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Australian Institute of Health and Welfare

AIHW

# Mental health services

## In brief 2019

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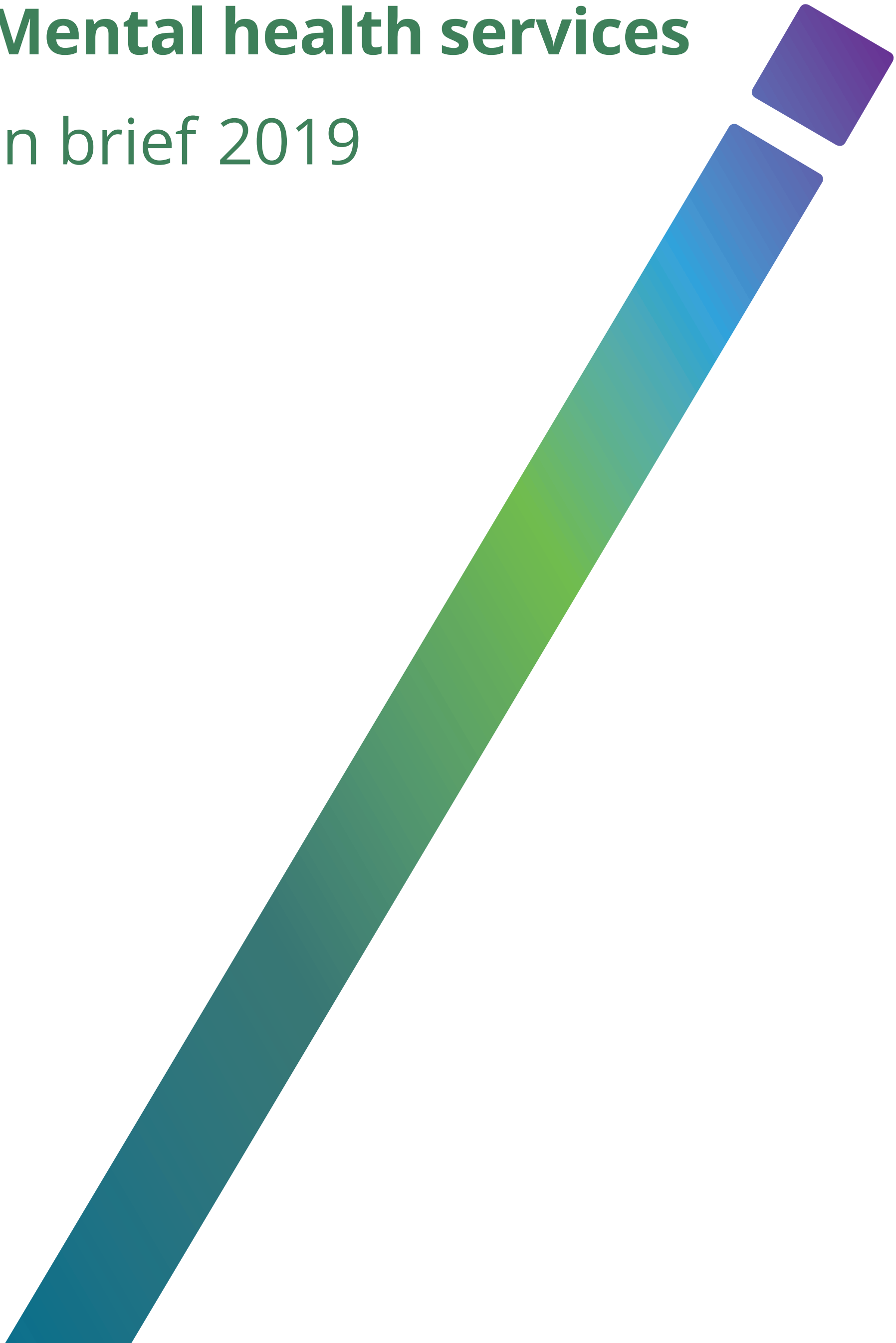

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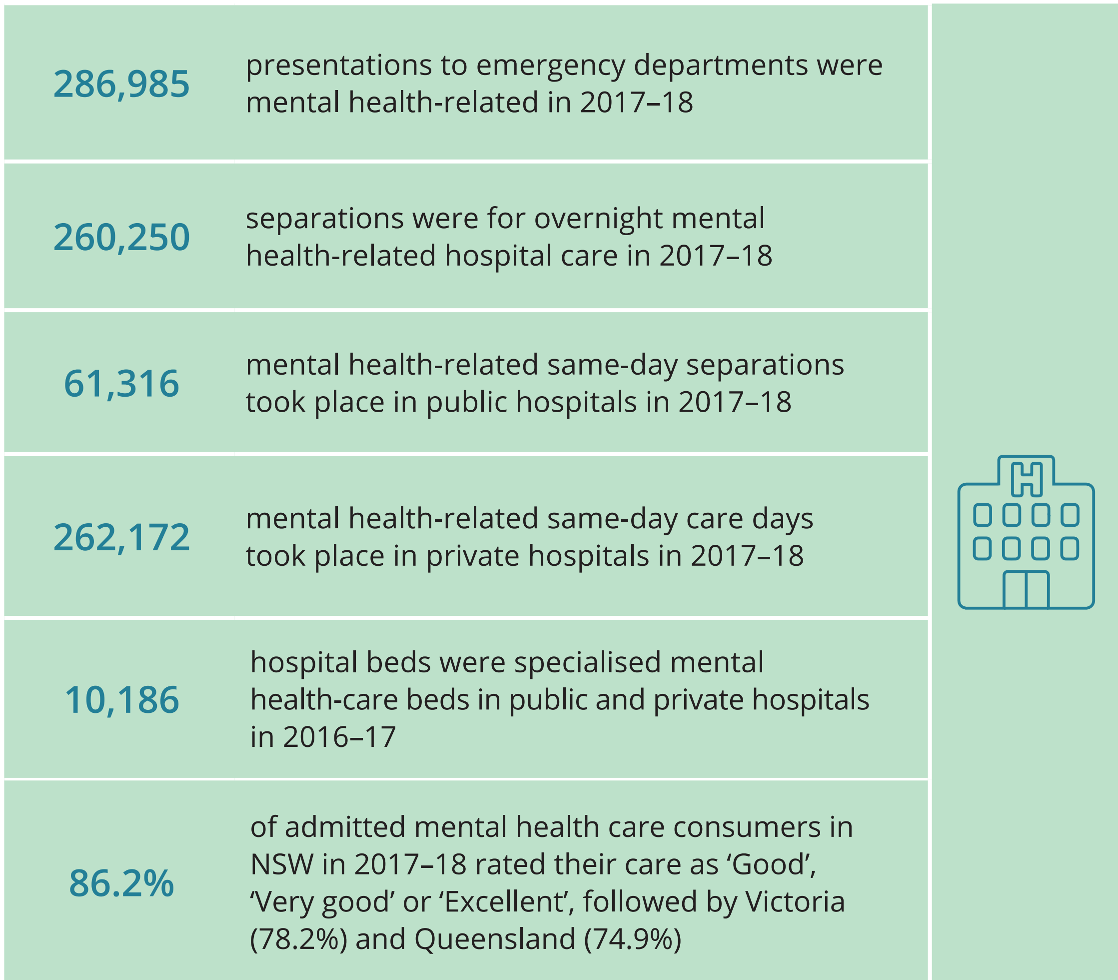
# Mental health services: at a glance



| | |
|---|---|
| 286,985 | presentations to emergency departments were mental health-related in 2017–18 |
| 260,250 | separations were for overnight mental health-related hospital care in 2017–18 |
| 61,316 | mental health-related same-day separations took place in public hospitals in 2017–18 |
| 262,172 | mental health-related same-day care days took place in private hospitals in 2017–18 |
| 10,186 | hospital beds were specialised mental health-care beds in public and private hospitals in 2016–17 |
| 86.2% | of admitted mental health care consumers in NSW in 2017–18 rated their care as 'Good', 'Very good' or 'Excellent', followed by Victoria (78.2%) and Queensland (74.9%) |

| | |
|---|---|
| 2.5 million | people received Medicare-subsidised mental health-specific services in 2017–18 |
| 4.2 million | patients received mental health-related prescriptions in 2017–18 |
| $9.1 billion | was spent on mental health-related services in 2016–17 |

| | |
|---|---|
| 11,315 | seclusion events occurred in mental health acute hospital services in 2017–18 |
| 16,917 | physical restraint events and 796 mechanical restraint events occurred in 2017–18 |

*Mental health services—in brief 2019* is the companion publication to the online report *Mental health services in Australia* (MHSA), which provides detailed data on the national response of the health and welfare system to the mental health care needs of Australians. MHSA is updated progressively throughout each year as data becomes available to ensure that the most up to date information is available at a point in time. For more information, see the www.aihw.gov.au/mhsa website.

This in brief report provides an overview of key statistics and related information on mental health services, incorporating updates made to the online report over the 12 months to October 2019. The report draws on data from various sources. As such, the data reference year reported varies between topic areas.

# The prevalence of mental illness in Australia

## What is mental illness?

Mental illness refers to a clinically diagnosable disorder(s) that significantly interferes with an individual's cognitive, emotional or social abilities (COAG Health Council 2017).

The term covers a spectrum of disorders that vary in severity and duration (Slade et al. 2009). Mental illness can have damaging effects on the 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.

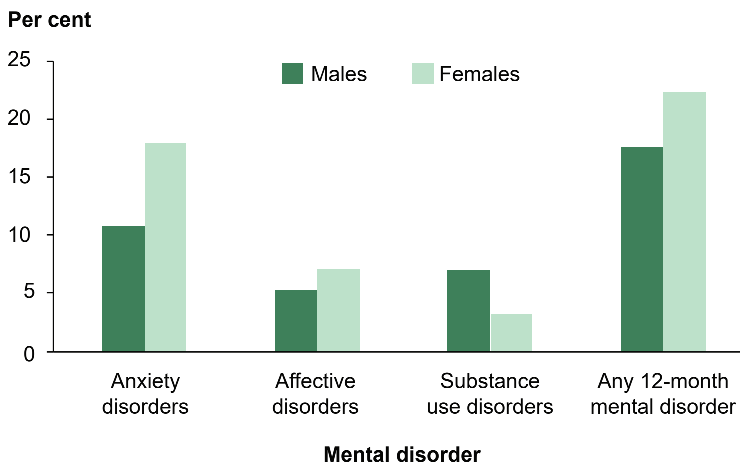
Those with mental illness often experience problems such as isolation, discrimination and stigma (WHO 2016). The terms mental illness and mental disorder are often used interchangeably.

### *Mental illness in adults*

Forty-five per cent of Australians will have a common mental disorder in their lifetime, according to data from the 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (aged 16–85). That equates to about 8.7 million people who will experience a common mental disorder in their lifetime, based on the estimated 2017 population. Each year, 1 in 5 Australians in this age range (20% or about 3.9 million Australians in 2017) are estimated to experience a mental disorder (ABS 2008).

