neurotic, stress-related and somatoform disorders* (such as anxiety disorders) and *Mental and behavioural disorders due to psychoactive substance use* (such as alcohol dependency disorders), which made up 28% and 26% of mental health-related ED occasions of service, respectively.

What services were provided?

In 2012–13, 82% of mental health-related ED occasions of service were classified at triage (initial assessment) as being either *urgent* (requiring care within 30 minutes) or *semi-urgent* (requiring care within 60 minutes). Occasions of service classified as *emergency* (requiring care within 10 minutes) or *resuscitation* (immediate care) made up 12% and 0.8%, respectively.

The most frequently recorded 'mode' for ending a mental health-related occasion of service was for the episode to have been completed without admission or referral to another hospital (60%). The next most recorded mode was admission of the patient to the hospital from ED (32%).

Admitted patient mental health-related care

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

Key facts

- There were about 250,000 mental health-related hospitalisations in 2013–14.
- About 61% of these hospitalisations included specialised psychiatric care.

How much mental health care did these services provide?

Of the 249,672 mental health-related hospitalisations during 2013–14, 61% (152,458) had specialised psychiatric care.

Essentially, all mental health-related hospitalisations in public psychiatric hospitals were for specialised psychiatric care. For private hospitals, around 4 in 5 (81%) and for public acute hospitals around 1 in 2 (53%) mental health-related hospitalisations were for specialised psychiatric care.

For public acute hospitals, the national hospitalisation rate with specialised psychiatric care was 4.1 per 1,000 population. Queensland had the highest

rate, followed by Western Australia (4.8 and 4.2, respectively). The Australian Capital Territory had the lowest rate (3.6) (Figure 9). The rate without specialised psychiatric care was 3.7 per 1,000 population nationally. For public acute and public psychiatric hospitals, South Australia had the highest rate, followed by the Northern Territory (5.5 and 5.0, respectively). The Australian Capital Territory had the lowest rate (2.8) (Figure 9).

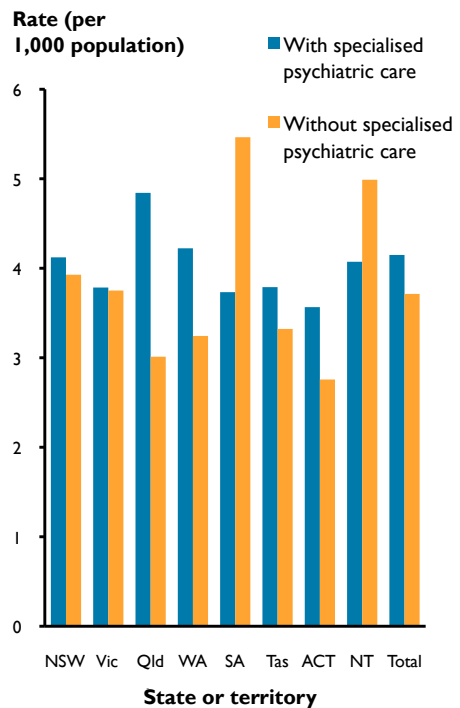


Figure 9: Public acute and public psychiatric hospital mental health-related hospitalisations per 1,000 population, 2013–14

Over the 5 years to 2013–14, the rate of hospitalisations with specialised psychiatric care rose by an annual average of 2.4%. For hospitalisations without specialised psychiatric care, the rate remained stable.

Why are people receiving these services?

For hospitalisations with specialised psychiatric care, *Depressive episode* and *Schizophrenia* were the most frequently recorded principal diagnoses (18% and 14%, respectively).

For hospitalisations without specialised psychiatric care, the most frequently recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* followed by *Depressive episode* (19% and 12%, respectively).

What services were provided?

Generalised allied health interventions was the most commonly reported procedure block for separations both with and without specialised psychiatric care (43% and 37%, respectively). Of these allied health interventions, services provided by social workers were the most common for both types of separations.

Personal Helpers and Mentors services

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

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

Key facts

- In 2013–14, there were more than 18,500 people participating in the PHaMs program.
- Almost 2 in 5 (37%) of PHaMs participants reported experiencing another significant disability.

How much mental health care did these services provide?

Nationally, there were 18,539 PHaMs participants during 2013–14. The number of participants rose by an annual average rate of 17% between 2009–10 and 2013–14. New South Wales had the largest number of participants and the Australian Capital Territory the smallest (5,256 and 326, respectively) (Figure 10).

