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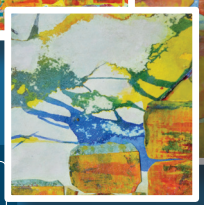
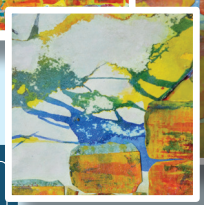


MENTAL HEALTH SERVICES

In brief

2016



MENTAL**HEALTH**SERVICES

In brief

The Australian Institute of Health and Welfare is a major national agency that provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's purpose is to provide authoritative information and statistics to promote better health and wellbeing among Australians.

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Reward

(Mixed media on paper)

Rebecca Ferdinandes

Rebecca Ferdinandes is an artist residing on the Sunshine Coast of Queensland who lives with mental health issues. She endures the varied complications that come with PTSD and believes that creativity is a great way to express one's feelings and experience inner peace.

The thought process of this artwork was based on the steps needed to be taken when we search for help, through our community networks. The steps will vary from person to person and it may be rocky, but the final outcome is a brighter future with much to look forward to, such as family, education, friends, outdoor activities or even creative activities; being active in life helps individuals to endure mental health issues.

Contents

Introduction 1

The prevalence of mental illness in Australia 1

The impact of mental illness in Australia 3

Australia's mental health care system—an overview 4

Mental health care services and support 5

Mental health care resources 20

Key Performance Indicators for Australian Public Mental Health Services 26

Glossary 28

References 30

Introduction

This *Mental health services—in brief 2016* report is the companion publication to the *Mental health services in Australia* website <http://mhsa.aihw.gov.au>. The report provides an annual overview of key statistics and related information on mental health services, while incorporating updates made to the website over the 12 months to October 2016. The most recent data from a number of data sources inform this report. As such, the reference year reported may vary between sections.

This report briefly describes the prevalence and impact of mental illness in Australia, followed by an overview of the mental health care system that supports people in Australia. Later sections provide insights into mental health-related services, medications and resources accessed by Australians with mental health issues. The report concludes by reporting on 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.

The prevalence of mental illness in Australia

Key facts:

- It is estimated that almost half of Australians will experience a common mental disorder in their lifetime.
- It is estimated that almost 1 in 7 young people aged 4–17 were assessed as having mental health disorders in the previous 12 months.
- It is estimated that 64,000 people or 0.45% of the population aged 18–64 accessed treatment annually for a psychotic disorder (based on 2010 population).

What do we mean by mental illness?

Mental illness refers to a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities (Slade et al. 2009).

The term comprises a spectrum of disorders that vary in severity and duration. Mental illness can have damaging effects on individuals and families affected and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma (WHO 2016). The terms mental illness and mental disorder are often used interchangeably.

How many people have mental illness?

The 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (aged 16–85) estimated that almost half (45.5%) of Australian adults (9.7 million people based on the 2011 Census) would experience a common mental disorder in their lifetime. Each year, 1 in 5 Australians in this age range (4.3 million Australians based on the 2011 Census) are estimated to experience a mental disorder (ABS 2008).

Which mental disorders are the most common?

Anxiety disorders (such as social phobia) were the most common type of disorder reported in the NSMHWB, with 14.4% of Australian adults experiencing an anxiety disorder in the previous 12 months. This was followed by affective disorders (such as depression, 6.2%) and substance-use disorders (for example, alcohol dependence, 5.1%) (ABS 2008).

Women experienced higher prevalence of 12-month mental disorders than men (22.3% compared to 17.6%) (see Figure 1).

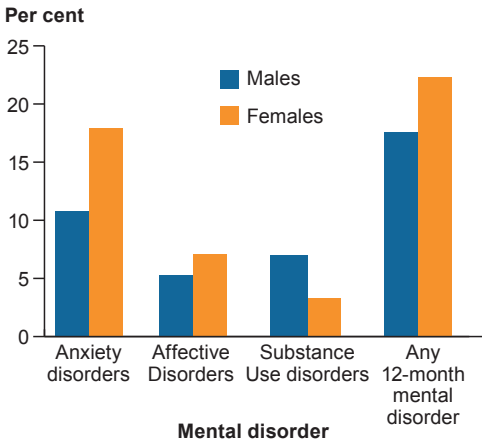


Figure 1: Prevalence of common mental disorders in Australian adults, by sex, 2007

Mental illness in young people

The most recent Australian Child and Adolescent Survey of Mental Health and Wellbeing (also known as the *Young Minds Matter* survey) was undertaken in 2013–14 (Lawrence et al. 2015). It estimated that almost 1 in 7 (13.9% or 560,000 people) young people aged 4–17 met the clinical criteria for one or more mental health disorders in the previous 12 months. *Attention Deficit Hyperactivity Disorder (ADHD)* was the most common mental disorder (7.4% or 298,000 children and adolescents), followed by *Anxiety disorders* (6.9% or 278,000), *Major depressive disorder* (2.8% or 112,000) and *Conduct disorder* (2.1% or 83,600).

A comparison of prevalence data from the *Young Minds Matter* survey with the first national Child and Adolescent Survey of Mental Health and Wellbeing (conducted in 1998) suggests that overall prevalence has remained relatively stable for common mental disorders over time, with modest declines in prevalence of ADHD and conduct disorder and a modest increase in the prevalence of major depressive disorder (Lawrence et al. 2015).

How common are more severe disorders such as psychotic disorders?

The National Survey of Psychotic Illness 2010 estimated that annually, 64,000 people aged 18–64 with a psychotic disorder accessed treatment from public specialised mental health services. More people had a diagnosis of *Schizophrenia* than any other type of psychotic illness (47.0%). About two-thirds (64.8%) of these people experienced their first episode of psychotic illness before age 25 (Morgan et al. 2011).

The impact of mental illness in Australia

Key facts:

- It is estimated that 2–3% of Australians have a severe mental disorder.
- Mental and substance use disorders were the leading cause of non-fatal burden of disease, accounting for almost one-quarter of all years lived with a disability.
- It is estimated that more than 1 in 10 adults with a mental disorder in the last 12 months also experienced a physical disorder.

What is the impact of mental illness?

Mental disorders can vary in severity and duration and may be episodic in nature. A recent review estimated that 2–3% of Australians (600,000 people) have severe mental 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. Around 4–6% of the Australian population (approximately 1 million people) have moderate disorders and a further 9–12% (approximately 2 million people) have a mild disorder (DoHA 2013).

Mental illness' contribution to the burden of disease in Australia

The 2011 Australian Burden of Disease Study examined the fatal and non-fatal impact of different diseases, conditions or injuries on Australians. This estimate of Australia's health provides an evidence base to inform health policy, program and service delivery (AIHW 2016a).

It is estimated that *Mental and substance use disorders* were responsible for 12.1% of total disease burden in Australia in 2011, making it the third ranked group of diseases behind *Cancer* and *Cardiovascular diseases* (see Figure 2). It was also the leading cause of non-fatal burden, accounting for almost one-quarter (23.6%) of all years lived with a disability.

Just over one-quarter (26.0%) of the burden due to *Mental and substance use disorders* was attributed to *Anxiety disorders*, and a similar proportion (23.5%) to *Depressive disorders*. A further 12.2% was attributed to *Alcohol use disorders*.

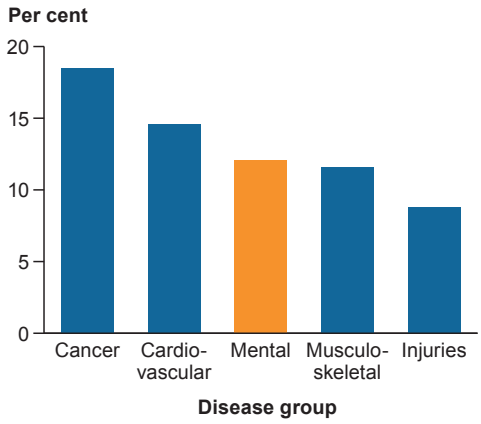


Figure 2: Australia's top 5 burden of disease groups, 2011

The comorbidity of mental illness

Mental disorders often coexist with one or more physical disorders, often referred to as a 'comorbid' disorder. From the 2007 NSMHWB, 11.7% of adults with a mental disorder in the last 12 months also reported a physical disorder, with 5.3% reporting 2 or more mental disorders and 1 or more comorbid physical conditions (ABS 2008).

