Australian Government
Australian Institute of Health and Welfare

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MENTAL HEALTH SERIES
Number 12

Mental health services in Australia 2007–08

August 2010

Australian Institute of Health and Welfare
Canberra
Cat. no. HSE 88

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better information and statistics for better health and wellbeing*.

This publication is part of the Australian Institute of Health and Welfare's Mental health series. A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 1443-6795

ISBN 978-1-74249-047-2

Suggested citation

Australian Institute of Health and Welfare 2010. Mental health services in Australia 2007–08. Mental health series no. 12. Cat. no. HSE 88. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

Printed by

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Foreword

Mental health is an important health issue in Australia with an estimated 20% of Australians experiencing symptoms of a mental disorder each year. *Mental health services in Australia 2007–08* provides detailed information on the national response to Australians' mental health care needs using 2007–08 data and, where available, 2008–09 data.

The report analyses data from the Australian Institute of Health and Welfare's national mental health databases and provides detailed information on expenditure and services provided by specialist mental health services. Mental health-related data are also provided on emergency department occasions of service, pharmaceuticals and Medicare services. The cooperation and advice of state and territory health authorities, the Australian Government and other stakeholders in providing data is acknowledged and is vital to the production of this report.

The AIHW strives to ensure that its outputs are policy-relevant and works to refine reports in response to policy initiatives, and incorporating measures developed to monitor policy implementation. The National Healthcare Agreement includes performance indicators that are being used to measure government progress towards achieving the Agreement's objectives, and *Mental health services in Australia* now includes summaries of the four mental health-specific indicators reported by the COAG Reform Council in its recently released baseline performance report for the Agreement.

The Institute will be shaping future reports on *Mental health services in Australia* in response to the *Fourth National Mental Health Plan*, released by health ministers in November 2009. It places an emphasis on accountability for both mental health reform and service delivery and outlines twenty-five indicators against which to measure progress. The AIHW will use these indicators to inform AIHW reporting on mental health services and on related issues such as homelessness.

The Plan also highlights the role of the *Mental health services in Australia* series as the source of descriptive data on the activity of specialised mental health services in Australia. The AIHW strongly supports the proposal in the Plan to increase online access to the Institute's source mental health data and enable customised analyses of the data. Work has already commenced on this initiative and it is envisaged that the next report in this series will be primarily web based.

The Institute looks forward to working with stakeholders to refine the format and content of *Mental health services in Australia* to ensure that it continues to provide a contemporary, timely evidence base relevant to monitoring mental health services.

Penny Allbon

Director

August 2010

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Acknowledgments

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

Within the AIHW, the key contributors to this report were Lyle Baker, Roxanne Foster, Rachelle Graham, Chaye Hosie, Trevor O'Donnell, Nikki Schroder and Michelle Shek, with assistance from Gary Hanson and Jenny Hargreaves.

Summary

The latest National Survey of Mental Health and Wellbeing conducted in 2007 by the Australian Bureau of Statistics (ABS 2008a) estimates that 3.2 million Australians, or 20%, of the adult population experienced symptoms of a mental disorder in the 12 months before the survey. This report on Australian mental health services provides detailed information on the national response to the mental health care needs of Australians using a range of AIHW and other data sources.

Service provision

- Overall, services for people with mental health care needs continue to show a steady increase, generally above the rate of population growth.
- General practitioners (GPs) are often a first contact point for mental health concerns. In 2008–09, the Bettering the Evaluation and Care of Health survey of general practice activity estimated that over 13.2 million GP-patient encounters involved management of a mental health issue, an increase on average of 5.7% each year from 2004–05.
- In 2008–09, there were about 4.6 million Medicare claims for subsidised psychiatrist, psychologist and other mental health-related allied health services, compared with 3.9 million claims in 2007–08, an increase of 17.4%. This sustained growth reflects the continuing uptake of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative introduced in November 2006. Mental health-specific GP service items constituted another 1.6 million claims made in 2008–09.
- Community mental health care services and hospital outpatient services also provide care for mental health consumers, with close to 6.4 million service contacts in 2007–08, a 6.8% increase from 2006–07.
- Mental health care is provided to admitted patients in public acute, public psychiatric and private hospitals. In 2007–08, there were nearly 213,000 mental health-related separations for admitted patients, compared with about 209,000 separations in 2006–07, an increase of 1.7%.

Expenditure and resources

- In 2007–08, there were 16 public psychiatric hospitals with 2,156 beds (an average annual decrease of 2.0% from 2003–04), and 141 public acute hospitals with a specialised psychiatric unit or ward with 4,395 beds (an average annual increase of 4.0%). A clear trend can be seen in the provision of public sector specialised mental health hospital beds, with beds in specialised psychiatric units or wards within public acute hospitals replacing beds in public psychiatric hospitals.
- Expenditure on state and territory mental health services increased by an annual average of 5.9% (adjusted for inflation) between 2003–04 and 2007–08, to $3,323 million. Public acute hospitals with specialised psychiatric wards and community mental health care services reported annual average increases in expenditure of 7.7% and 7.0% respectively. At the same time, public psychiatric hospital expenditure decreased by 1.2% per year, again reflecting the transfer of mental health beds to specialised psychiatric units or wards within public acute hospitals.
- In 2008–09, the Australian Government paid $666 million in benefits for Medicare-subsidised mental health-related services provided by psychiatrists, GPs,

psychologists and other allied health professionals. Nationally, Medicare benefits paid for these services averaged $30.78 per person. Between 2004–05 and 2008–09, Australian Government expenditure on MBS mental health-related items increased by an annual average of 26.8%, reflecting, in part, the introduction of items for psychologists during that period.

- In 2008–09, 21.4 million mental health-related prescriptions subsidised under the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme cost the Australian Government over $742 million. They comprised mainly antipsychotics (51%) and antidepressants (41%) and accounted for over 1 in 10 of all prescription claims.

1 Introduction

Mental health services in Australia 2007–08 is the latest in the Australian Institute of Health and Welfare's (AIHW) series of annual mental health reports that describe the activity and characteristics of Australia's mental health care services. In addition to providing information on a wide range of mental health services in Australia in a centralised and accessible form, a key aim of these reports is to make publicly available the data collected as specified in the Mental Health Care National Minimum Data Sets (NMDSs). These NMDSs cover specialised community and residential mental health care, specialised mental health care for patients admitted to public and private hospitals, and the facilities providing these services.

The latest year reported for most information in this report is 2007–08, with more recent data provided if available. Where appropriate and possible, time series data are also given. More detailed data on mental health services in the years before 2007–08 are available in previous reports in this series.

1.1 Report structure

This 2007–08 report covers the following broad areas, and is very similar in structure to the 2006–07 report:

- This introductory chapter provides a definition of mental health-related services, presents background information on the prevalence of mental illness in Australia, and outlines the major features of the current policy framework and government initiatives in mental health service provision.
- The main body of the report consists of four sections, as shown in Figure 1.1. The first section (chapters 2 to 10) describes the activities and characteristics of the wide range of health care and treatment services provided for people with mental health problems in Australia. This includes services provided by specialist mental health services and mental health-related services provided by general health services, in both residential and ambulatory settings. Many are government service providers, but private hospitals, non-government organisations and private medical practitioners are also included in the range of service providers covered.
- The second section (Chapter 11) provides information on prescriptions that are dispensed for mental health-related conditions and subsidised under the Pharmaceutical Benefits Scheme (PBS).
- The third section (chapters 12 to 14) looks at the resources used or involved in the provision of mental health services—namely facilities, the specialist mental health workforce and expenditure.
- The summary tables provide state, territory and national profiles (Chapter 15).

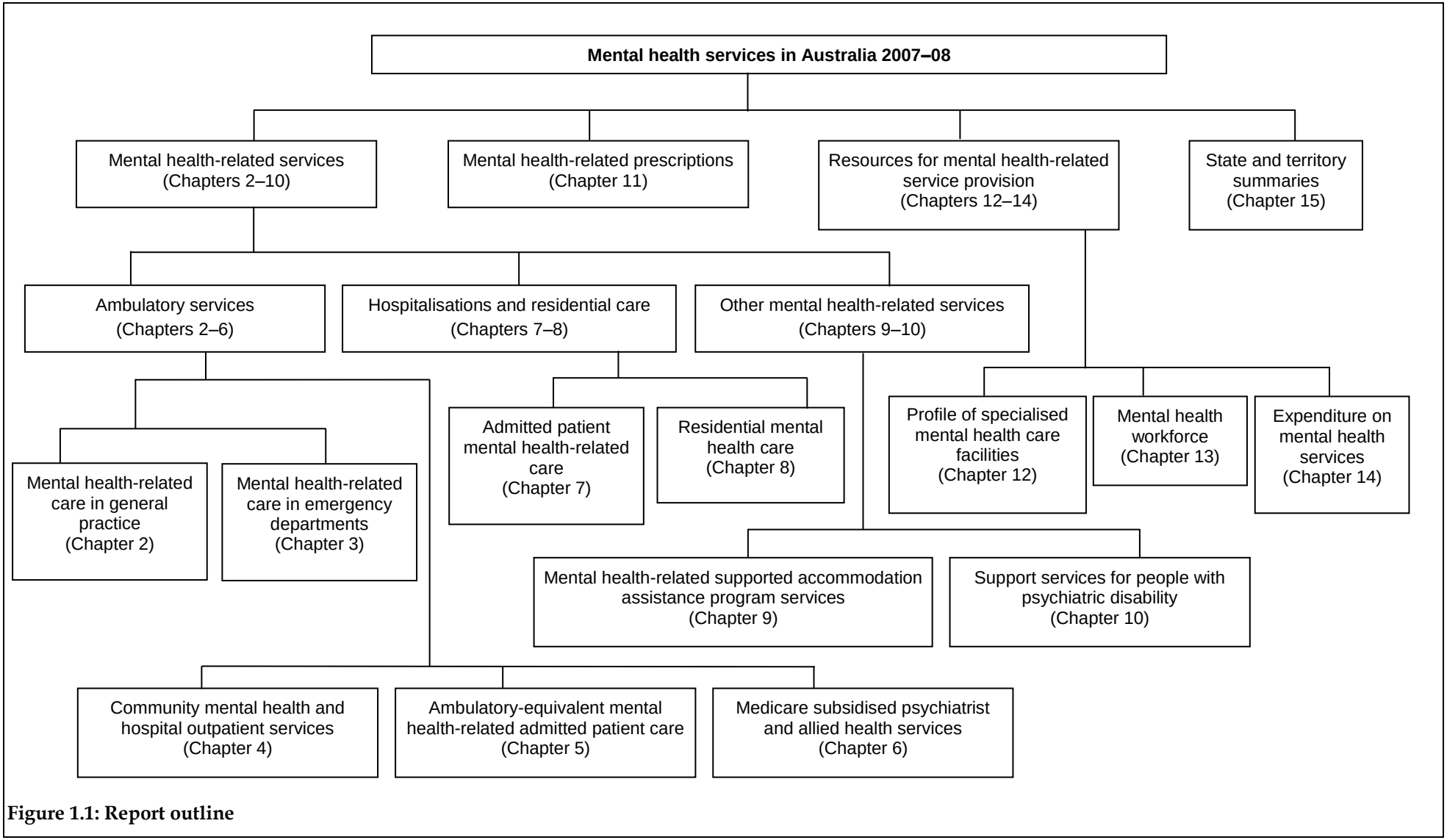


Figure 1.1: Report outline

- The appendixes provide information on the data sources used (Appendix 1), technical notes on data presentation and the calculation of rates (Appendix 2), information on the classifications used (Appendix 3) and the specific codes used to define 'mental health-related' encounters and separations in particular chapters of this report (Appendix 4).
- A comprehensive index follows the appendixes.

In addition to the information published in this report, detailed data on some mental health-related services are provided by the AIHW in the form of internet tables and data cubes. These can be found on the AIHW website. See Section 1.5 for further details.

Note that while the aim of this report is to provide a view of the broad range of mental health-related services provided in Australia, the ability to achieve this aim is driven to a large extent by the availability of quality comparable national data. Consequently, there are some overlaps and gaps in the information on services provided in this report.

1.2 Definition of mental health-related services

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

There is no standard way of defining 'mental health-related services'. In order to compile information on mental health services for this report, it was necessary to develop definitions of 'mental health-related services' that were applicable to each individual data source. For data sources relating to specialised mental health facilities—community mental health care services, hospital outpatient services dedicated to mental health patients and residential mental health services—all services are counted that satisfy the definitions of the relevant NMDSs (Community Mental Health Care NMDS and Residential Mental Health Care NMDS—see Appendix 1 for details). For data sources that are not specific to mental health, the classification of the diagnosis or the treatment provided, or the characteristics of the clients receiving the services are used to define the mental health-related component. Examples of the former are the general practice data extracted from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity and the Medicare system (Chapter 2) and the hospital-sourced data covered in chapters 3, 5 and 7. An example of the latter is the subset of Supported Accommodation Assistance Program (SAAP) clients who are the subject of Chapter 9. The specifics of how mental health-related services are defined in each data source are detailed in the respective chapters and in the appendixes.

1.3 Background on mental health in Australia

Mental health has been subject to concerted government action in recent years to reduce the burden and to improve the lives of people with mental disorders.

According to *The burden of disease and injury in Australia 2003* (Begg et al. 2007), mental disorders were estimated to be responsible for 13% of the total burden of disease in Australia in 2003. The effects of mental disorders on morbidity and mortality resulted in their being ranked third among the major disease groups in the burden of disease rankings, behind cancer and cardiovascular diseases.

The total burden of disease and injury is derived from adding fatal burden (years of life lost due to premature mortality) to non-fatal burden (years of 'healthy' life lost due to non-fatal health conditions—estimated by combining the average duration of new incident cases of a condition with a severity weight quantifying the effect of the condition). Non-fatal burden accounted for 51% of the total burden and mental illnesses were the leading cause (24%). The distribution of the mental disorders burden was 93% non-fatal and 7% fatal, most of the latter caused by substance abuse. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of the total burden attributable to mental illnesses (Begg et al. 2007).

Prevalence

Prevalence is a measure of how commonly a condition or illness occurs within a population. It can be measured as a 'lifetime prevalence', that is, where the condition has occurred at any time in the life of the individual, or a 'period (or point) prevalence' where the condition occurred during a specific period or at a specific point in time, such as in a 12-month period before a survey.

The second National Survey of Mental Health and Wellbeing was conducted by the Australian Bureau of Statistics (ABS) in 2007 (ABS 2008a) to provide information on the prevalence of lifetime and 12-month mental disorders in the Australian population. The survey focused on three major disorder groups—anxiety disorders (for example, social phobia), affective disorders (for example, depression) and substance use disorders (for example, harmful use of alcohol).

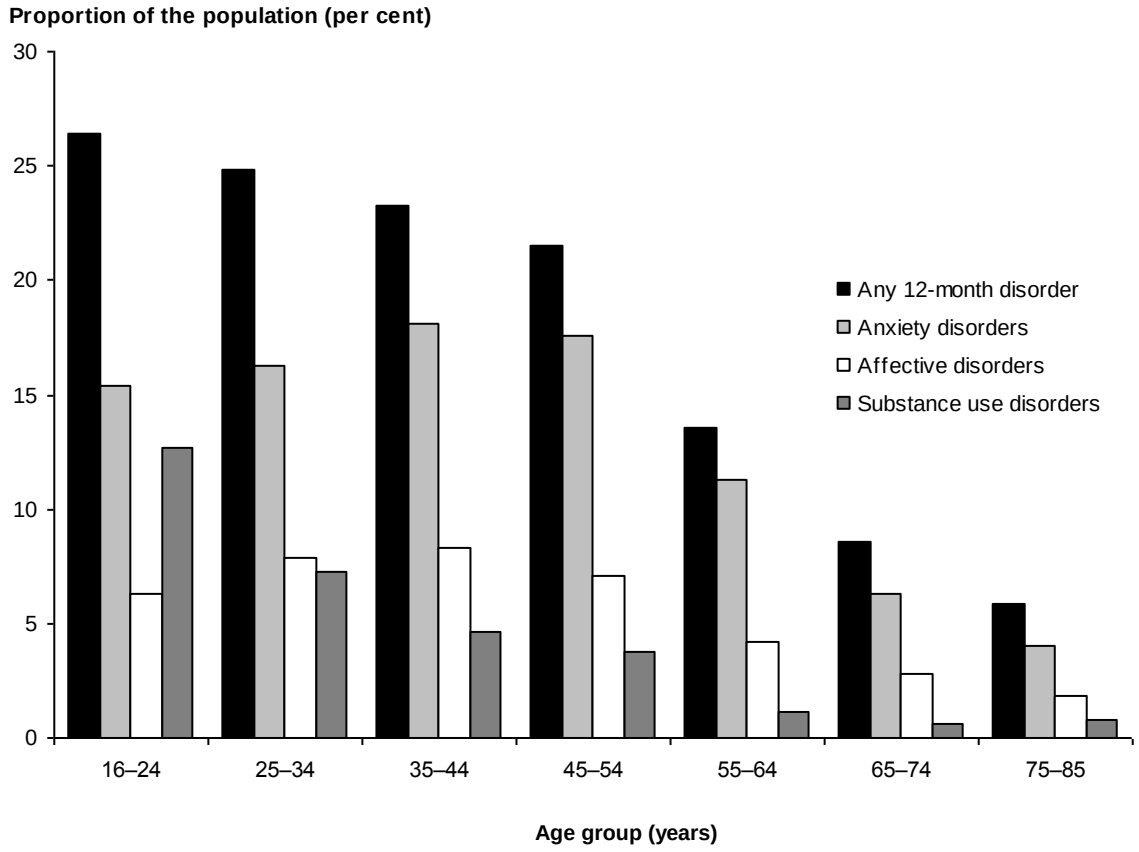
In order to determine whether survey respondents had experienced a mental disorder, the ABS interviewers used the *World Mental Health Survey Initiative* version of the World Health Organization's (WHO) *Composite International Diagnostic Interview, version 3.0*. The findings were classified according to the WHO *International Classification of Diseases and Related Health Problems, 10th revision* (ICD-10).

According to the survey, an estimated 7.3 million people, or 45.5% of Australians aged between 16 and 85 years, had experienced a mental disorder at some time in their life. An estimated 3.2 million, or 20% of the population, had experienced symptoms of a mental disorder in the 12 months before the survey (ABS 2008a). This was similar to the estimate for 1997.

Anxiety disorders were experienced by 14.4% of the Australian population aged between 16 and 85 years in the year before the survey, affective disorders by 6.2% and substance use disorders by 5.1% (ABS 2008a).

Women had higher 12-month mental disorder prevalence than men (22% compared with 18%), having higher prevalence of both anxiety and affective disorders, although men had a higher prevalence of substance use disorders (7% compared with 3.3% for women) (ABS 2008a).

More than a quarter (26%) of the youngest age group (16–24 years) had experienced mental illness in the 12 months before the survey. Prevalence rates were lower the older the age groups (Figure 1.2). Anxiety disorders were the most prevalent in all age groups, and substance use disorders the least prevalent, except in the 16–24 years age group (ABS 2008a).



Source: ABS 2008a.

Figure 1.2: The prevalence of 12-month mental disorders, by age group and by mental disorder group, 2007

Higher prevalence of 12-month mental disorders was associated with being in a one-parent family with children, not being in a married or de facto relationship, being unemployed, ever being homeless, ever being incarcerated, having no contact with friends, having no family members to rely on or confide in, smoking, misusing drugs, having high levels of psychological distress, having serious thoughts about suicide, having profound or severe core-activity disability or being unable to carry out usual activities (ABS 2008a). The direction of cause and effect in these associations is not ascertainable from the data collected.

People often experience more than one class of mental disorder with one-quarter of people (25.4% or 800,000 people) with mental disorders experiencing two or more classes of mental disorder in the 12 months before the interview (DoHA 2009e).

Mental disorders were more common among the population with chronic physical conditions than among those without chronic physical conditions (28.0% compared with 17.6%) (DoHA 2009e).

Use of mental health services

As well as measuring prevalence, the 2007 National Survey of Mental Health and Wellbeing collected data on the use of health services for mental health problems in the 12 months before the survey.

Of the 3.2 million people in the Australian population aged 16 to 85 years estimated to have a 12-month mental disorder, just over a third (34.9%) accessed services for mental health problems (Table 1.1). GPs were the most commonly consulted professional group. Women were more likely than men to have used any health service. People aged 35 and over were more likely to use a service than younger people, and people residing in major cities were more likely to use a service than people residing in all other areas.

People with affective disorders were more likely to use health services (49.7%) than those with anxiety or substance use disorders (22.0% and 11.1%, respectively). Those respondents experiencing multiple disorders were more likely to use health services than those with one disorder.

Mortality

A mental or behavioural disorder was recorded as the underlying cause for 667 deaths in Australia in 2007, at a rate of 3.0 deaths per 100,000 people (AIHW 2010a, ABS 2009b). Most of the deaths with a mental or behavioural disorder as the underlying cause were due to abuse of psychoactive substances such as alcohol and heroin. Suicides are not included in these figures.

Table 1.1: People with mental disorders[(a)], by health services[(b)] used for mental health problems, 2007

	General practitioner (per cent)	Psychologist (per cent)	Other[(c)] (per cent)	Total who used services (per cent)
Age group				
16–34 years	20.3	11.8	14.7	28.6
35–54 years	27.7	16.2	21.0	40.5
55–85 years	28.9	8.7	17.6	37.3
Sex				
Male	18.0	13.1	15.1	27.5
Female	29.9	13.2	19.9	40.7
Remoteness area				
Major cities	25.5	15.5	18.6	36.9
Other areas	22.9	8.3	16.0	30.8
Number and type of mental disorders				
Affective disorder only	41.9	*21.0	23.0	49.7
Anxiety disorder only	12.2	6.5	10.4	22.0
Substance-use disorder only	*6.9	**4.5	*5.6	*11.1
One mental disorder only	15.8	8.4	11.3	24.0
Two or more mental disorders	39.3	21.0	28.3	52.7
Mental disorders with physical conditions	27.1	12.7	17.8	37.4
Total aged 16–85 years	**24.7**	**13.2**	**17.8**	**34.9**

* estimate has a relative standard error of 25% to 50% and should be used with caution.

** estimate has a relative standard error of greater than 50% and is considered to be unreliable for general use.

(a) People aged 16–85 years with mental disorders within the previous 12 months.

(b) Health services used within the previous 12 months.

(c) Includes consultations with psychiatrist, mental health nurse, social worker, counsellor, medical specialist and complementary/alternative therapist.

Source: ABS 2009a.

1.4 National policies for mental health

State and territory governments and the Australian Government have committed to improving the mental health of Australians through the National Mental Health Strategy and the Council of Australian Governments' (COAG) National Action Plan on Mental Health. These two major initiatives set the broad agenda for mental health service provision in Australia. The National Healthcare Agreement and the National Health and Hospitals Network Agreement also provide additional guidance on government action to be taken and have specific implications for mental health care. A brief outline of the main aims and objectives of these initiatives follows.

National Mental Health Strategy

The National Mental Health Strategy was established to provide a framework to guide the reform agenda for mental health in Australia in a coordinated manner across the whole of government. The strategy consists of the National Mental Health Policy and the National Mental Health Plan, and is underpinned by the Mental Health Statement of Rights and Responsibilities. It was endorsed by the Australian and state and territory governments in 1992 (DoHA 2006) and has been reaffirmed by the health ministers several times since.

The broad aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental disorders
- reduce the impact of mental disorders on individuals, families and the community
- assure the rights of people with mental disorders.

The National Mental Health Policy was most recently revised in 2008 (DoHA 2009c). The policy provides a strategic vision for further whole-of-government mental health reform in Australia. The vision of the policy is for a mental health system that:

- enables recovery
- prevents and detects mental illness early
- ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014* was endorsed by all Australian Health Ministers in November 2009 (AHMC 2009). It signifies the commitment of governments (Australian and state and territory) to implement the policy's vision and seeks to involve sectors other than health to promote an integrated, whole-of-government response to the improvement of mental health outcomes. The plan consolidates reforms begun under the three previous plans and has five priority areas:

- social inclusion and recovery
- prevention and early intervention
- service access, coordination and continuity of care
- quality improvement and innovation
- accountability—measuring and reporting progress.

The addition of an accountability framework in the plan is seen as assisting in the monitoring and evaluation of progress in mental health outcomes for people with mental illness, their families and carers. Governments will be required to report progress annually to the COAG in accordance with 25 indicators included in the plan, with the development of targets and data sources for each indicator being given a priority during the first 12 months of the plan's operation.

COAG National Action Plan on Mental Health

In 2006, the COAG agreed to the *National Action Plan on Mental Health 2006–2011* (COAG 2006). This plan involves a joint package of measures and new investment by all governments over a 5-year period that is aimed at promoting better mental health and

providing additional support to people with mental illness, their families and their carers. In particular, the plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Progress on the plan is being monitored against nationally agreed progress measures over the 5-year period and will be subject to an independent review at the end of the period.

National Healthcare Agreement

The National Healthcare Agreement is an agreement, signed in December 2008, between the Commonwealth, state and territory governments of Australia to guide government action in the area of healthcare (COAG 2008). The agreement specifies agreed objectives, outcomes, progress measures and outputs. Mental health is mentioned in a number of places in the agreement including the progress and output section of primary and community, and the policy directions section for aged care.

There are 70 performance indicators associated with the agreement which are used to measure government progress towards achieving the specified objectives, outcomes and outputs. There are four mental health-specific indicators that are to be reported annually by the COAG Reform Council:

- Indicator 21—Treatment rate for mental illness. The numerator is the number of people receiving clinical mental health services, whilst the denominator is the estimated resident population (ERP).
- Indicator 28—Public sector community mental health services. The numerator for this indicator is the total number of service contacts provided by public sector community mental health services, whilst the denominator is the ERP.
- Indicator 29—Private sector mental health services. The numerator for this indicator is the number of mental health-specific MBS items provided by private psychiatrists, general practitioners, clinical psychologists and other allied health providers, whilst the denominator is the ERP.
- Indicator 32—Proportion of people with a mental illness with general practitioner care plans. The numerator for this indicator is the number of persons with a GP Mental Health Care Plan, that is, those persons accessing MBS item 2710. The denominator is the estimated number of people with mental illness sourced from the 2007 National Survey of Mental Health and Wellbeing conducted by the ABS.

The baseline performance report for the reference year 2008-09 was released in June 2010 (CRC 2010). Further details of the mental health-related indicators are included in chapters 2, 4 and 6 and Appendix 5 of this report.

National Health and Hospitals Network Agreement

In April 2010, the Commonwealth, state and territory governments of Australia, with the exception of Western Australia, signed a new National Health and Hospitals Network Agreement (COAG 2010). The agreement sets out the shared intention of the Commonwealth and state and territory governments (with the exception of Western Australia) to implement a National Health and Hospitals Network for Australia. The network will be a nationally unified and locally controlled health system, based on changed roles and responsibilities of the Commonwealth, state and territory governments.

With respect to mental health, the agreement specifies that, from 1 July 2011, the Commonwealth will take full funding and policy responsibility for the primary mental health care services, currently funded by state governments, which target the more common mild to moderate mental illnesses. Under the agreement the Commonwealth and state governments will also work together to create linkages and coordination mechanisms between Primary Health Care Organisations (PHCOs) and non-health state services that interact with the health system for people with serious mental illness.

The agreement also commits the Commonwealth and states to undertaking further work to consider whether specialist community mental health services, for people with severe mental illness, will transfer to the Commonwealth or be subject to strong national reform efforts within current governmental roles and responsibilities. This issue will be considered by COAG in 2011.

1.5 Additional information

An electronic version of this report is available from the AIHW's website at <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2007–08*). Additional tables containing more detailed data from the National Hospital Morbidity Database, the National Community Mental Health Care Database and the National Residential Mental Health Care Database are also available on the website. As well, data from the National Hospital Morbidity Database are available in interactive data cubes on the AIHW website <www.aihw.gov.au/mentalhealth/datacubes/index.cfm>. These data cubes allow users to choose and manipulate variables in order to create tables of data to suit their needs.

More detailed data from the 2007 National Survey of Mental Health and Wellbeing are presented in the publication *The mental health of Australians 2* (DoHA 2009e).

The *National mental health report* (DoHA 2008) provides a statistical report on progress made under the National Mental Health Strategy to 2004–05. Statistical indicators to provide comparisons of the performance of government mental health services by jurisdiction are provided in the *Report on government services 2010* (SCRGSP 2010). The Australian Health Ministers' Conference prepares an annual progress report on the *Council of Australian Governments National Action Plan for Mental Health* (AHMC 2008).

The inaugural *National Healthcare Agreement: Baseline performance report for 2008–09* (CRC 2010), prepared by the COAG Reform Council, presents a comparative analysis of the baseline indicators to track governments' performance against the National Healthcare Agreement objectives. As noted above, four indicators relate specifically to mental health services and are reported in Appendix 5 of this report.

2 Mental health-related care in general practice

2.1 Introduction

This chapter presents information on mental health-related services provided by ***general practitioners*** (GPs) using data from the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity and Medicare Benefits Schedule (MBS) data. Included is a description of National Healthcare Agreement performance indicator 32 – *Proportion of people with a mental illness with general practitioner care plans.*

2.2 Bettering the Evaluation and Care of Health survey data

The BEACH program is a survey of general practice activity across Australia. The data described in this chapter mainly relate to 101,100 GP ***encounters*** (see Key concepts) from a sample of 1,011 GPs over the period from April 2008 to March 2009, as this is the most recent data period available. This is described as BEACH 2008–09 in this chapter. Note that this reporting year differs from most of the chapters in this publication, which focus on 2007–08 data.

The GP encounters covered by the survey represent about 0.1% of all GP encounters over that time. After post-stratification weighting (to ensure that national general practice activity patterns are reflected) the data include 96,688 (weighted) encounters (Britt et al. 2009).

Key concepts

General practitioners (GPs) are those medical practitioners who are vocationally registered under Section 3F of the *Health Insurance Act 1973*, or are Fellows of the Royal Australian College of General Practitioners or trainees for vocational registration.

Other medical practitioners (OMPs) are primary care practitioners who are neither vocationally registered nor training to become vocationally registered.

Encounter refers to any professional interchange between a patient and a GP; it includes both face-to-face encounters and indirect encounters where there is no face-to-face meeting but where a service is provided (for example, a prescription or referral) (Britt et al. 2009).

Problem managed is a statement of the provider's understanding of a health problem presented by a patient, family or community. GPs are instructed to record at the most specific level possible from the information available at the time. It may be limited to the level of symptoms. Up to four problems managed can be recorded per encounter (Britt et al. 2009).

Mental health-related encounters are those encounters during which at least one mental health-related problem was managed.

Mental health-related problems, for the purposes of this chapter, are those that are classified in the psychological chapter (that is, the 'P' chapter) of the *International Classification of Primary Care, 2nd edition* (ICPC-2). A list of the 'P' chapter codes for problems, which includes alcohol and drug-related problems, is provided in Appendix 4.

The survey provides information on the reasons patients visited the GP, the ***problems managed***, and the types of management provided for each problem.

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

2.3 Mental health-related encounters

In 2008–09, 11.7% of all GP encounters reported for the BEACH data were ***mental health-related encounters*** (Table 2.1). These are defined as those encounters at which a ***mental health-related problem*** was managed. In terms of the MBS, these encounters were most often recorded as surgery consultations (almost 90% of all encounters for which an MBS item was recorded; see Table 2.7). The MBS mental health items claimable by GPs, introduced on 1 November 2006 as part of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative (item numbers 2710, 2712, 2713), represented 8.4% of MBS items recorded for mental health-related encounters in the 2008–09 BEACH survey. A further 0.2% were other mental health-specific MBS items. Section 2.5 includes a discussion of the encounters where these MBS mental health items were recorded, compared with other mental health-related encounters.

Table 2.1: Mental health-related encounters, BEACH, 2004–05 to 2008–09

	2004–05	2005–06	2006–07	2007–08	2008–09	Annual average change[(a)] (per cent)
Total GP encounters that are mental health-related (per cent)	10.8	10.5	10.4	10.8	11.7	2.0
Estimated number of mental health-related encounters[(b)]	10,591,000	10,624,000	10,713,000	11,862,000	13,202,000	5.7
Lower 95% confidence limit	10,067,000	10,074,000	10,261,000	11,280,000	12,661,000	. .
Upper 95% confidence limit	11,117,000	11,174,000	11,165,000	12,375,000	13,678,000	. .
Estimated number of mental health-related encounters per 1,000 population[(b)(c)]	523	517	514	560	610	3.9
Lower 95% confidence limit	497	490	492	533	585	. .
Upper 95% confidence limit	549	553	535	584	632	. .

. . Not applicable.

(a) The confidence intervals show that the difference between some of the years is not statistically significant.

(b) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse Items) as reported by the Department of Health and Ageing (Medicare 2009a).

(c) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Source: BEACH survey of general practice activity.

A simple extrapolation based on the 113 million unreferred (that is, non-specialist) attendances claimed from Medicare for 2008–09 suggests that there were an estimated 13.2 million mental health-related GP encounters for 2008–09. This corresponds to an estimated 610 encounters per 1,000 population, up from the 560 encounters per 1,000 population estimated in 2007–08.

The proportion of encounters that were mental health-related from the BEACH data showed an average annual increase of 2.0% between 2004–05 and 2008–09. Over the same period, the

estimated total number of mental health-related GP encounters in Australia showed an average annual increase of 5.7% (which comprises a 2.0% growth in the percentage of total GP encounters that are mental health-related and a 3.6% growth in all Medicare *Unreferred GP Attendances*). The number per 1,000 population showed an average annual increase of 3.9%.

Patient demographics

Table 2.2 presents information on mental health-related encounters according to the characteristics of those receiving care. The table shows the proportion of mental health-related encounters for each demographic characteristic, as well as the number of mental health-related encounters per 100 total encounters (that is, both mental health-related and non-mental health-related encounters) for that demographic subgroup. In addition, in order to account for differences in the relative size of the respective populations, a rate (per 1,000 population) is provided in the last column of the table. Since the data relate to encounters (rather than people), the rates provide information on the number of mental health-related encounters relative to the size of the population subgroup.

Table 2.2: Patient demographics for mental health-related encounters, BEACH, 2008–09

Patient demographics	Per cent of total mental health-related encounters[(a)]	Rate (per 100 demographic group specific encounters)	95% LCL	95% UCL	Estimated encounters per 1,000 population[(b)]
Age group					
Less than 15 years	2.7	2.8	2.4	3.2	85
15–24 years	8.0	11.1	10.1	12.1	339
25–34 years	12.2	14.7	13.7	15.8	516
35–44 years	17.3	17.2	16.1	18.2	707
45–54 years	19.0	15.8	14.8	16.7	814
55–64 years	15.2	11.8	11.2	12.5	796
65 years and over	25.6	10.1	9.5	10.7	1,139
Sex					
Male	38.5	10.6	10.0	11.1	461
Female	61.5	12.4	11.9	12.9	699
Indigenous status[(c)]					
Indigenous Australians	1.0	13.6	11.2	15.9	319
Non-Indigenous Australians	99.0	11.7	11.3	12.2	597
Remoteness area of usual residence					
Major cities	71.3	11.3	10.7	11.8	607
Inner regional	19.8	13.1	12.1	14.1	584
Outer regional	7.8	12.1	10.8	13.4	478
Remote and very remote	1.0	11.5	9.1	13.9	283
Total	**100.0**	**11.7**	**11.2**	**12.1**	**589**

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

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

(c) Information on this data element was not reported for more than 5 per cent of encounters.

Note: LCL—lower confidence limit; UCL—upper confidence limit.

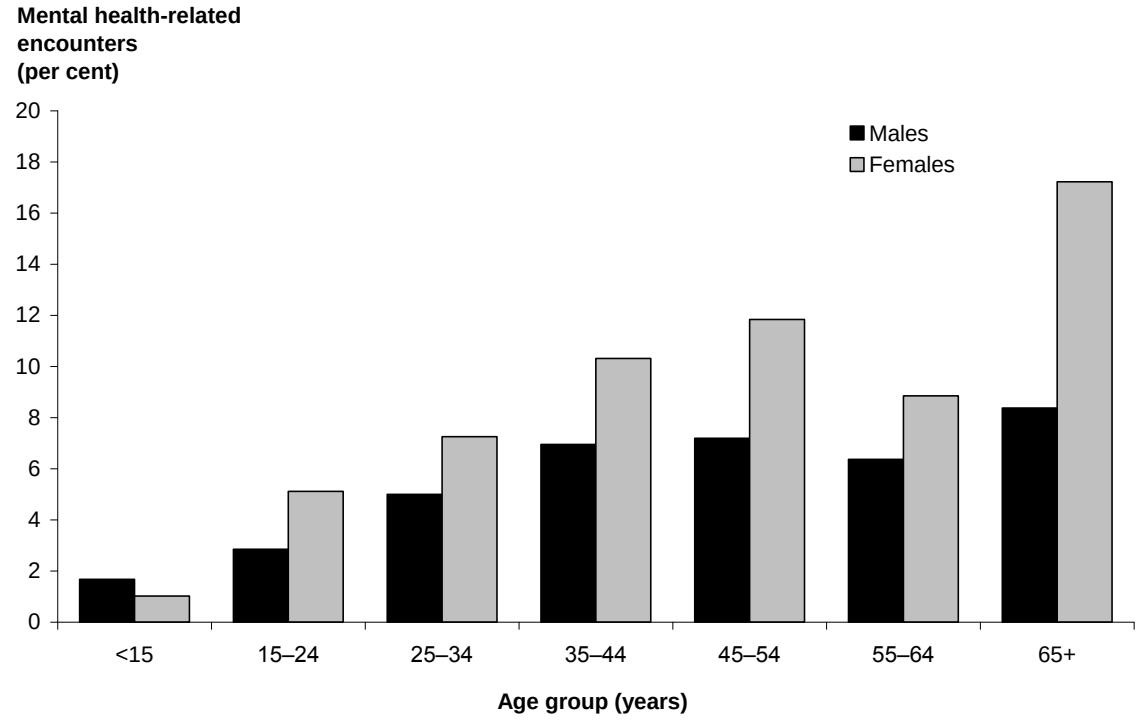
Source: BEACH survey of general practice activity.

In 2008–09, one in four (25.6%) mental health-related encounters were for patients aged 65 years and over. This age group had an estimated 1,139 mental health-related encounters per 1,000 population during the 2008–09 survey period, a much higher rate than any other age group. However, as a proportion of all GP encounters for the age group, those aged 65 years and over had fewer mental health-related GP encounters than any other age group except for those aged less than 15 years.

There were more mental health-related encounters for female patients than there were for male patients (61.5% and 38.5%, respectively). However, allowing for the higher rate of GP attendances for females, the difference between the sexes was not as marked—an estimated 12.4% of all female encounters with GPs were mental health-related compared with 10.6% for males.

The great majority of mental health-related encounters were for non-Indigenous Australians (99.0%) and, when relative population sizes and age structures were considered, Aboriginal and Torres Strait Islander Australians (319 per 1,000 population) had fewer mental health-related encounters than did non-Indigenous Australians (597 per 1,000 population). Mental health-related encounters per 1,000 population were highest among those living in *Major cities* (607), increasing from the rate reported in 2007–08 (561). The lowest encounter rates were among those in *Remote and very remote* areas (283).

Figure 2.1 shows the age and sex distribution for mental health-related encounters. The largest proportion of mental health-related encounters were for those aged 65 years and over.



Source: BEACH survey of general practice activity.

Figure 2.1: The age-sex distribution for mental health-related encounters, BEACH, 2008–09

Mental health-related problems managed

In the BEACH 2008–09 survey, mental health-related problems were managed at a rate of 11.7 per 100 encounters (Table 2.1). Table 2.3 presents data on the 10 most frequently reported mental health-related problems managed. *Depression* (ICPC-2 codes P03, P76) was the most frequently managed mental health-related problem in 2008–09, accounting for 34.3% of all mental health-related problems managed and 2.8% of all health problems managed.

Anxiety (P01, P74) was the next most frequently managed mental health-related problem (15.6% of all mental health-related problems managed and 1.2% of all problems managed), followed by *sleep disturbance* (P06; 12.6% of all mental health-related problems managed and 1.0% of all problems managed).

Table 2.3: The 10 most frequent mental health-related problems managed, BEACH, 2008–09

ICPC-2 code	Problem managed	Per cent of total mental health-related problems	Per cent of total problems	Rate (per 100 encounters)	95% LCL	95% UCL
P03, P76	Depression	34.3	2.8	4.3	4.0	4.5
P01, P74	Anxiety	15.6	1.2	1.9	1.8	2.1
P06	Sleep disturbance	12.6	1.0	1.6	1.4	1.7
P17	Tobacco abuse	5.7	0.5	0.7	0.6	0.8
P02	Acute stress reaction	4.9	0.4	0.6	0.5	0.7
P70	Dementia	4.6	0.4	0.6	0.4	0.7
P72	Schizophrenia	4.3	0.3	0.5	0.4	0.6
P19	Drug abuse	3.3	0.3	0.4	0.3	0.6
P15, P16	Alcohol abuse	2.7	0.2	0.3	0.3	0.4
P73	Affective psychosis	1.9	0.1	0.2	0.2	0.3
	Other	10.2	0.8	1.3	1.2	1.4
	Total	**100.0**	**8.0**	**12.4**	**11.9**	**12.9**

Note: LCL—lower confidence limit; UCL—upper confidence limit.

Source: BEACH survey of general practice activity.

Management of mental health-related problems

Table 2.4 presents the most common types of management reported for mental health-related problems. The most common management was a medication being prescribed, supplied or recommended by the GP (66.2 per 100 mental health-related problems managed). Antidepressants were the most commonly prescribed, recommended or supplied medication (26.4 per 100), followed by anxiolytics (12.7), and hypnotics and sedatives (11.1).

The second most common form of management was the GP providing counselling or advice (47.6 per 100 mental health-related problems managed) with psychological counselling (25.2 per 100) being most frequently provided.

Pathology was ordered at a rate of 13.3 tests/test batteries per 100 mental health-related problems managed. The most common pathology tests ordered were for full blood count (2.7 per 100 mental health-related problems managed), liver function tests (1.5 per 100) and thyroid-stimulating hormone tests (0.9).

Table 2.4: Most common types of management of mental health-related problems, BEACH, 2008–09

Type of management		Rate (per 100 mental health-related problems)	95% LCL	95% UCL	Rate for 2007–08 BEACH survey
	Medication prescribed, recommended or supplied[a]				
N06A	Antidepressants	26.4	25.0	27.8	26.7
N05B	Anxiolytics	12.7	11.6	13.8	13.1
N05C	Hypnotics and sedatives	11.1	10.2	11.9	11.9
N05A	Antipsychotics	6.3	5.6	7.1	5.5
	Other	9.7	8.5	11.0	8.0
Total		**66.2**	**63.9**	**68.4**	**65.2**
	Treatments, including counselling[b]				
P58001, P58002, P58004–P58007, P58013–P58015, P58018, P58019	Counselling—psychological	25.2	23.5	27.0	26.8
P45004, P58008	Counselling/advice/education—smoking	3.8	3.3	4.3	2.5
P45001, P45002	Advice/education/observe/wait —psychological	2.9	2.3	3.5	3.5
P45005, P58009	Counselling/advice/education—alcohol	1.8	1.5	2.2	1.8
A45015, A48003, A48005–A48011	Advice/education—medication	1.8	1.5	2.1	1.8
	Other	12.0	11.0	13.0	11.3
Total		**47.6**	**45.1**	**50.1**	**47.5**
	Pathology[b]				
A34011	Test—full blood count	2.7	2.3	3.0	2.7
D34008	Test—liver function	1.5	1.2	1.7	1.5
T34028	Test—thyroid-stimulating hormone	0.9	0.7	1.1	1.0
T34015	Test—thyroid function	0.8	0.6	1.0	0.7
A34010	Test—electrolytes /urea/ creatinine	0.8	0.6	1.0	0.6
	Other	6.6	5.8	7.5	7.3
Total		**13.3**	**11.7**	**14.8**	**13.7**
	Referral[b]				
P66003	Referral to psychologist	6.1	5.5	6.8	5.5
P67002	Referral to psychiatrist	1.8	1.5	2.0	1.9
A67004	Referral to paediatrician	0.6	0.4	0.8	0.5
P67006	Referral to sleep clinic	0.5	0.4	0.7	0.6
P66005	Referral to mental health team	0.5	0.3	0.7	0.3
	Other	4.0	3.6	4.4	3.6
Total		**13.0**	**12.1**	**14.0**	**12.1**

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

(b) Grouped according to ICPC-2 PLUS codes.

Note: LCL—lower confidence limit; UCL—upper confidence limit.

Source: BEACH survey of general practice activity.

A referral was given at a rate of 13.0 per 100 mental health-related problems managed. The most common referrals given were to psychologists (6.1 per 100) and to psychiatrists (1.8). While there was little change in the rate of referral to psychiatrists from the previous year, an increasing trend was noted in the rate of referral to psychologists from 2005–06 onwards:

- 2005–06: 1.6 per 100 (95% CI: 1.3–2.0)
- 2006–07: 3.6 per 100 (95% CI: 3.1–4.1)
- 2007–08: 5.5 per 100 (95% CI: 4.9–6.2)
- 2008–09: 6.1 per 100 (95% CI: 5.5–6.8).

This may have been influenced by the introduction of new Medicare items in November 2006 covering attendances by psychologists. As part of the Better Access initiative there is provision for a GP to prepare a Mental Health Care Plan, which can incorporate an initial referral to a psychologist for up to six sessions.

2.4 Additional general practice activity

In addition to the 11.7 per 100 GP encounters where a mental health-related problem was managed, there were 2.0 per 100 total GP encounters in the 2008–09 BEACH survey that did not involve a specific mental health-related problem but where:

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

A list of the 'P' chapter codes for treatments, counselling and referrals and the ATC group codes for medications is provided in Appendix 4. As these encounters did not involve a specific mental health-related problem managed, they were not classified as mental health-related encounters, as defined earlier in this chapter. However, these encounters may involve a generic request for a prescription or a referral as the 'problem' managed by the GP or they may be related to problems with relationships or other life issues which resulted in psychological management by the GP. The encounter was almost always recorded as a surgery consultation in terms of MBS items; a mental health-specific MBS item was recorded for less than 2% of these encounters.

An extrapolation based on the 113.0 million non-specialist attendances claimed from Medicare for 2008–09 suggests that these additional encounters in the BEACH 2008–09 data set equate to an estimated 2.3 million additional encounters for 2008–09. In turn, this corresponds to an estimated 105 encounters per 1,000 population. Note that the extent to which these additional encounters are related to mental health is unknown.

Table 2.5: Psychologically-related activity in other general practice encounters[a], BEACH, 2008–09

Type of psychologically-related activity			Encounters with psychologically-related activity	
Psychologically-related medication	Psychologically-related management[b]	Psychologically-related referral	Number (per 100 encounters)	Per cent
✓			1.2	61.2
	✓		0.7	33.0
		✓	0.1	4.0
✓	✓		—	1.3
✓		✓	—	0.1
	✓	✓	—	0.4
✓	✓	✓	—	0.1
Subtotal medications			*1.3*	*62.7*
	Subtotal management		*0.7*	*34.7*
		Subtotal referrals	*0.1*	*4.5*
Total psychologically-related activity in other general practice encounters[a][c]			**2.0**	**100.0**

— Rounded to zero.

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

(b) Management covers treatments, including counselling.

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

Source: BEACH survey of general practice activity.

More than half of these additional encounters (62.7%) consisted of a medication being prescribed, recommended or supplied that was classified in the main psychological groups in the ATC classification, without the reporting of a specific psychological problem managed (Table 2.5). Of these medications, the most common were anxiolytics (34.8%), followed by antidepressants (33.8%). These medications were most commonly prescribed, recommended or supplied for general and unspecified prescription requests and renewals (31.2% of the problems managed for this group of additional encounters) and management of pain (15.2%).

For 34.7% of these additional encounters, a treatment or counselling classified as psychological was reported (Table 2.5). The most common type of management was counselling, advice or education with regard to smoking (34.0%) and counselling, advice or education with regard to lifestyle (23.0%). This management was most commonly provided for hypertension (10.8% of the problems managed for this group of additional encounters).

For 4.5% of the additional encounters, a referral classified as psychological was provided (Table 2.5). The most common of these referrals were referral to a psychologist (54.5%), referral to a sleep clinic (20.9%) and referral to a psychiatrist (11.6%). At these encounters, the referrals were most commonly given for marital and relationship problems, and domestic violence (12.5% of the problems managed for this group of additional encounters).

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

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

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

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

This section reviews the use of these MBS items by GPs through analysis of both MBS data and BEACH survey data. The tables in this section show the numbers of patients and/or services for each of the main groups of MBS-subsidised specific mental health services provided by GPs and ***other medical practitioners*** (OMPs). These are MBS items that 'define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders' (DoHA 2009b) as distinct from general surgery consultations where a mental health-related problem is managed (see Key concepts).

There were 1.6 million MBS-subsidised mental health services provided by GPs and OMPs in 2008–09 (Table 2.6), which represents an increase of nearly 30% from the previous year. The great majority (96.9%) of these services were for GP Mental Health Care items. The 3 Step Mental Health Process item groups were phased out following the introduction of the new GP Mental Health Care items on 1 November 2006 and ceased after 30 April 2007. In the remainder of this chapter, which focuses on data for 2008–09, no further references are made to 3 Step Mental Health Process items.

Table 2.6: MBS-subsidised specific GP/OMP mental health services, by item group of service provided, 2004–05 to 2008–09

Item group[(a)]	2004–05	2005–06	2006–07	2007–08	2008–09
GP Mental Health Care[(b)]	. .	. .	546,515	1,183,690	1,549,943
Focussed Psychological Strategies	25,450	30,261	36,779	37,133	35,164
Family Group Therapy	17,618	16,904	16,385	16,176	14,936
3 Step Mental Health Process—GPs/OMPs	17,148	25,922	16,043	50[(c)]	20[(c)]
Total	**60,216**	**73,087**	**615,722**	**1,237,049**	**1,600,063**

. . Not applicable.

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

(b) These items introduced 1 November 2006.

(c) The 3 Step Mental Health Process items were discontinued after 30 April 2007. The figures appearing for these item groups represent delayed processing of previously provided items.

Source: MBS data (DoHA).

The BEACH 2008–09 survey required the GP to record the MBS item for each encounter. Analysis of the data collected for encounters where a mental health-related problem was managed showed that 9.2% of these encounters had an MBS item designated specifically as a mental health service recorded (Table 2.7). This percentage varied depending on the mental health related problem being managed. Among the 10 most commonly reported mental health related problems managed, depression and affective psychosis had higher than average percentages of encounters where a mental health-specific MBS item (GP Mental Health Care and Focussed Psychological Strategies) was recorded. Sleep disturbance, tobacco abuse and dementia had very low percentages of encounters where a mental health-specific MBS item was recorded (see Figure 2.2).

Table 2.7: Selected[(a)] MBS items recorded for mental health-related encounters, BEACH, 2008–09

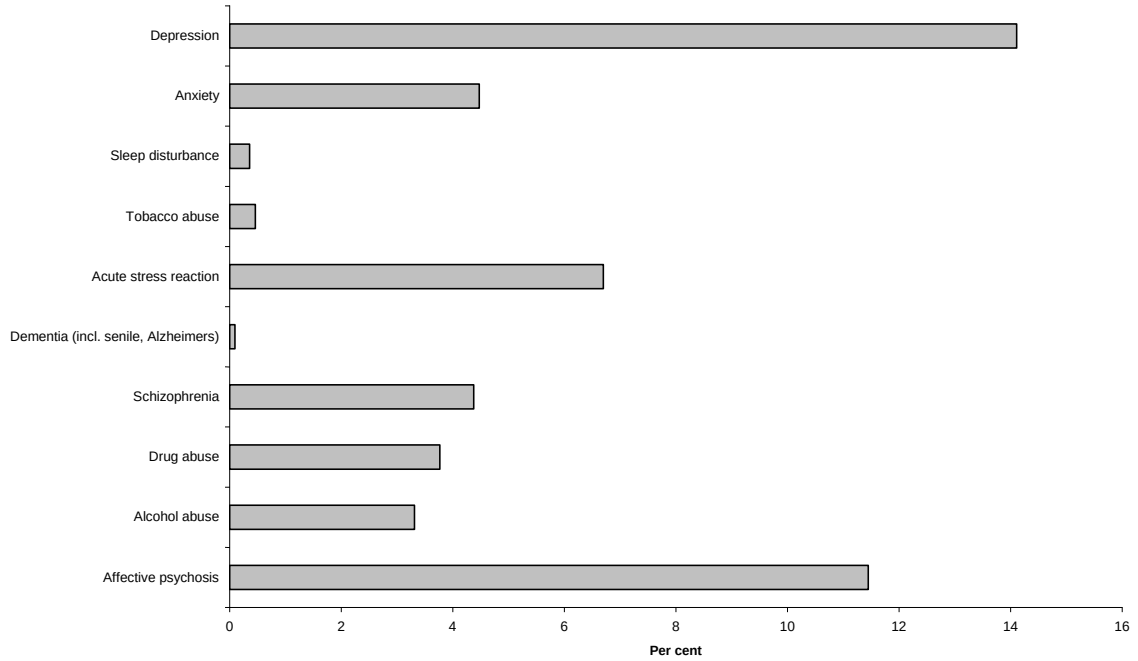
			Per cent of mental health-related encounters	
Rank	**MBS item no.**	**Item description**	**Item**	**Cumulative**
1	23	Surgery consultation—level 'B' (standard)	66.1	66.1
2	36	Surgery consultation—level 'C' (long)	14.1	80.2
3	2713	GP Mental Health Care— consultation	3.9	84.1
4	2710	GP Mental Health Care—preparation of plan	3.8	87.9
5	35	Consultation at a residential aged care facility—level 'B'	2.7	90.7
6	44	Surgery consultation—level 'D' (prolonged)	1.7	92.4
7	2712	GP Mental Health Care—review of plan	1.3	93.7
8	3	Surgery consultation—level 'A' (short)	1.1	94.8
9	24	Home visit—level 'B'	0.7	95.5
10	5020	Surgery consultation—after hours—level 'B'	0.7	96.2
11	25	Consultation at an institution other than a hospital or residential aged care facility—level 'B'	0.5	96.7
12	721	GP management plan—preparation	0.5	97.2
20	2725	Focussed Psychological Strategies—surgery consultation (extended)	0.1	98.7
27	2721	Focussed Psychological Strategies—surgery consultation	0.1	99.3
Subtotal—Better Access items introduced 1 November 2006[(b)]			*9.0*	*. .*
Subtotal—Better Outcomes in Mental Health Care items introduced 1 November 2002[(b)]			*0.2*	*. .*
Total mental health-specific items			**9.2**	**. .**
Total all items			**100.0**	**100.0**

. . Not applicable.

(a) Top 12 and then other mental health-specific items.

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

Source: BEACH survey of general practice activity.



Source: BEACH survey of general practice activity.

Figure 2.2: Percentage of encounters where mental health-specific MBS items were recorded for the 10 most commonly reported mental health-related problems managed, BEACH, 2008–09

Table 2.8 shows the demographic and geographic distribution of patients in receipt of mental health-specific GP MBS items. In terms of both absolute numbers and population-adjusted rates, two groups, females and people aged 35–44 years were the biggest consumers of these services. Most consumers of these services were resident in *Major cities*; however, once population size was taken into account, residents of *Inner regional* areas had higher rates of use.

Table 2.9 shows that, allowing for state and territory population size, the rate of provision of MBS-subsidised mental health-specific services provided by GPs was highest in Victoria (84.1 per 1,000) and lowest in the Northern Territory (31.3 per 1,000). New South Wales also had a relatively high rate (76.7 per 1,000).

Table 2.8: People receiving MBS-subsidised GP mental health services: patient demographic characteristics and services received, 2008–09

Patient demographics	Number of patients[a]	Per cent of patients	Rate[b] (per 1,000 population)	Number of services[c]	Per cent of services	Services per patient
Age group						
Less than 15 years	58,577	6.4	14.1	73,125	4.6	1.2
15–24 years	143,883	15.6	47.5	230,957	14.4	1.6
25–34 years	191,585	20.8	63.3	328,083	20.5	1.7
35–44 years	207,976	22.6	66.5	371,181	23.2	1.8
45–54 years	164,488	17.9	55.1	298,282	18.6	1.8
55–64 years	101,619	11.0	41.6	185,137	11.6	1.8
65 years and over	62,395	6.8	21.7	113,278	7.1	1.8
Sex						
Male	330,820	35.9	31.5	566,106	35.4	1.7
Female	589,573	64.1	55.9	1,033,937	64.6	1.8
Remoteness area of usual residence						
Major cities	663,484	72.1	45.8	1,161,202	72.6	1.8
Inner regional	189,809	20.6	48.2	318,666	19.9	1.7
Outer regional	65,901	7.2	34.5	106,995	6.7	1.6
Remote	6,258	0.7	20.0	9,572	0.6	1.5
Very remote	2,115	0.2	13.0	3,059	0.2	1.4
Total	**920,393**	**100.0**	**43.7**	**1,600,043**	**100.0**	**1.7**

(a) The number of patients for each demographic variable may not sum to the total GP items since a patient may receive a service in more than one age group or in more than one geographic area in the course of the year but will be counted only once in the total.

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

(c) The number of services for each demographic variable may not sum to the total due to omitted unknown/migratory data.

Source: MBS data (DoHA).

Table 2.9: MBS-subsidised specific GP mental health services, numbers of patients and services provided, by item group[a], states and territories[b], 2008–09

Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of patients				
GP Mental Health Care	309,667	250,842	172,573	79,559	64,425	18,390	12,421	4,240	909,559
Focussed Psychological Strategies	4,964	4,096	2,153	597	1,080	142	141	112	13,247
Family Group Therapy	3,719	3,203	627	209	369	96	74	12	8,306
Total patients[c]	**314,295**	**254,512**	**173,836**	**79,978**	**65,075**	**18,525**	**12,521**	**4,275**	**920,393**
Rate (per 1,000 population)[c][d]	44.6	47.4	40.0	36.3	40.4	37.0	36.0	19.3	42.5
					Number of services				
GP Mental Health Care	520,403	434,383	290,904	138,410	111,352	28,783	19,020	6,688	1,549,943
Focussed Psychological Strategies	13,238	10,693	6,037	1,115	3,261	249	345	226	35,164
Family Group Therapy	6,696	6,144	1,000	274	560	161	85	16	14,936
Total services	**540,337**	**451,220**	**297,941**	**139,799**	**115,173**	**29,193**	**19,450**	**6,930**	**1,600,043**
Rate (per 1,000 population)[d]	76.7	84.1	68.5	63.4	71.4	58.4	55.9	31.3	73.9

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

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

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

(d) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2008.

Source: MBS data (DoHA).

2.6 Proportion of people with a mental illness with a GP care plan

Under the 2009 National Healthcare Agreement, the proportion of people with a mental illness with general practitioner care plans (indicator 32) is a primary and community health outcome indicator (CRC 2010). For this indicator, the numerator is the number of persons with a GP Mental Health Care Plan, that is, those persons accessing MBS item 2710. The denominator is the estimated number of people with mental illness. This estimate is calculated by applying the estimated proportion (age and sex-specific) of the population with mental illness (from the 2007 ABS National Survey of Mental Health and Wellbeing) to the estimated resident population. The indicator is calculated both nationally and by state/territory and disaggregated by 10 year age group, residential remoteness and socioeconomic status as detailed in Appendix 5.

3 Mental health-related care in emergency departments

3.1 Introduction

Hospital emergency departments play a role in treating mental illness. The emergency department can be the initial point of care for a range of reasons. For example, a 2004 study of mental health presentations to Victorian emergency departments found that emergency departments were used as an initial point of care for those seeking mental health-related services for the first time, as well as an alternative point of care for people seeking after-hours mental health care (Victorian Government Department of Human Services 2006). The Victorian study found that emergency departments played a role in caring for those who:

- presented involuntarily with the police for a mental health assessment
- were brought in by ambulance after a self-harm attempt
- required containment and treatment in situations where no beds in specialist psychiatric wards were readily available
- presented with high-prevalence disorders, such as anxiety and depression.

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

All state and territory health authorities collect a core set of nationally comparable information on most ***emergency department occasions of service*** in public hospitals in their jurisdiction. The Australian Institute of Health and Welfare compiles this episode-level data annually into the National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD). In addition, although not compiled as part of the NNAPEDCD, all jurisdictions collect information (in some form) on the ***principal diagnosis*** for many of those emergency department occasions of service that they report to the NNAPEDCD. For the purposes of this chapter, this diagnosis information was used by states and territories to identify those emergency department occasions of service that were mental health-related. Data on these mental health-related occasions of service were provided by the states and territories from the same sources as those used to provide data on all emergency department occasions of service to the NNAPEDCD.

3.2 Mental health-related emergency department occasions of service

Mental health-related emergency department occasions of service are defined as occasions of service in public hospital emergency departments that have a principal diagnosis of mental and behavioural disorders (codes F00–F99) in the *International Statistical Classification of*

Diseases and Related Health Problems, 10th revision, Australian Modification (ICD-10-AM) or the equivalent codes in the *International Statistical Classification of Diseases Related Health Problems, 9th revision, Clinical Modification* (ICD-9-CM). A list of the relevant diagnosis codes for both ICD-10-AM and ICD-9-CM are provided in Appendix Table A1.2.

State and territory health authorities provided aggregate 2007–08 information on the demographic characteristics, principal diagnosis, triage category and episode end status of patients for whom mental health-related occasions of service were reported. Principal diagnosis was reported on the basis of the 11 diagnosis blocks that make up the Mental and behavioural disorders chapter (Chapter 5) in the ICD-10-AM.

Key concepts

Emergency department occasion of service refers to the period of treatment or care between when a patient presents at an emergency department and when the non-admitted emergency department treatment ends. It includes presentations of patients who do not wait for treatment once registered or triaged in the emergency department, those who are dead on arrival, and those who are subsequently admitted to hospital or to beds or units in the emergency department. An individual may have multiple occasions of service in a year. For further information, see the definition of *Non-admitted patient emergency department service episode* in the *National health data dictionary, Version 13* (HDSC 2006).

Mental health-related emergency department occasion of service refers to an emergency department occasion of service that has a principal diagnosis that falls within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes. It should be noted that this definition does not encompass all mental health-related presentations to emergency departments, as detailed below. Additional information about this and applicable caveats can be found in Appendix 1.

***Principal diagnosis*.** Currently, there is no national standard definition of 'principal diagnosis' for emergency department data. Thus, for the purposes of the data presented in this chapter, states and territories provided data on principal diagnosis based on local definitions used within their jurisdiction or emergency departments.

Triage is the process by which a patient is briefly assessed upon arrival in the emergency department to determine the urgency of their need for medical and nursing care.

The definition of mental health-related emergency department occasions of service in this chapter has the following limitations:

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

  Nationally, in 2007–08, an estimated 22% of the 5.5 million public hospital emergency department occasions of service were not reported with episode-level data and thus not included in the NNAPEDCD (Appendix Table A1.3). In addition, non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals are not included.

  The Australian Bureau of Statistics (ABS) estimates there were 453,572 non-admitted patient occasions of service provided by accident and emergency departments in private acute and psychiatric hospitals in 2006–07 (ABS 2008b).

- **Not all of the emergency department occasions of service that are reported with detailed episode-level data include a diagnosis.**

  It is estimated that in 2007–08 the proportion of reported occasions of service with a diagnosis was 89% (Appendix Table A1.3).

- **Not all conditions and problems that could be considered mental health-related are captured by the mental health-related definition used in this chapter.**

  For example, emergency department occasions of service for which the principal diagnosis did not fall within the Mental and behavioural disorders chapter (codes F00–F99) but for which an external cause of morbidity or mortality was identified as intentional self-harm are not included.
- **The definition is based on a single diagnosis only.**

  As a result, if a mental health-related condition was reported as a second or other diagnosis and not as the principal diagnosis, the occasion of service will not be included as mental health-related.
- **A patient may have a mental health-related condition that is not recognised or diagnosed (and thus not recorded) during the emergency department occasion of service.**

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

3.3 Mental health-related emergency department care

States and territories reported a total of 162,721 emergency department occasions of service with a mental health-related principal diagnosis in 2007–08 (Table 3.1). However, taking into account state and territory estimates of the coverage of their emergency department data collections and the proportion (69%) of all occasions of service with a principal diagnosis reported, it is estimated that there were about 258,500 mental health-related emergency department occasions of service in public hospitals in 2007–08 (Appendix Table A1.3). This represents an increase of 4.1% on the estimated number of mental health-related emergency department occasions of service reported in 2006–07 (248,500).

Emergency department occasions of service reported throughout this chapter are lower for 2007–08 than those reported in 2006–07. This is the result of a more limited coverage for 2007–08 due to the implementation of a new emergency department information system in New South Wales that led to lower numbers of mental health-related occasions of service being reported than in previous years. Data reported throughout this chapter for New South Wales and 2007–08 overall should be treated with caution. Further information on estimated and reported emergency department occasions of service is available in Appendix 1.

Patient demographics

Table 3.1 shows the demographic characteristics reported for mental health-related emergency department occasions of service in 2007–08. For comparative purposes, the characteristics reported for all emergency department occasions of service in that year (as sourced from the NNAPEDCD) are also provided.

Mental health-related emergency department occasions of service differ markedly in their age distribution when compared with all emergency occasions of service, featuring a higher

percentage in the 15–54 year age bracket (79.6% and 50.9%, respectively) and a much lower percentage of those aged less than 15 years (3.2% and 23.2%, respectively).

In 2007–08, males and females showed roughly equivalent proportions of mental health-related emergency department occasions of service (50.2% compared with 49.8%), while males exhibited a slightly higher proportion in the distribution for all emergency department occasions of service (51.9% male).

Table 3.1: Mental health-related emergency department occasions of service[(a)] in public hospitals, by patient demographic characteristics, 2007–08

Patient demographics	Number of occasions of service[(b)(c)]	Per cent of total mental health-related occasions of service[(d)]	Per cent of all emergency department occasions of service reported in the NNAPEDCD[(d)(e)]
Age group			
Less than 15 years	5,143	3.2	23.2
15–24 years	35,963	22.1	15.4
25–34 years	36,545	22.5	13.8
35–44 years	34,090	21.0	11.9
45–54 years	22,707	14.0	9.8
55–64 years	12,164	7.5	8.2
65–74 years	6,159	3.8	6.8
75 years and over	9,947	6.1	10.9
Sex			
Male	81,663	50.2	51.9
Female	81,050	49.8	48.1
Indigenous status			
Indigenous Australians	9,045	5.6	4.4
Other Australians[(f)]	153,676	94.4	95.6
Total	**162,721**	**100.0**	**100.0**

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the *Mental and behavioural disorders* chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

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

(c) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(d) The percentages shown do not include occasions of service for which the demographic information was missing and/or not reported.

(e) Occasions of service with episode-level data reported by state and territory health authorities to the NNAPEDCD 2007–08.

(f) Includes separations where Indigenous status was missing and/or not reported (see AIHW 2010b).

Source: Data provided by state and territory health authorities.

Aboriginal and Torres Strait Islander people represent 2.5% of the Australian population. However, they accounted for 5.6% of the mental health-related emergency department occasions of service, and 4.4% of all emergency department occasions of service. The majority of the data on emergency department occasions of service relate to emergency departments in hospitals within *Major cities* (see Appendix Table A1.3). Consequently, the coverage may not include areas where the proportion of Indigenous Australians (compared with other Australians) may be higher than average. Therefore, these data may not be indicative of the rate of use of emergency department services by Indigenous Australians on

a national level. In addition, when reporting data to the NNAPEDCD, most states and territories cautioned that information on Indigenous status collected in emergency departments could be less accurate than the corresponding information collected on admitted patients. Furthermore, the data are also of variable quality across jurisdictions (AIHW 2009a).

Principal diagnosis

States and territories provided data on mental health-related occasions of service by principal diagnosis, based on the broad categories within the Mental and behavioural disorders chapter (Chapter 5) in the ICD-10-AM (Table 3.2). Those jurisdictions which recorded diagnoses using ICD-9-CM codes were asked to map their data according to the specifications provided in Appendix Table A1.2.

In 2007–08, four diagnosis categories accounted for the majority (85.2%) of mental health-related occasions of service (Table 3.2). These were *Neurotic, stress-related and somatoform disorders* (F40–F48; 27.7%), *Mental and behavioural disorders due to psychoactive substance use* (F10–F19; 24.3%), *Mood (affective) disorders* (F30–F39; 17.9%) and *Schizophrenia, schizotypal and delusional disorders* (F20–F29; 15.3%). The 2007–08 proportion that these diagnosis categories accounted for (85.2%) is very similar to the 2006–07 and 2005–06 proportions, with the top four diagnoses accounting for 85.9% and 86.0% of mental health-related occasions of service in these previous reporting periods, respectively.

The extent to which these four diagnosis categories contributed to the mental health-related emergency department occasions of service varied across states and territories (Table 3.2). However, these variations should be interpreted carefully, as they may reflect the lack of national standards for the coding and collection of principal diagnosis information in emergency departments. In addition, differences in the data scope and coverage—for example, in some jurisdictions only occasions of service from emergency departments in metropolitan hospitals are included—may contribute to variations in principal diagnosis across states and territories.

Table 3.2: Mental health-related emergency department occasions of service[a] in public hospitals, by principal diagnosis, states and territories, 2007–08

Principal diagnosis (ICD-10-AM)	NSW[b][c]	Vic	Qld	WA[d]	SA[b]	Tas	ACT	NT	Total	Per cent
F00–F09: Organic, including symptomatic, mental disorders	1,953	1,478	1,651	1,235	823	275	122	94	7,631	4.7
F10–F19: Mental and behavioural disorders due to psychoactive substance use	12,775	9,367	8,183	3,066	3,602	843	542	1,166	39,544	24.3
F20–F29: Schizophrenia, schizotypal and delusional disorders	9,373	5,217	4,852	1,379	2,196	772	528	521	24,838	15.3
F30–F39: Mood (affective) disorders	9,550	6,832	7,155	1,899	1,652	1,128	659	265	29,140	17.9
F40–F48: Neurotic, stress-related and somatoform disorders	17,537	9,185	6,853	4,943	4,460	787	529	715	45,009	27.7
F50–F59: Behavioural syndromes associated with physiological disturbances and physical factors	184	172	3,104	99	118	37	15	19	3,748	2.3
F60–F69: Disorders of adult personality and behaviour	762	1,042	1,975	336	491	155	62	54	4,877	3.0
F70–F79: Mental retardation	10	16	133	1	7	0	2	0	169	0.1
F80–F89: Disorders of psychological development	62	0	139	10	23	4	3	1	242	0.1
F90–F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3,176	701	942	400	410	59	17	56	5,761	3.5
F99: Unspecified mental disorder	619	578	0	87	178	270	30	0	1,762	1.1
Total	**56,001**	**34,588**	**34,987**	**13,455**	**13,960**	**4,330**	**2,509**	**2,891**	**162,721**	**100.0**

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) New South Wales and South Australia used a combination of ICD-9-CM and ICD-10-AM. A mapping of the relevant ICD-9-CM codes to the ICD-10-AM code blocks is provided in Appendix Table A1.2.

(c) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(d) Western Australia data are sourced from a new Emergency Department Data Collection. Consequently, all data are preliminary and caution is advised when interpreting these data.

Source: Data provided by state and territory health authorities.

Triage category

The urgency of a patient's need for medical and nursing care is assessed when a patient is triaged in the emergency department and an appropriate ***triage*** category is assigned to reflect priority for care. For example, patients triaged to the emergency category are assessed as requiring care within 10 minutes. However, care may or may not actually be received within the designated time frames.

In 2007–08, 5.6% of mental health-related occasions of service in emergency departments were considered non-urgent (requiring care within 120 minutes), 35.6% were recorded as semi-urgent (within 60 minutes) and 46.3% as urgent (within 30 minutes). A further 11.5%

were classified as emergency (requiring care within 10 minutes) and 0.9% as resuscitation (immediate care) (Table 3.3). These proportions are similar to 2006–07 data. In addition, mental health-related occasions of service (57.8%) were more likely than all emergency department occasions of service (45.3%) to be assessed as urgent or emergency (AIHW 2009a).

Table 3.3: Mental health-related emergency department occasions of service[(a)] in public hospitals, by triage category, states and territories, 2007–08

Triage category	NSW[(b)]	Vic	Qld	WA[(c)]	SA	Tas	ACT	NT	Total	Per cent
Resuscitation	297	439	401	135	186	16	13	31	1,518	0.9
Emergency	5,047	3,879	5,123	1,785	1,804	543	244	294	18,719	11.5
Urgent	25,978	15,287	17,127	6,099	6,397	2,120	963	1,441	75,412	46.3
Semi-urgent	20,589	13,032	10,649	5,033	4,976	1,562	1,121	948	57,910	35.6
Non-urgent	4,082	1,951	1,687	403	597	89	168	177	9,154	5.6
Total[(d)]	**56,001**	**34,588**	**34,987**	**13,455**	**13,960**	**4,330**	**2,509**	**2,891**	**162,721**	**100.0**

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(c) Western Australia data are sourced from a new Emergency Department Data Collection. Consequently, all data are preliminary and caution is advised when interpreting these data.

(d) The number of occasions of service may not sum to the total due to missing and/or not reported data.

Source: Data provided by state and territory health authorities.

Because of differences over time in the scope and method of analysis, as well as variability in state and territory reporting and collection methods, data depicting change over time should be interpreted with caution. In addition, New South Wales implemented a new emergency department information system which resulted in missing or incomplete diagnosis codes for 15 hospitals and lead to lower numbers of mental health-related occasions of service being reported for 2007–08 compared with previous years. As New South Wales accounts for a large proportion of the total occasions of service data, 2007–08 data in particular should be treated with caution and are likely to be under-reported.

The number of mental health-related emergency department occasions of service increased over the period 2004–05 to 2006–07 (Table 3.4). The non-urgent triage category remained relatively stable, while all other triage categories showed increases over this broader time frame. Resuscitation increased consistently during the period 2004–05 to 2007–08 despite under-reporting for 2007–08 (Table 3.4) but accounted for only 0.9% of mental health-related emergency department occasions of service (Table 3.3). The majority of mental health-related emergency department occasions of service (81.9%) were classified as urgent and semi-urgent (Table 3.3).

Table 3.4: Mental health-related emergency department occasions of service[(a)] in public hospitals, by triage category, states and territories, 2004–05 to 2007–08

	2004–05[(b)]	2005–06[(b)]	2006–07	2007–08[(c)]
Resuscitation	1,247	1,220	1,369	1,518
Emergency	14,296	16,046	19,228	18,719
Urgent	59,524	67,454	80,366	75,412
Semi-urgent	52,300	54,813	65,804	57,910
Non-urgent	11,344	10,008	11,753	9,154
Total[(d)]	**138,729**	**149,566**	**178,595**	**162,721**

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Figures for 2004–05 and 2005–06 have been updated since previous publications of *Mental health services in Australia* due to revised figures from one jurisdiction.

(c) Mental health-related emergency department occasions of service are under-reported by New South Wales in 2007–08 due to the implementation of a new emergency department information system.

