Tracking progress of mental health
reform in Australia, 1993-2011

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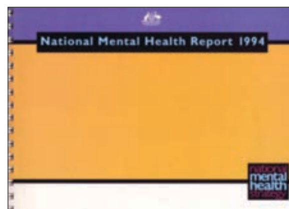
Guide to the National Mental Health Report series

National Mental Health Report 1993

Released: March 1994
Coverage: 1992-93 'baseline year'

National Mental Health Report 1994



Released: May 1995
Coverage: Progress in 1993-94

National Mental Health Report 1995

Released: July 1996
Coverage: Progress to 1994-95

National Mental Health Report 1996

Released: March 1998
Coverage: Progress to 1995-96

National Mental Health Report 1997

Released: March 1999
Coverage: Progress to 1996-97

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Coverage: Progress to 1997-98

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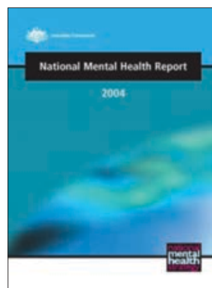

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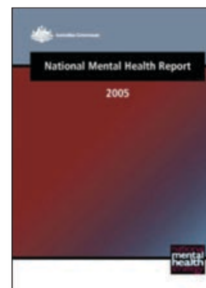
Coverage: Progress to 2001-02

National Mental Health Report 2005



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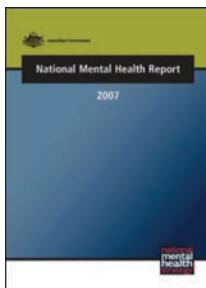
National Mental Health Report 2007



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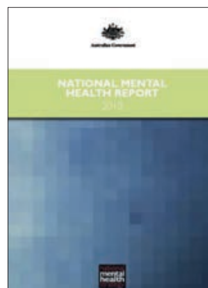

Released: December 2010
Coverage: Progress to 2007-08

National Mental Health Report 2013

Released: October 2013
Coverage: Progress to 2010-11

About the cover

Cover image

NEG, *Landscape of the Mind, 2005*, watercolour on paper, 32 x 24 cm
The Cunningham Dax Collection. www.daxcentre.org

Artist Profile

NEG has had an experience of mental illness since the age of nine. Following participation in the Prahran Mission's 2nd Story Program, she took a place as an artist in their Stables Studio. NEG has undertaken a Writing and Editing course at RMIT and various art therapy sessions. She has also worked as a secondary school teacher and bookshop assistant.

Artist Statement

"A friend once told me you never want to fight your demons, they always win. You can escape them tho' and ***that's what art does:*** you're so focussed on what you're doing: get that line just right, that shading there, and so on, that the demons don't even get a look in, unless you're drawing them, and like vampires they really don't like that, (They're 'sprung' as it were) so they just give up out of boredom and wander off until the next time they can take you by surprise." NEG, 2008, *The Borderline Picture Book.*

About the Cunningham Dax Collection

The Cunningham Dax Collection, amassed over a 70 year period, consists of over 15,000 artworks including works on paper, photography, paintings, sculptural work, journals, digital media and video created by people with an experience of mental illness and/or psychological trauma. The Cunningham Dax Collection is part of the Dax Centre. The Dax Centre promotes mental health and wellbeing by fostering a greater understanding of the mind, mental illness and trauma through art and creativity.

For more information on the Cunningham Dax Collection, The Dax Centre and to view the online gallery of past exhibitions, visit: www.daxcentre.org

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Foreword

Mental health reform has been a longstanding priority for all governments, commencing with the endorsement of the National Mental Health Strategy by Australian Health Ministers in 1992. Through various changes in government at the federal, state and territory levels, the Strategy has continued as a bipartisan reform agenda and the *National Mental Health Report* series has been maintained as the prime vehicle for monitoring reform progress. Continuation of the report was mandated in the *Fourth National Mental Health Plan* and its scope broadened to incorporate reporting on progress against the outcome indicators and actions agreed in the Plan. *The Fourth Plan* also required the report to be endorsed by all Health Ministers.

The current report is the twelfth in the series. It summarises the system level changes that have taken place in mental health between 1993 and 2011. As such, the report provides a view of trends and performance at the national and state and territory levels over the period spanning the first, second and third National Mental Health Plans and the first two years of the *Fourth National Mental Health Plan*. The time series and breadth of coverage of the report is unparalleled internationally.

It is clear from the information presented in this report that much has changed over the course of the National Mental Health Strategy. All governments have increased their reform efforts in recent times with significant investments in clinical and community support services. A key finding of the report is that government spending on mental health has outpaced overall health spending growth in recent years, with the result that mental health as a proportion of health expenditure in 2010-11 was the highest (7.7 per cent) recorded since the *National Mental Health Report* series commenced in 1993.

Readers of previous National Mental Health Reports will know that the report only tells part of the story. While the focus of the report on resources and high level indicators is essential, it does not tell us about what it is like to experience services from the perspective of those that they serve. For this we need different reporting arrangements that give greater transparency to the performance of mental health services from the perspective of people with a lived experience of mental illness, their families and carers. The recent addition of the annual *National Report Card on Mental Health and Suicide Prevention*, prepared by the National Mental Health Commission, serves this function and adds an important complement to the *National Mental Health Report.*

Despite the achievements made over the course of the National Mental Health Strategy, consumers, carers and other stakeholders rightly emphasise that much remains to be done to build a modern, responsive mental health system in Australia. It is important to note in this context that all governments renewed their commitment to further mental health reform with the endorsement and release by the Council of Australian Governments (COAG) in December 2012 of the *Roadmap for National Mental Health Reform 2012-2022.* The Roadmap outlines the directions that will be taken by governments over the next ten years and sets out new governance and accountability arrangements designed to directly engage stakeholders and ensure that governments are held to account. These new arrangements include the establishment of a COAG Working Group on Mental Health Reform that is required to develop, by mid-2014, a successor to the *Fourth National Mental Health Plan* that will set out how the Roadmap will be implemented.

Alongside the release of the Roadmap and pending development of a new National Mental Health Plan, states and territories have developed their own mental health plans that reflect the goals and principles of the national approach, but have been tailored to meet local requirements. Jurisdictions' own plans remain the key documents for setting out the specific details of how they will work towards achieving the objectives agreed under the National Mental Health Strategy.

On behalf of Australia's Health Ministers, I am pleased to endorse this twelfth *National Mental Health Report*, prepared by the Australian Government Department of Health and Ageing. These reports entail considerable work by many people including consumers, carers, service providers and the mental health units of various state and territory health administrations. I wish to extend my thanks to all who have contributed to the report.

The Hon Michelle O'Byrne MP
Chair
Standing Council on Health

July 2013

Acknowledgements

This report has been produced by the Australian Government Department of Health and Ageing. Drafting of the report was undertaken by a consortium led by the University of Melbourne, a consultancy arrangement managed by the Department of Health and Ageing. The report relies on data that could not have been presented without the cooperation of many people and organisations throughout Australia. In particular, the Department of Health and Ageing would like to acknowledge the assistance and cooperation of:

- State and territory governments for providing data through the various mental health National Minimum Data Sets, and other data submitted to the Department of Health and Ageing for the purposes of this report;

- The Department of Veterans' Affairs and Department of Families, Housing, Community Services and Indigenous Affairs for providing information on mental health initiatives and services;

- The Australian Bureau of Statistics for providing data from the annual Private Hospitals Establishment Collection, and updated data in relation to suicide statistics;

- The Private Mental Health Alliance for providing data in relation to mental health services delivered by the private hospital sector;

- The Pharmaceutical Benefits Division and Medicare Benefits Division of the Department of Health and Ageing for providing data in relation to mental health expenditure and services delivered through their respective programs;

- The Mental Health Information Strategy Standing Committee and its National Mental Health Report Editorial Advisory Group for providing expert advice on the drafting of the report;

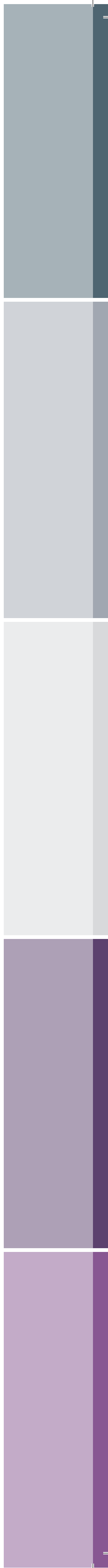
- The Australian Institute of Health and Welfare for its work in managing the mental health National Minimum Data Sets and for its detailed quality review of data used in this report;

- Strategic Data Pty Ltd, for providing the technical services to enable data processing and web based validation of the mental health National Minimum Data Set, and for data management associated with the production of this report;

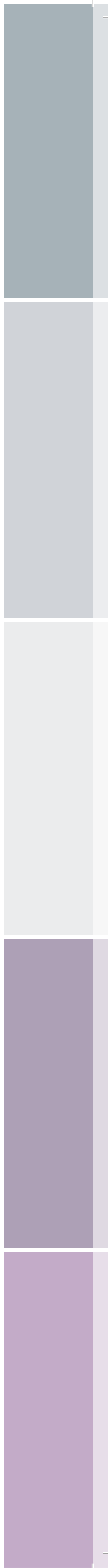
- Buckingham and Associates Pty Ltd, for assisting the Department of Health and Ageing with data analysis and advice on drafting the report.

Finally, the Department expresses its appreciation to the University of Melbourne consortium for its skilled work in drafting this report, and Richard O'Gorman for graphic design.

Whilst responsibility for conclusions drawn in this report is held by the Department of Health and Ageing, the contribution and assistance of all persons and organisations that contributed to its production are gratefully acknowledged.



Key messages



System-level indicators of mental health reform in Australia, 1993 to 2011

National spending on mental health

- The original commitment made by all governments to protect mental health resources under the National Mental Health Strategy has been met. Total government expenditure on mental health increased by 178% in real terms between 1992-93 and 2010-11. In 2010-11, Australia spent $4.2 billion more of public funds on mental health services than it did at the commencement of the Strategy in 1992-93.

- Until recently, growth in mental health spending mirrored overall health expenditure trends for most of the 18 year period since the Strategy began. In the most recent year (2010-11), mental health increased its position in terms of relative spending within the broader health sector.

- Australian Government spending has increased by 245% compared to an increase of 151% by state and territory governments. This increased the Australian Government share of total national spending on mental health from 28% in 1992-93 to 35% in 2010-11. Most of the increase in Australian Government spending in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently other activities have taken over as the main drivers of increased mental health spending.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*. The gap between the highest spending and the lowest spending jurisdiction increased over the 1992-93 to 2010-11 period. The disparity between the states and territories points to wide variation in the level of mental health services available to their populations.

- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.

National workforce trends

- The direct care workforce employed in state and territory mental health services increased by 72%, from 14,084 full-time equivalent (FTE) in 1992-93 to 24,292 FTE in 2010-11

- On a per capita basis, this equates to an increase from 80 FTE per 100,000 in the former period to 108 FTE per 100,000 in 2010-11, or an

increase of 35%. New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%).

- Nationally, the absolute increase in the direct care workforce size of 72% was lower than the increase in recurrent expenditure on state and territory inpatient and community-based services (119%). Factors such as rising labour costs and increases in overhead and infrastructure costs may contribute to this discrepancy.

- At a conservative estimate, 3,119 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).

- In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. The workforce mix mainly comprised nurses (1,165, 77%) and allied health professionals (310, 20%). Medical practitioner services provided to consumers treated in private hospitals are delivered primarily through the Medicare Benefits Schedule rather than direct employment arrangements.

Trends in state and territory mental health services

- Between 1992-93 and 2010-11, annual state and territory government spending on services provided in general hospitals and the community grew by $2.6 billion, or 283%. This was accompanied by a decrease in spending on stand-alone psychiatric hospitals of $289 million, or 35%. About two thirds of the $2.6 billion was invested in community-based services (ambulatory care services, services provided by non-government organisations or NGOs, and residential services). The remaining third was spent on increased investment in psychiatric units located in general hospitals.

- Funding to ambulatory care services increased between 1992-93 and 2010-11 by 291% (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce in these services also increased, but not by the same magnitude (215%).

- The non-government community support sector's share of the mental health budget increased from 2.1% to 9.3%, with $372 million allocated to NGOs in 2010-11. Psychosocial support services account for about one third of this funding, and staffed residential mental health services accounted for about one fifth.

- Community residential support services expanded between 1992-93 and 2010-11. The number of 24 hour staffed general adult beds doubled (from 410 to 846). The number of 24 hour staffed older persons' beds was also higher in 2010-11 (682) than it was in 1992-93 (414) although it reached a peak in 1998-99 (805) and has been declining since then. The number of non-24 hour staffed beds in general adult residential services and the number of supported public housing places also increased with time.

- The number and mix of inpatient beds has changed during the course of the National Mental Health Strategy. There were significant decreases in beds in stand-alone psychiatric hospitals in the early years of the Strategy, particularly non-acute beds and general adult and older persons' beds. These decreases have been followed by more gradual declines in recent years. The decreases have been accompanied by commensurate increases in psychiatric beds in general hospitals, particularly acute beds. The average bed day costs in inpatient settings have increased (by 77% in stand-alone hospitals and by 51% in general hospitals).

Trends in private sector mental health services

- There was significant growth in mental health care activity in private hospitals between 1992-93 and 2010-11. Bed numbers in specialist psychiatric units in private hospitals increased by 40%, the number of patient days increased by 106%, and the number of full-time equivalent staff increased by 87%. Expenditure by private hospital psychiatric units grew by 142% between 1992-93 and 2010-11.

- Medicare Benefits Schedule (MBS) expenditure on mental health services increased significantly with the introduction of the Better Access program. Better Access provided a rebate on the MBS for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists. In 2006-07, MBS expenditure on mental health services had reached a low of $474 million. In 2007-08, the first full year of Better Access, there was a sharp increase to $583 million, and by 2010-11 the overall MBS mental health specific expenditure figure rose to $852 million, accounting for 35% of overall Australian Government mental health spending.

- In 1992-93, services provided by psychiatrists and general practitioners accounted for all of the MBS expenditure on mental health services. By 2010-11, MBS-subsidised services provided by medical practitioners were complemented by services delivered by clinical psychologists, registered psychologists and other allied health professionals who accounted for 41% of MBS mental health specific expenditure.

- In 2011-12, 1.6 million people received mental health services subsidised by the Medicare system, some from several providers. In total, 7.9 million mental health services were provided in that year.

Consumer and carer participation in mental health care

- In 2010-11, about half of Australia's state and territory mental health services had either appointed a person to represent the interests of mental health consumers on their organisational management committees or had a specific Mental Health Consumer/Carer Advisory Group established to advise on all aspects of service delivery. However, one quarter had no structural arrangements in place for consumer and carer participation.

- Significant proportions of state and territory mental health services also had some other arrangements in place for consumer and carer participation, although the extent to which organisations had established particular initiatives varied. Mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

- In 2010-11, there were 4.6 consumer and carer workers employed for every 1,000 full-time equivalent staff in the mental health workforce. This figure has risen by 33% since 2002-03, when it was 3.5 per 1,000.

- In recent times, there have been a number of consumer and carer developments that have had an increased emphasis on social inclusion and recovery. For example, the recently established National Mental Health Commission has produced its first *Report Card*, identifying and reporting on several areas that are important to consumers' ability to lead a contributing life. Moves are also underway to establish a new national mental health consumer organisation, auspiced by the Mental Health Council of Australia, that will ensure that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform.

Monitoring progress and outcomes under the *Fourth National Mental Health Plan*

Priority area 1: Social inclusion and recovery

Indicator 1a: Participation rates by people with mental illness of working age in employment: General population

- In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness.

- Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory.

- Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62% in 2011-12.

Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population

- In 2011-12, 79% of Australians aged 16–30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, compared to 90% of their same age peers.
- Employment and education participation rates for this group for most states and territories were within 10% of the national average.
- Nationally, employment and education participation rates for this group remained stable between 2007-08 and 2011-12.

Indicator 3: Rates of stigmatising attitudes within the community

- Social distance is a term used to indicate the willingness of people to interact with people experiencing mental illness. In 2011, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to interact socially with people with a mental illness. Stigmatising attitudes varied across the different types of mental illness, with the average desire for social distance being highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.
- Comparing the 2011 results with equivalent data from 2003-04, Australians' desire for social distance from people with depression with suicidal thoughts had decreased. However, their desire for social distance from people with depression without suicidal thoughts, early schizophrenia and chronic schizophrenia remained relatively unchanged.
- There is evidence that the efforts of organisations like *beyondblue* may have contributed to this improvement, at least in the case of depression.

Indicator 4: Percentage of mental health consumers living in stable housing

- Nationally, the percentage of adult consumers of state and territory mental health services (aged 15-64) with no significant problems with their living conditions has been stable from 2007-08 to 2010-11 (sitting at around 78%). Consumers in the Australian Capital Territory were the least likely to report problems and those in the Northern Territory were the most likely to do so.
- The percentage of older adult consumers (aged 65+) with no significant problems with their living conditions has shown a slight improvement over time, rising from 79% in 2007-08 to 83% in 2010-11. Older consumers in New South Wales were the least likely to report problems, and those in Tasmania were the most likely to do so.
- Safe, secure and affordable accommodation is critical to recovery for people with living with a mental illness.

Priority area 2: Prevention and early intervention

Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum

- Australia has invested significant resources in programs that promote mental health literacy in schools – notably MindMatters in secondary schools and Kidsmatter in primary schools.
- In 2011, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources.

