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AIHW

Mental health services

In brief 2018

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Contents

Mental health services: at a glance

276,954	presentations to emergency departments were mental health-related in 2016–17
258,302	separations were for overnight mental health-related hospital care in 2016–17
64,692	mental health-related same-day separations took place in public hospitals in 2016–17
255,760	mental health-related same-day care days took place in private hospitals in 2016–17
9,812	hospital beds were specialised mental health-care beds in public and private hospitals in 2015–16

2.4 million	people received Medicare-subsidised mental health-specific services in 2016–17
4.05 million	patients received mental health-related prescriptions in 2016–17
$9.0 billion	was spent on mental health-related services in 2015–16

8.9 million	community mental health care service contacts occurred in 2016–17
294,113	residential care days were provided in 2016–17
100,939	people with a psychiatric disability received disability support services in 2016–17
77,569	clients with a mental health issue received specialist homelessness services in 2016–17
351,239	sessions were delivered under the ATAPS program in 2015–16

11,937	seclusion events occurred in mental health acute hospital services in 2016–17
13,321	physical restraint events and 1,479 mechanical restraint events occurred in 2016–17

The mental health workforce in Australia included:

3,244	psychiatrists in 2016
21,558	mental health nurses in 2016
24,522	registered psychologists in 2015

Mental health service—In brief 2018 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 2018. 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 (Slade et al. 2009).

The term covers 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.

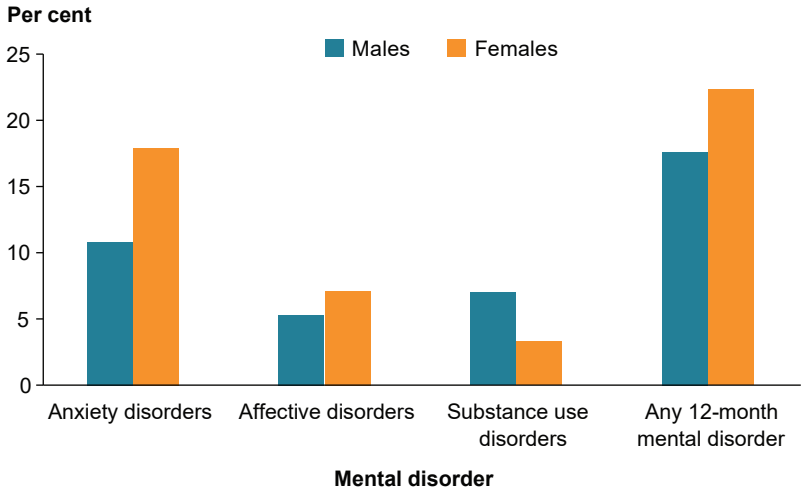
Those with mental illness often experience problems such as isolation, discrimination, and stigma (WHO 2016). The terms mental illness and mental disorder are often used interchangeably.

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 8.6 million people who will experience a common mental disorder in their lifetime, based on the estimated 2016 population. Each year, 1 in 5 Australians in this age range (20% or about 3.8 million Australians in 2016) are estimated to experience a mental disorder (ABS 2008).

Anxiety disorders (for example, *Post-traumatic stress 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. This was followed by *Affective disorders* (for example, *Depression*, 6.2%) and *Substance use disorders* (for example, *Alcohol dependence*, 5.1%) (ABS 2008).

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



Women experienced 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).

1 in 7 young people aged 4–17 (13.9% or just over 586,000 people based on the estimated 2016 population) met the clinical criteria for 1 or more mental disorders in the previous 12 months.

Attention deficit hyperactivity disorder (ADHD) was the most common mental disorder (7.4% or 312,000 children and adolescents based on the estimated 2016 population), followed by *Anxiety disorders* (6.9% or about 291,000), *Major depressive disorder* (2.8% or about 118,000), 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 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 disorders and a modest increase in the prevalence of *Major depressive disorders* (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 of People living with psychotic illness 2010, conducted in 2009–10. More people had a diagnosis of *Schizophrenia* (47.0%) than any other type of psychotic illness (Morgan et al. 2011). About two-thirds (64.8%) of these people had their first episode of psychotic illness before the age of 25.

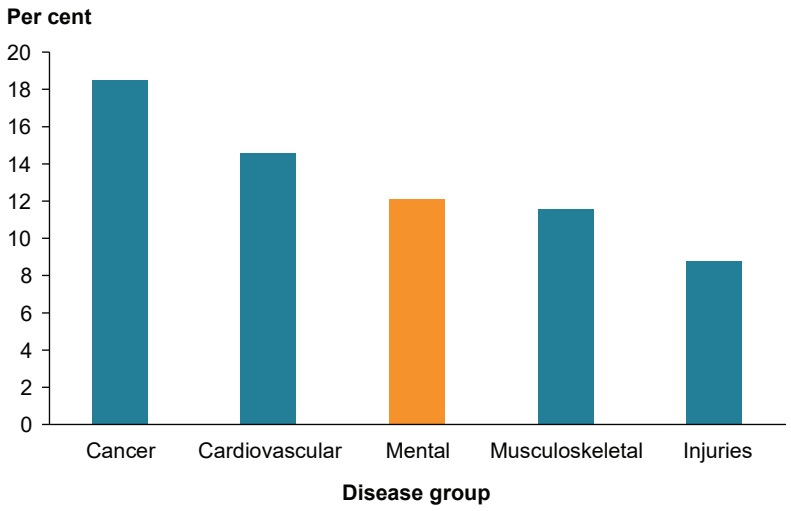
The impact of mental illness in Australia

Mental disorders can vary in severity and duration, and may also be episodic. Around 2–3% of Australians (equivalent to about 730,000 people based on the estimated 2016 population) have severe mental disorders, as judged by diagnosis, intensity of symptoms, duration of symptoms, and degree of disability (not limited to severe psychotic disorders) (DoHA 2013). Between 4–6% of the Australian population (about 1.5 million people) have moderate disorders, and a further 9–12% (about 2.9 million people) have a mild disorder.

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

The 2011 Australian Burden of Disease Study (AIHW 2016) looked at the fatal (years of life lost) and non-fatal (years of life lived with a disability) impact of different diseases, conditions or injuries on Australians.

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



In 2011, mental and substance use disorders were responsible for an estimated 12.1% of the total disease burden in Australia, making it the third highest group of diseases behind cancer and cardiovascular diseases. (Figure 2)

One in 4 years lived with a disability were due to mental and substance use disorders, making it the leading cause of non-fatal burden. The main causes of non-fatal burden for those suffering mental illness in 2011 were *Anxiety disorders* (27%), *Depressive disorders* (24%) and *Alcohol use disorders* (11%) (AIHW 2016).

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 a 'comorbid' disorder), 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 illness often had 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 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

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. These include income support, social and community support, disability services, 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 (ABS 2008). 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 MBS Initiative (Better Access) was introduced to 'provide better access to mental health practitioners through Medicare' (DoHA 2006). An updated estimate of treatment rates for people with mental illness 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 document).

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 mental disorder. 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.

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 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

Mental health care provided by general practitioners

The first professional encounter for many people seeking help for a mental illness is their GP. The Bettering the Evaluation and Care of Health (BEACH) survey of GPs has previously been used to estimate the mental health-related GP encounters. The BEACH survey was conducted for the final time in 2015–16. Medicare data describing GP activity for mental health-specific MBS items are also available on an ongoing annual basis.

Information provided

Data from the BEACH survey provided information on the number of GP encounters estimated to be mental health-related, a profile of people who received services, problems managed and insight into how issues were managed.

One in 8 (12.4%) of all GP encounters in 2015–16 were mental health-related (an estimated 18.0 million encounters). These estimates are much higher than the number of mental health-specific Medicare-subsidised GP services provided (3.2 million services in 2015–16). This suggests that only about 1 in 6 (18.1%) estimated GP encounters that were mental health-related were billed using mental health-specific MBS items numbers in 2015–16, with the remainder likely billed as general MBS items.

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 video link.

Profile of people who received services

About 2.4 million people (9.8% of the population) received Medicare-subsidised mental health-specific services in 2016–17. Around 1 in 9 females (11.7%) received services, compared with 7.9% of males. The proportion of people receiving services was highest for those aged 35–44 (13.4% of people in this age group received services).

In 2016–17, Victoria had the highest percentage of patients (10.7% of its population) and highest rate of services (527.6 per 1,000 population) while the Northern Territory had the lowest (4.7%, and a rate of 141.8 services per 1,000 population).