(d) The number of occasions of service may not sum to the total due to missing and/or not reported data.

Source: Data provided by state and territory health authorities.

Episode end status

In 2007–08, the episode end status for 59.5% of the mental health-related emergency department occasions of service was recorded as completed, indicating service resolution within the emergency department without admission or referral to another hospital (Table 3.5). Admission to the presenting hospital occurred in 34.1% of mental health-related occasions of service, showing a higher proportion of admissions for mental health-related occasions of service than recorded for all emergency department occasions of service (26.4%) (AIHW 2009a). Referrals to other hospitals for admission occurred in a further 3.6% of mental health-related occasions of service, with another 2.7% ending with the patient leaving the emergency department before episode completion.

Table 3.5: Mental health-related emergency department occasions of service[a] in public hospitals, by episode end status, states and territories, 2007–08

Episode end status	NSW[b]	Vic	Qld	WA[c]	SA	Tas	ACT	NT	Total	Per cent
Admitted to this hospital[d]	22,015	9,219	11,248	4,097	4,881	2,154	751	1,044	55,409	34.1
Non-admitted patient emergency department service episode completed[e]	29,667	23,132	22,110	8,361	8,077	2,067	1,645	1,765	96,824	59.5
Referred to another hospital for admission	2,026	1,364	978	673	736	49	77	7	5,910	3.6
Did not wait to be attended by a health care professional	585	0	3	34	35	10	4	2	673	0.4
Left at own risk[f]	1,668	872	643	286	201	47	32	73	3,822	2.3
Not reported[g]	40	1	5	4	30	3	0	0	83	0.1
Total	**56,001**	**34,588**	**34,987**	**13,455**	**13,960**	**4,330**	**2,509**	**2,891**	**162,721**	**100.0**

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(c) Western Australia data are sourced from a new Emergency Department Data Collection. Consequently, all data are preliminary and caution is advised when interpreting these data.

(d) Includes admissions to beds or units within the emergency department.

(e) Patient departed without being admitted or referred to another hospital.

(f) Patient left at own risk after being attended by a health care professional but before the non-admitted patient emergency department occasion of service was completed.

(g) Included in this category are 5 occasions of service with an episode end status of *Died in emergency department as a non-admitted patient* and 2 occasions of service with an episode end status of *Dead on arrival, not treated in emergency department*.

Source: Data provided by state and territory health authorities.

The number of patients who left at own risk after being attended by a health care professional (but before service completion) over the period 2004–05 to 2007–08 increased, despite under-reporting for 2007–08 (Table 3.6), but represented a minority of the proportion of mental health-related occasions of service (2.3%) (Table 3.5). Hospital admissions and completed service episodes, accounting for the majority of the occasions of service (93.6% in total) (Table 3.5), increased over the 5 year period, while referrals to other hospitals showed an increasing trend up to 2006–07.

Table 3.6: Mental health-related emergency department occasions of service[(a)] in public hospitals, by episode end status, states and territories, 2004–05 to 2007–08

	2004–05[(b)]	2005–06[(b)]	2006–07	2007–08[(c)]
Admitted to this hospital[(d)]	37,960	43,459	51,809	55,409
Non-admitted patient emergency department service episode completed[(e)]	84,884	94,528	113,516	96,824
Referred to another hospital for admission	6,718	7,603	8,041	5,910
Did not wait to be attended by a health care professional	1,270	790	1,198	673
Left at own risk[(f)]	2,619	2,909	3,805	3,822
Not reported[(g)]	5,278	277	226	83
Total	**138,729**	**149,566**	**178,595**	**162,721**

. . Not available.

(a) Includes emergency department occasions of service that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM codes.

(b) Figures for 2004–05 and 2005–06 have been updated since previous publications of *Mental health services in Australia* due to revised figures from one jurisdiction.

(c) Mental health-related emergency department occasions of service are under-reported by New South Wales in 2007–08 due to the implementation of a new emergency department information system.

(d) Includes admissions to beds or units within the emergency department.

(e) Patient departed without being admitted or referred to another hospital.

(f) Patient left at own risk after being attended by a health care professional but before the non-admitted patient emergency department occasion of service was completed.

(g) Included in this category are occasions of service with an episode end status of *Died in emergency department as a non-admitted patient* and occasions of service with an episode end status of *Dead on arrival, not treated in emergency department*.

Source: Data provided by state and territory health authorities.

4 Community mental health care and hospital outpatient services

4.1 Introduction

This chapter presents information on mental health care provided by community mental health care services and hospital outpatient services. The data are derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on government-operated specialised mental health services provided to non-admitted patients in community-based and hospital-based ambulatory care settings. These types of services are generally referred to as ***community mental health care*** (see Key concepts). The statistical unit for the NCMHCD is a ***service contact*** between a client and a specialised mental health care service provider. Appendix 1 provides information about the coverage and data quality of this collection. Included is a description of National Healthcare Agreement performance indicator 28 – *Public sector community mental health services.*

Key concepts

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

Service contacts are defined as the provision of a clinically significant service by a specialised mental health service provider for patient/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the relevant period (that is, 2007–08). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, and/or other professional or mental health worker, or other service provider.

4.2 States and territories

In 2007–08, there were 6,374,267 community mental health care service contacts reported nationally, for an estimated 327,873 patients. New South Wales reported the highest number of both service contacts (2,072,440) and patients (108,755) (Table 4.1). However, the Australian Capital Territory had the highest number of service contacts per 1,000 population (597.5). Victoria and the Australian Capital Territory had the highest number of service contacts per patient (just over 30) compared with a national average of 19.4 contacts per patient. These data should be interpreted in the light of the coverage information on page 43.

Table 4.1: Community mental health care service contacts, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service contacts	2,072,440	1,736,456	1,162,557	554,558	456,942	147,701	207,467	36,146	6,374,267
Patients[(a)]	108,755	57,197	75,541	37,566	27,793	9,499	6,801	4,721	327,873
Average service contacts per patient	19.1	30.4	15.4	14.8	16.4	15.5	30.5	7.7	19.4
				Rate[(b)] (per 1,000 population)					
Service contacts	302.2	328.5	276.9	259.3	294.5	299.6	597.5	158.8	302.1
Patients	15.8	10.8	18.0	17.6	18.0	19.6	19.5	21.2	15.5

(a) In previous publications of *Mental health services in Australia*, the provision of a patient count was optional and an AIHW estimate was derived for non-reporting state and territory jurisdictions. This year all jurisdictions provided a patient count, however, they differ in their capacity to provide accurate estimates of patients receiving services and differ in their approaches to counting clients under care. Therefore, comparisons between jurisdictions should be made with caution.

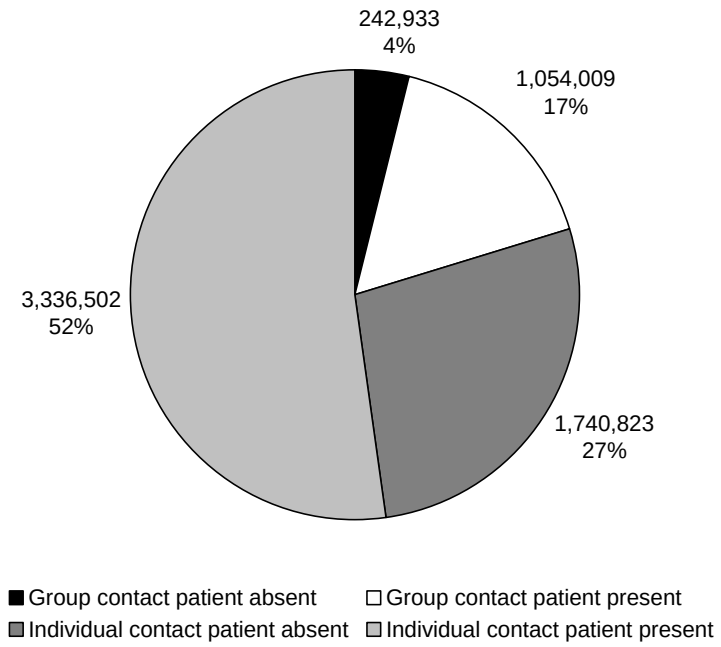
(b) Rates were directly age-standardised as detailed in Appendix 2.

Sources: National Community Mental Health Care Database, state and territory community mental health care data.

4.3 Type of service contacts

Community mental health care service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. These contacts can be conducted in the presence or the absence of the patient. Figure 4.1 shows the number of service contacts by contact type and patient presence status.

The majority (79%) of contacts reported were individual contacts. Of these, 66% were conducted in the presence of the patients. The pattern is similar for group contacts, where there were more group contacts conducted with the patient being present (81%) than those without (19%).

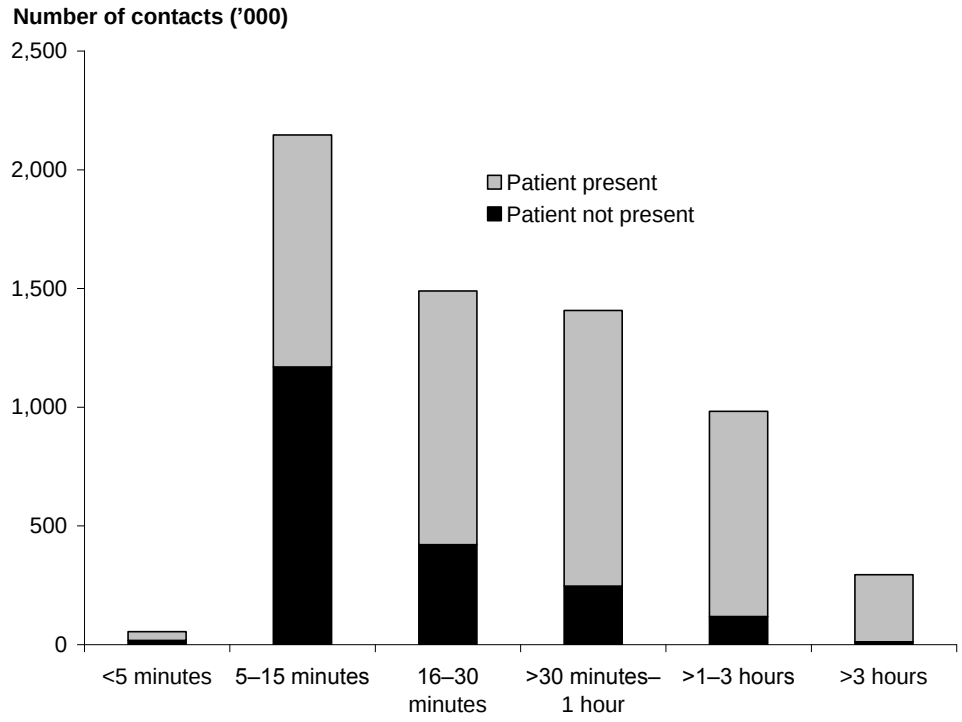


Source: National Community Mental Health Care Database.

Figure 4.1: Community mental health care service contacts, by contact type and patient presence status, 2007–08

4.4 Duration of service contacts

The duration of service contacts ranged from less than 5 minutes to more than 3 hours (Figure 4.2). The most common duration of service contact was 5–15 minutes, with 34% of contacts in this category.



Source: National Community Mental Health Care Database.

Figure 4.2: Duration of community mental health care service contacts, 2007–08

4.5 Mental health legal status

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

In the NCMHCD, the voluntary or involuntary nature of each service contact is recorded as the mental health legal status. Table 4.2 presents the number of service contacts by jurisdiction and by mental health legal status. Nationally, 16% of all service contacts were classified as involuntary. Western Australia reported the lowest proportion of involuntary contacts (2.6%), while the Australian Capital Territory reported the highest proportion (34.7%). These jurisdictional differences may be a reflection of the different legislative arrangements in place in the jurisdictions.

Table 4.2: Community mental health care service contacts, by mental health legal status, states and territories, 2007–08

Mental health legal status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Involuntary	289,382	461,606	104,200	14,430	70,791	6,831	71,922	1,632	1,020,794
Voluntary	1,783,058	1,274,850	1,058,357	540,128	356,275	139,403	135,545	34,514	5,322,130
Not reported	0	0	0	0	29,876	1,467	0	0	31,343
Total	**2,072,440**	**1,736,456**	**1,162,557**	**554,558**	**456,942**	**147,701**	**207,467**	**36,146**	**6,374,267**

Source: National Community Mental Health Care Database.

4.6 Patient demographics

Table 4.3 presents information on the number of service contacts in 2007–08 for various demographic groups. A rate (per 1,000 population) has also been provided to account for differences in the relative size and age structure of the respective populations. As these are reports of service contacts (rather than people), the rates cannot be interpreted as the number of people with specific characteristics per 1,000 population who received this type of mental health care. Rather, they provide information on the number of service contacts relative to the size of the population subgroup.

The highest number of contacts per 1,000 population was for patients aged 25–34 years (480.9), followed by those aged 35–44 years (427.5). The youngest age group (less than 15 years) was the least represented in both proportion of contacts (7.1%) and contacts per 1,000 population (107.6).

The data on contacts for Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians should be interpreted with caution due to uncertainty about the quality of Indigenous identification in the data. Table 4.3 presents national data on Indigenous status, but note that only data from Queensland, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory were reported by the states and territories to be of acceptable quality (see Appendix 1 for more information). As a consequence, it is likely that the number of contacts for Indigenous Australians is underestimated. Although there were fewer contacts reported for Indigenous Australians compared with non-Indigenous Australians, when the size and age structure of the two populations were taken into account, there was a higher number of contacts per 1,000 population for Indigenous Australians than for non-Indigenous Australians (736.8 and 272.2, respectively).

While the majority of service contacts were reported for patients residing in *Major cities*, when taking population numbers into account there was a higher rate of contacts per 1,000 population for patients in *Inner regional* areas (343.9).

More than half of the service contacts were reported by patients who were never married (61.6%) while those who were widowed were least represented (3.7%).

The data show that the typical service contact involves a patient who is an Australian-born non-Indigenous male aged 25–44 years who has never been married and lives in a major city.

Table 4.3: Community mental health care service contacts, by patient demographic characteristics, 2007–08

Patient demographics	Number of service contacts[a]	Per cent of service contacts[b]	Rate[c] (per 1,000 population)
Age group			
Less than 15 years	441,670	7.1	107.6
15–24 years	1,027,961	16.5	345.9
25–34 years	1,420,455	22.8	480.9
35–44 years	1,325,737	21.2	427.5
45–54 years	941,210	15.1	320.7
55–64 years	503,865	8.1	212.3
65 years and over	580,857	9.3	207.6
Sex			
Male	3,407,402	54.5	325.6
Female	2,841,436	45.5	266.0
Indigenous status[d]			
Indigenous Australians	362,429	6.1	736.8
Non-Indigenous Australians	5,577,420	93.9	272.2
Country of birth			
Australia	5,140,413	84.5	337.1
Overseas	943,188	15.5	156.5
Remoteness area of usual residence			
Major cities	4,164,097	67.9	285.7
Inner regional	1,340,584	21.9	343.9
Outer regional	520,190	8.5	273.6
Remote	72,893	1.2	233.4
Very remote	35,317	0.6	209.9
Marital status			
Never married	3,588,462	61.6	. .
Widowed	217,597	3.7	. .
Divorced	533,674	9.2	. .
Separated	358,069	6.1	. .
Married	1,129,209	19.4	. .
Total	**6,374,267**	**100.0**	**302.1**

. . Not applicable.

(a) The number of service contacts for each demographic variable may not sum to the total due to missing and/or not reported data.

(b) The percentages shown do not include service contacts for which the demographic information, including Indigenous status, was missing and/or not reported.

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

(d) These data should be interpreted with caution due to the varying quality of Indigenous identification across jurisdictions (see Appendix 1).

Source: National Community Mental Health Care Database.

4.7 Principal diagnosis

'Principal diagnosis' refers to the diagnosis established after study to be chiefly responsible for the service contact. Table 4.4 presents the number of service contacts for principal diagnosis groups for 2007–08. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3. Note that these data should be interpreted with caution due to variability in the data collection and coding practices for principal diagnosis across Australia (for more information, see Appendix 1).

In 2007–08, a principal diagnosis was specified for 91% (5,803,253) of community mental health care service contacts. The most common principal diagnosis reported was *Schizophrenia* (F20), reported for 31.5% of all contacts where a principal diagnosis was recorded. This was followed by *Depressive episode* (F32; 12.0%) and *Bipolar affective disorder* (F31; 6.5%).

Figure 4.3 shows the characteristics of community mental health care service contacts for the five most commonly reported principal diagnoses classified as mental and behavioural disorders. The proportion of contacts with duration lasting more than 1 hour was highest for *Depressive episode* (F32; 34%), for which the lowest proportion of contacts lasting 15 minutes or less was also recorded (26%). The diagnosis of *Depressive episode* also had the highest rate of group contacts (34%) and the lowest proportion of service contacts in the absence of the patient (24%).

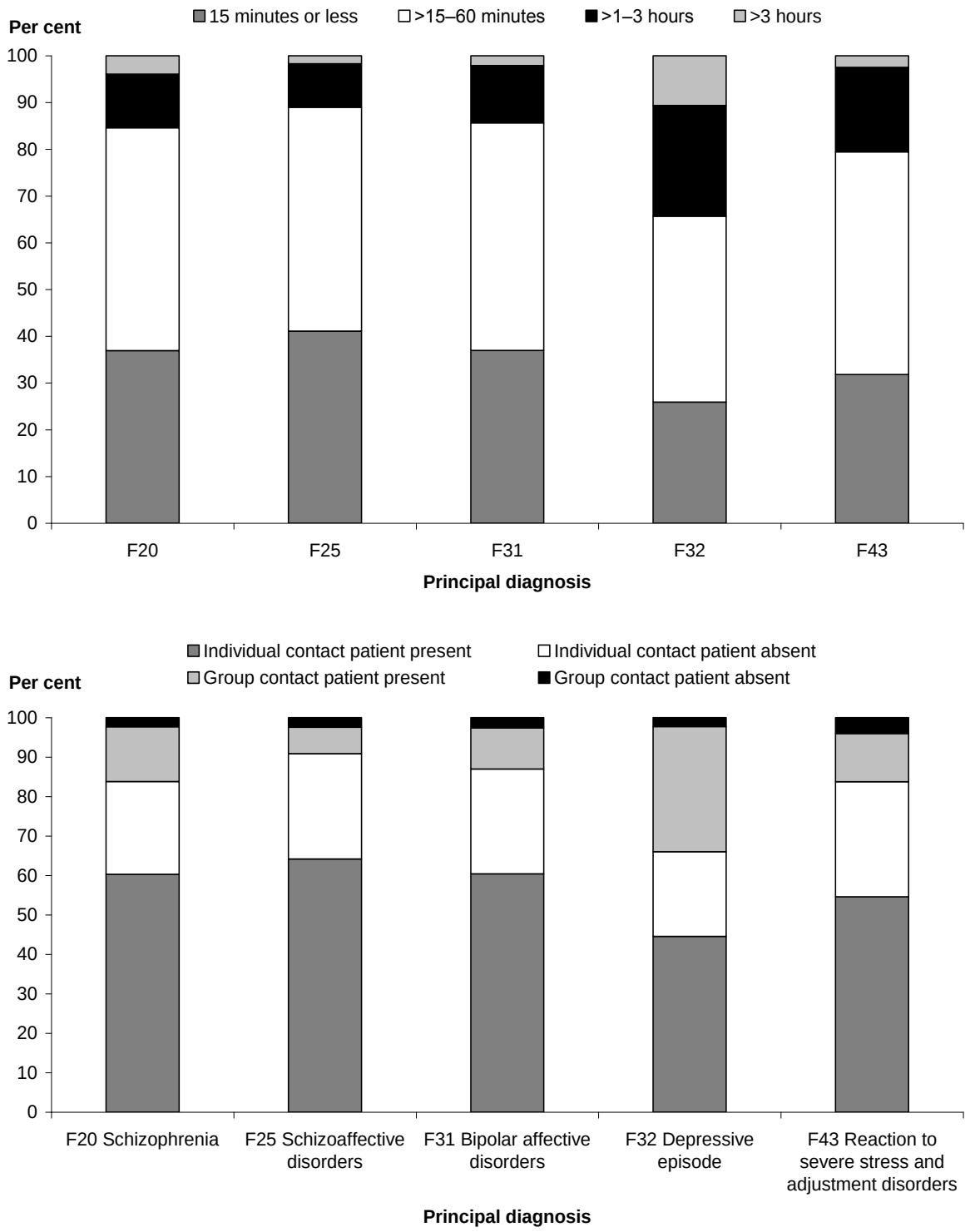
Table 4.4: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, 2007–08

Principal diagnosis		Number of service contacts	Per cent of specified principal diagnoses
F00–F03	Dementia	83,241	1.4
F04–F09	Other organic mental disorders	33,253	0.6
F10	Mental and behavioural disorders due to use of alcohol	53,824	0.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	117,379	2.0
F20	Schizophrenia	1,825,518	31.5
F21, F24, F28, F29	Schizotypal and other delusional disorders	83,219	1.4
F22	Persistent delusional disorders	43,620	0.8
F23	Acute and transient psychotic disorders	81,717	1.4
F25	Schizoaffective disorders	333,536	5.7
F30	Manic episode	20,747	0.4
F31	Bipolar affective disorders	376,320	6.5
F32	Depressive episode	695,385	12.0
F33	Recurrent depressive disorders	98,233	1.7
F34	Persistent mood (affective) disorders	43,598	0.8
F38, F39	Other and unspecified mood (affective) disorders	7,727	0.1
F40	Phobic anxiety disorders	27,219	0.5
F41	Other anxiety disorders	164,432	2.8
F42	Obsessive-compulsive disorders	37,026	0.6
F43	Reaction to severe stress and adjustment disorders	249,245	4.3
F44	Dissociative (conversion) disorders	5,769	0.1
F45, F48	Somatoform and other neurotic disorders	6,411	0.1
F50	Eating disorders	55,403	1.0
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	7,670	0.1
F60	Specific personality disorders	201,788	3.5
F61–F69	Disorders of adult personality and behaviour	25,160	0.4
F70–F79	Mental retardation	21,488	0.4
F80–F89	Disorders of psychological development	41,865	0.7
F90	Hyperkinetic disorders	27,911	0.5
F91	Conduct disorders	40,812	0.7
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	80,305	1.4
	Other[(a)]	913,432	15.7
Subtotal with specified principal diagnosis		*5,803,253*	*100.0*
F99	Mental disorder, not otherwise specified	218,465	. .
	Not reported	352,549	. .
Subtotal with unspecified principal diagnosis		*571,014*	. .
Total		**6,374,267**	**. .**

. . Not applicable.

(a) Includes all reported diagnoses that are not in the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99).

Source: National Community Mental Health Care Database.



Source: National Community Mental Health Care Database.

Figure 4.3: Community mental health care service contacts for the five most commonly reported principal diagnoses, by duration, contact type and patient presence status, 2007–08

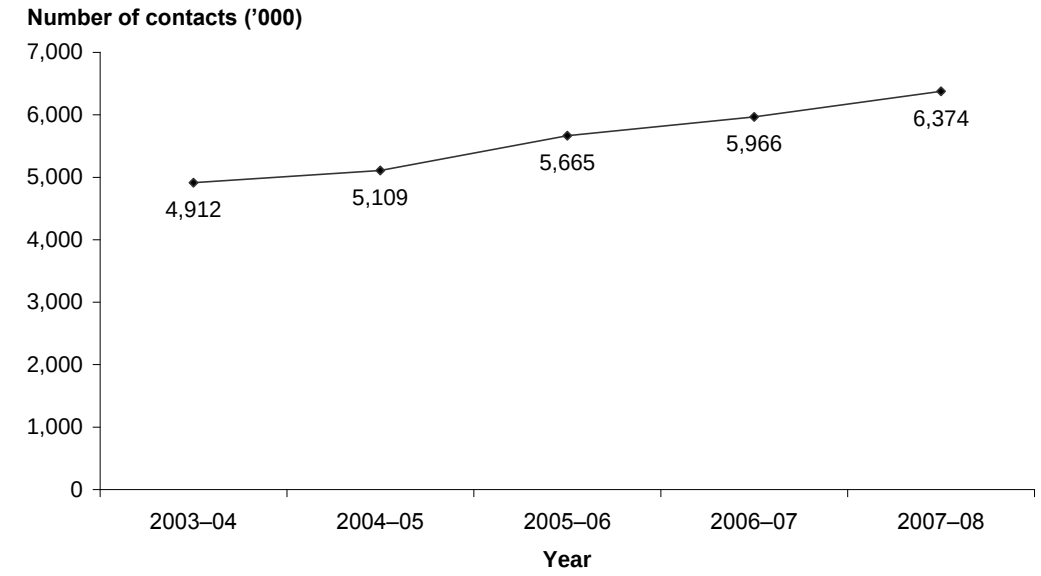
4.8 Change over time, 2003–04 to 2007–08

The number of service contacts reported to the NCMHCD increased over the 5 years to 2007–08 (Figure 4.4). In 2007–08, there was a 6.8% increase in the number of contacts reported compared with 2006–07. Note that these increases may reflect increases in the actual number of community mental health care services and improvements in data coverage. Not all jurisdictions were able to provide estimates of data coverage for the 2007–08 data. Consequently, it is not possible to determine conclusively what contribution the expanded data coverage (outlined below) may have made to the observed increase in the total number of service contacts being reported. State and territory estimates of coverage for 2007–08 are listed below:

- New South Wales estimated that their coverage for 2007–08 was similar to 2006–07, which was around 70% of full coverage.
- Victoria estimated that 100% of in-scope services reported service contact data for 2007–08, as was the case for 2006–07.
- Queensland estimated that 100% of in-scope services reported service contact data for 2007–08, the same as for 2006–07.
- Western Australia did not provide an estimate of data coverage for 2007–08.
- South Australia estimated their 2007–08 coverage to be about 95%, with the figure derived by comparing time series aggregations for all service units, in combination with comparisons with service units from 2006–07. In 2006–07, the estimated coverage was 70%.
- Tasmania reported their coverage to be 100% for 2007–08, which means that all in-scope services provided contact data. Coverage for 2006–07 was estimated to be 88%.
- The Australian Capital Territory reported their coverage to be 100%. In 2006–07 the estimated coverage was 99.7%.
- The Northern Territory estimated that coverage for 2007–08 could be between 75% and 85%. In 2006–07, it was reported that all service units had the capacity to directly record service contact data. However, there might have been undercounting of service contacts for some providers.

4.9 Public sector community mental health services

Under the 2009 National Healthcare Agreement, the number of public sector community mental health services (indicator 28) is a primary and community health outcome indicator (CRC 2010). For this indicator the numerator is the number of community mental health service contacts provided by public sector community mental health services. The denominator is the estimated resident population. The indicator is calculated both nationally and by state/territory and disaggregated by sex, 10 year age group, Indigenous status, residential remoteness and socioeconomic status as detailed in Appendix 5.



Source: National Community Mental Health Care Database.

Figure 4.4: Community mental health care service contacts, 2003–04 to 2007–08

4.10 Additional data

Additional tables containing data on community mental health care service contacts are available from the Australian Institute of Health and Welfare website (see Section 1.5 for details).

5 Ambulatory-equivalent mental health-related admitted patient care

5.1 Introduction

In addition to ambulatory (or non-admitted) care provided by community mental health care services and hospital-based ambulatory care services (as presented in the previous chapter), mental health care that could be considered to be equivalent to ambulatory care can be provided to patients admitted to hospital. In this chapter, information is presented on this form of care—that is, on ***mental health-related*** hospital ***separations*** that could be considered to be ***ambulatory-equivalent*** admitted patient care (see Key concepts).

The data presented in this chapter are from the National Hospital Morbidity Database. More detailed information on this database is given in Appendix 1.

Key concepts

A ***separation*** is defined as the process by which an episode of care for an admitted patient in hospital ceases. For more information, see Chapter 7.

A separation is classified as ***ambulatory-equivalent*** for this report if each of the following applies:

- the separation was a same-day separation (that is, admission and separation occurred on the same day)
- no procedure or other intervention was recorded, or any procedure recorded was identified as probably able to be provided in ambulatory mental health care (see Appendix 4 for a list of procedures identified in this way)
- the mode of admission did not include a care type change or transfer, and the mode of separation did not include a transfer (to another facility), a care type change, the patient leaving against medical advice or death.

A separation is classified as ***mental health-related*** if:

- it had a mental health-related principal diagnosis which, for admitted patient care in this report, is defined as a principal diagnosis that is either a diagnosis that falls within the chapter on Mental and behavioural disorders (Chapter 5) in the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM) classification (codes F00–F99) or a number of other selected diagnoses (see Appendix 4 for the full list of applicable diagnoses), or
- it included any specialised psychiatric care.

A separation is classified as having ***specialised psychiatric care*** if the patient was reported as having spent 1 or more days in a specialised psychiatric unit or ward.

5.2 States and territories and hospital type

In 2007–08, 7,873,945 separations were reported from public and private acute and psychiatric hospitals (AIHW 2009a). Of these, 4.2% (334,541) were mental health-related, comprising ambulatory-equivalent and other admitted patient separations. The other admitted patient separations are presented in Chapter 7.

There were 121,651 ambulatory-equivalent mental health-related separations reported in 2007–08, accounting for 1.5% of all separations and 36.4% of all mental health-related separations. Table 5.1 shows the number of separations for each state and territory by hospital type. The number of separations per 1,000 population is provided to account for differences in population size between jurisdictions.

Table 5.1: Ambulatory-equivalent mental health-related separations[(a)] with and without specialised psychiatric care, by hospital type, states and territories, 2007–08

Hospital type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					With specialised psychiatric care				
Public acute hospitals	2,436	247	985	100	76	93	17	28	3,982
Public psychiatric hospitals	1,118	0	2	15	7	3	. .	. .	1,145
Private hospitals	21,268	31,517	20,673	6,665	4	n.p.	n.p.	n.p.	83,221
Subtotal	*24,822*	*31,764*	*21,660*	*6,780*	*87*	*n.p.*	*n.p.*	*n.p.*	*88,348*
					Without specialised psychiatric care				
Public acute hospitals	6,893	5,470	2,504	1,491	1,361	369	151	228	18,467
Public psychiatric hospitals	60	0	0	0	0	0	. .	. .	60
Private hospitals	5,865	3,038	3,587	1,005	12	n.p.	n.p.	n.p.	14,776
Subtotal	*12,818*	*8,508*	*6,091*	*2,496*	*1,373*	*n.p.*	*n.p.*	*n.p.*	*33,303*
					All hospitals				
Public acute hospitals	9,329	5,717	3,489	1,591	1,437	462	168	256	22,449
Public psychiatric hospitals	1,178	0	2	15	7	3	. .	. .	1,205
Private hospitals	27,133	34,555	24,260	7,670	16	n.p.	n.p.	n.p.	97,997
Total	**37,640**	**40,272**	**27,751**	**9,276**	**1,460**	**n.p.**	**n.p.**	**n.p.**	**121,651**
					Rate[(b)] (per 1,000 population)				
Public acute hospitals	1.3	1.1	0.8	0.7	0.9	1.0	0.5	1.1	1.1
Public psychiatric hospitals	0.2	0.0.	—	—	—	—	. .	. .	0.1
Private hospitals	3.8	6.4	5.5	3.5	—	n.p.	n.p.	n.p.	4.5
All hospitals	**5.3**	**7.5**	**6.3**	**4.3**	**1.0**	**n.p.**	**n.p.**	**n.p.**	**5.6**

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

— Rounded to zero.

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

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

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

Source: National Hospital Morbidity Database.

The data show that private hospitals were the predominant providers (80.6%, 97,997 out of 121,651) of ambulatory-equivalent mental health-related admitted patient care. The number

of separations reported by public psychiatric hospitals constituted 1.0% (1,205 out of 121,651), with New South Wales being the major provider (97.8%).

Specialised psychiatric care was provided in 72.6% of all separations (88,348 out of 121,651), primarily by private hospitals (94.2%). This was particularly the case in Victoria, where private hospital separations constituted 99.2% of all separations (31,517 out of 31,764).

Public acute hospitals played a greater role in separations without specialised psychiatric care (55.5%, 18,467 out of 33,303).

Victoria reported the highest number of separations per 1,000 population (7.5) while South Australia had the lowest (1.0). The South Australian private hospital sector had a low rate of separations (less than 1) while the rate of separations for the private hospital sector was highest in Victoria (6.4).

5.3 Mental health legal status

Table 5.2 shows the number of ambulatory-equivalent mental health-related separations with specialised psychiatric care by hospital type and the patient's mental health legal status (the concept of legal status is discussed in Chapter 4). The mental health legal status of more than one-third of the separations was not reported, and the majority of these separations were from private hospitals. Among the separations for which mental health legal status was reported, 1.2% were involuntary and 84.5% of those (554 out of 656) were public acute hospital separations.

Table 5.2: Ambulatory-equivalent mental health-related separations[(a)] with specialised psychiatric care, by mental health legal status and hospital type, 2007–08

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	554	68	34	656
Voluntary	3,380	1,077	51,440	55,897
Not reported	48	0	31,747	31,795
Total	**3,982**	**1,145**	**83,221**	**88,348**

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

5.4 Patient demographics

Table 5.3 presents information on the demographic distribution of ambulatory-equivalent mental health-related separations in 2007–08. As the data report on the number of separations rather than the number of patients, it is not possible to determine how many separations an individual patient had.

The highest numbers of ambulatory-equivalent mental health-related separations were for patients aged between 35–54 years. However, the highest rate of separations (9.3 per 1,000 population) was for patients aged 55–64 years.

Table 5.3: Ambulatory-equivalent mental health-related separations[a], by patient demographic characteristics, 2007–08

Patient demographics	Number of separations[b]	Per cent of separations[c]	Rate[d] (per 1,000 population)
Age group			
Less than 15 years	5,375	4.4	1.3
15–24 years	14,629	12.0	4.9
25–34 years	17,683	14.5	6.0
35–44 years	23,416	19.2	7.6
45–54 years	23,265	19.1	7.9
55–64 years	22,118	18.2	9.3
65 years and over	15,165	12.5	5.4
Sex			
Male	48,753	40.1	4.5
Female	72,898	59.9	6.7
Indigenous status[e]			
Indigenous Australians	1,612	1.4	3.6
Other Australians[f]	115,043	98.6	5.6
Country of birth			
Australia	98,009	84.0	6.5
Overseas	18,644	16.0	2.9
Remoteness area of usual residence			
Major cities	103,060	85.4	7.0
Inner regional	12,961	10.7	3.1
Outer regional	3,810	3.2	1.9
Remote	521	0.4	1.7
Very remote	269	0.2	1.6
Marital status[g]			
Never married	35,571	37.4	. .
Widowed	6,856	7.2	. .
Divorced	7,232	7.6	. .
Separated	4,268	4.5	. .
Married	41,201	43.3	. .
Total	**121,651**	**100.0**	**5.6**

. . Not applicable.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

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

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

(e) Only Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions for which the data are considered to be of sufficient quality for analysis. However, caution should be used in the interpretation of these data due to jurisdictional data quality differences. The data does not necessarily represent the national trend (see AIHW 2010b).

(f) Includes separations where Indigenous status was missing and/or not reported (see AIHW 2010b).

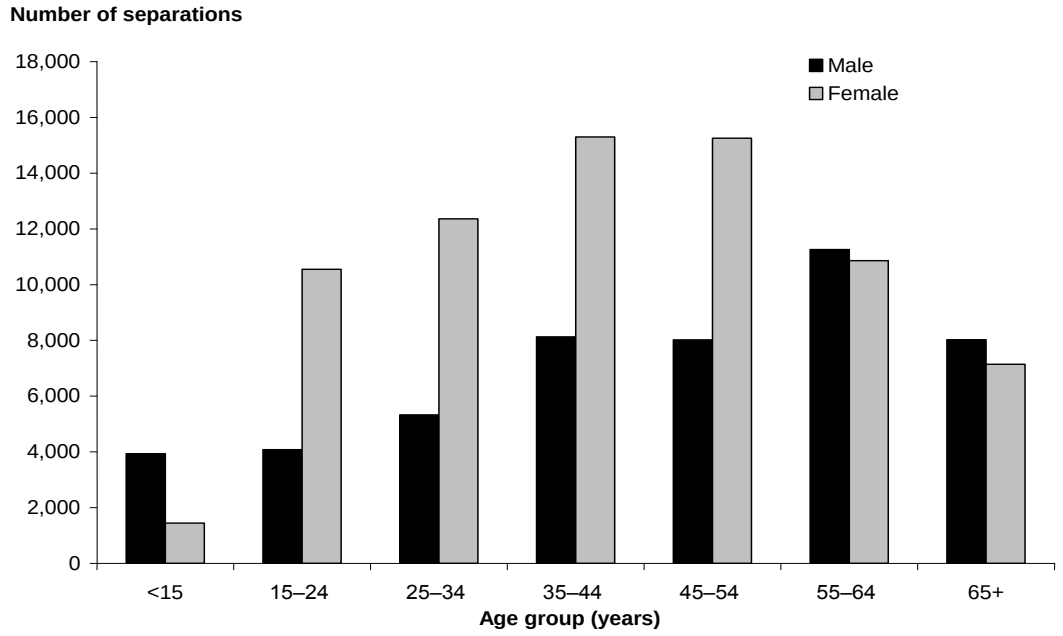
(g) Information on this data element was missing and/or not reported for more than 20% of separations.

Source: National Hospital Morbidity Database.

The separation rate for females (6.7 per 1,000 population) was nearly 50% higher than that of males (4.5). The rate of separations of Australian-born patients (6.5) was more than twice that of those born overseas (2.9).

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

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



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

Source: National Hospital Morbidity Database.

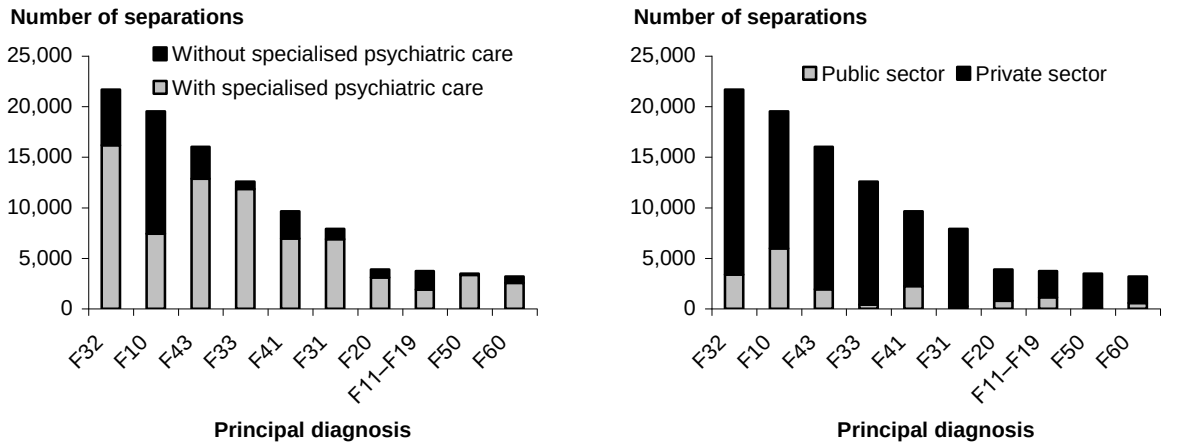
Figure 5.1: Ambulatory-equivalent mental health-related separations, by age and sex, 2007–08

5.5 Principal diagnosis

Principal diagnosis refers to the diagnosis established after study to be chiefly responsible for the patient's episode of admitted patient care. Tables 5.4, 5.5 and 5.6 show the distribution of ambulatory-equivalent mental health-related separations by principal diagnosis, broken down by hospital type and whether they involved specialised psychiatric care. Diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM). Further information on this classification is included in Appendix 3.

In 2007–08, the principal diagnosis of *Depressive episode* (F32) accounted for the largest number of separations (21,688 or 17.8%) across all hospitals and all separations with and without specialised psychiatric care (Table 5.6). However, for separations that did not

involve specialised care, *Mental and behavioural disorders due to use of alcohol* (F10) was the leading principal diagnosis (Table 5.5).



Key to the principal diagnosis codes:

F32	Depressive episode
F10	Mental and behavioural disorders due to use of alcohol
F43	Reaction to severe stress and adjustment disorders
F33	Recurrent depressive disorders
F41	Other anxiety disorders
F31	Bipolar affective disorders
F20	Schizophrenia
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F50	Eating disorders
F60	Specific personality disorders

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

Source: National Hospital Morbidity Database.

Figure 5.2: Ambulatory-equivalent mental health-related separations for the 10 most commonly reported principal diagnoses, by specialised care and sector, 2007–08

The majority of separations reported by public psychiatric hospitals involved the diagnoses of *Behavioural and emotional disorders with onset usually occurring in childhood and adolescence* (F90–F98) and *Disorders of psychological development* (F80–F89).

Figure 5.2 shows the 10 most commonly reported principal diagnoses by specialised care and sector. *Eating disorders* (F50) was the top 10 principal diagnosis with the highest proportion of separations with specialised psychiatric care (96.7%). *Mental and behavioural disorders due to use of alcohol* (F10) and *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) were the only commonly reported principal diagnoses having a markedly high proportion of separations that did not involve specialised psychiatric care (61.9% and 48.9%, respectively). These were also the two principal diagnoses with high proportions of separations reported by the public sector (more than 30%). The private sector accounted for the majority of separations for all the commonly reported diagnoses.

Table 5.4: Ambulatory-equivalent mental health-related separations[a] with specialised psychiatric care, by principal diagnosis and hospital type, 2007–08

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	2	0	63	65	0.1
F04–F09	Other organic mental disorders	4	1	211	216	0.2
F10	Mental and behavioural disorders due to use of alcohol	172	22	7,236	7,430	8.4
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	67	7	1,835	1,909	2.2
F20	Schizophrenia	175	11	2,905	3,091	3.5
F21, F24, F28, F29	Schizotypal and other delusional disorders	120	1	278	399	0.5
F22	Persistent delusional disorders	15	1	93	109	0.1
F23	Acute and transient psychotic disorders	15	1	184	200	0.2
F25	Schizoaffective disorders	35	1	2,251	2,287	2.6
F30	Manic episode	5	1	38	44	—
F31	Bipolar affective disorders	44	1	6,860	6,905	7.8
F32	Depressive episode	537	3	15,637	16,177	18.3
F33	Recurrent depressive disorders	67	6	11,775	11,848	13.4
F34	Persistent mood (affective) disorders	26	1	1,470	1,497	1.7
F38–F39	Other and unspecified mood (affective) disorders	4	0	163	167	0.2
F40	Phobic anxiety disorders	8	1	329	338	0.4
F41	Other anxiety disorders	273	31	6,662	6,966	7.9
F42	Obsessive-compulsive disorders	6	1	695	702	0.8
F43	Reaction to severe stress and adjustment disorders	412	17	12,437	12,866	14.6
F44	Dissociative (conversion) disorders	2	0	545	547	0.6
F45, F48	Somatoform and other neurotic disorders	1	0	39	40	—
F50	Eating disorders	24	0	3,337	3,361	3.8
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	0	1	242	243	0.3
F60	Specific personality disorders	146	9	2,407	2,562	2.9
F61–F69	Disorders of adult personality and behaviour	7	0	425	432	0.5
F70–F79	Mental retardation	12	1	1	14	—
F80–F89	Disorders of psychological development	119	322	95	536	0.6
F90	Hyperkinetic disorders	181	156	79	416	0.5
F91	Conduct disorders	1,033	413	13	1,459	1.7
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	121	129	16	266	0.3
F99	Mental disorder not otherwise specified	5	0	0	5	—
G30	Alzheimer's disease	1	0	1,401	1,402	1.6
	Other factors related to mental and behavioural disorders and substance use[b]	40	1	41	82	0.1
	Other specified mental health-related principal diagnosis[c]	8	0	0	8	—
	Other[d]	295	6	3,458	3,759	4.3
Total		**3,982**	**1,145**	**83,221**	**88,348**	**100.0**

— Rounded to zero.
(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.
(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.
(d) Includes all other codes not included as a mental health-related principal diagnosis as listed in Appendix 4.
Source: National Hospital Morbidity Database.

Table 5.5: Ambulatory-equivalent mental health-related separations[a] without specialised psychiatric care, by principal diagnosis and hospital type, 2007–08

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	126	0	2	128	0.4
F04–F09	Other organic mental disorders	103	0	4	107	0.3
F10	Mental and behavioural disorders due to use of alcohol	5,747	18	6,323	12,088	36.3
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,056	5	764	1,825	5.5
F20	Schizophrenia	604	3	197	804	2.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	99	0	60	159	0.5
F22	Persistent delusional disorders	73	0	1	74	0.2
F23	Acute and transient psychotic disorders	98	2	20	120	0.4
F25	Schizoaffective disorders	186	1	161	348	1.0
F30	Manic episode	32	0	2	34	0.1
F31	Bipolar affective disorders	206	0	778	984	3.0
F32	Depressive episode	2,845	1	2,665	5,511	16.5
F33	Recurrent depressive disorders	349	3	368	720	2.2
F34	Persistent mood (affective) disorders	203	0	104	307	0.9
F38–F39	Other and unspecified mood (affective) disorders	52	0	62	114	0.3
F40	Phobic anxiety disorders	11	0	5	16	—
F41	Other anxiety disorders	1,943	1	737	2,681	8.1
F42	Obsessive-compulsive disorders	9	0	40	49	0.1
F43	Reaction to severe stress and adjustment disorders	1,472	14	1,674	3,160	9.5
F44	Dissociative (conversion) disorders	131	2	31	164	0.5
F45, F48	Somatoform and other neurotic disorders	133	0	1	134	0.4
F50	Eating disorders	67	0	47	114	0.3
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	50	0	13	63	0.2
F60	Specific personality disorders	396	7	239	642	1.9
F61–F69	Disorders of adult personality and behaviour	18	1	34	53	0.2
F70–F79	Mental retardation	32	0	0	32	0.1
F80–F89	Disorders of psychological development	27	1	0	28	0.1
F90	Hyperkinetic disorders	14	0	0	14	—
F91	Conduct disorders	90	0	0	90	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	53	0	0	53	0.2
F99	Mental disorder not otherwise specified	39	0	0	39	0.1
G30	Alzheimer's disease	29	0	0	29	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	132	1	3	136	0.4
	Other specified mental health-related principal diagnosis[c]	2,042	0	441	2,483	7.5
Total		**18,467**	**60**	**14,776**	**33,303**	**100.0**

— Rounded to zero.
(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.
(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.
Source: National Hospital Morbidity Database.

Table 5.6: Ambulatory-equivalent mental health-related separations[a] with and without specialised psychiatric care, by principal diagnosis and hospital type, 2007–08

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	128	0	65	193	0.2
F04–F09	Other organic mental disorders	107	1	215	323	0.3
F10	Mental and behavioural disorders due to use of alcohol	5,919	40	13,559	19,518	16.0
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,123	12	2,599	3,734	3.1
F20	Schizophrenia	779	14	3,102	3,895	3.2
F21, F24, F28, F29	Schizotypal and other delusional disorders	219	1	338	558	0.5
F22	Persistent delusional disorders	88	1	94	183	0.2
F23	Acute and transient psychotic disorders	113	3	204	320	0.3
F25	Schizoaffective disorders	221	2	2,412	2,635	2.2
F30	Manic episode	37	1	40	78	0.1
F31	Bipolar affective disorders	250	1	7,638	7,889	6.5
F32	Depressive episode	3,382	4	18,302	21,688	17.8
F33	Recurrent depressive disorders	416	9	12,143	12,568	10.3
F34	Persistent mood (affective) disorders	229	1	1,574	1,804	1.5
F38–F39	Other and unspecified mood (affective) disorders	56	0	225	281	0.2
F40	Phobic anxiety disorders	19	1	334	354	0.3
F41	Other anxiety disorders	2,216	32	7,399	9,647	7.9
F42	Obsessive-compulsive disorders	15	1	735	751	0.6
F43	Reaction to severe stress and adjustment disorders	1,884	31	14,111	16,026	13.2
F44	Dissociative (conversion) disorders	133	2	576	711	0.6
F45, F48	Somatoform and other neurotic disorders	134	0	40	174	0.1
F50	Eating disorders	91	0	3,384	3,475	2.9
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	50	1	255	306	0.3
F60	Specific personality disorders	542	16	2,646	3,204	2.6
F61–F69	Disorders of adult personality and behaviour	25	1	459	485	0.4
F70–F79	Mental retardation	44	1	1	46	—
F80–F89	Disorders of psychological development	146	323	95	564	0.5
F90	Hyperkinetic disorders	195	156	79	430	0.4
F91	Conduct disorders	1,123	413	13	1,549	1.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	174	129	16	319	0.3
F99	Mental disorder not otherwise specified	44	0	0	44	—
G30	Alzheimer's disease	30	0	1,401	1,431	1.2
	Other factors related to mental and behavioural disorders and substance use[b]	172	2	44	218	0.2
	Other specified mental health-related principal diagnosis[c]	2,050	0	441	2,491	2.0
	Other[d]	295	6	3,458	3,759	3.1
Total		**22,449**	**1,205**	**97,997**	**121,651**	**100.0**

— Rounded to zero.
(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.
(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.
(d) Includes all other codes not included as a mental health-related principal diagnosis as listed in Appendix 4.
Source: National Hospital Morbidity Database.

5.6 Procedures

Table 5.7 details the number of separations relating to the 10 procedures (or interventions) most frequently reported for ambulatory-equivalent mental health-related hospital separations. The procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on the classification is included in Appendix 3.

Just over 64,000 procedures were reported for 54,540 separations. This reflects the fact that more than one procedure can be reported for each separation, with an average of 1.2 procedures being reported. No procedures were reported for 55.2% (67,111 out of 121,651) of the separations. The most frequently reported procedure was *Cognitive behaviour therapy*.

Table 5.7: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations[a], 2007–08

		Procedures[b]		Separations[b][c]	
Procedure		**Number**	**Per cent**	**Number**	**Per cent**
96101-00	Cognitive behaviour therapy	17,584	27.5	17,584	14.5
96180-00	Other psychotherapies or psychosocial therapies	8,232	12.9	8,230	6.8
95550-10	Allied health intervention, psychology	5,080	7.9	5,080	4.2
96185-00	Supportive psychotherapy, not elsewhere classified	5,007	7.8	5,002	4.1
96001-00	Psychological skills training	4,775	7.5	4,775	3.9
92002-00	Alcohol rehabilitation	3,960	6.2	3,960	3.3
96073-00	Substance addiction counselling or education	3,107	4.9	3,107	2.6
96177-00	Interpersonal psychotherapy	2,414	3.8	2,414	2.0
96175-00	Mental/behavioural assessment	2,299	3.6	2,299	1.9
96090-00	Other counselling or education	2,161	3.4	2,161	1.8
	Other reported procedures	9,388	14.7	9,380	7.7
		Totals			
Number of separations with at least one procedure		. .	. .	54,540	44.8
Number of separations with no procedure reported		. .	. .	67,111	55.2
Total		**64,007**	**100.0**	**121,651**	**100.0**

. . Not applicable.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations, as the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total, as multiple procedures can be reported for each separation.

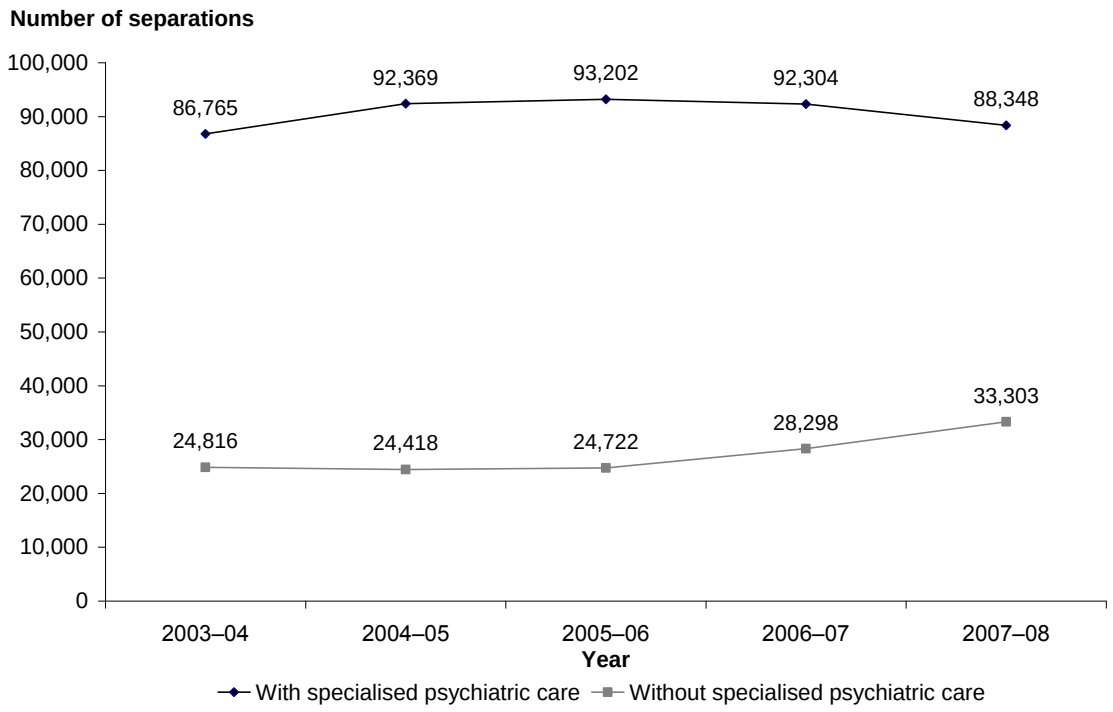
Source: National Hospital Morbidity Database.

5.7 Change over time, 2003–04 to 2007–08

Figure 5.3 depicts the number of ambulatory-equivalent mental health-related separations, with and without specialised care, from 2003–04 to 2007–08. It should be noted that the scope of the data collection and the actual definitions used by the data providers may vary from

year to year. Consequently, caution should be exercised when making comparisons between reporting years.

The total number of ambulatory-equivalent mental health-related separations increased by an annual average of 2.2% between 2003–04 (111,581) and 2007–08 (121,651). A marked increase at an annual average rate of 7.6% was observed for separations without specialised psychiatric care during the same period. However, separations with specialised psychiatric care increased very little over the 5-year period and, in fact, between 2005–06 and 2007–08 showed a decrease.



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

Source: National Hospital Morbidity Database.

Figure 5.3: Ambulatory-equivalent mental health-related separations, with and without specialised psychiatric care, 2003–04 to 2007–08

5.8 Additional data

Additional tables containing data on ambulatory-equivalent mental health-related separations are available from the Australian Institute of Health and Welfare (AIHW) website. Additional data on ambulatory-equivalent mental health-related separations from the National Hospital Morbidity Database can also be accessed via interactive data cubes on the AIHW website. The data cubes allow users to create customised tables based on the number of separations by age group, sex, sector, mental health legal status, year and type of separation for each principal diagnosis. Section 1.5 details how to access these additional resources.

6 Medicare-subsidised psychiatrist and allied health services

6.1 Introduction

This chapter presents information on Medicare Benefits Schedule-subsidised mental health-related services provided by psychiatrists and allied health professionals—psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers. Included is a description of National Healthcare Agreement performance indicator 29—*Private sector mental health services.*

Australia's universal health care system, Medicare, comprises three main elements designed to provide access to different types of health services. The Medicare Benefits Schedule (MBS) provides access to medical, including diagnostic, services; the Pharmaceutical Benefits Scheme (PBS) provides access to medicines; while the Australian Government contributed to public hospital services through intergovernmental agreements with the states and territories. Related data on expenditure on MBS-subsidised mental health-related services are presented in Chapter 14. MBS-subsidised mental health-related services provided by general practitioners (GPs) are covered in Chapter 2. PBS-subsidised mental health-related prescriptions are covered in chapters 11 and 14, and hospital services are covered in a number of other chapters.

This chapter includes the number and types of services provided by psychiatrists, psychologists and other allied health professionals under the MBS and the characteristics of people who received these services. Information on the psychiatrist workforce is presented in Chapter 13. Note that some of the services covered in this chapter (such as electroconvulsive therapy and in-hospital services) are also included in other parts of this publication.

The benefits paid by Medicare Australia are based on the MBS. The schedule allocates a unique item number to each medical service, as well as indicating the scheduled payment. More details on the specific MBS items and item groups can be found in the *Medicare Benefits Schedule book* (DoHA 2009b).

The MBS was extended to cover allied mental health services including psychologists, firstly with the introduction of the Enhanced Primary Care Program from 1 July 2004 and subsequently with the implementation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative from 1 November 2006. From 1 July 2008, the Australian Government Department of Health and Ageing implemented new Medicare items for the diagnosis and early intervention treatment of children with autism or any other pervasive developmental disorder. The items for psychiatrists and psychologists from this package have been added to the definition of mental health-related MBS items for reporting in this period. All item groups and item numbers included in this report as mental health-related are listed in Appendix Table A1.1.

Due to the predominance of psychologist items in the numbers of both patients and services recorded in 2008–09, the ***MBS-subsidised psychologist service*** items are presented separately from those of other allied mental health professionals in this chapter.

People who access ***MBS-subsidised psychiatrist*** and ***other allied mental health services*** (see Key concepts) may have been referred to a psychiatrist or allied health professional by a GP

for the specialised management of mental health-related conditions. As shown in Chapter 2, 13 of every 100 mental health-related problems managed by GPs in 2008–09 were managed by a referral being provided, with the most common referral being to a psychologist (6.1 per 100 mental health-related problems managed) or to a psychiatrist (1.8 per 100).

Note that a person may access more than one type of MBS-subsidised mental health service during the reporting period; each service is counted separately in the counts of services presented in this chapter and counts of patients are presented separately.

Key concepts

MBS-subsidised psychiatrist services are services provided by a psychiatrist (or, for electroconvulsive therapy, by either a psychiatrist or another medical practitioner) on a fee-for-service basis that are partially or fully funded under the Australian Government's Medicare program. These services cover patient attendances (or consultations) provided in different settings as well as services such as group psychotherapy, telepsychiatry, case conferences and electroconvulsive therapy. These item groups along with the relevant MBS item numbers are listed in Appendix Table A1.1. Note that for items in the range 291 to 370 (MBS Group A8) and 855 to 866 (Case conference—consultant psychiatrist) only medical practitioners who are recognised as psychiatrists for the purposes of the *Health Insurance Act 1973* are eligible to provide services attracting an MBS subsidy.

MBS-subsidised psychologist services are services provided by psychologists that are rebatable by Medicare through *Psychological Therapy Services*, *Focussed Psychological Strategies* and *Enhanced Primary Care* items. Appendix Table A1.1 lists these item groups with the relevant MBS item numbers. For these items to be eligible for Medicare rebates, the provider must meet the following eligibility requirements and be registered with Medicare Australia.

Medicare rebates for *Psychological Therapy Services* are only available for services provided by clinical psychologists who are fully registered in the relevant jurisdiction and are members of, or eligible for membership with, the Australian Psychological Society's College of Clinical Psychologists. Clinical membership is only available for registered psychologists who have completed the standard 4 years of study in psychology and attained an accredited doctorate degree in clinical psychology or masters degree in clinical psychology with 1 year of supervised post-masters clinical psychology experience.

Medicare rebates for *Focussed Psychological Strategies* and *Enhanced Primary Care* are available for services provided by psychologists who are fully registered in the relevant jurisdiction regardless of any specialist clinical training. Registered psychologists must complete the standard 4 years of study in psychology with an additional 2 years of supervised practice, postgraduate coursework or a research degree, and meet any other jurisdiction-specific requirement for registration.

MBS-subsidised other allied mental health services are services provided by other allied mental health professionals such as occupational therapists, social workers and mental health nurses. These services cover *Focussed Psychological Strategies*—allied mental health (occupational therapist and social worker items) and *Enhanced Primary Care*—allied health (mental health worker item). Mental health workers include Aboriginal health workers, mental health nurses, occupational therapists and some social workers as well as psychologists. Although some psychologists are covered by this item they cannot be readily separated from the other mental health workers covered so this item is counted under the heading of other allied mental health services. Appendix Table A1.1 lists these item groups and MBS item numbers. For Medicare payments to be made on these items the provider (occupational therapist, social worker or other appropriate provider) must be registered with Medicare Australia as meeting the credentialling requirements for provision of the service.

The data presented in this chapter refer to MBS-subsidised mental health services processed in the 2008–09 financial year; for comparison purposes, data are also presented from 2004–05

to 2007–08. More detailed information on the scope and coverage of the data presented in this chapter is provided in Appendix 1.

6.2 People accessing MBS-subsidised psychiatrist and allied mental health services

An estimated 740,183 people (3.4% of the Australian population) received MBS-subsidised psychiatrist or allied mental health services in 2008–09 (Table 6.1). Thus, on average, around one in every 29 Australians was provided with one or more of these MBS-subsidised mental health services in 2008–09. During this period, 4,606,770 MBS-subsidised mental health services were provided, an average of 6.2 services per patient.

Over half (54.0%) of the MBS-subsidised mental health services were provided by psychologists in 2008–09; there were also more patients accessing psychologist services than psychiatrist services. However, psychiatrists had the highest service-to-patient ratio (7.1).

Table 6.1: MBS-subsidised mental health services, by provider type, 2008–09

Provider type	Number of patients	Per cent of patients	Rate[(a)] (per 1,000 population)	Number of services	Per cent of services	Services per patient
Psychiatrist	275,229	37.2	12.7	1,967,222	42.7	7.1
Psychologist	490,098	66.2	22.6	2,489,799	54.0	5.1
Other allied mental health professional	29,619	4.0	1.4	149,749	3.3	5.1
Total[(b)]	**740,183**	**100.0**	**34.2**	**4,606,770**	**100.0**	**6.2**

(a) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2008.

(b) The number of patients may not sum to the total since a patient may receive a service from more than one type of provider in the course of the year but will be counted only once in the total.

Source: MBS data (DoHA).

Table 6.2 shows the age and sex distribution of patients receiving MBS-subsidised psychiatrist, psychologist and other allied mental health services, and the number of services each demographic group received. Females utilised services from all three provider types to a greater extent than males; however, the disparity was greater for psychologist and other allied mental health services than for psychiatrist services. For psychologist and other allied mental health services, females comprised around two-thirds of the patients and their utilisation rate was around double that for males.

The age distribution for patients of psychiatrists was slightly older than that for patients of psychologists and other allied mental health providers. The modal age group for psychiatrists' patients was 45–54 years while it was 35–44 years for patients of psychologists and other allied mental health services.

The number of services per patient was higher for patients of psychiatrists than for patients of psychologists and other allied health providers, except for patients aged less than 15 years.

The patient and service rates per 1,000 population for psychiatrists were noticeably higher in *Major cities* than in *Inner regional* areas (Table 6.3). Overall, services are used less with increasing remoteness.

Table 6.2: People receiving MBS-subsidised psychiatrist, psychologist and other allied mental health services, by patient demographic characteristics and number of services received, 2008–09

Patient demographics	Number of patients[(a)]	Per cent of patients[(a)]	Rate[(b)] (per 1,000 population)	Number of services	Per cent of services	Rate[(b)] (per 1,000 population)	Services per patient
			Psychiatrist services				
Age group							
Less than 15 years	10,436	3.8	2.5	38,123	1.9	9.2	3.7
15–24 years	34,905	12.7	11.5	204,793	10.4	67.6	5.9
25–34 years	47,155	17.1	15.6	318,801	16.2	105.3	6.8
35–44 years	60,106	21.8	19.2	442,236	22.5	141.5	7.4
45–54 years	60,192	21.9	20.2	456,382	23.2	153.0	7.6
55–64 years	44,503	16.2	18.2	329,677	16.8	134.9	7.4
65 years and over	29,260	10.6	10.2	177,210	9.0	61.7	6.1
Sex							
Male	125,686	45.7	12.5	769,899	39.1	70.8	6.1
Female	149,543	54.3	14.8	1,197,323	60.9	108.9	8.0
Total for psychiatrist services	**275,229**	**100.0**	**13.7**	**1,967,222**	**100.0**	**90.0**	**7.1**
			Psychologist services				
Age group							
Less than 15 years	48,856	10.0	11.7	223,729	9.0	53.8	4.6
15–24 years	73,000	14.9	24.1	342,173	13.7	112.9	4.7
25–34 years	103,665	21.2	34.2	518,623	20.8	171.3	5.0
35–44 years	115,500	23.6	37.0	591,074	23.7	189.1	5.1
45–54 years	88,817	18.1	29.8	457,489	18.4	153.3	5.2
55–64 years	51,355	10.5	21.0	260,788	10.5	106.7	5.1
65 years and over	20,974	4.3	7.3	95,923	3.9	33.4	4.6
Sex							
Male	174,249	35.6	17.1	854,010	34.3	79.9	4.9
Female	315,849	64.4	31.1	1,635,789	65.7	152.7	5.2
Total for psychologist services	**490,098**	**100.0**	**24.1**	**2,489,799**	**100.0**	**116.3**	**5.1**
			Other allied mental health services				
Age group							
Less than 15 years	3,422	11.6	0.8	20,048	13.4	4.8	5.9
15–24 years	4,142	14.0	1.4	17,624	11.8	5.8	4.3
25–34 years	5,734	19.4	1.9	28,200	18.8	9.3	4.9
35–44 years	7,238	24.4	2.3	36,394	24.3	11.6	5.0
45–54 years	5,364	18.1	1.8	26,656	17.8	8.9	5.0
55–64 years	3,003	10.1	1.2	14,840	9.9	6.1	4.9
65 years and over	1,357	4.6	0.5	5,987	4.0	2.1	4.4
Sex							
Male	9,731	32.9	1.0	48,883	32.6	4.6	5.0
Female	19,888	67.1	1.9	100,866	67.4	9.4	5.1
Total for other allied mental health services	**29,619**	**100.0**	**1.5**	**149,749**	**100.0**	**7.0**	**5.1**

(a) The number and per cent of patients will not sum to the total since a patient may receive a service in more than one age group in the course of the year but will be counted only once in the total.

(b) Rates for sex were directly age-standardised. Those for age are crude rates, as detailed in Appendix 2.

Source: MBS data (DoHA).

Table 6.3: People receiving MBS-subsidised psychiatrist, psychologist and other allied mental health services, by remoteness area of usual residence, 2008–09

Remoteness area of usual residence	Number of patients	Per cent of patients	Rate[a] (per 1,000 population)	Number of services[b]	Per cent of services	Rate[a] (per 1,000 population)	Services per patient
			Psychiatrist services				
Major cities	228,205	82.9	16.7	1,685,349	85.7	113.0	7.4
Inner regional	38,193	13.9	9.9	223,263	11.3	53.3	5.8
Outer regional	10,938	4.0	5.8	50,220	2.6	24.9	4.6
Remote	1,170	0.4	3.9	5,036	0.3	16.0	4.3
Very remote	519	0.2	3.4	1,661	0.1	10.4	3.2
Total for psychiatrist services[c]	**275,229**	**100.0**	**13.7**	**1,967,222**	**100.0**	**90.0**	**7.1**
			Psychologist services				
Major cities	372,309	76.0	26.6	1,937,625	77.8	131.5	5.2
Inner regional	95,481	19.5	24.9	428,288	17.2	106.4	4.5
Outer regional	26,361	5.4	14.1	113,560	4.6	57.9	4.3
Remote	1,723	0.4	5.6	6,838	0.3	21.2	4.0
Very remote	589	0.1	3.7	2,309	0.1	13.9	3.9
Total for psychologist services[c]	**490,098**	**100.0**	**24.1**	**2,489,799**	**100.0**	**116.3**	**5.1**
			Other allied mental health services				
Major cities	20,803	70.2	1.5	111,673	74.6	7.6	5.4
Inner regional	6,707	22.6	1.7	27,778	18.5	6.9	4.1
Outer regional	2,356	8.0	1.3	9,962	6.7	5.1	4.2
Remote	60	0.2	—	267	0.2	0.8	4.5
Very remote	11	—	—	39	—	0.2	3.5
Total for other allied mental health services[c]	**29,619**	**100.0**	**1.5**	**149,749**	**100.0**	**7.0**	**5.1**

— Rounded to zero.

(a) Rates directly age-standardised, as detailed in Appendix 2.

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

(c) The number and per cent of patients will not sum to the total since a patient may receive services in more than one area of residence in the course of the year but will be counted only once in the total.

Source: MBS data (DoHA).

New South Wales had the highest number of patients for psychiatrists, psychologists and other allied mental health professionals, but Victoria had the highest number per 1,000 population for psychologists and other allied health professionals at 27.4 and 1.7, respectively (Table 6.4). The Northern Territory had the lowest number per 1,000 population for patients of all three provider groups.

Table 6.4: People receiving MBS-subsidised psychiatrist and allied health services, by item group[a] of service, states and territories[b], 2008–09

Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[c]
					Psychiatrist services				
Initial consultation new patient—consulting room	25,638	21,765	14,661	7,090	6,711	1,421	1,076	277	78,564
Initial consultation new patient—hospital	3,382	2,300	1,865	688	385	266	69	16	8,959
Initial consultation new patient—home visit	625	255	32	n.p.	94	n.p.	13	9	1,040
Patient attendances—consulting room	77,775	69,079	43,888	19,521	22,676	4,264	3,134	681	240,125
Patient attendances—hospital	5,730	4,738	4,087	1,893	930	595	182	29	18,122
Patient attendances—other locations	2,071	820	147	56	300	14	22	12	3,437
Group psychotherapy	2,803	3,433	402	166	221	281	n.p.	n.p.	7,335
Interview with non-patient	1,931	1,608	1,341	379	405	92	44	11	5,808
Telepsychiatry	342	52	180	13	n.p.	n.p.	7	n.p.	601
Case conference	163	425	79	33	34	27	n.p.	n.p.	771
Electroconvulsive therapy[d]	532	606	511	248	152	85	n.p.	n.p.	2,141
Assessment and treatment of pervasive developmental disorder (PDD)—psychiatrist[e]	32	65	22	0	n.p.	0	0	n.p.	125
Total psychiatrist services[c]	**91,399**	**78,139**	**50,242**	**22,346**	**24,995**	**4,917**	**3,590**	**799**	**275,229**
Rate (per 1,000 population)[f]	13.0	14.6	11.6	10.1	15.5	9.8	10.3	3.6	12.7
					Psychologist services				
Psychological Therapy Services—clinical psychologist	57,742	41,719	24,082	27,207	16,985	5,698	2,718	409	175,935
Focussed Psychological Strategies—psychologist	108,241	108,743	69,840	15,692	14,171	5,342	5,370	1,225	327,461
Enhanced Primary Care—psychologist	1,145	830	626	114	113	30	27	8	2,891
Assessment and treatment of PDD—psychologist[e]	392	815	134	139	114	35	25	6	1,660
Total psychologist services[c]	**161,133**	**147,129**	**91,440**	**41,858**	**30,198**	**10,830**	**7,836**	**1,606**	**490,098**
Rate (per 1,000 population)[f]	22.9	27.4	21.0	19.0	18.7	21.6	22.5	7.2	22.6

(continued)

Table 6.4 (continued): People receiving MBS-subsidised psychiatrist and allied health services, by item group[a] of service provided, states and territories[b], 2008–09

Item group[a]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[c]
					Other allied mental health services				
Focussed Psychological Strategies—occupational therapist	1,606	1,210	734	409	407	116	n.p.	n.p.	4,511
Focussed Psychological Strategies—social worker	8,365	7,820	3,882	1,795	1,873	560	113	41	24,366
Enhanced Primary Care—mental health worker[g]	385	258	135	19	66	n.p.	0	n.p.	865
Total other allied mental health services[c]	**10,313**	**9,241**	**4,734**	**2,215**	**2,342**	**677**	**152**	**43**	**29,619**
Rate (per 1,000 population)[f]	1.5	1.7	1.1	1.0	1.5	1.4	0.4	0.2	1.4
Total psychiatrist and allied mental health services[c]	**244,292**	**218,603**	**136,823**	**61,631**	**53,798**	**15,242**	**10,794**	**2,348**	**740,183**
Rate (per 1,000 population)[f]	34.7	40.7	31.5	28.0	33.4	30.5	31.0	10.6	34.2

n.p. Not published due to confidentiality reasons.

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

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

(c) The number of patients may not sum to the total as a patient may receive more than one type of service in more than one state or territory but will be counted only once in the total.

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

(e) These items introduced 20 August 2008.

(f) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2008.

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

Sources: MBS data (Medicare 2009a, DoHA).

6.3 MBS-subsidised psychiatrist and allied health services

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

In 2008–09 there were 1,967,222 services provided by psychiatrists, 2,489,799 services provided by psychologists and 149,749 services provided by other allied mental health professionals that were subsidised through the MBS. Thus a total of 4,606,770 psychiatrist and allied mental health services were subsidised through the MBS. This is equivalent to a rate of 212.8 services per 1,000 population (Table 6.5), up 14.9% on the previous year when the rate was 185.2 services per 1,000 population (Table 6.6). This increase is largely due to the strong growth of psychologist services (32.6%) and other allied health services (58.1%) from the previous year. The Focussed Psychological Strategies item group accounted for 63.2% of MBS-subsidised psychologist services (Table 6.5), an increase of 28.9% from the previous year. The Psychological Therapy Services item group (available for clinical psychologists only) accounted for 36.3% (Table 6.5) of psychologist services, an increase of 39.3% from the previous year.

The 22.7% annual average increase in Medicare-subsidised mental health-related services for the 5 year period to 2008–09 can be mainly attributed to the implementation of the Better Access initiative in November 2006 (Table 6.6) which gave patients Medicare subsidised access to psychologists and other allied health providers. Depending on their needs, patients are eligible for up to 12 (or 18 in exceptional circumstances) individual and up to 12 group allied mental health services per calendar year. These services represented 1.6% of all MBS-subsidised services (294.0 million) in 2008–09 (Medicare 2009a).

The services provided by psychiatrists represented 8.5% of all the MBS-subsidised specialist attendances (23.1 million; Medicare 2009a) provided in 2008–09, a 0.3% decrease from 8.8% in 2007–08. This equates to a rate of 90.9 services per 1,000 population, down from 92.1 services per 1,000 population in 2007–08. Most of the MBS-subsidised psychiatrist services in 2008–09 (82.1%) were attendances provided in consulting rooms, followed by consultations in hospitals (13.3%). Group psychotherapy accounted for half of the other services provided. There was a decline in the number of MBS-subsidised psychiatrist services from 2004–05 to 2008–09 at an average annual rate of 0.5%, with the number per 1,000 population declining at an even greater average annual rate of 2.1% (Table 6.6). Over the 5-year period there has been growth in the telepsychiatry item group (average annual rate of 56.2%), although this group only accounts for a small percentage of the total number of psychiatrist services (0.07%).

Among the states and territories, Victoria had the highest number of services per 1,000 population (Table 6.5). Victoria's rate, at 273.7 per 1,000 population, was higher than the national average of 212.8 services per 1,000 population. The Northern Territory had the lowest rate, with 50.2 MBS-subsidised psychiatrist and allied health services provided per 1,000 population.