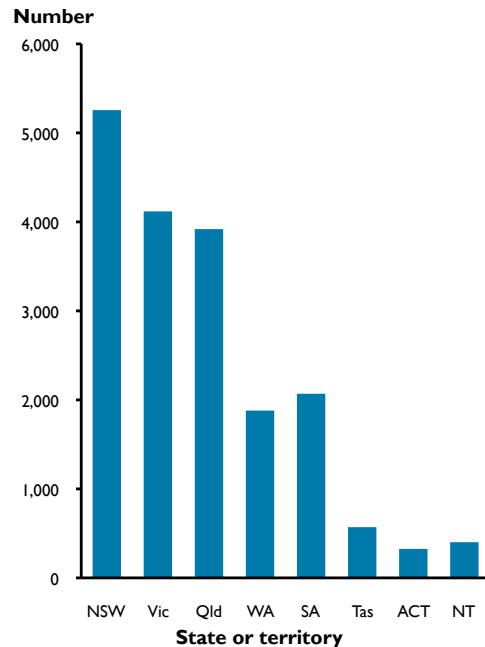


Figure 10: Number of PHaMs participants, 2013–14

Why are people receiving these services?

The most frequently reported mental illness diagnoses for PHaMs participants at the time of initial assessment were mood disorders, followed by anxiety disorders and psychotic delusional disorders (67%, 40% and 23%, respectively).

Almost 2 in 5 (37%) PHaMs participants reported experiencing another significant disability in addition to their primary mental illness. Of these, 20% reported a co-existing physical disability.

PHaMs participants are assessed on their areas of functional limitation resulting from mental illness. The most commonly reported limitations were: *Learning, applying knowledge and general demands*; *Social and community activities*; *Interpersonal relationships*; and *Working and employment* (97%, 97%, 96% and 95%, respectively).

PHaMs services identify 'special needs groups'; *Alcohol and/or drug issues* was the group most frequently reported (27%).

Where is the source of referral to PHaMs?

A specialist mental health care service was the most frequent source of referral, followed by self-referral (27% and 18%, respectively).

Specialist Homelessness Services

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

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

Key facts

- There were just over 56,000 SHS clients with a current mental health issue in 2013–14.
- *Housing crisis* was the most frequently recorded main reason for seeking assistance (17%), followed by *Domestic and family violence* (15%).

How much mental health care did these services provide?

Of the 213,000 SHS clients aged 10 years and over reported in 2013–14, 26% (56,281) had a current mental health issue. This equates to a rate of 241 people per 100,000 population.

Nationally, 57% of SHS clients with a current mental health issue accessed accommodation services (32,122 clients), which equates to a rate of 138 per 100,000 population. The Australian Capital Territory had the highest rate, followed by Tasmania (258 and 253, respectively). South Australia had the lowest rate (80) (Figure 11).

The national rate for clients accessing non-accommodation services was 108 per 100,000 population. The Australian Capital Territory had the highest rate, followed by Tasmania (195 and 155, respectively). Queensland had the lowest rate (60).

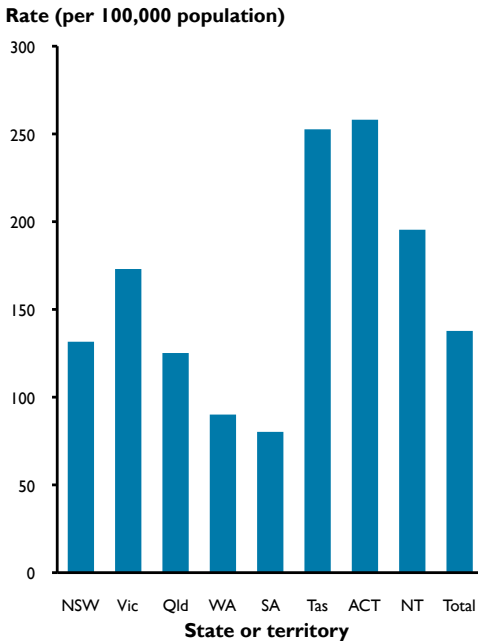


Figure 11: SHS clients with a current mental health issue accessing accommodation services per 100,000 population, 2013–14

Why are people receiving these services?

Of the clients with a current mental health issue presenting to an SHS agency in 2013–14, 44% reported being homeless in the previous 12 months.

For clients with a current mental health issue, *Housing crisis* was the most frequently recorded main reason for seeking assistance, followed by *Domestic and family violence* (17% and 15%, respectively).

What services were provided?

Of the 56,281 SHS clients with a current mental health issue in 2013–14, 55,352 (98%) received a service or referral. The most common service or referral provided was *Advice/information* (89%), followed by *Advocacy/liaison on behalf of client* (70%) and *Material aid/brokerage* (49%).