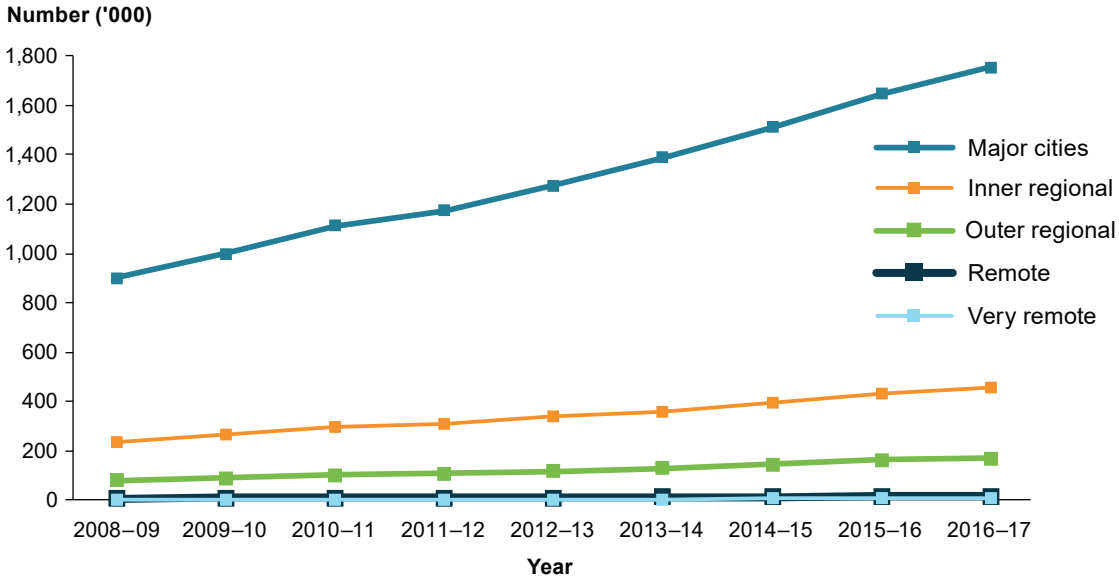
People who usually live in *Inner regional* areas were most likely to receive services, followed closely by those living in *Major cities*. For the remaining areas—that is, *Outer regional*, *Remote* and *Very remote* areas—the rate of people receiving services decreased as remoteness increased.

Changes over time

The number of patients receiving Medicare subsidised mental health-specific services has increased, from 1.2 million (or 5.7% of the population) in 2008–09 to 2.4 million (9.8%) in 2016–17. Services have also increased, from 6.2 million in 2008–09 to 11.1 million services in 2016–17.

The majority of people receiving services reside in *Major cities* (1,754,938 people or 73.1% of consumers), with numbers of people receiving services declining as remoteness increases. The number of Australians receiving Medicare-subsidised mental health-specific services who live in *Very remote* areas has increased by 9.9% per year over the 9 years to 2016–17 (from 2,474 people to 5,326 people, respectively) (Figure 3). Patients receiving services in *Remote* areas had the next largest increase (9.7%), followed by those in *Outer regional*, *Inner regional* and *Major cities*.

Figure 3: Number ('000) of people receiving Medicare-subsidised mental health-specific services, by remoteness, 2008–09 to 2016–17



Providers of Medicare-subsidised mental health-related services

GPs provided more services than other provider types in 2016–17; around 3 in 10 (30.9%) of all Medicare-subsidised mental health-specific services. This was followed by other psychologists (psychologists not classified as clinical psychologists) (24.7%), and psychiatrists (21.5%). Psychiatrists provided the highest number of services per patient (6.2 services per patient).

Mental health services provided in public hospital emergency departments

Public hospital emergency departments (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.

Services provided

An estimated 276,954 mental health-related ED presentations occurred in 2016–17 (3.6% of all ED occasions of service). Almost 4 in 5 (79.2%) 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 13.5% of presentations were classified as *Emergency* (requiring care within 10 minutes) and 0.9% as *Resuscitation* (requiring immediate care).The average length of a stay in the ED for a mental health-related presentation was around 3 and a half hours (207 minutes).

The most frequently recorded end status for a mental health-related ED presentation was *Departed without being admitted to another hospital* (58.0%).

Around 4 in 10 (39.0%) of mental health-related ED presentations resulted in admission to a hospital, either to the hospital where the emergency service was provided (34.8%), or *Referred to another hospital for admission* (4.2%) in 2016–17.

Changes over time

Nationally, the number of mental health-related ED presentations per 10,000 population has increased by 2.7% per year since 2014–15. Western Australia has experienced the largest growth, increasing by 8.8% per 10,000 population since 2014–15, while mental health-related presentations in Queensland decreased by 0.3% over the same period. Data for ACT were not available for 2015–16.

Profile of people who received services

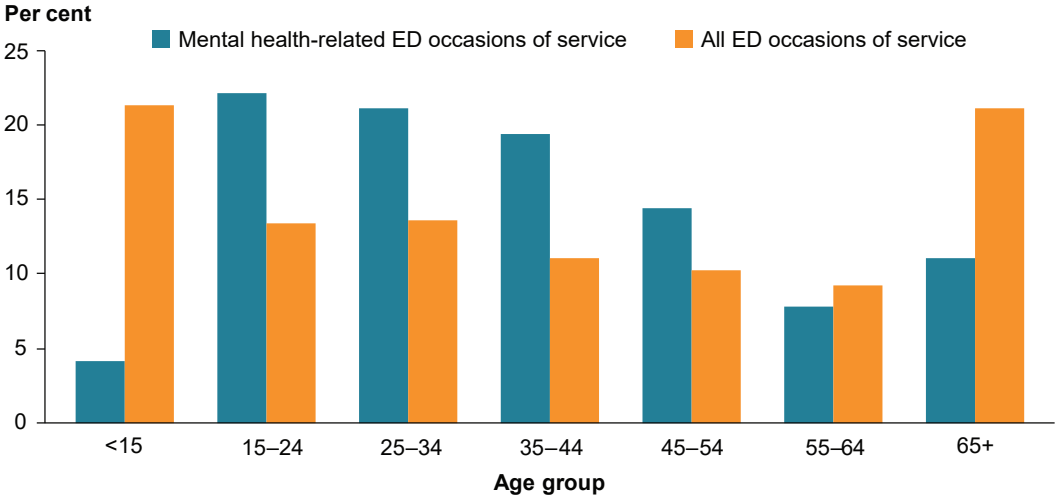
More than one-quarter (26.3%) of mental health-related emergency department presentations were for people aged under 25 in 2016–17, and more mental health-related ED presentations were for males (52.0%) than females (48.0%).

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) (26.9% and 26.7%, respectively).

ED mental health-related care compared with all ED visits

In 2016–17, nearly 8 out of 10 mental health-related ED presentations were for patients aged 15–54 (77.0%) compared with less than half of all ED presentations for the same age group (48.4%). The proportion of mental health presentations for patients under 15 (4.1%) was less than all ED presentations for patients the same age (21.3%). This was also seen in older age groups, with 11.0% of mental health presentations for patients aged 65 and over, compared with 21.1% of total ED presentations (Figure 4).

Figure 4: Emergency department occasions of service in public hospitals, by age group (years), 2016–17



State and territory community mental health care services

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

Services provided

About 8.9 million community mental health care service contacts were provided nationally to nearly 420,000 people in 2016–17; equating to an average of 21 service contacts per client. The national average rate of clients receiving services was 17.2 clients per 1,000 population. The rate was highest in the Northern Territory (30.2 clients per 1,000 population) and lowest in Victoria (10.7).

Nationally, about 1 in 7 (13.8%) service contacts were provided to people with an Involuntary mental health legal status in 2016–17. The Australian Capital Territory (37.2%) had the highest proportion of service contacts provided to people with an Involuntary mental health legal status, while Western Australia (3.1%) had the lowest.

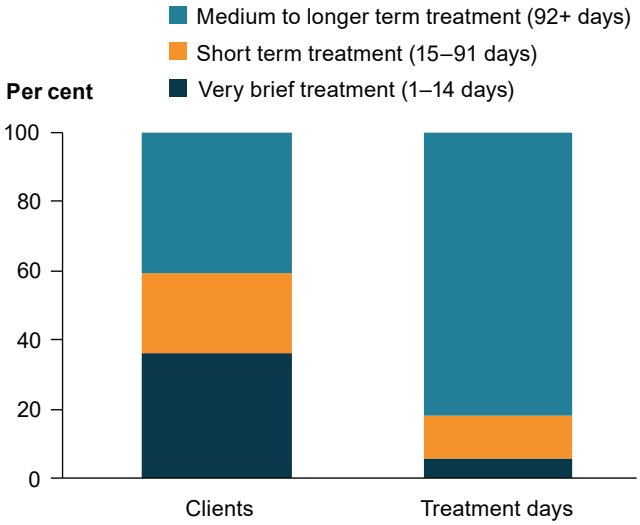
Changes over time

After taking population changes into account, service contact rates increased in most states and territories between 2012–13 and 2016–17. Data coverage issues in 2011–12 and 2012–13 mean that the change at the national level cannot be calculated for this period.

Profile of people who received services

Males (380.0 per 1,000 population) had a higher rate of service contacts than females (341.2) in 2016–17. The service contact rate for Indigenous Australians (1,189.9) was nearly 4 times the rate for non-Indigenous Australians (330.1).