*Anxiety disorders* (for example, *Generalised anxiety disorder* and *Social phobia*) were the most common types of disorder reported in the NSMHWB, with 14.4% of Australian adults experiencing an *Anxiety disorder* in the previous 12 months (ABS 2008). This was followed by *Affective disorders* (for example, *Depression*, 6.2%) and *Substance use disorders* (for example, *Alcohol dependence*, 5.1%).

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




Women experienced a higher prevalence of mental disorders in the preceding 12 months than men (22.3% compared with 17.6%) (Figure 1).

### *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).

One in 7 young people aged 4–17 (13.9% or around 591,000 people based on the estimated 2017 population) met the clinical criteria for 1 or more mental disorders in the previous 12 months (Lawrence et al. 2015).

*Attention deficit hyperactivity disorder* (ADHD) was the most common mental disorder (7.4% or 315,000 children and adolescents based on the estimated 2017 population), followed by *Anxiety disorders* (6.9% or about 293,000), *Major depressive disorder* (2.8% or about 119,000) and *Conduct disorder* (2.1% or about 89,000).

A comparison of prevalence data from the Young Minds Matter survey with the first national child and adolescent survey (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 an increase in the prevalence of *Major depressive disorder* (Lawrence et al. 2015).

### *Psychotic disorders*

Sixty-four thousand people aged 18–64 accessed treatment for a psychotic disorder from public specialised mental health services, according to the survey People Living with Psychotic Illness 2010, conducted in 2009–10 (Morgan et al. 2011). More people had a diagnosis of *Schizophrenia* (47.0%) than any other type of psychotic disorder and about two-thirds (64.8%) of these people had their first episode of psychotic disorder before the age of 25 (Morgan et al. 2011).

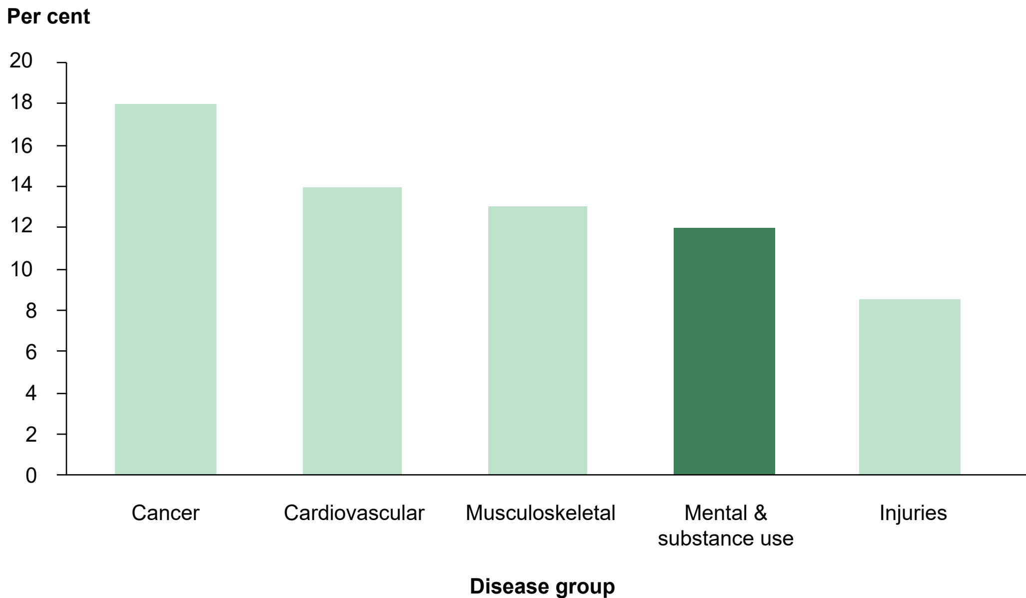
## The impact of mental illness in Australia

Mental disorders can vary in severity and duration, and may also be episodic. Around 2%–3% of Australians (equivalent to about 615,000 people based on the estimated 2017 population) have a severe mental disorder, according to diagnosis, intensity of symptoms, duration of symptoms and degree of disability (not limited to severe psychotic disorders) (DoHA 2013). Between 4% and 6% of the Australian population (about 1.2 million people) have a moderate mental disorder, and a further 9%–12% (about 2.6 million people) have a mild disorder.

## The contribution of mental illness to the burden of disease in Australia

The 2015 Australian Burden of Disease Study looked at the fatal (years of life lost) and non-fatal (years of life lived with a disability) impact of different diseases, conditions and injuries on Australians. In 2015, *Mental and substance use disorders* were responsible for an estimated 12% of the total disease burden in Australia, making it the fourth highest group of diseases behind *Cancer* (18%), *Cardiovascular diseases* (14%) and *Musculoskeletal conditions* (13%) (Figure 2) (AIHW 2019a).

**Figure 2: Australia's top 5 burden of disease groups, 2015**




*Mental and substance use disorders* (24%) were the second largest contributor to non-fatal burden, behind *Musculoskeletal conditions* (25%) (AIHW 2019a).

## Comorbid illnesses

The 2007 NSMHWB found that 11.7% of adults with a mental disorder in the previous 12 months also reported a physical disorder (referred to as comorbidity), with 5.3% reporting 2 or more mental disorders, and 1 or more comorbid physical conditions (ABS 2008).

According to the People Living with Psychotic Illness survey, people being treated for psychotic disorder often had poor physical health outcomes and comorbidity (Morgan et al. 2011). People being treated for psychotic disorder were more likely to experience a number of physical health conditions compared with the general population: for example, they were more than 3 times as likely to have diabetes, and more than 1.5 times as likely to have a heart or circulatory condition (Morgan et al. 2011).

# Australia's mental health care system—an overview

The Australian Government and state and territory governments have worked together to develop mental health programs and services to better meet the mental health needs of Australians via the National Mental Health Strategy. The Strategy, first endorsed in 1992, has included five 5-year National Mental Health Plans, which cover the period 1993 to 2022.

In Australia, people with mental illness have access to a variety of mental health care services provided by various professionals in different care settings (Table 1). Mental health care can be broadly divided into specialised mental health services and other support services where mental health-related care might be delivered.

**Table 1: Overview of Australia's mental health care system**

| Medicare-subsidised services | | |
|---|---|---|
| General practitioners | Psychiatrists | Psychologists |
| **Specialised mental health care settings** | | |
| Public and private hospitals | Community mental health care | Residential mental health care services |
| **Support services** | | |
| Disability support services | Homelessness support services | Mental health programs |

The Australian Government funds various mental health services through the Medicare Benefits Scheme (Medicare), as well as prescriptions through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS).

The Australian Government also funds various other essential support programs and services, some of which are managed by Primary Health Networks and Headspace. These include income support, social and community support, disability services (including National Disability Insurance Scheme), workforce participation programs and housing assistance. State and territory governments fund and deliver public sector specialised mental health care services, including admitted patient services delivered in hospitals and services delivered in community settings. They may also fund additional programs and support services, often delivered by the non-government sector.

## Estimates of people with mental illness receiving mental health care

The 2007 NSMHWB of adults (aged 16–85) estimated that about one-third of people with a mental disorder in the previous 12 months accessed mental health services (Slade et al. 2009). Of these:

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

Since the 2007 survey, the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) Initiative (Better Access) was introduced to 'provide better access to mental health practitioners through Medicare' (DoH 2018). An updated estimate of treatment rates for people with mental disorder showed a rise from about one-third in 2007 to about 46% in 2009–10 (Whiteford et al. 2014).

Since 2009–10, the rate of people accessing Medicare-subsidised mental health-specific services has continued to rise (see 'Medicare-subsidised mental health-related services' in this report).

For young people, more recent survey results are available. Based on the 2013–14 Young Minds Matter survey, about 1 in 6 (17.0%) young people aged 4–17 had used services for emotional or behavioural problems in the previous 12 months, with 56.0% of those having at least 1 diagnosable mental disorder (Lawrence et al. 2015). Service use was found to increase with severity of the disorder, with almost 9 in 10 (87.6%) of those with severe disorders accessing services.

Services used by people aged 4–17 with a mental disorder were provided by GPs (35.0%), psychologists (23.9%), paediatricians (21.0%), or counsellors or family therapists (20.7%), noting that people may receive services from more than 1 provider (Lawrence et al. 2015).

## Types of mental health care services and providers of care

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

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

Specialised mental health care is delivered in various health care settings 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 or non-government-operated residential mental health services.

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

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

The remainder of this publication provides information on the mental health services provided to Australians, summarises the care system providing these services and the total cost of mental health-related care in Australia.

# Mental health care services and support

## Consumer perspectives of mental health care

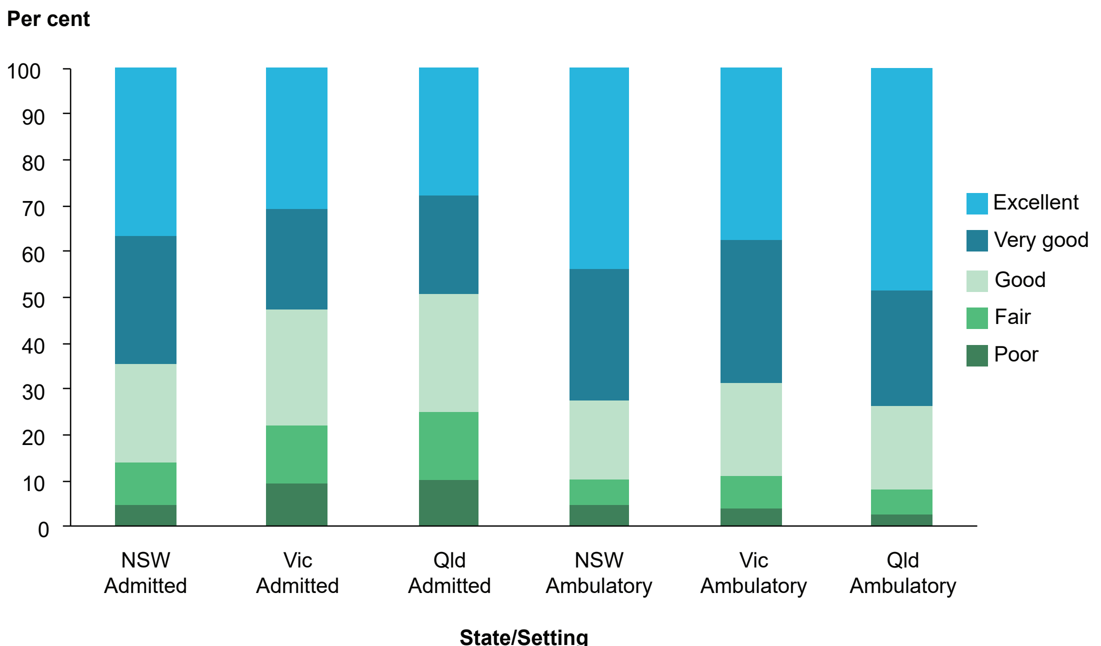
Monitoring mental health consumer and carer experiences of service has been a long-term goal of the National Mental Health Strategy. The nationally developed Your Experience of Service (YES) survey gathers information about consumer-rated experiences of care in public specialised mental health services. As of 2017–18, 3 jurisdictions (New South Wales, Victoria and Queensland) have implemented the YES survey, with a total of 28,651 surveys returned in 2017–18. In 2017–18, 16,385 admitted and 11,695 ambulatory (non-admitted) care consumers responded to the YES survey.

