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Australian Institute of Health and Welfare

Board Chair

Hon. Peter Collins, AM, QC

Director

Penny Allbon

Any enquiries about or comments on this publication should be directed to:

Mental Health Services Unit

Australian Institute of Health and Welfare

GPO Box 570

Canberra ACT 2601

Phone: (02) 6244 1000

Email: mentalhealth@aihw.gov.au

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Foreword

Mental health services in Australia 2006–07 is the eleventh in the series of mental health reports produced by the Australian Institute of Health and Welfare. It provides a detailed picture of the national response to the mental health care needs of Australians. The report assembles a diverse range of 2006–07 data, and where available 2007–08 data, on Australian mental health consumers; their use of mental health services and the resources allocated by the Australian and state and territory governments to care for them.

The cooperation and advice of state and territory health authorities, the Australian Government and other stakeholders is vital to the production of this report. However, while based on jurisdictional data, the report reflects the AIHW's expertise in applying impartial analysis to the raw data, to produce information and analysis that informs the community and policy makers.

This year, the report includes scene-setting summary data from the second National Survey of Mental Health and Wellbeing which was conducted in 2007 by the Australian Bureau of Statistics. Data from the survey have been used to estimate that 3.2 million, or 20%, of Australians experienced symptoms of a mental disorder in the 12 months prior to the survey, confirming the importance of mental health as a health issue in Australian society.

The report provides data from the Institute's National Mental Health Establishments Database, providing detailed information on specialised mental health expenditure, beds and staffing. The report also includes data on mental health-related service provision from other Institute databases: the National Hospital Morbidity Database, the National Community Mental Health Care Database, the National Residential Mental Health Care Database, the Commonwealth, State/Territory Disability Agreement Database and the Supported Accommodation Assistance Program data collection. Mental health-related data are also provided on emergency department occasions of service, pharmaceuticals and Medicare services.

At this stage of data development, the information we can provide is limited to the number of services, or visits, or prescriptions delivered across Australia. We still have very little information about the number of people involved, or the services used per person. This remains an important data gap that can only be addressed by connecting information for mental health consumers within and across various data sets. This might be achieved by a range of strategies including data linkage as well as the information that might flow from the implementation of e-health.

Timeliness is another area where improvement is needed. Mental health data flows in a complex pathway from the recording of the data by mental health service providers to the analysis of the validated information for this report. This whole process is currently under review within all areas of the health and welfare system as a result of the desire of the Council of Australian Governments for speedier information. It is my objective that next year's information will be reported earlier to reflect the various needs at all levels of government and community.

Penny Allbon

Director

August 2009

Contents

Acknowledgments .... **viii**

Summary .... **ix**

1 Introduction **1**

1.1 Report structure 1

1.2 Definition of mental health-related services 3

1.3 Background on mental health in Australia 4

1.4 National policies for mental health 7

1.5 Additional information 8

2 Mental health-related care in general practice **10**

2.1 Introduction 10

2.2 Bettering the Evaluation and Care of Health survey data 10

2.3 Mental health-related encounters 12

2.4 Additional general practice activity 17

2.5 Mental health-specific Medicare Benefits Schedule items for general practice 18

3 Mental health-related care in emergency departments **24**

3.1 Introduction 24

3.2 Mental health-related emergency department occasions of service 24

3.3 Mental health-related emergency department care 26

4 Community mental health care and hospital outpatient services **31**

4.1 Introduction 31

4.2 States and territories 31

4.3 Type of service contacts 33

4.4 Duration of service contacts 33

4.5 Mental health legal status 34

4.6 Patient demographics 35

4.7 Principal diagnosis 37

4.8 Change over time, 2002–03 to 2006–07 40

4.9 Additional data 41

5 Ambulatory-equivalent mental health-related admitted patient care **42**

5.1 Introduction 42

5.2 States and territories and hospital type 43

5.3 Mental health legal status 44

5.4 Patient demographics 44

5.5 Principal diagnosis 46

5.6 Procedures 51

5.7 Change over time, 2002–03 to 2006–07 52
5.8 Additional data....52

6 Medicare-subsidised psychiatrist and allied health services 53
6.1 Introduction 53
6.2 People accessing MBS-subsidised psychiatrist and allied health services....55
6.3 MBS-subsidised psychiatrist and allied health services 59

7 Admitted patient mental health-related care 63
7.1 Introduction 63
7.2 Change over time, 2002–03 to 2006–07....64
7.3 Specialised admitted patient mental health care 68
7.4 Non-specialised admitted patient mental health care 78
7.5 Separations with mental health-related additional diagnoses 87
7.6 Additional data....88

8 Residential mental health care 89
8.1 Introduction 89
8.2 States and territories 90
8.3 Changes 2004–05 to 2006–07....91
8.4 Mental health legal status 91
8.5 Patient demographics....93
8.6 Principal diagnosis....95
8.7 Length of episodes and residential stays....97
8.8 Additional data....98

9 Mental health-related Supported Accommodation Assistance Program services....99
9.1 Introduction 99
9.2 SAAP clients with mental health-related closed support periods 101
9.3 SAAP mental health-related closed support periods....104

10 Support services for people with psychiatric disability 108
10.1 Introduction 108
10.2 CSTDA services overview 109
10.3 Residential services....111
10.4 Non-residential services....115

11 Mental health-related prescriptions 120
11.1 Introduction 120
11.2 Prescriptions 122
11.3 Patients 126

12 Profile of specialised mental health care facilities 130
12.1 Introduction 130
12.2 Mental health facilities 132

12.3 Number of available beds 134
12.4 Staffing of state and territory specialist mental health facilities 138
12.5 Private psychiatric hospitals 141

13 Mental health workforce 143
13.1 Introduction 143
13.2 Psychiatrists 144

14 Expenditure on mental health services 149
14.1 Introduction 149
14.2 Recurrent expenditure on state and territory specialised mental health services 150
14.3 Private psychiatric hospital expenditure 155
14.4 Australian Government expenditure on Medicare-subsidised mental health-related services 157
14.5 Australian Government expenditure on mental health-related medications 160
14.6 Total Australian Government expenditure on mental health-related services 164
14.7 Sources of funding for specialised mental health services 165
14.8 Funding and expenditure for all mental health-related services 167

15 State and territory summary tables 168
15.1 New South Wales 169
15.2 Victoria 172
15.3 Queensland 175
15.4 Western Australia 178
15.5 South Australia 181
15.6 Tasmania 184
15.7 Australian Capital Territory 187
15.8 Northern Territory 190
15.9 Australia 193

Appendix 1: Data sources 196

Appendix 2: Technical notes 214

Appendix 3: Classifications used 217

Appendix 4: Codes used to define mental health-related general practice encounters and mental health-related hospital separations 220

Abbreviations 230

References 232

List of tables 235

List of figures 242

Index 244

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Within the AIHW, the key contributors to this report were Lyle Baker, Roxanne Foster, Rachelle Graham, Chaye Hosie, 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, or 20%, of the population had experienced symptoms of a mental disorder in the 12 months prior to 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

- General practitioners (GPs) are often a first contact point for mental health concerns. In 2007–08, the BEACH survey estimated that over 11.9 million GP-patient encounters involved management of a mental health issue. These GP encounters increased by an annual average of 4.4% from 2003–04 to 2007–08.
- Medicare provides specific payments for some GP mental health-related encounters, such as the preparation or review of GP mental health care plans. These *Medicare Benefits Schedule* (MBS)-subsidised mental health items were introduced in November 2006. In 2006–07 there were nearly 550,000 claims against these items and in 2007–08 there were almost 1.2 million claims.
- In November 2006, the MBS was also extended to cover specific allied mental health services. In 2006–07 there were approximately 2.6 million claims for subsidised psychiatrist, psychologist and other allied health professional services and in 2007–08 there were 3.9 million claims.
- Community mental health services and hospital outpatient services also provide care for mental health consumers, with close to 6 million mental health-related service contacts in 2006–07, a 5.3% increase from 2005–06.
- Mental health care is provided to admitted patients in public acute, public psychiatric and private hospitals. In 2006–07, there were over 209,000 mental health-related separations for admitted patients. Over the 5 years to 2006–07, the average annual rate of increase for admitted patient mental health-related separations was 2.2%.
- In 2007–08, there were 20 million mental health-related prescriptions subsidised by the *Pharmaceutical Benefits Scheme* (and for veterans), accounting for just over one in ten of all prescription claims, costing over $700 million. Prescriptions for antipsychotics (49%) and antidepressants (43%) accounted for the majority of the spending.

Expenditure and resources

- Expenditure on state and territory mental health services increased by an annual average of 5.6% (adjusted for inflation) between 2002–03 and 2006–07, to $3,040 million. Specialised psychiatric wards in public acute hospitals and community mental health care services experienced annual average increases in expenditure of 7.2% and 5.9%, respectively, while stand alone public psychiatric hospital expenditure remained relatively stable.

- In 2006–07, there were 16 stand alone public psychiatric hospitals, 25 private psychiatric hospitals, and 139 public acute hospitals with a specialised psychiatric unit or ward. The number of beds in specialised psychiatric wards of public acute hospitals increased on average by 3.1% from 2002–03 to 2006–07 to 4,196 beds, while over the same period, stand alone public psychiatric hospitals beds decreased by 1.6% to 2,211 beds.
- In 2007–08, $549 million was paid in benefits for Medicare-subsidised mental health services provided by psychiatrists, GPs, psychologists and other allied health professionals. Nationally, Medicare benefits paid for these services averaged $25.91 per head of population. Between 2003–04 and 2007–08, the total expenditure on MBS mental health-related items increased by an annual average of 22.4% reflecting, in part, the introduction of items for psychologists and other allied health professionals during that period.

1 Introduction

Mental health services in Australia 2006–07 is the latest in the Australian Institute of Health and Welfare's (AIHW) series of annual mental health reports describing the activity and characteristics of Australia's mental health care services. In addition to providing information on a wide range of mental health care services in Australia in a centralised and accessible form, a key role of these reports is to make publicly available the data collected as specified in the National Minimum Data Sets (NMDSs) for Mental Health Care. These NMDSs cover specialised community and residential mental health care, specialised mental health care for patients admitted to public and private hospitals and establishment-level data on the facilities providing these services.

The latest year reported for most information in this report is 2006–07, with more recent data provided if available. Where appropriate and possible, time series data are also provided. More detailed data on mental health services in the years prior to 2006–07 are available in previous reports in this series.

1.1 Report structure

This 2006–07 report is very similar in structure to the 2005–06 report. It covers the following broad areas:

- 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 relation to 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 Pharmaceutical Benefits Scheme-subsidised prescriptions dispensed for mental health-related conditions.
- The third section (chapters 12 to 14) looks at the resources used and/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).

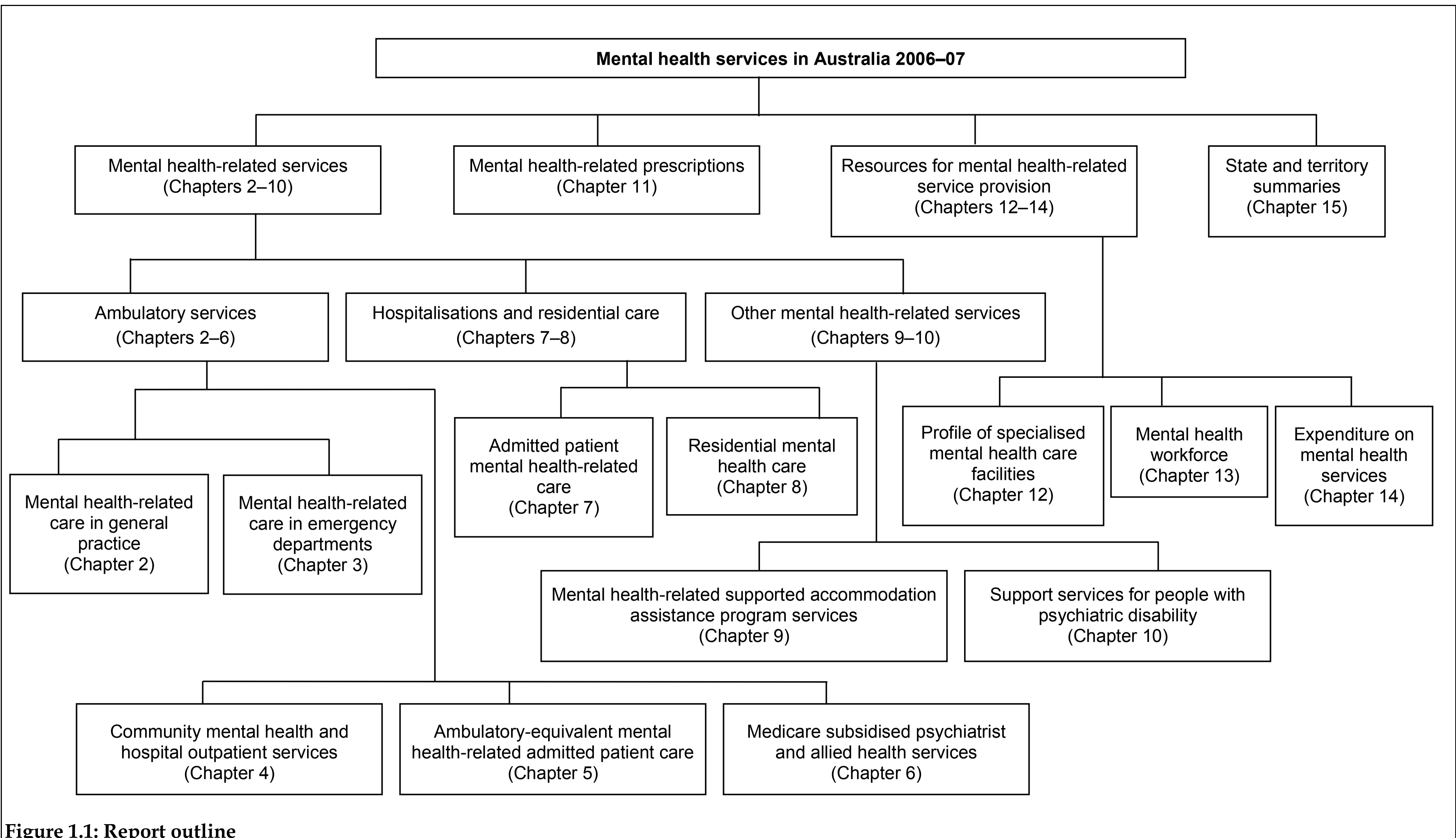


Figure 1.1: Report outline

- 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 establishments are counted that satisfy the definitions of the relevant National Minimum Data Sets (Community Mental Health Care National Minimum Data Set and Residential Mental Health Care National Minimum Data Set—see Appendix 1 for details). For data sources that are not mental-health specific, 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 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 relation to each data source are detailed in the respective chapters and in the appendixes.

1.3 Background on mental health in Australia

Mental health is one of Australia's national health priority areas and there has been 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 impact 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 impact 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.

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 prior to a survey.

The second National Survey of Mental Health and Wellbeing (SMHWB) was conducted by the ABS in 2007 (ABS 2008a) to provide information on the prevalence of lifetime and 12-month mental disorders within 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).

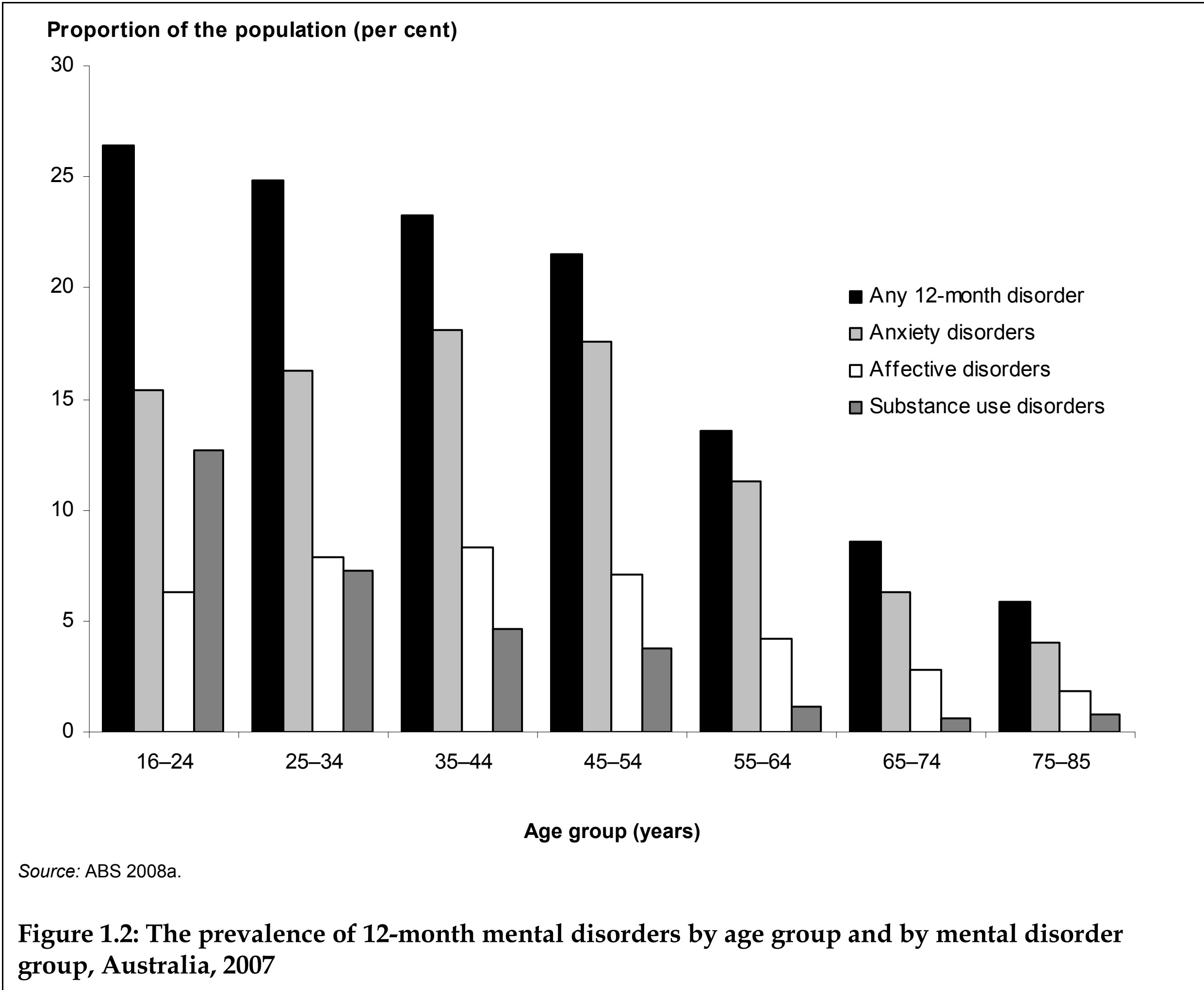
In order to determine whether survey respondents had experienced a mental disorder, the ABS interviewers used the *World Mental Health Survey Initiative* version of the World Health Organization's (WHO) *Composite International Diagnostic Interview, version 3.0* (WMH-CIDI 3.0). The findings were classified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

According to the survey, an estimated 7.3 million, or almost 45% 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 prior to the survey. 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 prior to the survey, affective disorders by 6.2% and substance use disorders by 5.1%.

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

More than a quarter (26%) of the youngest age group (16–24 years) had experienced mental illness in the 12 months preceding 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.



Source: ABS 2008a.

Figure 1.2: The prevalence of 12-month mental disorders by age group and by mental disorder group, Australia, 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 (25.4% or 800,000 people) of people with mental disorders experiencing two of more classes of mental disorder in the 12 months prior to the interview.

Mental disorders were more common among the population with chronic physical conditions than for those without chronic physical conditions (28% compared to 18%).

The use of mental health services

As well as measuring prevalence, the 2007 SMHWB collected data on the use of health services for mental health problems in the 12 months prior to 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 an anxiety or substance use disorder (22.0% and 11.1%, respectively). Those respondents experiencing multiple disorders were more likely to use health services than those with one disorder.

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				
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**

(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.

* 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.

Source: ABS 2009.

Mortality

A mental or behavioural disorder was recorded as the underlying cause for 580 deaths in Australia in calendar year 2006, at a rate of 2.7 deaths per 100,000 persons (AIHW 2008c). 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.

1.4 National policies for mental health

State and territory governments and the Australian Government have committed to improving the mental health of the Australian population 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. A brief outline of the main aims and objectives of these initiatives is given below.

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 2009b). 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 and
- 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 Policy will be operationalised and implemented through the development of the fourth *National Mental Health Plan* and plans developed by individual jurisdictions.

The current *National Mental Health Plan* (2003–2008) was endorsed by all Australian Health Ministers in July 2003 (AHMC 2003). The Plan consolidates reforms begun under the first two plans and has four priority themes:

- promoting mental health and preventing mental health problems
- increasing service responsiveness

- strengthening quality
- fostering research, innovation and sustainability.

COAG National Action Plan on Mental Health

In early 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.

Through the National Action Plan, the Australian and state and territory governments have committed to undertaking actions that emphasise coordination and collaboration between government, private and non-government providers to achieve the stated outcomes. The *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* initiative, introduced in November 2006 as part of the Australian government's contribution to the Plan, was designed to improve access to, and better teamwork between psychiatrists, clinical psychologists, GPs and other allied health professionals.

State and territory-based COAG mental health groups have been established to implement this Plan. These groups involve the Australian Government and the states and territories working together to coordinate the implementation of their commitments. 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.

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 2006–07*). 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 SMHWB are presented in the publication *The mental health of Australians 2* (DoHA 2009c).

The *National Mental Health Report* (DoHA 2008c) 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* (SCRGSP 2009). The Australian Health Ministers' Conference prepares an annual progress report on the *Council of Australian Governments' National Action Plan for Mental Health* (COAG 2008).

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) processing data.

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 95,300 GP ***encounters*** from a sample of 953 GPs over the period from April 2007 to March 2008, as this is the most recent data period available. This is described as BEACH 2007–08 in the remainder of this chapter. Note that this differs from the majority of chapters in this publication, which focus on 2006–07 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 95,898 encounters (Britt et al. 2008). The survey provides information on the reasons that patients visited the GP, the ***problems managed***, and the types of management that were provided for each problem.

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

Key concepts

General practitioners (GPs) are those medical practitioners who are vocationally registered with Medicare Australia or Fellows of the Royal Australian College of General Practitioners (RACGP) or trainees for vocational registration.

Other medical practitioners (OMPs) are primary care practitioners who are not vocationally registered or 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, prescription, referral) (Britt et al. 2008).

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. 2008).

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

Mental health-related problems managed, 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, version 2* (ICPC-2). A list of the 'P' chapter codes for problems, which includes alcohol and drug-related problems, is provided in Appendix 4.

Table 2.1: Mental health-related encounters, BEACH, 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Annual average change (per cent)[a]
Per cent of total GP encounters that are mental health-related	10.4	10.8	10.5	10.4	10.8	1.1
Estimated number of mental health-related encounters[b]	9,974,000	10,591,000	10,624,000	10,713,000	11,862,000	4.4
Lower 95% confidence limit	9,516,000	10,067,000	10,074,000	10,261,000	11,280,000	. .
Upper 95% confidence limit	10,433,000	11,117,000	11,174,000	11,165,000	12,375,000	. .
Estimated number of mental health-related encounters per 1,000 population[b][c]	498	523	517	514	560	3.0
Lower 95% confidence limit	475	497	490	492	533	. .
Upper 95% confidence limit	521	549	553	535	584	. .

(a) The confidence intervals suggest 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 (DoHA 2008b).

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

. . Not applicable.

Source: BEACH survey of general practice activity.

2.3 Mental health-related encounters

In 2007–08, 10.8% 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. Note that in terms of the *Medicare Benefits Schedule* (MBS) these encounters were most often recorded as surgery consultations (over 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 Medicare Benefits Schedule* initiative (item nos. 2710, 2712, 2713), represented 6.6% of MBS items recorded for mental health-related encounters in the 2007–08 BEACH survey. A further 0.15% 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 to other mental health-related encounters.

A simple extrapolation based on the 109.5 million unreferred (that is, non-specialist) attendances claimed from Medicare for 2007–08 suggests that there were an estimated 11.9 million mental health-related GP encounters for 2007–08. This corresponds to an estimated 560 encounters per 1,000 population, up from the 514 encounters per 1,000 population estimated in 2006–07.

The proportion of encounters that were mental health-related from the BEACH data showed an average annual increase of 1.1% between 2003–04 and 2007–08. Over the same period, the estimated total number of mental health-related GP encounters in Australia showed an average annual increase of 4.4% and the number per 1,000 population showed an average annual increase of 3.0%.

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 persons), the rates provide information on the number of mental health-related encounters relative to the size of the population subgroup.

In 2007–08, nearly one in four (24.6%) mental health-related encounters were for patients aged 65 years and over. This age group had an estimated 1,033 mental health-related encounters per 1,000 population during the 2007–08 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 between 25 and 64 years.

There were more mental health-related encounters for female patients than there were for male patients (59.8% and 40.2%, respectively). However, allowing for the higher rate of GP attendances for females, the difference between the genders was not as marked—an estimated 11.4% of all female encounters with GPs were mental health-related compared to 10.2% for males.

The great majority of mental health-related encounters were for non-Indigenous Australians (99.0%) and indeed, when relative population sizes and age structures were considered, Aboriginal and Torres Strait Islander Australians (311 per 1,000 population) had fewer mental health-related encounters than did non-Indigenous Australians (540 per 1,000 population). Whereas in 2006–07 a higher proportion of GP encounters for Aboriginal and Torres Strait Islander Australians were mental health-related (17.6% versus 10.6% for non-Indigenous Australians) the proportions recorded in 2007–08 were almost identical (11.1% versus 11.0%).

Mental health-related encounters were highest per 1,000 population among those living within *Major cities* (561), increasing from the rate reported in 2006–07 (515). The lowest encounter rates were among those in *Remote and very remote* areas (274), a decrease from 2006–07 (315).

Table 2.2: Patient demographics for mental health-related encounters, BEACH 2007–08

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					
Less than 15 years	2.4	2.2	1.9	2.5	69
15–24 years	7.5	8.6	7.8	9.5	300
25–34 years	14.4	13.7	12.6	14.8	575
35–44 years	17.6	15.7	14.6	16.8	666
45–54 years	18.7	14.5	13.6	15.5	750
55–64 years	14.8	11.3	10.6	12.1	733
65 years and over	24.6	9.8	9.1	10.4	1,033
Sex					
Male	40.2	10.2	9.5	10.8	439
Female	59.8	11.4	10.9	11.9	617
Indigenous status[(c)]					
Indigenous Australians	1.0	11.1	8.2	14.0	311
Non-Indigenous Australians	99.0	11.0	10.5	11.6	540
Remoteness area					
Major cities	72.2	10.6	10.0	11.2	561
Inner regional	18.5	12.0	11.0	13.1	501
Outer regional	8.2	10.9	9.6	12.2	468
Remote and very remote	1.1	9.5	6.6	12.4	274
Total	**100.0**	**10.8**	**10.3**	**11.3**	**560**

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

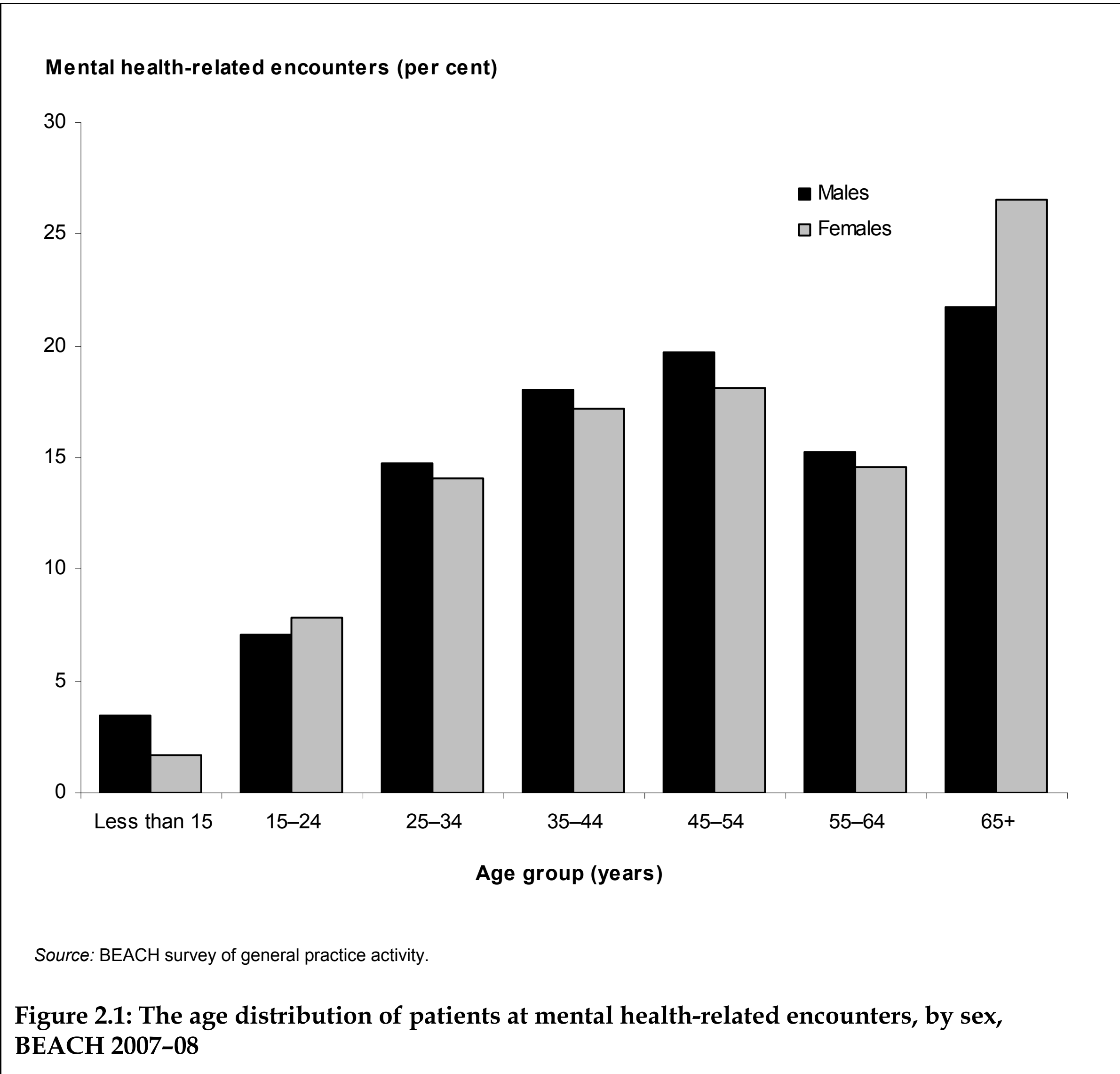
(b) Estimated encounter rates were directly age-standardised, with the exception of age, which is a crude rate, as detailed in Appendix 2.

(c) Information on this data element was missing or 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.

Figure 2.1 shows the age distribution of patients at mental health-related encounters by sex. The largest proportion of mental health-related encounters for both males and females were for those aged 65 years and over, especially for females.



Source: BEACH survey of general practice activity.

Figure 2.1: The age distribution of patients at mental health-related encounters, by sex, BEACH 2007–08

Mental health-related problems managed

In the BEACH 2007–08 survey, ***mental health-related problems managed*** occurred at a rate of 10.8 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 2007–08, accounting for 34.7% of all mental health-related problems managed and 2.6% of all health problems managed.

Anxiety (P01, P74) was the next most frequently reported mental health-related problem managed (15.4% of all mental health-related problems managed and 1.2% of all problems managed), followed by *sleep disturbance* (P06; 14.1% of all mental health-related problems managed and 1.1% of all problems managed).

Table 2.3: The 10 most frequent mental health-related problems managed, BEACH 2007–08

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	34.7	2.6	4.0	3.8	4.2
P01, P74	Anxiety	15.4	1.2	1.8	1.6	1.9
P06	Sleep disturbance	14.1	1.1	1.6	1.5	1.7
P02	Acute stress reaction	5.2	0.4	0.6	0.5	0.7
P72	Schizophrenia	4.3	0.3	0.5	0.4	0.6
P70	Dementia	3.8	0.3	0.4	0.3	0.5
P19	Drug abuse	3.8	0.3	0.4	0.3	0.6
P17	Tobacco abuse	3.6	0.3	0.4	0.3	0.5
P15, P16	Alcohol abuse	2.9	0.2	0.3	0.3	0.4
P73	Affective psychosis	1.8	0.1	0.2	0.2	0.2
	Other	10.6	0.8	1.2	1.1	1.3
	Total	**100.0**	**7.6**	**11.5**	**10.9**	**12.0**

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 way in which a mental health-related problem was managed was through a medication being prescribed, supplied or recommended by the GP—almost two-thirds of problems were handled in this way (65.2 per 100 mental health-related problems managed). Antidepressants were the most commonly prescribed, recommended or supplied medication (26.7 per 100), followed by anxiolytics (13.1) and hypnotics and sedatives (11.9).

The second most common form of management was the GP providing counselling or advice (47.5 per 100 mental health-related problems managed). This form of management occurred significantly more often than was the case in the 2006–07 BEACH survey when the rate was 42.8 per 100 (95% Confidence interval (CI): 40.4–45.2). By far the most common of these treatments was psychological counselling (26.8 per 100 mental health-related problems managed, about the same as the previous year's rate of 24.7 per 100).

Pathology was ordered at a rate of 13.7 tests 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) and thyroid-stimulating hormone tests (1.0).

A referral was given at a rate of 12.1 per 100 mental health-related problems managed. The most common referrals given were to psychologists (5.5 per 100 mental health-related problems managed) and to psychiatrists (1.9 per 100). While the rate of referrals to psychiatrists was unchanged from the previous year, the rate of referral to psychologists was significantly higher than 2006–07 when the rate was 3.6 per 100 (95% CI: 3.1–4.1), continuing the trend evident since 2005–06 when the rate was 1.6 per 100 (95% CI: 1.3–2.0). This may have been influenced by the introduction of new Medicare items in November 2006 covering attendances by psychologists, part of the *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* initiative.

Table 2.4: Most common types of management of mental health-related problems, BEACH 2007–08

Type of management		Rate (per 100 mental health-related problems)	95% LCL	95% UCL	Rate for 2006–07 BEACH survey
	Medication prescribed, recommended or supplied[(a)]				
N06A	Antidepressants	26.7	25.2	28.2	26.9
N05B	Anxiolytics	13.1	11.7	14.5	13.7
N05C	Hypnotics and sedatives	11.9	11.0	12.8	13.0
N05A	Antipsychotics	5.5	4.7	6.3	5.0
	Other	8.0	6.8	9.2	8.1
Total		**65.2**	**63.0**	**67.3**	**66.7**
	Treatments, including counselling[(b)]				
P58001, P58002, P58004–P58007, P58013–P58015, P58018, P58019	Counselling—psychological	26.8	25.0	28.6	24.7
P45001, P45002	Advice/education/observe/wait —psychological	3.5	2.7	4.3	2.5
P45004, P58008	Counselling/advice/education—smoking	2.5	2.1	3.0	2.6
P45005, P58009	Counselling/advice/education—alcohol	1.8	1.5	2.1	1.7
P45007, P58011, P58017	Counselling/advice/education—stress management, relaxation	1.6	1.3	1.9	2.2
	Other	11.3	10.3	12.2	9.2
Total		**47.5**	**45.2**	**49.8**	**42.8**
	Pathology[(b)]				
A34011	Test—full blood count	2.7	2.3	3.0	3.1
D34008	Test—liver function	1.5	1.2	1.8	1.4
T34028	Test—thyroid-stimulating hormone	1.0	0.8	1.2	1.3
T34015	Test—thyroid function	0.7	0.5	0.9	0.7
A34021	Test—electrolytes and liver function	0.6	0.5	0.8	0.7
	Other	7.3	6.4	8.2	7.9
Total		**13.7**	**12.2**	**15.3**	**15.2**
	Referral[(b)]				
P66003	Referral to psychologist	5.5	4.9	6.2	3.6
P67002	Referral to psychiatrist	1.9	1.5	2.2	1.9
P67006	Referral to sleep clinic	0.6	0.4	0.8	0.5
A67004	Referral to paediatrician	0.5	0.3	0.7	0.6
P66006	Referral to drug and alcohol professional	0.5	0.3	0.6	0.4
	Other	3.6	3.2	4.0	3.7
Total		**12.1**	**11.1**	**13.0**	**10.9**

(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.

2.4 Additional general practice activity

In addition to the 10.8 per 100 GP encounters where a mental health-related problem was managed, there were 2.1 per 100 total GP encounters in the 2007–08 BEACH survey which 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. Often, however, these encounters involved a generic request for a prescription or a referral as the 'problem' managed by the GP. Sometimes they 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 1% of encounters.

An extrapolation based on the 109.5 million non-specialist attendances claimed from Medicare for 2007–08 suggests that these additional encounters in the BEACH 2007–08 data set equate to an estimated 2.4 million additional encounters for 2007–08. In turn, this corresponds to an estimated 111 encounters per 1,000 population. Note that the extent of mental health-relatedness of these additional encounters is unknown.

Table 2.5: Psychologically-related activity in other[(a)] general practice encounters, BEACH 2007–08

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**
✓			1.1	50.4
	✓		1.0	44.9
		✓	0.1	3.2
✓	✓		0.0	1.1
✓		✓	0.0	0.1
	✓	✓	0.0	0.2
✓	✓	✓	0.0	0.0
Subtotal medications			1.1	51.7
	Subtotal management		1.0	46.3
		Subtotal referrals	0.1	3.6
Total psychologically-related activity in other[(a)] general practice encounters[(c)]			**2.1**	**100.0**

(a) These encounters did not involve a specific mental health-related problem managed (i.e., 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 (51.7%) 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. The most common of these medications were antidepressants (36.5%), followed by anxiolytics (35.9%). The medications were most commonly prescribed, recommended or supplied for general and unspecified prescription requests and renewals (29.3% of the problems managed for this group of additional encounters) and back symptoms and complaints (7.9%).

For 46.3% of these additional encounters, a treatment or counselling classified as psychological was reported. The most common type of management was counselling, advice or education with regard to lifestyle (37.2%) and counselling, advice or education with regard to smoking (29.2%). This management was most commonly provided for hypertension (13.8% of the problems managed for this group of additional encounters).

For 3.6% of the additional encounters, a referral classified as psychological was provided. The most common of these referrals were referral to a psychologist (49.4%), referral to a sleep clinic (18.9%) and referral to a counsellor (14.2%). At these encounters, the referrals were most commonly given for marital and relationship problems (16.1% of the problems managed for this group of additional encounters).

As was the case for the management of mental health-related problems, there was less use of psychologically-related medication by GPs in 2007–08 and more use of psychologically-related management activities and referrals than was the case in 2006–07.

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* (BOIMHC) 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 to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* initiative, designed to improve access to, and better teamwork between psychiatrists, clinical psychologists, GPs and other allied health professionals, introduced the *GP Mental Health Care Plan* as well as psychiatrist and allied health worker MBS items which 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 2007) as distinct

from general surgery consultations where a mental health-related problem is managed (see Key concepts).

There were 1,220,873 MBS-subsidised mental health services provided by GPs and OMPs in 2007–08 (Table 2.6), more than double the number for the previous year. The great majority (97%) of these services were for the preparation or review of *GP Mental Health Care Plans*. The *3 Step Mental Health Process* item groups were phased out following the introduction of the new *GP Mental Health Care Plan* items on 1 November 2006 and ceased after 30 April 2007. In the remainder of this chapter which focuses on data for 2007–08, no further references will be made to *3 Step Mental Health Process* items or OMPs.

Table 2.6: MBS-subsidised specific GP/OMP mental health services, by item group of service provided, 2003–04 to 2007–08

Item group[a]	2003–04	2004–05	2005–06	2006–07	2007–08
GP Mental Health Care Plans	. .	. .	. .	[b]546,515	1,183,690
Focussed Psychological Strategies	17,523	25,450	30,261	36,779	37,133
3 Step Mental Health Process—GPs	13,411	16,099	25,005	15,535	[c]53
3 Step Mental Health Process—OMPs	958	1,049	917	508	[c]–3
Total	**31,892**	**42,598**	**56,183**	**599,337**	**1,220,873**

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

(b) Introduced from 1 November 2006.

(c) The *3 Step Mental Health Process* items ceased after 30 April 2007. The figures appearing for these item groups in 2007–08 represent delayed processing of previously provided items. The negative value for the OMP item group is due to adjustments by Medicare Australia of previously processed claims.

. . Not applicable.

Source: MBS data (DoHA).

The BEACH 2007–08 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 in almost 90% of these encounters the MBS item recorded was for some form of consultation (Table 2.7). For 7.8% of these encounters, an MBS item designated specifically as a mental health service was recorded.

For mental health-related GP encounters, recording of mental health-specific MBS items (*GP Mental Health Care Plans and Focussed Psychological Strategies*) varied by the type of problem being managed as shown in Figure 2.2. The mental health-specific MBS items tended to be recorded comparatively more for depressive disorders and comparatively less for conditions such as sleep disturbance, dementia and drug, tobacco and alcohol abuse.

Table 2.7: Selected[a] MBS items recorded for mental health-related encounters, BEACH 2007–08

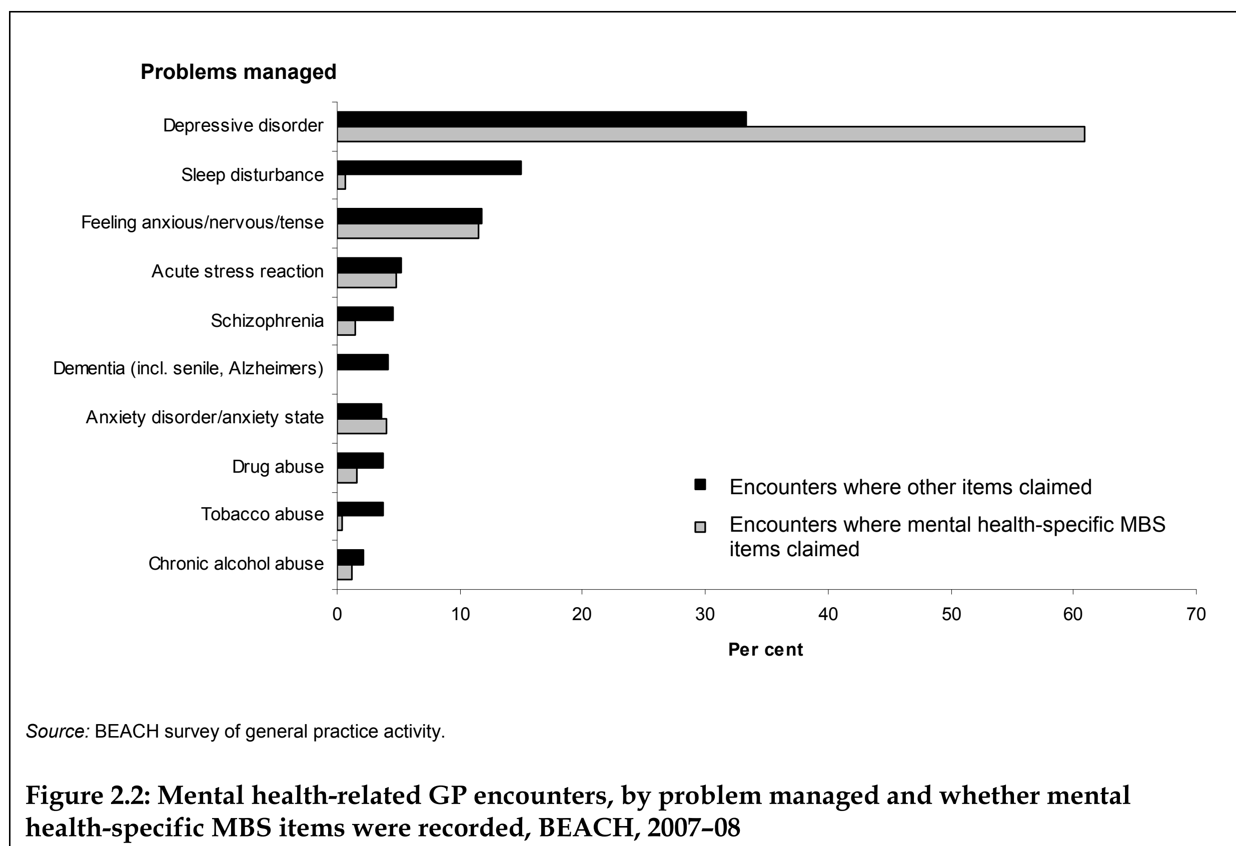
Rank	MBS Item No.	Item description	Per cent of mental health-related encounters	
			Item	Cumulative
1	23	Surgery consultation—level 'B' (standard)	62.9	62.9
2	36	Surgery consultation—level 'C' (long)	17.7	80.6
3	2710	GP Mental Health Care Plan—preparation	3.4	84.0
4	2713	GP Mental Health Care Plan—surgery consultation	3.3	87.3
5	35	Consultation at a residential aged care facility—level 'B'	2.4	89.6
6	44	Surgery consultation—level 'D' (prolonged)	1.9	91.6
7	3	Surgery consultation—level 'A' (short)	1.0	92.6
8	25	Consultation at an institution other than a hospital or residential aged care facility—level 'B'	1.0	93.6
9	2712	GP Mental Health Care Plan—review	1.0	94.6
10	5020	Surgery consultation—after hours—level 'B'	0.9	95.6
11	24	Home visit—level 'B'	0.8	96.3
12	721	GP management plan—preparation	0.4	96.7
23	2725	Focussed Psychological Strategies—surgery consultation (extended)	0.1	98.5
31	2721	Focussed Psychological Strategies—surgery consultation	0.1	99.2
Subtotal—Better Access items introduced 1 November 2006[b]			*7.7*	. .
Subtotal—BOIMHC items introduced in 2002[b]			*0.2*	. .
Total mental health specific items			**7.8**	**. .**
Total all items			**100.0**	**100.0**

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

(b) See the *Medicare Benefits Schedule* data section of Appendix 1 for a listing of these items.

. . Not applicable.

Source: BEACH survey of general practice activity.



Source: BEACH survey of general practice activity.

Figure 2.2: Mental health-related GP encounters, by problem managed and whether mental health-specific MBS items were recorded, BEACH, 2007–08

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, females and persons aged 35–44 years were the biggest consumers of these services. The majority of 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 usage.

Figure 2.3 shows rates of usage by remoteness area for *GP Mental Health Care Plan* items. These items constitute well over 90% of mental health-specific GP items (Table 2.9). The figure shows a concentration of utilisation of *GP Mental Health Care Plan* items in *Major cities* and *Inner regional* areas.

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 (66.0 per 1,000) and lowest in the Northern Territory (23.6 per 1,000). New South Wales also had a relatively high rate (60.8 per 1,000).

Table 2.8: People receiving MBS-subsidised GP mental health services: patient demographic characteristics and services received, 2007–08

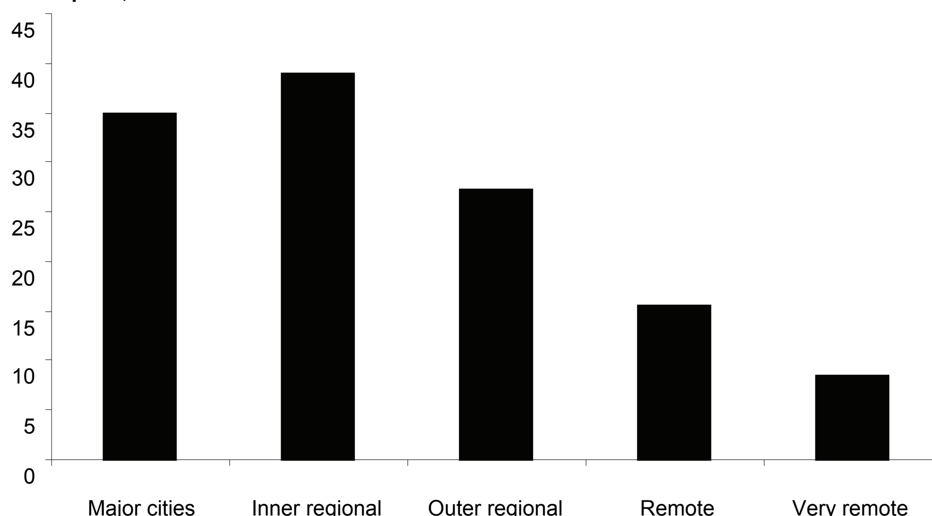
Patient demographics	Number of patients[(a)]	Per cent of patients	Rate (per 1,000 population)[(b)]	Number of services[(c)]	Per cent of services	Services per patient
Age						
Less than 15 years	39,851	5.5	9.7	47,980	3.9	1.2
15–24 years	111,134	15.4	37.7	171,217	14.0	1.5
25–34 years	156,595	21.7	53.4	259,339	21.2	1.7
35–44 years	169,283	23.5	54.7	290,101	23.8	1.7
45–54 years	133,285	18.5	45.4	232,023	19.0	1.7
55–64 years	79,475	11.0	33.5	138,032	11.3	1.7
65+ years	47,167	6.5	16.9	82,131	6.7	1.7
Sex						
Male	254,925	35.3	24.8	427,715	35.0	1.7
Female	466,393	64.7	45.1	793,108	65.0	1.7
Remoteness area						
Major cities	503,087	69.7	34.0	853,612	69.9	1.7
Inner regional	162,581	22.5	40.7	270,100	22.1	1.7
Outer regional	54,702	7.6	28.2	87,067	7.1	1.6
Remote	5,116	0.7	15.8	7,733	0.6	1.5
Very remote	1,474	0.2	8.8	2,222	0.2	1.5
Total GP items	**721,318**	**100.0**	**34.1**	**1,220,823**	**100.0**	**1.7**

(a) The number of patients for each demographic variable may not sum to the total 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).



(a) Crude rates based on the preliminary Australian estimated resident population by Australian Standard Geographical Classification Remoteness Area (ABS 2007a) as at 31 December 2006.

Source: MBS data (DoHA).

Figure 2.3: MBS-subsidised GP Mental Health Care Plans per 1,000 population, by remoteness area, 2007–08

Table 2.9: MBS-subsidised specific GP mental health services, numbers of patients and services provided, by item group[(a)], states and territories[(b)], 2007–08

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of patients				
GP Mental Health Care Plans	247,925	199,595	130,438	62,880	48,755	15,066	9,975	3,175	715,983
Focussed Psychological Strategies	5,411	4,044	2,567	772	1,374	190	168	31	14,527
Total patients[(c)]	**250,039**	**200,861**	**131,392**	**63,208**	**49,270**	**15,179**	**10,031**	**3,182**	**721,318**
Rate (per 1,000 population)[(c)(d)]	36.1	38.3	31.1	29.7	30.9	30.6	29.4	14.6	34.1
					Number of services				
GP Mental Health Care Plans	407,865	335,835	209,549	106,349	80,756	23,307	14,934	5,095	1,183,690
Focussed Psychological Strategies	13,254	10,350	7,051	1,474	4,168	414	376	46	37,133
Total services	**421,119**	**346,185**	**216,600**	**107,823**	**84,924**	**23,721**	**15,310**	**5,141**	**1,220,823**
Rate (per 1,000 population)[(d)]	60.8	66.0	51.2	50.6	53.3	47.8	44.9	23.6	57.6

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

Source: MBS data (DoHA).

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 another 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*** was included in this report for the first time in 2004–05, with the aim of providing a more complete picture of mental health-related services in Australia.

All state and territory health authorities collect a core set of nationally comparable information on most ***emergency department occasions of service*** in public hospitals within 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 which 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, 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 2006–07 information on the demographic characteristics, triage category, episode end status and principal diagnosis 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 in relation to 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.

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

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

  Nationally, in 2006–07, an estimated 22% of the 5.3 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 2006–07, the proportion of reported occasions of service with a diagnosis was 92% (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 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, 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 178,595 emergency department occasions of service with a mental health-related principal diagnosis in 2006–07 (Table 3.1). However, taking into account state and territory estimates of the coverage of their emergency department data collections and the total proportion (72%) of all occasions of service with a principal diagnosis reported, it is estimated that there were about 248,500 mental health-related emergency department occasions of service in public hospitals in 2006–07. This represents an increase of 19% on the estimated number of mental health-related emergency department occasions of service reported in 2005–06 (208,200—this figure has been updated from last year's report due to revised figures from one jurisdiction). Further information on estimated and reported emergency department occasions of service is available in Appendix 1.

Patient demographics

The demographic characteristics reported for mental health-related emergency department occasions of service in 2006–07 are contained in Table 3.1. 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 (79.1% and 51.8%, respectively) and a much lower percentage of those aged less than 15 years (3.4% and 22.6%, respectively).

In 2006–07, males made up a slightly higher proportion of mental health-related emergency department occasions of service than females (50.8% compared with 49.2%). This was in line with the distribution for all emergency department occasions of service (51.9% male).

Aboriginal and Torres Strait Islander peoples accounted for 5.7% of the mental health-related emergency department occasions of service. This compares with 4.3% of all emergency department occasions of service. It should be noted that most 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 2008a).

Table 3.1: Mental health-related emergency department occasions of service[(a)] in public hospitals, by patient demographic characteristics, 2006–07

Patient demographics	Number of occasions of service[(b)]	Per cent of total mental health-related occasions of service[(c)]	Per cent of all emergency department occasions of service reported in the NNAPEDCD[(c)(d)]
Age (years)			
Less than 15	6,120	3.4	22.6
15–24	39,314	22.0	15.8
25–34	40,427	22.6	14.3
35–44	36,539	20.5	12.0
45–54	24,914	14.0	9.7
55–64	13,032	7.3	8.1
65–74	7,017	3.9	6.8
75+	11,172	6.3	10.8
Sex			
Male	90,723	50.8	51.9
Female	87,856	49.2	48.1
Indigenous status			
Indigenous Australians	10,224	5.7	4.3
Other Australians[(e)]	168,371	94.3	95.7
Total	**178,595**	**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) The percentages shown do not include occasions of service for which the demographic information was missing and/or not reported.

(d) Occasions of service with episode-level data reported by state and territory health authorities to the NNAPEDCD 2006–07.

(e) Includes separations where Indigenous status was missing or not reported (see AIHW 2005).

Source: Data provided by state and territory health authorities.

Principal diagnosis

States and territories provided data on mental health-related occasions of services 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 2006–07, four diagnosis categories accounted for the majority (85.9%) of mental health-related occasions of service (Table 3.2). These were *Neurotic, stress-related and somatoform disorders* (F40–F48, 29.5%), *Mental and behavioural disorders due to psychoactive substance use* (F10–F19, 23.6%), *Mood (affective) disorders* (F30–F39, 17.7%) and *Schizophrenia, schizotypal and delusional disorders* (F20–F29, 15.1%). These proportions are very similar to the 2005–06 breakdown, where the top four diagnoses accounted for 86.0% of the total.

Table 3.2: Mental health-related emergency department occasions of service[(a)] in public hospitals, by principal diagnosis, states and territories, 2006–07

Principal diagnosis (ICD-10-AM)	NSW[(b)]	Vic	Qld	WA	SA[(b)]	Tas	ACT	NT	Total	Per cent of total
F00–F09: Organic, including symptomatic, mental disorders	3,044	1,415	1,168	1,258	809	232	133	75	8,134	4.6
F10–F19: Mental and behavioural disorders due to psychoactive substance use	17,845	8,802	6,398	3,134	3,503	916	510	982	42,090	23.6
F20–F29: Schizophrenia, schizotypal and delusional disorders	11,840	5,074	4,347	1,336	2,367	776	582	648	26,970	15.1
F30–F39: Mood (affective) disorders	12,758	6,691	6,029	1,913	1,905	1,307	592	343	31,538	17.7
F40–F48: Neurotic, stress-related and somatoform disorders	26,431	9,257	5,310	4,957	4,501	854	685	727	52,722	29.5
F50–F59: Behavioural syndromes associated with physiological disturbances and physical factors	464	182	2,155	88	123	34	19	9	3,074	1.7
F60–F69: Disorders of adult personality and behaviour	960	928	2,128	324	435	181	62	24	5,042	2.8
F70–F79: Mental retardation	8	28	102	0	3	0	2	0	143	0.1
F80–F89: Disorders of psychological development	85	0	165	12	17	0	4	1	284	0.2
F90–F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3,304	602	788	367	346	81	11	72	5,571	3.1
F99: Unspecified mental disorder	960	764	18	129	155	323	35	643	3,027	1.7
Total	**77,699**	**33,743**	**28,608**	**13,518**	**14,164**	**4,704**	**2,635**	**3,524**	**178,595**	**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.