Table 6.5: MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, states and territories[(b)], 2008–09

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Psychiatrist services				
Initial consultation new patient—consulting room	26,704	22,649	15,035	7,313	6,863	1,471	1,167	277	81,479
Initial consultation new patient—hospital	4,148	2,593	2,153	734	461	310	86	20	10,505
Initial consultation new patient—home visit	632	253	32	8	94	4	13	9	1,045
Patient attendances—consulting room	481,310	504,977	261,248	91,507	146,583	27,919	16,440	3,527	1,533,511
Patient attendances—hospital	55,539	74,923	68,897	26,183	14,286	9,384	1,459	284	250,955
Patient attendances—other locations	6,951	3,120	460	239	1,163	41	62	20	12,056
Group psychotherapy	20,082	17,924	2,479	678	574	3,106	201	30	45,074
Interview with non-patient	2,848	2,594	1,948	439	552	112	73	15	8,581
Telepsychiatry	752	78	447	26	8	1	15	29	1,356
Case conference	190	734	97	44	37	31	9	2	1,144
Electroconvulsive therapy[(c)]	5,425	6,326	5,462	1,852	1,628	589	103	6	21,391
Assessment and treatment of pervasive developmental disorder (PDD)[(d)]	32	65	22	5	0	0	0	1	125
Total psychiatrist services	**604,613**	**636,236**	**358,280**	**129,023**	**172,254**	**42,968**	**19,628**	**4,220**	**1,967,222**
Rate (per 1,000 population)[(e)]	85.9	118.6	82.4	58.5	106.9	85.9	56.4	19.0	90.9
					Psychologist services				
Psychological Therapy Services—clinical psychologist	298,137	226,729	111,728	145,385	77,824	28,968	14,297	1,767	904,835
Focussed Psychological Strategies—psychologist	517,849	550,951	315,067	76,491	59,519	23,591	25,367	4,963	1,573,798
Enhanced Primary Care—psychologist	2,705	1,858	1,413	267	178	88	68	14	6,591
Assessment and treatment of PDD[(d)]	1,180	2,196	399	348	244	101	87	20	4,575
Total psychologist services	**819,871**	**781,734**	**428,607**	**222,491**	**137,765**	**52,748**	**39,819**	**6,764**	**2,489,799**
Rate (per 1,000 population)[(e)]	116.4	145.7	98.5	100.9	85.5	105.4	114.5	30.5	115.0

(continued)

Table 6.5 (continued): MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, states and territories[(b)], 2008–09

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Other allied mental health services				
Focussed Psychological Strategies—occupational therapist	9,207	7,689	3,373	1,951	2,956	519	182	10	25,887
Focussed Psychological Strategies—social worker	42,707	41,722	17,111	9,107	7,860	2,451	449	133	121,540
Enhanced Primary Care—mental health worker[(f)]	1,059	742	298	39	169	13	0	2	2,322
Total other allied mental health services	**52,973**	**50,153**	**20,782**	**11,097**	**10,985**	**2,983**	**631**	**145**	**149,749**
Rate (per 1,000 population)[(e)]	7.5	9.3	4.8	5.0	6.8	6.0	1.8	0.7	6.9
Total psychiatrist and allied mental health services	**1,477,457**	**1,468,123**	**807,669**	**362,611**	**321,004**	**98,699**	**60,078**	**11,129**	**4,606,770**
Rate (per 1,000 population)[(e)]	209.8	273.7	185.7	164.5	199.1	197.3	172.7	50.2	212.8

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

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

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

(d) These items introduced 20 August 2008.

(e) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2008.

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

Sources: MBS data (Medicare 2009a, DoHA).

Table 6.6: MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, 2004–05 to 2008–09

Item group[(a)]	2004–05	2005–06	2006–07	2007–08	2008–09	Average annual change (per cent)
			Psychiatrist services			
Initial consultation new patient —consulting room[(b)]	. .	. .	42,944	76,309	81,479	. .
Initial consultation new patient —hospital[(b)]	. .	. .	3,591	8,730	10,505	. .
Initial consultation new patient —home visit[(b)]	. .	. .	448	903	1,045	. .
Patient attendances—consulting room	1,723,598	1,708,878	1,635,793	1,549,250	1,533,511	–2.9
Patient attendances—hospital	209,294	225,918	222,576	232,040	250,955	4.6
Patient attendances—other locations	12,419	13,355	14,115	13,310	12,056	–0.7
Group psychotherapy	40,611	43,797	41,689	41,360	45,074	2.6
Interview with non-patient	4,670	4,845	6,093	6,634	8,581	16.4
Telepsychiatry	228	369	665	1,125	1,356	56.2
Case conference	545	696	637	1,015	1,144	20.4
Electroconvulsive therapy[(c)]	15,853	18,083	17,982	19,026	21,391	7.8
Assessment and treatment of PDD —psychiatrist[(d)]	. .	. .	. .	. .	125	. .
Total psychiatrist services	**2,007,218**	**2,015,941**	**1,986,533**	**1,949,702**	**1,967,222**	**–0.5**
Rate (per 1,000 population)[(e)]	99.0	98.1	95.3	92.1	90.9	–2.1
			Psychologist services			
Psychological Therapy Services —clinical psychologist[(b)]	. .	. .	189,946	649,377	904,835	. .
Focussed Psychological Strategies —psychologist[(b)]	. .	. .	407,117	1,220,669	1,573,798	. .
Enhanced Primary Care—psychologist	23,092	45,541	49,190	7,788	6,591	–26.9
Assessment and treatment of PDD —psychologist	. .	. .	. .	. .	4,575	. .
Total psychologist services	**23,092**	**45,541**	**646,253**	**1,877,834**	**2,489,799**	**. .**
Rate (per 1,000 population)[(e)]	1.1	2.2	31.0	88.7	115.0	. .
			Other allied mental health services			
Focussed Psychological Strategies —occupational therapist[(b)]	. .	. .	2,502	15,439	25,887	. .
Focussed Psychological Strategies —social worker[(b)]	. .	. .	16,244	76,870	121,540	. .
Enhanced Primary Care —mental health worker[(f)]	748	2,730	3,903	2,400	2,322	32.7
Total other allied mental health services	**748**	**2,730**	**22,649**	**94,709**	**149,749**	**. .**
Rate (per 1,000 population)[(e)]	—	0.1	1.1	4.5	6.9	. .
Total psychiatrist and allied mental health services	**2,031,058**	**2,064,212**	**2,655,435**	**3,922,245**	**4,606,770**	**22.7**
Rate (per 1,000 population)[(e)]	100.2	100.4	127.3	185.2	212.8	20.7

. . Not applicable.

— Rounded to zero.

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

(b) These items introduced 1 November 2006.

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

(d) These items introduced 20 August 2008.

(e) Crude rate is based on the preliminary Australian estimated resident population as at 31 December of the reference year.

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

Sources: MBS data (Medicare 2009a, DoHA).

6.4 Private sector mental health services

Under the 2009 National Healthcare Agreement, the number of private sector mental health services (indicator 29) is a primary and community health outcome indicator (CRC 2010). For this indicator, the numerator is the number of mental health-specific MBS items provided by private psychiatrists, GPs and allied health providers (psychologists, occupational therapists, social workers, mental health nurses and Aboriginal health workers). The denominator is the estimated resident population. The indicator is calculated both nationally and by state/territory and disaggregated by 10 year age group, residential remoteness and socioeconomic status as detailed in Appendix 5.

7 Admitted patient mental health-related care

7.1 Introduction

Mental health-related hospital ***separations*** can be classified as ambulatory-equivalent or non-ambulatory. In this chapter, information on non-ambulatory ***admitted patient*** mental health-related care is presented. The data are from the National Hospital Morbidity Database (NHMD), which is a collation of data on admitted patient care in Australian hospitals (see Appendix 1 for more information on the database). The statistical unit for the NHMD is the separation (see Key concepts). Data are not available on the number of separations accrued by an individual, so all the tabulations in this chapter are in terms of separation events, not patients. Ambulatory-equivalent admitted patient care is presented in Chapter 5.

Admitted patient ***mental health-related*** separations can be divided into those that involved ***specialised psychiatric care*** (which are presented in Section 7.3 of this chapter) and those that did not (Section 7.4). Section 7.5 provides an overview on separations that were not considered to be mental health-related but for which a mental health-related additional diagnosis was reported.

Key concepts

Separation refers to an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing type of care. Separation data provide information on the number of hospital stays completed in a designated period, typically a financial year. These data can be used as a measure of hospital activity, but can represent quite different types of activity. That is, some separations will occur after same-day stays in hospital, some for stays of a few days, while others can be for stays of months or, rarely, years. Thus, the separation data do not allow accurate comparison of hospitals that tend to provide for longer stays and report fewer separations (for example, public psychiatric hospitals) with hospitals that concentrate on providing numerous short stays (for example, acute care hospitals).

An ***admitted patient*** is a patient who undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital.

A separation is classified as ***mental health-related*** for the purposes of this report if:

- it had a mental health-related principal diagnosis, which, for admitted patient care in this report, is defined as a principal diagnosis that is either
  - a diagnosis that falls within the chapter on Mental and behavioural disorders (Chapter 5) in the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM) (codes F00–F99), or
  - a number of other selected diagnoses (see Appendix 4 for a full list of applicable diagnoses), and/or
- it included any specialised psychiatric care.

(continued)

A separation is classified as having ***specialised psychiatric care*** if the patient was reported as having one or more days in a specialised psychiatric unit or ward.

Patient day means the occupancy of a hospital bed (or chair in the case of some same-day patients) by an admitted patient for all or part of a day. The patient day data (and psychiatric care day data) measure hospital activity in a way that is not as affected by variation in length of stay as separations data. The day data are proportional to the length of stay whereas separations data have the same value whatever the length of stay. The patient day data presented in this report include days within hospital stays that occurred before 1 July 2007 provided that the separation from hospital occurred during 2007–08. This has little or no impact in private and public acute hospitals, where separations are relatively brief, throughput is relatively high and the patient days that occurred in the previous year are expected to be approximately balanced by the patient days not included in the counts because they are associated with patients yet to separate from the hospital and therefore yet to be reported. However, some public psychiatric hospitals provide very long stays for small numbers of patients and, as a result, would have comparatively large numbers of patient days recorded that occurred before 2007–08 and may not be balanced by patient days associated with patients yet to separate from the hospital.

Psychiatric care days are the number of days or part-days the person received care as an admitted patient in a designated psychiatric unit or ward.

Average length of stay is the average number of patient days for admitted patient separations.

7.2 Change over time, 2003–04 to 2007–08

Table 7.1 provides a summary of admitted patient mental health-related separations both with and without specialised psychiatric care, as well as the ***patient days, psychiatric care days*** and ***average length of stay*** data related to those separations by hospital type from 2003–04 to 2007–08. It should be noted that the scope of the data collection and the actual definitions used by the data providers may vary from year to year, so comparisons between reporting years and hospital types should be made with caution.

As mentioned in Chapter 5, there were 7,873,945 separations reported from public and private acute and psychiatric hospitals in 2007–08. About 4.2% (334,541) of these separations were mental health-related, comprising both ambulatory-equivalent and non-ambulatory admitted patient separations.

In all, 212,890 non-ambulatory admitted patient mental health-related care separations were reported in 2007–08, accounting for 2.7% of all hospital separations and 63.6% (212,890 out of 334,541) of mental health-related separations. Of these, 124,247 (58.4% of 212,890) were separations with specialised psychiatric care.

Over the 5 years to 2007–08, the average annual rate of increase for all mental health-related separations was 1.9%, increasing from 197,712 separations in 2003–04. The proportion of separations with specialised care remained fairly constant at about 58–59%. While there have been generally increasing numbers of public acute hospital separations, there have been declining numbers of public psychiatric hospital separations, especially for separations without specialised psychiatric care. Private hospitals reported an increase for those with specialised care, and relatively steady numbers of separations without specialised care.

Table 7.1: Admitted patient mental health-related separations[a] with and without specialised psychiatric care, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
			Separations			
Separations with specialised psychiatric care						
Public acute hospitals	76,042	76,172	76,019	79,738	78,919	0.9
Public psychiatric hospitals	14,188	12,887	13,255	12,771	12,723	–2.7
Private hospitals	26,495	27,793	29,459	29,623	32,605	5.3
Subtotal	*116,725*	*116,852*	*118,733*	*122,132*	*124,247*	*1.6*
Separations without specialised psychiatric care						
Public acute hospitals	68,087	70,975	75,195	76,553	76,997	3.1
Public psychiatric hospitals[b]	1,048	1,136	770	660	544	–15.1
Private hospitals	11,852	10,390	9,488	10,011	11,102	–1.6
Subtotal	*80,987*	*82,501*	*85,453*	*87,224*	*88,643*	*2.3*
Total mental health-related separations						
Public acute hospitals	144,129	147,147	151,214	156,291	155,916	2.0
Public psychiatric hospitals	15,236	14,023	14,025	13,431	13,267	–3.4
Private hospitals	38,347	38,183	38,947	39,634	43,707	3.3
Total	**197,712**	**199,353**	**204,186**	**209,356**	**212,890**	**1.9**
			Patient days			
Patient days for separations with specialised psychiatric care[c]						
Public acute hospitals	1,118,512	1,208,422	1,215,274	1,329,835	1,337,467	4.6
Public psychiatric hospitals	666,275	757,916	652,375	636,857	661,847	–0.2
Private hospitals	424,787	441,617	456,146	492,777	518,388	5.1
Subtotal	*2,209,574*	*2,407,955*	*2,323,795*	*2,459,469*	*2,517,702*	*3.3*
Patient days for separations without specialised psychiatric care						
Public acute hospitals	399,342	384,160	419,669	411,417	413,119	0.9
Public psychiatric hospitals[b]	8,341	19,753	5,547	4,262	3,389	–20.2
Private hospitals	120,186	96,120	93,266	106,457	118,925	–0.3
Subtotal	*527,869*	*500,033*	*518,482*	*522,136*	*535,433*	*0.4*
Total mental health-related patient days						
Public acute hospitals	1,517,854	1,592,582	1,634,943	1,741,252	1,750,586	3.6
Public psychiatric hospitals	674,616	777,669	657,922	641,119	665,236	–0.3
Private hospitals	544,973	537,737	549,412	599,234	637,313	4.0
Total	**2,737,443**	**2,907,988**	**2,842,277**	**2,981,605**	**3,053,135**	**2.8**
			Psychiatric care days			
Public acute hospitals	1,099,446	1,183,862	1,190,652	1,307,383	1,313,393	4.5
Public psychiatric hospitals	663,541	753,328	644,104	627,233	660,665	–0.1
Private hospitals	423,507	440,663	454,719	490,697	514,750	5.0
Total	**2,186,494**	**2,377,853**	**2,289,475**	**2,425,313**	**2,488,808**	**3.3**

(continued)

Table 7.1 (continued): Admitted patient mental health-related separations[(a)] with and without specialised psychiatric care, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
			Average length of stay			
Separations with specialised psychiatric care						
Public acute hospitals	14.7	15.9	16.0	16.7	16.9	3.6
Public psychiatric hospitals	47.0	58.8	49.2	49.9	52.0	2.6
Private hospitals	16.0	15.9	15.5	16.6	15.9	1.0
Subtotal	*18.9*	*20.6*	*19.6*	*20.1*	*20.3*	*2.1*
Separations without specialised psychiatric care						
Public acute hospitals	5.9	5.4	5.6	5.4	5.4	–2.2
Public psychiatric hospitals[(b)]	8.0	17.4	7.2	6.5	6.2	1.3
Private hospitals	10.1	9.3	9.8	10.6	10.7	0.2
Subtotal	*6.5*	*6.1*	*6.1*	*6.0*	*6.0*	*0.2*
Total mental health-related separations						
Public acute hospitals	10.5	10.8	10.8	11.1	11.2	1.8
Public psychiatric hospitals	44.3	55.5	46.9	47.7	50.1	0.1
Private hospitals	14.2	14.1	14.1	15.1	14.6	1.2
Total	**13.8**	**14.6**	**13.9**	**14.2**	**14.3**	**1.5**

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Mental health-related separations without specialised psychiatric care reported by public psychiatric hospitals relate to the provision of alcohol and drug treatment in New South Wales public psychiatric hospitals.

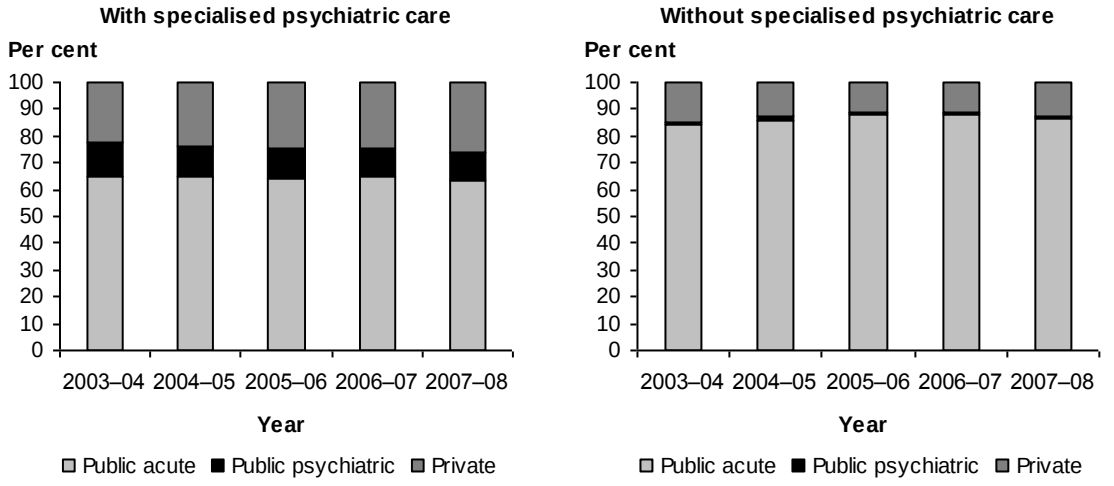
(c) These data indicate the number of patient days for separations with at least some specialised psychiatric care. This figure will not necessarily be equivalent to a count of psychiatric care days, as some separations will include days of specialised psychiatric care and days of other care.

Source: National Hospital Morbidity Database.

Figure 7.1 shows the percentage of separations by hospital type, with and without specialised psychiatric care, over the 5 years to 2007–08. Public acute hospitals were the dominant providers, both with and without specialised psychiatric care. The dominance of public acute hospitals was most pronounced in mental health-related separations without specialised psychiatric care (over 80% of separations). The major change noticeable in the distribution of mental health care by hospital type over the 5-year period is the decline, by about 2 percentage points in each case, of the share for both public acute hospital and public psychiatric hospital separations with specialised psychiatric care. The private hospital share of this form of care has increased by 3.5 percentage points.

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

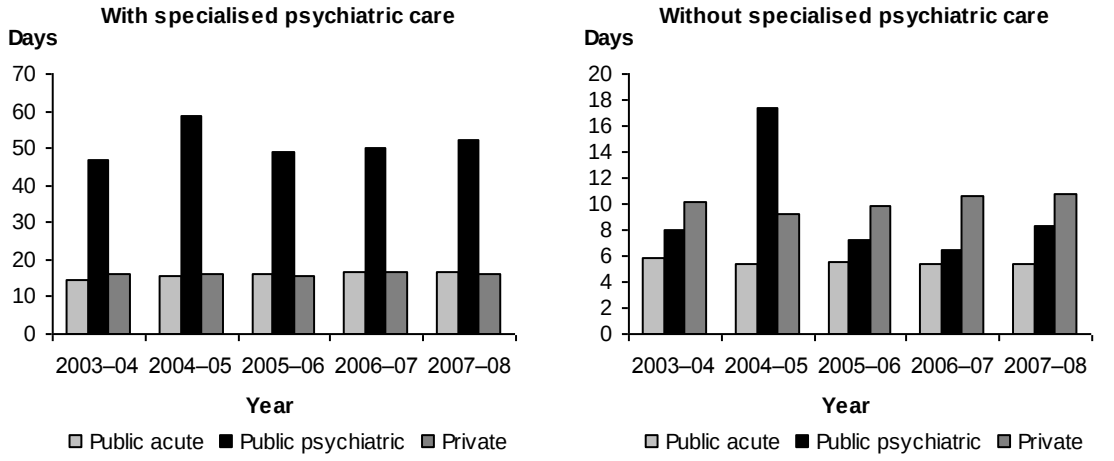
A different picture is apparent for mental health-related separations without specialised psychiatric care. The average length of stay was generally higher for private hospital separations compared with other hospital types in all years.



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

Source: National Hospital Morbidity Database.

Figure 7.1: Mental health-related separations with and without specialised psychiatric care, by hospital type, 2007–08



Notes

1. Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
2. These data should be interpreted with caution as length of stay of public psychiatric hospital patients can vary widely and separations may occur unevenly over time. For example, if a large number of long stay patients separated in a particular financial year, the average length of stay for that year may be artificially inflated.

Source: National Hospital Morbidity Database.

Figure 7.2: Average length of stay for mental health-related separations with and without specialised psychiatric care, by hospital type, 2007–08

7.3 Specialised admitted patient mental health care

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

Of the 212,890 mental health-related separations for admitted patient care, 124,247 (58.4%) involved specialised psychiatric care (Table 7.1).

States and territories by hospital type

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

The data indicate that, of the five jurisdictions with fully reported figures, Queensland had the highest percentage of public acute hospital separations (72.9%), while Western Australia had the lowest (52.5%). For private hospital separations, Victoria had the highest percentage (36.4%), which was more than twice that of South Australia (17.7%). Public psychiatric hospital separations constituted 10.2% of all separations, with New South Wales being the major provider (60.7%). Public psychiatric hospital separations in Victoria and Queensland constituted less than 2% of the total number of separations in each jurisdiction.

The number of separations per 1,000 population, referred to as the separation rate in the following discussion, varied greatly in each jurisdiction. For public acute hospitals, Tasmania had the highest separation rate (5.3) and Western Australia the lowest (3.2). The separation rate for Tasmania in 2007–08 was lower than for previous years, when it was over 6 per 1,000 population. Public acute hospital separation rates were higher compared with other hospital types across all jurisdictions.

Queensland was the jurisdiction with the highest number of public acute hospital patient days (65.9) per 1,000 population. The number of public psychiatric hospital patient days per 1,000 population varied greatly, from 5.9 days in Victoria to 56.3 days in Tasmania. South Australia reported the lowest number of patient days in private hospitals per 1,000 population (15.6).

At least 95.7% of patient days reported by jurisdictions involved specialised psychiatric care and in the case of South Australia and Tasmania this figure was 100.0%.

Figure 7.3 shows that the average length of stay in public acute hospitals was highest for Western Australia (19.8 days), nearly twice the average length of stay for Tasmania (10.1 days). The average lengths of stay for New South Wales and Victoria were also higher than the national average (16.9 days).

Table 7.2: Admitted patient separations[(a)] with specialised psychiatric care, states and territories, 2007–08

Hospital type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	24,239	18,209	18,691	6,869	6,126	2,562	1,266	957	78,919
Public psychiatric hospitals	7,720	403	415	1,548	1,986	651	. .	. .	12,723
Private hospitals	8,237	10,660	6,550	4,667	1,739	n.p.	n.p.	n.p.	32,605
Total	**40,196**	**29,272**	**25,656**	**13,084**	**9,851**	**n.p.**	**n.p.**	**n.p.**	**124,247**
					Separations per 1,000 population[(b)]				
Public acute hospitals	3.5	3.4	4.4	3.2	3.9	5.3	3.7	4.2	3.7
Public psychiatric hospitals	1.1	0.1	0.1	0.7	1.2	1.3	. .	. .	0.6
Private hospitals	1.2	2.0	1.5	2.2	1.1	n.p.	n.p.	n.p.	1.5
Total	**5.8**	**5.5**	**6.1**	**6.1**	**6.1**	**n.p.**	**n.p.**	**n.p.**	**5.8**
					Patient days				
Public acute hospitals	443,005	331,446	277,676	135,848	94,118	25,935	18,989	10,450	1,337,467
Public psychiatric hospitals	334,290	31,255	130,308	61,448	73,989	30,557	. .	. .	661,847
Private hospitals	135,835	181,084	107,528	55,402	25,844	n.p.	n.p.	n.p.	518,388
Total	**913,130**	**543,785**	**515,512**	**252,698**	**193,951**	**n.p.**	**n.p.**	**n.p.**	**2,517,702**
					Patient days per 1,000 population[(b)]				
Public acute hospitals	63.8	61.9	65.9	64.2	58.6	54.5	56.1	45.5	62.8
Public psychiatric hospitals	47.7	5.9	30.4	28.7	43.0	56.3	. .	. .	30.9
Private hospitals	19.2	33.6	25.0	25.6	15.6	n.p.	n.p.	n.p.	23.9
Total	**130.7**	**101.5**	**121.3**	**118.5**	**117.3**	**n.p.**	**n.p.**	**n.p.**	**117.5**
					Psychiatric care days				
Public acute hospitals	428,842	330,593	272,211	133,127	94,118	25,935	18,174	10,393	1,313,393
Public psychiatric hospitals	333,108	31,255	130,308	61,448	73,989	30,557	. .	. .	660,665
Private hospitals	132,579	181,008	107,508	55,118	25,844	n.p.	n.p.	n.p.	514,750
Total	**894,529**	**542,856**	**510,027**	**249,693**	**193,951**	**n.p.**	**n.p.**	**n.p.**	**2,488,808**

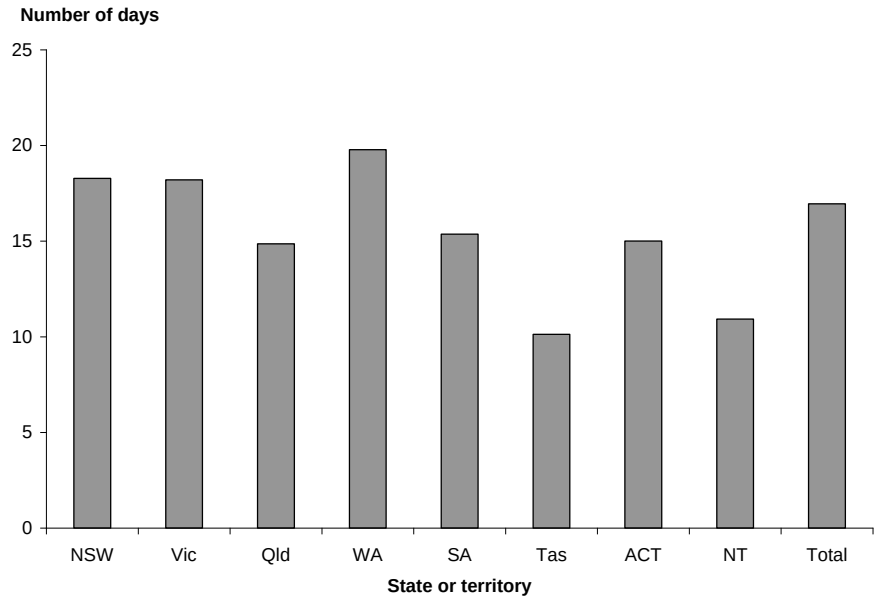
. . Not applicable. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

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

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

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

Source: National Hospital Morbidity Database.



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

Source: National Hospital Morbidity Database.

Figure 7.3: Average length of stay for separations with specialised psychiatric care in public acute hospitals, 2007–08

Mental health legal status

Table 7.3 shows the distribution of separations by the mental health legal status of the patient and by hospital type for separations with specialised psychiatric care. Involuntary patient separations comprised 32.9% of all such separations. This percentage varied considerably by hospital type, with 61.2% of public psychiatric hospital separations being involuntary and 0.2% of private hospital separations being involuntary (although for 38.6% of private hospital separations there was no mental health legal status reported). Public acute hospitals reported the highest number of involuntary patient separations (80.8% of total).

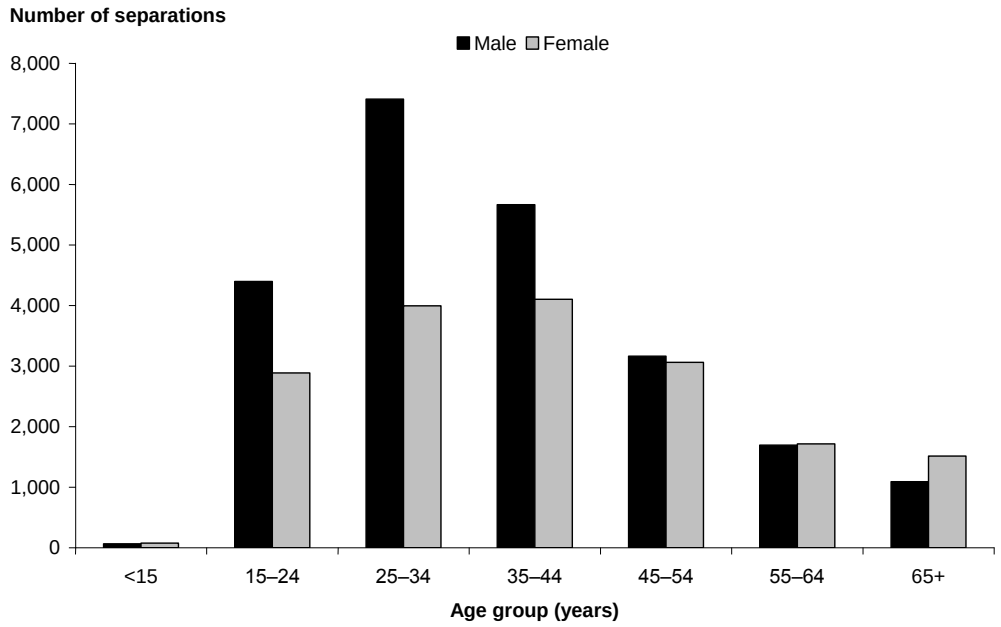
Table 7.3: Admitted patient separations[(a)] with specialised psychiatric care, by mental health legal status and hospital type, 2007–08

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	32,972	7,786	69	40,827
Voluntary	44,274	4,907	19,962	69,143
Not reported	1,673	30	12,574	14,277
Total	**78,919**	**12,723**	**32,605**	**124,247**

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 7.4 shows the relationship between involuntary mental health legal status and demographic characteristics. A relatively high number of involuntary separations were for males aged 15–44 years.



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

Source: National Hospital Morbidity Database.

Figure 7.4: Involuntary separations with specialised psychiatric care, by age group and sex, 2007–08

Patient demographics

Table 7.4 provides a summary of the demographics of patients receiving specialised psychiatric care in 2007–08. In addition, a rate (per 1,000 population) is reported to adjust for relative population sizes and age structures. As these are reports of separations (rather than patients), the rates should not be interpreted as the number of patients with specific characteristics per 1,000 population. Instead, they provide information on the number of separations relative to the size of the population subgroup.

The largest numbers and highest rates of separations were for patients aged 25–34 years and 35–44 years. These two age groups were almost equally represented. The lowest proportion of separations was for patients aged less than 15 years (1.4%).

Females accounted for a greater number of separations than males, both in absolute numbers and as a rate per 1,000 population (6.1 for females compared to 5.5 for males). Figure 7.5 shows that there were more female separations in all age groups apart from the 25–34 years age group. The biggest difference between the number of female and male separations was in the 65 years and over age group.

The rate of separations for Australian-born patients was higher than that of those born overseas (6.5 and 3.7, respectively). Those living in *Major cities* had nearly double the rate of separations of those in *Remote* areas (6.1 and 3.3, respectively). More than half of the separations (51.9%) involved those who had never been married.

The data show that the typical separation involved an Australian-born, non-Indigenous female aged 25–44 years who had never been married and lived in a major city.

Table 7.4: Admitted patient separations[(a)] with specialised psychiatric care, by patient demographic characteristics, 2007–08

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate[(d)] (per 1,000 population)
Age group			
Less than 15 years	1,747	1.4	0.4
15–24 years	18,481	14.9	6.2
25–34 years	26,914	21.7	9.1
35–44 years	27,787	22.4	9.0
45–54 years	20,669	16.6	7.0
55–64 years	13,307	10.7	5.6
65 years and over	15,342	12.3	5.5
Sex			
Male	58,368	47.0	5.5
Female	65,877	53.0	6.1
Indigenous status[(e)]			
Indigenous Australians	4,825	4.1	10.5
Other Australians[(f)]	114,191	95.9	5.7
Country of birth			
Australia	97,690	81.1	6.5
Overseas	22,828	18.9	3.7
Remoteness area of usual residence			
Major cities	89,876	73.8	6.1
Inner regional	22,076	18.1	5.6
Outer regional	8,304	6.8	4.4
Remote	1,018	0.8	3.3
Very remote	521	0.4	3.0
Marital status			
Never married	60,622	51.9	. .
Widowed	5,539	4.7	. .
Divorced	9,234	7.9	. .
Separated	5,986	5.1	. .
Married	35,357	30.3	. .
Total	**124,247**	**100.0**	**5.8**

. . Not applicable.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

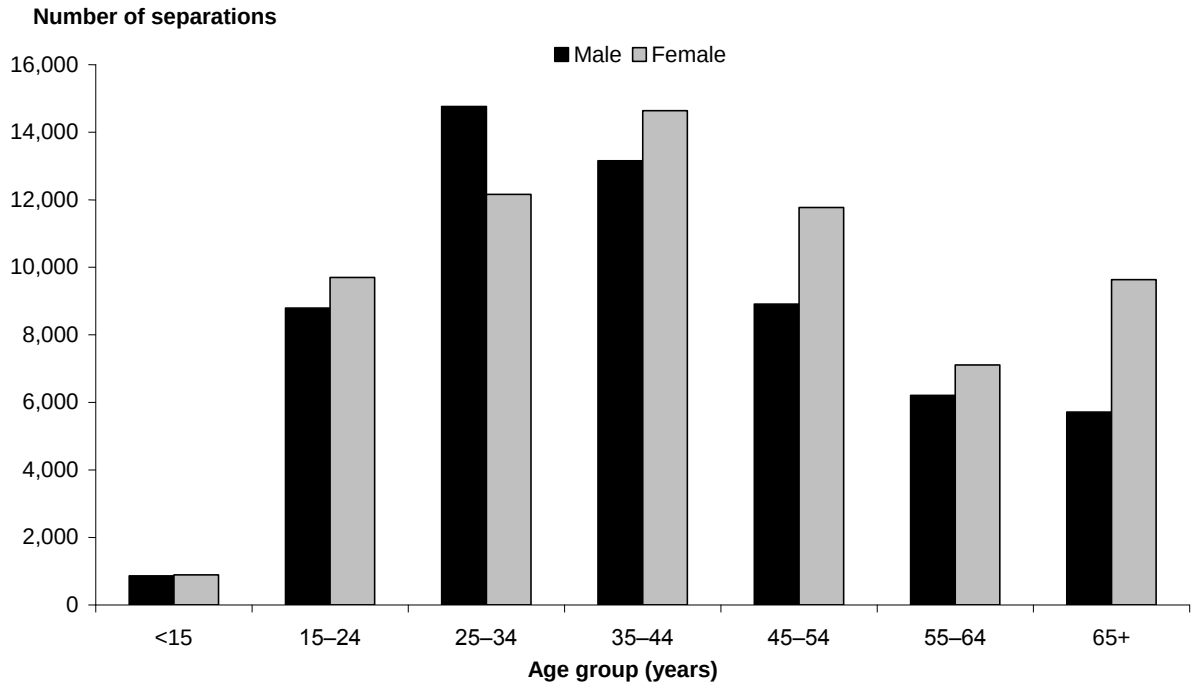
(c) The percentages shown do not include separations for which the demographic information was missing and/or not reported.

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

(e) Only Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions for which the data are considered to be of sufficient quality for analysis. However, caution should be used in the interpretation of these data due to jurisdictional data collection differences; the data does not necessarily represent the national trend (see AIHW 2010b).

(f) Includes separations where Indigenous status was missing and/or not reported (see AIHW 2010b).

Source: National Hospital Morbidity Database.



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

Source: National Hospital Morbidity Database.

Figure 7.5: Admitted patient mental health-related separations with specialised psychiatric care by age and sex, 2007–08

Principal diagnosis

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

In 2007–08, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of separations (21,358 or 17.2%). It was the most commonly reported diagnosis for public acute and psychiatric hospitals. *Depressive episode* (F32) ranked second and was the most commonly reported diagnosis for private hospitals. In fact, depressive disorders (F32 and F33) constituted 41.5% of the total number of private hospital separations.

Figures 7.6 and 7.7 show the 10 most commonly reported principal diagnoses by age and sex. The 35–44 years age group recorded the highest frequency of separations for five of the 10 most commonly reported principal diagnoses, including *Bipolar affective disorders* (F31) and *Reaction to severe stress and adjustment disorders* (F43). The 25–34 years age group recorded the highest frequency of separations for three of the 10 most commonly reported principal diagnoses. They were prominent in recorded separations for *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) and *Schizophrenia* (F20). The 65 years and over

age group recorded the highest frequency of separations for two of the 10 most commonly reported principal diagnoses, *Depressive episode* (F32) and *Recurrent depressive disorders* (F33).

There were marked sex differences in the number of separations for the 10 most commonly reported diagnoses (Figure 7.7). For the most commonly reported diagnosis of *Schizophrenia* (F20), the number of male separations was more than twice that of female separations. However, females recorded the higher frequency for 7 of the 10 most commonly reported diagnoses. The only exceptions where males dominated were for *Mental and behavioural disorders due to use of alcohol* (F10) and *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19).

Table 7.5: Admitted patient separations[a] with specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2007–08

Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	592	221	101	914	0.7
F04–F09	Other organic mental disorders	596	172	164	932	0.8
F10	Mental and behavioural disorders due to use of alcohol	2,128	690	2,565	5,383	4.3
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	3,155	779	1,004	4,938	4.0
F20	Schizophrenia	17,250	2,834	1,274	21,358	17.2
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,609	260	125	1,994	1.6
F22	Persistent delusional disorders	817	136	86	1,039	0.8
F23	Acute and transient psychotic disorders	1,432	168	65	1,665	1.3
F25	Schizoaffective disorders	5,354	949	1,344	7,647	6.2
F30	Manic episode	532	60	41	633	0.5
F31	Bipolar affective disorders	7,628	1,157	3,810	12,595	10.1
F32	Depressive episode	11,051	1,121	7,220	19,392	15.6
F33	Recurrent depressive disorders	2,997	554	6,300	9,851	7.9
F34	Persistent mood (affective) disorders	938	116	419	1,473	1.2
F38–F39	Other and unspecified mood (affective) disorders	145	25	44	214	0.2
F40	Phobic anxiety disorders	79	11	77	167	0.1
F41	Other anxiety disorders	1,089	99	1,442	2,630	2.1
F42	Obsessive-compulsive disorders	236	19	258	513	0.4
F43	Reaction to severe stress and adjustment disorders	8,501	1,098	2,811	12,410	10.0
F44	Dissociative (conversion) disorders	112	11	254	377	0.3
F45, F48	Somatoform and other neurotic disorders	106	8	46	160	0.1
F50	Eating disorders	523	6	717	1,246	1.0
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	155	9	88	252	0.2
F60	Specific personality disorders	3,834	614	522	4,970	4.0
F61–F69	Disorders of adult personality and behaviour	197	73	49	319	0.3
F70–F79	Mental retardation	147	56	2	205	0.2
F80–F89	Disorders of psychological development	199	42	20	261	0.2
F90	Hyperkinetic disorders	106	17	13	136	0.1
F91	Conduct disorders	262	29	4	295	0.2
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	172	58	5	235	0.2
F99	Mental disorder not otherwise specified	167	101	1	269	0.2
G30	Alzheimer's disease	491	150	55	696	0.6
	Other factors related to mental and behavioural disorders and substance use[b]	191	247	0	438	0.4
	Other specified mental health-related principal diagnosis[c]	296	10	212	518	0.4
	Other[d]	5,832	823	1,467	8,122	6.5
Total		**78,919**	**12,723**	**32,605**	**124,247**	**100.0**

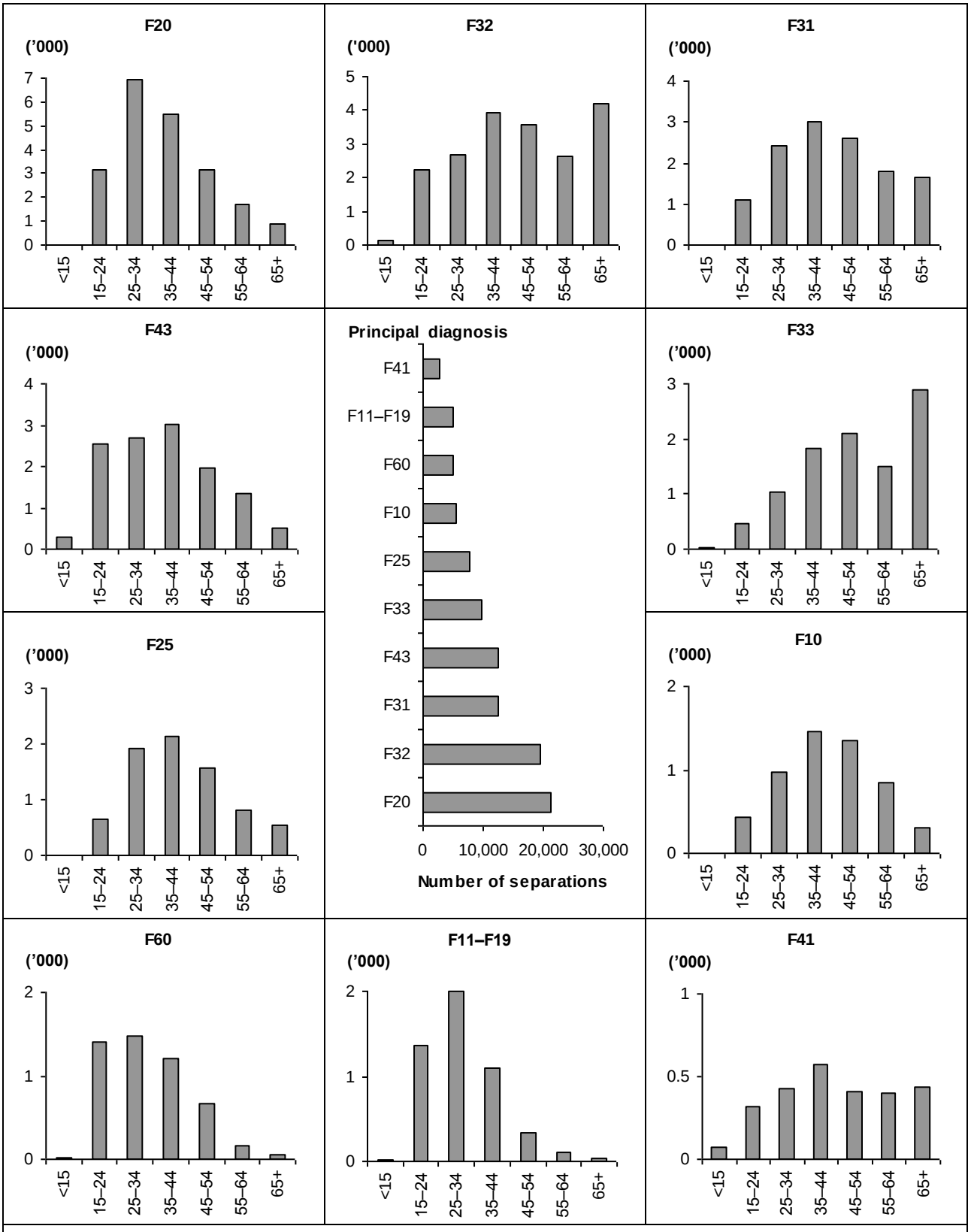
(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.

(d) Includes all other codes not included as a mental health principal diagnosis as listed in Appendix 4.

Source: National Hospital Morbidity Database.

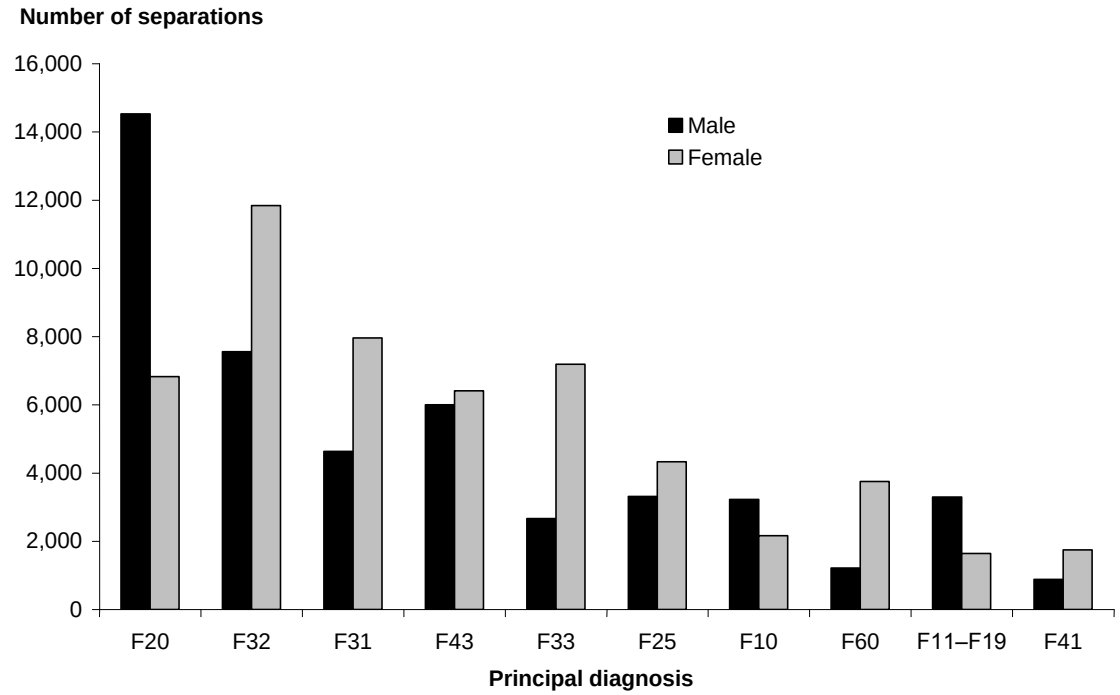


Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 7.6: Admitted patient mental health-related separations with specialised psychiatric care, by age group, for the 10 most commonly reported principal diagnoses, 2007–08

Key to the principal diagnosis codes in figures 7.6 and 7.7	
F10	Mental and behavioural disorders due to use of alcohol
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F20	Schizophrenia
F25	Schizoaffective disorders
F31	Bipolar affective disorders
F32	Depressive episode
F33	Recurrent depressive disorders
F41	Other anxiety disorders
F43	Reaction to severe stress and adjustment disorders
F60	Specific personality disorders



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

Source: National Hospital Morbidity Database.

Figure 7.7: Admitted patient mental health-related separations with specialised psychiatric care, by sex, for the 10 most commonly reported principal diagnoses, 2007–08

Procedures

Table 7.6 details the 10 procedures (or interventions) most frequently reported for separations with specialised psychiatric care. Procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on this classification is included in Appendix 3.

In all, 171,747 procedures were reported for 69,662 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 43.9% of separations. Non-emergency general anaesthesia (*General anaesthesia, American*

Society of Anesthesiologists (ASA) 99) was the most frequently reported procedure. This was most likely associated with the administration of electroconvulsive therapy, a form of treatment for depression, which was a commonly reported principal diagnosis. Allied health interventions from a number of different health disciplines also featured prominently in the 10 most frequently reported procedures.

Table 7.6: The 10 most frequently reported procedures for admitted patient separations[(a)] with specialised psychiatric care, 2007–08

		Procedures[(b)]		Separations[(b)(c)]	
Procedure		**Number**	**Per cent**	**Number**	**Per cent**
92514–99	General anaesthesia, ASA 99	31,184	18.2	11,053	8.9
95550–01	Allied health intervention, social work	24,457	14.2	24,429	19.7
95550–02	Allied health intervention, occupational therapy	15,246	8.9	15,230	12.3
93340–02	Electroconvulsive therapy ≤12 treatments	14,310	8.3	14,208	11.4
95550–10	Allied health intervention, psychology	8,921	5.2	8,913	7.2
56001–00	Computerised tomography of brain	5,590	3.3	5,570	4.5
92514–29	General anaesthesia, ASA 29	5,517	3.2	2,451	2.0
96175–00	Mental/behavioural assessment	5,313	3.1	5,308	4.3
95550–03	Allied health intervention, physiotherapy	4,579	2.7	4,573	3.7
95550–00	Allied health intervention, dietetics	4,568	2.7	4,563	3.7
	Other reported procedures	52,062	30.3	46,803	37.7
			Totals		
Number of separations with at least one procedure		. .	. .	69,662	56.1
Number of separations with no procedure reported		. .	. .	54,585	43.9
Total		**171,747**	**100.0**	**124,247**	**100.0**

. . Not applicable.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations, as the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total, as multiple procedures can be reported for each separation.

Source: National Hospital Morbidity Database.

7.4 Non-specialised admitted patient mental health care

This section presents information on mental health-related separations that did not involve any specialised psychiatric care (that is, the patient did not receive any days of care in a specialised psychiatric unit or ward). Despite this, these separations are classified as mental health-related because the reported principal diagnosis for the separation is either one that falls within the *Mental and behavioural disorders* chapter (Chapter 5) in the ICD-10-AM classification (codes F00–F99) or is one of a number of other selected diagnoses (see Appendix 4).

There were 88,643 mental health-related separations without specialised psychiatric care, accounting for 41.6% of all mental health-related separations for admitted patient care.

States and territories and hospital type

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

Table 7.7: Admitted patient separations[(a)] and patient days for mental health-related separations without specialised psychiatric care, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	26,973	22,218	9,550	7,359	8,383	1,152	821	541	76,997
Public psychiatric hospitals[(b)]	544	0	0	0	0	0	. .	. .	544
Private hospitals	3,689	2,585	2,392	965	584	n.p.	n.p.	n.p.	11,102
Total	**31,206**	**24,803**	**11,942**	**8,324**	**8,967**	**n.p.**	**n.p.**	**n.p.**	**88,643**
					Separations per 1,000 population[(c)]				
Public acute hospitals	3.8	4.2	2.3	3.5	5.2	2.3	2.5	2.8	3.6
Public psychiatric hospitals[(b)]	0.1	0	0	0	0	0	. .	. .	—
Private hospitals	0.5	0.5	0.6	0.5	0.3	n.p.	n.p.	n.p.	0.5
Total	**4.4**	**4.6**	**2.8**	**3.9**	**5.5**	**n.p.**	**n.p.**	**n.p.**	**4.1**
					Patient days				
Public acute hospitals	162,999	110,516	51,473	34,080	38,523	8,106	5,063	2,359	413,119
Public psychiatric hospitals[(b)]	3,389	0	0	0	0	0	. .	. .	3,389
Private hospitals	49,331	22,547	24,272	6,073	3,997	n.p.	n.p.	n.p.	118,925
Total	**215,719**	**133,063**	**75,745**	**40,153**	**42,520**	**n.p.**	**n.p.**	**n.p.**	**535,433**
					Patient days per 1,000 population[(c)]				
Public acute hospitals	22.3	20.0	12.3	16.3	22.0	15.7	16.0	22.0	18.9
Public psychiatric hospitals[(b)]	0.5	0	0	0	0	0	. .	. .	0.2
Private hospitals	6.9	4.1	5.7	3.0	2.1	n.p.	n.p.	n.p.	5.4
Total	**29.7**	**24.2**	**18.0**	**19.3**	**24.1**	**n.p.**	**n.p.**	**n.p.**	**24.5**

. . Not applicable.

— Rounded to zero.

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

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Mental health-related separations without specialised psychiatric care reported by New South Wales public psychiatric hospitals were mainly for alcohol and drug treatment episodes.

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

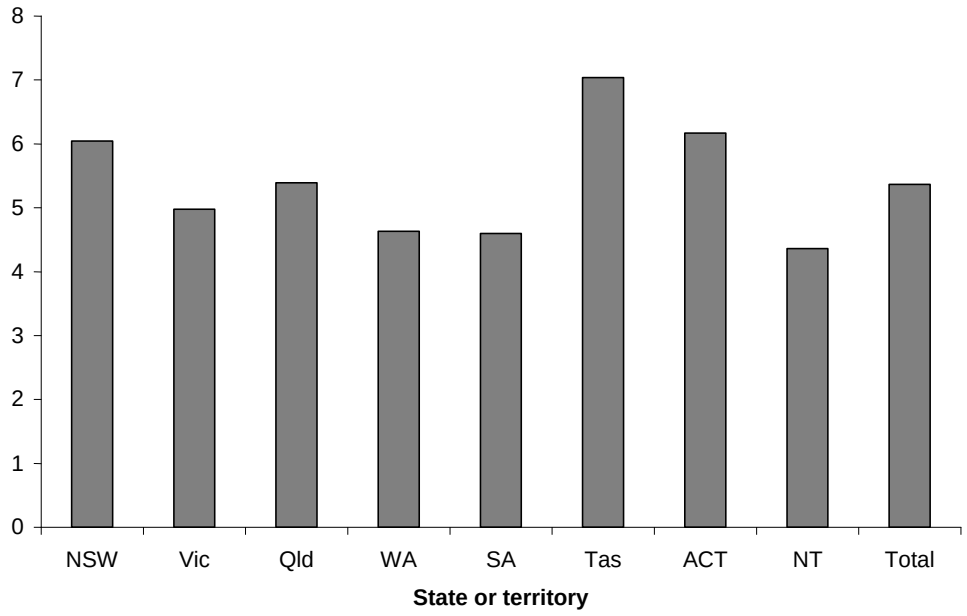
Note: The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

Source: National Hospital Morbidity Database.

Mental health-related separations without specialised psychiatric care were predominantly provided by public acute hospitals (86.9% of 88,643). South Australia reported the highest rate of public acute hospital separations per 1,000 population (5.2), and Queensland and Tasmania the lowest (2.3). The overall separation rate for South Australia across all hospital types was also the highest rate among the jurisdictions for which data are fully reported (5.5 per 1,000 population).

Private hospital separations constituted 12.5% of all mental health-related separations without specialised psychiatric care. Of the five jurisdictions with published private hospital figures, New South Wales reported the highest number of patient days (6.9 per 1,000 population).

Figure 7.8 shows the average length of stay in public acute hospitals for separations without specialised psychiatric care. The average length of stay across all jurisdictions was 5.4 days, which was much lower than the national average of 16.9 days for separations with specialised care (see Figure 7.3). Tasmania reported the highest average length of stay in public acute hospitals (7.0 days) and the Northern Territory the lowest (4.4 days).



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

Source: National Hospital Morbidity Database.

Figure 7.8: Average length of stay for separations without specialised psychiatric care in public acute hospitals, 2007–08

Patient demographics

Table 7.8 presents information on the number of separations without specialised psychiatric care in 2007–08 according to the characteristics of those receiving care. In addition, a rate (per 1,000 population) is reported to take into account relative population sizes and age structures. As for Table 7.4, the number of distinct individuals receiving care cannot be

derived from the figures presented. The reporting of marital status is not mandatory for separations without specialised psychiatric care, and is sparsely reported. Consequently, it has not been included in Table 7.8.

Table 7.8: Mental health-related admitted patient separations[(a)] without specialised psychiatric care, by patient demographic characteristics, 2007–08

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate[(d)] (per 1,000 population)
Age group			
Less than 15 years	5,704	6.4	1.4
15–24 years	9,858	11.1	3.3
25–34 years	15,724	17.7	5.3
35–44 years	16,076	18.1	5.2
45–54 years	11,949	13.5	4.1
55–64 years	7,693	8.7	3.2
65 years and over	21,639	24.4	7.7
Sex			
Male	41,867	47.2	4.0
Female	46,771	52.8	4.2
Indigenous status[(e)]			
Indigenous Australians	5,567	6.5	13.5
Other Australians[(f)]	80,216	93.5	4.0
Country of birth			
Australia	69,335	80.8	4.5
Overseas	16,464	19.2	2.6
Remoteness area of usual residence			
Major cities	53,734	61.7	3.6
Inner regional	18,354	21.1	4.5
Outer regional	11,294	13.0	5.8
Remote	2,419	2.8	8.0
Very remote	1,219	1.4	7.7
Total	**88,643**	**100.0**	**4.1**

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of separations for each demographic variable may not sum to the total due to missing and/or not reported data.

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

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

(e) Only Indigenous status data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory have been included in this table as they are the only jurisdictions for which the data are considered to be of sufficient quality for further analysis. However, caution should be used in the interpretation of these data due to jurisdictional data collection differences; the data does not necessarily represent the national trend (see AIHW 2010b).

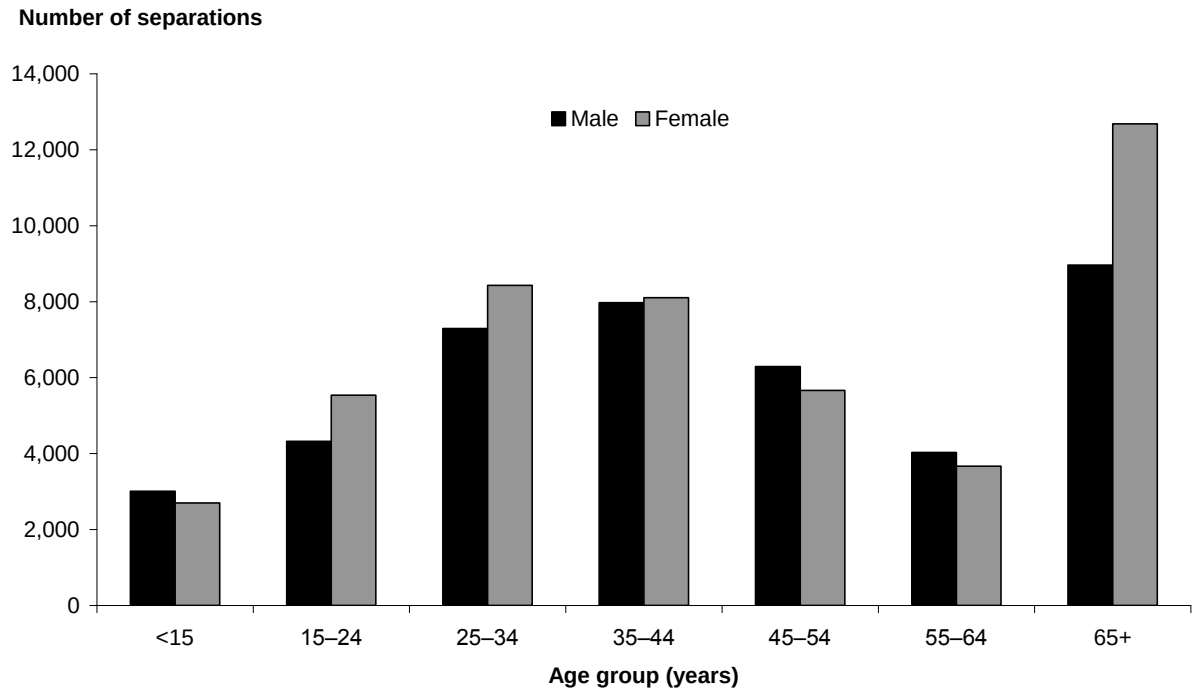
(f) Includes separations where Indigenous status was missing and/or not reported (see AIHW 2010b).

Source: National Hospital Morbidity Database.

With regard to age, the highest proportion of separations without specialised psychiatric care was for patients aged 65 years and over (24.4%). This age group also has the highest number of separations per 1,000 population (7.7). The lowest proportion of separations without specialised care was for patients aged less than 15 years (6.4%).

Generally, the rate of separations without specialised psychiatric care increased with increasing remoteness.

The number of male and female separations per 1,000 population (4.0 and 4.2, respectively) was similar. However, as in the case of separations with specialised psychiatric care, there were differences in distributions of separations when age groups were taken into consideration (Figure 7.9). The biggest differences between the number of male and female separations was in the 65 years and over age group, followed by the younger age groups, 15–24 years and 25–34 years, in all of which females were dominant.



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

Source: National Hospital Morbidity Database.

Figure 7.9: Admitted patient mental health-related separations without specialised psychiatric care, by age and sex, 2007–08

The highest number of separations per 1,000 population was for patients in *Remote* areas (8.0 per 1,000 population). The rate of separations involving Australian-born people was higher than for those born overseas (4.5 and 2.6, respectively).

The data showed that the typical separation without specialised care involved an Australian-born non-Indigenous female aged between 25 and 44 years who lived in a major city.

Principal diagnosis

Table 7.9 presents the principal diagnoses recorded for mental health-related separations without specialised psychiatric care, using various groupings of diagnosis codes from

ICD-10-AM. In 2007–08, the principal diagnosis of *Mental and behavioural disorders due to use of alcohol* (F10) accounted for the largest number of separations (18,304 or 20.6%). It was the most commonly reported diagnosis for public acute and private hospitals. *Depressive episode* (F32) ranked second, constituting 13.6% of the total number of reported principal diagnoses. Separations involving *Mental and behavioural disorders due to use of alcohol* (F10) and *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) constituted the majority of separations reported by public psychiatric hospitals (77.9%).

Figures 7.10 and 7.11 show the age and sex distribution of separations for the 10 most commonly reported principal diagnoses. The 65 years and over age group was most prominent in the number of separations for five of the top 10 principal diagnoses: *Dementia* (F00–F03), *Other organic mental disorders* (F04–F09), *Depressive episode* (F32), *Anxiety disorders* (F41) and *Recurrent depressive disorders* (F33). The 25–34 years age group was prominent in the number of separations for the principal diagnoses of *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19), *Reaction to severe stress and adjustment disorders* (F43) and *Schizophrenia* (F20).

For the principal diagnoses of *Mental and behavioural disorders due to use of alcohol* (F10), *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) and *Schizophrenia* (F20), more separations were reported for males than for females (Figure 7.11). For the remainder of the top 10 principal diagnoses female separations were in the majority.

Table 7.9: Mental health-related admitted patient separations[(a)] without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2007–08

Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	4,449	0	625	5,074	5.7
F04–F09	Other organic mental disorders	4,551	0	478	5,029	5.7
F10	Mental and behavioural disorders due to use of alcohol	16,119	174	2,011	18,304	20.6
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	5,402	250	548	6,200	7.0
F20	Schizophrenia	3,938	4	128	4,070	4.6
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,032	0	28	1,060	1.2
F22	Persistent delusional disorders	583	0	16	599	0.7
F23	Acute and transient psychotic disorders	919	0	17	936	1.1
F25	Schizoaffective disorders	1,480	0	150	1,630	1.8
F30	Manic episode	269	1	19	289	0.3
F31	Bipolar affective disorders	2,230	2	423	2,655	3.0
F32	Depressive episode	10,281	6	1,784	12,071	13.6
F33	Recurrent depressive disorders	1,924	0	402	2,326	2.6
F34	Persistent mood (affective) disorders	178	1	46	225	0.3
F38–F39	Other and unspecified mood (affective) disorders	63	1	16	80	0.1
F40	Phobic anxiety disorders	31	0	7	38	—
F41	Other anxiety disorders	4,717	4	700	5,421	6.1
F42	Obsessive-compulsive disorders	62	0	18	80	0.1
F43	Reaction to severe stress and adjustment disorders	5,305	20	634	5,959	6.7
F44	Dissociative (conversion) disorders	993	0	46	1,039	1.2
F45, F48	Somatoform and other neurotic disorders	365	0	258	623	0.7
F50	Eating disorders	925	0	153	1,078	1.2
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	805	0	279	1,084	1.2
F60	Specific personality disorders	1,198	13	62	1,273	1.4
F61–F69	Disorders of adult personality and behaviour	95	0	48	143	0.2
F70–F79	Mental retardation	177	0	4	181	0.2
F80–F89	Disorders of psychological development	398	3	14	415	0.5
F90	Hyperkinetic disorders	39	2	0	41	—
F91	Conduct disorders	350	4	4	358	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	365	7	7	379	0.4
F99	Mental disorder not otherwise specified	140	0	1	141	0.2
G30	Alzheimer's disease	1,852	1	285	2,138	2.4
	Other factors related to mental and behavioural disorders and substance use[(b)]	529	51	8	588	0.7
	Other specified mental health-related principal diagnosis[(c)]	5,233	0	1,883	7,116	8.0
Total		**76,997**	**544**	**11,102**	**88,643**	**100.0**

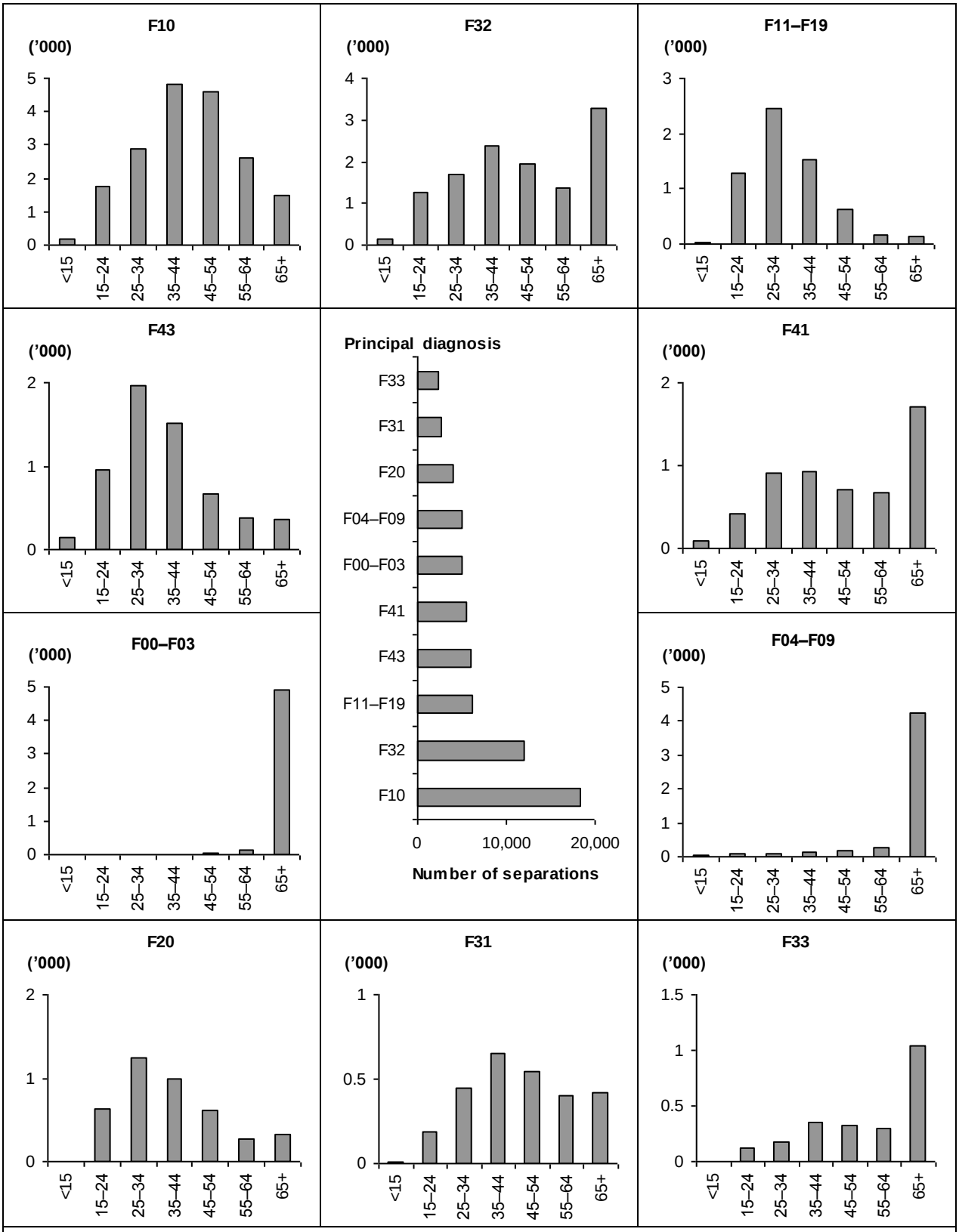
— Rounded to zero.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis as listed in Appendix 4.

Source: National Hospital Morbidity Database.



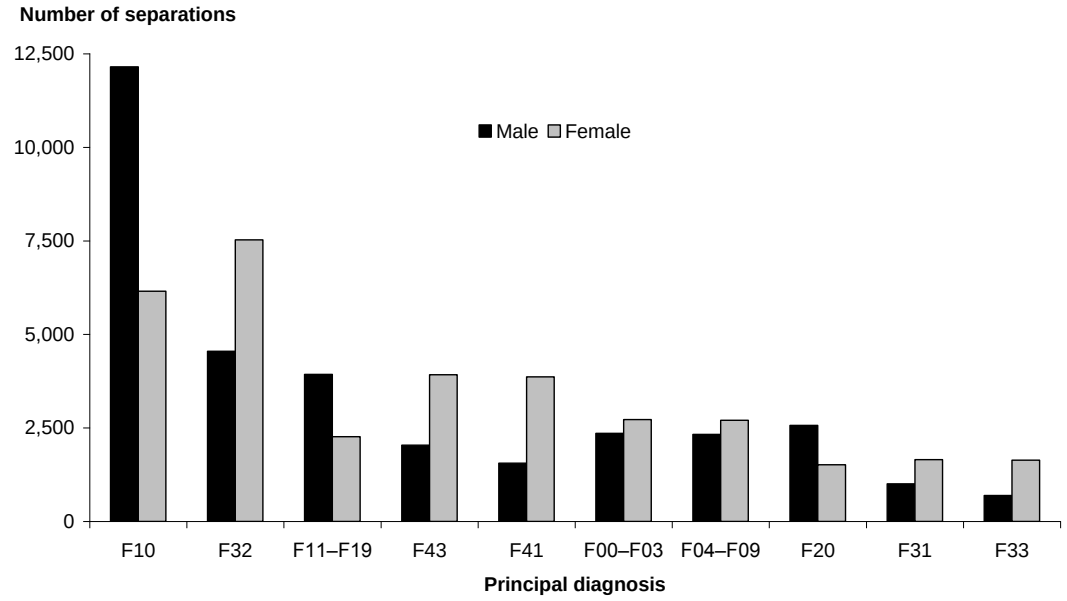
Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Source: National Hospital Morbidity Database.

Figure 7.10: Admitted patient mental health-related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and age group, 2007–08

Key to the principal diagnosis codes in figures 7.10 and 7.11

F00–F03	Dementia
F04–F09	Other organic mental disorders
F10	Mental and behavioural disorders due to use of alcohol
F11–F19	Mental and behavioural disorders due to other psychoactive substance use
F20	Schizophrenia
F31	Bipolar affective disorders
F32	Depressive episode
F33	Recurrent depressive disorders
F41	Other anxiety disorders
F43	Reaction to severe stress and adjustment disorders



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

Source: National Hospital Morbidity Database.

Figure 7.11: Admitted patient mental health-related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and sex, 2007–08

Procedures

Table 7.10 details the 10 procedures or interventions most frequently reported for mental health-related separations without specialised psychiatric care. Procedures are classified according to the *Australian Classification of Health Interventions, 5th edition*. Further information on the classification is included in Appendix 3.

In all, 111,055 procedures were reported for 50,646 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 42.9% (37,997 out of 88,643) of the separations. The most frequently reported procedure was *Allied health intervention, social work* (13,527 procedures for 13,503 separations). Other

allied health interventions also featured prominently in the 10 most frequently reported procedures.

Table 7.10: The 10 most frequently reported procedures for mental health-related admitted patient separations[(a)] without specialised psychiatric care, 2007–08

	Procedures[(b)]		Separations[(b)(c)]	
Procedure	**Number**	**Per cent**	**Number**	**Per cent**
95550-01 Allied health intervention, social work	13,527	12.2	13,503	15.2
95550-03 Allied health intervention, physiotherapy	10,403	9.4	10,385	11.7
56001-00 Computerised tomography of brain	8,808	7.9	8,776	9.9
93340-02 Electroconvulsive therapy ≤12 treatments	7,211	6.5	7,208	8.1
95550-02 Allied health intervention, occupational therapy	6,805	6.1	6,798	7.7
92514-99 General anaesthesia, ASA 99	6,594	5.9	5,767	6.5
95550-00 Allied health intervention, dietetics	4,872	4.4	4,862	5.5
92003-00 Alcohol detoxification	4,443	4.0	4,439	5.0
96175-00 Mental/behavioural assessment	2,841	2.6	2,837	3.2
95550-10 Allied health intervention, psychology	2,767	2.5	2,765	3.1
Other reported procedures	42,784	38.5	42,237	47.6
	Totals			
Number of separations with at least one procedure	. .	. .	50,646	57.1
Number of separations with no procedure reported	. .	. .	37,997	42.9
Total	**111,055**	**100.0**	**88,643**	**100.0**

. . Not applicable.

(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(b) The number of procedures may not equal the number of separations, as the same procedure may have been performed more than once for each separation.

(c) The sum of the number of separations is not necessarily equivalent to the total, as multiple procedures can be reported for each separation.

Source: National Hospital Morbidity Database.

7.5 Separations with mental health-related additional diagnoses

In addition to the 334,541 admitted patient mental health-related separations (both ambulatory and non-ambulatory), 288,960 separations were not classed as mental health-related (that is, did not have a mental health-related principal diagnosis or include specialised psychiatric care) but had at least one mental health-related additional diagnosis. These separations accounted for 2,920,276 patient days. The most commonly reported mental health-related additional diagnoses were *Mental and behavioural disorders due to use of alcohol* (F10; 61,907 separations), *Unspecified dementia* (F03; 52,353 separations) and *Depressive episode* (F32; 32,744 separations).

The most commonly reported principal diagnoses for these separations were *Care involving use of rehabilitation procedures* (Z50; 20,326 separations), *Other chronic obstructive pulmonary disease* (J44; 10,255 separations) and *Pneumonia, organism unspecified* (J18; 7,819 separations).

7.6 Additional data

Additional tables containing data on mental health-related admitted patient separations are available from the Australian Institute of Health and Welfare (AIHW) website. In addition, data on mental health-related separations for admitted patient mental health care from the NHMD can be accessed via interactive data cubes on the AIHW website. The data cubes allow users to create customised tables based on the number of separations by age group, sex, sector, mental health legal status, year and type of separation for each principal diagnosis. See Section 1.5 for details on how to access these additional resources.

8 Residential mental health care

8.1 Introduction

Non-ambulatory mental health-related care can be accessed in hospitals, as detailed in Chapter 7, or in facilities providing residential care. This chapter presents information on residential mental health services. The data presented are from the National Residential Mental Health Care Database (NRMHCD). The scope for this collection is all episodes of care in all government-funded residential mental health services in Australia, except those residential care services that are in receipt of funding under the *Aged Care Act 1997* and subject to Commonwealth reporting requirements. The inclusion of government-funded, non-government-operated services is optional.

For the 2007–08 data collection, all the facilities had mental health trained staff on-site 24 hours a day except for one South Australian facility that was staffed for 13 hours a day. Data from eight Tasmanian non-government organisations staffed 24 hours a day were also included in the 2007–08 collection. Appendix 1 provides information about the coverage and data quality of this collection.

Key concepts

Residential mental health care refers to residential care provided by residential mental health services. A residential mental health service is a specialised mental health service that:

- employs mental health trained staff on-site
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourages the residents to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of the day.

