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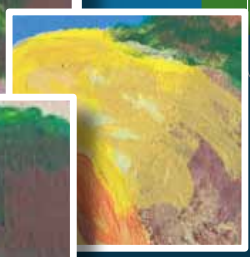
Australian Institute of Health and Welfare

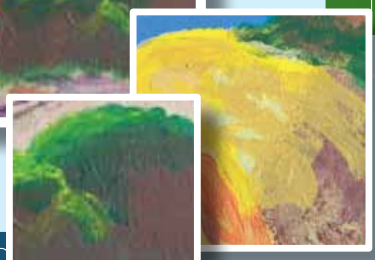
2012



MENTAL HEALTH SERVICES

In brief

2012



MENTAL**HEALTH**SERVICES

In brief

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

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Contents

Introduction

The *Mental Health Services in Australia* website (www.mhsa.aihw.gov.au) provides an overview of the national response of the health and welfare service system to the mental health care needs of Australians. This companion document, *Mental health services: in brief 2012,* summarises the key findings from the information presented online each year.

Mental illness comprises a spectrum of disorders that vary in severity. Mental illness can have damaging effects on the individuals and families concerned, and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma (WHO 2003).

How many people are affected?

Estimates from the 2007 National Survey of Mental Health and Wellbeing (SMHWB) suggest that 7.3 million Australians (45% of the population aged 16–85) will experience a common mental disorder (a mood disorder, such as depression; anxiety or a substance use disorder) over their lifetime. Each year, 20% of the population in this age range, or 3 million Australians, are estimated to experience symptoms of a mental disorder (DoHA 2009).

The second National Survey of People Living with Psychotic Illness conducted in March 2010 (Morgan et al. 2011) estimated that almost 64,000 people in Australia had a psychotic illness and were in contact with public specialised mental health services each year. Psychotic illnesses are less common but usually more severe forms of mental illness than those covered in the SMHWB. Schizophrenia is the most common psychotic illness.

What is the extent of service provision?

About 1.7 million Australians (8% of the population) received public or private mental health services in 2009–10.

There were an estimated 13.9 million mental health-related general practitioner (GP) encounters, or visits in 2010–11, which comprised 11.7% of all patient encounters with GPs in that period.

What is the extent of expenditure on mental health services?

Over $6.3 billion, or $287 per Australian, was spent on mental health-related services in 2009–10.

State and territory expenditure for specialised mental health services has increased by an annual average of 5.4% over the 5 years to 2009–10.

Additional Information

For more detailed statistics, interactive data and information on how to interpret the data, see the full online report at www.mhsa.aihw.gov.au

What services are provided to those affected by mental illness?

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, to consultations with specialists and GPs.

Services provided by general practitioners

The first professional encounter for many people seeking help for a mental illness is usually their GP. Data from the Bettering the Evaluation and Care of Health (BEACH) survey of GPs (Britt et al. 2011) provides a picture of these mental health-related GP encounters. Medicare Benefit Scheme (MBS) data on mental health-specific MBS items are also available.

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

Who used these services?

From the BEACH survey it is estimated that there were 13.9 million mental health-related GP encounters in 2010–11. This corresponds to 620 encounters per 1,000 population. One in four of these were for patients aged 65 and over and 60% were for females (Figure 1). Aboriginal and Torres Strait Islander people had a lower rate of encounters than non-Indigenous Australians (age standardised rates of 490.7 and 567.2 per 1,000 population respectively).

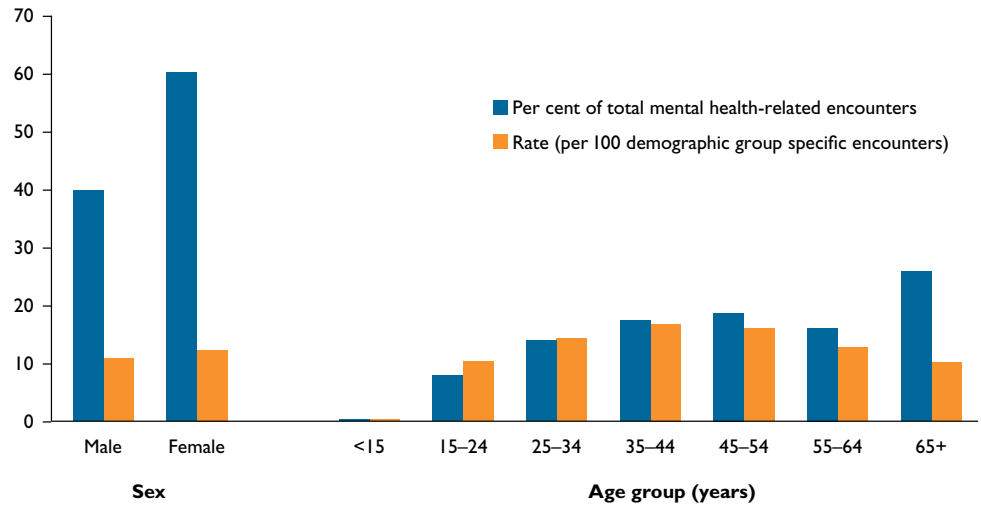

Figure 1: Mental health-related GP encounters, by sex and age group, 2010–11

How has this changed over time?

The estimated rate of mental health-related GP encounters per 1,000 population increased by an annual average of 4.8% between 2006–07 and 2010–11. The proportion of all GP encounters that are mental health-related has increased from 10.4% in 2006–07 to 11.7% in 2010–11.

The introduction of the GP Mental Health Treatment Medicare items as part of the Better Access initiative in November 2006 resulted in a noticeable growth in MBS-subsidised specific GP mental health services. Since 2007–08, when the Better Access initiatives were fully operational, there has been an average annual growth rate in services per 1,000 population of 17.0%. In 2010–11, GPs provided 2.1 million MBS-subsidised mental health-related services to 1.2 million patients.

Why are people receiving this care?

Depression, anxiety and sleep disturbance were the three mental health-related problems most frequently managed by GPs in 2010–11 according to the BEACH survey (Figure 2), accounting for over 60% of all mental health-related problems managed.

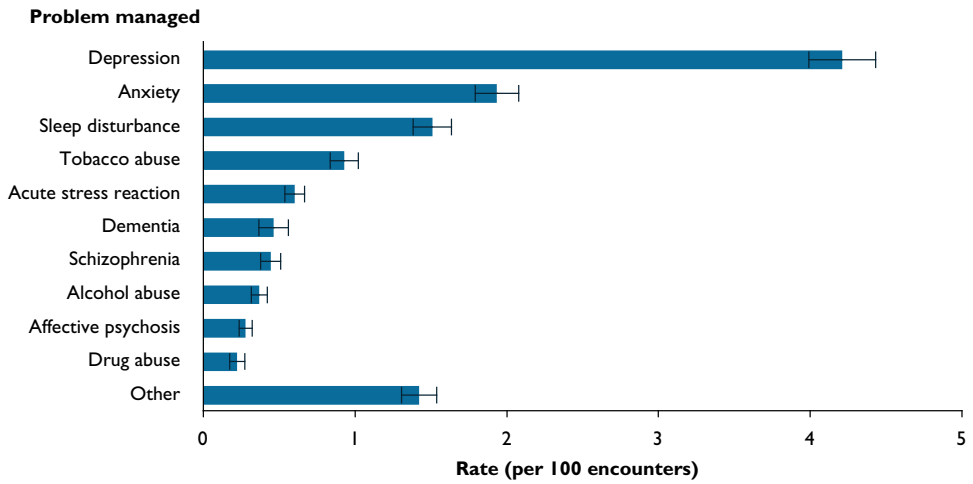

Figure 2: The 10 most frequent mental health-related problems managed by GPs, 2010–11

What were the characteristics of the care provided?

A GP was most likely to prescribe, supply, or recommend a medication for the management of mental health-related problems. Antidepressants were the most commonly prescribed medication, followed by anxiolytics (anti-anxiety medications) and hypnotics and sedatives.

The next most common form of management provided by GPs was counselling, advice or other treatments, with psychological counselling the most frequently provided service. Referral for specialised mental health care, particularly to psychologists, was the next most common form of management.

How does this differ between states and territories?

MBS data shows variation in mental health-specific GP activity across the states and territories. Victoria and New South Wales had a higher rate of patients (58.9 and 54.4 per 1,000 population respectively) receiving MBS-subsidised GP mental health services than the national average (52.9). The lowest patient rate was for the Northern Territory at 24.6 per 1,000 population. The highest service rate was for Victoria at 106.4 per 1,000 population which was higher than the national average (93.6 per 1,000 population). The lowest service rate was for the Northern Territory at 39.5 per 1,000 population.

Medicare-subsidised specialised mental health services

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

In addition to mental health services provided by GPs, MBS-subsidised mental health-related services are provided by psychiatrists, psychologists, and other allied health professionals (in particular, social workers, mental health nurses and occupational therapists). The services are provided in a range of settings—in hospitals, consulting rooms, home visits and over the phone (DoHA 2010).

Who used these services?

There were 5.6 million MBS-subsidised mental health-related services provided to more than 916,700 patients in 2010–11.

For those accessing psychologist and other allied health services, the rate (per 1,000 population) was highest for those aged 35–44. The 65 and over age group was the only age group that reported a higher patient rate for psychiatrist services than psychologist services. More females than males used the services provided, with nearly 20% more females accessing psychiatrists, and over 70% more females accessing psychologists and other allied health providers. For other allied health services, females comprised almost two-thirds of the patients and used services at a rate nearly double that for males.

How has this changed over time?

There has been an average annual increase of over 18% in the rate of MBS-subsidised specialised mental health-related services per 1,000 population over the 5 years to 2010–11 (Figure 3). This growth is largely attributable to the implementation of the Better Access initiative that gave patients MBS-subsidised access to psychologists and other allied health providers.

What were the characteristics of the care provided?

Close to 60% of the MBS-subsidised specialised mental health-related services were provided by psychologists (including clinical psychologists) in 2010–11. The majority of psychologist services were provided under the category of *Focussed psychological strategies*, a range of evidence-based strategies including *Psycho-education*, *Cognitive-behavioural therapy*, *Relaxation strategies*, *Skills training* and *Interpersonal therapy*. The majority of the psychiatrist services were provided in consulting rooms, followed by consultations in hospitals. Social workers provided the majority of the other allied mental health services.