Mental health care resources

Mental health workforce

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

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

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

Key facts

- In 2013, there were about 3,000 psychiatrists, 23,000 psychologists and 20,000 mental health nurses employed in Australia.
- Nationally, there were 13 FTE psychiatrists per 100,000 population, 82 FTE mental health nurses and 86 FTE psychologists.

Psychiatrists

In 2013, there were 2,977 psychiatrists employed in Australia, with an FTE rate of 13 per 100,000 population. South Australia had the highest rate per 100,000 population, followed by the Australian Capital Territory (15.4 and 14.7, respectively). The Northern Territory had the lowest rate (8.0) (Figure 12).

Psychologists

In 2013, there were 23,144 registered psychologists employed in Australia, with an FTE rate of 86 per 100,000 population. The Australian Capital Territory had the highest rate per 100,000 population, followed by New South Wales (150 and 91, respectively). South Australia had the lowest rate (62) (Figure 12).

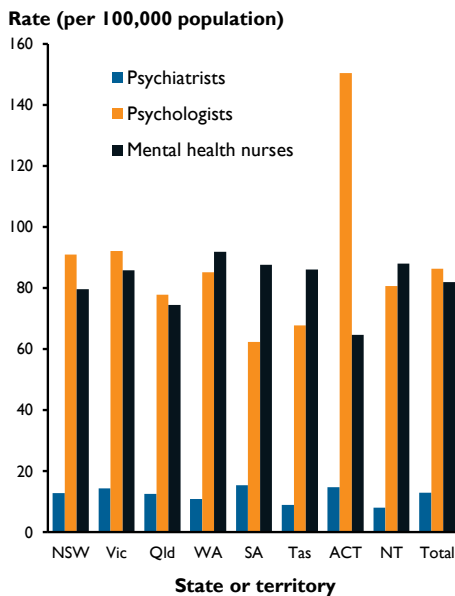


Figure 12: Employed psychiatrists, psychologists and mental health nurses per 100,000 population, 2013

Mental health nurses

In 2013, there were 19,626 mental health nurses employed in Australia, with an FTE rate of 82 per 100,000 population. Western Australia had the highest rate per 100,000 population, followed by South Australia (92 and 88, respectively). The Australian Capital Territory had the lowest rate (65) (Figure 12).

Mental health services expenditure

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

Key facts

- Over \$7.6 billion was spent on mental health-related services in Australia during 2012–13.
- The Australian Government spent \$906 million in benefits for Medicare-subsidised mental health-related services and \$788 million on subsidised mental health-related prescriptions during 2012–13.
- About \$4.6 billion was spent on state and territory specialised mental health services and \$309 million on specialised mental health services in private hospitals.

Expenditure on state and territory specialised mental health services

Recurrent expenditure (running costs only) for state and territory specialised mental health services was about \$4.6 billion in 2012–13, which equates to \$201 per person in the total population.

Western Australia had the highest per person expenditure followed by the Australian Capital Territory (\$252 and \$227, respectively). Victoria had the lowest per person expenditure (\$184) (Figure 13).

Per person expenditure (\$)

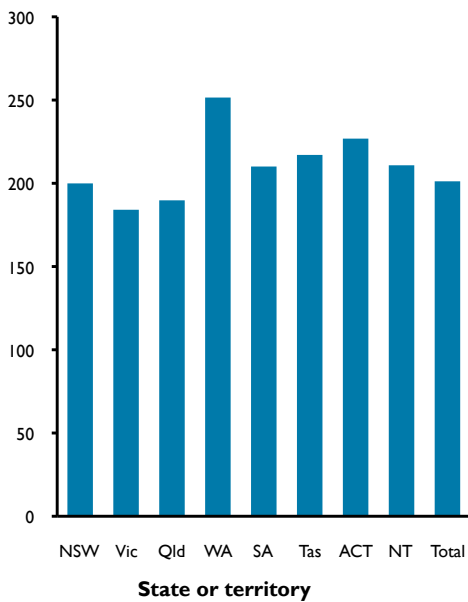


Figure 13: Recurrent expenditure on state and territory specialised mental health services per person, 2012–13

The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients (\$2.0 billion), comprising public acute hospitals with a specialist psychiatric unit or ward (\$1.5 billion) and public psychiatric hospitals (\$0.5 billion). This was closely followed by expenditure on community mental health care services totalling \$1.8 billion.

Australian Government expenditure

In 2012–13, the Australian Government spent almost \$2.8 billion, or \$121 per person, on mental health-related services.

About \$906 million was paid in benefits for Medicare-subsidised mental health-related services, which equates to \$40 per person nationally. Victoria had the highest per person expenditure on Medicare-subsidised

mental health-related services, followed by New South Wales (\$49 and \$40, respectively). The Northern Territory had the lowest per person expenditure (\$10).