According to the Australian National Survey of People Living with Psychotic Illness 2010, people being treated for psychotic illness also frequently experience poor physical health outcomes and comorbidities (Morgan et al. 2011).

People being treated for psychotic illness were more likely to experience a number of physical health conditions as compared to the general population, for example, they were more than 3 times as likely to have diabetes and more than one and a half times as likely to have a heart or circulatory condition (Morgan et al. 2011).

Australia's mental health care system—an overview

Key facts:

- 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.
- Specialised mental health care is delivered in a range of facilities designed to support people with a mental illness including public and private psychiatric hospitals, community mental health care services and government/ non-government-operated residential mental health services.
- The 2007 NSMHWB estimated that more than one-third (34.9%) of people with a mental disorder in the last 12 months had accessed services for mental health problems.

Australia's mental health 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 mental illness. These include admitted patient services delivered in hospitals and services delivered in community settings.

The Australian Government funds a range of 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 prescriptions through the Pharmaceutical Benefits Scheme (PBS)/ Repatriation Pharmaceutical Benefits Scheme (RPBS).

Who receives mental health care?

The 2007 NSMHWB estimated that more than one-third (34.9%) of people with a mental disorder in the previous 12 months accessed mental health services (1.1 million people) (ABS 2008). Of these:

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

Based on the *Young Minds Matter* survey, 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 1 mental disorder using services (Lawrence et al. 2015). The services used by those aged 4–17 with a mental disorder were provided by a GP (35%), a psychologist (24%), a paediatrician (21%) or a counsellor or family therapist (21%).

How is mental health care 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 and support include GPs, psychologists, psychiatrists, nurses, occupational therapists, social workers and peer 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 that non-government organisations deliver (such as telephone counselling services).

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 (EDs) 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.

Mental health care services and support

Mental health care provided by general practitioners

The first professional encounter for many people seeking help for a mental illness is their GP. Data from the Bettering the Evaluation and Care of Health (BEACH) survey of GPs provides a picture of these mental health-related GP encounters. Medicare data on mental health-related MBS items are also available.

Key facts:

- There were an estimated 17.6 million mental health-related GP encounters in 2014–15.
- GPs provided about 2.9 million MBS-subsidised mental health-related services to about 1.7 million patients in 2014–15.
- *Depression*, *Anxiety* and *Sleep disturbance* were the 3 mental health-related problems that GPs most frequently managed in 2014–15.

How many services were provided?

Data from the BEACH survey estimated that 12.7% of all GP encounters in 2014–15 were mental health-related (17.6 million GP encounters nationally). These estimates are much higher than the total number of MBS-subsidised mental health-related services that GPs provided in the same year. These estimates suggest that it is likely that most mental health-related GP activities are billed as general MBS items.

GPs provided 29.8% of all MBS-subsidised mental health-related services, a total of about 2.9 million services in 2014–15, or a rate of 123.5 services per 1,000 population. These services were provided to about

1.7 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 at 143.1 per 1,000 population, with the Northern Territory having the lowest with 54.0.

How is this changing over time?

The estimated rate of mental health-related GP encounters per 1,000 population increased by an annual average of 4.4% between 2010–11 and 2014–15. The proportion of all GP encounters that were mental health-related increased from 11.7% in 2010–11 to 12.7% in 2014–15.

Who is accessing these services?

About 1 in 4 mental health-related GP encounters were for patients aged 65 and over (24.7%), with almost three-fifths of encounters for females (58.9%). The proportion of GP encounters decreased as remoteness area of usual residence increased.

Why are people receiving services?

Depression, *Anxiety* and *Sleep disturbance* were the 3 mental health-related problems that GPs most frequently managed in 2014–15, accounting for 4.5, 2.2 and 1.7 per 100 GP encounters respectively (see Figure 3).

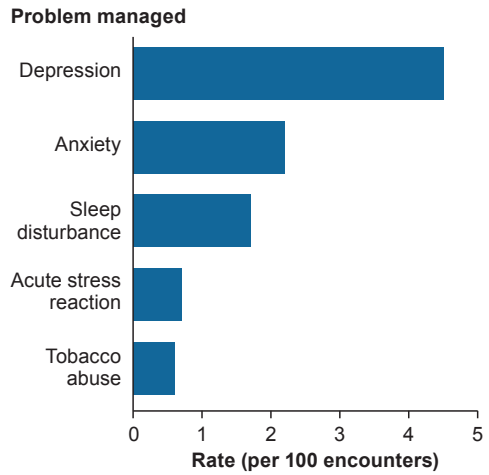


Figure 3: The 5 most common problems managed during mental health-related GP encounters, 2014–15

What services were provided?

Prescribing, recommending or supplying a mental health-related medication was the most frequent type of management that GPs provided in 2014–15 for mental health-related encounters, followed by counselling services (63.7 and 45.3 respectively, of every 100 mental health-related problems). Referrals to either a psychiatrist or psychologist were provided at rates of 2.0 and 9.1 respectively, per 100 mental health-related encounters.

Mental health care subsidised by Medicare

Medicare-subsidised mental health-related services are provided by psychiatrists, GPs, psychologists, and other allied health professionals (in particular, social workers, mental health nurses and occupational therapists). The services are provided in a range of settings—in hospitals, consulting rooms, home visits, over the phone and by video link.

Key facts:

- About 10 million MBS-subsidised mental health-related services were provided to an estimated 2 million patients in 2014–15, averaging about 5 services per patient.
- GPs provided the largest proportion of MBS-subsidised mental health-related services, followed by non-clinical psychologists and psychiatrists.
- Victoria had the highest number of patients and services per 1,000 population for MBS-subsidised mental health-related services.

Who provides these Medicare-subsidised mental health-related services?

In 2014–15 the largest proportion of MBS-subsidised mental health-related services were provided by GPs (29.8%), followed by non-clinical psychologist services (24.3%) and psychiatrists (23.5%). Psychiatrists had the highest number of services per patient, with 6.4 services provided per patient seen.

Who uses these services?

About 10 million MBS-subsidised mental health-related services were provided to an estimated 2 million patients in 2014–15; equivalent to a rate of 87.6 per 1,000 population. The rate of service access was highest for those aged 35–44 (122.2 per 1,000 population). This was true for all provider types except psychiatrists, for whom the rate of access was highest in people aged 45–54 (21.5 per 1,000 population). More females than males used MBS-subsidised mental health-related services (60.2% of people accessing services were female). Those in *Major cities* were most likely to access services, with access decreasing as remoteness increased. This finding was true for all provider types.

How is this changing over time?

The number of MBS-subsidised mental health-related services provided each year is increasing, with 7.7 million services observed in 2010–11 increasing to 9.8 million services in 2014–15. This is the case for all provider types (see Figure 4).

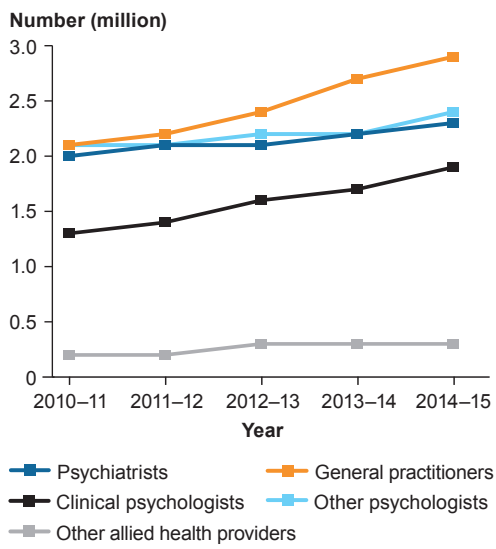


Figure 4: Medicare-subsidised mental health-related services, by provider type, 2010–11 to 2014–15

From 2010–11 to 2014–15, clinical psychologist services had the highest average annual increase (10.2%), followed by GP services (8.2%) and services provided by other allied mental health services (7.8%).

