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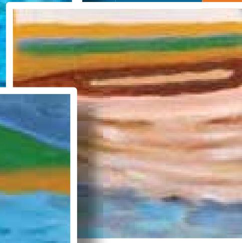
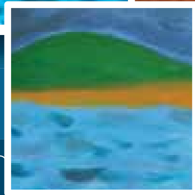
Australian Institute of Health and Welfare

2011

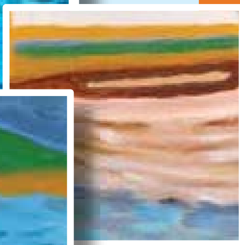


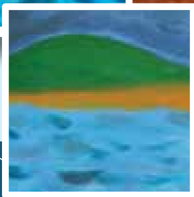


MENTAL**HEALTH**SERVICES

In brief

2011





MENTAL**HEALTH**SERVICES

In brief

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

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Please check the online version at <www.aihw.gov.au> or <http://mhsa.aihw.gov.au> for any amendments.

Foreword

Mental health is an important health issue in Australia, with an estimated 20% of Australians experiencing symptoms of a mental disorder each year. *Mental health services—In brief* has been designed as a companion document to the Institute's new online *Mental health services in Australia* report <http://mhsa.aihw.gov.au> which provides a comprehensive picture of the national response to the mental health care needs of Australians.

In producing an online version of *Mental health services in Australia*, the Institute has sought to make the data from its national mental health databases more readily accessible to all stakeholders by presenting the data in a range of media, including an interactive data portal. Additionally, the online publication format will enable Australian mental health services data to be published progressively as it becomes available each year, making it timelier. The publication of this accompanying hard copy *'In brief'* report aims to provide an overview by presenting only the key findings from each section of the online report.

Both reports provide a diverse range of information on the response of our system of health and welfare services to the mental health care needs of Australians. They include information on the expenditure and services provided by specialist mental health services, and mental health-related data on pharmaceutical and Medicare services and emergency department occasions of service.

Production of these reports in their new format would not have been possible without the cooperation and advice of state and territory authorities, the Australian Government and national Mental Health Information Strategy Subcommittee members. Their assistance is gratefully acknowledged.

The Institute will continue to work on refining the format and content of both these new reports to ensure that they better meet the information needs of all mental health stakeholders. Your feedback on how well they are meeting your needs would be most welcome.

David Kalisch
Director
Australian Institute of Health and Welfare

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Introduction

Mental health services in Australia 2011 is the first online presentation of the Australian Institute of Health and Welfare's (AIHW) series of annual mental health reports which provide a picture of the national response of the health and welfare service system to the mental health care needs of Australians. This *In brief* report summarises key findings from the online information on the range of mental health services provided in Australia and makes the data collected in the Mental Health Care National Minimum Data Sets (NMDSs) publicly available.

How many people are affected?

An estimated 7 million Australians (45% of the population aged 16–85 years) will experience a mental disorder over their lifetime. In addition, an estimated 3 million Australians (20% of the population aged 16–85 years) will experience symptoms of a mental disorder each year (DoHA 2009).

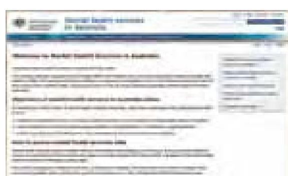
What is the impact of mental illness?

Mental disorders accounted for 13% of the total burden of disease in Australia in 2003 (Begg et al. 2007).

Mental disorders were responsible for 718 deaths in 2008, excluding suicide and dementia, with most deaths due to substance abuse involving alcohol and heroin (ABS 2010). Mental illnesses were the leading cause of non-fatal burden of disease (24%), with most mental illness burden attributable to anxiety, depression, alcohol abuse and personality disorders.

How many people are accessing mental health services?

One-third of the population estimated to have a mental disorder accessed mental health services in 2007, predominantly through a general practitioner (GP) consultation (ABS 2009).



Additional Information

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

What services are provided to those affected by mental illness?

Mental health-related services are provided in Australia in a variety of ways—from hospitalisation and other residential care, hospital-based outpatient services and community mental health care services through to consultations with both specialists and GPs.

Services provided by general practitioners

For more information regarding general practitioners see Section 2 online: **Mental health-related care in general practice**

The first port of call for people seeking help for a mental illness is often a GP. This section uses data from the Bettering the Evaluation and Care of Health (BEACH) survey, which provides some information on general practice activity across Australia.

Who used these services?

There were an estimated 13.3 million mental health-related GP encounters in 2009–10. One in four of these were for patients aged 65 and over. There was little difference in the rates for Aboriginal and Torres Strait Islander people and non-Indigenous Australians. The rate of encounters was highest among those living in *Inner regional* areas.

How did this change over time?

There was an average annual increase of 5.7% in the number of mental health-related GP encounters between 2005–06 and 2009–10. However, the final year saw an increase of only 0.6%.

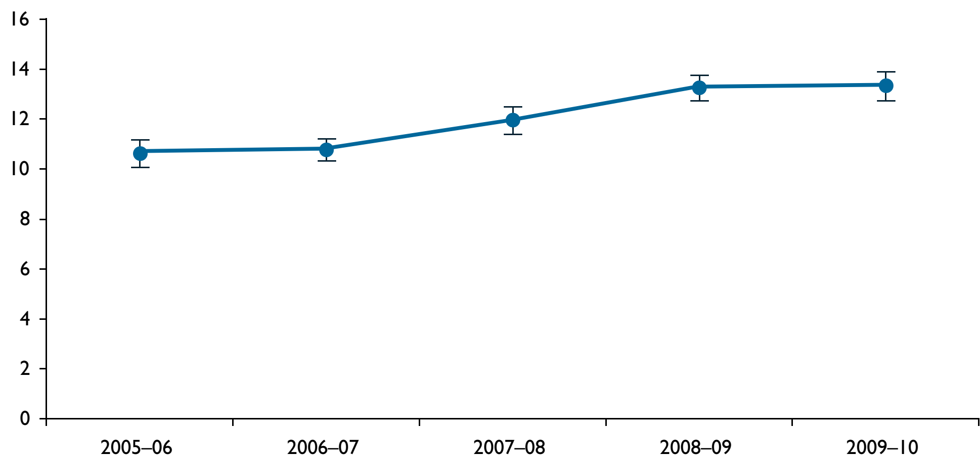


Figure 1: Estimated mental health-related GP encounters, 2005–06 to 2009–10

The estimated proportion of all GP encounters that were mental health-related remained relatively stable over the last year. Prior to this there was an increase due to the implementation of the Better Access initiative in November 2006, giving patients Medicare-subsidised access to psychologists and other allied health providers after consultation and referral from their GP.

What are people receiving this care for?

Depression, Anxiety and *Sleep disturbance* were the three mental health-related problems most frequently managed by GPs in 2009–10, accounting for over 60% of all mental health-related problems managed.

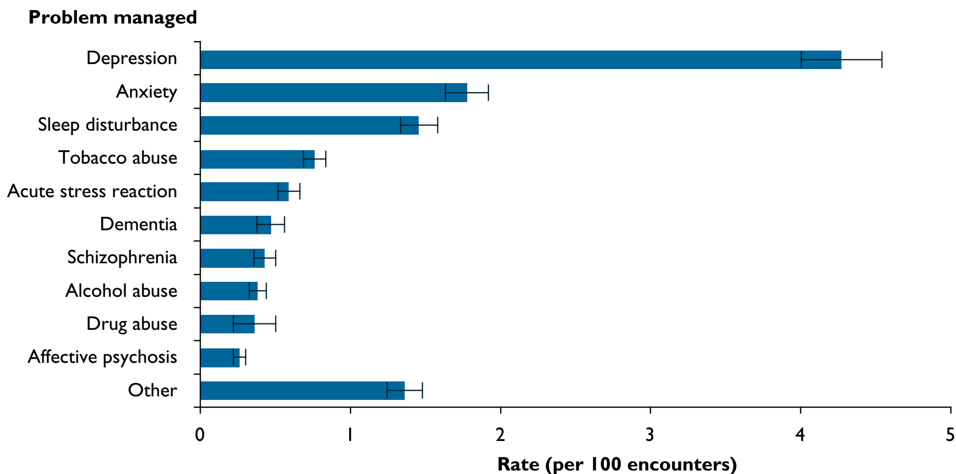


Figure 2: The 10 most frequent mental health-related problems managed by GPs, 2009–10

What were the characteristics of the care provided?

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

The next most common form of management by GPs was counselling, advice or other treatments, with psychological counselling the most frequently provided. GPs gave referrals for specialist mental health care at the rate of 13.1 per 100 mental health-related problems managed. The most common referrals given by GPs were to psychologists (6.3 per 100) and psychiatrists (1.7 per 100).

How does this differ between states and territories?

Using Medicare data, a more complete picture of GP activity in states and territories can be drawn. Victoria and New South Wales had a higher rate of patients (per 1,000 population) receiving MBS-subsidised GP mental health services (52.5 and 48.2 respectively) than the national average (46.9). Victoria had the highest service rate (93.5 per 1,000), which was 14% higher than the national average (81.7).