Nationally, \$788 million was paid on mental health-related subsidised prescriptions under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS). This equates to \$34 per person. South Australia had the highest per person expenditure for mental health-related subsidised prescriptions under the PBS/RPBS, followed by Tasmania (\$41 and \$40, respectively). The Northern Territory had the lowest per person expenditure (\$14).

State and territory specialised mental health care facilities and workforce

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

Key facts

- There were 1,578 facilities (public and private) across Australia providing specialised mental health services during 2012–13.
- Specialised mental health services for admitted patients were provided by 163 public hospitals and 56 private hospitals.
- There were about 6,800 specialised mental health hospital beds and just over 2,350 beds available in residential mental health services.

State and territory specialised mental health care facilities

Nationally, there were 1,578 specialised mental health care facilities providing care in 2012–13. These included:

- 17 public psychiatric hospitals and 146 public acute hospitals with a psychiatric unit or ward
- 56 private psychiatric hospitals
- 83 government operated and 83 non-government operated residential mental health services
- 1,193 community mental health services.

Specialised mental health care beds

Nationally, in 2012–13, there were 6,768 specialised mental health hospital beds in public hospitals, 2,286 in private hospitals and 2,356 in residential mental health services. These included:

- 1,831 beds in public psychiatric hospitals and 4,937 beds in psychiatric wards of public acute hospitals
- 1,439 beds in government operated and 917 beds in non-government operated residential mental health services.

State and territory specialised mental health care workforce

Of the 30,298 FTE staff employed in state and territory specialised mental health care services in 2012–13, 51% were nurses, with most being registered nurses. Diagnostic and allied health professionals made up 19% of FTE staff, comprising mostly social workers and psychologists. Salaried medical officers made up 10%, comprising consultant psychiatrists and psychiatrists, and psychiatry registrars and trainees.

Nationally, there were 132 FTE direct care staff per 100,000 population employed in state and territory specialised mental health care services in 2012–13. Western Australia had the highest rate per 100,000 population, followed by Tasmania (157 and 141, respectively). The Australian Capital Territory had the lowest rate (114) (Figure 14).

There were 2,467 FTE staff employed by specialised psychiatric services in private hospitals during 2012–13, equating to 11 FTE staff employed per 100,000 population.

FTE (per 100,000 population)

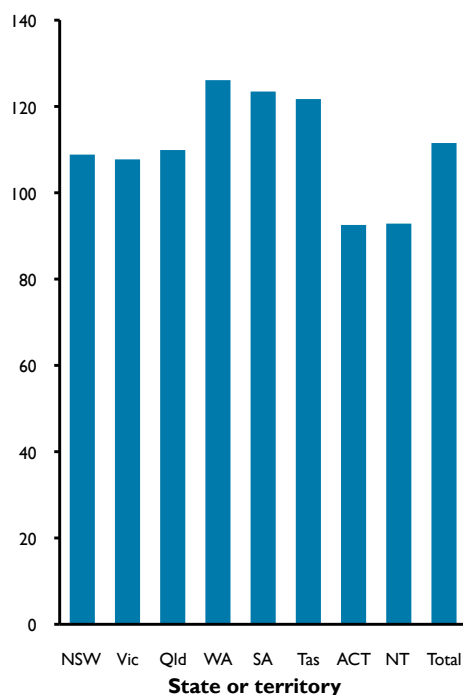


Figure 14: State and territory specialised mental health units, FTE direct care staff per 100,000 population, 2012–13

In focus 2015—mental health of children and adolescents

This section describes key findings from the second Child and Adolescent component of the National Survey of Mental Health and Wellbeing (the *Young Minds Matter* survey). The survey was conducted by the Telethon Kids Institute at the University of Western Australia in 2013–14 and released in August 2015. Refer to the full report for more detailed information about the survey (Lawrence et al. 2015).

How was the survey conducted?