Episodes of residential care are defined as a period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period (that is, 1 July 2007)) and the end of residential care (either through the formal end of residential care, commencement of leave intended to be greater than 7 days, or the end of the reference period (that is, 30 June 2008)). An individual can have one or more episodes of care during the reference period.

Residential stay refers to the period of care beginning with a formal start of residential care and ending with a formal end of the residential care. It may involve more than one reference period (that is, more than one episode of residential care).

A ***resident*** is a person who receives residential care intended to be for a minimum of 1 night.

Residential care days refer to the number of days of care the resident received in the episode of residential care.

8.2 States and territories

In 2007–08, there were 3,222 ***episodes of residential care*** with 237,685 ***residential care days*** provided to an estimated 2,127 ***residents*** (Table 8.1). This corresponds to an average of 1.5 episodes of care per resident and 74 residential care days per episode. The number of residents reported may be an overestimate because the figure was derived from counting the number of unique resident identifiers for each individual facility reported to the database. Consequently, residents who used services from multiple providers will be counted more than once, which will inflate the overall count.

There were noticeable differences in the data across the states and territories. This may be due to differences in service delivery practices and the types of establishments categorised as ***residential mental health care*** facilities. Therefore, caution should be used in the interpretation of differences between jurisdictions. Queensland does not have any residential mental health care services.

Table 8.1: Episodes of residential mental health care, number of residents and residential care days, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas[(a)]	ACT	NT	Total
Episodes	305	1,498	. .	240	192	907	75	5	3,222
Estimated number of residents[(b)]	237	1,025	. .	169	177	449	65	5	2,127
Average episodes per resident[(b)]	1.3	1.5	. .	1.4	1.1	2.0	1.2	1.0	1.5
Residential care days	35,130	105,154	. .	7,715	13,319	59,654	14,979	1,734	237,685
Average residential care days per episode	115	70	. .	32	69	66	200	347	74
				Rate[(c)] (per 10,000 population)					
Episodes	0.4	2.8	. .	1.1	1.3	17.3	2.1	0.3	1.5
Estimated number of residents	0.3	2.0	. .	0.8	1.2	8.6	1.8	0.3	1.0
Residential care days	49.9	200.9	. .	36.3	88.0	1,158.5	405.6	98.8	111.1

. . Not applicable. Queensland does not have any residential mental health services.

(a) Tasmanian information contains data for government-funded residential units operated by the non-government sector in that state, being the only jurisdiction providing this level of reporting.

(b) The number of residents is likely to be overestimated, as residents who made use of services from multiple providers are counted separately each time.

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

Source: National Residential Mental Health Care Database.

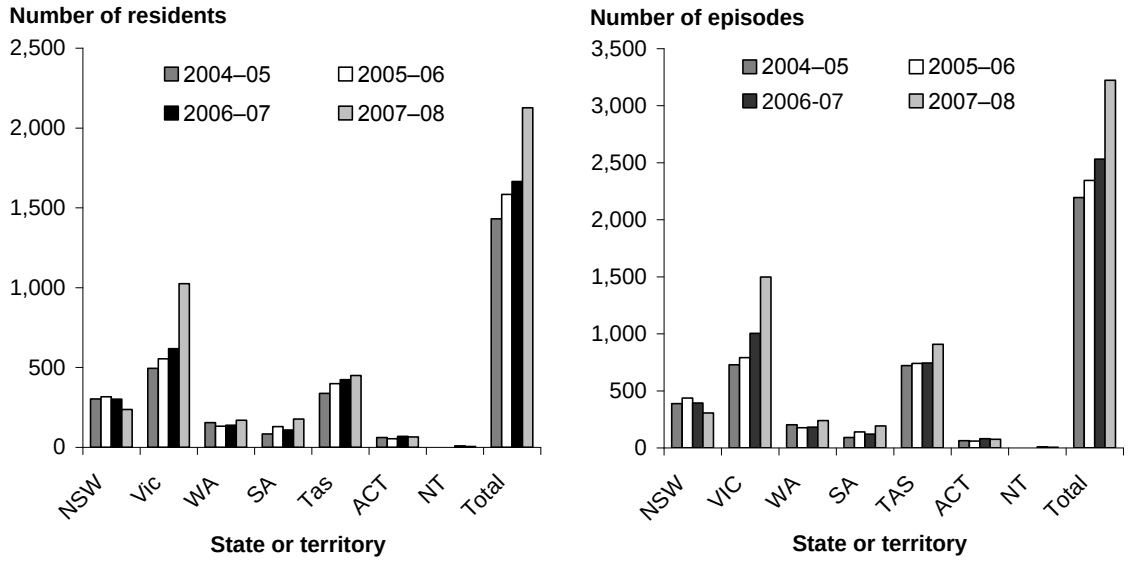
Tasmania reported an average of 2.0 episodes per resident, compared with the national average of 1.5. The highest average residential care days per episode was reported by the Northern Territory (347 days).

Tasmania also reported the highest number of episodes per 10,000 population (17.3), estimated number of residents (8.6) and residential care days (1,158.5). This may reflect the fact that Tasmania includes data from non-government residential units, which accounts for 12% of the Tasmanian episodes. New South Wales and the Northern Territory had the lowest number of residents (0.3 per 10,000 population), while Western Australia reported the lowest number of residential care days (36.3).

8.3 Change over time, 2004–05 to 2007–08

Nationally, there was an increase in the number of residential care episodes, from 2,531 episodes reported in 2006–07 to 3,222 episodes reported in 2007–08 (Figure 8.1). The number of residents accessing care also increased, with 2,127 residents accessing care in 2007–08 compared with 1,664 accessing care in 2006–07, an increase of 28%. The number of residential care days increased from 236.7 per 10,000 population in 2006–07 to 237.7 per 10,000 population in 2007–08.

Victoria reported the largest increases in the numbers of episodes and residents over the 4-year period. There were major increases in both episodes and residents in 2007–08, which was likely the result of six more Victorian service units operating and reporting to the database. New South Wales reported a decreasing number of residential episodes over the 4-year period.



Notes

1. The number of residents is likely to be overestimated, as residents who used services from multiple providers are counted separately each time.
2. Queensland does not have any residential mental health care services.

Source: National Residential Mental Health Care Database.

Figure 8.1: Residential mental health care episodes and residents, states and territories, 2004–05 to 2007–08

8.4 Mental health legal status

Table 8.2 presents data on the number of episodes of residential care by mental health legal status and jurisdiction for 2007–08. The majority of residential care episodes were for residents with voluntary legal status (60%) and, in the case of Western Australia, all residential care episodes were voluntary. The jurisdictional differences are likely to be a reflection of the different legislative arrangements in place in the jurisdictions.

Table 8.2: Episodes of residential mental health care, by mental health legal status, states and territories, 2007–08

Mental health legal status	NSW	Vic	WA	SA	Tas	ACT	NT	Total
Involuntary	67	783	0	35	66	54	3	1,008
Voluntary	220	715	240	157	564	21	2	1,919
Not reported	18	0	0	0	277	0	0	295
Total	**305**	**1,498**	**240**	**192**	**907**	**75**	**5**	**3,222**

Note: Queensland does not have any residential mental health care services.

Source: National Residential Mental Health Care Database.

Between 2004–05 and 2007–08, the number of involuntary residential mental health care episodes increased by an annual average of 63.4% (Table 8.3).

Table 8.3: Residential mental health care episodes, by mental health legal status, 2004–05 to 2007–08

Mental health legal status	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Involuntary	231	606	800	1,008	63.4
Voluntary	1,896	1,499	1,615	1,919	0.4
Not reported	67	240	116	295	63.9
Total	**2,194**	**2,345**	**2,531**	**3,222**	**13.7**

Source: National Residential Mental Health Care Database.

8.5 Patient demographics

Table 8.4 provides a summary of the demographics of residents receiving residential mental health care in 2007–08. In addition, a rate (per 10,000 population) is reported to account for relative population sizes and age structure differences. As these are reports of episodes of care rather than residents, the rates cannot be interpreted as the number of residents with specific characteristics per 10,000 population. Rather, they provide information on the number of episodes relative to the size of the population subgroup.

The highest proportion of residential care episodes was for residents aged 25–34 years (28.8%). This age group also had the highest number of episodes per 10,000 population (3.1). Those less than 15 years of age were least represented in residential mental health care.

There were more residential care episodes involving males than females. This is the case for all but the 55 years and over age groups (Figure 8.2).

While the highest proportion of residential care episodes was for residents of *Major cities*, the rate was highest for residents of *Inner regional* areas.

Table 8.4: Episodes of residential mental health care, by patient demographic characteristics, 2007–08

Patient demographics	Number of episodes[(a)]	Per cent of episodes[(b)]	Rate[(c)] (per 10,000 population)
Age group			
Less than 15 years	15	0.5	—
15–24 years	425	13.3	1.4
25–34 years	921	28.8	3.1
35–44 years	739	23.1	2.4
45–54 years	500	15.6	1.7
55–64 years	280	8.7	1.2
65 years and over	322	10.1	1.2
Sex			
Male	1,851	57.4	1.8
Female	1,371	42.6	1.3
Indigenous status[(d)]			
Indigenous Australians	87	2.9	1.9
Non-Indigenous Australians	2,962	97.1	1.4
Country of birth			
Australia	2,501	84.1	1.7
Overseas	474	15.9	0.8
Remoteness area of usual residence			
Major cities	1,631	51.7	1.1
Inner regional	1,307	41.4	3.3
Outer regional	206	6.5	1.1
Remote	10	0.3	0.3
Marital status[(e)]			
Never married	1,785	75.7	. .
Widowed	60	2.5	. .
Divorced	209	8.9	. .
Separated	89	3.8	. .
Married	216	9.2	. .
Total	**3,222**	**100.0**	**1.5**

. . Not applicable.

— Rounded to zero.

(a) The number of episodes for each demographic variable may not sum to the total due to missing and/or not reported data.

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

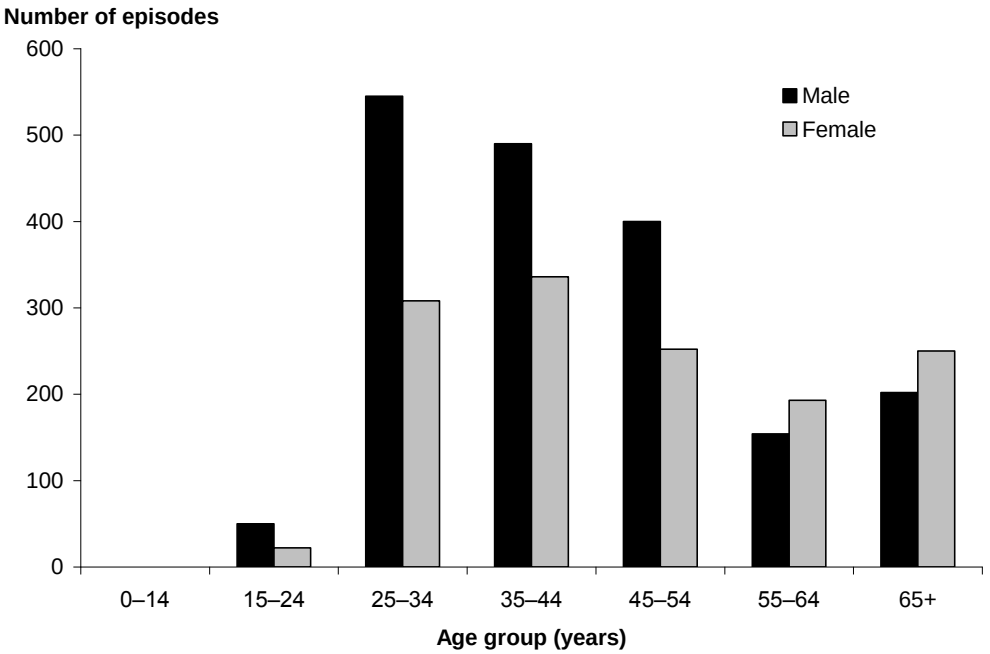
(c) Rates were directly age-standardised, with the exception of age, which is a crude rate, as detailed in Appendix 2.

(d) These data should be interpreted with caution due to the varying quality of Indigenous identification across jurisdictions (see Appendix 1).

(e) Information on this data element was missing and/or not reported for over 25 per cent of episodes.

Source: National Residential Mental Health Care Database.

The rate of episodes for Australian-born residents was noticeably higher than the rate of those born overseas (1.7 and 0.8, respectively). The majority of the episodes (75.7%) involved those who were never married. The data showed that the typical episode involved an Australian-born, non-Indigenous male aged 25–44 who had never been married and lived in a major city.



Source: National Residential Mental Health Care Database.

Figure 8.2: Residential mental health care episodes, by age and sex, 2007–08

8.6 Principal diagnosis

'Principal diagnosis' refers to the diagnosis established after study to be chiefly responsible for the resident's episode of residential mental health care. Table 8.5 presents the number of residential mental health care episodes for principal diagnosis groups for 2007–08. In this table, diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification* (ICD-10-AM) (NCCH 2006). Note that these data should be interpreted with caution due to variability in the data collection and coding practices for 'principal diagnosis' across Australia (for more information, see Appendix 1).

In 2007–08, a principal diagnosis was specified for 82.6% of episodes of residential care (2,661). For those episodes, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of residential care episodes (1,422 or 53.4%). Figure 8.3 shows that it was also a most commonly reported diagnosis for episodes with involuntary mental health legal status (494 or 49% of the total number of involuntary episodes).

Table 8.5: Episodes of residential mental health care, by principal diagnosis in ICD-10-AM groupings, 2007–08

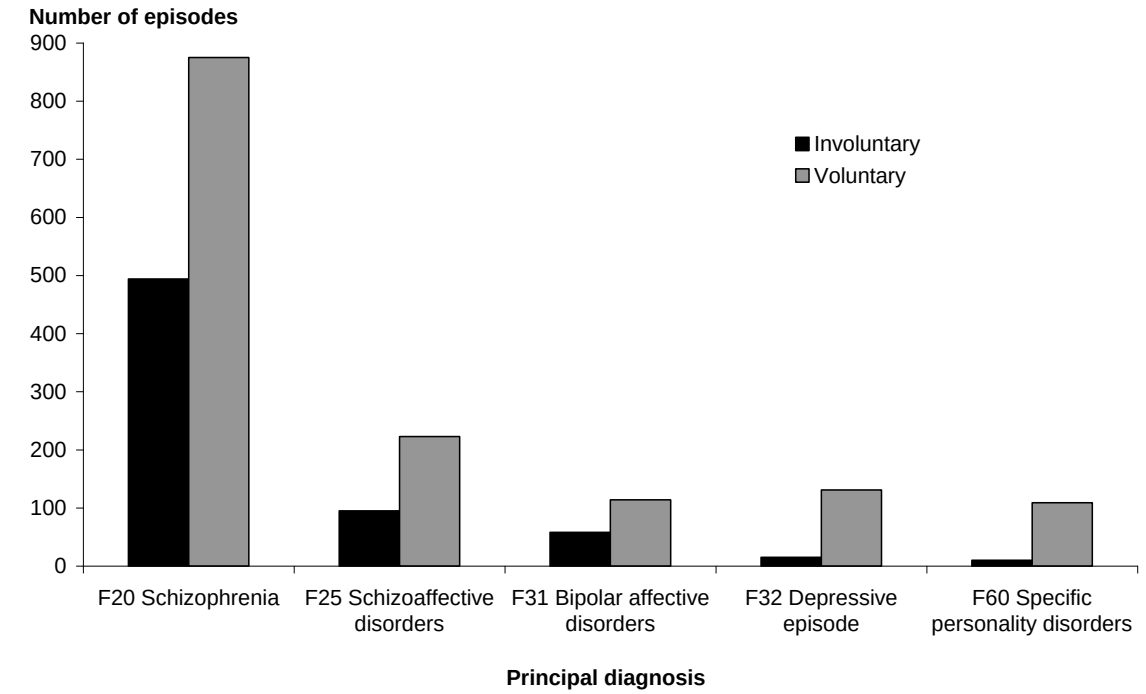
Principal diagnosis		Number of episodes	Specified principal diagnoses (per cent)
F00–F03	Dementia	60	2.3
F04–F09	Other organic mental disorders	11	0.4
F10	Mental and behavioural disorders due to use of alcohol	10	0.4
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	19	0.7
F20	Schizophrenia	1,422	53.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	33	1.2
F22	Persistent delusional disorders	14	0.5
F23	Acute and transient psychotic disorders	23	0.9
F25	Schizoaffective disorders	326	12.3
F30	Manic episode	7	0.3
F31	Bipolar affective disorders	237	8.9
F32	Depressive episode	196	7.4
F33	Recurrent depressive disorders	20	0.8
F34	Persistent mood (affective) disorders	17	0.6
F38, F39	Other and unspecified mood (affective) disorders	1	—
F40	Phobic anxiety	2	0.1
F41	Other anxiety disorders	29	1.1
F42	Obsessive-compulsive disorders	8	0.3
F43	Reaction to severe stress and adjustment disorders	37	1.4
F45, F48	Somatoform and other neurotic disorders	1	—
F50	Eating disorders	8	0.3
F60	Specific personality disorders	120	4.5
F61–F69	Disorders of adult personality and behaviour	8	0.3
F70–F79	Mental retardation	1	—
F80–F89	Disorders of psychological development	8	0.3
F90	Hyperkinetic disorders	1	—
F91	Conduct disorders	1	—
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	1	—
	Other[(a)]	40	1.5
Subtotal with specified principal diagnosis		*2,661*	*100.0*
F99	Mental disorder not otherwise specified	561	. .
Subtotal with unspecified principal diagnosis		*561*	. .
Total		**3,222**	**. .**

. . Not applicable.

— Rounded to zero.

(a) Includes all reported diagnoses that are not in the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99).

Source: National Residential Mental Health Care Database.



Source: National Residential Mental Health Care Database.

Figure 8.3: Residential episodes, for the five most commonly reported principal diagnoses, by mental health legal status, 2007–08

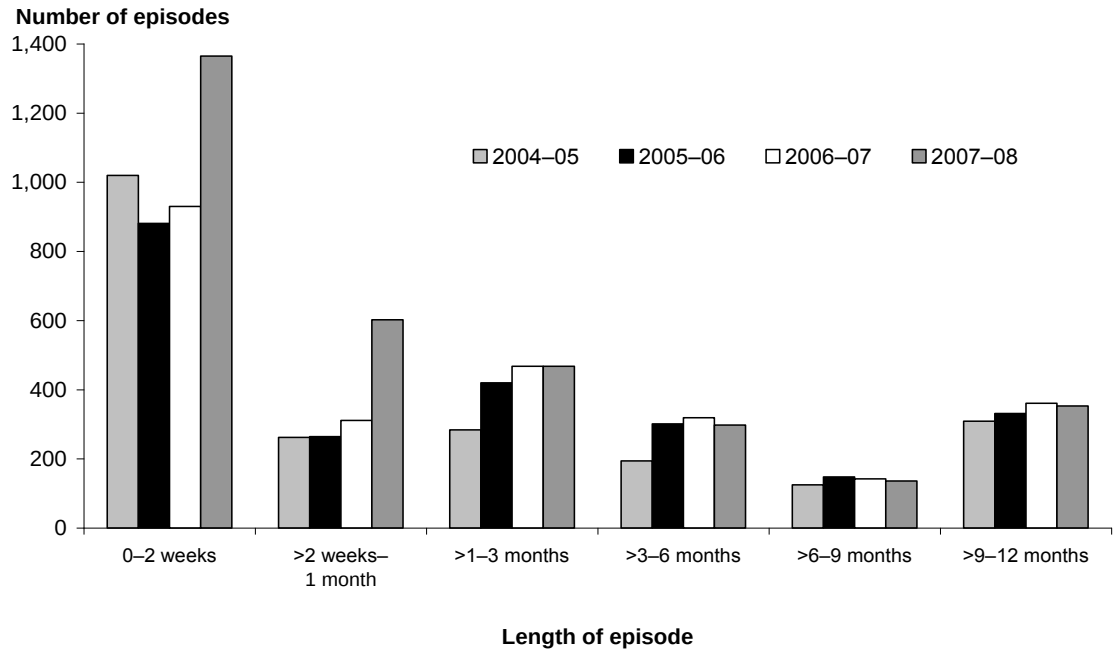
8.7 Length of episodes and residential stays

Episodes

The NRMHCD collects data on the episodes of residential mental health care that occurred during the collection period (that is, from 1 July 2007 to 30 June 2008). The length of episode is calculated by subtracting the date on which the episode started from the episode end date and deducting leave days. These leave days may occur for a variety of reasons, including receiving treatment by a specialised or non-specialised health service or spending time in the community. Note that episodes that started and ended on the same day are allocated an episode length of one day; in 2007–08 there were 63 such episodes, the great majority of them occurring in Victoria (79%).

For the 3,222 episodes of residential mental health care in 2007–08, there was a total of 237,685 residential mental health care days. The average length of stay per episode was 74 days and the median length of episode was 21 days. The most common length of episode was 3 days (195 episodes or 6%). There were 142 episodes (4%) that extended for the entire collection period (see Key concepts).

The increase in the number of episodes in 2007–08, is mainly due to the number of shorter length residential mental health care episodes (Figure 8.4).



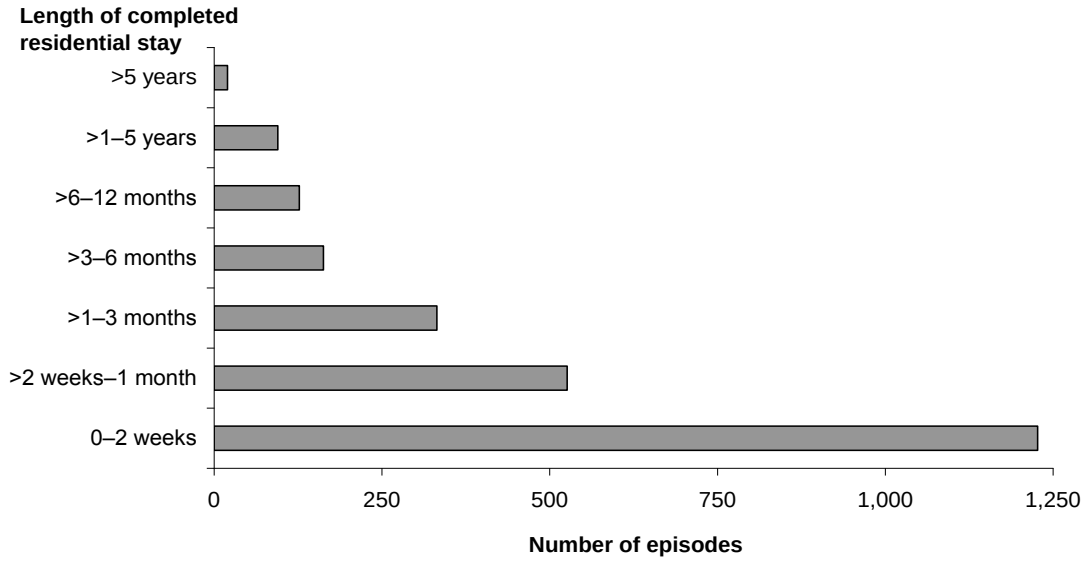
Source: National Residential Mental Health Care Database.

Figure 8.4: Episodes of residential mental health care, by length of episode, 2004–05 to 2007–08

Residential stays

Figure 8.5 shows the distribution of the length of residential stays for episodes which formally ended during 2007–08. There were 2,490 episodes (77% of 3,222) that fitted this criterion, noting that episodes with 30 June 2008 as the episode end date have been excluded. The number of days a resident was in residential care is calculated by subtracting the date on which the ***residential stay*** started from the episode end date and deducting any leave days recorded for 2007–08. A resident may have taken leave in the financial years before 2007–08 but these leave days cannot be accounted for because data on leave days prior to 2007–08 were not available. Consequently, the length of residential stay figures will be overestimates to the extent that leave days had occurred in previous years.

The average length of residential stay for episodes completed in 2007–08 was 93 days. The most common length of stay was 3 days and the median length of stay was 15 days. Episodes with a residential stay longer than 1 year constituted 4.6% (115 out of 2,490) of the episodes. There were eight reports of completed residential stays of 10 years or longer. The longest length of residential stay was 12.3 years.



Source: National Residential Mental Health Care Database.

Figure 8.5: Episodes of residential mental health care ending in 2007–08, by length of residential stay

8.8 Additional data

Additional tables containing data on episodes of residential mental health care are available on the Australian Institute of Health and Welfare website (see Section 1.5 for details).

9 Mental health-related Supported Accommodation Assistance Program services

9.1 Introduction

The Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC) includes data on the use of SAAP services by those clients with psychiatric or other mental health problems, defined by their having ***mental health-related closed support periods***. This chapter presents information on these mental health-related closed support periods, provided by SAAP agencies in 2007–08.

Supported Accommodation Assistance Program

The SAAP is governed by the *Supported Accommodation Assistance Act 1994*, with funding provided jointly by the Australian Government and the state and territory governments. The primary aim of SAAP is to provide people (***SAAP clients***) who are homeless or at risk of being homeless with transitional ***supported accommodation*** and ***other support services*** in order to help them achieve the greatest possible degree of self-reliance and independence (see Key concepts). Agencies funded through SAAP provide a range of both accommodation and non-accommodation support services.

Data presented in this chapter have been extracted from the Client Collection component of the SAAP NDC, one of three distinct segments of the SAAP NDC held by the Australian Institute of Health and Welfare. The Client Collection contains information on clients receiving SAAP support lasting for at least 1 hour. However, while participation and consent rates are high, not all SAAP agencies participate in the SAAP NDC and not all clients of participating agencies give valid consent to providing their details to the NDC. For further details regarding the scope and coverage of the SAAP Client Collection, see Appendix 1.

Key concepts

A ***SAAP client*** is a person aged 18 years or older or an unaccompanied child (aged under 18 years) who:

- receives support or assistance from a SAAP agency which entails generally 1 hour or more of a worker's time on a given day, or
- is accommodated by a SAAP agency, or
- enters into an ongoing support relationship with a SAAP agency.

Supported accommodation is accommodation paid for or provided directly by a SAAP agency. This includes crisis or short-term accommodation, medium- to long-term accommodation or other SAAP-funded arrangements such as accommodation in hostels, motels, hotels and caravans, or community placements. This category also includes other types of support, such as meals and/or showers, in addition to accommodation.

(continued)

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

An ***accommodation period*** is the period in which the client was in SAAP-supported accommodation. A client may have no accommodation periods or one or more accommodation periods within a support period.

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

Mental health-related closed support periods are closed support periods for which at least one of the following were reported:

- the source of referral to the SAAP agency was a dedicated psychiatric unit
- the main, or other, presenting reason for seeking assistance was the client's psychiatric illness or mental health issue
- the client reported an accommodation type of psychiatric institution either before or after SAAP support
- the type of support needed, provided or referred was psychological services or psychiatric services.

An ***accompanying child*** is less than 18 years of age and has a parent or guardian who is a SAAP client. This means that the child accompanies a parent or guardian at any time during the parent's or guardian's support period or receives SAAP assistance directly as a consequence of a parent's or guardian's support period.

Mental health-related SAAP services

The SAAP Client Collection includes information on source of referral, presenting reasons and type of assistance. Information from each of these data elements has been used to indicate whether or not a SAAP support period was mental health-related and, in turn, how many clients received mental health-related closed support periods.

The number of mental health-related closed support periods reported in this chapter is an underestimate of the actual number of such support periods for the following reasons:

- Data presented in this chapter are unweighted, meaning that there has been no adjustment for undercounting support periods due to the non-participation of some agencies and the non-consent of some SAAP clients to the provision of their data. The data, therefore, are not comparable with other data published from the SAAP Client Collection, nor between *Mental health services in Australia* publications.
- Information on presenting reasons for seeking assistance is only collected from clients who give consent. In addition, consenting clients with mental disorders may not report 'psychiatric illness' as a presenting reason.
- Information is collected by workers in SAAP agencies; these workers may not be trained to assess a client's need for psychiatric or psychological services.

It is important to note that some clients who were identified as having had mental health-related closed support periods may have had other closed support periods for which no mental health-related information was reported. These latter support periods are not included in the data presented in this chapter.

Further information on the SAAP collection, including coverage, data quality and the use of unweighted data in this chapter, is presented in Appendix 1.

9.2 SAAP clients with mental health-related closed support periods

In 2007–08, there were 15,215 SAAP clients with at least one mental health-related closed support period (Table 9.1). The average number of mental health-related closed support periods per client was 1.5.

Clients aged 25–44 years represented over half (51.7%) of the total number of clients for 2007–08. The number of clients per 100,000 population was highest for the group aged 18–19 years and lowest for those aged less than 15 years (145.4 and 7.4 per 100,000 population, respectively) (Table 9.1).

There were more female than male clients with mental health-related support periods in 2007–08 (51.3% compared with 48.7%). However, the rate of access to mental health-related closed support periods, as measured by the age-standardised rate, was higher for male clients (112.4 per 100,000) than for females (101.2).

In 2007–08, Aboriginal and Torres Strait Islander people made up 11.2% of clients with mental health-related closed support periods. This proportion is considerably higher than the estimated Indigenous population proportion of 2.5% of the total Australian population as at 30 June 2006 (ABS 2009a). The age-standardised rate for Indigenous Australians was 416.3 per 100,000 for closed support periods, which was nearly 5 times the rate for non-Indigenous Australians (88.0).

Most clients (86.0%) were born in Australia. The age-standardised rate for Australian-born people who had a SAAP mental health-related closed support period in 2007–08 was more than twice that of the overseas-born clients (83.2 and 39.0 per 100,000 population, respectively). The rate for the number of closed support periods for Australian-born clients was also more than twice the rate for overseas-born clients (116.9 and 53.3 per 100,000 population, respectively).

The SAAP clients in 2007–08 who were overseas-born (14.0%) can be classified into English Proficiency Country Groups (EP groups) (see Appendix 3 for details). There are four EP groups, with those classified in EP group 1 having the highest English proficiency. There was considerable variation in client rates of access between the EP country groups, ranging from 31.1 to 53.5 per 100,000 population. When usage rates were calculated for the number of closed support periods, those clients born in EP group 3 had the highest usage rates (69.8 closed support periods per 100,000 population).

Children accompanying clients

Information is collected on children who accompany their parent(s) or guardian(s) to SAAP agencies or who require assistance from a SAAP agency as a result of their parent or guardian being a client of the same agency. The number of ***accompanying children*** is additional to the number of clients (that is, adults and unaccompanied children) detailed above.

In 2007–08, 6,849 children accompanied clients who had mental health-related closed support periods. Over three-quarters of these children were aged 0 to 12 years (Figure 9.1).

Table 9.1: SAAP clients with mental health-related closed support periods: demographic characteristics and number of support periods, 2007–08

	Clients			Closed support periods		
Client demographics	Number[a][b]	Per cent of clients[b]	Rate[b][c] (per 100,000 population)	Number[a][b]	Per cent of support periods[b]	Rate[b][c] (per 100,000 population)
Age group						
Less than 15 years	304	2.0	7.4	341	1.6	8.3
15–17 years	1,168	7.7	134.2	1,479	7.0	169.9
18–19 years	853	5.6	145.4	1,095	5.2	186.7
20–24 years	1,944	12.8	128.4	2,536	12.0	167.5
25–44 years	7,869	51.7	130.0	11,098	52.4	183.3
45–64 years	2,847	18.7	53.6	4,238	20.0	79.8
65 years and over	230	1.5	8.2	389	1.8	13.9
Sex						
Female	7,805	51.3	75.1	10,547	47.2	101.2
Male	7,410	48.7	70.6	11,810	52.8	112.4
Indigenous status						
Indigenous Australians	1,621	11.2	312.4	2,131	10.6	416.3
Non-Indigenous Australians	12,887	88.8	63.1	18,002	89.4	88.0
Country of birth						
Australia	12,733	86.0	83.2	17,811	86.0	116.9
Overseas	2,080	14.0	39.0	2,900	14.0	53.3
Overseas-born[d]						
EP group 1	679	32.6	37.5	995	34.3	54.5
EP group 2	432	20.8	31.1	616	21.2	44.2
EP group 3	807	38.8	53.5	1,071	36.9	69.8
EP group 4	162	7.8	42.0	218	7.5	55.8
Total number	**15,215**	**100.0**	**72.7**	**22,509**	**100.0**	**107.3**

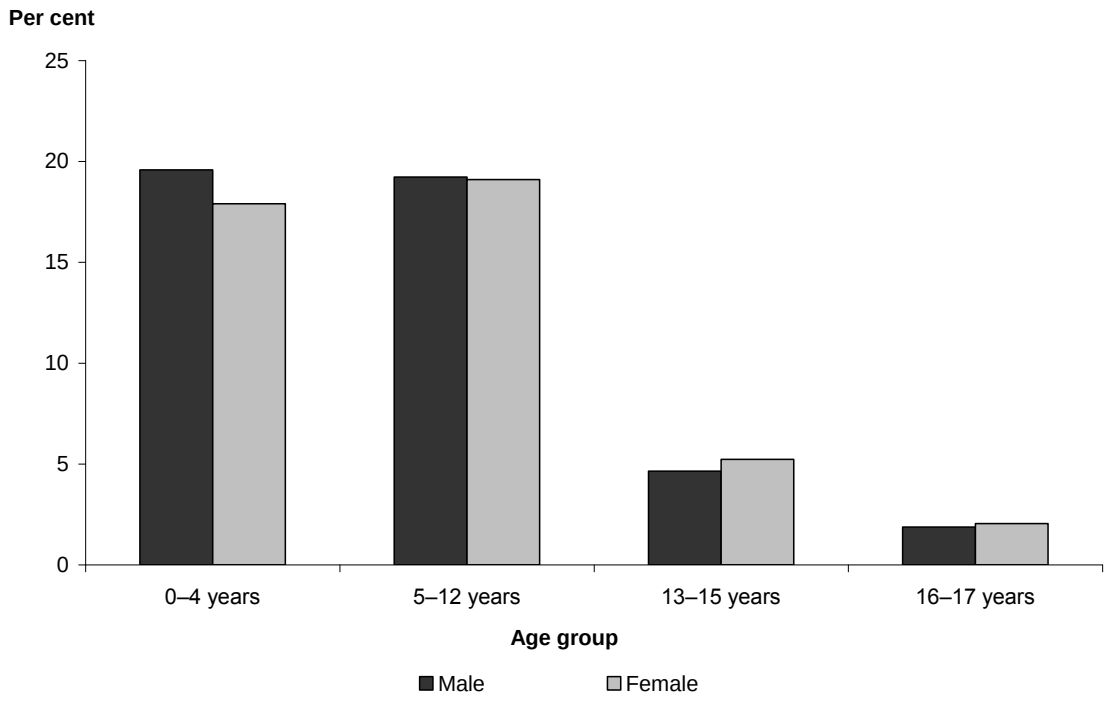
(a) The number of clients for Indigenous status, and number of closed support periods for Indigenous status and Country of birth, were missing and/or not reported for nearly 5% of the total.

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

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

(d) For definition of the EP groups, see Appendix 3.

Source: Supported Accommodation Assistance Program Client Collection.



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.1: Children accompanying SAAP clients with mental health-related closed support periods, by age and sex of child, 2007–08

9.3 SAAP mental health-related closed support periods

The previous section focused on the characteristics of SAAP clients who had a mental health-related closed support period in 2007–08. This section presents information on the closed support periods and the SAAP services provided to these clients. There were 172,140 closed support periods for all SAAP support types in 2007–08 (unweighted data), and 22,509 mental health-related closed support periods reported for clients, representing 13.1% of the total closed support periods.

Type of support period

Of the mental health-related closed support periods provided by SAAP in 2007–08, 10,321 (45.9%) involved supported accommodation services, which may include other support services, while 12,188 (54.1%) involved a range of other support services, which did not include accommodation (Table 9.2).

Supported accommodation services were the dominant SAAP support service provided to clients in New South Wales, Queensland, Western Australia, the Australian Capital Territory and the Northern Territory (Table 9.2). Other support services were the dominant SAAP service provided in Victoria and South Australia. Tasmania had an approximately even spread between supported accommodation services and other support services.

Taking population size differences into account, the distribution of mental health-related closed support periods varied considerably among the states and territories. In 2007–08, the Northern Territory had the highest rate of mental health-related closed support periods per 100,000 population (184.0), whereas Western Australia had the lowest rate (46.3) (Table 9.2).

Table 9.2: SAAP mental health-related closed support periods, by service type, states and territories, 2007–08

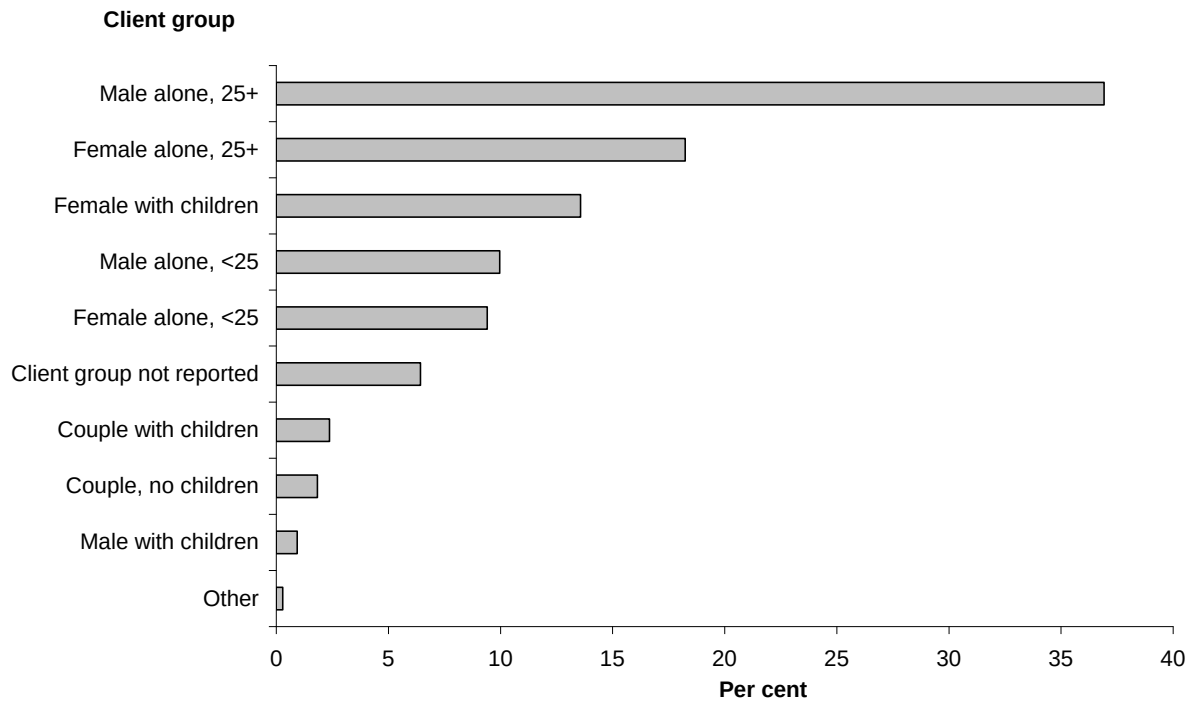
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number				
Supported accommodation	3,628	2,371	2,462	553	534	286	264	223	10,321
Other support services	2,546	6,290	1,228	436	1,066	280	165	177	12,188
Total	**6,174**	**8,661**	**3,690**	**989**	**1,600**	**566**	**429**	**400**	**22,509**
					Rate[(a)] (per 100,000)				
Supported accommodation	52.2	45.1	58.0	25.9	33.5	57.7	77.2	102.6	48.6
Other support services	36.7	119.5	28.9	20.4	66.9	56.5	48.2	81.4	57.4
Total	**88.9**	**164.6**	**87.0**	**46.3**	**100.4**	**114.3**	**125.4**	**184.0**	**106.0**

(a) Crude rate is based on the Australian estimated resident population as at 31 December 2007.

Source: Supported Accommodation Assistance Program Client Collection.

Client groups

In the SAAP data collection, each client is allocated to a client group based on the client's sex, age group and mode of presentation to the SAAP agency. In 2007–08, the client group with the highest proportion of mental health-related closed support periods was unaccompanied males aged 25 years and over (36.9%), followed by unaccompanied females aged 25 years and over (18.2%) (Figure 9.2).

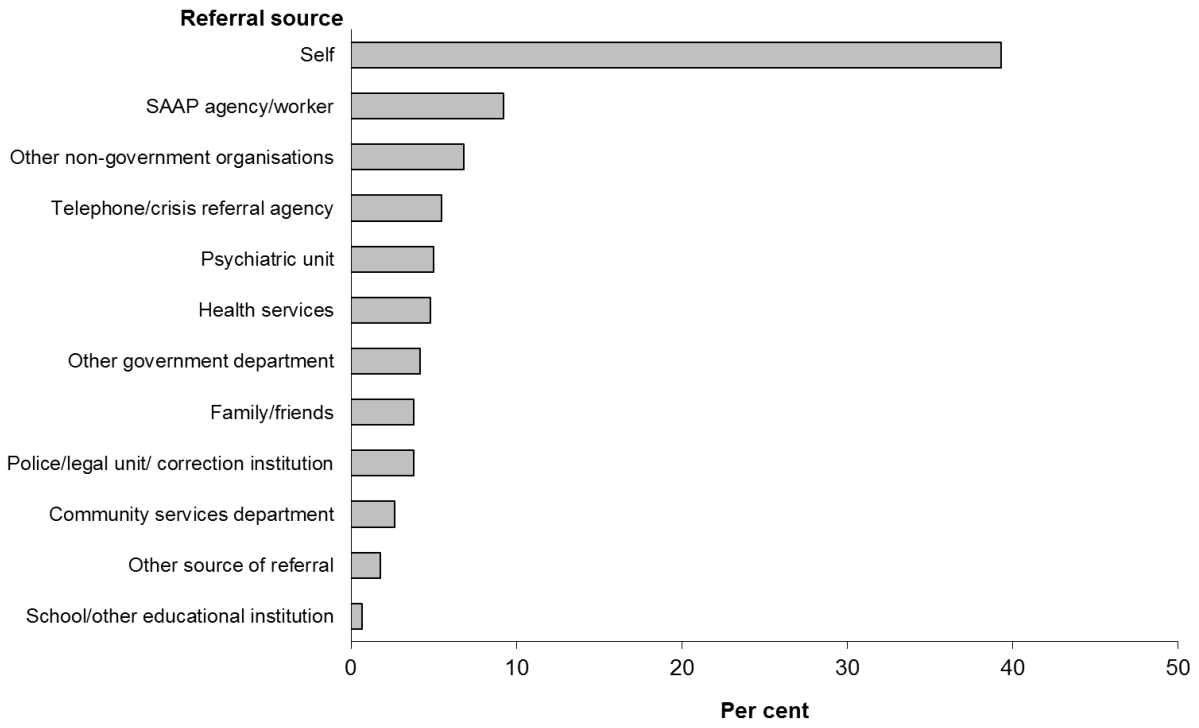


Source: Supported Accommodation Assistance Program Client Collection

Figure 9.2: SAAP mental health-related closed support periods, by client group type, 2007–08

Source of referral to SAAP services

There are several ways in which prospective SAAP clients come in contact with a SAAP agency. In 2007–08, self-referral was the most common form of referral to SAAP services for mental health-related support periods (39.3%), followed by referrals from other SAAP agencies or workers (9.2%) and referrals from other non-government organisations (6.8%) (Figure 9.3).



Note: Not shown here are those closed support periods for which source of referral was missing and/or not reported.

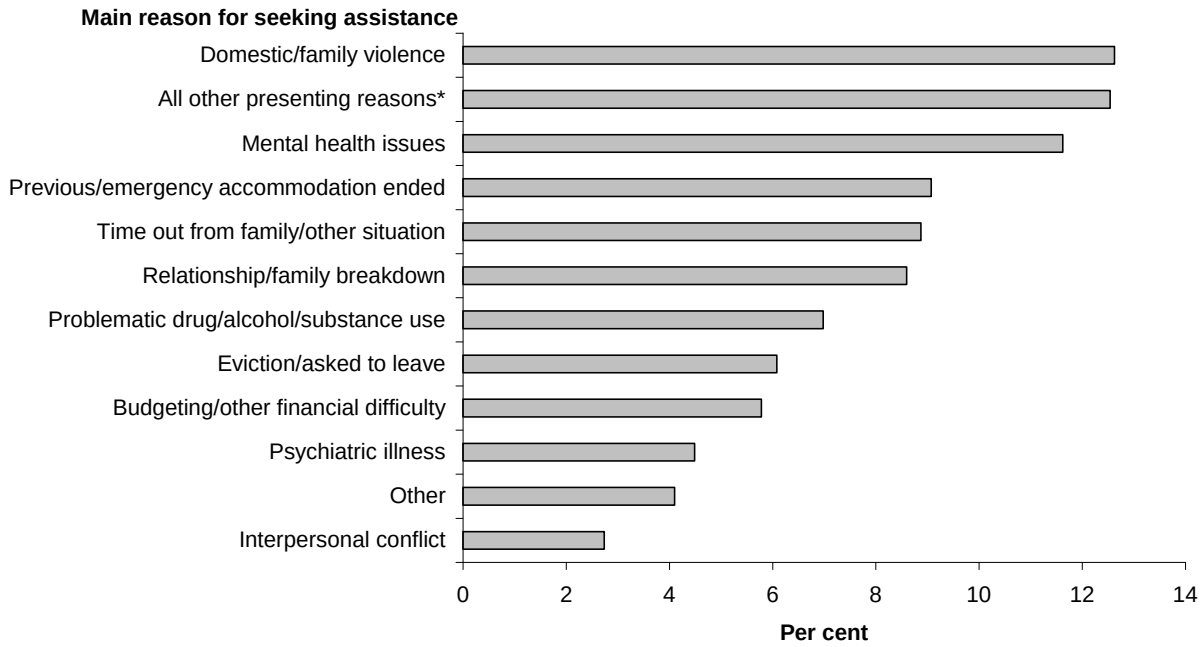
Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.3: SAAP mental health-related closed support periods, by source of referral, 2007–08

Main reason for seeking SAAP assistance

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

Figure 9.4 illustrates the main presenting reasons for clients receiving mental health-related closed support periods. During 2007–08, of those clients receiving a mental health-related closed support period, *Mental health issues* or *Psychiatric illness* were reported as the main reasons for seeking SAAP assistance in 11.6% and 4.5% of closed support periods, respectively (Figure 9.4). *Domestic or family violence* (12.6%) was the most common main reason for seeking assistance by clients receiving a mental health-related SAAP closed support period, while *All other presenting reasons* accounted for 12.5%.



* All other presenting reasons includes the categories *gambling*, *gay/lesbian/transgender issues*, *itinerant*, *other health issues*, *overcrowding issues*, *physical/emotional abuse*, *recent arrival to area with no means of support*, *recently left institution*, *rent too high*, and *sexual abuse*.

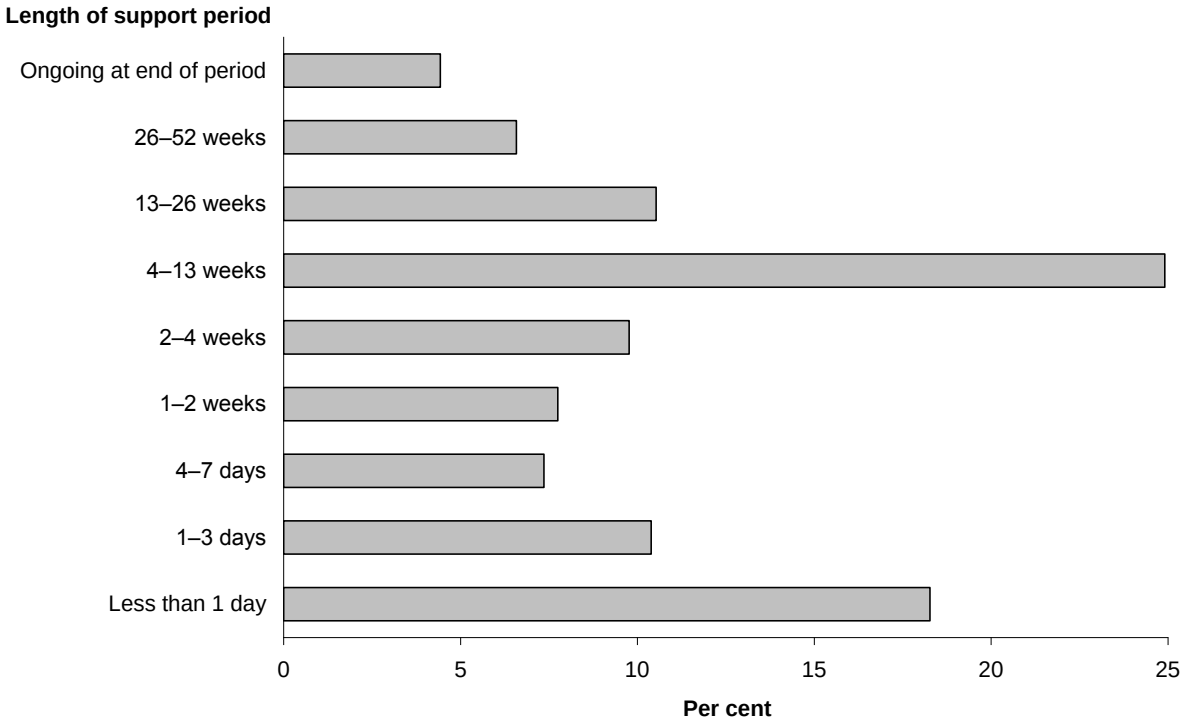
Note: Not shown are those closed support periods for which source of referral was missing and/or not reported or no consent was provided.

Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.4: SAAP mental health-related closed support periods, by main presenting reason for seeking assistance, 2007–08

Length of support period

The length of the closed support period is collected for each service provided. This can vary from less than 1 day to a full calendar year. The distribution of the length of stay for mental health-related support periods is shown in Figure 9.5. The most common length of stay was 4–13 weeks (24.9%) followed closely by less than 1 day (18.3%).



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.5: SAAP mental health-related closed support periods, by length of support, 2007–08

10 Support services for people with psychiatric disability

10.1 Introduction

The third Commonwealth State/Territory Disability Agreement (CSTDA) (FaCS 2002) provided the framework for the Australian and state and territory governments to collaboratively supply specialist support services to people with disabilities, until 31 December 2008. The framework promoted the shared core belief of a just and inclusive society that responded to the needs of all individuals. The CSTDA specifies that the Australian Government was responsible for the planning, policy setting and management of employment services, and that the states and territories were responsible for all other disability support services. Support for advocacy, information and print disability services was a shared responsibility (FaCS 2002). From 1 January 2009, the National Disability Agreement replaced the CSTDA for the provision of disability services in Australia.

The CSTDA defined 'people with disabilities' as those people with disabilities attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which was likely to be permanent and result in substantially reduced capacity in self-care or management, mobility or communication. In addition, the needs of these individuals should be identified as being likely to be significant and ongoing and/or require long-term episodic support. Also, the disability must have manifested itself before the age of 65 years (FaCS 2002).

Information presented in this chapter has been extracted from the CSTDA National Minimum Data Set (NMDS), which is a national collation of data on the disability support services receiving CSTDA funding, including the estimated number of service users. The data are from the most recent collection (2007–08), along with 2006–07 data, where applicable for comparative purposes. There were jurisdictional variations in the services funded under the CSTDA and thus comparisons among the states and territories must be undertaken with caution. See Appendix 1 for further information on data quality, coverage and other aspects of the CSTDA data collection.

The data presents detail on CSTDA-funded disability support services provided to service users with a psychiatric ***disability group*** either as their ***primary disability*** or as an ***other significant disability*** (see Key concepts). A person who fulfilled the CSTDA definition of 'people with disabilities' may receive a range of ***residential*** CSTDA-funded ***service types***, depending on availability and their individual needs. In addition, service users may receive ***non-residential*** CSTDA-funded services, described by ***service groups***, independent of, or in conjunction with, residential services.

Data presented cover both of these types of services. CSTDA-funded services providing the non-residential support group *employment*, received funding directly from the Australian Government, from the Department of Families, Housing, Community Services and Indigenous Affairs or the Department of Education, Employment and Workplace Relations. State or territory administered services include those CSTDA-funded services providing any residential service and those providing the non-residential service groups of *accommodation support*, *community support*, *community access* and *respite*. Joint funding of the agency may

occur between the state/territory and the Australian Government as specified by the CSTDA agreement.

For further details on CSTDA-funded services see *Disability support services 2007–08* (AIHW 2009b). Data on the quantity (or hours) of support received are *not* presented in this report, as the information collected relates only to selected non-residential services and has a high proportion of missing information.

Overall, 245,746 people across Australia made use of CSTDA-funded services during 2007–08, an increase of 5.8% from 2006–07. The most common primary disability among these clients was intellectual disability (31.5%). ***Psychiatric disability*** rated as the second most commonly reported primary disability, at 16.3%, ahead of physical disability, 14.8%.

Key concepts

Disability groups are a broad categorisation of disabilities in terms of the underlying health condition, impairment, activity limitations, participation restrictions, environmental factors and support needs (NCSDC 2006). The 12 categories for the CSTDA collection are: intellectual; specific learning/attention-deficit disorder; autism; physical; acquired brain injury; neurological; deaf/blind; vision; hearing; speech; psychiatric; and developmental delay. For the CSTDA data, the relevant disability groups are identified by the service user, carer and/or service provider.

Primary disability is the disability group that most clearly expresses the experience of disability by a person, causing the most difficulty for the person in their daily life.

Other significant disability refers to disability group(s) other than that indicated as being 'primary' that also clearly expresses the experience of disability by a person and/or causes difficulty for the person. A number of other significant disabilities may be identified for each service user from the categories mentioned above.

Psychiatric disability in the CSTDA collection includes clinically recognisable symptoms and behaviour patterns frequently associated with distress and which may impair functioning in normal social activity. The typical effects of conditions such as schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders are included but dementias, specific learning disorders (such as attention-deficit disorder) and autism are excluded. Note that items specific to autism are included in Medicare Benefits Schedule data (chapters 6 and 14).

Service type and ***service group*** refer to the classification of services according to the support activity that the service provider has been funded to provide under the CSTDA. For the purpose of this report, service types relate to residential services. Service groups relate to the provision of non-residential services.

Residential services are services that provide accommodation for people with a disability. They include accommodation in large and small residentials/institutions, hostels and group homes.

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

10.2 CSTDA services overview

In 2007–08, 58,044 people with a psychiatric disability used CSTDA-funded services, an increase of 22% from 2006–07 (tables 10.1 and 10.2). This increase may be due to an increase in the number of people identified as having a psychiatric disability, or due to an overall rise in the number of people with a psychiatric disability using CSTDA-funded services, or a combination of these two factors.

The number of service users with 'not stated' and 'not known' responses for primary disability group varies between collection periods and among jurisdictions, and affects the number of people identified as having a psychiatric disability. In 2007–08, the number of 'not stated' and 'not known' responses for primary disability ranged among jurisdictions from zero to 23.4%. See Appendix 1 for additional information.

While at both the national and the state and territory levels the number of non-residential service users far outweighed the number of residential service users, the proportions differed considerably across the states and territories. For example, 15.5% of service users in the Australian Capital Territory accessed residential services, whereas 2.7% did so in Queensland; the national average was 6.2%.

In 2007–08, 40,031 service users with a psychiatric disability identified as having a primary psychiatric disability (Table 10.1). Of these, non-residential services were provided to the greatest number of people accessing CSTDA-funded state- or territory-administered services, with a relatively small proportion receiving residential services. Australian Government-funded agencies provided employment services to 24,154 service users identified as having a primary psychiatric disability.

Table 10.1: CSTDA-funded service users with a psychiatric disability, states and territories[a], 2007–08

	NSW	Vic[b]	Qld	WA	SA[c]	Tas	ACT	NT	Total[d]
					Primary psychiatric disability[e]				
State/territory administered services									
Non-residential	881	13,636	2,061	185	172	164	26	13	15,626
Residential	160	145	79	n.p.	18	36	n.p.	n.p.	413
Australian Government funded services									
Non-residential	7,617	7,318	4,855	1,896	1,649	480	306	136	24,154
Subtotal[f]	*8,502*	*19,926*	*6,762*	*2,044*	*1,810*	*654*	*329*	*158*	*40,031*
					All service users with a psychiatric disability, all services[g]				
Non-residential	13,318	25,111	9,778	3,400	3,839	1,261	601	216	57,238
Residential	1,298	1,122	265	199	409	187	94	14	3,588
Total[h]	**13,589**	**25,383**	**9,863**	**3,451**	**3,899**	**1,312**	**607**	**226**	**58,044**

n.p. Not published.

(a) State/territory is based on the location of the CSTDA-funded service. Service type outlet response rates varied across jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2009b). See also Appendix 1.

(b) Users of residential rehabilitation services within Victoria's psychiatric disability rehabilitation and support sector (PDRSS) are classified as non-residential accommodation support services in the CSTDA NMDS.

(c) In South Australia, the psychiatric-specific disability services provided by the South Australian Department of Health's Mental Health Services and are not included in the CSTDA NMDS Collection.

(d) The number of service users may not sum to the total because service users may access services in more than one state or territory.

(e) Includes only those clients identified as having a primary psychiatric disability.

(f) The number of service users will not add to the total because service users may use both residential and non-residential services. In addition, service users may access services from both state/territory and Australian Government-funded agencies.

(g) Includes service users with a primary psychiatric disability and service users with a psychiatric disability not considered to be their primary disability.

(h) The number of service users will not add to the total because service users may use both residential and non-residential services.

Note: The extent to which psychiatric-specific services are included in the CSTDA NMDS Collection is included in Appendix 1.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Nationally, the number of service users accessing CSTDA-funded services between 2003–04 and 2007–08 increased by an annual average of 24.1% for non-residential services and 4.9% for residential services (Table 10.2). CSTDA-funded non-residential support service rates in 2007–08 increased to 270 per 100,000 population, from 182 in 2005–06. Residential service rates also increased in 2007–08 to 17 per 100,000 population, from 14 in 2005–06.

Table 10.2: CSTDA-funded service users with a psychiatric disability[(a)], 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
			Number			
Non-residential	24,108	34,833	37,309	46,848	57,238	24.1
Residential	2,958	3,014	2,959	3,397	3,588	4.9
Total[(b)]	**24,753**	**35,599**	**38,086**	**47,658**	**58,044**	**23.7**
			Rate[(c)] (per 100,000 population)			
Non-residential	n.a.	n.a.	182	225	270	. .
Residential	n.a.	n.a.	14	16	17	. .

. . Not applicable.

n.a. Not available.

(a) Includes service users with a primary psychiatric disability and service users with a psychiatric disability not considered to be their primary disability.

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

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

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

10.3 Residential services

A range of residential CSTDA-funded services are provided to service users, broadly defined as follows:

- *Large residentials/institutions* provide 24-hour residential support in a setting of more than 20 beds
- *Small residentials/institutions* provide 24-hour residential support in a setting of 7 to 20 beds
- *Hostels* provide residential support in a setting of usually less than 20 beds and may or may not provide 24-hour residential support. Unlike residentials/institutions, hostels do not provide segregated specialist services
- *Group homes* provide combined accommodation and community-based residential support to people in a residential setting and are generally staffed 24 hours a day. Usually, no more than six service users are located in any one home.

Nationally, service users with a psychiatric disability accessed residential services at a rate of 16.9 clients per 100,000 population. This rate was highest in Tasmania (37.7) and lowest in Queensland (6.2) (Table 10.3).

For clients with a psychiatric disability, *Group homes* were nationally the most widely used residential service type (71.5%) (Table 10.3). The profile of state and territory CSTDA-funded residential services used varied between jurisdictions (Table 10.3, Figure 10.1). *Group homes*

were the most used service type by clients with a psychiatric disability in all states. *Hostels* were most utilised in Tasmania (19.8%) while *Small institutions* were most utilised in Queensland (22.6%).

Table 10.3: CSTDA-funded residential service users with a psychiatric disability, by residential service type, states and territories[(a)], 2007–08

Residential service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]	Per cent
Large institutions	417	48	40	26	197	19	. .	. .	747	20.8
Small institutions	15	101	60	17	n.p.	n.p.	. .	. .	201	5.6
Hostels	10	40	. .	11	13	37	. .	. .	111	3.1
Group homes	866	948	166	151	199	129	94	14	2,567	71.5
Total[(c)]	**1,298**	**1,122**	**265**	**199**	**409**	**187**	**94**	**14**	**3,588**	**100.0**
Rate (per 100,000 population)[(d)]	18.7	21.3	6.2	9.3	25.7	37.7	27.5	6.4	16.9	. .

. . Not applicable.

n.p. Not published. Data cannot be derived from totals as service users may access more than one residential service type.

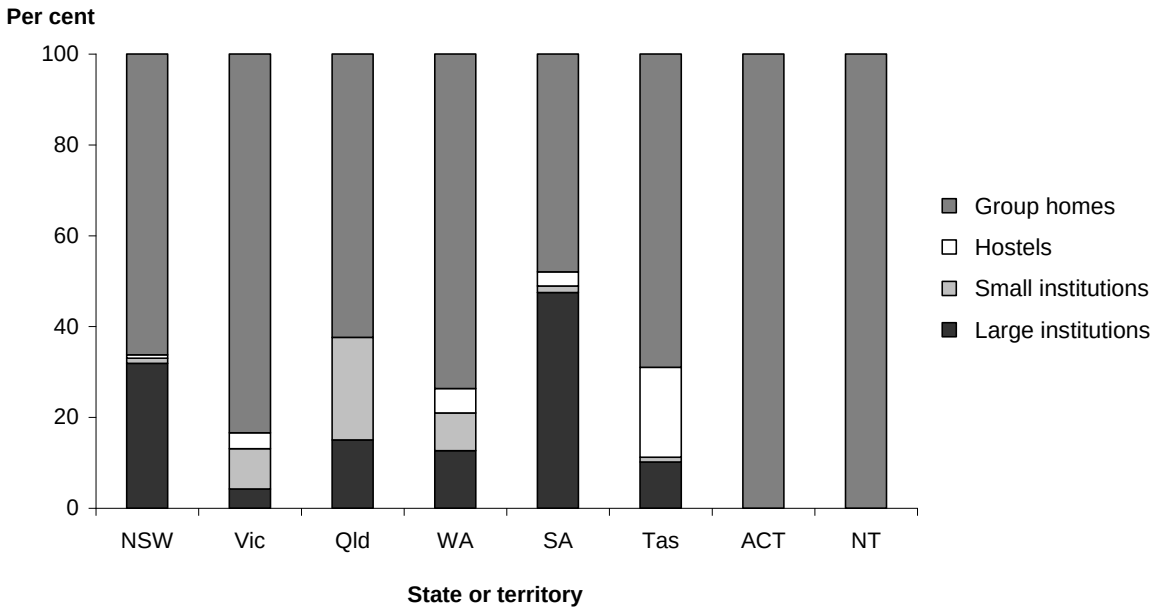
(a) State/territory is based on the location of the CSTDA-funded service. Service type outlet response rates varied across state/territory jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2009b). See also Appendix 1.

(b) The number of service users may not sum to the total because service users may access services in more than one state and/or territory.

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

(d) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2007.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.



Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Figure 10.1: Service users, by residential service type, states and territories, 2007–08

Profile of residential service users

As shown in Table 10.4, the most common primary disability of residential service users with a psychiatric disability for 2007–08 was intellectual disability (75.4%), with a relatively small proportion of users having a primary psychiatric disability (12.8%).

Table 10.4: CSTDA-funded residential service users with a psychiatric disability, by primary disability group, 2007–08

Primary disability group	Number of service users	Per cent of service users
Intellectual	2,705	75.4
Psychiatric	461	12.8
Physical	116	3.2
Acquired brain injury	112	3.1
Neurological	92	2.6
Autism	82	2.3
Other disability[(a)]	20	0.6
Total	**3,588**	**100.0**

(a) Includes the following disability groups: *hearing*, *vision*, *deaf/blind*, *speech*, *developmental delay* and *specific learning/attention-deficit disorder*.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.5 shows the demographic and geographic distribution of residential service users with a psychiatric disability in 2007–08.

There were more male users (57.1%) of CSTDA-funded residential services than females (42.9%), and the majority of residential users were aged 35–54 years (55.5%).

Aboriginal and Torres Strait Islander people made up a small proportion of CSTDA-funded residential service users (3.8%). However, when their population age structure and size were taken into account, Indigenous Australians were twice as likely as non-Indigenous Australians to utilise CSTDA-funded residential services (34 and 16 per 100,000 population, respectively).

The majority of residential service users were born in Australia (92.1%). When relative population sizes and age structures are considered, there was an under-representation of residential service users who were born overseas (4 per 100,000 population for overseas-born compared with 22 for Australian-born).

Most residential service users accessed CSTDA-funded services in *Major cities* (71.0%), followed by *Inner regional* areas (23.8%). However, *Inner regional* areas had the highest rate of usage (20 per 100,000 population). *Outer regional* and *Remote and very remote* areas had considerably lower numbers and rates of service use.

Almost all CSTDA-funded residential service users resided in some form of supported accommodation facility and/or received a disability support pension as shown in Table 10.6.

Table 10.5: Demographic characteristics of CSTDA-funded residential service users with a psychiatric disability, 2007–08

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate[(c)] (per 100,000 population)
Age group			
Less than 15 years	5	0.1	—
15–24 years	192	5.4	6
25–34 years	482	13.4	16
35–44 years	953	26.6	31
45–54 years	1036	28.9	35
55–64 years	673	18.8	28
65 years and over	245	6.8	9
Sex			
Male	2,047	57.1	19
Female	1,541	42.9	14
Indigenous status[(d)]			
Indigenous Australians	136	3.8	34
Non-Indigenous Australians	3,426	96.2	16
Country of birth			
Australia	3,282	92.1	22
Overseas	280	7.9	4
Remoteness area of usual residence[(e)]			
Major cities	2,536	71.0	17
Inner regional	848	23.8	20
Outer regional	180	5.0	9
Remote and very remote	6	0.2	1
Total	**3,588**	**100.0**	**17**

— Rounded to zero.

(a) The number of service users for each demographic variable may not sum to the total due to missing and/or not reported data.

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

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

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

(e) The number of service users in each remoteness area (RA) was estimated based on service users' residential postcodes. Some postcode areas were split between two or more RAs. Where this was the case, the data were weighted according to the proportion of the population of the postcode area in each RA. Therefore, the totals may not sum due to rounding of proportions.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.6: CSTDA-funded residential service users with a psychiatric disability, by usual residential setting, living arrangement and income source, 2007–08

	Number of service users[(a)]	Per cent of service users[(b)]
Usual residential setting		
Domestic-scale supported living facility	2,001	56.1
Supported accommodation facility	1,166	32.7
Private residence	189	5.3
Psychiatric/mental health community care facility	118	3.3
Residential aged care facility	33	0.9
Other[(c)]	63	1.8
Living arrangement		
Lives alone	182	5.1
Lives with family	96	2.7
Lives with others	3,292	92.2
Income source (adult 16 years and over)[(d)]		
Disability Support Pension	3,439	97.2
Other pension/benefit	63	1.8
Paid employment	6	0.2
Compensation income	15	0.4
Other income	8	0.2
No income	6	0.2
Total	**3,588**	**100.0**

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

(b) The percentages shown do not include those services for which information was missing and/or not reported.

(c) Other includes the following CSDTA NMDS usual residential setting categories: *short-term crisis*, *emergency or transitional accommodation*, *other accommodation type*, *boarding house/private hotel*, *hospital*, *independent living within a retirement village* and *public place/temporary shelter*.

(d) 3,576 of the residential service users with a psychiatric disability were aged 16 years or older. Each user can have more than one income source.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

10.4 Non-residential services

A range of non-residential CSTDA-funded services are provided to service users, defined under the following broad service group headings:

- *Accommodation support* involves support with the basic needs of living, assisting the individual to remain within their current living arrangement. It includes personal care by an attendant, in-home living support, alternative placement (such as shared-care arrangements and host family placements) and crisis accommodation support.
- *Community support* provides services to assist with non-institutionalised living arrangements, such as specialised therapeutic services, early childhood intervention, behaviour and specialist intervention, counselling and case management.

- *Community access* services are designed to provide opportunities for people with a disability to gain and use their abilities to enjoy their full potential for social independence. They include learning and life skills development, and recreation and holiday programs.
- *Respite* services provide a short-term and time-limited break for caregivers of people with a disability and include services such as those provided in the individual's home, in centres, in respite homes and with host families. Although respite is provided to both the person with a disability and their caregiver, in this report the person with the disability is regarded as the client, and numbers presented in tables reflect this definition.
- *Employment* support services include providing assistance in obtaining and/or retaining paid employment in both the open labour market and specialised and supported environments.
- *Advocacy, information and print disability* and *other* support include services such as advocacy, information, referral, mutual support, self-help groups, research, evaluation, training and development. (Note that no service user counts are collected for these services and therefore they are not included in Table 10.7 below.)

There was considerable variation between jurisdictions in the number of service users with a psychiatric disability accessing the different non-residential service groups in 2007–08, as shown in Table 10.7. Note that in this table the same person will be counted as multiple service users within each service group, if they have accessed more than one distinct service type. However, the totals shown in the table refer to the number of distinct individuals. Nationally, *Employment* services had the greatest number of users (59.3%), with *Respite* services having the least (7.4%). *Employment* services were provided to the most service users in most states and territories with the exception of Victoria, where *Community access* had the greatest number of users.

Table 10.7: CSTDA-funded non-residential service users[(a)] with a psychiatric disability, by service group, states and territories[(b)], 2007–08

Service group	NSW	Vic[(c)]	Qld	WA	SA	Tas	ACT	NT	Total	Per cent
Accommodation support	318	6,906	1,348	365	418	81	25	n.p.	9,195	16.1
Community support	1,682	3,045	1,983	793	1,400	261	350	41	7,830	13.7
Community access	1,918	10,124	2,076	420	720	380	102	14	15,105	26.4
Respite	531	3,100	704	225	148	23	87	n.p.	4,238	7.4
Employment	10,978	9,896	6,610	2,756	2,756	797	405	185	33,946	59.3
Total	**13,318**	**25,111**	**9,778**	**3,400**	**3,839**	**1,261**	**601**	**216**	**57,238**	**100.0**
Rate (per 100,000 population)[(d)]	192	477	230	159	241	255	176	99	270	. .

. . Not applicable.

n.p. Not published. Data cannot be derived from totals as service users may access more than one residential service group.

(a) Individual service users have been counted more than once within each service group if they have accessed more than one distinct service type within that group.

(b) State/territory is based on the location of the CSTDA-funded service. Service type outlet response rates varied across state/territory jurisdictions. Information relating to state/territory service user counts should be interpreted with reference to jurisdictional response rates (AIHW 2009b). See also Appendix 1.

(c) Users of residential rehabilitation services within Victoria's psychiatric disability rehabilitation and support sector are classified as users of non-residential accommodation support services in the CSTDA NMDS.

(d) Crude rate is based on the Australian estimated resident population as at 31 December 2007.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Profile of non-residential service users

In contrast to the users of residential services, 69.5% of CSTDA-funded non-residential service users who had a psychiatric disability reported psychiatric disability as their primary disability (Table 10.8).

Table 10.8: CSTDA-funded non-residential service users with a psychiatric disability, by primary disability group, 2007–08

Primary disability group	Number of service users	Per cent of service users
Psychiatric	39,780	69.5
Intellectual	7,117	12.4
Physical	5,139	9.0
Acquired brain injury	1,450	2.5
Neurological	1,088	1.9
Specific learning/attention deficit disorder	1,045	1.8
Other[(a)]	1,619	2.8
Total	**57,238**	**100.0**

(a) Includes the following disability groups: *autism*, *hearing*, *vision*, *deaf/blind*, *speech* and *developmental delay*.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.9 shows the demographic and geographic distribution of non-residential service users with a psychiatric disability in 2007–08.

There were more male users (56.7%) of CSTDA-funded non-residential services than female users (43.3%), which was almost the same as for users of residential services. Most non-residential users were aged 25–54 years (70.7%).

Although Aboriginal and Torres Strait Islander people made up a small proportion of users, when their population's relative age structure and size were taken into account Indigenous Australians were more than twice as likely as non-Indigenous Australians to have utilised non-residential CSTDA-funded services (579 and 2,54 per 100,000 population, respectively).

As was the case for the residential service users, most non-residential service users were born in Australia (82.3%). Those who were born overseas were relatively less likely than their Australian-born counterparts to have used these services (153 and 303 per 100,000 population, respectively). The highest rate of usage for non-residential services in the overseas-born group was the group of migrants born in countries in the lowest English Proficiency Country Group (EP group 4; 265 per 100,000 population).

Inner regional areas had the highest usage rate, and *Remote and very remote* areas had the lowest, when population age structure and size were taken into account.

Table 10.9: Demographic characteristics of CSTDA-funded non-residential service users with a psychiatric disability, 2007–08

Service user demographics	Number of service users[a]	Per cent of service users[b]	Rate[c] (per 100,000 population)
Age group			
Less than 15 years	471	0.8	11
15–24 years	7,411	13.0	249
25–34 years	12,702	22.2	430
35–44 years	14,667	25.6	473
45–54 years	13,109	22.9	447
55–64 years	6,742	11.8	284
65 years and over	2,115	3.7	76
Sex			
Male	32,443	56.7	308
Female	24,760	43.3	232
Indigenous status[d][e]			
Indigenous Australians	2,565	4.7	579
Non-Indigenous Australians	52,352	95.3	254
Country of birth[e]			
Australia	45,315	82.3	303
Overseas	9,719	17.7	153
Overseas-born[f]			
EP group 1	3,351	6.1	149
EP group 2	2,039	3.7	126
EP group 3	3,289	6.0	172
EP group 4	1,040	1.9	265
Remoteness area of usual residence[g]			
Major cities	36,787	65.0	251
Inner regional	13,858	24.5	358
Outer regional	5,317	9.4	280
Remote and very remote	652	1.2	131
Total	**57,238**	**100.0**	**270**

(a) The number of service users for each demographic variable may not sum to the total due to missing and/or not reported data.

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

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

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

(e) Information on this data element was missing and/or not reported for more than 3% of service users.

(f) For definition of EP groups see Appendix 3.

(g) The number of service users in each remoteness area (RA) was estimated based on service users' residential postcodes. Some postcode areas were split between two or more RAs. Where this was the case, the data were weighted according to the proportion of the population of the postcode area in each RA. Therefore, the totals may not sum due to rounding of proportions.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

In contrast with users of residential services, 83.3% of non-residential service users usually lived in a private residential setting, with 40.4% living with family (Table 10.10). Income source also contrasted greatly with residential users. Almost two-thirds (61.8%) of all non-residential service users received a disability support pension, this was well below the 97.2% of residential service users receiving this type of pension (Table 10.6).