How do rates differ between states and territories?

Among states and territories, Victoria had the highest rate of patients and services per 1,000 population (97.9 and 493.4, respectively) for Medicare-subsidised mental health-related services, substantially higher than the national rate of 87.6 patients and 414.2 services per 1,000 population. The Northern Territory had the lowest rate for both patients (38.9) and services (115.8).

Mental health services provided in public hospital emergency departments

Public hospital EDs play an important role in treating mental illness and are often used as an initial point of care for those seeking mental health-related services for the first time, as well as an alternative point of care for people seeking after-hours mental health care.

Data for the ACT were not available for the 2014–15 reporting period. This limits the presentation of national activity and comparisons over time.

Key facts:

- There were an estimated 256,178 ED occasions of service with a mental health-related principal diagnosis during 2014–15.
- The most frequently recorded principal diagnoses were *Mental and behavioural disorders due to psychoactive substance use* and *Neurotic, stress-related and somatoform disorders*.
- Mental health-related ED occasions of service had a higher proportion of patients aged 15–54 compared with all ED occasions of service.

How much mental health care did these services provide?

There were an estimated 256,178 ED occasions of service with a mental health-related principal diagnosis during 2014–15 (3.4% of all ED occasions of service). The rate of mental health-related ED occasions of services was highest in the Northern Territory (255.5 occasions per 10,000 population) and lowest in Victoria (82.7 occasions per 10,000 population).

What services were provided?

In 2014–15, 79.3% of mental health-related ED occasions of service were classified on 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 12.3% 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 (60.7%).

Why are people receiving these services?

The most frequently recorded principal diagnoses were *Mental and behavioural disorders due to psychoactive substance use* (such as alcohol dependency disorders) and *Neurotic, stress-related and somatoform disorders* (such as anxiety disorders), which made up 26.6% and 26.5% of mental health-related ED occasions of service, respectively.

How does ED mental health-related care compare to all ED visits?

Mental health-related ED occasions of service had a higher proportion of patients aged 15–54 (77.7%) compared with all ED occasions of service (49.4%) and a much lower proportion of patients aged less than 15 (3.7%) compared with all ED occasions of service (21.2%) (see Figure 5).

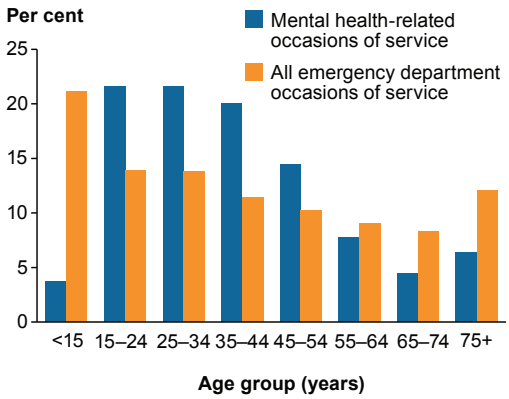


Figure 5: ED occasions of service in public hospitals, by age group, 2014–15

Aboriginal and Torres Strait Islander people accounted for 9.3% of mental health-related ED occasions of service, compared with 6.3% of all ED occasions of service.

Males and females were similarly represented in mental health-related ED occasions of service and all ED occasions of service.

State and territory community mental health care services

Mental illness is frequently treated in community and hospital-based ambulatory care settings. Collectively, these services are referred to as specialised Community Mental Health Care (CMHC).

Data for the ACT were not available for the 2014–15 reporting period. This limits the presentation of national activity and comparisons over time.

Key facts:

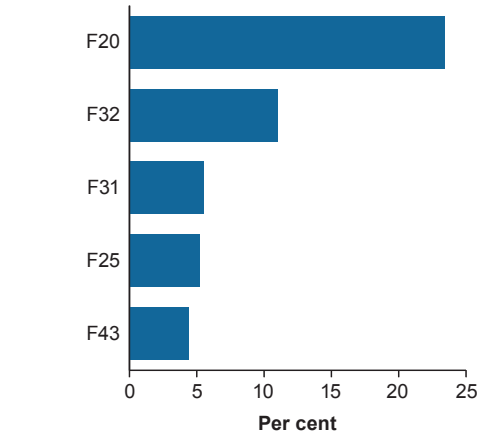
- About 8.5 million CMHC service contacts were recorded in 2014–15.
- On average, each patient had 21.8 service contacts during 2014–15.
- The most frequently recorded principal diagnosis for patients who had service contacts with specialised CMHC services was *Schizophrenia*, accounting for more than 1 in 5 contacts.

How much mental health care did these services provide?

Nationally, CMHC services provided 8.5 million service contacts in 2014–15. These were provided to 391,573 patients, equating to an average of 21.8 service contacts per patient per year.

Why are people receiving these services?

The most frequently recorded principal diagnoses for patients who had contact with CMHC services were *Schizophrenia* (accounting for 23.4% of contacts), followed by *Depressive episode* (11.0%) and *Bipolar affective disorders* (5.5%) (see Figure 6).



F20 Schizophrenia

F32 Depressive episode

F31 Bipolar affective disorders

F25 Schizoaffective disorders

F43 Reaction to severe stress and adjustment disorders

Figure 6: Community mental health care service contacts, for 5 commonly reported mental health-related principal diagnoses, 2014–15

Nationally, contacts for males aged 25–44 made up one-quarter of all service contacts (24.3%).

What services were provided?

CMHC service contacts can be conducted individually 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, 86.6% of service contacts (or 7.4 million contacts) were individual contacts and 62.2% (5.3 million contacts) of service contacts took place with the patient present.

State and territory residential mental health care

Residential mental health care (RMHC) services provide specialised mental health care on an overnight basis in a domestic-like environment. These services may include rehabilitation, treatment or extended care. RMHC services are not provided in Queensland.

Data for the ACT were not available for the 2014–15 reporting period. This limits the presentation of national activity and comparisons over time.

Key facts:

- About 7,750 residential episodes of care were provided to more than 5,800 residents in 2014–15.
- *Schizophrenia* (24.8%) and *Specific personality disorders* (10.8%) were the most common specified principal diagnoses.
- The proportion of involuntary admissions has decreased over time with 19.1% of episodes admitted involuntarily in 2014–15.

How much mental health care did these services provide?

Nationally, RMHC services provided 301,701 residential care days within 7,749 episodes of care, with an average of 1.3 episodes per resident and 39 residential care days per episode.

The provision of RMHC services differed among states and territories in 2014–15, with Tasmania reporting the highest rate of episodes of care and residents (21.3 and 11.9 per 10,000 population respectively) and New South Wales reporting the lowest rate for both episodes and residents (0.5 and 0.3 per 10,000 population respectively).

Who is accessing residential mental health care services?

In the past, males accessed a higher proportion of residential episodes than females. However, for the past 2 years, the proportion of residential episodes has been slightly higher for females than males (50.7% and 49.3% respectively in 2014–15). People aged 35–44 were the largest group of service users, accounting for around one-quarter of episodes (26.0%).

Almost two-thirds (64.0%) of residential care episodes were for people who live in *Major cities*. About three in ten residential episodes were for people classified as being in the most disadvantaged socioeconomic status quintile.

For episodes where a principal diagnosis was reported, the two most common principal diagnoses were *Schizophrenia* and *Specific personality disorders* (24.8% and 10.8% respectively).

What does a typical episode of residential care look like?

Over half (58.1%) of completed residential episodes had a length of stay of 2 weeks or less. Almost 1 in 25 episodes lasted 3 to 12 months (4.3%). Around 1 in 5 residents were admitted involuntarily (19.1% of episodes) (see Figure 7).