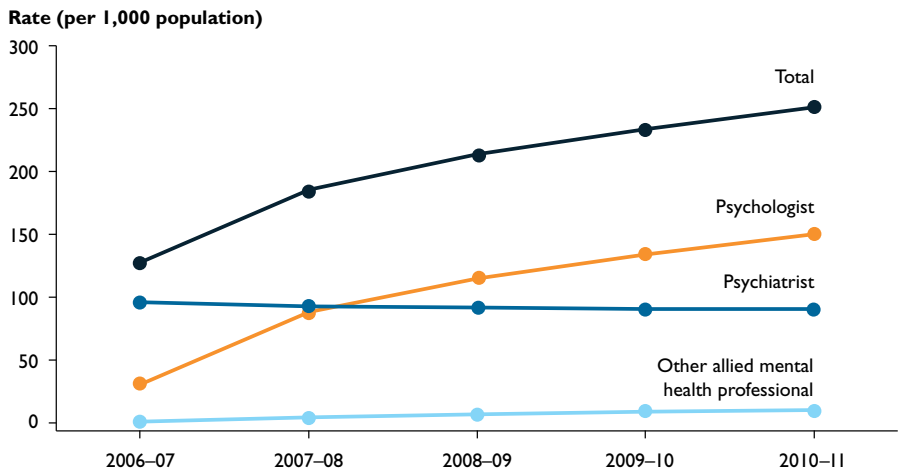

Figure 3: MBS-subsidised specialised mental health-related service rates, by provider type, 2006–07 to 2010–11

How does this differ between states and territories?

Among states and territories, Victoria had the highest number of patients and services per 1,000 population for MBS-subsidised mental health-related services, substantially higher than the national average (Figure 4). The Northern Territory had the lowest rate for both patients and services.

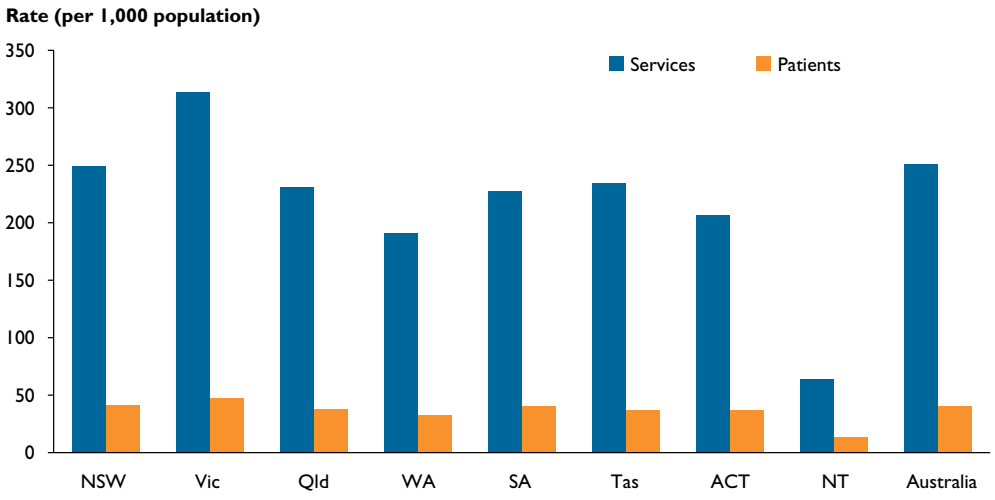

Figure 4: MBS-subsidised specialised mental health-related service rates and patient rates, states and territories, 2010–11

State and territory community mental health services

State and territory governments provide specialised mental health care services in community and hospital-based ambulatory care settings.

For more information, see the Services section of Mental Health Services in Australia online at www. mhsa.aihw.gov.au

Who used these services?

About 339,000 people in Australia accessed services in 2009–10, receiving almost 6.6 million service contacts. Australian-born men aged 25–34 who lived in *Inner regional* areas used services at the highest rates. The service contact rate for Indigenous Australians was more than three times that for non-Indigenous Australians, and the rate for Australian-born patients was more than double that for patients born overseas.

How have the rates changed over time?

Community mental health care service contact rates have increased by an annual average of 2.2% over the 5 years to 2009–10 (Figure 5). The slight decrease in 2008–09 is attributed to a change in the community mental health data reporting system in one state.

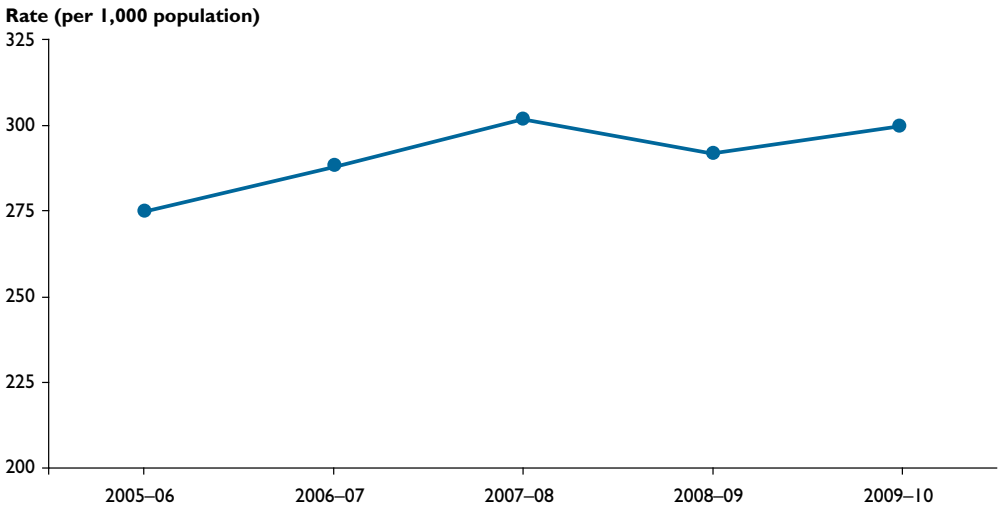

Figure 5: Community mental health care service contacts, 2005–06 to 2009–10

What are people receiving this care for?

The most common principal diagnosis for patients accessing community mental health care services was schizophrenia, accounting for almost one-third of all contacts, followed by depressive episode (11.7%), bipolar affective disorders (6.3%) and schizoaffective disorders (5.8%).

What is a typical contact?

Community mental health care service contacts can be conducted with one patient or a group of patients. Contacts can also be conducted with the patient present or absent, for example, with a third party such as a carer or family member or other professional. They can also be voluntary or involuntary.

The most common community mental health care service contact was with an individual patient, lasting 5–15 minutes. Involuntary contacts accounted for about 16% of all contacts.

How do rates differ between states and territories?

The Australian Capital Territory had the highest rate of community mental health care service contacts per 1,000 population (724.8) (Figure 6), compared with the national average of 299.9. Some caution is required when making comparisons between jurisdictions as differences in data reporting systems may contribute to varying service contact rates.

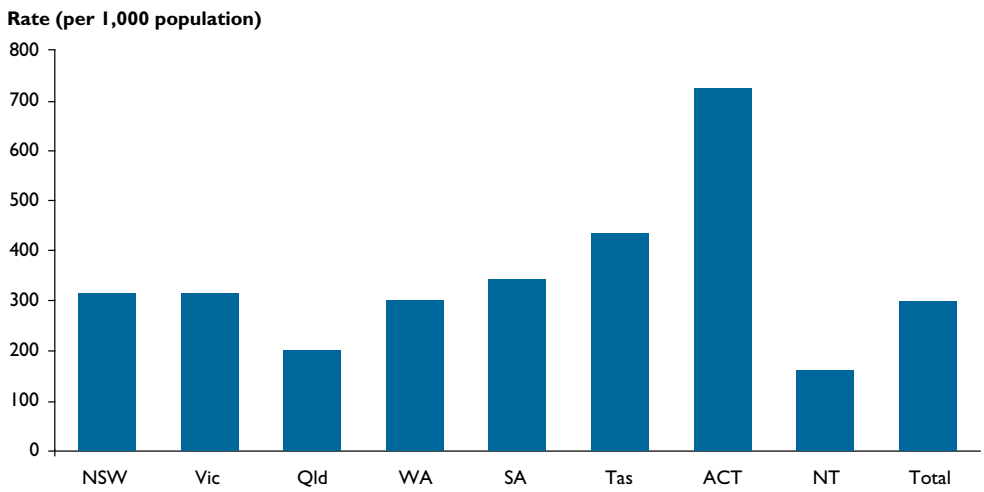

Figure 6: Community mental health care service contact rates, 2009–10

Services provided in hospitals and residential care facilities

Services provided in emergency departments

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

Emergency departments provide care for patients who may have an urgent need for medical care, including care for people presenting with a mental health-related problem.

Who used these services?

There were 172,445 public hospital emergency department visits with a mental health-related principal diagnosis in 2009–10. Almost 80% were for people aged 15–54, with slightly more visits for men than women. Indigenous Australians accounted for 6.2% of the mental health-related visits in emergency departments.

How has this care changed over time?

There was an increase in mental health-related visits in emergency departments from 2005–06 to 2006–07 (Figure 7). The decrease in 2007–08 is attributed to a change in the information data reporting system in one state. Since then the number of visits has remained relatively stable.