Source: Data provided by state and territory health authorities.

The extent to which these four diagnosis categories contributed to the mental health-related emergency department occasions of service varied substantially 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.

Triage category

Triage category is related to the urgency of the patient's need for medical and nursing care, assessed when a patient is triaged in the emergency department. For example, patients triaged to the emergency category are assessed as requiring care within 10 minutes. However, they may or may not actually receive care within that time frame.

In 2006–07, 6.6% of mental health-related occasions of service in emergency departments were considered non-urgent (requiring care within 120 minutes), 36.8% were recorded as semi-urgent (within 60 minutes) and 45.0% as urgent (within 30 minutes). A further 10.8% were classified as emergency (requiring care within 10 minutes) and 0.8% as resuscitation (within seconds) (Table 3.3). These proportions are similar to 2005–06 data. Mental health-related occasions of service (55.8%) were more likely than all emergency department occasions of service (44.8%) to be assessed as urgent or emergency (AIHW 2008a).

Table 3.3: Mental health-related emergency department occasions of service[(a)] in public hospitals, by triage category, states and territories, 2006–07

Triage category	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Per cent of total
Resuscitation	335	392	292	114	175	21	11	29	1,369	0.8
Emergency	6,847	3,681	3,745	1,639	2,147	579	243	347	19,228	10.8
Urgent	34,386	14,547	13,828	5,933	6,556	2,337	1,122	1,657	80,366	45.0
Semi-urgent	29,286	13,033	9,530	5,388	4,595	1,681	1,099	1,192	65,804	36.8
Non-urgent	6,827	2,090	1,200	442	691	86	160	257	11,753	6.6
Total[(b)]	**77,699**	**33,743**	**28,608**	**13,518**	**14,164**	**4,704**	**2,635**	**3,524**	**178,595**	**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 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 2006–07, the episode end status (formerly called departure status) for nearly two-thirds of the mental health-related emergency department occasions of service was recorded as completed (Table 3.4). That is, 63.6% of these occasions of service were completed without admission or referral to another hospital. Just under one-third (29.0%) of mental health-related occasions of service were closed with the patient being admitted to the hospital to which he or she presented, which is slightly higher than the 26.9% for all emergency department occasions of service (AIHW 2008a). A further 4.5% of mental health-related patients were referred to another hospital.

Table 3.4: Mental health-related emergency department occasions of service[(a)] in public hospitals, by episode end status, states and territories, 2006–07

Episode end status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Per cent of total
Admitted to this hospital[(b)]	21,491	8,237	9,078	3,967	4,628	2,287	794	1,327	51,809	29.0
Non-admitted patient emergency department service episode completed[(c)]	48,812	23,215	18,219	8,617	8,587	2,257	1,751	2,058	113,516	63.6
Referred to another hospital for admission	4,556	1,419	611	615	690	99	40	11	8,041	4.5
Did not wait to be attended by a health care professional	798	0	288	70	20	5	15	2	1,198	0.7
Left at own risk[(d)]	1,925	871	412	232	199	49	35	82	3,805	2.1
Not reported[(e)]	117	1	0	17	40	7	0	44	226	0.1
Total	**77,699**	**33,743**	**28,608**	**13,518**	**14,164**	**4,704**	**2,635**	**3,524**	**178,595**	**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) Includes admissions to beds or units within the emergency department.

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

(d) 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.

(e) Included in this category are 8 occasions of service with an episode end status of *Died in emergency department as a non-admitted patient* and 12 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***. The statistical unit for the NCMHCD is a ***service contact*** between a client and a specialised mental health service provider. Appendix 1 provides information about the coverage and data quality of this collection.

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(s) 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, 2006–07). 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 either be 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 2006–07, there were 5,966,277 community mental health care service contacts reported nationally. Victoria reported the highest number of service contacts (1,830,278) (Table 4.1). However, the Australian Capital Territory had the highest number of service contacts per 1,000 population (602.9).

Five of the jurisdictions—namely Victoria, Queensland, Western Australia, the Australian Capital Territory and the Northern Territory were able to provide an actual count of patients while estimated patient counts were provided for New South Wales, South Australia and Tasmania. The estimated figure was derived from counting the number of unique patient identifiers for each individual provider reporting to the database which means that patients who used services from multiple providers will be counted more than once. Therefore, the estimated patient counts provided cannot be used for comparative purposes to derive estimates of relative access to services.

Of the five jurisdictions which reported actual patient counts, the Australian Capital Territory had the highest number of service contacts per patient (34.4).

Table 4.1: Community mental health care service contacts, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service contacts	1,828,468	1,830,278	1,050,960	535,809	382,304	93,186	207,487	37,785	5,966,277
Patients[(a)]	n.a.	58,916	72,552	37,730	n.a.	n.a.	6,037	4,771	n.a.
Average service contacts per patient[(a)]	n.a.	31.1	14.5	14.2	n.a.	n.a.	34.4	7.9	n.a.
Estimated number of patients[(b)]	302,553	. .	. .	. .	41,294	8,733	. .	. .	. .
Average service contacts per estimated number of patients[(b)]	6.0	. .	. .	. .	9.3	10.7	. .	. .	. .
					Rate (per 1,000 population)[(c)]				
Service contacts	269.7	353.3	256.7	257.9	249.3	189.2	602.9	172.3	288.0
Patients[(a)]	n.a.	11.4	17.7	18.2	n.a.	n.a.	17.5	21.7	n.a.
Estimated number of patients[(b)]	44.4	. .	. .	. .	27.2	18.3	. .	. .	. .

(a) This refers to the actual number of patients involved in community mental health care service contacts. Supply of these data was optional for states and territories.

(b) This is an estimated number of patients based on the calculation of the number of unique person identifiers for each establishment. The number of patients may be overestimated, as patients registered with more than one establishment are counted separately each time. See Appendix 1 for more information.

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

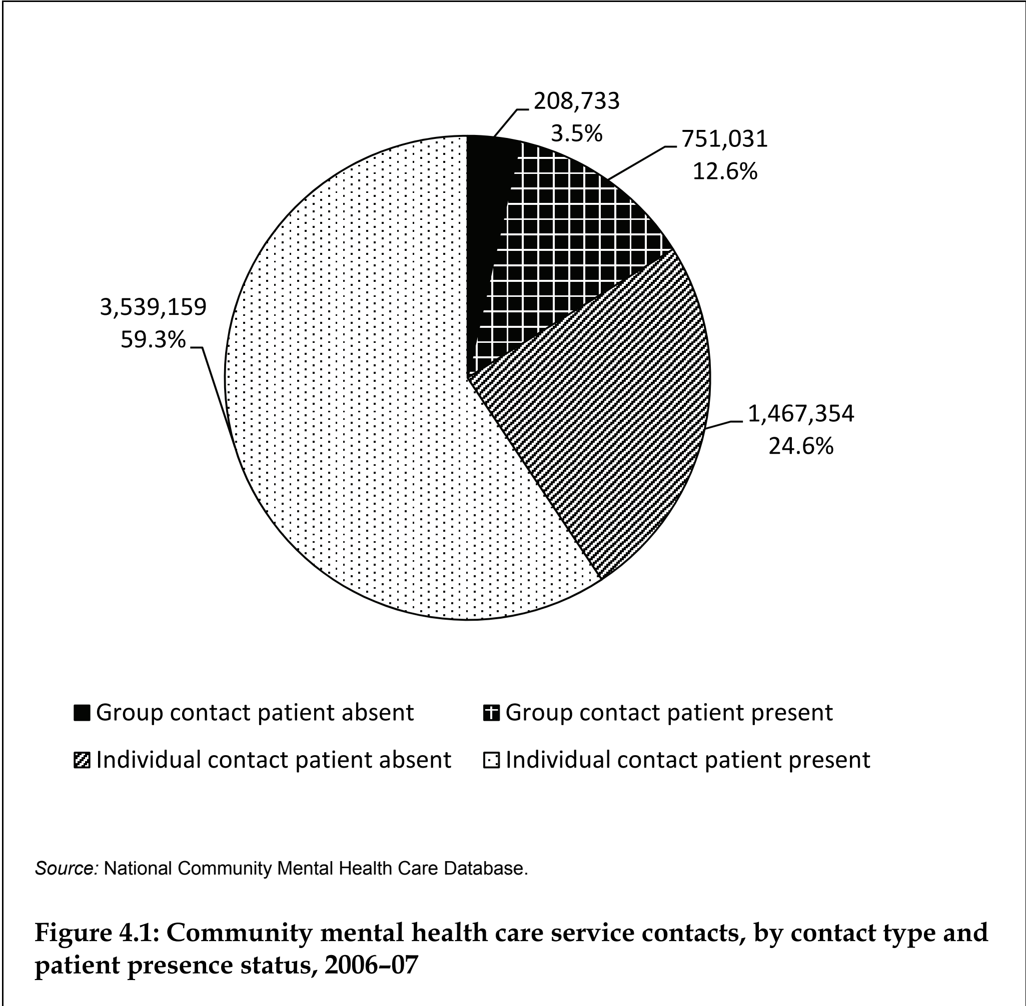
n.a. Not available.

. . Not applicable.

Source: National Community Mental Health Care Database.

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 (83.9%) of contacts reported were individual contacts. Of these, 70.7% 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 (78.3%) than those without (21.7%).

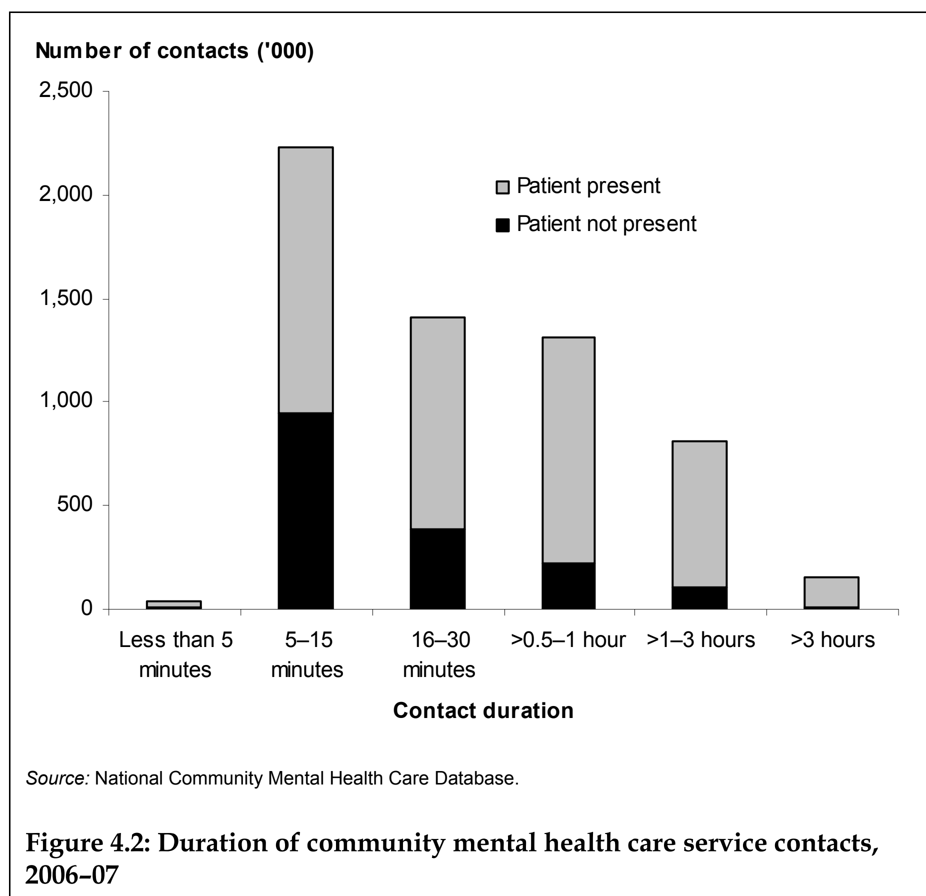


Source: National Community Mental Health Care Database.

Figure 4.1: Community mental health care service contacts, by contact type and patient presence status, 2006–07

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 contacts was 5–15 minutes, with 37.4% of contacts in this category.



Source: National Community Mental Health Care Database.

Figure 4.2: Duration of community mental health care service contacts, 2006–07

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. In the National Community Mental Health Care Database, a patient's mental health legal status refers to whether the patient is receiving treatment on a voluntary or involuntary basis. Patients with involuntary mental health legal status are 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'.

Table 4.2 presents the number of service contacts by jurisdiction and the patient's mental health legal status. Nationally, 16.4% of all service contacts were classified as involuntary. Western Australia reported the lowest proportion of involuntary contacts (2.2%), whilst 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, 2006–07

Mental health legal status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Involuntary	251,611	474,075	105,008	11,598	59,175	3,284	71,981	2,634	979,366
Voluntary	1,576,857	1,356,203	945,952	524,211	307,771	77,954	135,506	35,106	4,959,560
Not reported	0	0	0	0	15,358	11,948	0	45	27,351
Total	**1,828,468**	**1,830,278**	**1,050,960**	**535,809**	**382,304**	**93,186**	**207,487**	**37,785**	**5,966,277**

Source: National Community Mental Health Care Database.

4.6 Patient demographics

Table 4.3 presents information on the number of service contacts in 2006–07 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 persons), 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 (457.7) followed by those aged 35–44 years (392.0). The youngest age group (less than 15 years) was the least represented in both proportions of contacts (7.4%) and contacts per 1,000 population (106.4).

The data on contacts for Aboriginal and Torres Strait Islander peoples 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 (629.3 and 253.9, respectively).

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 (4.0%).

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, 2006–07

Patient demographics	Number of service contacts[(a)]	Per cent of service contacts[(b)]	Rate (per 1,000 population)[(c)]
Age (years)			
Less than 15	432,360	7.4	106.4
15–24	979,771	16.8	337.0
25–34	1,328,689	22.8	457.7
35–44	1,203,670	20.6	392.0
45–54	851,645	14.6	295.5
55–64	468,707	8.0	204.1
65+	565,186	9.7	207.2
Sex			
Male	3,124,748	53.5	304.5
Female	2,713,465	46.5	258.1
Indigenous status[(d)]			
Indigenous Australians	293,235	5.4	629.3
Other Australians	5,150,613	94.6	253.9
Country of birth			
Australia	4,794,990	84.2	321.4
Overseas	897,163	15.8	164.7
Remoteness area of usual residence			
Major cities	3,922,445	68.1	274.0
Inner regional	1,258,018	21.8	325.8
Outer regional	475,002	8.2	251.9
Remote	66,801	1.2	212.6
Very remote	36,937	0.6	220.3
Marital status			
Never married	3,347,233	61.6	. .
Widowed	217,805	4.0	. .
Divorced	507,659	9.3	. .
Separated	333,914	6.1	. .
Married	1,028,781	18.9	. .
Total	**5,966,277**	**100.0**	**288.0**

(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).

. . Not applicable.

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 2006–07. 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 in relation to principal diagnosis across Australia (for more information, see Appendix 1).

In 2006–07, a principal diagnosis was specified for 89.5% (5,340,739) of community mental health care service contacts. The most common principal diagnosis reported was *Schizophrenia* (F20), reported for 31.8% of all contacts. This was followed by *Depressive episode* (F32; 11.0%) and *Bipolar affective disorder* (F31; 6.7%).

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 one hour was highest for *Depressive episode* (F32; 22.5%), which also recorded the lowest percentage of contacts lasting 15 minutes or less (31.2%).

There were more group contacts for the diagnosis of *Depressive episode* (F32; 21.1%) and *Reaction to severe stress and adjustment disorders* (F43; 14.8%). The latter diagnosis was also the one with the highest percentage of service contacts in the absence of the patient (31.4%).

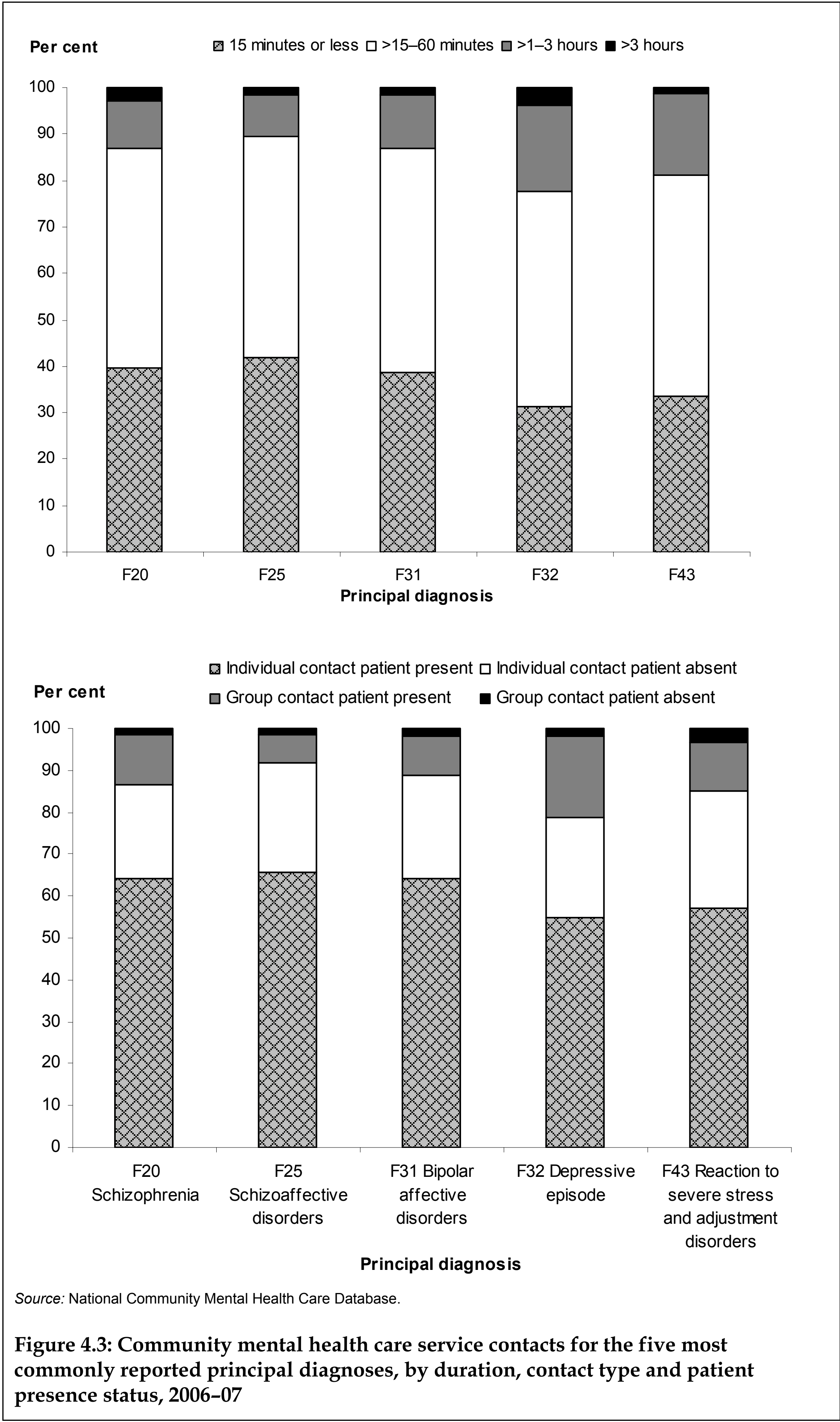
Table 4.4: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, 2006–07

Principal diagnosis		Number of service contacts	Per cent of specified principal diagnoses
F00–F03	Dementia	78,756	1.5
F04–F09	Other organic mental disorders	32,350	0.6
F10	Mental and behavioural disorders due to use of alcohol	49,550	0.9
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	104,650	2.0
F20	Schizophrenia	1,696,141	31.8
F21, F24, F28, F29	Schizotypal and other delusional disorders	76,459	1.4
F22	Persistent delusional disorders	40,037	0.7
F23	Acute and transient psychotic disorders	82,093	1.5
F25	Schizoaffective disorders	299,574	5.6
F30	Manic episode	17,289	0.3
F31	Bipolar affective disorders	358,497	6.7
F32	Depressive episode	586,605	11.0
F33	Recurrent depressive disorders	93,501	1.8
F34	Persistent mood (affective) disorders	43,046	0.8
F38, F39	Other and unspecified mood (affective) disorders	9,915	0.2
F40	Phobic anxiety disorders	26,846	0.5
F41	Other anxiety disorders	150,693	2.8
F42	Obsessive-compulsive disorders	33,623	0.6
F43	Reaction to severe stress and adjustment disorders	231,253	4.3
F44	Dissociative (conversion) disorders	4,693	0.1
F45, F48	Somatoform and other neurotic disorders	6,405	0.1
F50	Eating disorders	43,120	0.8
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	6,611	0.1
F60	Specific personality disorders	184,017	3.4
F61–F69	Disorders of adult personality and behaviour	19,851	0.4
F70–F79	Mental retardation	18,267	0.3
F80–F89	Disorders of psychological development	40,676	0.8
F90	Hyperkinetic disorders	29,580	0.6
F91	Conduct disorders	39,440	0.7
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	72,277	1.4
	Other[(a)]	864,924	16.2
Subtotal with specified principal diagnosis		*5,340,739*	*100.0*
F99	Mental disorder, not otherwise specified	250,514	. .
	Not reported	375,024	. .
Subtotal with unspecified principal diagnosis		*625,538*	*. .*
Total		**5,966,277**	**. .**

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

. . Not applicable.

Source: National Community Mental Health Care Database.



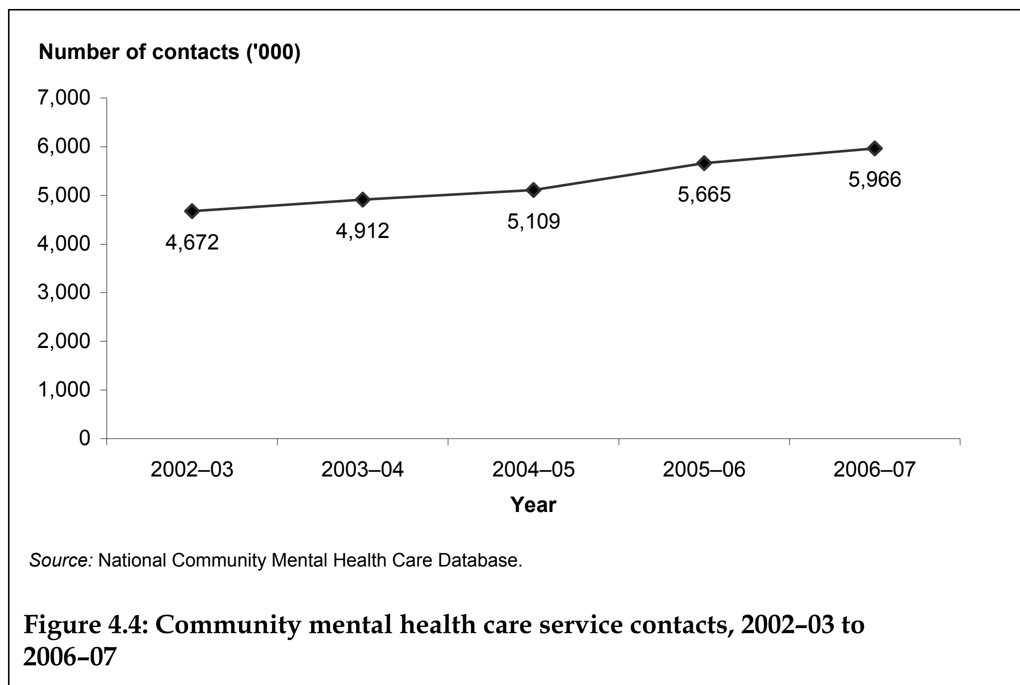
Source: National Community Mental Health Care Database.

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, 2006–07

4.8 Change over time, 2002–03 to 2006–07

The number of service contacts reported to the NCMHCD has increased over the five years to 2006–07 (Figure 4.4). In 2006–07, there was a 5.3% increase in the number of contacts reported compared with 2005–06. Note that these increases may reflect increases in the actual number of community mental health care services and/or improvements in data coverage. Not all jurisdictions were able to provide estimates of data coverage for the 2006–07 data. Consequently, it is not possible to determine conclusively what contribution the expanded data coverage may have made to the observed increase in the total number of service contacts being reported. State and territory estimates of coverage for 2006–07 are listed below:

- New South Wales estimated that their coverage for 2006–07 was similar to 2005–06, which was around 70% of full coverage.
- Victoria estimated that 100% of in-scope services have reported service contact data for 2006–07. Estimates of data coverage for 2005–06 were not available.
- Queensland estimated that 100% of in-scope services reported service contact data for 2006–07.
- Western Australia reported a significant growth in the number of service contacts in 2006–07 due to the introduction of a new reporting tool. Estimates of data coverage for 2005–06 were not available.
- South Australia estimated their 2006–07 coverage to be 70% with the figure derived as the number of organisations with incomplete or no patient level data for this NMDS divided by the number of organisations reporting community services via the national survey of mental health services for 2005–06. In 2005–06, the estimated coverage was 91%.
- Tasmania reported their coverage to be 88%. No estimated coverage was provided for 2005–06.
- The Australian Capital Territory reported their coverage to be 99.7%. In 2005–06 the estimated coverage was 98.9%.
- The Northern Territory reported 100% coverage for 2006–07. In 2005–06, the coverage was 90%.



Source: National Community Mental Health Care Database.

Figure 4.4: Community mental health care service contacts, 2002–03 to 2006–07

4.9 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.

The data presented in this chapter are from the National Hospital Morbidity Database (NHMD). More detailed information on the NHMD is available 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.
- 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 ICD-10-AM classification (codes F00–F99) or a number of other selected diagnoses (see Appendix 4 for the full list of applicable diagnoses), and/or
- it included any specialised psychiatric care.

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

5.2 States and territories and hospital type

In 2006–07, a total of 7,602,917 separations were reported from public and private acute and psychiatric hospitals (AIHW 2008a). Of these, 4.3% (329,958) were mental health-related comprising ambulatory-equivalent and admitted patient separations. Admitted patient separations are presented in Chapter 7.

There were 120,602 ambulatory-equivalent mental health-related separations reported in 2006–07, accounting for 1.6% of all separations and 36.6% 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, 2006–07

Hospital type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				With specialised psychiatric care					
Public acute hospitals	3,318	253	946	87	203	73	35	22	4,937
Public psychiatric hospitals	1,517	0	1	18	6	5	. .	. .	1,547
Private hospitals	24,017	30,110	20,674	7,217	10	n.p.	n.p.	n.p.	85,820
Subtotal	*28,852*	*30,363*	*21,621*	*7,322*	*219*	*n.p.*	*n.p.*	*n.p.*	*92,304*
				Without specialised psychiatric care					
Public acute hospitals	7,025	5,202	2,309	1,329	1,126	375	185	188	17,739
Public psychiatric hospitals	56	0	0	0	0	0	. .	. .	56
Private hospitals	2,186	2,903	3,345	511	12	n.p.	n.p.	n.p.	10,503
Subtotal	*9,267*	*8,105*	*5,654*	*1,840*	*1,138*	*n.p.*	*n.p.*	*n.p.*	*28,298*
				All hospitals					
Public acute hospitals	10,343	5,455	3,255	1,416	1,329	448	220	210	22,676
Public psychiatric hospitals	1,573	0	1	18	6	5	. .	. .	1,603
Private hospitals	26,203	33,013	24,019	7,728	22	n.p.	n.p.	n.p.	96,323
Total	**38,119**	**38,468**	**27,275**	**9,162**	**1,357**	**n.p.**	**n.p.**	**n.p.**	**120,602**
				Rate (per 1,000 population)[(b)]					
Public acute hospitals	1.5	1.1	0.8	0.7	0.9	1.0	0.6	1.0	1.1
Public psychiatric hospitals	0.2	0.0	0.0	0.0	0.0	0.0	. .	. .	0.1
Private hospitals	3.7	6.2	5.6	3.7	0.0	n.p.	n.p.	n.p.	4.5
All hospitals	**5.5**	**7.3**	**6.4**	**4.4**	**0.9**	**n.p.**	**n.p.**	**n.p.**	**5.7**

(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.

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.

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

Source: National Hospital Morbidity Database.

The data show that private hospitals were the predominant providers (79.9%, 96,323 out of 120,602) of ambulatory-equivalent mental health-related admitted patient care. The number of separations reported by public psychiatric hospitals constituted 1.3% (1,603 out of 120,602) with New South Wales being the major provider (98.1%).

Specialised psychiatric care was provided in 76.5% of all separations (92,304 out of 120,602) primarily by private hospitals (93.0%). This was particularly the case in Victoria where private hospital separations constituted 99.2% of all separations (30,110 out of 30,363).

Public acute hospitals played a greater role in separations without specialised psychiatric care (17,739 out of 28,298 or 62.7%).

Victoria reported the highest number of separations per 1,000 population (7.3) while South Australia had the lowest (0.9). Public acute hospitals in South Australia provided more than 97% of ambulatory-equivalent admitted patient care.

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 mental health legal status of about 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, 0.9% were involuntary and 84.6% of those (463 out of 547) 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, 2006–07

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	463	56	28	547
Voluntary	4,441	1,491	55,125	61,057
Not reported	33	0	30,667	30,700
Total	**4,937**	**1,547**	**85,820**	**92,304**

(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 number of ambulatory-equivalent mental health-related separations and the corresponding percentage of these separations for a number of demographic groups. A rate (per 1,000 population) has been provided to compare numbers of separations relative to the size of the respective population. 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 proportions of ambulatory-equivalent mental health-related separations were for patients aged 45–54 years and 55–64 years (19.5% and 18.8%, respectively). However, the highest number of separations per 1,000 population was for patients aged 55–64 years (9.9).

Table 5.3: Ambulatory-equivalent mental health-related separations[(a)], by patient demographic characteristics, 2006–07

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate (per 1,000 population)[(d)]
Age (years)			
Less than 15	5,792	4.8	1.4
15–24	15,328	12.7	5.3
25–34	16,960	14.1	5.8
35–44	22,252	18.5	7.2
45–54	23,570	19.5	8.2
55–64	22,666	18.8	9.9
65+	14,033	11.6	5.1
Sex			
Male	48,849	40.5	4.6
Female	71,741	59.5	6.8
Indigenous status[(e)]			
Indigenous Australians	1,679	1.5	3.9
Other Australians[(f)]	112,912	98.5	5.6
Country of birth			
Australia	95,108	83.8	6.3
Overseas	18,371	16.2	3.0
Remoteness area of usual residence			
Major cities	100,028	85.0	6.9
Inner regional	13,660	11.6	3.3
Outer regional	3,262	2.8	1.7
Remote	468	0.4	1.5
Very remote	230	0.2	1.3
Marital status[(g)]			
Never married	36,164	37.9	. .
Widowed	4,913	5.1	. .
Divorced	6,958	7.3	. .
Separated	4,515	4.7	. .
Married	42,877	44.9	. .
Total	**120,602**	**100.0**	**5.7**

(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 2005).

(f) Includes separations where Indigenous status was missing or not reported.

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

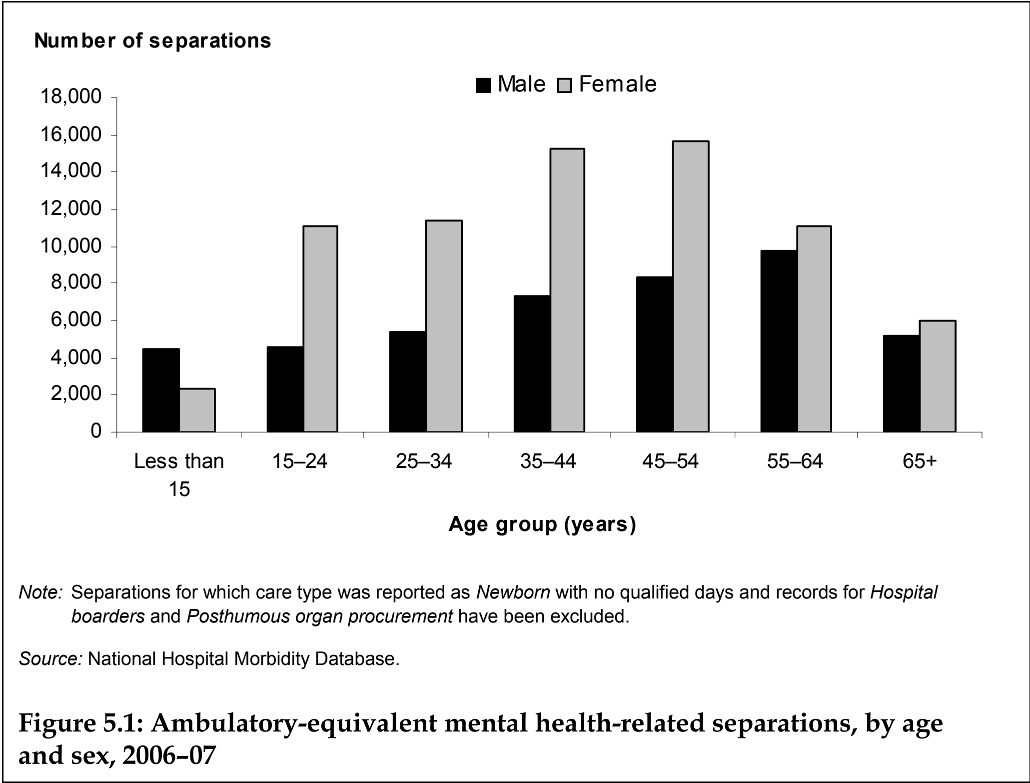
. . Not applicable.

Source: National Hospital Morbidity Database.

The separation rate for females (6.8 per 1,000 population) was nearly 50% higher than that of males (4.6). Likewise, the rate of separations of Australian-born patients (6.3) was more than twice that of those born overseas (3.0).

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 but with male separations in greater numbers. This situation was also seen in the less than 15 years age group, where male separations 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.

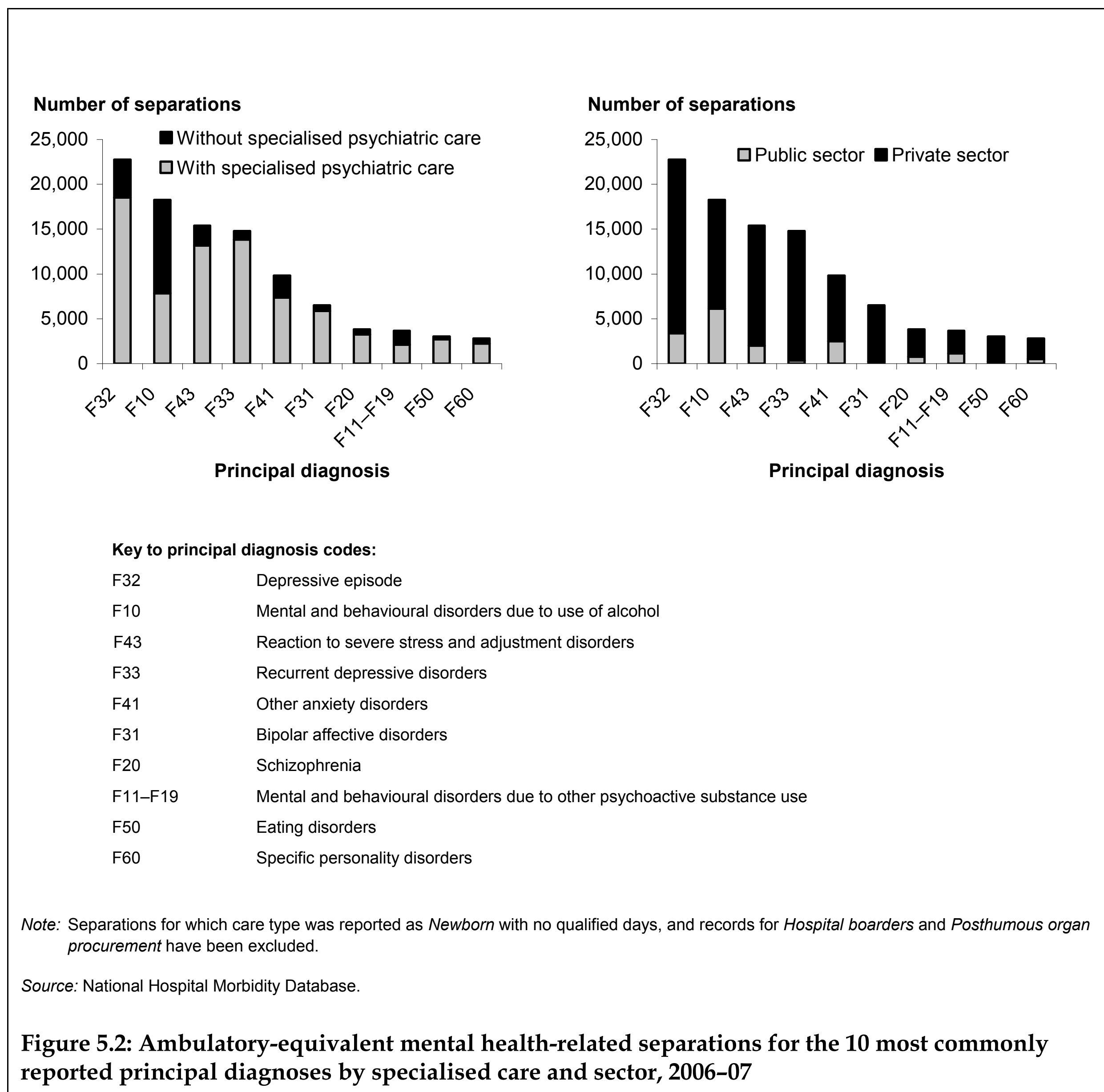
Source: National Hospital Morbidity Database.

Figure 5.1: Ambulatory-equivalent mental health-related separations, by age and sex, 2006–07

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 2006–07, the principal diagnosis of *Depressive episode* (F32) accounted for the largest number of separations (22,764 or 18.9%) 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).



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, 2006–07

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 *Other anxiety disorders* (F41).

Figure 5.2 shows the 10 most commonly reported principal diagnoses by specialised care and sector. *Recurrent depressive disorders* (F33) was the principal diagnosis with the highest proportion of separations with specialised psychiatric care (93.7%). *Mental and behavioural disorders due to use of alcohol or other psychoactive substance use* (F10 and F11–F19) were the only commonly reported principal diagnoses having a markedly higher proportion of separations that did not involve specialised psychiatric care (57.1% and 42.4%, respectively). These were also the two principal diagnoses with higher 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, 2006–07

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	0	1	115	116	0.1
F04–F09	Other organic mental disorders	6	1	112	119	0.1
F10	Mental and behavioural disorders due to use of alcohol	199	28	7,605	7,832	8.5
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	88	9	2,011	2,108	2.3
F20	Schizophrenia	240	18	2,982	3,240	3.5
F21, F24, F28, F29	Schizotypal and other delusional disorders	11	0	204	215	0.2
F22	Persistent delusional disorders	4	1	167	172	0.2
F23	Acute and transient psychotic disorders	11	1	231	243	0.3
F25	Schizoaffective disorders	76	3	2,376	2,455	2.7
F30	Manic episode	13	0	82	95	0.1
F31	Bipolar affective disorders	53	4	5,826	5,883	6.4
F32	Depressive episode	864	6	17,647	18,517	20.1
F33	Recurrent depressive disorders	93	1	13,764	13,858	15.0
F34	Persistent mood (affective) disorders	83	0	1,556	1,639	1.8
F38–F39	Other and unspecified mood (affective) disorders	49	0	314	363	0.4
F40	Phobic anxiety disorders	156	0	407	563	0.6
F41	Other anxiety disorders	244	336	6,790	7,370	8.0
F42	Obsessive-compulsive disorders	9	0	637	646	0.7
F43	Reaction to severe stress and adjustment disorders	629	25	12,524	13,178	14.3
F44	Dissociative (conversion) disorders	1	0	663	664	0.7
F45, F48	Somatoform and other neurotic disorders	25	0	56	81	0.1
F50	Eating disorders	4	0	2,714	2,718	2.9
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	1	0	322	323	0.3
F60	Specific personality disorders	149	4	2,106	2,259	2.4
F61–F69	Disorders of adult personality and behaviour	5	0	258	263	0.3
F70–F79	Mental retardation	3	0	0	3	0.0
F80–F89	Disorders of psychological development	69	94	61	224	0.2
F90	Hyperkinetic disorders	369	346	51	766	0.8
F91	Conduct disorders	965	186	2	1,153	1.2
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	179	282	13	474	0.5
F99	Mental disorder not otherwise specified	9	0	4	13	0.0
G30	Alzheimer's disease	0	0	591	591	0.6
	Other factors related to mental and behavioural disorders and substance use[b]	51	78	44	173	0.2
	Other specified mental health-related principal diagnosis[c]	15	0	0	15	0.0
	Other[d]	264	123	3,585	3,972	4.3
Total		**4,937**	**1,547**	**85,820**	**92,304**	**100**

(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, 2006–07

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	94	0	2	96	0.3
F04–F09	Other organic mental disorders	91	0	3	94	0.3
F10	Mental and behavioural disorders due to use of alcohol	5,901	15	4,505	10,421	36.8
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,015	11	523	1,549	5.5
F20	Schizophrenia	503	3	89	595	2.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	123	0	15	138	0.5
F22	Persistent delusional disorders	65	0	0	65	0.2
F23	Acute and transient psychotic disorders	127	0	6	133	0.5
F25	Schizoaffective disorders	193	1	96	290	1.0
F30	Manic episode	35	0	0	35	0.1
F31	Bipolar affective disorders	191	1	441	633	2.2
F32	Depressive episode	2,523	0	1,724	4,247	15.0
F33	Recurrent depressive disorders	245	0	687	932	3.3
F34	Persistent mood (affective) disorders	123	3	111	237	0.8
F38–F39	Other and unspecified mood (affective) disorders	34	1	21	56	0.2
F40	Phobic anxiety disorders	12	0	32	44	0.2
F41	Other anxiety disorders	1,924	0	533	2,457	8.7
F42	Obsessive-compulsive disorders	11	1	11	23	0.1
F43	Reaction to severe stress and adjustment disorders	1,337	12	861	2,210	7.8
F44	Dissociative (conversion) disorders	153	1	7	161	0.6
F45, F48	Somatoform and other neurotic disorders	135	0	2	137	0.5
F50	Eating disorders	251	0	60	311	1.1
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	52	0	54	106	0.4
F60	Specific personality disorders	344	5	220	569	2.0
F61–F69	Disorders of adult personality and behaviour	35	0	9	44	0.2
F70–F79	Mental retardation	24	2	0	26	0.1
F80–F89	Disorders of psychological development	40	0	0	40	0.1
F90	Hyperkinetic disorders	13	0	0	13	0.0
F91	Conduct disorders	90	0	0	90	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	50	0	1	51	0.2
F99	Mental disorder not otherwise specified	46	0	1	47	0.2
G30	Alzheimer's disease	36	0	2	38	0.1
	Other factors related to mental and behavioural disorders and substance use[b]	182	0	1	183	0.6
	Other specified mental health-related principal diagnosis[c]	1,741	0	486	2,227	7.9
Total		**17,739**	**56**	**10,503**	**28,298**	**100**

(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, 2006–07

ICD-10-AM code	Principal diagnosis description	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total	Per cent of separations
F00–F03	Dementia	94	1	117	212	0.2
F04–F09	Other organic mental disorders	97	1	115	213	0.2
F10	Mental and behavioural disorders due to use of alcohol	6,100	43	12,110	18,253	15.1
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	1,103	20	2,534	3,657	3.0
F20	Schizophrenia	743	21	3,071	3,835	3.2
F21, F24, F28, F29	Schizotypal and other delusional disorders	134	0	219	353	0.3
F22	Persistent delusional disorders	69	1	167	237	0.2
F23	Acute and transient psychotic disorders	138	1	237	376	0.3
F25	Schizoaffective disorders	269	4	2,472	2,745	2.3
F30	Manic episode	48	0	82	130	0.1
F31	Bipolar affective disorders	244	5	6,267	6,516	5.4
F32	Depressive episode	3,387	6	19,371	22,764	18.9
F33	Recurrent depressive disorders	338	1	14,451	14,790	12.3
F34	Persistent mood (affective) disorders	206	3	1,667	1,876	1.6
F38–F39	Other and unspecified mood (affective) disorders	83	1	335	419	0.3
F40	Phobic anxiety disorders	168	0	439	607	0.5
F41	Other anxiety disorders	2,168	336	7,323	9,827	8.1
F42	Obsessive-compulsive disorders	20	1	648	669	0.6
F43	Reaction to severe stress and adjustment disorders	1,966	37	13,385	15,388	12.8
F44	Dissociative (conversion) disorders	154	1	670	825	0.7
F45, F48	Somatoform and other neurotic disorders	160	0	58	218	0.2
F50	Eating disorders	255	0	2,774	3,029	2.5
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	53	0	376	429	0.4
F60	Specific personality disorders	493	9	2,326	2,828	2.3
F61–F69	Disorders of adult personality and behaviour	40	0	267	307	0.3
F70–F79	Mental retardation	27	2	0	29	0.0
F80–F89	Disorders of psychological development	109	94	61	264	0.2
F90	Hyperkinetic disorders	382	346	51	779	0.6
F91	Conduct disorders	1,055	186	2	1,243	1.0
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	229	282	14	525	0.4
F99	Mental disorder not otherwise specified	55	0	5	60	0.0
G30	Alzheimer's disease	36	0	593	629	0.5
	Other factors related to mental and behavioural disorders and substance use[(b)]	233	78	45	356	0.3
	Other specified mental health-related principal diagnosis[(c)]	1,756	0	486	2,242	1.9
	Other[(d)]	264	123	3,585	3,972	3.3
Total		**22,676**	**1,603**	**96,323**	**120,602**	**100**

(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.

A total of 60,032 procedures were reported in relation to 51,216 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 57.5% (69,386 out of 120,602) of the separations. The most frequently reported procedure was *Cognitive behaviour therapy* (16,462 procedures for 16,461 separations).

Table 5.7: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations[(a)], 2006–07

	Procedures[(b)]		Separations[(b) (c)]	
Procedure	**Number**	**Per cent**	**Number**	**Per cent**
96101–00 Cognitive behaviour therapy	16,462	27.4	16,461	13.6
96180–00 Other psychotherapies or psychosocial therapies	7,876	13.1	7,871	6.5
96185–00 Supportive psychotherapy, not elsewhere classified	5,258	8.8	5,253	4.4
96001–00 Psychological skills training	4,763	7.9	4,763	3.9
92002–00 Alcohol rehabilitation	3,565	5.9	3,564	3.0
96090–00 Other counselling or education	3,545	5.9	3,545	2.9
95550–10 Allied health intervention, psychology	3,387	5.6	3,387	2.8
96073–00 Substance addiction counselling or education	2,824	4.7	2,824	2.3
96175–00 Mental/behavioural assessment	2,230	3.7	2,230	1.8
96177–00 Interpersonal psychotherapy	2,061	3.4	2,060	1.7
Other reported procedures	8,061	13.4	8,052	6.7
	Totals			
Number of separations with at least one procedure	. .	. .	51,216	42.5
Number of procedures with no procedure reported	. .	. .	69,386	57.5
Total	**60,032**	**100.0**	**120,602**	**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) 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.

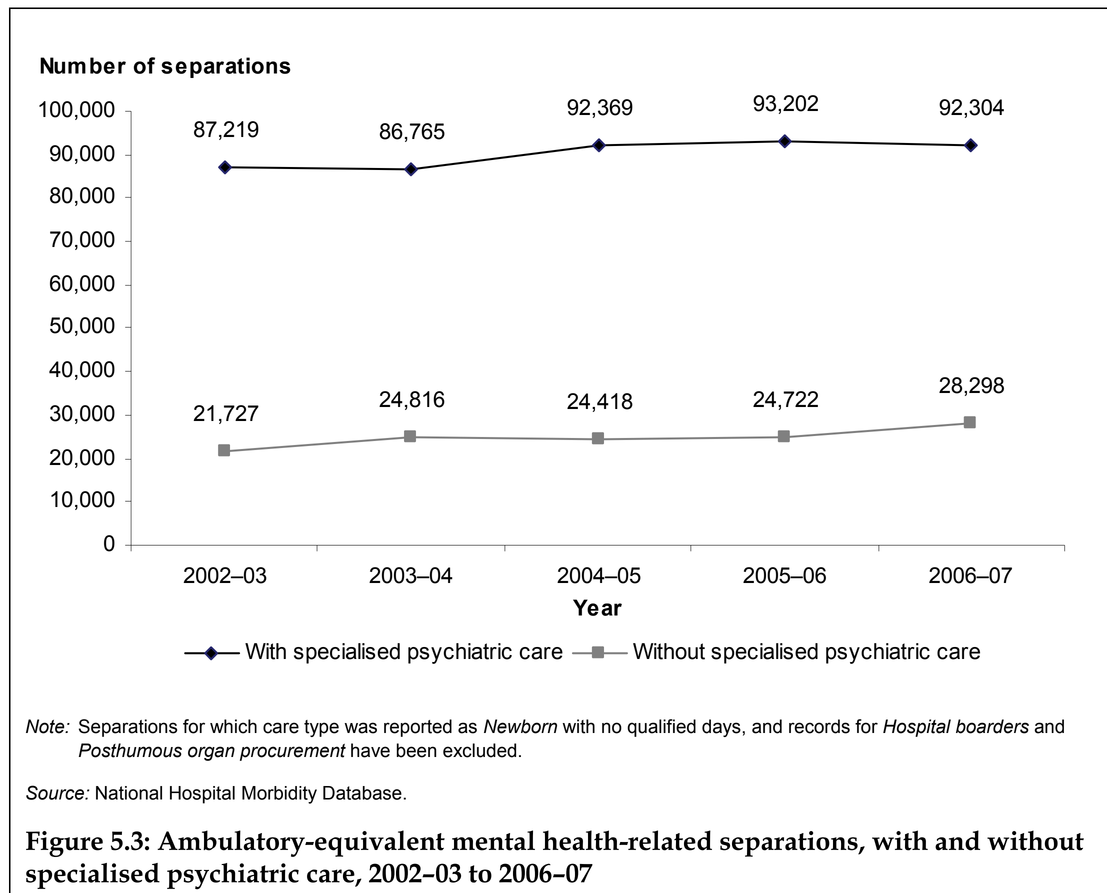
. . Not applicable.

Source: National Hospital Morbidity Database.

5.7 Change over time, 2002–03 to 2006–07

Figure 5.3 depicts the number of ambulatory-equivalent mental health-related separations, with and without specialised care from 2002–03 to 2006–07. 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 10.7% between 2002–03 (108,946) and 2006–07 (120,602). Separations involving specialised psychiatric care increased by 5.8% during the same period. A marked increase (30.2%) was observed for separations without specialised psychiatric care.



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, 2002–03 to 2006–07

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 NHMD 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, social workers and occupational therapists.

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 Schedule* (PBS) provides access to medicines; while through the *Australian Health Care Agreements* (AHCAs) with the states and territories, the Australian Government contributes to public hospital services. 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 also 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 2007).

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 Medicare Benefits Schedule* initiative from 1 November 2006. The item groups and item numbers comprising these initiatives are listed in Appendix Table A1.1. Due to the predominance of psychologist items in the numbers of both patients and services recorded in 2007–08, 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 health services*** may have been referred to a psychiatrist or allied health professional by a GP for the specialised management of mental health-related conditions. As described in Chapter 2, 12.1 of every 100 mental health-related problems managed by GPs in 2007–08 were managed by a referral being provided, with the most common referral being to a psychologist (5.5 per 100 mental health-related problems managed) or to a psychiatrist (1.9 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.

Key concepts

MBS-subsidised psychiatrist services: services provided by a psychiatrist (or, for electroconvulsive therapy (ECT), 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 conferencing and ECT. 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 are eligible to provide services attracting an MBS subsidy.

MBS-subsidised psychologist services: 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: services provided by 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). The mental health worker category covers Aboriginal health workers, mental health nurses, occupational therapists, some social workers as well as psychologists. Though 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 credentialing requirements for provision of the service.

The data presented in this chapter refer to MBS-subsidised mental health services processed in the 2007–08 financial year; for comparison purposes, data are also presented from 2002–03 to 2006–07. 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 health services

An estimated 620,237 people (2.9% of the Australian population) received MBS-subsidised psychiatrist or allied mental health services in 2007–08 (Table 6.1). Thus, on average, around one in every 34 Australians was provided with one or more of these MBS-subsidised mental health services in 2007–08. During this time period, 3,922,245 MBS-subsidised mental health services were provided, an average of 6.3 services per patient.

More patients accessed psychologist services than psychiatrist services in 2007–08. Psychiatrists provided slightly more services than psychologists, as they had a higher service/patient ratio.

Table 6.1: MBS-subsidised mental health services: numbers of patients and services, 2007–08

Provider type	Number of patients	Per cent of patients	Rate (per 1,000 population)[(a)]	Number of services	Per cent of services	Services per patient
Psychiatrist	269,582	43.5	12.7	1,949,702	49.7	7.2
Psychologist	375,411	60.5	17.7	1,877,834	47.9	5.0
Other allied mental health professional	18,995	3.1	0.9	94,709	2.4	5.0
Total[(b)]	**620,237**	**100.0**	**29.3**	**3,922,245**	**100.0**	**6.3**

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

(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 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 double that for males.

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

Services per patient were higher for psychiatrists for patients of both sexes and all age groups except for patients aged less than 15 years.

The majority of patients who used psychiatrist, psychologist or other allied mental health services lived in *Major cities* (Table 6.3). For other allied mental health services, while the numbers of both patients and services was several times greater in the *Major cities* than in the *Inner regional* areas, once adjusted for relative population numbers, the patient rate was higher in the *Inner regional* areas. For all provider types the patient rate is lower for *Remote* and *Very remote* areas.