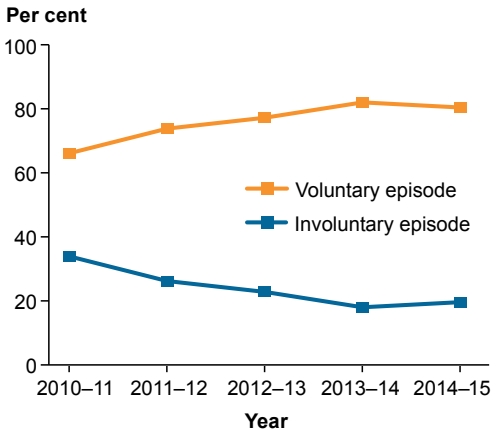


Figure 7: Episodes of residential care, by mental health legal status, 2010–11 to 2014–15

Over 4 in 5 (83.1%) residential mental health episodes ended as a result of formal discharge, with less than 1 in 50 (1.8%) leaving against clinical advice.

Admitted patient mental health-related care

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

Data for the ACT were not available for the 2014–15 reporting period. This limits the presentation of national activity and comparisons over time.

Key facts:

- There were about 254,800 mental health-related hospitalisations in public and private hospitals in 2014–15.
- About 3 in 5 of mental health-related hospitalisations included specialised care.
- For hospitalisations with specialised psychiatric care, *Depressive episode* and *Schizophrenia* were the most frequently recorded principal diagnoses.
- For hospitalisations without specialised psychiatric care, the most frequently recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol*.

How much mental health care did these services provide?

There were 254,808 mental health-related hospitalisations in public and private hospitals in 2014–15, of which more than 3 in 5 (61.7%) were with specialised psychiatric care.

Essentially all (99.8%) of mental health-related hospitalisations in public psychiatric hospitals were for specialised psychiatric care. For private hospitals, about 4 in 5 (82.0%)—and for public acute hospitals around half (53.6%)—mental health-related hospitalisations were for specialised psychiatric care.

Who uses these services?

For hospitalisations with specialised psychiatric care, females (7.2 per 1,000 population) used these services more frequently than males (6.3). The highest rates were for people aged 35–44 (10.7).

For hospitalisations without specialised care, the rate was higher for females (4.4 per 1,000 population) than males (4.0). The highest rate occurred for people aged 65 and over (9.2).

About one-third (31.1%) of all hospitalisations with specialised psychiatric care were for patients who had an involuntary admission; the majority of these (44,137 or 90.3%) occurred in public acute hospitals (see Figure 8).

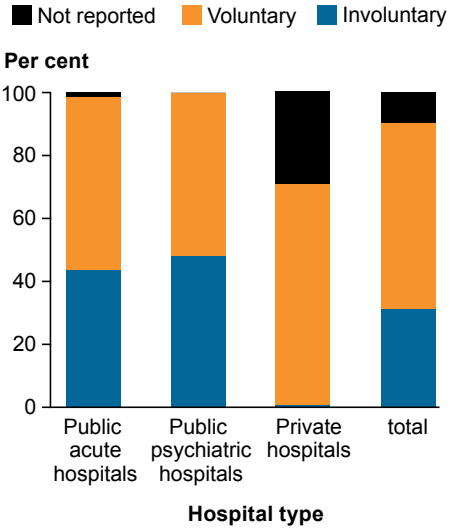


Figure 8: Mental health-related hospitalisations with specialised psychiatric care, by mental health legal status and hospital type, 2014–15

Indigenous Australians had a mental health-related hospitalisation rate without specialised psychiatric care that was more than 3 times that of other Australians (12.0 and 3.8 per 1,000 population respectively). A similar pattern can be seen in the rate of mental health-related hospitalisations with specialised care, at double the rate of other Australians (12.8 and 6.5 per 1,000 population respectively).

Why are people receiving these services?

For hospitalisations with specialised psychiatric care, *Depressive episode* (17.4%) and *Schizophrenia* (13.5%) were the most frequently recorded principal diagnoses. For hospitalisations without specialised psychiatric care, the most frequently recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (18.4%), followed by *Other organic mental disorders* (12.9%).

What services were provided?

Generalised allied health interventions was the most commonly reported procedure block for hospitalisations both with and without specialised psychiatric care (41.3% and 39.6% of separations respectively).

Ambulatory-equivalent mental health-related admitted patient care in public hospitals

In some circumstances, patients admitted to hospital are provided with care which is comparable to that provided by community mental health services. This is referred to as 'ambulatory-equivalent' mental health care and can be classified as being with or without specialised psychiatric care. This type of care can be provided in a public acute, public psychiatric or private hospitals.

Data for the ACT were not available for the 2014–15 reporting period. This limits the presentation of national activity and comparisons over time.

Key facts:

- There were about 28,500 ambulatory-equivalent mental health-related hospitalisations in public hospitals in 2014–15.
- Specialised psychiatric care was provided for about one-third of ambulatory-equivalent hospitalisations in public hospitals; more than two-thirds did not include specialised psychiatric care.
- Indigenous people represented 11.6% of ambulatory-equivalent hospitalisations without specialised care.

How much mental health care did these services provide?

In 2014–15, there were approximately 6.0 million hospitalisations reported from Australian public hospitals (AIHW 2016b) of which 28,489 (0.5%) were ambulatory-equivalent mental health-related hospitalisations in public acute and public psychiatric hospitals (AIHW 2016b).

For those states and territories which were able to be reported, there was some variability in the rates of ambulatory-equivalent mental health-related hospitalisations, with and without specialised psychiatric care. The highest rate was seen for the Northern Territory followed by Queensland (30.1 and 18.1 per 10,000 population respectively). Tasmania had the lowest rate for the 2014–15 reporting period (4.7) (see Figure 9).

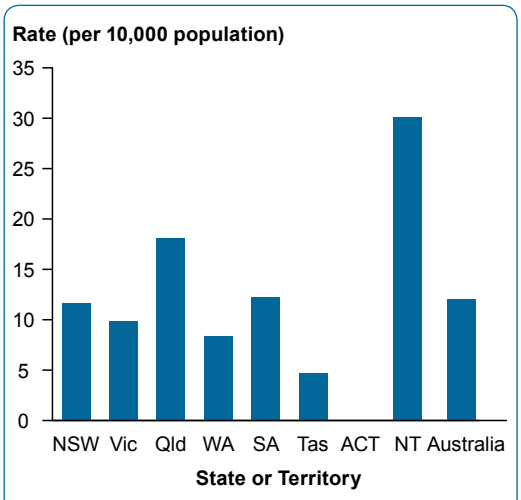


Figure 9: Ambulatory-equivalent mental health-related hospitalisations in public hospitals, with and without specialised psychiatric care, state or territory, 2014–15

Who uses these services?

The rate of ambulatory-equivalent mental health-related hospitalisations with specialised care was highest for patients aged 65 and over and lowest for those aged 55–64 (8.9 and 0.6 per 10,000 population respectively). Females were more likely to receive these services

than males, accounting for 58.1% of ambulatory-equivalent hospitalisations.

Overall, males and females had similar rates of ambulatory-equivalent hospitalisations without specialised care (8.5 and 8.0 respectively). The highest rate of ambulatory-equivalent mental health-related hospitalisations without specialised care was for people aged 15–24 (13.6 per 10,000 population) and the lowest was for those aged under 15 (3.0).

Why are people receiving these services?

For ambulatory-equivalent mental health-related hospitalisations with specialised care, *Other anxiety disorders* (which includes *Panic disorder*, *Generalised anxiety disorder*, *Mixed anxiety and depressive disorder*, as well as other mixed anxiety disorders) was the most common principal diagnosis (1,596 separations or 17.9%).

The most common principal diagnosis for ambulatory-equivalent hospitalisations without specialised care was *Mental and behavioural disorders due to use of alcohol* (7,267 or 36.7%).

What services were provided?

About 1 in 9 (11.6%) of all public hospital ambulatory-equivalent mental health-related hospitalisations included at least 1 procedure. In total, 3,591 procedures were recorded for hospitalisations with and without specialised psychiatric care. The most frequently recorded procedure was for *Generalised allied health interventions*, accounting for 41.7% of all recorded procedures.