Figure 5: Community mental health care clients and treatment days, by length of treatment period, 2016–17



About 4 in 10 (40.5%) patients, or just over 170,000 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 2016–17. These patients received more than 4 in 5 treatment days (82.0%) from CMHC services. (Figure 5)

The most frequently recorded principal diagnoses for patients receiving service contacts were *Schizophrenia* (18.8% of all contacts), *Depressive episode* (7.0%), and *Schizoaffective disorders* (4.5%).

Profile of service contacts

CMHC service contacts can be conducted individually or in a group session. Service contacts can also 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 2016–17, 93.4% of service contacts (or 8.3 million contacts) were individual contacts. More than half (57.2%) of all service contacts took place with the patient present.

In 2016–17, the average service contact length was 36 minutes. Service contacts with the patient present (45 minutes) were on average longer than contacts without the patient present (24 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 258,000 overnight mental health-related hospitalisations occurred in public and private hospitals in 2016–17, equating to nearly 4.5 million patient care days, with the average length of a mental health-related hospitalisation being 17 days.

Almost two-thirds (63.5%) of all overnight mental health-related separations involved specialised psychiatric care.

Nearly 4 in 5 (79.9%) mental health separations occurred in public hospitals, while 1 in 5 (20.1%) of separations took place in private hospitals. For public hospitals around 3 in 5 separations (58.9%) involved specialised psychiatric care, compared with about 4 in 5 (81.8%) for private hospitals.

Changes over time

The rate of overnight mental health-related separations increased by an average of 3.9% per year in the 5 years to 2016–17, from 91.0 per 10,000 population to 105.9. Non-mental health overnight separations increased by an annual average of 0.8% over the same period, from 1629.5 per 10,000 population to 1,684.7.

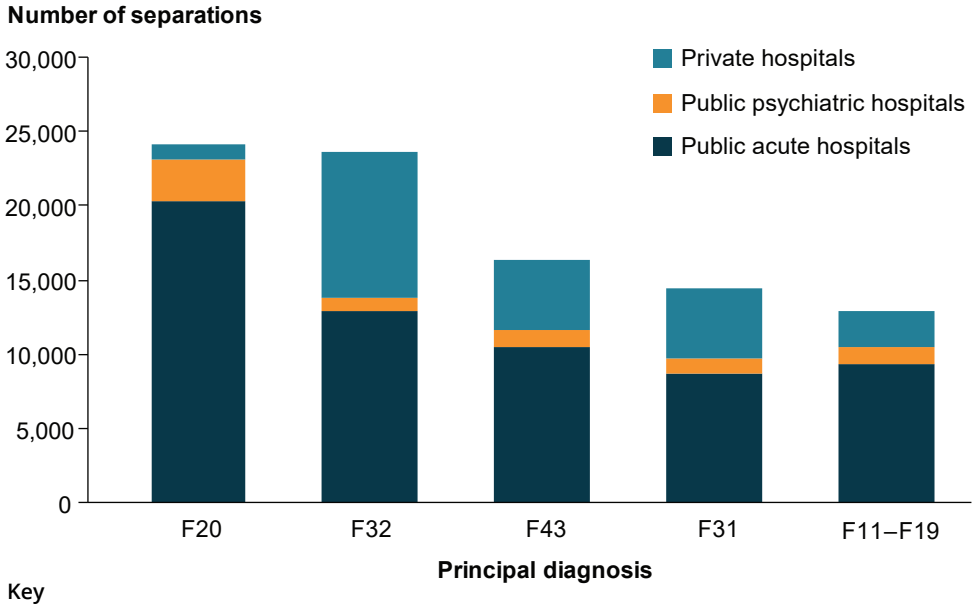
Profile of people who received services

With specialised care

For overnight mental health-related separations with specialised psychiatric care, females (69.6 per 10,000 population) had a higher rate of separations than males (64.9). The highest rate was for people aged 35–44 (108.2). The rate for Indigenous Australians (147.5) was more than double the rate for Other Australians (64.4).

Schizophrenia was the most common principal diagnosis for hospitalisations with specialised care (24,154 separations or 14.7%), followed closely by *Depressive episode* (23,613 or 14.4%). The profile of principal diagnoses for patients receiving care varied between hospital types (Figure 6).

Figure 6: Mental health-related hospitalisations with specialised psychiatric care, 5 most common mental health principal diagnoses, by hospital type, 2016–17



Key

F20: Schizophrenia
F32: Depressive episode
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

For overnight mental health-related separations without specialised care, the rate for females (39.0 per 10,000 population) was higher than for males (38.2). The highest rate among the age groups occurred for people aged 65 and over (92.1). The rate for Indigenous Australians (126.0) was more than 3.5 times the rate for non-Indigenous (34.2).

The most frequently recorded principal diagnoses for overnight mental health-related separations without specialised care were *Mental and behavioural disorders due to use of alcohol* (21.1%), and *Other organic mental disorders* (18.0%).

Interventions provided

Generalised allied health interventions was the most commonly reported procedure for hospitalisations both with and without specialised psychiatric care (48.6% and 68.4% of separations, 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

Almost 65,000 same-day mental health-related separations were provided by public hospitals in 2016–17, a rate of 2.7 separations per 1,000 population.

About 1 in 3 (34.3%) of public hospital same-day separations involved specialised mental health care.

Changes over time

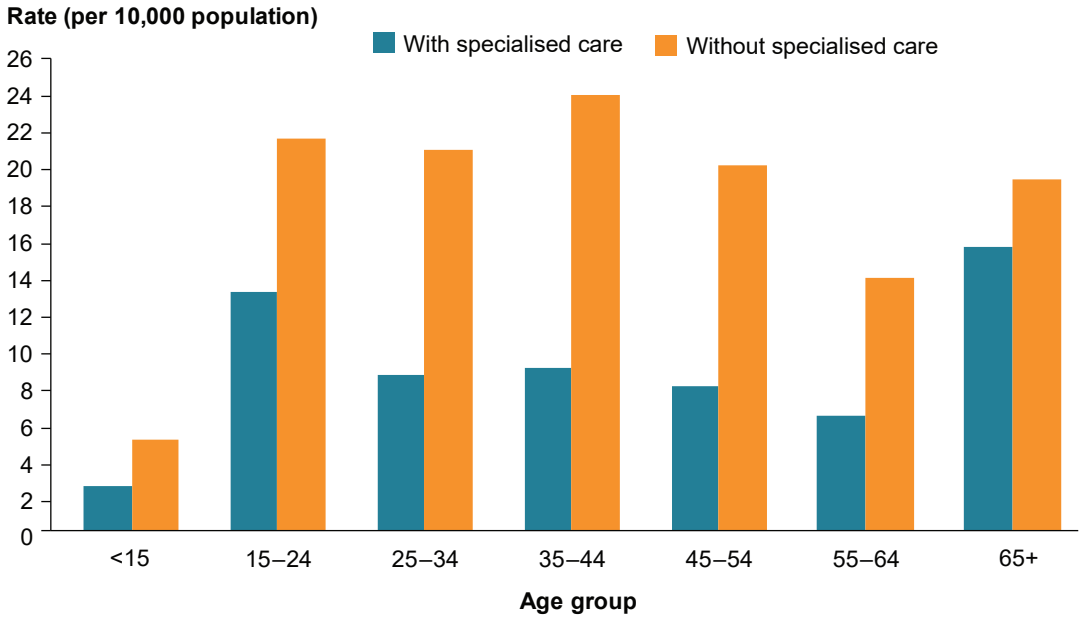
Increases in the population rate of public hospital same-day admitted mental health separations and non-mental health separations were similar over the 5 years to 2016–17, with annual average increases of 4.8% and 4.3%, respectively.

Profile of people who received specialised care services

The rate of same-day mental health-related separations with specialised psychiatric care in public hospitals was highest for patients aged 65 and over (15.8 per 10,000 population) and lowest for those aged under 15 (2.8) (Figure 7).

Females were more likely to receive services than males, accounting for 56.8% of the separations. The most commonly recorded principal diagnosis was *Depressive episode* (5,094 separations or 23.0%).

Figure 7: Same-day mental health-related separations with and without specialised psychiatric care in public hospitals, by age group (years), 2016–17



For same-day mental health separations with specialised psychiatric care, 43.4% included at least 1 procedure. The most frequently recorded procedure for these separations was for *Electroconvulsive therapy* (23.4%).

Profile of people who received non-specialised care services

In 2016–17, males and females had similar rates of same day mental health-related separations in public hospitals without specialised care (17.6 per 10,000 population for males and 17.2 for females).

The highest rate was for people aged 35–44 (24.0 per 10,000 population) (Figure 7), and lowest for those aged under 15 (5.4).

Similar to overnight hospitalisations, the most commonly recorded principal diagnosis was *Mental and behavioural disorders due to use of alcohol* (9,578 separations or 22.5% of separations).

Interventions provided

Around one-third (36.9%) of same-day mental health separations without specialised psychiatric care included at least 1 procedure. The most frequently recorded procedure for these separations was for *Cerebral anaesthesia* (22.6%), which is commonly used with the administration of *Electroconvulsive therapy*.