Table 6.2: People receiving MBS-subsidised psychiatrist, psychologist and allied mental health services: patient demographic characteristics and number of services received, 2007–08

Patient demographics	Number of patients	Per cent of patients	Rate (per 1,000 population)[(a)]	Number of services	Per cent of services	Rate (per 1,000 population)[(a)]	Services per patient
				Psychiatrist services			
Age							
Less than 15 years	10,064	3.7	2.5	38,284	2.0	9.3	3.8
15–24 years	33,667	12.5	11.4	202,039	10.4	68.5	6.0
25–34 years	46,608	17.3	15.9	319,136	16.4	108.8	6.8
35–44 years	59,565	22.1	19.3	442,734	22.7	143.1	7.4
45–54 years	59,849	22.2	20.4	461,998	23.7	157.5	7.7
55–64 years	43,248	16.0	18.2	316,809	16.2	133.5	7.3
65+ years	27,576	10.2	9.9	168,702	8.7	60.3	6.1
Sex							
Male	122,613	45.5	12.5	763,671	39.2	71.8	6.2
Female	146,969	54.5	14.9	1,186,031	60.8	110.2	8.1
Total for psychiatrist services[(b)]	**269,582**	**100.0**	**13.7**	**1,949,702**	**100.0**	**92.1**	**7.2**
				Psychologist services			
Age							
Less than 15 years	33,234	8.9	8.1	150,948	8.0	36.8	4.5
15–24 years	54,939	14.6	18.6	254,304	13.5	86.2	4.6
25–34 years	81,087	21.6	27.6	398,943	21.2	136.0	4.9
35–44 years	89,744	23.9	29.0	452,951	24.1	146.4	5.0
45–54 years	69,300	18.5	23.6	352,886	18.8	120.3	5.1
55–64 years	39,471	10.5	16.6	195,774	10.4	82.5	5.0
65+ years	16,078	4.3	5.7	72,028	3.8	25.7	4.5
Sex							
Male	129,161	34.4	12.3	624,624	33.3	59.6	4.8
Female	246,250	65.6	23.4	1,253,210	66.7	119.4	5.1
Total for psychologist services[(b)]	**375,411**	**100.0**	**17.9**	**1,877,834**	**100.0**	**88.7**	**5.0**
				Other allied mental health services			
Age							
Less than 15 years	2,000	10.5	0.5	11,460	12.1	2.8	5.7
15–24 years	2,552	13.4	0.9	11,217	11.8	3.8	4.4
25–34 years	3,862	20.3	1.3	18,517	19.6	6.3	4.8
35–44 years	4,620	24.3	1.5	22,993	24.3	7.4	5.0
45–54 years	3,553	18.7	1.2	17,859	18.9	6.1	5.0
55–64 years	1,844	9.7	0.8	8,641	9.1	3.6	4.7
65+ years	902	4.7	0.3	4,022	4.2	1.4	4.5
Sex							
Male	5,992	31.5	0.6	29,416	31.1	2.8	4.9
Female	13,003	68.5	1.3	65,293	68.9	6.2	5.0
Total for other allied mental health services[(b)]	**18,995**	**100.0**	**0.9**	**94,709**	**100.0**	**4.5**	**5.0**

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

(b) The number 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.

Source: MBS data (DoHA).

Table 6.3: People receiving MBS-subsidised psychiatrist, psychologist and allied mental health services: patient area of residence by remoteness area, 2007–08

Patient area of residence	Number of patients	Per cent of patients	Rate (per 1,000 population)[a]	Number of services	Per cent of services	Rate (per 1,000 population)[a]	Services per patient
				Psychiatrist services			
Major cities	220,623	81.8	16.3	1,647,500	84.5	121.8	7.5
Inner regional	40,677	15.1	10.6	245,164	12.6	64.2	6.0
Outer regional	10,837	4.0	5.8	50,417	2.6	27.0	4.7
Remote	1,178	0.4	3.9	4,824	0.2	15.8	4.1
Very remote	472	0.2	3.0	1,577	0.1	10.1	3.3
Total for psychiatrist services[b]	**269,582**	**100.0**	**13.7**	**1,949,702**	**100.0**	**121.8**	**7.2**
				Psychologist services			
Major cities	277,489	73.9	19.9	1,422,334	75.7	101.9	5.1
Inner regional	80,112	21.3	21.0	360,614	19.2	94.4	4.5
Outer regional	21,125	5.6	11.3	87,932	4.7	47.0	4.2
Remote	1,476	0.4	4.7	5,776	0.3	18.3	3.9
Very remote	310	0.1	1.9	1,033	0.1	6.2	3.3
Total for psychologist services[b]	**375,411**	**100.0**	**17.8**	**1,877,689**	**100.0**	**101.9**	**5.0**
				Other allied mental health services			
Major cities	12,454	65.6	0.9	66,369	70.1	4.7	5.3
Inner regional	5,114	26.9	1.3	21,774	23.0	5.6	4.3
Outer regional	1,562	8.2	0.8	6,361	6.7	3.4	4.1
Remote	42	0.2	0.1	164	0.2	0.5	3.9
Very remote	12	0.1	0.1	41	0.0	0.2	3.5
Total for other allied mental health services[b]	**18,995**	**100.0**	**0.9**	**94,709**	**100.0**	**4.7**	**5.0**

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

(b) The number 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.

. . Not applicable.

Source: MBS data (DoHA)

New South Wales had the highest number of patients for psychiatrists, psychologists and allied health professionals but Victoria had the highest number per 1,000 population for psychologists and other allied health professionals at 23.4 and 1.1, 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)], 2007–08

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(c)]
				Psychiatrist services					
Initial consultation new patient—consulting room	23,973	19,953	14,363	6,170	6,696	1,177	1,019	301	73,593
Initial consultation new patient—hospital	2,794	1,866	1,633	642	370	257	60	10	7,624
Initial consultation new patient—home visit	580	178	35	10	88	3	8	1	903
Patient attendances —consulting room	77,070	68,165	43,628	18,529	22,506	4,016	3,111	655	236,778
Patient attendances—hospital	5,181	4,330	3,835	1,862	933	608	196	24	16,921
Patient attendances—other locations	2,132	821	149	99	298	21	17	7	3,540
Group psychotherapy	2,274	3,235	418	178	255	280	26	4	6,662
Interview with non-patient	1,411	1,357	1,110	371	344	92	42	18	4,740
Telepsychiatry	355	54	148	9	7	1	6	5	582
Case conferencing	69	393	35	26	36	34	4	0	596
Electroconvulsive therapy[(d)]	513	535	468	212	125	94	8	1	1,946
Total psychiatrist services[(c)]	**89,754**	**76,291**	**49,162**	**20,960**	**24,693**	**4,402**	**3,426**	**747**	**269,582**
Rate (per 1,000 population)[(e)]	13.9	15.7	12.7	10.6	17.0	10.4	10.9	3.8	13.7
				Psychologist services					
Psychological Therapy Services—clinical psychologist	41,369	32,264	15,461	21,616	10,990	4,140	2,172	313	127,914
Focussed Psychological Strategies—psychologist	85,338	86,352	53,775	11,438	12,011	4,985	4,096	861	257,954
Enhanced Primary Care —psychologist	1,273	930	730	100	189	39	14	4	3,274
Total psychologist services[(c)]	**123,021**	**115,843**	**66,948**	**31,999**	**21,919**	**8,762**	**5,788**	**1,102**	**375,411**
Rate (per 1,000 population)[(e)]	18.8	23.4	16.8	15.8	14.9	19.7	17.7	5.4	17.9
				Other allied mental health services					
Focussed Psychological Strategies—occupational therapist	994	681	398	344	269	88	22	1	2,794
Focussed Psychological Strategies—social worker	5,250	4,692	2,761	1,092	1,227	349	105	47	15,479
Enhanced Primary Care —mental health worker[(f)]	323	217	126	19	135	5	0	2	825
Total other allied mental health services[(d)]	**6,533**	**5,549**	**3,242**	**1,446**	**1,616**	**435**	**125**	**48**	**18,995**
Rate (per 1,000 population)[(e)]	1.0	1.1	0.8	0.8	1.0	1.0	0.4	0.2	0.9
Total psychiatrist and allied mental health services[(c)]	**204,574**	**184,669**	**111,542**	**50,692**	**45,447**	**12,644**	**8,692**	**1,789**	**620,237**
Rate (per 1,000 population)[(e)]	29.5	35.2	26.4	23.8	28.5	25.5	25.5	8.2	29.3

(a) See the *Medicare Benefits Schedule* data sources 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 since 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) Rates directly age-standardised, as detailed in Appendix 2.

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

Source: MBS data (Medicare Australia 2008 and 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 2007–08 there were 1,949,702 services provided by psychiatrists, 1,877,834 services provided by psychologists and 94,709 services provided by other allied mental health professionals which were subsidised through the MBS. Thus a total of 3,922,245 psychiatrist and allied mental health services were subsidised through the MBS. This is equivalent to a rate of 185.2 services per 1,000 population (Table 6.5), up 48% on the previous year when the rate was 127.3 services per 1,000 population (Table 6.6). These services represented 1.4% of all MBS-subsidised services (278.7 million).

The introduction of MBS allied health items for people with chronic conditions and complex care needs in July 2004, followed by the introduction of the MBS items provided by psychologists, occupational therapists and social workers from November 2006, resulted in the overall number of services subsidised by Medicare for both psychiatrists and allied health professionals to almost double to nearly 4 million in 2007–08, from just over 2 million services per annum in the three years prior to 2006–07.

The services provided by psychiatrists represented 8.8% of all the MBS-subsidised specialist attendances (22.3 million) provided in 2007–08, a 4.4% decrease from 9.2% in 2006–07. This equates to a rate of 92.1 services per 1,000 population, down from 95.3 services per 1,000 population in 2006–07. Most of the MBS-subsidised psychiatrist services in 2007–08 (83.4%) were attendances provided in consulting rooms, followed by attendances in hospitals (12.3%). Group psychotherapy accounted for half of the other services provided. There was a decline in the number of MBS-subsidised psychiatrist services from 2003–04 to 2007–08 at an average annual rate of 1.0%, with the number per 1,000 population declining at an even greater average annual rate of 2.4% (Table 6.6).

The *Focussed Psychological Strategies* item group accounted for 65% of MBS-subsidised psychologist services, while the *Psychological Therapy Services* item group (available for clinical psychologists only), accounted for 35% (Table 6.5). Among other allied mental health services, the *Focussed Psychological Strategies* item group for social workers accounted for 81% of services, while the items for occupational therapists accounted for 16%.

Among the states and territories, Victoria accounted for both the highest number and rate (per 1,000 population) of MBS-subsidised psychiatrist and allied health services provided in 2007–08 (Table 6.5). Victoria's rate at 242.6 per 1,000 population was substantially higher than the national average of 185.2 services per 1,000 population. The Northern Territory had the lowest rate, with 43.6 MBS-subsidised psychiatrist and allied health services provided per 1,000 population, well below the national average.

Table 6.5: MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, states and territories[(b)], 2007–08

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Psychiatrist services				
Initial consultation new patient—consulting room	24,860	20,780	14,790	6,338	6,909	1,216	1,110	306	76,309
Initial consultation new patient—hospital	3,365	2,051	1,846	674	426	294	64	10	8,730
Initial consultation new patient—home visit	580	178	35	10	88	3	8	1	903
Patient attendances—consulting room	486,150	513,538	265,193	88,657	148,308	27,205	16,912	3,287	1,549,250
Patient attendances—hospital	52,471	68,184	61,251	25,603	13,323	9,455	1,501	252	232,040
Patient attendances—other locations	7,383	3,471	601	477	1,247	65	58	8	13,310
Group psychotherapy	15,850	18,137	2,898	870	567	2,877	146	15	41,360
Interview with non-patient	1,982	1,987	1,601	439	433	126	48	18	6,634
Telepsychiatry	643	92	334	15	9	2	11	19	1,125
Case conferencing	80	763	41	42	47	38	4	0	1,015
Electroconvulsive therapy[(c)]	5,280	5,327	4,886	1,480	1,216	790	45	2	19,026
Total psychiatrist services	**598,644**	**634,508**	**353,476**	**124,605**	**172,573**	**42,071**	**19,907**	**3,918**	**1,949,702**
Rate (per 1,000 population)[(d)]	86.4	120.9	83.6	58.5	108.4	84.9	58.4	18.0	92.1
					Psychologist services				
Psychological Therapy Services—clinical psychologist	208,032	174,404	69,774	114,269	49,556	20,361	11,577	1,404	649,377
Focussed Psychological Strategies—psychologist	402,284	431,801	237,281	54,998	48,985	22,620	19,001	3,699	1,220,669
Enhanced Primary Care—psychologist	3,056	2,213	1,731	263	356	127	28	14	7,788
Total psychologist services	**613,372**	**608,418**	**308,786**	**169,530**	**98,897**	**43,108**	**30,606**	**5,117**	**1,877,834**
Rate (per 1,000 population)[(d)]	88.5	116.0	73.0	79.6	62.1	87.0	89.8	23.5	88.7

(continued)

Table 6.5 (continued): MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, states and territories[(b)], 2007–08

Item group[(a)]	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Other allied mental health services					
Focussed Psychological Strategies—occupational therapist	5,830	3,826	1,999	1,563	1,642	494	3	82	15,439
Focussed Psychological Strategies—social worker	26,594	25,519	12,119	5,505	5,052	1,571	135	375	76,870
Enhanced Primary Care—mental health worker[(e)]	1,045	599	323	37	375	18	3	0	2,400
Total other allied mental health services	**33,469**	**29,944**	**14,441**	**7,105**	**7,069**	**2,083**	**141**	**457**	**94,709**
Rate (per 1,000 population)[(d)]	4.8	5.7	3.4	3.3	4.4	4.2	0.4	2.1	4.5
Total psychiatrist and allied mental health services	**1,245,485**	**1,272,870**	**676,703**	**301,240**	**278,539**	**87,262**	**50,654**	**9,492**	**3,922,245**
Rate (per 1,000 population)[(d)]	179.8	242.6	160.0	141.4	175.0	176.0	148.6	43.6	185.2

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

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

Source: MBS data (Medicare Australia 2008 and DoHA).

Table 6.6: MBS-subsidised psychiatrist and allied health services, by item group[(a)] of service provided, 2003–04 to 2007–08

Item group[(a)]	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
			Psychiatrist services			
Initial consultation new patient —consulting room	. .	. .	. .	[(b)]42,944	76,309	. .
Initial consultation new patient —hospital	. .	. .	. .	[(b)]3,591	8,730	. .
Initial consultation new patient —home visit	. .	. .	. .	[(b)]448	903	. .
Patient attendances—consulting room	1,745,472	1,723,598	1,708,878	1,635,793	1,549,250	–2.9
Patient attendances—hospital	208,996	209,294	225,918	222,576	232,040	2.6
Patient attendances—other locations	12,128	12,419	13,355	14,115	13,310	2.4
Group psychotherapy	41,641	40,611	43,797	41,689	41,360	–0.2
Interview with non-patient	4,301	4,670	4,845	6,093	6,634	11.4
Telepsychiatry	177	228	369	665	1,125	58.8
Case conferencing	274	545	696	637	1,015	38.7
Electroconvulsive therapy[(c)]	15,469	15,853	18,083	17,982	19,026	5.3
Total psychiatrist services	**2,028,458**	**2,007,218**	**2,015,941**	**1,986,533**	**1,949,702**	**–1.0**
Rate (per 1,000 population)[(d)]	101.3	99.0	98.1	95.3	92.1	–2.4
			Psychologist services			
Psychological Therapy Services —clinical psychologist	. .	. .	. .	[(b)]189,946	649,377	. .
Focussed Psychological Strategies —psychologist	. .	. .	. .	[(b)]407,117	1,220,669	. .
Enhanced Primary Care—psychologist	. .	23,092	45,541	49,190	7,788	. .
Total psychologist services	**. .**	**23,092**	**45,541**	**646,253**	**1,877,834**	**. .**
Rate (per 1,000 population)[(d)]	. .	1.1	2.2	31.0	88.7	. .
			Other allied mental health services			
Focussed Psychological Strategies —occupational therapist	. .	. .	. .	[(b)]2,502	15,439	. .
Focussed Psychological Strategies —social worker	. .	. .	. .	[(b)]16,244	76,870	. .
Enhanced Primary Care —mental health worker[(e)]	. .	748	2,730	3,903	2,400	. .
Total other allied mental health services	**. .**	**748**	**2,730**	**22,649**	**94,709**	**. .**
Rate (per 1,000 population)[(d)]	. .	0.0	0.1	1.1	4.5	. .
Total psychiatrist and allied mental health services	**2,028,458**	**2,031,058**	**2,064,212**	**2,655,435**	**3,922,245**	**17.9**
Rate (per 1,000 population)[(d)]	101.3	100.2	100.4	127.3	185.2	16.3

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

(b) Introduced from 1 November 2006.

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

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

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

. . Not applicable.

Source: MBS data (Medicare Australia 2008 and DoHA)

7 Admitted patient mental health-related care

7.1 Introduction

Mental health-related ***separations*** can be classified as ambulatory 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 the episode of admitted patient care, 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, and 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* (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 (and psychiatric care day) data measure hospital activity in a way that is not as affected by variation in length of stay, as short-stay activity is represented in the same way as long-stay activity. The patient day data presented in this report include days within hospital stays that occurred before 1 July 2006 provided that the separation from hospital occurred during 2006–07. 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 2006–07 and that 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, 2002–03 to 2006–07

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 2002–03 to 2006–07. 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, a total of 7,602,917 separations were reported from public and private acute and psychiatric hospitals in 2006–07. Approximately 4.3% (329,958) of these separations were mental health-related, comprising both ambulatory-equivalent and non-ambulatory-equivalent admitted patient separations.

A total of 209,356 non-ambulatory-equivalent admitted patient mental health-related care separations were reported in 2006–07, accounting for 2.8% of all hospital separations and 63.4% (209,356 out of 329,958) of mental health-related separations. Of these, 122,132 (58.3% of 209,356) were separations with specialised psychiatric care.

Over the 5 years to 2006–07, the average annual rate of increase for all mental health-related separations was 2.2%. The proportions of separations with specialised care remained fairly constant at approximately 58–59%. Public acute hospitals reported average annual increases in all separations. Private hospitals reported a decline in separations without specialised care of 3.3%, but an increase of 3.6% for those with specialised care.

Table 7.1: Admitted patient mental health-related separations[(a)] with and without specialised psychiatric care, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
			Separations			
Separations with specialised psychiatric care						
Public acute hospitals	73,972	76,042	76,172	76,019	79,738	1.9
Public psychiatric hospitals[(b)]	13,371	14,188	12,887	13,255	12,771	–1.1
Private hospitals	25,702	26,495	27,793	29,459	29,623	3.6
Subtotal	*113,045*	*116,725*	*116,852*	*118,733*	*122,132*	*2.0*
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	66,607	68,087	70,975	75,195	76,553	3.5
Public psychiatric hospitals[(b)(c)]	1,055	1,048	1,136	770	660	–11.1
Private hospitals	11,462	11,852	10,390	9,488	10,011	–3.3
Subtotal	*79,124*	*80,987*	*82,501*	*85,453*	*87,224*	*2.5*
Total mental health-related separations						
Public acute hospitals	140,579	144,129	147,147	151,214	156,291	2.7
Public psychiatric hospitals[(b)]	14,426	15,236	14,023	14,025	13,431	–1.8
Private hospitals	37,164	38,347	38,183	38,947	39,634	1.6
Total	**192,169**	**197,712**	**199,353**	**204,186**	**209,356**	**2.2**
			Patient days			
Patient days for separations with specialised psychiatric care[(c)]						
Public acute hospitals	1,078,122	1,118,512	1,208,422	1,215,274	1,329,835	5.4
Public psychiatric hospitals[(b)]	885,541	666,275	757,916	652,375	636,857	–7.9
Private hospitals	420,496	424,787	441,617	456,146	492,777	4.0
Subtotal	*2,384,159*	*2,209,574*	*2,407,955*	*2,323,795*	*2,459,469*	*0.8*
Patient days for mental health-related separations without specialised psychiatric care						
Public acute hospitals	427,315	399,342	384,160	419,669	411,417	–0.9
Public psychiatric hospitals[(b)(c)]	9,758	8,341	19,753	5,547	4,262	–18.7
Private hospitals	125,438	120,186	96,120	93,266	106,457	–4.0
Subtotal	*562,511*	*527,869*	*500,033*	*518,482*	*522,136*	–1.8
Total mental health-related patient days						
Public acute hospitals	1,505,437	1,517,854	1,592,582	1,634,943	1,741,252	3.7
Public psychiatric hospitals[(b)]	895,299	674,616	777,669	657,922	641,119	–8.0
Private hospitals	545,934	544,973	537,737	549,412	599,234	2.4
Total	**2,946,670**	**2,737,443**	**2,907,988**	**2,842,277**	**2,981,605**	**0.3**
			Psychiatric care days			
Public acute hospitals	1,061,681	1,099,446	1,183,862	1,190,652	1,307,383	5.3
Public psychiatric hospitals[(b)]	866,761	663,541	753,328	644,104	627,233	–7.8
Private hospitals	417,560	423,507	440,663	454,719	490,697	4.1
Total	**2,346,002**	**2,186,494**	**2,377,853**	**2,289,475**	**2,425,313**	**0.8**

(continued)

Table 7.1 (continued): Admitted patient mental health-related separations[(a)] with and without specialised psychiatric care, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
			Average length of stay			
Separations with specialised psychiatric care						
Public acute hospitals	14.6	14.7	15.9	16.0	16.7	3.4
Public psychiatric hospitals[(b)]	66.2	47.0	58.8	49.2	49.9	–6.8
Private hospitals	16.4	16.0	15.9	15.5	16.6	0.4
Subtotal	*21.1*	*18.9*	*20.6*	*19.6*	*20.1*	*–1.1*
Mental health-related separations without specialised psychiatric care						
Public acute hospitals	6.4	5.9	5.4	5.6	5.4	–4.3
Public psychiatric hospitals[(b)(c)]	9.2	8.0	17.4	7.2	6.5	–8.6
Private hospitals	10.9	10.1	9.3	9.8	10.6	–0.7
Subtotal	*7.1*	*6.5*	*6.1*	*6.1*	*6.0*	*–4.2*
Total mental health-related separations						
Public acute hospitals	10.7	10.5	10.8	10.8	11.1	1.0
Public psychiatric hospitals[(b)]	62.1	44.3	55.5	46.9	47.7	–6.4
Private hospitals	14.7	14.2	14.1	14.1	15.1	0.7
Total	**15.3**	**13.8**	**14.6**	**13.9**	**14.2**	**–1.8**

(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.

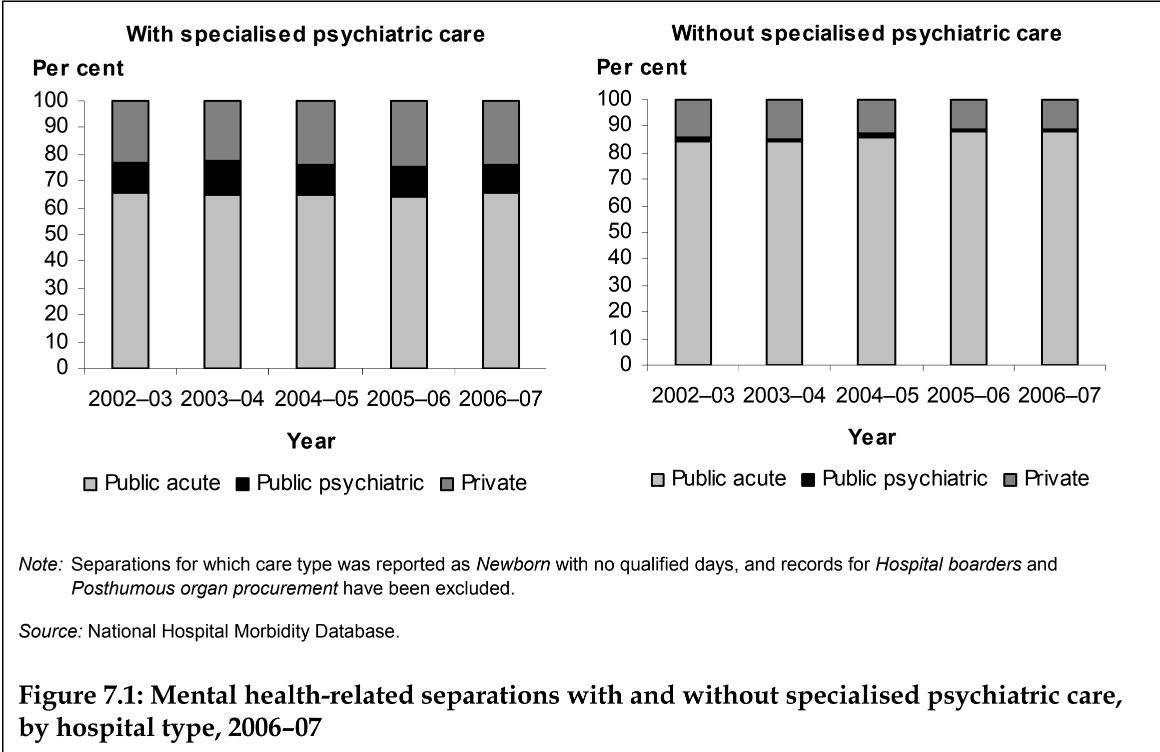
Source: National Hospital Morbidity Database.

Figure 7.1 shows the percentage of separations with and without specialised psychiatric care by hospital type. For separations with specialised psychiatric care, public acute hospitals maintained their dominance as providers (over 60%) of admitted patient services over the 5 years to 2006–07. In 2006–07, there was a slight increase (1.3%) in the overall percentage of public acute hospital separations and a corresponding reduction in private hospital (0.5%) and public psychiatric hospital (0.7%) separations. The dominance of public acute hospitals was even more pronounced (over 80%) in mental health-related separations without specialised psychiatric care. This is partly explained by the smaller role of public psychiatric hospitals in providing non-specialised psychiatric care, although private hospitals also played a lesser role in this type of care. In general, the proportion of separations reported by each hospital type remained fairly constant over the 5 years.

Figure 7.2 shows the average length of stay for separations with and without specialised psychiatric care by hospital type. As outlined in the 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 noticeably higher for private hospital

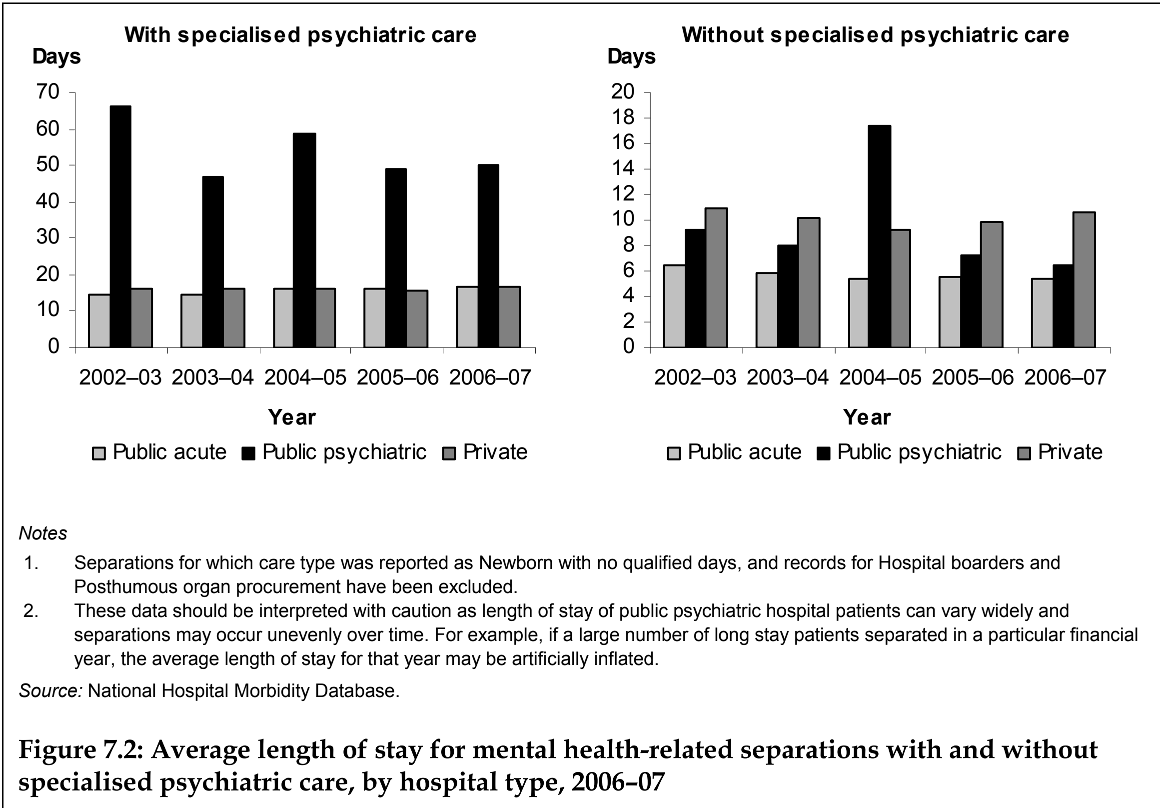
separations compared to other hospital types across all years except in 2004–05 when there was a longer average length of stay for public psychiatric hospitals.



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, 2006–07



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, 2006–07

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 209,356 mental health-related separations for admitted patient care, 122,132 (58.3%) involved specialised psychiatric care (Table 7.1).

States and territories and 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 number of separations and patient days per 1,000 population are provided to account for differences in population between jurisdictions. It should be noted that jurisdictional data differences may reflect differences in service delivery practices, admission practices and/or 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 hospitals separations (73.4%), while Western Australia had the lowest (59.5%). For private hospital separations, Victoria had the highest percentage (34.9%), which was more than twice that of South Australia (17.0%). Public psychiatric hospital separations constituted 10.5% (12,771 out of 122,132) of all separations with New South Wales being the major provider (65.4%). 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 has the highest separation rate (6.0) which was 57.9% higher than the national average of 3.8. Public 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 (71.9) per 1,000 population. The number of public psychiatric hospital patient days per 1,000 population varied greatly from 9.2 days in Victoria to 50.2 days in Tasmania. South Australia reported the lowest number of patient days in private hospitals per 1,000 population (15.1).

All the separations reported by South Australia involved specialised psychiatric care (100.0%). The lowest percentage of psychiatric care days compared with the total number of patient days was reported by public acute hospitals in the Australian Capital Territory (94.9%).

Table 7.2: Admitted patient separations[(a)] with specialised psychiatric care, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	23,433	17,537	19,100	7,137	7,496	2,868	1,183	984	79,738
Public psychiatric hospitals	8,354	326	404	1,427	1,752	508	. .	. .	12,771
Private hospitals	7,472	9,593	6,506	3,432	1,889	n.p.	n.p.	n.p.	29,623
Total	**39,259**	**27,456**	**26,010**	**11,996**	**11,137**	**n.p.**	**n.p.**	**n.p.**	**122,132**
					Separations per 1,000 population[(b)]				
Public acute hospitals	3.5	3.4	4.7	3.4	4.7	6.0	3.4	4.4	3.8
Public psychiatric hospitals	1.2	0.1	0.1	0.7	1.1	1.0	. .	. .	0.6
Private hospitals	1.1	1.8	1.6	1.6	1.2	n.p.	n.p.	n.p.	1.4
Total	**5.8**	**5.3**	**6.3**	**5.8**	**7.0**	**n.p.**	**n.p.**	**n.p.**	**5.9**
					Patient days				
Public acute hospitals	393,489	335,719	293,494	140,295	112,363	27,219	15,930	11,326	1,329,835
Public psychiatric hospitals	311,696	47,449	122,069	51,904	77,028	26,711	. .	. .	636,857
Private hospitals	140,535	159,683	106,754	48,394	24,884	n.p.	n.p.	n.p.	492,777
Total	**845,720**	**542,851**	**522,317**	**240,593**	**214,275**	**n.p.**	**n.p.**	**n.p.**	**2,459,469**
					Patient days per 1,000 population[(b)]				
Public acute hospitals	57.5	64.2	71.9	68.2	68.8	56.1	46.4	52.9	63.7
Public psychiatric hospitals	45.5	9.2	29.7	25.0	49.2	50.2	. .	. .	30.6
Private hospitals	20.1	30.3	25.6	22.9	15.1	n.p.	n.p.	n.p.	23.2
Total	**123.1**	**103.8**	**127.1**	**116.1**	**133.1**	**n.p.**	**n.p.**	**n.p.**	**117.4**
					Psychiatric care days				
Public acute hospitals	378,814	335,172	289,293	138,174	112,363	27,219	15,123	11,225	1,307,383
Public psychiatric hospitals	302,072	47,449	122,069	51,904	77,028	26,711	. .	. .	627,233
Private hospitals	139,010	159,552	106,734	48,002	24,884	n.p.	n.p.	n.p.	490,697
Total	**819,896**	**542,173**	**518,096**	**238,080**	**214,275**	**n.p.**	**n.p.**	**n.p.**	**2,425,313**

(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.

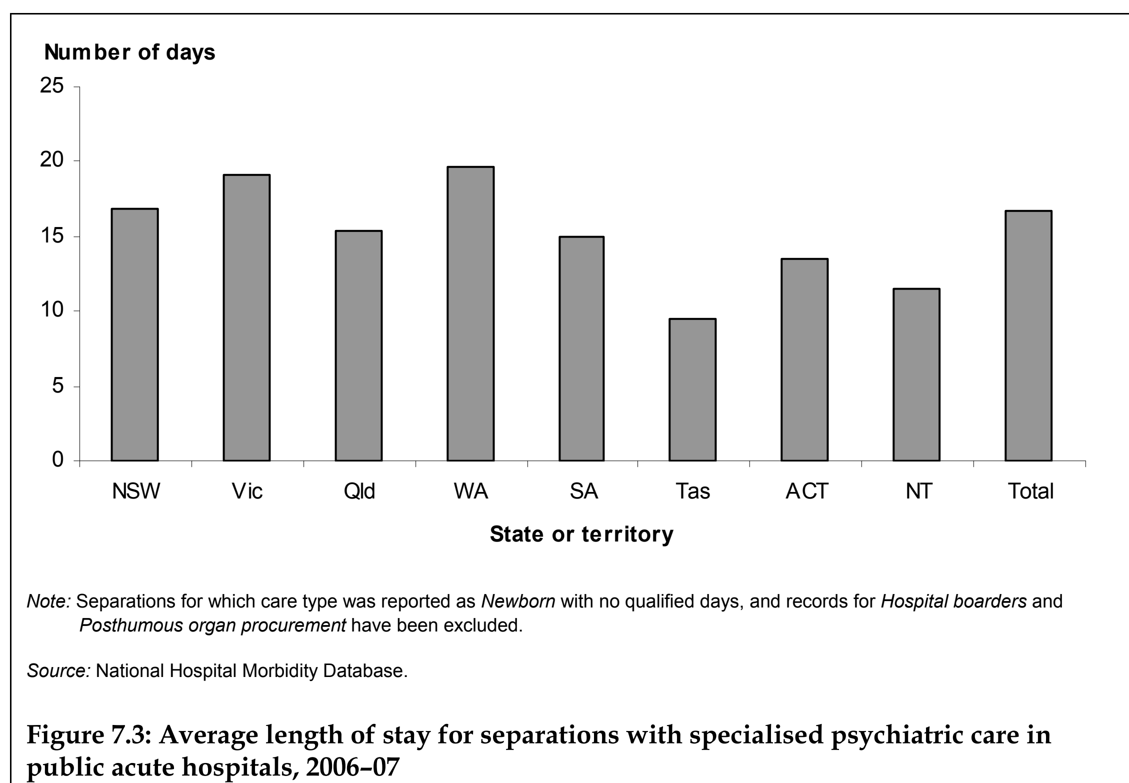
(b) Rates were directly age-standardised as detailed in Appendix 2.

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.

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

Source: National Hospital Morbidity Database.

Figure 7.3 shows that the average length of stay in public acute hospitals was highest for Western Australia, which was more than twice the average length of stay for Tasmania. The average lengths of stay for New South Wales and Victoria were also higher than the national average (16.7 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 7.3: Average length of stay for separations with specialised psychiatric care in public acute hospitals, 2006–07

Mental health legal status

Table 7.3 shows the number of separations with specialised psychiatric care by hospital type and the patient's mental health legal status. Voluntary separations comprised 57.8% of all separations. Public acute hospitals reported the highest number of involuntary separations (80.7%). The majority (66.6%) of private hospital separations were voluntary but there was a relatively high number of private hospital separations with no mental health legal status reported (9,797 or 33.1%). Public psychiatric hospitals have a higher proportion (61.6%) of separations with involuntary status compared with the other hospital types.

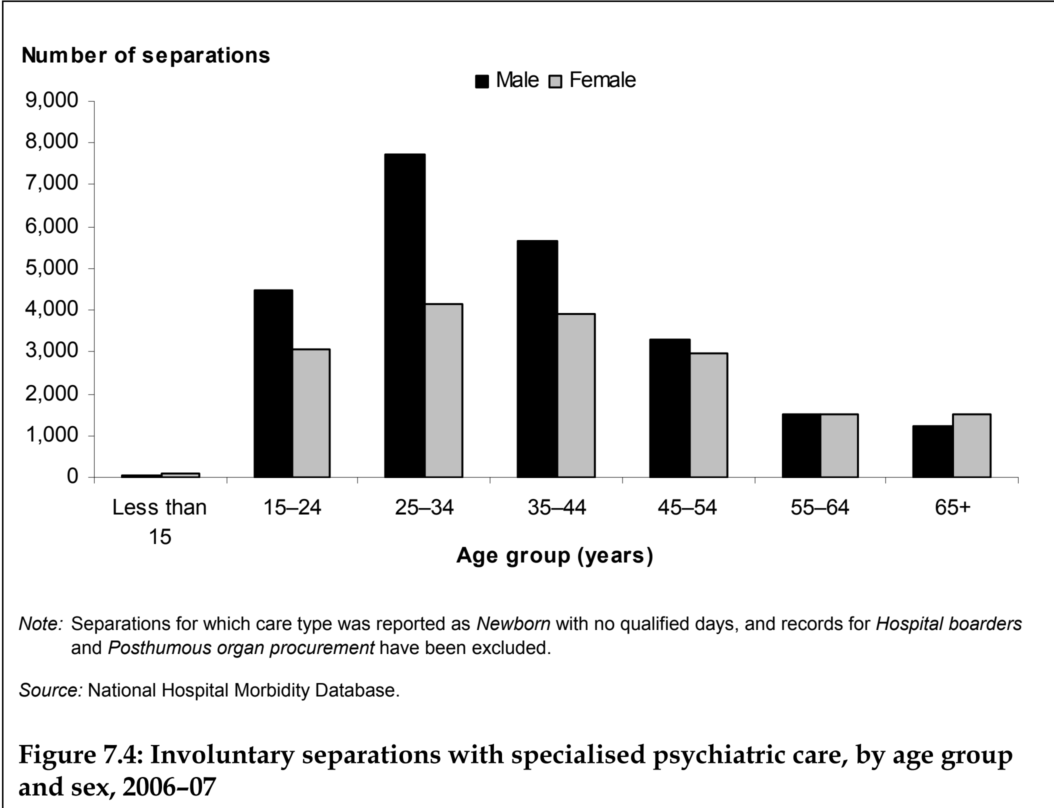
Table 7.3: Admitted patient separations[(a)] with specialised psychiatric care, by mental health legal status and hospital type, 2006–07

Mental health legal status	Public acute hospitals	Public psychiatric hospitals	Private hospitals	Total
Involuntary	33,194	7,861	101	41,156
Voluntary	45,904	4,910	19,725	70,539
Not reported	640	0	9,797	10,437
Total	**79,738**	**12,771**	**29,623**	**122,132**

(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. However, more than half of the involuntary separations for those aged less than 15 years were for females. These apparent sex differences were less pronounced in the older age groups.



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, 2006–07

Patient demographics

Table 7.4 provides a summary of the demographics of patients receiving specialised psychiatric care in 2006–07. 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 highest proportion of separations was for patients aged 25–34 years and 35–44 years (22.6% and 21.9%, respectively). The 25–34 age group also had the highest number of separations per 1,000 population (9.5). The lowest proportion of separations was for patients aged less than 15 years (1.5%).

There was no major difference between male and female separations per 1,000 population (5.7 and 6.0, respectively), but there were differences in distributions of separations when age was taken into consideration (Figure 7.5). There were more female separations in all age groups apart from the 25–34 years age group. The biggest difference between the number of male and female separations was in the 65 years and over age group, followed by those aged 25–34 years. Separations were evenly distributed for those aged less than 15 years.

The rate of separation for Australian-born patients was noticeably higher than that of those born overseas (6.4 and 3.7, respectively). Those living in *Major cities* had nearly double the rate of separations of those in *Remote* areas (6.1 and 3.5, respectively).

More than half of the separations (52.1%) involved those who had never been married.

The data showed that the typical separation involved an Australian-born, non-Indigenous male 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, 2006–07

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate (per 1,000 population)[(d)]
Age (years)			
Less than 15	1,782	1.5	0.4
15–24	18,758	15.4	6.5
25–34	27,563	22.6	9.5
35–44	26,740	21.9	8.7
45–54	19,918	16.3	6.9
55–64	12,359	10.1	5.4
65+	15,011	12.3	5.5
Sex			
Male	58,656	48.0	5.7
Female	63,475	52.0	6.0
Indigenous status[(e)]			
Indigenous Australians	4,904	4.2	11.3
Other Australians[(f)]	111,938	95.8	5.7
Country of birth			
Australia	95,641	81.2	6.4
Overseas	22,093	18.8	3.7
Area of usual residence			
Major cities	87,549	73.5	6.1
Inner regional	21,630	18.2	5.6
Outer regional	8,447	7.1	4.5
Remote	1,078	0.9	3.5
Very remote	461	0.4	2.6
Marital status			
Never married	59,789	52.1	. .
Widowed	5,450	4.8	. .
Divorced	9,408	8.2	. .
Separated	6,066	5.3	. .
Married	33,941	29.6	. .
Total	**122,132**	**100.0**	**5.9**

(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.

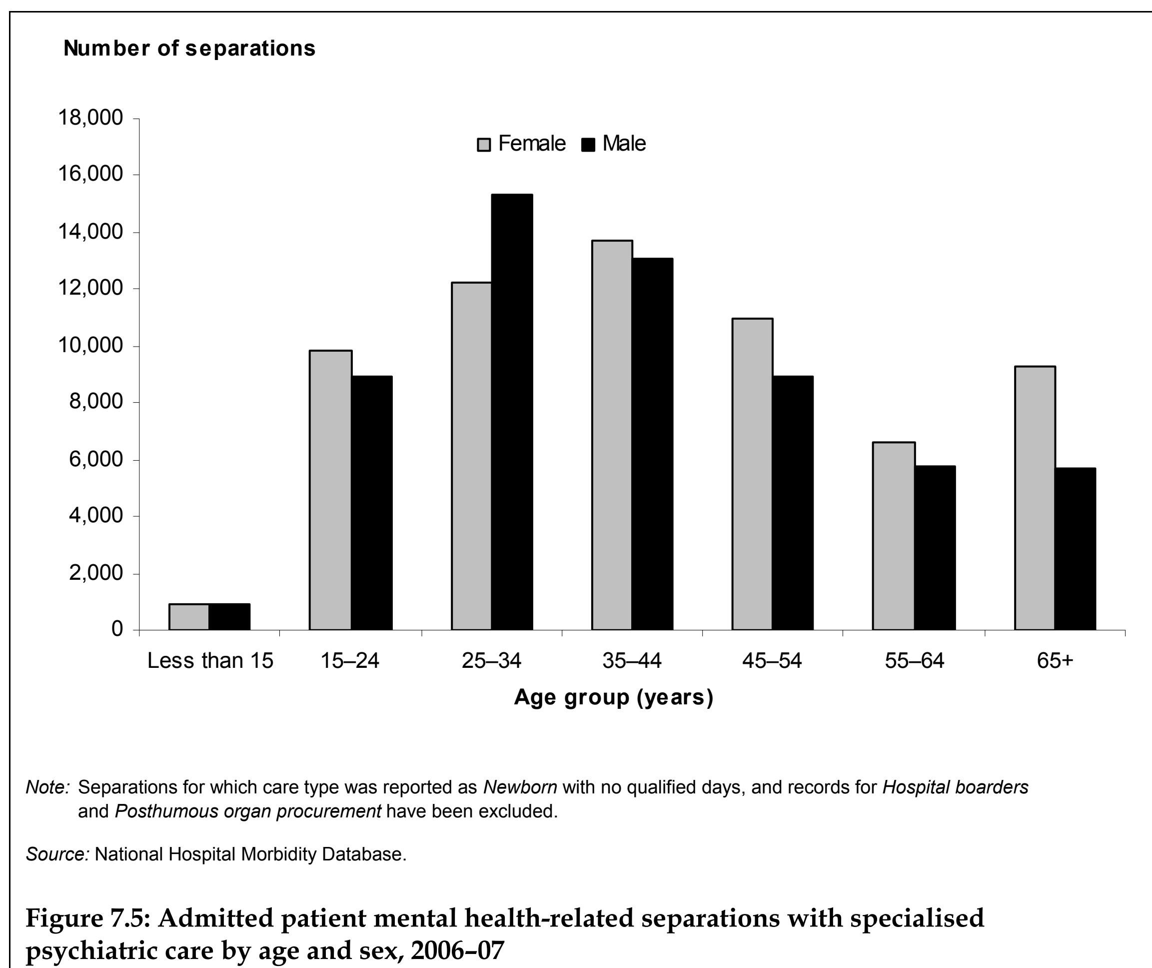
(d) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(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 2005).

(f) Includes separations where Indigenous status was missing or not reported.

. . Not applicable.

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, 2006–07

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 2006–07, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of separations (21,857 or 17.9%). 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 44.0% 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. For separations involving those aged less than 15 years, *Reaction to severe stress and adjustment disorder* (F43) was the most commonly reported diagnosis. Other common diagnoses for the less than 15 years age group included *Conduct disorders* (F91) and *Depressive episode* (F32).

Over 30% of separations with the principal diagnosis of *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) and *Specific personality disorders* (F60) were attributed to the 15–24 years age group. *Eating disorders* (F50) were also commonly reported by this age

group. The 25–34 years age group reported the highest proportion of separations for five of the 10 most commonly reported principal diagnoses. Of these, the highest proportion was for *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) with 38.9% of separations reported by this age group. The proportion of separations attributed to the 35–44 years age group ranged from 17.9% for *Recurrent depressive disorders* (F33) to 26.3% for *Mental and behavioural disorders due to use of alcohol* (F10). For the 45–54 years age group, there was a higher proportion of separations involving *Mental and behavioural disorders due to use of alcohol* (F10) compared with other commonly reported principal diagnoses. Apart from those aged 15 and under, the 55–64 years age group was least represented in separations for the 10 most commonly reported principal diagnoses. Depressive disorders (F32 and F33) were the most common principal diagnoses reported in separations involving those aged 65 years and over.

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. The diagnoses of *Mental and behavioural disorders due to use of alcohol and other psychoactive substance use* (F10 and F11–F19) also displayed a similar pattern with noticeably more male separations than female separations. Female separations, though, were noticeably higher for the principal diagnoses of *Recurrent depressive disorders* (F33) and *Specific personality disorders* (F60).

Table 7.5: Admitted patient separations[(a)] with specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2006–07

Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	557	178	129	864	0.7
F04–F09	Other organic mental disorders	569	133	125	827	0.7
F10	Mental and behavioural disorders due to use of alcohol	1,980	621	2,346	4,947	4.1
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	3,606	981	959	5,546	4.5
F20	Schizophrenia	17,610	3,014	1,233	21,857	17.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,456	248	103	1,807	1.5
F22	Persistent delusional disorders	776	130	95	1,001	0.8
F23	Acute and transient psychotic disorders	1,395	211	75	1,681	1.4
F25	Schizoaffective disorders	5,359	1,021	1,296	7,676	6.3
F30	Manic episode	559	69	35	663	0.5
F31	Bipolar affective disorders	7,935	1,089	3,334	12,358	10.1
F32	Depressive episode	11,103	1,065	6,978	19,146	15.7
F33	Recurrent depressive disorders	3,701	314	6,067	10,082	8.3
F34	Persistent mood (affective) disorders	998	118	428	1,544	1.3
F38–F39	Other and unspecified mood (affective) disorders	133	30	49	212	0.2
F40	Phobic anxiety disorders	54	6	87	147	0.1
F41	Other anxiety disorders	1,160	102	1,196	2,458	2.0
F42	Obsessive-compulsive disorders	226	24	243	493	0.4
F43	Reaction to severe stress and adjustment disorders	8,141	1,274	2,713	12,128	9.9
F44	Dissociative (conversion) disorders	116	8	246	370	0.3
F45, F48	Somatoform and other neurotic disorders	81	8	42	131	0.1
F50	Eating disorders	575	7	685	1,267	1.0
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	193	12	128	333	0.3
F60	Specific personality disorders	3,744	531	513	4,788	3.9
F61–F69	Disorders of adult personality and behaviour	163	33	50	246	0.2
F70–F79	Mental retardation	156	44	2	202	0.2
F80–F89	Disorders of psychological development	175	31	22	228	0.2
F90	Hyperkinetic disorders	112	9	16	137	0.1
F91	Conduct disorders	298	32	3	333	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	190	58	10	258	0.2
F99	Mental disorder not otherwise specified	267	86	3	356	0.3
G30	Alzheimer's disease	497	85	59	641	0.5
	Other factors related to mental and behavioural disorders and substance use[(b)]	218	324	1	543	0.4
	Other specified mental health-related principal diagnosis[(c)]	235	36	23	294	0.2
	Other[(d)]	5,400	839	329	6,568	5.4
Total		**79,738**	**12,771**	**29,623**	**122,132**	**100.0**

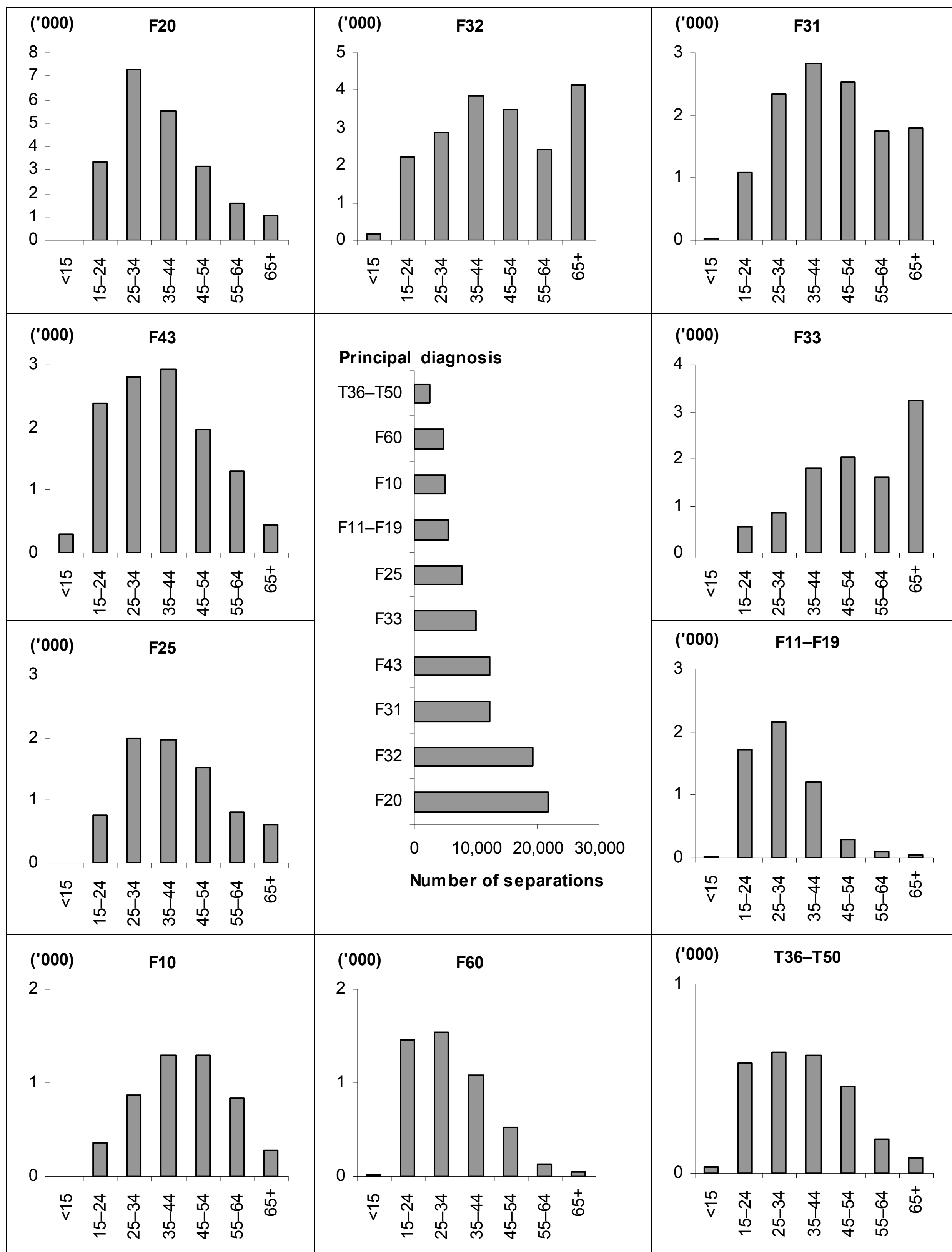
(a) Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

(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.

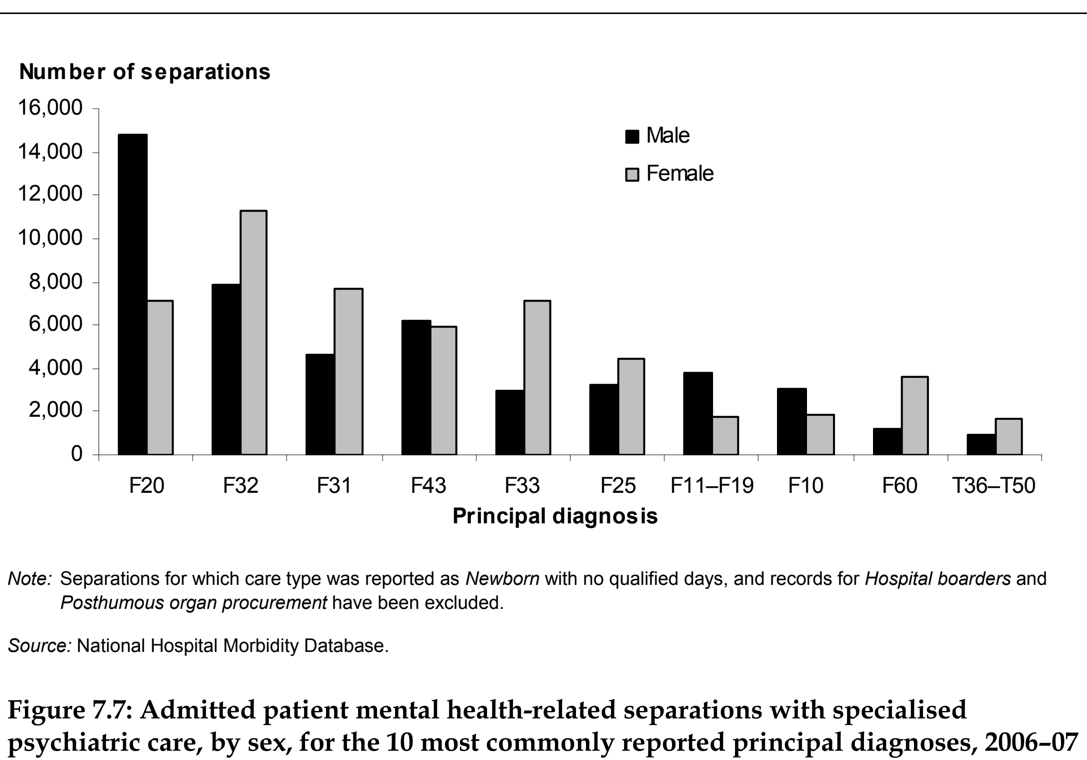


Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

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, 2006–07

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
F43	Reaction to severe stress and adjustment disorders
F60	Specific personality disorders
T36–T50	Poisoning by drugs, medicaments and biological substances



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, 2006–07

Procedures

Table 7.6 details 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.