Indicator 7: Rates of contact with primary mental health care by children and young people

- There was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177). This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so.
- The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).
- This improvement is largely due to the introduction of the Better Access initiative in 2006.

Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people

- Data from the National Drug Strategy Household Survey show that use of both licit and illicit drugs has decreased over time.
- In 2001, 47% of 14-29 year olds engaged in risky drinking in the previous year. This had reduced to 42% by 2010, the lowest figure recorded to date.
- In 1998, 36% of 14-29 year olds used cannabis. By 2010, this figure had halved (19%), although the latter figure represented a rise from 2007.
- Ten per cent of 14-29 year olds used amphetamines in 1998 compared with 4% in 2010. As with alcohol, these are the lowest figures recorded to date.

Indicator 9: Rates of suicide in the community

- In 2011, there were 2,273 suicides in Australia, 76% of which were by males.
- Nationally, the average annual suicide rate for the period 2007-11 was 10.6 per 100,000 (16.3 per 100,000 for males; 4.9 per 100,000 for females). The Northern Territory stood out as having particularly high rates.
- The average suicide rate has remained stable since 2003-07. The rate is considerably lower than it was before Australia began its concerted efforts to address suicide through strategic national action.

Indicator 11: Rates of understanding of mental health problems and mental illness in the community

- In 2011, nearly three quarters (74%) of Australian adults could recognise depression. This figure was even higher (86%) for depression accompanied by suicidal thoughts.
- Rates of recognition of early and chronic schizophrenia and post-traumatic stress disorder were lower, with only about one third of the population being able to recognise these disorders. Rates of recognition of social phobia were the worst at 9%.
- Rates of recognition of depression have improved since 1995, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since. Recognition of post-traumatic stress disorder and social phobia were only assessed in 2011, so no comparison data are available.

Indicator 12: Prevalence of mental illness

- In 1997, 18% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders) in the past 12 months. In 2007, the figure was slightly higher at 20% but this may be explained by methodological differences in the way in which these prevalence figures were gathered.
- In both 1997 and 2007, young adults experienced higher rates of mental illness than older adults.
- In 1998, 14% of children and adolescents were affected by a clinically significant mental health problem. More current data will be collected in 2013.

Priority area 3: Service access, coordination and continuity of care

Indicator 13: Percentage of population receiving mental health care

- The percentage of the population seen by state and territory community mental health services from 2006-07 to 2010-11 remained relatively stable at 1.5%.
- The percentage of the population receiving mental health specific Medicare-funded services rose from 3.1% in 2006-07 to 6.9% in 2010-11. This increase was largely due to the introduction and uptake of services provided through the Better Access initiative.
- Targets for population coverage by mental health services are yet to be agreed but are expected to be advanced as part of the continuing development of the *Roadmap for Mental Health Reform*[1] agreed by the Council of Australian Governments (COAG) in December 2012.

Indicator 14: Readmission to hospital within 28 days of discharge

- In 2010-11, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 15% nationally. This figure has been stable since 2005-06.
- Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%). South Australia's figures should be interpreted with caution because they may represent an undercount.
- There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

Indicator 15: Rates of pre-admission community care

- In 2010-11, 47% of admissions to state and territory acute inpatient psychiatric units were preceded by community care in the seven days before the admission. This figure represents a small improvement over recent years.
- There is considerable cross-jurisdictional variability. The Australian Capital Territory is the only jurisdiction to have achieved rates above 70%, with 76% of its acute inpatient admissions in 2010-11 being preceded by community care in the seven days prior to admission.
- The 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

Indicator 16: Rates of post-discharge community care

- In 2010-11, 54% of Australian admissions to state and territory acute psychiatric inpatient units were followed by community care (in the seven days after discharge). This percentage has been improving incrementally since 2005-06.
- There is substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory).

Indicator 19: Prevalence of mental illness among homeless populations

- Routinely collected data from the former Supported Accommodation Assistance Program (SAAP) suggests that, in 2010-11, 11% of SAAP clients sought accommodation because of mental health problems, 9% did so because of substance use problems, and 7% did so because of comorbid mental health and substance use problems.
- These figures are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral.
- From July 2011, the Special Homelessness Services (SHS) collection will enable more accurate estimates of mental illness among homeless populations to be calculated.

Indicator 20a: Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities

- In 2010, 31% of new entrants to adult prisons reported having been told by a health professional that they had a mental illness, 16% reported that they were currently taking mental health related medication, and 14% reported very high levels of psychological distress.
- These figures indicate that new prisoners have poorer mental health than the general population.
- Ongoing collaborative efforts between the health and justice sectors are required to reduce the prevalence of mental illness among prisoners.

Priority area 4: Quality improvement and innovation

Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers

- Nationally, in 2010-11, 4.6 per 1,000 (or 0.5%) of the total full-time equivalent (FTE) mental health workforce was accounted for by consumer and carer workers. This represents an increase of 33% since the 2002-03 level of 3.5 FTE per 1,000 (0.3%). This growth is due to an almost fourfold increase in the number of FTE carer workers per 1,000, compared to a slight decrease in FTE consumer workers per 1,000.

- There is substantial variation across jurisdictions, with the highest proportions in South Australia (6.3 per 1,000 in 2010-11, or 0.6%) and Victoria (6.1 per 1,000, 0.6%), and the lowest rates in the Australian Capital Territory and the Northern Territory (0.0 per 1,000, or 0.0%).

Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

- In 2010-11, 84% of specialised mental health services in Australia had undertaken external accreditation and been judged to meet all standards set out in the National Standards for Mental Health Services (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4).

- In two jurisdictions (the Australian Capital Territory and the Northern Territory) 100% of services met the standards set for Level 1. Three others (Queensland, Victoria and South Australia) came close to this, with at least 96% of their services achieving Level 1. In other states the proportion of services achieving Level 1 was lower. In New South Wales (79% at Level 1) and Tasmania (48% at Level 1), the balance of services had undertaken external review and reached threshold for Level 2, whereas in Western Australia (49% at Level 1), the balance had not completed external review and were graded as Levels 3 or 4.

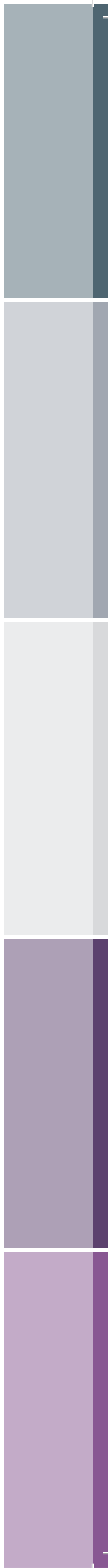
- Ongoing effort is required to ensure more uniform levels of accreditation across jurisdictions.

Indicator 23: Mental health outcomes for people who receive treatment from state and territory services and the private hospital system

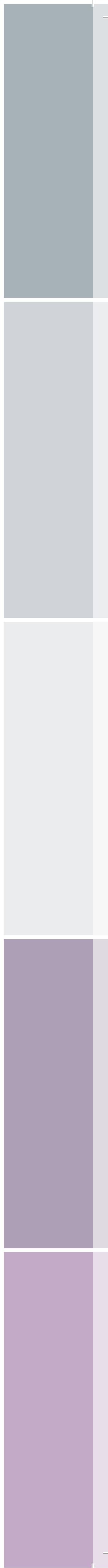
- Around three quarters of consumers admitted to state and territory public sector mental health inpatient services improve significantly, just under one quarter show no change, and a small percentage deteriorate. This pattern also holds true in private psychiatric hospital units.
- In state and territory community services, the picture depends on the nature of the episode of care. Fifty per cent of those who receive relatively short term care and are then discharged improve significantly, 42% show no change, and 8% deteriorate. Twenty six per cent of those who receive longer term, ongoing care show significant improvement, 58% show no change, and 16% deteriorate.
- This picture is complex and requires careful interpretation in light of the goals of care within each setting and for each type of episode and the limitations of the measurement process. Further work needs to be done to determine what outcomes are consistent with a service system offering ‘best practice’ care across the board.

Profiles of state and territory reform progress

- State and territory data are provided on a range of indicators of resourcing levels, outputs and outcomes.
- The comparisons emerging from the data highlight differences in service levels and mix, outputs and outcomes, as well as identifying common ground between the various mental health service systems in Australia.
- In interpreting relative progress, it is important to recognise the different histories, circumstances and priorities of each jurisdiction, and the requirement for mental health service planning to be based on local population needs.



Part 1: Introduction
and background



1.1 Purpose of the report

At the time of releasing this report, Australia is at the beginning of a third decade of targeted reform of mental health services that is referred to as the National Mental Health Strategy. Commencing in April 1992 with the endorsement by Health Ministers of a *National Mental Health Policy*,[2] the National Mental Health Strategy committed governments to undertake action within their respective jurisdictions, as well as to collaborate on policy and service development issues requiring a national focus. This was the first attempt in Australia to set a common course of action by governments in the development of public mental health services which had been the exclusive responsibility of the eight state and territory governments since Federation.

Much has changed since the original agreement of 1992, with the Strategy progressing through a series of five year national mental health plans, and more recently, a number of whole-of-government national plans and initiatives endorsed through Australia's peak intergovernmental coordinating body, the Council of Australian Governments (COAG). The national policy environment for mental health reform in Australia is now far more complex than was the case when the original agreement to a *National Mental Health Policy* was signed in 1992.

The *National Mental Health Report* has been a constant throughout this process. In agreeing to the National Mental Health Strategy, Health Ministers recognised that an important aspect of the reform process was to ensure that progress is monitored and publicly reported. The *National Mental Health Report* was prescribed as the main vehicle for this to be achieved.

Its original stated purpose was to:

- present relevant information about the resources that underpin mental health service delivery (human and financial), their funding sources and how those resources are being applied to achieve the national reform aspirations;
- monitor changes that have taken place in the provision of mental health care;
- act as an information resource on the state of mental health services in Australia, for use by a range of interested parties; and
- improve community understanding of the reform of Australia's mental health services.

The *Fourth National Mental Health Plan*,[3] covering the current period to 2014, placed greater emphasis on monitoring of outcomes than its predecessors and committed to a restructured *National Mental Health Report*. The current report is consistent with this new focus. It includes the most current information on a series of indicators associated with particular outcomes, and reports on the progress of the actions committed to by governments in each of the five priority areas outlined in the *Fourth Plan*. At the same time, it continues to provide an analysis of the key measures that were central to all previous *National Mental Health Reports* (for example, per capita expenditure, workforce levels, hospital/community mix).

This redesigned *National Mental Health Report*, the twelfth in the series, draws on a range of sources to present an analysis of reform trends, and has the imprimatur of Health Ministers who have bound their respective administrations to collecting and reporting on relevant data in a timely fashion. The reference year for the majority of the data presented in the report is 2010-11.

1.2 The magnitude of the problem: Indicators of mental illness in Australia

In order to examine the achievements of the National Mental Health Strategy, it is necessary to gauge the number of people affected by mental illness in the Australian population, and to understand how mental illness affects their lives.

When the National Mental Health Strategy began, no information was available about the extent and impact of mental illness in Australia, so, in the late 1990s, a program of population surveying was commenced. Known collectively as the National Survey of Mental Health and Wellbeing, it comprised three cross-sectional surveys. The first took place in 1997 and investigated the prevalence and impact of common mental disorders (depression, anxiety and substance use disorders) in adults.[4] The second survey, also conducted in 1997 and targeted at adults, focused on the less common mental illnesses (in particular, psychotic disorders).[5] Because neither of the first two surveys could shed light on young people's mental health, the third study was commissioned in 1998 to capture information about the mental health of children and adolescents.[6] The two surveys of adults were repeated in 2007 and 2010, respectively.[7-9] A new survey of children and adolescents has been commissioned and will be conducted in 2013. More detail about the scope of these studies is provided in Table 1 National Survey of Mental Health and Wellbeing: Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia. The text below the table draws on data from the most recent surveys only.

Table 1
National Survey of Mental Health and Wellbeing Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia

Survey	Year	Target group and focus	Sample size	Recruitment method	Data collection method	Prevalence estimates
Survey of adult population	1997	Adults (aged 18+), common mental disorders (depression, anxiety and substance use)	10,641	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 17.7%
	2007	Adults (aged 16-85), common mental disorders (particularly depression, anxiety and substance use disorders)	8,841	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 20.0% Lifetime prevalence (community): 45.0%
Survey of people living with psychotic illness	1997	Adults (aged 18-64), psychotic disorders	980	Recruited through specialist mental health services, GPs and private psychiatrists	Census, interviews, information from service providers	One month prevalence (treated): 0.4-0.7%
	2010	Adults (aged 18-64), psychotic disorders	1,825	Recruited through specialist mental health services and non-government organisations	Census, interviews, information from GPs and other service providers	One month prevalence (treated): 0.3%; One year prevalence (treated): 0.5%
Survey of children and adolescents	1998	Children and adolescents (aged 4-17), common mental disorders	4,509	Recruited through households	Interviews	Point prevalence (community): 14.1%
	Survey in the field May to December 2013	Children and adolescents (aged 4-17), common mental disorders	6,300	Recruited through households	Structured diagnostic interviews	Results due for publication late 2014

The 2007 survey of the adult population found that one in five (20%) – 3.2 million individuals – experienced one of the common mental disorders in the preceding year. Fourteen per cent experienced anxiety disorders, 6% mood disorders, and 5% substance use disorders. One quarter experienced two or more of these conditions in the year of interest. Prevalence was highest among those aged 16-24 (26%) and declined with age, and two thirds of those with depression and/or anxiety disorders had experienced their first episode before the age of 21. This highlights the need for an emphasis on early intervention services that target younger people.

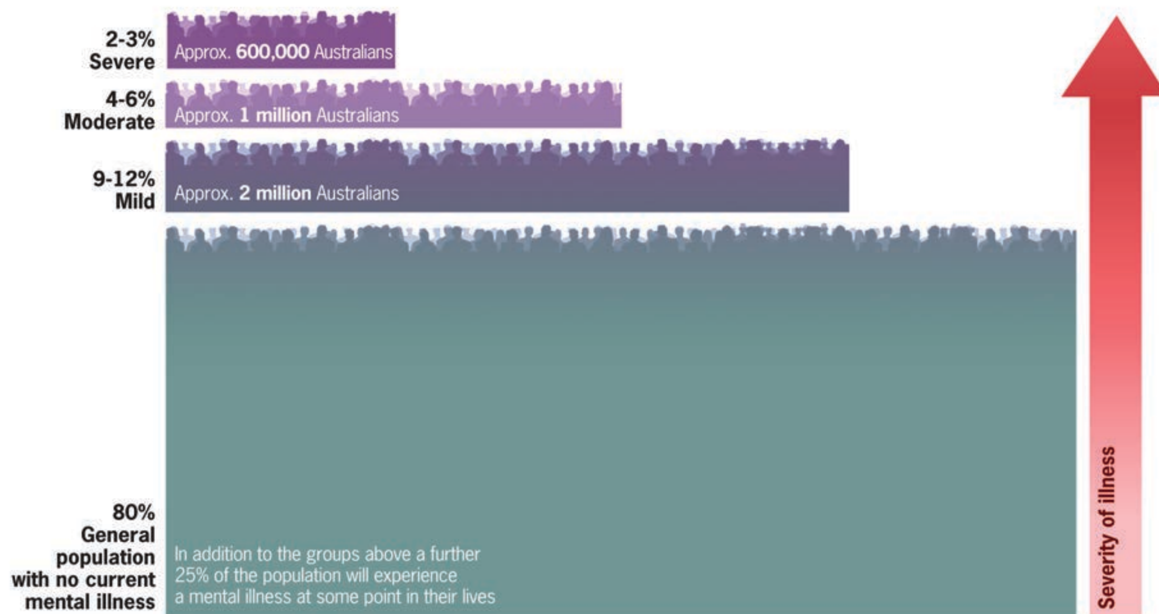
Turning to lower prevalence disorders, the 2010 Survey of People Living with Psychotic Illness found that 0.5% of the adult population had been treated for a psychotic disorder in the previous year. This equates to 64,000 people, almost half of whom had schizophrenia. Two thirds of these people experienced their initial episode before they turned 25, and many of them had experienced disabling, unremitting symptoms since the onset of their illness.[7] Psychotic illnesses are the focus of many state and territory mental health services and account for the majority of resources devoted to specialist mental health care in Australia.

The above adult surveys showed that many people with mental illness experience symptoms quite early in their lives. The 1998 child and adolescent survey further emphasised the importance of the early years, showing that 14% of those aged 4-17 were affected by a clinically significant mental health problem. This amounted to about 500,000 individuals, including 93,000 with anxiety or depression, 200,000 with aggressive behaviours, and 93,000 with attention deficit disorders. As noted above, these figures will be updated by the 2013 survey data.

Prevalence estimates only provide part of the picture and need to be complemented by an understanding of the extent to which mental illness contributes to overall ill health. Figures from the 2003 World Health Organization's Global Burden of Disease (GBD) study provide some insights here. The GBD study measured the burden of all diseases using a common metric that is based on years of life lost due to premature mortality and years of life lived in less than full health (morbidity). Most of the burden of mental disorders is associated with morbidity, not mortality. Mental disorders accounted for 24% of the total burden of non-fatal disease and injury in Australia in 2003.[10] The recently released figures from the 2010 GBD study present a similar picture.[11]

Mental illness impacts on people's lives at different levels of severity. Various modelling exercises have been conducted that combine data from the Australian prevalence studies with data from other sources, including the GBD study, in order to inform service system planning (see Figure 1).[12] These analyses suggest that an estimated 2-3% of Australians – around 600,000 people – have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability. This group is not confined to those with psychotic disorders who in fact represent only about one third of those with severe mental illness; it also includes people with severe and disabling forms of depression and anxiety. Another 4-6% of the population (approximately 1 million people) have moderate disorders, and a further 9-12% (approximately 2 million people) have mild disorders.