Private hospitals

Services provided

Almost 255,760 same-day mental health-related care days were provided by private hospitals to 19,248 patients in 2016–17.

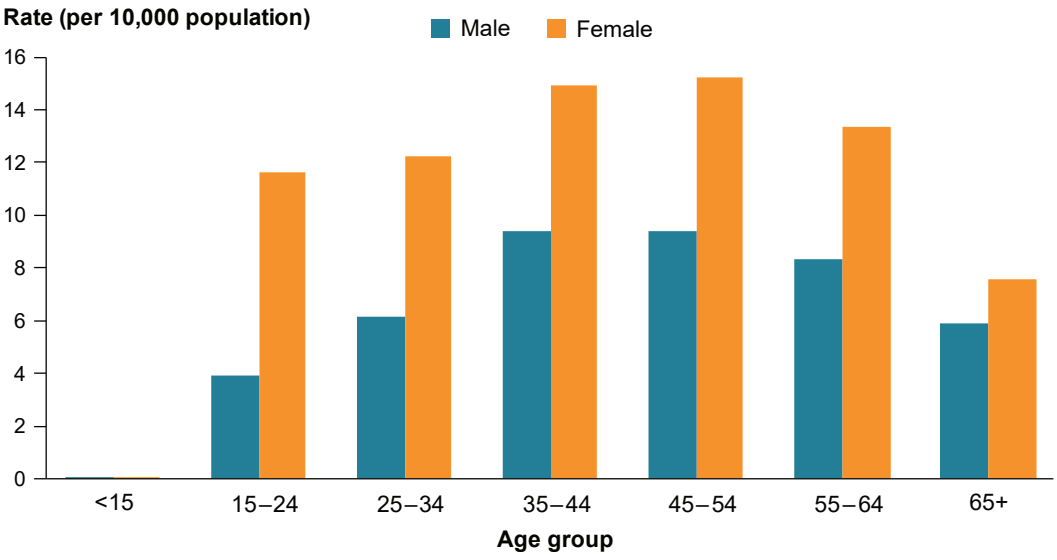
Changes over time

The data source for same-day private admitted mental health care is limited to 2012–13 to 2016–17. Over that period, the number of patients increased by 22.7%, while the number of care days increased by 25.1%.

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). The rate was lowest for those aged under 15, with only 8 patients in total for 2016–17 (Figure 8). Almost two-thirds (64.2%) of patients were female. Female patients accessed private hospital-based psychiatric services at a rate of almost double that of male patients (10.0 patients per 10,000 population compared with 5.7).

Figure 8: Same-day private hospital admitted mental health care patients, by sex and age group (years), 2016–17



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 (14.0 care days) than for people in non-urban areas (12.0).

In 2016–17, *Major affective and other mood disorders* (46.6% 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* (16.8% of episodes) and *Anxiety 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. RMHC services are not reported by Queensland.

Services provided

Almost 7,300 episodes of RMHC care were provided to 5,476 residents in 2016–17. RMHC services provided 294,113 residential care days, an average of 40 residential care days per episode.

The provision of RMHC services differed among states and territories in 2016–17, with Tasmania reporting the highest rate of episodes of care (19.2 per 10,000 population) and residents (9.3 residents per 10,000 population), and New South Wales reporting the lowest (0.3 and 0.2, respectively).

Changes over time

Between 2012–13 and 2016–17, residential mental health care episodes increased at an average annual rate of 1.2% per 10,000 population. The average annual change in the number of residents per 10,000 population increased by a similar amount over the same time period (1.6%), but the rate of care days decreased by 0.9%.

Profile of people who received services

Males (2.9 episodes per 10,000 population) and females (3.1) had similar rates of residential mental health care episodes in 2016–17. People aged 35–44 (5.2) had the highest rate of episodes while people aged 12–17 had the lowest (0.6). There were no episodes for consumers aged under 12 years old.

The rate of episodes was highest for those who usually lived in *Inner regional* areas (5.1 per 10,000 population), and for those living in areas with the lowest socioeconomic status (4.0).

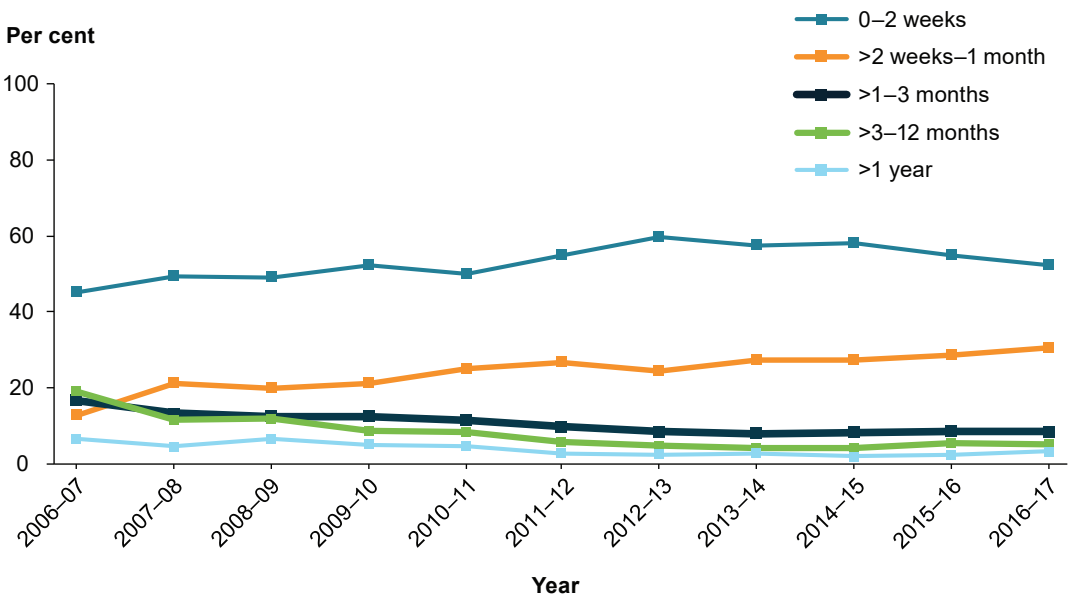
Schizophrenia was the most common specified principal diagnosis (24.3%), followed by *Specific personality disorders* (11.3%).

About 1 in 5 episodes (19.0%) were provided to patients with an Involuntary mental health legal status.

Typical completed episode of residential care

In 2016–17, around half (52.3%) of all completed residential episodes lasted 2 weeks or less and 1 in 20 episodes lasted 3 to 12 months. Longer episodes have reduced over time, with 3.4% of all completed stays lasting more than 1 year in 2016–17, compared with 6.6% of stays in 2006–07 (Figure 9).

Figure 9: Residential mental health care episodes, by length of completed residential stay, 2006–07 to 2016–17



More than 4 in 5 (85.4%) 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. People with mental illness and their carers advocate that restrictive practices do not benefit the patient and that these interventions either always or often infringe on human rights and compromise the therapeutic relationship between the patient and the clinician (Melbourne Social Equity Institute 2014). Working towards reducing and where possible eliminating the use of seclusion and restraint is a policy priority in Australian mental health care, which has been supported by changes to legislation, policy and clinical practice. Public reporting and monitoring of the restrictive practice usage rates enables services to review their individual results against state/territory, national rates and like services, thereby supporting service reform and quality improvement agendas.

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.

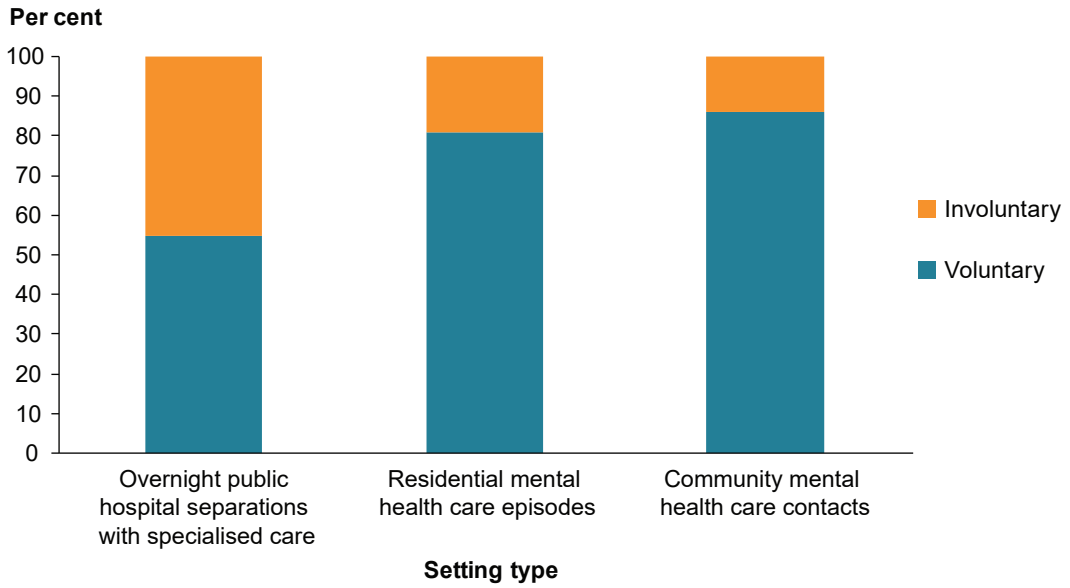
Seclusion is the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.