A total of 157,012 procedures were reported in relation to 65,155 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 46.7% of the separations (56,977 out of 122,132). Non-emergency general anaesthesia (*General anaesthesia, American Society of Anaesthesiologists (ASA) 99*) was the most frequently reported procedure. This was most likely associated with the administration of electroconvulsive therapies (93340-02), 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, 2006–07

Procedure		Procedures[(b)]		Separations[(b)(c)]	
		Number	Per cent	Number	Per cent
92514–99	General anaesthesia, ASA 99	29,163	18.6	10,873	8.4
95550–01	Allied health intervention, social work	22,844	14.5	22,817	17.7
93340–02	Electroconvulsive therapy ≤12 treatments	14,793	9.4	14,646	11.3
95550–02	Allied health intervention, occupational therapy	14,349	9.1	14,330	11.1
95550–10	Allied health intervention, psychology	7,855	5.0	7,853	6.1
92514–29	General anaesthesia, ASA 29	5,426	3.5	2,163	1.7
56001–00	Computerised tomography of brain	5,111	3.3	5,087	3.9
95550–00	Allied health intervention, dietetics	4,295	2.7	4,290	3.3
96175–00	Mental/behavioural assessment	4,294	2.7	4,275	3.3
92514–39	General anaesthesia, ASA 39	4,255	2.7	1,418	1.1
Other reported procedures		44,627	28.4	41,370	32.0
		Totals			
Number of separations with at least one procedure		. .	. .	65,155	53.3
Number of separations with no procedure reported		. .	. .	56,977	46.7
Total		**157,012**	**100**	**122,132**	**100**

(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.

. . Not applicable.

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 one or more days of care in a specialised psychiatric unit or ward). 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 87,224 mental health-related separations without specialised psychiatric care, accounting for 41.7% of all mental health-related separations for admitted patient care.

States and territories and hospital type

Table 7.7 presents the number of separations and patient days for mental health-related separations without specialised psychiatric care for each state and territory. The number of separations and patient days per 1,000 population are also presented, to account for variations in the population size 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, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public acute hospitals	27,216	22,962	9,396	7,669	7,352	1,138	365	455	76,553
Public psychiatric hospitals[(b)]	660	0	0	0	0	0	. .	. .	660
Private hospitals	2,116	2,507	2,678	1,130	619	n.p.	n.p.	n.p.	10,011
Total	**29,992**	**25,469**	**12,074**	**8,799**	**7,971**	**n.p.**	**n.p.**	**n.p.**	**87,224**
					Separations per 1,000 population[(c)]				
Public acute hospitals	3.9	4.4	2.3	3.7	4.6	2.3	1.2	2.6	3.7
Public psychiatric hospitals[(b)]	0.1	0.0	0.0	0.0	0.0	0.0	. .	. .	0.0
Private hospitals	0.3	0.5	0.6	0.6	0.4	n.p.	n.p.	n.p.	0.5
Total	**4.4**	**4.9**	**2.9**	**4.3**	**4.9**	**n.p.**	**n.p.**	**n.p.**	**4.2**
					Patient days				
Public acute hospitals	152,307	108,879	54,312	34,955	42,058	14,035	2,369	2,502	411,417
Public psychiatric hospitals[(b)]	4,262	0	0	0	0	0	. .	. .	4,262
Private hospitals	28,080	21,373	31,245	7,968	4,860	n.p.	n.p.	n.p.	106,457
Total	**184,649**	**130,252**	**85,557**	**42,923**	**46,918**	**n.p.**	**n.p.**	**n.p.**	**522,136**
					Patient days per 1,000 population[(c)]				
Public acute hospitals	21.5	20.4	13.2	17.1	24.8	26.9	8.2	21.2	19.3
Public psychiatric hospitals[(b)]	0.6	0.0	0.0	0.0	0.0	0.0	. .	. .	0.2
Private hospitals	4.0	4.1	7.5	4.0	2.7	n.p.	n.p.	n.p.	5.0
Total	**26.2**	**24.4**	**20.8**	**21.1**	**27.6**	**n.p.**	**n.p.**	**n.p.**	**24.5**

(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 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.

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.

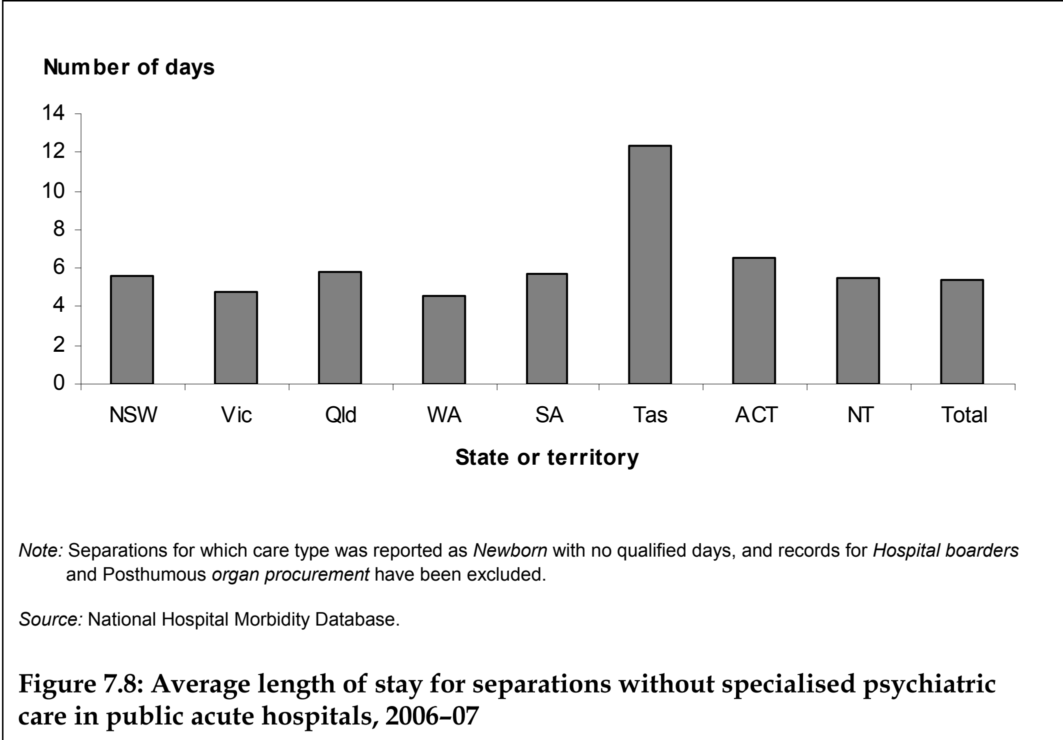
. . Not applicable. The Australian Capital Territory and the Northern Territory do not have any public psychiatric hospitals.

Source: National Hospital Morbidity Database.

Mental health-related separations without specialised psychiatric care were predominantly provided by public acute hospitals (87.8% of 87,224). The percentage for this type of separation was lowest for Australian Capital Territory (0.4%). South Australia reported the highest rate of public acute hospital separations per 1,000 population (4.6). The overall separation rates for Victoria and South Australia across all hospital types were also the highest rate among the jurisdictions for which data are fully reported (4.9).

Private hospital separations constituted 11.5% of all mental health-related separations without specialised psychiatric care. Of the five jurisdictions with published private hospital figures, Queensland reported the highest number of patient days per 1,000 population (7.5).

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 16.7 days for separations with specialised care (see Figure 7.3). Tasmania reported the highest average length of stay in public acute hospitals (12.3 days). Only Victoria and Western Australia reported lower average length of stay figures with 4.7 and 4.6 days, respectively compared to the national average of 5.4 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, 2006–07

Patient demographics

Table 7.8 presents information on the number of separations without specialised psychiatric care in 2006–07 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. Again, the number of distinct individuals receiving care cannot be derived from the figures presented.

The highest proportion of separations without specialised psychiatric care was for patients aged 65 years and over (24.8%). This age group also has the highest number of separations per 1,000 population (7.9). The lowest proportion of separations without specialised care was for patients aged less than 15 years (6.6%).

Table 7.8: Mental health-related admitted patient separations[(a)] without specialised psychiatric care, by patient demographic characteristics, 2006–07

Patient demographics	Number of separations[(b)]	Per cent of separations[(c)]	Rate (per 1,000 population)[(d)]
Age (years)			
Less than 15	5,741	6.6	1.4
15–24	9,707	11.1	3.3
25–34	15,685	18.0	5.4
35–44	15,703	18.0	5.1
45–54	11,340	13.0	3.9
55–64	7,440	8.5	3.2
65+	21,606	24.8	7.9
Sex			
Male	40,499	46.6	3.9
Female	46,376	53.4	4.3
Indigenous status[(e)]			
Indigenous Australians	5,199	6.1	13.3
Other Australians[(f)]	79,561	93.9	4.0
Country of birth			
Australia	67,883	81.1	4.5
Overseas	15,844	18.9	2.5
Area of usual residence			
Major cities	51,724	60.8	3.6
Inner regional	18,086	21.2	4.5
Outer regional	11,602	13.6	6.0
Remote	2,463	2.9	8.1
Very remote	1,260	1.5	8.0
Total	**87,224**	**100**	**4.2**

(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.

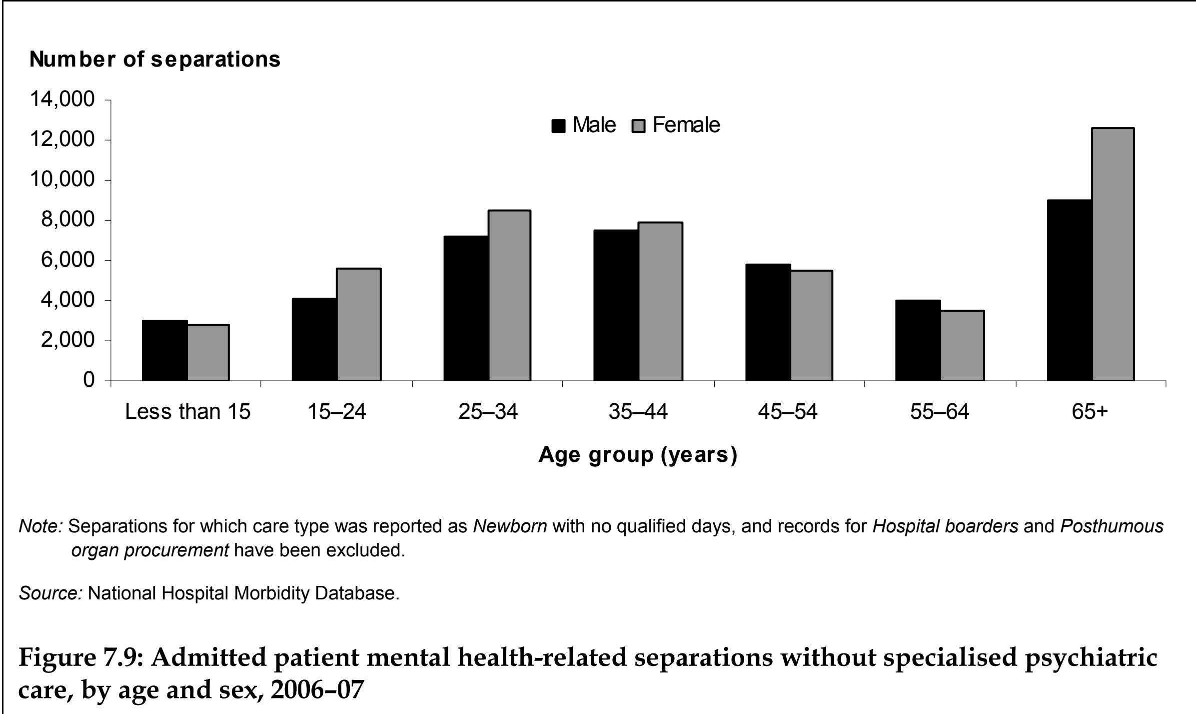
(d) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Appendix 2.

(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 2005).

(f) Includes separations where Indigenous status was missing or not reported.

Source: National Hospital Morbidity Database.

There was no major difference between the number of male and female separations per 1,000 population (3.9 and 4.3, respectively). 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 difference between the number of male and female separations was in the 65 years and over age group, followed by those aged 15–24 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 7.9: Admitted patient mental health-related separations without specialised psychiatric care, by age and sex, 2006–07

The majority of mental health-related separations without specialised psychiatric care reported were for patients living in *Major cities* (60.8%). However, the highest number of separations per 1,000 population was for patients in *Remote* areas (8.1 per 1,000 population). The rate of separations involving Australian-born people was higher than for those born overseas (4.5 and 2.5, respectively). 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 this report.

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 2006–07, the principal diagnosis of *Mental and behavioural disorders due to use of alcohol* (F10) accounted for the largest number of separations (17,516 or 20.1%). It was the most commonly reported diagnosis for public acute and private hospitals. *Depressive episode* (F32) ranked second, constituting 13.8% of the total number of reported principal diagnoses. Separations involving *Mental and behavioural disorders due to use of alcohol and other psychoactive*

substance use (F10 and F11–F19) constituted the majority of separations reported by public psychiatric hospitals (90.9%).

Figures 7.10 and 7.11 show the 10 most commonly reported principal diagnoses by age and sex. For patients aged less than 15 years, the most common principal diagnoses were *Sleep disorders* (G47) which were grouped under the category *Other specified mental health-related principal diagnosis* (see Table 7.9). In this category, sleep-related disorders constituted 65% of all separations. For the age group 15–24 years, *Mental and behavioural disorders due to use of alcohol* (F10) were the most common diagnoses. These diagnoses were also common for the age group 25–34 years, followed by *Mental and behavioural disorders due to other psychoactive substance use* (F11–F19) and *Depressive episode* (F32). More than half of separations associated with the use of alcohol (F10) were reported by those aged 35–54 years (50.9%). Alcohol-related disorders (F10) were also top of the list for those aged 55–64 years.

Not surprisingly, separations with the principal diagnosis of *Dementia* (F00–F03) were predominantly reported for those aged 65 years and over. This was also the case for separations with the diagnosis of *Other organic mental disorders* (F04–F09). However, there were also more separations reported for this age group for *Depressive episode*, *Anxiety disorders* and *Bipolar affective disorders* (F32, F41 and F31) compared with other age groups.

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

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, 2006–07

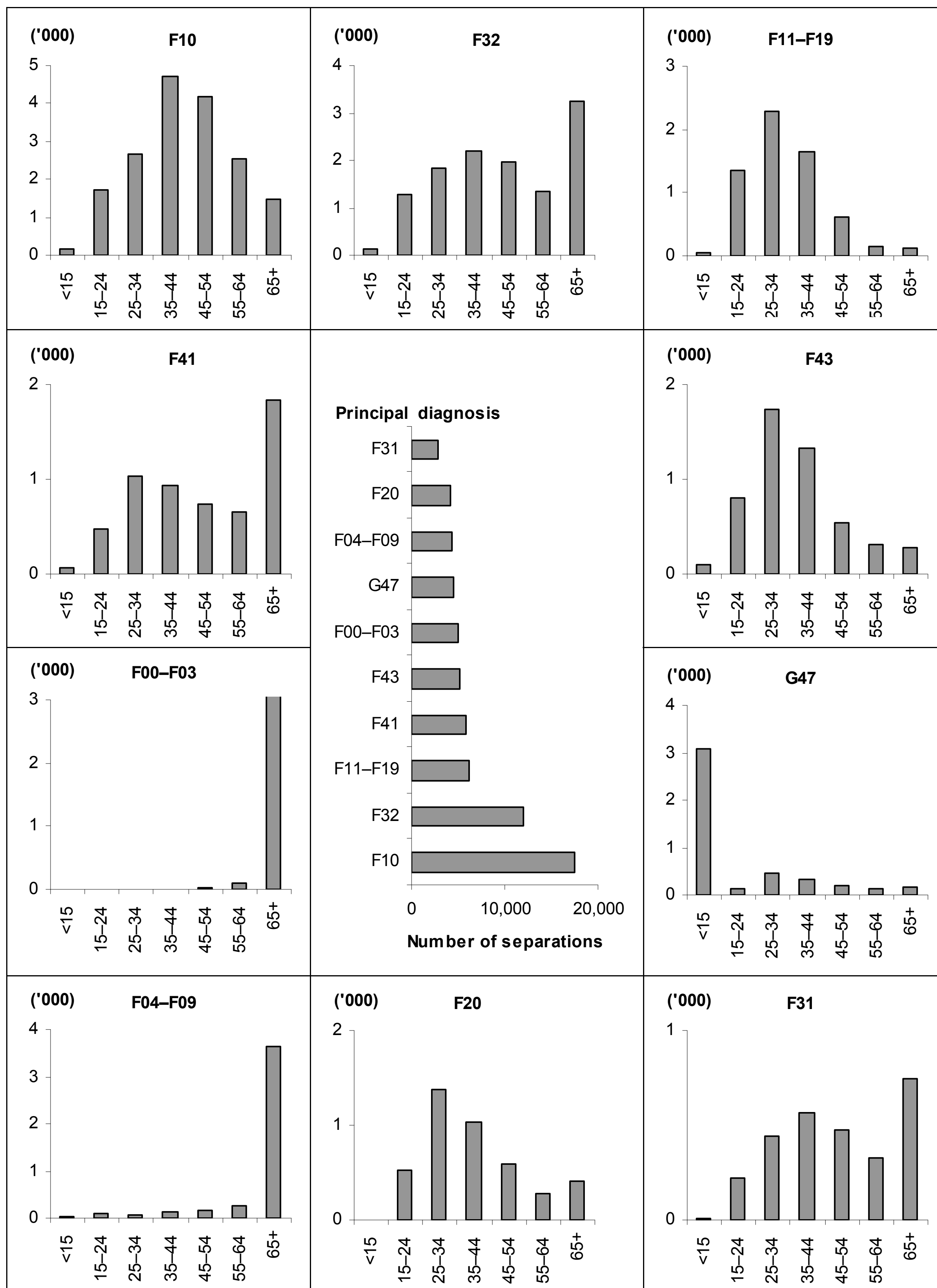
Principal diagnosis		Public acute	Public psychiatric	Private	Total	Per cent
F00–F03	Dementia	4,322	1	704	5,027	5.8
F04–F09	Other organic mental disorders	3,874	1	511	4,386	5.0
F10	Mental and behavioural disorders due to use of alcohol	15,580	233	1,703	17,516	20.1
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	5,324	367	535	6,226	7.1
F20	Schizophrenia	4,137	3	83	4,223	4.8
F21, F24, F28, F29	Schizotypal and other delusional disorders	1,074	1	26	1,101	1.3
F22	Persistent delusional disorders	536	0	31	567	0.7
F23	Acute and transient psychotic disorders	1,042	1	21	1,064	1.2
F25	Schizoaffective disorders	1,373	0	89	1,462	1.7
F30	Manic episode	275	0	12	287	0.3
F31	Bipolar affective disorders	2,411	3	361	2,775	3.2
F32	Depressive episode	10,669	11	1,341	12,021	13.8
F33	Recurrent depressive disorders	2,219	0	334	2,553	2.9
F34	Persistent mood (affective) disorders	205	3	57	265	0.3
F38–F39	Other and unspecified mood (affective) disorders	65	0	13	78	0.1
F40	Phobic anxiety disorders	28	0	17	45	0.1
F41	Other anxiety disorders	5,037	1	720	5,758	6.6
F42	Obsessive-compulsive disorders	58	0	16	74	0.1
F43	Reaction to severe stress and adjustment disorders	4,478	21	608	5,107	5.9
F44	Dissociative (conversion) disorders	942	0	59	1,001	1.1
F45, F48	Somatoform and other neurotic disorders	364	0	211	575	0.7
F50	Eating disorders	970	0	101	1,071	1.2
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	923	0	305	1,228	1.4
F60	Specific personality disorders	1,116	8	43	1,167	1.3
F61–F69	Disorders of adult personality and behaviour	80	0	62	142	0.2
F70–F79	Mental retardation	156	0	0	156	0.2
F80–F89	Disorders of psychological development	379	0	47	426	0.5
F90	Hyperkinetic disorders	51	0	1	52	0.1
F91	Conduct disorders	360	0	5	365	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	544	0	5	549	0.6
F99	Mental disorder not otherwise specified	190	1	2	193	0.2
G30	Alzheimer's disease	1,888	0	360	2,248	2.6
	Other factors related to mental and behavioural disorders and substance use[(b)]	540	5	29	574	0.7
	Other specified mental health-related principal diagnosis[(c)]	5,343	0	1,599	6,942	8.0
Total		**76,553**	**660**	**10,011**	**87,224**	**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.

Source: National Hospital Morbidity Database.

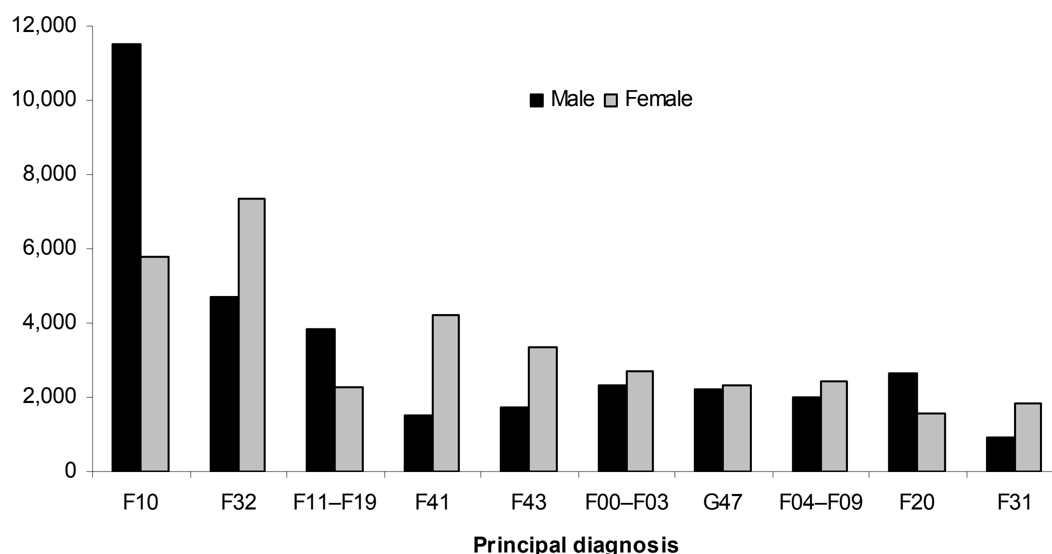


Note: Separations for which care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

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, 2006–07

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
F41	Other anxiety disorders
F43	Reaction to severe stress and adjustment disorders
G47	Sleep 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, 2006–07

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.

A total of 106,899 procedures were reported in relation to 48,369 separations. This reflects the fact that more than one procedure can be reported for each separation. No procedures were reported for 44.5% (38,855 out of 87,224) of the separations. The most frequently reported procedures were *Allied health intervention, social work* (12,714 procedures for 12,689 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, 2006–07

	Procedures[(b)]		Separations[(b)(c)]	
Procedure	**Number**	**Per cent**	**Number**	**Per cent**
95550–01 Allied health intervention, social work	12,714	11.9	12,689	12.0
95550–03 Allied health intervention, physiotherapy	9,642	9.0	9,636	9.1
56001–00 Computerised tomography of brain	8,067	7.5	8,037	7.6
93340–02 Electroconvulsive therapy ≤12 treatments	7,652	7.2	7,649	7.3
92514–99 General anaesthesia, ASA 99	6,981	6.5	6,428	6.1
95550–02 Allied health intervention, occupational therapy	6,363	6.0	6,349	6.0
95550–00 Allied health intervention, dietetics	4,561	4.3	4,553	4.3
92003–00 Alcohol detoxification	4,063	3.8	4,062	3.9
95550–10 Allied health intervention, psychology	2,981	2.8	2,980	2.8
92006–00 Drug detoxification	2,647	2.5	2,646	2.5
Other reported procedures	41,228	38.6	40,297	38.3
	Totals			
Number of separations with at least one procedure	. .	. .	48,369	55.5
Number of separations with no procedure reported	. .	. .	38,855	44.5
Total	**106,899**	**100**	**87,224**	**100**

(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.

. . Not applicable.

Source: National Hospital Morbidity Database.

7.5 Separations with mental health-related additional diagnoses

In addition to the 329,958 admitted patient mental health-related separations, 287,493 separations were not classed as mental health-related (that is, did not have a mental health-related principal diagnosis or receive specialised psychiatric care) but had at least one mental health-related additional diagnosis. These separations accounted for 2,803,784 patient days.

In relation to these separations, the most commonly reported mental health-related additional diagnoses were *Mental and behavioural disorders due to use of alcohol* (F10; 59,891 separations), *Unspecified dementia* (F03; 51,252 separations) and *Depressive episode* (F32; 36,657 separations).

The most commonly reported principal diagnoses for these separations were *Care involving use of rehabilitation procedures* (Z50; 18,397 separations), *Other chronic obstructive pulmonary disease* (J44; 10,131 separations) and *Fracture of femur* (S72; 7,439 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 and 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 via hospitals, as detailed in Chapter 7, or through 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 and subject to Commonwealth reporting requirements. Government-funded, non-government-operated services could be included optionally. The database was inaugurated in 2004–05 and this is the third time that the data are being reported.

For the 2006–07 data collection, all the facilities had mental health trained staff on-site 24 hours a day except for one South Australian facility which was staffed for 13 hours a day and one Northern Territory facility which was staffed on average 9 hours a day. Data from six Tasmanian non-government organisations staffed 24 hours a day were also included in the 2006–07 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 2006) 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 2007)). 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 2006–07, there were 2,531 ***episodes of residential care*** with 236,733 ***residential care days*** provided to 1,664 ***residents*** (Table 8.1). This corresponds to an average of 1.5 episodes of care per resident and 94 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/or 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, 2006–07

	NSW	Vic	Qld	WA	SA	Tas[(a)]	ACT	NT	Total
Episodes	393	1,003	. .	181	121	743	81	9	2,531
Estimated number of residents[(b)]	301	617	. .	138	108	423	68	9	1,664
Average episodes per resident[(b)]	1.3	1.6	. .	1.3	1.1	1.8	1.2	1.0	1.5
Residential care days	46,921	95,535	. .	4,972	8,669	65,464	13,793	1,379	236,733
Average residential care days per episode	119	95	. .	27	72	88	170	153	94
				Rate[(c)] (per 10,000 population)					
Episodes	0.6	2.0	. .	0.9	0.8	14.7	2.3	0.5	1.2
Estimated number of residents	0.4	1.2	. .	0.7	0.7	8.5	1.9	0.5	0.8
Residential care days	66.8	186.6	. .	23.9	58.4	1,306.1	393.4	61.3	113.6

(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.

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

Source: National Residential Mental Health Care Database.

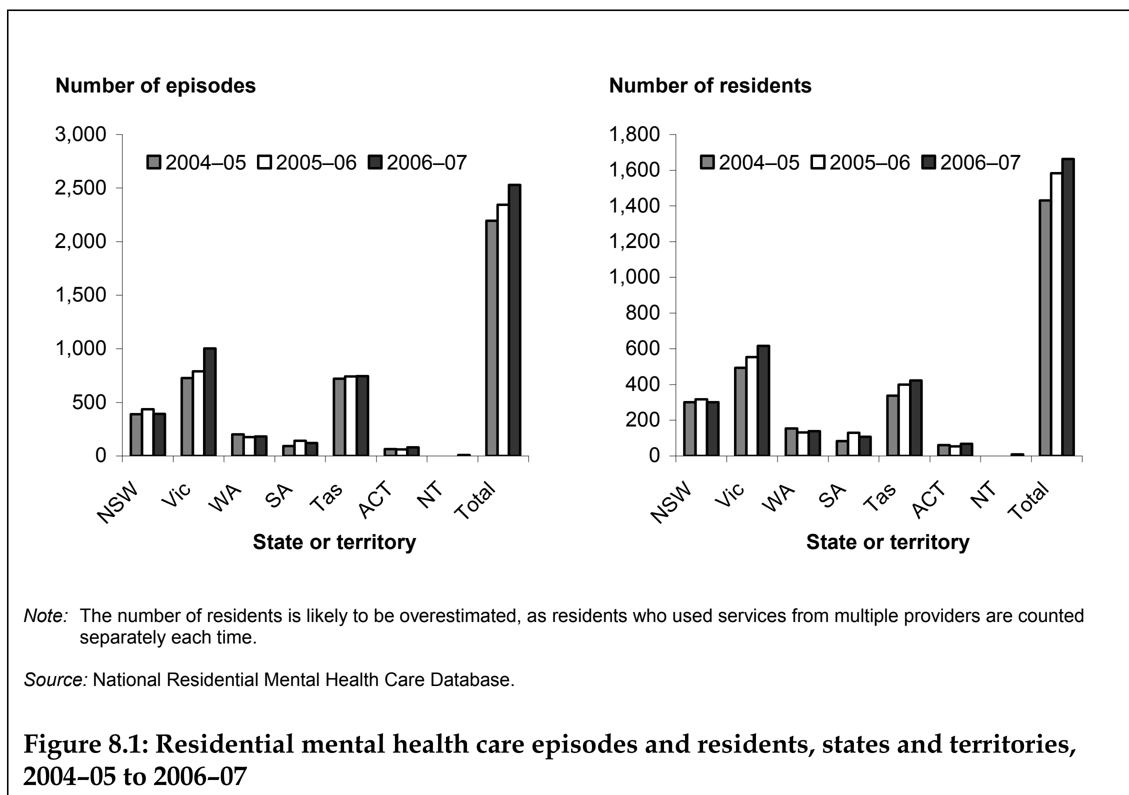
Tasmania reported an average of 1.8 episodes per resident, compared with the national average of 1.5. The highest average residential care days per episode was reported by the Australian Capital Territory (170 days).

Taking population size into consideration, Tasmania reported the highest number per 10,000 population for the number of episodes (14.7), estimated number of residents (8.5) and residential care days (1,306.1). However, this may be due to the inclusion of data from non-government residential units in the Tasmanian dataset. New South Wales had the lowest number of residents (0.4) per 10,000 population, while Western Australia reported the lowest number of residential care days (23.9).

8.3 Changes 2004–05 to 2006–07

Nationally, there was an increase in the number of residential care episodes with 2,194 episodes reported in 2004–05 and 2,531 episodes reported in 2006–07 (Figure 8.1). The number of residents accessing care also increased with 1,431 residents accessing care in 2004–05 and 1,664 accessing care in 2006–07. As noted previously, 2006–07 was the first year the Northern Territory reported residential mental health care data.

Victoria reported an increasing number of episodes and residents over the 3-year period. There was a noticeable increase in both episodes and residents in 2006–07 which was likely to be the result of three more service units operating and reporting to the Database. While all jurisdictions except Western Australia reported increases in the number of episodes from 2004–05 to 2006–07, New South Wales and South Australia reported fewer episodes in 2006–07 compared to 2005–06.



Note: The number of residents is likely to be overestimated, as residents who used services from multiple providers are counted separately each time.

Source: National Residential Mental Health Care Database.

Figure 8.1: Residential mental health care episodes and residents, states and territories, 2004–05 to 2006–07

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. The majority of residential care episodes were for residents with voluntary legal status (63.8%) and, in the case of Western Australia and Northern Territory, 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, 2006–07

Mental health legal status	NSW	Vic	WA	SA	Tas	ACT	NT	Total
Involuntary	59	568	0	33	82	58	0	800
Voluntary	304	435	181	88	575	23	9	1,615
Not reported	30	0	0	0	86	0	0	116
Total	**393**	**1,003**	**181**	**121**	**743**	**81**	**9**	**2,531**

Source: National Residential Mental Health Care Database.

Figure 8.2 shows the jurisdictional comparison of episodes by mental health legal status between 2004–05 and 2006–07. Increases in the proportion of involuntary episodes were reported by New South Wales, Victoria, South Australia and the Australian Capital Territory.

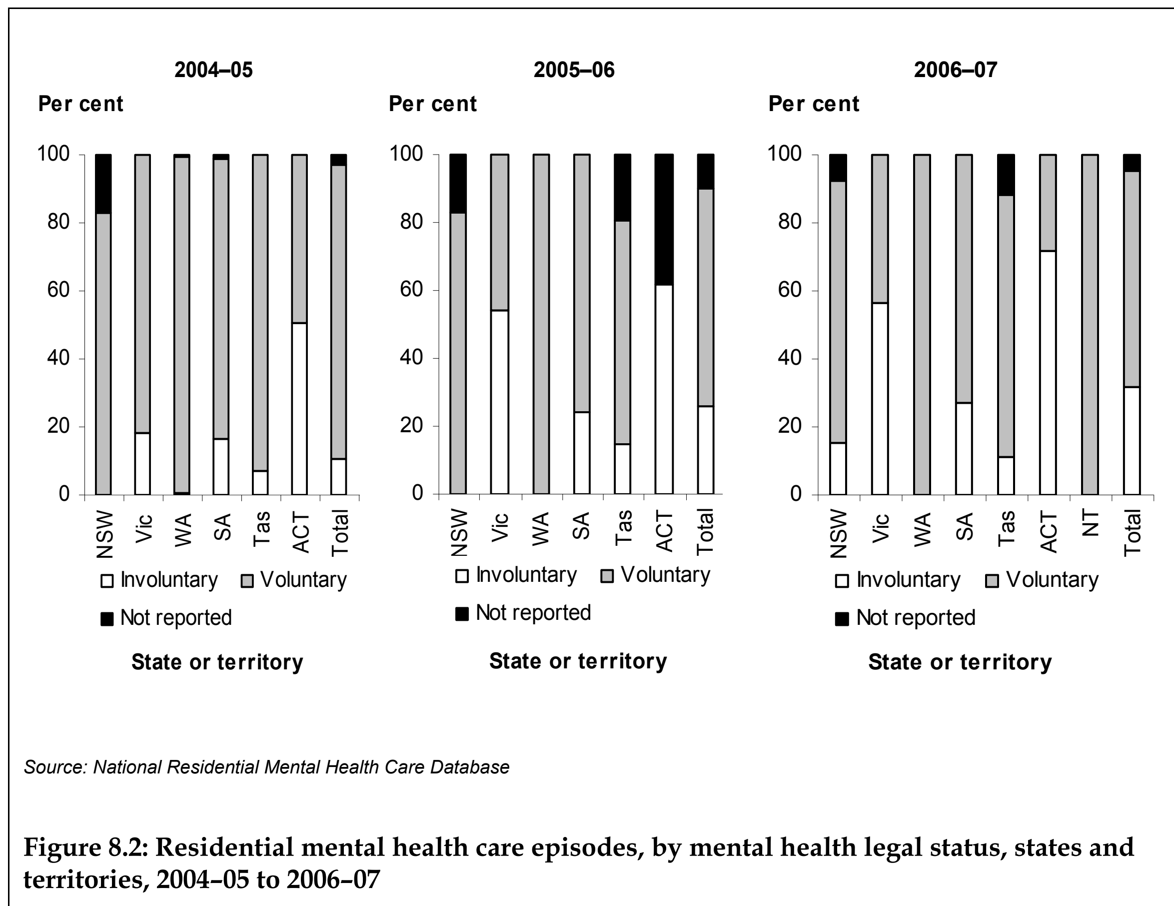


Figure 8.2: Residential mental health care episodes, by mental health legal status, states and territories, 2004–05 to 2006–07

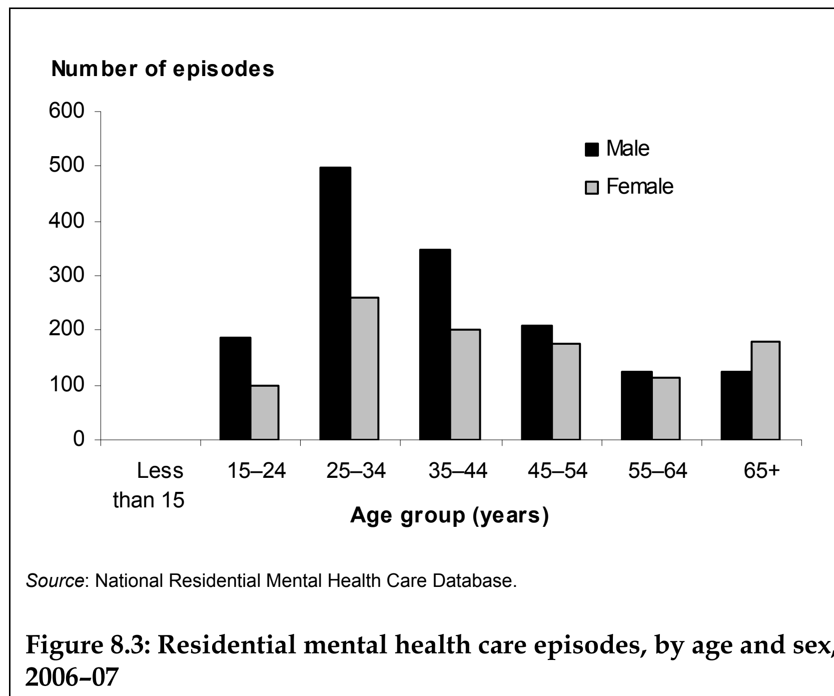
8.5 Patient demographics

Table 8.3 provides a summary of the demographics of residents receiving residential mental health care in 2006–07. 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 and 35–44 years (30.0% and 21.8%, respectively). The 25–34 age group also had the highest number of episodes per 10,000 population, which was twice that of the 45–54 years age group (2.6 and 1.3, respectively). 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 particularly marked for those aged 25–44 years (Figure 8.3).

The rate of episodes for Australian-born residents was noticeably higher than the rate of those born overseas (1.5 and 0.6, respectively). Likewise, the rate of episodes for those living in *Inner regional* areas was higher than those in *Major cities* (2.8 and 0.9, respectively). The majority of the episodes (69.5%) 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 8.3: Residential mental health care episodes, by age and sex, 2006–07

Table 8.3: Episodes of residential mental health care, by patient demographic characteristics, 2006–07

Patient demographics	Number of episodes[(a)]	Per cent of episodes[(b)]	Rate (per 10,000 population)[(c)]
Age (years)			
Less than 15	1	0.0	0.0
15–24	282	11.2	1.0
25–34	756	30.0	2.6
35–44	550	21.8	1.8
45–54	387	15.4	1.3
55–64	238	9.5	1.0
65+	304	12.1	1.1
Sex			
Male	1,500	59.3	1.5
Female	1,029	40.7	1.0
Indigenous status[(d)]			
Indigenous Australians	60	2.5	1.8
Other Australians	2,344	97.5	1.2
Country of birth			
Australia	2,149	85.6	1.5
Overseas	361	14.4	0.6
Remoteness area of usual residence			
Major cities	1,240	50.0	0.9
Inner regional	1,086	43.8	2.8
Outer regional	151	6.1	0.8
Remote	5	0.2	0.2
Marital status[(e)]			
Never married	1,591	69.5	. .
Widowed	160	7.0	. .
Divorced	208	9.1	. .
Separated	111	4.8	. .
Married	219	9.6	. .
Total	**2,531**	**100.0**	**1.2**

(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, including Indigenous status, was missing 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 recorded by jurisdictions (see Appendix 1).

(e) Information on this data element was missing or not reported for nearly 10% of episodes.

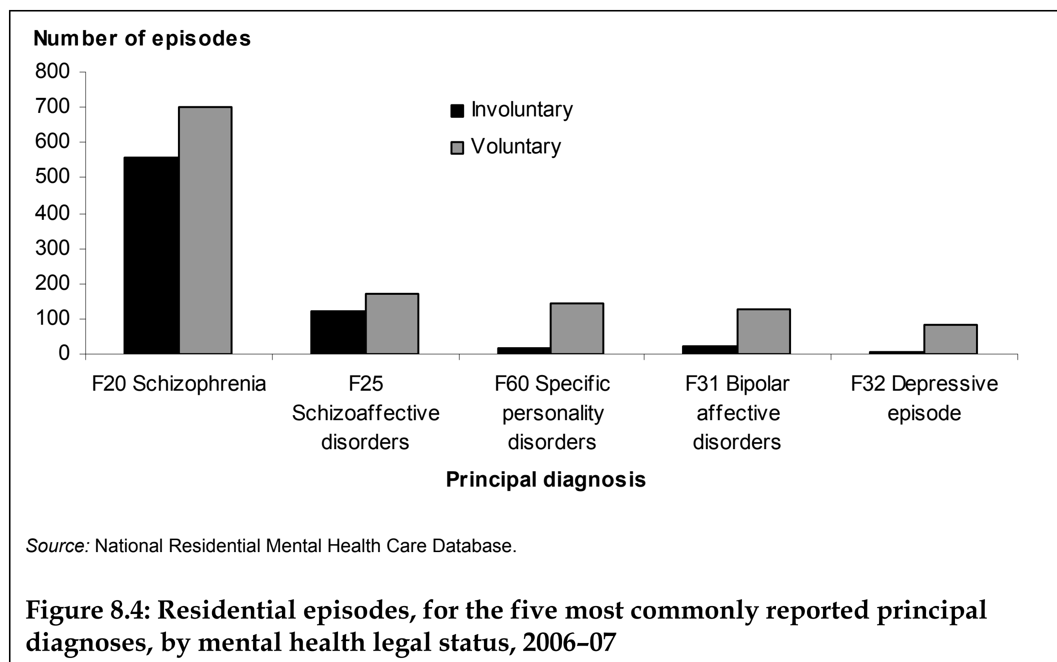
. . Not applicable.

Source: National Residential Mental Health Care Database.

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 8.4 presents the number of residential mental health care episodes for principal diagnosis groups for 2006–07. 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). Note that these data should be interpreted with caution due to variability in the data collection and coding practices in relation to principal diagnosis across Australia (for more information, see Appendix 1).

In 2006–07, a principal diagnosis was specified for 89.5% of episodes of residential care (2,265). For those episodes, the principal diagnosis of *Schizophrenia* (F20) accounted for the largest number of residential care episodes (1,287 or 56.8%). It was also the most commonly reported diagnosis for episodes with involuntary mental health legal status (556 or 69.5% out of 800) (Table 8.2; Figure 8.4).



Source: National Residential Mental Health Care Database.

Figure 8.4: Residential episodes, for the five most commonly reported principal diagnoses, by mental health legal status, 2006–07

Table 8.4: Episodes of residential mental health care, by principal diagnosis in ICD-10-AM groupings, 2006–07

Principal diagnosis		Number of episodes	Specified principal diagnoses (per cent)
F00–F03	Dementia	54	2.4
F04–F09	Other organic mental disorders	6	0.3
F10	Mental and behavioural disorders due to use of alcohol	15	0.7
F11–F19	Mental and behavioural disorders due to other psychoactive substance use	20	0.9
F20	Schizophrenia	1,287	56.8
F21, F24, F28, F29	Schizotypal and other delusional disorders	27	1.2
F22	Persistent delusional disorders	11	0.5
F23	Acute and transient psychotic disorders	21	0.9
F25	Schizoaffective disorders	290	12.8
F30	Manic episode	2	0.1
F31	Bipolar affective disorders	150	6.6
F32	Depressive episode	100	4.4
F33	Recurrent depressive disorders	16	0.7
F34	Persistent mood (affective) disorders	2	0.1
F41	Other anxiety disorders	13	0.6
F42	Obsessive-compulsive disorders	3	0.1
F43	Reaction to severe stress and adjustment disorders	28	1.2
F50	Eating disorders	2	0.1
F60	Specific personality disorders	160	7.1
F61–F69	Disorders of adult personality and behaviour	10	0.4
F70–F79	Mental retardation	2	0.1
F80–F89	Disorders of psychological development	10	0.4
F91	Conduct disorders	1	0.0
F92–F98	Other and unspecified disorders with onset in childhood and adolescence	1	0.0
	Other[(a)]	34	1.5
Subtotal with specified principal diagnosis		*2,265*	100.0
F99	Mental disorder not otherwise specified	266	. .
Subtotal with unspecified principal diagnosis		*266*	. .
Total		**2,531**	**. .**

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

. . Not applicable.

Source: National Residential Mental Health Care Database.

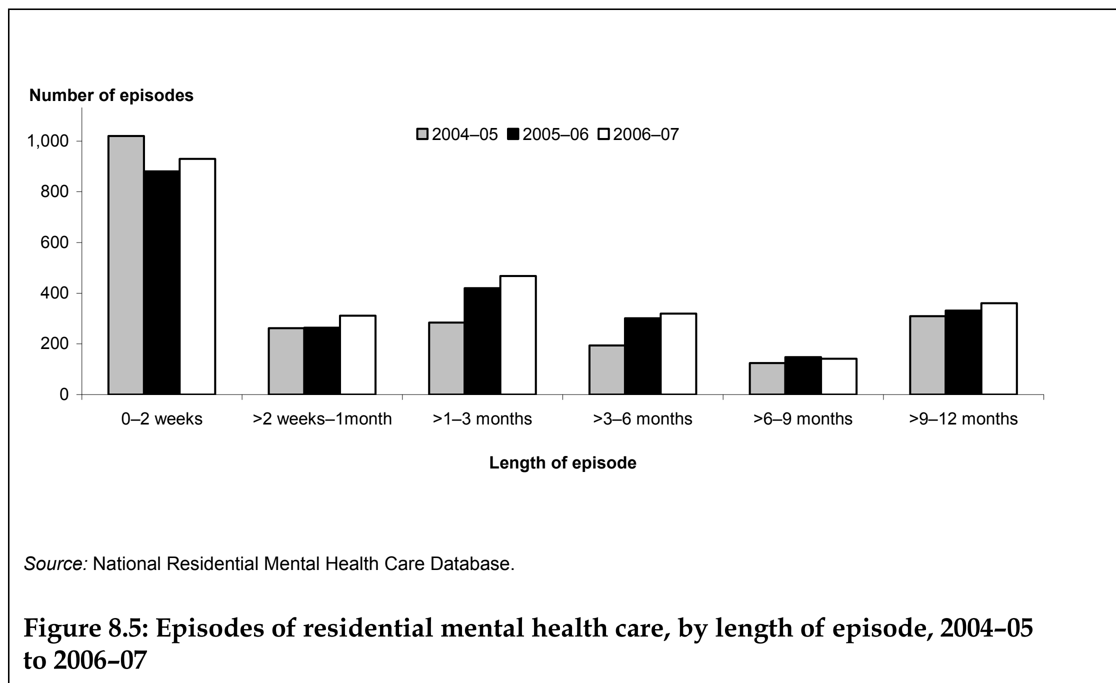
8.7 Length of episodes and residential stays

Episodes

The NRMHCD collects data on the episodes of residential mental health care that occurred during the collection period (that is, from 1 July 2006 to 30 June 2007). 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 2006–07, there were 67 such episodes.

In relation to the 2,531 episodes of residential mental health care in 2006–07, there was a total of 236,733 residential mental health care days. The average length of stay per episode was 94 days and the median length of episode was 32 days. The most common length of episode was 365 days (207 episodes or 8.2%), a result of some residents being in residential care for the whole collection period (see Key concepts).

Over the 3 years to 2006–07, there is no apparent trend evident in the length of residential mental health care episodes.



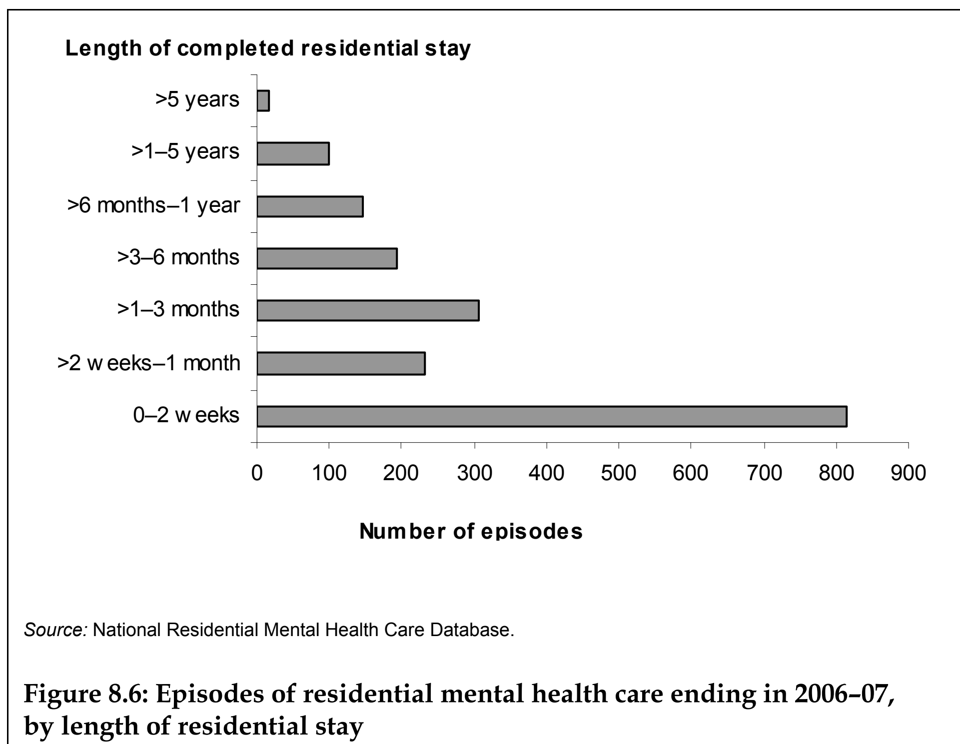
Source: National Residential Mental Health Care Database.

Figure 8.5: Episodes of residential mental health care, by length of episode, 2004–05 to 2006–07

Residential stays

Figure 8.6 shows the distribution of the length of residential stays for episodes which formally ended during 2006–07. There were 1,815 episodes (71.7% of 2,531) which fitted this criterion, noting that episodes with 30 June 2007 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 2006–07. A resident may have taken leave in the financial years preceding 2006–07 but these leave days cannot be accounted for because data on leave days prior to 2006–07 were not available. Consequently, the length of residential stay figures may be overestimates.

The average length of residential stay for episodes completed in 2006–07 was 118 days. The most common length of stay was 3 days and the median length of stay was 20 days. Episodes with a residential stay longer than 1 year constituted 6.4% (116 out of 1,815) of the episodes. There were six reports of completed residential stays of longer than 10 years. The longest length of residential stay was 14.7 years.



Source: National Residential Mental Health Care Database.

Figure 8.6: Episodes of residential mental health care ending in 2006–07, 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 that provide information regarding 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*** (see Key concepts box below). This chapter presents information on these mental health-related closed support periods, provided by SAAP agencies in 2006–07.

The 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 assist them to achieve the maximum possible degree of self-reliance and independence. 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 held by the Australian Institute of Health and Welfare, one of three distinct segments of the SAAP NDC. 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 or guardian's support period and/or receives SAAP assistance directly as a consequence of a parent 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 there has been no adjustment for undercounting of 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 that 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 2006–07, there were 15,067 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 1.6.

Clients aged 25–44 years represented over half (52.5%) of the total number of clients for 2006–07. The number of clients per 100,000 population was highest for the group aged 18–19 years and lowest for those aged 65 years and over (150.2 and 8.7 per 100,000 population, respectively) (Table 9.1).

There were more female than male clients with mental health-related support periods in 2006–07 (52.5% compared with 47.5%). However, the rate of access to mental health-related closed support periods, as measured by the age standardised rate, was higher for male clients (116.5 per 100,000) than for females (100.0).

In 2006–07, Aboriginal and Torres Strait Islander peoples made up 12.0% 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 2007b). The age standardised rate for Indigenous Australians was 447.7 per 100,000 for closed support periods, which was almost 5 times the rate for non-Indigenous Australians (91.5).

Most clients (86.1%) were born in Australia. The age standardised rate for Australian-born people who had a SAAP mental health-related closed support period in 2006–07 was twice that of the overseas-born clients (81.8 and 40.8 per 100,000 population, respectively). The rate for the number of closed support periods for Australian-born clients was also twice the rate for overseas-born clients (123.3 and 60.3 per 100,000 population, respectively).

The SAAP clients in 2006–07 who were overseas-born (13.9%) can be classified into English Proficiency (EP) Country Groups (see Appendix 3 for details). There was considerable variation in client rates of access between the EP country groups, ranging from 35.3 to 55.2 per 100,000 population. When usage rates were calculated for the number of closed support periods, those individuals born in EP group 3 had the highest usage rates (76.5 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 (i.e. adults and unaccompanied children) detailed above.

In 2006–07, 6,713 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, 2006–07

	Clients			Closed support periods		
Client demographics	Number[(a)]	Per cent of clients [(b)]	Rate[(b)(c)] (per 100,000 population)	Number[(a)]	Per cent of support periods [(b)]	Rate[(b)(c)] (per 100,000 population)
Age (years)						
Under 15 years	382	2.5	9.4	449	2.0	11.1
15 to 17	1,263	8.4	147.0	1,557	7.0	181.2
18 to 19	852	5.7	150.2	1,087	4.9	191.6
20 to 24	1,952	13.0	131.8	2,482	11.1	167.6
25 to 44	7,906	52.5	132.4	11,801	52.9	197.6
45 to 64	2,476	16.4	47.8	4,401	19.7	85.0
65 years and over	236	1.6	8.7	539	2.4	19.8
Sex						
Female	7,907	52.5	77.5	10,877	46.2	100.0
Male	7,160	47.5	69.5	12,679	53.8	116.5
Indigenous status						
Indigenous Australians	1,668	12.0	334.7	2,256	10.7	447.7
Other Australians	12,275	88.0	61.3	18,754	89.3	91.5
Country of birth						
Australia	12,685	86.1	81.8	19,029	85.7	123.3
Overseas	2,055	13.9	40.8	3,185	14.3	60.3
Overseas-born [(d)]						
EP country group 1	694	33.8	42.0	1,122	35.2	62.9
EP country group 2	426	20.7	35.3	672	21.1	45.3
EP country group 3	774	37.7	52.4	1,165	36.6	76.5
EP country group 4	161	7.8	55.2	226	7.1	71.1
Total number	**15,067**	**100.0**	**73.4**	**23,678**	**100.0**	**108.5**

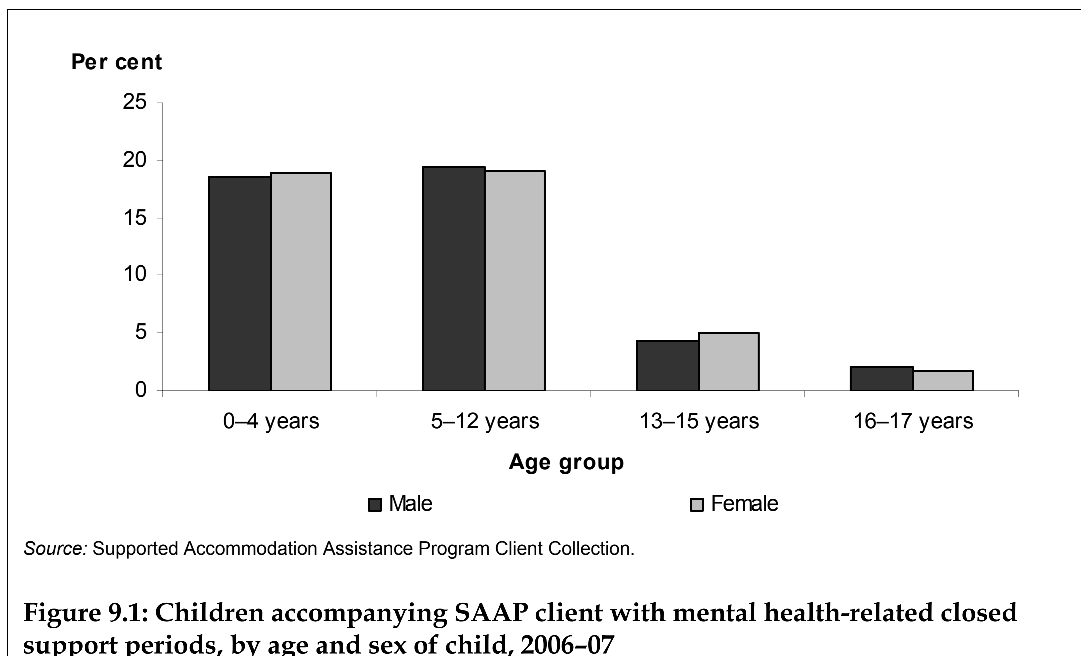
(a) Number of clients for Indigenous status, and number of closed support periods for Indigenous status and Country of birth, were missing or not reported for more than 5% of the total.

(b) The percentages and rates shown do not include those clients or closed support periods for which the demographic information was missing 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 English Proficiency (EP) Country Groups, see Appendix 3.

Source: Supported Accommodation Assistance Program Client Collection.