Table 10.10: CSTDA-funded non-residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2007–08

	Number of service users[(a)]	Per cent of service users[(b)]
Residential setting[(c)]		
Private residence	44,598	83.3
Supported accommodation facility	2,500	4.7
Domestic-scale supported living facility	2,188	4.1
Boarding house/private hotel	1,053	2.0
Psychiatric/mental health community care facility	1,023	1.9
Short-term crisis, emergency or transitional accommodation	766	1.4
Other accommodation type	642	1.2
Residential aged care facility	264	0.5
Hospital	234	0.4
Residence within an Aboriginal community	135	0.3
Public place/temporary shelter	91	0.2
Independent living within a retirement village	62	0.1
Living arrangement[(c)]		
Lives alone	15,317	31.1
Lives with family	19,855	40.4
Lives with others	14,022	28.5
Income source (adult 16 years and over)[(c)(d)]		
Disability Support Pension	30,004	61.8
Other pension/benefit	15,845	32.6
Paid employment	1,149	2.4
Compensation income	267	0.5
Other income	1,025	2.1
No income	276	0.6
Total	**57,238**	**100.0**

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

(b) The percentages shown do not include those services for which information was missing and/or not reported.

(c) Information on this data element was missing and/or not reported for more than 6% of service users.

(d) 56,652 of the non-residential service users with a psychiatric disability were aged 16 years or more. Each user can have more than one income source.

Source: AIHW analysis of data from the 2007–08 Commonwealth State/Territory Disability Agreement NMDS.

11 Mental health-related prescriptions

11.1 Introduction

This chapter presents information on prescriptions for ***mental health-related medications*** (see Key concepts) from two sources. Firstly, information is presented on prescribed mental health-related medications that are subsidised by the Australian Government through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) from Medicare Australia records. Under both schemes, Medicare Australia makes payments to pharmacists to subsidise pharmaceutical products that are regarded as necessary and are listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2009d). Secondly, data are presented for subsidised and non-subsidised ***prescriptions*** for mental health-related medications from the Drug Utilisation Sub-Committee (DUSC) database. The database combines prescription estimates for non-subsidised prescriptions, that is, for prescriptions that cost the patient less than the copayment amount required under the PBS, and private prescriptions, from a Pharmacy Guild survey of pharmacies (DoHA 2009a), with the actual counts of PBS- and RPBS-subsidised prescriptions submitted to Medicare Australia. Use of the DUSC-sponsored Pharmacy Guild survey enables a more comprehensive estimate of the use of mental health-related prescription medicines in the Australian community than use of the PBS and RPBS data alone.

Key concepts

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

- five selected medication groups as classified in the ATC Classification System (WHO 2009b), namely antipsychotics (code N05A), anxiolytics (code N05B), hypnotics and sedatives (code N05C), antidepressants (code N06A), and psychostimulants and nootropics (code N06B)—prescribed by all medical practitioners (that is, general practitioners (GPs), non-psychiatrist specialists and psychiatrists)
- all other medications prescribed by psychiatrists.

Prescriptions

The information on prescriptions in this chapter is sourced from the PBS/RPBS and /or the Pharmacy Guild Survey and refers to medications prescribed by medical practitioners and subsequently dispensed in community pharmacies (or, for Section 100 drugs, by hospital pharmacies). Consequently, it is a count of medications dispensed rather than a count of the prescriptions written by medical practitioners.

The information on PBS- and RPBS-subsidised prescriptions for mental health-related medications for 2008–09 is presented according to the type of medication prescribed and the prescribing medical practitioner, followed by data that cover the 5-year period from 2004–05 to 2008–09. Secondly, tables present the number of patients receiving subsidised mental health-related prescriptions for 2008–09, disaggregated by demographic characteristics and area of residence as well as by prescribing medical practitioner and type of medication prescribed. The latter is also presented in time series format for the period from 2004–05 to 2008–09. Finally, data are presented for both subsidised and non-subsidised prescriptions for

the five mental health-related Anatomical Therapeutic Chemical (ATC) Classification System groups from the combined DUSC database.

Note that the intent of the definition of mental health-related medications used in this chapter is to capture, as far as possible, medications that were dispensed for mental health-related reasons. However, it is likely that some medications are included that were prescribed for non-mental health-related reasons (for example, some medications prescribed by psychiatrists may not relate directly to the patient's mental health problems), while other medications that would have related to mental health problems have been excluded (for example, some medications prescribed by general practitioners (GPs) or non-psychiatrist specialists that fall outside of the five selected medication groups may have been prescribed for mental health-related problems).

In interpreting the information provided in this chapter, note that individual prescriptions will vary in the number of doses, the strength of each individual dose and the type of preparation (such as tablets or injections).

Each of the pharmaceutical products subsidised through the PBS or RPBS is listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2009d). The coding of the pharmaceutical products in this schedule is based on the ATC Classification System, defined by the World Health Organization (WHO 2009b). This classification assigns therapeutic drugs to different groups according to the organ or system on which they act, as well as their therapeutic and chemical characteristics. In Table 11.1, the five selected medication groups that have been defined as mental health-related are briefly described.

For further information on the PBS and RPBS, and on data on medications covered by these schemes and the DUSC, refer to Appendix 1. Related data on expenditure on medications subsidised under the PBS and RPBS are presented in Chapter 14 of this publication.

Table 11.1: Drug groups defined for this report as mental health-related medications in the PBS and RPBS data

ATC code	Drug group	Brief description of effects and indications
N05	**Psycholeptics**	**A group of drugs that tranquillises (central nervous system depressants)**
N05A	Antipsychotics	Drugs used to treat symptoms of psychosis (a severe mental disorder characterised by loss of contact with reality, delusions and hallucinations), common in conditions such as schizophrenia, mania and delusional disorder.
N05B	Anxiolytics	Drugs prescribed to treat symptoms of anxiety.
N05C	Hypnotics and sedatives	Hypnotic drugs are used to induce sleep and treat severe insomnia.
		Sedative drugs are prescribed to reduce excitability or anxiety.
N06	**Psychoanaleptics**	**A group of drugs that stimulates the mood (central nervous system stimulants)**
N06A	Antidepressants	Drugs used to treat the symptoms of clinical depression.
N06B	Psychostimulants and nootropics	Agents used for attention-deficit hyperactivity disorder and to improve impaired cognitive abilities (nootropics).

11.2 PBS/RPBS-subsidised prescriptions

This section presents information on the number and type of mental health-related medications prescribed that were subsidised under the PBS and RPBS. In interpreting this information, note that a person may have obtained several subsidised mental health-related

prescriptions during the period covered. Information on the number of people receiving mental health-related prescriptions is presented in the following section (Section 11.3).

In 2008–09, there were 195.3 million PBS- and RPBS-subsidised prescriptions for medications (Medicare 2009b), of which 21.4 million (11.0%) were for mental health-related medications (Table 11.2). This is equivalent to 990 subsidised mental health-related prescriptions per 1,000 population (Table 11.3).

Of the 21.4 million subsidised mental health-related prescriptions, the great majority (85.2%) were provided by GPs, with another 9.4% being prescribed by psychiatrists and 5.3% by non-psychiatrist specialists.

Most of the 21.4 million prescriptions were for antidepressant medication (57.4%, or 12.3 million), followed by anxiolytics (15.1%), hypnotics and sedatives (12.2%) and antipsychotics (11.7%).

Table 11.2: Mental health-related subsidised prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, 2008–09

ATC group (code)	GPs	Non-psychiatrist specialists	Psychiatrists	Total[(b)]	Per cent
Antipsychotics (N05A)[(c)]	1,816,160	217,970	475,305	2,511,874	11.7
Anxiolytics (N05B)	2,999,903	89,194	139,349	3,231,447	15.1
Hypnotics and sedatives (N05C)	2,477,622	85,396	51,123	2,616,188	12.2
Antidepressants (N06A)	10,908,706	421,886	963,001	12,305,222	57.4
Psychostimulants and nootropics (N06B)	71,114	317,947	88,018	477,218	2.2
Other ATC groups[(d)]	. .	. .	295,230	295,230	1.4
Total	**18,273,505**	**1,132,393**	**2,012,026**	**21,437,179**	**. .**
Per cent	85.2	5.3	9.4	. .	100.0

. . Not applicable.

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) Includes prescriptions where the prescriber's specialty was unknown.

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

(d) Includes other N codes as well as other ATC medication groups, as presented in Chapter 14 (Table 14.15). Note that data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

Sources: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data, (DoHA).

There was some variation in the number and type of mental health-related medications prescribed across states and territories in 2008–09 (Table 11.3). The rate of prescriptions per 1,000 population was relatively low in the Australian Capital Territory (697 per 1,000 population). In contrast, Tasmania and South Australia had considerably higher rates of prescriptions than the national average (1,328 and 1,185 prescriptions per 1,000 population, respectively).

In the distribution of mental health-related prescriptions according to ATC groups, Tasmanian providers prescribed a higher proportion of anxiolytics than the national average (19.8% compared with 15.1% for Australia) and a lower proportion of antipsychotics (8.0% compared with 11.7% for Australia). Providers in the Australian Capital Territory prescribed the highest proportion of antidepressants (62.1% compared with 57.4% for

Australia) and providers from the Northern Territory prescribed a higher proportion of psychostimulants and nootropics (4.0% compared with 2.2% for Australia).

Most jurisdictions showed the same relationships between the type of mental health-related medication and the medical practitioner who provided the prescription. Exceptions include the Northern Territory, which had a higher proportion of antipsychotic prescriptions provided by non-psychiatrist specialists than the national average (16.0% compared with 8.7% for Australia), and the Australian Capital Territory, which had a higher proportion of antipsychotic prescriptions provided by psychiatrists (25.4% compared with 18.9% for Australia). Queensland and the Northern Territory also had higher proportions of psychostimulant and nootropic prescriptions provided by GPs than the national average (33.9% and 24.5%, respectively, compared with 14.9% for Australia) while the Northern Territory and Tasmania had a lower proportion provided by psychiatrists (4.4% and 9.4%, respectively, compared with 18.4% for Australia). New South Wales, Victoria, Tasmania and the Northern Territory had a higher proportion of psychostimulant and nootropic prescriptions provided by non-psychiatrist specialists than the national average (over 70% compared with 66.6% for Australia).

Table 11.4 shows the trends in the prescription of mental health-related medications over the 5 years from 2004–05 to 2008–09. PBS- and RPBS-subsidised mental health-related prescriptions rose from 20.4 million in 2007–08 to 21.4 million in 2008–09. This is in contrast to the decline over the previous 3 years. Similarly, the rate of prescriptions (per 1,000 population) increased from 959 in 2007–08 to 990 in 2008–09. Overall, the rate declined from 1,054 per 1,000 population in 2004–05 to 990 per 1,000 in 2008–09 at an average annual rate of 1.5%.

There were increases in the number of psychostimulants and nootropics, and antipsychotics prescribed for the 5-year period (on average by 19.6% and 10.6% per year, respectively). However, prescriptions for hypnotics and sedatives decreased on average by 3.4% per year, while prescriptions for anxiolytics, antidepressants and other medications prescribed by psychiatrists decreased on average by less than 1% per year.

The biggest increase for the 5-year period in prescription of a particular ATC group by a provider type was for the prescription of psychostimulants and nootropics by non-psychiatrist specialists, which rose by an average annual rate of change of 26.9%. GPs also increased their prescribing of this group, which covers attention-deficit hyperactivity disorder medications, by 16.4% per year. The prescription of antipsychotics by non-psychiatrist specialists saw an increase of 18.4% per year.

Table 11.3: Mental health-related subsidised prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, states and territories[(b)], 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Antipsychotics (N05A)				
GPs	615,120	496,143	319,608	143,257	173,811	40,995	20,324	6,850	1,816,160
Non-psychiatrist specialists	46,193	85,752	41,350	26,081	11,249	3,073	2,674	1,598	217,970
Psychiatrists	160,939	144,648	83,395	27,019	41,007	8,815	7,940	1,542	475,305
Subtotal[(c)]	*823,021*	*727,128*	*444,751*	*196,527*	*226,167*	*52,939*	*31,296*	*9,993*	*2,511,874*
					Anxiolytics (N05B)				
GPs	821,548	866,470	619,583	240,373	293,135	124,537	26,638	7,602	2,999,903
Non-psychiatrist specialists	20,136	30,591	19,877	8,207	7,736	1,876	490	280	89,194
Psychiatrists	33,979	48,586	30,169	7,889	12,494	4,825	998	408	139,349
Subtotal[(c)]	*877,384*	*945,958*	*669,998*	*256,701*	*313,428*	*131,392*	*28,265*	*8,302*	*3,231,447*
					Hypnotics and sedatives (N05C)				
GPs	778,051	642,526	478,954	238,272	233,372	80,516	19,860	6,031	2,477,622
Non-psychiatrist specialists	22,049	27,470	18,409	9,230	6,224	1,257	531	225	85,396
Psychiatrists	12,074	15,216	12,354	4,183	5,440	1,128	666	56	51,123
Subtotal[(c)]	*813,445*	*685,399*	*509,910*	*251,850*	*245,099*	*82,980*	*21,140*	*6,318*	*2,616,188*
					Antidepressants (N06A)				
GPs	3,348,924	2,669,531	2,334,886	1,071,826	963,895	346,432	134,919	38,128	10,908,706
Non-psychiatrist specialists	105,877	131,967	91,291	49,288	28,375	9,224	3,799	2,063	421,886
Psychiatrists	283,371	270,981	204,091	85,245	85,810	20,618	11,052	1,827	963,001
Subtotal[(c)]	*3,745,138*	*3,073,533*	*2,631,687*	*1,207,204*	*1,078,385*	*376,517*	*150,538*	*42,047*	*12,305,222*
					Psychostimulants and nootropics (N06B)				
GPs	12,231	5,860	32,334	12,161	5,025	2,027	780	696	71,114
Non-psychiatrist specialists	137,445	63,489	49,617	36,247	12,916	11,438	4,774	2,021	317,947
Psychiatrists	24,262	11,986	13,494	29,196	5,083	1,397	2,474	126	88,018
Subtotal[(c)]	*173,990*	*81,346*	*95,487*	*77,620*	*23,028*	*14,870*	*8,032*	*2,845*	*477,218*
					Other medications prescribed by psychiatrists[(d)]				
Psychiatrists	88,121	81,469	68,226	23,355	23,975	5,530	3,269	1,282	295,230
Total[(c)]	**6,521,099**	**5,594,833**	**4,420,059**	**2,013,257**	**1,910,082**	**664,228**	**242,540**	**70,787**	**21,437,179**
Rate (per 1,000 population)[(e)]	926	1,043	1,016	913	1,185	1,328	697	319[(f)]	990

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the supplying pharmacy is used. A small number of records for which state/territory is unknown appear only in the total.

(c) Includes prescriptions where the prescriber's specialty was unknown.

(d) Includes other N codes as well as other ATC medication groups prescribed by a psychiatrist as presented in Chapter 14 (Table 14.15). Note that data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(e) Crude rate is based on the Australian estimated resident population as at 31 December 2008.

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

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

Table 11.4: Mental health-related subsidised prescriptions, by type of medication prescribed[a] and prescribing medical practitioner, 2004–05 to 2008–09

Medication prescribed/ prescriber	2004–05	2005–06	2006–07	2007–08	2008–09	Average annual change (per cent)
Antipsychotics (N05A)						
GPs	1,227,787	1,341,098	1,451,383	1,603,631	1,816,160	10.3
Non-psychiatrist specialists	110,765	134,626	152,344	183,438	217,970	18.4
Psychiatrists	334,599	369,109	390,404	422,319	475,305	9.2
Subtotal[b]	*1,677,579*	*1,848,371*	*1,996,375*	*2,211,209*	*2,511,874*	*10.6*
Anxiolytics (N05B)						
GPs	3,117,701	3,063,615	3,040,758	2,952,874	2,999,903	–1.0
Non-psychiatrist specialists	80,350	82,854	83,168	86,246	89,194	2.6
Psychiatrists	147,715	142,417	141,613	137,532	139,349	–1.4
Subtotal[b]	*3,349,889*	*3,292,480*	*3,268,587*	*3,179,289*	*3,231,447*	*–0.9*
Hypnotics and sedatives (N05C)						
GPs	2,848,764	2,729,020	2,635,248	2,506,631	2,477,622	–3.4
Non-psychiatrist specialists	87,912	85,946	83,447	82,781	85,396	–0.7
Psychiatrists	61,636	57,660	54,477	52,137	51,123	–4.6
Subtotal[b]	*3,001,438*	*2,875,194*	*2,775,440*	*2,643,327*	*2,616,188*	*–3.4*
Antidepressants (N06A)						
GPs	11,249,912	10,873,982	10,647,914	10,312,369	10,908,706	–0.8
Non-psychiatrist specialists	408,078	398,213	387,532	388,815	421,886	0.8
Psychiatrists	1,082,312	1,030,608	1,005,013	944,717	963,001	–2.9
Subtotal[b]	*12,774,177*	*12,327,048*	*12,056,443*	*11,657,069*	*12,305,222*	*–0.9*
Psychostimulants and nootropics (N06B)						
GPs	38,689	44,246	48,901	57,119	71,114	16.4
Non-psychiatrist specialists	122,730	144,179	155,350	259,209	317,947	26.9
Psychiatrists	71,625	66,210	69,997	76,056	88,018	5.3
Subtotal[b]	*233,603*	*254,966*	*274,413*	*392,502*	*477,218*	*19.6*
Other medications prescribed by psychiatrists[c]						
Psychiatrists	301,260	292,185	290,915	286,042	295,230	–0.5
Total[b]	**21,337,946**	**20,890,244**	**20,662,173**	**20,369,438**	**21,437,179**	**0.1**
Rate (per 1,000 population)[d]	1,054	1,017	990	959	990	–1.5

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) Includes prescriptions where the prescriber's specialty was unknown.

(c) Includes other N codes as well as other ATC medication groups as presented in Chapter 14 (Table 14.15). Note that data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(d) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Note: Figures reported in previous years may be different due to historical validation.

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

11.3 PBS/RPBS-subsidised patients

In 2008–09, 21.4 million PBS- and RPBS-subsidised prescriptions for mental health-related medications were provided to 2.3 million patients (Table 11.5). This represents an average of 9.4 prescriptions per patient.

There was some variation in the number of subsidised prescriptions per patient across sex, age and area of residence groups, with lower average rates for young people and those in *Very remote* areas. There was more marked variation in the number of people receiving mental health-related medications per 1,000 population (rather than prescriptions per patient). Females, people aged 55 and over, and people living in *Inner regional* and *Outer regional* areas had higher rates of receipt of subsidised mental health-related medications than the national average of 105 patients per 1,000 population.

Table 11.5: Patients dispensed with mental health-related subsidised prescriptions[(a)], by patient demographic characteristics and services received, 2008–09

Patient demographics	Number of patients[(b)]	Per cent of patients[(c)]	Rate[(d)] (per 1,000 population)	Number of scripts[(b)]	Per cent of scripts[(c)]	Rate[(d)] (per 1,000 population)	Scripts per patient
Age group							
Less than 15 years	55,766	2.4	13	382,498	1.8	92	6.9
15–24 years	128,118	5.6	42	809,195	3.8	267	6.3
25–34 years	202,433	8.9	67	1,790,067	8.4	591	8.8
35–44 years	287,481	12.6	92	2,871,648	13.5	919	10.0
45–54 years	313,435	13.8	105	3,259,530	15.4	1,092	10.4
55–64 years	368,837	16.2	151	3,613,923	17.0	1,479	9.8
65 years and over	921,002	40.4	321	8,492,878	40.0	2,956	9.2
Sex							
Male	883,063	38.8	82	8,108,465	38.2	753	9.2
Female	1,394,010	61.2	128	13,111,287	61.8	1,206	9.4
Remoteness area of usual residence							
Major cities	1,490,145	65.5	101	13,948,991	65.8	949	9.4
Inner regional	533,620	23.4	126	4,988,542	23.5	1,181	9.3
Outer regional	222,567	9.8	110	2,018,673	9.5	998	9.1
Remote	23,132	1.0	72	199,781	0.9	625	8.6
Very remote	6,724	0.3	40	52,774	0.2	311	7.8
Total	**2,277,748**	**100.0**	**105**	**21,437,179**	**100.0**	**990**	**9.4**

(a) Does not include public hospital prescriptions dispensed through Section 100 arrangements.

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

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

(d) Crude rate is based on the Australian estimated resident population as at 31 December 2008, except for area of residence where 30 June 2008 estimates of resident population by Australian Standard Geographical Classification remoteness area were used.

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

Commensurate with the rates of mental health-related medications prescribed among the states and territories, the rate of patients receiving these medications (per 1,000 population) in 2008–09 was relatively low in the Australian Capital Territory (80 per 1,000 population),

while Tasmania and South Australia had high patient rates (137 and 123 patients per 1,000 population, respectively) compared with the national average of 105 (Table 11.6).

Antidepressants were prescribed to 67.9% of all patients receiving mental health-related medication. Tasmania had a higher rate of patients prescribed anxiolytics than the national average (31.0% compared with 25.0% for Australia) and a lower rate of antipsychotics (10.2% compared with 13.7% for Australia). The Australian Capital Territory also had a higher rate of patients prescribed antidepressants (72.1% compared with 67.9% for Australia) and a higher proportion of patients from the Western Australia were prescribed psychostimulants and nootropics (4.8% compared with 3.1% for Australia).

Most jurisdictions showed the same relationships between the type of mental health-related medication and the medical practitioner who provided the prescription. Exceptions include the Northern Territory, which had a higher proportion of patients with antipsychotic prescriptions provided by non-psychiatrist specialists than the national average (25.7% compared with 16.4% for Australia), and the Australian Capital Territory, which had a higher proportion of patients with antipsychotic prescriptions provided by psychiatrists (32.1% compared with 24.4% for Australia). Queensland and the Northern Territory also had higher proportions of patients with psychostimulant and nootropic prescriptions provided by GPs than the national average (41.9% and 35.2%, respectively, compared with 18.8% for Australia) while the Northern Territory and Tasmania had a lower proportion provided by psychiatrists (6.0% and 10.4%, respectively, compared with 20.0% for Australia). New South Wales, Tasmania, Victoria, and the Northern Territory had a higher proportion of patients prescribed psychostimulant and nootropics by non-psychiatrist specialists than the national average (over 76% compared with 70.6% for Australia).

The number of patients receiving subsidised mental health-related medications declined over the 5 years to 2008–09 by an average annual rate of 3.6%, from 122 per 1,000 population in 2004–05 to 105 in 2008–09 (Table 11.7).

There were increases in the number of patients prescribed psychostimulants and nootropics, and antipsychotics for the 5-year period (on average by 14.7% and 6.5% per year, respectively). However, the number of patients prescribed other mental health-related medications decreased on average by up to 2.6% per year.

The biggest increase for the 5-year period in the number of patients prescribed medication of a particular ATC group by a provider type was for psychostimulants and nootropics by non-psychiatrist specialists, which rose by an average annual rate of change of 18.9%. GPs also had an increased number of patients to whom they prescribed this group of medication (14.0% per year). The number of patients prescribed antipsychotics by non-psychiatrist specialists saw an increase of 11.7% per year.

Table 11.6: Patients dispensed with mental health-related subsidised prescriptions, by type of medication prescribed[a] and prescribing medical practitioner, states and territories[b], 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Antipsychotics (N05A)				
GPs	85,975	66,257	46,023	19,856	23,832	5,953	3,044	1,063	252,010
Non-psychiatrist specialists	11,859	18,183	11,450	5,356	2,727	652	607	353	51,187
Psychiatrists	26,531	22,023	14,077	4,296	6,356	1,315	1,290	323	76,211
Subtotal[c][d]	*104,527*	*84,789*	*57,597*	*24,861*	*28,349*	*6,962*	*4,020*	*1,374*	*312,486*
					Anxiolytics (N05B)				
GPs	155,117	149,033	114,491	41,287	51,287	20,475	4,362	1,475	537,536
Non-psychiatrist specialists	10,309	15,403	11,229	3,770	3,187	1,032	275	165	45,371
Psychiatrists	7,645	10,005	6,499	1,660	2,514	885	240	100	29,549
Subtotal[d(e)]	*163,272*	*159,750*	*121,204*	*43,627*	*53,573*	*21,244*	*4,637*	*1,601*	*568,918*
					Hypnotics and sedatives (N05C)				
GPs	167,152	141,116	103,582	50,736	50,226	15,983	4,812	1,431	535,045
Non-psychiatrist specialists	12,205	15,872	10,658	5,005	3,644	860	329	142	48,716
Psychiatrists	3,846	4,202	3,347	1,072	1,485	332	226	17	14,529
Subtotal[c][d]	*174,079*	*149,498*	*109,200*	*53,304*	*52,483*	*16,523*	*5,099*	*1,510*	*561,704*
					Antidepressants (N06A)				
GPs	448,020	349,101	304,265	137,250	125,456	44,508	18,614	5,634	1,432,873
Non-psychiatrist specialists	35,741	44,199	31,821	14,860	9,721	3,092	1,292	642	141,370
Psychiatrists	45,646	39,018	29,712	11,630	12,340	2,959	1,858	362	143,526
Subtotal[c][d]	*481,861*	*381,996*	*326,201*	*147,741*	*134,899*	*46,881*	*19,954*	*6,041*	*1,545,601*
					Psychostimulants and nootropics (N06B)				
GPs	2,437	1,167	6,177	1,844	830	340	151	140	13,086
Non-psychiatrist specialists	21,026	9,464	8,816	5,249	1,980	1,536	705	305	49,081
Psychiatrists	4,098	2,002	2,453	3,934	757	198	439	24	13,905
Subtotal[c][d]	*26,036*	*11,916*	*14,734*	*10,109*	*3,195*	*1,912*	*1,209*	*398*	*69,509*
					Other medications prescribed by psychiatrists[e]				
Other N codes	12,496	11,411	8,538	2,618	3,352	809	500	125	39,850
Other ATC codes	9,729	7,977	6,859	2,545	2,653	679	359	161	30,963
Total[c][d]	**723,118**	**574,688**	**466,728**	**209,974**	**198,324**	**68,470**	**27,670**	**8,738**	**2,277,748**
Rate (per 1,000 population)[f]	103	107	107	95	123	137	80	39[g]	105

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the supplying pharmacy is used. A small number of records for which state/territory is unknown appear only in the total.

(c) Includes patients where the prescriber's specialty was unknown.

(d) As a patient may obtain prescriptions for medications from more than one type of prescriber, the total may be less than the sum of each prescriber type.

(e) Includes other N codes and other ATC medication groups prescribed by a psychiatrist as presented in Chapter 14 (Table 14.15). Note that data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(f) Crude rate is based on the Australian estimated resident population as at 31 December 2008.

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

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

Table 11.7: Patients dispensed with mental health-related subsidised prescriptions, by prescribing medical practitioner and type of medication prescribed[a][b], 2004–05 to 2008–09

Medication prescribed/ prescriber	2004–05	2005–06	2006–07	2007–08	2008–09	Average annual change (per cent)
Antipsychotics (N05A)						
GPs	195,332	208,554	217,438	232,656	252,010	6.6
Non-psychiatrist specialists	32,915	36,770	39,985	45,355	51,187	11.7
Psychiatrists	59,854	63,709	65,182	69,850	76,211	6.2
Subtotal[b][c]	*242,727*	*258,815*	*269,526*	*288,725*	*312,486*	*6.5*
Anxiolytics (N05B)						
GPs	561,120	549,503	541,144	530,595	537,536	–1.1
Non-psychiatrist specialists	39,192	40,941	41,247	42,680	45,371	3.7
Psychiatrists	31,637	30,511	29,914	29,625	29,549	–1.7
Subtotal[b][c]	*592,075*	*580,449*	*571,843*	*561,304*	*568,918*	*–1.0*
Hypnotics and sedatives (N05C)						
GPs	581,613	559,064	542,453	532,166	535,045	–2.1
Non-psychiatrist specialists	48,604	47,394	46,230	46,517	48,716	0.1
Psychiatrists	17,234	15,766	15,029	14,610	14,529	–4.2
Subtotal[b][c]	*609,269*	*585,358*	*568,284*	*557,852*	*561,704*	*–2.0*
Antidepressants (N06A)						
GPs	1,587,355	1,546,483	1,490,078	1,383,019	1,432,873	–2.5
Non-psychiatrist specialists	135,335	132,758	129,021	129,524	141,370	1.1
Psychiatrists	168,685	160,242	152,335	142,659	143,526	–4.0
Subtotal[b][c]	*1,713,919*	*1,669,815*	*1,607,757*	*1,494,587*	*1,545,601*	*–2.6*
Psychostimulants and nootropics (N06B)						
GPs	7,737	8,914	9,665	11,175	13,086	14.0
Non-psychiatrist specialists	24,594	31,434	34,559	44,501	49,081	18.9
Psychiatrists	11,101	10,422	10,998	12,424	13,905	5.8
Subtotal[b][c]	*40,194*	*47,169*	*50,957*	*62,819*	*69,509*	*14.7*
Other medications prescribed by psychiatrists[d]						
Other N codes	40,272	39,451	39,015	38,709	39,850	–0.3
Other ATC codes	34,716	31,774	30,917	30,769	30,963	–2.8
Total[b][c]	**2,463,533**	**2,408,493**	**2,330,334**	**2,219,203**	**2,277,748**	**–1.9**
Rate (per 1,000 population)[e]	122	117	112	104	105	–3.6

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) Includes patients where the prescriber's specialty was unknown.

(c) As a patient may obtain prescriptions for medications from more than one type of prescriber, the total may be less than the sum of each prescriber type.

(d) Includes other N codes and other ATC medication groups prescribed by a psychiatrist as presented in Chapter 14 (Table 14.15). Note that data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(e) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Note: Differences in figures reported in previous *Mental health services in Australia* publications are due to historical validation.

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

11.4 Non-subsidised prescriptions

As previously noted, the PBS and RPBS data on prescriptions for mental health-related medications drawn from Medicare Australia records do not cover non-subsidised prescriptions. However, by using data from the DUSC-sponsored Pharmacy Guild survey, an ongoing survey of community pharmacies, it is possible to estimate the non-subsidised use of mental health-related prescription medicines in the Australian community. The survey data are combined with the actual PBS and RPBS counts from Medicare Australia in the DUSC database. Tabulation of the data from this database shows the number and proportion of PBS and RPBS, below copayment and private prescriptions within each of the mental health-related ATC groups (Table 11.8).

Based on the DUSC database, 75% of prescriptions for mental health-related medications were dispensed under the PBS or RPBS in 2008–09. The remainder (7.1 million) were privately funded due either to the ineligibility of the patient or the medication, or the price being below the required patient contribution. For the 1.9 million prescriptions dispensed to ineligible patients, the highest proportion was for hypnotics and sedatives (46.1%). In comparison, for the 5.2 million prescriptions not subsidised due to being below the required patient contribution, the majority (75.5%) were for antidepressants.

It should be noted that the DUSC data are based on the date of supply of prescription. This differs from information presented in previous sections of this chapter that use the date the service was processed by Medicare Australia. Therefore, the PBS and RPBS mental health-related prescriptions data presented in Table 11.8 will not exactly match those presented elsewhere in this chapter and any comparisons with previous tables should be made with caution.

Table 11.8: Mental health-related prescriptions[a] by patient category group for mental health-related ATC groups, 2008–09[b]

	PBS	RPBS	*Subtotal (PBS + RPBS)*	Below copayment	Private	Total
Number of scripts						
Antipsychotics (N05A)	2,413,148	94,875	*2,508,023*	28,979	199,004	2,736,006
Anxiolytics (N05B)	3,020,877	182,948	*3,203,825*	655,758	573,089	4,432,672
Hypnotics and sedatives (N05C)	2,277,769	306,723	*2,584,492*	481,094	876,527	3,942,113
Antidepressants (N06A)	11,597,369	662,522	*12,259,891*	3,932,637	204,477	16,397,005
Psychostimulants and nootropics (N06B)	476,245	1,300	*477,545*	113,169	46,824	637,538
Total	**19,785,408**	**1,248,368**	***21,033,776***	**5,211,637**	**1,899,921**	**28,145,334**
Per cent of scripts						
Antipsychotics (N05A)	88.2	3.5	*91.7*	1.1	7.3	100.0
Anxiolytics (N05B)	68.2	4.1	*72.3*	14.8	12.9	100.0
Hypnotics and sedatives (N05C)	57.8	7.8	*65.6*	12.2	22.2	100.0
Antidepressants (N06A)	70.7	4.0	*74.8*	24.0	1.2	100.0
Psychostimulants and nootropics (N06B)	74.7	0.2	*74.9*	17.8	7.3	100.0
Total	**70.3**	**4.4**	***74.7***	**18.5**	**6.8**	**100.0**

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) Prescriptions data using date of supply basis.

Source: Drug Utilisation Sub-Committee database (DoHA).

Table 11.9 shows that the rate of prescriptions for mental health-related medications increased over the 3-year period from 2006–07 to 2008–09. This can be attributed to an increase in non-subsidised prescriptions, particularly the number of mental health-related medications dispensed below the copayment threshold which has seen an annual average increase of 18.3%.

Table 11.9: Community-dispensed prescriptions[a] per 1,000 population[b], by patient category group for mental health-related ATC groups, 2006–07 to 2008–09[c]

Patient category group	2006–07	2007–08	2008–09	Average annual change (per cent)
Subsidised prescriptions				
PBS	913	901	914	0.1
RPBS	64	61	58	–5.3
Subtotal	*977*	*962*	*972*	*–0.3*
Non-subsidised prescriptions				
Below copayment	172	234	241	18.3
Private	99	91	88	–6.1
Subtotal	*272*	*325*	*329*	*10.0*
Total	**1,248**	**1,287**	**1,300**	**2.1**

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, including Clozapine.

(b) Crude rate is based on the preliminary Australian estimated resident population as at 31 December of the reference year.

(c) Prescriptions data using date of supply basis.

Source: Drug Utilisation Sub-Committee database (DoHA).

12 Profile of specialised mental health care facilities

12.1 Introduction

The facilities delivering specialised mental health care in Australia include ***public*** and ***private psychiatric hospitals***, ***psychiatric units or wards*** in ***public acute hospitals***, ***community mental health care services*** and ***government*** and ***non-government-operated residential mental health services*** (see Key concepts). In this chapter, information on the number of facilities, the number of available beds, the number of ***patient days*** and the number of staff employed is drawn from the National Mental Health Establishments Database, for the period 2005–06 through 2007–08. Some additional historical information is taken from the National Survey of Mental Health Services, previously undertaken by the Australian Government Department of Health and Ageing.

Data presented in this chapter is the most current data across all years presented. The data validation process for the 2007–08 collection may have resulted in changes to historical data. Therefore, comparisons to previous *Mental health services in Australia* publications should be approached with caution. See Appendix 1 for information relating to the data validation process for the National Mental Health Establishments Database.

Previous issues of *Mental health services in Australia* have included information on private hospitals sourced from the Private Health Establishments Collection (PHEC), held by the Australian Bureau of Statistics (ABS). However, this collection was not conducted for the 2007–08 data period, and therefore information presented in this chapter on private hospitals is limited to previously published data.

Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database.

Key concepts

A ***public psychiatric hospital*** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is controlled by a state or territory health authority and offers free diagnostic services, treatment, care and accommodation to all eligible patients.

A ***private psychiatric hospital*** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. The data are sourced from the Private Health Establishments (PHEC), held by the Australian Bureau of Statistics (ABS), which identifies private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and that cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2008b), that is, providing 50% or more of the total patient days for psychiatric patients. The data published in this chapter describe only those private psychiatric hospitals meeting this definition.

(continued)

A ***public acute hospital*** is an establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provides round-the-clock comprehensive qualified nursing services as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average length of stay is relatively short.

Psychiatric units or wards are specialised units or wards, within public acute hospitals, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.

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

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

- are operated by a state or territory government
- employ mental health trained staff on-site for a minimum of 6 hours per day and at least 50 hours per week
- provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourage the resident to take responsibility for their daily living activities.

Non-government-operated residential mental health services are specialised residential mental health services that meet the same criteria as government-operated residential mental health services. These services, while partially or fully funded by governments, are operated by non-government agencies.

A ***specialised mental health service organisation*** is a separate entity within states and territories responsible for the clinical governance, administration and financial management of services providing specialised mental health care. For most states and territories, a specialised mental health service organisation is equivalent to the area/district mental health service. These organisations may consist of one or more ***specialised mental health service units***, sometimes based in different locations. Each separately identifiable unit provides either specialised mental health admitted patient hospital services or residential mental health services or community mental health care services (see Metadata Online Registry (METeOR) identifier 286449).

Some specialised mental health services data are categorised using four ***target population*** groups (see METeOR identifier 288957):

- *Child and adolescent* services focus on those aged under 18 years.
- *Older person* programs focus on those aged 65 years and over.
- *Forensic* health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment.
- *General* provides services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people.

Public sector specialised mental health hospital services can be categorised based on ***program type***, which describes the principal purpose(s) of the program rather than the classification of the individual patients. *Acute* care admitted patient programs involve short-term treatment for individuals with acute episodes of a mental disorder, characterised by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self and/or others. *Non-acute* care refers to all other admitted patient programs, including rehabilitation and extended care services (see METeOR identifier 288889).

(continued)

A ***consumer*** is a person who is currently utilising, or has previously utilised, a mental health service. Mental health service consumers include persons receiving care for their own, or another person's mental illness or psychiatric disability (see METeOR identifier 288866).

Specialised mental health organisations report the level of ***consumer committee representation arrangements***. To be regarded as having a formal position on a management or advisory committee, the consumer representative needs to be a voting member (METeOR identifier 288855).

A ***carer*** is a person whose life is affected by virtue of a family or close relationship and caring role with a mental health consumer (see METeOR identifier 288833).

Patient days are days of admitted patient care provided to admitted patients in public psychiatric hospitals or specialised psychiatric units or wards in public acute hospitals and in residential mental health services. The total number of patient days is reported by specialised mental health service units.

12.2 Mental health care facilities

There are six key types of specialised mental health care facilities involved in the provision of mental health-related services (Table 12.1). Nationally, during 2007–08, there were 16 public psychiatric hospitals, with a further 141 public acute hospitals providing a dedicated psychiatric unit or ward. Note that the data presented are a representation of the reporting structures of each jurisdiction and do not necessarily reflect the number or size of services provided.

Table 12.1: Number of specialised mental health care facilities[(a)], states and territories, 2007–08

	NSW[(b)]	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	8	2	3	1	2	. .	. .	. .	16
Public acute hospitals with a specialised psychiatric unit or ward[(c)]	51	30	27	15	8	6	2	2	141
Government-operated residential mental health services[(d)]	13	51	. .	3	4	5	1	. .	77
Non-government-operated residential mental health services[(d)]	5	34	. .	12	1	6	6	1	65
Community mental health care services[(e)]	433	217	133	45	89	17	11	13	958
Private psychiatric hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Total facilities[(f)]	**510**	**334**	**163**	**76**	**104**	**34**	**20**	**16**	**1,257**

. . Not applicable.

n.a. Not available.

(a) These figures differ from *Australian hospital statistics 2007–08* (AIHW 2009a) due to differences in definitions and jurisdictional reporting.

(b) In New South Wales, seven residential mental health services in 2006–07 were reclassified as specialised units within public acute hospitals in 2007–08. See Appendix 1 for further information.

(c) Includes three publicly funded private hospitals in Western Australia.

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

(e) The number of community mental health care services is a representation of the reporting structure in each jurisdiction and does not necessarily reflect the number or size of services provided.

(f) Excludes private psychiatric hospitals as data for 2007–08 was not collected.

Source: National Mental Health Establishments Database.

Table 12.2 provides data on the change in the number of services between 2003–04 and 2007–08. While there was an average annual decline of 5.4% in the number of public psychiatric hospitals, there was an increase of 3.3% in the number of specialised psychiatric units or wards in public acute hospitals. This increase was mostly due to the reclassification of seven services in New South Wales from residential mental health services to specialised units within public acute hospitals.

In 2007–08, there were 958 community mental health care services in Australia (Table 12.3). The largest proportion of these services provided care to the *General* ***target population*** group (63.0% or 604 services). Of the remaining services, 22.3% (214 services) were specialised *Child and adolescent* services, 12.4% (119) were *Older person* services and 2.2% (21) were *Forensic* services.

Table 12.2: Number of specialised mental health care facilities, 2003–04 to 2007–08

	2003–04[(a)]	2004–05[(a)]	2005–06	2006–07	2007–08	Average annual change (per cent)
Public psychiatric hospitals	20	20	15	16	16	–5.4
Public acute hospitals with a specialised psychiatric unit or ward[(b)(c)]	124	122	134	135	141	3.3
Government-operated residential mental health services[(b)(d)]	52	46	77	82	77	10.3
Non-government-operated residential mental health services[(d)(e)]	n.a.	n.a.	58	60	65	. .
Community mental health care services[(e)]	n.a.	n.a.	931	931	958	. .
Private psychiatric hospitals	25	26	26	25	n.a.	. .
Total facilities[(f)]	**221**	**214**	**1,241**	**1,249**	**1,257**	**. .**

. . Not applicable.

n.a. Not available.

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

(b) In New South Wales, seven residential mental health services in 2006–07 were reclassified as specialised units within public acute hospitals in 2007–08. See Appendix 1 for further information.

(c) Includes publicly funded WA private hospitals.

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

(e) Data only available from 2005–06 onwards with the introduction of the National Mental Health Establishments Database.

(f) Totals for 2005–06 onwards include both non-government-operated residential mental health services and community mental health care services.

Sources: National Mental Health Establishments Database, National Public Hospital Establishments Database, Community Mental Health Establishments Database, Private Health Establishments Collection (private psychiatric hospitals only).

Table 12.3: Community mental health care services[(a)], by target population, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
General	282	148	70	18	64	7	6	9	604
Child and adolescent	99	33	42	15	17	3	3	2	214
Older person	46	35	16	11	4	6	1	. .	119
Forensic	6	1	5	1	4	1	1	2	21
Total	**433**	**217**	**133**	**45**	**89**	**17**	**11**	**13**	**958**

. . Not applicable.

(a) The number of community mental health care services are a representation of the reporting structure in each jurisdiction and do not necessarily reflect the number or size of services provided.

Source: National Mental Health Establishments Database.

12.3 Specialised mental health service organisations

This section describes ***specialised mental health service organisations*** (equivalent to the area or district mental health service for most states and territories). Data on the employment of ***consumer*** and ***carer*** consultants by the organisations and their consumer committee representation arrangements are presented in this section.

Table 12.4 describes the specialised mental health organisations responsible for the administration of public psychiatric hospitals, public acute hospitals with a specialised psychiatric unit or ward, residential mental health services and community mental health care services in Australia in 2007–08. Included in this table is the number of beds (see Section 12.5 for definitions), the number of patient days, the number of community mental health care services and their associated number of service contacts, as reported to the National Mental Health Establishments Database. These data provide information on the relative size of each organisation. Note that due to different data supply timelines and internal jurisdictional consistency issues these data are not comparable to the number of patient days reported to the National Hospital Morbidity Database (Chapter 7), the number of residential care days reported to the National Residential Mental Health Care Database (Chapter 8), nor the number of service contacts reported to the National Community Mental Health Care Database (Chapter 4).

Nationally, during 2007–08, there were 221 specialised mental health service organisations (Table 12.4). The most common organisation type comprised public acute hospital(s) with a specialised psychiatric unit or ward and community mental health care service(s) (28.5%). These organisations accounted for just over half of the beds and patient days in public hospitals with a specialised psychiatric unit or ward. They also accounted for around one-third of all community mental health care service units, and 42.8% of reported service contacts.

The next most common organisational type was community mental health care services only (25.3%). These organisations accounted for 15.4% of all community mental health care services and 6.5% of patient service contacts.

Organisations with public psychiatric hospital(s) and community mental health care service(s) were the most common type of organisation for public psychiatric hospitals, accounting for 649 (30.1%) of all public psychiatric hospital beds. A similar number of beds

in public psychiatric hospitals (678 or 31.4%) were in organisations comprising public psychiatric hospitals, residential mental health services and community mental health care services.

Organisations with public acute hospital(s) with a specialised psychiatric unit or ward, residential mental health service(s) and community mental health care service(s), were the most common organisation for residential services, accounting for 58.4% of all residential beds. An additional 32.6% of residential mental health service beds were in organisations that consisted of residential mental health services only.

Table 12.4: Number of specialised mental health organisations, 2007–08

		Public acute hospitals with a specialised psychiatric unit or ward		Public psychiatric hospitals		Residential mental health services		Community mental health care services	
	Number of organisations	Available beds	Patient days[a]	Available beds	Patient days[a]	Available beds	Patient days[b]	Number of services[c]	Number of service contacts[d]
Public acute hospital(s) only	21	393	119,737	. .	. .	. .	. .	. .	. .
Public acute hospital(s), public psychiatric hospital(s) and community mental health care service(s) only	5	227	69,531	486	150,803	. .	. .	59	307,293
Public acute hospital(s) and community mental health care service(s) only	63	2,269	731,125	. .	. .	. .	. .	335	2,944,997
Public acute hospital(s), residential mental health service(s) and community mental health care service(s) only	28	1,506	481,121	. .	. .	1,276	406,022	331	2,658,737
Public psychiatric hospital(s) only	2	. .	. .	206	68,477	. .	. .	. .	. .
Public psychiatric hospital(s) and residential mental health service(s) only	2	. .	. .	137	41,739	19	5,731	. .	. .
Public psychiatric hospital(s) and community mental health care service(s) only	8	. .	. .	649	210,348	. .	. .	16	63,688
Public psychiatric hospital(s), residential mental health service(s) and community mental health care service(s) only	4	. .	. .	678	220,207	116	29,393	31	165,710
Residential mental health service(s) only	24	. .	. .	. .	. .	711	221,103	. .	. .
Residential mental health service(s) and community mental health care service(s) only	8	. .	. .	. .	. .	62	18,279	38	289,997
Community mental health care service(s) only	56	. .	. .	. .	. .	. .	. .	148	449,172
Total	**221**	**4,395**	**1,401,514**	**2,156**	**691,574**	**2,184**	**680,528**	**958**	**6,879,594**

. . Not applicable.

(a) The number of patient days is not comparable with the number of patient days reported to the National Hospital Morbidity Database (Chapter 7).

(b) The number of patient days is not comparable with the residential care days reported to the National Residential Mental Health Care Database (Chapter 8).

(c) The number of community mental health care services is a representation of the reporting structure in each jurisdiction and do not necessarily reflect the number or size of services provided.

(d) The number of service contacts is not comparable with the number of service contacts reported to the National Community Mental Health Care Database (Chapter 4).

Source: National Mental Health Establishments Database.

Consumer and carer consultant employment

Consumer and carer consultant arrangements are generally managed by specialised mental health service organisations rather than individual service units. Consumer and carer consultants are employed (or engaged through contracts) on a part-time or full-time basis to represent the interests of consumers and carers and advocate for their needs, to promote the participation of mental health carers and consumers in the planning, delivery and evaluation of the services. The consultant must have received a salary or contract fee on a regular basis to be considered as being employed by the organisation.

Of the 221 specialised mental health service organisations reported nationally, 86 (38.9%) employed consumer consultants, and 55 (24.9%) employed carer consultants (Table 12.5). Victoria had the highest proportion of mental health organisations employing consumer and carer consultants, 54.5% and 48.5% respectively. Specialised mental health organisations in the Australian Capital Territory and the Northern Territory did not employ any consumer or carer consultants during 2007–08. The number of full-time-equivalent (FTE) consumer and carer consultants employed by organisations is presented in Section 12.6 (Table 12.19) of this chapter.

Table 12.5: Number of specialised mental health service organisations, by employment of consumer and carer consultants, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of organisations	90	33	23	27	35	7	3	3	221
Consumer consultants employed	44	18	11	3	7	3	0	0	86
Carer consultants employed	26	16	4	2	4	3	0	0	55

Source: National Mental Health Establishments Database.

Consumer committee representation arrangements

Specialised mental health organisations also report the extent to which consumer participation arrangements are in place to promote the inclusion of mental health consumers in the planning, delivery and evaluation of the service. Organisations can report their consumer participation arrangements at various levels, as detailed in Table 12.6.

Table 12.6: Levels of consumer participation arrangements

Level	Description
Level 1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers. Alternatively, specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation.
Level 2	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation.
Level 3	Consumers participate on a broadly based advisory committee that includes a mixture of organisations and groups representing a wide range of interests.
Level 4	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required. Alternatively, no specific arrangements exist for consumer participation in planning and evaluation of services.

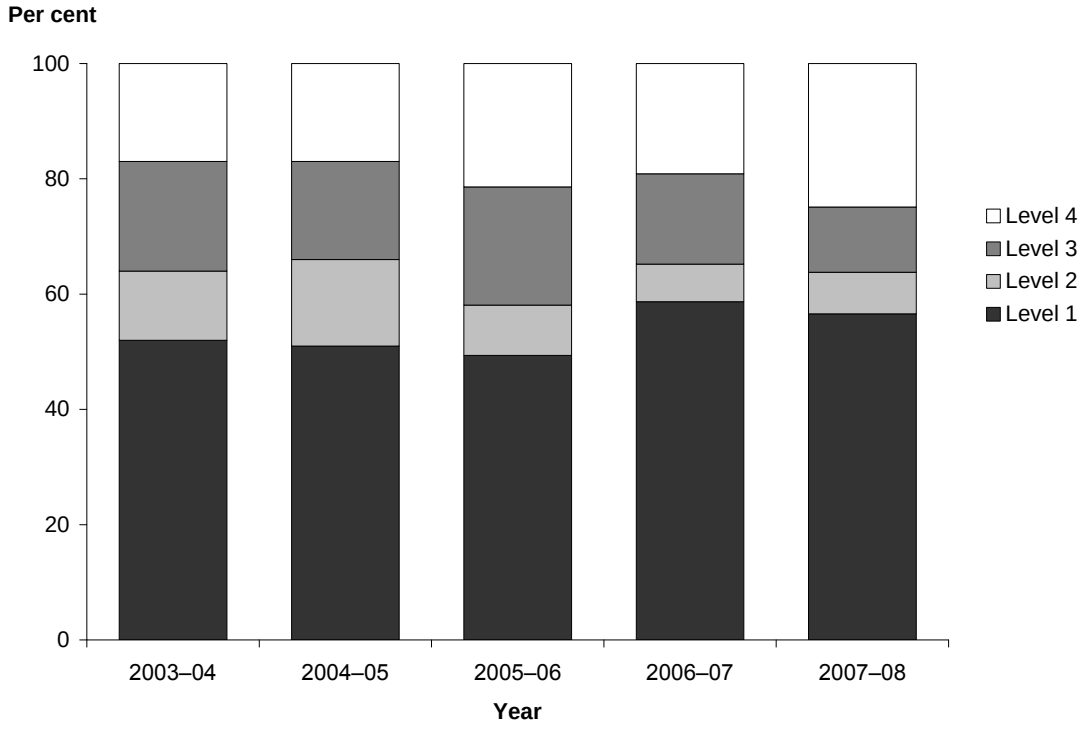
In 2007–08, 125 specialised mental health organisations reported level 1 consumer participation arrangements (Table 12.7). All mental health service organisations in the Northern Territory and the Australian Capital Territory reported level 1 consumer participation arrangements. Queensland (69.6%) reported the next greatest proportion of organisations with level 1 arrangements, with New South Wales (61.1%) also above the national average of 56.6%. South Australia (28.6%) had the greatest proportion of organisations with level 4 arrangements for consumer participation.

Table 12.7: Number of specialised mental health service organisations, by level of consumer participation arrangements, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Per cent
Level 1	55	18	16	10	17	3	3	3	125	56.6
Level 2	1	2	1	8	4	0	0	0	16	7.2
Level 3	10	4	1	2	4	4	0	0	25	11.3
Level 4	24	9	5	7	10	0	0	0	55	24.9
Total	**90**	**33**	**23**	**27**	**35**	**7**	**3**	**3**	**221**	**100.0**

Source: National Mental Health Establishments Database.

The proportion of specialised mental health service organisations with level 1 consumer committee representation fluctuated between 2003–04 and 2007–08, with an overall increase from 51.6% of all organisations during 2003–04 to 56.6% during 2007–08 (Figure 12.1).



Sources: National Mental Health Establishments Database and the *National mental health report* (DoHA 2008).

Figure 12.1: Number of specialised mental health organisations, by level of consumer committee representation, 2003–04 to 2007–08

12.4 National Standards for Mental Health Services

The *National standards for mental health services* (DHFS 1996) were developed under the *First National Mental Health Plan*.

There are eight levels available to describe a service unit's status (METeOR identifier 287800). See Appendix 1 for the full description of all eight levels. For reporting purposes, the data presented are restricted to:

- level 1: the service unit has been reviewed by an external accreditation agency and was judged to have met the standards
- level 2: the service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known.

Nationally, during 2007–08, the standards review was applicable for 1,330 service units (Table 12.8). Of these, 1,094 (82.3%) met the standards (level 1). An additional 52 service units (3.9%) reported level 2 standards implementation. In total, 86.0% of all mental health service units met either level 1 or 2. The Australian Capital Territory and the Northern Territory were the only jurisdictions to report all service units meeting level 1 standards implementation. Tasmania (50.0%) reported the least number of service units achieving level 1 or 2 standards implementation.

Table 12.8: Number of specialised mental health service units[(a)], by National Standards for Mental Health Services review status level, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number of service units[(b)]	594	309	181	75	113	28	15	16	1,330
Level 1	511	299	156	26	58	14	15	15	1,094
Level 2	15	2	5	28	2	0	0	0	52

(a) Service units are a reporting structure used by jurisdictions and do not necessarily reflect the number or size of services provided by jurisdictions. The total number of services cannot be compared with Table 12.1 as public hospitals, counted once in Table 12.1, may have more than one specialised mental health service unit.

(b) Excludes service units that are non-government mental health service units and private hospital service units in receipt of government funding where the National Standards for Mental Health Services do not apply. Also excludes aged care residential services subject to Commonwealth residential aged care reporting and service standards requirements.

Source: National Mental Health Establishments Database.

12.5 Number of available beds

The number of available mental health beds refers to the average number of beds that are immediately available for use by an admitted patient within the mental health facility over the financial year, estimated using monthly figures (METeOR identifier 270133). Data prior to 2005–06 was sourced from the National Survey of Mental Health Services, which reported the total number of beds available as at 30 June. Comparison of historical data should therefore be approached with caution.

Public hospital specialised mental health beds

There were 6,551 specialised mental health public hospital beds available in 2007–08 in Australia (Table 12.9). About two-thirds of these beds (67.1% or 4,395 beds) were in

specialised psychiatric units or wards within public acute hospitals, while the remaining 2,156 beds were in public psychiatric hospitals.

Table 12.9: Public sector specialised mental health hospital beds, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	1,024	154	376	245	357	. .	. .	. .	2,156
Specialised psychiatric units or wards in public acute hospitals	1,400	1,062	1,033	425	243	128	70	34	4,395
Total beds	**2,424**	**1,216**	**1,409**	**670**	**600**	**128**	**70**	**34**	**6,551**

. . Not applicable.

Source: National Mental Health Establishments Database.

The total number of available public sector specialised mental health hospital beds increased between 2003–04 and 2007–08 by an annual average of 1.8% (Table 12.10). The annual average decrease in public psychiatric hospital beds of 2.0% was offset by a 4.0% increase in the number of public acute hospital beds within a specialised psychiatric unit or ward. This increase was partly due to seven units (105 beds) in New South Wales being reclassified from residential mental health services in 2006–07 to specialised psychiatric units in public acute hospitals in 2007–08.

Table 12.10: Public sector specialised mental health hospital beds, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Public psychiatric hospitals	2,335	2,339	2,263	2,211	2,156	–2.0
Specialised psychiatric units or wards in public acute hospitals [(a)]	3,753	3,863	4,011	4,191	4,395	4.0
Total beds	**6,088**	**6,202**	**6,274**	**6,402**	**6,551**	**1.8**

(a) In New South Wales, seven residential mental health services in 2006–07 were reclassified as specialised units within public acute hospitals in 2007–08. See Appendix 1 for further information.

Sources: National Mental Health Establishments Database and *National mental health report* (DoHA 2008).

Target population and program type

Public sector specialised mental health hospital beds can be described using target population categories, ***program type*** categories or a combination of both. During 2007–08, most specialised mental health hospital beds (4,539 or 69.3%) were within *General* services providing care to the adult population (18–64 years) (Table 12.11). A further 17.2% of specialised mental health hospital beds were within *Older person* services, 9.4% were in *Forensic* services and 4.1% were in *Child and adolescent* services. Beds for *General* services made up the greatest proportion of specialised mental health hospital beds in all states and territories. Not all target population categories were specifically catered for in each state and territory.

About two-thirds of all public specialised mental health hospital beds across Australia were for *Acute* services during 2007–08 (Table 12.11). The proportion of *Acute* and *Non-acute* specialised mental health hospital beds varied between states and territories. Victoria had the greatest proportion of *Acute* beds (85.4%), while Queensland had an almost even split between

Acute and *Non-acute* beds. The two territories described all of their mental health hospital beds as *Acute* for 2007–08.

When the combination of target population and program type was considered, *Acute* beds accounted for around three-quarters of the *General* and *Child and adolescent* service beds nationally (Table 12.11). There was an approximate even split between *Acute* and *Non-acute Older person* service beds. In contrast, nearly two-thirds (64.9%) of *Forensic* service beds were reported as *Non-acute*.

South Australia (37.7) had the highest number of beds per 100,000 population, while the Northern Territory had the least (15.6) (Table 12.11). Western Australia (23.4) had the highest number of specialised *Acute* beds per 100,000 population, while the Northern Territory (15.6) had the least. Of those jurisdictions reporting *Non-acute* specialised beds, Queensland (16.6) had the highest number of beds per 100,000 population.

Table 12.11: Public sector specialised mental health hospital beds and beds per 100,000 population, by target population and program type, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of beds				
General									
Acute	1,217	680	602	362	260	81	50	34	3,286
Non-acute	541	100	390	112	83	27	. .	. .	1,253
Child and adolescent									
Acute	54	67	52	20	12	. .	. .	. .	205
Non-acute	41	. .	15	8	. .	. .	. .	. .	64
Older person									
Acute	161	215	51	100	78	. .	20	. .	625
Non-acute	205	. .	138	30	127	. .	. .	. .	500
Forensic									
Acute	94	76	. .	19	8	20	. .	. .	217
Non-acute	111	78	161	19	32	. .	. .	. .	401
Total	**2,424**	**1,216**	**1,409**	**670**	**600**	**128**	**70**	**34**	**6,551**
					Beds per 100,000 population[(a)]				
Acute	22.0	19.7	16.6	23.4	22.5	20.4	20.5	15.6	20.4
Non-acute	12.9	3.4	16.6	7.9	15.2	5.5	. .	. .	10.4
Total	**34.9**	**23.1**	**33.2**	**31.3**	**37.7**	**25.8**	**20.5**	**15.6**	**30.8**

. . Not applicable.

(a) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2007.

Source: National Mental Health Establishments Database.

Nationally, the number of beds in *General*, *Child and adolescent* and *Older person* services remained relatively constant during the period 2003–04 to 2007–08 (Table 12.12). The number of beds for *Forensic* services increased by an annual average of 3.5% during the same period.

Table 12.12: Public sector specialised mental health hospital beds, by target population, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
General	4,210	4,340	4,401	4,484	4,539	1.9
Child and adolescent	282	284	259	270	269	–1.2
Older person[(a)]	1,058	1,037	1,035	1,048	1,125	1.5
Forensic	538	541	579	600	618	3.5
Total	**6,088**	**6,202**	**6,274**	**6,402**	**6,551**	**1.8**

(a) In New South Wales, seven residential mental health services in 2006–07 were reclassified as *Older person* specialised units within public acute hospitals in 2007–08. See Appendix 1 for further information.

Sources: National Mental Health Establishments Database and *National mental health report* (DoHA 2008).

Residential mental health service beds

During 2007–08 there were 2,184 residential mental health service beds available nationally (Table 12.13). They can be characterised by the service operator (government or non-government) and the level of staffing provided. Almost two-thirds (1,401 or 64.1%) of residential mental health service beds were provided by government-operated services. There were 1,569 (71.8%) residential beds operating with mental health trained staff on the premises for the entire 24-hour period. The remaining 615 beds were provided by residential mental health services with less intensive staffing (but on-site for more than 6 hours per day and at least 50 hours per week).

Table 12.13: Number of residential mental health service beds, by service operator and staffing provided, states and territories, 2007–08

	NSW	Vic[(a)]	Qld	WA	SA	Tas	ACT	NT	Total
Service operator									
Government-operated	169	1,021	. .	31	59	91	30	. .	1,401
Non-government-operated	152	383	. .	99	12	85	47	5	783
Staffing provided									
24-hour staffing									
Government-operated	115	1,015	. .	31	52	91	30	. .	1,334
Non-government-operated	16	48	. .	57	12	85	12	5	235
Subtotal	*131*	*1,063*	. .	*88*	*64*	*176*	*42*	*5*	*1,569*
Non-24-hour staffing									
Government-operated	54	6	. .	. .	7	. .	. .	. .	67
Non-government-operated	136	335	. .	42	. .	. .	35	. .	548
Subtotal	*190*	*341*	. .	*42*	*7*	. .	*35*	. .	*615*
Total	**321**	**1,404**	**. .**	**130**	**71**	**176**	**77**	**5**	**2,184**

. . Not applicable.

(a) Residential mental health service beds provided by Victorian Prevention and Recovery Care services are classified as government-operated.

Source: National Mental Health Establishments Database.

Target population

With the exception of the Australian Capital Territory and New South Wales, each of which had a number of *Child and adolescent* beds (see footnote (a) of Table 12.14), residential mental health beds were reported as *General* and *Older person* services. The majority of residential mental health specialised beds were in *General* services (68.2%). When population was considered, nationally there were 7.0 *General* residential beds per 100,000 population, compared with 3.3 *Older person* beds per 100,000 population. Tasmania (27.1) had the highest number of residential *General* beds per 100,000 population, while the Northern Territory (2.3) had the least. Of those jurisdictions reporting specialised *Older person* residential mental health service beds, Victoria (11.9) had the highest number of residential beds per 100,000 population, while New South Wales (0.3) had the least.

Table 12.14: Residential mental health service beds and beds per 100,000 population, by target population, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of beds				
General[(a)]	302	778	. .	130	71	134	70	5	1,490
Older person	19	626	. .	. .	. .	42	7	. .	694
Total	**321**	**1,404**	**. .**	**130**	**71**	**176**	**77**	**5**	**2,184**
					Beds per 100,000 population[(b)]				
General[(a)]	4.3	14.8	. .	6.1	4.5	27.1	20.5	2.3	7.0
Older person	0.3	11.9	. .	. .	. .	8.5	2.0	. .	3.3
Total	**4.6**	**26.7**	**. .**	**6.1**	**4.5**	**35.5**	**22.5**	**2.3**	**10.3**

. . Not applicable.

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

(b) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2007.

Source: National Mental Health Establishments Database.

Since 2003–04, there have been changes in the number of specialised residential mental health care beds, with bed numbers ranging between 1,990 and 2,209 (Table 12.15). Between 2003–04 and 2007–08, there were average annual increases in 24-hour (2.2%) and non-24-hour (0.8%) staffed bed numbers. Specialised residential mental health beds within *General* services increased by an average of 5.0% annually between 2003–04 and 2007–08. In contrast, beds within *Older person* services decreased over the same time period by an average of 3.7%. This decrease was mostly due to the reclassification of seven services in New South Wales (105 beds) from 24-hour staffed *Older person* residential mental health services to specialised units within public acute hospitals.

Table 12.15: Residential mental health service beds, by hours staffed and target population, 2003–04 to 2007–08

	2003–04	2004–05	2005–06[a]	2006–07[a]	2007–08[a]	Average annual change (per cent)
Staffing provided						
24-hour staffing[b]	1,439	1,427	1,492	1,568	1,569	2.2
Non-24-hour staffing	596	563	654	641	615	0.8
Target population						
General	1,227	1,206	1,342	1,395	1,490	5.0
Older person[b]	808	784	804	814	694	–3.7
Total	**2,035**	**1,990**	**2,146**	**2,209**	**2,184**	**1.8**

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

(b) In New South Wales, seven *Older person* 24-hour staffed residential mental health services in 2006–07 were reclassified as specialised units within public acute hospitals in 2007–08. See Appendix 1 for further information.

Sources: National Mental Health Establishments Database and *National mental health report* (DoHA 2008).

12.6 Patient days

In this chapter, patient days refers to:

- the total number of days of care provided to admitted patients of public hospital specialised mental health services
- the total number of days of care provided to residents of residential mental health services.

For consistency in data reporting, the following patient day data collection guidelines apply: admission and discharge on the same day equals 1 day; all days are counted during a period of admission except for the day of discharge; and leave days are excluded from the total.

Note that the number of patient days reported to the National Mental Health Establishments Database is not directly comparable with the number of patient days reported to neither the National Hospital Morbidity Database (Chapter 7) nor the number of residential care days reported to the National Residential Mental Health Care Database (Chapter 8).

Public hospital specialised mental health services

Over 2 million patient days were provided by public hospital specialised mental health services during 2007–08 (Table 12.16). Around two-thirds (67.0%) of all patient days were in specialised psychiatric units or wards in public acute hospitals. South Australia (124) had the highest number of patient days per 1,000 population, while the Northern Territory (51) had the least.

Table 12.16: Number of patient days, public hospital specialised mental health services, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	326,867	51,308	114,568	83,878	114,953	. .	. .	. .	691,574
Specialised psychiatric units or wards in public acute hospitals [(a)]	453,870	334,207	326,464	136,701	82,691	38,052	18,539	10,990	1,401,514
Total days	**780,737**	**385,515**	**441,032**	**220,579**	**197,644**	**38,052**	**18,539**	**10,990**	**2,093,088**
Patient days per 1,000 population[(a)]	112	73	104	103	124	77	54	51	99

. . Not applicable.

(a) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2007.

Source: National Mental Health Establishments Database.

When the combination of target population and program type was considered, the majority of patient days for *General* and *Child and adolescent* services were within acute services, compared with an almost even split between acute and non-acute for *Older person* services (Table 12.17). This contrasts with *Forensic* services, where the majority of patient days were in non-acute services. This pattern of use is consistent with the number of available beds by target population and program type (Table 12.11).

Table 12.17: Number of patient days, public hospital specialised mental health services, by target population and program type, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
General									
Acute	408,024	219,438	195,000	123,299	90,413	24,804	14,997	10,990	1,086,965
Non-acute	168,283	35,036	119,454	33,642	24,468	7,128	. .	. .	388,011
Child and adolescent									
Acute	14,398	11,774	11,031	6,567	1,703	. .	. .	. .	45,473
Non-acute	6,605	. .	3,435	881	. .	. .	. .	. .	10,921
Older person									
Acute	52,651	67,959	15,975	33,228	24,863	. .	3,542	. .	198,218
Non-acute	60,759	. .	45,124	9,754	42,789	. .	. .	. .	158,426
Forensic									
Acute	31,611	22,916	. .	6,723	2,829	6,120	. .	. .	70,199
Non-acute	38,406	28,392	51,013	6,485	10,579	. .	. .	. .	134,875
Total days	**780,737**	**385,515**	**441,032**	**220,579**	**197,644**	**38,052**	**18,539**	**10,990**	**2,093,088**

. . Not applicable.

Source: National Mental Health Establishments Database.

Residential mental health services

Residential mental health services provided 680,528 patient days during 2007–08 (Table 12.18). Almost three-quarters (71.1%) of all patient days were for residents of 24-hour staffed services.

Table 12.18: Number of patient days, residential mental health services, by staffing provided and target population, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Staffing provided									
24-hour staffing	36,678	351,548	. .	17,157	15,277	48,086	13,599	1,737	484,082
Non-24-hour staffing	55,449	114,897	. .	13,197	2,024	. .	10,879	. .	196,446
Target population									
General	85,895	242,841	. .	30,354	17,301	39,422	22,128	1,737	439,678
Older person	6,232	223,604	. .	. .	. .	8,664	2,350	. .	240,850
Total days	**92,127**	**466,445**	**. .**	**30,354**	**17,301**	**48,086**	**24,478**	**1,737**	**680,528**

. . Not applicable.

Source: National Mental Health Establishments Database.

12.7 Staffing of state and territory specialised mental health care facilities

The staff numbers reported in this section refer to the average number of full-time-equivalent (FTE) staff employed in public psychiatric hospitals, specialised psychiatric units or wards in public acute hospitals, community mental health care services and residential mental health services.

Nurses accounted for the majority of the national workforce in all specialised mental health care facilities, totalling 13,727 FTE or 51.4% (tables 12.19 and 12.20). At the state level, Victoria (55.9%) had the highest proportion of staff employed as nurses in specialised mental health care services, while the Australian Capital Territory (44.9%) had the lowest.

Diagnostic and allied health professionals (19.2%) made up the second largest group of staff in specialised mental health care services (Table 12.20), with the majority of the total 5,113 FTE staff in this group being psychologists and social workers (1,741 and 1,592 FTE, respectively) (Table 12.19).

Salaried medical officers made up 9.4% of staff in specialised mental health care services, with a relatively even spread between consultant psychiatrists and psychiatrists, and psychiatry registrars and trainees (tables 12.19 and 12.20).

In 2007–08, there were 11.8 FTE salaried medical officers per 100,000 population, ranging from 14.5 in South Australia to 8.9 in Tasmania (Table 12.21). The number of FTE nurses per 100,000 population varied across states and territories, from 78.0 FTE in South Australia to 46.7 in the Northern Territory. The number of FTE other staff per 100,000 population, which includes the *Administrative and clerical* and *Domestic and other staff* categories, also varied across states and territories. Western Australia (31.4) employed the highest number of other staff per 100,000 population, compared with the national average of 21.1.

Between 2003–04 and 2007–08 there was an average annual growth of 3.6% in the number of FTE staff in specialised mental health care services (Table 12.22). During this period, all staffing categories, except other staff, experienced growth in their total FTE staffing numbers. Notably, salaried medical officers increased at an average annual rate of 6.1%, diagnostic and allied health professionals increased by 4.5% and nurses increased by 3.9%. The number of

carer consultants increased by an annual average rate of 30.2%; however, the number of consumer consultants remained relatively stable (1.4%).

Table 12.19: Full-time-equivalent staff by staffing category, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[a]
Salaried medical officers									
Consultant psychiatrists and psychiatrists	384.3	224.6	235.2	102.6	96.8	27.0	14.8	8.7	1,094.0
Psychiatry registrars and trainees	371.3	250.6	231.9	101.6	89.2	16.0	16.5	8.8	1,086.0
Other medical officers	57.9	111.9	36.6	77.2	44.9	0.9	1.4	5.0	335.8
Subtotal[a]	*813.5*	*587.1*	*503.8*	*281.4*	*230.9*	*43.9*	*32.7*	*22.4*	*2,515.8*
Nurses									
Registered	3,857.5	2,652.5	2,170.8	1,304.9	1,006.4	293.6	139.8	92.5	11,517.9
Enrolled	598.3	749.1	343.3	188.9	236.3	54.6	29.6	9.1	2,209.1
Subtotal[a]	*4,455.8*	*3,401.6*	*2,514.1*	*1,493.8*	*1,242.7*	*348.1*	*169.4*	*101.6*	*13,727.0*
Diagnostic and allied health professionals									
Psychologist	600.6	389.6	395.5	159.1	109.7	24.8	48.9	12.5	1,740.7
Social worker	320.3	464.3	319.0	203.5	225.6	27.8	23.4	8.3	1,592.2
Occupational therapist	228.7	233.4	163.7	144.7	68.7	11.0	7.4	1.6	859.4
Diagnostic and health professionals[b]	385.6	173.6	127.0	121.7	69.1	29.4	0.6	13.2	920.2
Subtotal[a]	*1,535.3*	*1,260.9*	*1,005.3*	*628.9*	*473.1*	*93.0*	*80.4*	*35.7*	*5,112.5*
Other staffing categories									
Other personal care[c]	71.1	155.7	199.1	131.6	23.1	154.7	32.2	7.8	775.2
Carer consultants	7.0	15.5	1.5	0.8	1.8	0.0	0.0	0.0	26.6
Consumer consultants	27.9	20.0	9.7	1.2	4.7	—	0.0	0.0	63.5
Other staff[d]	1,667.5	646.5	802.3	670.6	483.6	118.0	62.3	24.5	4,475.3
Subtotal[a]	*1,773.4*	*837.7*	*1,012.5*	*804.2*	*513.2*	*272.7*	*94.5*	*32.3*	*5,340.6*
Total[a]	**8,578.0**	**6,087.3**	**5,035.7**	**3,208.3**	**2,459.9**	**757.7**	**377.0**	**192.0**	**26,695.9**
FTE per 10,000 clinical FTE[e]									
Carer consultants	10.1	28.7	3.5	3.0	9.3	. .	. .	. .	12.0
Consumer consultants	40.5	37.0	23.0	4.8	23.9	0.5	. .	. .	28.7

. . Not applicable.

— Rounded to zero.

(a) Totals may not add due to rounding.

(b) *Diagnostic and health professionals* includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff) (METeOR identifier 287611).

(c) *Other personal care* staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR identifier 270171).

(d) *Other staff* includes *Administrative and clerical* and *Domestic and other staff* categories.

(e) Crude rate is based on the total number of clinical FTE, includes *Salaried medical officers*, *Nurses*, *Diagnostic and allied health professionals* and *Other personal care* staff.

Source: National Mental Health Establishments Database.

Table 12.20: Full-time-equivalent staff by staffing category, per cent, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	9.5	9.6	10.0	8.8	9.4	5.8	8.7	11.7	9.4
Nurses	51.9	55.9	49.9	46.6	50.5	45.9	44.9	52.9	51.4
Diagnostic and allied health professionals[(a)]	17.9	20.7	20.0	19.6	19.2	12.3	21.3	18.6	19.2
Other personal care[(b)]	0.8	2.6	4.0	4.1	0.9	20.4	8.5	4.0	2.9
Carer consultants	0.1	0.3	—	—	0.1	. .	. .	. .	0.1
Consumer consultants	0.3	0.3	0.2	—	0.2	—	. .	. .	0.2
Other staff[(c)]	19.4	10.6	15.9	20.9	19.7	15.6	16.5	12.8	16.8
Total[(d)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

. . Not applicable.

— Rounded to zero.

(a) *Diagnostic and allied health professionals* includes psychologists, social workers, occupational therapists and diagnostic and allied health professionals.

(b) *Other personal care* staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR identifier 270171).

(c) *Other staff* includes *Administrative and clerical* and *Domestic and other staff* categories.

(d) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 12.21: Full-time-equivalent staff per 100,000 population by staffing category[(a)], states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	11.7	11.2	11.9	13.2	14.5	8.9	9.6	10.3	11.8
Nurses	64.2	64.6	59.3	69.9	78.0	70.3	49.5	46.7	64.6
Diagnostic and allied health professionals[(b)]	22.1	24.0	23.7	29.4	29.7	18.8	23.5	16.4	24.1
Other personal care[(c)]	1.0	3.0	4.7	6.2	1.4	31.2	9.4	3.6	3.7
Carer consultants	0.1	0.3	—	—	0.1	. .	. .	. .	0.1
Consumer consultants	0.4	0.4	0.2	0.1	0.3	—	. .	. .	0.3
Other staff[(d)]	24.0	12.3	18.9	31.4	30.3	23.8	18.2	11.3	21.1
Total[(e)]	**123.5**	**115.7**	**118.7**	**150.1**	**154.4**	**153.0**	**110.2**	**88.3**	**125.7**

. . Not applicable.