Figure 1
12 month prevalence estimates of mental illness in the population by severity level, based on diagnosis, disability and chronicity



Taken together, the combined estimates of prevalence, disability and severity provide guidance for planning services, allocating resources and evaluating the overall effectiveness of the National Mental Health Strategy. They show that mental illness is a common problem in the Australian community. They also suggest, however, that individuals experience mental illness in different ways. Some people have severe and debilitating disorders, whereas others have mild or moderate conditions.

The corollary of this is that there is not a one size fits all solution to mental health care. Some people have extensive and ongoing needs for services whereas others may only need care occasionally or for a brief period, or may not need care at all. The 2007 National Survey of Mental Health and Wellbeing of adults showed that only 35% of those who met criteria for a mental disorder made use of services for mental health problems, but that this varied by level of severity (64% of those with severe disorders received services, 39% of those with moderate disorders did so, and 17% of those with mild disorders did so).[8 13] However, 86% of those who did not receive mental health care indicated that they had no need for any of the kinds of services that are typically offered (for example, information, medication, talking therapy, social intervention and skills training).[14] Ensuring that appropriate, high quality services are available to those who need them, when they need them, has been a consistent goal of the National Mental Health Strategy since its inception.

The National Mental Health Strategy aims to reduce both the prevalence and severity of mental illness. This is embodied in the Strategy's population health approach, which recognises that the determinants of mental health status comprise a range of psychosocial and environmental factors (including, for example, income, employment, education and access to community resources), and encompasses the entire spectrum of interventions from mental health promotion and mental illness prevention through to recovery. A reduction in the prevalence of mental illness may be brought about by preventive efforts to stop an illness occurring in the first place, or by increasing access to effective treatments to reduce the duration of illness for those who already have symptoms. Reducing the severity of mental illness requires a range of services designed to alleviate the disablement that may be associated with a person's social, personal and vocational functioning.

1.3 Setting the scene: The national mental health reform context

Overview of the National Mental Health Strategy

The National Mental Health Strategy has provided the overarching policy framework that has guided an extensive process of mental health reform in Australia for the last 20 years. Commencing with the endorsement of the *National Mental Health Policy* in 1992, the concept of the National Mental Health Strategy has grown to encompass the range of national policy and planning documents relating to mental health reform that have been agreed by all governments, either through their respective Health Ministers, or at the level of First Ministers through the Council of Australian Governments (COAG). These include four five year *National Mental Health Plans* covering the period 1993 to 2014, a revised *National Mental Health Policy* released in 2008,[15] the COAG *National Action Plan on Mental Health* endorsed in 2006[16] and, more recently, an agreement by COAG in December 2012 to the *Roadmap for National Mental Health Reform 2012-2022*.[1] As a national agreement endorsed by all heads of governments, the *Roadmap* represents the most current statement of intergovernmental commitment to mental health reform as an ongoing national priority, and outlines the directions that reform will take over the next 10 years.

The direction of reform has changed considerably over the 20 years that the National Mental Health Strategy has been in place, reflecting both the achievement of previous objectives and the incorporation of new priorities, driven by emerging knowledge and changing community expectations. A brief, chronological history of the policy directions of the Strategy is provided below.

The *First National Mental Health Plan* (1993-1998) represented the first attempt to coordinate mental health care reform in Australia. It focused primarily on state and territory mental health services and advocated for major structural reform, with a particular emphasis on decreasing the reliance on stand-alone psychiatric hospitals, expanding community based care alternatives, and 'mainstreaming' the delivery of acute inpatient care into general hospitals.

An evaluation of the *First National Mental Health Plan* was conducted in 1997.[17] This was generally positive, but observed that there were some areas that could be strengthened. As a result, when the *Second National Mental Health Plan* (1998-2003)[18] was released in 1998 it continued the work of the *First Plan* towards structural reform, but expanded into additional areas such as mental health promotion, mental illness prevention and destigmatisation. In terms of mental illnesses, the remit of the *Second Plan* was broader than that of the *First Plan*; it moved beyond the severe and disabling disorders that are typically treated in state and territory-funded services, and also considered more prevalent conditions like depression and anxiety. It also fostered important partnerships – between the public and private sectors, between specialist services and primary care providers, and, more broadly, between the health sector and sectors outside health that have an influence on people's lives.

The *Second National Mental Health Plan* underwent a mid-term review in 2001.[19] It was evaluated more formally in 2003,[20] and the *Third National Mental Health Plan (2003-2008)*[21] was released later that year. Again, the findings of the review and evaluation of the *Second Plan* helped to shape the directions of the *Third Plan*. The *Third Plan* set out to consolidate the achievements of the previous two plans by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Both the *Second* and *Third Plans* emphasised the importance of cross-sectoral partnerships in supporting mental health and wellbeing, and the need to respond to mental illness through a whole-of-government approach. These themes were elevated as priorities in 2006 when COAG

agreed to the *National Action Plan on Mental Health*. The *National Action Plan* was developed by governments to give further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the first three *National Mental Health Plans*. It represented the first time that heads of governments had focused on the issue of mental health and agreed to a national plan of action to reform mental health services. It took the delivery of services for people with mental illness into areas beyond the boundaries of traditional health care. Key human service programs operating outside the health system with major responsibilities under the COAG *National Action Plan* include housing, employment, education and correctional services. The *National Action Plan* also emphasised the role of the non-government sector in the delivery of a wide range of community support services.

In 2008, the National Mental Health Strategy was extended through a new *National Mental Health Policy*, endorsed by Health Ministers. The new *Policy* carried forward the central tenets of the previous *Policy*, but updated various elements of it to bring it into closer alignment with the whole-of-government approach articulated in the COAG *National Action Plan*. The new *Policy* provided an overarching vision 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.

2008 also saw a summative evaluation of the *Third National Mental Health Plan*,[22] the findings from which influenced the *Fourth National Mental Health Plan* which was released in the following year. The *Fourth Plan* specified priorities for collaborative government action, identifying 34 reform actions to be undertaken across five priority areas, namely:

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

In 2010, Health Ministers endorsed the Implementation Strategy for the *Fourth National Mental Health Plan* that detailed specific implementation strategies against each of the 34 actions in the *Fourth Plan*, and the first report on implementation progress was released in 2011. More recently, the Australian Health Ministers' Advisory Council endorsed a more focused approach to implementation, with a view to integrating mental health reform efforts outlined in the 2011-12 Federal Budget and broader reforms that are being progressed through the COAG *National Action Plan*. The result of this decision was that the approach to implementation of the *Fourth Plan* became more streamlined and strategic in focus. Emphasis was given to 22 of the actions that were identified as capable of being progressed independently of the wider national reforms, and this was later increased to 23.

In January 2012, the Federal Government established a new agency – the National Mental Health Commission – to provide a new approach to guiding and monitoring mental health reform in Australia. The Commission's core function is to monitor and evaluate the mental health system as a whole, and do this by working closely with consumers, carers, stakeholders and all jurisdictions. The Commission is located in the Prime Minister's portfolio, recognising the importance to mental health reform of cross sectoral, whole-of-government leadership. Similar state-level Commissions have also been established by New South Wales and Queensland. The Western Australian Mental Health Commission, the first in Australia, was established with a broader range of functions including the responsibility for public investment in mental health.

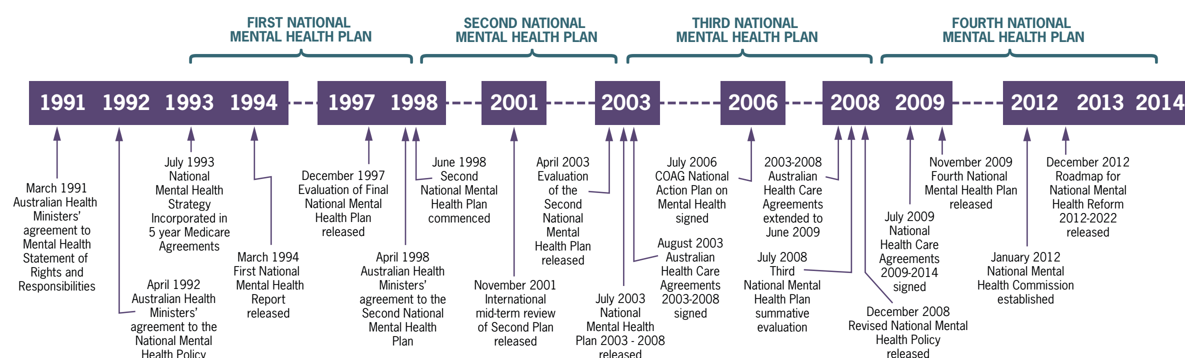
Most recently, in December 2012, COAG agreed to the *Roadmap for National Mental Health Reform* that outlines the directions that will be taken by governments over the next 10 years. The *Roadmap* set out new governance and accountability arrangements designed to directly engage stakeholders and ensure that governments are held to account. These new arrangements include the establishment of a COAG Working Group on Mental Health Reform that is required to develop, for COAG's consideration by mid-2014, a successor to the

Fourth National Mental Health Plan that will set out how the *Roadmap* will be implemented.

Alongside the above national activities, states and territories have developed their own mental health plans that have reflected the goals and principles of the national approach, but have been tailored to meet local requirements. Jurisdictions' own plans remain the key documents for setting out the specific details of how they will work towards achieving the objectives agreed under the National Mental Health Strategy.

A summary of key milestones in the life of the National Mental Health Strategy is provided in Figure 2.

Figure 2
Milestones in the life of the National Mental Health Strategy



Framework for national action

From its inception, the National Mental Health Strategy has been premised on an understanding of the complementary roles of the Australian Government and state and territory governments.

The states and territories have traditionally been responsible for the funding and provision of the public sector mental health services that provide specialist care for people with severe mental illness. These include services delivered in inpatient settings and services delivered by community-based teams. As the main source of both funding for specialised mental health services, the states/territories have occupied a central position in Australia's mental health system.

For its part, the Australian Government is responsible for providing leadership to guide national action, and monitoring the reform process. It also funds a range of services for people with mental illness via the Medicare Benefits Schedule, the Pharmaceutical Benefits Schedule and programs administered by the Department of Health and Ageing (DoHA), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Veterans' Affairs (DVA). Its role expanded substantially as a result of the COAG *National Action Plan on Mental Health* in 2006, and more recently through a broad range of new and expanded programs announced in the 2011 Federal Budget. These included the expansion of mental health services subsidised by Medicare, and a range of mental health specific community support programs managed through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).
The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

1.4 Reporting on mental health services in Australia

Few national policy areas in Australia are subject to an equivalent level of reporting and accountability as required under the National Mental Health Strategy. The *National Mental Health Report* is complemented by four other major reports on mental health services and mental health reform, described below:

- *Mental Health Services in Australia* is published by the Australian Institute of Health and Welfare and presents detailed information on the activity and resourcing of mental health services, primarily drawing on the National Minimum Data Sets for Mental Health.[23]

- Annual *Progress Reports on the COAG National Action Plan on Mental Health* are prepared under the auspices of the Australian Health Ministers Standing Council on Health (SCoH) and focus on the agreed actions and indicators in the COAG *National Action Plan*. The final report on the *National Action Plan* is due for release in 2013.[24-27]

- The mental health chapter of the *Report on Government Services (RoGS)* is published by the Productivity Commission on behalf of the COAG Steering Committee on Government Service Provision.[28] It provides summary information on resourcing and delivery of mental health services, drawing on data presented in *Mental Health Services in Australia* and the *National Mental Health Report,* and data provided by the Australian Bureau of Statistics.

- The annual *National Report Card on Mental Health and Suicide Prevention* is prepared by the National Mental Health Commission.[29] This new report aims to give a whole-of-government view of mental health reform in Australia, giving greater transparency to the performance of the systems that support people with a lived experience of mental health issues, their families, carers and other support people. The Commission released its first *Report Card* in November 2012.

All of these publications are published annually or biennially, and, with the exception of the COAG *National Action Plan on Mental Health Annual Progress Reports*, all are expected to continue into the foreseeable future.

Most recently, an additional report on mental health reform has been endorsed by COAG as a component of its *Roadmap for National Mental Health Reform 2012-2022*. The National Mental Health Commission will prepare three yearly reports to COAG to document progress towards achieving the *Roadmap* vision, with monitoring of progress focused on long term change at the national level, reflecting the ten year span of the *Roadmap*.

1.5 Structure of the current report

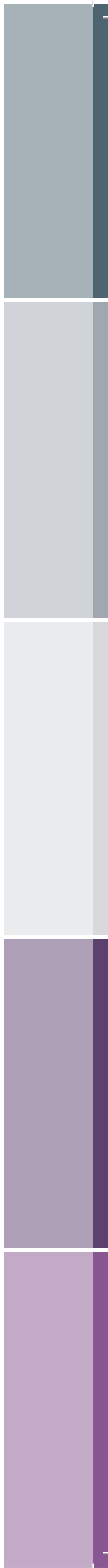
This report is presented in four parts, followed by a set of appendices:

- Part 1 outlines the purpose of the report and sets the scene by providing an overview of the National Mental Health Strategy.
- Part 2 presents system-level indicators of mental health resourcing and service delivery in Australia. It is organised around five groups of indicators (national spending on mental health, national workforce trends, trends in state and territory mental health services, trends in private sector mental health services, and consumer and carer participation in mental health care).
- Part 3 is dedicated to monitoring the actions of the *Fourth National Mental Health Plan*. It is organised around the *Plan's* five priority areas, and describes progress in implementation of key action areas and presents data for relevant indicators.
- Part 4 presents jurisdiction-level indicators, and includes resourcing indicators on the provision of mental health services and selected indicators reported at a national level in Part 2.
- The appendices identify the sources of data used in the report and provide explanatory notes on selected indicators.

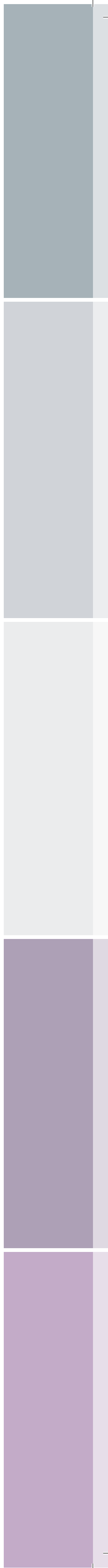
1.6 Conventions used in the current report

Several conventions are used to improve the readability of this report.

- Financial years are generally presented in a standard format (for example, 2010-11 refers to the year from 1 July 2010 to 30 June 2011). Occasionally, financial years are abbreviated by referring to the last calendar year of the pair (for example, 2010-11 is abbreviated to 2011 and the period 1992-93 to 2010-11 is abbreviated to 1993-2011).
- Unless otherwise stated, all expenditure and revenue are expressed in 2010-11 constant prices.
- Unless otherwise stated, all population data are expressed as crude (non-age standardised) rates.
- In general, figures are rounded to whole numbers and decimal points are only used in the text, figures and tables when an individual number in the series is less than 10. The effect of this rounding is that totals do not always equal 100%.
- Government bodies, initiatives and reports are referred to by their full name the first time they are mentioned in a given section but are often abbreviated on subsequent mentions (for example, the Council of Australian Goverments is sometimes referred to as 'COAG', the 'National Mental Health Strategy' is sometimes referred to as 'the Strategy' and the *Fourth National Mental Health Plan* is sometimes referred to as the *Fourth Plan*).



Part 2: System-level indicators of mental health reform in Australia, 1993 to 2011



2.1 Introduction

Since its original publication, the *National Mental Health Report* has focused on building a long term picture of mental health reform in Australia. It has done this by presenting summary information on system-level indicators of reform that track changes in the mix of services along with the financial and human resources that underpin those services. Part 2 continues that tradition by adding the most recently available data in five key areas, namely:

- National spending on mental health;
- National workforce trends;
- Trends in public sector mental health services;
- Trends in private sector mental health services; and
- Consumer and carer participation in mental health care.

Data sources and explanatory notes for data presented in Part 2 are provided in Appendix 1.

2.2 National spending on mental health

KEY MESSAGES:

- The original commitment made by all governments to protect mental health resources under the National Mental Health Strategy has been met. Total government expenditure on mental health increased by 178% in real terms between 1992-93 and 2010-11. In 2010-11, Australia spent $4.2 billion more of public funds on mental health services than it did at the commencement of the Strategy in 1992-93.

- Until recently, growth in mental health spending mirrored overall health expenditure trends for most of the 18 year period since the Strategy began. In the most recent year (2010-11), mental health increased its position in terms of relative spending within the broader health sector.

- Australian Government spending has increased by 245% compared to an increase of 151% by state and territory governments. This increased the Australian Government share of total national spending on mental health from 28% in 1992-93 to 35% in 2010-11. Most of the increase in Australian Government spending in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently other activities have taken over as the main drivers of increased mental health spending.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*. The gap between the highest spending and the lowest spending jurisdiction increased over the 1992-93 to 2010-11 period. The disparity between the states and territories points to wide variation in the level of mental health services available to their populations.
- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.

Public reporting on the level of spending on mental health services has been a central function of previous *National Mental Health Reports*. Under the *First National Mental Health Plan*, all governments agreed to maintain a level of expenditure on specialised mental health services at least equivalent to the level at the beginning of the National Mental Health Strategy, and to review annually whether this was occurring.