Medicare-subsidised specialised mental health services

In addition to mental health services provided by GPs, Medicare Benefits Schedule (MBS)-subsidised mental health-related services are provided by psychiatrists, psychologists, and other allied health professionals (for example social workers, mental health nurses and occupational therapists). They are provided in a range of settings, for example, in hospital, consulting rooms, home visits, and over the phone.

For more information regarding subsidised medical services see Section 6 online: **Medicare-subsidised psychiatric and allied health services**

Who used these services?

In Australia, there were almost 7 million MBS-subsidised mental health-related services in 2009–10, 1.8 million of which were provided by GPs (see *Services provided by GPs* section for more detail) and over 5.1 million for services provided by psychiatrists, psychologists and other allied mental health professionals. These 5.1 million specialised services were provided to over 836,000 patients in 2009–10.

For those accessing psychologist services, the rate (per 1,000 population) was highest for those aged 35–44 years. The services provided by all three provider types were accessed by females more than by males, particularly for other allied mental health professionals.

How did this care change over time?

There has been an average annual increase of 25.7% in the number of MBS-subsidised specialised mental health-related services between 2005–06 and 2009–10.

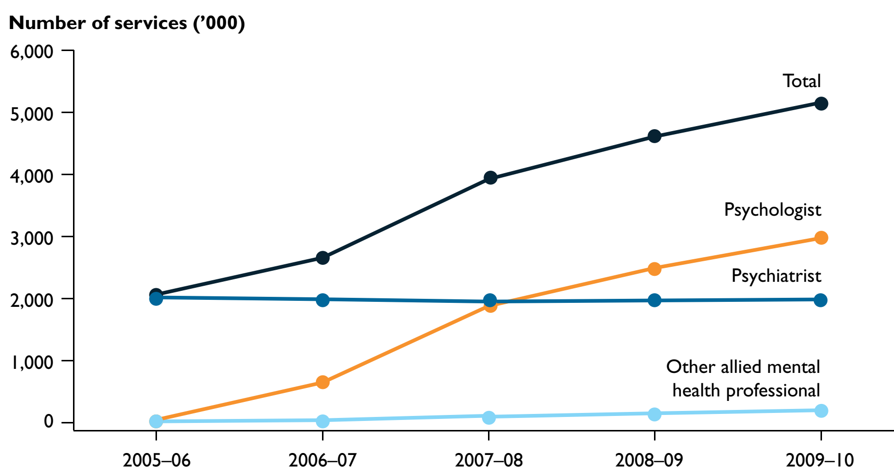


Figure 3: MBS-subsidised specialised mental health services, 2005–06 to 2009–10

This growth is attributable to the implementation of the Better Access initiative in November 2006 which gave patients Medicare subsidised access to psychologists and other allied health providers.

What are the characteristics of the care provided?

Almost 60% of the MBS-subsidised mental health-related services were provided by psychologists (including clinical psychologists) in 2009–10. The majority of the psychiatrist services were provided in consulting rooms, followed by consultations in hospitals. Social workers provided the vast majority of the other allied mental health professional services.

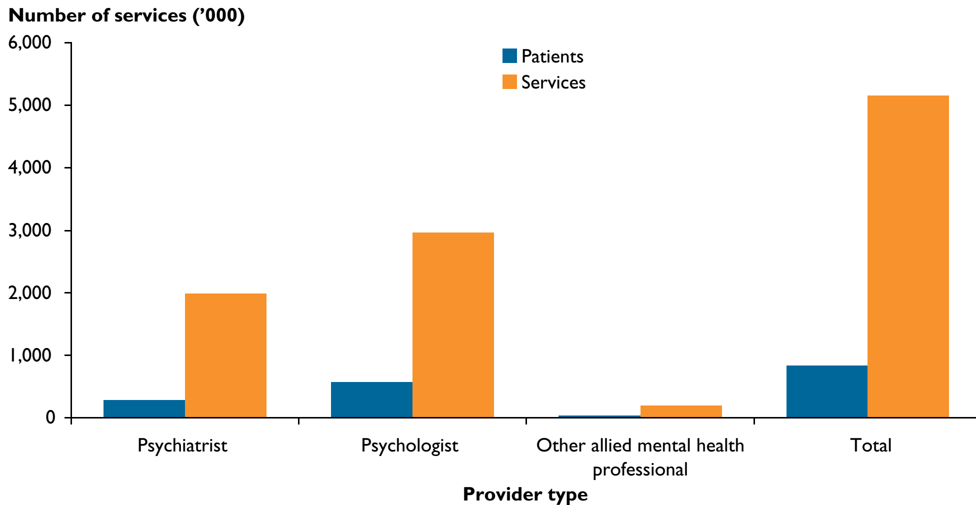


Figure 4: MBS-subsidised specialised mental health services and patients, 2009–10

How does this care differ between states and territories?

Among states and territories, Victoria had the highest usage rates for both MBS-subsidised mental health-related patients and services (psychiatrist and allied mental health-related). The Northern Territory had the lowest rate for both patients and services.

State and territory community mental health services

For more information regarding community services see Section 4 online: **Community mental health care and hospital outpatient services**

This section presents information on the state and territory government-operated specialised mental health care services provided in community-based and hospital-based ambulatory care settings.

Who used these services?

336,000 people in Australia accessed community mental health care services in 2008–09, and, with each person likely to use these services more than once, there were over 6 million contacts involving clients and community mental health care practitioners. People aged 25–34 years had the highest rates of contact, as did those living in *Inner regional* areas. The rates for Australian-born patients were more than double those of patients born overseas.

How did this change over time?

There was an average annual increase of 5.3% in the number of community mental health care service contacts between 2004–05 and 2008–09. The slight decrease in 2008–09 is likely due to a change in the information reporting system in one state.

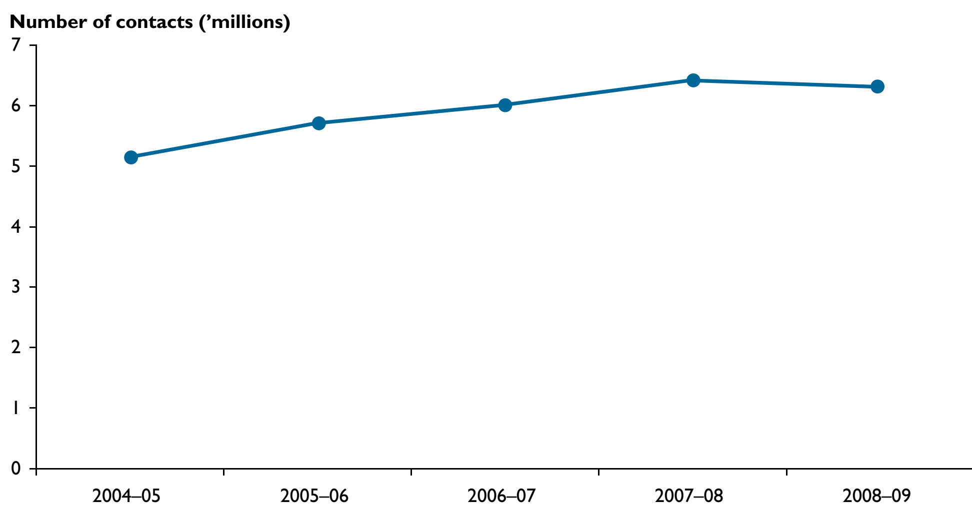


Figure 5: Community mental health care services contacts, 2004–05 to 2008–09

What are people receiving this care for?

The most common principal diagnosis was *Schizophrenia,* which accounted for nearly one-third of all contacts, followed by *Depressive episode* (11.9%) and *Bipolar affective disorder* (6.4%).

What were the characteristics of the care provided?

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

How does this differ between states and territories?

The Australian Capital Territory had the highest number of community service contacts per 1,000 population (632.5) and the Northern Territory had the highest number of people using the services per 1,000 population (21.8). The Australian Capital Territory also had the highest proportion of involuntary contacts (34.7%) and Western Australia the lowest (3.1%).

Figure 6: Community mental health care service contact rates, 2008–09

Services provided in hospitals and residential care facilities

Services provided in emergency departments

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

For more information regarding emergency department services see Section 3 online: **Mental health-related care in emergency departments**

Who used these services?

There were approximately 172,000 mental health-related visits to public hospital emergency departments in 2008–09. Almost 80% of these were for people aged 15–54 years, with slightly more visits for men than for women. Indigenous Australians accounted for 6.1% of the mental health-related visits.

How did this care change over time?

There was an average annual increase of 5.5% in mental health-related visits in emergency departments between 2004–05 and 2008–09. The observed decrease in 2007–08 is attributed to a change in the information reporting system in one state.