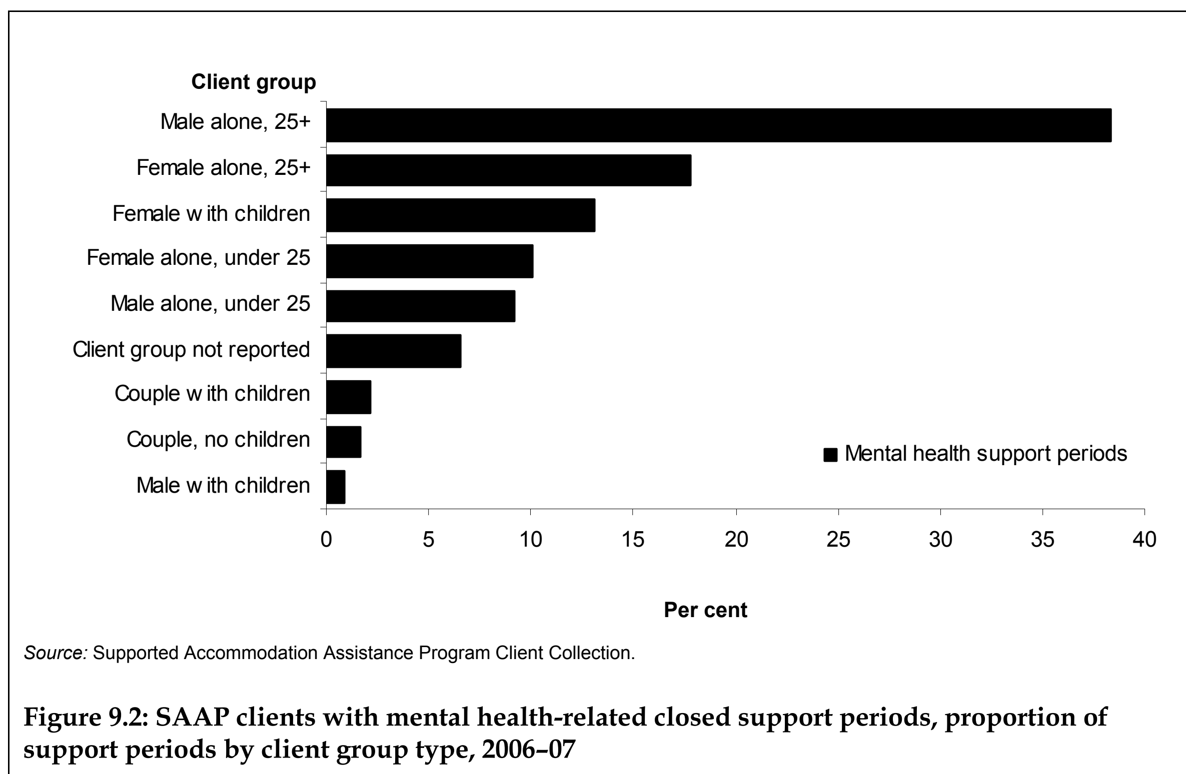


Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.1: Children accompanying SAAP client with mental health-related closed support periods, by age and sex of child, 2006–07

Client groups

In the SAAP data collection, each client is allocated to a client group based on the client's sex, age group and the mode of presentation to the SAAP agency. In 2006–07, the most commonly reported client group with mental health-related closed support periods was unaccompanied males aged 25 years and over (38.3%), followed by unaccompanied females aged 25 years and over (17.8%; Figure 9.2). The client group least receiving mental health-related SAAP closed support periods was males with children (0.9%).



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.2: SAAP clients with mental health-related closed support periods, proportion of support periods by client group type, 2006–07

9.3 SAAP mental health-related closed support periods

The previous section provided details on SAAP clients who had a mental health-related closed support period in 2006–07. This section presents information on the closed support periods and the SAAP services provided to these clients. There were 164,896 closed support periods for all SAAP support types in 2006–07 (unweighted data), and 23,678 mental health-related closed support periods reported for clients, representing 14.4% of the total.

Type of support period

Of the mental health-related closed support periods provided by SAAP in 2006–07, 10,908 (46.1%) involved supported accommodation services, which may include other support services, while 12,770 (53.9%) 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 across each state and territory. In 2006–07, the Northern Territory had the highest rate of mental health-related closed support periods per 100,000 population (260.7), whereas Western Australia had the lowest rate (40.2).

Table 9.2: SAAP mental health-related closed support periods, by service type, states and territories, 2006–07

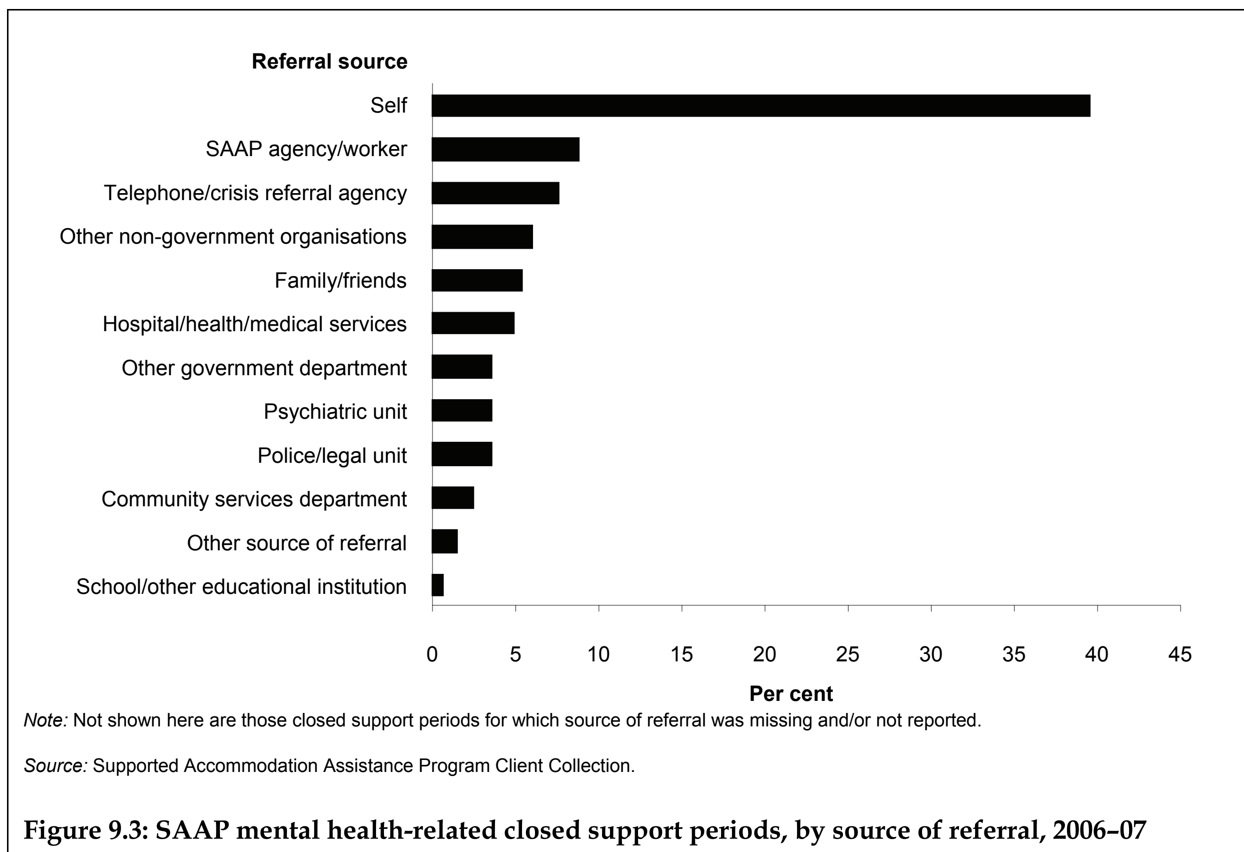
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number				
Supported accommodation	3,937	3,058	1,736	542	529	370	294	442	10,908
Other support services	2,014	8,008	821	294	1,068	309	144	112	12,770
Total	**5,951**	**11,066**	**2,557**	**836**	**1,597**	**679**	**438**	**554**	**23,678**
					Rate (per 100,000)[(a)]				
Supported accommodation	57.4	59.2	42.0	26.0	33.6	75.2	87.4	208.0	52.3
Other support services	29.4	155.1	19.9	14.1	67.8	62.8	42.8	52.7	61.3
Total	**86.8**	**214.3**	**61.9**	**40.2**	**101.4**	**138.1**	**130.2**	**260.7**	**113.6**

(a) Crude rate based on the Australian estimated resident population as at 31 December 2006.

Source: Supported Accommodation Assistance Program Client Collection.

Source of referral to SAAP services

There are several ways in which prospective SAAP clients come in contact with a SAAP agency. In 2006–07, self-referral was the most common source of referral to SAAP services for mental health-related support periods (39.6%), followed by referrals from other SAAP agencies or workers (8.8%) and referrals from telephone/crisis referral agencies (7.6%; Figure 9.3).



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

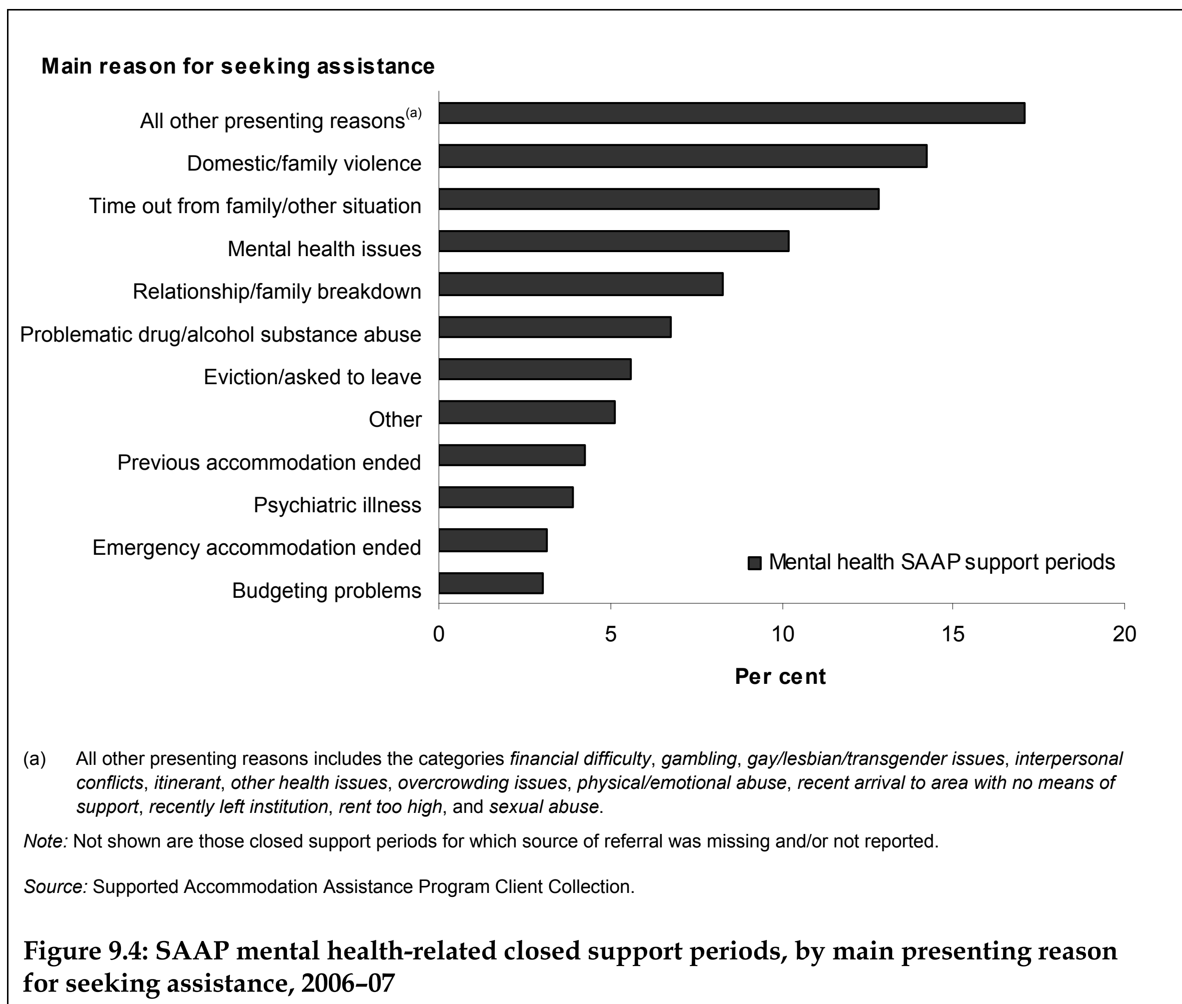
Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.3: SAAP mental health-related closed support periods, by source of referral, 2006–07

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 2006–07, 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 10.2% and 3.9% of closed support periods, respectively (Figure 9.4). 'Domestic or family violence' (14.2%) was the most common main reason for seeking assistance by clients receiving a mental health-related SAAP closed support period.



(a) All other presenting reasons includes the categories *financial difficulty*, *gambling*, *gay/lesbian/transgender issues*, *interpersonal conflicts*, *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*.

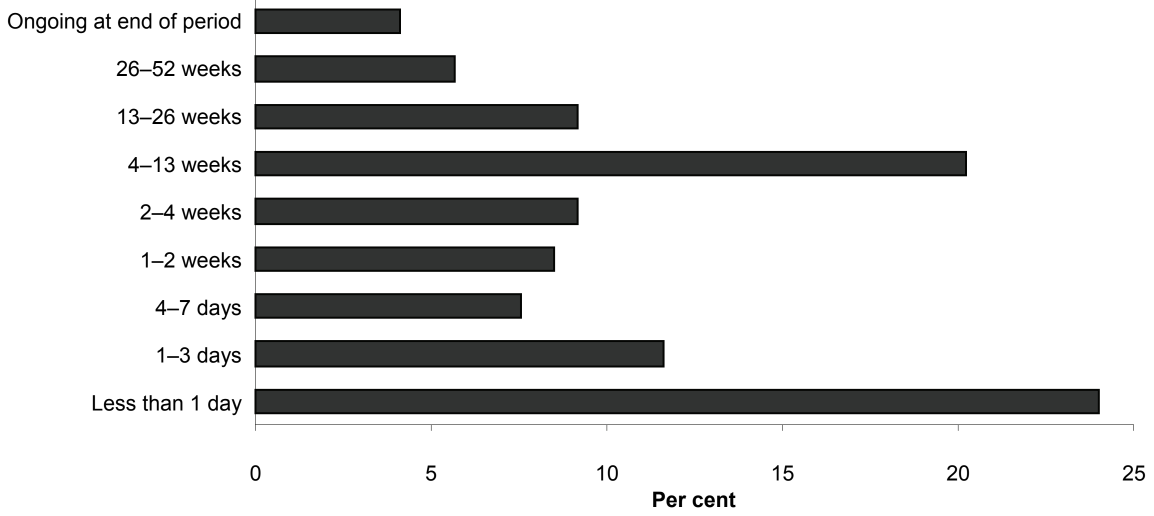
Note: Not shown are those closed support periods for which source of referral was missing and/or not reported.

Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.4: SAAP mental health-related closed support periods, by main presenting reason for seeking assistance, 2006–07

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 less than 1 day (24.0%) followed closely by 4–13 weeks (20.2%).



Source: Supported Accommodation Assistance Program Client Collection.

Figure 9.5: SAAP mental health-related closed support periods, by length of support, 2006–07

10 Support services for people with psychiatric disability

10.1 Introduction

The third Commonwealth State/Territory Disability Agreement (CSTDA) (FaCS 2002), provides 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 promotes the shared core belief of a just and inclusive society which responds to the needs of all individuals. The CSTDA specifies that the Australian Government is responsible for the planning, policy setting and management of employment services, and that the states and territories are responsible for all other disability support services. Support for advocacy, information and print disability services is a shared responsibility (FaCS 2002).

The CSTDA defines 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 is likely to be permanent and result in substantially reduced capacity in self-care/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 manifest 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 is from the most recent collection (2006–07), along with 2005–06 data, where applicable for comparative purposes. As reported previously (AIHW 2008g*)*, there were jurisdictional variations in the services funded under the CSTDA and thus comparisons across 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 either as their ***primary disability*** or as an ***other significant disability***. A person who fulfilled the CSTDA definition of 'people with disabilities' may receive a range of CSTDA-funded ***service types***, depending on availability and their individual needs. Services may be either ***residential*** or ***non-residential***, or a combination of the two. Data presented cover both of these types of services. For further details on CSTDA-funded services see *Disability support services 2006–07* (AIHW 2008b). Data on the quantity (or hours) of support received are *not* presented here, as the information collected relates only to selected non-residential services, and has a high proportion of missing information.

Overall, 232,253 people across Australia made use of CSTDA-funded services during 2006–07, an increase of 7% from 2005–06. The most common primary disability among these clients was intellectual disability (33%). ***Psychiatric disability*** rated as the second most commonly reported primary disability, at 15%, ahead of physical disability, 13%.

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 are: intellectual; specific learning/attention-deficit disorder; autism; physical; acquired brain injury; neurological; deafblind; 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.

Service type and ***service group*** refer to the classification of services according to the support activity which 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 2006–07, 47,658 people with a psychiatric disability used CSTDA-funded services, an increase of 25% from 2005–06 (Table 10.1). This increase may be due to an overall rise in the number of people with a psychiatric disability using CSTDA-funded services or it may be due to an increase in the number of people self-identifying as having a psychiatric disability, or a combination of the two factors. There is also some evidence of changes in coding practices affecting the counts of service users.

The number of service users with 'not stated' and 'not known' responses for primary disability group varies between collection periods and within jurisdictions, which impacts on the number of people identified as having a psychiatric disability. In 2006–07, the number of 'not stated' and 'not known' responses ranged from 0.7% to 26.6%. See Appendix 1 for additional information.

CSTDA-funded non-residential support service rates in 2006–07 increased to 2,251 (per million population), from 1,816 (per million population) in 2005–06 (Table 10.1). Residential service rates also increased in 2006–07 to 161 (per million population), from 144 (per million population) in 2005–06.

While at both the national and the state/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. In particular, 18.0% of service users in Tasmania accessed residential services, whereas 2.5% did so in Queensland, compared to the national average of 7.1%.

There was a marked difference between residential and non-residential service users in terms of whether their primary disability was psychiatric. For residential service users, psychiatric disability was the primary disability in 10.0% of cases, whereas for non-residential service users it was the primary disability in 75.6% of cases (tables 10.3 and 10.7, respectively).

There was also a difference between residential and non-residential service users in terms of their country of birth. Service users born in Australia accounted for 93.0% of residential service users, compared to 83.1% of non-residential service users (tables 10.4 and 10.8, respectively).

Table 10.1: CSTDA-funded service users with a psychiatric disability, states and territories, 2005–06 and 2006–07

	2005–06			2006–07		
State or territory[(a)]	Non-residential	Residential	Total[(b)]	Non-residential	Residential	Total[(b)]
NSW	6,432	1,218	6,834	9,726	1,304	10,065
Vic	20,619	963	20,784	22,671	1,018	22,862
Qld	5,570	183	5,631	7,574	191	7,629
WA	1,698	20	1,704	2,584	[(c)]195	[(c)]2,637
SA	1,927	335	2,004	2,814	410	2,920
Tas	797	184	846	937	178	989
ACT	317	34	320	535	83	543
NT	87	22	103	147	18	157
Total[(d)]	**37,309**	**2,959**	**38,086**	**46,848**	**3,397**	**47,658**
Rate (per 1,000,000 population[(e)])	1,816	144	. .	2,251	161	. .

(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 2008b). See also Appendix 1.

(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) The increase in the number of residential service users in 2006–07 may be the result of changed coding practices in one CSTDA-funded service.

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

. . Not applicable.

Source: AIHW analysis of data from the 2005–06 and 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

10.3 Residential services

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

- *Large residentials/institutions* provide 24-hour residential support in a setting of more than 20 beds (these are referred to as large institutions in this report).
- *Small residentials/institutions* provide 24-hour residential support in a setting of 7 to 20 beds (these are referred to as small institutions in this report).
- *Hostels* provide residential support in a setting of usually less than 20 beds and may or may not provide 24-hour residential support.
- *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 6 service users are located in any one home.

Nationally, service users accessed residential services at a rate of 16.3 clients per 100,000 population. This rate was highest in Tasmania (36.2) and lowest in Queensland (4.6) (Table 10.2).

While group homes nationally were the most widely used residential service type (70.9%), the profiles of state/territory CSTDA-funded residential services varied considerably (Table 10.2 and Figure 10.1). Group homes were the largest service type in all states/territories except South Australia, where large institutions were the most used service type (54.4%). All clients resided in group homes in the two territories. Across jurisdictions, hostels were most utilised in Tasmania (15.2%) while small institutions were most utilised in Queensland (28.3%).

Table 10.2: CSTDA-funded residential service users with a psychiatric disability, by residential service type, states and territories[(a)], 2006–07

Residential service type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]	Total (per cent)
Large institutions	432	70	43	26	223	21	0	0	815	24.0
Small institutions	8	0	54	29	6	2	0	0	99	2.9
Hostels	22	38	0	11	13	27	0	0	111	3.3
Group homes	860	914	99	129	177	128	83	18	2,408	70.9
Total[(c)]	**1,304**	**1,018**	**191**	**195**	**410**	**178**	**83**	**18**	**3,397**	. .
Rate (per 100,000 population)[(d)]	19.0	19.7	4.6	9.4	26.0	36.2	24.7	8.5	16.3	. .

(a) 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 2008b). See also Appendix 1.

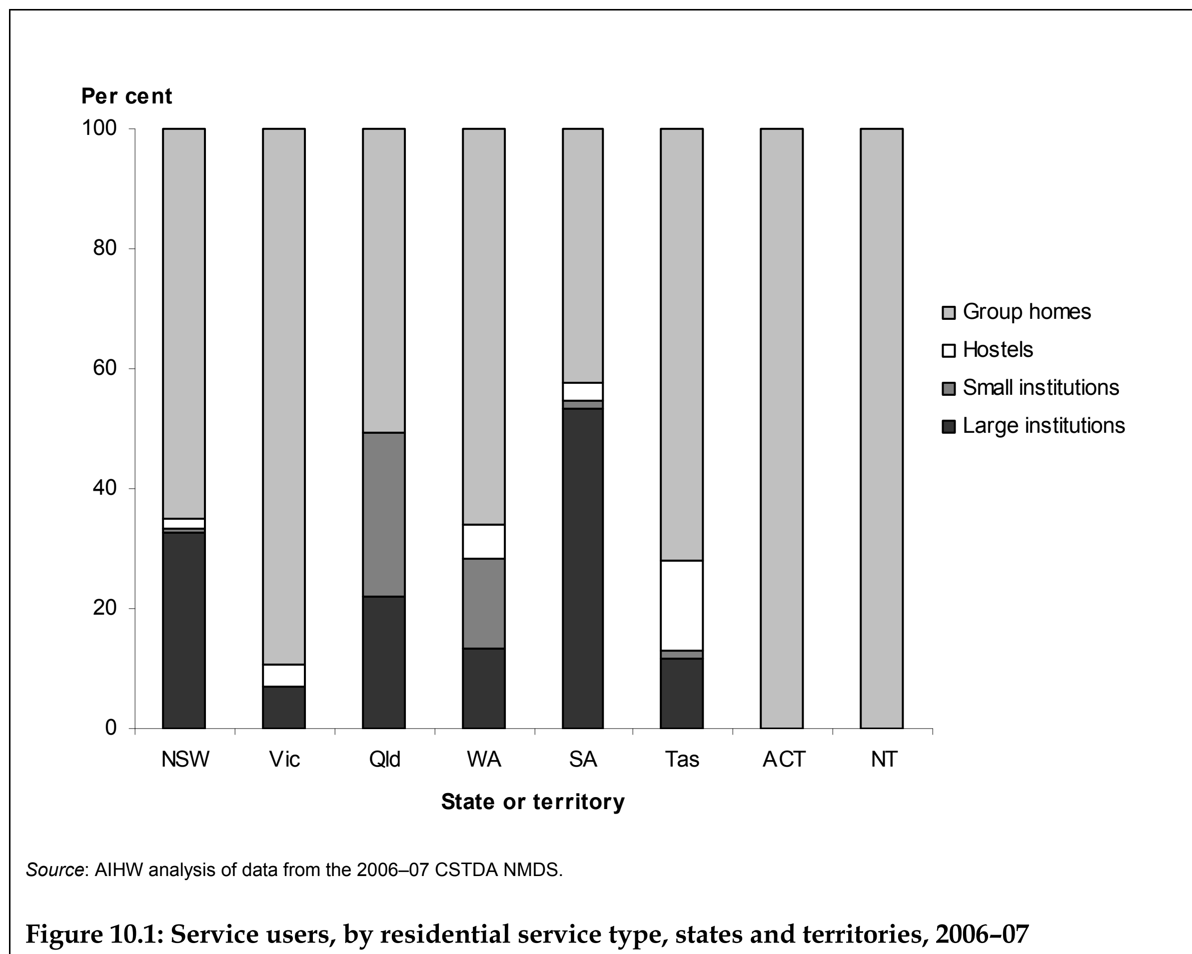
(b) The number of service users may not sum to the total because users may have accessed services from more than one state and/or territory.

(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 based on the Australian estimated resident population as at 31 December 2006.

. . Not applicable.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.



Source: AIHW analysis of data from the 2006–07 CSTDA NMDS.

Figure 10.1: Service users, by residential service type, states and territories, 2006–07

Profile of residential service users

As shown in Table 10.3, the most common primary disability of residential service users with a psychiatric disability for 2006–07 was intellectual disability, with a relatively small proportion of users having a primary psychiatric disability (10%).

Table 10.3: CSTDA-funded residential service users with a psychiatric disability, by primary disability group, 2006–07

Primary disability group	Service users (number)	Service users (per cent)
Intellectual	2,687	79.1
Psychiatric	339	10.0
Acquired brain injury	111	3.3
Physical	93	2.7
Autism	83	2.4
Neurological	64	1.9
Other disability[(a)]	20	0.6
Total	**3,397**	**100.0**

(a) Includes the following disability groups: *specific learning/attention-deficit disorder*; *sensory*; *speech*; and *developmental delay*.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.4 shows the demographic and geographic distribution of residential service users with a psychiatric disability in 2006–07.

There were more male users (58.2%) of CSTDA-funded residential services than females (41.8%) and the majority of residential users were aged 35–54 years (55.2%).

Aboriginal and Torres Strait Islander peoples made up a small proportion of CSTDA-funded residential service users. However, when their age structure and population size were taken into account, Indigenous Australians were relatively more likely than other Australians to utilise these services (317 and 157 per million population, respectively).

The majority of residential service users were born in Australia (93.0%). When relative population sizes and age structures are considered, there was an under-representation of residential service users who were born overseas (43 per million population for overseas-born compared with 216 per million population for Australian-born). Within the overseas-born population there were differences in the rates of usage of CSTDA-funded residential services, with migrants born in countries in the lowest English Proficiency Country Group (EP country group 4) (see Appendix 3 for details) having higher rates of usage (Table 10.4).

Most residential service users accessed CSTDA-funded services in *Major cities* (71.4%), followed by *Inner regional* areas (23.1%). However, *Inner regional* areas had the highest rate of usage. *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 were on Disability Support Pensions as shown in Table 10.5.

Table 10.4: Demographic characteristics of CSTDA-funded residential service users with a psychiatric disability, 2006–07

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate (per 1,000,000 population)[(c)]
Age group			
Less than 15 years	12	0.4	3
15–24 years	180	5.3	62
25–34 years	513	15.1	177
35–44 years	929	27.3	303
45–54 years	948	27.9	329
55–64 years	599	17.6	261
65+ years	216	6.4	79
Sex			
Male	1,975	58.2	189
Female	1,421	41.8	133
Indigenous status[(d)]			
Indigenous Australians	120	3.6	317
Other Australians	3,248	96.4	157
Country of birth			
Australia	3,140	93.0	216
Overseas	238	7.0	43
Overseas-born[(e)]			
EP country group 1	84	2.5	41
EP country group 2	66	2.0	43
EP country group 3	71	2.1	44
EP country group 4	17	0.5	67
Remoteness area of usual residence[(f)]			
Major cities	2,397	71.4	166
Inner regional	775	23.1	191
Outer regional	176	5.2	90
Remote and very remote	7	0.2	12
Total	**3,397**	**100.0**	**161**

(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 likely under-identification of Indigenous Australians.

(e) For definition of the English Proficiency (EP) Country Groups see Appendix 3.

(f) The number of service users in each remoteness area (RA) were 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.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.5: CSTDA-funded residential service users with a psychiatric disability, by usual residential setting, living arrangement and income source, 2006–07

	Service users (number)[(a)]	Service users (per cent)[(b)]
Usual residential setting		
Private residence	108	3.2
Domestic-scale supported living facility	1,961	57.9
Supported accommodation facility	1,195	35.3
Residential aged care facility	43	1.3
Psychiatric/mental health community care facility	37	1.1
Other[(c)]	43	1.3
Living arrangement		
Lives alone	98	2.9
Lives with family	57	1.7
Lives with others	3,235	95.4
Income source (adult 16+ years)[(d)]		
Disability Support Pension	3,107	92.6
Compensation income	183	5.5
Other pension or benefit	44	1.3
Paid employment	6	0.2
Other income sources	9	0.3
No income	8	0.2
Total	**3,397**	**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 CSTDA NMDS categories: *residence within an Aboriginal/Torres Strait Islander community*; *boarding house/private hotel*; *independent living unit within a retirement village*; *hospital*; *short-term crisis, emergency or transitional accommodation*; and *other* accommodation type.

(d) A total of 3,380 of the 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 2006–07 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/or 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.)

There was considerable variation between jurisdictions in the number of people with a psychiatric disability accessing the different non-residential service groups in 2006–07, as shown in Table 10.6. Nationally, employment services had the greatest number of users (52.9%), with respite services having the least (8.8%). Employment services had the greatest number of people accessing services in most states and territories with the exception of Victoria, where community access had the greatest number of users, and the Australian Capital Territory, where community support had the greatest.

Table 10.6: CSTDA-funded non-residential service users with a psychiatric disability, by service group, states and territories[(a)], 2006–07

Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]	Total (per cent)
Accommodation support	454	6,703	1,344	156	358	84	25	7	8,853	18.9
Community support	1,296	2,906	1,411	681	974	246	324	5	6,587	14.1
Community access	1,947	10,024	1,771	262	657	331	79	20	14,385	30.7
Respite	448	3,146	624	113	129	27	110	7	4,139	8.8
Employment	7,447	7,932	4,828	2,002	1,937	553	321	123	24,795	52.9
Total[(c)]	**9,726**	**22,671**	**7,574**	**2,584**	**2,814**	**937**	**535**	**147**	**46,848**	**. .**
Rate (per 100,000 population)[(d)]	141.9	439.0	183.3	124.2	178.6	190.6	159.1	69.2	224.7	. .

(a) 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 2008b). See also Appendix 1.

(b) Row totals may not equate to the sum of components because service users may receive services from more than one state/territory during the reporting period.

(c) Column totals may not equate to the sum of components because service users may receive more than one service group during the reporting period.

(d) Crude rate based on the Australian estimated resident population as at 31 December 2006.

. . Not applicable.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

Profile of non-residential service users

In contrast to the users of residential services, the 75.6% of CSTDA-funded non-residential service users who had a psychiatric disability reported this psychiatric disability as their primary disability (Table 10.7).

Table 10.7: CSTDA-funded non-residential service users with a psychiatric disability, by primary disability group, 2006–07

Primary disability group	Service users (number)	Service users (per cent)
Psychiatric	35,414	75.6
Intellectual	6,343	13.5
Physical	1,984	4.2
Acquired brain injury	1,153	2.5
Autism	561	1.2
Neurological	561	1.2
Specific learning/attention-deficit disorder	459	1.0
Sensory	348	0.7
Other disability[(a)]	25	0.1
Total	**46,848**	**100.0**

(a) Includes the disability groups *Speech* and *Developmental delay*.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

Table 10.8 shows the demographic and geographic distribution of non-residential service users with a psychiatric disability in 2006–07.

There were more male users (57.6%) of CSTDA-funded non-residential services than females (42.4%), which was almost the same as for users of residential services. The majority of non-residential users were aged 25–54 years.

Although Aboriginal and Torres Strait Islander peoples made up a small proportion of users, when the relative age structures and population sizes were taken into account, Indigenous Australians were almost twice as likely as other Australians to have utilised non-residential CSTDA-funded services (4,125 and 2,114 per million population, respectively).

As was the case for the residential service users, most non-residential service users were born in Australia (83.1%). Those who were born overseas were relatively less likely than their Australian-born counterparts to have used these services (1,303 and 2,512 per million population, respectively). Similar to residential services, the highest rate of usage for non-residential services in the overseas-born group was the group of migrants born in countries within the lowest English Proficiency Country Group (EP country group 4; 1,990 per million population).

Approximately two-thirds of non-residential service users accessed CSTDA-funded services in *Major cities*, about a quarter in *Inner regional* areas and much lower numbers in *Outer regional* and *Remote and very remote* areas. *Inner regional* had the highest usage rate, and *Remote and very remote* areas had the lowest, when relative age structures and population sizes were taken into account.

Table 10.8: Demographic characteristics of CSTDA-funded non-residential service users with a psychiatric disability, 2006–07

Service user demographics	Number of service users[(a)]	Per cent of service users[(b)]	Rate (per 1,000,000 population)[(c)]
Age group			
Less than 15 years	637	1.4	157
15–24 years	5,909	12.6	2,032
25–34 years	10,977	23.4	3,781
35–44 years	11,916	25.4	3,881
45–54 years	10,354	22.1	3,593
55–64 years	5,125	10.9	2,231
65+ years	1,919	4.1	704
Sex			
Male	26,951	57.6	2,607
Female	19,852	42.4	1,890
Indigenous status[(d)(e)]			
Indigenous Australians	1,692	3.8	4,125
Other Australians	43,089	96.2	2,114
Country of birth[(e)]			
Australia	37,240	83.1	2,512
Overseas	7,563	16.9	1,303
Overseas-born[(f)]			
EP country group 1	2,626	5.9	1,194
EP country group 2	1,720	3.8	1,125
EP country group 3	2,511	5.6	1,496
EP country group 4	706	1.6	1,990
Remoteness area of usual residence[(g)]			
Major cities	30,665	66.1	2,126
Inner regional	11,152	24.1	2,927
Outer regional	4,115	8.9	2,191
Remote and very remote	434	0.9	867
Total	**46,848**	**100.0**	**2,251**

(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 likely under-identification of Indigenous Australians.

(e) Information on this data element was missing or not reported for more than 4% of service users.

(f) For definition of the English Proficiency (EP) Country Groups see Appendix 3.

(g) The number of service users in each remoteness area (RA) were 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.

Source: AIHW analysis of data from the 2006–07 Commonwealth State/Territory Disability Agreement NMDS.

In contrast with users of residential services, 77.3% of non-residential service users usually lived in a private residential setting (Table 10.9), with more than a quarter living with family. Income source also contrasted greatly with residential users. Over half (62.5%) of all non-residential service users were dependent on a disability support pension, however this was well below the 92.6% (Table 10.5) of residential service users on this type of pension.

Table 10.9: CSTDA-funded non-residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2006–07

	Service users (number)[(a)]	Service users (per cent)[(b)]
Residential setting		
Private residence	33,846	77.3
Domestic-scale supported living facility	2,214	5.1
Supported accommodation facility	2,598	5.9
Psychiatric/mental health community care facility	1,137	2.6
Residence within an Aboriginal/Torres Strait Islander community	124	0.3
Boarding house/private hotel	2,114	4.8
Independent living unit within a retirement village	55	0.1
Residential aged care facility	241	0.6
Hospital	70	0.2
Short-term crisis, emergency or transitional accommodation	671	1.5
Public place/temporary shelter	89	0.2
Other	626	1.4
Living arrangement		
Lives alone	14,001	33.6
Lives with family	12,830	30.8
Lives with others	14,859	35.6
Income source (adult 16+ years)[(c)]		
Disability Support Pension	26,320	62.5
Other pension/benefit	10,073	23.9
Paid employment	1,644	3.9
Compensation income	638	1.5
Other income	3,022	7.2
No income	429	1.0
Total	**46,848**	**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) A total of 46,114 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 2006–07 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*** that are subsidised by the Australian Government through the *Pharmaceutical Benefits Scheme* (PBS) and the *Repatriation Pharmaceutical Benefits Scheme* (RPBS). Under both schemes, Medicare Australia makes payments to pharmacists to subsidise pharmaceutical products that are regarded as necessary and/or life-saving and are listed in the *Schedule of Pharmaceutical Benefits* (DoHA 2008d).

Key concepts

Mental health-related medications are defined in this chapter as:

- five selected medication groups as classified in the Anatomical Therapeutic Chemical (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, GPs, non-psychiatrist specialists and psychiatrists)
- all other medications prescribed by psychiatrists.

Mental health-related prescriptions are defined as prescriptions for mental health-related medications subsidised under the PBS/RPBS, which were dispensed by an approved pharmacist and for which the claim was processed by Medicare Australia in the reporting period.

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 including use of hypnotics and sedatives during post-operative care), while other medications that were related to mental health problems may have been excluded (for example, some medications prescribed by GPs or non-psychiatrist specialists that fall outside of the five selected medication groups may have been prescribed for mental health-related problems).

It should also be noted that over-the-counter medications (including orthodox and alternative medications) and non-subsidised medications, such as private prescriptions and below co-payment prescriptions (where the patient co-payment covers the total cost of the prescribed medication), are not included in the PBS and RPBS data. Based on the Drug Utilisation Sub-Committee database, 75% of ***mental health-related prescriptions*** were dispensed under the PBS or RPBS in 2007–08 (DoHA 2009a). The remainder were privately funded due either to the ineligibility of the patient or the price being below the maximum patient contribution.

This chapter first presents information on mental health-related prescriptions for 2007–08, according to the type of medication prescribed and the prescribing medical practitioner, followed by data that cover the period from 2003–04 to 2007–08. Secondly, tables present the number of patients receiving mental health-related prescriptions for 2007–08, 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 2003–04 to 2007–08.

The number of prescriptions issued through community pharmacies that are not covered by the PBS and RPBS is estimated through the Pharmacy Guild Survey (AIHW 2007b). These survey data are combined with PBS and RPBS data from Medicare Australia in the Drug Utilisation Sub-Committee (DUSC) database. This database estimates that the total number of community dispensed prescriptions for mental health-related ATC groups in 2007–08 was about 27 million (see Appendix Table A1.5). For further information on the PBS and RPBS, the DUSC database, and about data on medications covered by these schemes, refer to Appendix 1.

Related data on expenditure on medications under the PBS and RPBS are presented in Chapter 14 of this publication.

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 2008d). The coding of the pharmaceutical products in this schedule is based on the Anatomical Therapeutic Chemical (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.

Table 11.1: Drug groups defined for this report as mental health-related medications in the PBS/RPBS data

ATC code	Drug groups	Brief description of effects and indications
N05	**Psycholeptics**	**A group of drugs that tranquilises (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 (ADHD) and to improve impaired cognitive abilities (nootropics).

11.2 Prescriptions

This section presents information on the number and type of mental health-related prescriptions 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.

In 2007–08, there were 184.7 million PBS/RPBS-subsidised prescriptions for medications, of which 20.4 million (11.0%) were for mental health-related medications (Table 11.2). This is equivalent to 962 mental health-related prescriptions per 1,000 population (Table 11.3).

Of the 20.4 million mental health-related prescriptions, the great majority (85.6%) were provided by GPs, with another 9.4% being prescribed by psychiatrists and 4.9% by non-psychiatrist specialists.

Most of the 20.4 million prescriptions were for antidepressant medication (57.2%, or 11.7 million), followed by anxiolytics (15.6%), hypnotics and sedatives (13.0%) and antipsychotics (10.9%).

Table 11.2: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, 2007–08

ATC group (code)	General practitioners	Non-psychiatrist specialists	Psychiatrists	Total[(b)]	Total (per cent)
Antipsychotics (N05A)[(c)]	1,603,542	183,694	421,898	2,211,209	10.9
Anxiolytics (N05B)	2,950,696	88,003	137,423	3,179,289	15.6
Hypnotics and sedatives (N05C)	2,505,034	84,038	52,088	2,643,327	13.0
Antidepressants (N06A)	10,309,722	391,091	944,228	11,657,069	57.2
Psychostimulants and nootropics (N06B)	57,134	259,170	76,058	392,502	1.9
Other ATC groups[(d)]	. .	. .	285,830	285,830	1.4
Total	**17,426,128**	**1,005,996**	**1,917,525**	**20,369,226**	. .
Total (per cent)	85.6	4.9	9.4	. .	100.0

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, in particular for 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 Table 11.4. 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.

Source: 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 2007–08 (Table 11.3). The rate of prescriptions per 1,000 population was relatively low in the Australian Capital Territory (684 per 1,000 population) and New South Wales and Western Australia were also below the national average of 962 prescriptions per 1,000 population. In contrast, Tasmania and South Australia had considerably higher rates of prescriptions than the national average (1,314 and 1,155 prescriptions per 1,000 population, respectively) while Victoria and Queensland were also above average.

Regarding the distribution of mental health-related prescriptions across the ATC groups, Tasmanian providers prescribed a higher proportion of anxiolytics than the national average (21.0% compared with 15.6% for Australia) and a lower proportion of antipsychotics (7.3% compared with 10.9% for Australia) while providers in the Australian Capital Territory and the Northern Territory prescribed higher proportions of antidepressants (62.5% and 61.2%, respectively compared with 57.2% for Australia) and Western Australian providers prescribed a higher proportion of psychostimulants and nootropics (3.6% compared with 1.9% 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 (24.6% compared with 8.3% for Australia), and the Australian Capital Territory, which had a higher proportion of antipsychotic prescriptions provided by psychiatrists (28.0% compared with 19.1% for Australia). Queensland and the Northern Territory also had higher proportions of psychostimulant and nootropic prescriptions provided by GPs than the national average (33.6% and 26.5%, respectively, compared with 14.6% for Australia) while the Northern Territory and Tasmania had a lower proportion provided by psychiatrists (3.3% and 9.6%, respectively, compared with 19.4% for Australia). Victoria, New South Wales, Tasmania and the Northern Territory had a higher proportion of psychostimulant and nootropic prescriptions provided by non-psychiatrist specialists than the national average (70% and over compared with 66.0% for Australia).

Table 11.4 shows the trends in the prescription of mental health-related medications over the five years from 2003–04 to 2007–08.

Overall, mental health-related prescriptions decreased from 20.7 million in 2003–04 to 20.4 million in 2007–08, at an annual average rate of 0.4%. The rate of prescriptions (per 1,000 population) declined from 1,035 in 2003–04 to 962 in 2007–08 at an average annual rate of 1.8%. There were increases in the number of psychostimulants and nootropics, and antipsychotics prescribed (on average by 12.0% and 8.7% per year, respectively). However, prescriptions for hypnotics and sedatives decreased on average by 3.5% per year, while prescriptions for anxiolytics, antidepressants and other medications prescribed by psychiatrists decreased on average by around 1% per year.

The biggest increase 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 17.9%. GPs also increased their prescribing of this group, which covers attention-deficit hyperactivity disorder (ADHD) medications, by 11.1% per year. The prescription of antipsychotics by non-psychiatrist specialists also saw a substantial increase of 16.3% per year.

Table 11.3: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, states and territories[(b)], 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Antipsychotics including Clozapine (N05A)				
General practitioners	541,060	438,135	282,250	125,167	156,617	37,143	17,765	5,334	1,603,542
Non-psychiatrist specialists	38,332	74,048	35,711	20,602	8,255	2,581	2,023	2,142	183,694
Psychiatrists	142,444	127,582	72,418	24,499	38,356	7,513	7,862	1,222	421,898
Subtotal[(c)]	*722,762*	*640,020*	*390,595*	*170,376*	*203,346*	*47,272*	*28,065*	*8,700*	*2,211,209*
					Anxiolytics (N05B)				
General practitioners	812,735	845,941	605,353	233,337	289,888	129,830	26,439	7,137	2,950,696
Non-psychiatrist specialists	20,563	29,149	18,947	7,713	8,850	1,987	519	275	88,003
Psychiatrists	33,821	47,427	29,858	7,347	12,706	4,857	1,087	316	137,423
Subtotal[(c)]	*869,250*	*922,668*	*654,585*	*248,554*	*311,548*	*136,735*	*28,164*	*7,745*	*3,179,289*
					Hypnotics and sedatives (N05C)				
General practitioners	783,279	649,894	481,240	241,091	237,684	85,674	20,238	5,872	2,505,034
Non-psychiatrist specialists	22,314	26,186	17,584	9,250	6,448	1,431	580	244	84,038
Psychiatrists	12,458	15,563	12,374	4,080	5,593	1,256	671	89	52,088
Subtotal[(c)]	*819,619*	*691,731*	*511,393*	*254,554*	*249,781*	*88,393*	*21,575*	*6,214*	*2,643,327*
					Antidepressants (N06A)				
General practitioners	3,143,411	2,531,368	2,194,993	1,024,186	917,418	331,540	130,045	36,602	10,309,722
Non-psychiatrist specialists	99,998	120,231	85,150	46,706	25,039	8,137	3,589	2,240	391,091
Psychiatrists	276,121	265,216	201,198	82,216	86,403	20,096	11,162	1,786	944,228
Subtotal[(c)]	*3,527,702*	*2,917,452*	*2,482,685*	*1,153,725*	*1,029,130*	*359,873*	*145,598*	*40,714*	*11,657,069*
					Psychostimulants and nootropics (N06B)				
General practitioners	9,568	4,276	23,989	11,433	4,990	1,665	642	571	57,134
Non-psychiatrist specialists	109,969	53,632	37,057	31,562	11,241	10,387	3,824	1,498	259,170
Psychiatrists	20,847	9,835	10,406	26,503	5,149	1,282	1,965	71	76,058
Subtotal[(c)]	*140,454*	*67,758*	*71,473*	*69,507*	*21,385*	*13,338*	*6,436*	*2,151*	*392,502*
					Other medications prescribed by psychiatrists[(d)]				
Psychiatrists	82,895	83,053	64,150	21,629	24,232	5,588	3,264	1,008	285,830
Total[(c)]	**6,162,682**	**5,322,682**	**4,174,881**	**1,918,345**	**1,839,422**	**651,199**	**233,102**	**66,532**	**20,369,226**
Rate (per 1,000 population)[(e)]	890	1,015	987	900	1,155	1,314	684	306[(f)]	962

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, in particular for 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 Australia column.

(c) Includes prescriptions where the prescriber's specialty was unknown.

(d) Includes other N codes as well as other ATC medication groups. 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 based on the preliminary Australian estimated resident population as at 31 December 2007.

(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 (DoHA 2008a).

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

Table 11.4: Mental health-related prescriptions, by type of medication prescribed[(a)] and prescribing medical practitioner, 2003–04 to 2007–08

Medication prescribed/ prescriber	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Antipsychotics including Clozapine (N05A)						
General practitioners	*1,166,841	*1,227,712	*1,340,445	*1,450,377	1,603,542	8.3
Non-psychiatrist specialists	*100,476	*110,866	*134,925	*152,808	183,694	16.3
Psychiatrists	*309,143	*334,539	*368,469	*389,997	421,898	8.1
Subtotal[(b)]	**1,582,039*	**1,677,579*	**1,848,871*	**1,996,375*	*2,211,209*	*8.7*
Anxiolytics (N05B)						
General practitioners	3,110,660	3,117,091	3,060,719	3,037,662	2,950,696	–1.3
Non-psychiatrist specialists	75,753	80,868	84,636	85,216	88,003	3.8
Psychiatrists	149,124	147,707	142,263	141,540	137,423	–2.0
Subtotal[(b)]	*3,341,964*	*3,349,889*	*3,292,480*	*3,268,587*	*3,179,289*	*–1.2*
Hypnotics and sedatives (N05C)						
General practitioners	2,888,136	2,848,365	2,726,783	2,632,598	2,505,034	–3.5
Non-psychiatrist specialists	88,786	88,245	87,303	85,360	84,038	–1.4
Psychiatrists	64,380	61,629	57,594	54,435	52,088	–5.2
Subtotal[(b)]	*3,045,796*	*3,001,438*	*2,875,194*	*2,775,440*	*2,643,327*	*–3.5*
Antidepressants (N06A)						
General practitioners	10,666,972	11,249,261	10,869,136	10,642,397	10,309,722	–0.8
Non-psychiatrist specialists	403,139	408,700	401,446	391,199	391,091	–0.8
Psychiatrists	1,070,005	1,082,196	1,029,864	1,004,580	944,228	–3.1
Subtotal[(b)]	*12,184,282*	*12,774,177*	*12,327,048*	*12,056,443*	*11,657,069*	*–1.1*
Psychostimulants and nootropics (N06B)						
General practitioners	37,453	38,688	44,293	48,906	57,134	11.1
Non-psychiatrist specialists	134,319	122,732	144,145	155,341	259,170	17.9
Psychiatrists	76,809	71,623	66,180	69,984	76,058	–0.2
Subtotal[(b)]	*249,402*	*233,603*	*254,966*	*274,413*	*392,502*	*12.0*
Other medications prescribed by psychiatrists[(c)]						
Psychiatrists	*299,126	*301,204	*291,879	*290,679	285,830	–1.1
Total[(b)]	***20,702,609**	***21,337,890**	***20,889,938**	***20,661,937**	**20,369,226**	**–0.4**
Rate (per 1,000 population)[(d)]	1,035	1,054	1,017	991	962	–1.8

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, in particular for 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 Table 11.5. 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 based on the preliminary Australian estimated resident population as at 31 December of the reference year.

* Differences in figures reported in previous years caused by item 1330 *Tetrabenazine* which was classified previously to N05A and is now classified to N07X *Other nervous system drugs*.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

11.3 Patients

In 2007–08, 20.4 million PBS/RPBS-subsidised prescriptions for mental health-related medications were provided to 2.2 million patients (Table 11.5). This represents an average of 9.2 prescriptions per patient.

There was some variation in the number of 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 obtaining mental health-related prescriptions 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 mental health-related prescriptions than the national average of 105 patients per 1,000 population.

Table 11.5: Patients dispensed with mental health-related prescriptions[(a)]: patient demographic characteristics and services received, 2007–08

Patient demographics	Number of patients[(b)]	Per cent of patients[(c)]	Rate (per 1,000 population)[(d)]	Number of scripts	Per cent of scripts	Rate (per 1,000 population)[(c)]	Scripts per patient
Age (years)							
Less than 15	52,037	2.3	13	323,777	1.6	79	6.2
15–24	121,312	5.5	41	749,700	3.7	254	6.2
25–34	199,114	9.0	68	1,714,090	8.5	584	8.6
35–44	283,735	12.8	92	2,743,918	13.6	887	9.7
45–54	308,693	13.9	105	3,120,428	15.5	1,064	10.1
55–64	361,545	16.3	152	3,457,224	17.1	1,457	9.6
65+	892,013	40.2	319	8,059,868	40.0	2,880	9.0
Sex							
Male	859,498	38.7	82	7,674,377	38.1	729	8.9
Female	1,358,951	61.3	128	12,494,628	61.9	1,173	9.2
Area of residence							
Major cities	1,389,301	63.4	96	12,617,705	63.5	870	9.1
Inner regional	544,830	24.9	130	4974,316	25.0	1,191	9.1
Outer regional	228,480	10.4	114	2037,765	10.3	1,015	8.9
Remote	23,729	1.1	73	201,732	1.0	619	8.5
Very remote	6,044	0.3	35	46,037	0.2	264	7.6
Total	**2,219,234**	**100.0**	**105**	**20,369,226[(e)]**	**100.0**	**962**	**9.2**

(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 based on the preliminary Australian estimated resident population as at 31 December 2007, except for area of residence where 30 June 2006 preliminary estimates of resident population by Australian Standard Geographical Classification remoteness area were used and then pro-rated using the preliminary Australian estimated resident population as at 31 December 2007.

(e) Includes 197,930 prescriptions for which no patient identifying information exists.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

Commensurate with the rates of mental health-related medications prescribed across states and territories, the rate of patients obtaining mental health-related prescriptions (per 1,000 population) in 2007–08 was very low in the Australian Capital Territory (80 per 1,000 population), while Tasmania and South Australia had very high patient rates (135 and 122 patients per 1,000 population, respectively) compared with the national average of 105 (Table 11.6).

Tasmania had a low rate of patients obtaining mental health-related prescriptions from psychiatrists (5.8% of patients compared with 11.1% in the Australian Capital Territory and 9.2% nationally). Tasmania also had a higher rate of patients obtaining mental health-related prescriptions from GPs than other jurisdictions (94.2% compared with 91.6% nationally), while a higher proportion of patients in Victoria obtained mental health-related prescriptions from non-psychiatric specialists (14.1% compared with 12.1% nationally).

A high proportion of patients of psychiatrists in Western Australia obtained prescriptions for psychostimulant and nootropic medications (22.5% compared with a national average of only 6.1%). The Australian Capital Territory also had a high proportion (12.5%) of patients of psychiatrists obtaining prescriptions for psychostimulant and nootropic medications. Similarly, a high proportion of patients of non-psychiatric specialists receiving mental health-related medications in Tasmania, New South Wales and the Australian Capital Territory obtained prescriptions for psychostimulants and nootropics (around 25% compared with a national average of 16.6%).

The number of patients obtaining mental health-related prescriptions declined over the 5 years to 2007–08 by an average annual rate of 3.6%, from 121 per 1,000 population in 2003–04 to 105 in 2007–08 (Table 11.7). The fall in the last 2 years of the period in particular was over 5% per year. The number of patients obtaining mental health-related prescriptions from GPs fell by 2.4% per year over the 5-year period, and by 4.4% per year over the last 2 years of the period. The number of patients obtaining mental health-related prescriptions from psychiatrists also fell over the 5 years while those obtaining mental health-related prescriptions from non-psychiatric specialists rose by 2.5% per year over the 5-year period and by 14.0% per year for psychostimulant and nootropic prescriptions in particular. Antipsychotics (including Clozapine) and psychostimulants and nootropics were the mental health-related medication groups with the greatest increase in patient numbers over the 5-year period across all prescriber types.

Table 11.6: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner and type of medication prescribed[(a)], states and territories[(b)(c)], 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					General practitioners				
N05A	79,190	61,398	42,061	18,508	22,350	5,614	2,713	887	232,730
N05B	154,467	145,606	112,309	40,540	50,848	20,756	4,437	1,435	530,406
N05C	165,888	139,591	102,478	51,060	50,294	16,427	4,857	1,399	532,006
N06A	430,538	337,561	291,272	135,523	121,697	42,775	18,187	5,447	1,383,028
N06B	2,037	900	5,115	1,798	827	282	125	118	11,202
Subtotal[(d)]	*640,606*	*509,564*	*417,405*	*188,747*	*181,459*	*63,183*	*24,608*	*7,527*	*2,033,140*
					Non-psychiatrist specialists				
N05A	10,371	16,540	10,285	4,645	2,269	582	528	401	45,621
N05B	10,234	14,749	10,619	3,678	3,223	1,019	270	152	43,944
N05C	12,264	14,907	10,207	5,054	3,778	846	324	130	47,511
N06A	33,955	40,237	29,908	14,203	8,802	2,766	1,181	612	131,665
N06B	18,763	8,852	7,624	4,998	1,897	1,489	625	266	44,514
Subtotal[(d)]	*75,998*	*79,289*	*57,638*	*27,691*	*17,303*	*5,778*	*2,588*	*1,376*	*267,663*
					Psychiatrists				
N05A	24,163	20,349	12,447	3,990	6,172	1,180	1,233	252	69,788
N05B	7,720	9,939	6,461	1,608	2,632	868	278	89	29,597
N05C	3,793	4,277	3,416	1,040	1,483	333	221	34	14,600
N06A	45,042	38,996	29,624	11,357	12,530	2,904	1,794	344	142,596
N06B	3,615	1,736	1,965	3,750	789	178	377	13	12,423
Other N codes	12,014	11,348	7,943	2,550	3,376	783	551	113	38,679
Other ATC codes	9,174	8,453	6,811	2,460	2,711	632	402	144	30,790
Subtotal[(d)]	*65,653*	*55,614*	*40,736*	*16,695*	*17,512*	*3,919*	*3,011*	*589*	*203,734*
					All prescribers[(e)]				
N05A	96,360	78,528	52,622	23,095	26,634	6,534	3,676	1,265	288,725
N05B	162,697	156,034	118,839	42,787	53,204	21,433	4,735	1,565	561,304
N05C	172,756	147,510	107,922	53,608	52,488	16,932	5,131	1,491	557,852
N06A	464,348	369,883	312,920	145,960	131,097	44,983	19,506	5,859	1,494,587
N06B	23,278	10,887	12,617	9,674	3,138	1,824	1,059	342	62,819
Total[(d)(f)]	**702,552**	**560,438**	**450,879**	**207,781**	**194,778**	**67,077**	**27,214**	**8,741**	**2,219,234**
Rate (per 1,000 population)[(g)]	101	107	107	98	122	135	80	39[(h)]	105

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, in particular for Clozapine. See Table 11.1 for a key to the ATC codes.