### Consumers in admitted care

#### Consumer ratings of care

A higher number of admitted care respondents in 2017–18 rated the care they received as 'Excellent', followed by ratings of 'Very Good', 'Good', 'Fair' and 'Poor' (Figure 3). In New South Wales, 86.2% of admitted care respondents rated the care they received as 'Good', 'Very Good' or 'Excellent', 78.2% of respondents gave these ratings in Victoria, and 74.9% in Queensland.

**Figure 3: Consumer ratings of care by state and service setting, 2017–18**



### Consumer experience of service

New South Wales had the highest proportion of respondents with a positive experience of service (that is, a score of 80 and above out of 100 across 22 YES survey items) in 2017–18 (68.7%), followed by Victoria (50.4%) and Queensland (47.1%). The proportion of admitted care respondents with a positive experience of service score was higher for respondents with *Voluntary* mental health legal status than *Involuntary* status. For all 3 states, the proportion of Aboriginal and/or Torres Strait Islander admitted care respondents who generated a score of 80 or above (that is, a positive experience) was lower than that for non-Indigenous Australians. New South Wales had the highest proportions, with 68.1% of Indigenous respondents and 69.1% of non-Indigenous respondents rating their experience of service positively, followed by Queensland (38.8% Indigenous and 48.8% non-Indigenous) and Victoria (31.6% Indigenous and 52.4% non-Indigenous).

## Consumers in ambulatory care

### Consumer ratings of care

In 2017–18, a higher number of ambulatory care respondents rated their care as 'Excellent', followed by 'Very Good', 'Good', 'Fair' and 'Poor'. In Queensland, 91.9% of ambulatory care respondents rated the care they received as 'Good', 'Very Good', or 'Excellent', 89.9% of respondents gave these ratings in New South Wales, and 89.3% in Victoria.

### Consumer experience of service

Queensland had the highest proportion of ambulatory care consumers with a positive experience of service (79.1%), followed by New South Wales (77.9%) and Victoria (73.8%).

In all 3 states the proportion with a positive experience of service score was higher for respondents with *Voluntary* mental health legal status than *Involuntary* status and mental health legal status *Not recorded*. The proportion of Indigenous ambulatory care respondents who generated a positive experience of service score was similar to the proportion for non-Indigenous respondents for all 3 states.

# Medicare-subsidised mental health-related services

Medicare-subsidised mental health-specific services are provided by GPs, psychiatrists, psychologists and other allied health professionals (in particular, social workers, mental health nurses and occupational therapists). The services are provided in various settings, such as in consulting rooms, in hospitals, by home visits, over the phone, and by videoconferencing. Following the discontinuation of the Bettering the Evaluation and Care of Health (BEACH) survey in 2015–16, this section now provides the main source of information on GP mental health-specific services activity in the *Mental health services in Australia* report.

## Profile of people who received services

About 2.5 million people (10.2% of the population) received Medicare-subsidised mental health-specific services in 2017–18. Around 1 in 8 females (12.2%) received services, compared with 8.3% of males. The proportion of people receiving services was highest for those aged 35–44 (13.8% of people in this age group received services).

In 2017–18, Victoria had the highest proportion of people receiving services (11.0% of its population) while the Northern Territory had the lowest (5.0%).

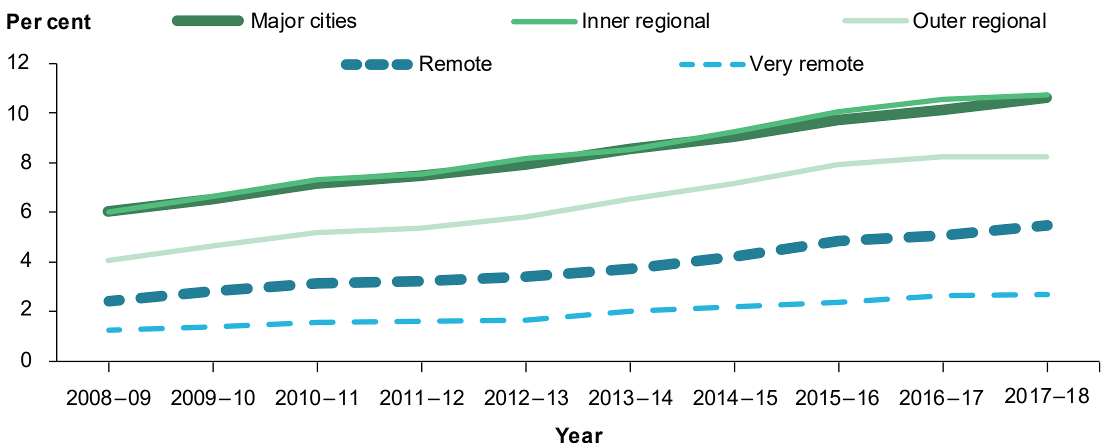
People who usually live in *Inner regional* areas were most likely to receive services (10.7% of the *Inner regional* population), followed closely by those living in *Major cities* (10.6%). For the remaining areas—that is, *Outer regional*, *Remote* and *Very remote* areas—the rate of people receiving services decreased as remoteness increased.

## Changes over time

The number of people receiving Medicare subsidised mental health-specific services has increased, from 1.2 million (or 5.7% of the population) in 2008–09 to 2.5 million (10.2%) in 2017–18. Services have also increased, from 6.2 million in 2008–09 to 11.7 million services in 2017–18.

The per cent of the population receiving Medicare-subsidised mental health-specific services has increased over time in all remoteness areas. In terms of average annual change between 2013–14 and 2017–18, the highest growth in the proportion of the population receiving these services was in *Remote* areas (from 3.7% of the *Remote* area population to 5.5% over the period—an average annual change of 10.0%), followed by *Very remote* (2.0% to 2.7% over the period) and *Outer regional* areas (6.5% to 8.2%) (Figure 4).

**Figure 4: Per cent of population receiving Medicare-subsidised mental health-specific services, by remoteness, 2008–09 to 2017–18**



### Providers of Medicare-subsidised mental health-related services

GPs provided more services than other provider types in 2017–18: around 3 in 10 (31.1%) of all Medicare-subsidised mental health-specific services. This was followed by other psychologist services (not clinical psychologist services) (24.9%), psychiatrist services (20.8%) and clinical psychologist services (19.7%).

## Mental health services provided in public hospital emergency departments

Public hospital EDs play an important role in treating mental illness. They can be the 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 (ACEM 2018).

### Services provided

An estimated 286,985 mental health-related ED presentations occurred in 2017–18 (3.6% of all ED occasions of service). Almost 4 in 5 (78.6%) mental health-related ED presentations were classified on initial assessment as being either *Urgent* (requiring care within 30 minutes) or *Semi-urgent* (requiring care within 60 minutes). Another 14.4% of presentations were classified as *Emergency* (requiring care within 10 minutes) and 1.0% as *Resuscitation* (requiring immediate care).The average length of a stay in the ED for a mental health-related presentation was around 3.5 hours (213 minutes).

The most frequently recorded end status for a mental health-related ED presentation was *Departed without being admitted or referred to another hospital* (58.1%).

Around 4 in 10 (39.1%) presentations resulted in admission to a hospital, either to the hospital where the emergency service was provided (34.9%), or *Referred to another hospital for admission* (4.2%).

### Changes over time

Nationally, the number of mental health-related ED presentations as a proportion of total ED presentations has increased from 3.3% in 2013–14 to 3.6% in 2017–18.

The national number of ED mental health-related presentations per 10,000 population increased by 10.3% between 2013–14 and 2017–18. Western Australia experienced the largest growth, increasing by 61.1% over the period, while the number in Queensland dropped by 5.8%.

## Profile of people who received services

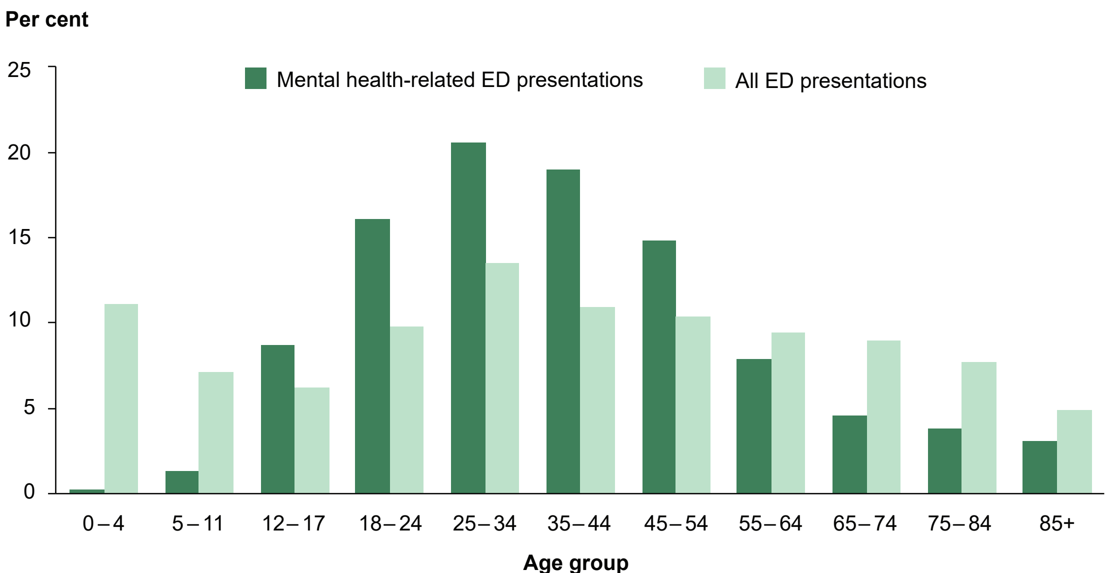
Around 1 in 5 (20.6%) mental health-related emergency department presentations were for people aged 25–34 in 2017–18, and more mental health-related ED presentations were for males (52.1%) than for females (47.9%).

The most frequently recorded mental health-related principal diagnosis groups 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) (27.2% and 26.2%, respectively).

## ED mental health-related care compared with all ED visits

In 2017–18, about 7 in 10 mental health-related ED presentations were for patients aged 18–54 (70.5%) compared with less than half of all ED presentations for the same age group (44.5%). The proportion of mental health presentations for patients under 18 (10.3%) was less than all ED presentations for patients the same age (24.5%). This was also seen in older age groups, with 11.4% of mental health presentations for patients aged 65 and over, compared with 21.6% of total ED presentations (Figure 5).

**Figure 5: Presentations to public hospital emergency departments, by age group (years), 2017–18**




## State and territory community mental health care services

Mental illness is often treated in community and hospital-based outpatient care services provided by state and territory governments. Collectively, these services are referred to as specialised community mental health care (CMHC) services.

## Services provided

About 9.5 million CMHC service contacts were provided nationally to over 430,000 people in 2017–18, equating to an average of 22 service contacts per patient. The national average rate of patients receiving services was 17.6 patients per 1,000 population. The rate was highest in the Northern Territory (28.5 patients per 1,000 population) and lowest in Victoria (11.5).