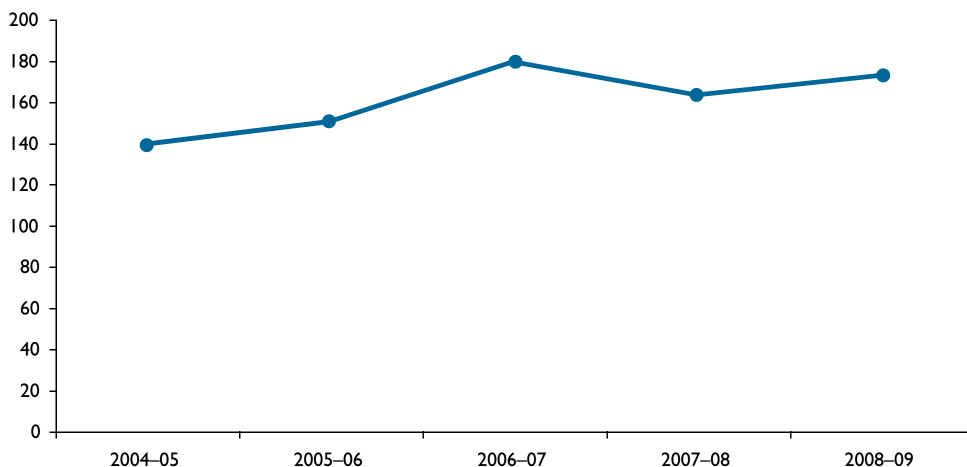


Figure 7: Mental health-related emergency department visits in public hospitals, 2004–05 to 2008–09

What are people receiving this care for?

The most common principal diagnoses for emergency department mental health-related presentations were *Neurotic, stress-related and somatoform disorders* (27.9%), followed by *Mental and behavioural disorders due to psychoactive substance use* (25.1%), *Mood disorders* (16.7%) and *Schizophrenia* spectrum disorders (13.6%).

What were the characteristics of the visits?

Over 80% of mental health-related emergency department visits were classified as urgent or semi-urgent. A further 11% were classified as emergency.

More than 60% of the mental health-related visits were resolved without the need for admission or referral to another hospital. However, 36% resulted in admission to hospital.

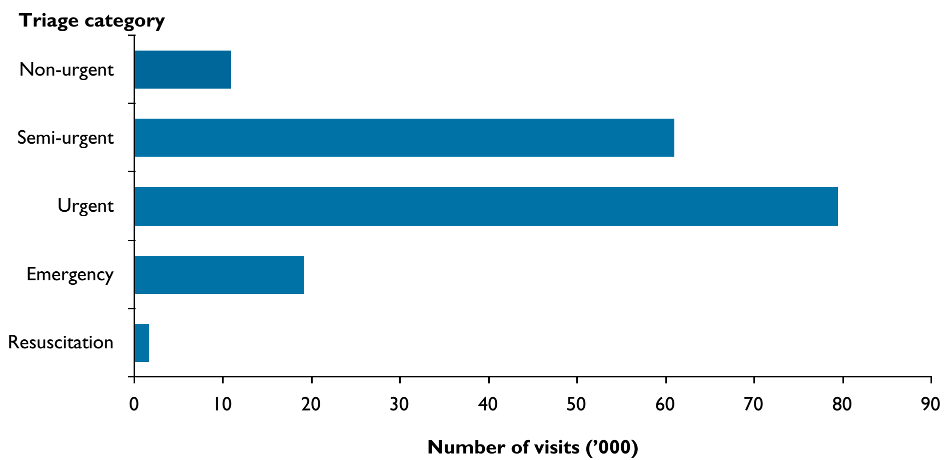


Figure 8: Mental health-related emergency department visits in public hospitals, by triage category, 2008–09

Ambulatory-equivalent admitted patient care

In some circumstances, patients admitted to hospital can be provided with care that is similar to care provided by community mental health care services.

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

For more information regarding ambulatory-equivalent care see Section 5 online: **Ambulatory-equivalent admitted patient care**

Who used these services?

There were nearly 133,000 ambulatory-equivalent mental health-related separations in 2008–09, accounting for 1.6% of all hospital separations and 38.1% of all mental health-related separations. People aged 55–64 years had the highest rate of separations, and the rate for females was higher than that for males. The rate for Australian-born patients was more than double that for those born overseas.

How did this care change over time?

There was an average annual increase of 3.2% in the total number of ambulatory-equivalent mental health-related separations between 2004–05 and 2008–09, which includes both those with and without specialised care. Between 2007–08 and 2008–09, separations with specialised psychiatric care increased by 16.0% while those without decreased by 9.6%.

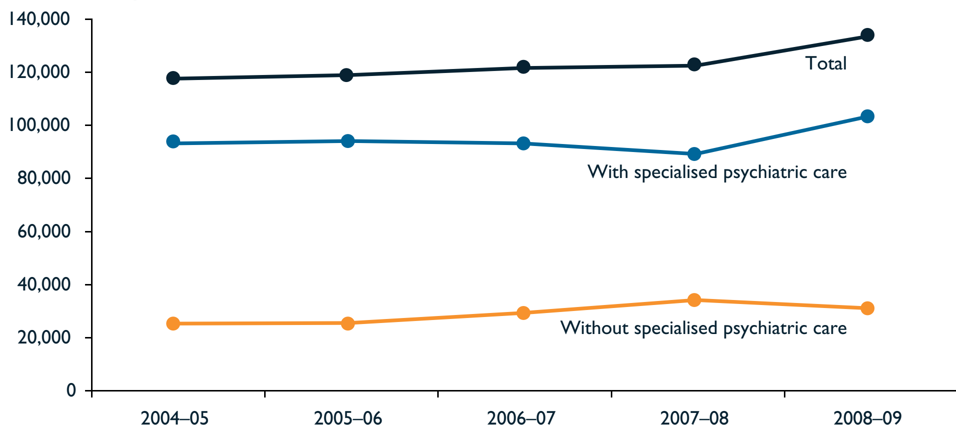


Figure 9: Ambulatory-equivalent mental health-related separations, 2004–05 to 2008–09

What are people receiving this care for?

People with a diagnosis of *Depressive episode* accounted for the largest number of separations (20.2%). For separations without specialised psychiatric care, *Mental and behavioural disorders due to use of alcohol* was the leading diagnosis (8.2%).

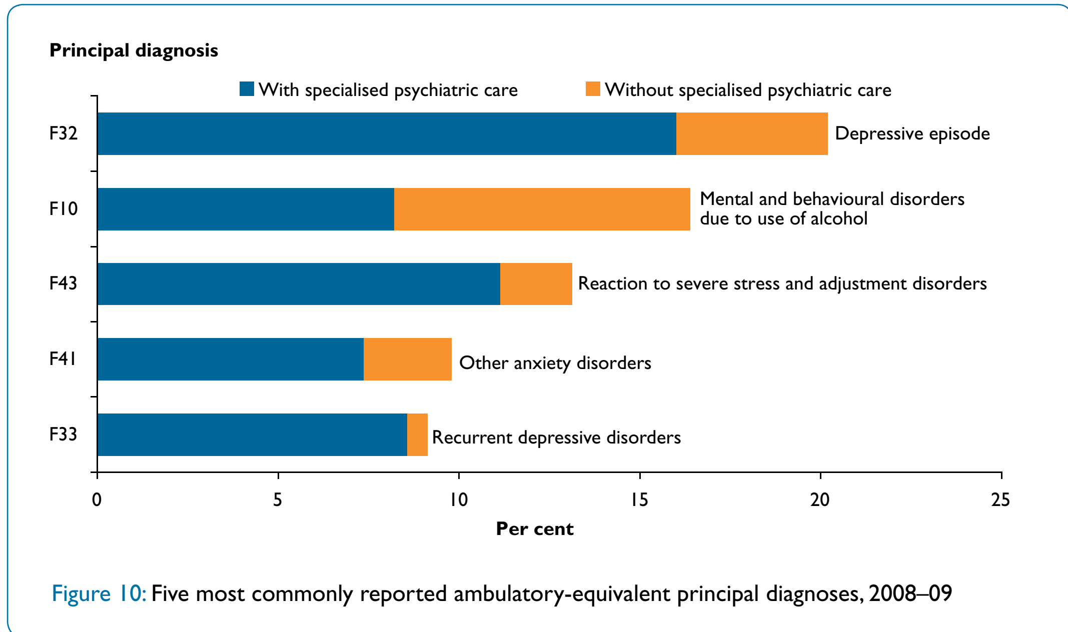


Figure 10: Five most commonly reported ambulatory-equivalent principal diagnoses, 2008–09

What were the characteristics of the care provided?

Almost 45% of the separations had an associated procedure (or intervention) recorded. The most frequent was *Cognitive behaviour therapy* (30.2%), followed by *Other psychotherapies or psychosocial therapies* (11.8%). Among those with at least one procedure recorded, the average number of procedures was 1.2.

How does this care differ between states and territories?

Victoria had the highest number of separations per 1,000 population, while South Australia had the lowest. The majority of the ambulatory-equivalent mental health-related separations were from private hospitals (82.5%).

Admitted patient mental health-related care

Admitted patient (hospital) mental health-related separations are classified as being with or without specialised psychiatric care. This care is provided in either a public acute, public psychiatric or private hospital.

For more information regarding admitted patient mental health-related care see Section 7 online: **Admitted patient mental health-related care**

Who used these services?

There were over 215,000 non-ambulatory admitted patient mental health-related separations reported in 2008–09, accounting for 2.6% of all hospital separations.

For separations with specialised psychiatric care, the rate was higher for females (6.5 per 1,000 population) than males (5.6), and the highest rate was for patients aged 35–44 years. For separations without specialised care, there was no difference between males and females, and the highest rate occurred for those aged 65 years and over.