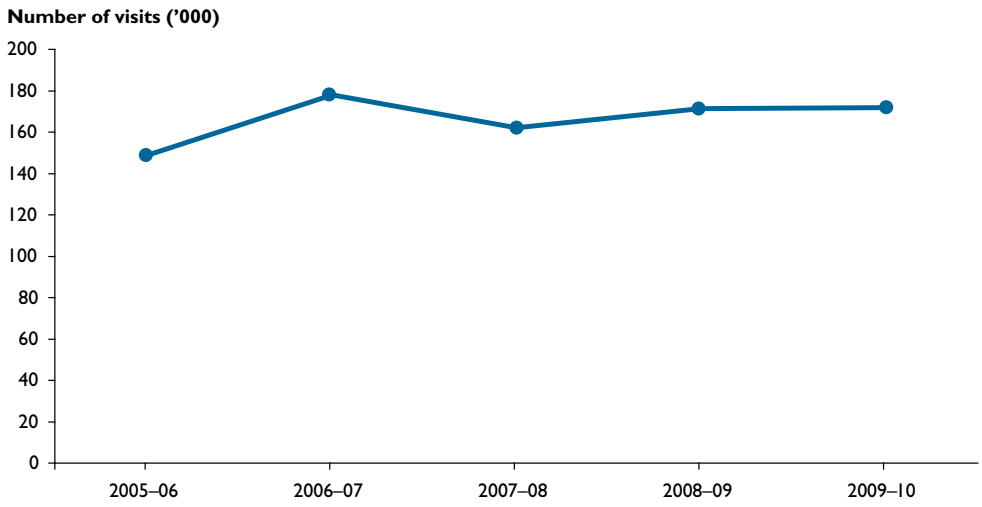

Figure 7: Mental health-related emergency department visits in public hospitals, 2005–06 to 2009–10

What are people receiving this care for?

The most frequently recorded principal diagnoses for emergency department mental health-related presentations were *Neurotic, Stress-related* and *Somatoform disorders* (28.2%), followed by *Mental and behavioural disorders due to psychoactive substance use* (24.9%), *Mood disorders* (15.9%) and *Schizophrenia spectrum disorders* (12.8%).

What were the characteristics of the visits?

Over 80% of mental health-related emergency department visits were classified as urgent or semi-urgent (requiring care within 30 and 60 minutes respectively) in 2009–10 (Figure 8). A further 11.2% were classified as emergency (within 10 minutes).

More than 60% of the mental health-related visits were resolved without the need for admission or referral to another hospital. A further 34.8% resulted in an admission.

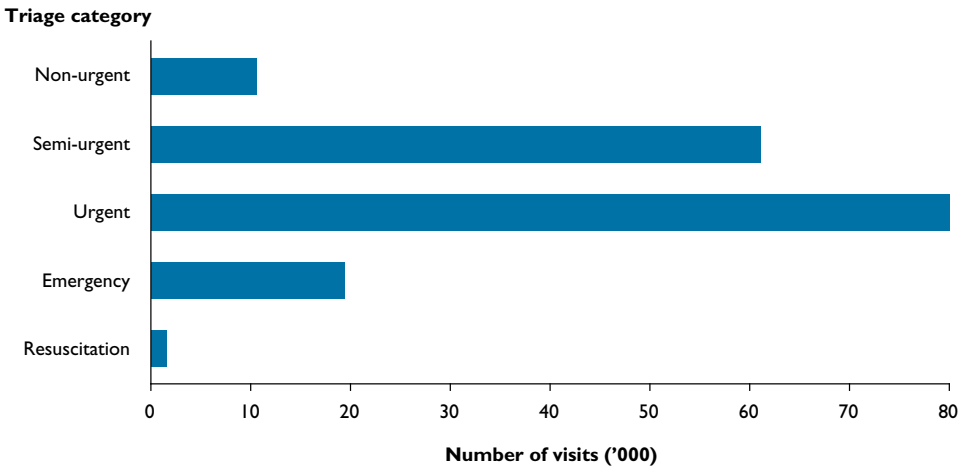

Figure 8: Mental health-related emergency department visits in public hospitals, by triage category, 2009–10

Ambulatory-equivalent admitted patient care

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

In some circumstances, patients admitted to hospital are provided with care comparable to care provided by community mental health care services.

This is referred to as 'ambulatory-equivalent' mental health care and can be classified as being with or without specialised psychiatric care. It can be provided in a public acute, public psychiatric or private hospital.

Who used these services?

There were over 142,200 ambulatory-equivalent mental health-related separations in 2009–10, accounting for 1.7% of all hospital separations and 39.0% of all mental health-related separations. Private hospitals provided 83.5% of all ambulatory-equivalent services.

For separations with specialised care, people aged 55–64 had the highest rate of separations (per 1,000 population) and the rate was higher for females than males. The rate for Australian-born patients was more than double that for those born overseas.

Patients aged 65 and over had the highest rate per 1,000 separations without specialised care and males and females experienced similar separation rates. Indigenous Australians had a separation rate over double that of other Australians.

How has this changed over time?

The rate (per 1,000 population) of separations with specialised care had an average annual increase of 2.7% from 2005–06 to 2009–10 (Figure 9). Over the same period, the rate (per 1,000 population) of separations without specialised care had a similar average annual increase of 2.4%. However, since 2007–08 the rate of separations with specialised psychiatric care has increased, while separations without specialised psychiatric care has decreased.

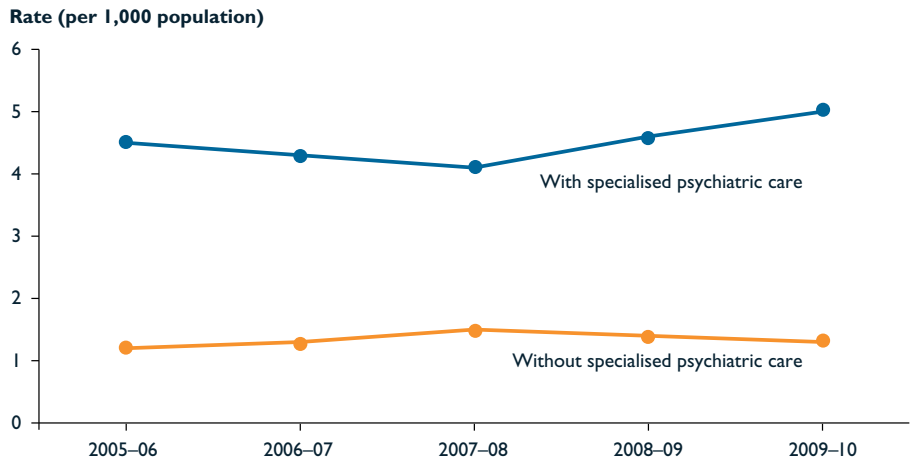

Figure 9: Ambulatory-equivalent mental health-related separation rates, 2005–06 to 2009–10

What are people receiving this care for?

People with a diagnosis of depressive episode accounted for the largest number of ambulatory-equivalent separations with specialised care (18.1%) (Figure 10). Mental and behavioural disorders due to the use of alcohol was the leading diagnosis (8.8%) for separations without specialised psychiatric care.

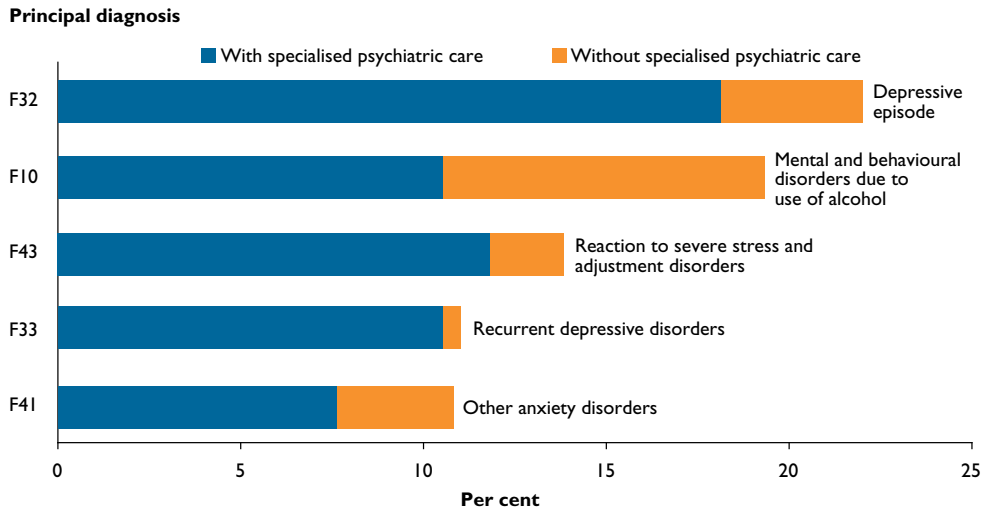

Figure 10: Five most commonly reported principal diagnoses for ambulatory-equivalent separations, 2009–10

What were the characteristics of the care provided?

A procedure, or intervention, was recorded for 42% of all ambulatory-equivalent separations. The most frequent procedure was *Cognitive behaviour therapy* (26.6%), followed by *Other psychotherapies* or *Psychosocial therapies* (13.1%). For separations with at least one procedure recorded, the average number of procedures was 1.1.

How does this differ between states and territories?

Victoria had the highest rate of separations per 1,000 population (9.0) while South Australia the lowest (1.1), compared to a national rate of 6.3 per 1,000 population.

Admitted patient mental health-related care

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

For more information, see the Services section of Mental Health Services in Australia online at

www.mhsa.aihw.gov.au

Who used these services?

There were over 222,500 admitted patient mental health-related separations reported in 2009–10, accounting for 2.6% of all hospital separations.

For separations with specialised psychiatric care, the rate was higher for females (6.3 per 1,000) than males (5.4), and the highest rates were for patients aged 35–44. For separations without specialised care, there was minimal difference between males and females, and the highest rates occurred for those aged 65 and over.

About 30% of all separations with specialised psychiatric care were for patients who had an involuntary admission, while only 0.3% of private hospital separations were from involuntary admissions (Figure 11).

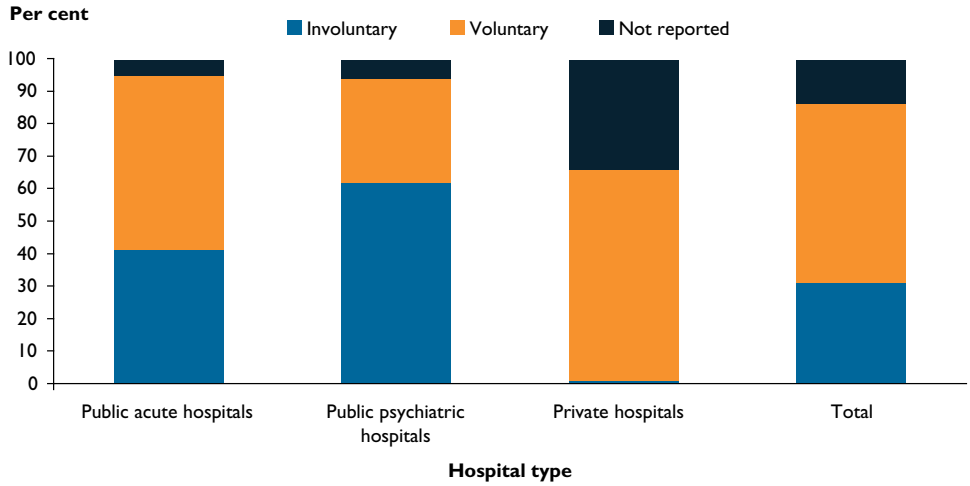

Figure 11: Admitted patient separations with specialised psychiatric care, 2009–10

How has this changed over time?