(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 Australia column.

(c) Excludes prescriptions where the patient identity is unknown.

(d) As a patient may obtain prescriptions for medications in more than one group, the total may be less than the sum of each ATC group.

(e) Includes counts for 12,695 patients where the prescriber's specialty was unknown.

(f) Includes other N codes and other ATC medication groups prescribed by a psychiatrist. 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.

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

(h) 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 (DoHA 2008a).

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

Table 11.7: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner and type of medication prescribed[(a)(b)], 2003–04 to 2007–08

Prescriber/ medication prescribed	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
General practitioners						
N05A	*187,863	*195,346	*208,551	*217,411	232,730	5.5
N05B	565,574	561,061	549,147	540,725	530,406	–1.6
N05C	590,619	581,576	558,701	542,087	532,006	–2.6
N06A	1,539,759	1,587,354	1,546,274	1,489,824	1,383,028	–2.6
N06B	7,570	7,738	8,951	9,692	11,202	10.3
Subtotal[(c)]	**2,242,935*	**2,283,279*	**2,225,755*	**2,149,177*	*2,033,140*	*–2.4*
Non-psychiatrist specialists						
N05A	*29,914	*32,980	*37,065	*40,301	45,621	11.1
N05B	38,413	39,478	42,270	42,930	43,944	3.4
N05C	49,595	48,829	48,606	47,818	47,511	–1.1
N06A	135,443	135,902	135,909	132,033	131,665	–0.7
N06B	26,334	24,601	31,437	34,579	44,514	14.0
Subtotal[(c)]	**242,526*	**244,319*	**254,840*	**255,659*	*267,663*	*2.5*
Psychiatrists						
N05A	*57,124	*59,846	*63,589	*65,090	69,788	5.1
N05B	31,915	31,635	30,452	29,883	29,597	–1.9
N05C	17,798	17,230	15,737	14,997	14,600	–4.8
N06A	169,248	168,666	160,068	152,247	142,596	–4.2
N06B	11,305	11,101	10,413	10,993	12,423	2.4
Other N codes	39,306	40,266	39,395	38,964	38,679	–0.4
Other ATC codes	36,176	34,708	31,713	30,887	30,790	–4.0
Subtotal[(c)]	**233,246*	**233,656*	**224,642*	**217,462*	*203,734*	*–3.3*
All prescribers[(d)]						
N05A	*233,518	*242,727	*258,815	*269,526	288,725	5.4
N05B	596,296	592,075	580,449	571,843	561,304	–1.5
N05C	618,929	609,269	585,358	568,284	557,852	–2.6
N06A	1,668,225	1,713,919	1,669,815	1,607,757	1,494,587	–2.7
N06B	41,854	40,194	47,169	50,957	62,819	10.7
Total[(c)(e)]	***2,425,621**	***2,463,533**	***2,408,467**	***2,330,327**	**2,219,234**	–2.2
Rate (per 1,000 population)[(f)]	121	122	117	112	105	–3.6

(a) Classified according to the ATC Classification System (WHO 2009b). Does not include public hospital prescriptions dispensed through Section 100 arrangements, in particular for Clozapine. See Table 11.1 for a key to the ATC codes.

(b) Excludes prescriptions where the patient identity is unknown.

(c) As a patient may obtain prescriptions for medications in more than one group, the total may be less than the sum of each ATC group.

(d) Includes counts for patients where the prescriber's specialty was unknown.

(e) Includes other N codes and other ATC medication groups prescribed by a psychiatrist. 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 based on the preliminary Australian estimated resident population as at 31 December of the reference year.

* Differences in figures reported in previous years caused by item 1330 *Tetrabenazine* which classified previously to N05A and now classifies to N07X *Other nervous system drugs*.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (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***. In this chapter, information is presented on the number of facilities, number of available beds, and the number of staff employed for public and private sector facilities, for the period 2006–07. The public sector data are sourced from the National Mental Health Establishments Database, while some historical information is taken from the National Survey of Mental Health Services, previously undertaken by the Australian Government Department of Health and Ageing. Private hospital information is sourced from the Private Health Establishments Collection (PHEC) held by the Australian Bureau of Statistics (ABS). For information relating to the scope of the National Mental Health Establishments Database, see Appendix 1.

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 PHEC, held by the ABS, which identifies private psychiatric hospitals as those that are licensed/approved by a state or territory health authority and which 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.

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/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/liaison services.

(continued)

Government-operated residential mental health services are specialised residential mental health services which:

- are operated by a state or territory government
- employ mental health-trained staff on-site
- 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 which meet the same criteria as government-operated residential mental health services. These services, while funded by governments, are operated by non-government agencies.

Target population

In this report, some data are presented based on public sector specialised mental health services categorised by 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 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. This can include prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component. The remaining category, *General,* targets the adult population, aged 18 to 64. *General* mental health services may also provide assistance to children, adolescents or older people (Metadata Online Registry (METeOR) identifier 288957).

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.

Program type

The provision of public sector specialised mental health care can also be categorised as being either *Acute* or *Non-acute*, based on 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 mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder 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).

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 establishment over the financial year, estimated using monthly figures (METeOR identifier 270133).

12.2 Mental health facilities

There are six key types of specialised mental health facilities involved in the provision of mental health-related services. Their distribution is detailed in Table 12.1. Nationally, during 2006–07, there were 16 stand alone public psychiatric hospitals and 25 stand alone private psychiatric hospitals, with a further 139 public acute hospitals providing a dedicated psychiatric unit or ward.

Table 12.1: Number of specialised mental health facilities[(a)], states and territories, 2006–07

	NSW	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[(b)]	46	34	27	14	8	6	2	2	139
Government-operated residential mental health services[(c)]	20	48	. .	3	4	5	1	. .	81
Non-government-operated residential mental health services[(c)]	5	30	. .	8	1	6	5	1	56
Community mental health care services[(d)]	409	214	135	44	85	21	11	13	932
Private psychiatric hospitals	9	6	4	n.a.	n.a.	n.a.	n.a.	n.a.	25
Total facilities	**497**	**334**	**169**	**70**	**100**	**38**	**19**	**16**	**1,249**

(a) These figures differ from *Australian hospital statistics 2006–07* (AIHW 2008a) due to differences in definitions and jurisdictional reporting.

(b) Includes three publicly funded WA private hospitals which may also be included in the total for private psychiatric hospitals sourced from the ABS Private Health Establishments Collection.

(c) 'Services' 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 jurisdiction and do not necessarily reflect the number or size of services provided.

n.a. Not available but included in totals where applicable, unless otherwise indicated.

. . Not applicable.

Source: National Mental Health Establishments Database and Private Health Establishments Collection (ABS) (Private psychiatric hospitals only).

Table 12.2 provides data on the change in the number of services between 2002–03 and 2006–07. While there has been an average annual decline of 4.2% in the number of public psychiatric hospitals, there has been an increase of 2.1% in the number of specialised psychiatric units or wards in public acute hospitals. There has also been an average annual increase of 12.8% in the number of government-operated residential mental health services during the reported time period.

In 2006–07, there were 932 community mental health care services in Australia (Table 12.3). The largest proportion of these services provided care to the *General* target population group (64.8% or 604 services). Of the remainder, 21.5% (200 services) were specialised *Child and adolescent* services, 11.7% (109) were *Older person* services and 2.0% (19) were *Forensic* services.

Table 12.2: Number of specialised mental health facilities, 2002–03 to 2006–07

	2002–03[(a)]	2003–04[(a)]	2004–05[(a)]	2005–06	2006–07	Average annual change (per cent)
Public psychiatric hospitals	19	20	20	15	16	–4.2
Public acute hospitals with a specialised psychiatric unit or ward[(b)]	128	124	122	138	139	2.1
Government-operated residential mental health services[(c)]	50	52	46	77	81	12.8
Non-government-operated residential mental health services[(c)(d)]	n.a.	n.a.	n.a.	55	56	. .
Community mental health care services[(d)]	n.a.	n.a.	n.a.	927	932	. .
Private psychiatric hospitals	25	25	26	26	25	0.0
Total facilities [(e)]	**222**	**221**	**214**	**1,238**	**1,249**	**. .**

(a) Historical data for public hospitals and government-operated residential services were sourced from the National Public Hospitals Establishments and Community Mental Health Establishments databases and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) Includes publicly funded WA private hospitals which may also be included in the total for private psychiatric hospitals sourced from the ABS Private Health Establishments Collection.

(c) 'Services' refers to the number of actual residential mental health service units, not the number of organisations providing the services.

(d) Data only available from 2005–06 onwards with the introduction of the National Mental Health Establishments Database.

(e) Totals for 2005–06 onwards include both non-government-operated residential mental health services and community mental health care services.

n.a. Not available.

. . Not applicable.

Source: National Mental Health Establishments Database, National Public Hospitals Establishments Database, Community Mental Health Establishments Database and Private Health Establishments Collection (ABS) (Private psychiatric hospitals only).

Table 12.3: Community mental health care services[(a)], by target population, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
General	283	146	70	18	60	12	6	9	604
Child and adolescent	85	33	42	14	18	3	3	2	200
Older person	36	34	18	11	4	5	1	. .	109
Forensic	5	1	5	1	3	1	1	2	19
Total	**409**	**214**	**135**	**44**	**85**	**21**	**11**	**13**	**932**

(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.

. . Not applicable.

Source: National Mental Health Establishments Database.

12.3 Number of available beds

Public hospital specialised mental health beds

There were 6,407 specialised mental health hospital beds available in 2006–07 in Australia (Table 12.4). Almost two-thirds of these beds (65.5% or 4,196 beds) were in specialised psychiatric units or wards within public acute hospitals, while the remaining 2,211 beds were in public psychiatric hospitals.

The total number of available public sector specialised mental health hospital beds increased between 2002–03 and 2006–07 by an annual average of 1.3% (Table 12.5). The annual average decrease in public psychiatric hospital beds of 1.6% was offset by an increase in the number of public acute hospital beds within a specialised psychiatric unit or ward of 3.1%.

Table 12.4: Public sector specialised mental health hospital beds, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public psychiatric hospitals	1,060	134	375	254	388	. .	. .	. .	2,211
Public acute hospitals with a specialised psychiatric unit or ward	1,227	1,055	1,022	415	247	126	70	34	4,196
Total beds	**2,287**	**1,189**	**1,397**	**669**	**635**	**126**	**70**	**34**	**6,407**

. . Not applicable.

Source: National Mental Health Establishments Database.

Table 12.5: Public sector specialised mental health hospital beds, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Public psychiatric hospitals	2,360	2,335	2,339	*2,255	2,211	–1.6
Public acute hospitals with a specialised psychiatric unit or ward	3,713	3,753	3,863	*4,016	4,196	3.1
Total beds	**6,073**	**6,088**	**6,202**	**6,271**	**6,407**	**1.3**

* Data updated from published figures in *Mental health services in Australia 2005–06.*

Source: National Mental Health Establishments Database and *National Mental Health Report* (DoHA 2008c).

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 2006–07, the majority of specialised mental health hospital beds were within *General* services providing care to the adult population (18–64 years) (Table 12.6). Approximately 16.4% of the total 6,407 specialised mental health hospital beds were in *Older person* services, 9.4% were in *Forensic* services and 4.3% were in *Child and adolescent* services. Although beds for *General* services made up the greatest proportion of specialised mental health hospital beds in all states and territories, not all service types were specifically catered for in each state and territory.

Approximately two-thirds of all public specialised mental health hospital beds across Australia were specifically for *Acute* services during 2006–07 (Table 12.6). The proportion of

Acute and *Non-acute* specialised mental health hospital beds varied substantially between states and territories. Victoria had the greatest proportion of *Acute* beds (85.0%), 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 2006–07.

When the combination of target population and program type were considered, nationally *Acute* beds accounted for around three-quarters of the *General* and *Child and adolescent* service beds (Table 12.6), while *Acute* beds accounted for nearly two-thirds of *Older person* service beds. Beds allocated to *Forensic* services differed markedly from the other specialist bed types, with the majority of the total 600 beds being classified as *Non-acute*.

When state and territory populations were considered, South Australia (40.3) had the highest number of beds per 100,000 population, while the Northern Territory had the least (16.0) (Table 12.6). Western Australia (24.2) had the highest number of specialised *Acute* beds per 100,000 population, while the Northern Territory (16.0) had the least. Of those jurisdictions reporting *Non-acute* specialised beds, Queensland (17.3) had the highest number of beds per 100,000 population.

Table 12.6: Public sector specialised mental health hospital beds, by target population and program, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Number of beds					
General									
Acute	1,176	668	579	356	282	81	50	26	3,218
Non-acute	546	100	390	107	96	27	. .	. .	1,266
Child and adolescent									
Acute	54	72	52	20	12	. .	. .	. .	210
Non-acute	42	. .	15	8	. .	. .	. .	. .	65
Older person									
Acute	163	215	53	108	78	. .	20	. .	637
Non-acute	114	. .	138	32	127	. .	. .	. .	411
Forensic									
Acute	81	56	. .	19	8	18	. .	8	190
Non-acute	111	78	170	19	32	. .	. .	. .	410
Total	**2,287**	**1,189**	**1,397**	**669**	**635**	**126**	**70**	**34**	**6,407**
				Beds per 100,000 population[(a)]					
Acute	21.5	19.6	16.6	24.2	24.1	20.1	20.8	16.0	20.4
Non-acute	11.9	3.4	17.3	8.0	16.2	5.5	. .	. .	10.3
Total	**33.4**	**23.0**	**33.8**	**32.1**	**40.3**	**25.6**	**20.8**	**16.0**	**30.7**

(a) Crude rate based on the total state and territory estimated resident population as at 31 December 2006.

. . Not applicable.

Source: National Mental Health Establishments Database.

Nationally, the number of beds for *Child and adolescent* and *Older person* services remained relatively constant during the period 2002–03 to 2006–07 (Table 12.7). During the reported period, the number of beds for the *Forensic* and *General* services increased by an annual average of 5.4% and 1.4% respectively.

Table 12.7: Public sector specialised mental health hospital beds, by target population, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
General	4,234	4,210	4,340	4,401	4,484	1.4
Child and adolescent	270	282	284	256	275	0.5
Older person	1,083	1,058	1,037	1,035	1,048	–0.8
Forensic	486	538	541	579	600	5.4
Total	**6,073**	**6,088**	**6,202**	**6,271**	**6,407**	**1.3**

Source: National Mental Health Establishments Database and *National Mental Health Report* (DoHA 2008c).

Residential mental health service beds

During 2006–07 there were 2,165 mental health-related residential care beds available nationally (Table 12.8). They can be characterised by the service operator (government or non-government) and the level of staffing provided. The majority (1,490 or 68.8%) of residential mental health service beds were provided by government-operated services. There were 1,592 (73.5%) residential beds operating with mental health-trained staffed on the premises for the entire 24-hour period. The remaining 573 beds were provided by residential mental health services with mental health-trained staff on site for more than 6 hours, but less than 24 hours per day, totalling at least 50 hours per week.

Table 12.8: Number of residential mental health services beds, by service operator and staffing provided, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service operator									
Government-operated	291	1,002	. .	23	53	91	30	. .	1,490
Non-government-operated	155	313	. .	62	10	85	45	5	675
Staffing provided									
24-hour staffing									
Government-operated	237	996	. .	23	40	91	30	. .	1,417
Non-government-operated	16	36	. .	18	10	85	10	. .	175
Subtotal	*253*	*1,032*	. .	*41*	*50*	*176*	*40*	. .	*1,592*
Non-24-hour staffing									
Government-operated	54	6	. .	. .	13	. .	. .	. .	73
Non-government-operated	139	277	. .	44	. .	. .	35	5	500
Subtotal	*193*	*283*	. .	*44*	*13*	. .	*35*	*5*	*573*
Total	**446**	**1,315**	**. .**	**85**	**63**	**176**	**75**	**5**	**2,165**

. . Not applicable.

Source: National Mental Health Establishments Database.

Target population

With the exception of New South Wales, which has a small number of *Child and adolescent* beds (see footnote (a) Table 12.9), the only residential mental health target population groups were *General* and *Older person*. The majority of residential mental health specialised beds were in services categorised as *General* (61.0%). However, when population was considered,

nationally there were 4.0 *Older person* residential beds per 100,000 population, compared to 6.3 *General* beds (Table 12.9). Tasmania (27.3) had the highest number of residential *General* beds per 100,000 population, while the Northern Territory (2.4) had the least. Of those jurisdictions reporting specialised *Older person* residential mental health service beds, Victoria (12.7) had the highest number of residential beds per 100,000 population, while New South Wales (2.0) had the least.

Table 12.9: Residential mental health services beds and beds per 100,000 population, by target population, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Number of beds				
General[(a)]	310	659	. .	85	63	134	65	5	1,321
Older person	136	656	. .	. .	. .	42	10	. .	844
Total	**446**	**1,315**	**. .**	**85**	**63**	**176**	**75**	**5**	**2,165**
					Beds per 100,000 population[(b)]				
General[(a)]	4.5	12.8	0.0	4.1	4.0	27.3	19.3	2.4	6.3
Older person	2.0	12.7	0.0	0.0	0.0	8.5	3.0	0.0	4.0
Total	**6.5**	**25.5**	**0.0**	**4.1**	**4.0**	**35.8**	**22.3**	**2.4**	**10.4**

(a) A small number of residential beds reported by NSW as *Child and adolescent* residential services beds were included in *General* at the request of NSW Health.

(b) Crude rate based on the total state and territory estimated resident population as at 31 December 2006. This is different to previous *Mental health services in Australia* publications.

. . Not applicable.

Source: National Mental Health Establishments Database.

Since 2002–03, there have been changes in the number of specialised residential mental health care beds, with numbers ranging between 1990 and 2165 (Table 12.10). Specialised residential mental health beds within services categorised as *General* increased by an average of 2.2% annually between 2002–03 and 2006–07. Beds within *Older person* services also increased over the same time period (1.5%).

Table 12.10: Residential mental health services beds, by hours staffed and target population, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06[(a)]	2006–07[(a)]	Average annual change (per cent)
Staffing provided						
24-hour staffing	1,407	1,439	1,427	1,496	1,592	3.1
Non-24-hour staffing	598	596	563	597	573	–1.1
Target population						
General	1,211	1,227	1,206	1,279	1,321	2.2
Older person	794	808	784	814	844	1.5
Total	**2,005**	**2,035**	**1,990**	**2,093**	**2,165**	**1.9**

(a) A small number of residential beds reported by NSW as *Child and adolescent* residential services beds were included in *General* at the request of NSW Health.

Source: National Mental Health Establishments Database and *National Mental Health Report* (DoHA 2008c).

12.4 Staffing of state and territory specialist mental health facilities

The specialist mental health facility staff numbers reported in Table 12.11 refer to the average number of full-time-equivalent (FTE) staff reported by states and territories for 2006–07, in the three specialist mental health service settings. These settings are admitted patient services in public psychiatric hospitals or public acute hospitals with a specialised psychiatric unit or ward, community mental health care services, and residential mental health services, including government and non-government-operated services. This data does not include staff employed at the higher organisational level, usually performing organisation level management roles, nor the categories of carer consultant or consumer consultant. They are included in Table 12.12.

In 2006–07, 25,772 FTE staff were employed nationally in the provision of specialised mental health care services (Table 12.11). More than half (51.2%) of these staff provided specialised mental health services for patients in admitted patient services. The next largest employment sector was community mental health care services with 10,609 FTE staff (41.2%).

Table 12.11: Full-time-equivalent staff[(a)] by service setting, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Hospital admitted patient services	4,892.3	2,151.1	2,632.3	1,617.6	1,410.7	313.0	108.1	77.7	13,202.8
Community mental health care services	3,300.5	2,623.1	1,961.9	1,313.3	854.8	242.0	214.2	99.6	10,609.4
Residential mental health services	338.2	1,262.9	. .	81.8	23.7	182.0	68.4	3.0	1,960.0
Total	**8,531.0**	**6,037.1**	**4,594.2**	**3,012.7**	**2,289.2**	**737.0**	**390.7**	**180.3**	**25,772.2**

. . Not applicable.

Source: National Mental Health Establishments Database.

The FTE staff employed within specialised mental health care services can also be described by labour force categories.

Nurses accounted for the majority of the national workforce in all specialised mental health facilities, totalling 13,222 FTE or 51.1% (tables 12.12 and 12.13). At the state level, Victoria (55.5%) had the highest proportion of the specialised mental health-related workforce employed as nurses, while the Australian Capital Territory (43.4%) had the lowest.

Salaried medical officers made up 9.1% of the national specialised mental health-related workforce, with a relatively even spread between consultant psychiatrists and psychiatrists, and psychiatry registrars and trainees (tables 12.12 and 12.13).

Diagnostic and allied health professionals (18.8%) made up the second largest group of FTE staff nationally (Table 12.13), with the majority of the total 4,866 FTE staff in this group being psychologists and social workers (1,662 and 1,541 FTE, respectively; Table 12.12).

Table 12.12: Full-time-equivalent staff by staffing category, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
				Salaried medical officers					
Consultant psychiatrists and psychiatrists	376.0	237.1	187.3	99.3	89.8	22.2	13.0	8.3	1,033.0
Psychiatry registrars and trainees	365.9	229.3	229.1	99.0	94.8	14.0	15.3	8.4	1,055.8
Other medical officers	46.1	81.7	33.3	69.9	25.6	5.1	1.6	4.6	267.9
Subtotal	*788.0*	*548.1*	*449.7*	*268.2*	*210.2*	*41.3*	*29.9*	*21.3*	*2,356.7*
				Nurses					
Registered	3,688.7	2,653.8	2,031.3	1,279.6	954.4	319.7	141.0	88.3	11,156.8
Enrolled	554.6	717.8	306.1	181.0	215.5	52.0	28.4	9.4	2,064.8
Subtotal	*4,243.3*	*3,371.6*	*2,337.4*	*1,460.6*	*1,169.9*	*371.7*	*169.4*	*97.7*	*13,221.6*
				Diagnostic and allied health professionals					
Psychologist	561.1	422.7	329.9	168.5	80.0	27.1	60.6	12.4	1,662.3
Social worker	356.2	448.0	283.9	198.2	197.7	29.8	20.1	7.1	1,541.0
Occupational therapist	220.8	242.2	141.7	131.3	56.2	14.6	6.2	1.0	814.0
Diagnostic and health professionals[(a)]	367.6	144.1	119.0	109.8	61.2	28.4	6.9	12.0	849.0
Subtotal	*1,505.7*	*1,257.0*	*874.5*	*607.8*	*395.1*	*99.9*	*93.8*	*32.5*	*4,866.3*
				Additional staffing categories					
Other personal care[(b)]	160.6	118.7	203.0	89.7	23.6	143.3	28.7	7.0	774.6
Carer consultants	8.6	13.6	0.9	. .	. .	. .	. .	. .	23.1
Consumer consultants	24.8	19.0	10.3	0.8	2.1	. .	. .	. .	57.0
Other staff[(c)]	1,833.4	741.7	729.6	586.3	490.9	109.2	68.9	22.0	4,582.0
Subtotal	*2,027.4*	*893.0*	*943.8*	*676.8*	*516.6*	*252.5*	*97.6*	*29.0*	*5,436.7*
Total	**8,564.4**	**6,069.7**	**4,605.4**	**3,013.4**	**2,291.8**	**765.4**	**390.7**	**180.5**	**25,881.3**

(a) *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 327164).

(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.

. . Not applicable.

Source: National Mental Health Establishments Database.

In 2006–07, there were 11.3 FTE salaried medical officers per 100,000 population, ranging from 13.3 in South Australia to 8.4 in Tasmania (Table 12.14). The number of FTE nurses per 100,000 population varied substantially across states and territories, from 75.6 FTE in Tasmania to 46.0 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 substantially across states and territories (Table 12.14). South Australia (31.2) employed the highest number of other staff per 100,000 population, compared to the national average of 22.0.

Table 12.13: Full-time-equivalent staff by staffing category, states and territories, 2006–07 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	9.2	9.0	9.8	8.9	9.2	5.4	7.7	11.8	9.1
Nurses	49.5	55.5	50.8	48.5	51.0	48.6	43.4	54.1	51.1
Diagnostic and allied health professionals[(a)]	17.6	20.7	19.0	20.2	17.2	13.1	24.0	18.0	18.8
Other personal care[(b)]	1.9	2.0	4.4	3.0	1.0	18.7	7.3	3.9	3.0
Carer consultants	0.1	0.2	0.0	. .	. .	. .	. .	. .	0.1
Consumer consultants	0.3	0.3	0.2	0.0	0.1	. .	. .	. .	0.2
Other staff[(c)]	21.4	12.2	15.8	19.5	21.4	14.3	17.6	12.2	17.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

(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.

. . Not applicable.

Source: National Mental Health Establishments Database.

Table 12.14: Full-time-equivalent staff per 100,000 population by staffing category[(a)], states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers	11.5	10.6	10.9	12.9	13.3	8.4	8.9	10.0	11.3
Nurses	61.9	65.3	56.6	70.2	74.3	75.6	50.4	46.0	63.4
Diagnostic and allied health professionals[(b)]	22.0	24.3	21.2	29.2	25.1	20.3	27.9	15.3	23.3
Other personal care[(c)]	2.3	2.3	4.9	4.3	1.5	29.1	8.5	3.3	3.7
Carer consultants	0.1	0.3	0.0	. .	. .	. .	. .	. .	0.1
Consumer consultants	0.4	0.4	0.2	0.0	0.1	. .	. .	. .	0.3
Other staff[(d)]	26.7	14.4	17.7	28.2	31.2	22.2	20.5	10.4	22.0
Total	**125.0**	**117.5**	**111.5**	**144.8**	**145.5**	**155.7**	**116.2**	**84.9**	**124.1**

(a) Crude rate based on state and territory estimated resident population as at 31 December 2006.

(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.

. . Not applicable.

Source: National Mental Health Establishments Database.

Between 2002–03 and 2006–07 there was an average annual growth of 3.5% in the national specialised mental health-related workforce (Table 12.15). 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 5.3%, diagnostic and allied health professionals increased by 4.2% and nurses increased by 4.0%.

Table 12.15: Full-time-equivalent staff by staffing category, 2002–03 to 2006–07

	*2002–03	*2003–04	*2004–05	2005–06	2006–07	Average annual change (per cent)
Salaried medical officers	1,920	1,985	2,141	2,235	2,357	5.3
Nurses	11,312	11,765	12,150	12,754	13,222	4.0
Diagnostic and allied health professionals[(a)]	4,125	4,295	4,411	*4,700	4,866	4.2
Other personal care[(b)]	580	533	604	738	775	7.5
Carer consultants	9	9	14	15	23	28.0
Consumer consultants	54	60	55	61	57	1.5
Other staff[(c)]	4,575	4,558	4,512	*4,202	4,582	0.0
Total	**22,574**	**23,206**	**23,886**	**24,705**	**25,881**	**3.5**

(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.

n.a. Not available.

* Data updated from published figures in *Mental health services in Australia 2005–06*.

Source: National Mental Health Establishments Database and the *National Mental Health Report* (DoHA 2003, 2005 and 2008c) and unpublished Department of Health and Ageing.

12.5 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 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. In 2006–07, there were 25 private hospitals defined as psychiatric, with 1,554 total average available beds (Table 12.16).

Table 12.16: Private psychiatric hospitals, available beds and available beds per 100,000 population, states[(a)], 2006–07

	NSW	Vic	Qld	WA	SA	Tas	Total
Private psychiatric hospitals	9	6	4	n.a.	n.a.	n.a.	25
Available beds[(b)]	537	432	279	n.a.	n.a.	n.a.	1,554
Available beds per 100,000 population[(c)]	7.8	8.4	6.8	n.a.	n.a.	n.a.	7.5

(a) There were no private psychiatric hospitals in the Australian Capital Territory or the Northern Territory.

(b) Average available beds.

(c) Crude rate based on the Australian estimated resident population as at 31 December 2006.

n.a. Not available but included in totals where applicable, unless otherwise indicated.

Source: Private Health Establishments Collection (ABS).

In 2006–07, there were 1,591 FTE staff employed by private psychiatric hospitals (Table 12.17). Nurses made up the majority of the private psychiatric hospital workforce, accounting for almost half of the FTE staff.

Table 12.17: Full-time-equivalent staff by staffing category[(a)], private psychiatric hospitals, states[(b)], 2006–07

	NSW	Vic	Qld	SA	WA	Tas	Total
Salaried medical officers	16.9	5.1	1.3	n.a.	n.a.	n.a.	25.6
Nurses[(c)]	264.5	197.7	157.1	n.a.	n.a.	n.a.	772.6
Allied health professionals	70.9	40.6	35.1	n.a.	n.a.	n.a.	163.5
Administrative and clerical staff	130.6	108.3	48.3	n.a.	n.a.	n.a.	343.6
Domestic and other staff[(d)]	105.0	67.1	61.5	n.a.	n.a.	n.a.	285.8
Total staff	**587.9**	**418.9**	**303.3**	**n.a.**	**n.a.**	**n.a.**	**1,591.0**

(a) Average full-time-equivalent staff.

(b) There were no private psychiatric hospitals in the Australian Capital Territory or the Northern Territory.

(c) Includes *Nursing administrators*, *Nurse educators*, *Other registered nurses*, *Enrolled nurses*, *Student nurses*, *Trainee nurses*, *Other nursing staff* and *Other personal care staff* categories.

(d) Includes *Catering and kitchen*, *Domestic*, *Engineering and maintenance* and *Other* categories.

n.a. Not available but included in totals where applicable, unless otherwise indicated.

Source: Private Health Establishments Collection (ABS).

13 Mental health workforce

13.1 Introduction

Information presented in this chapter describes the size and characteristics of the psychiatrist workforce providing specialised mental health care. The information has been obtained from the annual AIHW Medical Labour Force Survey, as outlined in Appendix 1. Surveys are also conducted for the psychologist and mental health nurses workforces, however, since previous *Mental health services in Australia* publications there has been no new data available for these groups. For information on mental health nurses, refer to *Mental health services in Australia 2005–06* (AIHW 2008g). For information on psychologists, refer to *Mental health services in Australia 2004–05* (AIHW 2007a). 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.

The annual AIHW survey of all registered medical practitioners is conducted in consultation with the state and territory health departments, and in cooperation with the medical registration boards in each jurisdiction. For the purposes of this report, estimates of the psychiatrist workforce are based on those psychiatrist and psychiatrists-in-training 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. 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.

While the data are weighted to the overall medical practitioner registration numbers to account for non-response to the survey, not all possible non-response bias can be removed. In addition, the survey questionnaires, 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 across states and territories.

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 (that is, for psychiatrists, at the time of 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 FTE per 100,000 population figures provide a standardised measure of supply of professionals. The standard of 38 hours was used in this report to provide comparable figures with previous published data. This differs from the approach used in *Mental health services in Australia* reports published prior to 2004–05, and with data on the medical and nursing labour force published by the AIHW (AIHW 2008f, 2008h). FTE numbers presented in this chapter will, therefore, not be 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).

13.2 Psychiatrists

Psychiatrists (including psychiatrists-in-training) made up 5.2% of all employed medical practitioners in Australia, with an estimated 3,258 working in Australia in 2006 (Table 13.1). Psychiatrists-in-training made up 23.1% (or 753) of these psychiatrists. In 2006, 63.7% of employed psychiatrists were male. The average age of psychiatrists in 2006 was 48.8 years, remaining relatively constant since 2002, with female psychiatrists being younger, on average, than their male counterparts. The psychiatrist workforce increased by an annual average of 2.5% between 2002 and 2006, mostly due to the growth in the number of female psychiatrists (4.1% annual average increase).

Including clinical and non-clinical hours, psychiatrists worked an average of 40.5 total hours per week in 2006 (Table 13.2). The hours worked per week were, on average, lower for females than males (36.7 hours compared with 42.7 hours) and was higher for psychiatrists-in-training than for those not in training (44.1 hours compared with 39.5 hours).

Table 13.1: Employed psychiatrists and psychiatrists-in-training, demographic characteristics, 2002–2006

	2002	2003	2004	2005	2006	2006 Distribution (per cent)	Average annual change (per cent)
Psychiatrists	2,367	2,395	2,409	2,454	2,505	76.9	1.4
Psychiatrists-in-training	587	631	742	726	753	23.1	6.4
Sex							
Males	1,946	1,972	2,020	1,991	2,076	63.7	1.6
Females	1,008	1,054	1,131	1,189	1,182	36.3	4.1
Age and sex							
Males							
Less than 35 years	227	196	274	266	237	7.3	1.1
35–44 years	450	505	469	489	464	14.2	0.8
45–54 years	537	546	543	505	566	17.4	1.3
55–64 years	471	453	463	464	489	15.0	0.9
65 years and over	262	272	272	267	320	9.8	5.1
Females							
Less than 35 years	197	227	268	285	233	7.2	4.3
35–44 years	291	323	353	380	373	11.5	6.4
45–54 years	308	289	304	323	332	10.2	1.9
55–64 years	171	161	159	152	177	5.4	0.9
65 years and over	40	53	48	49	66	2.0	13.3
Average age (years)							
Males	50.7	50.5	49.9	49.9	50.8	. .	0.0
Females	45.5	45.0	44.0	43.7	45.2	. .	–0.2
Total	*48.9*	*48.6*	*47.8*	*47.6*	*48.8*	. .	–0.1
Total number[(a)]	**2,954**	**3,026**	**3,152**	**3,180**	**3,258**	**100.0**	2.5
All employed medical practitioners	53,991	56,207	58,211	60,252	62,425	. .	3.7

(a) The number for each variable may not sum to the total due to the estimation process and rounding.

. . Not applicable.

Source: AIHW Medical Labour Force Surveys, 2002–2006.

Table 13.2: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, type and sex, 2002–2006

	2002	2003	2004	2005	2006	Average annual change (per cent)
Psychiatrists	41.4	40.8	40.0	39.8	39.5	–1.2
Psychiatrists-in-training	44.0	45.4	43.8	43.4	44.1	0.1
Sex						
Males	44.2	44.3	43.3	42.8	42.7	–0.9
Females	37.5	36.9	36.6	36.9	36.7	–0.5
Total	**41.9**	**41.8**	**40.9**	**40.6**	**40.5**	–0.8

Source: AIHW Medical Labour Force Surveys, 2002–2006.

Size and distribution of the psychiatrist workforce

Nationally, there were 18 full-time-equivalent (FTE) psychiatrists per 100,000 population in 2006 (Table 13.3). The number of FTE psychiatrists per 100,000 population varied between the states and territories, ranging from 13 for Tasmania and the Australian Capital Territory, to 23 for Victoria. The average hours worked varied across jurisdictions, ranging from 30.4 hours per week in the Australian Capital Territory to 41.5 for Queensland.

Table 13.3: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, states and territories, 2006

	Number of psychiatrists	Number of psychiatrists-in-training	Total number	Average total hours worked per week	FTE	FTE per 100,000 population[(a)]
NSW	778	290	1,067	40.6	1,140	18
Vic	782	239	1021	40.8	1,096	23
Qld	407	95	502	41.5	548	15
WA	214	40	254	38.9	260	14
SA	217	54	271	39.9	285	20
Tas	58	5	62	36.8	60	13
ACT	41	11	51	30.4	41	13
NT[(b)]	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.
Total[(c)]	**2,505**	**753**	**3,258**	**40.5**	**3,472**	**18**

(a) Crude rate based on the Australian estimated resident population as at 30 June 2006.

(b) Estimates for the Northern Territory for 2006 are not separately published. The data were based on responses to the 2007 Medical Labour Force Survey weighted to 2006 registration numbers and are equivalent to a response rate of 28.6%.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

n.p Not published, however, the figures are included in the totals.

Note: FTE based on a 38-hour standard working week.

Source: AIHW Medical Labour Force Survey, 2006.

In 2006, approximately 90%of FTE psychiatrists (for whom region was reported) worked mainly in the *Major cities* (Table 13.4). Once population sizes for each region were taken into account, the FTE psychiatrists per 100,000 population was highest for *Major cities* (21), followed by *Inner regional* (6) and *Outer regional* (4).

Table 13.4: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, by region[(a)], 2006

Region[(a)]	Number	Average total hours worked per week	FTE	FTE per 100,000 population[(b)]
Major cities	2,840	40.5	3,027	21
Inner regional	247	39.2	255	6
Outer regional	77	42.6	86	4
Remote and very remote	14	n.p.	n.p.	n.p.
Not reported	79	41.0	85	. .
Total[(c)]	**3,258**	**40.5**	**3,472**	**17**

(a) Region is derived from the postcode of the respondent's main job and is classified according to the remoteness area structure within the Australian Standard Geographical Classification (ABS 2007a). See also Appendix 3. This data should be treated with caution due to the large number of *Not reported* values for region, relative to the number in *Outer regional* and *Remote and very remote* regions.

(b) Crude rate based on the Australian estimated resident population as at 30 June 2006.

(c) The number for each variable may not sum to the total due to the estimation process and rounding.

n.p. Not published.

. . Not applicable.

Note: FTE based on a 38-hour standard working week.

Source: AIHW Medical Labour Force Survey, 2006.

Changes in the psychiatrist workforce

The size and characteristics of the psychiatrist workforce, including the hours worked, changed in the period from 2002 to 2006. During this period, the number of employed psychiatrists (and psychiatrists-in-training) increased by 10.3%, which is one-third lower than the 15.6% increase in the total number of all employed medical practitioners. These figures equate to average annual increases of 2.5% for psychiatrists and 3.7% for all employed medical practitioners (Table 13.1). The average hours worked by psychiatrists decreased over the same period, by an average of 1.2% per year (Table 13.2).

The proportion of psychiatrists in the workforce who were female increased from 34.1% in 2002 to 36.3% in 2006 (Table 13.1).

Nationally, the supply of psychiatrists and psychiatrists in training, measured as FTE and FTE per 100,000 population, increased between 2002 and 2006 (Table 13.5). The supply increased in some, but not all, jurisdictions in this period (Table 13.6). In Queensland the number of psychiatrist FTE per 100,000 population increased by an annual average of 4.9%, while in South Australia there was an annual average decrease of 0.4%.

Table 13.5: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, 2002–2006

	2002	2003	2004	2005	2006	Average annual change (per cent)
Psychiatrists	2,579	2,571	2,536	2,570	2,604	0.2
Psychiatrists-in-training	680	754	856	830	874	6.5
Total FTE[(a)]	**3,257**	**3,328**	**3,392**	**3,398**	**3,472**	1.6
FTE per 100,000 population[(b)]	17	17	17	17	18	1.7

(a) The number for each variable may not sum to the total due to the estimation process and rounding.

(b) Crude rate 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.

Source: AIHW Medical Labour Force Surveys, 2002–2006.

Table 13.6: Employed psychiatrists and psychiatrists-in-training, FTE, states and territories, 2002–2006

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT[(a)]	Total[(b)]
					FTE				
2002	1,094	1,047	434	233	302	63	56	29	3,257
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	41	n.p.	3,472
Average annual change (per cent)	1.0	1.2	6.0	2.8	–1.5	–1.2	–7.6	n.p.	1.6
					FTE per 100,000 population[(c)]				
Average annual change (per cent)	1.7	1.4	4.9	3.4	–0.4	0.6	–6.0	12.3	1.7

(a) Estimates for the Northern Territory for 2006 are not separately published. The data were based on responses to the 2007 Medical Labour Force Survey weighted to 2006 registration numbers and are equivalent to a response rate of 28.6%.

(b) The number for each variable may not sum to the total due to the estimation process and rounding.

(c) Crude rate based on the Australian estimated resident population as at 30 June of the reference year.

n.p. Not published, however, the figures are included in the totals.

Note: FTE based on a 38-hour standard working week.

Source: AIHW Medical Labour Force Surveys, 2002–2006.

14 Expenditure on mental health services

14.1 Introduction

This chapter reviews the available information on ***recurrent expenditure*** for mental health services, commencing with recurrent expenditure on state and territory government-operated specialised mental health facilities. Information is then provided on private psychiatric hospital expenditure and Australian Government expenditure on Medicare-subsidised mental health-related services, mental health related medications and 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 2006–07* (AIHW 2008d).

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 further in the Key concepts box below).

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 2008d).

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 2008d).

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 2008d).

Current prices refer to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditures reflect changes in both price and volume (AIHW 2008d).

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 re-weighted 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 2008d).

14.2 Recurrent expenditure on state and territory specialised mental health services

Expenditure data for public psychiatric hospitals, public acute hospitals with a specialised psychiatric unit or ward, community mental health care services, government and non-government-operated residential mental health services are reported in this section. Expenditure reported as non-government-operated residential mental health services refers only to the funding provided by state and territory governments, not the total expenditure of the non-government-operated organisation. The data are presented in both ***current*** and ***constant prices***. Unless otherwise stated, constant price estimates are expressed in 2006–07 prices.

For definitional information and the scope of these services, refer to Chapter 12 of this report. Information on the number of services, available beds and staffing is in Chapter 12 of this report.

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 billion during 2006–07 (Table 14.1). The largest proportion of recurrent expenditure was spent on the provision of public hospital services for admitted patients ($1.35 billion), comprising public acute hospitals with a specialist psychiatric unit or ward ($0.9 billion) and psychiatric hospitals ($0.4 billion). Most states reported public hospital expenditure as the largest proportion of total 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, $1.1 billion was reported as being spent on community mental health care services during 2006–07.

Total expenditure, in constant prices, on state and territory specialised mental health services increased by an annual average of 5.6% over the 2002–03 to 2006–07 period (Table 14.2). Public acute hospitals with a specialised psychiatric unit or ward and community mental health care services experienced considerable annual average increases in expenditure of 7.2% and 5.9%, respectively. Public psychiatric hospital expenditure, in constant prices, remained relatively stable between 2002–03 and 2006–07. Grants to non-government organisations increased by an annual average of 11.4%; these grants made up 6.2% of overall recurrent specialised mental health services expenditure in 2006–07.

Table 14.1: Recurrent expenditure ($'000)[(a)] on specialised mental health services, states and territories, 2006–07

	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Total[(c)]
Public psychiatric hospitals[(d)]									
Salaries and wages expenditure	138,152	21,900	51,430	51,647	57,399	. .	. .	. .	320,527
Non-salary expenditure	37,432	11,016	16,888	14,064	20,814	. .	. .	. .	100,213
Indirect expenditure[(e)]	13,231	0	2,058	1,225	1,816	. .	. .	. .	18,329
Subtotal[(c)]	*188,815*	*32,916*	*70,375*	*66,936*	*80,028*	. .	. .	. .	*439,070*
Specialised psychiatric units or wards in public acute hospitals[(d)]									
Salaries and wages expenditure	219,864	144,797	138,888	79,926	40,558	19,820	8,519	7,423	659,795
Non-salary expenditure	71,951	47,332	38,255	18,222	12,539	7,624	4,211	1,283	201,416
Indirect expenditure[(e)]	17,840	14,080	12,890	419	1,912	1,046	615	1,591	50,393
Subtotal[(c)]	*309,655*	*206,209*	*190,034*	*98,566*	*55,009*	*28,489*	*13,345*	*10,297*	*911,604*
Community mental health care services									
Salaries and wages expenditure	245,376	203,340	150,191	117,025	62,197	17,181	18,505	10,676	824,490
Non-salary expenditure	62,819	64,068	47,422	35,764	21,258	7,587	6,873	2,209	248,000
Indirect expenditure[(e)]	25,527	17,617	11,262	1,693	5,012	1,201	2,039	2,355	66,707
Subtotal[(c)]	*333,722*	*285,024*	*208,876*	*154,482*	*88,466*	*25,969*	*27,418*	*15,240*	*1,139,197*
Residential mental health services[(f)]									
Salaries and wages expenditure	21,881	83,600	. .	4,783	2,103	10,549	3,417	196	126,528
Non-salary expenditure	4,718	31,224	. .	1,660	630	6,875	3,075	148	48,331
Indirect expenditure[(e)]	1,262	7,202	. .	43	252	489	415	5	9,667
Subtotal[(c)]	*27,861*	*122,026*	. .	*6,485*	*2,985*	*17,913*	*6,906*	*349*	*184,525*
Other expenditure									
Grants to non-government organisations[(g)]	40,548	65,364	31,120	18,025	21,803	3,266	5,283	4,093	189,500
Other indirect expenditure[(e)]	79,236	42,990	30,684	10,696	4,760	4,263	1,778	2,117	176,523
Total state/territory expenditure[(c)]	**979,835**	**754,529**	**531,088**	**355,190**	**253,051**	**79,900**	**54,730**	**32,095**	**3,040,419**

(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 includes expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(e) See Appendix 2 for information on the method used to calculate indirect expenditure.

(f) Residential mental health services include non-government-operated residential mental health facilities in receipt of government funding.

(g) Grants to non-government-operated expenditure excludes funding of staffed residential services managed by non-government organisations. These are included in residential mental health services.

. . Not applicable.

Source: National Mental Health Establishments Database.

Table 14.2: Recurrent expenditure ($'000)[(a)] on specialised mental health services, states and territories, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
			Current prices			
Public psychiatric hospitals[(b)(c)]	370,167	402,807	416,810	431,657	439,070	4.4
Public acute hospitals with a specialised psychiatric unit or ward[(b)(c)]	593,768	652,201	727,747	809,757	911,604	11.3
Community mental health care services	763,429	827,323	913,146	1,021,335	1,139,197	10.5
Residential mental health services[(d)]	143,692	148,873	155,559	174,481	184,525	6.5
Grants to non-government organisations[(e)]	103,591	111,351	129,524	160,272	189,500	16.3
Other indirect expenditure[(f)]	103,546	116,262	126,113	144,731	176,523	14.3
Total state/territory expenditure[(g)]	**2,078,193**	**2,258,817**	**2,468,899**	**2,742,232**	**3,040,419**	**10.0**
			Constant prices[(h)]			
Public psychiatric hospitals[(b)]	431,210	452,737	451,653	448,387	439,070	0.5
Public acute hospitals with a specialised psychiatric unit or ward[(b)(c)]	691,526	733,073	788,430	841,407	911,604	7.2
Community mental health care services	907,456	941,665	995,565	1,066,771	1,139,197	5.9
Residential mental health services[(d)]	170,801	169,448	169,600	182,243	184,525	2.0
Grants to non-government organisations[(e)]	123,134	126,740	141,215	167,402	189,500	11.4
Other indirect expenditure[(f)]	120,740	130,722	136,648	150,411	176,523	10.0
Total state/territory expenditure[(g)]	**2,444,867**	**2,554,386**	**2,683,111**	**2,856,621**	**3,040,419**	**5.6**

(a) Expenditure excludes depreciation.

(b) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals includes 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-operated expenditure excludes funding of staffed residential services managed 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) Totals may not add due to rounding to nearest $'000.

(h) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

Source: National Mental Health Establishments Database and *National Mental Health Report* (DoHA 2005 and 2008c).

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 of mental disorder 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).

Almost two-thirds ($264 million) of public psychiatric hospital expenditure during 2006–07 was spent on *Non-acute* services (Table 14.3). In contrast, almost 90% ($818 million) of expenditure on public hospitals with a specialised psychiatric unit or ward was allocated to the provision of *Acute* services.

Table 14.3: Recurrent expenditure ($'000)[(a)] on admitted patient services in specialised mental health public hospitals, by program type, states and territories, 2006–07

	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Total[(c)]
Public psychiatric hospitals[(d)]									
Acute	80,728	18,381	. .	37,378	38,699	. .	. .	. .	175,185
Non-acute	108,087	14,535	70,375	29,558	41,329	. .	. .	. .	263,884
Public acute hospitals with a specialised psychiatric unit or ward[(d)]									
Acute	292,780	190,129	144,248	89,953	55,009	22,557	13,345	10,297	818,316
Non-acute	16,875	16,080	45,786	8,613	. .	5,933	. .	. .	93,287
Total[(c)]	**498,470**	**239,125**	**260,409**	**165,502**	**135,036**	**28,489**	**13,345**	**10,297**	**1,350,673**

(a) Expenditure excludes depreciation.

(b) 2006–07 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 includes expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

. . Not applicable.

Source: National Mental Health Establishments Database.

Target population

For the purpose of mental health services, individual units can be categorised based on four target population groups. *Child and adolescent* services are targeted to those aged under 18 years. *Older person* programs are targeted towards the 65 years and over age group. *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, however 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, the type of service that incurred the majority of recurrent hospital expenditure was *General* services ($966 million; Table 14.4). Not all jurisdictions provide services for each of the target population categories. However, of those reporting all types there was a similar distribution of funds, with the majority spent on *General* services, followed by *Older person*, *Forensic* and *Child and adolescent* services. Queensland was the exception, with the majority of

funds spent on *General* services, followed by *Forensic, Older person* and *Child and adolescent* services.

Table 14.4: Recurrent expenditure ($'000)[a] on admitted patient services in specialised mental health public hospitals[b], by target population, states and territories, 2006–07

	NSW	Vic	Qld	WA[c]	SA	Tas	ACT	NT	Total[d]
General	388,913	153,804	173,617	117,502	87,189	22,699	11,945	10,222	965,890
Child and adolescent	26,995	15,353	17,486	6,728	3,017	. .	. .	. .	69,580
Older person	51,842	37,052	28,766	29,652	33,189	. .	1,400	. .	181,901
Forensic	30,719	32,916	40,541	11,619	11,642	5,791	. .	75	133,302
Total[c]	**498,470**	**239,125**	**260,409**	**165,502**	**135,036**	**28,489**	**13,345**	**10,297**	**1,350,673**

(a) Expenditure excludes depreciation.

(b) Public psychiatric hospitals and specialised psychiatric units or wards in public acute hospitals includes expenditure on admitted patient services only. Public hospital outpatients departments are included in community mental health care services.

(c) 2006–07 public psychiatric hospital expenditure in WA includes publicly funded private hospitals.

(d) Totals may not add due to rounding to nearest $'000.

. . Not applicable.

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/liaison services. Community mental health care services accounted for $1.1 billion of recurrent mental health services expenditure during 2006–07 (Table 14.5).

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 ($827 million or 72.6%). 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 ($201 million or 17.7%).

Table 14.5: Recurrent expenditure ($'000)[a] on community mental health care services, by target population, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[b]
General	246,929	210,399	147,968	112,210	63,713	16,080	17,173	12,385	826,856
Child and adolescent	57,589	41,476	46,371	26,618	17,264	5,179	5,272	1,384	201,154
Older person	18,092	29,114	6,895	14,003	5,697	3,025	2,904	. .	79,730
Forensic	11,112	4,035	7,642	1,652	1,792	1,684	2,068	1,470	31,456
Total[b]	**333,722**	**285,024**	**208,876**	**154,482**	**88,466**	**25,969**	**27,418**	**15,240**	**1,139,197**

(a) Expenditure excludes depreciation.

(b) Totals may not add due to rounding to nearest $'000.

. . Not applicable.

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, and totalling more than 50 hours per week. Residential services generally provide specialised care to the *General* and *Older person* target population groups.

During 2006–07, $185 million was spent on residential mental health services (Table 14.6). *General* services ($103 million) accounted for over half of the residential total. Recurrent expenditure for 24-hour staffed residential facilities accounted for approximately $160 million or 87.0%.

Table 14.6: Recurrent expenditure ($'000)[a] on residential mental health services[b], by target population and hours staffed, states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[c]
General services									
24-hour staffing	9,032	47,726	. .	4,799	2,035	11,964	5,235	. .	80,792
Non-24-hour staffing	5,064	13,510	. .	1,686	950	. .	1,104	349	22,663
Older person services									
24-hour staffing	12,979	60,202	. .	. .	. .	5,949	567	. .	79,696
Non-24-hour staffing	786	588	. .	. .	. .	. .	. .	. .	1,374
Total[c]	**27,861**	**122,026**	**. .**	**6,485**	**2,985**	**17,913**	**6,906**	**349**	**184,525**

(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.

. . Not applicable.

Source: National Mental Health Establishments Database.

14.3 Private psychiatric hospital expenditure

Expenditure information is available for private psychiatric hospitals from the Private Health Establishments Collection, held by the ABS. For that collection, 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 data published in this chapter describe only those private psychiatric hospitals meeting this definition.

In 2006–07, total recurrent expenditure for private psychiatric facilities was $181 million (Table 14.7). Expenditure on private psychiatric hospitals, in constant prices, declined by an annual average of 0.5% per year over the period 2002–03 to 2006–07 (Table 14.8).

Table 14.7: Private psychiatric hospital expenditure ($'000)[(a)], states, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	Total[(b)]
Salaries and wages expenditure	37,878	28,089	20,122	n.a.	n.a.	n.a.	106,036
Non-salary expenditure	26,164	22,445	11,667	n.a.	n.a.	n.a.	74,518
Total recurrent expenditure[(b)]	**64,042**	**50,534**	**31,789**	**n.a.**	**n.a.**	**n.a.**	**180,554**

(a) Recurrent expenditure excludes depreciation.

(b) Totals may not add due to rounding to nearest $'000.

n.a. Not available for publication but included in totals where applicable, unless otherwise indicated.

Source: Private Health Establishments Collection (ABS).

Table 14.8: Private psychiatric hospital expenditure ($'000)[(a)], 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
Total expenditure (current prices)	158,529	162,066	168,490	176,781	180,554	3.3
Total expenditure (constant prices)[(b)]	184,567	182,076	182,578	183,652	180,554	–0.5

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 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 2003–04 to 2007–08. More detailed information on the MBS items included over time is in chapters 2 and 6. (Appendix 1 provides further information on data quality, coverage and other aspects of the Medicare data.)

In 2007–08, $549 million was paid in benefits for MBS-subsidised mental health-related services (Table 14.9); this represented 4.2% of total Medicare benefits expenditure ($13,007 million) for that year.

The majority of the $549 million was spent on initial consultations and patient attendances in psychiatrists' consulting rooms ($213 million or 38.9%). Expenditure on services provided by psychologists was the next largest expenditure group (31.0%), followed by the Medicare items associated with *GP Mental Health Care Plans*, accounting for 23.3% of total mental health-related Medicare benefits expenditure (Table 14.9).

Nationally, benefits paid for mental health-related Medicare services averaged $25.91 per capita in 2007–08. The average benefits paid per capita in Victoria and New South Wales were above the national average, while those in the Northern Territory were substantially lower, at $6.29 per capita.

During the period between 2003–04 and 2007–08, the total expenditure on MBS mental health-related items increased by an annual average of 22.4%, in constant prices (Table 14.10). This change is also reflected in a change in per capita spending of 20.7%, in constant prices. These changes are reflected by the increase across all subsections of MBS spending. The only item numbers experiencing a decline in expenditure relate to the *3 Step Mental Health Process*, which was replaced by *GP Mental Health Care Plans* in November 2006.