Close to 30% of all separations with specialised care were for patients who had an involuntary admission, with the majority of these separations in public acute hospitals.

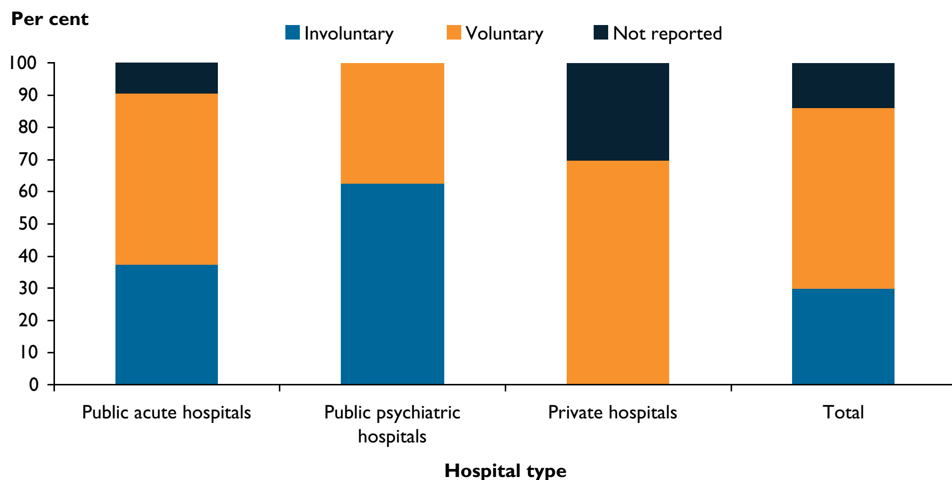


Figure 11: Admitted patient separations with specialised psychiatric care, 2008–09

How did this care change over time?

There was an average annual increase of 2.0% in the number of admitted patient mental health-related separations between 2004–05 and 2008–09. Separations with specialised care increased by 3.1% in the 5-year period to 2008–09, while those without specialised care increased by 0.3%.

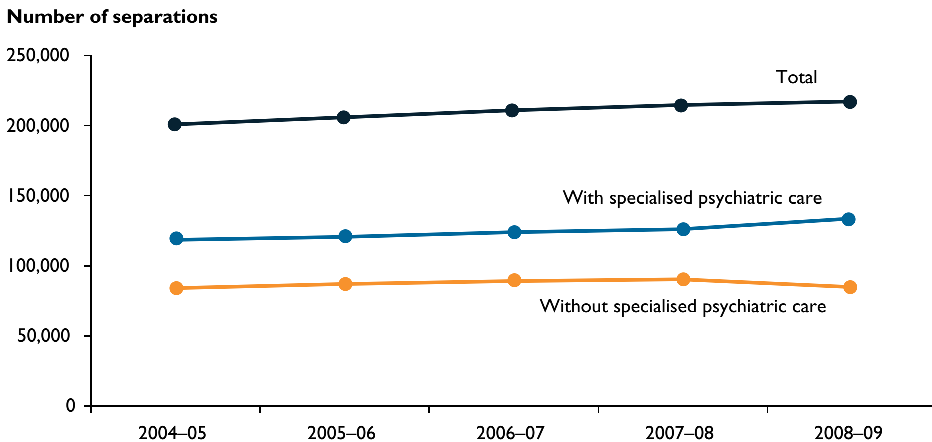


Figure 12: Admitted patient mental health-related separations, 2004–05 to 2008–09

What are people receiving this care for?

People with diagnoses of *Depressive episode* and *Recurrent depressive disorders* accounted for over a quarter of separations with specialised care in 2008–09. The most commonly reported diagnosis for separations without specialised care was *Mental and behavioural disorders due to use of alcohol*, followed by *Depressive episode.*

What were the characteristics of the care provided?

The most common procedure (clinical intervention) reported for separations with specialised care was *Non-emergency general anaesthesia.* This was most likely associated with the administration of electroconvulsive therapy, a form of treatment for depression which was a commonly reported principal diagnosis. Allied health interventions from a number of different health disciplines were also commonly reported for separations with or without specialised care. These include interventions from social workers and occupational therapists.

No procedures were reported for 40.7% of separations with specialised psychiatric care and 44.8% of separations without specialised care.

How does this differ between states and territories?

For mental health-related separations with specialised care, Queensland had the highest separation rate (4.7 per 1,000 population) and Western Australia the lowest (3.4) for public acute hospitals.

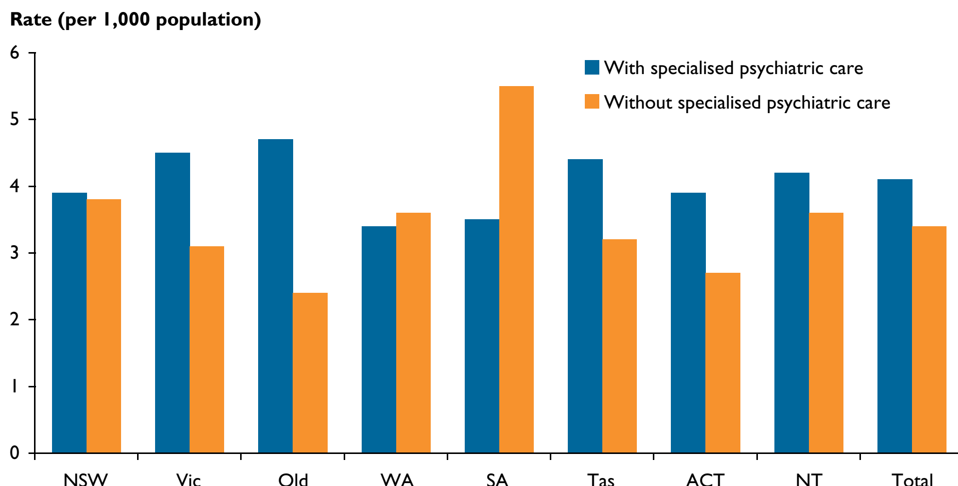


Figure 13: Admitted patient mental health-related separation rates in public acute hospitals, 2008–09

Residential care

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

For more information regarding residential care see Section 8 online: **Residential mental health care**

Who used these services?

Almost 2,400 Australians used these services in 2008–09, resulting in nearly 3,500 residential episodes of care.

One-quarter of the episodes were for people aged 25–34 years and there were more episodes for males than females. Overall, almost half of all residential episodes were for people located in *Major cities*, but the number of episodes per 10,000 population was highest for residents from *Inner regional* areas.

How did this care change over time?

There was an average annual increase of 12.4% in the number of residential mental health care episodes between 2004–05 and 2008–09.

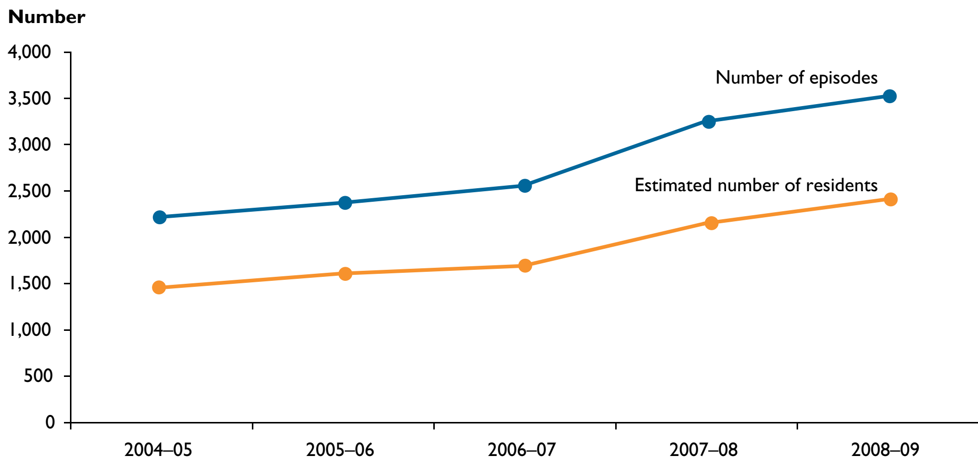


Figure 14: Residential mental health care episodes and residents, 2004–05 to 2008–09

What are people receiving this care for?

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

What were the characteristics of the care provided?

The most common length of stay for a completed residential episode was 2 weeks or less (50.6%), and a further 4.3% of all episodes involved a residential stay of more than 1 year. Residents admitted involuntarily accounted for around 30% of all episodes, and these have increased noticeably over the last 5 years.

How does this care differ between states and territories?