The rates of separation with and without specialised psychiatric care have remained relatively stable between 2005–06 and 2009–10; separations with specialised care had an annual average increase of 0.4%, while separations without specialised care had an annual average decrease of 0.4% (Figure 12).

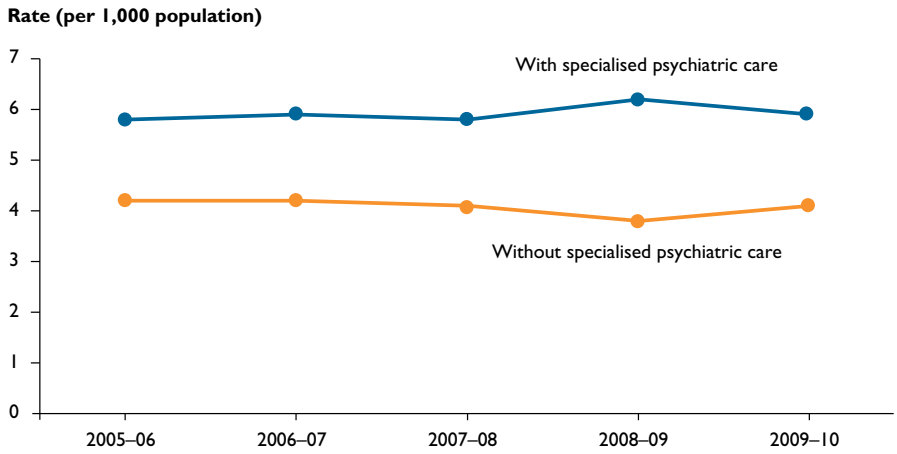

Figure 12: Admitted patient mental health-related separations, 2005–06 to 2009–10

Why are people receiving this care?

People with a primary diagnosis of either depressive episode or schizophrenia accounted for over one-third of separations with specialised care in 2009–10. The most commonly reported diagnosis for separations without specialised care was mental and behavioural disorders due to use of alcohol, followed by depressive episode.

What were the characteristics of the care provided?

About 41% of all mental health-related separations did not have a procedure recorded. It is likely that the procedures provided to admitted patients during these mental health-related separations were not able to be coded using the existing procedure classification system. The administration of mental health-related medications, for example, are not explicitly defined in the classification system.

From the data available, a commonly reported procedure for all mental health-related separations was an allied health service intervention, including services provided by social workers and occupational therapists. A common procedure for separations with specialised care was non-emergency general anaesthesia. This was most likely associated with the administration of electroconvulsive therapy, a form of treatment for depression—a commonly reported principal diagnosis.

How does this differ between states and territories?

The average length of stay in public acute hospitals for separations providing specialised care varied across jurisdictions, from 11.7 days in the Northern Territory to 18.5 days in Western Australia.

Residential care

Residential mental health care services assist people with a mental illness by providing specialised mental health services, including rehabilitation, treatment or extended care, in domestic-like environment on an overnight basis.

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

Who used these services?

Almost 2,800 Australians used these services in 2009–10, resulting in nearly 4,000 residential episodes of care. One-quarter of the episodes were for people aged 25–34 and there were more episodes for males than females. Overall, almost half of all residential episodes were for people located in *Major cities*, but the number of episodes per 10,000 population was highest for residents from *Inner regional* areas.

How have service rates changed over time?

There was an average annual increase of 12.9% in the number of residential mental health care episodes per 10,000 population between 2005–06 and 2009–10 (Figure 13).

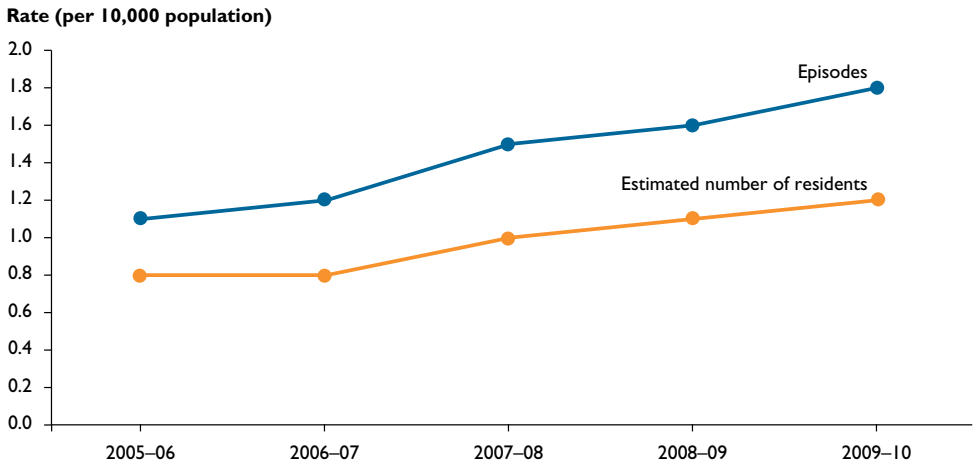

Figure 13: Residential mental health care episodes and residents, 2005–06 to 2009–10

Why are people receiving this care?

The most common principal diagnosis was *Schizophrenia*, which represented nearly half of all episodes, followed by *Schizoaffective disorder* and *Depressive episode*.

What is a typical episode of residential care?

The most common length of stay for a completed residential episode was 2 weeks or less (50.7%). About 5% of all episodes involved a residential stay of more than 1 year. Residents admitted involuntarily accounted for about 29% of all episodes. The proportion of involuntary episodes has declined from a peak of 31.6% in 2006–07.

How do rates differ between states and territories?

Tasmania had the highest rates of residential care use (including episodes, residents and care days), noticeably higher than the Australian average, indicating a greater reliance on this type of care in the Tasmanian mental health system (Figure 14). New South Wales had the lowest rates for both residents and episodes. Queensland does not report any residential mental health care services.

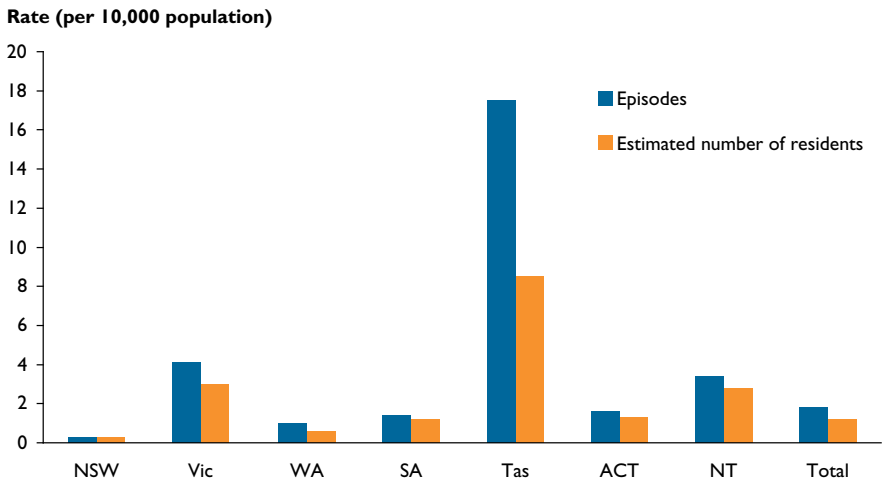

Figure 14: Residential mental health care episodes and resident rates, 2009–10

Other mental health-related services

Psychiatric disability support services

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

Support services are available for Australians with disability, including psychiatric disability. These include both residential and non-residential services funded under the National Disability Agreement.

Over 80,000 people with psychiatric disability made use of disability support services in 2009–10. The number of non-residential service users far outweighed the number of residential service users across all states and territories.

Non-residential support services include accommodation support, community support, community access, employment services, respite services, advocacy, information and alternative forms of communication and other support. Residential support services include large and small residential facilities/institutions, hostels and group homes.

Who used non-residential services?

Over 79,000 people with psychiatric disability accessed non-residential support services in 2009–10. The most common user was male, aged 25–54, who lived with others in a private residence in a major city. The main source of income for users of non-residential services was a disability support pension. Employment services were the most widely used service.

How has the non-residential rate changed over time?

There has been an average annual increase of 18.5% in the rate of non-residential service users with psychiatric disability over the 5 years to 2009–10 (Figure 15).

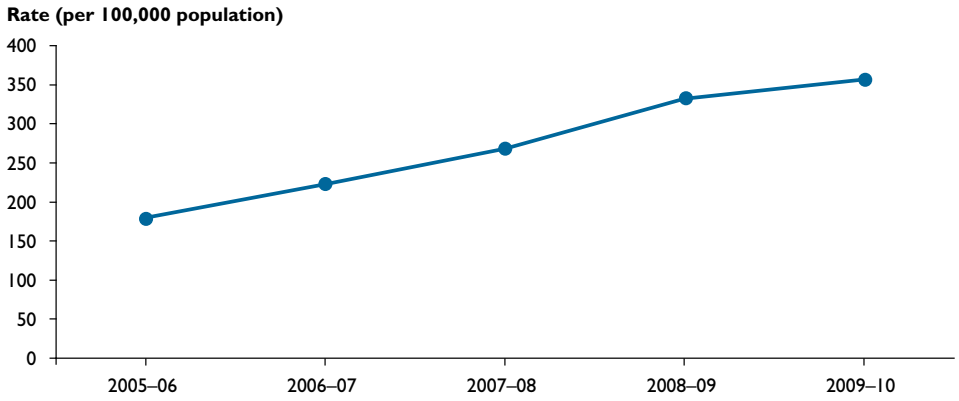

Figure 15: Service users with psychiatric disability accessing non-residential support services, 2005–06 to 2009–10

How do rates of non-residential service users differ between states and territories?