Ambulatory-equivalent mental health-related admitted patient care in private hospitals

Hospital care can also be provided in an 'outpatient'-like setting in a private hospital, referred to as 'private hospital-based ambulatory psychiatric care'. These hospitalisations do not involve an overnight hospital stay, but instead are provided on either an admitted 'same day' basis or on a home-based admitted patient service. Private hospital-based ambulatory psychiatric care is provided in either private hospitals with psychiatric beds or private psychiatric day hospitals (PMHA 2015).

Key facts:

- About 18,000 patients were provided with private hospital-based ambulatory psychiatric care in 2014–15.
- On average, 13.5 care days were provided per patient.
- About half of private hospital-based ambulatory psychiatric episodes provided in 2014–15 had a principal diagnosis of *Major affective and other mood disorder*.

How much mental health care did these services provide?

In 2014–15, there were approximately 4.2 million hospitalisations reported from Australian private hospitals of which 15,060 were private hospital-based ambulatory psychiatric episodes (AIHW 2016b).

Private hospital-based ambulatory psychiatric care episodes were provided to 17,723 patients, with a total of 238,555 care days in 2014–15.

Who uses these services?

The rate of private hospital-based ambulatory psychiatric care was highest for patients aged 35–44 (11.9 per 10,000 population). People aged under 15 were least likely to be private hospital-based ambulatory psychiatric patients (see Figure 10).

The majority of private hospital-based ambulatory psychiatric patients were females (65.1%).

On average 13.5 care days were provided per patient. The rate was higher for patients who resided in urban areas (13.7), compared with people in non-urban areas (11.6 care days).

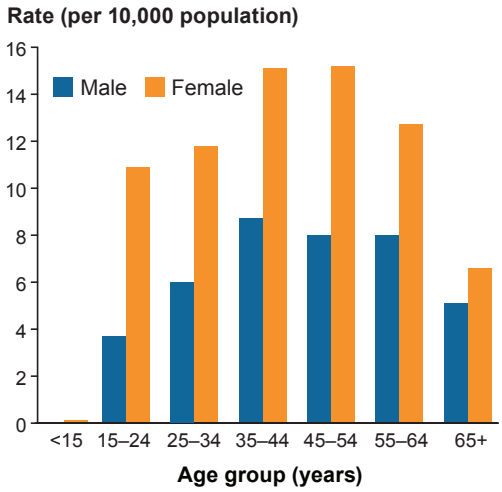


Figure 10: Private hospital-based ambulatory psychiatric patients, by sex and age group, 2014–15

Why are people receiving these services?

In 2014–15, the most common principal diagnosis associated with a private hospital-based ambulatory psychiatric episode was *Major affective and other mood disorders* (47.1% of episodes) followed by *Alcohol and other substance use disorders* (18.7% of episodes).

Psychiatric disability support services

Specialist disability support services are provided under the National Disability Agreement (NDA) to service users with psychiatric disability either as their primary disability or as another significant disability. Residential service types include large and small facilities/institutions, hostels and group homes. Non-residential support services include accommodation support, community support, community access, respite services and employment services.

Key facts:

- More than 96,000 people with a psychiatric disability used disability support services in 2014–15.
- *Employment services* were the most frequently provided service group for non-residential service users with psychiatric disability.
- Psychiatric disability was the most frequently reported primary disability among non-residential service users (66.1%).

How much mental health care did these services provide?

Across Australia, about 333,800 people used specialist disability support services during 2014–15 (AIHW 2016c). Of these, 96,245 clients had a psychiatric disability, with over two-thirds of these (63,510) having a psychiatric disability as their primary disability. The rate of clients accessing psychiatric disability services was highest in Victoria (542.3 per 100,000 population), and lowest in the Northern Territory (146.2), compared with the national rate of 407.4 (see Figure 11).

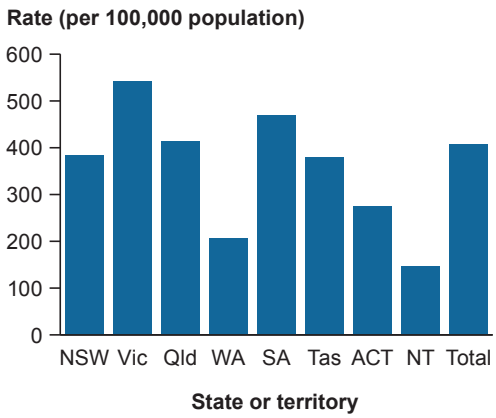


Figure 11: Specialist disability support service users with a psychiatric disability, state or territory, 2014–15

In 2014–15, 95,741 clients with a psychiatric disability accessed non-residential specialist disability support services, while 3,686 clients accessed residential services.

Who uses these services?

Residential service users were on average more likely to be Indigenous, male, aged 45–54, living with others, living in a domestic-scale supported living facility, in an *Inner regional* area, and reporting a disability support pension as their primary source of income.

Why are people receiving these services?

Of the non-residential service users who identified as having a psychiatric disability, two-thirds (66.1%) reported this as their primary disability.

Of residential service users with a psychiatric disability, intellectual disability was the most frequently reported with 7 in 10 users (71.1%) reporting it as their primary disability. Psychiatric disability was a more commonly reported primary disability in non-residential users (66.1%) compared with residential service users (14.7%).

What services were provided?

The type of services accessed by the highest rate of non-residential service users was *Employment* (309.7 per 100,000), followed by *Community support* (70.5). Nationally, *Group homes* were the most common residential service type, with 12.5 service users per 100,000 population.

Specialist homelessness services

Governments fund various agencies across Australia to provide Specialist Homelessness Services (SHS). Services provided include accommodation and non-accommodation services (such as counselling). This section discusses SHS clients with a current mental health issue.

Key facts:

- More than 63,000 SHS clients (30%) were estimated to have a current mental health issue in 2014–15.
- *Housing crisis* was the most common main reason for seeking assistance, with almost 1 in 4 clients seeking services for this reason, followed by *Domestic and family violence*.
- Clients aged 18–24 had the highest rate of SHS agency use.

What services were provided to clients with a current mental health issue?

Of the 214,000 SHS clients aged 10 or over nationally, almost one-third (29.5% or 63,061 clients) were estimated to have a current mental health issue. Australia-wide, this equates to a rate of 266.9 clients with a current mental health issue per 100,000 population.

Nationally, more than half of SHS clients with a mental health issue (53.0% or 33,406 clients) accessed accommodation services at a rate of 141.4 per 100,000 population. Rates varied between jurisdictions, ranging from 318.3 per 100,000 population in Tasmania to 93.3 in South Australia. Non-accommodation services were accessed nationally at a rate of 120.5 per 100,000. The Australian Capital Territory had the highest rate of clients accessing non-accommodation services (217.0 per 100,000), followed by Victoria (216.3 per 100,000). Queensland had the lowest rate with 73.9 per 100,000.

Who uses SHS services?

Clients with a current mental health issue aged 18–24 had the highest rate of SHS agency use (575.4 per 100,000 population), followed by those aged 15–17 (494.5 per 100,000). Female clients used SHS services at a greater rate than males (308.2 and 225.2 per 100,000 respectively). The rate of Indigenous SHS clients with a current mental health issue was more than 6 times that of non-Indigenous Australians (1,450.5 compared to 227.2 per 100,000 population).

Why are people receiving these services?

Of the clients with a mental health issue presenting to an SHS agency, about half (47.5% or 29,942 clients) reported being homeless within the previous 12 months. For clients with a current mental health issue, *Housing crisis* was the most commonly recorded main reason for seeking assistance followed by *Domestic and family violence* (see Figure 12).