Nationally, about 1 in 7 (14.5%) service contacts were provided to people with an *Involuntary* mental health legal status in 2017–18. The Australian Capital Territory (34.5%) had the highest proportion of service contacts provided to people with an *Involuntary* mental health legal status, while Western Australia (3.4%) had the lowest.

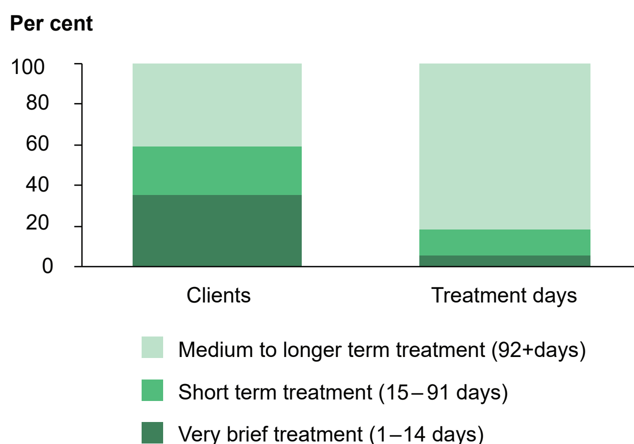
## Changes over time

After taking population changes into account, service contact rates varied across states and territories between 2013–14 and 2017–18, with rates increasing in most states and territories (Victoria, Queensland, Western Australia, South Australia, Northern Territory) and decreasing in others (New South Wales, Australian Capital Territory, Tasmania) over the period. Nationally, the service contact rate increased from 373.9 per 1,000 population in 2013–14 to 383.9 in 2017–18.

## Profile of people who received services

Males (388.9 per 1,000 population) had a higher rate of service contacts than females (367.7) in 2017–18. The service contact rate for Indigenous Australians (1,223.9) was nearly 4 times the rate for non-Indigenous Australians (347.6).

**Figure 6: Community mental health care clients and treatment days, by length of treatment period, 2017–18**




**About 4 in 10 (40.6%) patients, or just over 176,000 people, had a length of treatment of 92 days or more (that is, the time between their first and last service contact during the reporting period) in 2017–18. These patients received the majority of treatment days (81.4%) from CMHC services (Figure 6).**

The most frequently recorded principal diagnoses for patients receiving service contacts were *Schizophrenia* (22.4% of all contacts), *Depressive episode* (6.8%) and *Schizoaffective disorders* (6.0%).

## Profile of service contacts

CMHC service contacts can be conducted individually or in a group session. Service contacts can be delivered with the patient present, such as face to face, via telephone or video link, or by using other forms of direct communication. They can also be conducted without the patient present, such as with a carer or family member, and/or other professional or mental health worker.

Nationally in 2017–18, 94.2% of service contacts (almost 9.0 million contacts) were individual contacts. More than half (54.4%) of all service contacts took place with the patient present.

In 2017–18, the average service contact length was 35 minutes. Service contacts with the patient present (46 minutes) were on average longer than contacts without the patient present (23 minutes).

# Overnight mental health-related hospital care

Overnight mental health-related hospitalisations (also referred to as separations) occur in public acute, public psychiatric, or private hospitals. These hospitalisations can also take place on a general ward, and can be classified as being with or without specialised psychiatric care.

## Services provided

More than 260,000 overnight mental health-related hospitalisations occurred in public and private hospitals in 2017–18, equating to over 3.5 million patient days, with the average length of a mental health-related hospitalisation being 14 days.

Nearly 4 in 5 (79.0%) mental health hospitalisations occurred in public hospitals, while 1 in 5 (21.0%) hospitalisations took place in private hospitals. For public hospitals around 3 in 5 hospitalisations (58.5%) involved specialised psychiatric care, compared with about 4 in 5 (82.7%) for private hospitals.

## Changes over time

The rate of overnight mental health-related hospitalisations increased by an average of 3.5% per year in the 5 years to 2017–18, from 91.5 per 10,000 population to 105.1. Non-mental health overnight hospitalisations increased by an annual average of 0.7% over the same period, from 1,627.5 to 1,673.3 per 10,000 population.

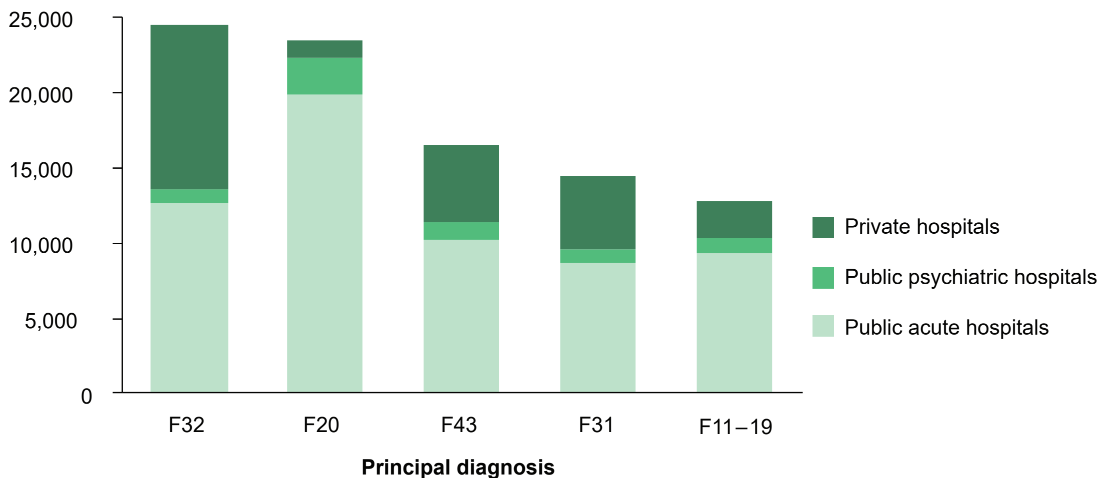
## Profile of people who received services

### *With specialised care*

Almost two-thirds (165,452 or 63.6%) of all overnight mental health-related hospitalisations involved specialised psychiatric care. Of these, females (69.2 per 10,000 population) had a higher rate of hospitalisations than males (64.3). The highest rate was for people aged 35–44 (105.4). The age standardised rate for Indigenous Australians (150.6) was more than double the rate for non-Indigenous Australians (63.7).

*Depressive episode* was the most common principal diagnosis for hospitalisations with specialised care (24,457 hospitalisations, or 14.8%), followed closely by *Schizophrenia* (23,410 or 14.1%). The profile of principal diagnoses for patients receiving care varied between hospital types (Figure 7).

**Figure 7: Mental health-related hospitalisations with specialised psychiatric care, 5 most common mental health principal diagnoses, by hospital type, 2017–18**




Key

F32: Depressive episode

F20: Schizophrenia

F43: Reaction to severe stress and adjustment disorders

F31: Bipolar affective disorders

F11–19: Mental and behavioural disorders due to other psychoactive substance use

### *Without specialised care*

Over one-third (94,798 or 36.4%) of all overnight mental health-related hospitalisations did not involve specialised psychiatric care. Of these, the rate for females (39.1 per 10,000 population) was higher than for males (37.4). The highest rate among the age groups occurred for people aged 85 and over (281.8). The age standardised rate for Indigenous Australians (116.6) was almost 3.5 times the rate for non-Indigenous (33.9).

The most frequently recorded principal diagnoses for overnight mental health-related hospitalisations without specialised care were *Mental and behavioural disorders due to use of alcohol* (21.2%), and *Other organic mental disorders* (19.9%).

## Interventions provided

*Generalised allied health interventions* was the most commonly reported procedure for hospitalisations both with and without specialised psychiatric care (54.2% and 50.6% of hospitalisations, respectively).

# Same-day mental health-related hospital care

In some cases, patients are only admitted to hospital for a portion of the day that they receive care. This could be due to factors such as the hospital's model of care or the type of intervention provided. Models of care differ between the states and territories, and between public and private hospitals, and this has an impact on the reported volume of same-day admitted care, and the inclusion/omission of some types of hospital-based care.

For private hospitals, same-day care may be provided at the hospital or as a home-based service.

## Public hospitals

### *Services provided*

Over 61,000 same-day mental health-related hospitalisations were provided by public hospitals in 2017–18: a rate of 24.8 hospitalisations per 10,000 population.

About 1 in 3 (32.3%) of public hospital same-day hospitalisations involved specialised mental health care.

### *Changes over time*

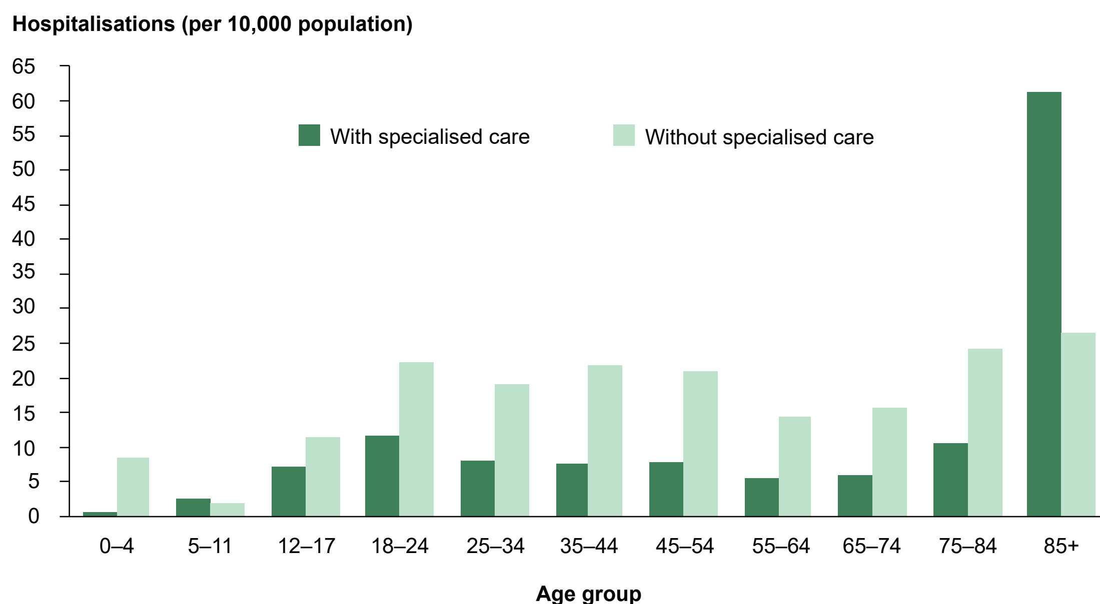
Increases in the population rate of public hospital same-day admitted mental health hospitalisations and non-mental health hospitalisations were similar over the 5 years to 2017–18, with average annual increases of 2.8% and 3.8%, respectively.

### *Profile of people who received specialised psychiatric care*

The rate of same-day mental health-related hospitalisations with specialised psychiatric care in public hospitals was highest for patients aged 85 and over (61.3 per 10,000 population) and lowest for those aged 0–4 (0.7) (Figure 8).