Non-residential disability support services were most widely used by people with psychiatric disability in Victoria, with 572.6 users per 100,000 population. The national average was 358.2 and the Northern Territory had the lowest overall usage rate of 96.5 per 100,000 population.

Who accessed residential services?

Almost 3,900 people with psychiatric disability accessed residential support services in 2009–10. The most common user was male, aged 35–54, who lived with others in a *Major city* in a domestic-scale supported living facility, and was receiving a disability support pension as the main source of income.

How did the residential rate change over time?

There has been an average annual increase of 5.0% in the rate of residential service users with psychiatric disability over the 5 years to 2009–10 (Figure 16). However, since 2008–09 the rate has remained relatively unchanged.

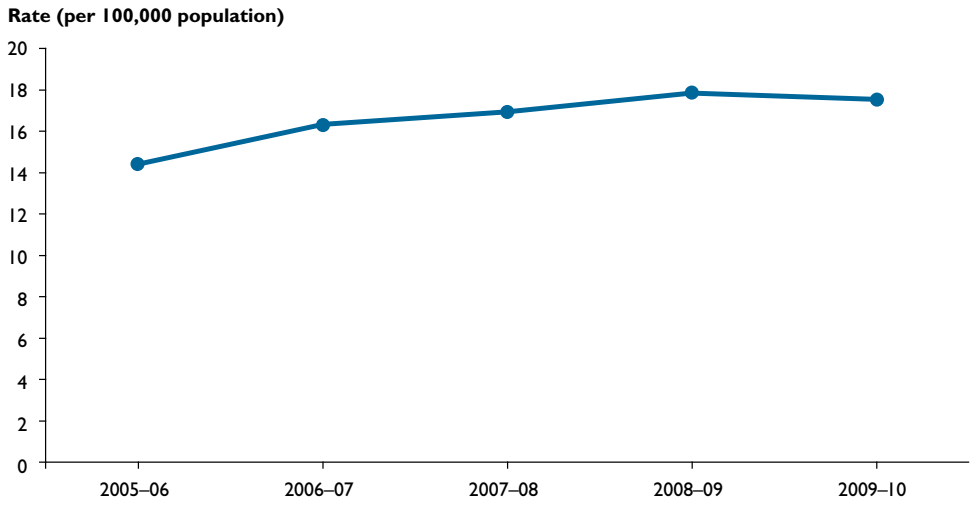

Figure 16: Service users with psychiatric disability accessing residential support services, 2005–06 to 2009–10

How do rates of residential service users differ between states and territories?

People with psychiatric disability accessed residential disability support services most commonly in Tasmania, with 35.4 users per 100,000 population. The lowest rate was in the Northern Territory (2.2) and the national average was 17.5 users per 100,000 population.

Supported accommodation assistance

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

The Supported Accommodation Assistance Program (SAAP) provides support to people who are homeless or at risk of being homeless (SAAP clients), including those with psychiatric or other mental health problems. Services provided to SAAP clients include transitional supported accommodation and other support services to help them achieve the highest level of self-reliance and independence. The data presented here is based on SAAP closed support periods, that is, a support period under the program that had finished on or before 30 June of the reporting year.

Who used these services?

Clients with mental health-related referrals (18,509) had 25,561 SAAP closed support periods, representing 14.2% of all closed support periods for 2010–11.

Clients aged 18–19 had the highest rate (per 100,000 population) of mental health-related closed support periods, and the rate was higher for male than female clients. The rate of closed support periods for Indigenous Australians was more than five times the rate for non-Indigenous Australians.

How has service use changed over time?

There was an average annual increase of 3.4% in the rate (per 100,000 population) of SAAP clients with a mental health-related referral between 2006–07 and 2010–11, and an average annual increase of 1.5% in the rate of closed support periods (Figure 17).

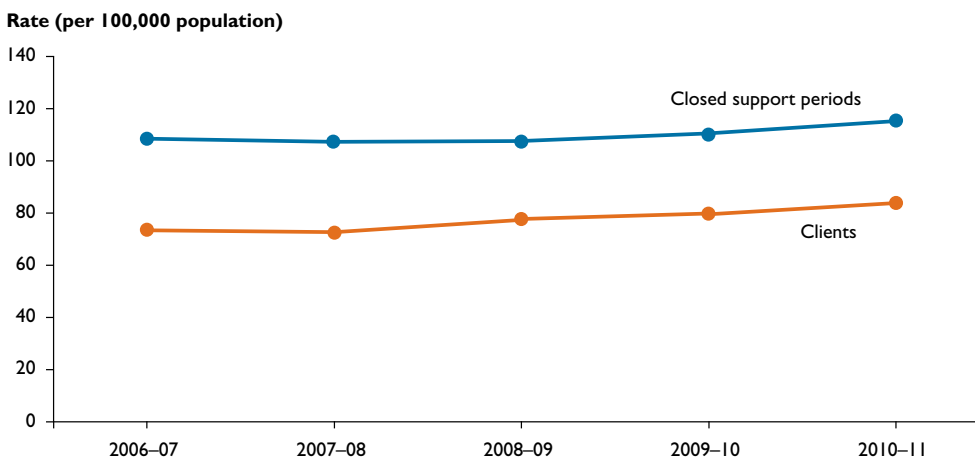

Figure 17: SAAP clients with mental health-related referrals and closed support periods, 2006–07 to 2010–11

Characteristics of mental health-related support periods

Nearly 40% of clients were self-referred. The next most common form of referral was from other supported accommodation assistance agencies (8.6%) followed by referrals from other non-government organisations (8.2%). Mental health issues or psychiatric illness were the main reasons for seeking assistance (Figure 18). The most common duration for a closed support period was 4–13 weeks, and 6.1% of support periods were longer than 1 year.

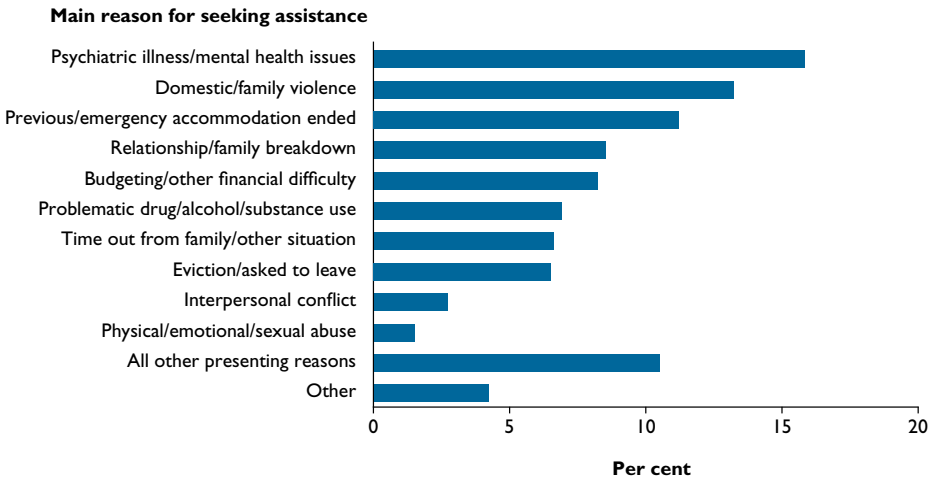

Figure 18: Closed support periods for SAAP clients with mental health-related referrals, by reason for seeking assistance, 2010–11

How does this care differ between states and territories?

The Northern Territory had the highest rate of supported accommodation services per 100,000 population (90.5) for SAAP clients with mental health-related referrals, and South Australia had the lowest (26.8), compared with the national average (46.1). For other support services involving SAAP clients with mental health-related referrals, the rate was highest for Victoria (125.7 per 100,000), compared with the national average (67.6 per 100,000).

Personal Helpers and Mentors

For more information, see the Services section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

The Personal Helpers and Mentors (PHaMs) program is an Australian Government initiative, administered by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

The program aims to increase recovery opportunities for people whose lives are severely affected by their experience of mental illness. PHaMs takes a strengths-based recovery approach to helping participants better manage their daily activities and reconnect to their community.

Who used these services?

About 12,400 people participated in the PHaMs program in 2010–11; a 25.6% increase from 2009–10. PHaMs participants were most likely to be aged 25–44, female, Australian-born and have a formal mental illness diagnosis at the time of initial assessment into the program, although this is not a prerequisite for entry to these services.

What are the functional limitations reported by PHaMs participants?

On entry into a PHaMs service, participants are assessed on their areas of functional limitation resulting from a severe mental illness. The most commonly reported limitations were *Learning, applying knowledge and general demands; Social and community activities; Interpersonal relationships* and *Working and employment* (Figure 19).

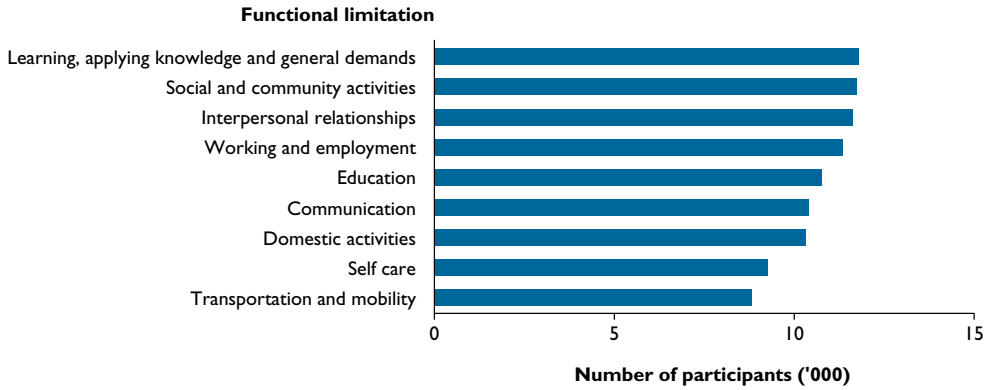

Figure 19: PHaMs participants, by functional limitation area at time of initial assessment, 2010–11

What resources are provided?

Resources used or involved in the provision of mental health-related services include expenditure on mental health services, provision of facilities, mental health-related workforce and subsidised prescriptions for mental health-related medications.