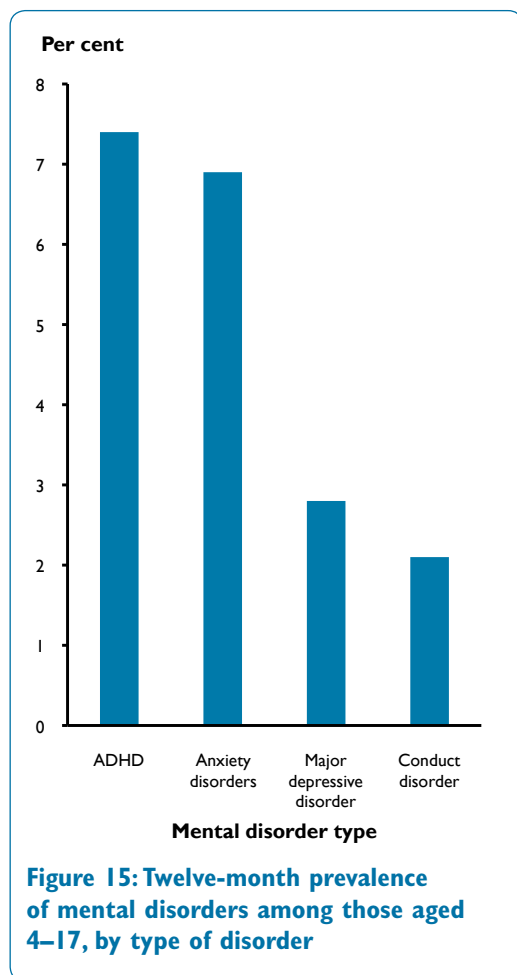
The Diagnostic Interview Schedule for Children Version IV was used to assess young people against the Diagnostic and Statistical Manual of Mental Disorders Version IV criteria.

A total of 76,606 households were approached to participate in the survey. In total, 6,310 parents and carers (that is, 55% of eligible households with children aged 4–17) responded and 2,967 (or 89% of eligible young people aged 11–17) participated with their parent's permission.

How many Australian children and adolescents have mental health problems and disorders?

Based on the *Young Minds Matter* survey, almost 1 in 7 (or 14%) of those aged 4–17 were assessed as having mental health disorders in the previous 12 months—equivalent to 560,000 children and adolescents. Mental disorders were more common in males than females (16% and 12%, respectively). The prevalence of mental disorders among males was similar for younger and older age groups (17% for those aged 4–11 and 16% for those aged 12–17); it was slightly higher for older rather than younger females (13% for those aged 12–17 and 11% for those aged 4–11).

Attention Deficit Hyperactivity Disorder (ADHD) was the most common mental disorder (just over 7% of 4–17 year olds or 298,000), followed by anxiety disorders (just under 7% or 278,000), major depressive disorder (3% or 112,000) and conduct disorder (2% or 83,600)—see Figure 15. Almost one-third (30% or 4% of all those aged 4–17) with a disorder had two or more mental disorders at some time in the previous 12 months.



The overall prevalence estimate from the second Child and Adolescent Mental Health Survey was similar to the estimate from the first survey conducted in 1998 of approximately 14%. However, there were changes in the prevalence for each of the mental disorders covered by both surveys: the prevalence of major depressive disorder increased from 2% to 3%, ADHD decreased from 10% to 8%, and conduct disorder decreased from 3% to 2%.

How do mental health problems and disorders impact children and adolescents?

Mental illness can affect young people in a variety of ways and to differing degrees. The survey used performance at school, relationships with friends and family as well as personal distress to assess impact. Using these criteria, it was determined that for children and adolescents aged 4–17 with a mental disorder, three-fifths (60%) had a mild disorder, one-quarter (25%) had a moderate disorder and 15% had a severe mental disorder.

The survey found that major depressive disorder had a greater impact on functioning than the other disorders, with almost 80% of cases being severe or moderate (43% severe and 36% moderate). The majority of ADHD, conduct disorder and anxiety disorders cases were mild (66%, 59% and 54%, respectively) (Figure 16).

Of the four types of disorder, major depressive disorder had the greatest impact on school attendance (Figure 17). The average number of days absent from school in the past 12 months due to major depressive disorder was 20 days, followed by 12 days for anxiety disorders, 8 days for conduct disorder and 5 days for ADHD.

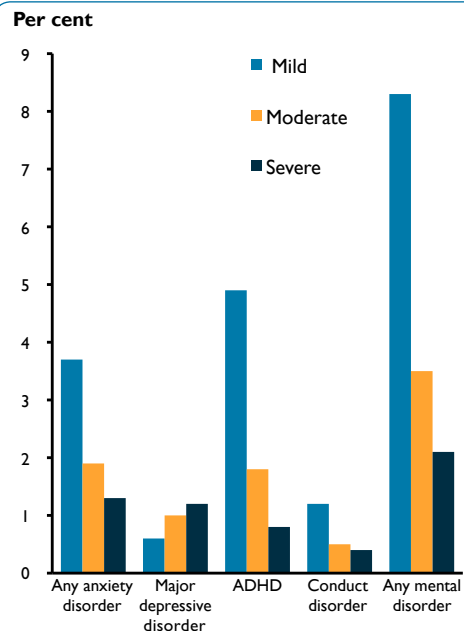


Figure 16: Twelve-month prevalence of mental disorders among those aged 4–17, by type of disorder and severity