Regular monitoring of the relative contributions of the main funding authorities responsible for mental health services also serves as a check against the possibility that the reform process may simply lead to shifts of financial responsibility from one funder to another, rather than overall growth in services. This was a concern expressed by advocacy groups at the outset of the Strategy.

This section of the report provides an overview of 2010-11 spending on mental health services within the context of information about spending patterns since the Strategy began.

Total spending on mental health services, 2010-11

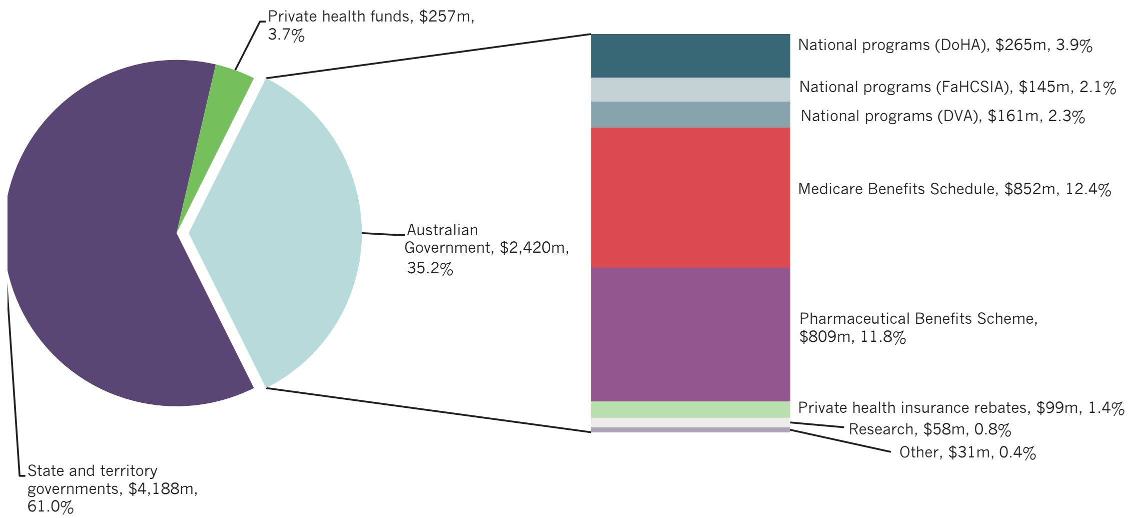
Total spending on mental health services by the major funders in Australia in 2010-11 was $6.9 billion. This represents an increase of 6.7% in real terms from 2009-10. Spending on mental health services and related activity represented 7.7% of total government health spending in 2010-11, compared with 7.3% at the beginning of the National Mental Health Strategy.[A] This is the highest level of mental health spending as a share of overall health expenditure recorded since the *National Mental Health Report* series commenced in 1993.

The major funders are the Australian Government, state and territory governments and private health insurers. Their relative contributions are summarised in Figure 3. Collectively, state and territory governments continue to play the largest role in specialised mental health service delivery, as they are primarily responsible, either directly or indirectly, for the delivery and management of most services. They have been the main focus of previous *National Mental Health Reports*, and remain a major feature of the current report.

The Australian Government is the largest single funder and was responsible for more than one third (35%) of total spending in 2010-11. It provides funding for a range of services and programs but does not deliver these services directly.

[A] Based on Department of Health and Ageing analysis of health expenditure data prepared by the Australian Institute of Health and Welfare and extracted from the national database used for the publication *Health Expenditure Australia 2010-11* (Health and Welfare Expenditure Series No. 47, Cat. No. HWE 46). Canberra: Australian Institute of Health and Welfare, 2012. The calculation of the proportion of total health expenditure directed to mental health includes only government and private health insurance revenue sources.

Figure 3
Distribution of recurrent spending on mental health, 2010-11 ($millions)

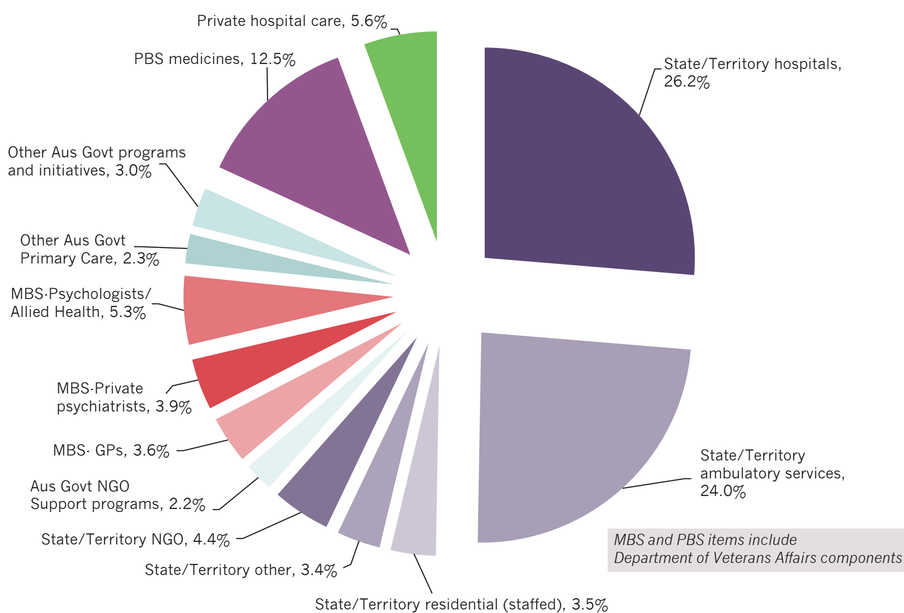


How Australia's 2010-11 spending was invested

Figure 4 shows how Australia's $6.9 billion investment in mental health in 2010-11 was spent. Hospital services administered by state and territory governments accounted for the largest share of total national spending (26%).

This was followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Scheme (13%).

Figure 4
National spending on mental health, 2010-11



Total 2010 –11 spending on mental health programs and services: $6.9 billion

National spending trends

Annual recurrent expenditure on mental health services by the major funding authorities increased by 171% from 1992-93 (the year before the National Mental Health Strategy began) to 2010-11 (the mid-point year of the *Fourth National Mental Health Plan*). Figure 5 shows that growth occurred to varying extents in all three major funding streams:

- Combined state and territory spending increased by 151% or $2.5 billion;
- Australian Government expenditure increased by 245% or $1.7 billion; and
- Spending by private health funds increased by 59% or $95 million.

In per capita terms, national spending on mental health increased from $144 in 1992-93 to $309 in 2010-11.

To put this in context, it is worth considering how the combined expenditure on mental health by the Australian Government and state and territory governments compares with their overall expenditure on health. Looking at government spending only, recurrent expenditure on mental health increased by 178% between 1992-93 and 2010-11, averaging 6% growth per year. This figure is difficult to compare with overall expenditure on health because it includes some expenditure from outside health departments, most notably by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in the more recent years. Removing funding administered by FaHCSIA from the equation, recurrent expenditure on mental health increased by 172% from 1992-93 to 2010-11, whereas recurrent expenditure on health increased by 157% (see Figure 6). In the first decade of the National Mental Health Strategy, the two figures tracked closer together, but commencing in the mid-2000s, mental health has incrementally increased its position in terms of relative spending within the overall health sector. The increased growth of mental health relative to general health is most pronounced in 2010-11.

Figure 5
National expenditure on mental health by source of funds, 1992-93 to 2010-11 ($millions)

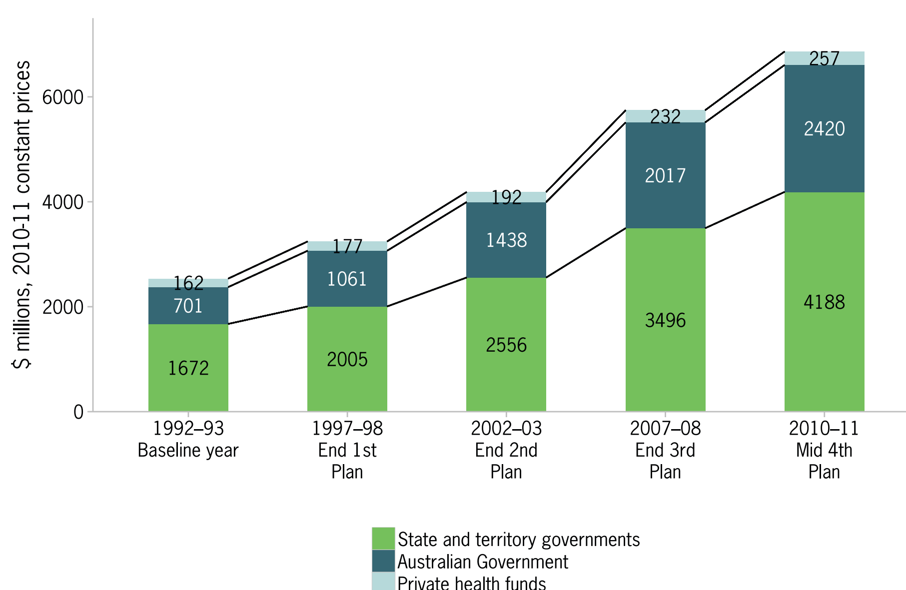
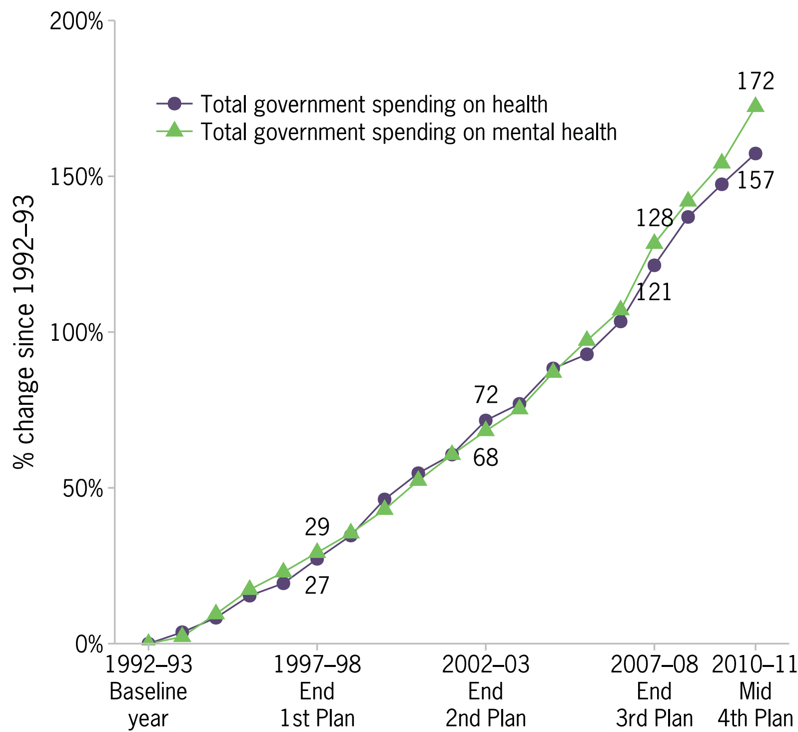


Figure 6
Cumulative growth in government spending on health and mental health, 1992-93 to 2010-11



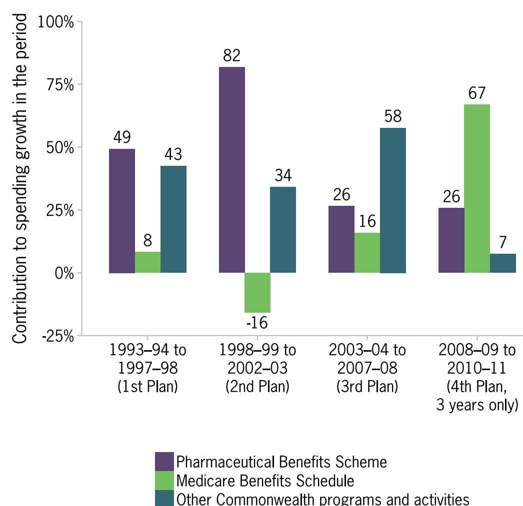
Further context would ideally be provided by comparisons to other countries from around the world. Unfortunately, there are no reliable benchmarks available to assess whether the 'right' level of funding is allocated for a given population's mental health needs. Significant differences exist between countries in how mental health is defined, how expenditure is reported, what is included as 'health expenditure', and what costing methodologies are employed, making comparisons of available data unreliable and potentially misleading. Substantial collaboration between countries will be required for any future international comparisons of mental health spending to be valid.

Australian Government expenditure

The Australian Government's spending on mental health increased from $701 million in 1992-93 (28% of national mental health spending) to $2.4 billion in 2010-11 (35% of national spending). This increased share was due to a combination of growth in new activities and programs and increases in existing services. Figure 7 shows that in the early years of the National Mental Health Strategy, the main driver of growth was expenditure on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme (PBS). Increased spending on subsidised pharmaceuticals accounted for 49% of the growth in Australian Government expenditure under the *First National Mental Health Plan* and 82% under the *Second National Mental Health Plan*. The impact of psychiatric medicines on Australian Government mental health spending reduced markedly under the *Third* and *Fourth National Mental Health Plans*, dropping to 26% in both of these periods. This was due to a combination of factors, including the fact that several commonly prescribed antidepressants came off patent during this time, allowing new generic products into the Australian

market. The costs of these products fell below the PBS subsidy threshold, or required significantly less Australian Government subsidisation than the patented products. Additionally new programs funded under the COAG *National Action Plan* began to be rolled out between 2006 and 2008, including the introduction of new Medicare-funded 'talking therapies' provided by psychologists and other allied health professionals. Each of these factors moderated the previous role of the PBS as the main driver of Australian Government mental health spending.

Figure 7
Drivers of growth in expenditure on mental health by the Australian Government under the National Mental Health Plans, 1992-93 to 2010-11



State and territory government expenditure

The commitment by state and territory governments to some form of budget protection was part of the original *National Mental Health Policy* and has since been reinforced at various points through the Strategy. The commitment was intended to serve three purposes. Firstly, the Australian Government required a guarantee that the benefits of additional funds provided under the National Mental Health Strategy would not be negated by a reduction in state and territory funding for mental health. Secondly, there was recognition that existing service levels in Australia were struggling to meet even the highest priority needs and could not be further reduced without serious consequences. Thirdly, the commitment safeguarded against erosion of resources that was believed to be occurring with the downsizing of state- and territory-managed psychiatric hospitals and the incorporation of mental health services into mainstream health care.

The original *National Mental Health Report*, released in 1994, established the baseline for measuring change in state and territory mental health resources and documented the gross recurrent expenditure by each jurisdiction in 1992-93. The current report compares ongoing expenditure against this baseline, using the same approach that has been taken in the intervening reports. This approach describes what was spent by a particular state or territory, as opposed to what was spent within it, by deducting specific Australian Government payments from the total spending reported by each state and territory. This reduces the impact of growth in state and territory expenditure caused by mental health specific grants made by the Australian Government under the former Health Care Agreements and more current mental health specific Commonwealth-State funding agreements and payments provided by the Department of Veterans' Affairs for the mental health care of veterans by state and territory services. The intent of this approach is to focus on health funding that is under the discretionary control of state and territory governments – that is, funding that may or may not be spent on mental health.

Table 2 shows the summary picture of expenditure by state and territory governments, comparing baseline spending in 1992-93 with spending at the close of the first three *National Mental Health Plans* and the mid-point of the *Fourth National Mental Health Plan*.

All state and territory governments have met their commitment to maintaining mental health spending over the period 1992-93 to 2010-11. Spending growth increased by 145% overall, averaging 8% per year. With the exception of Victoria, all jurisdictions more than doubled their expenditure during the period.

Table 2
Recurrent expenditure on mental health services by state and territory governments, 1992-93 to 2010-11 ($millions)[a]

	1992-93 (Baseline year)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)	Change since 1992-93	Average annual growth
NSW	$564	$653	$867	$1,085	$1,303	131%	7%
Vic	$496	$534	$673	$857	$974	96%	5%
Qld	$253	$361	$454	$681	$830	228%	13%
WA	$164	$244	$305	$434	$523	219%	12%
SA	$150	$184	$205	$295	$327	118%	7%
Tas	$47	$54	$59	$98	$116	149%	8%
ACT	$23	$28	$45	$63	$72	208%	12%
NT	$14	$20	$22	$36	$43	211%	12%
Total	$1,710	$2,168	$2,630	$3,550	$4,188	145%	8%

(a) Excludes Australian Government dedicated mental health funding to states and territories but includes revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and non-specific Australian Government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments.

Per capita spending by state and territory governments

Different population sizes and rates of growth need to be taken into account when reviewing trends in resourcing of mental health services. Higher population growth in some jurisdictions places greater demands upon the resources available for mental health care. Adjusting for this growth is necessary given that this report covers an 18 year period during which significant population shifts occurred.

When population growth is taken into account, growth in mental health spending becomes more conservative than the 145% suggested in Table 2.

Figure 8 shows that per capita adjusted growth over the 18 years was 94%, or an annual average of 5%. Figure 9 shows that the relative positions of the states and territories have shifted over time with, for example, Victoria investing the highest amount per capita in 1992-93 and the lowest amount in 2010-11. Additional detail on jurisdictions' growth is provided in Part 4.