— Rounded to zero.

(a) Crude rate is based on the preliminary state and territory estimated resident population as at 31 December 2007.

(b) *Diagnostic and allied health professionals* includes psychologists, social workers, occupational therapists and diagnostic and allied health professionals.

(c) *Other personal care* staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR identifier 270171).

(d) *Other staff* includes *Administrative and clerical* and *Domestic and other staff* categories.

(e) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 12.22: Full-time-equivalent staff by staffing category, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change[(a)] (per cent)
Salaried medical officers	1,985.3	2,141.4	2,235.3	2,357.0	2,515.8	6.1
Nurses	11,765.1	12,149.5	12,753.6	13,221.8	13,727.0	3.9
Diagnostic and allied health professionals[(b)]	4,295.0	4,411.2	4,709.8	4,876.3	5,112.5	4.5
Other personal care[(c)]	533.2	603.6	738.0	774.6	775.2	9.8
Carer consultants	9.3	13.5	14.8	23.1	26.6	30.2
Consumer consultants	60.0	55.3	61.3	57.0	63.5	1.4
Other staff[(d)]	4,557.6	4,511.7	4,221.4	4,601.6	4,475.3	–0.5
Total[(e)]	**23,205.5**	**23,886.3**	**24,734.2**	**25,911.4**	**26,695.9**	**3.6**

(a) Calculated from source data before rounding to one decimal place.

(b) *Diagnostic and allied health professionals* includes psychologists, social workers, occupational therapists and diagnostic and allied health professionals.

(c) *Other personal care* staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants (METeOR identifier 270171).

(d) *Other staff* includes *Administrative and clerical* and *Domestic and other staff* categories.

(e) Totals may not add due to rounding.

Sources: National Mental Health Establishments Database and Department of Health and Ageing (unpublished data).

Specialised mental health service unit staff

The FTE staff numbers reported in Table 12.19 refer to the average number of FTE staff employed in specialised mental health service organisations. As previously noted, specialised mental health service organisations comprise specialised mental health services (see Section 12.3). Staffing of specialised mental health service units is reported for three specialist mental health service settings. These settings are admitted patient services in public psychiatric hospitals and public acute hospitals with specialised psychiatric units or wards; community mental health care services; and residential mental health services, including government and non-government-operated services.

The number of FTE staff reported for these service units is presented in Table 12.23. The table excludes some staff employed by specialised mental health service organisations, mainly those performing organisational management roles. The categories of carer consultants and consumer consultants are also excluded from service unit level staff data.

In 2007–08, 26,576 FTE staff were employed nationally in the provision of specialised mental health care services (Table 12.23), as reported at the service unit level. Around half (50.6%) of these staff provided specialised mental health services for patients in admitted patient services. Community mental health care services employed the next largest number of FTE staff (11,187 or 42.1%).

Nationally, 125.1 FTE staff per 100,000 population were employed in specialised mental health service units during 2007–08 (Table 12.24). Of these, hospital admitted patient services employed 63.3 FTE staff per 100,000 population, with variation between the states and territories ranging from 87.8 in South Australia to 32.1 in the Australian Capital Territory. Community mental health care services employed on average 52.7 FTE staff per 100,000 population during 2007–08. As with hospital admitted patient services, there was variation

among jurisdictions, ranging from 65.0 FTE staff per 100,000 population in Western Australia to 46.9 in Tasmania.

Table 12.23: Full-time-equivalent staff[(a)], specialised mental health service units, by service setting, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Hospital admitted patient services	4,917.7	2,145.0	2,813.5	1,672.5	1,399.9	309.6	109.8	80.3	13,448.1
Community mental health care services	3,449.6	2,600.9	2,210.9	1,388.9	996.1	232.6	200.1	108.0	11,186.9
Residential mental health services	175.5	1,306.1	. .	145.0	57.6	186.1	67.1	3.7	1,941.0
Total[(b)]	**8,542.8**	**6,051.9**	**5,024.4**	**3,206.3**	**2,453.5**	**728.2**	**376.9**	**192.0**	**26,576.1**

. . Not applicable.

(a) Excludes consumer and carer consultants and staff employed at a higher organisational level.

(b) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 12.24: Full-time-equivalent staff[(a)] per 100,000 population, specialised mental health service units, by service setting, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Hospital admitted patient services	70.8	40.8	66.3	78.2	87.8	62.5	32.1	36.9	63.3
Community mental health care services	49.7	49.4	52.1	65.0	62.5	46.9	58.5	49.7	52.7
Residential mental health services	2.5	24.8	. .	6.8	3.6	37.6	19.6	1.7	9.1
Total[(b)]	**123.0**	**115.0**	**118.4**	**150.0**	**154.0**	**147.0**	**110.2**	**88.3**	**125.1**

. . Not applicable.

(a) Excludes consumer and carer consultants and staff employed at a higher organisational level.

(b) Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

12.8 Private psychiatric hospitals

The Private Health Establishments Collection, held by the ABS, defines private psychiatric hospitals as those licensed or approved by a state or territory health authority and that cater primarily for admitted patients with psychiatric, mental or behavioural disorders. This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients.

This collection was not conducted for the 2007–08 data period. Data for 2008–09 is now available but was not released in time to be included in this report. In 2006–07, there were 25 private hospitals defined as psychiatric, the same number as in 2003–04 (Table 12.25). There were 1,554 total average available beds in 2006–07, an increase of 113 beds since 2003–04.

Table 12.25: Private psychiatric hospitals, available beds and available beds per 100,000 population, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08
Private psychiatric hospitals	25	26	26	25	n.a.
Available beds[(a)]	1,441	1,512	1,573	1,554	n.a.
Available beds per 100,000 population[(b)]	7.2	7.5	7.7	7.5	n.a.

n.a. Not available.

(a) Average available beds.

(b) Crude rate is based on the Australian estimated resident population as at 31 December for the reference year.

Source: Private Health Establishments Collection (ABS).

In 2006–07 there were 1,591 FTE staff employed by private psychiatric hospitals, decreasing from a peak of 1,711 FTE in 2005–06 (Table 12.26). Nurses made up the majority of the private psychiatric hospital workforce between 2003–04 and 2006–07, accounting for around half of the FTE staff.

Table 12.26: Full-time-equivalent staff by staffing category[(a)], private psychiatric hospitals, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08
Salaried medical officers	24	21	19	26	n.a.
Nurses[(b)]	861	932	879	773	n.a.
Allied health professionals	151	151	180	164	n.a.
Administrative and clerical staff	314	281	311	344	n.a.
Domestic and other staff[(c)]	322	294	322	286	n.a.
Total staff	**1,672**	**1,680**	**1,711**	**1,591**	**n.a.**

n.a. Not available.

(a) Average full-time-equivalent staff.

(b) Includes *Nursing administrators*, *Nurse educators*, *Other registered nurses*, *Enrolled nurses*, *Student nurses*, *Trainee nurses*, *Other nursing staff* and *Other personal care staff* categories.

(c) Includes *Catering and kitchen*, *Domestic*, *Engineering and maintenance* and *Other* categories.

Source: Private Health Establishments Collection (ABS).

13 Mental health workforce

13.1 Introduction

The information presented in this chapter describes the size and characteristics of the workforce of psychiatrists and nurses specialising in mental health care. The annual AIHW Medical Labour Force Survey (AIHW 2009e) provides information for psychiatrists, while the AIHW Nursing and Midwifery Labour Force Survey (AIHW 2009f) provides information for mental health nurses. Further details on these data sources are outlined in Appendix 1.

Surveys have also been conducted for the psychologist workforce in the past; however, there have been no new data available since the publication of *Mental health services in Australia 2004–05* (AIHW 2007b). Other health care professionals providing mental health-related services, for example general practitioners (GPs), counsellors and social workers, are not covered since equivalent workforce data are not available.

Key concepts

In this report, an ***employed*** health professional is defined as one who:

- worked for a total of 1 hour or more, principally in the relevant profession, for pay, commission, payment in kind or profit; mainly or only in a particular state or territory during a specified period (for psychiatrists, at the time of the survey and for nurses, in the week before the survey), or
- usually worked but was away on leave (with some pay) for less than 3 months, on strike or locked out, or rostered off.

This includes those involved in clinical and non-clinical roles, for example education, research, and administration. 'Employed' people are referred to as the 'workforce' in this chapter. This excludes those medical practitioners practising psychiatry as a second or third speciality, and those who were on extended leave for more than 3 months or who were not employed.

Full-time-equivalent (FTE) is the number of 38-hour-week workloads worked by professionals. FTE is calculated by multiplying the number of employed professionals in a specific category by the average total hours worked by employed people in that category, and dividing by 38. The figures for FTE per 100,000 population provide a standardised measure of supply of professionals. The standard of 38 hours was used in this report to provide comparable figures with previously published data. This differs from the approach used in *Mental health services in Australia* reports published before 2004–05, and with data on the medical and nursing labour force published by the AIHW (AIHW 2008b, c). FTE numbers presented in this chapter will therefore not be easily comparable with those reports.

Total hours are the total hours worked per week in the profession, including paid and unpaid work. Average total weekly hours are calculated only for those people who reported their hours (that is, those who did not report them are excluded).

It should be noted that the data presented in this chapter on psychiatrists, psychiatrists-in-training and mental health nurses are estimates, based on the responses to the AIHW labour force surveys (as outlined in Appendix 1). While the data are weighted to population benchmarks (which are based on professional registration numbers), not all non-response bias can be accounted for or measured. In addition, the surveys, while generally consistent in content and design, have been modified over time and can vary by jurisdiction.

As a result, care needs to be taken in interpreting changes in numbers and rates, and variations among the states and territories.

13.2 Psychiatrists

The annual AIHW Medical Labour Force Survey of all registered medical practitioners provides estimates on the number of psychiatrists and psychiatrists-in-training practising in Australia. It is conducted in consultation with the state and territory health departments, and in cooperation with the medical registration boards in each jurisdiction. Estimates are based on those who 'self-identify' and who state that they were ***employed*** as a medical practitioner at the time of the survey.

To enable meaningful comparison in the supply of psychiatrists across Australia over time, ***full-time-equivalent*** (FTE) figures are provided in addition to the number of psychiatrists and the average ***total hours*** worked (see Key concepts). The FTE measures the number of 38-hour-week workloads worked by psychiatrists, regardless of how many worked full-time or part-time. Population standardised FTE figures (FTE per 100,000 population) are also reported as these take into account differences in the size of the relevant populations between regions and over time.

Characteristics of the psychiatrist workforce

Psychiatrists (including psychiatrists-in-training) made up 5.4% of all employed medical practitioners in Australia (AIHW 2009e), with an estimated 3,607 working in Australia in 2007 (Table 13.1). Psychiatrists-in-training made up 23.9% (or 862) of these psychiatrists.

In 2007, 64.7% of employed psychiatrists were male. The average age of psychiatrists was 48.5 years, with female psychiatrists being younger, on average, than their male counterparts.

Including clinical and non-clinical hours, psychiatrists worked an average of 40.1 total hours per week in 2007 (Table 13.2). The hours worked per week were, on average, lower for females than males (36.4 hours compared with 42.1 hours) and higher for psychiatrists-in-training than for those not in training (44.3 hours compared with 38.8 hours).

Table 13.1: Employed psychiatrists and psychiatrists-in-training, demographic characteristics, 2003–2007

	2003	2004	2005	2006	2007	2007 (per cent)	Average annual change (per cent)
Psychiatrists	2,395	2,409	2,454	2,505	2,745	76.1	3.5
Psychiatrists-in-training	631	742	726	753	862	23.9	8.1
Sex							
Males	1,972	2,020	1,991	2,076	2,334	64.7	4.3
Females	1,054	1,131	1,189	1,182	1,274	35.3	4.9
Age group and sex							
Males							
Less than 35 years	196	274	266	237	304	8.4	11.6
35–44 years	505	469	489	464	543	15.1	1.8
45–54 years	546	543	505	566	606	16.8	2.6
55–64 years	453	463	464	489	500	13.9	2.5
65 years and over	272	272	267	320	380	10.5	8.7
Females							
Less than 35 years	227	268	285	233	268	7.4	4.2
35–44 years	323	353	380	373	385	10.7	4.5
45–54 years	289	304	323	332	349	9.7	4.8
55–64 years	161	159	152	177	203	5.6	6.0
65 years and over	53	48	49	66	69	1.9	6.8
Total[(a)]	**3,026**	**3,152**	**3,180**	**3,258**	**3,607**	**100.0**	**4.5**
Average age (years)							
Males	50.5	49.9	49.9	50.8	50.5	. .	0.0
Females	45.0	44.0	43.7	45.2	44.9	. .	–0.1
All	*48.6*	*47.8*	*47.6*	*48.8*	*48.5*	. .	*–0.1*
All employed medical practitioners							
Total	**56,207**	**58,211**	**60,252**	**62,425**	**67,208**	**. .**	**4.6**

. . Not applicable.

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

Sources: AIHW Medical Labour Force Surveys, 2003, 2004, 2005, 2006, 2007.

Table 13.2: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, type and sex, 2003–2007

	2003	2004	2005	2006	2007	Average annual change (per cent)
Psychiatrists	40.8	40.0	39.8	39.5	38.8	–1.2
Psychiatrists-in-training	45.4	43.8	43.4	44.1	44.3	–0.6
Sex						
Males	44.3	43.3	42.8	42.7	42.1	–1.3
Females	36.9	36.6	36.9	36.7	36.4	–0.3
Total	**41.8**	**40.9**	**40.6**	**40.5**	**40.1**	**–1.0**

Sources: AIHW Medical Labour Force Surveys, 2003, 2004, 2005, 2006, 2007.

Nationally, there were 18 FTE psychiatrists per 100,000 population in 2007 (Table 13.3). The number of FTE psychiatrists per 100,000 population varied among the states and territories, ranging from 13 for Western Australia to 23 for Victoria. The average hours worked varied across jurisdictions, ranging from 37.1 hours per week for Tasmania to 41.4 for Queensland.

Table 13.3: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, FTE and FTE per 100,000 population, states and territories, 2007

	NSW[(a)]	Vic	Qld[(a)]	WA	SA	Tas[(a)]	ACT	NT[(b)]	Total[(c)]
Number of psychiatrists	798	873	498	209	219	66	n.p.	n.p.	2,745
Number of psychiatrists-in-training	287	268	143	51	65	10	n.p.	n.p.	862
Total number	1,084	1,141	641	260	284	76	n.p.	n.p.	3,607
Average total hours worked per week	40.2	39.5	41.4	40.9	40.2	37.1	n.p.	n.p.	40.1
Total FTE	**1,147**	**1,186**	**698**	**280**	**301**	**74**	**n.p.**	**n.p.**	**3,807**
FTE per 100,000 population[(d)]	17	23	17	13	19	15	n.p.	n.p.	18

n.p. Not published, however, the figures are included in the total.

(a) The number of medical practitioners in New South Wales, Queensland and Tasmania are underestimates as the benchmark figures did not include all registered medical practitioners.

(b) Estimates for the Northern Territory are not separately published due to the low response rate to the survey in that jurisdiction (27.1%). Data for the Australian Capital Territory have been suppressed to maintain the confidentiality of Northern Territory data.

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

(d) Crude rate is based on Australian estimated resident population as at 30 June 2007.

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

Source: AIHW Medical Labour Force Survey, 2007.

In 2007, approximately 88.8% of FTE psychiatrists (for whom region was reported) worked mainly in the *Major cities* (Table 13.4). Once population sizes for each remoteness area were taken into account, the FTE psychiatrists per 100,000 population was highest for *Major cities* (23), followed by *Inner regional* (7) and *Outer regional* (5) areas.

Table 13.4: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, FTE and FTE per 100,000 population, by remoteness area[a], 2007

Remoteness area of main job[a]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[b]
Major cities	3,023	40.3	3,206	23
Inner regional	285	38.2	286	7
Outer regional	87	39.1	89	5
Remote and very remote	18	45.3	21	4
Not reported	195	38.5	197	. .
Total[c]	**3,607**	**40.1**	**3,807**	**18**

. . Not applicable.

(a) Remoteness area is derived from the postcode of the respondent's location of main job. These data should be treated with caution due to the large number of *Not reported* values for remoteness area, relative to the number of values reported in *Outer regional* and *Remote and very remote* areas.

(b) Crude rate is based on the Australian estimated resident population as at 30 June 2007.

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

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

Source: AIHW Medical Labour Force Survey, 2007.

Changes in the psychiatrist workforce

The size and characteristics of the psychiatrist workforce, including the hours worked, changed in the period from 2003 to 2007. During this period, the number of employed psychiatrists (and psychiatrists-in-training) increased by an annual average of 4.5% compared with 4.6% for all employed medical practitioners (Table 13.1). These figures equate to average annual increases of 3.5% for psychiatrists and 8.1% for psychiatrists-in-training, respectively.

Between 2003 and 2007, the number of male and female psychiatrists increased by annual averages of 4.3% and 4.9%, respectively. However, for the age group less than 35 years, the number of male psychiatrists increased by an annual average of 11.6%, while the number of female psychiatrists in the same age group increased by an annual average of 4.2%. The proportion of psychiatrists in the workforce who were female increased from 34.8% in 2003 to 35.3% in 2007 (Table 13.1). However, the proportion of female psychiatrists in the workforce peaked in 2005 at 37.4% and has since been declining.

The average hours worked by psychiatrists (and psychiatrists-in-training) per week has declined by an annual average of 1.0% over the past 5 years (Table 13.2), with the number of hours worked per week decreasing for both males and females by annual averages of 1.3% and 0.3%, respectively.

Nationally, the supply of psychiatrists and psychiatrists-in-training, measured as FTE per 100,000 population, increased between 2003 and 2007 by an annual average of 1.4% (Table 13.5). The supply increased in some, but not all, jurisdictions during this period (Table 13.6). In Queensland, the number of FTE psychiatrists per 100,000 population increased by an annual average of 9.1%.

Table 13.5: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, 2003–2007

	2003	2004	2005	2006	2007	Average annual change (per cent)
Psychiatrists	2,571	2,536	2,570	2,604	2,803	2.2
Psychiatrists-in-training	754	856	830	874	1,005	7.4
Total FTE[(a)]	**3,328**	**3,392**	**3,398**	**3,472**	**3,807**	**3.4**
FTE per 100,000 population[(b)]	17	17	17	18	18	1.4

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

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

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

Sources: AIHW Medical Labour Force Surveys, 2003, 2004, 2005, 2006, 2007.

Table 13.6: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, states and territories, 2003–2007

	NSW	Vic	Qld	WA	SA	Tas	ACT[(a)]	NT[(a)]	Total[(b)]
					FTE				
2003	1,063	1,049	463	271	319	71	50	36	3,328
2004	1,129	1,076	474	247	335	68	44	20	3,392
2005	1,144	1,028	541	223	313	63	63	25	3,398
2006	1,140	1,096	548	260	285	60	n.p.	n.p.	3,472
2007	1,147	1,186	698	280	301	74	n.p.	n.p.	3,807
Average annual change (per cent)	1.9	3.1	10.8	0.8	–1.4	1.0	n.p.	n.p.	3.4
					FTE per 100,000 population[(c)]				
2003	16	21	12	14	21	15	15	18	17
2004	17	22	12	12	22	14	13	10	17
2005	17	20	14	11	20	13	19	12	17
2006	18	23	15	14	20	13	13	22	18
2007	17	23	17	13	19	15	n.p.	n.p.	18
Average annual change (per cent)	1.5	2.3	9.1	–1.8	–2.5	—	n.p.	n.p.	1.4

n.p. Not published, however, the figures are included in the total.

— Rounded to zero.

(a) Estimates for the Northern Territory for 2007 and 2006 are not separately published due to the low response rates to the survey in that jurisdiction (27.1% and 28.6%, respectively). Data for the Australian Capital Territory have been suppressed to maintain the confidentiality of Northern Territory data.

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

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

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

Sources: AIHW Medical Labour Force Surveys, 2003, 2004, 2005, 2006, 2007.

13.3 Mental health nurses

Mental health nurses are another group of health professionals who can provide care to people with mental health problems. In this report, the definition of mental health nursing is based on a self-identified principal area of nursing activity rather than the qualification of the nurse. An ***employed*** registered or enrolled nurse with a principal area of activity in their main nursing job of mental health nursing is considered to be a mental health nurse. Nurses working principally with alcohol and other substance use are not defined as mental health nurses.

Information on the mental health nursing workforce is derived from responses to the AIHW Nursing and Midwifery Labour Force Survey, with these responses weighted to available nursing registration data from each state and territory. As described in Appendix 1, this is a survey of all enrolled and registered nurses in Australia conducted by the state and territory departments of health, in conjunction with nursing registration boards and the AIHW. The survey collects information on the demographic characteristics of nurses, the hours they worked, their qualifications, their place of work and their main area of nursing activity in the week before the survey.

In this section of the chapter, some comparisons are made between employed mental health nurses and all employed nurses. Detailed data on the total nursing labour force are available from *Nursing and midwifery labour force 2007* (AIHW 2009f).

Characteristics of the mental health nursing workforce

Of the 263,331 nurses employed in Australia in 2007, an estimated 14,959 (5.7%) worked principally in the area of mental health nursing (Table 13.7). Nurses working in mental health are more likely to work full time, are slightly older on average and are more likely to be male when compared with nurses in the general workforce (AIHW 2009f).

The usual minimum educational requirements for a registered nurse are a 3-year degree or equivalent. Enrolled nurses, whose minimum educational requirement is a 1-year diploma or equivalent, usually work under the direction of registered nurses to provide basic care (AIHW 2009f). In 2007, 80.3% of nurses working principally in mental health and 80.6% of all employed nurses in Australia were registered nurses, with the remainder being enrolled nurses (AIHW 2009f).

The average age of employed mental health nurses in 2007 was 45.8 years (Table 13.7), which is slightly older than the 43.7 years for all employed nurses (AIHW 2009f). Female nurses working in mental health nursing in 2007 were younger, on average, than their male counterparts (45.5 years compared with 46.6 years).

In general, nursing is a very female-dominated profession, with only 9.6% of all nurses employed in Australia in 2007 being male (AIHW 2009f). By contrast, male nurses made up a third (33.1%) of employed mental health nurses in 2007 (Table 13.7).

Mental health nurses worked an average of 36.7 total hours per week in 2007 (Table 13.8). The hours worked per week were, on average, lower for females than males (35.7 hours compared with 38.8 hours) and higher for registered nurses than for enrolled nurses (37.2 hours compared with 34.8 hours).

Table 13.7: Employed mental health nurses, demographic characteristics, 2003–2007[(a)]

	2003	2004	2005	2007	Per cent (2007)	Average annual change (per cent)
Registered nurses	10,315	10,134	11,066	12,019	80.3	3.9
Enrolled nurses	3,463	3,702	2,406	2,940	19.7	–4.0
Sex						
Males	4,469	4,676	4,211	4,956	33.1	2.6
Females	9,308	9,160	9,261	10,003	66.9	1.8
Age group and sex						
Males						
Less than 25 years	72	52	38	125	0.8	14.8
25–34 years	533	557	407	621	4.2	3.9
35–44 years	1,255	1,172	901	1,115	7.5	–2.9
45–54 years	1,875	2,035	1,917	1,995	13.3	1.6
55–64 years	668	779	862	973	6.5	9.9
65 years and over	67	81	86	127	0.8	17.3
Females						
Less than 25 years	285	349	204	283	1.9	–0.2
25–34 years	1,483	1,445	1,215	1,498	10.0	0.3
35–44 years	2,767	2,425	2,289	2,441	16.3	–3.1
45–54 years	3,402	3,465	3,852	3,743	25.0	2.4
55–64 years	1,214	1,309	1,523	1,813	12.1	10.5
65 years and over	157	166	177	225	1.5	9.4
Average age (years)						
Males	45.6	46.2	47.7	46.6	. .	0.5
Females	44.1	44.3	45.8	45.5	. .	0.8
Total	*44.6*	*44.9*	*46.4*	*45.8*	*. .*	*0.7*
Total number[(b)]	**13,777**	**13,836**	**13,472**	**14,959**	**100.0**	**2.1**
All employed nurses	236,645	243,916	244,360	263,331	. .	2.7

. . Not applicable.

(a) The Nursing and Midwifery Labour Force Survey was not conducted nationally in 2006.

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

Sources: AIHW Nursing and Midwifery Labour Force Surveys, 2003, 2004, 2005, 2007.

Table 13.8: Employed mental health nurses, average total hours worked per week, by sex, 2003–2007[(a)]

	2003	2004	2005	2007	Average annual change (per cent)
Registered nurses	37.0	37.3	37.5	37.2	0.1
Enrolled nurses	36.0	35.9	35.8	34.8	–0.8
Sex					
Males	39.1	39.2	39.5	38.8	–0.2
Females	35.6	35.8	36.1	35.7	0.1
Total	**36.7**	**36.9**	**37.2**	**36.7**	**0.0**

(a) The Nursing and Midwifery Labour Force Survey was not conducted nationally in 2006.

Sources: AIHW Nursing and Midwifery Labour Force Surveys, 2003, 2004, 2005, 2007.

As with psychiatrists, nurses working in mental health areas are not evenly distributed among the states and territories or the regions of Australia. Their distribution also does not mirror the distribution of all employed nurses in Australia (AIHW 2009f). In 2007, there were 69 FTE mental health nurses per 100,000 population in Australia, with Tasmania and South Australia reporting the highest rates of 81 and 80 FTE per 100,000 population, respectively (Table 13.9).

Table 13.9: Employed mental health nurses, average total hours worked per week, FTE and FTE per 100,000 population, states and territories[(a)], 2007

	NSW	Vic	Qld	WA	SA	Tas	ACT[(a)]	NT[(b)]	Total[(c)]
Number	4,675	4,223	2,736	1,319	1,337	408	n.p.	n.p.	14,959
Average total hours worked per week	37.2	35.6	37.3	37.3	36.2	37	n.p.	n.p.	36.7
Total FTE	**4,577**	**3,956**	**2,686**	**1,295**	**1,274**	**398**	**n.p.**	**n.p.**	**14,447**
				FTE per 100,000 population[(d)]					
Mental health nurses	66	76	64	61	80	81	n.p.	n.p.	69
All nurses	1,007	1,226	1,032	973	1,286	1,255	1,106	1,433	1,095

n.p. Not published, however figures are included in the totals.

(a) State and territory estimates should be treated with caution due to low response rates in some jurisdictions.

(b) Estimates for the Northern Territory are not separately published due to the low response rate to the survey in that jurisdiction (28.7%). Data for the Australian Capital Territory have been suppressed to maintain the confidentiality of Northern Territory data.

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

(d) Crude rate is based on the Australian estimated resident population as at 30 June 2007.

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

Source: AIHW Nursing and Midwifery Labour Force Survey 2007.

Information on the supply of mental health nurses by remoteness area (derived from the location of the respondent's main nursing job as reported in the survey) is provided in Table 13.10. The figures are underestimates for each individual region as nurses who did not provide information on the location of their main job could not be allocated to a region. The figure for the total FTE per 100,000 population is calculated based on all employed nurses.

For nurses who reported information on the location of their main job, the number of FTE mental health nurses per 100,000 population was highest in *Inner regional* areas (83 FTE per 100,000 population in 2007) and in *Major cities* (67 FTE per 100,000 population). *Outer regional*

and *Remote and very remote* regions had lower rates than the national average, with 41 and 32 FTE per 100,000 population, respectively. This compares with a national rate of 69 FTE per 100,000 population for mental health nurses and a national rate of 1,095 FTE per 100,000 population for all nurses.

Table 13.10: Employed mental health nurses, average total hours worked per week, and FTE and FTE per 100,000 population, by remoteness area[(a)], 2007

	Mental health nurses				All nurses
Remoteness area of main job[(a)]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(b)]	FTE per 100,000 population[(b)]
Major cities	9,735	36.9	9,453	67	1,028
Inner regional	3,533	36.5	3,394	83	1,160
Outer regional	831	37.2	814	41	1,126
Remote and very remote	150	39.3	155	32	1,125
Not reported	711	34.1	638	. .	. .
Total[(c)]	**14,959**	**36.7**	**14,447**	**69**	**1,095**

. . Not applicable.

(a) Remoteness area is derived from the postcode of the respondent's location of main job. These data should be treated with caution due to the large number of *Not reported* values for remoteness area, relative to the number of values reported in *Outer regional* and *Remote and very remote* areas.

(b) Crude rate is based on the Australian estimated resident population as at 30 June 2007.

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

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

Source: AIHW Nursing and Midwifery Labour Force Survey 2007.

Changes in the mental health nursing workforce

The size and characteristics of the mental health nursing workforce changed in the period from 2003 to 2007. The number of nurses working in mental health nursing increased by an annual average of 2.1% compared with 2.7% for all employed nurses in Australia (Table 13.7).

Demographic characteristics of the mental health nursing workforce also changed over this time. While the proportion of males and females in this workforce remained similar from 2003 to 2007, there was an average annual increase of 2.6% for male mental health nurses and a 1.8% increase for females (Table 13.7). The proportion of mental health nurses who were registered nurses (rather than enrolled nurses) increased over the same period, from 74.9% in 2003 to 80.3% in 2007. This equates to an average annual increase of 3.9% for registered nurses compared with an average annual decrease of 4.0% for enrolled nurses.

As with the general nursing population (AIHW 2009f), the mental health nursing workforce is ageing, with the average age increasing from 44.6 in 2003 to 45.8 years in 2007 (Table 13.7 and Figure 13.1). This reflects a 0.7% average annual increase in the average age of mental health nurses since 2003. The proportion of mental health nurses aged 55 years and over also increased, from 15.3% in 2003 to 21.0% in 2007.

While there was no overall change in the average hours that employed mental health nurses worked per week from 2003 to 2007 (Table 13.8), the increase in the number of mental health nurses resulted in increased supply (69 FTE per 100,000 population) (Table 13.11).

Table 13.11: Employed mental health nurses, FTE and FTE per 100,000 population, 2003–2007

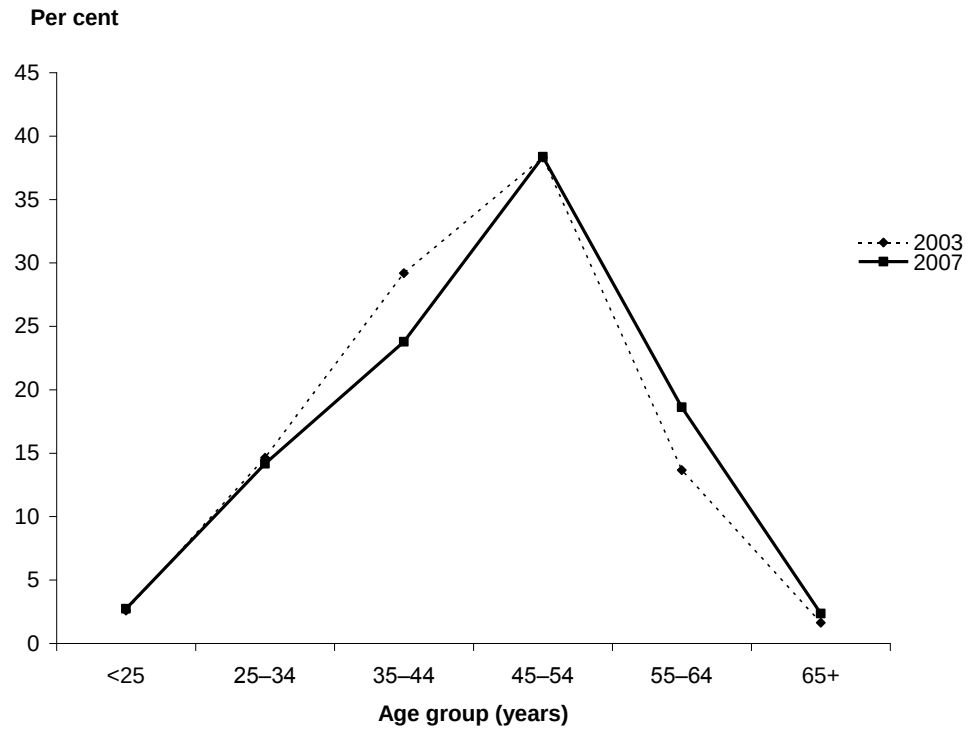
	2003	2004	2005	2007	Average annual change (per cent)
Registered nurses	10,043	9,947	10,920	11,766	4.0
Enrolled nurses	3,281	3,497	2,266	2,692	–4.8
Total FTE[(a)]	**13,306**	**13,435**	**13,188**	**14,447**	**2.1**
FTE per 100,000 population[(b)]	67	67	65	69	0.7

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

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

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

Sources: AIHW Nursing and Midwifery Labour Force Surveys, 2003, 2004, 2005, 2007.



Sources: AIHW Nursing and midwifery labour force survey, 2003 and 2007.

Figure 13.1: Employed mental health nurses, by age, 2003 and 2007

There is considerable variability in the state and territory estimates of FTE mental health nurses and FTE per 100,000 population in the period from 2003 to 2007 (Table 13.12). As outlined in Appendix 1, at least part of this variation may be due to changes in the survey methodology and variations in response rates, and thus jurisdictional differences should be

interpreted with caution. For example, Victorian responses for 2005 were derived from 2006 data (weighted to 2005 benchmarks) due to the unavailability of Victorian data for that reporting period.

Table 13.12: Employed mental health nurses, FTE and FTE per 100,000 population[(a)], states and territories, 2003–2007[(b)]

	NSW	Vic[(c)]	Qld	WA[(d)]	SA	Tas	ACT[(a)]	NT[(e)]	Total[(f)]
					FTE				
2003	4,846	3,660	2,254	916	1,098	320	167	54	13,306
2004[(g)]	4,336	3,955	2,369	1,175	1,072	295	166	77	13,435
2005[(f)]	4,293	3,706	2,256	n.p.	1,116	339	n.p.	n.p.	13,188
2007[(f)(g)]	4,577	3,956	2,686	1,295	1,274	398	n.p.	n.p.	14,447
Average annual change (per cent)	–1.4	2.0	4.5	9.0	3.8	5.6	n.p.	n.p.	2.1
					FTE per 100,000 population[(a)]				
2003	73	74	59	47	72	67	51	27	67
2004[(g)]	65	79	61	59	70	61	51	38	67
2005[(f)]	64	73	56	n.p.	72	70	65	n.p.	65
2007[(f)(g)]	66	76	64	61	80	81	n.p.	n.p.	69
Average annual change (per cent)	–2.5	0.7	2.1	6.7	2.7	4.9	n.p.	n.p.	0.7

n.p. Not published, however, the figures are included in the totals.

(a) Crude rate is based on the Australian estimated resident population as at 30 June 2007.

(b) The Nursing and Midwifery Labour Force Survey was not conducted nationally in 2006.

(c) Estimates for Victoria for 2005 are derived from responses to the 2006 AIHW Nursing and Midwifery Labour Force Census, weighted to 2005 registration and enrolment benchmark figures.

(d) Estimates for Western Australia are not separately published for 2005 due to the low response rate to the survey in that jurisdiction (26.9%).

(e) Estimates for the Northern Territory are not separately published for 2005 and 2007 due to the low response rates to the survey in that jurisdiction (13.7% in 2005 and 28.7% in 2007). Data for the Australian Capital Territory have been suppressed to maintain the confidentiality of Northern Territory data.

(f) The 2005 total for Australia includes estimates for the Northern Territory and Western Australia. The 2007 total for Australia includes estimates for the Northern Territory. Due to the relative size of the nursing and midwifery workforces in these jurisdictions, any biases in their estimates are unlikely to have a significant effect on the accuracy of the national figure. The number for each state may not sum to the total due to the estimation process and rounding.

(g) State and territory estimates for 2007 should be treated with caution due to low response rates in some jurisdictions. See Appendix 1 for further information.

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

Sources: AIHW Nursing and Midwifery Labour Force Surveys, 2003, 2004, 2005, 2007.

14 Expenditure on mental health services

14.1 Introduction

This chapter reviews the available information on ***recurrent expenditure*** for mental health services, beginning with recurrent expenditure on the state and territory specialised mental health facilities, as detailed in Chapter 12. Information is then provided on private psychiatric hospital expenditure and Australian Government expenditure on Medicare-subsidised mental health-related services, subsidised mental health-related prescriptions and other mental health-related services. Finally, information on the sources of funding for mental health services is provided. Data on expenditure and funding are derived from a variety of sources, as outlined in Appendix 1. Further information on health expenditure is available in *Health expenditure Australia 2007–08* (AIHW 2009c).

Health expenditure and ***health funding*** are distinct but related concepts, essential to understanding the financial resources utilised by the health system. Expenditure information relates to who incurs the expenditure, while funding information relates to the provider of the financial resources (as detailed in Key concepts).

Key concepts

Health expenditure is reported in terms of who incurs the expenditure rather than who ultimately provides the funding. In the case of public hospital care, for example, all expenditures (that is, expenditure on medical and surgical supplies, drugs, salaries of doctors and nurses, and so forth) are incurred by the states and territories, but a proportion of those expenditures are funded by transfers from the Australian Government (AIHW 2009c).

Health funding is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospital care, for example, the Australian Government and the states and territories together provide over 90% of the funding; these funds are derived ultimately from taxation and other sources of government revenue. Some other funding comes from private health insurers and from individuals who choose to be treated as private patients and pay hospital fees out of their own pockets (AIHW 2009c).

Recurrent expenditure refers to expenditure that does not result in the acquisition or enhancement of an asset—for example, salaries and wages expenditure and non-salary expenditure such as payments to visiting medical officers (AIHW 2009c).

Current price refers to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditures reflect changes in both price and volume (AIHW 2009c).

Constant price estimates are derived by adjusting the current prices to remove the effects of inflation. This allows for expenditures in different years to be compared and for changes in expenditure to reflect changes in the volume of health goods and services. Generally, the constant price estimates have been derived using annually reweighted chain price indexes produced by the Australian Bureau of Statistics (ABS). In some cases, such indexes are not available, and ABS implicit price deflators have been used instead (AIHW 2009c).

Previous issues of *Mental health services in Australia* have included information on private hospitals sourced from the Private Health Establishments Collection (PHEC), held by the Australian Bureau of Statistics (ABS). However, this collection was not conducted for the

2007–08 data period, therefore information presented in this chapter on private hospitals is limited to previously published data.

14.2 Recurrent expenditure on state and territory specialised mental health services

Expenditure data for public psychiatric hospitals, specialised psychiatric units or wards in public acute hospitals, community mental health care services, government and non-government-operated residential mental health services are reported in this section. Also included in this section is mental health-related expenditure at the state, region and organisation levels, described as 'indirect' expenditure, and some apportioned to service units, as described in Appendix 2.

Expenditure reported as non-government-operated residential mental health services refers to grants provided to the non-government organisation providing the residential service, not the total operating costs of the non-government organisation as an entity.

The data are presented in both ***current*** and ***constant prices***. Unless otherwise stated, constant price estimates are expressed in 2007–08 prices.

For definitional information and the scope of these services, refer to Chapter 12. Information on the number of services, available beds and staffing is also in Chapter 12.

This section draws on data from the National Mental Health Establishments Database and, for some historical data, the *National mental health reports* published by the Australian Government Department of Health and Ageing. For further information on these data sources see Appendix 1.

Total recurrent expenditure on specialised mental health services by states and territories exceeded $3.3 billion during 2007–08 (Table 14.1). The largest proportion of recurrent expenditure was spent on the provision of public hospital services for admitted patients ($1.47 billion), comprising specialised psychiatric units or wards in public acute hospitals ($1.0 billion) and psychiatric hospitals ($0.4 billion). Most states reported public hospital expenditure as the largest proportion of mental health services expenditure, except for Victoria, the Australian Capital Territory and the Northern Territory, where community mental health care services accounted for the largest proportion. Nationally, $1.3 billion was reported as being spent on community mental health care services during 2007–08. Per capita expenditure ranged from $186 per person in Western Australia and Tasmania, to $146 in Queensland.

Total expenditure, in constant prices, on state and territory specialised mental health services increased by an annual average of 5.9% over the 2003–04 to 2007–08 period (Table 14.2). Specialised psychiatric units or wards in public acute hospitals and community mental health care services experienced considerable annual average increases in expenditure of 7.7% and 7.0%, respectively. Public psychiatric hospital expenditure declined, in constant prices, by an annual average of 1.2% between 2003–04 and 2007–08. Grants to non-government organisations increased by an annual average of 14.5%; these grants made up 6.8% of national specialised mental health services recurrent expenditure in 2007–08. Real per capita expenditure (constant prices) increased on average by 4.4% between 2003–04 and 2007–08.

Table 14.1: Recurrent expenditure[a] ($'000) on specialised mental health services, states and territories, 2007–08

	NSW	Vic	Qld	WA[b]	SA	Tas	ACT	NT	Total[c]
Public psychiatric hospitals[d]									
Salaries and wages expenditure	131,070	26,748	57,359	54,201	56,057	. .	. .	. .	325,434
Non-salary expenditure	31,658	12,983	18,511	13,308	22,448	. .	. .	. .	98,908
Indirect expenditure[e]	19,041	0	1,882	0	2,096	. .	. .	. .	23,019
Subtotal[c]	*181,769*	*39,731*	*77,752*	*67,508*	*80,601*	*. .*	*. .*	*. .*	*447,360*
Specialised psychiatric units or wards in public acute hospitals[d]									
Salaries and wages expenditure	245,378	152,497	159,249	92,582	43,388	21,602	9,233	8,446	732,377
Non-salary expenditure	76,587	53,183	46,431	20,415	15,575	10,663	4,747	1,675	229,276
Indirect expenditure[e]	22,466	14,717	15,831	53	1,281	1,937	2,026	1,542	59,853
Subtotal[c]	*344,431*	*220,397*	*221,511*	*113,050*	*60,245*	*34,203*	*16,006*	*11,663*	*1,021,505*
Community mental health care services									
Salaries and wages expenditure	265,455	213,901	180,681	132,950	69,349	17,408	16,768	11,308	907,821
Non-salary expenditure	74,649	70,723	54,382	41,237	24,955	9,667	7,375	2,923	285,911
Indirect expenditure[e]	29,014	19,416	14,177	393	4,398	2,096	2,907	2,169	74,570
Subtotal[c]	*369,118*	*304,040*	*249,240*	*174,580*	*98,702*	*29,171*	*27,051*	*16,399*	*1,268,301*
Residential mental health services[f]									
Salaries and wages expenditure	11,471	89,437	. .	7,023	4,312	11,178	3,482	253	127,156
Non-salary expenditure	2,640	32,439	. .	2,114	1,738	7,514	3,337	189	49,971
Indirect expenditure[e]	1,091	9,526	. .	0	287	633	581	14	12,131
Subtotal[c]	*15,201*	*131,402*	*. .*	*9,137*	*6,337*	*19,325*	*7,400*	*456*	*189,258*
Other expenditure									
Grants to non-government organisations[g]	60,171	65,625	39,436	21,079	24,487	4,690	6,117	3,843	225,448
Other indirect expenditure[h]	67,226	42,036	33,167	12,781	5,662	4,748	3,281	2,444	171,346
Total state/territory expenditure[c]	**1,037,916**	**803,232**	**621,105**	**398,136**	**276,033**	**92,137**	**59,854**	**34,805**	**3,323,219**
Per capita expenditure ($)[i]	149.47	152.64	146.39	186.21	173.23	185.99	174.97	160.07	156.48

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Public psychiatric hospital expenditure in WA includes publicly funded private hospitals.

(c) Totals may not add due to rounding to nearest $'000.

(d) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(e) Includes indirect expenditure at the region and organisation levels apportioned to service units. See Appendix 2 for information on the method used for apportioning.

(f) Residential mental health services include grants to non-government-operated residential mental health facilities.

(g) Grants to non-government organisations excludes funding of staffed residential services managed by non-government organisations. These are included in residential mental health services.

(h) Includes indirect expenditure at the state, region and organisation levels not apportioned to service units. See Appendix 2 for information on the method used to calculate indirect expenditure.

(i) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2007.

Source: National Mental Health Establishments Database.

Table 14.2: Recurrent expenditure[a] ($'000) on specialised mental health services, states and territories, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
			Current prices			
Public psychiatric hospitals[b][c]	402,807	416,810	431,429	439,508	447,360	2.7
Specialised psychiatric units or wards in public acute hospitals[b][c]	652,201	727,747	807,557	914,218	1,021,505	11.9
Community mental health care services	826,446	912,236	1,020,171	1,138,832	1,268,301	11.3
Residential mental health services[d]	148,873	155,559	176,285	187,778	189,258	6.2
Grants to non-government organisations[e]	112,228	130,433	159,251	189,812	225,448	19.1
Other indirect expenditure[f]	116,262	126,113	144,731	159,191	171,346	10.2
Total state/territory expenditure[g]	**2,258,817**	**2,468,899**	**2,739,425**	**3,029,339**	**3,323,219**	**10.1**
			Constant prices[h]			
Public psychiatric hospitals[b]	468,810	467,677	464,036	454,975	447,360	–1.2
Specialised psychiatric units or wards in public acute hospitals[b][c]	759,343	816,875	869,167	946,690	1,021,505	7.7
Community mental health care services	968,522	1,030,106	1,103,930	1,181,385	1,268,301	7.0
Residential mental health services[d]	174,790	175,904	191,486	195,379	189,258	2.0
Grants to non-government organisations[e]	131,299	147,321	172,351	197,042	225,448	14.5
Other indirect expenditure[f]	135,410	141,580	155,819	164,878	171,346	6.1
Total state/territory expenditure[g]	**2,638,175**	**2,779,464**	**2,956,789**	**3,140,349**	**3,323,219**	**5.9**
Per capita expenditure[i]	131.83	137.24	143.92	150.45	156.48	4.4

(a) Expenditure excludes depreciation. Figures reported in previous *Mental health services in Australia* publications may be different due to historical revisions resulting from data validation.

(b) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(c) Public psychiatric hospital expenditure in WA includes publicly funded private hospitals.

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services managed by non-government organisations. These are included in residential mental health services.

(f) Includes indirect expenditure at the state, region and organisation levels not apportioned to service units. See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) Totals may not add due to rounding to nearest $'000.

(h) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(i) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Sources: National Mental Health Establishments Database and Department of Health and Ageing (unpublished data).

Public acute and psychiatric hospitals

Expenditure on each service setting, broken down by program type and target population (where applicable), is presented in this section. For additional information on these service types, refer to the explanations provided in Chapter 12.

Program type

As described in Chapter 12, *Acute* care admitted patient programs involve short-term treatment for individuals with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms that have potential for prolonged dysfunction or risk to self and/or others. *Non-acute* care refers to all other admitted patient programs, including rehabilitation and extended care services (METeOR identifier 288889).

Around 60% ($268 million) of public psychiatric hospital expenditure during 2007–08 was spent on *Non-acute* services (Table 14.3). In contrast, the majority ($908 million) of expenditure on specialised psychiatric units or wards in public acute hospitals was spent providing *Acute* admitted patient services.

Table 14.3: Recurrent expenditure[(a)] ($'000) on specialised mental health public hospital services, by program type, states and territories, 2007–08

	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Total[(c)]
Public psychiatric hospitals[(d)]									
Acute	75,958	18,904	. .	47,991	36,506	. .	. .	. .	179,359
Non-acute	105,811	20,827	77,752	19,517	44,094	. .	. .	. .	268,001
Specialised psychiatric units or wards in public acute hospitals[(d)]									
Acute	313,179	203,569	172,878	102,030	60,245	28,284	16,006	11,663	907,853
Non-acute	31,252	16,828	48,633	11,019	. .	5,919	. .	. .	113,652
Total[(c)]	**526,200**	**260,128**	**299,262**	**180,558**	**140,846**	**34,203**	**16,006**	**11,663**	**1,468,865**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Expenditure in WA includes publicly funded private psychiatric hospitals.

(c) Totals may not add due to rounding to nearest $'000.

(d) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

Source: National Mental Health Establishments Database.

The average cost per patient day (Table 14.4) can be determined by dividing the total expenditure of the specialised mental health hospital service by the total number of patient days in these services (see Section 12.5). Average patient day costs can also be presented by program type and target population.

The average national cost in 2007–08 was $702 per patient day (Table 14.4). The Northern Territory ($1,061) had the highest average cost per patient day, while average costs in New South Wales ($674), Victoria ($675) and Queensland ($679) were lower than the national average.

Table 14.4: Average cost[(a)] per patient day ($)[(b)], specialised mental health public hospital services[(c)], by program type, states and territories, 2007–08

	NSW	Vic	Qld	WA[(d)]	SA	Tas	ACT	NT	Aust
Public psychiatric hospitals									
Acute	681	825	. .	1,049	984	. .	. .	. .	825
Non-acute	491	734	679	512	567	. .	. .	. .	565
Specialised psychiatric units or wards in public acute hospitals									
Acute	793	680	779	822	729	915	863	1,061	767
Non-acute	532	480	466	873	. .	830	. .	. .	521
Total average cost	**674**	**675**	**679**	**819**	**713**	**899**	**863**	**1,061**	**702**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Data are not casemix adjusted.

(c) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(d) Expenditure in WA includes publicly funded private psychiatric hospitals.

Source: National Mental Health Establishments Database.

Target population

Specialised mental health services data can be categorised using four target population groups. *Child and adolescent* services focus on those aged under 18 years, while *Older person* programs focus on those aged 65 years and over. *Forensic* health services concentrate on clients whose health condition has led them to commit, or be suspected of, a criminal offence. This includes prison-based services but excludes services that are primarily for other target groups even where they include a forensic component. *General* services target the adult population aged 18 to 64. *General* mental health services may also provide assistance to children, adolescents or older people (METeOR identifier 288957).

Nationally, most recurrent hospital expenditure was spent on *General* services ($1.0 billion) (Table 14.5). Not all jurisdictions provided specialised mental health public hospital services for each of the target population categories. However, there were similar expenditure profiles for those jurisdictions reporting all four target population groups, with the most spent on *General* services and the least spent on *Child and adolescent* services.

The average cost per patient day varied considerably between the four target population groups (Table 14.6). The average cost per patient day for *Child and adolescent* services ($1,275 per day) was the most expensive, followed by *Forensic* ($734), *General* ($706) and *Older person* services ($574). Of those jurisdictions reporting all four target population categories, Western Australia had the highest average cost per patient day for *General* services ($847 per day) and *Older person* services ($669). South Australia had the highest average cost per patient day for *Child and adolescent* services ($1,819 per day) and *Forensic* services ($945).

Table 14.5: Recurrent expenditure[(a)] ($'000) on specialised mental health public hospital services[(b)], by target population, states and territories, 2007–08

	NSW	Vic	Qld	WA[(c)]	SA	Tas	ACT	NT	Total[(d)]
General	399,976	166,136	204,022	132,909	87,990	25,897	12,923	11,663	1,041,516
Child and adolescent	26,713	14,939	19,697	7,480	3,099	. .	. .	. .	71,927
Older person	65,743	39,322	30,862	28,760	37,091	. .	3,082	. .	204,862
Forensic	33,768	39,731	44,681	11,409	12,666	8,305	. .	. .	150,561
Total[(d)]	**526,200**	**260,128**	**299,262**	**180,558**	**140,846**	**34,203**	**16,006**	**11,663**	**1,468,865**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(c) Public psychiatric hospital expenditure in WA includes publicly funded private hospitals.

(d) Totals may not add due to rounding to nearest $'000.

Source: National Mental Health Establishments Database.

Table 14.6: Average cost[(a)] per patient day ($)[(b)], specialised mental health public hospital services[(c)], by target population, states and territories, 2007–08

	NSW	Vic	Qld	WA[(d)]	SA	Tas	ACT	NT	Aust
General	694	653	649	847	766	811	862	1,061	706
Child and adolescent	1,272	1,269	1,362	1,004	1,819	. .	. .	. .	1,275
Older person	580	579	505	669	548	. .	870	. .	574
Forensic	482	774	876	864	945	1,357	. .	. .	734
Total average cost	**674**	**675**	**679**	**819**	**713**	**899**	**863**	**1,061**	**702**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Data are not casemix adjusted.

(c) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals include expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(d) Public psychiatric hospital expenditure in WA includes publicly funded private hospitals.

Source: National Mental Health Establishments Database.

Community mental health care services

Community mental health care services include hospital outpatient clinics and non-hospital community mental health care services, such as crisis or mobile assessment and treatment services, day programs, outreach services, and consultation or liaison services. Community mental health care services accounted for $1.3 billion of recurrent mental health services expenditure during 2007–08 (Table 14.7).

As with admitted patient services, community mental care services can be defined for mental health service purposes by target population. Nationally, the majority of these funds were spent providing *General* community mental health care services ($911 million or 71.8%). In contrast to public hospital expenditure, the next largest expenditure by target population was for the provision of *Child and adolescent* community mental health care services ($228 million or 17.9%).

Table 14.7: Recurrent expenditure[(a)] ($'000) on community mental health care services, by target population, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]
General	265,994	225,620	173,894	128,048	69,667	18,090	16,773	12,603	910,688
Child and adolescent	63,999	43,768	55,062	31,290	20,940	5,344	5,413	1,821	227,637
Older person	24,722	30,457	8,543	13,256	6,130	3,492	3,183	. .	89,784
Forensic	14,404	4,196	11,741	1,986	1,964	2,245	1,681	1,975	40,193
Total[(b)]	**369,118**	**304,040**	**249,240**	**174,580**	**98,702**	**29,171**	**27,051**	**16,399**	**1,268,301**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Totals may not add due to rounding to nearest $'000.

Source: National Mental Health Establishments Database.

Residential mental health services

Residential services are focused on providing overnight care in a supportive domestic-like environment, where individuals are encouraged to take responsibility for meeting their own daily needs. Residential services can either be staffed for 24 hours per day, or between 6 and 24 hours, totalling more than 50 hours per week. Residential services generally provide specialised care to the *General* and *Older person* target population groups.

During 2007–08, $189 million was spent on residential mental health services (Table 14.8). *General* services ($117 million) accounted for well over half of the residential total. Recurrent expenditure for 24-hour staffed residential services accounted for about $164 million or 86.9%.

Table 14.8: Recurrent expenditure[(a)] ($'000) on residential mental health services[(b)], by target population and hours staffed, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(c)]
General services[(d)]									
24-hour staffing	8,021	52,616	. .	7,520	5,451	13,070	5,947	456	93,080
Non-24-hour staffing	5,435	14,642	. .	1,618	886	. .	1,065	. .	23,646
Older person services									
24-hour staffing	1,175	63,598	. .	. .	. .	6,255	388	. .	71,416
Non-24-hour staffing	570	546	. .	. .	. .	. .	. .	. .	1,116
Total[(c)]	**15,201**	**131,402**	**. .**	**9,137**	**6,337**	**19,325**	**7,400**	**456**	**189,258**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(c) Totals may not add due to rounding to nearest $'000.

(d) A small number of residential services reported by NSW and the ACT as *Child and adolescent* residential services were included in the *General* category at the request of those jurisdictions.

Source: National Mental Health Establishments Database.

The average national cost per patient day for residential mental health services was $278 per day (Table 14.9). Average costs varied between the states and territories, ranging from $165 in New South Wales to $402 per residential care day in Tasmania. Average costs for services

providing staff on-site for 24-hours were higher than those for services providing less intensive staffing.

Table 14.9: Average cost[a] per residential care day ($)[b], residential mental health services[c], by target population and hours staffed, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
General services[d]									
24-hour staffing	235	405	. .	438	357	332	529	263	374
Non-24-hour staffing	105	130	. .	123	438	. .	98	. .	124
Older person services									
24-hour staffing	465	287	. .	. .	. .	722	165	. .	304
Non-24-hour staffing	154	284	. .	. .	. .	. .	. .	. .	198
Total average cost	**165**	**282**	**. .**	**301**	**366**	**402**	**302**	**263**	**278**

. . Not applicable.

(a) Expenditure excludes depreciation.

(b) Data are not casemix adjusted.

(c) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(d) A small number of residential services reported by NSW and the ACT as *Child and adolescent* residential services were included in the *General* category at the request of those jurisdictions.

Source: National Mental Health Establishments Database.

14.3 Private psychiatric hospital expenditure

Expenditure information is available for private psychiatric hospitals from the PHEC. For that collection, the ABS defines 'private psychiatric hospitals' as those licensed or approved by a state or territory health authority and which primarily cater for admitted patients with psychiatric, mental or behavioural disorders (ABS 2008b). This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients. The data in this chapter describe only those private psychiatric hospitals meeting this definition. It should be emphasised that these figures do not include expenditure on psychiatric units within private hospitals not meeting the above definition.

Previous issues of *Mental health services in Australia* have included information on private hospitals sourced from the PHEC. This collection was not conducted for the 2007–08 data period. Data for 2008–09 is now available but was not released in time to be included in this report. Data presented in this chapter are therefore limited to previously published data. Between 2003–04 and 2006–07, expenditure on private psychiatric hospitals, adjusted for inflation, decreased from $188 million to $186 million (Table 14.10).

Table 14.10: Private psychiatric hospital expenditure ($'000), 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08
Total expenditure (current prices)	162,066	168,490	176,781	180,554	n.a.
Total expenditure (constant prices)[a]	188,580	189,081	190,230	186,967	n.a.

n.a. Not available.

(a) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

Source: Private Health Establishments Collection (ABS).

14.4 Australian Government expenditure on Medicare-subsidised mental health-related services

This section outlines the Australian Government's funding through the Medicare Benefits Schedule (MBS) for mental health-related services provided by psychiatrists, GPs, psychologists and other allied health professionals for the financial years 2004–05 to 2008–09. More detailed information on the MBS items included over time is in chapters 2 and 6. See Appendix 1 for further information on data quality, coverage and other aspects of the MBS data.

In 2008–09, $666 million was paid in benefits for MBS-subsidised mental health-related services (Table 14.11); this represented 4.7% of total Medicare expenditure ($14,322 million) for that year (Medicare 2009b).

The largest amount of the $666 million was spent on services provided by psychiatrists ($249 million or 37.4%) (Table 14.11). The bulk of this expenditure was on initial consultations and patient attendances in psychiatrists' consulting rooms ($219 million or 88.1%). Expenditure on services provided by psychologists was the next largest expenditure group ($234 million or 35.1%), split mainly between *Psychological Therapy Services – clinical psychologist* and *Focussed Psychological Strategies – psychologist* items. GP expenditure comprised $172 million (25.8%) of total MBS mental health-related benefits. Medicare items associated with *GP Mental Health Care* accounted for $167 million or 96.8% of GP expenditure.

Nationally, benefits paid for mental health-related Medicare services averaged $30.78 per person in 2008–09. The average benefits paid per person in Victoria and New South Wales were above the national average, while those in the Northern Territory were lower, at $7.97 per person.

During the period between 2004–05 and 2008–09, the total expenditure on MBS mental health-related items increased by an annual average of 26.8%, in constant prices (Table 14.12). This change is also reflected in a change in per person spending of 24.7%, in constant prices. These changes are reflected by the increase across all subsections of MBS spending, with the largest increases occurring for psychologists and other allied mental health providers. The only item numbers experiencing a decline in expenditure relate to the *3 Step Mental Health Process* items, which were replaced by *GP Mental Health Care* items in November 2006, and to the psychologist items in the *Enhanced Primary Care* program.

It is worth noting that analysis of the Bettering the Evaluation and Care of Health GP survey data reveals an estimated 88% of mental health-related GP encounters were reported as having been billed as *surgery consultations* and not as mental health-related MBS items. For further information on this issue, see Section 2.3 of this report.

Table 14.11: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[a], states and territories[b], 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[c]
					Psychiatrists				
Initial consultation new patient —consulting room	5,553	4,684	3,112	1,533	1,398	299	247	56	16,883
Initial consultation new patient —hospital	740	462	384	131	82	55	15	4	1,873
Initial consultation new patient —home visit	153	61	8	2	23	1	3	2	253
Patient attendances—consulting room	66,191	68,407	32,081	11,378	19,069	2,963	2,101	300	202,490
Patient attendances—hospital	5,199	6,487	5,153	2,182	1,242	764	119	24	21,171
Patient attendances—other locations	975	428	72	27	174	6	9	2	1,694
Group psychotherapy	979	1,139	138	42	37	110	7	1	2,453
Interview with non-patient	306	308	203	51	63	11	9	2	951
Telepsychiatry	79	7	50	2	1	—	2	5	147
Case conference	23	80	11	14	7	3	1	—	138
Electroconvulsive therapy[d]	262	310	264	89	79	29	5	—	1,037
Assessment and treatment of pervasive developmental disorder (PDD)[e]	7	13	5	0	1	0	0	—	26
Subtotal[c]	*80,466*	*82,385*	*41,481*	*15,451*	*22,176*	*4,242*	*2,521*	*397*	*249,119*
					General practitioners				
GP Mental Health Care	56,199	46,999	31,152	14,764	11,580	3,146	2,156	715	166,710
Focussed Psychological Strategies	1,438	1,141	635	110	368	25	39	24	3,780
Family Group Therapy	778	684	109	31	60	17	10	2	1,692
Subtotal[c][f]	*58,415*	*48,824*	*31,896*	*14,906*	*12,008*	*3,189*	*2,206*	*740*	*172,184*
					Psychologists				
Enhanced Primary Care —psychologist	157	111	78	16	9	5	4	1	381
Focussed Psychological Strategies—psychologist	42,336	44,741	25,336	6,198	4,757	1,888	2,144	409	127,810
Psychological Therapy Services —clinical psychologist	35,024	26,094	12,964	17,111	8,972	3,324	1,644	207	105,341
Assessment and treatment of PDD[e]	119	209	35	46	21	15	8	2	455
Subtotal[c]	*77,637*	*71,157*	*38,413*	*23,372*	*13,759*	*5,233*	*3,800*	*619*	*233,988*
					Other allied health providers				
Enhanced Primary Care—mental health worker[g]	55	40	16	2	8	1	0	—	121
Focussed Psychological Strategies —occupational therapist	719	579	268	146	206	36	14	1	1,970
Focussed Psychological Strategies —social worker	3,147	2,980	1,228	645	551	171	33	10	8,765
Subtotal[c][f]	*3,921*	*3,599*	*1,513*	*793*	*765*	*208*	*46*	*10*	*10,856*
Total expenditure ($'000)[c]	**220,439**	**205,965**	**113,303**	**54,521**	**48,708**	**12,870**	**8,573**	**1,766**	**666,146**
Per capita ($)[h]	31.31	38.39	26.05	24.74	30.22	25.73	24.65	7.97	30.78

— Rounded to zero.

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

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

(c) Totals may not add due to rounding to nearest $'000.

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

(e) These items introduced 1 July 2008.

(f) Includes a small amount of expenditure for *3 Step Mental Health Process* items which are not listed separately.

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

(h) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2008.

Source: MBS data (DoHA).

Table 14.12: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[a], 2004–05 to 2008–09

	2004–05	2005–06	2006–07	2007–08	2008–09	Average annual change (per cent)
Psychiatrists						
Initial consultation new patient—consulting room[b]	. .	. .	8,490	15,409	16,883	. .
Initial consultation new patient—hospital[b]	. .	. .	619	1,523	1,873	. .
Initial consultation new patient—home visit[b]	. .	. .	90	212	253	. .
Patient attendances—consulting room	193,820	198,057	198,184	197,978	202,490	1.1
Patient attendances—hospital	15,321	17,046	17,490	19,007	21,171	8.4
Patient attendances—other locations	1,601	1,772	1,894	1,896	1,694	1.4
Group psychotherapy	2,325	2,470	2,378	2,333	2,453	1.4
Interview with non-patient	250	290	623	718	951	39.7
Telepsychiatry	24	41	68	124	147	57.6
Case conference	62	85	88	123	138	22.4
Electroconvulsive therapy[c]	704	819	831	902	1,037	10.2
Assessment and treatment of pervasive developmental disorder (PDD)[d]	. .	. .	. .	. .	26	. .
Subtotal[e]	*214,106*	*220,579*	*230,755*	*240,225*	*249,119*	*3.9*
General practitioners						
GP Mental Health Care[b]	. .	. .	62,323	127,802	166,710	. .
Focussed Psychological Strategies	2,131	2,828	3,639	3,883	3,780	15.4
Family Group Therapy	1,671	1,765	1,726	1,760	1,692	0.3
3 Step Mental Health Process—GP[f]	962	1,658	1,044	4	1	. .
Subtotal[e]	*4,764*	*6,251*	*68,732*	*133,449*	*172,184*	*145.2*
Psychologists						
Enhanced Primary Care—psychologist	1,120	2,263	2,462	415	381	–23.6
Focussed Psychological Strategies—psychologist[b]	. .	. .	30,961	96,268	127,810	. .
Psychological Therapy Services—clinical psychologist[b]	. .	. .	20,974	73,621	105,341	. .
Assessment and treatment of PDD[d]	. .	. .	. .	. .	455	. .
Subtotal[e]	*1,120*	*2,263*	*54,398*	*170,304*	*233,988*	*. .*
Other allied health providers						
Enhanced Primary Care—mental health worker[g]	36	134	190	120	121	35.4
Focussed Psychological Strategies—occupational therapist[b]	. .	. .	170	1,147	1,970	. .
Focussed Psychological Strategies—social worker[b]	. .	. .	1,093	5,395	8,765	. .
3 Step Mental Health Process—OMP[f]	43	43	24	—	—	. .
Subtotal[e]	*79*	*177*	*1,477*	*6,661*	*10,856*	*. .*
Total expenditure in current prices ($'000)[e]	**220,069**	**229,271**	**355,362**	**550,639**	**666,146**	**31.9**
Total expenditure in constant prices ($'000)[h]	246,300	242,949	365,073	550,639	635,878	26.8
Per capita (constant prices) ($)[h][i]	12.16	11.83	17.51	26.00	29.38	24.7

. . Not applicable.

— Rounded to zero.

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

(b) These items introduced 1 November 2006.

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

(d) These items introduced 1 July 2008.

(e) Totals may not add due to rounding to nearest $'000.

(f) These items were discontinued after 30 April 2007.

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

(h) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(i) Crude rate is based on the preliminary Australian estimated resident population as at 31 December of the reference year.

Source: MBS data (DoHA).

14.5 Australian Government expenditure on mental health-related medications

In 2008–09, 195 million claims were processed under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) for subsidised prescribed medications (Medicare 2009b). The total benefits paid for these claims, excluding patient contributions, were $7,392 million (Medicare 2009b). Of this, 10.1% ($743 million) was spent on subsidised mental health-related prescriptions. For further information on data quality, coverage and other aspects of the PBS and RPBS database refer to Appendix 1.

Almost three-quarters (72.2%) of the expenditure on mental health-related prescriptions were issued by GPs (Table 14.13). This was followed by prescriptions written by psychiatrists (19.1%), with non-psychiatrist specialists' prescriptions accounting for the remaining 8.6%.

In 2008–09, prescriptions for antipsychotics and antidepressants accounted for the majority of mental health-related PBS and RPBS expenditure (51.2% and 40.5%, respectively), followed by prescriptions for psychostimulants (2.9%), anxiolytics (2.1%), and hypnotics and sedatives (1.4%) (Table 14.13). Other medications prescribed by psychiatrists accounted for 1.8% of the expenditure on mental health-related prescriptions. For further information on mental health-related medications, see Section 11.1 of this report.

Table 14.13: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS and RPBS, by type of medication prescribed[(a)] and medical practitioner, 2008–09

	Anti-psychotics[(b)] (N05A)	Anxiolytics (N05B)	Hypnotics and sedatives (N05C)	Anti-depressants (N06A)	Psycho-stimulants (N06B)	Other[(c)]	Total[(d)]	Per cent
GPs	250,629	14,443	9,861	258,652	2,884	. .	536,470	72.2
Non-psychiatrist specialists	39,208	367	312	8,442	15,737	. .	64,066	8.6
Psychiatrists	90,440	1,053	278	33,631	3,206	13,222	141,830	19.1
Total[(e)]	**380,599**	**15,873**	**10,458**	**300,977**	**21,833**	**13,222**	**742,961**	**. .**
Per cent	51.2	2.1	1.4	40.5	2.9	1.8	. .	100.0

. . Not applicable.

(a) Classified according to the ATC Classification System (WHO 2009b).

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

(c) Includes other N codes as well as other ATC medication groups as presented in Table 14.15. Data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(d) Totals may not add due to rounding to nearest $'000.

(e) Includes expenditure where the prescriber's specialty was unknown.

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

The cost to the Australian Government of PBS- and RPBS-subsidised mental health-related prescriptions in 2008–09 ($743 million) was equivalent to $34.33 per person (Table 14.14). Consistent with the distribution of prescriptions outlined in Chapter 11, the average benefits paid in South Australia, Victoria and Tasmania were above the national average, while those paid in the Northern Territory and the Australian Capital Territory were markedly below the national average. A substantial proportion of the Australian Government subsidy of pharmaceuticals in the Northern Territory is funded through the Aboriginal Health Services program, which is not visible through the PBS payment systems.

Table 14.14: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS and RPBS, by type of medication prescribed[a] and type of medical practitioner, states and territories[b], 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT[c]	Total
					Antipsychotics[d] (N05A)				
GPs	86,317	69,352	42,728	19,123	23,781	5,373	2,875	1,078	250,629
Non-psychiatrist specialists	8,049	15,408	7,288	4,650	2,238	703	496	377	39,208
Psychiatrists	30,746	26,998	15,838	4,988	8,151	1,956	1,478	285	90,440
Subtotal[e]	*125,182*	*111,824*	*65,913*	*28,786*	*34,185*	*8,041*	*4,923*	*1,740*	*380,599*
					Anxiolytics (N05B)				
GPs	3,879	4,422	2,923	1,088	1,381	600	118	33	14,443
Non-psychiatrist specialists	86	128	74	33	35	8	2	1	367
Psychiatrists	244	383	228	66	95	28	7	2	1,053
Subtotal[e]	*4,214*	*4,934*	*3,227*	*1,189*	*1,511*	*636*	*126*	*36*	*15,873*
					Hypnotics and sedatives (N05C)				
GPs	3,071	2,510	1,984	924	944	328	77	23	9,861
Non-psychiatrist specialists	82	98	68	34	23	5	2	1	312
Psychiatrists	58	58	80	33	38	5	6	—	278
Subtotal[e]	*3,216*	*2,667*	*2,132*	*992*	*1,004*	*338*	*85*	*24*	*10,458*
					Antidepressants (N06A)				
GPs	78,045	65,206	55,149	25,752	22,545	8,093	3,050	806	258,652
Non-psychiatrist specialists	2,052	2,702	1,840	1,035	528	173	74	38	8,442
Psychiatrists	9,403	9,597	7,278	3,161	2,955	829	353	54	33,631
Subtotal[e]	*89,646*	*77,527*	*64,298*	*29,968*	*26,035*	*9,101*	*3,499*	*899*	*300,977*
					Psychostimulants and nootropics (N06B)				
GPs	631	224	1,406	345	140	74	45	20	2,884
Non-psychiatrist specialists	6,617	3,232	2,789	1,592	637	524	256	89	15,737
Psychiatrists	1,046	394	781	692	158	52	81	4	3,206
Subtotal[e]	*8,295*	*3,850*	*4,978*	*2,629*	*935*	*650*	*382*	*114*	*21,833*
					Other medications prescribed by psychiatrists[f]				
Psychiatrists	3,908	3,891	3,075	974	1,004	188	136	47	13,222
Expenditure ($'000)[g]					**Total expenditure**				
	234,462	**204,692**	**143,622**	**64,538**	**64,675**	**18,953**	**9,150**	**2,861**	**742,961**
Per capita ($)[h]	33.30	38.15	33.02	29.28	40.12	37.89	26.31	12.90	34.33
					Total cost of Clozapine (Government cost plus patient contribution)				
Clozapine ($'000)[i]	12,503	11,736	7,549	3,149	2,790	881	514	254	39,375

— Rounded to zero.

(a) Classified according to the ATC Classification System (WHO 2009b).

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

(c) A substantial proportion of the Australian Government subsidy of pharmaceuticals in the Northern Territory is funded through the Aboriginal Health Services program, which is supplied through the Aboriginal Health Services and not through the usual PBS payment systems.

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

(e) Includes expenditure where the prescriber's specialty was unknown.

(f) Includes other N codes as well as other ATC medication groups as presented in Table 14.15. Data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.

(g) Totals may not add due to rounding to nearest $'000.

(h) Crude rate is based on the Australian estimated resident population as at 31 December 2008.

(i) Clozapine is a Section 100, atypical antipsychotic. Total cost equals Government cost plus patient contribution for public hospitals only.

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

PBS and RPBS expenditure for medications prescribed by psychiatrists accounted for $142 million in 2008–09 (Table 14.15). About 97.0% ($138 million) of this was for medications pertaining to the central nervous system (including antipsychotics, anxiolytics, hypnotics and sedatives, antidepressants and psychostimulants), while the remainder (3.0%, or $4 million) was for other medications.

Table 14.15: Australian Government expenditure ($'000) on medications prescribed by psychiatrists subsidised under the PBS and RPBS, by type of medication prescribed[(a)], states and territories[(b)], 2008–09

ATC code		NSW	Vic	Qld	WA	SA	Tas	ACT	NT[(c)]	Total
N	**Central nervous system**									
N05A	Antipsychotics	30,746	26,998	15,838	4,988	8,151	1,956	1,478	285	90,440
N05B	Anxiolytics	244	383	228	66	95	28	7	2	1,053
N05C	Hypnotics and sedatives	58	58	80	33	38	5	6	—	278
N06A	Antidepressants	9,403	9,597	7,278	3,161	2,955	829	353	54	33,631
N06B	Psychostimulants and nootropics	1,046	394	781	692	158	52	81	4	3,206
	Subtotal[(d)]	*41,496*	*37,429*	*24,205*	*8,941*	*11,396*	*2,869*	*1,925*	*346*	*128,608*
	Other central nervous system medications	2,578	2,912	1,955	598	667	123	86	33	8,954
Total central nervous system medications[(d)]		**44,074**	**40,341**	**26,160**	**9,540**	**12,064**	**2,993**	**2,012**	**379**	**137,562**
	Other medications									
A	Alimentary tract and metabolism	300	274	252	73	82	17	10	2	1,010
B	Blood and blood-forming organs	29	32	30	12	13	1	1	—	119
C	Cardiovascular system	465	341	346	112	127	24	17	5	1,438
D	Dermatologicals	11	9	9	7	3	—	1	—	39
G	Genitourinary system and sex hormones	164	69	197	68	33	6	10	1	549
H	Systemic hormonal preparations, excluding sex hormones	23	22	25	18	9	2	—	—	99
J	General anti-infectives for systematic use	74	44	51	26	11	2	3	1	211
L	Antineoplastic and immunomodulating agents	56	23	11	7	6	1	1	—	105
M	Musculoskeletal system	58	59	46	11	12	3	2	1	192
R	Respiratory system	91	72	69	19	21	5	3	3	282
S	Sensory organs	16	17	10	3	4	1	—	0	50
	Other[(e)]	43	17	73	20	16	2	1	—	173
	Subtotal[(d)]	*1,330*	*979*	*1,119*	*376*	*336*	*64*	*49*	*14*	*4,268*
Total expenditure ($'000)[(d)]		**45,404**	**41,320**	**27,280**	**9,915**	**12,400**	**3,057**	**2,061**	**392**	**141,830**
Per capita ($)[(f)]		6.45	7.70	6.27	4.50	7.69	6.11	5.92	1.77	6.55

— Rounded to zero.