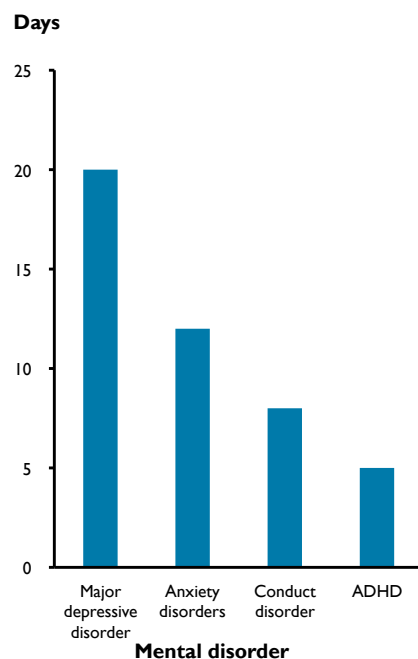


Figure 17: Days absent from school in the previous 12 months due to mental disorder symptoms

Service use by children and adolescents

Around 1 in 6 or 17% of those surveyed aged 4–17 had used services for emotional or behavioural problems in the previous 12 months, with 56% of those with at least one mental disorder using services. The services used by those aged 4–17 with a mental disorder were provided by a GP (35%), a psychologist (24%), a paediatrician (21%) and a counsellor or a family therapist (21%). Nearly 13% of children and adolescents with mental disorders had taken a medication for emotional or behavioural problems in the 2 weeks before the survey. A smaller proportion of those aged 4–17 with mental disorders were admitted to hospital/attended an emergency or outpatient department (6%) and received support from a specialist child and adolescent mental health service in the previous 12 months (3%).

Almost one-fifth of those surveyed who were aged 4–17 (19%) received informal support for emotional and behavioural problems; this type of support was received more commonly by those with a mental disorder (51%). Almost one-quarter (23%) of young people who used health services had been referred by their school.

Self-harm, suicidal behaviour and major depressive disorder

In the *Young Minds Matter* survey, self-harm refers to deliberately harming or injuring oneself without trying to end one's life. The survey estimated that 186,000 of those aged 12–17 (11% of that age group) have self-harmed, and a large majority of these people self-harmed in the previous 12 months (74%). Self-harm was more common in females than in males, and more common in older than in younger age groups (Figure 18); 17% of females aged 16–17 had self-harmed in the previous 12 months.

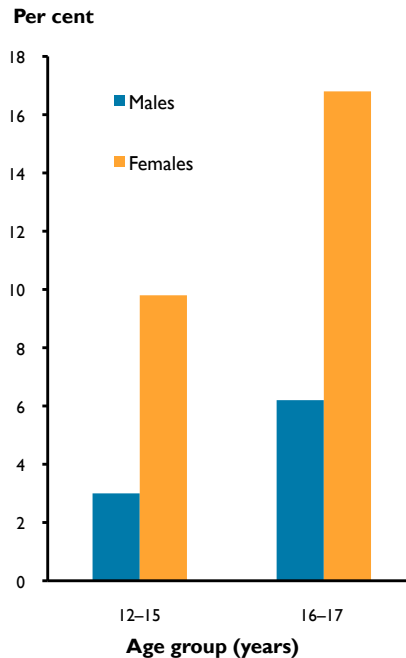


Figure 18: Self-harm in the previous 12 months in those aged 12–17, by sex and age group

Self-harm was particularly prevalent in young people with major depressive disorder; 26% of males and 55% of females aged 12–17 self-harmed in the previous year (Figure 19).

The survey found that 8% of young people aged 12–17 had seriously considered suicide in the previous year, with 2% reporting having attempted suicide. Suicidal ideation (serious thoughts about taking one's own life) is more prevalent in older adolescents and in females, with 15% of females aged 16–17 considering suicide. This contrasts with the sex difference in suicide mortality rate. In 2013, males aged 15–19 were two-and-a-half times as likely to suicide as females their age (14.3 and 5.6, respectively, per 100,000 population) (ABS 2015). Suicide is a complex phenomenon which is not fully understood. Some of the sex difference in the suicide rate may be

accounted for by the use of more lethal mechanisms of suicide by males. Use of firearm and hanging are two of the most lethal mechanisms of suicide, and more males than females suicide using these mechanisms (AIHW 2014).

Suicide attempts were particularly prevalent in young people with major depressive disorder; 14% of males and 22% of females aged 12–17 attempted suicide in the previous year. Experience of being bullied was common among young people with major depressive disorder, with 63% reporting having been bullied in the previous year.