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

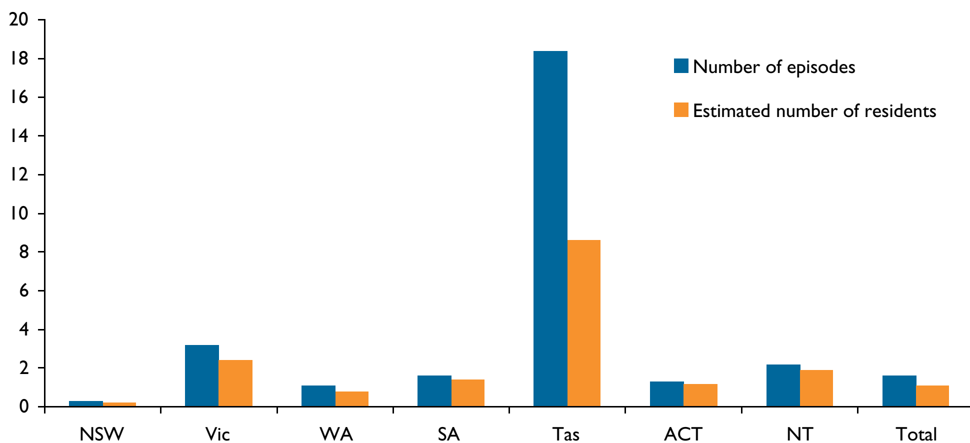


Figure 15: Residential mental health care episode and resident rates, 2008–09

Other mental health-related services

Support services for those with a psychiatric disability

Support services are available for Australians with disability, including psychiatric disability. These include both residential and non-residential services, and are funded under the Commonwealth State/Territory Disability Agreement (CSTDA), and the National Disability Agreement (NDA) from 1 January 2009.

For more information regarding disability support services see Section 10 online: **Psychiatric disability support**

Almost 73,000 people with a psychiatric disability made use of CSTDA/NDA-funded services in 2008–09.

The proportion of people reporting primary psychiatric disability among those who used any CSTDA/NDA-funded service has increased steadily between 2004–05 (8.0%) and 2008–09 (17.8%). The number of non-residential service users far outweighed the number of residential service users in all years.

Residential services

Residential services, including *Large* and *Small residential/institutions*, *Hostels* and *Group homes*, provide accommodation for people with a disability. Nationally, 5.3% of disability service users with a psychiatric disability accessed residential services in 2008–09, an average annual increase of 6.4% between 2004–05 and 2008–09. *Group homes* were the most common type of residential services provided to people with a psychiatric disability.

Non-residential services

Non-residential services include *Accommodation support*, *Community support*, *Community access*, *Respite*, *Employment support* and *Advocacy, information and print disability.*

Who used these non-residential services?

More than two-thirds of people using non-residential services who reported having a psychiatric disability named it as their primary disability. The majority were aged 25–54 years, and males accessed services more than females. Indigenous Australians were more than twice as likely to have utilised these services than non-Indigenous Australians.

How did this non-residential care change over time?

There was an average annual increase of 20.0% in the number of people with a psychiatric disability accessing non-residential services between 2004–05 and 2008–09.

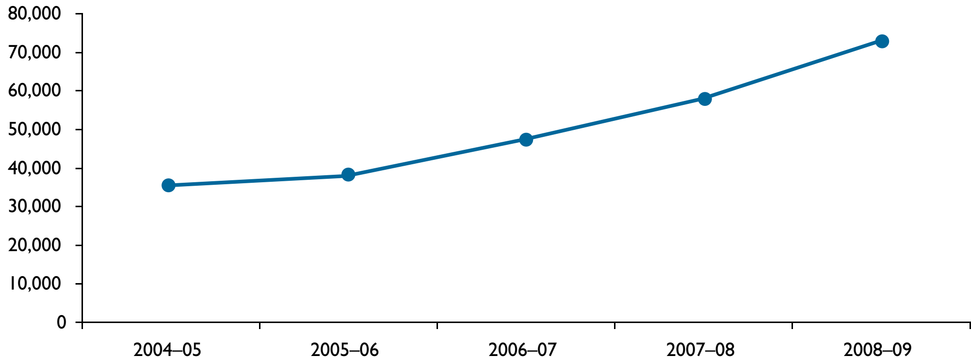


Figure 16: CSTDA/NDA-funded non-residential services users with a psychiatric disability, 2004–05 to 2008–09

What non-residential care was provided?

The majority of non-residential service users with a psychiatric disability were provided with *Employment* support services. Note that service users can access more than one service group.

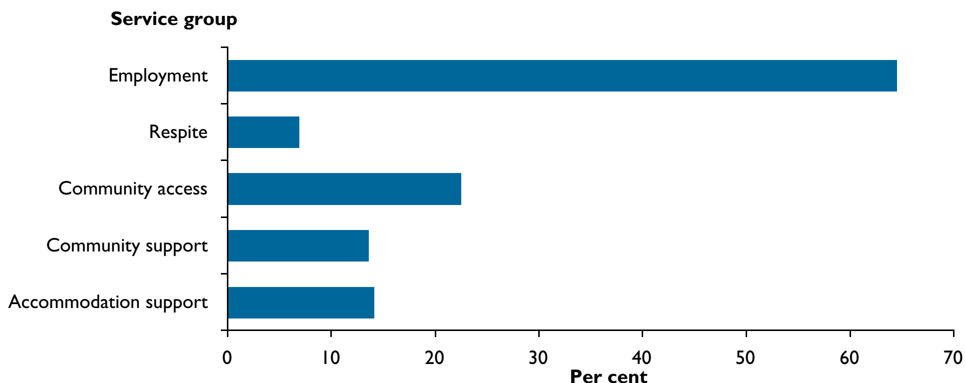


Figure 17: CSTDA/NDA-funded non-residential service users with a psychiatric disability, by service group, 2008–09

How does this non-residential care differ between states and territories?

Victoria had the highest rate for non-residential CSTDA/NDA-funded services (566.4 per 100,000 population), and Northern Territory the lowest (99.2 per 100,000), compared with a national average of 333.5 per 100,000.

Supported accommodation assistance

The Supported Accommodation Assistance Program (SAAP) provides support to people who are homeless or at risk of being homeless (SAAP clients), including those with psychiatric or other mental health problems. Services include transitional supported accommodation and other support services to help them achieve the highest level of self-reliance and independence.

For more information regarding accommodation support services see Section 9 online: Supported Accommodation Assistance

Who used these services?

Clients with mental health-related referrals (17,370) had 24,148 SAAP closed support periods, which represents 12.8% of the total number of closed support periods in 2009–10.

Over half of these clients were aged 25–44 years, and the rate of service access was slightly higher for male clients than female clients. The rate for Indigenous Australians using these services was more than 5 times the rate for non-Indigenous Australians.

How did this care change over time?

There has been an average annual increase of 5.9% in the number of SAAP clients with mental health-related referrals between 2005–06 and 2009–10. Over the same period, there has been an average annual increase of 4.3% in the number of closed support periods for SAAP clients with mental health-related referrals. The proportion of closed support periods that are mental health-related has fluctuated over the past 5 years, between 14.4% and 12.8%.

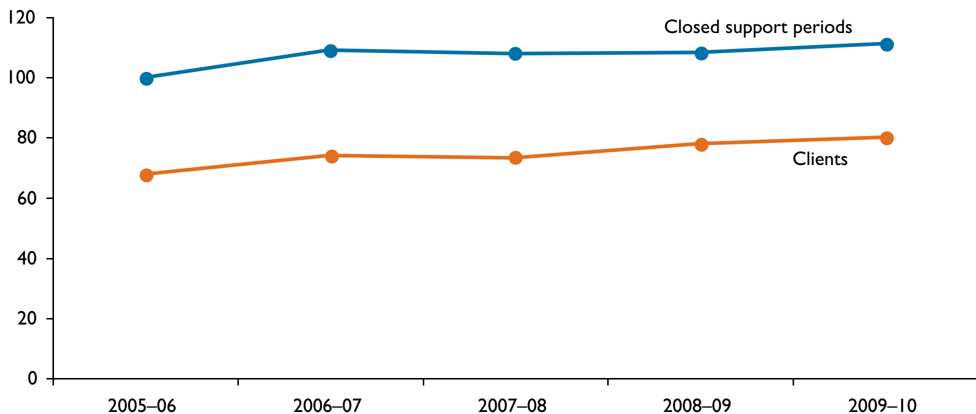


Figure 18: SAAP clients with mental health-related referrals and closed support periods, 2005–06 to 2009–10

What are the characteristics of the care provided?

Nearly 40% of clients were self-referred. The next most common form of referral was from other non-government organisations (8.3%) followed by referrals from other supported accommodation assistance agencies (8.0%). *Mental health issues* or *Psychiatric illness* were the main reasons for seeking assistance. The most common duration for a completed support period was 4–13 weeks, while 5.5% of support periods were longer than 1 year.

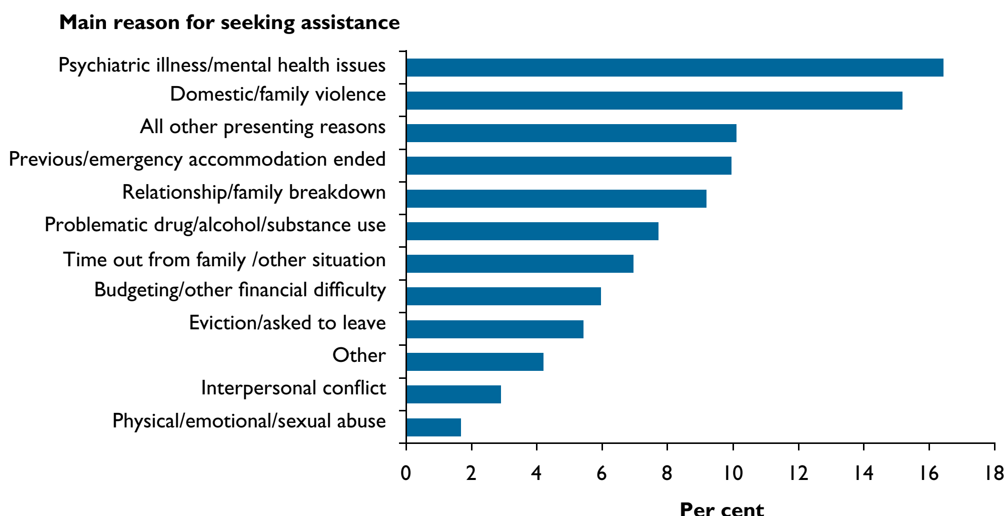


Figure 19: Closed support periods for SAAP clients with mental health-related referrals, by reason for seeking assistance, 2009–10

How does this care differ between states and territories?