Figure 8
Average per capita expenditure by state and territory governments, 1992-93 to 2010-11 ($)

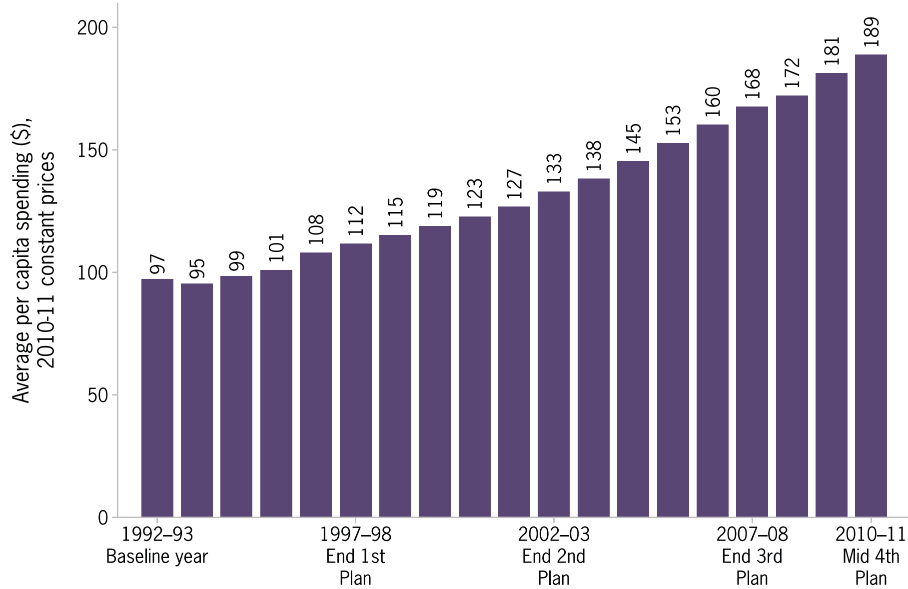
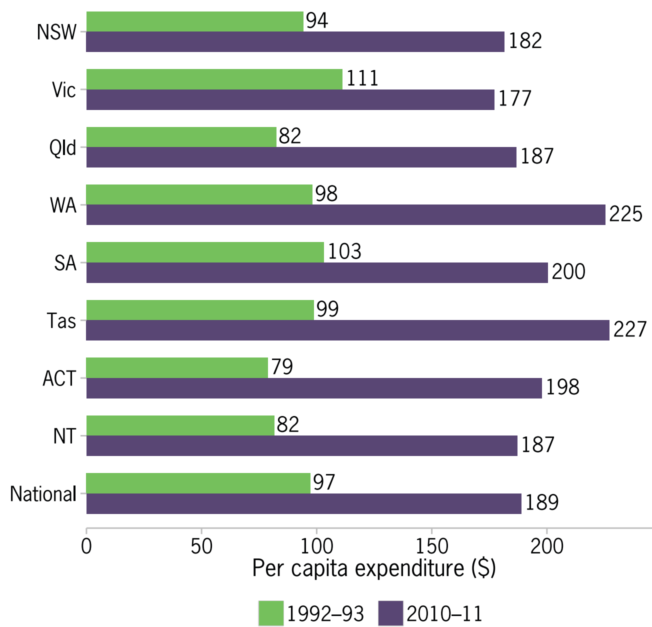


Figure 9
Per capita expenditure by state and territory governments, 1992-93 and 2010-11 ($)



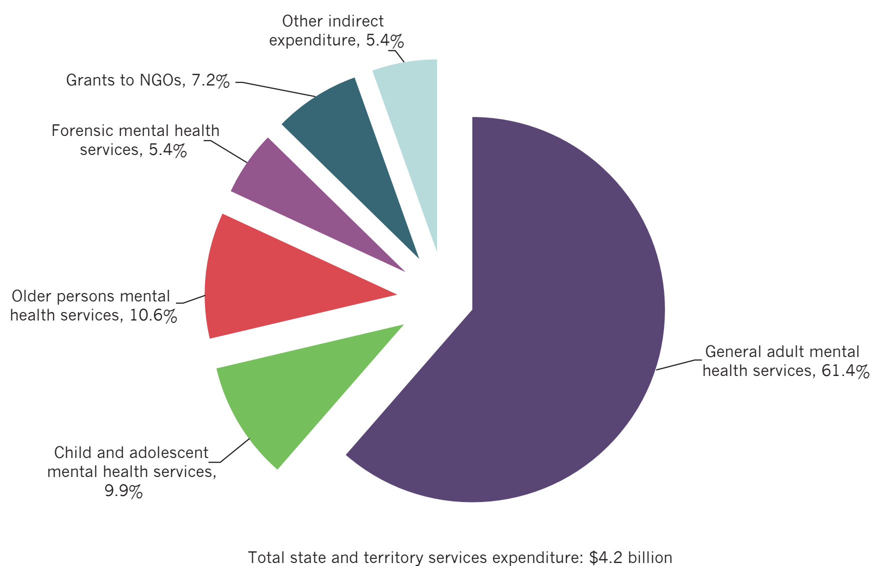
State and territory investment in programs for age specific populations

The above perspective provides an overall picture of the relative investments by each of the states and territories in providing mental health services, but does not shed light on how particular population groups are served. Data from the 2010-11 National Minimum Data Set – Mental Health Establishments collection provide the basis for such an analysis, although they do not permit the exclusion of mental health specific grants made by the Australian Government in the same way as the data reported in the overall state and territory analyses described above.

Distribution of funds in each state and territory is organised into general adult, older persons, child and adolescent and forensic programs and services. Figure 10 summarises how state and territory funding was distributed across these program areas in 2010-11. It shows that just under two thirds of expenditure was directed to general adult services, which primarily serve those aged 18-64 years. The remainder was distributed across the other population groups, in grants to NGOs and in other indirect expenditure.

Substantial differences exist between jurisdictions in both the extent to which mental health services are differentiated according to age specific programs and the level at which these programs are funded. Figure 11 shows the per capita level of funding provided for general adult mental health services by each state and territory, and Figure 12 and Figure 13 provide the same information for child and adolescent services and older persons' services respectively.

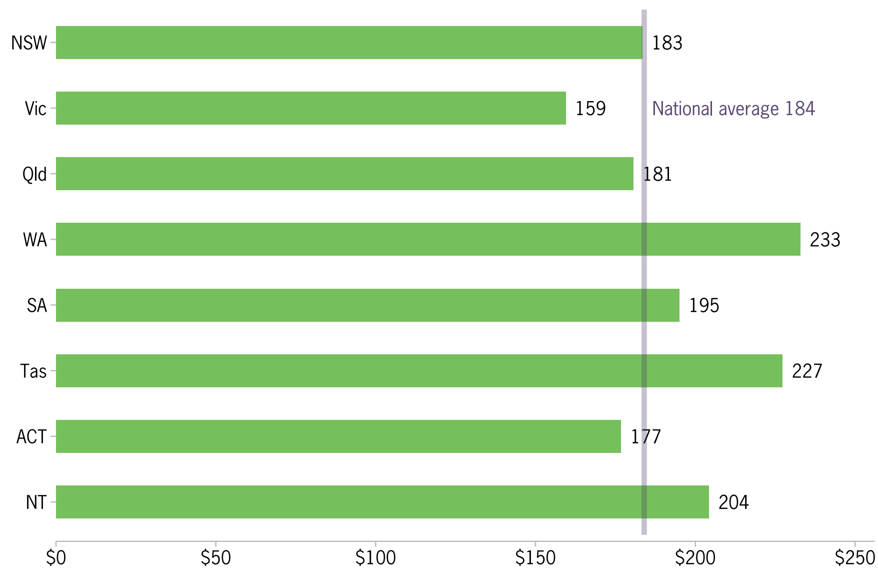
Figure 10
National summary of state and territory government mental health expenditure by program type, 2010-11[a,b]



Total state and territory services expenditure: $4.2 billion

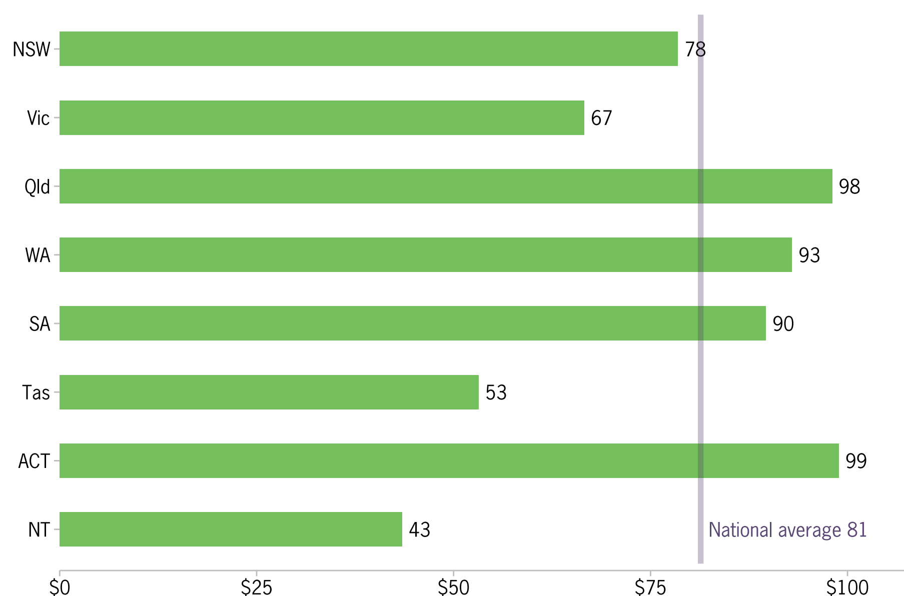
(a) Youth mental health services (0.2% of total state and territory mental health expenditure) have been included in child and adolescent mental health services; (b) NGO expenditure excludes residential services managed by the NGO sector. This expenditure is targeted mainly at the adult population.

Figure 11
Per capita expenditure by states and territories on general adult mental health services ($), 2010-11[a,b,c]



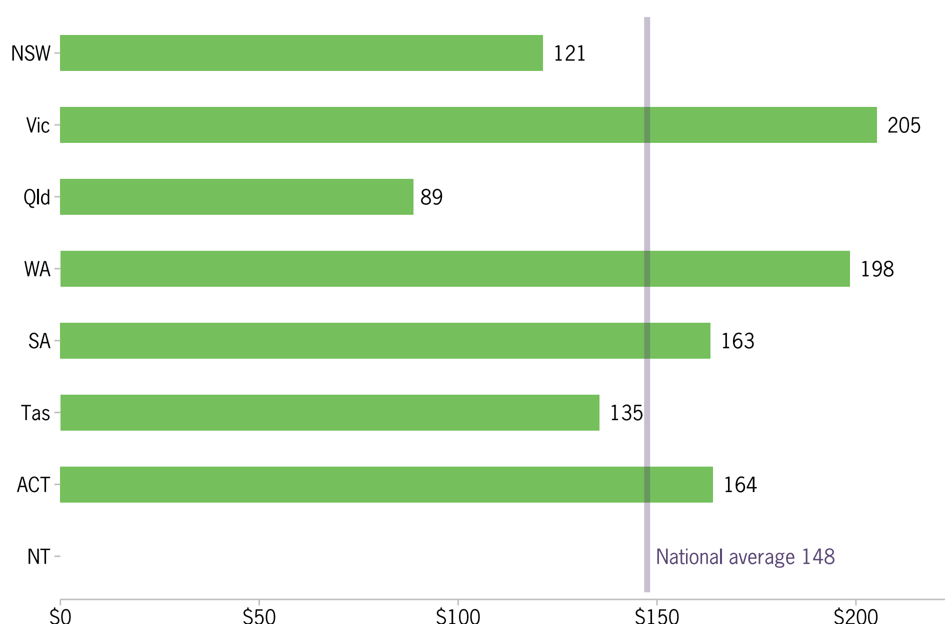
(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Figure 12
Per capita expenditure by states and territories on child and adolescent mental health services ($), 2010-11[a,b,c]



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Figure 13
Per capita expenditure by states and territories on older persons' mental health services ($), 2010-11[a,b,c]



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Together, these figures show that the relative positions of the 'well resourced' and 'poorly resourced' jurisdictions differ depending on which age related program is considered. For example, although Queensland is one of the lower per capita spending jurisdictions, its expenditure on child and adolescent mental health services in 2010-11 was 21% above the national average. Tasmania, on the other hand, is the second top spending jurisdiction overall, but spends 35% less than the national average on child and adolescent mental health services.

The analysis highlights that, while mental health services are not provided uniformly across Australia, the greatest variation is in the availability of specialist child and adolescent and older persons' services, with a nearly two and a half fold difference between the highest and lowest spending jurisdictions.

It should also be noted that general adult mental health services provide care not only for the adult population but also for children and adolescents and older persons. Indeed, where such services do not exist or are less well developed (such as in the Northern Territory), general adult services substitute. The net impact is that in some jurisdictions, estimates of the total expenditure on adults are overstated because a proportion of the resources is necessarily used to provide services to younger or older people.

Differences between the jurisdictions may reflect different population needs, different ways of organising services, or a combination of both. At this stage, there is no national agreement on how mental health budgets should be split across age specific programs.

Caveats about mental health spending trends

The data presented in this report on mental health spending trends need to be interpreted in the context of two reminders about the limitations of an exclusive focus on health spending.

The first concerns the fact that spending patterns do not tell us about what is actually delivered in terms of the volume and quality of services and the outcomes they achieve. In the context of the National Mental Health Strategy, understanding how resources are allocated is necessary but not sufficient to judge whether policy directions are achieving the intended benefits for the community. Simply put, more dollars do not necessarily produce more or better services. The indicators reported in Part 3 go some way towards addressing this issue, offering a basis for monitoring 'value for money' in current mental health investment.

The second limitation concerns the relationship between resources and needs. Measuring growth over the past 18 years informs us about changes since the commencement of the Strategy. It does not tell us whether the original 1992-93 funding levels were adequate to meet community need, or whether the growth that has taken place has been sufficient to meet new demands that have emerged since the Strategy began. The 2007 National Survey of Mental Health and Wellbeing highlighted continuing and substantial levels of unmet need for mental health services.

The implication is that current funding levels may not be enough to meet priority needs of the Australian population. These concerns underpinned many of the new initiatives announced under the 2006 COAG *National Action Plan on Mental Health,* and, more recently, the 2010 and 2011 Federal Budget measures that allocated $2.2 billion over five years for a broad range of mental health initiatives. The *Fourth National Mental Health Plan* includes a commitment by all governments to develop a National Mental Health Service Planning Framework that establishes targets for the optimal mix and level of the full range of mental health services that will provide a framework to guide future investment.

2.3 National workforce trends

KEY MESSAGES:

- The direct care workforce employed in state and territory mental health services increased by 72%, from 14,084 full-time equivalent (FTE) in 1992-93 to 24,292 FTE in 2010-11.
- On a per capita basis, this equates to an increase from 80 FTE per 100,000 in the former period to 108 FTE per 100,000 in 2010-11, or an increase of 35%. New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%).
- Nationally, the absolute increase in the direct care workforce size of 72% was lower than the increase in recurrent expenditure on state and territory inpatient and community-based services (119%). Factors such as rising labour costs and increases in overhead and infrastructure costs may contribute to this discrepancy.
- At a conservative estimate, 3,119 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).
- In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. The workforce mix mainly comprised nurses (1,165, 77%) and allied health professionals (310, 20%). Medical practitioner services provided to consumers treated in private hospitals are delivered primarily through the Medicare Benefits Schedule rather than direct employment arrangements.

The wide-ranging changes that have occurred in the financing and structure of Australia's mental health sector over the period from 1992-93 to 2010-11 are reflected in shifts in the profile of the workforce. These changes are summarised below.

Size and composition of the workforce in state and territory mental health services

Between 1992-93 and 2010-11, the direct care workforce[B] in state and territory mental health services increased by 72% (see Figure 14). This is equivalent to 10,208 full-time staff.

Figure 15 summarises this trend at a national level, showing that the number of full-time equivalent direct care staff rose from 80.1 per 100,000 in 1992-93 to 108.1 per 100,000 in 2010-11. Although all jurisdictions increased the overall size of their respective workforces during this period, New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%). More detail on individual jurisdictions' growth can be found in Part 4.

[B] 'Direct care staff' include those within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'.