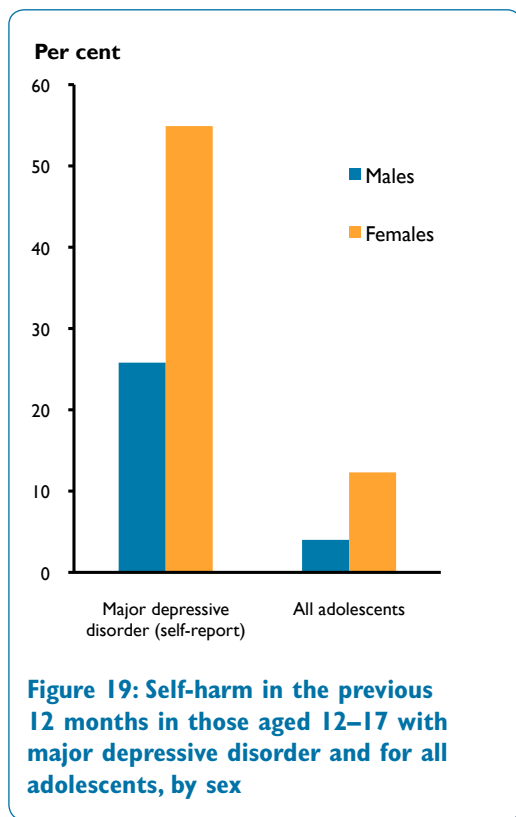


Figure 19: Self-harm in the previous 12 months in those aged 12–17 with major depressive disorder and for all adolescents, by sex

Key Performance Indicators for Australian Public Mental Health Services

The Key Performance Indicators (KPIs) for Australian Public Mental Health Services define a common framework and a standardised set of indicators to measure mental health sector performance across states and territories. First released in 2005, the Mental Health Services KPIs (MHS KPIs) are published on the AIHW's *Mental health services in Australia* website in interactive form at <http://mhsa.aihw.gov.au/indicators/nkpi>.

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

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

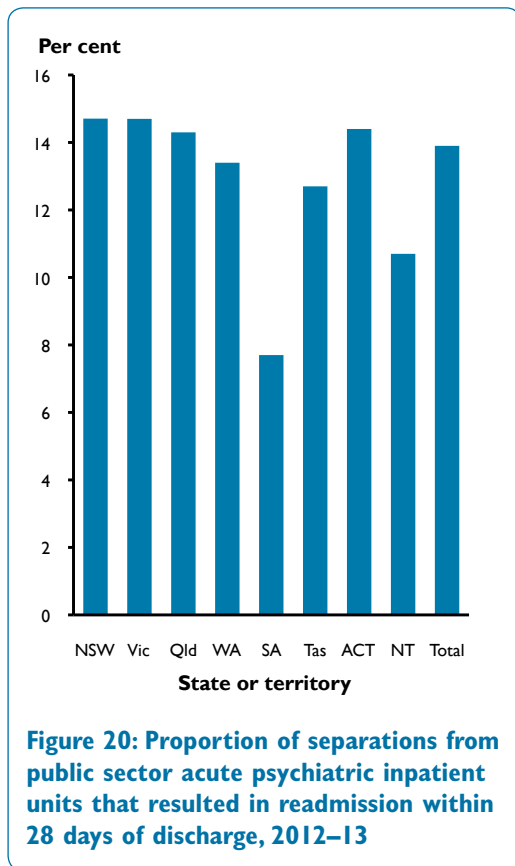
MHS KPI 2: 28 day readmission rate

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

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

28 day readmission rate: states and territories

In 2012–13, of the 81,925 separations from a psychiatric facility, 11,397 (14%) were followed by readmission within 28 days of discharge. New South Wales and Victoria had the highest rate (both 15%), followed by the Australian Capital Territory and Queensland (both 14%). South Australia had the lowest rate (8%) (Figure 20).



MHS KPI 11: Rate of pre-admission community care

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

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

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

Rate of pre-admission community care: states and territories

In 2012–13, 41% of public sector acute psychiatric inpatient unit admissions involved pre-admission community care. The Australian Capital Territory had the highest rate (67%), followed by the Northern Territory (54%). Tasmania had the lowest rate (12%) (Figure 21). Data are not available for Victoria in 2012–13.