The Northern Territory had the highest rate of supported accommodation services per 100,000 population (113.2) for SAAP clients with mental health-related referrals, and Victoria had the lowest (27.2), compared with the national average (46.8). For other support services involving SAAP clients with mental health-related referrals, the rate was highest for Victoria (104.8 per 100,000), compared with the national average (62.3 per 100,000).

What resources are provided?

This section provides information on the resources used or involved in the provision of the mental health-related services described in this report. These resources include: subsidised prescriptions for mental health-related medications; mental health-related workforce; provision of facilities; and funding to deliver these mental health care services.

Prescriptions

For more information regarding prescribed medications see Section 11 online: **Mental health-related prescriptions**

Mental health-related medications include subsidised and non-subsidised prescriptions. Prescriptions subsidised by the Australian Government are provided through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Estimates of the number of non-subsidised prescriptions, including private prescriptions and those for which the price is below the required patient contribution (copayment), are obtained from a Pharmacy Guild survey.

How many prescriptions?

There were an estimated 29 million prescriptions for mental health-related medications dispensed in 2009–10, of which 76% were estimated to have been subsidised by the Australian Government. There were an estimated 7 million non-subsidised prescriptions for mental health-related medications dispensed in 2009–10.

Subsidised prescriptions for mental health-related medications accounted for 11% of all subsidised prescriptions dispensed in Australia.

How did this change over time?

There was an increase in the rate (per 1,000 population) of mental health-related prescriptions dispensed, averaging 1.9% per year between 2005–06 and 2009–10.

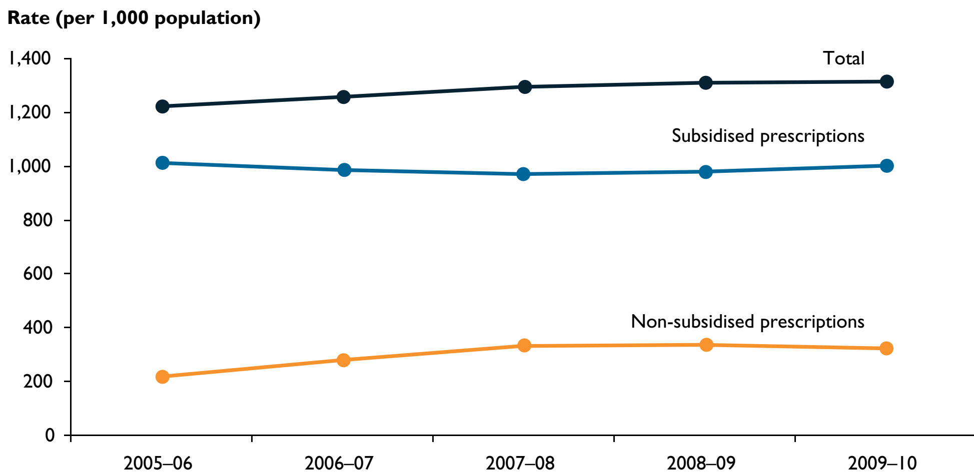


Figure 20: Mental health-related subsidised and non-subsidised prescriptions, 2005–06 to 2009–10

What prescriptions were dispensed and by whom?

Antidepressant medication accounted for nearly 60% (13 million) of all mental health-related subsidised prescriptions dispensed in 2009–10, followed by anxiolytics (14.2%), antipsychotics (12.1%) and hypnotics and sedatives (11.1%).

GPs provided the majority of the prescriptions (85.3%), with 9.4% prescribed by psychiatrists and 5.3% by non-psychiatrist specialists.

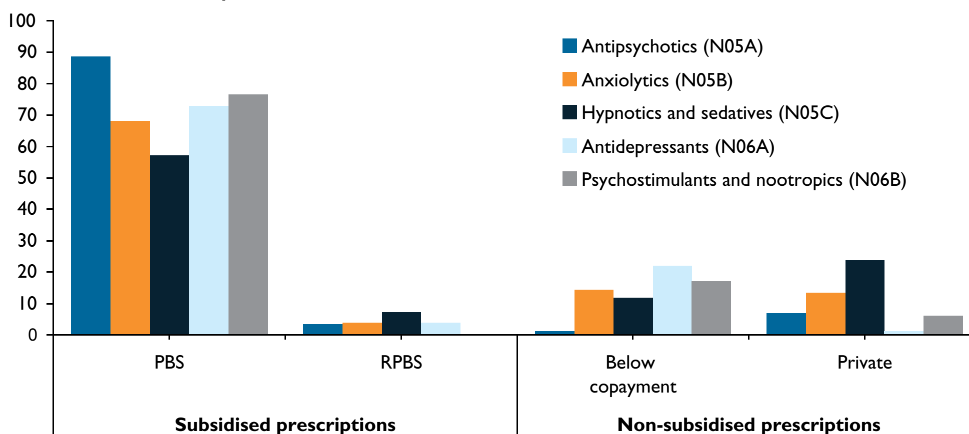


Figure 21: Mental health-related prescriptions, by medication prescribed, 2009–10

How does this differ between states and territories?

The rate of mental health-related subsidised prescriptions was relatively low in the Australian Capital Territory (705 per 1,000 population). In contrast, Tasmania and South Australia had considerably higher rates of prescriptions (1,345 and 1,207 respectively) than the national average (996 per 1,000).

Not surprisingly, the rate of patients receiving these medications (per 1,000 population) had a similar pattern, with a relatively low rate in the Australian Capital Territory, while Tasmania and South Australia reported higher patient rates compared with the national average (106).

Workforce

For more information regarding workforce see Section 13 online: **Mental health workforce**

Health-care professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, provide the mental health-related services described within this report. However, contemporary workforce data is currently only available for psychiatrists and nurses specialising in mental health care and reported here. To enable comparison in the mental health workforce, full-time-equivalent (FTE) figures are provided in addition to the number of psychiatrists and nurses employed.

Who comprises the mental health workforce?

There were an estimated 2,744 psychiatrists and 772 psychiatrists-in-training working in Australia in 2008, comprising 5.1% of all employed medical practitioners. Around 85% worked in *Major cities*, their average age was 48.6 years, and nearly two-thirds were male.

In the same period there were an estimated 15,211 mental health nurses, representing 5.6% of all nurses employed in Australia. They were predominantly working in *Major cities*, and their average age was 46.2 years. One-third of these nurses were male, which is in contrast to the 9.4% reported in the general nursing population (AIHW 2010).

How did this workforce change over time?

There were an estimated 17 FTE psychiatrists per 100,000 population employed in 2008. There has been an average annual increase of 2.0% in the number of FTE psychiatrists employed between 2004 and 2008.

For mental health nurses, there were an estimated 69 FTE per 100,000 population employed in 2008, an average annual increase in the number of FTE nurses of 2.5% since 2004.

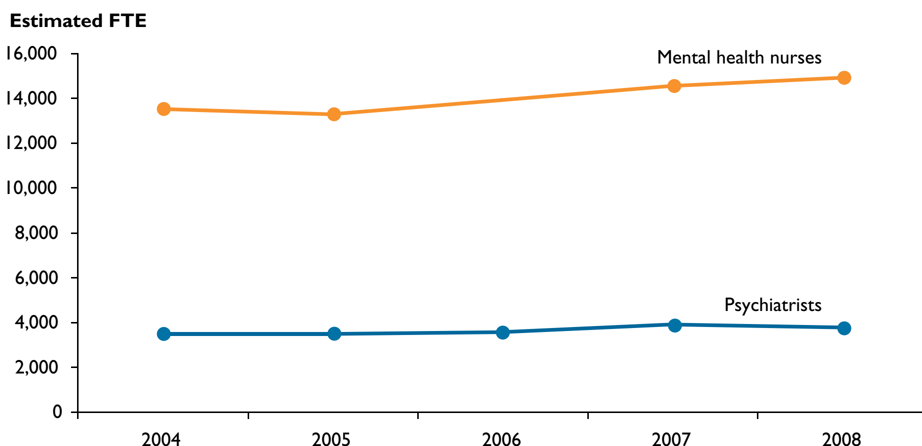


Figure 22: Estimated full-time-equivalent psychiatrists and mental health nurses employed, 2004 to 2008

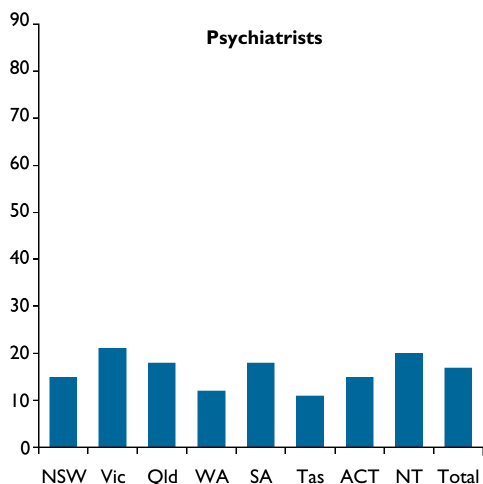
What were the hours of work?