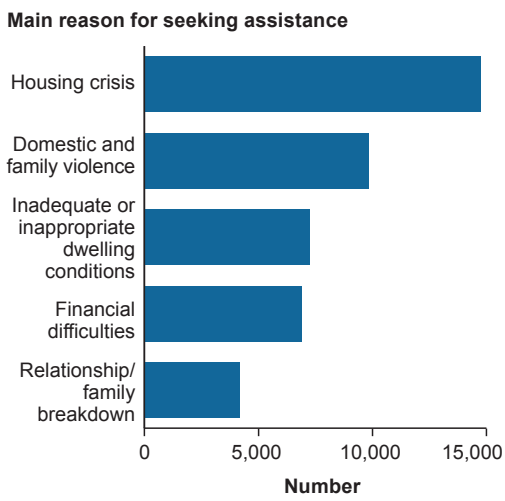


Figure 12: Top 5 main reasons for SHS clients with a current mental health issue seeking assistance, 2014–15

What services were provided?

Nationally, 577,003 services were provided to SHS clients with a current mental health issue. *General assistance and support*, such as advice/information and basic assistance, was the most frequently provided service (73.0%), followed by *Specialised services* (14.1%) and *Housing and accommodation* (12.9%).

Personal Helpers and Mentors

Personal Helpers and Mentors (PHaMs) services is an Australian Government initiative administered by the Commonwealth Department of Social Services (DSS) 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:

- The number of PHaMs participants increased by an annual average of 13.2% between 2010–11 and 2014–15.
- The most commonly reported special needs group was *Alcohol and/or drug misuse*.
- Of the 6,730 participants who exited a PHaMs service in 2014–15, about 2 in 5 exited because they reached their goals.

How much mental health care did these services provide?

Nationally, there were 20,337 PHaMs participants during 2014–15. New South Wales had the largest number of participants (5,889) and the Australian Capital Territory the smallest (360).

Who uses PHaMs services?

PHaMs participants were most commonly aged 25–44 (46.3% of participants), female (56.9% of participants), Australian born (83.5%) and residing in a *Major city* (58.9%). Nine in 10 (91.4%) of participants had a mental illness diagnosis at the time of initial assessment for the program.

Almost 2 in 5 (37.5%) PHaMs participants also reported experiencing another significant disability in addition to a mental illness.

The most commonly recorded mental illness diagnosis categories were *Mood disorders* (67.5%), *Anxiety disorders* (42.9%) and *Schizophrenia and psychotic delusional disorders* (21.8%). The most commonly reported comorbidities were *Physical* (20.2% of participants) followed by *Specific learning/Attention Deficit Disorder* (4.6%) and *Intellectual disabilities* (3.7%).

PHaMs services identify groups of people that face additional disadvantage in their recovery as special needs groups. The most commonly reported special needs group was *Alcohol and/or drug misuse* (25.6%) (see Figure 13).

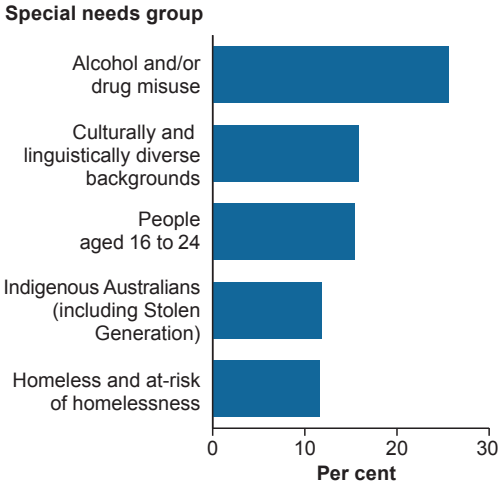


Figure 13: PHaMS participants by special needs group, 2014–15

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* (97.4%); *Social and community activities* (96.9%); *Interpersonal relationships* (96.3%); and *Working and employment* (95.0%).

What are the reasons for exiting the service?

Of the 6,730 participants who exited a PHaMs service, almost 2 in 5 (37.5%) exited because they reached their goals, with about 1 in 5 (21.3%) choosing to leave the service, and about 1 in 9 (11.1%) not returning to the PHaMs service after 6 months.

Access to Allied Psychological Services

The Access to Allied Psychological Services (ATAPS) program enables a range of health, social welfare and other professionals to refer consumers who have been diagnosed with a mild or moderate mental disorder to a mental health professional to provide short-term focused psychological strategies and services.

ATAPS is designed to treat people with common mental disorders (for example, anxiety and depression) who have difficulty accessing Medicare-subsidised mental health services due to reasons such as the lack of services in some geographical locations.

Key facts:

- In 2013–14, more than 73,500 consumers accessed ATAPS services, resulting in about 365,000 sessions.
- GPs were the source of 9 out of 10 referrals to ATAPS.
- *Depression* was the most commonly diagnosed condition among ATAPS consumers followed by *Anxiety disorders*.

How much mental health care did these services provide?

In 2013–14, 73,550 consumers accessed ATAPS at a rate of 315.7 consumers per 100,000 population. The Northern Territory had the highest rate of consumers with 351.8 per 100,000 population, and Tasmania the lowest (247.7).

Over the 5 years to 2013–14, both the number of referrals and sessions more than doubled; 43,164 referrals and 182,656 sessions were observed in 2009–10 increasing to 86,593 referrals and 397,953 sessions in 2013–14.

Who uses these services?

Females were more likely to use ATAPS than males (401.2 per 100,000 population compared to 228.3). Consumers aged 15–24 accessed services most frequently of all age groups, at a rate of 450.0 per 100,000 population. Indigenous ATAPS consumers accessed services at a rate more than 3.5 times greater than that of non-Indigenous users (831.1 and 228.6 respectively).

What services were provided?

ATAPS entitle a consumer to 12 sessions, although consumers may receive 6 additional sessions in exceptional circumstances. About 1 in 30 (3.3%) consumers received additional sessions after the completion of the initial 12 sessions.

Nine out of 10 (89.0%) sessions were individual sessions, with a similar proportion (88.2%) being 46–60 minutes in duration. The majority of sessions occurred face to face (96.8%).

Why are people receiving these services?

GPs were the most common referral method to ATAPS, with more than 9 out of 10 (91.9%) consumers receiving their referral from a GP. Less than 1 in 1,000 consumers referred themselves to ATAPS (0.1%).

Depression was the most commonly diagnosed condition among ATAPS consumers (48.0% of consumers), followed by *Anxiety disorders* (40.2%) (see Figure 14).

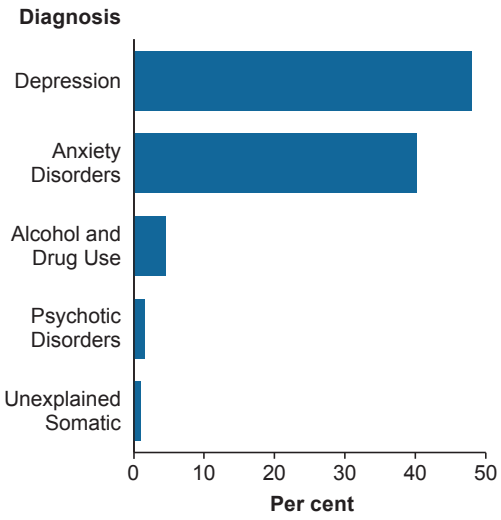


Figure 14: Five most common diagnoses of ATAPS consumers, 2013–14

Mental health care resources

Mental health workforce

A range of health-care professionals including GPs, psychiatrists, psychologists, nurses, social workers, occupational therapists and peer workers provide mental health-related services and support. Workforce data are currently only available for psychiatrists, nurses and registered psychologists who work principally in mental health care.

Key facts:

In 2014, there were an estimated:

- 3,090 psychiatrists, equating to 13.3 full-time equivalent (FTE) per 100,000 population
- 20,192 mental health nurses equating to 82.4 FTE per 100,000 population
- 23,878 registered psychologists equating to 87.4 FTE registered psychologists per 100,000 population in Australia.

Who comprises the mental health workforce?

There were an estimated 3,090 psychiatrists or 13.3 FTE psychiatrists per 100,000 population in Australia in 2014. Rates ranged from 8.1 per 100,000 population for the Northern Territory to 16.1 for South Australia (see Figure 15). The majority of psychiatrists were employed in *Major cities* (87.6% or 16.6 FTE per 100,000 population). FTE per 100,000 population decreased as remoteness increased.