Females were more likely to receive services than males, accounting for 58.3% of the hospitalisations. The most commonly recorded principal diagnosis was *Depressive episode* (4,219 hospitalisations or 21.3%).

**Figure 8: Same day mental health-related hospitalisations with and without specialised psychiatric care in public hospitals, by age group (years), 2017–18**




For same-day mental health hospitalisations with specialised psychiatric care, 41.9% included at least 1 procedure. The most frequently recorded procedures for these hospitalisations were for *Electroconvulsive therapy* and *Cerebral anaesthesia* (both 21.9%).

### *Profile of people who received services without specialised care*

In 2017–18, males and females had similar rates of same day mental health-related hospitalisations in public hospitals without specialised care (16.6 per 10,000 population for males and 16.9 for females).

The highest rate was for people aged 85 and over (26.4 per 10,000 population) (Figure 8) and lowest for those aged 5–11 (1.8).

Similar to overnight hospitalisations, the most commonly recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (9,509 hospitalisations or 22.9% of hospitalisations).

### *Interventions provided*

Around 4 in 10 (39.0%) of same-day mental health hospitalisations without specialised psychiatric care included at least 1 procedure. The most frequently recorded procedure for these hospitalisations was for *Cerebral anaesthesia* (24.3%), which is commonly used with the administration of *Electroconvulsive therapy*.

## Private hospitals

### *Services provided*

Over 262,000 same-day mental health-related care days were provided by private hospitals to 19,763 patients in 2017–18.

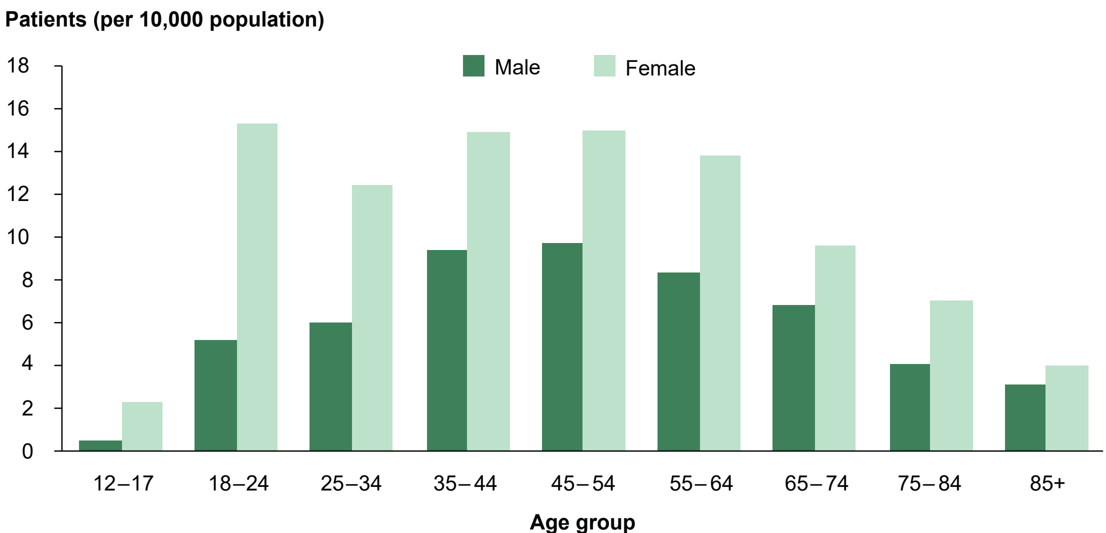
### *Changes over time*

Over the 5 years to 2017–18, the number of patients increased by 20.7%, while the number of care days increased by 22.1%.

### *Profile of people who received services*

The rate of private hospital same-day admitted mental health care was highest for patients aged 45–54 (12.4 per 10,000 population), closely followed by those aged 35–44 (12.1) and lowest for those aged 12–17 (1.3) (Figure 9). Almost two-thirds (64.6%) of patients were female. Female patients accessed private hospital-based psychiatric services at a rate almost double that of male patients (10.2 patients per 10,000 population compared with 5.7).

**Figure 9: Same day private hospital admitted mental health care patients, by sex and age group (years), 2017–18**



On average, 13.3 care days were provided per patient. The average number of care days was higher for patients who usually lived in urban areas (13.5 care days) than for people in non-urban areas (12.1).

In 2017–18, *Major affective and other mood disorders* (45.7% of episodes) was the most common principal diagnosis associated with a same-day private admitted mental health care episode, followed by *Alcohol or other substance use disorders* (16.0% of episodes) and *Anxiety and adjustment disorders* (11.5%).

## Residential mental health care

Residential mental health care (RMHC) services provide overnight specialised mental health care in a domestic-like environment. These services may include rehabilitation, treatment or extended care.

### Services provided

Over 7,700 episodes of RMHC care were provided to 5,973 residents in 2017–18. RMHC services provided 370,592 residential care days: an average of 48.0 residential care days per episode.

The provision of RMHC services differed among states and territories in 2017–18, with Tasmania reporting the highest rates of episodes of care (17.9 per 10,000 population) and residents (9.9 residents per 10,000 population) and New South Wales reporting the lowest (0.2 for both episodes and residents).

### Changes over time

Between 2013–14 and 2017–18, residential mental health care episodes increased marginally from 3.0 to 3.1 per 10,000 population (an average annual change of 1.1% over the period). The average annual change in the number of residents per 10,000 population was greater over the same time period (2.0%).

### Profile of people who received services

Males and females had the same rate of residential mental health care episodes in 2017–18 (3.1 episodes per 10,000 population). People aged 35–44 (5.5) had the highest rate of episodes while people aged 12–17 had the lowest (0.8). There were no episodes for consumers aged under 12.

The rate of episodes was highest for those who usually lived in *Inner regional* areas (4.9 per 10,000 population) and for those living in areas with the most socioeconomic disadvantage (4.0).

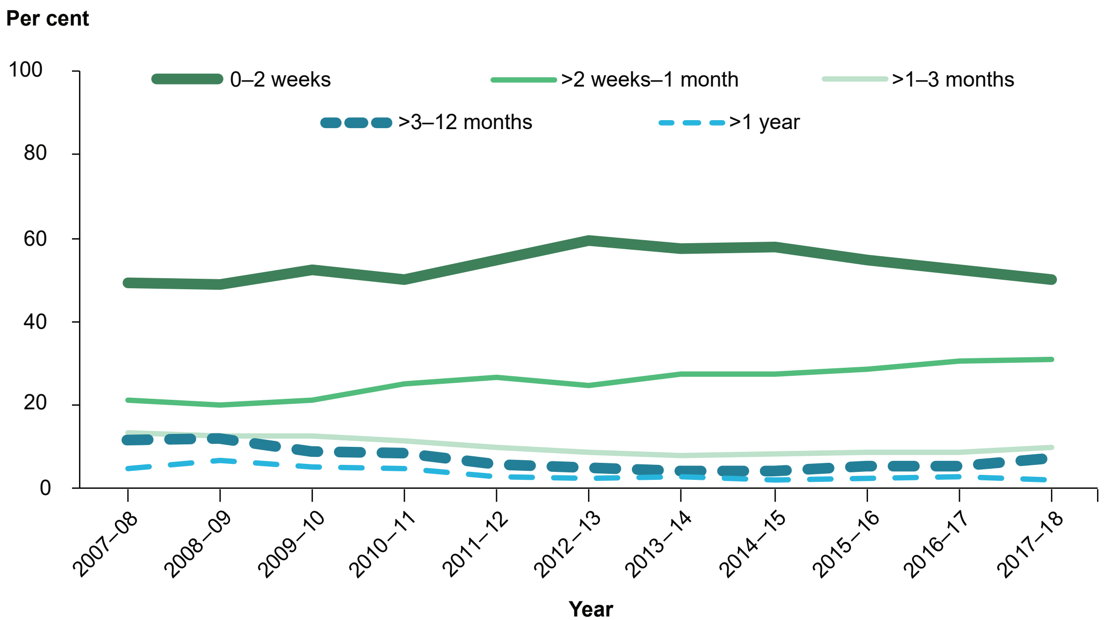
*Schizophrenia* was the most common specified principal diagnosis (26.9%), followed by *Specific personality disorders* (11.9%).

Patients with an *Involuntary* mental health legal status accounted for 1 in 5 episodes (20.0%).

## Typical completed episode of residential care

In 2017–18, around half (50.1%) of all completed residential episodes lasted 2 weeks or less and about 1 in 14 episodes lasted 3–12 months (7.4%). Longer episodes have reduced over time, with 2.0% of all completed episodes lasting more than 1 year in 2017–18, compared with 4.6% in 2007–08 (Figure 10).

**Figure 10: Residential mental health care episodes, by length of completed residential stay, 2007–08 to 2017–18**




More than 4 in 5 (83.1%) residential mental health care episodes ended as a result of formal discharge.

## Restrictive practices

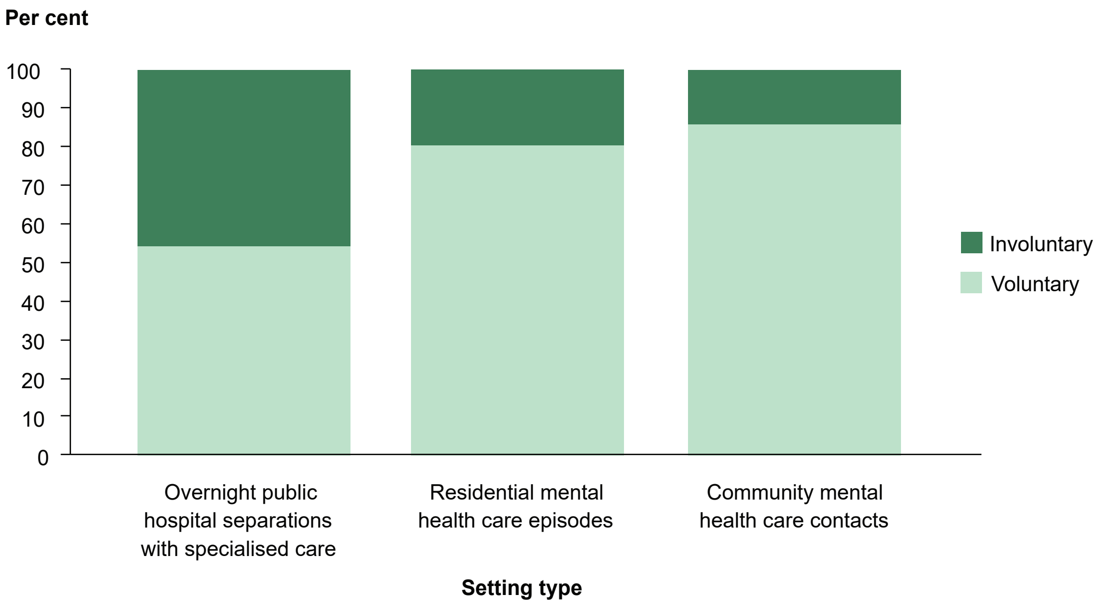
Restrictive practices is a term used to refer to interventions (involuntary treatment, seclusion and restraint) that may be used in mental health facilities to manage a person's behaviour. Working towards reducing, and where possible eliminating, the use of seclusion (confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented) and restraint (restriction of an individual's freedom of movement by physical or mechanical means) is a policy priority in Australia, which has been supported by changes to legislation, policy and clinical practice. Public reporting and monitoring of restrictive practice use supports service reform and quality improvement agendas.