Expenditure on mental health services

Over $6.3 billion, or $287 per Australian, was spent on mental health-related services in Australia during 2009–10. This was funded by a combination of state and territory governments, the Australian Government and private health insurance funds. Expenditure on services has increased by an average annual rate of 4.5% per Australian between 2005–06 and 2009–10.

For more information, see the Resources section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

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

Over $3.9 billion was spent on state and territory specialised mental health services in 2009–10 (running costs only). The largest proportion was spent on public hospital services for admitted mental health care ($1.7 billion), which equates to an average cost of $802 per patient day (Figure 20).

Community mental health care spending accounted for $1.5 billion in 2009–10. A further $220 million was spent on residential mental health services, with the majority spent on 24-hour staffed services.

Expenditure on state and territory specialised mental health services increased from $154 to $177 per Australian between 2005–06 and 2009–10, an average annual increase of 3.4%.

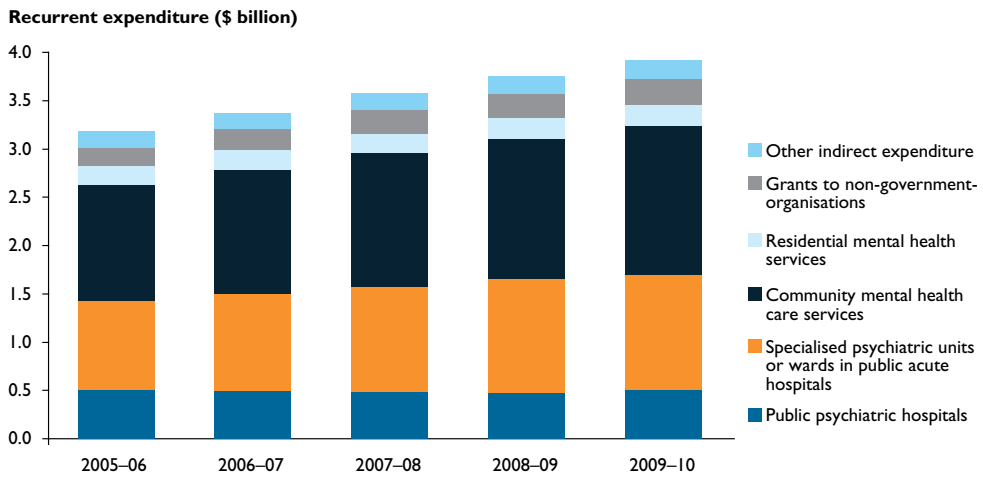

Figure 20: Recurrent expenditure on state and territory specialised mental health services, constant prices, 2005–06 to 2009–10

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

The Australian Government spent $2.2 billion, or $101 per Australian, on mental health-related services in 2009–10, an average annual increase of 7.0% in expenditure between 2005–06 and 2009–10. The majority ($1.5 billion) was spent on MBS-subsidised mental health-related services and medications subsidised under the Pharmaceutical Benefis Scheme and/or the Repatriation Pharmaceutical Benefits Scheme (PBS/RPBS).

Spending on MBS-subsidised services and PBS/RPBS-subsidised prescriptions has continued to increase, which is evident in the most recently available 2010–11 data.

How much was spent on MBS-subsidised services in 2010–11?

The 2010–11 data shows that $852 million was paid in benefits for MBS-subsidised mental health-related services, equating to 5.2% of total MBS expenditure or $38 per Australian. Adjusted for inflation, this has increased by an average annual rate of 18.8% per Australian between 2006–07 and 2010–11 (Figure 21). The largest portion of this spending was for services provided by psychologists (39.3%), followed by psychiatrists (32.0%) and GPs (26.6%).

How much was spent on PBS/RPBS-subsidised prescriptions in 2010–11?

In 2010–11, $834 million was spent on mental health-related subsidised prescriptions, equating to 10.1% of all subsidised prescriptions, or $37 per Australian. This has increased by an average annual rate of 2.6% per Australian between 2006–07 and 2010–11 (Figure 21). Over 70% of the expenditure on prescriptions was for prescriptions issued by GPs, followed by psychiatrists and non-psychiatrist specialists. Antipsychotics and antidepressants accounted for the majority of expenditure, 53.9% and 40.1% respectively.

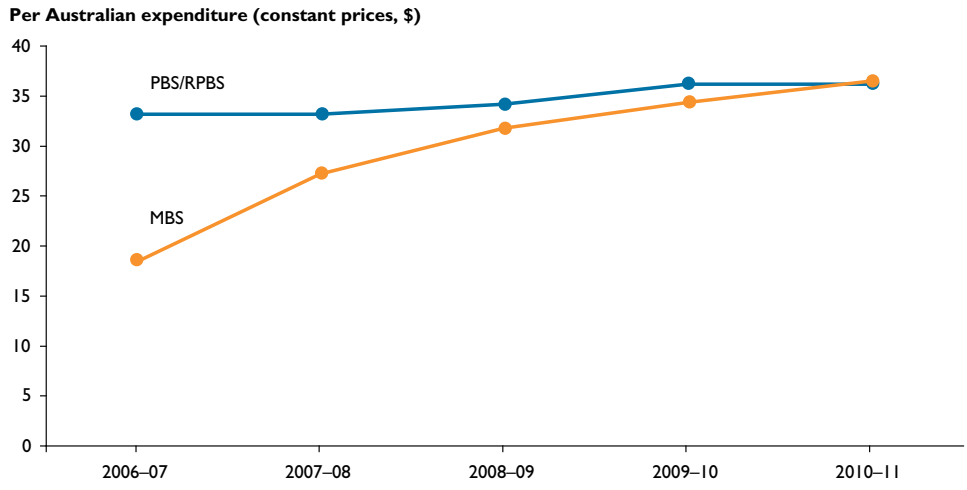

Figure 21: Australian Government expenditure on mental health-related MBS and PBS/RPBS, 2006–07 to 2010–11

Specialised mental health care facilities

Specialised mental health care in Australia is delivered in and by a range of facilities, including public and private psychiatric hospitals, psychiatric units or wards in public and private acute hospitals, community mental health care services and residential mental health services (Figure 22).

For more information, see the Resources section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

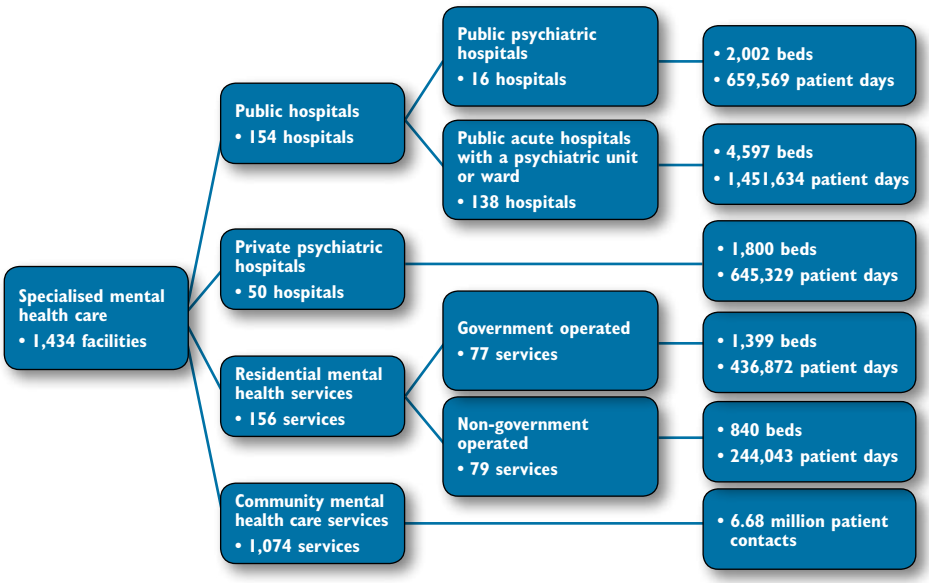

Figure 22: Number of specialised mental health care facilities, available beds and activity in Australia, 2009–10

There were 1,434 specialised mental health care facilities nationwide in 2009–10, of which 1,384 were state and territory specialised mental health facilities, including hospital, residential and community mental health care services. These state and territory facilities were administered by 210 specialised mental health service organisations, equivalent to the area health services or district mental health services in most states and territories. The most common of these organisations comprised a specialised mental health public hospital service and a community mental health care service.

In addition to the above, there were 50 private psychiatric hospitals and about 440 non-government organisations (data not shown) funded by state and territory governments to provide mental health services. The Australian Government also directly funded a range of services that are not represented in Figure 22, and work is under way to collect and report data relating to these services in future versions of this report.

How are consumers and carers involved in service planning and delivery?

Specialised mental health organisations often employ consumer and carer consultants to contribute to mental health service planning and delivery. The proportion of specialised mental health organisations employing consumer consultants increased from 31.4% in 2005–06 to 45.2% in 2009–10, with a similar increase in the employment of carer consultants over the same period (from 10.5% to 31.0% respectively).

The number of consumer and carer consultants employed, as a proportion of direct care staff, provides a further indicator of the involvement of consumers and carers in the planning and delivery of mental health services. Direct care staff refers to the staffing categories of *Medical staff, Nurses, Diagnostic and allied health professionals* and *Other personal care staff*. There were 27.8 full-time equivalent (FTE) consumer consultants per 10,000 direct care staff in 2009–10, which has remained relatively stable between 2005–06 and 2009–10. However, over the same period, the number of carer consultants has risen from 7.2 to 16.0 FTE per 10,000 direct care staff.

How many specialised mental health beds were available?

There were 8,399 specialised mental health hospital beds available during 2009–10, with 6,599 beds provided by public hospital services and 1,800 beds in private hospitals. In addition, there were 2,239 beds available in residential mental health services.

Two-thirds (4,597) of the public sector hospital beds available in 2009–10 were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals.

About two-thirds of all residential mental health beds were in services that were government-operated, however, the number of beds in non-government-operated services increased from 720 beds in 2005–06 to 840 beds in 2009–10, an annual average increase of 5.3%.

While the actual number of available state and territory specialised mental health beds increased from 8,420 beds in 2005–06 to 8,838 in 2009–10, the rate of beds per 100,000 population has remained relatively constant (Figure 23).