Figure 14
Number of direct care staff (FTE) employed in state and territory mental health service delivery, 1992-93 to 2010-11

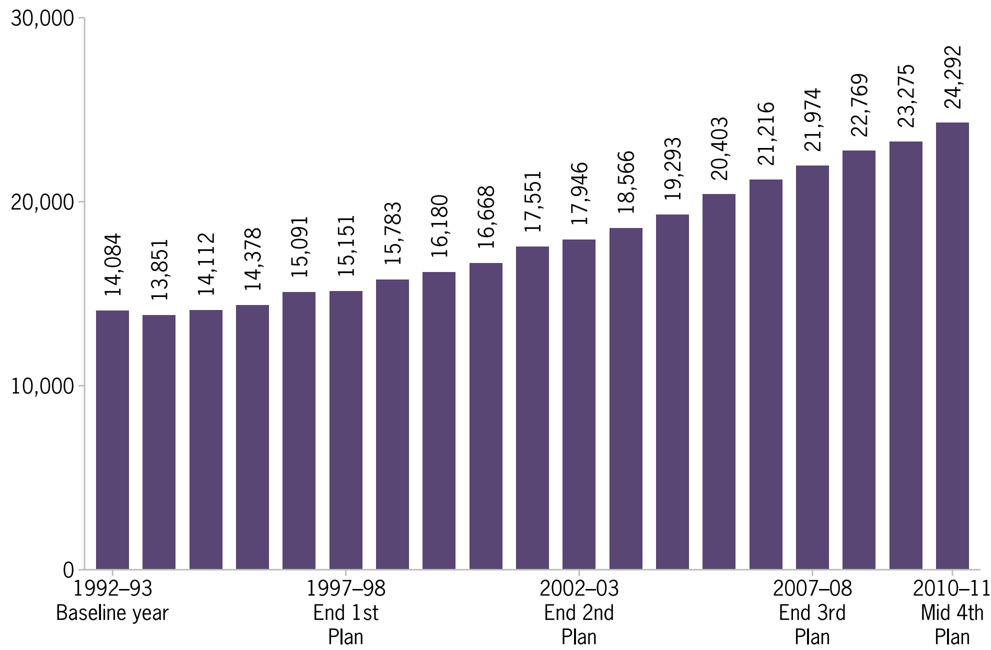
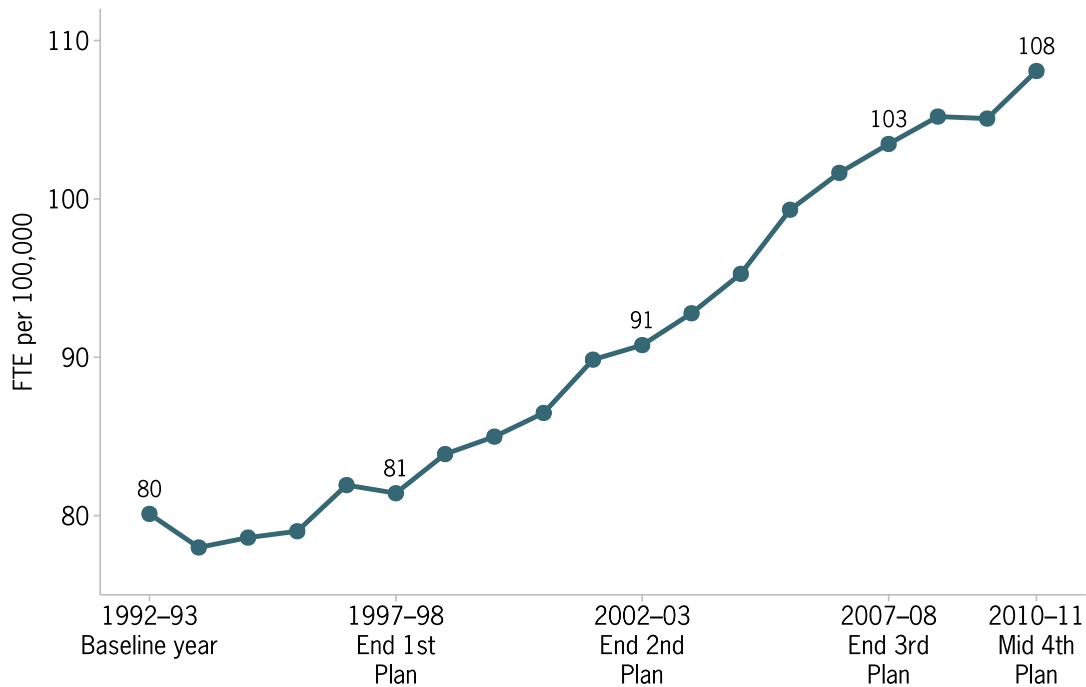


Figure 15
Number of direct care staff (FTE) employed in state and territory mental health service delivery per 100,000, 1992-93 to 2010-11



The growth in the direct care workforce in state and territory mental health services equates to a 35% increase when population size is taken into account.

Table 3 summarises the composition of the mental health professional workforce since 1994-95, the year for which a breakdown by provider types first became available. It shows that all provider groups have expanded under the Strategy, but there has been a shift in the professional staffing mix. The numbers of allied health professionals grew the most (120%), followed by medical practitioners (106%) and then nurses (54%). In 2010-11, nurses accounted for 64% of the mental health professional workforce, allied health professionals for 24% and medical practitioners for 12%. This represents a drop of 7% for nurses as a percentage of the total state and territory workforce and an increase of 5% for allied health professionals, reflecting a move to develop multi-disciplinary community services.

Nationally, increases in spending by states and territories on inpatient and community-based services were greater than the workforce growth in these settings. Figure 16 shows that by 2010-11, when the direct care workforce had grown 72% compared with the baseline year, recurrent expenditure had increased by 119%.

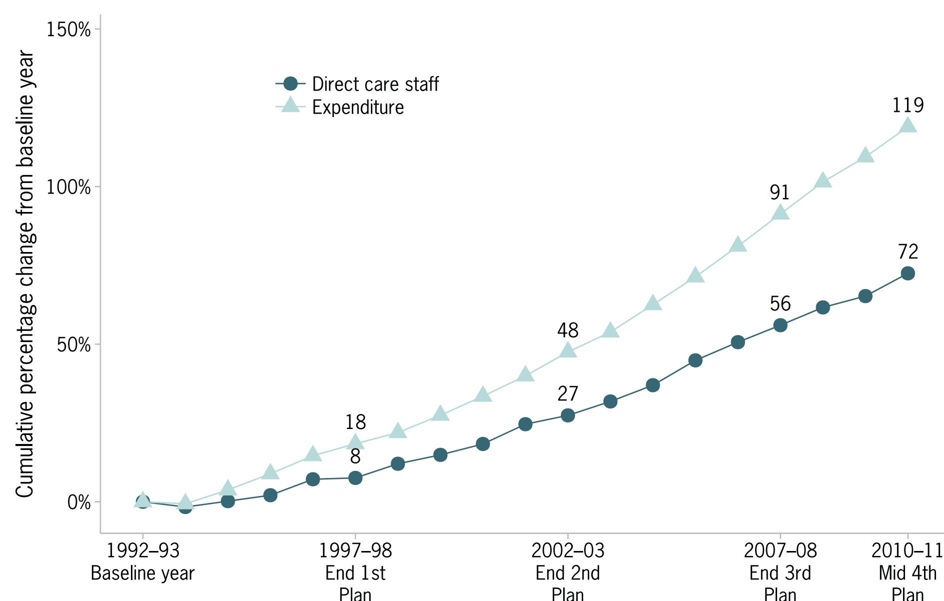
There are various reasons why higher spending may not translate into proportionally equivalent numbers of staff, and these may have a differential impact in different jurisdictions. These include, for example, rising labour costs and increases in overhead and infrastructure (including training and support) costs.

Table 3
Change in the health professional workforce (FTE) in state and territory mental health services, 1994-95 to 2010-11[a]

		1994-95 (Mid 1st Plan)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)
Medical	Consultant psychiatrists	560	657	753	1,094	1,355
	Psychiatry registrars and trainees	568	659	882	1,102	1,259
	Other medical officers	273	303	284	329	271
	Total medical	1,401	1,619	1,920	2,525	2,885
Nursing	Registered nurses	8,318	8,504	9,649	11,405	12,592
	Enrolled nurses	1,262	1,323	1,663	2,166	2,196
	Total nursing	9,580	9,827	11,312	13,571	14,788
Allied health	Psychologists	696	1,024	1,417	1,741	1,810
	Social workers	759	975	1,233	1,563	1,867
	Occupational therapists	525	548	697	859	1,038
	Other allied health professionals	546	624	779	864	845
	Total allied health	2,527	3,171	4,125	5,027	5,560
Total		13,508	14,617	17,357	21,122	23,232

(a) Totals differ slightly from those in Figure 14 because they do not include other personal care staff and do include a small number of staff employed at the organisational level.

Figure 16
Growth in service expenditure compared with growth in direct care staff (FTE), 1992-93 to 2010-11



Size and composition of the Australian Government funded primary mental health care and private hospital workforce

There is a significant workforce of mental health professionals delivering services in primary mental health care settings and in private hospitals. This workforce has grown over time as a result of a range of factors, most notably the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative ('Better Access', described in more detail at 2.5, below). Better Access introduced a series of new item numbers on the Medicare Benefits Schedule which provided a rebate for mental health care services delivered by eligible providers, expanding the MBS-funded services provided by general practitioners and psychiatrists and introducing services provided by psychologists and other allied health professionals. Other programs have also contributed to an expansion of this workforce, including the Access to Allied Psychological Services (ATAPS) program introduced in 2002 which enables general practitioners to refer consumers to allied health professionals, through Medicare Locals. Additionally, the Mental Health Nurse Incentive Program (MHNIP) was introduced in 2006 and provides a non-MBS incentive payment to community based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.

It is not possible to quantify the exact magnitude of workforce growth associated with these initiatives, because comprehensive figures on workforce numbers in the early years are not available. However, estimates for 2010-11 exist and are shown in Table 4. It should be noted that these estimates are conservative because they only include selected programs (Better Access, ATAPS and MHNIP) and providers. They exclude initiatives such as *headspace* and certain providers (notably general practitioners who are key providers of primary mental health care) for which reliable mental health specific workforce estimates are not yet available. Table 4 shows that 3,119 full-time equivalent mental health professionals provided

services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).

Table 4 also shows the size of the workforce of mental health professionals working in private hospitals in 2010-11. Again, these figures are an underestimate because they do not include psychiatrists and other medical practitioners with admitting rights who are funded on a fee for service basis through the Medicare Benefits Schedule. In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. Of these, 1,165 (77%) of these were nurses and 310 (20%) were allied health professionals.

Overall, 4,635 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives and in private hospitals in 2010-11. This is around one fifth of the size of the workforce employed in state and territory mental health services (23,232), reported in Table 3.

Table 4
Health professional direct care workforce (FTE) in Australian Government funded primary mental health care[a,b] and private hospitals[c], 2010-11

MBS and other Australian Government funded primary mental health care	Psychiatrists	817
	Mental health nurses	240
	Psychologists	1,928
	Other allied health professionals	134
	Total	3,119
Private hospitals	Medical professionals	42
	Nurses	1,165
	Allied health professionals	310
	Total	1,517
Total		4,635

(a) Excludes general practitioners because their numbers cannot be accurately estimated; (b) Excludes providers funded through the Department of Veterans Affairs, or providers offering services through *headspace*, the National Youth Mental Health Foundation; (c) Excludes psychiatrists and other medical practitioners with admitting rights who work in private hospitals on a fee for service basis through the Medicare Benefits Schedule.

2.4 Trends in state and territory mental health services

KEY MESSAGES:

- Between 1992-93 and 2010-11, annual state and territory government spending on services provided in general hospitals and the community grew by $2.6 billion, or 283%. This was accompanied by a decrease in spending on stand-alone psychiatric hospitals of $289 million, or 35%. About two thirds of the $2.6 billion was invested in community-based services (ambulatory care services, services provided by non-government organisations or NGOs, and residential services). The remaining third was spent on increased investment in psychiatric units located in general hospitals.

- Funding to ambulatory care services increased between 1992-93 and 2010-11 by 291% (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce in these services also increased, but not by the same magnitude (215%).

- The non-government community support sector's share of the mental health budget increased from 2.1% to 9.3%, with $372 million allocated to NGOs in 2010-11. Psychosocial support services account for about one third of this funding, and staffed residential mental health services accounted for about one fifth.

- Community residential support services expanded between 1992-93 and 2010-11. The number of 24 hour staffed general adult beds doubled (from 410 to 846). The number of 24 hour staffed older persons' beds was also higher in 2010-11 (682) than it was in 1992-93 (414) although it reached a peak in 1998-99 (805) and has been declining since then. The number of non-24 hour staffed beds in general adult residential services and the number of supported public housing places also increased with time.

- The number and mix of inpatient beds has changed during the course of the National Mental Health Strategy. There were significant decreases in beds in stand-alone psychiatric hospitals in the early years of the Strategy, particularly non-acute beds and general adult and older persons' beds. These decreases have been followed by more gradual declines in recent years. The decreases have been accompanied by commensurate increases in psychiatric beds in general hospitals, particularly acute beds. The average bed day costs in inpatient settings have increased (by 77% in stand-alone hospitals and by 51% in general hospitals).

Monitoring the progress of states and territories in the restructuring of their mental health services has been a central component of all *National Mental Health Reports*. Each of the four *National Mental Health Plans* has advocated fundamental change in the balance of services, focused on overhauling the institutional-centred systems of care that prevailed at the beginning of the 1990s.

The first *National Mental Health Report* documented the 'baseline' situation in 1992-93

and pointed to the scale of the task ahead. At the commencement of the Strategy:

- 73% of specialist psychiatric beds were located in stand-alone institutions;
- only 29% of mental health resources were directed towards community-based care;
- stand-alone hospitals consumed half of the total mental health spending by states and territories;
- less than 2% of resources were allocated to non-government programs aimed at supporting people in the community.

Agreement on a national approach to mental health reform committed state and territory governments to expand their community-based services and devolve management from separate 'head office' administrations to the mainstream health system. In those jurisdictions where decentralisation had occurred prior to 1992-93, the *First National Mental Health Plan* promoted the integration of inpatient and community services into cohesive mental health programs. The *Second, Third* and *Fourth National Mental Health Plans* continued this direction, but expanded the focus of reform to additional activities to complement development of the specialist mental health system.

Previous *National Mental Health Reports* have provided evidence of significant change in the direction advocated by the Strategy, although this change has been variable across jurisdictions. National trends in the first five years were largely dominated by extensive structural changes in Victoria. The restructuring of services in other jurisdictions became more prominent in the early part of the *Second National Mental Health Plan*.

This section of the report updates information published in previous *National Mental Health Reports* and presents a summary of progress to 2010-11.

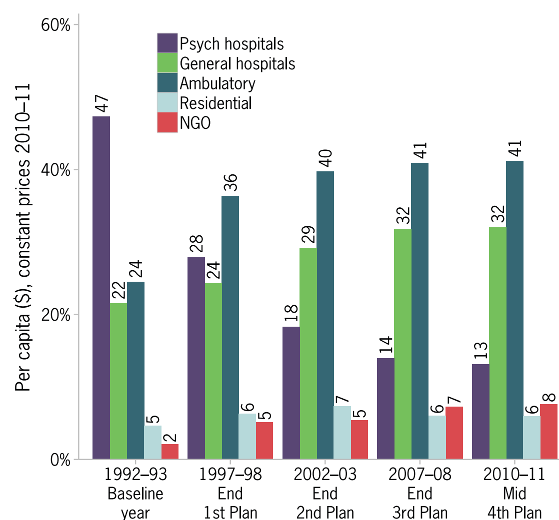
Investment in service mix reform

Information collected through the annual National Minimum Data Set – Mental Health Establishments collection (and its predecessor, the National Survey of Mental Health Services) provides the basis for assessing changes in the structure of the mental health service systems administered by state and territory governments.

Figure 17 shows the relative proportions of the total state and territory mental health budgets that were spent on various types of services between 1992-93 and 2010-11. Annual spending on stand-alone psychiatric hospitals decreased by 35% ($289 million), taking their share of total spending on services from 47% to 13%. Annual spending on services provided in general hospitals and in the community grew by 283%, equivalent to $2.6 billion in real terms.

The impact has been to reduce Australia's reliance on institutional care and strengthen community alternatives that address the inadequacies of service systems that were the focus of the original *National Mental Health Policy*.

Figure 17
Distribution of total state and territory expenditure on mental health services, 1992-93 to 2010-11[a]



(a) NGO managed residential services are included in the 'Residential' category.

Expansion of community-based services

About two thirds of the $2.6 billion growth in annual spending on services to replace stand-alone hospitals has been invested in expansion of community-based services – most notably ambulatory care services (48%), but also services provided by NGOs (11%) and residential services (6%). The remainder is accounted for by increased investment in psychiatric units located in general hospitals (36%). Each of these developments is described in more detail below.

Ambulatory care

Ambulatory care services comprise outpatient clinics (hospital and clinic-based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care of people affected by mental illness or psychiatric disability who live in the community.

Figure 18 shows that there has been significant growth in the resources directed to ambulatory mental health care services during the course of the National Mental Health Strategy. Between 1992-93 and 2010-11, there was a 291% increase in expenditure on ambulatory services (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce employed in ambulatory settings increased by 215% (from 3,358 to 10,592). In per capita terms, this is an increase from 19.1 per 100,000 population to 47.1 per 100,000 population (see Figure 19).

All jurisdictions have more than doubled their ambulatory care workforce over the course of the Strategy. Two (Western Australia and Queensland) stand out with increases of 307% and 440%, respectively. More detail on jurisdictions' performance can be found in Part 4.

Figure 18 also shows that growth in expenditure has outstripped growth in the direct care workforce, even when inflation is taken into account. The implication is that more dollars have not proportionally translated into increased staffing levels in state and territory ambulatory services. Nationally, the purchasing power of the mental health dollar in 2010-11 was 24% less than in 1992-93 when measured by the number of staff employed in ambulatory care. This may be due to a number of factors, including employment of clinical staff with higher qualifications (and salaries), a greater overall increase in costs in mental health relative to overall health care, or higher administrative overhead costs associated with the process of managing an increasingly complex service system. As noted later in this report, similar cost increases have occurred in inpatient services.