## Legal status

The mental health legal status of a person is whether the person is treated on an involuntary basis under the relevant state or territory mental health legislation at any time during the period of care.

Nearly half (45.8%) of public hospital overnight hospitalisations with specialised care were patients with an *Involuntary* mental health legal status in 2017–18; this was higher than residential mental health care (20.0% of episodes) and community mental health care (14.5% of service contacts) settings in 2017–18 (Figure 11).

**Figure 11: Mental health care, by setting and mental health legal status (per cent), 2017–18**




## Seclusion

Nationally, there were 11,315 seclusion events (6.9 seclusion events per 1,000 bed days) in public sector acute mental health hospital services in 2017–18. The Northern Territory (22.0 events per 1,000 bed days) had the highest rate of seclusion and Western Australia had the lowest (4.3) (Figure 12). About 1 in 26 (3.8%) of all hospitalisations in public sector acute mental health hospital services included a seclusion event. The national seclusion rate fell from 13.9 events per 1,000 bed days in 2009–10 to 6.9 in 2017–18.

**Figure 12: Rate of seclusion, and physical and mechanical restraint events, public sector acute mental health hospital services, by state or territory, 2017–18**

## Restraint

Nationally, 16,917 physical restraint events and 796 mechanical restraint events occurred in 2017–18, equating to 10.3 physical restraint and 0.5 mechanical restraint events per 1,000 bed days.

In 2017–18, the use of restraint (both physical and mechanical) was more common in *Forensic services* than other types of services, although there was an overall reduction in the rate of restraint in *Forensic services* between 2015–16 and 2017–18. The rate of restraint in *General services* remained stable, however the rate of physical and mechanical restraint increased in *Child and adolescent* services. The rate of mechanical restraint decreased but the rate of physical restraint increased in *Older person services*.

## Psychiatric disability support services

Specialist disability support services are provided under the National Disability Agreement (NDA) to support people 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*. From 2013–14, clients have been transitioning into the National Disability Insurance Scheme (NDIS), which impacts the time series analyses. This section also includes data on the number of NDA service users who transitioned to the NDIS in the period 2013–14 to 2017–18.

There were 9,551 NDA service users with a psychiatric disability who transitioned to the NDIS during this period; of these, 5,009 (52.4%) transitioned during 2017–18. With the transition of clients to the NDIS completed in 2016–17, the Australian Capital Territory was not required to collect data under the NDA during 2017–18, therefore, Australian Capital Territory data includes only clients accessing Australian Government administered services.

## Services provided

Across Australia, 280,274 people used specialist disability support services provided under the NDA during 2017–18 (AIHW 2019b). Of these, 100,866 people had a psychiatric disability (primary or other significant disability), with about two-thirds of these (65,412) reporting their psychiatric disability as their primary disability.

The rate of clients accessing psychiatric disability services was highest in South Australia (614.6 per 100,000 population) and lowest in the Northern Territory (131.7). The national rate was 407.2 (Figure 13).

**Figure 13: Specialist disability support service users with a psychiatric disability, by state and territory, 2017–18**

## Changes over time

The rate of non-residential service users with a psychiatric disability increased by an average of 1.6% per year—from 380.0 per 100,000 population in 2013–14 to 405.6 in 2017–18. Over the same period, the rate of residential service users decreased by an annual average of 12.4%—from 16.3 per 100,000 population in 2013–14 to 9.6 in 2017–18.

## Profile of service users and the type of support provided

### *Non-residential service users*

In 2017–18, 100,477 people with a psychiatric disability accessed non-residential disability support services. Almost two-thirds of those (65,284 or 65.0%) reported psychiatric disability as their primary disability.

The highest rates of non-residential service users with a psychiatric disability among the demographic groups were:

- Indigenous Australians (768.0 per 100,000 population)
- people aged 45–54 (752.0)
- people from *Inner regional* areas (511.2)
- males (427.0).

*Employment services* were the most common type of service provided to non-residential users, followed by *Community support* and *Community access*.

### *Residential service users*

In 2017–18, 2,375 people with a psychiatric disability (primary or other significant disability) accessed residential support services. About 1 in 8 of those (299 people or 12.6%) reported psychiatric disability as their primary disability.

*Group homes* were the most frequently provided residential service. While there were fewer users of residential services than non-residential services, the profile of service users was similar, with the highest rates among the demographic groups seen for:

- Indigenous Australians (15.9 per 100,000 population)
- people from *Inner regional* areas (11.7)
- males (11.1).

People aged 55–64 used residential support services at the highest rate (20.9 per 100,000).

## Specialist homelessness services

Governments fund various agencies across Australia to provide Specialist Homelessness Services (SHS), including accommodation and other non-accommodation services such as counselling.

Data in this section describe SHS clients with a current mental health issue, who:

- indicated they were receiving services or assistance for their mental health issues or reported 'mental health issues' as a reason for seeking assistance, or
- had a mental health service as their formal referral source to the agency, or
- had a psychiatric hospital or unit as their most recent dwelling type, or had been in a psychiatric hospital or unit in the last 12 months, or
- at some stage during their support period, needed psychological services, psychiatric services or mental health services.

### Services provided

About 81,000, or 374.9 clients per 100,000 population, had a current mental health issue in 2017–18, which is about one-third of the 241,113 national SHS clients aged 10 and over.

Almost half of SHS clients with a mental health issue accessed accommodation services (47.9% or 38,832 clients), at a rate of 179.7 clients per 100,000 population. A further 50.2% (40,629 or 188.1 clients per 100,000 population) received other support services, while 1.9% (1,543 clients) did not receive a service or referral to a service in 2017–18.

### Changes over time

The national rate of clients with a current mental health issue increased by an annual average of 7.8% over the 5 years to 2017–18. The rate of support periods increased by an average of 9.5% per year over the 5 year period to 2017–18.

### Profile of people who received services

Almost half (47.2%) of SHS clients with a current mental health issue reported an episode of homelessness in the 12 months before presenting to an agency.

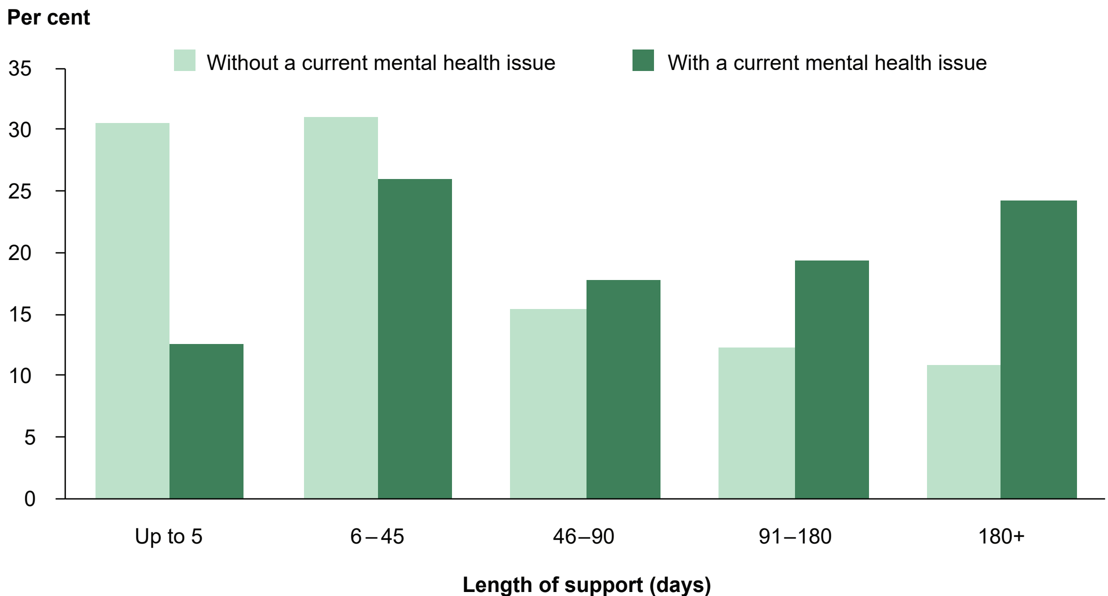
Clients with a current mental health issue aged 15–17 had the highest rate of SHS agency use (726.2 clients per 100,000 population), followed by those aged 18–24 (643.7). Female clients (446.3) sought services at a higher rate than male clients (301.6). The rate of SHS clients with a current mental health issue was over 7 times as high for Indigenous than for non-Indigenous clients (1,933.1 and 265.8 per 100,000 population, respectively).

*Housing crises* (24.5%) was the most commonly reported main reason for SHS clients with a current mental health issue to seek assistance, followed by *Domestic and family violence* (18.8%).

## Length of support period

In 2017–18, almost two-thirds of clients (61.5%) with a current mental health issue received more than 45 days of support (Figure 14). In contrast, about one-third of clients (38.5%) without a current mental health issue received more than 45 days of support.

**Figure 14: SHS clients with and without a current mental health issue, by total length of support provided, 2017–18**



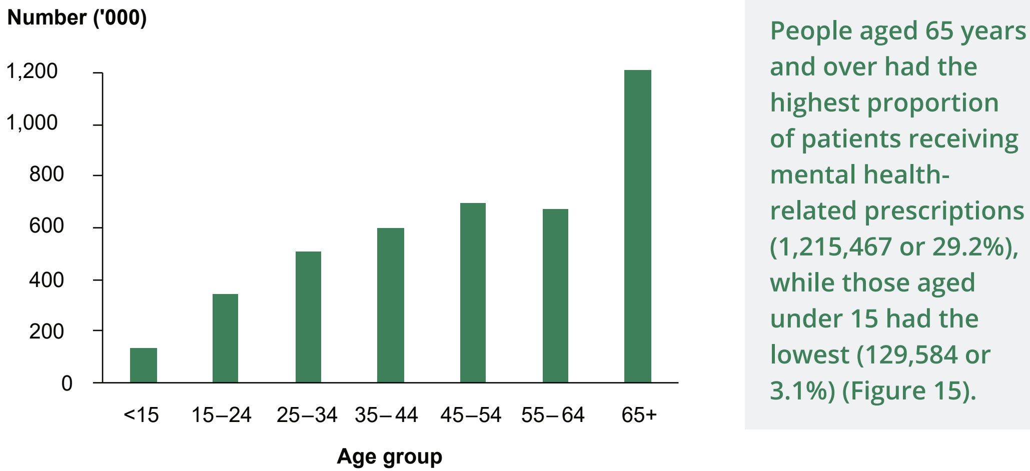

# Mental health-related prescriptions

Mental health-related medications may be subsidised, where they are paid for through the Australian Government's PBS or RPBS. If the patient is not eligible or the total cost of the prescription is under the threshold for PBS/RPBS subsidy, medications are supplied under co-payment and the total cost is covered by the patient. As some medications classified as mental health-related may be prescribed for non-mental health conditions, data are likely an over count of prescriptions dispensed to treat mental illness. The proportion of prescriptions for non-mental health conditions cannot be accurately removed from the data presented in this section.