Psychiatrists worked an average of 39.7 total hours per week in 2008. On average, the hours worked were higher for males than females.

Mental health nurses worked an average of 37.0 total hours per week, again with males working more hours than females on average.

How does this workforce differ between states and territories?

The estimated number of FTE psychiatrists per 100,000 population varied between states and territories, ranging from 11 for Tasmania to 21 for Victoria, compared with a national average of 17. For mental health nurses, the national FTE was 69 per 100,000 population and ranged from 54 for Western Australia to 82 for South Australia.



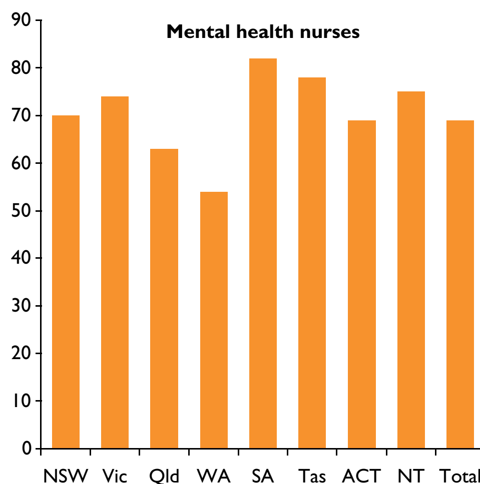


Figure 23: Employed psychiatrists and mental health nurses, 2008

Specialised mental health care facilities

Specialised mental health care in Australia is delivered in and by a range of facilities which include: public and private psychiatric hospitals, psychiatric units in public and private acute hospitals, community mental health care services and residential mental health services.

For more information regarding facilities see Section12 online: **Specialised mental health care facilities**

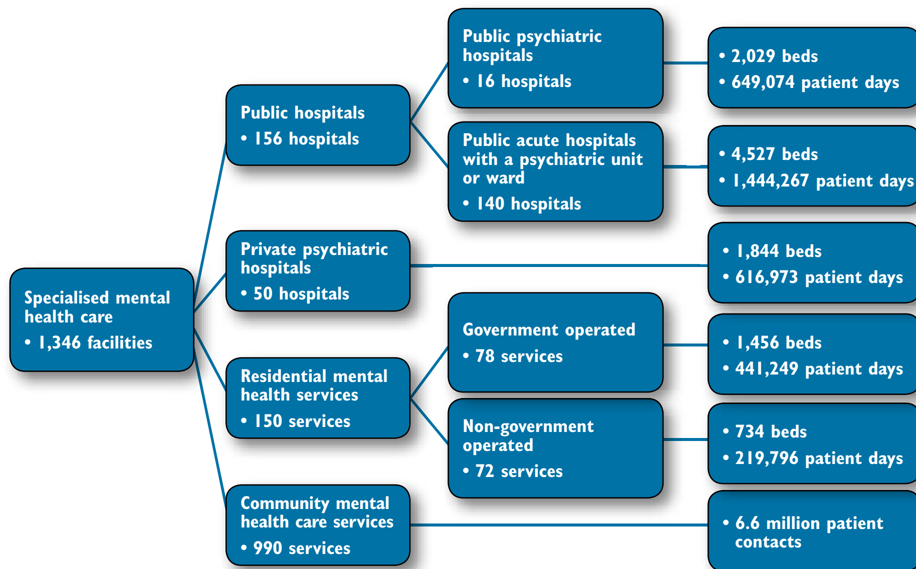


Figure 24: Number of specialised mental health care facilities, available beds and activity in Australia, 2008–09

There were 1,346 specialised mental health care facilities nationwide in 2008–09. Of these 1,296 were state and territory specialised mental health facilities, administered by 208 specialised mental health service organisations. These organisations are equivalent to the area health services or district mental health services in most states and territories. The most common of these organisations comprised a specialised mental health public hospital service and a community mental health care service.

How many specialised mental health beds were available?

There were 8,400 specialised mental health hospital beds available during 2008–09, with 6,556 beds provided by public hospital services and an additional 1,844 beds provided by private hospitals.

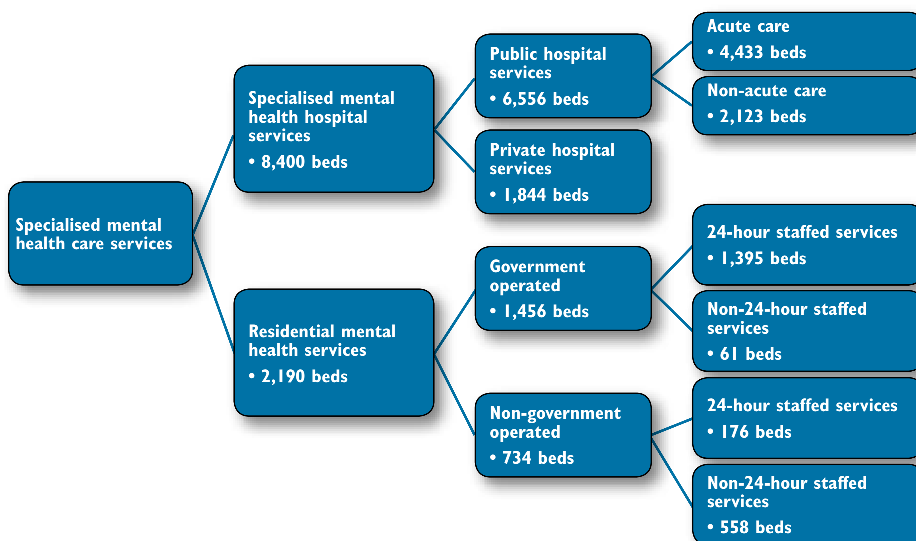


Figure 25: Specialised mental health beds, 2008–09

The number of available specialised mental health beds provided by public hospitals and residential services increased by an average annual rate of 1.6% between 2004–05 and 2008–09.

Two-thirds (4,527) of the 6,556 public sector hospital beds available in 2008–09 were in specialised psychiatric units or wards within public acute hospitals, with the remainder in public psychiatric hospitals. South Australia had the most beds per 100,000 population (35.7), while the Northern Territory had the least (15.3), compared with a national average rate of 30.3 in 2008–09.

There were also 2,190 beds available in residential mental health services, with two-thirds of these provided by government-operated services. Around three-quarters were operated with mental health trained staff working in active shifts for 24 hours a day. Nationally, there were 10.1 residential mental health service beds per 100,000 population available during 2008–09.

24-hour staffed public sector care

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

Tasmania had the highest number of these 24-hour care beds per 100,000 population (44.4), while the Northern Territory had the least (21.2), compared with a national average rate of 37.5 in 2008–09.

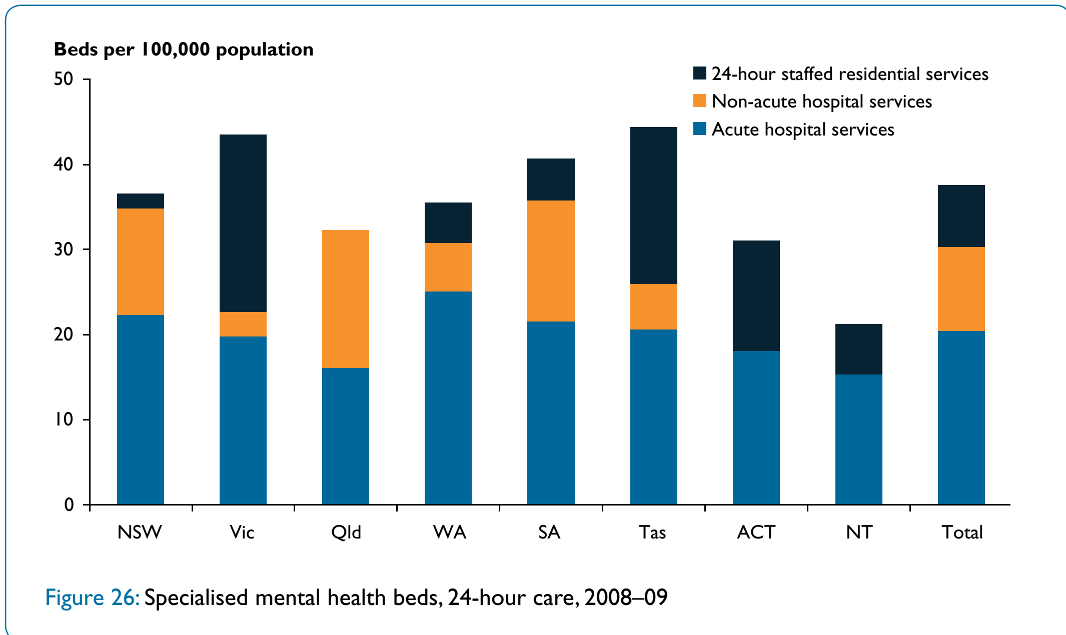


Figure 26: Specialised mental health beds, 24-hour care, 2008–09

How many staff were employed by specialised mental health care facilities in 2008–09?