It is worth noting that analysis of Bettering the Evaluation and Care of Health GP survey data reveals an estimated 90% of mental health-related GP encounters were reported as having been billed as *surgery consultations* and not as mental health-related items under the Medicare *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* program. For further information on this issue, see Section 2.3 of this report.

Table 14.9: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[(a)], states and territories[(b)], 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(c)]
				Psychiatrists					
Initial consultation new patient —consulting room	5,035	4,192	2,988	1,288	1,375	242	230	61	15,409
Initial consultation new patient —hospital	587	358	322	118	74	51	11	2	1,523
Initial consultation new patient —home visit	136	42	8	2	21	1	2	0	212
Patient attendances—consulting room	64,454	67,522	31,453	10,576	18,708	2,900	2,075	290	197,978
Patient attendances—hospital	4,730	5,713	4,413	2,082	1,158	762	128	21	19,007
Patient attendances—other locations	1,077	461	91	62	186	10	9	1	1,896
Group psychotherapy	816	1,162	159	51	37	101	5	1	2,333
Interview with non-patient	207	230	165	48	48	13	5	2	718
Telepsychiatry	71	8	37	2	1	0	2	3	124
Case conferencing	10	84	5	13	7	4	1	0	123
Electroconvulsive therapy[(d)]	249	255	231	70	58	37	2	0	902
Subtotal[(c)]	*77,373*	*80,027*	*39,871*	*14,311*	*21,673*	*4,121*	*2,469*	*381*	*240,225*
				General practitioners					
GP Mental Health Care Plans	44,044	36,380	22,661	11,409	8,513	2,579	1,696	520	127,802
Focussed Psychological Strategies	1,395	1,073	729	144	451	43	42	5	3,883
Subtotal[(c)]	*45,439*	*37,453*	*23,390*	*11,553*	*8,963*	*2,622*	*1,739*	*525*	*131,685*
				Psychologists					
Psychological Therapy Services —clinical psychologist	23,853	19,525	7,906	13,055	5,548	2,274	1,301	159	73,621
Focussed Psychological Strategies—psychologist	31,940	33,995	18,598	4,339	3,810	1,741	1,551	293	96,268
Enhanced Primary Care —psychologist	164	119	91	15	18	6	1	1	415
Subtotal[(c)]	*55,957*	*53,639*	*26,595*	*17,409*	*9,376*	*4,021*	*2,854*	*453*	*170,304*
				Other allied mental health providers					
Focussed Psychological Strategies —occupational therapist	431	283	167	109	115	34	6	1	1,147
Focussed Psychological Strategies —social worker	1,914	1,775	844	375	345	107	26	9	5,395
Enhanced Primary Care—mental health worker[(e)]	53	31	15	2	18	1	0	0	120
Subtotal[(c)]	*2,397*	*2,089*	*1,027*	*486*	*478*	*141*	*32*	*10*	*6,662*
Total expenditure in current prices ($'000)[(c)]	**181,166**	**173,208**	**90,883**	**43,759**	**40,490**	**10,905**	**7,094**	**1,369**	**548,875**
Per capita ($)[(f)]	26.15	33.02	21.49	20.54	25.43	22.00	20.81	6.29	25.91

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

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

Source: Medicare data (DoHA).

Table 14.10: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group[(a)], 2003–04 to 2007–08

	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Psychiatrists						
Initial consultation new patient—consulting room[(b)]	. .	. .	. .	8,490	15,409	. .
Initial consultation new patient—hospital[(b)]	. .	. .	. .	619	1,523	. .
Initial consultation new patient—home visit[(b)]	. .	. .	. .	90	212	. .
Patient attendances—consulting room	181,868	193,820	198,057	198,184	197,978	2.1
Patient attendances—hospital	14,826	15,321	17,046	17,490	19,007	6.4
Patient attendances—other locations	1,538	1,601	1,772	1,894	1,896	5.4
Group psychotherapy	2,120	2,325	2,470	2,378	2,333	2.4
Interview with non-patient	208	250	290	623	718	36.3
Telepsychiatry	19	24	41	68	124	59.9
Case conferencing	39	62	85	88	123	33.4
Electroconvulsive therapy[(c)]	671	704	819	831	902	7.7
Subtotal[(d)]	*201,290*	*214,106*	*220,579*	*230,755*	*240,225*	*4.5*
General practitioners						
GP Mental Health Care Plans[(b)]	. .	. .	. .	62,323	127,802	. .
Focussed Psychological Strategies	1,328	2,131	2,828	3,639	3,883	30.8
3 Step Mental Health Process—GP[(e)]	725	962	1,658	1,044	. .	. .
Subtotal[(d)]	*2,053*	*3,093*	*4,486*	*67,006*	*131,685*	*183.0*
Psychologists						
Psychological Therapy Services—clinical psychologist[(b)]	. .	. .	. .	20,974	73,621	. .
Focussed Psychological Strategies—psychologist[(b)]	. .	. .	. .	30,961	96,268	. .
Enhanced Primary Care—psychologist[(f)]	. .	1,120	2,263	2,462	415	. .
Subtotal[(d)]	*. .*	*1,120*	*2,263*	*54,397*	*170,304*	*. .*
Other mental allied health providers						
3 Step Mental Health Process—OMP[(e)]	37	43	43	24	. .	. .
Focussed Psychological Strategies—occupational therapist[(b)]	. .	. .	. .	170	1,147	. .
Focussed Psychological Strategies—social worker[(b)]	. .	. .	. .	1,093	5,395	. .
Enhanced Primary Care—mental health worker[(f)(g)]	. .	36	134	190	120	. .
Subtotal[(d)]	*37*	*79*	*177*	*1,477*	*6,662*	*. .*
Total expenditure in current prices ($'000)[(d)]	**203,380**	**218,398**	**227,506**	**353,635**	**548,875**	**28.2**
Total expenditure in constant prices ($'000)[(h)]	231,464	238,123	238,639	353,635	519,484	22.4
Per capita (constant prices) ($)[(h)(i)]	11.57	11.76	11.62	16.96	24.53	20.7

(a) See the *Medicare Benefits Schedule* data section of Appendix 1 for a listing of these item groups.
(b) These mental health-related MBS items commenced November 2006.
(c) Information for electroconvulsive therapy may include data for services provided by medical practitioners other than psychiatrists.
(d) Totals may not add due to rounding to nearest $'000.
(e) This item discontinued April 2008.
(f) Includes psychologists, mental health nurses, occupational therapists, social workers and Aboriginal health workers.
(g) This mental health-related MBS item commenced July 2004.
(h) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.
(i) Crude rate based on the preliminary Australian estimated resident population as at 31 December of the reference year.
. . Not applicable.
Source: Medicare data (DoHA).

14.5 Australian Government expenditure on mental health-related medications

In 2007–08, 185 million claims were processed under the PBS and RPBS for prescribed medications. The total benefits paid for these claims, excluding patient contributions, were $6,695 million (Medicare Australia 2009a). Of this, 10.5% ($704 million) was spent on mental health-related medications. For further information on data quality, coverage and other aspects of the PBS/RPBS database refer to Appendix 1.

Almost three-quarters (72.8%) of the expenditure on mental health-related medications was for prescriptions issued by general practitioners. This was followed by prescriptions written by psychiatrists (19.1%), with non-psychiatrist specialists' prescriptions accounting for the remaining 8.1% (Table 14.11).

In 2007–08, prescriptions for antipsychotics and antidepressants accounted for the majority of mental health-related PBS/RPBS expenditure (49.0% and 42.8%, respectively), followed by prescriptions for psychostimulants (2.6%), anxiolytics (2.3%) and hypnotics and sedatives (1.5%) (Table 14.11). 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 14.11: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[(a)] and medical practitioner, 2007–08

	Anti-psychotics (N05A)[(b)]	Anxiolytics (N05B)	Hypnotics and sedatives (N05C)	Anti-depressants (N06A)	Psycho-stimulants (N06B)	Other[(c)]	Total[(d)]	Total (per cent)
General practitioners	227,643	14,751	9,982	258,088	1,888	. .	512,352	72.8
Non-psychiatrist specialists	34,399	378	307	8,215	13,788	. .	57,087	8.1
Psychiatrists	82,853	1,169	266	34,570	2,523	12,640	134,020	19.1
Total[(e)]	**345,206**	**16,308**	**10,562**	**301,144**	**18,204**	**12,640**	**704,064**	. .
Total (per cent)	49.0	2.3	1.5	42.8	2.6	1.8	. .	100.0

(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 other N codes as well as other ATC medication, as presented in Table 14.13. 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.

. . Not applicable.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

From a benefits paid perspective, the cost to the Australian Government of subsidising mental health-related prescriptions under the PBS/RPBS in 2007–08 ($704 million) was equivalent to $33.24 per capita (Table 14.12). 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. This is consistent with the distribution of prescriptions outlined in more detail in Chapter 11.

Table 14.12: Australian Government expenditure ($’000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[(a)] and type of medical practitioner, states and territories[(b)], 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
				Antipsychotics (N05A)[(c)]					
General practitioners	77,852	63,283	38,751	17,485	21,869	4,979	2,660	763	227,643
Non-psychiatrist specialists	6,929	13,897	6,666	3,908	1,499	597	368	534	34,399
Psychiatrists	28,014	24,531	14,263	4,694	7,851	1,704	1,564	231	82,853
Subtotal[(d)]	*112,910*	*101,749*	*59,719*	*26,103*	*31,243*	*7,290*	*4,662*	*1,527*	*345,206*
				Anxiolytics (N05B)					
General practitioners	3,949	4,540	2,938	1,087	1,415	667	123	32	14,751
Non-psychiatrist specialists	91	131	72	32	40	9	2	1	378
Psychiatrists	272	429	245	68	110	34	8	3	1,169
Subtotal[(d)]	*4,318*	*5,100*	*3,257*	*1,187*	*1,565*	*710*	*134*	*36*	*16,308*
				Hypnotics and sedatives (N05C)					
General practitioners	3,112	2,534	1,988	939	954	352	79	24	9,982
Non-psychiatrist specialists	85	94	64	33	23	5	2	1	307
Psychiatrists	57	58	74	30	36	4	6	0	266
Subtotal[(d)]	*3,259*	*2,686*	*2,126*	*1,003*	*1,013*	*362*	*87*	*25*	*10,562*
				Antidepressants (N06A)					
General practitioners	77,019	65,426	54,579	26,132	22,841	8,180	3,071	836	258,088
Non-psychiatrist specialists	2,004	2,622	1,784	1,061	479	150	71	44	8,215
Psychiatrists	9,511	9,830	7,560	3,272	3,130	842	370	53	34,570
Subtotal[(d)]	*88,713*	*77,894*	*63,953*	*30,479*	*26,457*	*9,174*	*3,534*	*934*	*301,144*
				Psychostimulants, agents used for ADHD and nootropics (N06B)					
General practitioners	440	139	820	286	117	44	27	15	1,888
Non-psychiatrist specialists	6,022	2,927	2,049	1,466	522	490	230	80	13,788
Psychiatrists	861	273	570	575	150	38	53	3	2,523
Subtotal[(d)]	*7,327*	*3,339*	*3,441*	*2,328*	*789*	*572*	*311*	*99*	*18,204*
				Other medications prescribed by psychiatrists[(e)]					
Psychiatrists	3,685	3,790	2,899	938	975	185	128	38	12,640
				Total expenditure					
Expenditure ($’000)[(f)]	**220,212**	**194,558**	**135,395**	**62,039**	**62,042**	**18,294**	**8,854**	**2,660**	**704,064**
Per capita ($)[(g)]	31.79	37.09	32.02	29.12	38.97	36.90	25.98	12.22	33.24
				Total cost of Clozapine (Government cost plus patient contribution)					
Clozapine ($'000)[(h)]	12,164	11,415	7,063	3,025	2,627	838	467	248	37,847

(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 Australia column.

(c) Includes Clozapine dispensed through Section 100 arrangements by private hospitals but not by public hospitals.

(d) Includes expenditure where the prescriber’s specialty was unknown.

(e) Includes other N codes as well as other ATC medication as presented in Table 14.13. 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) Totals may not add due to rounding to nearest $’000.

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

(h) Clozapine is a Section 100, atypical antipsychotic. Total cost equals Government cost plus patient contribution for public hospitals only.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

PBS/RPBS expenditure for medications prescribed by psychiatrists accounted for $134 million in 2007–08. About 97.0% ($130 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 14.13).

Table 14.13: Australian Government expenditure ($'000) on medications prescribed by psychiatrists subsidised under the PBS/RPBS, by type of medication prescribed(a), states and territories(b), 2007–08

ATC code		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
N	**Central nervous system**									
N05A	Antipsychotics	28,014	24,531	14,263	4,694	7,851	1,704	1,564	231	82,853
N05B	Anxiolytics	272	429	245	68	110	34	8	3	1,169
N05C	Hypnotics and sedatives	57	58	74	30	36	4	6	0	266
N06A	Antidepressants	9,511	9,830	7,560	3,272	3,130	842	370	53	34,570
N06B	Psychostimulants, agents for ADHD and nootropics	861	273	570	575	150	38	53	3	2,523
	Subtotal(c)	*38,715*	*35,121*	*22,713*	*8,639*	*11,277*	*2,623*	*2,001*	*290*	*121,380*
	Other N Codes	2,409	2,746	1,820	591	651	111	77	27	8,433
Total N Codes(c)		**41,124**	**37,867**	**24,533**	**9,230**	**11,928**	**2,734**	**2,078**	**317**	**129,813**
	Other Codes									
A	Alimentary tract and metabolism	289	273	244	69	77	22	9	2	985
B	Blood and blood-forming organs	24	31	28	9	11	1	1	0	106
C	Cardiovascular system	436	364	306	101	113	25	17	5	1,367
D	Dermatologicals	9	7	6	4	2	0	0	0	29
G	Genitourinary system and sex hormones	156	94	185	60	36	5	9	1	547
H	Systemic hormonal preparations, excluding sex hormones	19	21	21	13	8	2	1	0	84
J	General anti-infectives for systematic use	60	48	51	23	7	2	3	0	194
L	Antineoplastic and immunomodulating agents	59	24	7	6	6	1	2	0	105
M	Musculoskeletal system	58	66	49	12	14	4	2	1	205
R	Respiratory system	93	83	62	21	22	8	5	2	295
S	Sensory organs	22	15	10	4	4	0	1	0	56
	Other(d)	50	19	110	27	25	2	1	0	234
	Subtotal(c)	*1,276*	*1,044*	*1,080*	*347*	*324*	*74*	*51*	*11*	*4,208*
Total expenditure ($'000)(c)		**42,400**	**38,911**	**25,612**	**9,577**	**12,252**	**2,807**	**2,129**	**328**	**134,020**
Per capita ($)(e)		6.12	7.42	6.06	4.49	7.70	5.66	6.25	1.51	6.33

(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 Australia column.

(c) Totals may not add due to rounding to nearest $'000.

(d) Includes extemporaneously prepared items and/or PBS items with no ATC equivalent.

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

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

Table 14.14: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed[(a)] and type of medical practitioner, 2003–04 to 2007–08

ATC group (code)	2003–04	2004–05	2005–06	2006–07	2007–08	Average annual change (per cent)
Antipsychotics (N05A)[(b)]						
General practitioners	*154,121	*169,369	*193,609	*212,260	227,643	10.2
Non-psychiatrist specialists	*16,595	*19,843	*27,387	*31,526	34,399	20.0
Psychiatrists	*57,257	*65,379	*75,861	*80,665	82,853	9.7
Subtotal[(c)]	**228,907*	**255,381*	**297,633*	**324,961*	*345,206*	*10.8*
Anxiolytics (N05B)						
General practitioners	15,297	14,845	14,329	14,507	14,571	–0.9
Non-psychiatrist specialists	333	335	342	348	378	3.3
Psychiatrists	1,229	1,205	1,167	1,177	1,169	–1.2
Subtotal[(c)]	*16,884*	*16,401*	*15,855*	*16,046*	*16,308*	*–0.9*
Hypnotics and sedatives (N05C)						
General practitioners	12,001	11,186	10,353	10,065	9,982	–4.5
Non-psychiatrist specialists	347	322	305	299	307	–3.0
Psychiatrists	311	290	269	264	266	–3.9
Subtotal[(c)]	*12,675*	*11,809*	*10,939*	*10,638*	*10,562*	*–4.5*
Antidepressants (N06A)						
General practitioners	279,738	285,736	255,736	255,156	258,088	–2.0
Non-psychiatrist specialists	8,922	8,826	8,123	7,948	8,215	–2.0
Psychiatrists	42,082	41,560	38,053	36,776	34,570	–4.8
Subtotal[(c)]	*331,918*	*337,000*	*302,527*	*300,292*	*301,144*	*–2.4*
Psychostimulants, agents used for ADHD and nootropics (N06B)						
General practitioners	611	639	735	891	1,888	32.6
Non-psychiatrist specialists	2,057	1,886	2,268	3,052	13,788	60.9
Psychiatrists	1,354	1,308	1,208	1,213	2,523	16.8
Subtotal[(c)]	*4,034*	*3,841*	*4,218*	*5,161*	*18,204*	*45.7*
Other[(d)]						
Psychiatrists	*12,715	*13,349	*13,262	*12,924	12,640	–0.1
Total expenditure in current prices ($'000)[(e)]	***607,133**	***637,782**	***644,435**	***670,021**	**704,064**	**3.8**
Total expenditure in constant prices ($'000)[(f)]	*610,716	*640,557	*645,883	*670,021	702,659	3.6
Per capita (constant prices, $)[(g)]	*30.52	*31.63	*31.44	*32.14	33.17	2.1
Total cost of Clozapine (Government cost plus patient contribution, current prices)						
Clozapine ($'000)[(h)]	28,663	30,091	33,462	35,187	37,847	7.2

(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, as presented in Table 14.13. 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 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(g) Crude rate 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.

* Differences in figures reported in previous years caused by item 1330 *Tetrabenazine* which was classified previously to N05A and is now classified to N07X *Other nervous system drugs*.

Source: Pharmaceutical Benefits Scheme and *Repatriation Pharmaceutical Benefits Scheme* data (DoHA).

Overall, expenditure on medications prescribed by psychiatrists under the PBS/RPBS averaged $6.33 per capita in 2007–08. The average benefits paid per capita 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 South Australia and Victoria.

Real growth in expenditure (constant prices) for mental health-related prescriptions averaged 3.6% per year between 2003–04 and 2007–08 (Table 14.14). Per capita, this represents an average growth rate of 2.1% per year over the period. These rises can be largely attributed to the increase in expenditure on antipsychotics, which has seen an average annual rate of change of 10.8% over 2003–04 to 2007–08.

Expenditure on psychostimulants rose sharply in 2007–08 from 2006–07. This appears to be partly the result of the listing of atomoxetine (a non-stimulant drug for the treatment of attention-deficit hyperactivity disorder) on the PBS in 2007–08, adding $3 million to the total cost of psychostimulants (Medicare Australia 2009).

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 14.12 and 14.14 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 2003–04 to 2007–08 period, from $28.6 to $37.8 million (current prices), respectively, with an average annual rate of change of 7.2%.

14.6 Total Australian Government expenditure on mental health-related services

The Australian Government has estimated the total expenditure on mental health-related services between 2002–03 and 2006–07 (Table 14.15). During this time, there was an annual average increase in total expenditure of 2.8% in constant prices. Expenditure on Medicare-subsidised mental health services and medications provided through the PBS, accounted for 71% of the total $1,587 million spending on mental health by the Australian Government in 2006–07. Expenditure on items relating to the Department of Veterans' Affairs, including RPBS, accounted for around 9%.

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* (AHCAs). These are included in the estimates of specialised mental health services in Table 14.16.

Table 14.15: Australian Government expenditure ($'000) on mental health-related services, 2002–03 to 2006–07

	2002–03	2003–04	2004–05	2005–06	2006–07	Average annual change (per cent)
PBS—psychiatric drugs	543,995	594,428	625,929	637,503	663,867	5.1
MBS—general practitioners[a]	168,740	173,556	201,021	232,739	171,175	0.4
MBS—consultant psychiatrist services	197,663	201,604	214,356	220,879	230,883	4.0
MBS—clinical psychologists[b]	. .	. .	. .	. .	20,974	. .
MBS—other allied health[c]	. .	. .	. .	. .	34,877	. .
National Mental Health Strategy[d]	94,829	92,635	108,951	140,981	132,432	8.7
Department of Veterans' Affairs[e]	129,420	126,069	123,715	125,505	143,973	2.7
Private hospital insurance premium rebates	46,791	48,000	56,605	63,884	66,608	9.2
Research	23,121	24,625	30,682	35,927	40,216	14.8
National Suicide Prevention Strategy	10,106	9,846	12,080	8,648	17,311	14.4
FaHCSIA-managed COAG Action Plan programs[a]	. .	. .	. .	. .	15,470	. .
DoHA-managed COAG Action Plan programs[a]	. .	. .	. .	. .	37,821	. .
Other	8,208	8,742	8,782	9,243	11,526	8.9
Total expenditure in current prices ($'000)	**1,222,873**	**1,279,504**	**1,382,120**	**1,475,308**	**1,587,134**	**6.7**
Total expenditure in constant prices ($'000)[f]	1,423,726	1,437,481	1,497,686	1,532,648	1,587,134	2.8
Per capita ($) (constant prices)[g]	72.01	71.83	73.95	74.60	76.13	1.4

(a) For additional information on the scope of this item refer to Appendix 1.

(b) These mental health-related MBS items commenced 1 November 2006.

(c) Includes services provided by *registered psychologists*, *social workers* and *occupational therapists* approved by Medicare. These mental health-related MBS items commenced 1 November 2006.

(d) Includes specific grants to states and territories.

(e) Includes RPBS expenditure.

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

(g) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

. . Not applicable

Source: Unpublished Department of Health and Ageing.

14.7 Sources of funding for 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 general practitioners (GPs), medical specialists and other professionals (in private practices), residential aged care and pharmaceuticals, for which benefits were paid under the *Pharmaceutical Benefits Scheme* (PBS) and the *Repatriation Pharmaceutical Benefits Scheme* (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 incidentals, including over-the-counter pharmaceuticals, dental and other professional services and private hospital services.

State and territory specialised mental health services

During 2006–07, state and territory specialised mental health services (for which expenditure is described in section 14.2), were funded from a variety of sources. In 2006–07, 93.3% ($2,839 million) of funds for specialised mental health services were provided by state or territory governments (Table 14.16). A further 4.4% ($134 million) was provided by the Australian Government, with the remaining 2.2% ($68 million) sourced from patients and other revenues and recoveries.

Table 14.16: Source of funding for specialised mental health services ($'000)[(a)], states and territories, 2006–07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total[(b)]
State/territory funds[(c)]	929,110	680,272	496,220	341,246	238,730	71,367	52,047	29,934	2,838,927
Australian Government funds									
National Mental Health Strategy[(d)]	24,194	17,247	14,013	7,252	5,821	1,748	1,513	1,564	73,352
Department of Veterans' Affairs[(e)]	7,492	7,906	2,780	2,710	2,988	442	144	15	24,476
Other Australian Government funds[(f)]	131	19,940	8,348	670	2,230	3,586	344	555	35,804
Total Australian Government funds[(b)]	*31,817*	*45,093*	*25,140*	*10,632*	*11,039*	*5,776*	*2,002*	*2,134*	*133,632*
Other revenue[(g)]	18,909	29,163	9,728	3,312	3,282	2,757	682	27	67,859
Total funds[(b)]	**979,835**	**754,529**	**531,088**	**355,190**	**253,051**	**79,900**	**54,730**	**32,095**	**3,040,419**

(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 Commonwealth Government used to resource recurrent expenditure on services within the scope of the MHE NMDS.

(g) Other revenue includes *Other revenue, Patient revenue* and *Recoveries*.

Source: National Mental Health Establishments Database (State/territory funds, other Australian Government funds and other revenue) and unpublished Department of Health and Ageing 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 14.16); Australian government expenditure on mental health-related services (Table 14.15) and contributions to specialised mental health services (Table 14.16); and DoHA estimates of the private health insurance fund component.

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 Department of Veterans' Affairs 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 2006–07, DoHA estimates that private health insurance fund expenditure was $177 million (Table 14.17).

Combining the funding from the three sources, the national recurrent expenditure on all mental health-related services in 2006–07 was estimated to be $4,707 million (Table 14.17). Of this total, 62% ($2,907 million) came from state and territory governments, 34% ($1,623 million) from the Australian Government and 4% ($177 million) from private health insurance funds.

During the period 1997–98 to 2006–07, total expenditure on mental health-related services by state and territory governments increased by an annual average of 5.3% (in constant prices) to $2.9 billion. Funding by the Australian Government increased by an annual average rate of 5.3% during the same period to $1.62 billion.

Table 14.17: Expenditure ($ million) on mental health-related services[(a)], by source of funding, 1997–98 to 2006–07

Source of funding[(b)]	1997–98	2002–03	2004–05	2005–06	2006–07	Average annual change (per cent)
			Current prices			
State and territory governments[(c)]	1,354	1,954	2,361	2,618	2,907	8.9
Australian Government[(d)]	754	1,245	1,397	1,505	1,623	8.9
Private health insurance funds[(e)]	120	148	165	178	177	4.4
Total	**2,228**	**3,347**	**3,923**	**4,301**	**4,707**	**8.7**
			Constant prices[(f)]			
State and territory governments	1,825	2,275	2,558	2,720	2,907	5.3
Australian Government	1,016	1,450	1,513	1,563	1,623	5.3
Private health insurance fund[(e)]	162	172	179	185	177	1.0
Total	**3,003**	**3,897**	**4,250**	**4,468**	**4,707**	**5.1**

(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* and *Other revenue* from Table 14.16.

(d) Includes *Total expenditure* from Table 14.15 and *Other Australian Government funds* from Table 14.16.

(e) DoHA notes that estimates are derived and subject to some degree of error. Direct measures are not possible from source data.

(f) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

Source: Tables 14.15, 14.16 and unpublished Department of Health and Ageing (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 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 data (DoHA) (chapters 2, 6 and 11).
vi	National Residential Mental Health Care Database (Chapter 8).
vii	Supported Accommodation Assistance Program Client Collection (Chapter 9).
viii	Commonwealth State/Territory Disability Agreement National Minimum Data Set (Chapter 10).
ix	Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (DoHA) (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).

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, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	3,158,925	3,061,082	3,576,947	3,431,919	3,461,510	3,828,548
95% lower confidence limit	2,920,602	2,851,222	3,252,254	3,184,730	3,199,179	3,474,766
95% upper confidence limit	3,397,256	3,270,956	3,901,674	3,679,130	3,723,878	4,182,360
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	*53,549	*58,920	77,699	n.a.
Community mental health care service contacts[(iii)]	1,301,233	1,431,729	1,363,770	1,832,177	1,828,468	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	32,579	32,026	32,950	34,030	38,119	n.a.
With specialised psychiatric care	26,473	26,752	28,093	29,151	28,852	n.a.
Public hospitals	8,893	8,310	7,155	7,060	4,835	n.a.
Private hospitals	17,580	18,442	20,938	22,091	24,017	n.a.
Without specialised psychiatric care	6,106	5,274	4,857	4,879	9,267	n.a.
Public hospitals	3,782	3,830	4,617	4,604	7,081	n.a.
Private hospitals	2,324	1,444	240	275	2,186	n.a.
Medicare-subsidised psychiatrist services[(v)]	666,357	637,441	627,107	615,006	608,203	598,644
Mental health-related hospital separations[(iv)]	60,703	62,864	63,664	67,773	69,251	n.a.
With specialised psychiatric care	34,948	36,070	36,517	38,413	39,259	n.a.
Public hospitals	27,815	29,103	28,462	29,983	31,787	n.a.
Private hospitals	7,133	6,967	8,055	8,430	7,472	n.a.
Without specialised psychiatric care	25,755	26,794	27,147	29,360	29,992	n.a.
Public hospitals	23,165	24,305	25,995	28,097	27,876	n.a.
Private hospitals	2,590	2,489	1,152	1,263	2,116	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	388	436	393	n.a.
SAAP mental health-related closed support periods[(vii)]	3,001	3,276	3,569	4,757	5,951	n.a.
Accommodated	2,443	2,521	2,646	3,514	3,937	n.a.
Supported	558	755	923	1,243	2,014	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	6,217	6,495	6,834	10,065	n.a.
Residential care	n.a.	1,072	1,142	1,218	1,304	n.a.
Non-residential care	n.a.	5,993	6,175	6,432	9,726	n.a.

(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 (DoHA 2008b).

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 168 for data sources.

Table 15.2: Mental health-related prescriptions, New South Wales, 2003–04 to 2007–08(ix)

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*608,856	*606,486	*584,588	581,299	568,586
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*5,666,339	*5,801,364	*5,682,918	*5,659,482	5,581,229

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.3: Mental health facilities, New South Wales, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals(a)(x)					
Number of hospitals	9	10	10	8	8
Average available beds	1,166	1,237	1,161	*1,064	1,060
Public acute hospitals with a specialised psychiatric unit or ward(a)(x)					
Number of hospitals	42	44	42	46	46
Average available beds	810	911	895	*1,159	1,227
Private psychiatric hospitals(b)(xi)					
Number of hospitals	9	9	9	9	9
Average available beds	531	*508	494	512	537
Government-operated residential mental health services(x)					
Number of services(c)	6	7	5	19	20
Average available beds	138	137	138	296	291

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

* Indicates where previously published data have been revised.

(x-xi) See page 168 for data sources.

Table 15.4: Workforce: psychiatrists and psychiatrists-in-training, New South Wales, 2001–2006(xii)

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	922	1,094	1,063	1,129	1,144	1,140

(xii) See page 168 for data source.

Table 15.5: Recurrent expenditure ($'000)[(a)] for specialised mental health services, New South Wales, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	187,100	201,663	192,466	198,961	188,815	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	208,079	229,060	248,305	280,150	309,655	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	307,452	315,125	308,690	323,882	333,722	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	32,258	30,045	25,663	25,542	27,861	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	68,537	64,839	60,941	60,387	64,042	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	77,387	77,538	83,383	84,306	88,576	92,389
Medicare expenditure on services provided by general practitioners[(v)]	227	861	1,173	1,847	28,115	54,258
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	506	1,052	19,168	61,011
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	38,004	39,718	41,254	42,411	42,650
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	149,204	155,936	157,380	166,158	178,551

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.2 Victoria

Table 15.6: Mental health services, Victoria, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	2,825,914	2,665,939	2,823,060	3,242,467	2,756,515	3,304,636
95% lower confidence limit	2,477,470	2,426,857	2,543,588	2,813,312	2,511,151	3,014,808
95% upper confidence limit	3,174,347	2,905,008	3,102,549	3,671,599	3,001,882	3,594,468
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	28,757	31,329	33,743	n.a.
Community mental health care service contacts[(iii)]	1,610,674	1,599,800	1,778,559	1,833,205	1,830,278	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	38,985	41,250	43,165	42,855	38,468	n.a.
With specialised psychiatric care	31,483	32,568	33,525	33,437	30,363	n.a.
Public hospitals	1,099	624	729	237	253	n.a.
Private hospitals	30,384	31,944	32,796	33,200	30,110	n.a.
Without specialised psychiatric care	7,502	8,682	9,640	9,418	8,105	n.a.
Public hospitals	5,129	5,758	5,593	5,721	5,202	n.a.
Private hospitals	2,373	2,924	4,047	3,697	2,903	n.a.
Medicare-subsidised psychiatrist services[(v)]	667,309	658,143	650,089	663,942	656,061	634,508
Mental health-related hospital separations[(iv)]	47,913	48,558	49,227	50,980	52,925	n.a.
With specialised psychiatric care	24,341	25,097	24,858	25,696	27,456	n.a.
Public hospitals	17,712	18,192	17,356	17,230	17,863	n.a.
Private hospitals	6,629	6,905	7,502	8,466	9,593	n.a.
Without specialised psychiatric care	23,572	23,461	24,369	25,284	25,469	n.a.
Public hospitals	20,045	20,486	21,968	22,801	22,962	n.a.
Private hospitals	3,527	2,975	2,401	2,483	2,507	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	728	791	1,003	n.a.
SAAP mental health-related closed support periods[(vii)]	4,019	5,071	4,579	8,877	11,066	n.a.
Accommodated	1,689	1,872	2,188	3,125	3,058	n.a.
Supported	2,330	3,199	2,391	5,752	8,008	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	16,556	18,798	20,784	22,862	n.a.
Residential care	n.a.	983	948	963	1,018	n.a.
Non-residential care	n.a.	8,396	18,631	20,619	22,671	n.a.

(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 (DoHA 2008b).

n.a. Not available.

(i–viii) See page 168 for data sources.

Table 15.7: Mental health-related prescriptions, Victoria, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*563,705	*581,750	*571,162	*562,219	548,676
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*4,739,793	*4,915,168	*4,874,233	*4,815,883	4,772,860

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.8: Mental health facilities, Victoria, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	1	1	1	2	2
Average available beds	95	115	115	116	134
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	37	31	31	34	34
Average available beds	870	916	899	1,045	1,055
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	6	6	6	6	6
Average available beds	358	378	423	437	432
Government-operated residential mental health services[(c)(x)]					
Number of services[(d)]	31	31	30	47	48
Average available beds	893	891	907	962	1,002

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) Data from 2002–03 to 2004–05 was sourced from the National Residential Mental Health Care Database (NRHD). 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) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(x–xi) See page 168 for data sources.

Table 15.9: Workforce: psychiatrists and psychiatrists-in-training, Victoria, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	991	1,047	1,049	1,076	1,028	1,096

(xii) See page 168 for data source.

Table 15.10: Recurrent expenditure ($'000)[a] for specialised mental health services, Victoria, 2002–03 to 2007–08, constant prices[b]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	37,239	37,614	39,566	31,335	32,916	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	182,084	186,344	208,493	201,189	206,209	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	243,304	250,638	271,537	281,591	285,024	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	107,235	107,738	110,768	126,259	122,026	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	50,798	52,709	53,083	54,418	50,534	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	78,196	79,847	84,863	88,696	92,826	95,558
Medicare expenditure on services provided by general practitioners[(v)]	215	709	1,042	1,481	23,341	44,722
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	392	708	19,822	58,484
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	33,913	37,072	39,386	39,476	39,141
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	132,489	139,188	141,960	148,289	156,511

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.3 Queensland

Table 15.11: Mental health services, Queensland, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	1,641,61*	1,950,654	2,002,270	2,148,140	2,093,580	2,282,713
95% lower confidence limit	1,499,72*	1,695,439	1,807,137	1,870,799	1,896,617	2,081,241
95% upper confidence limit	1,783,50*	2,205,860	2,197,415	2,425,495	2,290,551	2,484,169
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	21,393	24,306	28,608	n.a.
Community mental health care service contacts[(iii)]	779,527	889,011	901,706	892,393	1,050,960	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	23,386	23,813	24,810	25,365	27,275	n.a.
With specialised psychiatric care	19,256	19,233	19,743	19,954	21,621	n.a.
Public hospitals	3,405	3,930	3,924	1,324	947	n.a.
Private hospitals	15,851	15,303	15,819	18,630	20,674	n.a.
Without specialised psychiatric care	4,130	4,580	5,067	5,411	5,654	n.a.
Public hospitals	1,173	1,345	1,499	2,179	2,309	n.a.
Private hospitals	2,957	3,235	3,568	3,232	3,345	n.a.
Medicare-subsidised psychiatrist services[(v)]	344,217	344,548	352,380	365,911	357,166	353,476
Mental health-related hospital separations[(iv)]	36,310	37,503	38,405	38,462	38,084	n.a.
With specialised psychiatric care	25,597	26,922	27,322	26,445	26,010	n.a.
Public hospitals	19,618	20,384	20,851	19,877	19,504	n.a.
Private hospitals	5,979	6,538	6,471	6,568	6,506	n.a.
Without specialised psychiatric care	10,713	10,581	11,083	12,017	12,074	n.a.
Public hospitals	8,024	8,083	8,422	9,221	9,396	n.a.
Private hospitals	2,689	2,498	2,661	2,796	2,678	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	. .	. .	. .	n.a.
SAAP mental health-related closed support periods[(vii)]	1,251	1,238	1,680	2,263	2,557	n.a.
Accommodated	991	910	1,326	1,838	1,736	n.a.
Supported	260	328	354	425	821	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	4,752	5,204	5,631	7,629	n.a.
Residential care	n.a.	203	166	183	191	n.a.
Non-residential care	n.a.	4,711	5,157	5,570	7,574	n.a.

(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 (DoHA 2008b).

n.a. Not available.

. . Not applicable.

(i–viii) See page 168 for data sources.

Table 15.12: Mental health-related prescriptions, Queensland, 2003–04 to 2007–08[ix]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*358,631	*379,985	*386,303	*395,146	390,404
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*3,791,428	*3,999,112	*3,859,471	*3,827,712	3,782,274

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.13: Mental health facilities, Queensland, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	4	4	4	3	3
Average available beds	503	476	476	375	375
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	18	18	18	27	27
Average available beds	887	904	908	1,014	1,022
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	4	4	4	4	4
Average available beds	290	288	289	278	279
Government-operated residential mental health services[(x)]					
Number of services[(c)]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

. . Not applicable.

(x–xi) See page 168 for data sources.

Table 15.14: Workforce: psychiatrists and psychiatrists-in-training, Queensland, 2001–2006[xii]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	437	434	463	474	541	548

(xii) See page 168 for data source.

Table 15.15: Recurrent expenditure ($'000)[(a)] for specialised mental health services, Queensland, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	68,418	68,191	67,351	68,315	70,375	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	146,471	154,816	161,187	184,269	190,034	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	132,624	139,047	149,602	166,904	208,876	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	7,404	7,577	7,672	. .	. .	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	33,775	34,083	32,981	33,269	31,789	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	36,880	38,007	41,353	43,816	45,461	47,609
Medicare expenditure on services provided by general practitioners[(v)]	110	370	612	936	13,798	27,930
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	202	480	9,412	28,997
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	20,248	22,502	24,100	25,523	25,763
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	96,989	102,918	100,354	104,130	110,359

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.4 Western Australia

Table 15.16: Mental health services, Western Australia, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	747,376	964,322	905,815	843,099	977,016	916,954
95% lower confidence limit	671,206	830,455	771,124	723,024	859,898	800,770
95% upper confidence limit	823,540	1,098,185	1,040,505	963,177	1,094,130	1,033,136
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	10,114	11,279	13,518	n.a.
Community mental health care service contacts[(iii)]	414,183	418,484	466,670	492,468	535,809	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	7,791	7,437	8,972	8,644	9,162	n.a.
With specialised psychiatric care	6,749	5,659	7,230	6,921	7,322	n.a.
Public hospitals	194	121	100	70	105	n.a.
Private hospitals	6,555	5,538	7,130	6,851	7,217	n.a.
Without specialised psychiatric care	1,042	1,778	1,742	1,723	1,840	n.a.
Public hospitals	892	862	959	1,177	1,329	n.a.
Private hospitals	150	916	783	546	511	n.a.
Medicare-subsidised psychiatrist services[(v)]	111,539	121,961	121,072	119,611	119,454	124,605
Mental health-related hospital separations[(iv)]	19,125	20,107	20,540	19,603	20,795	n.a.
With specialised psychiatric care	11,547	11,901	11,731	11,599	11,996	n.a.
Public hospitals	8,561	8,525	8,404	8,120	8,564	n.a.
Private hospitals	2,986	3,376	3,327	3,479	3,432	n.a.
Without specialised psychiatric care	7,578	8,206	8,809	8,004	8,799	n.a.
Public hospitals	6,621	6,299	6,349	6,631	7,669	n.a.
Private hospitals	957	1,907	2,460	1,373	1,130	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	203	177	181	n.a.
SAAP mental health-related closed support periods[(vii)]	809	590	601	815	836	n.a.
Accommodated	660	468	424	597	542	n.a.
Supported	149	122	177	218	294	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	1,936	1,711	1,704	2,637	n.a.
Residential care	n.a.	186	208	20	195	n.a.
Non-residential care	n.a.	1,915	1,675	1,698	2,584	n.a.

(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 (DoHA 2008b).

n.a. Not available.

(i–viii) See page 168 for data sources.

Table 15.17: Mental health-related prescriptions, Western Australia, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*171,006	*175,037	*165,183	*170,455	166,274
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*1,853,087	*1,899,577	*1,838,650	*1,815,864	1,751,047

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.18: Mental health facilities, Western Australia, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	1	1	1	1	1
Average available beds	201	203	205	245	254
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	16	16	16	11	11
Average available beds	391	393	414	403	415
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	3	n.a.	n.a.	n.a.	n.a.
Average available beds	155	n.a.	n.a.	n.a.	n.a.
Government-operated residential mental health services[(x)]					
Number of services[(c)]	3	2	2	2	3
Average available beds	22	21	21	18	23

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xi) See page 168 for data sources.

Table 15.19: Workforce: psychiatrists and psychiatrists-in-training, Western Australia, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	274	233	271	247	223	260

(xii) See page 168 for data source.

Table 15.20: Recurrent expenditure ($'000)[(a)] for specialised mental health services, Western Australia, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	57,765	61,966	64,834	65,399	66,936	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	82,279	88,007	95,587	95,497	98,566	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	109,243	116,839	129,149	148,576	154,482	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	4,474	4,257	4,567	5,132	6,485	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	16,079	n.a.	n.a.	n.a	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	11,653	13,226	14,295	14,540	15,467	17,088
Medicare expenditure on services provided by general practitioners[(v)]	63	153	243	363	6,757	13,795
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	46	88	5,832	18,982
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	8,539	9,228	9,327	9,482	9,634
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	48,800	50,598	49,045	51,184	52,739

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.5 South Australia

Table 15.21: Mental health services, South Australia, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	933,310	1,003,211	899,267	871,919	983,515	1,054,911
95% lower confidence limit	743,684	873,798	718,860	737,541	847,235	919,421
95% upper confidence limit	1,122,933	1,132,616	1,079,670	1,006,303	1,119,794	1,190,400
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	15,426	12,996	14,164	n.a.
Community mental health care service contacts[(iii)]	314,085	311,535	298,459	302,400	382,304	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	2,409	1,749	1,389	1,232	1,357	n.a.
With specialised psychiatric care	1,443	689	294	216	219	n.a.
Public hospitals	242	268	263	197	209	n.a.
Private hospitals	1,201	421	31	19	10	n.a.
Without specialised psychiatric care	966	1,060	1,095	1,016	1,138	n.a.
Public hospitals	942	1,048	1,085	1,003	1,126	n.a.
Private hospitals	24	12	10	13	12	n.a.
Medicare-subsidised psychiatrist services[(v)]	202,988	192,073	182,959	180,380	177,437	172,573
Mental health-related hospital separations[(iv)]	19,388	19,716	18,332	18,041	19,108	n.a.
With specialised psychiatric care	10,617	10,945	10,180	10,318	11,137	n.a.
Public hospitals	8,393	8,985	8,481	8,565	9,248	n.a.
Private hospitals	2,224	1,960	1,699	1,753	1,889	n.a.
Without specialised psychiatric care	8,771	8,771	8,152	7,723	7,971	n.a.
Public hospitals	7,958	7,949	7,438	7,063	7,352	n.a.
Private hospitals	813	822	714	660	619	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	91	140	121	n.a.
SAAP mental health-related closed support periods[(vii)]	649	830	934	1,740	1,597	n.a.
Accommodated	413	445	449	652	529	n.a.
Supported	236	385	485	1,088	1,068	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	2,095	2,143	2,004	2,920	n.a.
Residential care	n.a.	271	317	335	410	n.a.
Non-residential care	n.a.	2,000	2,027	1,927	2,814	n.a.

(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 (DoHA 2008b).

n.a. Not available.

(i–viii) See page 168 for data sources.

Table 15.22: Mental health-related prescriptions, South Australia, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*186,149	*179,988	*175,447	*172,065	172,439
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*1,699,566	*1,733,715	*1,712,592	*1,674,796	1,666,430

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.23: Mental health facilities, South Australia, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	1	1	1	1	2
Average available beds	478	461	461	455	388
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	8	8	8	8	8
Average available beds	172	172	172	188	247
Private psychiatric hospitals[(b)(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.
Government-operated residential mental health services[(x)]					
Number of services[(c)]	1	2	1	3	4
Average available beds	20	27	20	33	53

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xi) See page 168 for data sources.

Table 15.24: Workforce: psychiatrists and psychiatrists-in-training, South Australia, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	318	302	319	335	313	285

(xii) See page 168 for data source.

Table 15.25: Recurrent expenditure ($'000)[a] for specialised mental health services, South Australia, 2002–03 to 2007–08, constant prices[b]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[c][x]	80,688	83,301	87,436	84,377	80,028	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[c][x]	32,599	33,279	34,462	37,987	55,009	n.a.
Total recurrent expenditure for community mental health care services[c][x]	68,776	69,928	77,690	82,840	88,466	n.a.
Total recurrent expenditure for residential mental health services[c][d][x]	686	1,224	2,329	2,941	2,985	n.a.
Total recurrent expenditure for private psychiatric hospitals[e][xi]	60,746	62,425	70,217	n.a.	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[v]	24,142	23,763	23,447	23,860	24,947	25,879
Medicare expenditure on services provided by general practitioners[v]	58	271	467	523	5,022	10,703
Medicare expenditure on services provided by psychologists[v]	. .	. .	55	88	2,674	10,223
PBS and RPBS expenditure on prescriptions by psychiatrists[ix]	n.a.	10,776	11,027	11,637	12,012	12,325
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[ix]	n.a.	43,318	44,757	45,225	46,716	50,052

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.6 Tasmania

Table 15.26: Mental health services, Tasmania, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	253,520	332,791	307,156	243,229	281,930	294,422
95% lower confidence limit	213,041	248,072	237,845	194,003	234,692	236,647
95% upper confidence limit	294,000	417,509	376,467	292,457	329,166	352,197
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	4,539	4,517	4,704	n.a.
Community mental health care service contacts[(iii)]	51,314	67,581	64,317	65,576	93,186	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	75	65	56	46	78	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	176	233	285	370	375	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare-subsidised psychiatrist services[(v)]	46,653	48,115	46,190	44,316	42,965	42,071
Mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	3,104	2,979	3,192	3,175	3,376	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	1,315	1,351	1,303	1,364	1,138	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	721	741	743	n.a.
SAAP mental health-related closed support periods[(vii)]	279	317	321	611	679	n.a.
Accommodated	165	160	158	317	370	n.a.
Supported	114	157	163	294	309	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	764	839	846	989	n.a.
Residential care	n.a.	183	193	184	178	n.a.
Non-residential care	n.a.	707	775	797	937	n.a.

(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 (DoHA 2008b).

n.a. Not available.

(i–viii) See page 168 for data sources.

Table 15.27: Mental health-related prescriptions, Tasmania, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*47,408	*43,427	*42,293	*40,420	40,592
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*610,570	*624,668	*634,947	*614,409	610,375

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.28: Mental health facilities, Tasmania, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	3	3	3	. .	. .
Average available beds	80	69	69	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	3	3	3	6	5
Average available beds	74	86	86	125	126
Private psychiatric hospitals[(b)(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.
Government-operated residential mental health services[(x)]					
Number of services[(c)]	9	9	7	5	5
Average available beds	140	140	112	91	91

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

. . Not applicable.

(x–xi) See page 168 for data sources.

Table 15.29: Workforce: psychiatrists and psychiatrists-in-training, Tasmania, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	57	63	71	68	63	60

(xii) See page 168 for data source.

Table 15.30: Recurrent expenditure ($'000)[a] for specialised mental health services, Tasmania, 2002–03 to 2007–08, constant prices[b]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	21,253	21,079	21,021	22,177	28,489	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	16,696	17,545	20,196	25,040	25,969	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	12,548	11,469	11,838	15,885	17,913	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	4,745	5,026	4,922	4,775	4,892	4,921
Medicare expenditure on services provided by general practitioners[(v)]	21	55	121	162	1,631	3,131
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	11	25	1,444	4,384
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	2,168	2,215	2,566	2,533	2,825
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	13,480	13,952	14,092	14,429	15,564

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.7 Australian Capital Territory

Table 15.31: Mental health services, Australian Capital Territory, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	143,804	87,966	120,213	103,178	118,128	107,769
95% lower confidence limit	104,792	63,242	79,767	64,199	82,991	70,378
95% upper confidence limit	182,815	112,690	160,660	142,156	153,266	145,162
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	2,248	2,737	2,635	n.a.
Community mental health care service contacts[(iii)]	178,751	167,541	198,666	210,833	207,487	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	30	4	32	33	35	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	40	102	113	183	185	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare-subsidised psychiatrist services[(v)]	21,305	21,454	22,534	22,301	20,877	19,907
Mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	1,314	1,136	1,139	1,178	1,183	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	222	341	307	335	365	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	63	60	81	n.a.
SAAP mental health-related closed support periods[(vii)]	531	523	408	582	438	n.a.
Accommodated	490	481	349	426	294	n.a.
Supported	41	42	59	156	144	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	348	369	320	543	n.a.
Residential care	n.a.	34	19	34	83	n.a.
Non-residential care	n.a.	340	365	317	535	n.a.

(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 (DoHA 2008b).

n.a. Not available.

(i–viii) See page 168 for data sources.

Table 15.32: Mental health-related prescriptions, Australian Capital Territory, 2003–04 to 2007–08[ix]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*27,824	*27,336	*27,065	*25,501	26,011
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*248,628	*250,696	*223,548	*209,537	205,664

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.33: Mental health facilities, Australian Capital Territory, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[a][x]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[a][x]					
Number of hospitals	2	2	2	2	2
Average available beds	45	45	44	50	70
Private psychiatric hospitals[b][xi]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Government-operated residential mental health services[x]					
Number of services[c]	1	1	1	1	1
Average available beds	30	28	28	30	30

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

. . Not applicable.

(x–xi) See page 168 for data sources.

Table 15.34: Workforce: psychiatrists and psychiatrists-in-training, Australian Capital Territory, 2001–2006[xii]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	45	56	50	44	63	41

(xii) See page 168 for data source.

Table 15.35: Recurrent expenditure ($'000)[(a)] for specialised mental health services, Australian Capital Territory, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	9,347	10,111	8,875	9,364	13,345	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	19,907	21,444	25,656	24,939	27,418	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	5,899	6,899	6,516	6,205	6,906	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	. .	. .	. .	. .	. .	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	2,375	2,474	2,900	2,989	2,914	2,948
Medicare expenditure on services provided by general practitioners[(v)]	27	11	14	23	1,024	2,076
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	9	25	817	3,111
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	1,700	1,786	2,052	2,078	2,141
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	6,885	6,741	6,121	6,142	6,672

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.8 Northern Territory

Table 15.36: Mental health services, Northern Territory, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	60,364	38,128	39,302	55,625	44,957	48,338
95% lower confidence limit	36,689	17,097	26,406	25,235	24,320	35,100
95% upper confidence limit	84,039	59,158	52,198	86,015	65,594	61,577
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	2,703	3,482	3,524	n.a.
Community mental health care service contacts[(iii)]	22,656	26,054	36,377	36,356	37,785	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	28	27	25	27	22	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	88	71	97	142	188	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Medicare-subsidised psychiatrist services[(v)]	4,722	4,722	4,887	4,474	4,370	3,918
Mental health-related hospital separations[(iv)]	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
With specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	826	926	1,174	1,146	984	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Without specialised psychiatric care	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Public hospitals	312	321	329	453	455	n.a.
Private hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Episodes of residential mental health care[(vi)]	. .	. .	. .	. .	9	n.a.
SAAP mental health-related closed support periods[(vii)]	215	179	135	747	554	n.a.
Accommodated	166	146	94	600	442	n.a.
Supported	49	33	41	147	112	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	145	129	103	157	n.a.
Residential care	n.a.	26	21	22	18	n.a.
Non-residential care	n.a.	133	116	87	147	n.a.

(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 (DoHA 2008b).

n.a. Not available.

. . Not applicable.

* Indicates where previously published data have been revised.

(i–viii) See page 168 for data sources.

Table 15.37: Mental health-related prescriptions, Northern Territory, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*4,980	*4,841	*4,181	*4,079	4,492
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*62,767	*67,869	*67,159	*63,838	61,915

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.38: Mental health facilities, Northern Territory, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	2	2	2	2	2
Average available beds	32	31	32	32	34
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .
Government-operated residential mental health services[(x)]					
Number of services[(c)]	. .	. .	. .	. .	. .
Average available beds	. .	. .	. .	. .	. .

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

. . Not applicable.

(x–xi) See page 168 for data sources.

Table 15.39: Workforce: psychiatrists and psychiatrists-in-training, Northern Territory, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	20	29	36	20	25	n.p.

(xii) See page 168 for data source.

n.p. Not published.

Table 15.40: Recurrent expenditure ($'000)[(a)] for specialised mental health services, Northern Territory, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	. .	. .	. .	. .	. .	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	9,415	10,376	10,500	10,776	10,297	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	9,454	11,100	13,045	13,000	15,240	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	297	240	247	280	349	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	. .	. .	. .	. .	. .	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	443	473	494	405	455	454
Medicare expenditure on services provided by general practitioners[(v)]	4	21	19	21	321	627
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	1	1	141	494
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	276	267	264	288	330
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	1,741	1,917	2,034	2,157	2,343

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 for data sources.

15.9 Australia

Table 15.41: Mental health services, Australia, 2002–03 to 2007–08

Mental health services	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Estimated number of mental health-related general practice encounters[(a)(i)]	9,467,000	9,974,000	10,591,000	10,624,000	10,713,000	11,862,000
95% lower confidence limit	9,024,000	9,516,000	10,067,000	10,074,000	10,261,000	11,280,000
95% upper confidence limit	9,909,000	10,433,000	11,117,000	11,174,000	11,165,000	12,375,000
Mental health-related occasions of service in emergency departments in public hospitals[(ii)]	n.a.	n.a.	*138,729	*149,566	178,595	n.a.
Community mental health care service contacts[(iii)]	4,672,423	4,911,735	5,108,524	5,665,408	5,966,277	n.a.
Ambulatory-equivalent mental health-related hospital separations[(iv)]	108,946	111,581	116,787	117,924	120,602	n.a.
With specialised psychiatric care	87,219	86,765	92,369	93,202	92,304	n.a.
Public hospitals	13,966	13,349	12,285	8,994	6,484	n.a.
Private hospitals	73,253	73,416	80,084	84,208	85,820	n.a.
Without specialised psychiatric care	21,727	24,816	24,418	24,722	28,298	n.a.
Public hospitals	12,222	13,249	14,248	15,379	17,795	n.a.
Private hospitals	9,505	11,567	10,170	9,343	10,503	n.a.
Medicare-subsidised psychiatrist services[(v)]	2,065,075	2,028,458	2,007,218	2,015,941	1,986,533	1,949,702
Mental health-related hospital separations[(iv)]	192,169	197,712	199,353	204,186	209,356	n.a.
With specialised psychiatric care	113,045	116,725	116,852	118,733	122,132	n.a.
Public hospitals	87,343	90,230	89,059	89,274	92,509	n.a.
Private hospitals	25,702	26,495	27,793	29,459	29,623	n.a.
Without specialised psychiatric care	79,124	80,987	82,501	85,453	87,224	n.a.
Public hospitals	67,662	69,135	72,111	75,965	77,213	n.a.
Private hospitals	11,462	11,852	10,390	9,488	10,011	n.a.
Episodes of residential mental health care[(vi)]	n.a.	n.a.	2,194	2,345	2,531	n.a.
SAAP mental health-related closed support periods[(vii)]	10,754	12,024	12,227	20,392	23,678	n.a.
Accommodated	7,017	7,003	7,634	11,069	10,908	n.a.
Supported	3,737	5,021	4,593	9,323	12,770	n.a.
CSTDA-funded service users with a psychiatric disability[(viii)]	n.a.	24,753	35,599	38,086	47,658	n.a.
Residential care	n.a.	2,958	3,014	2,959	3,397	n.a.
Non-residential care	n.a.	24,108	34,833	37,309	46,848	n.a.