Restraint is the restriction of an individual's freedom of movement by physical or mechanical means. It can be mechanical (the application of devices on a person's body to restrict his or her movement) or physical (the application by health care staff of hands-on immobilisation to prevent the person from harming themselves or endangering others or to ensure the provision of essential medical treatment).

Legal status

Nearly half (45.4%) of public hospital overnight separations with specialised care were patients with an involuntary mental health legal status in 2016–17; this was higher than residential mental health care (19.0% of episodes) and community mental health care (13.8% of service contacts) settings in 2016–17 (Figure 10).

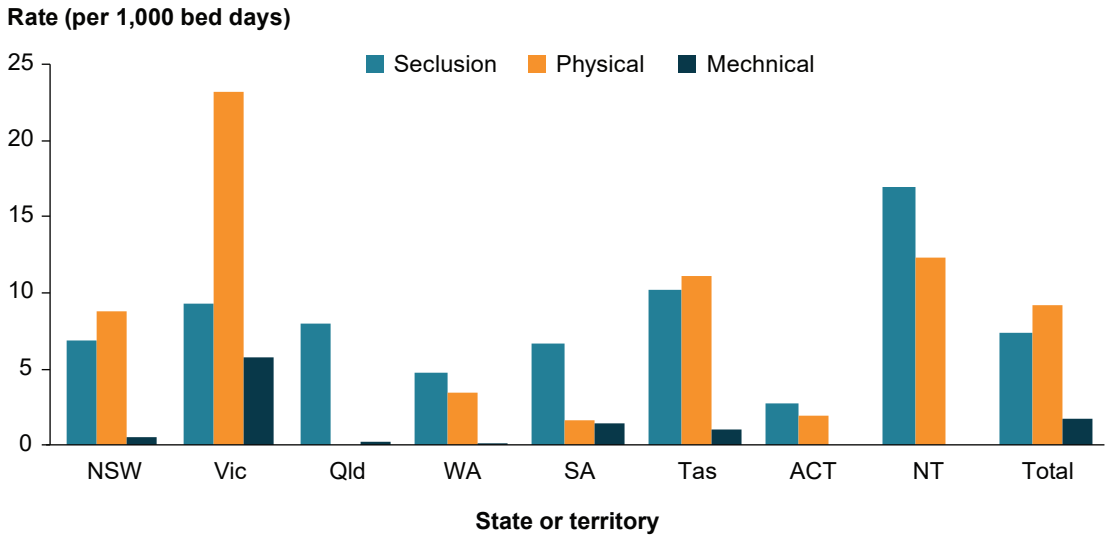
Figure 10: Mental health care, by setting and mental health legal status (per cent), 2016–17



Seclusion

Nationally, there were 11,937 seclusion events (7.4 seclusion events per 1,000 bed days) in public sector acute mental health hospital services in 2016–17. The Northern Territory (17.0 events per 1,000 bed days) had the highest rate of seclusion and the Australian Capital Territory had the lowest (2.8 per 1,000) (Figure 11). Less than 1 in 20 (4.3%) of all hospitalisations in public sector acute mental health hospital services included a seclusion event.

Figure 11: Rate of seclusion, and physical and mechanical restraint events, public sector acute mental health hospital services, by state or territory, 2016–17



The national seclusion rate fell from 13.9 events per 1,000 bed days in 2009–10 to 7.4 in 2016–17, with rates falling in 7 of the 8 states and territories over that period.

In 2017, AIHW published national restraint data for the first time. Caution should be used in interpreting these data, especially the comparability between states and territories—each have different policy and legislative requirements on the use of restraint, so have different definitions of restraint, and different processes and systems for collecting relevant data.

Restraint

Nationally, 13,321 physical restraint events and 1,479 mechanical restraint events occurred in 2016–17, equating to 8.3 physical restraint and 0.9 mechanical restraint events per 1,000 bed days.

In 2016–17, 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 2016–17. General services have remained stable in their use of restraint, while child and adolescent and older person services have increased their rate of restraint over the period.

Psychiatric disability support services

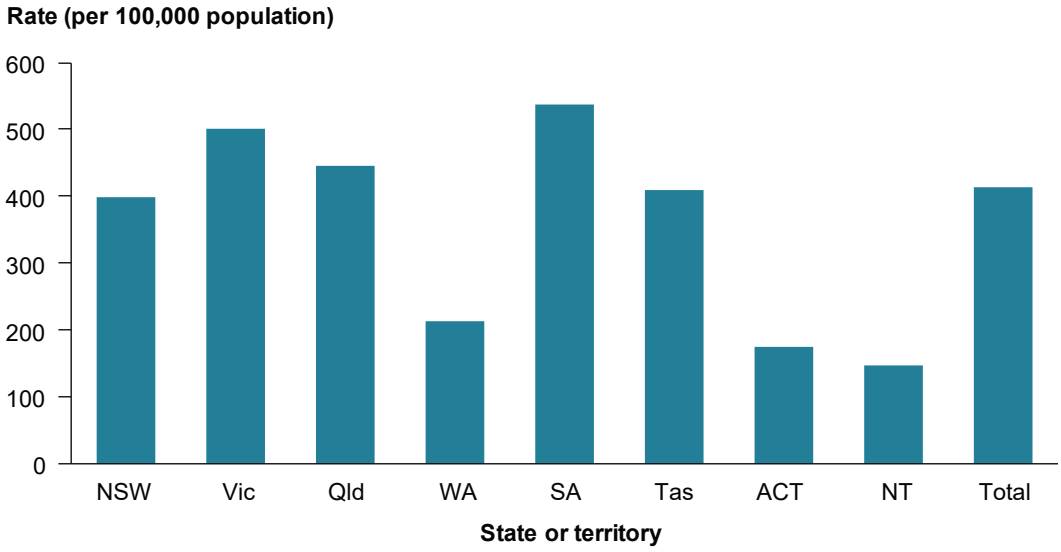
Specialist disability support services are provided under the National Disability Agreement (NDA) to support people with psychiatric disability, either as their primary disability or as another significant disability. Residential service types include large and small *Facilities/institutions*, *Hostels*, 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 time series analyses. The Australian Capital Territory (ACT) did not collect data under the National Disability Agreement during 2016–17, therefore, ACT data only includes clients accessing Australian Government administered services.

Services provided

About 331,000 people used specialist disability support services provided under the NDA during 2016–17 (AIHW 2018). Of these, about 100,939 people had a psychiatric disability (primary or other significant disability), with about two-thirds of these (64,578) reporting their psychiatric disability as their primary disability.

The rate of clients accessing psychiatric disability services was highest in South Australia (537.5 per 100,000 population), and lowest in the Northern Territory (146.9). The national rate was 413.9 (Figure 12).

Figure 12: Specialist disability support service users with a psychiatric disability, by state and territory, 2016–17



Changes over time

The rate of non-residential service users with a psychiatric disability increased by an average of 3.0% per year—from 365.6 per 100,000 population in 2012–13 to 411.9 in 2016–17. Over the same period, the rate of residential service users decreased by an annual average of 3.3%—from 16.2 per 100,000 population in 2012–13 to 14.2 in 2016–17.

Profile of service users and the type of support provided

Non-residential service users

In 2016–17, 100,438 people with a psychiatric disability (primary or other significant disability) accessed non-residential disability support services. Almost two-thirds of those (64,390 or 64.1%) reported psychiatric disability as their primary disability.

The highest rates of non-residential service users with a psychiatric disability (primary or other significant disability) among the demographic groups were:

- Indigenous Australians (765.0 per 100,000 population)
- those aged 45–54 (736.0)
- those from *Inner regional* areas (522.5)
- males (439.3).

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 2016–17, 3,455 people with a psychiatric disability (primary or other significant disability) accessed residential support services. About 1 in 8 of those (435 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 (per 100,000 population) seen for:

- Indigenous Australians (21.3)
- those from *Inner regional* areas (17.1)
- males (16.7).

Users aged 55–64 utilised residential support services at the highest rate (30.8 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
- had a mental health service as their formal referral source to the agency
- 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
- at some stage during their support period, needed psychological services, psychiatric services, or mental health services.

Services provided

About 77,500, or 365.2 clients per 100,000 population, had a current mental health issue in 2016–17. That is equal to about one-third of the 240,949 national SHS clients aged 10 and over.

Almost half of SHS clients with a mental health issue accessed accommodation services (49.3% or 38,276 clients), at a rate of 180.2 clients per 100,000 population. A further 48.7% (37,814 or 178.0 clients per 100,000 population) received other support services, while 1.9% (1,479 clients) did not receive a service or referral to a service in 2016–17.