Figure 18
Changes in resourcing of ambulatory care services, 1992-93 to 2010-11

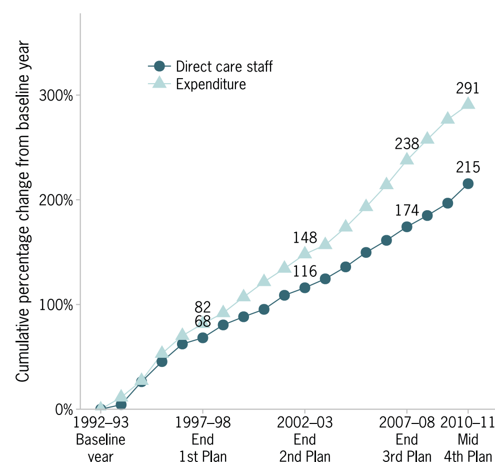
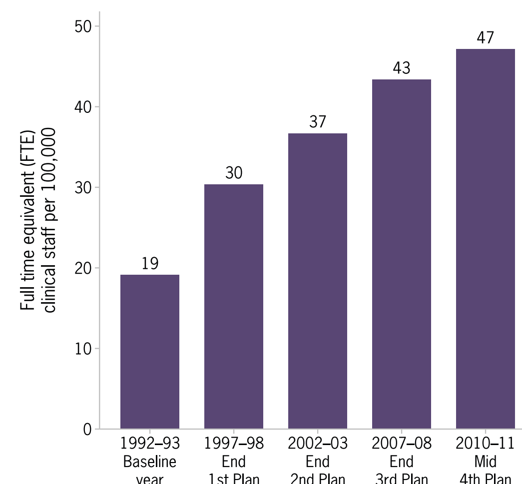


Figure 19
Full-time equivalent (FTE) direct care staff per 100,000 population employed in ambulatory mental health care services, 1992-93 to 2010-11



These indicators provide a simplified view of the collective progress of the states and territories. However, they do not tell us about the workforce levels required to meet priority community needs, nor about the amount of care actually provided. The National Mental Health Service Planning Framework, mentioned above, will establish targets for the optimal mix and level of the full range of mental health services, including ambulatory services.

The non-government community support sector

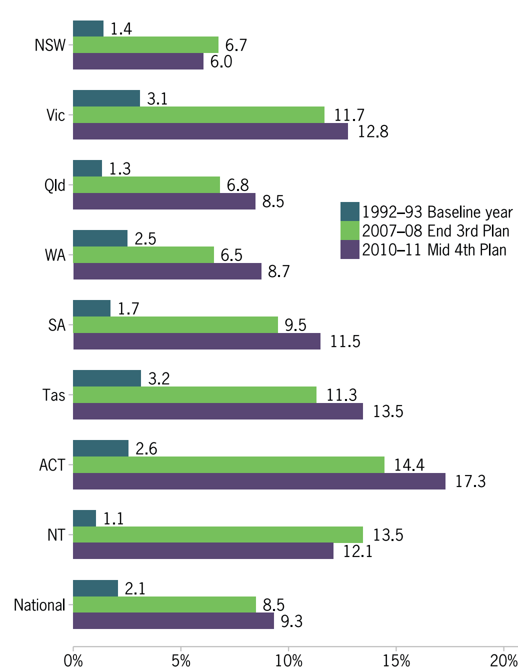
The non-government community support sector includes services provided by not-for-profit NGOs, funded by governments to provide support for people with a psychiatric disability arising from a mental illness. The NGO sector provides a wide range of services including accommodation, outreach to support people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy.

From the outset, the National Mental Health Strategy advocated the expansion of the role of NGOs in providing support services to consumers and carers whose lives are affected by mental illness. Expansion of the sector was promoted as a means to strengthen community support and develop service approaches that complement the clinical services provided by inpatient services and community teams. More recently, the COAG *National Action Plan on Mental Health* renewed the call to elevate the priority of the NGO sector, and stimulated a major expansion of funding by most jurisdictions.

Figure 20 shows that the overall proportion of mental health budgets allocated to NGOs before the National Mental Health Strategy began was only 2.1%. This share grew during the course of the *First* and *Second National Mental Health Plans,* such that by the end of the *Third Plan* (2007-08), 8.5% of state and territory mental health budgets was directed to the sector. Mid-way through the *Fourth Plan*, the figure now sits at 9.3%. Total state and territory funding allocated to NGOs in 2010-11 amounted to $372 million, distributed to a broad range of organisations from some very small entities employing only a few workers to complex, multi-million dollar organisations.[c]

Figure 20 also shows that despite the significant growth in recent years, differences between jurisdictions remain prominent. By 2010-11, the 'NGO share' was strongest in the Australian Capital Territory (17.3%) and lowest in New South Wales (6.0%).

Figure 20
Percentage of total mental health services expenditure allocated to non-government organisations, 1992-93 to 2010-11



[c] Prior to 1999-00, all services provided by non-government organisations were reported only in terms of total funds allocated by state and territory governments. Commencing in 1999-00, staffed community residential units managed by the sector began to report separately and were grouped with 'government managed' residential services in previous *National Mental Health Reports*. For the purposes of the analysis in this section, funding to NGO-managed staffed residential services (approximately $66 million in 2010-11) has been combined with non-residential NGO programs to ensure better consistency in monitoring the 18 year spending trends. The 2010-11 estimate of 9.3% of expenditure allocated to NGOs described in this section differs from the 7.6% shown in Figure 17 because, in the latter, NGO-managed residential programs are grouped with other residential services.

Previous *National Mental Health Reports* have observed that the role played by NGOs varies across the jurisdictions, reflecting differences in the extent to which states and territories fund the organisations that take on the functions that substitute for those traditionally provided by the government sector, or to develop complementary services. In this environment, a diverse array of services has been developed by the NGO sector to meet varied needs. Figure 21 shows the national profile of NGO services funded by states and territories in 2010-11. Psychosocial support services account for about one third of the funding, and staffed residential mental health services account for about one fifth.

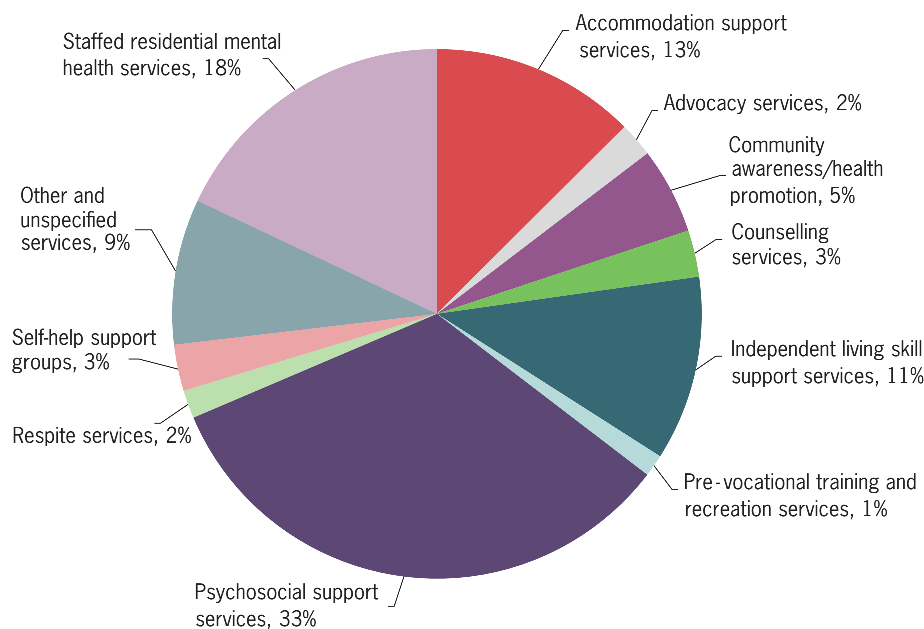
Community residential services

From its inception, the National Mental Health Strategy recognised the central place of accommodation in promoting quality of life and recovery for people living with a mental illness. A wide spectrum of accommodation services is needed, including tenured housing, supervised community residential units, crisis and respite places and flexible support systems that provide assistance to people living in independent settings.

Deficiencies in accommodation options to replace the former role of large stand-alone institutions have been linked to the failure of mental health reform initiatives overseas and were the focus of criticism in Australia by the Human Rights and Equal Opportunities Commission in the period immediately preceding the Strategy. Similar opinions have been voiced by consumer advocacy groups over the course of the Strategy.

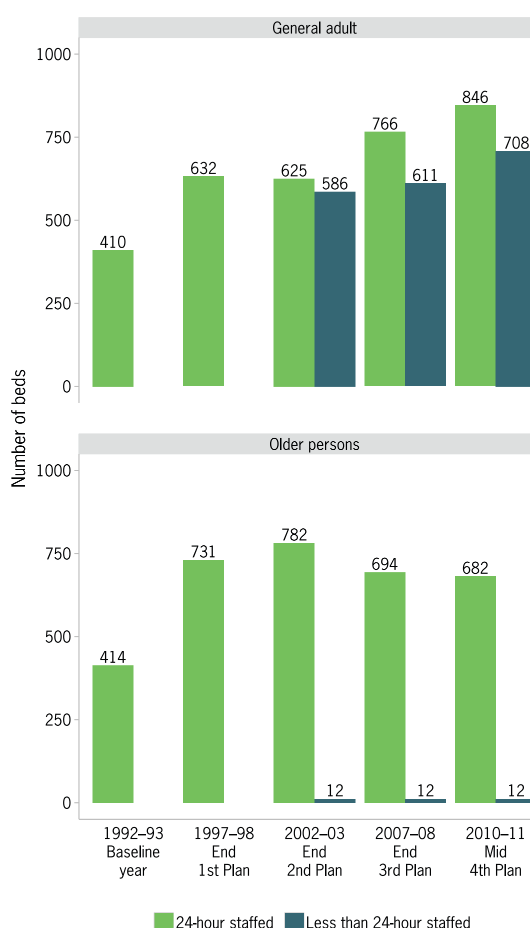
The approach taken by previous *National Mental Health Reports* to monitoring community accommodation under the Strategy has focused mainly on the extent to which each state and territory has developed specialised community residential services, staffed by trained mental health workers, that provide alternative care to that previously available in longer term psychiatric institutions. This report also presents information on 24 hour staffed beds in these specialised services, but augments it with data on services with beds staffed on a less than 24 hour basis. Figure 22 shows that in 2010-11, the number of 24 hour staffed general adult beds was more than double that in 1992-93 (846 compared with 410). The number of 24 hour staffed older persons' beds was also

Figure 21
Types of services funded by state and territory grants to non-government organisations, 2010-11



higher in 2010-11 (682) than it was in 1992-93 (414), although it reached a peak in 1998-99 (805) and has been declining since then. Data on non-24 hour staffed beds have not been available for the full period, but have increased since 2002-03 (from 586 to 708) in general adult residential services and remained the same (12) in older persons' residential services.

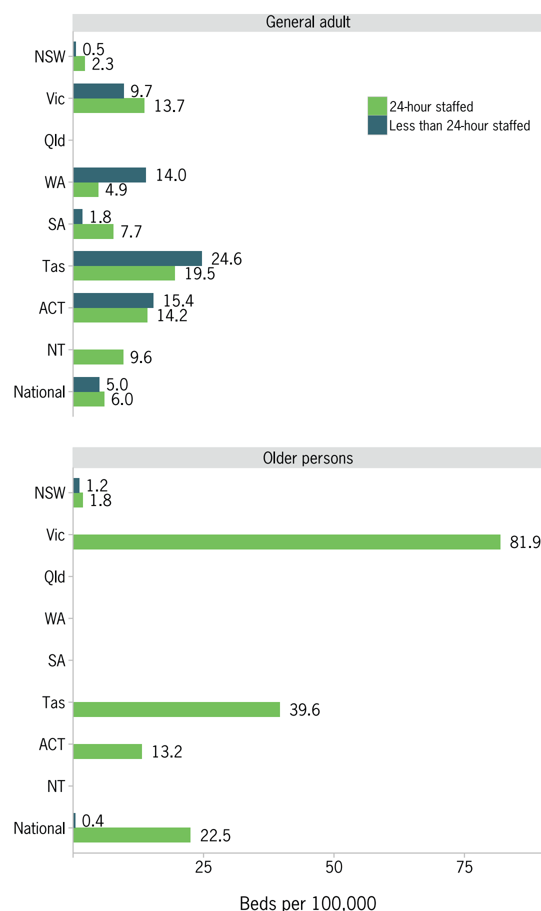
Figure 22
Total beds in general adult and older persons' residential services, 1992-93 to 2010-11[a]



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Development of staffed community residential services has been patchy, with much variation between jurisdictions. Until well into the mid-2000s, Victoria led the way. More recently, however, jurisdictions with very limited early development have begun investing in staffed residential services for adult consumers to fill a widely acknowledged service gap.

Figure 23
Number of beds per 100,000 in general adult and older persons' residential services by jurisdiction, 2010-11[a]



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Figure 23 compares the jurisdictions on adult and older persons' residential services available in 2010-11. For general services, three jurisdictions – Tasmania, the Australian Capital Territory and Victoria – were the leading providers, standing well above their peers. For older persons' residential services there was greater variability but the same three jurisdictions were marked by their service provision levels relative to other jurisdictions. Victoria in particular is unusual when compared to other jurisdictions in terms of its investment in specific residential services for older consumers. Nine out of ten residential beds for older persons available in Australia in 2010-11 were provided by Victoria.[D]

[D] Caution is required when interpreting residential services data for Queensland. A substantial number of general adult beds in Queensland that meet the definition of beds in staffed residential services were reported by Queensland as non-acute inpatient beds. Queensland has foreshadowed that it will review reporting of these beds in future years.

At a national level, the growth since 1992-93 in 24 hour staffed residential services (717 beds) is equivalent to only about one quarter of the reduction in longer stay (non-acute) beds in psychiatric hospitals (2,719 beds). The additional 730 beds staffed on less than a 24 hour basis became available during the period and provide partial compensation, but it is not possible to chart how these have developed over the full 18 year period. They have almost exclusively been developed for adults rather than older persons, and provide varying levels of on site supervision, ranging from six to 18 hours per day.

The number of supported public housing places is also relevant here. These places are designed to assist people to live as independently as possible through the provision of ongoing clinical and disability support, including outreach services in their homes. These are seen by consumer advocates as essential components of a recovery oriented system, and provide independent living support to some people who, in 1992-93, might have been in receipt of long stay institutional care. Several jurisdictions are developing individual care and support packages tied to public housing in preference to investing in staffed residential units, arguing that this sort of care is preferred by many consumers. The New South Wales Housing and Support initiative, for example, provides for support packages ranging from low to intensive support, the latter of which have similar costs to individual care provided in staffed residential services.

Figure 24 summarises the data on the availability of supported public housing places over time. It shows that 4,997 such places were available in 2010-11, 87% more than in 2002-03. This equates to 22.2 places per 100,000 in the latter period, an increase of 64% over the 13.5 places per 100,000 that were available in 2002-03.

Figure 25 shows that although all states and territories provided supported public housing places in 2010-11 and contribute to the above national averages, there was considerable cross-jurisdiction variation. Western Australia was the clear leader, with 62.1 places per 100,000. Queensland and Tasmania provided far fewer than the national average, at 6.1 and 4.5 per 100,000, respectively.

Figure 24
Growth in supported public housing places (absolute and per 100,000), 2002-03 to 2010-11

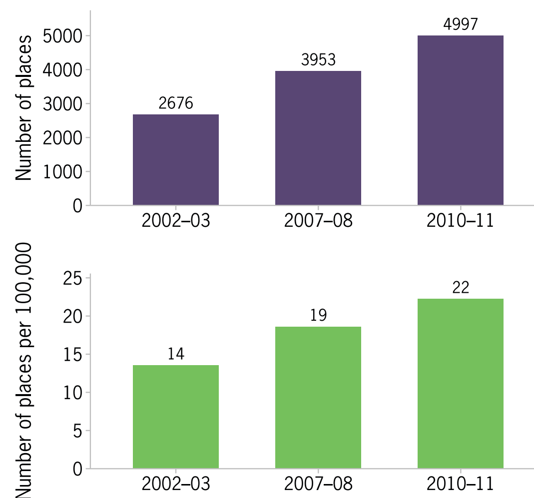
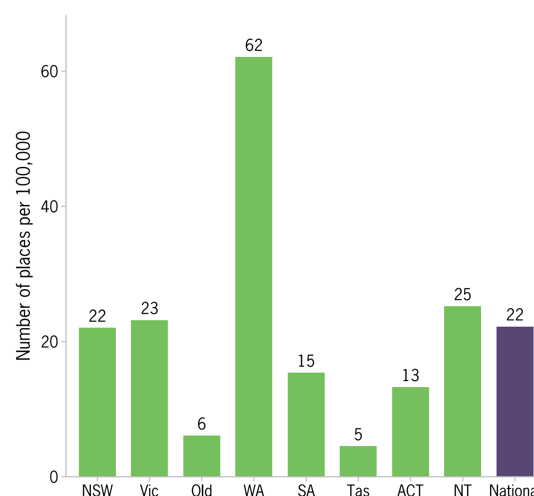


Figure 25
Number of supported public housing places per 100,000 by state and territory, 2010-11



There is no national consensus on planning benchmarks for the provision of community residential services or supported housing places. However, there is agreement that such services are an integral part of the full range of community services required to replace the historical functions of the stand-alone psychiatric hospitals. Developments during the *Third* and *Fourth National Mental Health Plans* indicate that jurisdictions are undertaking the service development needed to fill gaps that existed when the National Mental Health Strategy began. As noted earlier, the National Mental Health Service Planning Framework will establish targets for residential and supported housing places that will guide future service development.

Changes in inpatient services

The profile of inpatient services has changed significantly during the course of the National Mental Health Strategy. As noted in Part 1, the *First National Mental Health Plan* emphasised decreasing the number of psychiatric beds in favour of community-based options, reducing the reliance on stand-alone psychiatric hospitals, and 'mainstreaming' the delivery of acute inpatient care into general hospitals. Progress against these indicators has been extensively discussed in previous *National Mental Health Reports* and is presented in a more abbreviated fashion here because the majority of the change occurred during the early part of the Strategy.