(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 (DoHA 2008b).

n.a. Not available.

* Indicates where previously published data have been revised.

(i–viii) See page 168 for data sources.

Table 15.42: Mental health-related prescriptions, Australia, 2003–04 to 2007–08[(ix)]

Mental health-related prescriptions	2003–04	2004–05	2005–06	2006–07	2007–08
PBS and RPBS-subsidised prescriptions by psychiatrists	*1,968,587	*1,998,898	*1,956,249	*1,951,215	1,917,525
PBS and RPBS-subsidised mental health-related prescriptions by non-psychiatrists	*18,672,535	*19,292,528	*18,893,831	*18,681,864	18,432,124

* Indicates where previously published data have been revised.

(ix) See page 168 for data source.

Table 15.43: Mental health facilities, Australia, 2002–03 to 2006–07

Mental health facilities	2002–03	2003–04	2004–05	2005–06	2006–07
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	19	20	20	15	16
Average available beds	2,523	2,560	2,487	*2,255	2,211
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	128	124	122	136	136
Average available beds	3,281	3,458	3,450	*4,016	4,196
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	25	25	26	26	25
Average available beds	1,463	1,441	1,512	1,573	1,554
Government-operated residential mental health services[(c)(x)]					
Number of services[(d)]	50	52	46	77	81
Average available beds	1,241	1,246	1,226	1,430	1,490

(a) 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. Data from 2002–03 to 2004–05 were sourced from the National Public Hospitals Establishments Database and therefore may differ from 2005–06 and 2006–07 data due to definitions and reporting requirements.

(b) 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.

(c) Data from 2002–03 to 2004–05 was sourced from the National Residential Mental Health Care Database (NRHD). 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) The count of government-operated residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

* Indicates where previously published data have been revised.

(x–xi) See page 168 for data sources.

Table 15.44: Workforce: psychiatrists and psychiatrists-in-training, Australia, 2001–2006[(xii)]

Workforce	2001	2002	2003	2004	2005	2006
Full-time-equivalent employed psychiatrists and psychiatrists-in-training	3,066	3,257	3,328	3,392	3,398	3,472

(xii) See page 168 for data source.

Table 15.45: Recurrent expenditure ($'000)[(a)] for specialised mental health services, Australia, 2002–03 to 2007–08, constant prices[(b)]

Mental health expenditure	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Total recurrent expenditure for public psychiatric hospitals[(c)(x)]	431,210	452,737	451,653	448,387	439,070	n.a.
Total recurrent expenditure for public acute hospitals with a specialised psychiatric unit or ward[(c)(x)]	691,526	733,073	788,430	841,407	911,604	n.a.
Total recurrent expenditure for community mental health care services[(c)(x)]	907,456	941,665	995,565	1,066,771	1,139,197	n.a.
Total recurrent expenditure for residential mental health services[(c)(d)(x)]	170,801	169,448	169,600	182,243	184,525	n.a.
Total recurrent expenditure for private psychiatric hospitals[(e)(xi)]	184,567	182,076	182,578	183,652	180,554	n.a.
Medicare expenditure on services provided by psychiatrists[(v)]	235,820	240,355	255,658	263,388	275,538	286,846
Medicare expenditure on services provided by general practitioners[(v)]	725	2,451	3,693	5,357	80,010	157,242
Medicare expenditure on services provided by psychologists[(v)]	. .	. .	1,221	2,468	59,311	185,685
PBS and RPBS expenditure on prescriptions by psychiatrists[(ix)]	n.a.	115,626	123,817	130,587	133,804	134,811
PBS and RPBS expenditure on mental health-related prescriptions by non-psychiatrists[(ix)]	n.a.	492,913	516,014	516,216	539,215	572,799

(a) Expenditure excludes depreciation.

(b) Constant prices are referenced to 2006–07 and are adjusted for inflation. See Appendix 2 for deflator description.

(c) Data from 2002–03 to 2004–05 were sourced from the National Mental Health Report (DoHA 2008c).

(d) Residential mental health services includes non-government-operated residential mental health facilities in receipt of funding from state and/or federal government, as reported in the National Mental Health Establishments Database.

(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.

n.a. Not available.

. . Not applicable.

(v–xi) See page 168 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 (NHMD) 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 and the Commonwealth State/Territory Disability Agreement (CSTDA) National Minimum Data Set collection.

Data from collections external to the AIHW were also used, including the Australian Bureau of Statistics 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 2007–08 BEACH survey can be obtained from *General practice activity in Australia 2007–08* (Britt et al. 2008).

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 2007). Services that are not included in the MBS are not included in the data.

The MBS items included in the 2002 *Better Outcomes in Mental Health Care,* the 2004 *Enhanced Primary Care* and 2006 *Better access to psychiatrists, psychologists and general practitioners through*

the Medicare Benefits Schedule initiatives, as well as existing psychiatrist items, are at Table A1.1.

Table A1.1: MBS items (2002 Better Outcomes in Mental Health Care, 2004 Enhanced Primary Care and 2006 Better Access)

Initiative	Item group	MBS Group & Subgroup	MBS item numbers
Better Outcomes in Mental Health Care (BOIMHC) 2002	3 Step Mental Health Process —GP[(a)]	Group A18 Subgroup 4	2574, 2575, 2577, 2578
	3 Step Mental Health Process —OMP[(a)]	Group A19 Subgroup 4	2704, 2705, 2707, 2708
	Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
	Case conferencing —psychiatrist		855, 857, 858, 861, 864, 866
Enhanced Primary Care, 2004	Enhanced Primary Care — mental health worker	Group M3	10956
	Enhanced Primary Care —psychologist	Group M3	10968
Better Access, 2006	GP Mental Health Care Plans	Group A20 Subgroup 1	2710, 2712, 2713
	Psychological Therapy Services —clinical psychologist	Group M6	80000, 80005, 80010, 80015, 80020
	Focussed Psychological Strategies (Allied Mental Health)	Group M7	
	—psychologist		80100, 80105, 80110, 80115, 80120
	—occupational therapist		80125, 80130, 80135, 80140, 80145
	—social worker		80150, 80155, 80160, 80165, 80170
	Initial consultation new patient —psychiatrist	Group A8	296, 297, 299
Psychiatrist items	Patient attendances—consulting room	Group A8	291, 293, 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[(b)]	Group A8	353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370
	Electroconvulsive therapy	Group T1 Subgroup 13	14224

(a) This item discontinued April 2008.

(b) This item group includes two new items 359 and 361 which were introduced from 1 November 2007 to allow psychiatrists to provide initial tele-consultations on new patients and review referred assessment and management plans created under item 291. There have been few uses of these items since their introduction and so they have not been separately identified in the data presented in this publication.

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 2008a). The data are collected by state and territory health authorities according to definitions in the Non-admitted Patient Emergency Department National Minimum Data Set (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 2006–07, 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 2006–07 was 6.7 million. Episode-level data were collected by state and territory health authorities departments for 78% of these occasions of service (a total of 5 million occasions of service) (AIHW 2008a). Episode-level data were available for approximately 100% of all emergency department occasions of service for public hospitals in peer groups A and B, and approximately 32% 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, 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 2006–07, all jurisdictions did collect some information on the principal diagnosis of an estimated 92% 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	2982, 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	—

(a) *International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian Modification.*

(b) *International Classification of Diseases, 9th revision, Clinical Modification.*

This definition does not capture all mental health-related presentation 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 2006–07 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 in relation to 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 for public hospitals in 2006–07, 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 92% 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 72% 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 would be about 248,500 rather than the reported 178,595 (Table A1.3).

In addition, it should be noted that coverage of the data are 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, states and territories, 2006–07

	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	98	99	100	100	100	100	100
Other hospitals[(c)]	49	36	. .	31	23	. .	. .	100	32
Total estimated per cent[(c)]	**81**	**89**	**64**	**72**	**69**	**96**	**100**	**100**	**78**
Estimated per cent of occasions of service reported at episode-level that have a principal diagnosis code[(d)]	95	90	100	70	91	100	100	94	92
Estimated per cent of total emergency department occasions of service with a principal diagnosis[(e)]	77	80	64	50	63	96	100	94	72
Number of emergency department occasions of service with a mental health-related principal diagnosis[(f)]	77,699	33,743	28,608	13,518	14,164	4,704	2,635	3,524	178,595
Estimated actual number of emergency department occasions of service with a mental health-related principal diagnosis[(g)]	100,973	42,126	44,700	26,821	22,558	4,900	2,635	3,749	248,463

(a) The proportion of all occasions of service in emergency departments in public hospitals in 2006–07 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 2006–07* (AIHW 2008a).

(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 per cent of all occasions of service in emergency departments in public hospitals in 2006–07 that are reported at episode-level to the NNAPEDCD by the per cent of emergency department occasions of service reported at episode-level to the NNAPEDCD that had a diagnosis (divided by 100).

(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 per cent.

. . Not applicable.

Source: Data provided by state and territory health authorities, AIHW 2008.

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 National Minimum Data Set (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 information 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 National Minimum Data Set (MHE NMDS) which was inaugurated in 2005–06. A list of the government-operated community mental health care services which contribute patient-level data to 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 2006–07*).

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(s) 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, 2006–07). 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 either be with the patient or with a third party, such as a carer or family member, and/or other professional or mental health workers or other service providers.

It should be noted that there are variations across jurisdictions on the scope and definition of a service contact. For example, New South Wales, Queensland, South Australia and Tasmania may include written correspondences 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. Across 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 the NCMHCD 2006–07 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 this data.
- Western Australia reported that the quality of Indigenous status data for 2006–07 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 the 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) Mental Health Manual, ICD-10-AM, *International Classification of Diseases, 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 Fifth Edition* 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.

Estimating the number of patients

Some states and territories were able to provide actual counts of patients (Northern Territory, Queensland, Victoria, Western Australia and the Australian Capital Territory). For the remaining states and territories the estimated number of patients in the NCMHCD has been calculated by counting the number of unique person identifier—establishment identifier combinations. Within each establishment or facility, a patient is allocated a unique identifier. However, this means that persons who used services in more than one establishment will be counted more than once; therefore the number of patients may be overestimated.

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, external causes of injury and poisoning and the Australian Refined Diagnosis Related Groups (AR-DRG) information are also recorded.

The 2006–07 collection contains data for hospital separations that occurred between 1 July 2006 and 30 June 2007. Data on separations which commenced before 1 July 2006 are included provided that the discharge dates fell within the collection period (2006–07). 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 2006–07* (AIHW 2008a).

Specialised mental health care is identified through the fact that a patient had 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 or psychiatric care days only. 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 jurisdiction may reflect different service delivery practices, differences in admission practices and/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 National Minimum Data Set (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 information of residents, such as age and sex, and clinical information, like 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 and subject to Commonwealth reporting requirements (that is, they report to the System for the

Payment of Aged Residential Care collection). Government-funded, non-government-operated services and non-24-hour staffed services could be included optionally. For the 2006–07 data collection, all the data providers have mental health trained staff on-site 24 hours a day except for one South Australian facility which was staffed for 13 hours a day and one Northern Territory facility which was staffed on average 9 hours a day. Data from six Tasmanian non-government organisations staffed 24 hours a day were also included in the 2006–07 collection. A list of the residential mental health services contributing data to 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 2006–07*).

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 2006–07 as a proportion of full coverage:

- Victoria, New South Wales, the Northern Territory, the Australian Capital Territory and Tasmania estimated their data coverage to be 100%.
- Data coverage for South Australia was estimated to be 75% based upon number of in-scope services.
- Western Australia did not report any undercounting of residential care from service units within scope.
- 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 Western Australia, Tasmania, the Northern Territory and the Australian Capital Territory considered their Indigenous status data of acceptable quality. New South Wales have not evaluated the quality of their Indigenous data. Likewise, 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 National Centre for Classification in Health (NCCH) Mental Health Manual, ICD-10-AM, *International Classification of Diseases, 10th revision, Primary Care* (ICD-10-PC), and local codes where there were no ICD-10-PC equivalents. For the Northern Territory, principal diagnosis codes were inherited from the referring mental health organisation clinical summary details. It was not possible to ascertain the classification used.

Chapter 9: Supported Accommodation Assistance Program National Data Collection

The Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC) is a nationally consistent information system that combines information from SAAP agencies, state and territory and Australian Government funding departments. The AIHW manages the collection.

The scope of the SAAP NDC includes all agencies that receive funding through the national SAAP agreement and/or state and territory SAAP funds. In 2006–07, 1,523 non-government, community and local government agencies were funded nationally under the program. Of the agencies required to participate in the collection, 87.2% 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 that 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 socio-demographic 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 in 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 2006–07, valid consent was obtained from clients in 81.1% 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 were a total of 164,896 closed support periods reported in the SAAP Client Collection for 2006–07. For the same period, the number of closed support periods using weighted data was estimated to be 178,082.

For further information on the SAAP collection, refer to the 2006–07 AIHW publication *Homeless people in SAAP: SAAP National Data Collection annual report* (AIHW 2008e).

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 National Minimum Data Set (NMDS). This NMDS, which is 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 while 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 2006–07 collection period was released in *Disability support services 2006–07* (AIHW 2008b). For the 2006–07 collection, there was an overall service type outlet response rate of 94%. 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 persons 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 Queensland, psychiatric-specific disability services that receive CSTDA funding through Disability Services Queensland are included in the CSTDA NMDS collection.
- 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.
- Tasmania, the Australian Capital Territory and the Northern Territory do not include any services classified as 'psychiatric disability services'. However, these jurisdictions do provide 'mental health services'. There appears to be no sharp distinction between what is classified as a 'psychiatric disability service' and a 'mental health service', with some mental health services providing support to people with psychiatric disability.

In addition, there was a change that occurred in the way Victoria reports psychiatric service users since the *Mental health services in Australia 2005–06* publication was prepared. Previously most service users accessing specialised psychiatric disability rehabilitation and support services in Victoria were not identified as having a psychiatric disability. For 2005–06 data, and retrospectively for 2003–04 and 2004–05, these previously unidentified users of Victorian psychiatric services were incorporated in the total numbers of

non-residential and residential mental health-related service user counts. This doubled the number of non-residential service users recorded for Victoria for 2005–06, however there was a relatively small impact on the number of residential service users. Comparisons of CSTDA data between *Mental health services in Australia* publications should therefore 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 between collection periods is not available. 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 vary considerably between jurisdictions. The service outlet response rates and the non-response rates for states and territories, for 2005–06 and 2006–07 are shown in Table A1.4.

Table A1.4: CSTDA response rates, by states and territories, 2005–06 to 2006–07 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus 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
					'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

Source: Disability support services 2006–07 (AIHW 2008b).

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 the persons 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 the majority of prescribed medicines dispensed in Australia, it has the following limitations:

- It refers 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. It excludes adjustments made against pharmacists' claims, any manually paid claims, or any benefits paid as a result of retrospective entitlement or refund of patient contributions.
- It excludes 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, which means that some medicines that were captured in previous years might be below the copayment level and thus excluded in following years.
- Programs funded by PBS which do not use the Medicare Australia PBS processing system, include:
  - most Section 100 drugs funded through public hospitals (though the pharmaceutical reform measures for public hospitals under the Australian Health Care Agreement 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.

  The only one of these that has a significant bearing on the mental health-related prescriptions data published in chapters 11 and 14 of this publication is 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 (DoHA 2008a).

The number of prescriptions issued through community pharmacies that are not covered by the PBS and RPBS is estimated through the Pharmacy Guild Survey, which is an ongoing survey of community pharmacies that provide records of all dispensed prescriptions for medicines listed on the PBS/RPBS (AIHW 2007b). These survey data are combined with PBS and RPBS data from Medicare Australia in the Drug Utilisation Sub-Committee (DUSC) database. Tabulation of the data from this database shows the number and proportion of prescriptions covered by the PBS and RPBS within each of the mental health-related Anatomical Therapeutic Chemical (ATC) groups (Table A1.5).

Table A1.5: Community-dispensed prescriptions[(a)] by patient category group for mental health-related ATC groups, 2007–08

	PBS	RPBS	*Subtotal (PBS + RPBS)*	Under co-payment	Private	Total
Number of scripts						
N05A	2,179,140	92,480	*2,271,620*	33,204	161,048	2,465,872
N05B	3,028,160	196,759	*3,224,919*	671,677	541,212	4,437,808
N05C	2,341,480	334,269	*2,675,749*	472,899	962,624	4,111,272
N06A	11,183,246	669,201	*11,852,447*	3,676,251	183,444	15,712,142
N06B	405,745	1,174	*406,919*	115,447	74,395	596,761
Total	**19,137,771**	**1,293,883**	***20,431,654***	**4,969,478**	**1,922,723**	**27,323,855**
Per cent of scripts						
N05A	88.4	3.8	*92.1*	1.3	6.5	100.0
N05B	68.2	4.4	*72.7*	15.1	12.2	100.0
N05C	57.0	8.1	*65.1*	11.5	23.4	100.0
N06A	71.2	4.3	*75.4*	23.4	1.2	100.0
N06B	68.0	0.2	*68.2*	19.3	12.5	100.0
Total	**70.0**	**4.7**	***74.8***	**18.2**	**7.0**	**100.0**
Per cent (excluding private)						
N05A	94.5	4.0	*98.6*	1.4	. .	100.0
N05B	77.7	5.0	*82.8*	17.2	. .	100.0
N05C	74.4	10.6	*85.0*	15.0	. .	100.0
N06A	72.0	4.3	*76.3*	23.7	. .	100.0
N06B	77.7	0.2	*77.9*	22.1	. .	100.0
Total	**75.3**	**5.1**	***80.4***	**19.6**	**. .**	**100.0**

(a) Prescriptions data using date of service basis. PBS Schedule ATC used except for some private prescriptions where the item does not exist in the PBS schedule and WHO ATC was used.

. . Not applicable.

Source: Drug Utilisation Sub-Committee database.

The ATC classification version used is the primary classification as it appears in the 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 antiemetics* (A04AD) in the PBS Schedule while it is an *Antipsychotic* according to the WHO classification. *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 (Table A1.6).

Table A1.6: Differences between the WHO ATC classification and the PBS Schedule Classification

Drug Name	WHO ATC Code	PBS Schedule Code	Scripts dispensed in 2007–08[(a)]
Prochlorperazine	N05AB04	A04AD	641,619
Lithium carbonate	N05AN01	N06AX	100,534

(a) Prescriptions data using date of service basis.

Source: Drug Utilisation Sub-Committee database.

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 one 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/territory is unknown, then the state or territory of the pharmacy supplying the item is reported.

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.

Chapter 12: National Mental Health Establishments Database

Collection for the National Mental Health Establishments Minimum Database (MHE NMDS) commenced on 1 July 2005, replacing the Community Mental Health Establishments National Minimum Data Set (CMHE NMDS) and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the CMHE 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 by state or territory health authorities. Specialised mental health services are those with a primary function to provide 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 mental health care days, number of separations, number of contacts and episodes of residential care. In addition, the service unit level also includes salary and non-salary expenditure and depreciation.

Chapters 12 and 14: Private Health Establishments Collection

The ABS conducts an annual 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.

Additional information on the Private Health Establishments Collection can be obtained from the annual ABS publication *Private hospitals, Australia* (ABS 2008b).

Chapter 13: AIHW Medical Labour Force Survey

The AIHW Medical Labour Force Survey is conducted by the state and territory departments of health with the cooperation of the medical 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 survey is a mail-out survey conducted in association with the annual registration renewal process. The Medical Labour Force Survey has been conducted annually since 1993.

In the survey, information on demographic details, main areas and specialty of work, qualifications and hours worked are collected from registered professionals. The data collected for medical practitioners generally relate to the 4 weeks before the survey. Average weekly hours worked refers to average total hours worked per week in the main, second and third medical job for medical practitioners.

Survey responses are weighted by state, age and sex to produce state and territory and national estimates of the total medical 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 across jurisdictions. In 2006, the estimated national response rate for the Medical Labour Force Survey was 70.2%, ranging from 28.6% for the Northern Territory to 79.7% for Queensland. Estimates for the Northern Territory should be treated with caution as they are derived from responses to the 2007 Medical Labour Force Survey weighted to 2006 registration figures, equivalent to a response rate of 28.6%. In addition, 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. In 2006, the scope is consistent, that is, the survey population and the benchmark figures are based on general and conditional registrants. This has resulted in a fall in response rates for Western Australia between 2005 and 2006.

It should also be noted that 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 change over time and differences across jurisdictions.

More detailed information about how these surveys were conducted is available from the *Medical labour force 2006* (AIHW 2008f).

Chapter 14: National Mental Health Report series

The *National Mental Health Report* is an irregular series produced by the Australian Government. It provides a summary of fourteen years of reform in Australia's mental health services under the *National Mental Health Strategy*, 1993–2007. The current report primarily draws on the *2007 National Mental Health Report* which covers progress under the Strategy to 2004–05.

The 2006–07 data in Table 14.15 include the introduction of the Medicare-subsidised *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* 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 prior to November 2006, was estimated as 6.1% of total MBS benefits paid for GP attendances, based on data and assumptions as detailed in the *National Mental Health Report* (DoHA 2008c). To incorporate these changes, GP expenditure reported for 2006–07 was based on total MBS benefits paid against these new mental health specific items, plus 6.1% of total GP benefits paid in the period preceding the introduction of the new items (July to November 2006). In future years, expenditure on GP mental health care will be fully based on actual benefits paid and not on derived estimates. Comparisons of GP mental health related expenditure reported in Table 14.15 should be approached with caution.

Expenditure on the Department of families, housing, community services and indigenous affairs (FaHCSIA) managed Council of Australian Governments (COAG) Action Plan programs 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*. Expenditure is as reported in the annual progress report on the *COAG National Action Plan for Mental Health 2006–2011* (COAG 2008).

Expenditure on Department of Health and Ageing (DoHA) managed COAG Action Plan programs covers all programs funded by the Australian Government under the Action Plan and administered by DoHA not reported elsewhere. A small number of initiatives funded by the Australian Government under the Action Plan are not included in the data reported here because they are components of general assistance programs and do not meet the criteria for classification as 'specialised mental health services' expenditure.

Appendix 2: Technical notes

Data presentation

Throughout this publication, data may not sum to the totals shown due to missing and/or not stated values, as well as rounding. Totals reported include missing and/or not stated values. The percentages shown within the tables are calculated excluding the missing and/or 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 ABS Estimated Resident Population (ERP) at the midpoint of the data range (for example, rates for 2006–07 data were calculated using ERP at 31 December 2006, while rates for 2006 calendar year data were calculated using ERP at 30 June 2006). Rates for 2007–08 data were calculated using preliminary ERP at 31 December 2007.

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. In this publication we use direct standardisation in which age-specific rates are multiplied against a standard population (the Australian Estimated Resident Population 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 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%), and we say that 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:

- at the organisational level, which may or may not comprise a number of individual services
- the regional level
- at the state/territory level.

Some of these indirect expenditure items can be directly linked to the provision of services within the reported level. Specifically, at the organisational and regional levels the expenditure on the following items are directly related to individual mental health service units and thus have been apportioned to units within the organisation or region reporting the indirect funds:

- expenditure on 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 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 level indirect 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 excluded from the indirect fund calculations.

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 for the various items in Chapter 14 are outlined in Table A2.2. For further information on the methodology used to calculate deflators refer to *Health expenditure Australia 2006–07* (AIHW 2008d).

Table A2.2: 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 on 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 care workers wage rate index[(a)]
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 care workers wage rate index[(a)]
Grants to non-government-operated organisations	14.2	Professional health care workers wage rate index[(a)]
Other indirect expenditure	14.2	Government final consumption expenditure on hospitals and nursing homes[(a)]
Private psychiatric hospital expenditure	14.8, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	Government final consumption expenditure on hospitals and nursing homes[(a)]
Medicare expenditure on mental health-related services	14.10, 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/RPBS	14.14, 15.5, 15.10, 15.15, 15.20, 15.25, 15.30, 15.35, 15.40, 15.45	PBS pharmaceuticals[(b)]
Australian Government expenditure of mental health-related services	14.15	Government final consumption expenditure on hospitals and nursing homes[(a)]
Expenditure on specialised mental health services	14.17	Government final consumption expenditure on hospitals and nursing homes[(a)]

(a) ABS, unpublished.

(b) AIHW health expenditure database (AIHW 2008d).

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 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. DoHA updates the MBS at least twice each year and these code changes are either incorporated into ACHI or the MBS codes are mapped to existing ACHI codes.

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 ACHI is anatomically based, rather than based on the surgical specialty.

To maintain parity with disease classification, ACHI chapters resemble the chapter headings of the ICD-10. ACHI is updated biennially by the NCCH in line with the disease section of ICD-10-AM. Use of the codes is guided by the *Australian Coding Standards, volume 5* of ICD-10-AM.

Further information on ACHI is available from the NCCH website: <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 ABS for the collection and dissemination of geographically classified statistics. It is an essential reference for understanding and interpreting the geographical context of statistics in Australia.

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 2007a).

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.

For further information on this classification system, refer to the WHO website <http://www.whocc.no/atcddd/>.

English Proficiency Country Groups

The English Proficiency Country 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 prior to the Census who spoke good English (the EP index).

The latest published version of the English Proficiency Country Groups (often abbreviated to 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 <http://www.who.int/classifications/icd/en/>.

International Statistical Classification of Diseases, 9th revision, Clinical Modification

The *International Statistical Classification of Diseases, 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 National Centre for Classification in Health (NCCH) with the purpose of making ICD-10 more relevant to Australian clinical practice (NCCH 2006).

International Classification of Primary Care, version 2, and ICPC-2 PLUS

The *International Classification of Primary Care, version 2* (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 the Australian general practice.

The ICPC-2 is currently being used in electronic health records within the clinical general practice, as well as in the research of general practice (that is, BEACH) and other statistical collections such as the ABS National Health Survey.

Further information on ICPC-2 is available from the WHO website <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 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*, *version 2* (ICPC-2). While in the great majority of cases the codes appearing in the diagnosis/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 2.4% of all mental health-related problems managed in BEACH, 2007–08) 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, 2007–08

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
P80			Personality 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, 2007–08

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Problems managed (continued)			
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
	P45013		Anger management

(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, 2007–08

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Treatments, including counselling (continued)			
	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
	P49001		Preventive; procedure; 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, 2007–08

ICPC-2 code	ICPC-2 PLUS code	ATC code	ICPC-2/ICPC-2 PLUS/ATC label
Treatments, including counselling (continued)			
	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

National Hospital Morbidity Database data

During the preparation of *Mental health services in Australia 1999–00*, attention was given to ensuring that for data on hospital separations from the National Hospital Morbidity Database (NHMD) the definition of a 'mental health-related diagnosis' included all codes which were either clinically or statistically relevant to mental health. This definition was revised for *Mental health services in Australia 2000–01* 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 AR-DRG 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 (which is 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.

Thus, 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 codes	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		✓		

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
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	✓		✓	
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	✓		✓	
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	✓			

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F52	Sexual dysfunction, not caused by organic disorder or disease	✓[(a)]		✓	✓
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				✓
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	Pervasive developmental disorders	✓[(b)]		✓	
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	✓		✓	

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
F94	Disorders of social functioning with onset specific to childhood and adolescence	✓			
F95	Tic disorders	✓		✓	
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence	✓[(c)]		✓	
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	✓			
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				✓

(continued)

Table A4.2 (continued): ICD-10-AM diagnosis codes used to define mental health-related hospital separations

ICD-10-AM codes	Diagnosis	MDC 19	MDC 20	Statistically relevant	Apparently otherwise relevant
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.

Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACHI	Australian Classification of Health Interventions
ADHD	attention-deficit hyperactivity disorder
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
ASA	Australian Society of Anaesthesiologists
ASGC	Australian Standard Geographical Classification
ATC	Anatomical Therapeutic Chemical
A+E	Accident and emergency
BEACH	Bettering the Evaluation and Care of Health
BOIMHC	Better Outcomes in Mental Health Care
COAG	Council of Australian Governments
CSTDA	Commonwealth State/Territory Disability Agreement
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
ECT	Electroconvulsive therapy
EP	English proficiency
ERP	Estimated resident population
FaCS	Department of Family and Community Services
FTE	full-time-equivalent
GP	general practitioner
GRIM	General Record of Incidence of Mortality
HDSC	Health Data Standards Committee
ICD-9-CM	International Statistical Classification of Diseases, 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
ICPC-2	International Classification of Primary Care, version 2
LCL	lower confidence limit
MBS	Medicare Benefits Schedule
METeOR	Metadata Online Registry

NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
NCMHCD	National Community Mental Health Care Database
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NPHED	National Public Hospital Establishments Database
NRMHCD	National Residential Mental Health Care Database
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Cooperation and Development
OMP	other medical practitioner
PBS	Pharmaceutical Benefits Scheme
Qld	Queensland
RPBS	Repatriation Pharmaceutical Benefits Scheme
RACGP	Royal Australian College of General Practitioners
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAAP NDC	Supported Accommodation Assistance Program National Data Collection
SMHWB	National Survey of Mental Health and Wellbeing
Tas	Tasmania
UCL	upper confidence limit
Vic	Victoria
WA	Western Australia
WHO	World Health Organization
WMH-CIDI 3.0	World Health Organization's Composite International Diagnostic Interview, version 3.0

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List of tables

Table 1.1: People with mental disorders by health services used for mental health problems, 2007 6
Table 2.1: Mental health-related encounters, BEACH, 2003–04 to 2007–08 11
Table 2.2: Patient demographics for mental health-related encounters, BEACH 2007–08....13
Table 2.3: The 10 most frequent mental health-related problems managed, BEACH 2007–08 15
Table 2.4: Most common types of management of mental health-related problems, BEACH 2007–08 16
Table 2.5: Psychologically-related activity in other general practice encounters, BEACH 2007–08 17
Table 2.6: MBS-subsidised specific GP/OMP mental health services, by item group of service provided, 2003–04 to 2007–08 19
Table 2.7: Selected MBS items recorded for mental health-related encounters, BEACH 2007–08 20
Table 2.8: People receiving MBS-subsidised GP mental health services: patient demographic characteristics and services received, 2007–08....22
Table 2.9: MBS-subsidised specific GP mental health services, numbers of patients and services provided, by item group, states and territories, 2007–08 23
Table 3.1: Mental health-related emergency department occasions of service in public hospitals, by patient demographic characteristics, 2006–07 27
Table 3.2: Mental health-related emergency department occasions of service in public hospitals, by principal diagnosis, states and territories, 2006–07 28
Table 3.3: Mental health-related emergency department occasions of service in public hospitals, by triage category, states and territories, 2006–07....29
Table 3.4: Mental health-related emergency department occasions of service in public hospitals, by episode end status, states and territories, 2006–07 30
Table 4.1: Community mental health care service contacts, states and territories, 2006–07 32
Table 4.2: Community mental health care service contacts, by mental health legal status, states and territories, 2006–07....35
Table 4.3: Community mental health care service contacts, by patient demographic characteristics, 2006–07 36
Table 4.4: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, 2006–07 38
Table 5.1: Ambulatory-equivalent mental health-related separations with and without specialised psychiatric care, by hospital type, states and territories, 2006–07 43
Table 5.2: Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by mental health legal status and hospital type, 2006–07....44
Table 5.3: Ambulatory-equivalent mental health-related separations, by patient demographic characteristics, 2006–07 45
Table 5.4: Ambulatory-equivalent mental health-related separations with specialised psychiatric care, by principal diagnosis and hospital type, 2006–07....48
Table 5.5: Ambulatory-equivalent mental health-related separations without specialised psychiatric care, by principal diagnosis and hospital type, 2006–07....49

Table 5.6: Ambulatory-equivalent mental health-related separations with and without specialised psychiatric care, by principal diagnosis and hospital type, 2006–07 50

Table 5.7: The 10 most frequently reported procedures for ambulatory-equivalent mental health-related separations, 2006–07 51

Table 6.1: MBS-subsidised mental health services: numbers of patients and services, 2007–08 55

Table 6.2: People receiving MBS-subsidised psychiatrist, psychologist and allied mental health services: patient demographic characteristics and number of services received, 2007–08 56

Table 6.3: People receiving MBS-subsidised psychiatrist, psychologist and allied mental health services: patient area of residence by remoteness area, 2007–08 57

Table 6.4: People receiving MBS-subsidised psychiatrist and allied health services, by item group of service, states and territories, 2007–08 58

Table 6.5: MBS-subsidised psychiatrist and allied health services, by item group of service provided, states and territories, 2007–08 60

Table 6.6: MBS-subsidised psychiatrist and allied health services, by item group of service provided, 2003–04 to 2007–08 62

Table 7.1: Admitted patient mental health-related separations with and without specialised psychiatric care, 2002–03 to 2006–07 65

Table 7.2: Admitted patient separations with specialised psychiatric care, states and territories, 2006–07 69

Table 7.3: Admitted patient separations with specialised psychiatric care, by mental health legal status and hospital type, 2006–07 70

Table 7.4: Admitted patient separations with specialised psychiatric care, by patient demographic characteristics, 2006–07 72

Table 7.5: Admitted patient separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2006–07 75

Table 7.6: The 10 most frequently reported procedures for admitted patient separations with specialised psychiatric care, 2006–07 78

Table 7.7: Admitted patient separations and patient days for mental health-related separations without specialised psychiatric care, states and territories, 2006–07 79

Table 7.8: Mental health-related admitted patient separations without specialised psychiatric care, by patient demographic characteristics, 2006–07 81

Table 7.9: Mental health-related admitted patient separations without specialised psychiatric care, by principal diagnosis in ICD-10-AM groupings and hospital type, 2006–07 84

Table 7.10: The 10 most frequently reported procedures for mental health-related admitted patient separations without specialised psychiatric care, 2006–07 87

Table 8.1: Episodes of residential mental health care, number of residents and residential care days, states and territories, 2006–07 90

Table 8.2: Episodes of residential mental health care, by mental health legal status, states and territories, 2006–07 92

Table 8.3: Episodes of residential mental health care, by patient demographic characteristics, 2006–07 94

Table 8.4: Episodes of residential mental health care, by principal diagnosis in ICD-10-AM groupings, 2006–07 96

Table 9.1: SAAP clients with mental health-related closed support periods: demographic characteristics and number of support periods, 2006–07 102

Table 9.2: SAAP mental health-related closed support periods, by service type, states and territories, 2006–07 104
Table 10.1: CSTDA-funded service users with a psychiatric disability, states and territories, 2005–06 and 2006–07 110
Table 10.2: CSTDA-funded residential service users with a psychiatric disability, by residential service type, states and territories, 2006–07 111
Table 10.3: CSTDA-funded residential service users with a psychiatric disability, by primary disability group, 2006–07 112
Table 10.4: Demographic characteristics of CSTDA-funded residential service users with a psychiatric disability, 2006–07 114
Table 10.5: CSTDA-funded residential service users with a psychiatric disability, by usual residential setting, living arrangement and income source, 2006–07 115
Table 10.6: CSTDA-funded non-residential service users with a psychiatric disability, by service group, states and territories, 2006–07 116
Table 10.7: CSTDA-funded non-residential service users with a psychiatric disability, by primary disability group, 2006–07 117
Table 10.8: Demographic characteristics of CSTDA-funded non-residential service users with a psychiatric disability, 2006–07 118
Table 10.9: CSTDA-funded non-residential service users with a psychiatric disability, by residential setting, living arrangement and income source, 2006–07 119
Table 11.1: Drug groups defined for this report as mental health-related medications in the PBS/RPBS data 121
Table 11.2: Mental health-related prescriptions, by type of medication prescribed and prescribing medical practitioner, 2007–08 122
Table 11.3: Mental health-related prescriptions, by type of medication prescribed and prescribing medical practitioner, states and territories, 2007–08 124
Table 11.4: Mental health-related prescriptions, by type of medication prescribed and prescribing medical practitioner, 2003–04 to 2007–08 125
Table 11.5: Patients dispensed with mental health-related prescriptions: patient demographic characteristics and services received, 2007–08 126
Table 11.6: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner and type of medication prescribed, states and territories, 2007–08 128
Table 11.7: Patients dispensed with mental health-related prescriptions, by prescribing medical practitioner and type of medication prescribed, 2003–04 to 2007–08 129
Table 12.1: Number of specialised mental health facilities, states and territories, 2006–07 132
Table 12.2: Number of specialised mental health facilities, 2002–03 to 2006–07 133
Table 12.3: Community mental health care services, by target population, states and territories, 2006–07 133
Table 12.4: Public sector specialised mental health hospital beds, states and territories, 2006–07 134
Table 12.5: Public sector specialised mental health hospital beds, 2002–03 to 2006–07 134
Table 12.6: Public sector specialised mental health hospital beds, by target population and program, states and territories, 2006–07 135
Table 12.7: Public sector specialised mental health hospital beds, by target population, 2002–03 to 2006–07 136

Table 12.8: Number of residential mental health services beds, by service operator and staffing provided, states and territories, 2006–07 136

Table 12.9: Residential mental health services beds and beds per 100,000 population, by target population, states and territories, 2006–07 137

Table 12.10: Residential mental health services beds, by hours staffed and target population, 2002–03 to 2006–07 137

Table 12.11: Full-time-equivalent staff by service setting, states and territories, 2006–07 138

Table 12.12: Full-time-equivalent staff by staffing category, states and territories, 2006–07 139

Table 12.13: Full-time-equivalent staff by staffing category, states and territories, 2006–07 (per cent) 140

Table 12.14: Full-time-equivalent staff per 100,000 population by staffing category, states and territories, 2006–07 140

Table 12.15: Full-time-equivalent staff by staffing category, 2002–03 to 2006–07 141

Table 12.16: Private psychiatric hospitals, available beds and available beds per 100,000 population, states, 2006–07 141

Table 12.17: Full-time-equivalent staff by staffing category, private psychiatric hospitals, states, 2006–07 142

Table 13.1: Employed psychiatrists and psychiatrists-in-training, demographic characteristics, 2002–2006 145

Table 13.2: Employed psychiatrists and psychiatrists-in-training, average total hours worked per week, type and sex, 2002–2006 145

Table 13.3: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, states and territories, 2006 146

Table 13.4: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, by region, 2006 147

Table 13.5: Employed psychiatrists and psychiatrists-in-training, FTE and FTE per 100,000 population, 2002–2006 148

Table 13.6: Employed psychiatrists and psychiatrists-in-training, FTE, states and territories, 2002–2006 148

Table 14.1: Recurrent expenditure ($’000) on specialised mental health services, states and territories, 2006–07 151

Table 14.2: Recurrent expenditure ($’000) on specialised mental health services, states and territories, 2002–03 to 2006–07 152

Table 14.3: Recurrent expenditure ($’000) on admitted patient services in specialised mental health public hospitals, by program type, states and territories, 2006–07 153

Table 14.4: Recurrent expenditure ($’000) on admitted patient services in specialised mental health public hospitals, by target population, states and territories, 2006–07 154

Table 14.5: Recurrent expenditure ($’000) on community mental health care services, by target population, states and territories, 2006–07 154

Table 14.6: Recurrent expenditure ($’000) on residential mental health services, by target population and hours staffed, states and territories, 2006–07 155

Table 14.7: Private psychiatric hospital expenditure ($’000), states, 2006–07 156

Table 14.8: Private psychiatric hospital expenditure ($’000), 2002–03 to 2006–07 156

Table 14.9: Australian Government Medicare expenditure ($’000) on mental health-related services, by item group, states and territories, 2007–08 158

Table 14.10: Australian Government Medicare expenditure ($'000) on mental health-related services, by item group, 2003–04 to 2007–08 159

Table 14.11: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed and medical practitioner, 2007–08 160

Table 14.12: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed and type of medical practitioner, states and territories, 2007–08 161

Table 14.13: Australian Government expenditure ($'000) on medications prescribed by psychiatrists subsidised under the PBS/RPBS, by type of medication prescribed, states and territories, 2007–08 162

Table 14.14: Australian Government expenditure ($'000) on mental health-related medications subsidised under the PBS/RPBS, by type of medication prescribed and type of medical practitioner, 2003–04 to 2007–08 163

Table 14.15: Australian Government expenditure ($'000) on mental health-related services, 2002–03 to 2006–07 165

Table 14.16: Source of funding for specialised mental health services ($'000), states and territories, 2006–07 166

Table 14.17: Expenditure ($ million) on mental health-related services, by source of funding, 1997–98 to 2006–07 167

Table 15.1: Mental health services, New South Wales, 2002–03 to 2007–08 169

Table 15.2: Mental health-related prescriptions, New South Wales, 2003–04 to 2007–08 170

Table 15.3: Mental health facilities, New South Wales, 2002–03 to 2006–07 170

Table 15.4: Workforce: psychiatrists and psychiatrists-in-training, New South Wales, 2001–2006 170

Table 15.5: Recurrent expenditure ($'000) for specialised mental health services, New South Wales, 2002–03 to 2007–08, constant prices 171

Table 15.6: Mental health services, Victoria, 2002–03 to 2007–08 172

Table 15.7: Mental health-related prescriptions, Victoria, 2003–04 to 2007–08 173

Table 15.8: Mental health facilities, Victoria, 2002–03 to 2006–07 173

Table 15.9: Workforce: psychiatrists and psychiatrists-in-training, Victoria, 2001–2006 173

Table 15.10: Recurrent expenditure ($'000) for specialised mental health services, Victoria, 2002–03 to 2007–08, constant prices 174

Table 15.11: Mental health services, Queensland, 2002–03 to 2007–08 175

Table 15.12: Mental health-related prescriptions, Queensland, 2003–04 to 2007–08 176

Table 15.13: Mental health facilities, Queensland, 2002–03 to 2006–07 176

Table 15.14: Workforce: psychiatrists and psychiatrists-in-training, Queensland, 2001–2006 176

Table 15.15: Recurrent expenditure ($'000) for specialised mental health services, Queensland, 2002–03 to 2007–08, constant prices 177

Table 15.16: Mental health services, Western Australia, 2002–03 to 2007–08 178

Table 15.17: Mental health-related prescriptions, Western Australia, 2003–04 to 2007–08 179

Table 15.18: Mental health facilities, Western Australia, 2002–03 to 2006–07 179

Table 15.19: Workforce: psychiatrists and psychiatrists-in-training, Western Australia, 2001–2006 179

Table 15.20: Recurrent expenditure ($'000) for specialised mental health services, Western Australia, 2002–03 to 2007–08, constant prices....180
Table 15.21: Mental health services, South Australia, 2002–03 to 2007–08....181
Table 15.22: Mental health-related prescriptions, South Australia, 2003–04 to 2007–08....182
Table 15.23: Mental health facilities, South Australia, 2002–03 to 2006–07....182
Table 15.24: Workforce: psychiatrists and psychiatrists-in-training, South Australia, 2001–2006....182
Table 15.25: Recurrent expenditure ($'000) for specialised mental health services, South Australia, 2002–03 to 2007–08, constant prices....183
Table 15.26: Mental health services, Tasmania, 2002–03 to 2007–08....184
Table 15.27: Mental health-related prescriptions, Tasmania, 2003–04 to 2007–08....185
Table 15.28: Mental health facilities, Tasmania, 2002–03 to 2006–07....185
Table 15.29: Workforce: psychiatrists and psychiatrists-in-training, Tasmania, 2001–2006....185
Table 15.30: Recurrent expenditure ($'000) for specialised mental health services, Tasmania, 2002–03 to 2007–08, constant prices....186
Table 15.31: Mental health services, Australian Capital Territory, 2002–03 to 2007–08....187
Table 15.32: Mental health-related prescriptions, Australian Capital Territory, 2003–04 to 2007–08...188
Table 15.33: Mental health facilities, Australian Capital Territory, 2002–03 to 2006–07....188
Table 15.34: Workforce: psychiatrists and psychiatrists-in-training, Australian Capital Territory, 2001–2006....188
Table 15.35: Recurrent expenditure ($'000) for specialised mental health services, Australian Capital Territory, 2002–03 to 2007–08, constant prices....189
Table 15.36: Mental health services, Northern Territory, 2002–03 to 2007–08....190
Table 15.37: Mental health-related prescriptions, Northern Territory, 2003–04 to 2007–08....191
Table 15.38: Mental health facilities, Northern Territory, 2002–03 to 2006–07....191
Table 15.39: Workforce: psychiatrists and psychiatrists-in-training, Northern Territory, 2001–2006..191
Table 15.40: Recurrent expenditure ($'000) for specialised mental health services, Northern Territory, 2002–03 to 2007–08, constant prices....192
Table 15.41: Mental health services, Australia, 2002–03 to 2007–08....193
Table 15.42: Mental health-related prescriptions, Australia, 2003–04 to 2007–08....194
Table 15.43: Mental health facilities, Australia, 2002–03 to 2006–07....194
Table 15.44: Workforce: psychiatrists and psychiatrists-in-training, Australia, 2001–2006....194
Table 15.45: Recurrent expenditure ($'000) for specialised mental health services, Australia, 2002–03 to 2007–08, constant prices....195
Table A1.1: MBS items (2002 Better Outcomes in Mental Health Care, 2004 Enhanced Primary Care and 2006 Better Access)....197
Table A1.2: Mental health-related emergency department occasions of service, principal diagnosis codes included, ICD-10-AM and ICD-9-CM....199
Table A1.3: Emergency department occasions of service in public hospitals, estimated coverage and estimated actual number, states and territories, 2006–07....201
Table A1.4: CSTDA response rates, by states and territories, 2005–06 to 2006–07 (per cent)....208
Table A1.5: Community-dispensed prescriptions by patient category group for mental health-related ATC groups, 2007–08....210

Table A1.6: Differences between the WHO ATC classification and the PBS Schedule Classification 210
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, 2007–08 221
Table A4.2: ICD-10-AM diagnosis codes used to define mental health-related hospital separations 225

List of figures

Figure 1.1: Report outline....2

Figure 1.2: The prevalence of 12-month mental disorders by age group and by mental disorder group, Australia, 2007....5

Figure 2.1: The age distribution of patients at mental health-related encounters, by sex, BEACH 2007–08....14

Figure 2.2: Mental health-related GP encounters, by problem managed and whether mental health-specific MBS items were recorded, BEACH, 2007–08....21

Figure 2.3: MBS-subsidised GP Mental Health Care Plans per 1,000 population, by remoteness area, 2007–08....23

Figure 4.1: Community mental health care service contacts, by contact type and patient presence status, 2006–07....33

Figure 4.2: Duration of community mental health care service contacts, 2006–07....34

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, 2006–07....39

Figure 4.4: Community mental health care service contacts, 2002–03 to 2006–07....41

Figure 5.1: Ambulatory-equivalent mental health-related separations, by age and sex, 2006–07....46

Figure 5.2: Ambulatory-equivalent mental health-related separations for the 10 most commonly reported principal diagnoses by specialised care and sector, 2006–07....47

Figure 5.3: Ambulatory-equivalent mental health-related separations, with and without specialised psychiatric care, 2002–03 to 2006–07....52

Figure 7.1: Mental health-related separations with and without specialised psychiatric care, by hospital type, 2006–07....67

Figure 7.2: Average length of stay for mental health-related separations with and without specialised psychiatric care, by hospital type, 2006–07....67

Figure 7.3: Average length of stay for separations with specialised psychiatric care in public acute hospitals, 2006–07....70

Figure 7.4: Involuntary separations with specialised psychiatric care, by age group and sex, 2006–07....71

Figure 7.5: Admitted patient mental health-related separations with specialised psychiatric care by age and sex, 2006–07....73

Figure 7.6: Admitted patient mental health-related separations with specialised psychiatric care, by age group, for the 10 most commonly reported principal diagnoses, 2006–07....76

Figure 7.7: Admitted patient mental health-related separations with specialised psychiatric care, by sex, for the 10 most commonly reported principal diagnoses, 2006–07....77

Figure 7.8: Average length of stay for separations without specialised psychiatric care in public acute hospitals, 2006–07....80

Figure 7.9: Admitted patient mental health-related separations without specialised psychiatric care, by age and sex, 2006–07....82

Figure 7.10: Admitted patient mental health-related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and age group, 2006–07....85

Figure 7.11: Admitted patient mental health-related separations without specialised psychiatric care, by the 10 most commonly reported principal diagnoses and sex, 2006–07.................86

Figure 8.1: Residential mental health care episodes and residents, states and territories, 2004–05 to 2006–07.....91

Figure 8.2: Residential mental health care episodes, by mental health legal status, states and territories, 2004–05 to 2006–07 92

Figure 8.3: Residential mental health care episodes, by age and sex, 2006–07.....93

Figure 8.4: Residential episodes, for the five most commonly reported principal diagnoses, by mental health legal status, 2006–07 95

Figure 8.5: Episodes of residential mental health care, by length of episode, 2004–05 to 2006–07.......97

Figure 8.6: Episodes of residential mental health care ending in 2006–07, by length of residential stay.....98

Figure 9.1: Children accompanying SAAP client with mental health-related closed support periods, by age and sex of child, 2006–07.....103

Figure 9.2: SAAP clients with mental health-related closed support periods, proportion of support periods by client group type, 2006–07 103

Figure 9.3: SAAP mental health-related closed support periods, by source of referral, 2006–07 105

Figure 9.4: SAAP mental health-related closed support periods, by main presenting reason for seeking assistance, 2006–07 106

Figure 9.5: SAAP mental health-related closed support periods, by length of support, 2006–07.......107

Figure 10.1: Service users, by residential service type, states and territories, 2006–07.....112

Index

3 Step Mental Health Process, 18, 157
admitted patient care, 63
  additional diagnosis
    separations, 87
  average length of stay, 64
  non-specialised psychiatric care, 78
    demographics, 80
    Indigenous Australians, 82
    principal diagnosis, 82
    procedures, 86
    separations, 78
  patient days, 64
  psychiatric care days, 64
  specialised psychiatric care, 68
    demographics, 71
    Indigenous Australians, 72
    mental health legal status, 70
    principal diagnosis, 73
    procedures, 77
    separations, 68
age-standardisation. *See* population rates
alcohol abuse, 74, 83
ambulatory-equivalent admitted patient care, 42
  demographics, 44
  mental health legal status, 44
  principal diagnosis, 46
  procedures, 51
  separations, 43
  specialised psychiatric care, 44, 46, 52
antidepressants, 122, 160
antipsychotics, 122, 123, 160, 164
anxiety, 24, 83
anxiolytics, 122, 123, 160
beds, specialised mental health
  public hospital, 134
  residential care, 136
Better Access to psychiatrists, psychologists and GPs through the MBS, 8, 12, 15, 18, 19, 53, 157, 213
Better Outcomes in Mental Health Care (BOIMHC), 18
Bettering the Evaluation and Care of Health survey data (BEACH), 10
bipolar affective disorder, 37
burden of disease, 4
Clozapine, 127, 164
Commonwealth State/Territory Disability Agreement (CSTDA), 108
community mental health care, 31
  demographics, 35
  duration of service contacts, 33
  Indigenous Australians, 35
  legal status, 34
  principal diagnosis, 37
  service contacts, 31, 33
CSTDA National Minimum Data Set, 108
data coverage
  community mental health care, 40
data presentation, 214
deflators, 216
dementia, 83

demographics
admitted patient care
non-specialised psychiatric care, 80
specialised psychiatric care, 71
ambulatory-equivalent admitted patient care, 44
BEACH, 12
community mental health care, 35
disability support services
non-residential, 118
residential, 114
emergency departments, 26
Medicare-subsidised mental health-related services, 56
medications, mental health-related
patients, 126
residential mental health care, 93
supported accommodation services, 101, 102
depression, 24, 73, 77, 83
depressive episode, 37
disability support services, 108
non-residential, 115
demographics, 118
Indigenous Australians, 117
service users, 117
residential, 111
demographics, 114
Indigenous Australians, 113
service users, 111
residential service users
disability group, 112
eating disorders, 73
emergency departments, 24
demographics, 26
departure status, 29
occasions of service, 24
principal diagnosis, 27
triage category, 29
Enhanced Primary Care Program, 53
expenditure and funding
Australian Government expenditure, 164
Medicare-subsidised mental health-related services, 158
medication, 160
private psychiatric hospital expenditure, 155
source of funding
mental health-related services, 167
specialised mental health services, 166
sources of funding, 165
specialised mental health facilities, 150
facilities, specialised mental health, 130, 132
expenditure, 150
community services, 150, 154
public hospitals, 150, 152
residential services, 150, 155
private psychiatric hospitals, 141
program type, definition, 131
public hospital beds, 134
program type, 134
target population, 134
residential care beds, 136
target population, 136
source of funding, 166
staffing, 138
target population, definition, 131

Focussed Psychological Strategies, 18, 53
funding. *See* expenditure and funding
general practice
additional activity, 17
encounters, 12
mental health-related problems managed, 15
problems managed, 14
general practitioner, 157
GP Mental Health Care Plan, 18, 157
hypnotics, 122, 123, 160
Indigenous Australians
admitted patient care
non-specialised psychiatric care, 82
specialised psychiatric care, 72
ambulatory-equivalent admitted patient care, 46
community mental health care, 35
disability support services
non-residential, 117
residential services, 113
emergency departments, 27
general practice, 13
quality of identification, 202
residential mental health care, 94
supported accommodation services, 101
Medicare Benefits Schedule (MBS), 10, 217
Medicare-subsidised mental health-related services, 18, 53
demographics, 56
expenditure, 157
number of patients, 54
number of services, 59
medication, mental health related
expenditure, 160
medication, mental health-related, 120
demographics, patients, 126
number of prescriptions, 122
prescribing medical practitioner, 122
type of, 121
mental health facilities. *See* facilities, specialised mental health
mental health legal status, 34, 44
admitted specialised psychiatric care, 70
residential mental health care, 91
Mental Health Statement of Rights and Responsibilities, 7
mental health-related services
definition, 3
mortality of mental illness, 7
National Action Plan on Mental Health, 7
National Community Mental Health Care Database, 31, 168
National Hospital Morbidity Database, 42, 63, 168
National Mental Health Policy, 7
National Mental Health Strategy, 7
National Residential Mental Health Care Database, 89, 168
nootropics, 123, 127
occupational therapist, 157
personality disorders, 73
Pharmaceutical Benefits Scheme (PBS), 120, 208
population rates, 214
prescriptions. *See* medication
prevalence of mental illness, 4

principal diagnosis
admitted patient care
non-specialised psychiatric care, 82
specialised psychiatric care, 73
ambulatory-equivalent admitted patient care, 46
community mental health care, 37
emergency departments, 27
residential mental health care, 95
private psychiatric hospitals, 141, 155, 211
expenditure, 155
procedures
admitted patient care
non-specialised psychiatric care, 86
specialised psychiatric care, 77
ambulatory-equivalent admitted patient care, 51
psychiatrist, 157
workforce, 144
psychoactive substance use, 73, 74, 83
Psychological Therapy Services, 53
psychologist, 157
psychostimulants, 123, 127, 164
Repatriation Pharmaceutical Benefits Scheme (RPBS), 120, 208
residential mental health care, 89
demographics, 93
episode length, 97
episodes, 90, 96
episodes of care, 90
mental health legal status, 91
principal diagnosis, 95
residential care days, 90
residential stay, 98
Schedule of Pharmaceutical Benefits, 120
schizophrenia, 37, 73, 83, 95
sedatives, 122, 123, 160
separations
admitted patient care
additional diagnoses, 87
non-specialised psychiatric care, 78
specialised psychiatric care, 68
ambulatory-equivalent admitted patient care, 43
social worker, 157
state and territory summary tables, 168
stress reaction, 73, 83
supported accommodation services, 99
children accompanying clients, 101
client groups, 103
clients, 101
closed support periods, 104
demographics, 101, 102
Indigenous Australians, 101
length of support period, 106
mental health-related SAAP services, 100
reason for seeking assistance, 105
SAAP Client Collection, 100
source of referral, 104
Supported Accommodation Assistance Program (SAAP), 99
type of support period, 104
workforce, 143
psychiatrists
distribution, 146