Changes over time

Nationally, the rate of clients with a current mental health issue increased by an annual average of 10.7% over the 5 years to 2016–17. The rate of support periods increased by an average of 10.5% per year over the 5 year period to 2016–17.

Profile of people who received services

Almost half (47.8%) of SHS clients with a current mental health issue had been homeless at some point in the 12 months before presenting to an agency.

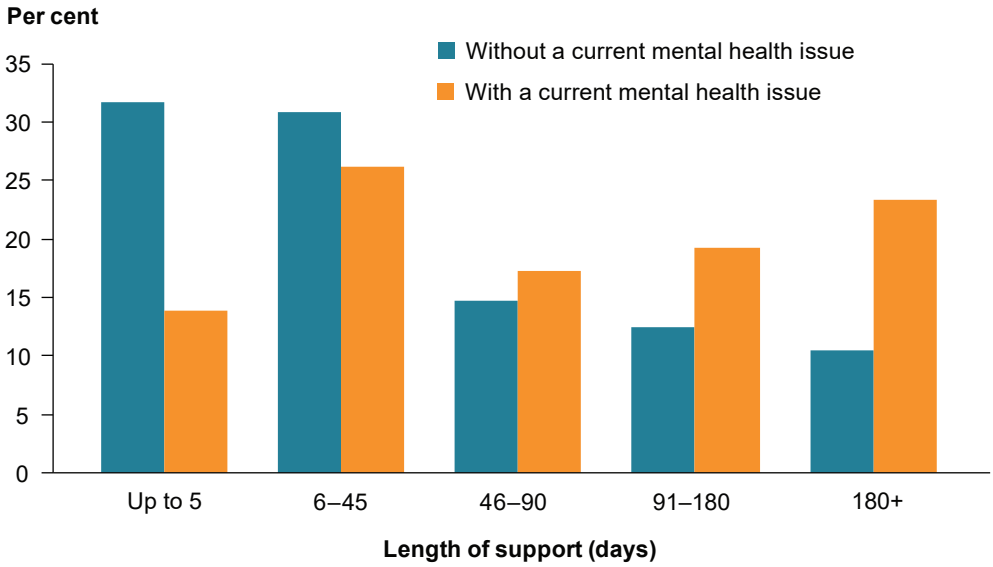
Clients with a current mental health issue aged 18–24 had the highest rate of SHS agency use (658.3 clients per 100,000 population), followed by those aged 15–17 (603.9). Female clients (429.8) sought services at a greater rate than males (298.9). Indigenous SHS clients with a current mental health issue (1,834.7) sought assistance at 7 times the rate of non-Indigenous Australians (259.9).

Housing crisis (27.2%) was the most commonly reported reason for SHS clients with a current mental health issue to seek assistance, followed by *Domestic and family violence* (17.6%).

Length of support period

In 2016–17, more than half of clients (59.9%) with a current mental health issue received more than 45 days of support (Figure 13). In contrast, about one third of clients (37.5%) without a current mental health issue received more than 45 days of support.

Figure 13: SHS clients with and without a current mental health issue, by total length of support provided, 2016–17



Access to Allied Psychological Services

The Access to Allied Psychological Services (ATAPS) program enabled various 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 was designed for people who have difficulty accessing Medicare-subsidised mental health services for various reasons, such as the lack of services in some geographical locations. Management of services previously delivered under the ATAPS program has transitioned to Primary Health Networks so information on ATAPS was last collected for the 2015–16 period.

Services provided

Almost 72,500 consumers accessed ATAPS, equating to 301.7 consumers per 100,000 population in 2015–16. The Northern Territory (545.0) had the highest rate of consumers, while the Australian Capital Territory had the lowest (122.6). The majority of sessions were individual sessions (81.7%), lasted 46–60 minutes (86.4%) and occurred face to face (96.3%).

More than 350,000 sessions were delivered in 2015–16. Consumers are entitled to 12 sessions under the ATAPS program, and may receive another 6 sessions in exceptional circumstances. About 1 in 30 consumers (2,487 or 3.4%) received additional sessions after the completion of the initial 12 sessions.

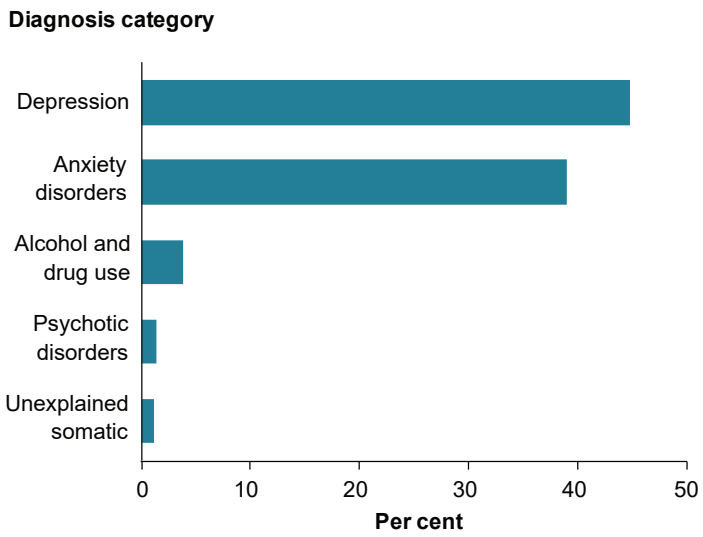
GPs (94.6%) were the most common source of referral for ATAPS consumers.

Over the 5 years to 2015–16, the number of ATAPS consumers increased from around 48,600 to just over 72,400. The number of sessions provided increased by about 1.5 over the same period.

Profile of people who received services

Females (380.7 per 100,000 population) were more likely to use ATAPS than males (220.4) in 2015–16. People aged 15–24 had the highest rate of ATAPS access (432.0). Indigenous Australians (826.1) accessed ATAPS at a rate more than 4 times that of non-Indigenous Australians (193.0).

Figure 14: Top 5 specific diagnosis categories for ATAPS consumers, 2015–16



Depression (44.7%) was the most commonly reported diagnostic category among ATAPS consumers, followed by *Anxiety disorders* (38.9%), noting that consumers may have more than one diagnosis. (Figure 14)

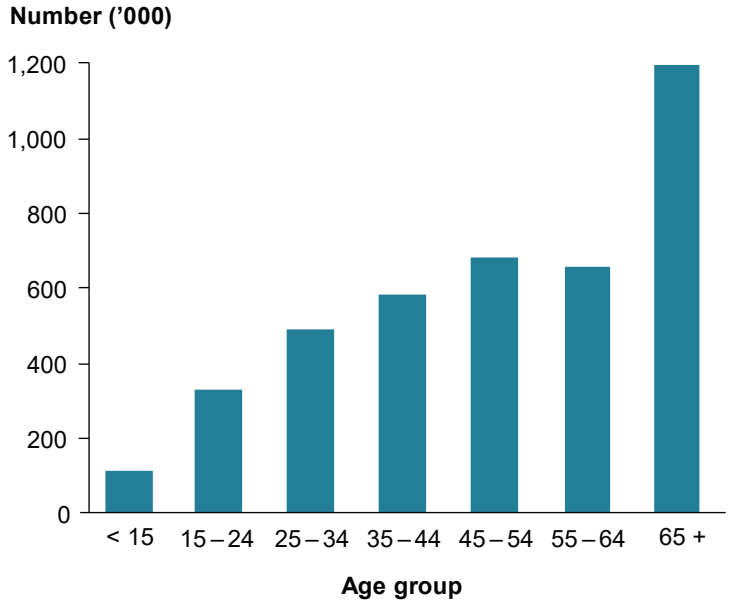
Mental health-related prescriptions

Mental health-related medications may be subsidised, where they are paid for through the Commonwealth Government's Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (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 for 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

Four million patients (16.6% of the population) received 35.7 million prescriptions for mental health-related medications (subsidised and under co-payment) in 2016–17. Two-thirds of these prescriptions (65.2% or 23.3 million) were subsidised by the Australian Government under the PBS or RPBS. About 1 in 5 (19.8%) of females received a mental health-related prescription, which was higher than for males (13.4%).

Figure 15: Number of patients receiving subsidised and under co-payment prescriptions, by age group, 2016–17



People aged 65 years and over had the highest proportion of patients receiving mental health-related prescriptions (1,195,341 or 29.5%), compared with those under 15 years (110,697 or 2.7%) which was the lowest. (Figure 15)

Tasmania had the highest percentage of people (21.2% of their total population) receiving mental health-related prescriptions, with each patient receiving an average of 9.3 prescriptions in 2016–17. The Northern Territory had the lowest (8.7% of the population, and 7.4 prescriptions per patient).

The percentage 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 (21.1% of the population) compared with those living in *Very remote* areas, where 5.8% of people received prescriptions.

Over time

Since 2012–13, the proportion of people receiving subsidised mental health-related prescriptions fell from 10.8% of the population in 2012–13 to 9.0% in 2016–17. However, the proportion of people receiving subsidised and under co-payment prescriptions increased from 15.1% in 2012–13 to 16.6% in 2016–17.