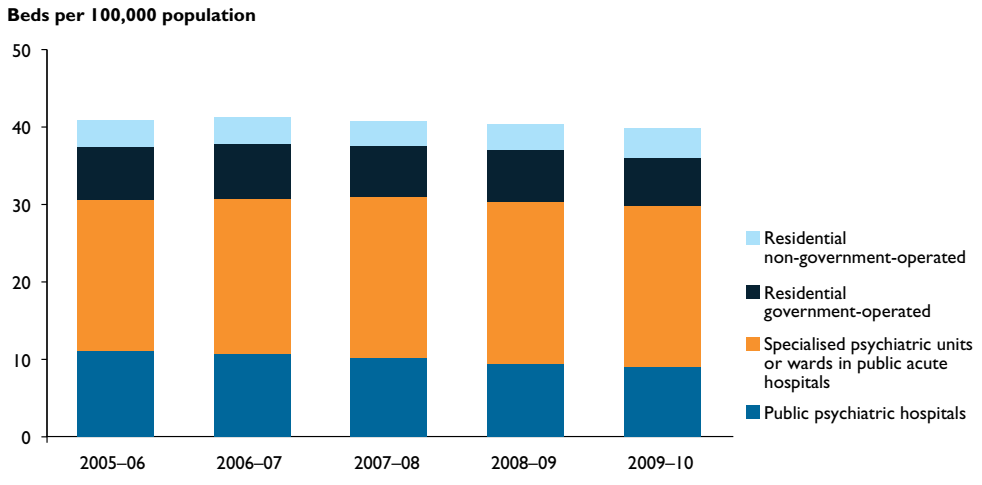

Figure 23: Specialised mental health beds, 2005–06 to 2009–10

24-hour staffed public sector care

Mental health services with staff employed in active shifts for 24 hours a day are provided through either public sector specialised mental health hospital services or 24-hour staffed residential mental health services. Comparisons between states and territories can be made if these different types of 24-hour care are combined.

Tasmania had the highest number of 24-hour care beds per 100,000 population (44.3), while the Northern Territory had the lowest (20.6), compared with a national average of 37.2 in 2009–10 (Figure 24).

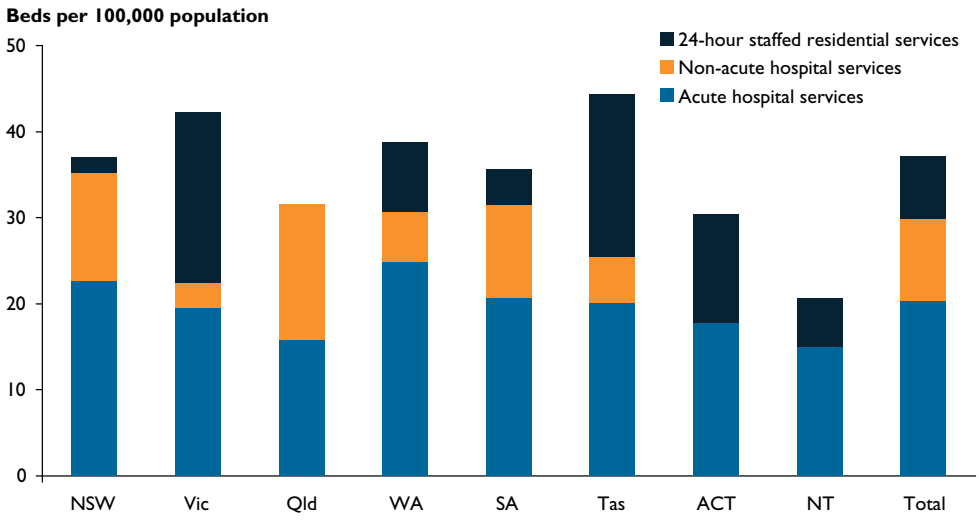

Figure 24: Specialised mental health beds, 24-hour care, 2009–10

How many staff were employed by specialised mental health care facilities?

State and territory services

Over 28,000 FTE staff were employed by state and territory specialised mental health care services in 2009–10. There was an average annual increase of 3.2% in the number of these FTE staff between 2005–06 and 2009–10.

The majority of FTE staff were *Nurses* (50.9%), followed by *Diagnostic and allied health professionals* (18.7%) and *Salaried medical officers* (9.8%).

Tasmania had the highest rate (per 100,000 population) of FTE staff (157.1), while the Northern Territory had the lowest (98.7), compared with a national rate of 126.6 in 2009–10.

When only direct care staff are considered, specialised mental health hospital admitted patient services employed the highest rate of staff at 52.2 direct care FTE staff per 100,000 population during 2009–10 (Figure 25).

Community mental health care services employed 45.0 direct care FTE staff per 100,000 population and residential mental health services employed 7.9 direct care FTE staff per 100,000. Community mental health care services experienced the greatest average annual increase (2.5%) in the rate of direct care FTE staff, from 40.8 FTE per 100,000 population in 2005–06 to 45.0 in 2009–10.

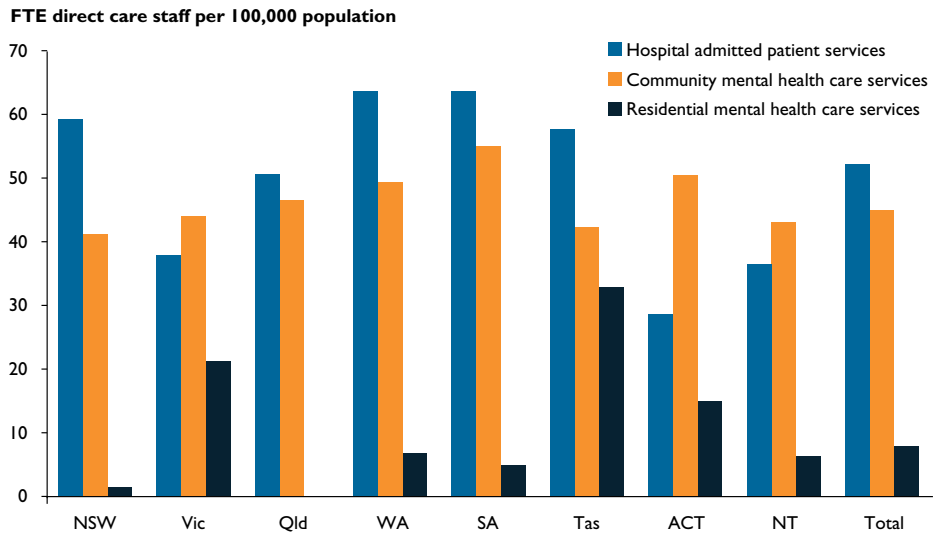

Figure 25: **Full-time-equivalent direct care staff, state and territory specialised mental health service units, 2009–10**

Private hospital services

In addition to state and territory specialised mental health care services, there were just under 2,500 FTE staff, or 11.1 FTE per 100,000 population, employed by private hospitals providing specialised mental health services in 2009–10. These figures do not include Medicare-subsidised medical practitioners and other health professionals who also provide services to people admitted to private hospitals for mental health care.

Other private sector services

In addition to state and territory services and private hospitals, there are a substantial number of health professionals employed in the private sector, funded through the MBS and other Australian Government sources. Work is under way to report data on these professionals in future versions of this report.

Workforce

Health care professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, provide the mental health-related services described in this report. Data presented here describe the national workforce, which includes the state and territory workforce outlined in the previous section. Up to date national workforce data are only available for psychiatrists, psychiatrists-in-training and nurses who work principally in mental health care.

For more information, see the Resources section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

Who comprises the mental health workforce?

There were an estimated 3,005 psychiatrists and 725 psychiatrists-in-training working in Australia in 2009, representing one in twenty (5.1%) employed medical practitioners; the majority (89.5%) of whom worked in *Major cities*. The average age of psychiatrists was 52, and over two-thirds were men, whereas the average age of psychiatrists-in-training was 35 and about half (52%) were men (AIHW 2011a). For the same period, there were an estimated 15,557 mental health nurses, representing about one in twenty (5.6%) of all employed nurses in Australia. Over two-thirds were working in *Major cities*, and their average age was 46. About one-third of these nurses were men, which is in contrast to the roughly one in ten reported for the general nursing population (AIHW 2011b).

How has this changed over time?

There were an estimated 18 FTE psychiatrists (including FTE psychiatrists-in-training) per 100,000 population employed in 2009. There was an average annual increase of 1.4% in the number of employed psychiatrists (including psychiatrists-in-training) between 2005 and 2009 (Figure 26).

For mental health nurses, there were an estimated 69 employed FTE per 100,000 population in 2009, with an average annual increase of 1.5% since 2005.

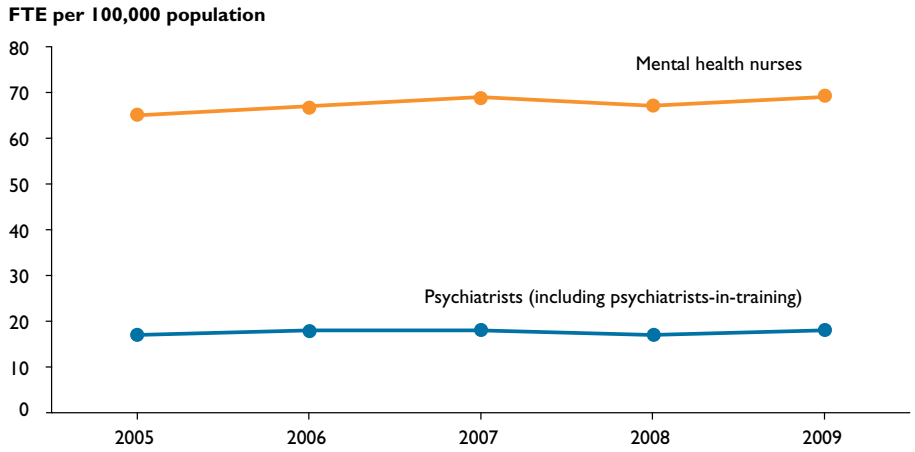

Figure 26: Employed psychiatrists (including psychiatrists-in-training) and mental health nurses, 2005–2009

What hours were worked?

Psychiatrists (including psychiatrists-in-training) worked an average of 40 hours per week in 2009. On average, men worked more hours than women.

Mental health nurses worked an average of 37 total hours per week, with men again working more hours than women on average.