## Patients and prescriptions

In 2017–18, 4.2 million patients (16.8% of the population) received 37.7 million prescriptions for mental health-related medications (subsidised and under co-payment). Around two-thirds of these prescriptions (64.0% or 24.2 million) were subsidised by the Australian Government under the PBS or RPBS. About 1 in 5 (20.0%) females received a mental health-related prescription, which was higher than for males (13.6%).

**Figure 15: Number of patients receiving subsidised and under co-payment prescriptions, by age group, 2017–18**




People aged 65 years and over had the highest proportion of patients receiving mental health-related prescriptions (1,215,467 or 29.2%), while those aged under 15 had the lowest (129,584 or 3.1%) (Figure 15).

Tasmania had the highest proportion of people (21.8% of their total population) receiving mental health-related prescriptions in 2017–18, while the Australian Capital Territory had the lowest (15.5%).

The proportion of patients receiving mental health-related prescriptions varied depending on the patient's usual area of residence. The highest proportion of patients and prescriptions were for people living in *Inner regional* areas (20.7% of the population) compared with those living in *Very remote* areas, where 7.0% of people received prescriptions.

## Over time

The proportion of people receiving subsidised mental health-related prescriptions fell from 10.8% of the population in 2013–14 to 9.7% in 2017–18. However, the proportion of people receiving subsidised and under co-payment prescriptions increased from 16.2% in 2013–14 to 16.8% in 2017–18.

## Type of mental health-related medications provided

*Antidepressants* were the most frequently dispensed mental health-related medications (subsidised and under co-payment) in 2017–18 (3.0 million people, 26.4 million prescriptions). About 968,000 people received *Anxiolytics*, 755,000 people received *Hypnotics and sedatives* and 473,000 people received *Antipsychotics*, noting that individuals may receive a prescription for more than 1 medication type.

Of the 5 mental health-related prescription types (subsidised and under co-payment), the number of people receiving *Antipsychotics*, *Anxiolytics*, *Antidepressants* and *Psychostimulants and nootropics* increased between 2013–14 and 2017–18, while the number of patients receiving prescriptions for *Hypnotics and sedatives* fell.

## Prescriber type

GPs prescribed mental health-related medications (subsidised and under co-payment) to about 3.9 million people (92.7% of patients receiving prescriptions). Non-psychiatrist specialists prescribed medication to 380,943 people (9.1%) and psychiatrists provided prescriptions for medications to 349,935 people (8.4%), noting that individuals may receive a prescription for more than 1 medication type.

# Mental health resources

## Mental health workforce

Various health-care professionals—including GPs, psychiatrists, psychologists, nurses, social workers, occupational therapists and peer workers—provide mental health-related services and support to Australians with mental health issues. Detailed data on the size and characteristics of the mental health workforce presented in this section are limited to psychiatrists, mental health nurses and psychologists who worked principally in mental health care.

### Psychiatrists

An estimated 3,369 psychiatrists, or 13.3 full-time-equivalent (FTE) psychiatrists per 100,000 population, were estimated to work in Australia in 2017.

When considering time spent as a clinician, there were 11.0 clinical FTE psychiatrists per 100,000 population, with rates ranging from 6.6 in the Northern Territory to 12.3 in South Australia (Figure 16). The majority of clinical FTE psychiatrists were in *Major cities* (13.4 FTE per 100,000 population), while *Very remote* areas had the lowest rate (3.5).

Psychiatrists worked an average of 38.8 total hours and 32.2 clinical hours per week in 2017. On average, male psychiatrists worked 6.6 total hours and 5.5 clinical hours more per week than female psychiatrists.

There was a slight increase in psychiatrists nationally between 2013 and 2017 from 12.3 to 13.3 FTE per 100,000 population. The average hours worked per week was relatively stable over the period, averaging around 39 hours per week.

### Mental health nurses

An estimated 22,159 (6.9% of total nurses) indicated they were working principally in mental health in 2017. This equates to 85.8 FTE mental health nurses per 100,000 population. The national rate of clinical FTE mental health nurses was 79.0 per 100,000 population, ranging from 69.3 in the Australian Capital Territory to 89.5 in Western Australia (Figure 16).

More than three-quarters of FTE mental health nurses (76.2% or 91.0 per 100,000 population) worked in *Major cities*. Rates mostly decreased with increasing remoteness, with 36.3 FTE mental health nurses per 100,000 population working in *Very remote* areas.

Mental health nurses worked an average of 36.2 total hours, and 33.3 clinical hours, per week, with male nurses (34.8 hours) working more clinical hours on average than female nurses (32.7 hours).

There was an increase between 2013 and 2017 in the supply of mental health nurses, from 83.6 to 85.8 FTE per 100,000 population. The average hours worked per week by mental health nurses declined slightly for registered (36.9 to 36.4) and enrolled nurses (35.0 to 34.7) over the period.

## Psychologists

An estimated 26,311 psychologists were working in Australia in 2017, equating to 91.1 FTE psychologists per 100,000 population.

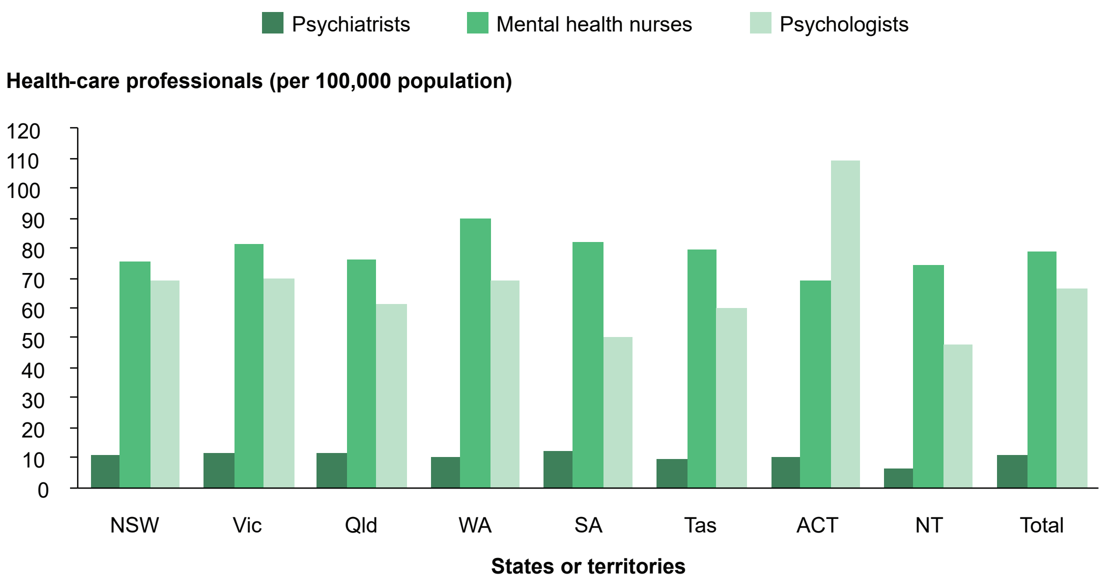
When considering time spent as a clinician, there were 66.5 FTE psychologists per 100,000 population, with rates ranging from 47.6 in the Northern Territory to 109.1 in the Australian Capital Territory (Figure 16).

More than 8 in 10 FTE psychologists (83.0%) worked in *Major cities*. Rates decreased with increasing remoteness, with 27.3 FTE psychologists per 100,000 population working in *Very remote* areas.

Psychologists worked an average of 32.4 total hours, and 23.6 clinical hours per week. The average clinical hours ranged from 22.7 hours for psychologists in Victoria to 26.1 hours for psychologists in Tasmania. Male psychologists worked more clinical hours on average (25.2 hours) than female psychologists (23.2 hours).

There was an increase in the supply of psychologists from 2013 to 2017, from 86.2 to 91.1 FTE per 100,000 population. The average total hours worked per week by psychologists has remained comparatively stable at around 33 hours per week over the period.

**Figure 16: Employed psychiatrists, mental health nurses and psychologists, clinical FTE per 100,000 population, by state and territory, 2017**



## Expenditure on mental health services

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

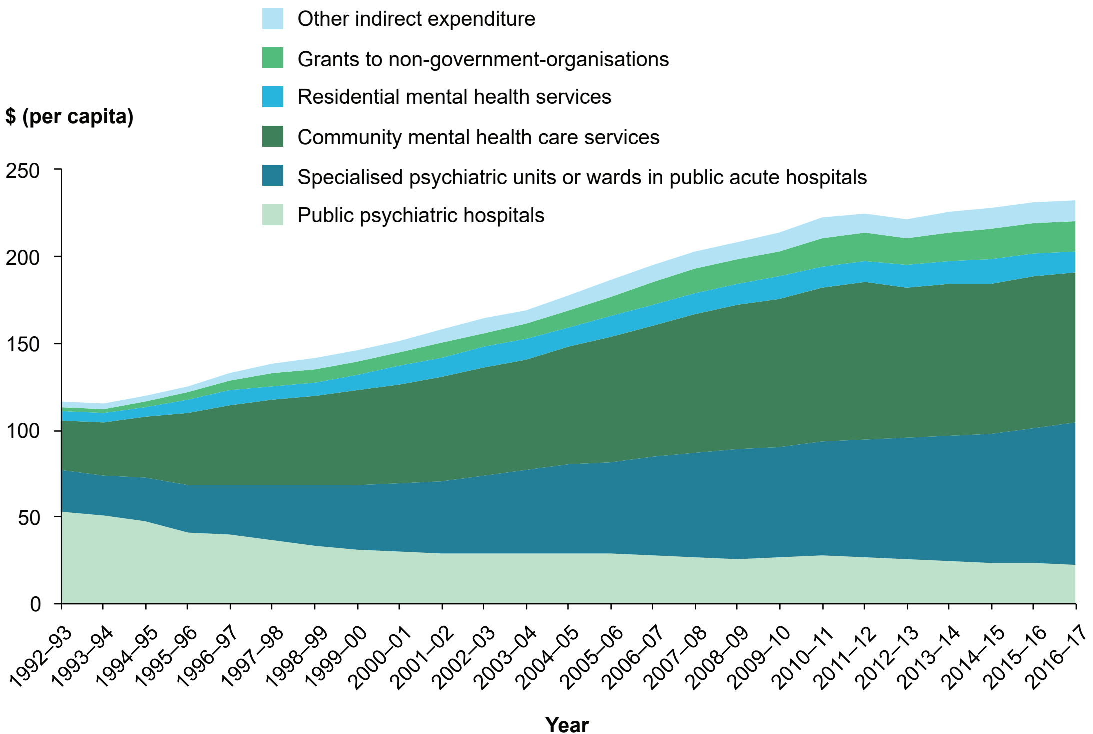
Mental health services were estimated to comprise 7.4% of combined Australian and state and territory government recurrent health spending in 2016–17.