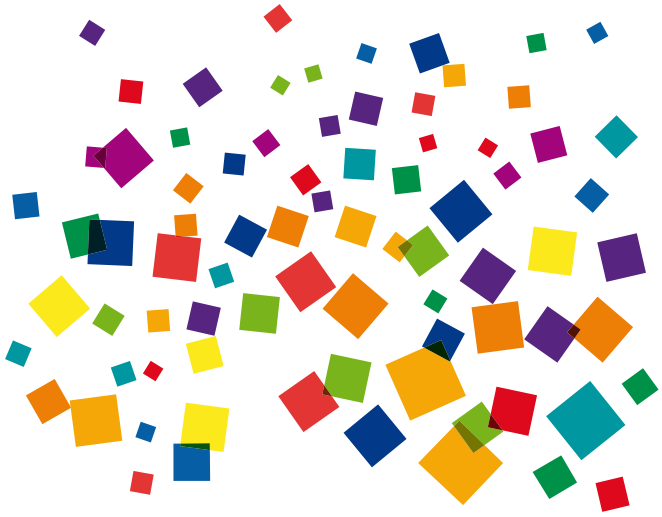
Type of mental health-related medications provided

Antidepressants were the most frequently dispensed mental health-related medications (subsidised and under co-payment), in 2016–17 (2.9 million people, 24.8 million prescriptions). About 962,000 people received *Anxiolytics*, 765,000 people received *Hypnotics and sedatives*, and 461,000 people received *Antipsychotics*, noting that individuals may receive more than one 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 2012–13 and 2016–17, 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 almost 3.8 million people (93.0% of patients receiving prescriptions). Psychiatrists provided medications to 385,225 people and non-psychiatrist specialists prescribed medication to 338,739 people, noting that individuals may receive 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. Detailed data on the size and characteristics of the mental health workforce presented in this section are limited to psychiatrists, nurses, and registered psychologists who worked principally in mental health care. Data became available for the first time in 2017 on the amount of time spent working as a clinician—that is, working in a direct clinical role. At the time of writing, updated data on registered psychologists was not available, so related information has not been updated since *Mental health services—in brief 2017*.

Psychiatrists

More than 3,200 psychiatrists, or 13.0 full-time-equivalent (FTE) psychiatrists per 100,000 population were estimated to work in Australia in 2016.

When considering time spent as a clinician, there were 10.8 clinical FTE psychiatrists per 100,000 population, with rates ranging from 6.8 in the Northern Territory to 12.5 in South Australia (Figure 16). The majority of clinical FTE psychiatrists were in *Major cities* (13.2 FTE per 100,000 population), while *Very remote* areas had the lowest rate (3.3 FTE per 100,000 population).

Psychiatrists worked an average of 39.0 total hours, and 32.2 clinical hours, per week in 2016. On average, male psychiatrists worked 6.4 total hours, and 5.3 clinical hours, more per week than female psychiatrists.

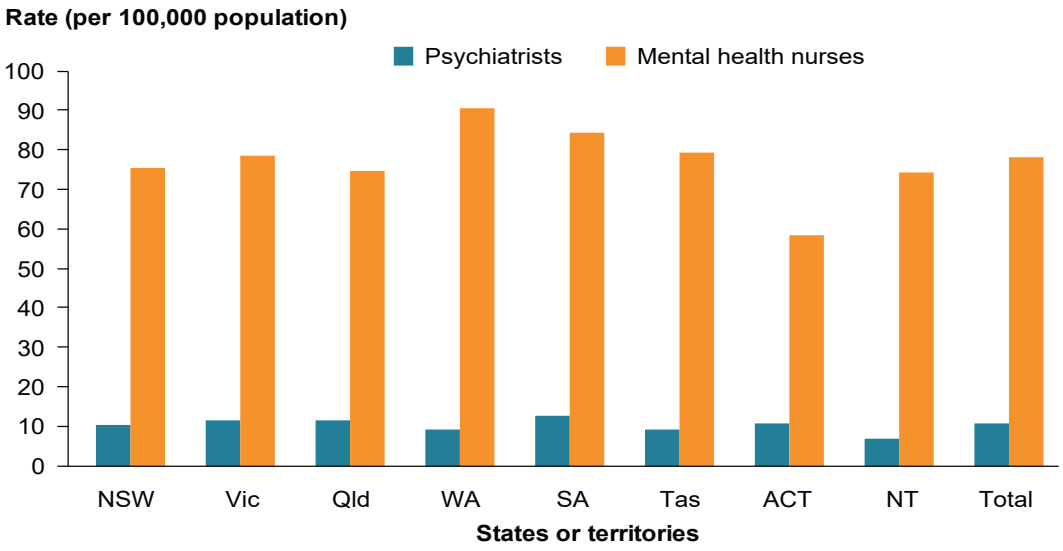
Nurses

Around 21,500 (6.8% of total nurses) indicated they were working principally in mental health in 2016. This equates to 85.1 FTE mental health nurses per 100,000 population. The national rate of clinical FTE mental health nurses was 78.1 per 100,000 population, ranging from 58.2 in the Australian Capital Territory to 90.5 in Western Australia (Figure 16).

More than three-quarters of FTE mental health nurses (76.2% or 90.8 per 100,000 population) worked in *Major cities*. Rates mostly decreased with increasing remoteness, with 31.1 FTE mental health nurses per 100,000 population working in *Very remote* areas.

Mental health nurses worked an average of 36.3 total hours, and 33.3 clinical hours, per week, with male nurses (34.7 hours) working more clinical hours on average than female nurses (32.7 hours).

Figure 16: Employed psychiatrists and mental health nurses, clinical FTE per 100,000 population, by state and territory, 2016



Registered psychologists

More than 24,500 fully registered psychologists were working in Australia in 2015, equating to 88.1 FTE registered psychologists per 100,000 population.

When considering time spent as a clinician, there were 63.9 clinical FTE psychologists per 100,000 population, with rates ranging from 47.7 in South Australia to 101.2 in the Australian Capital Territory.

More than 8 in 10 FTE registered psychologists (82.7%) worked in *Major cities*. Rates decreased with increasing remoteness, with 23.2 FTE per 100,000 population registered psychologists working in *Very remote* areas.

Registered psychologists worked an average of 32.4 total hours, and 23.5 clinical hours per week. The average clinical hours ranged from 22.6 hours for Victorian psychologists to 25.4 hours for Northern Territory psychologists. Male psychologists (25.2 hours) worked more clinical hours on average than female psychologists (23.1 hours).

Community-managed mental health workforce

Mental health non-government organisations 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, reflecting their governance structure. National data about the activities of mental health non-government organisations 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-related services.

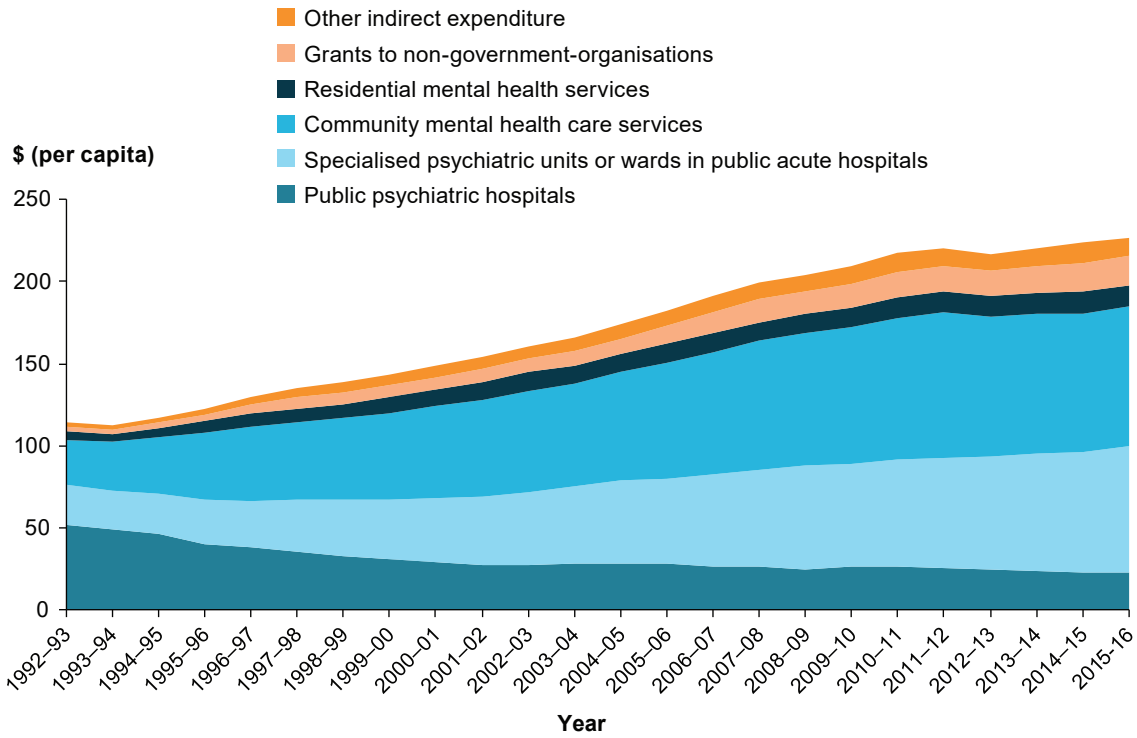
Mental health services were estimated to comprise 7.7% of combined Australian and state and territory government recurrent health spending in 2015–16.