How does this differ between states and territories?

The estimated number of FTE psychiatrists (including psychiatrists-in-training) and mental health nurses per 100,000 population varied between states and territories. Psychiatrists ranged from 11 FTE per 100,000 population for Northern Territory to 22 for Queensland, compared with a national average of 18 (Figure 27). For mental health nurses, the national FTE was 69 per 100,000 population and ranged from 57 for the Australian Capital Territory to 84 for the Northern Territory.

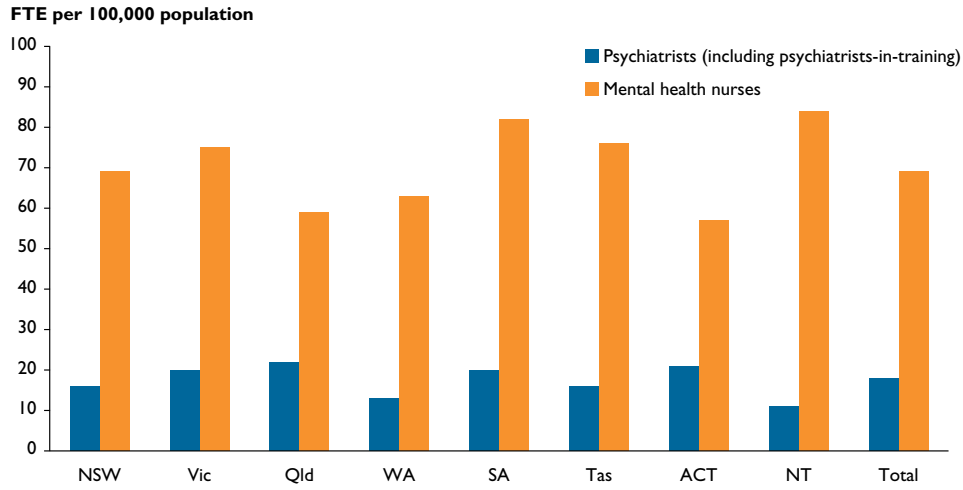

Figure 27: Employed psychiatrist (including psychiatrists-in-training) and mental health nurses, 2009

Mental health-related prescriptions

Mental health-related medications are provided through non-subsidised prescriptions as well as prescriptions subsidised by the Australian Government through the PBS and RPBS (DoHA 2012). This section uses data from these schemes as well as estimates of the number of non-subsidised prescriptions, including private prescriptions and those for which the price is below the required patient contribution (co-payment), obtained from a Pharmacy Guild survey (DoHA 2011).

For more information, see the Resources section of Mental Health Services in Australia online at www.mhsa.aihw.gov.au

How many prescriptions?

There were an estimated 31.1 million prescriptions for mental health-related medications dispensed in 2010–11, of which 76% have been subsidised by the Australian Government. Subsidised prescriptions for mental health-related medications accounted for 11% of all subsidised prescriptions dispensed in Australia in 2010–11.

How has this changed over time?

There was an increase in the rate (per 1,000 population) of mental health-related prescriptions dispensed, averaging 2.6% per year between 2006–07 and 2010–11 (Figure 28). There has been an annual increase of 1.8% in subsidised prescriptions and 5.2% in non-subsidised prescriptions.

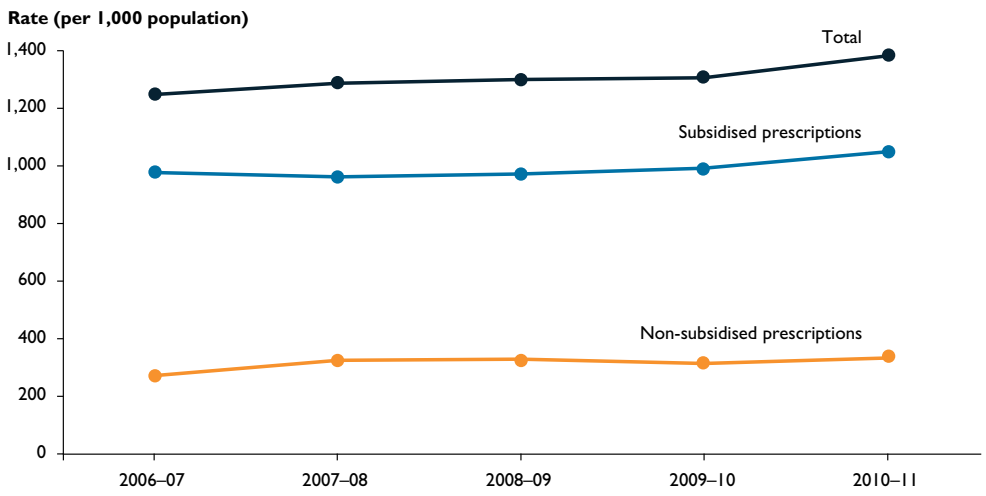

Figure 28: Mental health-related subsidised and non-subsidised prescriptions, 2006–07 to 2010–11

What was prescribed and by whom?

Antidepressant medication accounted for over 60% (13.7 million) of all subsidised mental health-related prescriptions dispensed in 2010–11 (Figure 29).

GPs provided the majority of the subsidised prescriptions (86%), with 8% prescribed by psychiatrists and 6% by non-psychiatrist specialists.

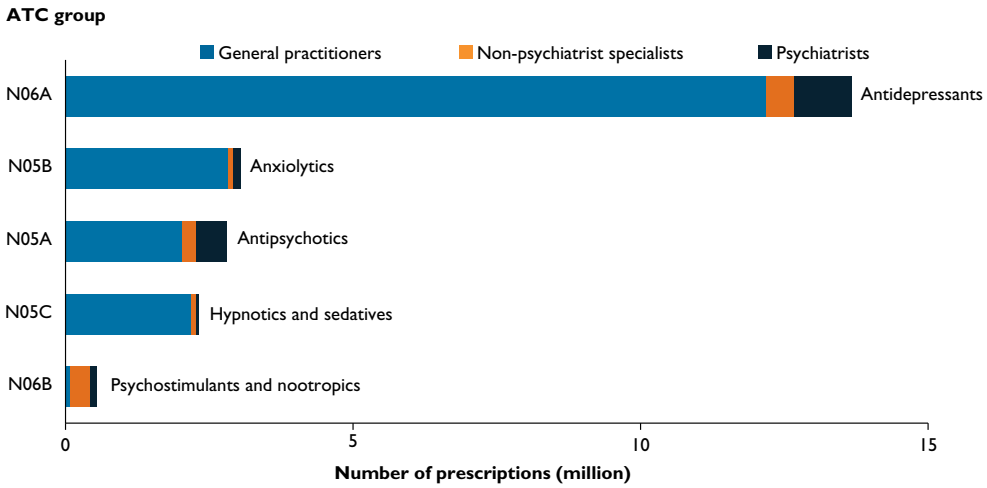

Figure 29: Mental health-related subsidised prescriptions, by ATC group of medication prescribed and prescribing medical practitioner, 2010–11

Sources: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA). Anatomical Therapeutic Chemical (ATC) Classification System (WHO 2011)

How does this differ between states and territories?

The rate of prescriptions per 1,000 population was relatively low in Western Australia at 914.0, but higher than the national average (995.8) in Tasmania (1,381.9) and South Australia (1,186.6).

Glossary

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

- **Ambulatory-equivalent:** when the care provided is similar to that provided by community mental health care services.
- **Admitted patient care:** when the care provided is specific to the hospital setting. Patients can have separations **with specialised psychiatric care** (within a specialised psychiatric unit or ward) or **without specialised psychiatric care** (no care within a specialised psychiatric unit or ward).

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

Closed support period: a support period within the Supported Accommodation Assistance Program that had finished on or before 30 June of the reporting year.

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

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

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

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

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

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

PBS: the Pharmaceutical Benefits Scheme subsidises the cost of prescription medicine. The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides a wide range of pharmaceuticals and dressings at a concession rate for the treatment of eligible veterans, war widows/widowers, and their dependants.

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

Remoteness areas: the Australian Standard Geographical Classification is based on an index which measures the remoteness of a point based on the physical road distance to the nearest urban centre. Some examples of localities in different remoteness categories include:

Major cities, which include most capital cities, as well as major urban areas such as Newcastle, Geelong and the Gold Coast.

Inner regional, which includes towns such as Hobart, Launceston, Mackay and Tamworth.

Outer regional, which includes towns such as Darwin, Whyalla, Cairns and Gunnedah.

Remote, which includes towns such as Alice Springs, Mount Isa and Esperance.

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

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

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Data sources

Mental health services in Australia—in brief 2012 draws on a wide range of health and welfare data sources to provide an overview of the national response to the mental health needs of Australians. Data included in the national databases are collected according to National Data Dictionaries published online in the AIHW Metadata Online Registry (METeOR).

Current data sources for this publication can be found at the *Mental Health Services in Australia* website and include the following:

Bettering the Evaluation and Care of Health survey of general practitioners (Services provided by general practitioners section).

Data provided by state and territory health authorities (Services provided in emergency departments section).

MBS data (DoHA) (Services provided by general practitioners section; MBS-subsidised specialised mental health services section; Expenditure on mental health services section).

National Community Mental Health Care Database (State and territory community mental health services section).

National Hospital Morbidity Database (Ambulatory-equivalent admitted patient care section; Admitted patient mental health-related care section).

National Residential Mental Health Care Database (Residential care section).

National Disability Agreement, Disability Services National Minimum Data Sets (Psychiatric disability support services section).

Supported Accommodation Assistance Program Client Collection (Supported accommodation assistance section).

Personal Helpers and Mentors Eligibility and Reporting System (Personal Helpers and Mentors section).

National Mental Health Establishments Database (Specialised mental health care facilities section; Expenditure on mental health services section).

Private Health Establishments Collection (Specialised mental health care facilities section; Expenditure on mental health services section).

AIHW Medical Labour Force Survey (Workforce section).

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA) (Mental health-related prescriptions section; Expenditure on mental health services section).

Mental health services—in brief 2012 **provides an overview of the characteristics and activity of Australia's mental health services, the availability of mental health resources and the changes that have occurred in these over time.**

It is designed to accompany the more comprehensive data on Australia's mental health services available online at www.mhsa.aihw.gov.au.