State and territory services

Over 27,000 FTE staff were employed by state and territory specialised mental health care services in 2008–09. There has been an average annual increase of 3.6% in the number of these FTE staff between 2004–05 and 2008–09.

The majority of this workforce comprised nurses (51.1%), followed by diagnostic and allied health professionals (18.7%) and salaried medical officers (9.5%).

Tasmania had the highest rate (per 100,000 population) of FTE staff (154.1), while the Northern Territory had the least (100.5), compared with a national rate of 127.3 in 2008–09.

Hospital admitted patient services employed 64.2 FTE staff per 100,000 population nationally during 2008–09. Community mental health care services employed 53.3 FTE staff per 100,000 population and residential mental health services employed 9.3 FTE staff per 100,000.

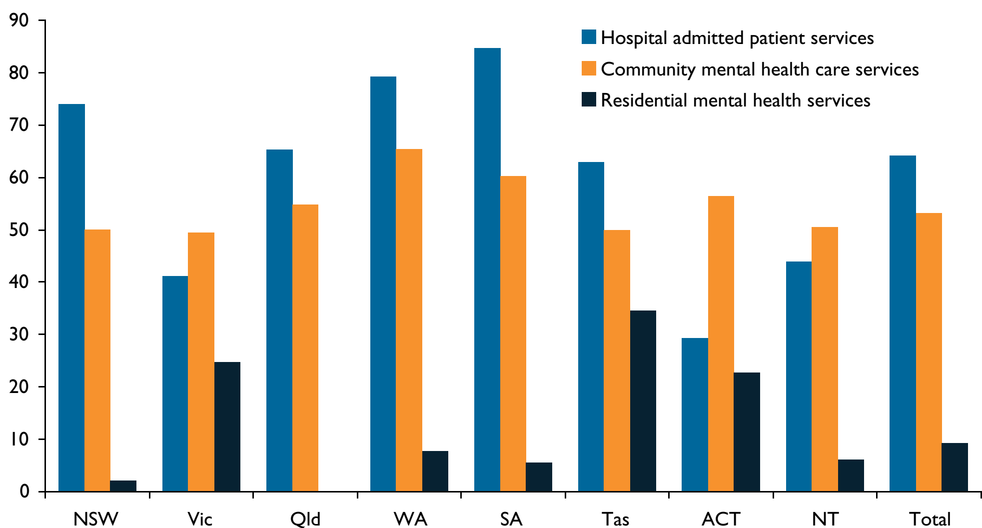


Figure 27: Full-time-equivalent staff in state and territory specialised mental health service units, 2008–09

Private hospital services

In addition to state and territory specialised mental health care services, there were just over 2,300 FTE staff employed by private hospitals providing specialised mental health services in 2008–09, an average annual increase of 4.8% between 2004–05 and 2008–09.

Expenditure on mental health services

Over $5.8 billion, or $272 per Australian was spent on mental health-related services in Australia during 2008–09. This was funded by a combination of state and territory governments, the Australian Government and private health insurance funds. Expenditure on these services has seen an average annual increase of 4.8% per Australian between 2004–05 and 2008–09.

For more information regarding expenditure see Section 14 online: **Expenditure on mental health services**

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

Almost $3.6 billion was spent on state and territory specialised mental health services in 2008–09 (running costs only). The largest proportion was spent on public hospital services for admitted patient mental health care ($1.6 billion) equating to an average cost of $757 per patient day.

Community mental health care accounted for $1.4 billion. $207 million was spent on residential mental health services with the majority of the expenditure in 2008–09 being for 24-hour staffed services.

Expenditure on state and territory services has increased from $142 per Australian to $166 between 2004–05 and 2008–09, an average annual increase of 4.0%.

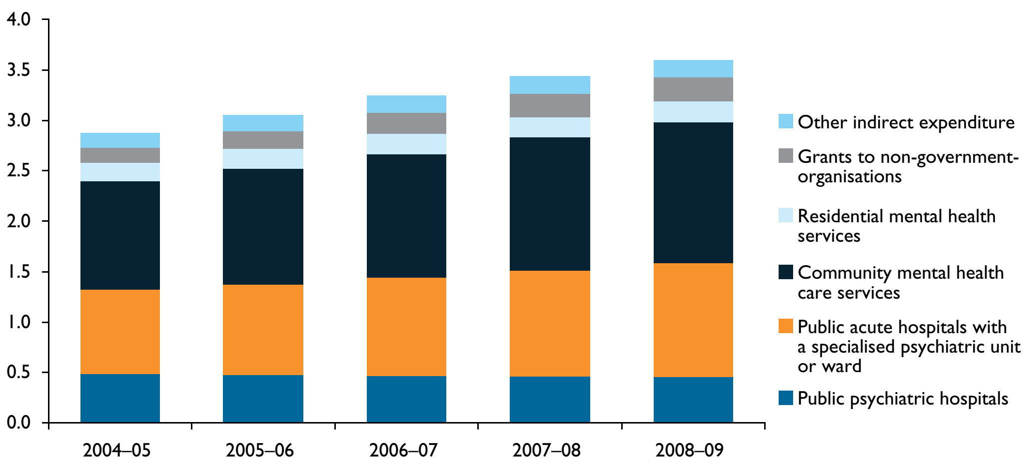


Figure 28: Recurrent expenditure on state and territory specialised mental health services, 2004–05 to 2008–09

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

The Australian Government spent $2.2 billion on mental health-related services in 2008–09, an average annual increase of 7.5% in expenditure between 2004–05 and 2008–09. During 2008–09, the majority ($1.4 billion) was spent on MBS-subsidised mental health-related services and PBS/RPBS-subsidised prescriptions for mental health-related medications.

Australian Government expenditure on mental health-related services has increased from $80 per Australian to $100 between 2004–05 and 2008–09, an average annual increase of 5.8%.

Spending on MBS-subsidised services and PBS/RPBS-subsidised prescriptions has continued to increase, which is evident in the most recently available 2009–10 data.

How much was spent on MBS-subsidised services in 2009–10?

The 2009–10 data shows that $755 million was paid in benefits for MBS-subsidised mental health-related services, equating to 4.9% of total Medicare expenditure. This spending averaged at $34 per Australian, which has increased by an average annual rate of 28.5% between 2005–06 and 2009–10. The largest portion of this spending was for services provided by psychologists (38.0%), followed by psychiatrists (34.3%) and GPs (25.7%).

How much was spent on PBS/RPBS-subsidised prescriptions in 2009–10?

In 2009–10, $770 million was spent on mental health-related subsidised prescriptions, equating to 9.7% of all subsidised prescriptions. This averaged at $35 per Australian, and has increased by an average annual rate of 2.3% between 2005–06 and 2009–10. Almost three-quarters of the expenditure on subsidised prescriptions were for prescriptions issued by GPs, followed by psychiatrists and non-psychiatrist specialists. Antipsychotics and antidepressants accounted for the majority of expenditure, 50.9% and 40.9% respectively.

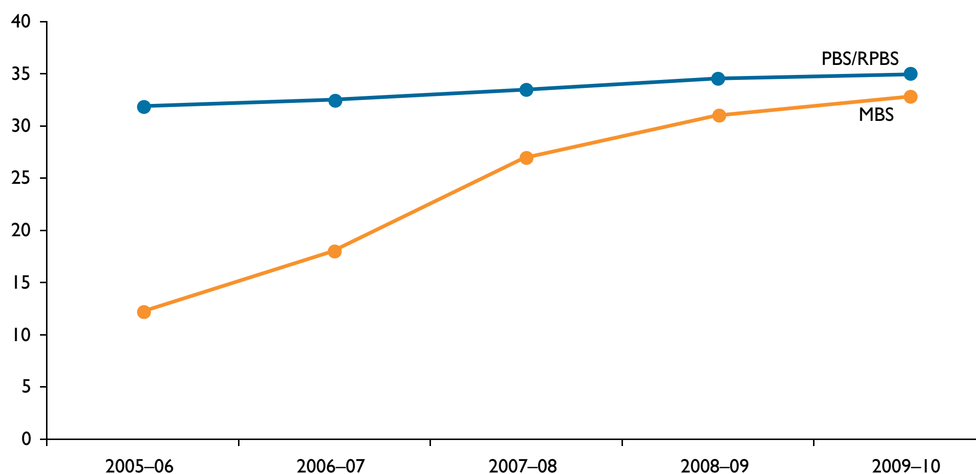


Figure 29: Australian Government expenditure on mental health-related MBS and PBS/RPBS, 2005–06 to 2009–10

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Mental health services—in brief 2011 provides an overview of the characteristics and activity of Australia's mental health services, the availability of mental health resources and the changes that have occurred in these over time.

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