Approximately 1 in 15 employed nurses (20,192 or 6.8% of nurses) indicated they were working principally in mental health in 2014. This equates to 82.4 FTE per 100,000 population. As with psychiatrists, rates of employed nurses ranged between states and territories with 68.0 FTE per 100,000 population working in the Australian Capital Territory increasing to 88.2 FTE per 100,000 in Victoria.

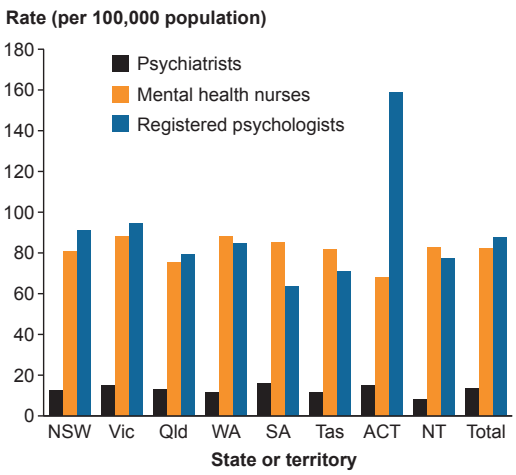


Figure 15: Employed psychiatrists, registered psychologists and mental health nurses, FTE per 100,000 population, state or territory, 2014

Three-quarters of mental health nurses (75.0%) were employed in *Major cities* in 2014, equating to 87.3 FTE per 100,000 population. FTE per 100,000 population decreased as remoteness increased.

It is estimated that 23,878 registered psychologists (87.4 FTE per 100,000 population) were working in Australia in 2014. Rates ranged from 63.4 per 100,000 population in South Australia to 159.0 per 100,000 population in the Australian Capital Territory.

Three-quarters of psychologists (74.8%) were employed in *Major cities*. As with psychiatrists and mental health nurses, FTE per 100,000 decreased as remoteness increased.

What hours were worked?

Psychiatrists worked an average of 38.5 hours per week in 2014. On average, men worked more hours than women (41.5 hours for males compared to 33.4 hours for females).

Mental health nurses worked an average of 36.4 total hours per week, with men again working more hours (38.3) than women (35.6) on average.

Registered psychologists worked on average fewer hours than psychiatrists and mental health nurses, working on average 32.7 hours per week (males working 36.6. hours and females 31.6 hours).

Community-managed mental health workforce

Mental health non-government organisations (NGOs) also play an important role in Australia's mental health system. These organisations are typically not-for-profit and values-driven. Not-for-profit organisations are also referred to as community-managed organisations (CMOs), reflecting their governance structure. National data about the activities of mental health NGOs and their workforce are not currently collected on a routine basis in Australia.

Expenditure on mental health services

A combination of state and territory governments, the Australian Government and private health insurance companies fund mental health services.

Key facts:

- Over $8 billion, or $344 per person, was estimated to be spent on mental health-related services in Australia during 2013–14.
- The Australian Government paid about $1 billion in benefits for Medicare-subsidised mental health-related services in 2013–14, equating to 5.0% of all Medicare subsidies.
- The Australian Government spent over $753 million, or $32 per person, on subsidised prescriptions under the PBS/RPBS for mental health-related medications during 2013–14, equating to 8.1% of all PBS/RPBS subsidies.

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

Over $4.9 billion was spent on state and territory specialised mental health services (running costs only) in 2013–14. After adjusting for inflation, this figure has increased by an average annual rate of 3.0% over the last 5 years, or an increase in spending of $10.88 per person (see Figure 16). The largest portion of this expenditure ($2.1 billion) was spent on public hospital services for admitted patients, closely followed by community mental health care spending ($1.9 billion).

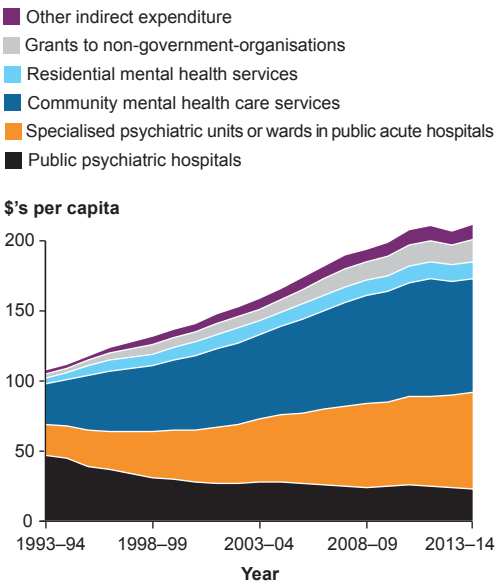


Figure 16: Recurrent expenditure per capita on state and territory specialised mental health services, constant prices, 1993–94 to 2013–14

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

In 2013–14, the Australian Government spent an estimated $2.9 billion, or $124.30 per person, on mental health-related services. Australian Government expenditure, after adjusting for inflation, has increased by an annual average rate of 4.7%, or $14.15 per person over the last 5 years. Increased spending on national programs and initiatives managed by the Department of Health and mental health specific payments to states and territories are responsible for most of this increase.

About one-third (33.5%) was spent on Medicare-subsidised mental health-related services with a further 25.4% spent on the PBS and the RPBS subsidised prescriptions. Other areas of expenditure included:

- national Department of Health programs and initiatives (15.6%)
- national DSS programs and initiatives (7.3%)
- national DVA programs and initiatives (6.0%)
- private health insurance premium rebates (3.8%).

How much is spent on Medicare-subsidised services?

About $1 billion was paid in benefits for Medicare-subsidised mental health-related services in 2013–14, equating to $40.33 per person nationally. After adjusting for inflation, in the 5 years to 2013–14 mental health-related Medicare costs increased by an average annual rate of 2.5% per Australian. The largest proportion of spending was for services that psychologists (42.4%), psychiatrists (33.0%) and GPs (22.3%) provided.

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

Nationally, $753 million was paid on mental health-related subsidised prescriptions under the PBS and RPBS, equating to $32.31 per person. After adjusting for inflation, expenditure on mental health-related PBS/RPBS prescriptions decreased on average by 1.4% per year between 2009–10 and 2013–14 due to a decrease in the subsidised cost of a number of medications. More than two-thirds (70.8%) of this expenditure was for prescriptions issued by GPs, followed by psychiatrists (17.1%) and non-psychiatrist specialists (10.4%).

Specialised mental health care facilities

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

Key facts:

- There were 1,605 specialised mental health care facilities providing care nationwide in 2013–14.
- There were 9,384 specialised mental health hospital beds and 2,427 beds available in residential mental health services.
- Over the 5 years to 2013–14, the number of FTE staff employed in public sector specialised mental health services increased by an annual average of 2.3%.

How many mental health care facilities and beds were available?

Nationally, there were 1,605 specialised mental health care facilities providing care in 2013–14.

Of the 11,811 beds that specialised mental health care services provided in 2013–14, 9,384 were in specialised mental health hospital services. About three-quarters of these beds were in public hospitals (6,791, or 72.4%) and the remainder were in private hospitals (2,593 beds). There were 2,427 beds in residential mental health services, comprising 1,493 government-operated beds and 934 non-government-operated beds (see Table 1).

Table 1: Specialised mental health care facilities 2013–14

Facility	Number	Beds
Public hospitals	159	6,791
Residential mental health care services	171	2,427
Community mental health care services	1,212	n.a.
Private psychiatric hospitals	63	2,593

n.a. not applicable

How many staff were employed to provide specialised mental health care services?

Of the 30,544 FTE staff employed in state and territory specialised mental health care services in 2013–14, half were nurses (51.2%, or 15,647 FTE), with the majority of these being registered nurses (13,497 FTE). Diagnostic and allied health professionals were the next largest staffing group making up 19.3% or 5,884 FTE, comprising mostly social workers (1,998 FTE) and psychologists (1,831 FTE). Salaried medical officers made up 10.4% of staff, comprising consultant psychiatrists and psychiatrists (1,386 FTE), and psychiatry registrars and trainees (1,481).