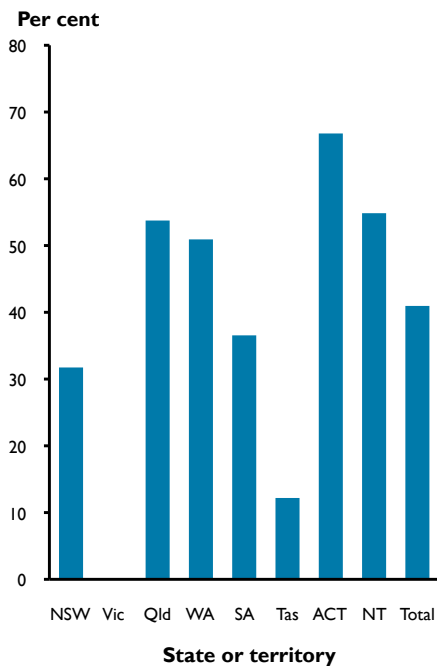


Figure 21: Rate of admissions to public sector acute psychiatric inpatient units that had community care in the 7 days preceding admission, 2012–13

MHS KPI 12: Rate of post-discharge community care

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

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

Rate of post-discharge community care: states and territories

In 2012–13, of the 62,386 separations from an acute psychiatric inpatient unit, 37,851 (61%) involved post-discharge community care. The Australian Capital Territory had the highest rate (74%) followed by Queensland (73%). Tasmania had the lowest rate (21%) (Figure 22). Data are not available for Victoria in 2012–13.

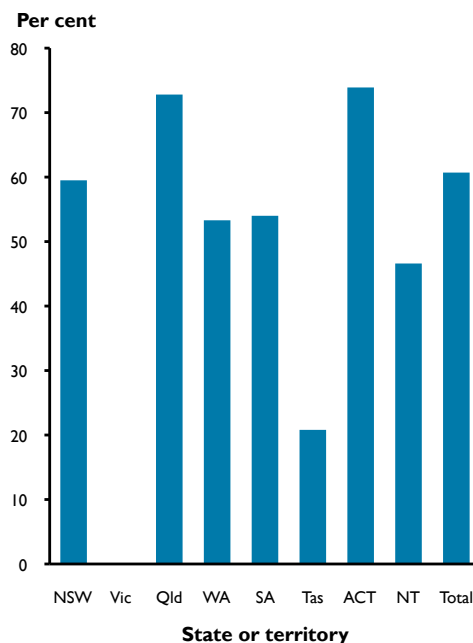


Figure 22: Proportion of separations from public sector acute psychiatric inpatient units that had post-discharge community care in the 7 days following discharge, 2012–13

Glossary

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

admitted patient care—when the care provided is specific to the hospital setting. Patients can have separations with specialised psychiatric care (within a specialised psychiatric unit or ward) or without specialised psychiatric care (no care within a specialised psychiatric unit or ward).

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

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

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

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

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

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

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

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

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

PBS: stands for Pharmaceutical Benefits Scheme, which subsidises the cost of prescription medicine.

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

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

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

Major cities— includes most capital cities, as well as major urban areas such as Newcastle, Geelong and the Gold Coast

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

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

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

Very remote—includes towns such as Tennant Creek, Longreach and Coober Pedy.

residential mental health care:

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

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

References

- ABS (Australian Bureau of Statistics) 2008. National Survey of Mental Health and Wellbeing 2007: summary of results. ABS cat. no. 4326.0. Canberra: ABS.
- ABS 2015. Causes of death, Australia, 2013. ABS cat. no. 3303.0. Canberra: ABS.
- AIHW (Australian Institute of Health and Welfare): Harrison JE & Henley G 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat. no. INJCAT 169. Canberra: AIHW.
- Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez AD 2007. The burden of disease and injury in Australia. Cat. no. PHE 82. Canberra: AIHW.
- DoHA (Department of Health and Ageing) 2013. National mental health report 2013: tracking progress of mental health reform in Australia 1993–2011. Canberra: DoHA.
- DSS (Department of Social Services) 2014. Characteristics of disability support pension recipients, June 2013. Canberra: DSS.
- IHME (Institute for Health Metrics and Evaluation) 2013. The global burden of disease: generating evidence, guiding policy. Washington: IHME. Viewed 29 July 2015, <<http://www.healthmetricsandevaluation.org/gbd>>.
- Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR 2015. The mental health of children and adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health. Viewed 7 October 2015, <[http://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/\\$File/child2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf)>.
- Morgan VA, Waterreus A, Jablensky A, Mackinnon A, McGrath JJ, Carr V et al. 2011. People living with psychotic illness 2010. Canberra: DoHA.
- NMHPSC (National Mental Health Performance Subcommittee) 2011. Key performance indicators for Australian public mental health services. 2nd edn. Canberra: NMHPSC.
- Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J et al. 2009. The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: DoHA.
- Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ et al. 2014. Estimating treatment rates for mental disorders in Australia. Australian Health Review 38:80–5.



Mental health services—in brief 2015 provides an overview of data about the national response of the health and welfare system to the mental health care needs of Australians. It is designed to accompany the more comprehensive data on Australia's mental health services available online at <http://mhsa.aihw.gov.au>.