(a) Classified according to the ATC Classification System (WHO 2009b).

(b) State/territory is based on the patient's residential address. If the patient's address is unknown, the state or territory of the supplying pharmacy is used. A small number of records for which state/territory is unknown appear only in the total.

(c) A substantial proportion of the Australian Government subsidy of pharmaceuticals in the Northern Territory is funded through the Aboriginal Health Services program, which is supplied through the Aboriginal Health Services and not through the usual PBS payment systems.

(d) Totals may not add due to rounding to nearest $'000.

(e) Includes extemporaneously prepared items and/or PBS items with no ATC equivalent.

(f) Crude rate is based on the Australian estimated resident population as at 31 December 2008.

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

Table 14.16: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS and RPBS, by type of medication prescribed[a] and type of medical practitioner, 2004–05 to 2008–09

ATC group (code)	2004–05	2005–06	2006–07	2007–08	2008–09	Average annual change (per cent)
Antipsychotics (N05A)[b]						
General practitioners	169,385	193,682	212,421	227,655	250,629	10.3
Non-psychiatrist specialists	19,824	27,334	31,440	34,346	39,208	18.6
Psychiatrists	65,387	75,996	80,739	82,929	90,440	8.4
Subtotal[c]	*255,381*	*297,633*	*324,961*	*345,206*	*380,599*	*10.5*
Anxiolytics (N05B)						
General practitioners	14,848	14,340	14,518	14,759	14,443	–0.7
Non-psychiatrist specialists	333	335	341	371	367	2.5
Psychiatrists	1,205	1,167	1,177	1,169	1,053	–3.3
Subtotal[c]	*16,401*	*15,855*	*16,046*	*16,308*	*15,873*	*–0.8*
Hypnotics and sedatives (N05C)						
General practitioners	11,188	10,361	10,074	9,987	9,861	–3.1
Non-psychiatrist specialists	320	300	293	303	312	–0.6
Psychiatrists	290	270	264	266	278	–1.0
Subtotal[c]	*11,809*	*10,939*	*10,638*	*10,562*	*10,458*	*–3.0*
Antidepressants (N06A)						
General practitioners	285,752	255,834	255,273	258,143	258,652	–2.5
Non-psychiatrist specialists	8,809	8,057	7,868	8,166	8,442	–1.1
Psychiatrists	41,563	38,072	36,787	34,582	33,631	–5.2
Subtotal[c]	*337,000*	*302,527*	*300,292*	*301,144*	*300,977*	*–2.8*
Psychostimulants and nootropics (N06B)						
General practitioners	639	735	890	1,886	2,884	45.8
Non-psychiatrist specialists	1,886	2,268	3,053	13,790	15,737	69.9
Psychiatrists	1,308	1,209	1,213	2,523	3,206	25.1
Subtotal[c]	*3,841*	*4,218*	*5,161*	*18,204*	*21,833*	*54.4*
Other medications prescribed by psychiatrists[d]						
Psychiatrists	13,351	13,272	12,930	12,649	13,222	–0.2
Total expenditure in current prices ($'000)[e]	**637,783**	**644,444**	**670,028**	**704,074**	**742,961**	**3.9**
Total expenditure in constant prices ($'000)[f]	643,640	648,987	673,260	704,074	741,626	3.6
Per capita (constant prices, $)[f][g]	31.78	31.59	32.25	33.15	34.26	1.9
Total cost of Clozapine (Government cost plus patient contribution, current prices)						
Clozapine ($'000)[h]	30,091	33,462	35,187	37,847	39,375	7.0

(a) Classified according to the ATC Classification System (WHO 2009b).
(b) Includes Clozapine dispensed through Section 100 arrangements by private hospitals but not by public hospitals.
(c) Includes expenditure where the prescriber's specialty was unknown.
(d) Includes other N codes as well as other ATC medication groups as presented in Table 14.15. Data for other ATC groups prescribed by GPs and non-psychiatrist specialists are not presented because they are not included in the definition of mental health-related medications.
(e) Totals may not add due to rounding to nearest $'000.
(f) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.
(g) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.
(h) Clozapine is a Section 100, atypical antipsychotic. Total cost equals Government cost plus patient contribution for public hospitals only. A component of these data may relate to drugs distributed in earlier claim periods for which details were submitted late.

Note: Figures reported in previous *Mental health services in Australia* publications may be different due to historical data validation.

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

Overall, expenditure on medications prescribed by psychiatrists under the PBS and RPBS averaged $6.55 per person in 2008–09 (Table 14.15). The average benefits paid per person for mental health-related medications prescribed by psychiatrists were below the national average in the Northern Territory and Western Australia, and above the average in Victoria and South Australia.

Real growth in expenditure (constant prices) for mental health-related prescriptions averaged 3.6% per year between 2004–05 and 2008–09 (Table 14.16). Per person, this represents an average growth rate of 1.9% per year over the period. These rises can be largely attributed to the increase in expenditure on antipsychotics.

Expenditure on psychostimulants rose over the 5-year period from 2004–05 to 2008–09 (Table 14.16). This appears to be the result of new listings on the PBS in 2007–08.

Data have been included on the cost of Clozapine, an atypical antipsychotic, which is a highly specialised drug provided under Section 100 of the *National Health Act 1953*. Due to the nature of reporting Section 100 medications, the values in tables 14.14 and 14.16 reflect government cost plus patient contributions, so they are therefore not directly comparable with the PBS-listed medications. The expenditure on Clozapine increased steadily over the 2004–05 to 2008–09 period, from $30.1 to $39.4 million (current prices).

14.6 Total Australian Government expenditure on mental health-related services

The Australian Government annually estimates the total Australian Government expenditure on mental health-related services (Table 14.17). The reported expenditure does not include contributions to the running of state and territory hospital-based psychiatric units provided through the non-specific 'base grants' of the Australian Health Care Agreements. These are also excluded in the estimates of Australian government funding in Table 14.18, as they can not be specifically identified.

Australian Government estimates of expenditure on MBS mental health-related services provided by psychiatrists may differ slightly from those presented in Table 14.12. For information on the AIHW methodology refer to Appendix 1.

During the period 2003–04 to 2007–08 the Australian Government estimates that expenditure on mental health-related services increased by an annual average of 6.6%, from $1.5 billion to $1.9 billion, in constant prices (Table 14.17). Per capita expenditure increased from $74.34 per person in 2003–04 to $90.37 in 2007–08, in constant prices. Most ($13.38 per capita) of this increase occurred between 2006–07 and 2007–08. Expenditure on Medicare-subsidised mental health services and medications provided through the PBS accounted for 65.3% of the total. Expenditure on items relating to the Department of Veterans' Affairs (DVA), including RPBS, accounted for 7.4% (Table 14.17).

Table 14.17: Australian Government expenditure ($'000) on mental health-related services, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Health Care Agreements—grants to states and territories	60,967	67,044	71,342	73,352	80,310	7.1
National programs and initiatives (DoHA managed)[(a)]	40,410	50,688	76,182	104,714	209,570	50.9
National programs and initiatives (FaHCSIA managed)[(a)]	. .	. .	. .	15,470	99,025	. .
National programs and initiatives (DVA managed)[(b)]	126,069	123,715	125,505	*140,347	142,138	3.0
National Suicide Prevention Program	9,846	12,080	8,648	17,311	18,737	17.5
Medicare Benefits Schedule—psychiatrists	201,604	214,356	220,879	230,883	240,588	4.5
Medicare Benefits Schedule—GPs[(c)]	173,556	201,021	232,739	*150,692	133,449	–6.4
Medicare Benefits Schedule —psychologists/allied health[(d)(e)]	. .	. .	. .	55,851	176,965	. .
Pharmaceutical Benefits Scheme[(b)]	*593,405	*624,378	*635,504	663,867	701,749	4.3
Private Health Insurance Premium Rebates	48,000	56,605	*57,970	*59,296	66,808	8.6
Research[(f)]	24,625	30,682	35,927	40,216	49,971	19.4
Total expenditure in current prices ($'000)	**1,278,481**	**1,380,569**	**1,464,696**	**1,551,999**	**1,919,309**	**10.7**
Total expenditure in constant prices ($'000)[(g)]	1,487,644	1,549,286	1,576,128	1,607,123	1,919,309	6.6
Per capita ($) (constant prices)[(h)]	74.34	76.50	76.72	76.99	90.37	5.0

* Indicates where previously published data has been revised.

. . Not applicable

(a) For additional information on the scope of this item refer to Appendix 1.

(b) RPBS expenditure is included in the Department of Veterans' Affairs expenditure.

(c) Historical data comparisons should be approached with caution due to a change in methodology. See Appendix 1 for detailed information.

(d) Includes MBS items for *Psychological Therapy services—clinical psychologists*, introduced 1 November 2006.

(e) Includes services provided by *registered* psychologists, social workers and occupational therapists approved by Medicare. These mental health-related MBS items were introduced 1 November 2006.

(f) Mental health-related grants administered by the National Health and Medical Research Council.

(g) Constant prices, calculated by AIHW, are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(h) Crude rate, calculated by AIHW, is based on the Australian estimated resident population as at 31 December of the reference year.

Note: The structure of this table has been revised by DoHA.

Source: Department of Health and Ageing (unpublished data).

14.7 Sources of funding for state and territory specialised mental health services

Funding for health products and services is derived from both government and non-government sources, depending on the type of good or service provided. The Australian Government, for example, funds the majority of Medicare services. These services include those provided by GPs, medical specialists and other professionals (in private practices), residential aged care and pharmaceuticals, for which benefits were paid under the PBS and the RPBS. As well as these direct forms of expenditure, the Australian Government provides subsidies for private health insurance and health-related Special Purpose Payments to the states and territories.

Responsibility for funding public hospitals and public health activities is shared by the Australian Government and the states and territories, while state and territory governments provide the main funding for other health services, including ambulance and community health services.

The main non-government funding sources are out-of-pocket payments by individuals, benefits paid by health insurance companies and payments by injury compensation insurers. These non-government sources provide the majority of funding for over-the-counter pharmaceuticals, dental and other professional services, and private hospital services.

During 2007–08, state and territory specialised mental health services (for which expenditure is described in Section 14.2) were funded from a variety of sources. In 2007–08, 93.9% ($3,120 million) of funds for specialised mental health services were provided by state or territory governments (Table 14.18). A further 4.2% ($138 million) was provided by the Australian Government, with the remaining 2.0% ($65 million) sourced from patients and other revenues and recoveries.

Table 14.18: Source of funding[a] for state and territory specialised mental health services ($'000), states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[b]
State/territory funds[c]	986,283	728,885	589,320	383,865	259,916	84,556	55,967	31,485	3,120,278
Australian Government funds									
National Mental Health Strategy[d]	25,554	19,188	15,433	7,934	5,942	2,207	2,171	1,881	80,310
Department of Veterans' Affairs[e]	7,637	6,264	2,233	2,352	3,586	303	222	33	22,629
Other Australian Government funds[f]	331	22,541	5,111	925	2,287	1,784	1,012	1,024	35,014
Total Australian Government funds[b]	*33,522*	*47,992*	*22,777*	*11,210*	*11,814*	*4,294*	*3,406*	*2,937*	*137,953*
Other revenue[g]	18,111	26,354	9,008	3,060	4,303	3,288	481	382	64,988
Total funds[b]	**1,037,916**	**803,232**	**621,105**	**398,136**	**276,033**	**92,137**	**59,854**	**34,805**	**3,323,219**

(a) Excludes depreciation.

(b) Totals may not add due to rounding to nearest $'000. Total funds is equal to the total expenditure in Table 14.1.

(c) Excludes specified Australian Government funding sources. Values are derived by subtracting Total Australian Government funds and Other revenue from Total funds.

(d) Actual payments to states and territories by the Australian Government for mental health reform under the Australian Health Care Agreements.

(e) Actual payments to states and territories, as estimated by the Department of Veterans' Affairs.

(f) Other Australian Government funds includes funds paid directly to a jurisdiction by the Australian Government used to resource recurrent expenditure on services within the scope of the National Mental Health Establishments Database.

(g) Other revenue includes *Other revenue*, *Patient revenue* and *Recoveries*.

Sources: National Mental Health Establishments Database (State/territory funds, other Australian Government funds and other revenue), Department of Health and Ageing (unpublished data) (*National Mental Health Strategy* and *Department of Veterans' Affairs*).

14.8 Funding and expenditure for all mental health-related services

The national recurrent expenditure on all mental health-related services can be estimated by combining funding from three sources: state and territory contributions to specialised mental health services (Table 14.18), which may include funding from the Australian government under the Australian Health Care Agreements; Australian government expenditure on mental health-related services (Table 14.17) and contributions to specialised mental health services (Table 14.18); and the private health insurance fund component, as estimated by the Department of Health and Ageing (DoHA).

DoHA calculates the private health insurance fund component by estimating the total mental health-related private hospital revenue and then deducting all payments made to these hospitals by the DVA and estimates of the private hospital mental health component of the Australian Government Private Health Insurance Rebate. The remaining amount is then deemed to represent the payments made by private health insurers in respect of private hospital psychiatric care. For 2007–08, DoHA estimates that private health insurance fund expenditure was $185 million (Table 14.19).

Combining the funding from the three sources, the national recurrent expenditure on all mental health-related services in 2007–08 was estimated to be $5,325 million (Table 14.19).

Of this total, 60.5% ($3,220 million) came from state and territory governments, 36.0% ($1,919 million) from the Australian Government and 3.5% ($185 million) from private health insurance funds.

During the period 1998–99 to 2007–08, total expenditure on mental health-related services by state and territory governments increased by an annual average of 5.5% (in constant prices) to $3.22 billion. Funding by the Australian Government increased by an annual average rate of 6.2% during the same period to $1.92 billion.

Table 14.19: Expenditure ($ million) on mental health-related services[a], by source of funding[b], 1998–99 to 2007–08

Source of funding	1998–99	2003–04	2005–06	2006–07	2007–08	Average annual change (per cent)
			Current prices			
State and territory governments[c]	1,459	2,165	2,645	2,932	3,220	9.2
Australian Government[d]	825	1,278	1,465	1,552	1,919	9.8
Private health insurance funds[e]	130	156	183	184	185	4.0
Total	**2,414**	**3,599**	**4,293**	**4,667**	**5,325**	**9.2**
			Constant prices[f]			
State and territory governments	1,984	2,520	2,846	3,036	3,220	5.5
Australian Government	1,121	1,488	1,576	1,607	1,919	6.2
Private health insurance funds[e]	177	181	197	190	185	0.5
Total	**3,282**	**4,189**	**4,619**	**4,833**	**5,325**	**5.5**

(a) Some mental health services (for example, mental health services in aged care facilities) are not included.

(b) Some sources of funding are not included, for example private out-of-pocket patient costs.

(c) Includes *State/territory funds*, *Other revenue* and *Other Australian Government funds* from Table 14.18. *State/territory funds* may include Australian government funds provided under the Australian Health Care Agreements.

(d) Includes *Total expenditure* from Table 14.17.

(e) DoHA notes that estimates are derived and subject to some degree of error. Direct measures are not possible from source data. Data are not available for 2007–08 as a PHEC survey was not conducted. Estimates of expenditure and revenue are equivalent to 2006–07 data, inflated to 2007–08 prices.

(f) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

Sources: Tables 14.17, 14.18 and Department of Health and Ageing (unpublished data) (private health insurance funds).

15 State and territory summary tables

This section presents a summary of mental health services data for each state and territory, and for Australia as a whole.

Listed below are the data sources from which the summary information was derived, as well as the corresponding chapter in this report in which the data and related analyses were described. Roman numerals are used in each summary table in this chapter to provide a link between the statistics shown with the data sources, as listed below:

i	Bettering the Evaluation and Care of Health (BEACH) survey of general practitioners (Chapter 2).
ii	Data provided by state and territory health authorities (Chapter 3).
iii	National Community Mental Health Care Database (Chapter 4).
iv	National Hospital Morbidity Database (chapters 5 and 7).
v	Medicare Benefits Schedule (MBS) data (Department of Health and Ageing) (chapters 2, 6 and 11).
vi	National Residential Mental Health Care Database (Chapter 8).
vii	Supported Accommodation Assistance Program (SAAP) Client Collection (Chapter 9).
viii	Commonwealth State/Territory Disability Agreement (CSTDA) National Minimum Data Set (Chapter 10).
ix	Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data (Department of Health and Ageing) (chapters 11 and 14).
x	Mental Health Establishments Database (chapters 12 and 14).
xi	Private Health Establishments Collection (chapters 12 and 14).
xii	AIHW Medical Labour Force Survey (Chapter 13).

Figures reported may be different to those in previous publications of *Mental health services in Australia* due to historical validation.

For further information on the scope and coverage of each of these data sources, refer to Appendix 1.

15.1 New South Wales

Table 15.1: Mental health services, New South Wales, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	3,061,000	3,577,000	3,432,000	3,462,000	3,829,000	4,396,000
95% lower confidence limit	2,851,000	3,252,000	3,185,000	3,199,000	3,475,000	4,097,000
95% upper confidence limit	3,271,000	3,902,000	3,679,000	3,724,000	4,182,000	4,694,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	53,549	58,920	77,699	56,001[(b)]	n.a.
Community mental health care service contacts[(iii)]	1,431,729	1,363,770	1,832,177	1,828,468	2,072,440	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	32,026	32,950	34,030	38,119	37,640	n.a.
With specialised psychiatric care	26,752	28,093	29,151	28,852	24,822	n.a.
Public hospitals	8,310	7,155	7,060	4,835	3,554	n.a.
Private hospitals	18,442	20,938	22,091	24,017	21,268	n.a.
Without specialised psychiatric care	5,274	4,857	4,879	9,267	12,818	n.a.
Public hospitals	3,830	4,617	4,604	7,081	6,953	n.a.
Private hospitals	1,444	240	275	2,186	5,865	n.a.
Medicare-subsidised psychiatrist services[(v)]	637,440	627,107	615,006	608,203	598,644	604,613
Mental health-related hospital separations[(iv)]	62,864	63,664	67,773	69,251	71,402	n.a.
With specialised psychiatric care	36,070	36,517	38,413	39,259	40,196	n.a.
Public hospitals	29,103	28,462	29,983	31,787	31,959	n.a.
Private hospitals	6,967	8,055	8,430	7,472	8,237	n.a.
Without specialised psychiatric care	26,794	27,147	29,360	29,992	31,206	n.a.
Public hospitals	24,305	25,995	28,097	27,876	27,517	n.a.
Private hospitals	2,489	1,152	1,263	2,116	3,689	n.a.
Episodes of residential mental health care[(vi)]	n.a.	388	436	393	305	n.a.
SAAP mental health-related closed support periods[(vii)]	3,276	3,569	4,757	5,951	6,174	n.a.
Accommodated	2,521	2,646	3,514	3,937	3,628	n.a.
Supported	755	923	1,243	2,014	2,546	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	6,217	6,495	6,834	10,065	13,589	n.a.
Residential care	1,072	1,142	1,218	1,304	1,298	n.a.
Non-residential care	5,993	6,175	6,432	9,726	13,318	n.a.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(b) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(i–viii) See page 194 for data sources.

Table 15.2: Mental health-related prescriptions, New South Wales, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	607,348	585,305	581,740	568,881	602,746
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	5,806,014	5,685,643	5,660,032	5,581,328	5,907,574

(ix) See page 194 for data source.

Table 15.3: Mental health facilities, New South Wales, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	10	10	8	8	8
Average available beds	1,091	1,106	1,072	1,060	1,024
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	44	42	46	46	51
Average available beds	1,002	1,078	1,151	1,227	1,400
Government-operated residential mental health services[x]					
Number of services[c]	7	5	19	20	13
Average available beds	n.a.	251	296	291	169
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	5	5	5
Average available beds	n.a.	164	144	155	152
Community mental health care services					
Number of services[d]	n.a.	n.a.	388	409	433
Private psychiatric hospitals[e][xi]					
Number of hospitals	9	9	9	9	n.a.
Average available beds	508	494	512	537	n.a.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.4: Workforce: psychiatrists and mental health nurses, New South Wales, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	1,063	1,129	1,144	1,140	1,147
Full-time-equivalent employed mental health nurses	4,846	4,336	4,293	n.a.	4,577

n.a. Not available.

(xii) See page 194 for data source.

Table 15.5: Recurrent expenditure[a] ($'000) for specialised mental health services, New South Wales, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	209,035	199,552	205,983	196,096	181,769	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	237,434	257,446	286,717	321,350	344,431	n.a.
Total recurrent expenditure for community mental health care services[c][x]	327,452	320,760	333,974	345,780	369,118	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	31,220	26,666	26,534	29,015	15,201	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	18,693	19,892	34,451	42,127	60,171	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	49,692	56,219	69,117	65,522	67,226	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	67,210	63,185	62,593	66,358	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	78,796	78,277	74,729	76,309	77,373	76,737
Medicare expenditure on services provided by general practitioners[v]	1,905	1,946	2,429	24,963	46,245	55,707
Medicare expenditure on services provided by psychologists[v]	. .	520	1,021	18,085	55,957	74,039
Medicare expenditure on services provided by other allied health professionals[v]	16	44	84	563	2,397	3,740
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	39,880	41,339	42,396	42,425	45,323
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	156,541	157,602	166,988	177,488	162,989

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.2 Victoria

Table 15.6: Mental health services, Victoria, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	2,666,000	2,823,000	3,242,000	2,757,000	3,305,000	3,697,000
95% lower confidence limit	2,427,000	2,544,000	2,813,000	2,511,000	3,015,000	3,404,000
95% upper confidence limit	2,905,000	3,103,000	3,672,000	3,002,000	3,594,000	3,991,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	28,757	31,329	33,743	34,588	n.a.
Community mental health care service contacts[(iii)]	1,599,800	1,778,559	1,833,205	1,830,278	1,736,456	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	41,250	43,165	42,855	38,468	40,272	n.a.
With specialised psychiatric care	32,568	33,525	33,437	30,363	31,764	n.a.
Public hospitals	624	729	237	253	247	n.a.
Private hospitals	31,944	32,796	33,200	30,110	31,517	n.a.
Without specialised psychiatric care	8,682	9,640	9,418	8,105	8,508	n.a.
Public hospitals	5,758	5,593	5,721	5,202	5,470	n.a.
Private hospitals	2,924	4,047	3,697	2,903	3,038	n.a.
Medicare-subsidised psychiatrist services[(v)]	658,143	650,089	663,942	656,061	634,508	636,236
Mental health-related hospital separations[(iv)]	48,558	49,227	50,980	52,925	54,075	n.a.
With specialised psychiatric care	25,097	24,858	25,696	27,456	29,272	n.a.
Public hospitals	18,192	17,356	17,230	17,863	18,612	n.a.
Private hospitals	6,905	7,502	8,466	9,593	10,660	n.a.
Without specialised psychiatric care	23,461	24,369	25,284	25,469	24,803	n.a.
Public hospitals	20,486	21,968	22,801	22,962	22,218	n.a.
Private hospitals	2,975	2,401	2,483	2,507	2,585	n.a.
Episodes of residential mental health care[(vi)]	n.a.	728	791	1,003	1,498	n.a.
SAAP mental health-related closed support periods[(vii)]	5,071	4,579	8,877	11,066	8,661	n.a.
Accommodated	1,872	2,188	3,125	3,058	2,371	n.a.
Supported	3,199	2,391	5,752	8,008	6,290	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	16,556	18,798	20,784	22,862	25,383	n.a.
Residential care	983	948	963	1,018	1,122	n.a.
Non-residential care	8,396	18,631	20,619	22,671	25,111	n.a.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.7: Mental health-related prescriptions, Victoria, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	582,627	572,238	562,732	548,791	572,886
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	4,920,086	4,877,264	4,816,814	4,773,017	5,019,799

(ix) See page 194 for data source.

Table 15.8: Mental health facilities, Victoria, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	1	1	2	2	2
Average available beds	143	132	116	134	154
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	31	31	30	30	30
Average available beds	1,013	1,054	1,048	1,050	1,062
Government-operated residential mental health services[c][x]					
Number of services[d]	31	30	47	49	51
Average available beds	n.a.	914	958	978	1,021
Non-government-operated residential mental health services					
Number of services[d]	n.a.	n.a.	32	34	34
Average available beds	n.a.	274	361	381	383
Community mental health care services					
Number of services[e]	n.a.	n.a.	223	213	217
Private psychiatric hospitals[f][xi]					
Number of hospitals	6	6	6	6	n.a.
Average available beds	378	423	437	432	n.a.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(c) Data from 2003–2004 and 2004–05 were sourced from the National Residential Mental Health Care Database (NRMHCD). The number of establishments providing residential care services reported to the National Mental Health Establishments Database (NMHED) is larger than the number of establishments reporting to the NRMHCD due to Victoria reporting specialised aged care residential services in the NMHED that are not in scope for the NRMHCD.

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

(e) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(f) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.9: Workforce: psychiatrists and mental health nurses, Victoria, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	1,049	1,076	1,028	1,096	1,186
Full-time-equivalent employed mental health nurses	3,660	3,955	3,706	n.a.	3,956

n.a. Not available.

(xii) See page 194 for data source.

Table 15.10: Recurrent expenditure[a] ($'000) for specialised mental health services, Victoria, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	38,998	41,033	32,480	34,117	39,731	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	193,201	216,220	208,539	213,730	220,397	n.a.
Total recurrent expenditure for community mental health care services[c][x]	257,639	280,881	291,739	295,375	304,040	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	110,748	114,580	131,870	129,702	131,402	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	57,083	60,262	66,104	66,866	65,625	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	29,413	29,483	34,676	44,558	42,036	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	54,649	55,050	56,406	52,378	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	79,872	78,958	78,223	79,561	80,027	78,747
Medicare expenditure on services provided by general practitioners[v]	1,439	1,680	2,055	20,770	38,174	46,668
Medicare expenditure on services provided by psychologists[v]	. .	399	684	18,606	53,639	68,014
Medicare expenditure on services provided by other allied health professionals[v]	21	21	51	404	2,089	3,440
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	37,240	39,525	39,471	38,934	41,245
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	139,849	142,257	148,156	155,585	162,989

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.3 Queensland

Table 15.11: Mental health services, Queensland, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	1,951,000	2,002,000	2,148,000	2,094,000	2,283,000	2,519,000
95% lower confidence limit	1,695,000	1,807,000	1,871,000	1,897,000	2,081,000	2,283,000
95% upper confidence limit	2,206,000	2,197,000	2,425,000	2,291,000	2,484,000	2,756,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	21,393	24,306	28,608	34,987	n.a.
Community mental health care service contacts[(iii)]	889,011	901,706	892,393	1,050,960	1,162,557	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	23,813	24,810	25,365	27,275	27,751	n.a.
With specialised psychiatric care	19,233	19,743	19,954	21,621	21,660	n.a.
Public hospitals	3,930	3,924	1,324	947	987	n.a.
Private hospitals	15,303	15,819	18,630	20,674	20,673	n.a.
Without specialised psychiatric care	4,580	5,067	5,411	5,654	6,091	n.a.
Public hospitals	1,345	1,499	2,179	2,309	2,504	n.a.
Private hospitals	3,235	3,568	3,232	3,345	3,587	n.a.
Medicare-subsidised psychiatrist services[(v)]	344,548	352,380	365,911	357,166	353,476	358,280
Mental health-related hospital separations[(iv)]	37,503	38,405	38,462	38,084	37,598	n.a.
With specialised psychiatric care	26,922	27,322	26,445	26,010	25,656	n.a.
Public hospitals	20,384	20,851	19,877	19,504	19,106	n.a.
Private hospitals	6,538	6,471	6,568	6,506	6,550	n.a.
Without specialised psychiatric care	10,581	11,083	12,017	12,074	11,942	n.a.
Public hospitals	8,083	8,422	9,221	9,396	9,550	n.a.
Private hospitals	2,498	2,661	2,796	2,678	2,392	n.a.
Episodes of residential mental health care[(vi)]	n.a.	. .	. .	. .	. .	n.a.
SAAP mental health-related closed support periods[(vii)]	1,238	1,680	2,263	2,557	3,690	n.a.
Accommodated	910	1,326	1,838	1,736	2,462	n.a.
Supported	328	354	425	821	1,228	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	4,752	5,204	5,631	7,629	9,863	n.a.
Residential care	203	166	183	191	265	n.a.
Non-residential care	4,711	5,157	5,570	7,574	9,778	n.a.

. . Not applicable.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.12: Mental health-related prescriptions, Queensland, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	380,324	387,094	395,137	390,959	411,729
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	4,001,474	3,861,345	3,829,147	3,782,410	4,005,909

(ix) See page 194 for data source.

Table 15.13: Mental health facilities, Queensland, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	4	4	3	3	3
Average available beds	395	395	375	375	376
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	18	18	27	27	27
Average available beds	945	949	1,014	1,022	1,033
Government-operated residential mental health services[x]					
Number of services[c]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Non-government-operated residential mental health services					
Number of services[c]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Community mental health care services					
Number of services[d]	n.a.	n.a.	134	135	133
Private psychiatric hospitals[e][xi]					
Number of hospitals	4	4	4	4	n.a.
Average available beds	288	289	278	279	n.a.

. . Not applicable.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.14: Workforce: psychiatrists and mental health nurses, Queensland, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	463	474	541	548	698
Full-time-equivalent employed mental health nurses	2,254	2,369	2,256	n.a.	2,686

n.a. Not available.

(xii) See page 194 for data source.

Table 15.15: Recurrent expenditure[a] ($'000) for specialised mental health services, Queensland, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	70,569	69,745	70,724	72,822	77,752	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	160,214	166,917	190,766	196,641	221,511	n.a.
Total recurrent expenditure for community mental health care services[c][x]	143,688	155,786	173,389	216,856	249,240	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	7,830	7,989	. .	. .	. .	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	25,136	27,696	27,504	33,782	39,436	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	28,519	28,709	28,832	30,282	33,167	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	35,271	34,153	34,443	32,894	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	38,088	38,604	38,855	38,957	39,871	39,627
Medicare expenditure on services provided by general practitioners[v]	508	736	988	11,936	23,502	30,470
Medicare expenditure on services provided by psychologists[v]	. .	207	467	8,833	26,595	36,695
Medicare expenditure on services provided by other allied health professionals[v]	3	11	32	286	1,027	1,445
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	22,588	24,189	25,495	25,643	27,231
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	103,301	100,506	104,075	109,701	116,039

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.4 Western Australia

Table 15.16: Mental health services, Western Australia, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	964,000	906,000	843,000	977,000	917,000	941,000
95% lower confidence limit	830,000	771,000	723,000	860,000	801,000	834,000
95% upper confidence limit	1,098,000	1,041,000	963,000	1,094,000	1,033,000	1,048,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	10,114	11,279	13,518	13,455	n.a.
Community mental health care service contacts[(iii)]	418,484	466,670	492,468	535,809	554,558	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	7,437	8,972	8,644	9,162	9,276	n.a.
With specialised psychiatric care	5,659	7,230	6,921	7,322	6,780	n.a.
Public hospitals	121	100	70	105	115	n.a.
Private hospitals	5,538	7,130	6,851	7,217	6,665	n.a.
Without specialised psychiatric care	1,778	1,742	1,723	1,840	2,496	n.a.
Public hospitals	862	959	1,177	1,329	1,491	n.a.
Private hospitals	916	783	546	511	1,005	n.a.
Medicare-subsidised psychiatrist services[(v)]	121,961	121,072	119,611	119,454	124,605	129,023
Mental health-related hospital separations[(iv)]	20,107	20,540	19,603	20,795	21,408	n.a.
With specialised psychiatric care	11,901	11,731	11,599	11,996	13,084	n.a.
Public hospitals	8,525	8,404	8,120	8,564	8,417	n.a.
Private hospitals	3,376	3,327	3,479	3,432	4,667	n.a.
Without specialised psychiatric care	8,206	8,809	8,004	8,799	8,324	n.a.
Public hospitals	6,299	6,349	6,631	7,669	7,359	n.a.
Private hospitals	1,907	2,460	1,373	1,130	965	n.a.
Episodes of residential mental health care[(vi)]	n.a.	203	177	181	240	n.a.
SAAP mental health-related closed support periods[(vii)]	590	601	815	836	989	n.a.
Accommodated	468	424	597	542	553	n.a.
Supported	122	177	218	294	436	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	1,936	1,711	1,704	2,637	3,451	n.a.
Residential care	186	208	20	195	199	n.a.
Non-residential care	1,915	1,675	1,698	2,584	3,400	n.a.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.17: Mental health-related prescriptions, Western Australia, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	175,263	165,332	170,504	166,360	176,887
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,901,642	1,840,157	1,816,562	1,751,466	1,834,942

(ix) See page 194 for data source.

Table 15.18: Mental health facilities, Western Australia, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	1	1	1	1	1
Average available beds	245	245	245	254	245
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	16	16	13	14	15
Average available beds	394	398	403	415	425
Government-operated residential mental health services[x]					
Number of services[d]	2	2	2	3	3
Average available beds	n.a.	21	18	23	31
Non-government-operated residential mental health services					
Number of services[d]	n.a.	n.a.	8	8	12
Average available beds	n.a.	60	62	62	99
Community mental health care services					
Number of services[e]	n.a.	n.a.	45	44	45
Private psychiatric hospitals[f][xi]					
Number of hospitals	n.a.	n.a.	n.a.	n.a.	n.a.
Average available beds	n.a.	n.a.	n.a.	n.a.	n.a.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(c) Includes publicly funded WA private hospitals.

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

(e) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(f) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.19: Workforce: psychiatrists and mental health nurses, Western Australia, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	271	247	223	260	280
Full-time-equivalent employed mental health nurses	916	1,175	n.p.	n.a.	1,295

n.a. Not available.

n.p. Not published.

(xii) See page 194 for data source.

Table 15.20: Recurrent expenditure[a] ($'000) for specialised mental health services, Western Australia, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	64,156	67,098	67,691	69,292	67,508	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	91,116	98,926	98,843	102,035	113,050	n.a.
Total recurrent expenditure for community mental health care services[c][x]	115,899	129,277	150,336	158,022	174,580	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	4,222	4,572	5,193	6,634	9,137	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	14,755	16,010	17,411	18,438	21,079	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	15,665	11,703	7,761	11,073	12,781	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	13,835	13,832	13,311	13,522	14,311	14,684
Medicare expenditure on services provided by general practitioners[v]	211	283	371	5,937	11,582	14,166
Medicare expenditure on services provided by psychologists[v]	. .	49	89	5,584	17,409	22,212
Medicare expenditure on services provided by other allied health professionals[v]	1	7	8	118	486	753
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	9,265	9,341	9,475	9,581	9,897
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	50,828	49,139	51,148	52,437	54,478

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.5 South Australia

Table 15.21: Mental health services, South Australia, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	1,003,000	899,000	872,000	984,000	1,055,000	1,057,000
95% lower confidence limit	874,000	719,000	738,000	847,000	919,000	899,000
95% upper confidence limit	1,133,000	1,080,000	1,006,000	1,120,000	1,190,000	1,215,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	15,426	12,996	14,164	13,960	n.a.
Community mental health care service contacts[(iii)]	311,535	298,459	302,400	382,304	456,942	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	1,749	1,389	1,232	1,357	1,460	n.a.
With specialised psychiatric care	689	294	216	219	87	n.a.
Public hospitals	268	263	197	209	83	n.a.
Private hospitals	421	31	19	10	4	n.a.
Without specialised psychiatric care	1,060	1,095	1,016	1,138	1,373	n.a.
Public hospitals	1,048	1,085	1,003	1,126	1,361	n.a.
Private hospitals	12	10	13	12	12	n.a.
Medicare-subsidised psychiatrist services[(v)]	192,073	182,959	180,380	177,437	172,573	172,254
Mental health-related hospital separations[(iv)]	19,716	18,332	18,041	19,108	18,818	n.a.
With specialised psychiatric care	10,945	10,180	10,318	11,137	9,851	n.a.
Public hospitals	8,985	8,481	8,565	9,248	8,112	n.a.
Private hospitals	1,960	1,699	1,753	1,889	1,739	n.a.
Without specialised psychiatric care	8,771	8,152	7,723	7,971	8,967	n.a.
Public hospitals	7,949	7,438	7,063	7,352	8,383	n.a.
Private hospitals	822	714	660	619	584	n.a.
Episodes of residential mental health care[(vi)]	n.a.	91	140	121	192	n.a.
SAAP mental health-related closed support periods[(vii)]	830	934	1,740	1,597	1,600	n.a.
Accommodated	445	449	652	529	534	n.a.
Supported	385	485	1,088	1,068	1,066	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	2,095	2,143	2,004	2,920	3,899	n.a.
Residential care	271	317	335	410	409	n.a.
Non-residential care	2,000	2,027	1,927	2,814	3,839	n.a.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.22: Mental health-related prescriptions, South Australia, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	180,158	175,767	172,238	172,515	173,809
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	1,734,591	1,713,251	1,675,163	1,666,625	1,735,738

(ix) See page 194 for data source.

Table 15.23: Mental health facilities, South Australia, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	1	1	1	2	2
Average available beds	461	461	455	388	357
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	8	8	8	8	8
Average available beds	177	172	188	247	243
Government-operated residential mental health services[x]					
Number of services[c]	2	1	3	4	4
Average available beds	n.a.	27	33	53	59
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	1	1	1
Average available beds	n.a.	10	10	10	12
Community mental health care services					
Number of services[d]	n.a.	n.a.	92	85	89
Private psychiatric hospitals[e][xi]					
Number of hospitals	n.a.	n.a.	n.a.	n.a.	n.a.
Average available beds	n.a.	n.a.	n.a.	n.a.	n.a.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.24: Workforce: psychiatrists and mental health nurses, South Australia, 2003–2007[(xii)]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	319	335	313	285	301
Full-time-equivalent employed mental health nurses	1,098	1,072	1,116	n.a.	1,274

n.a. Not available.

(xii) See page 194 for data source.

Table 15.25: Recurrent expenditure[(a)] ($'000) for specialised mental health services, South Australia, 2003–04 to 2008–09, constant prices[(b)]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	86,052	90,250	87,159	82,648	80,601	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(c)(x)]	34,377	35,571	39,239	56,809	60,245	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	72,594	82,657	86,717	91,923	98,702	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	1,270	2,478	3,078	3,102	6,337	n.a.
Total recurrent expenditure for grants to non-government organisations[(e)(x)]	6,459	11,076	16,057	22,655	24,487	n.a.
Total recurrent expenditure for other indirect expenditure[(f)(x)]	5,730	7,238	5,509	4,916	5,662	n.a.
Total recurrent expenditure for private psychiatric hospitals[(g)(xi)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	23,627	21,731	21,022	21,443	21,673	21,262
Medicare expenditure on services provided by general practitioners[(v)]	381	504	562	4,416	9,033	11,513
Medicare expenditure on services provided by psychologists[(v)]	. .	55	85	2,517	9,376	13,191
Medicare expenditure on services provided by other allied health professionals[(v)]	3	5	11	113	478	734
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	11,079	11,681	12,019	12,257	12,378
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	44,951	45,294	46,673	49,763	52,157

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.6 Tasmania

Table 15.26: Mental health services, Tasmania, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	333,000	307,000	243,000	282,000	294,000	350,000
95% lower confidence limit	248,000	238,000	194,000	235,000	237,000	285,000
95% upper confidence limit	418,000	376,000	292,000	329,000	352,000	414,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	4,539	4,517	4,704	4,330	n.a.
Community mental health care service contacts[(iii)]	67,581	64,317	65,576	93,186	147,701	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	65	56	46	78	96	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	233	285	370	375	369	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	48,115	46,190	44,316	42,965	42,071	42,968
Mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	2,979	3,192	3,175	3,376	3,213	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	1,351	1,303	1,364	1,138	1,152	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	721	741	743	907	n.a.
SAAP mental health-related closed support periods[(vii)]	317	321	611	679	566	n.a.
Accommodated	160	158	317	370	286	n.a.
Supported	157	163	294	309	280	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	764	839	846	989	1,312	n.a.
Residential care	183	193	184	178	187	n.a.
Non-residential care	707	775	797	937	1,261	n.a.

n.a. Not available.

n.p. Not published.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.27: Mental health-related prescriptions, Tasmania, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	43,450	42,314	40,428	40,741	42,313
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	625,000	635,471	614,629	610,337	621,375

(ix) See page 194 for data source.

Table 15.28: Mental health facilities, Tasmania, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	3	3	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	3	3	6	6	6
Average available beds	140	130	125	126	128
Government-operated residential mental health services[x]					
Number of services[c]	9	7	5	5	5
Average available beds	n.a.	91	91	91	91
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	4	6	6
Average available beds	n.a.	. .	83	85	85
Community mental health care services					
Number of services[d]	n.a.	n.a.	23	21	17
Private psychiatric hospitals[e][xi]					
Number of hospitals	n.a.	n.a.	n.a.	n.a.	n.a.
Average available beds	n.a.	n.a.	n.a.	n.a.	n.a.

. . Not applicable.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.29: Workforce: psychiatrists and mental health nurses, Tasmania, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	71	68	63	60	74
Full-time-equivalent employed mental health nurses	320	295	339	n.a.	398

n.a. Not available.

(xii) See page 194 for data source.

Table 15.30: Recurrent expenditure[a] ($'000) for specialised mental health services, Tasmania, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	21,808	21,749	24,211	30,798	34,203	n.a.
Total recurrent expenditure for community mental health care services[c][x]	18,554	21,507	28,386	29,116	29,171	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	12,128	12,606	18,086	19,405	19,325	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	2,861	4,864	1,906	3,430	4,690	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	1,724	2,899	5,338	4,408	4,748	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	5,057	4,583	4,230	4,219	4,121	4,066
Medicare expenditure on services provided by general practitioners[v]	78	131	159	1,424	2,640	3,056
Medicare expenditure on services provided by psychologists[v]	. .	11	24	1,364	4,021	5,016
Medicare expenditure on services provided by other allied health professionals[v]	—	—	1	23	141	199
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	2,223	2,569	2,530	2,820	3,051
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	14,003	14,131	14,419	15,464	15,852

. . Not applicable.

— Rounded to zero.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.7 Australian Capital Territory

Table 15.31: Mental health services, Australian Capital Territory, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	88,000	120,000	103,000	118,000	108,000	200,000
95% lower confidence limit	63,000	80,000	64,000	83,000	70,000	160,000
95% upper confidence limit	113,000	161,000	142,000	153,000	145,000	240,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	2,248	2,737	2,635	2,509	n.a.
Community mental health care service contacts[(iii)]	167,541	198,666	210,833	207,487	207,467	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	4	32	33	35	17	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	102	113	183	185	151	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.a.	n.a.
Medicare-subsidised psychiatrist services[(v)]	21,456	22,534	22,301	20,877	19,907	19,628
Mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	1,136	1,139	1,178	1,183	1,266	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	341	307	335	365	821	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	63	60	81	75	n.a.
SAAP mental health-related closed support periods[(vii)]	523	408	582	438	429	n.a.
Accommodated	481	349	426	294	264	n.a.
Supported	42	59	156	144	165	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	348	369	320	543	607	n.a.
Residential care	34	19	34	83	94	n.a.
Non-residential care	340	365	317	535	601	n.a.

n.a. Not available.

n.p. Not published.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.32: Mental health-related prescriptions, Australian Capital Territory, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	25,074	25,917	25,517	26,013	26,399
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	235,491	217,005	209,457	205,663	214,789

(ix) See page 194 for data source.

Table 15.33: Mental health facilities, Australian Capital Territory, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	2	2	2	2	2
Average available beds	50	50	50	70	70
Government-operated residential mental health services[x]					
Number of services[c]	1	1	1	1	1
Average available beds	n.a.	40	30	30	30
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	6	5	6
Average available beds	n.a.	48	50	45	47
Community mental health care services					
Number of services[d]	n.a.	n.a.	13	11	11
Private psychiatric hospitals[e][xi]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .

. . Not applicable.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.34: Workforce: psychiatrists and mental health nurses, Australian Capital Territory, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	50	44	63	n.p.	n.p.
Full-time-equivalent employed mental health nurses	167	166	n.p.	n.a.	n.p.

n.a. Not available.

n.p. Not published.

(xii) See page 194 for data source.

Table 15.35: Recurrent expenditure[a] ($'000) for specialised mental health services, Australian Capital Territory, 2002–03 to 2007–08, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	10,450	9,175	9,696	14,664	16,006	n.a.
Total recurrent expenditure for community mental health care services[c][x]	22,134	26,596	25,859	28,415	27,051	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	7,121	6,755	6,434	7,157	7,400	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	3,846	4,920	5,562	5,475	6,117	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	2,191	2,409	2,384	1,928	3,281	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	. .	. .	. .	. .	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	2,397	2,629	2,560	2,446	2,469	2,408
Medicare expenditure on services provided by general practitioners[v]	17	21	28	865	1,746	2,107
Medicare expenditure on services provided by psychologists[v]	. .	9	24	751	2,854	3,630
Medicare expenditure on services provided by other allied health professionals[v]	—	—	—	8	32	44
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	1,687	1,989	2,078	2,129	2,057
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	6,287	5,881	6,131	6,634	6,982

. . Not applicable.

— Rounded to zero.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.8 Northern Territory

Table 15.36: Mental health services, Northern Territory, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[(a)(i)]	38,000	39,000	56,000	45,000	48,000	69,000
95% lower confidence limit	17,000	26,000	25,000	24,000	35,000	41,000
95% upper confidence limit	59,000	52,000	86,000	66,000	62,000	96,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	2,703	3,482	3,524	2,891	n.a.
Community mental health care service contacts[(iii)]	26,054	36,377	36,356	37,785	36,146	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	27	25	27	22	28	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	71	97	142	188	228	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Medicare-subsidised psychiatrist services[(v)]	4,722	4,887	4,474	4,370	3,918	4,220
Mental health-related hospital separations[(iv)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
With specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	926	1,174	1,146	984	957	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Without specialised psychiatric care	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Public hospitals	321	329	453	455	541	n.a.
Private hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	. .	. .	9	5	n.a.
SAAP mental health-related closed support periods[(vii)]	179	135	747	554	400	n.a.
Accommodated	146	94	600	442	223	n.a.
Supported	33	41	147	112	177	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	145	129	103	157	226	n.a.
Residential care	26	21	22	18	14	n.a.
Non-residential care	133	116	87	147	216	n.a.

. . Not applicable.

n.a. Not available.

n.p. Not published.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(i–viii) See page 194 for data sources.

Table 15.37: Mental health-related prescriptions, Northern Territory, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	4,855	4,195	4,092	4,492	5,241
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	68,031	67,330	63,898	61,937	65,494

(ix) See page 194 for data source.

Table 15.38: Mental health facilities, Northern Territory, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	2	2	2	2	2
Average available beds	32	32	32	34	34
Government-operated residential mental health services[x]					
Number of services[c]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	2	1	1
Average available beds	n.a.	10	10	5	5
Community mental health care services					
Number of services[d]	n.a.	n.a.	13	13	13
Private psychiatric hospitals[e][xi]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .

. . Not applicable.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.39: Workforce: psychiatrists and mental health nurses, Northern Territory, 2003–2007[xii]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	36	20	25	n.p.	n.p.
Full-time-equivalent employed mental health nurses	54	77	n.p.	n.a.	n.p.

n.a. Not available.

n.p. Not published.

(xii) See page 194 for data source.

Table 15.40: Recurrent expenditure[a] ($'000) for specialised mental health services, Northern Territory, 2003–04 to 2008–09, constant prices[b]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[c][x]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[c][x]	10,743	10,871	11,158	10,662	11,663	n.a.
Total recurrent expenditure for community mental health care services[c][x]	11,600	13,672	13,530	15,898	16,399	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	251	259	291	364	456	n.a.
Total recurrent expenditure for grants to non-government organisations[e][x]	1,429	1,573	3,356	4,269	3,843	n.a.
Total recurrent expenditure for other indirect expenditure[f][x]	2,475	2,921	2,203	2,192	2,444	n.a.
Total recurrent expenditure for private psychiatric hospitals[g][xi]	. .	. .	. .	. .	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	516	499	386	410	381	377
Medicare expenditure on services provided by general practitioners[v]	24	21	23	292	527	702
Medicare expenditure on services provided by psychologists[v]	. .	1	1	139	453	587
Medicare expenditure on services provided by other allied health professionals[v]	0	0	—	1	10	10
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	270	267	288	328	392
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	1,928	2,048	2,157	2,329	2,463

. . Not applicable.

— Rounded to zero.

n.a. Not available

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

15.9 Australia

Table 15.41: Mental health services, Australia, 2003–04 to 2008–09

Mental health services	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Estimated number of mental health-related general practice encounters[a][i]	9,974,000	10,591,000	10,624,000	10,713,000	11,862,000	13,202,000
95% lower confidence limit	9,516,000	10,067,000	10,074,000	10,261,000	11,280,000	12,661,000
95% upper confidence limit	10,433,000	11,117,000	11,174,000	11,165,000	12,375,000	13,678,000
Mental health-related occasions of service in emergency departments in public hospitals[ii]	n.a.	138,729	149,566	178,595	162,721[b]	n.a.
Community mental health care service contacts[iii]	4,911,735	5,108,524	5,665,408	5,966,277	6,374,267	n.a.
Ambulatory-equivalent mental health-related hospital separations[iv]	111,581	116,787	117,924	120,602	121,651	n.a.
With specialised psychiatric care	86,765	92,369	93,202	92,304	88,348	n.a.
Public hospitals	13,349	12,285	8,994	6,484	5,127	n.a.
Private hospitals	73,416	80,084	84,208	85,820	83,221	n.a.
Without specialised psychiatric care	24,816	24,418	24,722	28,298	33,303	n.a.
Public hospitals	13,249	14,248	15,379	17,795	18,527	n.a.
Private hospitals	11,567	10,170	9,343	10,503	14,776	n.a.
Medicare-subsidised psychiatrist services[v]	2,028,458	2,007,218	2,015,941	1,986,533	1,949,702	1,967,222
Mental health-related hospital separations[iv]	197,712	199,353	204,186	209,356	212,890	n.a.
With specialised psychiatric care	116,725	116,852	118,733	122,132	124,247	n.a.
Public hospitals	90,230	89,059	89,274	92,509	91,642	n.a.
Private hospitals	26,495	27,793	29,459	29,623	32,605	n.a.
Without specialised psychiatric care	80,987	82,501	85,453	87,224	88,643	n.a.
Public hospitals	69,135	72,111	75,965	77,213	77,541	n.a.
Private hospitals	11,852	10,390	9,488	10,011	11,102	n.a.
Episodes of residential mental health care[vi]	n.a.	2,194	2,345	2,531	3,222	n.a.
SAAP mental health-related closed support periods[vii]	12,024	12,227	20,392	23,678	22,509	n.a.
Accommodated	7,003	7,634	11,069	10,908	10,321	n.a.
Supported	5,021	4,593	9,323	12,770	12,188	n.a.
CSTDA-funded service users with a psychiatric disability[viii]	24,753	35,599	38,086	47,658	58,044	n.a.
Residential care	2,958	3,014	2,959	3,397	3,588	n.a.
Non-residential care	24,108	34,833	37,309	46,848	57,238	n.a.

n.a. Not available.

(a) The estimated number of encounters is based on the proportion of encounters in the BEACH survey of general practice activity that are mental health-related, multiplied by the total number of Medicare services for *Non-Referred (GP) Attendances* (excluding practice nurse items) as reported by the Department of Health and Ageing (Medicare 2009a).

(b) Mental health-related emergency department occasions of service are under-reported in New South Wales due to the implementation of a new emergency department information system.

(i–viii) See page 194 for data sources.

Table 15.42: Mental health-related prescriptions, Australia, 2004–05 to 2008–09[ix]

Mental health-related prescriptions	2004–05	2005–06	2006–07	2007–08	2008–09
PBS and RPBS-subsidised prescriptions by psychiatrists	1,999,147	1,958,189	1,952,419	1,918,803	2,012,026
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	19,292,688	18,897,779	18,686,045	18,433,113	19,405,898

(ix) See page 194 for data source.

Table 15.43: Mental health facilities, Australia, 2003–04 to 2007–08

Mental health facilities	2003–04[a]	2004–05[a]	2005–06	2006–07	2007–08
Public psychiatric hospitals[x]					
Number of hospitals[b]	20	20	15	16	16
Average available beds	2,335	2,339	2,263	2,211	2,156
Specialised psychiatric units or wards in public acute hospitals[x]					
Number of hospitals[b]	124	122	134	135	141
Average available beds	3,753	3,863	4,011	4,191	4,395
Government-operated residential mental health services[x]					
Number of services[c]	52	46	77	82	77
Average available beds	n.a.	1,424	1,426	1,466	1,401
Non-government-operated residential mental health services					
Number of services[c]	n.a.	n.a.	58	60	65
Average available beds	n.a.	566	720	743	783
Community mental health care services					
Number of services[d]	n.a.	n.a.	931	931	958
Private psychiatric hospitals[e][xi]					
Number of hospitals	25	26	26	25	n.a.
Average available beds	1,441	1,512	1,573	1,554	n.a.

n.a. Not available.

(a) Data from 2003–04 and 2004–05 for public hospital and government-operated residential services were sourced from the National Public Hospital Establishments and Community Mental Health Establishments databases and therefore may differ from subsequent data due to definitions and reporting requirements.

(b) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

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

(d) The number of community mental health care services are a representation of the reporting structure in each jurisdictions and do not necessarily reflect the number or size of services provided.

(e) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(x-xi) See page 194 for data sources.

Table 15.44: Workforce: psychiatrists and mental health nurses, Australia, 2003–2007[(xii)]

Workforce	2003	2004	2005	2006	2007
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	3,328	3,392	3,398	3,472	3,807
Full-time-equivalent employed mental health nurses	13,306	13,435	13,188	n.a.	14,447

n.a. Not available.

(xii) See page 194 for data source.

Table 15.45: Recurrent expenditure[(a)] ($'000) for specialised mental health services, Australia, 2003–04 to 2008–09, constant prices[(b)]

Mental health expenditure	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	468,810	467,677	464,036	454,975	447,360	n.a.
Total recurrent expenditure for specialised psychiatric units or wards in public acute hospitals[(c)(x)]	759,343	816,875	869,167	946,690	1,021,505	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	969,559	1,031,136	1,103,930	1,181,385	1,268,301	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	174,790	175,904	191,486	195,379	189,258	n.a.
Total recurrent expenditure for grants to non-government organisations[(e)(x)]	130,262	146,292	172,351	197,042	225,448	n.a.
Total recurrent expenditure for other indirect expenditure[(f)(x)]	135,410	141,580	155,819	164,878	171,346	n.a.
Total recurrent expenditure for private psychiatric hospitals[(g)(xi)]	188,580	189,081	190,230	186,967	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	242,811	239,626	233,739	237,061	240,225	237,799
Medicare expenditure on services provided by general practitioners[(v)]	4,570	5,332	6,623	70,611	133,449	164,360
Medicare expenditure on services provided by psychologists[(v)]	. .	1,253	2,399	55,884	170,304	223,356
Medicare expenditure on services provided by other allied health professionals[(v)]	45	89	188	1,518	6,661	10,362
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	124,233	130,902	133,753	134,119	141,575
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	517,694	516,864	538,756	569,407	599,457

. . Not applicable.

n.a. Not available.

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2007–08 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2003–04 to 2004–05 were sourced from the *National mental health report* (DoHA 2008).

(d) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(e) Grants to non-government organisations expenditure excludes funding of staffed residential services operated by non-government organisations. These are included in residential mental health services.

(f) See Appendix 2 for information on the method used to calculate indirect expenditure.

(g) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(v–xi) See page 194 for data sources.

Appendix 1: Data sources

To present a broad picture of mental health-related care in Australia, this report uses data drawn from a variety of sources. These data sources include Australian Institute of Health and Welfare (AIHW) databases such as the National Hospital Morbidity Database and the National Mental Health Establishments Database (NMHED), for which data were supplied under the National Health Information Agreement and specified in the National Minimum Data Sets (NMDSs) for Mental Health Care in the *National health data dictionary, Version 13* (HDSC 2006).

This report also presents data from other AIHW data collections such as the AIHW Medical Labour Force Survey, the Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity, the Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC) and the Commonwealth State/Territory Disability Agreement (CSTDA) National Minimum Data Set (NMDS) collection.

Data from collections external to the AIHW were also used, including the Australian Bureau of Statistics (ABS's) Private Health Establishments Collection (PHEC) and the Department of Health and Ageing's (DoHA's) Medicare, Pharmaceutical and Repatriation Pharmaceutical Benefits Schemes (MBS, PBS and RPBS) data collections.

The characteristics of each of the data sources used in this report should be considered when interpreting the data. The data sources used in this report are briefly described below.

Chapter 2: Bettering the Evaluation and Care of Health survey

The BEACH survey of general practice activity is a collaborative study between the AIHW and the University of Sydney. For each year's data collection, a random sample of about 1,000 general practitioners (GPs) each report details of 100 consecutive GP encounters of all types on structured encounter forms. Each form collects information about the consultations (for example, date and type of consultation), the patient (for example, date of birth, sex, and reasons for encounter), the problems managed and the management of each problem (for example, treatment provided, prescriptions and referrals). Data on patient risk factors, health status and GP characteristics are also collected.

Additional information on the 2008–09 BEACH survey can be obtained from *General practice activity in Australia 2008–09* (Britt et al. 2009).

Chapters 2, 6 and 14: Medicare Benefits Schedule data

Medicare Australia collects data on the activity of all providers making claims through the Medicare Benefits Schedule (MBS) and provides this information to DoHA. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare Australia for the service. The item number and benefits paid by Medicare Australia are based on the *Medicare Benefits Schedule Book* (DoHA 2009b). Services that are not included in the MBS are not included in the data.

Table A1.1 lists all MBS items that have been defined as mental health-related.

Table A1.1: MBS mental health-related items

Provider	Item group	MBS Group & Subgroup	MBS item numbers
Psychiatrists	Initial consultation new patient —psychiatrist[a]	Group A8	296, 297, 299
	Patient attendances—consulting room	Group A8	291[a], 293[a], 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319
	Patient attendances—hospital	Group A8	320, 322, 324, 326, 328
	Patient attendances—other locations	Group A8	330, 332, 334, 336, 338
	Group psychotherapy	Group A8	342, 344, 346
	Interview with non-patient	Group A8	348, 350,352
	Telepsychiatry	Group A8	353, 355, 356, 357, 358, 359[b], 361[b], 364, 366, 367, 369, 370
	Case conference—psychiatrist		855, 857, 858, 861, 864, 866
	Electroconvulsive therapy	Group T1 Subgroup 13	14224
	Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD)—psychiatrist[c]	Group A8	289
General practitioners	GP Mental Health Care[a]	Group A20 Subgroup 1	2710, 2712, 2713
	Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
	Family Group Therapy	Group A6	170, 171, 172
	3 Step Mental Health Process —GP[d]	Group A18 Subgroup 4	2574, 2575, 2577, 2578
Psychologists	Enhanced Primary Care —psychologist	Group M3	10968
	Focussed Psychological Strategies (Allied Mental Health)—psychologist[a]	Group M7	80100, 80105, 80110, 80115, 80120
	Psychological Therapy Services —clinical psychologist[a]	Group M6	80000, 80005, 80010, 80015, 80020
	Assessment and treatment of PDD —psychologist[c]	Group A10	82000, 82015
Other allied health providers	Enhanced Primary Care — mental health worker	Group M3	10956
	Focussed Psychological Strategies (Allied Mental Health)—occupational therapist[a]	Group M7	80125, 80130, 80135, 80140, 80145
	Focussed Psychological Strategies (Allied Mental Health)—social worker[a]	Group M7	80150, 80155, 80160, 80165, 80170
	3 Step Mental Health Process —OMP[d]	Group A19 Subgroup 4	2704, 2705, 2707, 2708

(a) These items introduced 1 November 2006.

(b) These items introduced 1 November 2007.

(c) These items introduced 1 July 2008.

(d) These items were discontinued after 30 April 2007.

The MBS data presented in this report relate to services provided on a fee-for-service basis for which MBS benefits were paid. The year is determined from the date the service was processed by Medicare Australia, rather than the date the service was provided. The state or territory is determined according to the postcode of the patient's mailing address at the time of making the claim. In some cases, this will not be the same as the postcode of the patient's residential address.

Chapter 3: Mental health-related emergency department data

While there is no national agreement on the collection of information on mental health-related services provided by emergency departments in hospitals in Australia, states and territories agreed to provide the AIHW with aggregate data to compile national information on mental health-related occasions of service provided by emergency departments in public hospitals.

All state and territory health authorities collect a core set of nationally comparable information on most of the emergency department occasions of service in public hospitals within their jurisdiction. The AIHW compiles these episode-level data annually to form the National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD) (AIHW 2009a). The data are collected by state and territory health authorities according to definitions in the Non-admitted Patient Emergency Department NMDS and cover occasions of service provided in emergency departments of public hospitals categorised in the previous financial year as peer groups A (that is, principal referral and specialist women's and children's hospitals) and B (large hospitals). For 2007–08, data were also collected by some states and territories for hospitals in peer groups other than A and B.

The total number of emergency department occasions of service for all public hospitals in 2007–08 was 7.1 million. Episode-level data were collected by state and territory health authorities departments for 78% of these occasions of service (a total of 5.5 million occasions of service) (AIHW 2009a). Episode-level data were available for almost 100% of all emergency department occasions of service for public hospitals in peer groups A and B, and about 29% of emergency department occasions of service for other public hospitals.

Definition of mental health-related emergency department occasions of service

While there is a national data compilation of episode-level data on emergency department occasions of service (NNAPEDCD), there is currently no national agreement to collect information on the principal diagnosis for emergency department occasions of service. In addition, there is no standard or agreed classification for diagnoses in use across emergency departments that could be used uniformly to identify mental health-related care, or any other data item (for example, reason for the occasion of service, intentional self-harm codes and mental health flags) collected in a nationally consistent manner that would allow for the identification of mental health-related occasions of service in emergency departments. Thus it is difficult to identify and report on mental health-related emergency department occasions of service in a comparable manner across jurisdictions.

However, in 2007–08, all jurisdictions did collect some information on the principal diagnosis of an estimated 89% of emergency service department occasions of service for which they reported episode-level data to the NNAPEDCD. As a result, it was determined that a definition of 'mental health-related' based on the collected diagnosis information could be applied nationally, for the purposes of compiling data for this publication.

Data on mental health-related emergency department occasions of service reported in Chapter 3 of this report have been provided by the state and territory health authorities according to the following definition: occasions of service in public hospital emergency departments that have a principal diagnosis of *Mental and behavioural disorders* (that is, codes F00–F99) in ICD-10-AM or the equivalent codes in ICD-9-CM.

Table A1.2: Mental health-related emergency department occasions of service, principal diagnosis codes included, ICD-10-AM and ICD-9-CM

ICD-10-AM[(a)] codes		ICD-9-CM[(b)] codes
F00–F09	Organic, including symptomatic, mental disorders	290, 293, 294, 310
F10–F19	Mental and behavioural disorders due to psychoactive substance use	291, 292, 303, 304, 305 (excluding 305.8 and 305.9)
F20–F29	Schizophrenia, schizotypal and delusional disorders	295, 297, 298 (excluding 298.0, 298.1, 298.2), 301.22
F30–F39	Mood (affective) disorders	296, 298.0, 298.1, 300.4, 301.1, 311
F40–F48	Neurotic, stress-related and somatoform disorders	298.2, 300 (excluding 300.4, 300.19), 306 (excluding 306.3, 306.51, 306.6), 307.53, 307.80, 307.89, 308, 309 (excluding 309.21, 309.22)
F50–F59	Behavioural syndromes associated with physiological disturbances and physical factors	302.7, 305.8, 305.9, 306.3, 306.51, 306.6, 307.1, 307.4, 307.5 (excluding 307.53), 316, 648.44
F60–F69	Disorders of adult personality and behaviour	300.19, 301 (excluding 301.1, 301.22), 302 (excluding 302.7), 312.3
F70–F79	Mental retardation	317, 318, 319
F80–F89	Disorders of psychological development	299, 315, 330.8
F90–F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	307.0, 307.2, 307.3, 307.6, 307.7, 307.9, 309.21, 309.22, 312 (excluding 312.3), 313, 314
F99	Unspecified mental disorder	. .

. . Not applicable.

(a) *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification.*

(b) *International Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification.*

This definition does not capture all mental health-related presentations to emergency departments, and the caveats listed below should be taken into consideration when interpreting the data presented on mental health-related emergency department occasions of service.

Most jurisdictions had coded the principal diagnosis of emergency department occasions of service in 2007–08 using ICD-10-AM. However, for those using ICD-9-CM, mapping of the relevant ICD-10-AM codes to ICD-9-CM codes was undertaken by the relevant state or territory (Table A1.2).

Aggregate data on the demographic characteristics of the patients, the triage category, episode end status and the diagnosis category were provided by all states and territories to AIHW for occasions of service that met the definition of a mental health-related occasion of service.

Caveats

To ensure that the data on emergency department mental health-related occasions of service are interpreted correctly, the following should be noted:

- There is no nationally agreed-upon method of identifying mental health-related occasions of service in emergency departments.
- There is no standard diagnosis classification in use across states and territories for emergency department data.
- There is no standard way to disaggregate those occasions of service identified as mental health-related into subcategories of mental health conditions.

- Not all potential mental health-related emergency department occasions of service are represented in the data, for the following reasons
  - not all emergency department occasions of service are collected by state and territory authorities at the episode level
  - not all occasions of service episode-level data collected by state and territory authorities include diagnosis information
  - the principal diagnosis codes included in the definition do not cover all mental health-related conditions
  - the mental health-related condition or illness may not have been coded as the diagnosis, if it was either not diagnosed by the emergency department or was not recognised as a reason for presentation at an emergency department.
- The definition is based on a single diagnosis only. As a result, if a mental health-related condition was reported as a second or other diagnosis and not as the *principal diagnosis*, the occasion of service will not be included as mental health-related.
- The data refer to occasions of service and not to individuals. An individual may have had multiple occasions of service within the same year.

Coverage

As noted above, episode-level data were available for 78% of public hospital emergency department occasions of service in 2007–08, and these data are mainly from the larger metropolitan hospitals (Table A1.3). Of the data available on emergency department occasions of service, it is estimated that 89% had a diagnosis code.

Using these figures, and assuming that mental health-related occasions of service are evenly distributed, it can be roughly estimated that the number of mental health-related occasions of service reported in this publication represents 69% of all public hospital emergency department mental health-related occasions of service as defined above. Taking this into account, the actual number of such occasions of service could be about 258,500 rather than the reported 162,721 (Table A1.3).

In addition, it should be noted that coverage of the data is biased toward the larger metropolitan emergency departments. Mental health-related occasions of service in smaller rural hospitals may differ from those in the larger metropolitan hospitals.

Table A1.3: Emergency department occasions of service in public hospitals, estimated coverage and estimated actual number of mental health-related occasions of service, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Estimated per cent of total public hospital emergency department occasions of service with episode-level data for the following hospital groups:[(a)]									
Peer group A and B[(b)(c)]	100	100	100	99	100	100	100	100	100
Other hospitals[(c)]	45	32	. .	32	22	. .	. .	100	29
Total estimated per cent[(c)]	**81**	**89**	**64**	**72**	**67**	**88**	**100**	**100**	**78**
Estimated per cent of occasions of service reported at episode-level that have a principal diagnosis code[(d)]	86	90	100	70	90	100	100	98	89
Estimated per cent of total emergency department occasions of service with a principal diagnosis[(e)]	56	80	64	50	60	88	100	98	69
Number of emergency department occasions of service with a mental health-related principal diagnosis[(f)]	56,001	34,588	34,987	13,455	13,960	4,330	2,509	2,891	162,721
Estimated actual number of emergency department occasions of service with a mental health-related principal diagnosis[(g)]	100,373	43,181	54,667	26,754	23,202	4,920	2,509	2,950	258,557

. . Not applicable.

(a) The proportion of all occasions of service in emergency departments in public hospitals in 2007–08 that are reported at episode-level to the NNAPEDCD.

(b) Peer group A: Principal referral and specialist women's and children's hospitals; Peer group B: Large hospitals.

(c) The number of presentations reported to NNAPEDCD divided by the number of accident and emergency (A+E) occasions of service reported to the National Public Hospital Establishments Database (NPHED) as a percentage. This may underestimate the NNAPEDCD coverage because some A+E occasions of service are for other than emergency presentations. As A+E occasions of service may have been under-enumerated for some jurisdictions and peer groups, coverage may also be overestimated. The coverage has been adjusted to 100% for jurisdictions and peer groups, coverage may also be overestimated. The coverage has been adjusted to 100% for jurisdictions where the number of presentations reported to NNAPEDCD exceeded the number of A+E occasions of service reported to the NPHED. See *Australian hospital statistics 2007–08* (AIHW 2009a).

(d) The proportion of emergency department occasions of service reported at episode-level to the NNAPEDCD that had a diagnosis. Total is estimated based on state and territory proportions and numbers.

(e) Calculated by multiplying the total percentage of all occasions of service in emergency departments in public hospitals in 2007–08 that are reported at episode-level to the NNAPEDCD by the percentage of emergency department occasions of service reported at episode-level to the NNAPEDCD that had a diagnosis (divided by 100) with the exception of the New South Wales estimate, which takes into account a new emergency department information system which captured only 80% of hospitals in that jurisdiction for 2007–08.

(f) Number of *Mental health-related emergency department occasions of service* as defined for the purposes of this publication, and provided by state and territory health authorities.

(g) Estimate of the actual number of *Mental health-related emergency department occasions of service*, as defined for the purposes of this publication, if coverage were 100%.

Sources: Data provided by state and territory health authorities, *Australian hospital statistics 2007–08* (AIHW 2009a).

Chapter 4: National Community Mental Health Care Database

Scope

The National Community Mental Health Care Database (NCMHCD) contains data on all ambulatory mental health service contacts provided by government-operated community mental health care services as specified by the Community Mental Health Care (CMHC)

NMDS. Data collated include information relating to each individual service contact provided by the relevant mental health services. Examples of data elements are demographic characteristics of patients such as age and sex and clinical information like principal diagnosis and mental health legal status. Detailed data specifications for the CMHC NMDS can be found in METeOR, the AIHW's online metadata registry, at <www.aihw.gov.au>.

The scope for this collection is all services mentioned above that are included in the Mental Health Establishments (MHE) NMDS which was inaugurated in 2005–06. A list of the government-operated community mental health care services that contribute patient-level data to the NCMHCD can be found online in the 'Internet-only tables' that accompany this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2007–08*).

A mental health service contact for the purposes of this collection is defined as the provision of a clinically significant service by a specialised mental health service provider for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and those resident in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any one patient can have one or more service contacts over the relevant period (that is, 2007–08). Service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, or other professional or mental health workers or other service providers.

It should be noted that there are variations across jurisdictions in the scope and definition of a service contact. For example, New South Wales, Queensland, South Australia, Tasmania and the Northern Territory may include written correspondence as service contacts while others do not. Data on contacts with unregistered clients are not included by all jurisdictions.

Quality of Indigenous identification

Data from the NCMHCD on Indigenous status should be interpreted with caution. Among the jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown.

States and territories provided information on the quality of the Indigenous data for 2007–08 as follows:

- New South Wales stated that the quality of Indigenous data has not been evaluated.
- Victoria considered the quality of Indigenous data was not acceptable due to lack of consistency in data entry across its services.
- Queensland reported that the quality of Indigenous data is acceptable at the broad level; that is, in distinguishing Indigenous Australians and other Australians. However, they believe that there are quality issues regarding the coding of more specific details (that is, *Aboriginal*, *Torres Strait Islander*, or *Both Aboriginal and Torres Strait Islander*). Queensland reported that several strategies have been implemented to improve the quality of Indigenous data and noted that a replacement for the existing collection system with in-built validation checks would further improve the quality of these data.
- Western Australia reported that the quality of Indigenous status data for 2007–08 was acceptable. However, the data could be improved with the appropriate resources, training and reporting standards.

- South Australia indicated that there has been limited analysis of the quality of Indigenous status data. Therefore, the quality of these data is uncertain at this stage.
- Tasmania reported the quality of its data to be acceptable.
- The Australian Capital Territory considered the quality of its Indigenous status data to be acceptable.
- The Northern Territory indicated its Indigenous status data to be of acceptable quality.

Principal diagnosis data quality

The quality of principal diagnosis data in the NCMHCD may also be affected by the variability in collection and coding practices across jurisdictions. In particular, there are:

a. differences among states and territories in the classification used
   - five of the state and territory health authorities used the complete ICD-10-AM classification to code principal diagnosis
   - New South Wales used a combination of National Centre for Classification in Health (NCCH) *ICD-10-AM Mental Health Manual*; *International Classification of Diseases and Related Health Problems, 10th revision, Primary Care* (ICD-10-PC); and local codes where there were no ICD-10-PC equivalents
   - Queensland used a combination of ICD-10-AM and NCCH *ICD-10-AM Mental Health Manual*
   - Northern Territory used the NCCH *ICD-10-AM Mental Health Manual*

b. differences according to the size of the facility (for example, large versus small) in the ability to accurately code principal diagnosis

c. differences in the availability of appropriate clinicians to assign principal diagnoses (diagnoses are generally to be made by psychiatrists, whereas service contacts are mainly provided by non-psychiatrists)

d. differences according to whether the principal diagnosis is applied to an individual service contact or to a period of care. New South Wales and the Australian Capital Territory mainly report the current diagnosis for each service contact rather than a principal diagnosis for a longer period of care. The remaining jurisdictions mainly report principal diagnosis as applying to a longer period of care.

Chapters 5 and 7: National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of electronic summary separation records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone, and external causes of injury and poisoning are also recorded.

The 2007–08 collection contains data for hospital separations that occurred between 1 July 2007 and 30 June 2008. Data on separations that began before 1 July 2007 are included if the separation date fell within the collection period (2007–08). A record is generated for each separation rather than each patient. Therefore, patients who separated more than once in the reference year have more than one record in the database.

Data relating to admitted patients in almost all hospitals are included. The coverage is described in greater detail in *Australian hospital statistics 2008–09* (AIHW 2009a).

Specialised mental health care is identified by the patient having one or more psychiatric care days recorded—that is, care was received in a specialised psychiatric unit or ward. In acute care hospitals, a 'specialised' episode of care or separation may comprise some psychiatric care days and some days in general care. An episode of care from a public psychiatric hospital is deemed to comprise psychiatric care days only and to be 'specialised', unless some care was given in a unit other than a psychiatric unit, such as a drug and alcohol unit.

Before interpreting any NHMD data presented in this report, note that mental health care for admitted patients in Australia is provided in a large and complex system, and there are state and territory differences in the scope of services provided for admitted patients. Differences in the data presented by jurisdictions may reflect different service delivery practices, differences in admission practices or differences in the types of establishments categorised as hospitals. Interpretation of the differences between jurisdictions therefore needs to be done with care.