Specialised mental health hospital admitted patient services employed the highest rate of staff with 53.3 direct care FTE staff per 100,000 population during 2013–14. Community mental health care services employed 46.0 direct care FTE staff per 100,000 population and residential mental health services employed 8.1 direct care FTE staff per 100,000.

There were 2,490 FTE staff employed by specialised psychiatric services in private hospitals during 2013–14, equating to 10.7 FTE staff employed per 100,000 population. These figures do not include Medicare-subsidised medical practitioners and other health professionals, who also provide services to people admitted to private hospitals for mental health care.

Mental health-related prescriptions

Mental health-related medications are provided through non-subsidised prescriptions as well as prescriptions subsidised by the Australian Government through the PBS and the RPBS.

Key facts:

- There were 35 million prescriptions (subsidised and under co-payment) dispensed for mental health-related medications during 2014–15.
- These were provided to 3.9 million patients, which equates to an average of 9 prescriptions per patient.
- There was an annual average increase of 2.6% in the number of dispensed mental health-related prescriptions between 2010–11 and 2014–15.
- Antidepressant medication was the most frequently dispensed mental health-related medication across all prescriber groups.

How many mental health-related prescriptions were provided?

There were 35.3 million prescriptions (subsidised and under co-payment) filled for mental health-related medications during 2014–15, of which 70.1% (24.8 million) were subsidised by the Australian Government under the PBS and RPBS. These were provided to 3.9 million patients, which equates to an average of 9 prescriptions per patient and a rate of 1,494.8 prescriptions per 1,000 population.

The rate of mental health-related prescriptions dispensed has increased over the 5 years to 2014–15, averaging 2.6% increase per year.

How do rates differ across Australia?

The rate of patients dispensed with mental health-related prescriptions and total prescriptions dispensed varied depending on the patient's usual area of residence. The rate of prescriptions and patients was highest for those living in *Inner regional* areas (1,933.8 prescriptions, 206.7 patients per 1,000 population) followed by *Outer regional* (1,541.1 prescriptions and 170.0 patients per 1,000 population). Those living in *Very remote* areas had the lowest rates of prescriptions and patients dispensed with mental health-related prescriptions (436.4 prescriptions and 55.4 patients per 1,000 population).

Tasmania had the highest rate of prescriptions and patients per 1,000 population (1,942.1 prescriptions and 207.3 patients) with the Northern Territory having the lowest rate (737.8 prescriptions and 96.9 patients per 1,000 population).

What mental health-related medications were provided?

Antidepressant medication was the most frequently dispensed mental health-related medication, accounting for almost 7 in 10 (67.8%, 24.0 million) mental health-related prescriptions dispensed in 2014–15 (see Figure 17).

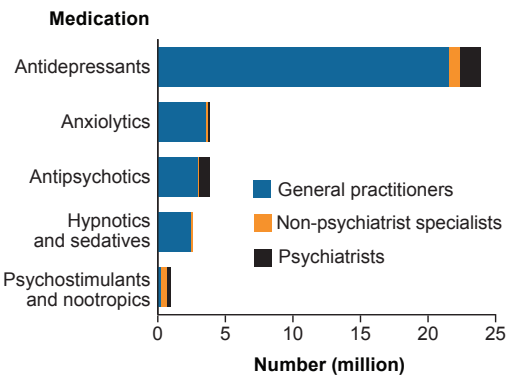


Figure 17: Mental health medications by provider type, 2014–15

Who prescribed these medications?

GPs prescribed 86.8% of all mental health-related prescriptions, or 30.7 million prescriptions, followed by psychiatrists (8.0%, 2.8 million prescriptions) and non-psychiatrist specialists (4.6%, 1.6 million prescriptions).

The most commonly prescribed medication type across all prescribing medical practitioners was antidepressants (70.3% of prescriptions prescribed by GPs, 55.3% prescribed by psychiatrists and 46.5% for non-psychiatrist specialists).

Key Performance Indicators for Australian Public Mental Health Services

The KPIs for Australian Public Mental Health Services define a common framework and a standardised set of indicators to measure the states' and territories' mental health sector performance. KPIs in the public mental health sector cover different aspects of services, may be affected by many factors, and are often interconnected. They can inform consumers', service providers' and funders' impressions of service and service performance. Data are currently available for 13 out of the 15 nationally agreed KPIs, and can be disaggregated by a number of demographic variables. Key KPI results are summarised in the following diagram.

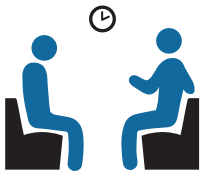
What happens during a period of care?

1.8%
of the population received clinical mental health care

MHS PI 8

41.4%
of admissions had a proceeding community contact

MHS PI 11



41.7%
of clients were new clients

MHS PI 9

7.8
seclusion events occurred per 1,000 patient days

MHS PI 15

How long does the period of care last?

Average length of stay in acute psychiatric impatient units

MHS PI 4

Average number of community treatment days per 3-month period of ambulatory care

MHS PI 6

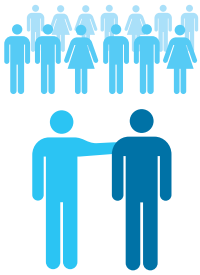
How much does the period of care cost?

$1,061
is the average cost per patient day in general acute impatient units

MHS PI 5

$305
is the average cost per community treatment day

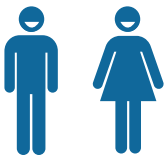
MHS PI 7



What was the outcome of the period of care?

72.4%
of people who received mental health inpatient care got significantly better

MHS PI 1

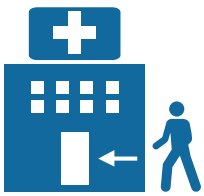


66.4%
of patients leaving acute inpatient care were followed up with a community mental health service contact within 7 days of discharge

MHS PI 12

13.7%
of people were readmitted to a psychiatric inpatient unit within 28 days of discharge from a psychiatric inpatient unit

MHS PI 2



MHS PI 1: Change in consumers' clinical outcomes (2013–14)
MHS PI 2: 28 day readmission rate (2013–14)
MHS PI 4: Average length of acute impatient stay (2013–14)
MHS PI 5: Average cost per acute admitted patient day (2013–14)
MHS PI 6: Average treatment days per three-month community care period (2013–14)
MHS PI 7: Average cost per community treatment day (2013–14)
MHS PI 8: Proportion of population receiving clinical mental health care (2013–14)
MHS PI 9: New client index (2013–14)
MHS PI 11: Rate of pre-admission community care (2013–14)
MHS PI 12: Rate of post-discharge community care (2013–14)
MHS PI 15: Rate of seclusion (2014–15)

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' or 'hospitalisations' and can be classified as:

- Ambulatory-equivalent—when the care provided is comparable to that which could be provided by community mental health care services, in that it does not involve an overnight stay and if any procedure is recorded, it is of the nature of counselling, skills training or some similar form of therapy.
- Admitted patient care—when the care provided is specific to the hospital setting. Patients can have separations with specialised psychiatric care (within a specialised psychiatric unit or ward) or without specialised psychiatric care (no care within a specialised psychiatric unit or ward).

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

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

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

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

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

Medicare-subsidised mental health-related services: Mental health-related services, provided by psychiatrists, GPs, psychologists and other allied health professionals, that are subsidised under the Medicare Benefits Schedule (MBS).

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).

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

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

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.

Psychiatrist: A medical doctor who has completed a medical degree followed by further study to specialise in the diagnosis, treatment and prevention of mental illness.

Psychologist: A mental health professional that has studied the brain, memory, learning, human development and the processes determining how people think, feel, behave and react and is registered with the Psychology Board of Australia.

Remoteness Areas: Refers to categories within the Australian Statistical Geographical Standard, 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.

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Mental health services—in brief 2016 **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>.**