### Spending on state and territory specialised mental health services

In 2016–17, $9.1 billion was spent on mental health-related services (recurrent expenditure only), equating to $375 per person. Over $2.6 billion was spent on public hospital services for admitted patients and $2.1 billion on community mental health care services. After adjusting for inflation, spending on state and territory specialised mental health services increased by an average 2.8% per year over the 5 years to 2016–17.

Detailed expenditure data are available from 1992–93 to 2016–17. Spending on community mental health care services has seen the largest per capita rise over this time—from $28 per person in 1992–93 to $86 (constant prices) in 2016–17 (Figure 17).

**Figure 17: Recurrent expenditure per capita on state and territory specialised mental health services, constant prices, 1992–93 to 2016–17**



In 2016–17, the Australian Government spent an estimated $3.0 billion on mental health-related services, equating to $123 per person. More than half (55.8%) was spent on Medicare-subsidised mental health-specific services and mental health-related medications, with a further 23.8% spent on programs and initiatives funded by the Department of Health.

Other areas of expenditure included:

- Department of Veterans' Affairs programs and initiatives (6.5%)
- private health insurance premium rebates (5.2%).

Australian Government spending on mental health-related services, after adjusting for inflation, has increased by an average of 0.8% per year between 2012–13 and 2016–17. This rise was mostly due to increased spending on national programs and initiatives managed by the Department of Health and on Medicare-subsidised mental health-specific services. However, expenditure on disability services for people with mental illness (for example, Personal Helpers and Mentors service) previously funded by the Australian and state and territory governments has transitioned to the NDIS and is not currently included in these expenditure figures.

### Medicare-subsidised mental health-specific services

Around $1.2 billion was paid in benefits for Medicare-subsidised mental health specific services in 2017–18, equating to $49 per person nationally.

The largest proportion of spending was for services provided by psychologists (44.4%), followed by psychiatrists (28.9%), and GPs (24.1%). After adjusting for inflation, spending on Medicare-subsidised mental health-specific services increased by an average of 5.4% per capita per year in the 5 years to 2017–18.

### PBS and RPBS-subsidised prescriptions

Around $534 million was spent on mental health-related subsidised prescriptions under the PBS and RPBS in 2017–18, equating to $22 per person.

About three-quarters (73.2%) of total spending was for prescriptions issued by GPs, followed by psychiatrists (16.9%) and non-psychiatrist specialists (8.7%). After adjusting for inflation, spending on mental health-related PBS and RPBS prescriptions per Australian fell by an average of 7.9% per year in the 5 years to 2017–18. This was likely the result of a decrease in the subsidised cost of some medications, partly due to some medications no longer being under patent and a decrease in the number of people receiving subsidised mental health-related prescriptions.

## Specialised mental health care facilities

Specialised mental health care is delivered by a variety of state and territory facilities in Australia. This section excludes services subsidised by the Medicare Benefits Scheme.

## Specialised mental health care facilities

Nationally, 1,652 specialised mental health care facilities provided specialised mental health care in 2016–17. Of these, 391 provided overnight care, with 7,175 specialised mental health care beds available in public hospitals, 3,011 in private hospitals and 2,281 in residential mental health care services (Table 2).

**Table 2: Specialised mental health care beds, 2016–17**

| Facility type | Beds |
|---|---|
| Public hospitals | 7,175 |
| *Acute beds* | *5,056* |
| *Non-acute beds* | *2,120* |
| Private hospitals | 3,011 |
| Residential services | 2,281 |
| *24-hour staffed* | *1,680* |
| *Non-24-hour staffed* | *602* |

*Note:* Numbers do not sum to totals due to rounding.

## Consumer and carer involvement

The employment of mental health consumer and carer workers is an indicator of the engagement of consumers and carers in the delivery of mental health services.

Of the 170 state and territory specialised mental health service organisations in 2016–17, 76 organisations (44.7%) employed mental health consumer workers and 46 organisations (27.1%) employed mental health carer workers.

## Staffing of specialised mental health care services

In 2016–17, 32,573 FTE staff were employed by state and territory mental health services. About half were nurses (51.0% or 16,603 FTE staff), with most of those being registered nurses (14,286 FTE). Diagnostic and allied health professionals were the next largest staffing group (19.4% or 6,310 FTE staff), comprised mostly of social workers (2,115) and psychologists (1,832). Since 1993–94, the number of FTE staff employed in admitted patient hospital services has remained relatively stable (averaging about 13,000), while those employed by community mental health services has almost tripled (from about 4,000 in 1993–94, to more than 12,000 in 2016–17).

Specialised psychiatric services in private hospitals employed a further 3,541 FTE staff in 2016–17.

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.

# Key Performance Indicators for Australian Public Mental Health Services

The Key Performance Indicators for Australian Public Mental Health Services (MHS KPIs) are standardised measures used to monitor the performance of the state and territory mental health services. Data are available for 13 out of the 16 nationally agreed MHS KPIs, and can be broken down by some service type or patient demographic variables. More detailed interactive data is available on the *Mental health services in Australia* www.aihw.gov.au/mhsa website.

## *Effectiveness of care*

### Change in consumers' clinical outcomes

**71.4%** of completed hospital stays saw a significant improvement in the consumers' mental health in 2016–17.

### Outcomes readiness

**33.1%** of completed inpatient episodes had outcomes measures at baseline and follow-up in 2016–17.

### 28-day readmission rate

**14.9%** of hospital stays had a readmission to hospital in 2016–17.

## *Appropriateness of care*

### National Services Standards compliance

In 2016–17, **83.2%** of services met the national mental health standards.

## *Efficiency of care*

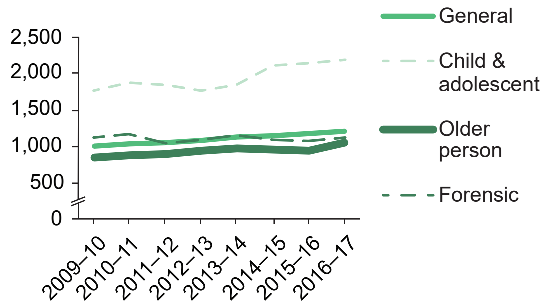
### Average length of acute admitted patient stay

The average length of a stay in an inpatient mental health unit was **12.7 days** in 2016–17.

## *Efficiency of care* (continued)

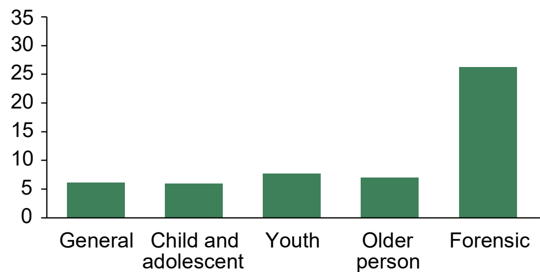
### Average cost per acute admitted patient day

The average cost per day for an acute child and adolescent inpatient mental health unit was **$2,184** in 2016–17. The average per day cost of child and adolescent care continues to be higher than for other groups. General care was the second highest at $1,206 per day.




### Average treatment days per 3-month community care period

The average number of treatment days provided per 3-month community care period in 2016–17 was **6.7 days**. The average number of community treatment days for those receiving care from forensic services was at least 3 times greater than all other target groups, with clients receiving an average of 25.4 days per 3-month period.




### Average cost per community treatment day

The average cost per community treatment day in 2016–17 was **$325**.

## *Accessibility of care*

### Proportion of people receiving clinical mental health care

**1.8%** of people received clinical mental health care in 2016–17.

### New client index

In 2016–17, **41.9%** of clients were new.

## *Continuity of care*

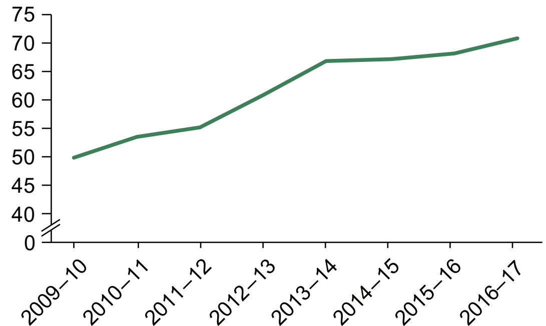
### Rate of pre-admission community care

**40.4%** of hospital stays involved community mental health care in the 7 days before the hospital stay in 2016–17.

### Rate of post-discharge community care

In 2016–17, **70.8%** of hospital stays involved community mental health care after discharge from the hospital.

The number of consumers receiving post-discharge follow-up care in the community has steadily increased from **49.8%** in 2009–10.

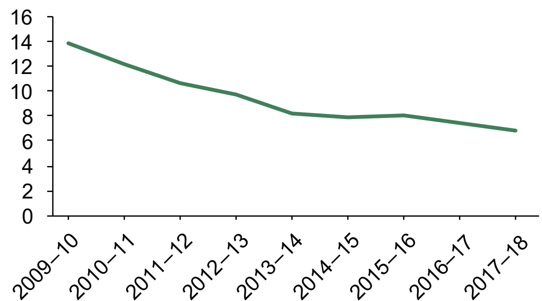



## *Safety of services*

### Rate of seclusion

**6.9** seclusion events per 1,000 days took place in public acute hospital inpatient services in 2017–18.

The rate of seclusion has had an overall decrease from 13.9 events per 1,000 bed days in 2009–10.




### Rate of restraint

**0.5** mechanical restraint and **10.3** physical restraint events per 1,000 bed days took place in 2017–18. Total rates of restraint have decreased since reporting began in 2015–16.

# 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:

- **same day:** Care provided during a single day, and the patient does not stay in hospital overnight.
- **overnight:** When the care provided included an overnight stay in the hospital setting. Patients can have hospitalisations 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).

**ambulatory patient mental health-related care:** A specialised mental health service that provides services to people who are not currently admitted to a mental health or residential service.

**average annual rate:** The 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 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.

**full-time equivalent (FTE):** A measure of the number of standard week workloads that professionals work. Workforce data is drawn from the National Health Workforce Dataset, which uses a standard of a 40-hour week for medical practitioners and a 38-hour week for all other professions.

**Medicare-subsidised mental health-specific services:** Services provided by psychiatrists, GPs, psychologists and other allied health professionals subsidised according to the 'item numbers' listed in 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 or the International Classification of Diseases.

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

**Pharmaceutical Benefits Scheme:** An Australian Government scheme that subsidises the cost of prescription medicine.

**psychiatric disability:** 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 who has studied the brain, memory, learning, human development and the processes determining how people think, feel, behave and react, and who is registered with the Psychology Board of Australia.

**recurrent expenditure:** Expenditure that does not result in the acquisition or enhancement of an asset. Example of recurrent expenditure include salary and wages expenditure and non-salary expenditure such as payments to visiting medical officers.

**remoteness areas:** 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.

**Repatriation Pharmaceutical Benefits Scheme:** An Australian Government scheme that provides a wide variety of pharmaceuticals and dressings at a concessional rate for the treatment of eligible veterans, war widows/widowers and their dependants.

**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 (also referred to as hospitalisation):** The process by which an episode of care for an admitted patient ceases.

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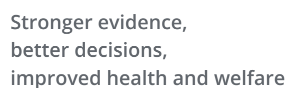

Stronger evidence,
better decisions,
improved health and welfare