Chapter 8: National Residential Mental Health Care Database

Scope

The National Residential Mental Health Care Database (NRMHCD) contains data on episodes of residential care provided by government-funded residential mental health services as specified by the Residential Mental Health Care (RMHC) NMDS. Data collated include information relating to each episode of residential care provided by the relevant mental health services. Examples of data elements are demographic characteristics of residents, such as age and sex, and clinical information, such as principal diagnosis and mental health legal status. Detailed data specifications for the RMHC NMDS can be found in METeOR, the AIHW's online metadata registry, at <www.aihw.gov.au>.

The scope for this collection is all episodes of residential care for residents in all government-funded and operated residential mental health services in Australia, except those residential care services that are in receipt of funding under the *Aged Care Act 1997* and subject to Commonwealth reporting requirements (that is, they report to the System for the Payment of Aged Residential Care collection). The inclusion of government-funded, non-government-operated services and services that are not staffed for 24 hours a day is optional. For the 2007–08 data collection, all the facilities reported had mental health trained staff on-site 24 hours a day except for one South Australian facility that was staffed for 13 hours a day. Data from eight Tasmanian non-government organisations staffed 24 hours a day were also included in the 2007–08 collection. A list of the residential mental health services included in the NRMHCD can be found online in the 'Internet only tables' that accompany this publication on the AIHW website <www.aihw.gov.au/mentalhealth/> (follow the link to *Mental health services in Australia 2007–08*).

Queensland does not have any in-scope government-operated residential mental health services and therefore does not report to this collection.

Coverage

States and territories provided estimates of their data from government-operated residential mental health services for 2007–08 as a proportion of full coverage:

- New South Wales, Victoria, Western Australia, South Australia, Tasmania, the Australian Capital Territory and the Northern Territory estimated their data coverage to be 100%.
- Queensland does not have any residential mental health services.

Indigenous data quality

Data from the NRMHCD on Indigenous status should be interpreted with caution due to the varying quality and completeness of Indigenous identification across all jurisdictions. Only New South Wales, Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory considered their Indigenous status data of acceptable quality. Limited analysis was done on the quality of Indigenous data in South Australia. Victoria considered the quality of Indigenous data not to be acceptable due to the lack of consistency in data entry across their services.

Principal diagnosis coding

Victoria, Western Australia, South Australia, Tasmania and the Australian Capital Territory used the complete ICD-10-AM classification to code principal diagnosis. New South Wales used a combination of the NCCH *ICD-10-AM Mental Health Manual*, ICD-10-PC, and local codes where there were no ICD-10-PC equivalents. For the Northern Territory, the *ICD-10-AM Mental Health Manual* subset codes were used.

Chapter 9: Supported Accommodation Assistance Program National Data Collection

From 1985 to 31 December 2008, the Supported Accommodation Assistance Program (SAAP) played a major role in supporting people experiencing, or at risk of, homelessness in Australia. The SAAP National Data Collection (NDC) is a nationally consistent information system that combines information from SAAP agencies, and state and territory and Australian Government funding departments. The AIHW manages the collection.

On 1 January 2009, the SAAP V Agreement between the Australian Government and the states and territories was replaced by the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH). However, data collection from government-funded specialist homelessness services has continued under the new arrangements as the SAAP NDC.

The scope of the SAAP NDC includes all agencies that received funding through the national SAAP agreement and/or state and territory SAAP funds. In 2007–08, 1,562 non-government, community and local government agencies were funded nationally under the program. Of the agencies required to participate in the collection, 92.1% participated in the data collection.

The data presented in this report were extracted from the Client Collection component of the SAAP NDC, which includes information about all clients receiving SAAP accommodation or support that is of an ongoing nature or that generally lasts for more than 1 hour on a given day. Data recorded by service providers during or immediately following contact with clients are then forwarded to the AIHW after the clients' support periods have ended or, for ongoing clients, at the end of the reporting period (30 June of each year).

Data collected include basic sociodemographic information and information on the services needed by, and provided to, each client. Information about each client's situation before and after receiving SAAP services is also collected.

There are high levels of non-response to particular questions on the data collection forms received by the AIHW. This means that caution should be exercised when interpreting the data because the results may not fully reflect the entire population of interest.

Furthermore, the protocols established for the NDC require that SAAP clients provide information in a climate of informed consent. If a client's consent is not obtained, only a limited number of questions can be completed on data collection forms. In 2007–08, valid consent was obtained from clients in 82.5% of support periods in participating agencies.

While data reported from the SAAP Client Collection are generally weighted to take non-participation of agencies and non-consent of clients into account, unweighted data are presented in this report. Based on unweighted responses, there was a total of 172,140 closed support periods reported in the SAAP Client Collection for 2007–08. For the same period, the number of closed support periods using weighted data was estimated to be 186,982.

For further information on the SAAP collection, refer to the 2007–08 AIHW publication *Homeless people in SAAP: SAAP National Data Collection annual report* (AIHW 2009d).

Chapter 10: Commonwealth State/Territory Disability Agreement National Minimum Data Set collection

Data pertaining to the Commonwealth State/Territory Disability Agreement (CSTDA) are collected through the CSTDA NMDS. This NMDS, managed by the AIHW, facilitates the annual collation of nationally comparable data about CSTDA-funded services. Services within the scope of the collection are those for which funding has been provided during the specified period by a government organisation operating under the CSTDA. A funded agency may receive funding from multiple sources. Where a funded agency is unable to differentiate service users according to funding source (that is, CSTDA or other), they are asked to provide details of all service users or to apportion the number of service users against the amount of funding provided (that is, if 50% of funding is from CSTDA then services are asked to report 50% of their service users).

With the exceptions noted below, agencies funded under the CSTDA are asked to provide information about:

- each of the service types they are funded to provide (that is, service type outlets they operate)
- all service users who received support over a specified period
- the CSTDA NMDS service type(s) the service users received.

However, certain service type outlets—such as those providing advocacy or information and referral services—are not requested to provide any service user details, and other service type outlets (such as recreation and holiday programs) are only asked to provide minimal service user details.

The most recent data available for the 2007–08 collection period was released in *Disability support services 2007–08* (AIHW 2009b). For the 2007–08 collection, there was an overall service type outlet response rate of 95%. The user response rate within these outlets cannot be estimated.

The collection includes those disability support service providers that receive funding under the CSTDA, including psychiatric-specific disability service providers, as well as other disability service providers that may be accessed by people with a psychiatric disability. It should be noted that the CSTDA does not apply to the provision of services with a specialist clinical focus. In addition, the collection does not include psychiatric-specific disability support services that are not funded through the CSTDA.

There is some variation between jurisdictions in the services included under the CSTDA as follows:

- In New South Wales, psychiatric-specific disability services are provided by the New South Wales Department of Health and are not included in the CSTDA NMDS collection.
- In Victoria, psychiatric-specific disability services are included in the CSTDA NMDS collection and all service users accessing these services are identified as having a psychiatric disability.
- In Western Australia, only some psychiatric disability services are included in the CSTDA NMDS collection. The health department is the main provider of services for people with a psychiatric disability and these services are not included.
- In South Australia, psychiatric-specific disability services are provided by the South Australian Department of Health and are not included in the CSTDA NMDS collection.
- In Tasmania, the Australian Capital Territory and the Northern Territory, psychiatric-specific disability services are not included in the CSTDA NMDS collection.

In addition, Victoria has changed the way service users with a psychiatric disability were reported between *Mental health services in Australia* publications. Therefore, comparisons between publications should be approached with caution.

Response rates

Service outlet response rates vary across jurisdictions. The response rates estimate the number of service outlets providing patient data. Information on which services provided information for each collection period is not available as part of the CSTDA NMDS. Therefore, there is the possibility that, between collection periods, different outlets, with different proportions of psychiatric disability users, are providing service user information to the CSTDA NMDS. In addition, the number of non-responses for the item 'Primary disability group' also varies considerably between jurisdictions. The service outlet response rates and the non-response rates for states and territories for 2005–06 to 2007–08 are shown in Table A1.4.

Table A1.4: CSTDA response rates, by states and territories, 2005–06 to 2007–08 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust Gov	Total
Service outlet response rates										
2005–06	89	90	99	100	100	100	100	100	100	94
2006–07	89	90	100	100	100	100	100	100	100	94
2007–08	90	93	100	99	99	100	100	99	100	95
'Not stated' and 'not known' response rates for Primary disability group										
2005–06	11.1	41.8	0.8	3.5	1.8	0.6	21.0	27.6	13.9	19.7
2006–07	9.1	23.8	0.9	1.0	1.4	4.5	9.5	26.6	0.7	9.2
2007–08	8.0	23.4	1.4	1.6	3.6	0.3	3.3	16.2	0.0	8.5

Sources: Disability support services (AIHW 2007a, 2008a, 2009b).

Chapters 11 and 14: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

Medicare Australia collects data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) and provides the data to DoHA. Information collected includes the characteristics of the person who is provided with the prescription, the medication prescribed (for example, type and cost), the prescribing practitioner and the supplying pharmacy (for example, location). The figures reported in this publication relate to the number of mental health-related prescriptions processed by Medicare Australia in the reporting period, the number of people provided with the prescriptions and their characteristics, as well as the prescription costs funded by the PBS and RPBS.

Although the PBS and RPBS data capture most the of prescribed medicines dispensed in Australia, these data have the following limitations:

- They refer only to prescriptions scripted by registered medical practitioners who are approved to work within the PBS and RPBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions. They exclude adjustments made against pharmacists' claims, any manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions.
- They exclude non-subsidised medications, such as private and below copayment prescriptions (where the patient copayment covers the total costs of the prescribed medication) and over-the-counter medications.
- The level of the copayment increases annually and drug prices can reduce for a variety of factors (for example, patent changes), which means that some medicines that were captured in previous years might fall below the copayment level and thus be excluded in following years.
- Programs funded by the PBS that do not use the Medicare Australia PBS processing system include
  - most Section 100 drugs funded through public hospitals (although the pharmaceutical reform measures for public hospitals under the Australian Health Care Agreements and the Chemotherapy Pharmaceutical Access Program are paid through Medicare Australia)
  - Aboriginal health services program
  - Opiate Dependence Treatment Program
  - Special Authority Program
  - Botox (including Dysport)
  - in vitro fertilisation
  - human growth hormones.

Only one of these has a significant bearing on the mental health-related prescriptions data published in chapters 11 and 14 of this publication: the Aboriginal health services program. Most affected are the data for *Remote* and *Very remote* areas and the data for the Northern Territory. Consequently, the mental health-related prescriptions data in these chapters will not fully reflect Australian government expenditure on mental health-related medications.

The ATC classification version used is the primary classification as it appears in the PBS Schedule of Pharmaceutical Benefits. This can differ slightly from the WHO version. There are two differences between the WHO ATC classification and the PBS Schedule classification that

have a bearing on mental health data. *Prochlorperazine* is regarded as an *other antiemetic* (A04AD) in the PBS Schedule while it is an *antipsychotic* according to the WHO classification. This means that information on *prochlorperazine* will not appear in the data provided as it is not classed an N code in the PBS Schedule. *Lithium carbonate* on the other hand is classified as an *antidepressant* in the PBS Schedule while it is an *antipsychotic* according to the WHO classification. This means that *lithium carbonate* will appear in the data as an *antidepressant* rather than an *antipsychotic* (Table A1.5).

Table A1.5: Differences between the WHO ATC classification and the PBS Schedule of Pharmaceutical Benefits classification

Drug name	WHO ATC Code	PBS Schedule Code	Scripts dispensed in 2008–09[(a)]
Prochlorperazine	N05AB04	A04AD	616,463
Lithium carbonate	N05AN01	N06AX	102,444

(a) Prescriptions data using date of service basis.

Source: Drug Utilisation Sub-Committee database (DoHA).

To avoid double-counting in the demographic tabulations, patients are allocated to the last category in which they appear. The category most affected by this will be the age group data as the age is calculated at the time of supply, and patients' ages will be 1 year greater for prescriptions supplied after their birthday than before it.

State and territory are determined by DoHA according to the patient's residential address. If the patient's state or territory is unknown, then the state or territory of the pharmacy supplying the item is reported.

Unless otherwise indicated, the year was determined from the date the service was processed by Medicare Australia, rather than the date of prescribing or the date of supply by the pharmacy.

Chapters 12 and 14: National Mental Health Establishments Database

Collection of data for the Mental Health Establishments (MHE) NMDS began on 1 July 2005, replacing the Community Mental Health Establishments NMDS and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the Community Mental Health Establishments NMDS and replicate the data previously collected by the National Survey of Mental Health Services. The Mental Health Establishments Database is compiled as specified by the MHE NMDS.

The scope of the MHE NMDS includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The MHE NMDS data are reported at a number of levels: state, regional, organisational and individual mental health service unit. The data elements at each level in the NMDS collect information appropriate to that level. The state, regional and organisational levels include data elements for revenue, grants to non-government organisations and indirect expenditure.

The organisational level also includes data elements for salary and non-salary expenditure, numbers of full-time-equivalent staff and consumer and carer consultant participation arrangements. The individual mental health service unit level comprises data elements that describe the function of the unit. Where applicable, these include target population, program type, number of beds, number of accrued patient days, number of separations, number of service contacts and episodes of residential care. In addition, the service unit level also includes salary and non-salary expenditure and depreciation.

Data validation

Data presented in this publication are the most current data for all years presented. The validation process rigorously scrutinises the data for consistency in the current collection and across historical data. The validation process applies hundreds of rules to the data to test for potential issues. Jurisdictional representatives respond to each issue before the data are accepted as the most reliable current data collection. This process may highlight issues with historical data. In such cases, historical data may be adjusted to ensure data are more consistent. Therefore, comparisons with previous *Mental health services in Australia* publications should be approached with caution.

New South Wales CADE and T-BASIS services

All New South Wales Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as specialised mental health admitted patient hospital services, termed Transitional Behavioural Assessment and Intervention Service (T-BASIS), from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards, including number of services, number of beds, staffing and expenditure. Comparison of data over time should therefore be approached with caution.

National standards for mental health services review status

There are eight levels used to describe the extent to which a service unit has implemented the national standards (Table A1.6).

Table A1.6: National standards for mental health services review status levels.

Level	Description
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the national standards.
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the national standards.
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known.
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review.
5	The service unit was engaged in self-assessment in relation to the national standards but did not have a contractual arrangement with an external accreditation agency for review.
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future.
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the national standards.
8	The national standards are not applicable to this service unit.

Source: National Standards for Mental Health Services (DHFS 1996).

Chapters 12 and 14: Private Health Establishments Collection

The ABS conducts a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by DoHA. As part of that census, data on the staffing, finances and activity of these establishments are collected and compiled in the Private Health Establishments Collection.

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary*, *Version 13* (HDSC 2006). The ABS defines private psychiatric hospitals as those licensed or approved by a state or territory health authority and which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2008b). This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients.

The most recent data was collected for the 2006–07 period. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2008b).

Chapter 13: Mental health workforce

The AIHW Medical Labour Force Survey and the Nursing and Midwifery Labour Force Survey are conducted by the state and territory departments of health with the cooperation of the medical and nursing registration boards in each jurisdiction, and in consultation with the AIHW. The AIHW is the data custodian for these national collections and is responsible for collating, editing and weighting the survey data.

The Medical Labour Force Survey is a census of all registered medical practitioners in each state and territory in Australia. The Nursing and Midwifery Labour Force Survey is a census of all registered nurses and midwives in each state and territory in Australia. The surveys are mail-outs conducted in association with the annual registration renewal process. The Medical Labour Force Survey has been conducted annually since 1993. The Nursing and Midwifery Labour Force Survey was conducted every 2 years from 1995 to 2003, annually from 2003 to 2005, and again in 2007.

In the surveys, information on demographic details, main areas and specialty of work, qualifications and hours worked is collected from registered professionals. The data collected generally relate to the 4 weeks before the survey for medical practitioners and to the week before the survey for nurses. Average weekly hours worked refers to average total hours worked per week in the main, second and third medical job for medical practitioners, and the main and second nursing jobs for nurses.

Survey responses are weighted by state, age and sex (and the number of registered and enrolled nurses for nursing) to produce state and territory and national estimates of the total medical labour force and nursing and midwifery labour force. Benchmarks for weighting come from registration information provided by state and territory registration boards.

The response rates to these surveys vary from year to year and among jurisdictions. In 2007, the estimated national response rate for the Medical Labour Force Survey was 69.9%, ranging from 27.1% for the Northern Territory to 84.3% for New South Wales. Estimates for the Northern Territory were particularly low and, as a result, no estimates have been published for the Northern Territory. In addition, estimates for the Australian Capital Territory have been suppressed to prevent calculation of Northern Territory estimates from the supplied figures. From 2002 to 2005, the response rate in Western Australia was artificially around

12–19% higher than 2006 due to the survey being administered to both general and conditional registrants; however, benchmark figures were for general registrants only. The scope is consistent in 2006 and 2007, that is, the survey population and the benchmark figures are based on general and conditional registrants. This resulted in a fall in response rates for Western Australia between 2005 and 2006.

For the Nursing and Midwifery Labour Force Survey, the response rate declined from 62.7% in 2003 to 49.6% in 2007. In 2007, response rates in the Northern Territory (28.7%) were particularly low, with low response rates also noticeable in Queensland (33.9%), Western Australia (36.7%) and Victoria (39.9%). As a result, no estimates have been published for the Northern Territory and estimates for states and territories included in this report should be treated with care. The national estimates are based on census results from all jurisdictions, as the effect of any bias in responses from states with low response rates is likely to be relatively small at the national level.

It should also be noted that, for both surveys (although more so for the nursing than for the medical survey), the questionnaire has varied over time and across jurisdictions. Mapping of data items has been undertaken to provide time series data. However, because of this and the variation in response rates, some caution should be used in interpreting changes over time and differences across jurisdictions. This is particularly the case for mental health nurses, as the definition of these is reliant on the responses to one particular question in the questionnaire.

More detailed information about how these surveys were conducted is available from the *Medical labour force 2007* (AIHW 2009e) and *Nursing and midwifery labour force 2007* (AIHW 2009f).

Chapter 14: Australian Government expenditure

Expenditures reported in Table 14.17 have been determined by DoHA. The Department has advised the AIHW that further detail will be reported in future *National mental health reports* and COAG National Action Plan on Mental Health progress reports.

The 2007–08 data in Table 14.17 include the introduction of the Medicare-subsidised Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative described in Section 14.4 and chapters 2 and 6. However, as these new Medicare items were introduced in November 2006, the 2006–07 data do not represent a full financial year for these specific items. The data for this item before November 2006 was estimated to be 6.1% of total MBS benefits paid for GP attendances, based on data and assumptions as detailed in the *National mental health report 2007* (DoHA 2008). To incorporate these changes, GP expenditure reported for 2006–07 was based on total MBS benefits paid against these new items specific to mental health, plus 6.1% of total GP benefits paid in the period preceding the introduction of the new items (July to November 2006). For all future years, expenditure on GP mental health care is fully based on actual benefits paid and not on derived estimates. Comparisons of GP mental health-related expenditure reported in Table 14.17 should be approached with caution.

Expenditure on national programs and initiatives managed by Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), refers to funding outlays on three new initiatives funded by the Australian Government under the COAG Action Plan on Mental Health. These programs are *Personal helpers and mentors*, *More respite care places to help families and carers* and *Community based programmes to help families coping with mental illness*.

Appendix 2: Technical notes

Data presentation

Throughout this publication, data may not sum to the totals shown due to missing and not stated values, as well as rounding. Totals reported include missing and not stated values. The percentages shown in the tables are calculated excluding the missing and not stated figures, unless indicated otherwise. Percentage distributions may not sum to 100 due to rounding.

Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.

Population rates

Crude rates were calculated using the Australian Bureau of Statistics estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2007–08 data were calculated using ERP at 31 December 2007, while rates for 2007 calendar year data were calculated using ERP at 30 June 2007). Rates for 2008–09 data were calculated using preliminary ERP at 31 December 2008.

Crude rates for Indigenous status, country of birth and remoteness area data were calculated using ERP at 30 June of the relevant year.

Age-standardised rates

Rates are adjusted for age to facilitate comparisons between populations that have different age structures, for example, between states and territories. This publication uses direct standardisation in which age-specific rates are multiplied against a standard population (the Australian ERP as at 30 June 2001 unless otherwise specified). This effectively removes the influence of age structure on the calculated rate that is described as the age-standardised rate. The method used for this calculation comprises three steps.

Step 1 Calculate the crude age-specific rate for each 5-year age group.

Step 2 Calculate the expected number of cases in each 5-year age group by multiplying the age-specific rates by the corresponding standard population and dividing by the base number for the rate calculation (for example 100,000), giving the expected number of cases.

Step 3 Sum the expected number of cases in each age group to give the age-standardised total expected number. Divide this sum by the total of the standard population and multiply by applicable base number (100,000 in this example).

In some instances in this publication where the numbers in particular 5-year age groups are very small (less than 5), neighbouring age groups have been combined to enable the calculation of a meaningful crude rate.

Average annual rates of change

Average annual rates of change or growth rates have been calculated as geometric rates:

$$\text{Average rate of change} = ((P_n/P_o)^{1/N} - 1) \times 100$$

where P_n = value in the later time period

P_o = value in the earlier time period

N = number of years between the two time periods.

Confidence intervals

A confidence interval is a range of values that is used to describe the uncertainty around an estimate, usually from a sample survey. Generally speaking, confidence intervals describe how much difference the estimate could have been if the underlying conditions stayed the same but chance had led to a different set of data. Confidence intervals are calculated with a stated probability (commonly 95%); there is a 95% chance that the confidence interval covers the true value.

Indirect expenditure

The National Mental Health Establishments Database collects information on direct and indirect recurrent expenditure. Direct recurrent expenditure comprises salaries and wages and selected non-salary expenditure, and is collected at the individual mental health service unit level.

Indirect recurrent expenditure is additional expenditure associated with the provision of mental health services not incurred or reported at the individual service unit level. Indirect expenditure is reported at three overarching levels above the individual service unit level:

- the organisational level; an organisation may or may not comprise a number of individual service units
- the regional level
- the state/territory level.

Some of these indirect expenditure items can be directly linked to the provision of services by the service units. Specifically, at the organisational and regional levels the expenditure on the following items is directly related to individual mental health service units and thus has been apportioned to units in the organisation or region reporting the indirect funds:

- program administration
- support services
- academic chairs
- superannuation
- workers compensation
- insurance
- patient transport services
- property leasing
- other indirect expenditure.

The apportioning of indirect expenditure is calculated on the total direct funds for the service, as a proportion of the total for all service units in the organisation or region. The total allocation or apportioning of funds is reported in the indirect expenditure rows in Table 14.1.

The remaining indirect expenditure categories of education and training, research, mental health promotion and costs associated with the establishment and operation of Mental Health Act review bodies are not apportioned to mental health service units. State/territory level expenditure is also not apportioned to mental health service units. The total for these residual categories is reported in the row 'Other indirect expenditure' in Table 14.1. Note that grants to non-government organisations are not regarded as indirect expenditure.

Deflators

Expenditure aggregates in this report are expressed in current prices and/or constant prices. The transformation of current prices to constant prices is termed 'deflation', using price indexes or 'deflators'. There are a variety of deflators that can be used to translate current prices into constant prices. The deflators that were used by AIHW for the various items in Chapter 14 are outlined in Table A2.1. For further information on the methodology used to calculate deflators, refer to *Health expenditure Australia 2007–08* (AIHW 2009c).

Table A2.1: Area of health expenditure, by type of deflator applied

Area of expenditure	Table reference	Deflator applied
Public psychiatric hospitals/acute hospitals with a specialised psychiatric unit or ward	14.2, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Government final consumption expenditure (GFCE) hospitals and nursing homes[(a)]
Community mental health care services	14.2, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Professional health workers wage rate index
Residential mental health services	14.2, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Professional health workers wage rate index
Grants to non-government-operated organisations	14.2	Professional health workers wage rate index
Other indirect expenditure	14.2	Government final consumption expenditure (GFCE) hospitals and nursing homes[(a)]
Private psychiatric hospital expenditure	14.10, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Government final consumption expenditure (GFCE) hospitals and nursing homes[(a)]
Medicare expenditure on mental health-related services	14.12, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Medicare fees charged per service by specialists[(b)]
Expenditure on mental health-related medications subsidised under the PBS and RPBS	14.16, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	PBS pharmaceuticals[(b)]
Australian Government expenditure on mental health-related services	14.17	Government final consumption expenditure (GFCE) hospitals and nursing homes[(a)]
Expenditure on specialised mental health services	14.19	Government final consumption expenditure (GFCE) hospitals and nursing homes[(a)]

(a) Australian Bureau of Statistics (unpublished data).

(b) AIHW health expenditure database (AIHW 2009c).

Appendix 3: Classifications used

Health-related classifications have multiple purposes, including the facilitation of data collection and management in the clinical setting, the analysis of data to inform public policy, and the allocation of financial and other resources. This section provides a short description of the classification systems referenced in this report.

Australian Classification of Health Interventions

The Australian Classification of Health Interventions (ACHI) is the Australian national standard for procedure and intervention coding in Australian hospitals.

The National Centre for Classification in Health (NCCH) developed the ACHI based on the Medicare Benefits Schedule (MBS). The MBS is a fee schedule for Medicare services including general practice consultations, specialist consultations, operations and other medical services, such as diagnostic investigations and optometric services. The Department of Health and Ageing (DoHA) updates the MBS at least twice each year and these code changes are incorporated into the ACHI or the MBS codes are mapped to existing ACHI codes.

The ACHI classifies procedures and interventions performed in public and private Australian hospitals, day centres and ambulatory settings, as well as allied health interventions, dentistry and imaging. The structure of the ACHI is anatomically based, rather than based on the surgical specialty.

To maintain parity with disease classification, ACHI chapters resemble the ICD-10 chapters. The ACHI is updated biennially by the NCCH in line with the disease section of the ICD-10-AM. Use of the codes is guided by the *Australian Coding Standards* of the ICD-10-AM.

Further information on the ACHI is available from the NCCH website at <http://nis-web.fhs.usyd.edu.au/ncch_new/2.15.aspx>.

Australian Standard Geographical Classification

The Australian Standard Geographical Classification (ASGC) was developed by the Australian Bureau of Statistics (ABS) for the collection and dissemination of geographically classified statistics. It is an essential reference for understanding and interpreting the geographical context of Australian statistics.

In this report the ASGC applies to the data presented by remoteness area. This is based on the Accessibility/Remoteness Index of Australia, which measures the remoteness of a point based on the physical road distance to the nearest urban centre.

This report uses the ASGC to present data in the following categories:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote.*

For further information on this classification system, refer to *Australian Standard Geographical Classification* (ABS 2007).

Anatomical Therapeutic Chemical Classification System

The Anatomical Therapeutic Chemical (ATC) Classification System, developed by the WHO, assigns therapeutic drugs to different groups according to the organ or system on which they act, as well as their therapeutic and chemical characteristics.

The coding of pharmaceutical products within the Schedule of Pharmaceutical Benefits is based on the ATC Classification System but with some differences as outlined in Appendix 1.

For further information on this classification system, refer to the WHO website at <http://www.whocc.no/atcddd/>.

English Proficiency Country Groups

The English Proficiency Country Groups (EP groups) were developed by the then Bureau of Immigration, Multicultural and Population Research, based on the 1991 Census. It is a classification of countries of birth to enable the analysis and presentation of data on immigrants to Australia. Countries are classified to one of four groups depending on the proportion of immigrants in the 5 years before the Census who spoke good English (the EP index).

The latest published version of the EP groups was based on the 2001 Census (DIMIA 2003). They are:

- EP1—all countries rating 98.5% or higher on the EP index with at least 10,000 residents in Australia
- EP2—countries rating 84.5% or higher on the EP index, other than those in EP1
- EP3—countries rating 57.5% to less than 84.5%
- EP4—countries rating less than 57.5%.

International Classification of Diseases

The International Classification of Diseases (ICD), which was developed by the WHO, is the international standard for coding morbidity and mortality statistics. It was designed to promote international comparability in the collection, processing, classification and presentation of these statistics. The ICD is periodically reviewed to reflect changes in clinical and research settings (WHO 2009a).

Although the ICD is primarily designed for the classification of diseases and injuries with a formal diagnosis, it also classifies a wide variety of signs, symptoms, abnormal findings, complaints and social circumstances that may stand in place of a diagnosis.

Further information on the ICD is available from the WHO website at <http://www.who.int/classifications/icd/en/>.

International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification

The *International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification* (ICD-9-CM) is based on the ninth revision of the ICD (NCC 1996). The ICD-9-CM was the official system of assigning codes to diagnoses and procedures associated with hospital use in Australia before it was superseded by the ICD-10-AM.

International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification

The Australian Modification of ICD-10 (called ICD-10-AM) is used to classify diagnoses in the health sector in Australia. It is used in public and private hospitals, and in community and residential mental health care services. The ICD-10-AM was developed in Australia by the NCCH with the purpose of making ICD-10 more relevant to Australian clinical practice (NCCH 2006).

International Classification of Primary Care, 2nd edition, and ICPC-2 PLUS

The *International Classification of Primary Care, 2nd edition* (ICPC-2) is a classification method for primary care (that is, general practice) encounters; this method has been adopted by the WHO. It allows for the classification of three elements of a health care encounter in relation to the patient: reasons for encounter; diagnoses or problems; and process of care.

The ICPC-2 PLUS (which is also known as the BEACH coding system) is an extended vocabulary of terms classified according to the ICPC-2, which enables greater specificity in coding. The ICPC-2 PLUS is primarily used in the context of Australian general practice.

The ICPC-2 is currently being used in electronic health records in the clinical general practice as well as in the research of general practice (that is, the BEACH project) and other statistical collections such as the ABS National Health Survey.

Further information on ICPC-2 is available from the WHO website at <http://www.who.int/classifications/icd/adaptations/icpc2/en/> and information on ICPC-2 PLUS is available from the BEACH website: <http://www.fmrc.org.au/icpc2plus/>.

Appendix 4: Codes used to define mental health-related general practice encounters and mental health-related hospital separations

This appendix provides a list of codes used to define 'mental health-related' general practice encounters from the Bettering the Evaluation and Care of Health (BEACH) database (as used in Chapter 2) and 'mental health-related' hospital separations from the National Hospital Morbidity Database (as used in chapters 5 and 7).

BEACH survey of general practice activity data

For the purpose of this report, 'mental health-related' general practice encounters are defined as those encounters where a mental health-related problem was managed. Mental health-related problems are those that are classified in the psychological chapter (that is, the 'P' chapter) of the *International Classification of Primary Care, 2nd edition* (ICPC-2). In the great majority of cases the codes appearing in the diagnosis or problem fields of the BEACH survey form are those listed in this appendix under the 'Problems managed' heading. Occasionally a code more relevant to treatments or referrals has appeared. These cases (accounting for 2.6% of all mental health-related problems managed in BEACH in 2008–09) are still counted as 'mental health-related' general practice encounters for the purpose of the report, in particular the estimates in Table 2.1.

For treatments and referrals, codes that are classified in the psychological chapter of the ICPC-2 PLUS have been used as these enable greater specificity in coding.

For medications, Anatomical Therapeutic Chemical (ATC) classification codes (WHO 2009b) have been used, where the medication falls into one of four groups.

Table A4.1 presents a list of the ICPC-2, ICPC-2 PLUS and ATC codes classed as 'psychological' for problems managed, treatments, referrals and medications.

Table A4.1: ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2008–09

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Problems managed			
P01			Feeling anxious/nervous/tense
P02			Acute stress reaction
P03			Feeling depressed
P04			Feeling/behaving irritable/angry
P05			Senility, feeling/behaving old
P06			Sleep disturbance
P07			Sexual desire reduced
P08			Sexual fulfilment reduced
P09			Concern about sexual preference
P10			Stammering, stuttering, tics
P11			Eating problems in children
P12			Bed-wetting, enuresis
P13			Encopresis/bowel training problem
P15			Chronic alcohol abuse
P16			Acute alcohol abuse
P17			Tobacco abuse
P18			Medication abuse
P19			Drug abuse
P20			Memory disturbance
P22			Child behaviour symptom/complaint
P23			Adolescent behaviour symptom/complaint
P24			Specific learning problem
P25			Phase of life problem in adult
P27			Fear of mental disorder
P28			Limited function/disability psychological
P29			Psychological symptom/complaint, other
P70			Dementia (including senile, Alzheimer's)
P71			Organic psychoses, other
P72			Schizophrenia
P73			Affective psychoses
P74			Anxiety disorder/anxiety state
P75			Somatisation disorder
P76			Depressive disorder
P77			Suicide/suicide attempt
P78			Neurasthenia
P79			Phobia, compulsive disorder

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2008–09

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Problems managed (continued)			
P80			Personality disorder
P81			Hyperkinetic disorder
P82			Post-traumatic stress disorder
P85			Mental retardation
P86			Anorexia nervosa, bulimia
P98			Psychoses not otherwise specified/other
P99			Psychological disorders, other
Treatments, including counselling			
Check-ups			
	P30001		Exploration; psychological; complete
	P30002		Check up; complete; psychological
	P30003		Exam; complete; psychological
	P31001		Exploration; psychological; partial
	P31002		Check up; partial; psychological
	P31003		Exam; partial; psychological
	P31004		Exam; mental state
	P31005		Monitoring; drug rehab
Tests and investigations			
	P34001		Test; blood; psychological
	P34002		Test; lithium
	P34003		Test; methadone
	P35001		Test; urine; psychological
	P38001		Test; other lab; psychological
	P39001		Test; physical function; psychological
	P41001		Radiology; diagnostic; psychological
	P43001		Test; psychological
	P43003		Procedures; diagnostic; psychological
	P43004		Exam; mini mental state
Advice/counselling			
	P45001		Advice/education; psychological
	P45002		Observe/wait; psychological
	P45004		Advice/education; smoking
	P45005		Advice/education; alcohol
	P45006		Advice/education; illicit drugs
	P45007		Advice/education; relaxation
	P45008		Advice/education; lifestyle
	P45009		Advice/education; sexuality
	P45010		Advice/education; life stage

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2008–09

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Treatments, including counselling (continued)			
	P45013		Anger management
	P58001		Counselling; psychiatric
	P58002		Psychotherapy
	P58004		Counselling; psychological
	P58005		Counselling; sexual; psychological
	P58006		Counselling; individual; psychological
	P58007		Counselling; bereavement
	P58008		Counselling; smoking
	P58009		Counselling; alcohol
	P58010		Counselling; drug abuse
	P58011		Counselling; relaxation
	P58012		Counselling; life style
	P58013		Counselling; anger
	P58014		Counselling; self-esteem
	P58015		Counselling; assertiveness
	P58016		Counselling; life stage
	P58017		Counselling; stress management
	P58018		Therapy; group
	P58019		Cognitive behavioural therapy
	P58020		Rehabilitation; drug
	P58021		Rehabilitation; alcohol
	P58022		Counselling; body image
Therapeutic procedures			
	P59001		Therapeutic procedure; psychological
	P59002		Therapy; electroconvulsive
	P59003		Hypnosis/hypnotherapy
	P59005		Therapy; relaxation
Other management			
	P42001		Electrical tracings; psychological
	P46001		Consultation; other general practitioner/allied health professional; psychological
	P46002		Consultation; primary care provider; psychological
	P46003		Consultation; psychiatrist
	P46004		Consultation; mental health worker
	P47003		Consultation; psychiatrist
	P48002		Discuss; patient reason for encounter; psychological

(continued)

Table A4.1 (continued): ICPC-2, ICPC-2 PLUS and ATC codes classified as psychological for problems managed, treatments, referrals and medications in the BEACH database, 2008–09

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Treatments, including counselling (continued)			
	P49001		Preventive; procedure; psychological
	P49002		Exchange; needle/syringe
	P49003		Mental health plan
	P50001		Medications; psychological
	P50002		Medication; request; psychological
	P50003		Medication; renew; psychological
	P50004		Prescription; psychological
	P50006		Injection; psychological
	P60001		Test; result(s); psychological
	P60002		Results; procedures; psychological
	P62001		Administrative; psychological
	P63001		Encounter; follow-up; psychological
	P64002		Encounter; provider initiated; psychological
	P69001		Encounter; other; psychological
	P69002		Assist at operation; psychological
Referrals			
	P66003		Referral; psychologist
	P66004		Referral; counsellor
	P66005		Referral; mental health team
	P66006		Referral; drug & alcohol
	P66007		Referral; hypnotherapy
	P67002		Referral; psychiatrist
	P67004		Referral; clinic; psychiatrist
	P67005		Referral; hospital; psychiatrist
	P67006		Referral; sleep clinic
	P68003		Referral; needle/syringe exchange
Medications			
		N05A	Antipsychotics
		N05B	Anxiolytics
		N05C	Hypnotics and sedatives
		N06A	Antidepressants

ICPC-2 *International Classification of Primary Care, 2nd edition*

National Hospital Morbidity Database data

Data from the National Hospital Morbidity Database (NHMD) is the source for chapters 5 and 7 of this publication. The definition of the scope of each chapter is provided in the chapter's introduction. Key elements of these definitions depend on the ICD-10-AM diagnosis codes and the Australian Classification of Health Interventions (ACHI) procedure codes. The codes in-scope are listed below.

During the preparation of *Mental health services in Australia 1999–00* (AIHW 2002), attention was given to ensuring that, for data on hospital separations from the NHMD, the definition of a 'mental health-related diagnosis' included all codes that were either clinically or statistically relevant to mental health. This definition was revised for *Mental health services in Australia 2000–01* (AIHW 2003) to increase the accuracy of the data. More specifically, for the analyses of the 2000–01 National Hospital Morbidity data, a diagnosis was considered clinically relevant to mental health if:

- it was included as a principal diagnosis defining Australian Refined Diagnosis Related Group Version 4.2 Major Diagnostic Categories 19 (*Mental diseases and disorders)* and 20 (*Alcohol/drug use and alcohol/drug induced organic mental disorders*), or
- it appeared to be specific for a mental health-related condition based on expert advice.

A diagnosis was defined as being statistically relevant to mental health if:

- during 2000–01 there were more than 20 separations with specialised psychiatric care for that principal diagnosis at the 3-character level of ICD-10-AM or more than 10 at the 4-character level, or
- over 50% of separations with that principal diagnosis included specialised psychiatric care.

This method was developed in consultation with the National Mental Health Working Group Information Strategy Committee (now called the Mental Health Information Strategy Subcommittee) and the Clinical Casemix Committee of Australia.

Certain codes were statistically relevant during 1999–00 but not in 2000–01; these were examined and included if over 50% of total separations over the 2 years included specialised psychiatric care.

For this edition of *Mental health services in Australia*, the same codes used for the analysis of the 2000–01 data have been used to define 'mental health-related' hospital separations in chapters 5 and 7. However, updates have been made to incorporate changes in codes that have occurred as new editions of ICD-10-AM have been released.

The full list of codes used to define mental health-related hospital separations is shown in Table A4.2.

Table A4.2: ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM code	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F00	Dementia in Alzheimer's disease				✓
F01	Vascular dementia				✓
F02	Dementia in other diseases classified elsewhere			✓	
F03	Unspecified dementia				✓
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances				✓
F05	Delirium, not induced by alcohol and other psychoactive substances				✓
F06	Other mental disorders due to brain damage and dysfunction and to physical disease			✓	✓
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction			✓	✓
F09	Unspecified organic or symptomatic mental disorder			✓	
F10	Mental and behavioural disorders due to use of alcohol		✓		
F11	Mental and behavioural disorders due to use of opioids		✓		
F12	Mental and behavioural disorders due to use of cannabinoids		✓	✓	
F13	Mental and behavioural disorders due to use of sedatives or hypnotics		✓		
F14	Mental and behavioural disorders due to use of cocaine		✓		
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine		✓	✓	
F16	Mental and behavioural disorders due to use of hallucinogens		✓		
F17	Mental and behavioural disorders due to use of tobacco		✓		
F18	Mental and behavioural disorders due to use of volatile solvents		✓		
F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances		✓	✓	
F20	Schizophrenia	✓		✓	
F21	Schizotypal disorder	✓		✓	
F22	Persistent delusional disorders	✓		✓	
F23	Acute and transient psychotic disorders	✓		✓	
F24	Induced delusional disorder	✓		✓	
F25	Schizoaffective disorders	✓		✓	
F28	Other non-organic psychotic disorders	✓		✓	
F29	Unspecified non-organic psychosis	✓		✓	
F30	Manic episode	✓		✓	
F31	Bipolar affective disorder	✓		✓	

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM code	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F32	Depressive episode	✓		✓	
F33	Recurrent depressive disorder	✓		✓	
F34	Persistent mood (affective) disorders	✓		✓	
F38	Other mood (affective) disorders	✓		✓	
F39	Unspecified mood (affective) disorder	✓		✓	
F40	Phobic anxiety disorders	✓		✓	
F41	Other anxiety disorders	✓			
F42	Obsessive–compulsive disorder	✓		✓	
F43	Reaction to severe stress, and adjustment disorders	✓		✓	
F44	Dissociative (conversion) disorders	✓			
F45	Somatoform disorders	✓			
F48	Other neurotic disorders	✓			
F50	Eating disorders	✓		✓	
F51	Non-organic sleep disorders	✓			
F52[(a)]	Sexual dysfunction, not caused by organic disorder or disease	✓		✓	✓
F53	Mental and behavioural disorders associated with the puerperium, not elsewhere classified				✓
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere	✓			
F55	Harmful use of non-dependence-producing substances		✓		✓
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors	✓			
F60	Specific personality disorders	✓		✓	
F61	Mixed and other personality disorders	✓		✓	
F62	Enduring personality changes, not attributable to brain damage and disease	✓		✓	
F63	Habit and impulse disorders	✓		✓	
F64	Gender identity disorders	✓			
F65	Disorders of sexual preference	✓		✓	
F66	Psychological and behavioural disorders associated with sexual development and orientation	✓		✓	
F68	Other disorders of adult personality and behaviour	✓		✓	
F69	Unspecified disorder of adult personality and behaviour	✓			
F70	Mild mental retardation			✓	
F71	Moderate mental retardation				✓

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM code	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F72	Severe mental retardation				✓
F73	Profound mental retardation				✓
F78	Other mental retardation				✓
F79	Unspecified mental retardation			✓	
F80	Specific developmental disorders of speech and language	✓			
F81	Specific developmental disorders of scholastic skills	✓			
F82	Specific developmental disorder of motor function	✓			
F83	Mixed specific developmental disorders	✓			
F84[(b)]	Pervasive developmental disorders	✓		✓	
F88	Other disorders of psychological development	✓			
F89	Unspecified disorder of psychological development	✓			
F90	Hyperkinetic disorders	✓		✓	
F91	Conduct disorders	✓		✓	
F92	Mixed disorders of conduct and emotions	✓		✓	
F93	Emotional disorders with onset specific to childhood	✓		✓	
F94	Disorders of social functioning with onset specific to childhood and adolescence	✓			
F95	Tic disorders	✓		✓	
F98[(c)]	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence	✓		✓	
F99	Mental disorder, not otherwise specified	✓			
G30.0	Alzheimer's disease with early onset			✓	
G30.1	Alzheimer's disease with late onset			✓	
G30.8	Other Alzheimer's disease				✓
G30.9	Alzheimer's disease, unspecified				✓
G47.0	Disorders initiating and maintaining sleep	✓			
G47.1	Disorders excessive somnolence	✓			
G47.2	Disorders of the sleep–wake schedule	✓			
G47.8	Other sleep disorders	✓			
G47.9	Sleep disorder, unspecified	✓			
O99.3	Mental disorder nervous system pregnancy and birth				✓
R44.0	Auditory hallucinations	✓			
R44.1	Visual hallucinations				✓
R44.2	Other hallucination	✓			

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM code	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
R44.3	Hallucinations, unspecified	✓			
R44.8	Other/not otherwise specified symptom involving general sensation perception	✓			
R45.0	Nervousness	✓			
R45.1	Restlessness and agitation	✓			
R45.4	Irritability and anger	✓			
R48.0	Dyslexia and alexia	✓			
R48.1	Agnosia	✓			
R48.2	Apraxia	✓			
R48.8	Other and unspecified symbolic dysfunctions	✓			
Z00.4	General psychiatric examination, not elsewhere classified			✓	
Z03.2	Observation for suspected mental and behavioural disorder	✓		✓	
Z04.6	General psychiatric examination, requested by authority			✓	
Z09.3	Follow-up examination after psychotherapy				✓
Z13.3	Special screening examination for mental and behavioural disorders				✓
Z50.2	Alcohol rehabilitation				✓
Z50.3	Drug rehabilitation				✓
Z54.3	Convalescence following psychotherapy				✓
Z61.9	Negative life event in childhood, unspecified			✓	
Z63.1	Problems relationship w parents & in-laws			✓	
Z63.8	Other spec problems related to prim support group			✓	
Z63.9	Problem related to primary support group, unspecified			✓	
Z65.8	Other specified problems related to psychosocial circumstances			✓	
Z65.9	Problem related to unspecified psychosocial circumstances				✓
Z71.4	Counselling and surveillance for alcohol use disorder				✓
Z71.5	Counselling and surveillance for drug use disorder				✓
Z76.0	Issue of repeat prescription			✓	

(a) Excluding F52.5.

(b) Excluding F84.2.

(c) Excluding F98.5 and F98.6.

Procedures component of the definition of ambulatory-equivalent mental health-related separations

The full list of ACHI codes as part of the definition of ambulatory-equivalent mental health-related hospital separations, set out in the Key concepts of Chapter 5, is shown in Table A4.3. If there is no procedure recorded, or only procedure(s) in this list, and other criteria as outlined in Chapter 5 are met, then the separation will be categorised as ambulatory-equivalent.

Table A4.3: ACHI codes used as part of the definition of ambulatory-equivalent mental health-related hospital separations

Block code	Procedure code	Block or procedure label
1822	All	Assessment of personal care and other activities of daily/independent living
1823	All	Mental, behavioural or psychosocial assessment
1867	All	Counselling or education relating to personal care and other activities of daily/independent living
1868	All	Psychosocial counselling
1869	All	Other counselling or education
1872	All	Alcohol and drug rehabilitation and detoxification
1873	All	Psychological/psychosocial therapies
1875	All	Skills training in relation to learning, knowledge and cognition
1878	All	Skills training for personal care and other activities of daily/independent living
1916	95550-01	Allied health intervention, social work
1916	95550-02	Allied health intervention, occupational therapy
1916	95550-10	Allied health intervention, psychology

Appendix 5: National Healthcare Agreement performance indicators—mental health-related

This appendix presents the data for the four mental health-related National Healthcare Agreement performance indicators AIHW provided for the COAG Reform Council's *National Healthcare Agreement: Baseline performance report for 2008–09* (CRC 2010). Further detail of these indicators are included in Chapter 1 and in the CRC report.

Age-standardised rates in Appendix 5 were calculated using the Australian Bureau of Statistics estimated resident population (ERP) at 30 June of the relevant year (for example, rates for 2007–08 data were calculated using ERP at 30 June 2007, while rates for 2008–09 data were calculated using preliminary ERP at 30 June 2008.

NHA performance indicator 21—Treatment rate for mental illness

Table A5.1: Proportion of people receiving clinical mental health services by service type, states and territories, 2007–08

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
						Age-standardised rates[a]				
Public[b]										
Number	no.	108,755	57,197	75,541	37,566	27,793	11,651	6,801	4,721	330,025
Rate	%	1.6	1.1	1.8	1.8	1.8	2.4	2.0	2.1	1.6
Private[c]										
Number	no.	7,286	6,144	4,919	n.p.	n.p.	n.p.	n.p.	. .	23,180
Rate	%	0.1	0.1	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1
MBS										
Number	no.	343,242	284,343	182,247	85,877	73,223	20,305	13,793	3,955	1,006,985
Rate—Total MBS[d]	%	5.0	5.4	4.3	4.0	4.7	4.3	3.9	1.8	4.8
Rate—Psychiatrist[e]	%	1.3	1.4	1.2	1.0	1.5	0.9	1.0	0.4	1.3
Rate—Clinical psychologist[f]	%	0.6	0.6	0.4	1.0	0.7	0.9	0.6	0.1	0.6
Rate—GP[g]	%	3.7	3.9	3.1	3.0	3.2	3.2	2.8	1.4	3.5
Rate—Other allied health[h]	%	1.3	1.8	1.4	0.6	0.9	1.1	1.2	0.4	1.3

. . Not applicable.

n.p. Not published.

(a) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(b) South Australia and Tasmania submitted data that was not based on unique patient identifier or data matching approaches. Therefore caution needs to be taken when making interjurisdictional comparisons.

(c) Private psychiatric hospital figures are not published for Western Australia, South Australia, Tasmania, and the Australian Capital Territory due to confidentiality reasons but are included in the Australia figures.

(d) MBS services are those provided under any of the Medicare-funded service types described at (e) to (h). Persons seen by more than one provider type are counted only once in the total.

(e) Psychiatrist services—MBS items 134, 136, 138, 140, 142, 289, 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224.

(f) Clinical psychologist services—MBS items 80000, 80005, 80010, 80015, 80020.

(g) GP services—MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2721, 2723, 2725, 2727.

(h) Other allied health services—MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 82000, 82015.

Sources: State and territory community mental health care data (unpublished), Private Mental health Alliance Centralised Data Management System, MBS data (DoHA).

Table A5.2: Proportion of people receiving clinical mental health services by service type and Indigenous status[a], states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
	Age-standardised rates[b] (per cent)									
Public[c]										
Indigenous	4.5	3.1	3.9	3.5	5.0	1.6	5.1	2.9	3.8	19,213
Other Australians[d]	1.5	1.1	1.7	1.7	1.7	2.4	1.9	1.9	1.5	310,812
Private[e]										
Indigenous	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	. .	n.a.	n.a.
Other Australians	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	. .	n.a.	n.a.
MBS										
Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Other Australians	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.

. . Not applicable.

n.a. Not available.

n.p. Not published.

(a) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions.

(b) Rates are age-standardised using 5-year age groups to 64 years.

(c) South Australia and Tasmania submitted data that was not based on unique patient identifier or data matching approaches. Therefore caution needs to be taken when making interjurisdictional comparisons.

(d) Includes contacts where Indigenous status was missing or not reported.

(e) Indigenous information is not collected for private psychiatric hospitals.

Sources: State and territory community mental health care data (unpublished), Private Mental health Alliance Centralised Data Management System, MBS data (DoHA).

Table A5.3: Proportion of people receiving clinical mental health services by service type and remoteness area[a], states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-standardised rates[b] (per cent)					
Public[c]										
Major cities	1.2	0.9	1.4	1.3	1.6	. .	3.7	. .	1.1	160,965
Inner regional	2.6	1.6	2.5	3.8	1.7	1.5	n.p.	. .	2.8	109,719
Outer regional	3.4	1.8	2.1	2.1	2.6	2.4	. .	2.0	2.4	46,230
Remote	4.3	1.1	1.8	0.9	1.9	4.0	. .	2.2	1.9	5,891
Very remote	12.5	. .	3.8	5.3	2.1	0.0	. .	2.1	3.7	6,292
Private[d]										
Major cities	0.1	0.1	0.2	n.p.	n.p.	. .	n.p.	. .	0.1	19,596
Inner regional	0.1	0.0	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1	2,887
Outer regional	0.0	0.0	0.0	n.p.	n.p.	n.p.	. .	. .	0.0	558
Remote	0.0	0.0	0.0	n.p.	n.p.	n.p.	. .	. .	0.0	62
Very remote	0.0	. .	0.0	n.p.	n.p.	n.p.	. .	. .	0.0	29
MBS										
Major cities	5.2	5.7	4.9	4.5	5.1	. .	3.9	. .	5.1	751,449
Inner regional	4.9	5.1	4.2	3.6	4.4	4.8	4.2	. .	4.7	186,849
Outer regional	3.6	3.5	2.8	3.4	3.1	3.4	. .	2.4	3.1	60,869
Remote	2.4	4.6	1.7	1.4	2.4	2.1	. .	0.9	1.7	5,460
Very remote	2.4	. .	1.1	0.7	2.6	5.4	. .	1.2	1.2	2,000

. . Not applicable.

n.p. Not published.

(a) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. Not all remoteness areas are represented in each state or territory.

(b) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(c) South Australia and Tasmania submitted data that was not based on unique patient identifier or data matching approaches. Therefore caution needs to be taken when making interjurisdictional comparisons.

(d) Private psychiatric hospital figures are not published for Western Australia, South Australia, Tasmania, and the Australian Capital Territory due to confidentiality reasons but are included in the Australia figures.

Sources: State and territory community mental health care data (unpublished), Private Mental health Alliance Centralised Data Management System, MBS data (DoHA).

Table A5.4: Proportion of people receiving clinical mental health services by service type and SEIFA quintile[a], states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
	Age-standardised rates[b] (per cent)									
Public[c]										
1 (most disadvantaged)	1.7	1.4	3.2	2.7	2.7	2.3	n.p.	1.7	2.1	56,989
2	2.0	1.5	2.0	2.3	2.0	2.1	6.2	4.1	1.9	83,827
3	1.6	1.3	1.9	1.9	1.4	1.5	3.8	4.6	1.7	71,441
4	1.3	0.9	1.5	1.5	1.2	0.9	2.4	1.4	1.3	61,485
5 (least disadvantaged)	1.3	0.7	1.0	1.4	0.8	. .	1.6	0.1	1.1	48,736
Private[d]										
1 (most disadvantaged)	0.1	0.2	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1	2,757
2	0.1	0.0	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.0	2,263
3	0.1	0.1	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1	3,453
4	0.1	0.1	0.2	n.p.	n.p.	n.p.	n.p.	. .	0.1	5,493
5 (least disadvantaged)	0.2	0.2	0.2	n.p.	n.p.	. .	n.p.	. .	0.2	9,161
MBS										
1 (most disadvantaged)	4.1	4.9	3.9	1.8	4.5	4.1	4.0	0.8	4.1	109,830
2	5.1	5.0	4.2	4.0	4.4	3.5	4.2	1.2	4.7	208,693
3	5.0	5.0	4.1	3.8	4.1	4.7	3.9	1.5	4.5	195,282
4	5.1	5.4	4.5	3.8	4.9	5.2	4.1	1.7	4.8	237,627
5 (least disadvantaged)	5.3	6.2	4.8	4.6	5.3	. .	3.8	1.4	5.3	245,032

. . Not applicable.

n.p. Not published.

(a) SEIFA quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Disaggregation by SEIFA area is based on a person's usual residence, not the location of the service provider. SEIFA quintiles have an equal number of SLAs nationally, but do not necessarily have the same population size nationally or within any state or territory.

(b) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(c) South Australia and Tasmania submitted data that was not based on unique patient identifier or data matching approaches. Therefore caution needs to be taken when making interjurisdictional comparisons.

(d) Private psychiatric hospital figures are not published for Western Australia, South Australia, Tasmania, and the Australian Capital Territory due to confidentiality reasons but are included in the Australia figures.

Sources: State and territory community mental health care data (unpublished), Private Mental health Alliance Centralised Data Management System, MBS data (DoHA).

Table A5.5: Proportion of people receiving clinical mental health services by service type and age, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-specific rates					
Public[(a)]										
Less than 15 years	0.8	0.5	1.4	0.9	1.7	1.4	0.6	1.1	0.9	38,129
15–24 years	2.1	1.3	2.6	2.1	2.2	2.6	2.9	3.1	2.0	60,538
25–34 years	2.2	1.4	2.5	2.5	2.4	2.3	2.6	3.2	2.1	62,883
35–44 years	2.2	1.4	2.2	2.3	2.2	2.2	2.6	2.9	2.0	61,915
45–54 years	1.6	1.1	1.6	1.6	1.7	1.6	1.9	2.0	1.5	43,400
55–64 years	1.1	0.9	1.1	1.3	1.1	1.1	1.3	1.2	1.1	25,141
65 year and over	1.1	1.3	1.3	1.9	0.9	1.7	2.0	1.4	1.3	35,201
All ages[(b)]	**1.6**	**1.1**	**1.8**	**1.8**	**1.8**	**2.4**	**2.0**	**2.2**	**1.6**	**330,025**
Private[(c)]										
Less than 15 years	0	0	0	0	0	0	0	. .	0.0	0
15–24 years	0.1	0.1	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1	2,138
25–34 years	0.1	0.1	0.1	n.p.	n.p.	n.p.	n.p.	. .	0.1	3,510
35–44 years	0.2	0.2	0.2	n.p.	n.p.	n.p.	n.p.	. .	0.2	4,775
45–54 years	0.2	0.2	0.2	n.p.	n.p.	n.p.	n.p.	. .	0.2	4,697
55–64 years	0.2	0.2	0.3	n.p.	n.p.	n.p.	n.p.	. .	0.2	4,481
65 years and over	0.1	0.2	0.2	n.p.	n.p.	n.p.	n.p.	. .	0.1	3,459
All ages[(b)]	**0.1**	**0.1**	**0.1**	**n.p.**	**n.p.**	**n.p.**	**n.p.**	**. .**	**0.1**	**23,180**
MBS										
Less than 15 years	1.4	1.6	1.3	1.2	1.5	1.0	1.0	0.3	1.4	57,980
15–24 years	4.7	5.1	4.3	4.5	4.8	5.1	4.2	1.7	4.7	138,752
25–34 years	6.7	7.7	6.0	6.2	6.7	6.9	5.7	2.7	6.7	196,376
35–44 years	7.6	8.3	6.6	6.0	6.8	6.5	6.2	2.9	7.3	224,548
45–54 years	6.9	7.4	5.9	5.1	6.3	5.4	5.0	2.6	6.5	189,319
55–64 years	5.7	6.0	4.8	4.0	5.1	4.1	3.9	2.1	5.3	122,754
65 years and over	3.1	3.1	2.5	2.1	2.4	1.7	2.4	1.1	2.8	77,255
All ages[(b)]	**5.0**	**5.4**	**4.3**	**4.1**	**4.6**	**4.1**	**4.0**	**1.8**	**4.8**	**1,006,985**

. . Not applicable.

n.p. Not published.

(a) South Australia and Tasmania submitted data that was not based on unique patient identifier or data matching approaches. Therefore caution needs to be taken when making interjurisdictional comparisons.

(b) Includes contacts where Age was missing or not reported.

(c) Private psychiatric hospital figures are not published for Western Australia, South Australia, Tasmania, and the Australian Capital Territory due to confidentiality reasons but are included in the Australia figures.

Sources: State and territory community mental health care data (unpublished), Private Mental health Alliance Centralised Data Management System, MBS data (DoHA).

NHA performance indicator 28—Public sector community mental health services

Table A5.6: Rate (per 1,000 population) of community mental health service contacts provided by public sector community mental health services by demographics, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-standardised rates[a]					
Sex										
Males	355	351	301	245	306	267	563	179	328	3,407,402
Females	227	310	258	273	253	294	627	143	268	2,841,436
Indigenous status[b]										
Indigenous	1,231	943	679	412	729	194	1,077	172	737	362,429
Other Australians[c]	284	327	266	256	287	305	593	157	294	6,011,838
Remoteness of residence[d]										
Major cities	252	304	277	278	308	. .	577	. .	286	4,164,097
Inner regional	380	415	301	223	160	307	n.p.	. .	344	1,340,584
Outer regional	341	425	255	213	198	229	. .	175	274	520,190
Remote	446	400	224	231	164	227	. .	194	233	72,893
Very remote	848	. .	366	145	117	219	. .	85	210	35,317
SEIFA of residence[e]										
1 (most disadvantaged)	299	453	381	284	365	282	n.p.	134	351	1,431,701
2	362	377	304	283	312	220	946	169	342	1,393,252
3	285	370	290	271	222	266	946	300	304	1,290,545
4	227	274	250	245	214	315	711	140	258	1,068,000
5 (least disadvantaged)	220	229	171	236	147	. .	498	59	227	971,510
Total[f]	**304**	**331**	**280**	**262**	**295**	**300**	**598**	**161**	**304**	**6,374,267**

(continued)

Table A5.6 (continued): Rate (per 1,000 population) of community mental health service contacts provided by public sector community mental health services by demographics, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Number of contacts					
Total[(f)]	**2,072,440**	**1,736,456**	**1,162,557**	**554,558**	**456,942**	**147,701**	**207,467**	**36,146**	**6,374,267**	**. .**

. . Not applicable.

n.p. Not published.

(a) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(b) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Rates are age-standardised using 5-year age groups to 64 years.

(c) Includes contacts where Indigenous status was missing or not reported.

(d) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. Not all remoteness areas are represented in each state or territory.

(e) SEIFA quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Disaggregation by SEIFA area is based on a person's usual residence, not the location of the service provider. SEIFA quintiles represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory.

(f) Includes contacts where sex, Indigenous status, SLA or postcode of residence was missing or not reported.

Source: National Community Mental Health Care Database.

Table A5.7: Rate (per 1,000 population) of community mental health service contacts provided by public sector community mental health services by sex and age, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-specific rates					
Males										
Less than 15 years	80	107	175	135	200	190	256	62	126	263,238
15–24 years	380	363	356	230	270	223	870	185	351	531,687
25–34 years	734	636	527	378	556	405	1,008	384	614	903,409
35–44 years	590	515	419	318	457	306	685	276	491	753,677
45–54 years	390	358	285	251	341	307	466	159	340	490,227
55–64 years	221	243	179	216	170	161	240	87	211	245,561
65 years and over	108	261	150	210	110	255	365	94	171	214,019
All ages[(a)]	**351**	**350**	**298**	**244**	**298**	**257**	**584**	**186**	**325**	**3,407,402**
Females										
Less than 15 years	56	77	128	84	117	166	332	31	90	178,317
15–24 years	285	405	344	320	264	347	1,109	186	344	495,958
25–34 years	337	383	351	323	335	302	643	229	354	516,530
35–44 years	345	402	342	358	388	329	652	220	367	571,065
45–54 years	278	355	277	325	299	309	525	181	307	450,799
55–64 years	185	273	191	266	218	200	353	118	221	258,187
65 years and over	144	360	189	322	177	487	742	75	242	366,733
All ages[(a)]	**225**	**315**	**256**	**276**	**249**	**304**	**628**	**150**	**268**	**2,841,436**

(continued)

Table A5.7 (continued): Rate (per 1,000 population) of community mental health service contacts provided by public sector community mental health services by sex and age, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-specific rates					
Persons[(b)]										
Less than 15 years	68	93	152	111	159	178	293	47	108	441,670
15–24 years	334	383	350	274	267	284	987	186	348	1,027,961
25–34 years	535	510	439	351	447	352	828	308	485	1,420,455
35–44 years	468	458	380	338	422	318	669	249	429	1,325,737
45–54 years	333	357	281	288	320	308	497	170	323	941,210
55–64 years	203	258	185	241	194	180	298	101	216	503,865
65 years and over	128	316	171	270	147	382	573	85	210	580,857
All ages[(a)]	**300**	**333**	**277**	**262**	**288**	**299**	**608**	**168**	**302**	**6,374,267**
					Number of contacts					
Males[(a)]	1,200,743	906,012	625,063	260,826	232,893	62,527	98,692	20,646	3,407,402	. .
Females[(a)]	785,095	830,400	537,415	288,596	200,195	76,035	108,200	15,500	2,841,436	. .
Total[(b)]	**2,072,440**	**1,736,456**	**1,162,557**	**554,558**	**456,942**	**147,701**	**207,467**	**36,146**	**6,374,267**	**. .**

(a) Includes contacts where age was missing or not reported.

(b) Includes contacts where sex was missing or not reported.

Source: National Community Mental Health Care Database.

NHA performance indicator 29—Private sector mental health services

For this indicator, ambulatory mental health services include mental health-specific MBS items only. It is not equivalent to the term 'ambulatory' used in chapters 4 and 5 in respect of community mental health care and hospital outpatient services, and ambulatory-equivalent mental-health related admitted patient care.

Table A5.8: Rate (per 1,000 population) of ambulatory mental health services provided, by service stream (MBS), states and territories, 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
	Age-standardised rates[(a)]									
Service stream										
Psychiatrist[(b)]	85.5	117.9	82.9	58.6	105.4	85.6	55.8	19.2	90.6	1,967,222
Clinical psychologist[(c)]	43.3	43.0	26.3	66.6	49.9	61.1	40.0	8.0	42.6	904,835
GP[(d)]	77.5	84.9	69.7	64.1	72.6	61.0	53.9	30.1	74.7	1,600,063
Other allied health[(e)]	83.1	114.8	79.2	40.5	45.6	55.8	73.5	22.4	81.6	1,734,728
Total	**289.4**	**360.6**	**258.1**	**229.8**	**273.5**	**263.6**	**223.2**	**79.6**	**289.6**	**6,206,848**

(a) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(b) Psychiatrist services—MBS items 134, 136, 138, 140, 142, 289, 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224.

(c) Clinical psychologist services—MBS items 80000, 80005, 80010, 80015, 80020.

(d) GP services—MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2721, 2723, 2725, 2727.

(e) Other allied health services—MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 82000, 82015.

Source: MBS data (DoHA).

Table A5.9: Rate (per 1,000 population) of ambulatory mental health services provided, by demographics (MBS), states and territories, 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-standardised rates[(a)]					
Sex										
Males	219.2	258.0	181.9	156.1	202.9	176.5	152.8	56.2	209.6	2,238,841
Females	358.5	461.8	333.9	306.2	343.6	348.4	292.5	104.9	369.1	3,968,007
Indigenous status										
Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Non-Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Remoteness of residence[(b)]										
Major cities	317.0	396.7	310.5	269.1	315.3	. .	223.2	. .	330.1	4,894,118
Inner regional	239.9	272.9	228.6	166.4	221.6	316.2	. .	. .	245.7	1,000,865
Outer regional	152.4	159.1	134.7	150.1	117.2	169.5	. .	110.3	141.9	279,706
Remote	70.3	216.3	71.8	52.2	106.7	103.0	. .	38.9	67.8	21,647
Very remote	97.9	. .	38.5	25.7	56.1	204.9	. .	41.9	41.5	6,772
SEIFA of residence[(c)]										
1 (most disadvantaged)	144.3	159.5	114.2	46.6	155.4	125.3	126.8	27.6	135.4	567,463
2	237.2	332.0	305.9	136.5	349.4	841.2	105.5	63.0	271.0	1,142,978
3	360.2	240.4	236.3	215.8	161.0	228.3	231.9	65.1	261.0	1,123,350
4	323.6	493.0	296.8	267.8	400.8	514.4	182.1	82.8	359.8	1,546,654
5 (least disadvantaged)	409.2	497.8	352.9	306.2	356.9	. .	239.4	70.4	398.5	1,750,542

. . Not applicable.

n.p. Not published.

(a) Rates are age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years.

(b) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. Not all remoteness areas are represented in each state or territory.

(c) SEIFA quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Disaggregation by SEIFA area is based on a person's usual residence, not the location of the service provider. SEIFA quintiles represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory.

Source: MBS data (DoHA).

Table A5.10: Rate (per 1,000 population) of ambulatory mental health services provided, by age (MBS), states and territories, 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Number
					Age-specific rates					
Males										
Less than 15 years	98.2	119.8	89.2	75.3	111.3	72.0	66.9	19.2	97.9	207,343
15–24 years	175.1	205.5	151.8	152.1	174.6	166.7	126.4	34.4	172.8	266,043
25–34 years	273.5	329.9	219.0	226.0	254.4	253.1	222.1	72.7	266.7	400,544
35–44 years	346.3	400.1	274.5	223.8	288.7	266.1	234.2	100.1	321.7	497,863
45–54 years	315.7	369.9	259.5	198.8	285.0	253.0	214.2	88.0	297.6	436,397
55–64 years	259.1	297.8	216.9	167.3	248.6	183.6	154.0	67.0	244.2	293,694
65 years and over	110.4	129.3	99.1	75.9	94.4	69.1	72.8	30.2	106.5	136,957
All ages[(a)]	**219.1**	**258.5**	**182.0**	**157.9**	**202.9**	**171.8**	**156.8**	**57.6**	**210.0**	**2,238,841**
Females										
Less than 15 years	64.3	77.7	60.8	53.2	62.5	52.4	41.7	12.8	64.3	129,075
15–24 years	336.2	429.4	295.5	326.7	329.6	377.5	317.1	94.4	347.5	508,058
25–34 years	494.3	658.2	465.4	477.5	490.0	519.6	424.0	161.8	523.1	776,351
35–44 years	583.6	761.5	544.7	491.2	522.9	569.1	496.8	179.3	600.9	941,243
45–54 years	538.6	686.4	497.9	416.9	522.3	499.7	416.6	147.2	546.3	815,891
55–64 years	421.5	529.8	404.9	321.6	419.5	376.5	292.0	121.9	429.4	519,475
65 years and over	175.8	220.7	171.9	136.1	162.5	133.7	131.4	51.0	179.7	277,914
All ages[(a)]	**357.0**	**462.5**	**333.5**	**306.5**	**339.6**	**337.5**	**302.2**	**107.6**	**368.4**	**3,968,007**
Persons										
Less than 15 years	81.7	99.3	75.4	64.6	87.4	62.5	54.5	16.1	81.5	336,418
15–24 years	253.8	314.4	222.2	236.2	250.2	269.6	218.6	63.1	257.9	774,101
25–34 years	384.1	493.4	341.3	347.8	370.6	388.6	322.4	116.8	394.1	1,176,895
35–44 years	466.0	583.0	410.6	355.2	405.7	421.4	366.8	138.6	462.1	1,439,106
45–54 years	428.3	530.0	380.0	307.1	405.1	378.4	318.4	116.5	423.1	1,252,288
55–64 years	340.6	415.6	310.1	243.0	335.8	280.6	224.4	91.8	337.1	813,169
65 years and over	146.4	179.6	138.0	108.2	132.3	104.4	105.0	39.9	146.5	414,871
All ages[(a)]	**288.7**	**361.4**	**257.8**	**231.2**	**272.1**	**255.8**	**230.1**	**81.7**	**289.6**	**6,206,848**

(a) Includes contacts where age was missing or not reported.

Source: MBS data (DoHA).

NHA performance indicator 32—Proportion of people with a mental illness with general practitioner care plans

Table A5.11: Proportion of people with mental illness[(a)] with GP care plans, states and territories, 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Age-standardised rates[(b)]				
Per cent	17.5	18.9	15.5	14.1	14.7	14.3	14.1	7.3	16.7
Number	186,485	156,436	102,204	47,568	35,987	10,894	7,940	2,427	549,941

(a) People aged 16–84 with selected 12-month mental disorders.

(b) Rates are age-standardised to the Australian population aged 16–84 as at 30 June 2001.

Source: MBS data (DoHA), National Survey of Mental Health and Wellbeing 2007 (ABS).

Table A5.12: Number of people with GP care plans, by age, 2008–09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Aust. (per cent)
					Number					Age specific rate[(a)]
0–15 years	17,497	14,007	10,503	4,350	3,926	913	640	159	51,995	. .
16–24 years	29,579	25,631	17,289	8,208	6,360	2,116	1,487	380	91,050	12.6
25–34 years	42,621	37,506	23,685	11,698	7,923	2,364	2,091	653	128,541	17.4
35–44 years	46,062	39,176	25,519	11,772	8,367	2,517	1,873	659	135,945	18.6
45–54 years	35,600	28,893	19,061	8,443	6,927	2,137	1,391	469	102,921	15.9
55–64 years	21,239	16,955	11,317	5,014	4,215	1,240	775	203	60,958	18.4
65–74 years	8,057	6,004	4,012	1,769	1,550	398	243	49	22,082	17.1
75–84 years	3,327	2,271	1,321	664	645	122	n.p.	n.p.	8,444	15.1
85 years and over	512	461	226	115	119	16	n.p.	n.p.	1,466	. .
Total[(b)]	**204,494**	**170,904**	**112,933**	**52,033**	**40,032**	**11,823**	**8,595**	**2,588**	**603,402**	**. .**

. . Not applicable.

n.p. Not published.

(a) Proportion of people aged 16–84 with selected 12-month mental disorders with GP care plans.

(b) Includes contacts where age was missing or not reported.

Source: MBS data (DoHA).

Table A5.13: Proportion of people with mental illness[(a)] with GP care plans, by remoteness area, by SEIFA quintile, 2008–09

	Age-standardised rates[(b)] (per cent)	Number
Remoteness of residence[(c)]		
Major cities	16.8	393,846
Inner regional	18.2	113,728
Outer regional	12.6	37,855
Remote	n.p.	3,300
Very remote	n.p.	1,009
SEIFA of residence[(d)]		
1 (most disadvantaged)	13.9	59,148
2	17.0	119,393
3	16.4	112,819
4	16.4	129,999
5 (least disadvantaged)	16.5	122,759

n.p. Not published.

(a) People aged 16–84 with selected 12-month mental disorders.

(b) Rates are age-standardised to the Australian population aged 16–84 as at 30 June 2001.

(c) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. Not all remoteness areas are represented in each state or territory.

(d) SEIFA quintiles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Disaggregation by SEIFA area is based on a person's usual residence, not the location of the service provider. SEIFA quintiles have an equal number of SLAs nationally, but do not necessarily have the same population size nationally or within any state or territory.

Source: MBS data (DoHA) and National Survey of Mental Health and Wellbeing 2007 (ABS).

Abbreviations

A+E	accident and emergency
ABS	Australian Bureau of Statistics
ACHI	Australian Classification of Health Interventions
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ASA	American Society of Anesthesiologists
ASGC	Australian Standard Geographical Classification
ATC	Anatomical Therapeutic Chemical
Aust	Australia
BEACH	Bettering the Evaluation and Care of Health
Better Access	Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS
CMHC	Community Mental Health Care
COAG	Council of Australian Governments
CSTDA	Commonwealth State/Territory Disability Agreement
DoHA	Department of Health and Ageing
DUSC	Drug Utilisation Sub-Committee
DVA	Department of Veterans' Affairs
EP	English proficiency
ERP	estimated resident population
FTE	full-time-equivalent
GP	general practitioner
HDSC	Health Data Standards Committee
ICD	International Statistical Classification of Diseases
ICD-9-CM	International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification
ICD-10-PC	International Classification of Diseases, 10th revision, Primary Care
ICPC-2	International Classification of Primary Care, 2nd edition
LCL	lower confidence limit
MBS	Medicare Benefits Schedule
METeOR	Metadata Online Registry

MHE	Mental Health Establishments
NNAPEDCD	National Non-Admitted Patient Emergency Department Care Database
NCCH	National Centre for Classification in Health
NDC	National Data Collection
NCMHCD	National Community Mental Health Care Database
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NMHED	National Mental Health Establishments Database
NNAPEDCD	National Non-Admitted Patient Emergency Department Care Database
NPHED	National Public Hospital Establishments Database
NRMHCD	National Residential Mental Health Care Database
NSW	New South Wales
NT	Northern Territory
OMP	other medical practitioner
PBS	Pharmaceutical Benefits Scheme
PDD	pervasive developmental disorder
Qld	Queensland
RMHC	Residential Mental Health Care
RPBS	Repatriation Pharmaceutical Benefits Scheme
SA	South Australia
SAAP	Supported Accommodation Assistance Program
Tas	Tasmania
UCL	upper confidence limit
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

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