Spending on state and territory specialised mental health services

In 2015–16, $9.0 billion was spent on mental health-related services (recurrent expenditure only), equating to $227 per person. Over $2.4 billion was spent on public hospital services for admitted patients and $2.0 billion on community mental health care services. After adjusting for inflation, spending on state and territory specialised mental health services increased by an average 2.3% per year over the 5 years to 2015–16.

Detailed expenditure data are available from 1992–93 to 2015–16. 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 $85 (constant prices) in 2015–16 (Figure 17).

Figure 17: Recurrent expenditure per capita on state and territory specialised mental health services, constant prices, 1992–93 to 2015–16



In 2015–16, the Australian Government spent an estimated $3.1 billion on mental health-related services, equating to $131 per person. More than one-third (36.0%) was spent on Medicare-subsidised mental health-specific services, with a further 19.8% spent on programs and initiatives funded by the Commonwealth Department of Health.

Other areas of expenditure included:

- prescriptions subsidised under the PBS and RPBS (17.5%)
- Department of Social Services programs and initiatives (7.8%)
- Department of Veterans' Affairs programs and initiatives (6.1%)
- private health insurance premium rebates (4.7%).

Australian Government spending on mental health-related services, after adjusting for inflation, has increased by an average of 3.5% per year over the 5 years to 2015–16. This rise was mostly due to increased spending on national programs and initiatives managed by the Australian Government Department of Health, and on Medicare-subsidised mental health-specific services.

Medicare-subsidised mental health-specific services

About $1.2 billion was paid in benefits for Medicare-subsidised mental health specific services in 2016–17, equating to $49 per person nationally.

The largest proportion of spending was for services provided by psychologists (43.7%), followed by psychiatrists (29.5%), and GPs (24.1%). After adjusting for inflation, spending on Medicare-subsidised mental health-specific services increased by an average of 5.7% per capita per year in the 5 years to 2016–17.

PBS and RPBS-subsidised prescriptions

About $511 million was spent on mental health-related subsidised prescriptions under the PBS and RPBS in 2016–17, equating to $21 per person.

About three-quarters (74.6%) of total spending was for prescriptions issued by GPs, followed by psychiatrists (17.2%), and non-psychiatrist specialists (8.0%). After adjusting for inflation, spending on mental health-related PBS and RPBS prescriptions per Australian fell by an average of 10.2% per year in the 5 years to 2016–17. 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 facilities in Australia. This section excludes services subsidised by the Medicare Benefits Scheme.

Specialised mental health care facilities

Nationally, 1,591 specialised mental health care facilities provided specialised mental health care in 2015–16. Of these, 394 provided overnight care, with 12,194 specialised mental health care beds available in public and private hospitals (9,812 beds) and residential mental health care services (2,383 beds) (Table 2).

Table 2: Specialised mental health care beds, 2015–16

Facility type	Beds
Public hospitals	**7,058**
Acute beds	5,360
Non-acute beds	1,698
Private hospitals	**2,754**
Residential services	**2,383**
24-hour staffed	1,757
Non-24-hour staffed	626

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 2015–16, 79 organisations (46.5%) employed mental health consumer workers, and 42 organisations (24.7%) employed mental health carer workers.

Staffing of specialised mental health care services

Nearly 32,000 full-time-equivalent staff were employed by state and territory mental health services in 2015–16. About half were nurses (51.0%, or 16,318 FTE staff), with most of those being registered nurses (14,001). Diagnostic and allied health professionals were the next largest staffing group (18.9% or 6,045 FTE staff), comprised mostly of social workers (2,113) and psychologists (1,805). 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 2015–16).

Specialised psychiatric services in private hospitals employed a further 3,368 FTE staff in 2015–16.

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 15 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 (MHS KPI 1)

72.5% of completed hospital stays saw a significant improvement in the consumers mental health in 2015–16.

28-day readmission rate (MHS KPI 2)

14.6% of hospital stays had a readmission to hospital in 2015–16.

Appropriateness of care

National Services Standards compliance (MHS KPI 3)

In 2015–16, **82.9%** of services met the national mental health standards.

Efficiency of care

Average length of acute admitted patient stay (MHS KPI 4)

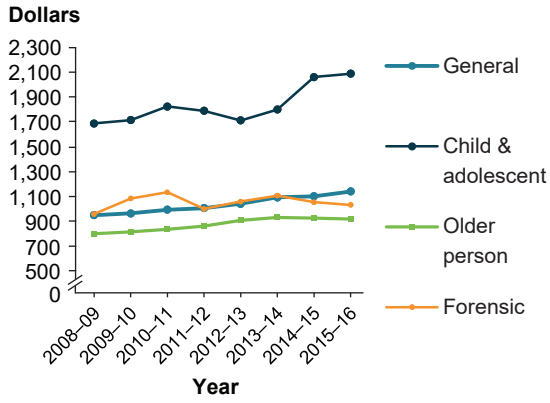
The average length of a stay in an inpatient mental health unit was **13 days** in 2015–16.

Average cost per acute admitted patient day (MHS KPI 5)

$2,097 was the average cost per day for an acute child and adolescent inpatient mental health unit.

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 $1,153 per day in 2015–16.

Average cost of admitted patient day care



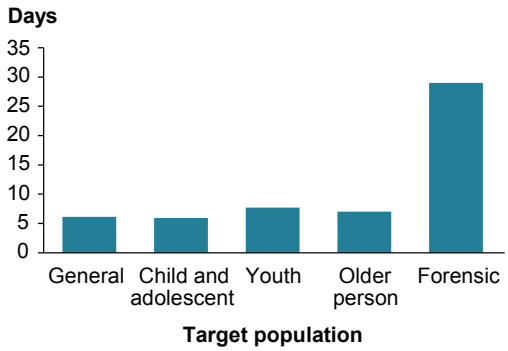
Efficiency of care (continued)

Average treatment days per 3-month community care period (MHS KPI 6)

7.0 days was the average number of treatment days provided per 3-month community care period in 2015–16.

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 29 days per 3-month period.

Average days receiving community care in a 3 month period



Average cost per community treatment day (MHS KPI 7)

$305 was the average cost per community treatment day in 2015–16.

Accessibility of care

Proportion of people receiving clinical mental health care (MHS KPI 8)

1.8% of people received clinical mental health care in 2015–16.

New client index (MHS KPI 9)

In 2015–16, **42.0%** were new clients, within the previous 12 months.

Continuity of care

Rate of pre-admission community care (MHS KPI 11)

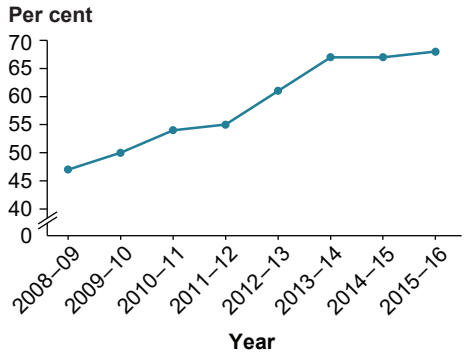
40.3% of hospital stays involved community mental health care before the hospital stay in 2015–16.

Rate of post-discharge community care (MHS KPI 12)

In 2015–16, **68.2%** 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 47.2% in 2008–09.

Consumers receiving follow-up community care



Capability of services

Outcomes readiness (MHS KPI 14)

35.7% of completed inpatient episodes had a valid outcome measurement in 2015–16.

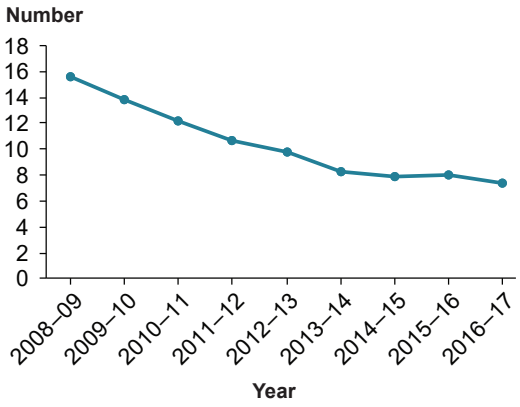
Safety of services

Rate of seclusion (MHS KPI 15)

7.4 seclusion events per 1,000 days took place in public acute hospital inpatient services in 2016–17.

The rate of seclusion has had an overall decrease from 15.6 events per 1,000 patients days in 2008–09.

Seclusion events per 1,000 bed days



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 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: 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: A measure of the number of standard week workloads (usually 38 hours) that professionals work.

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

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