In the year before the *First National Mental Health Plan* was launched (1992-93), the number of psychiatric beds available in Australia was 7,991 (46 per 100,000). By the end of the *First Plan* (1997-98) this had dropped to 6,265 (34 per 100,000), and by the end of the *Second Plan* (2002-03) it had reduced further to 6,073 (31 per 100,000). After this, the bed numbers increased slightly in absolute terms but plateaued on a per capita basis. In 2010-11, mid-way through the Fourth Plan, there were 6,755 psychiatric beds (30 per 100,000).

Reduction in stand-alone psychiatric hospitals

To put these reductions in context, Australia, like many other countries around the world, had already instituted a significant process of deinstitutionalisation in the decades before the National Mental Health Strategy began. In the mid-1960s, when the isolation and detention of people with mental illness in long stay institutions dominated the treatment culture, bed numbers had peaked at around 30,000.

A significant proportion of the reduction in beds is accounted for by ongoing closures of stand-alone psychiatric hospitals. Between 1992-93 and 2002-03, the number of beds in stand-alone hospitals decreased by 59%, from 5,802 (33 per 100,000) to 2,360 (12 per 100,000). By 2010-11, there had been a further 5% decrease (to 2,083, or nine per 100,000).

During this period there was a commensurate increase in psychiatric beds located in general hospitals. In 1992-93, Australia had 2,189 such beds (13 per 100,000). By 2002-03, this had increased by 70% to 3,713 (19 per 100,000), and by 2010-11 it had increased by an additional 44% to 4,672 (21 per 100,000).

Changes in the inpatient program mix

The decrease in hospital bed numbers has been accompanied by changes in the mix of inpatient services. Reductions during the National Mental Health Strategy have been selectively targeted at the service type mostly delivered by psychiatric hospitals – that is, hospital wards that provide medium to longer term care. Figure 26 charts the changes in the provision of acute and non-acute beds from 1992-93 to 2010-11. On a per capita basis, the availability of acute beds has remained level (at around 20 per 100,000), whereas the availability of non-acute beds has dropped (from 25 per 100,000 to 10 per 100,000). There is general consensus that 20 acute beds per 100,000 constitutes a reasonable level of service delivery,

whereas there is less agreement about the provision of non-acute beds and much greater variability across jurisdictions. In part this relates to the varying levels of community residential services that provide longer term care in different states and territories (see above).

Figure 27 provides data on beds available for each of the four target populations served by public sector inpatient units. The denominator has been calculated separately for each group from 2010-11 back to 1993-94 (the first year of the National Mental Health Strategy), rather than 1992-93 (the baseline year used elsewhere). Figure 27 shows that most of the reductions in bed numbers have taken place within adult and older persons' mental health services, with the former reducing by 29% and the latter by 57%. Beds provided in child and adolescent and forensic mental health services increased in per capita terms by 15% and 25%, respectively, both from a low baseline.

Changes in the resourcing of inpatient units

A concern expressed at the outset of the National Mental Health Strategy was that the transfer of inpatient services to general hospitals would lead to increased bed day costs and absorb much of the savings potentially available to expand community care.

Analysis of data collected over the period from 1992-93 to 2010-11 confirms that the reconfiguration of inpatient services has been associated with significant movement in unit costs. Figure 28 shows the average bed day costs for stand-alone psychiatric hospitals and for psychiatric beds in general hospitals. Over the 18 year period, the average bed day costs in the former increased by 77% in constant price terms, and in the latter by 51%. The average cost per patient day in stand-alone hospitals was 23% below that in general hospitals in the baseline year, but by the beginning of the *Second National Mental Health Plan* was almost equal to it. These costs tracked alongside each other until towards the end of the *Third National Mental Health Plan* and then diverged again. In 2010-11, the average bed day cost in stand-alone hospitals was 9% lower than that in general hospitals.

Figure 26
Acute and non-acute psychiatric inpatient beds per 100,000, 1992-93 to 2010-11

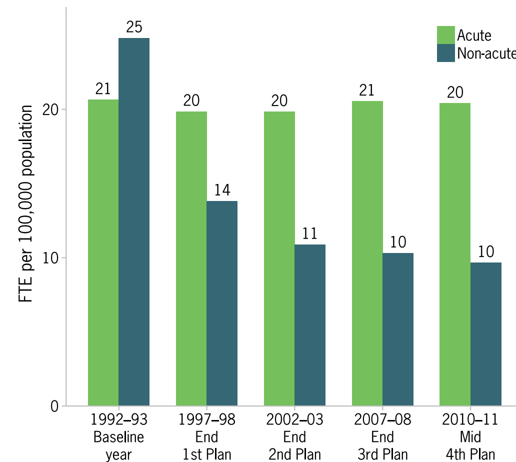


Figure 27
Total psychiatric inpatient beds per 100,000 by target population, 1993-94 to 2010-11

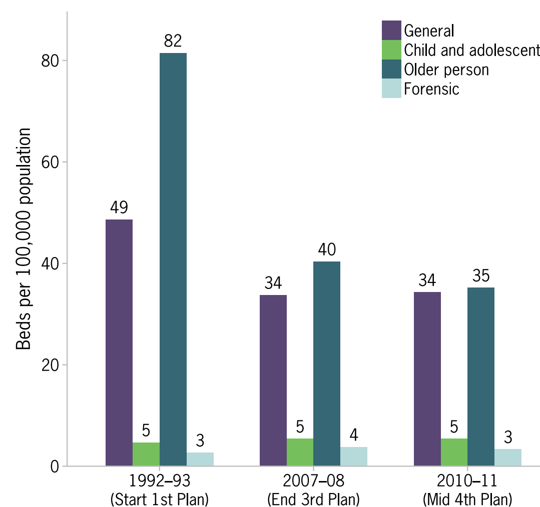
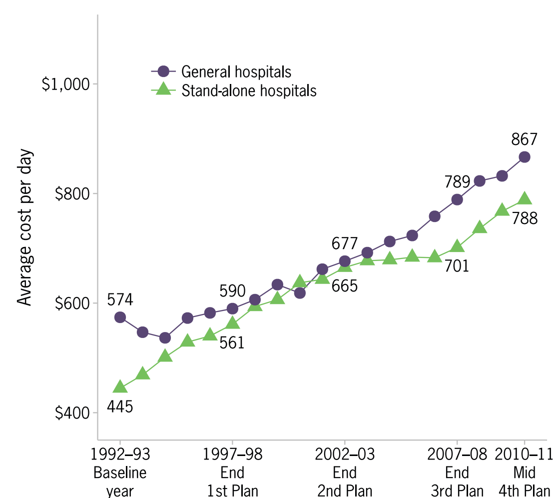


Figure 28
Average costs per day in psychiatric inpatient units, 1992-93 to 2010-11



Economic and clinical factors are responsible for the increase in the costs of hospital care, although the relative contribution of each is not known. Economic factors are implicated in the data shown in Figure 29 which charts resource shifts within Australia's psychiatric inpatient services over the period from 1992-93 to 2010-11. It shows that, at the national level, reduced bed numbers have not translated into reduced overall spending. While the number of beds and the number of bed days have reduced by 15% and 13%, respectively, spending on hospital services has increased by 52%. Direct care staffing levels in inpatient units have increased by 19%, about one third of the rate of growth in overall expenditure on inpatient services. The implication is that inpatient services are substantially more costly than they were at the beginning of the National Mental Health Strategy. When measured in terms of days in hospital, 2010-11 funding would buy 47% less by way of services than the same level of funding 18 years earlier.

Clinical factors contributing to increased costs include the changing role of stand-alone psychiatric hospitals. These services have developed specialised roles as they have reduced in size, treating consumers with more complex conditions that require increased staff:consumer ratios. Specific efforts have also been made to bring overall staffing within these hospitals to an acceptable level, commensurate with that provided in general hospital psychiatric units. Data reported by states and territories over the course of the Strategy provide some support for this view, and suggest that average direct care staffing levels within psychiatric inpatient units have increased by 38% (see Figure 30).

Figure 29
Changes in the number of psychiatric inpatient beds, patient days, expenditure and direct care full-time equivalent staff relative to 1992-93

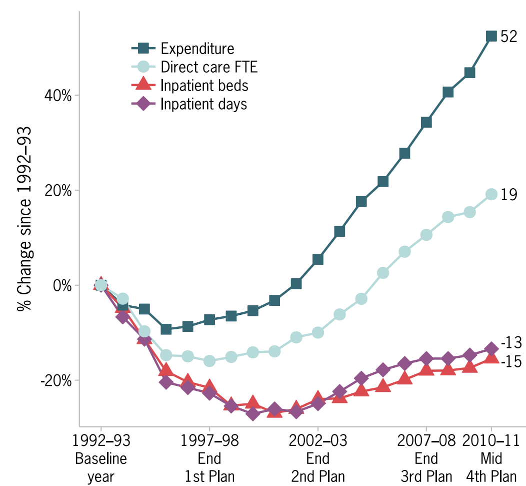
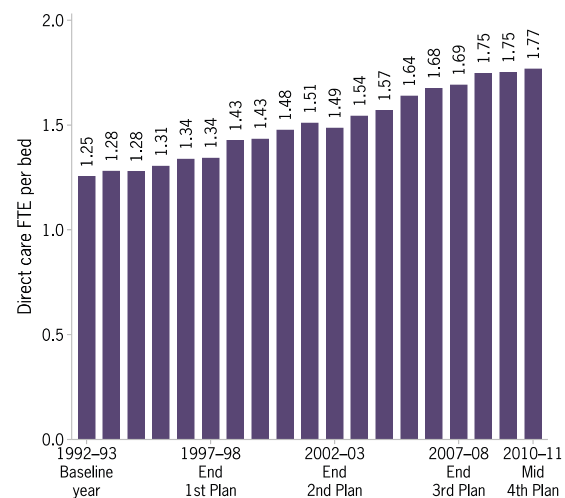


Figure 30
Average number of direct care staff (FTE) per bed, psychiatric inpatient units, 1992-93 to 2010-11



Comparative service levels in 24 hour staffed residential community services and in inpatient services

It is important to consider inpatient and community residential services data in tandem in order to gain a fuller understanding of how Australia has progressed in terms of levels of service availability. Table 5 provides a detailed view of the inpatient and residential service mix available for specific target populations in each jurisdiction in 2010-11. When inpatient and community residential beds are combined, the average number of beds is 40 per 100,000. Two jurisdictions provide well above this per capita average – Tasmania at 58 per 100,000 and Victoria at 49 per 100,000. These states are among the lower providing states when public sector inpatient beds are considered in isolation, but their relatively high provision of beds in community residential settings – particularly those with 24 hour staffing – increases their overall per capita provision to above the other jurisdictions.

Another way of thinking about this is the relative proportions of all psychiatric beds that are located in the different settings. Nationally, 75% of all public sector beds are available in inpatient units, and 17% and 8% in 24 hour staffed and non-24 hour staffed community residential units, respectively. There is considerable variation across jurisdictions, however, with Queensland and New South Wales being particularly heavily reliant on their inpatient units, and Tasmania, the Australian Capital Territory and Victoria providing less than 50% of their beds in these settings.

Table 5
Inpatient and community residential beds per 100,000 population, 2010-11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Nat. Avg.
GENERAL ADULT									
Acute inpatient	28.9	20.6	21.6	24.5	24.5	25.9	20.3	21.3	24.3
Non-acute inpatient	13.3	3.0	17.4	8.9	5.9	8.6	0.0	0.0	10.0
24 hour staffed residential	2.3	13.7	0.0	4.9	7.7	19.5	14.2	9.6	6.0
Non-24 hour staffed residential	0.5	9.7	0.0	14.0	1.8	24.6	15.4	0.0	5.0
Total general adult	45.0	46.9	39.0	52.2	39.9	78.7	49.9	31.0	45.3
CHILD AND ADOLESCENT									
Acute inpatient	4.5	5.4	4.9	3.7	3.4	0.0	0.0	0.0	4.4
Non-acute inpatient	1.9	0.0	1.4	1.1	0.0	0.0	0.0	0.0	1.0
24 hour staffed residential	0.5	0.0	0.0	0.0	0.0	0.0	6.3	0.0	0.3
Non-24 hour staffed residential	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total child and adolescent	7.5	5.4	6.3	4.8	3.4	0.0	6.3	0.0	5.9
OLDER PERSONS									
Acute inpatient	17.6	28.1	9.0	40.7	26.8	0.0	39.6	0.0	21.3
Non-acute inpatient	18.6	0.0	25.2	7.1	26.4	0.0	0.0	0.0	13.9
24 hour staffed residential	1.8	81.9	0.0	0.0	0.0	39.6	13.2	0.0	22.5
Non-24 hour staffed residential	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Total older persons	39.2	110.0	34.2	47.8	53.2	39.6	52.8	0.0	58.1
FORENSIC									
Acute inpatient	2.5	2.2	0.0	1.7	0.6	4.9	0.0	0.0	1.7
Non-acute inpatient	2.3	1.3	1.8	0.4	2.4	0.0	0.0	0.0	1.6
Total forensic	4.8	3.5	1.8	2.1	3.0	4.9	0.0	0.0	3.4
ALL BEDS									
All inpatient	36.4	22.6	31.2	30.2	30.2	25.0	18.0	14.5	30.1
All 24 hour staffed residential	1.8	19.8	0.0	3.2	4.8	18.3	12.4	6.5	6.9
All non-24 hour staffed residential	0.6	6.1	0.0	9.1	1.1	15.1	10.5	0.0	3.2
TOTAL	38.8	48.5	31.2	42.4	36.1	58.3	40.9	21.0	40.2

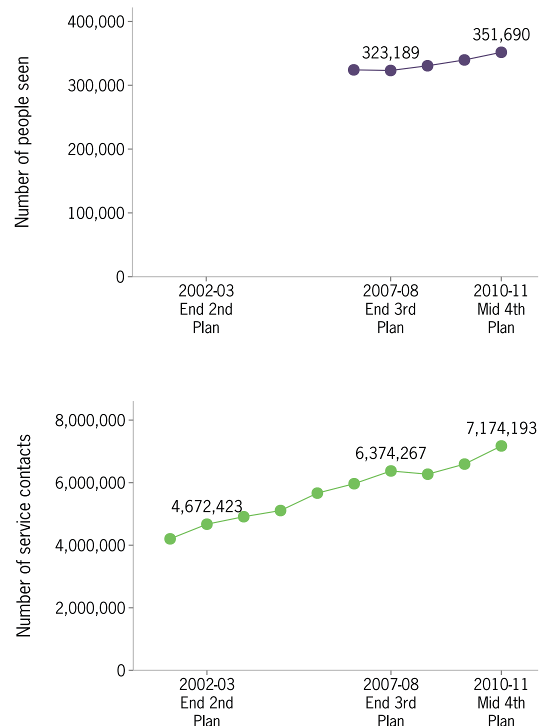
Trends in service delivery

Reliable national data on the number of people seen by state and territory community mental health care are available from 2006-07 to 2010-11. These raw numbers are provided in Figure 31 and show that the number of people seen increased from 324,160 in 2006-07 to 351,690 in 2010-11. In the latter year, about 40% of persons seen were new clients (i.e., clients who had not been seen by the service in the preceding five years). [28]

Figure 31 also provides data on the number of service contacts provided and the number of people seen in community mental health care from 2001-02 to 2010-11. The number of service contacts rose from 4.2 million in 2001-02 to 7.2 million in 2010-11.

The frequency of services provided to people seen by state and territory community mental health services has remained fairly stable when measured by the number of days on which a service is provided (referred to as a 'treatment day'). Figure 32 shows that on average, consumers of state and territory mental health services are seen on 6.0 to 6.5 days each three month period while under care, equating roughly to once per fortnight. On average, registered consumers are seen on 14 days over a 12 month period, although there is substantial variation and many consumers receive community mental health care over substantially briefer periods than a full year. Ten per cent of consumers are seen by state and territory mental health services on more than 30 days over the year.

Figure 31
Number of service contacts[a] provided, 2001-02 to 2010-11, and number of people seen by state and territory community mental health services, 2006-07 to 2010-11



(a) Includes unregistered contacts. Not all jurisdictions report unregistered contacts and reporting practices may have changed over time.

In the inpatient setting, the total number of patient days decreased on an annual basis from 2.5 million in the year before the National Mental Health Strategy began (1992-93) to a low of just over 1.8 million in 1999-00. Since then, the number has risen again and in 2010-11 it was 2.1 million. Figure 33 provides a detailed picture of the change in patient days over time.

Taken together, it can be seen that these trends in service delivery are consistent with the changes in investment in service mix, particularly in terms of the expansion of community-based services described above. The increased numbers of people seen and services provided in community mental health care settings reflect the significant growth in resources directed to these services during the life of the National Mental Health Strategy.

Figure 32
Average number of treatment days per three month period of community mental health care, 2005-06 to 2010-11

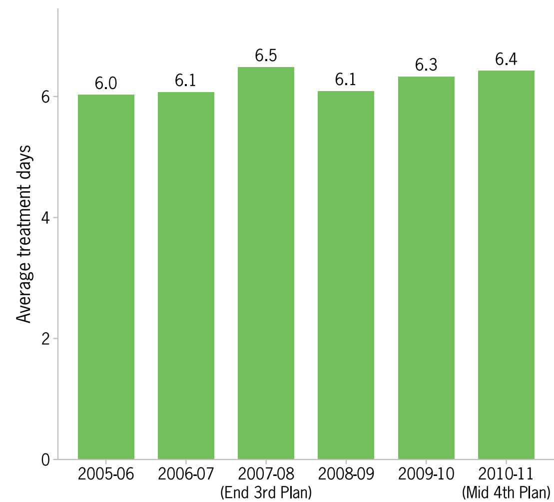
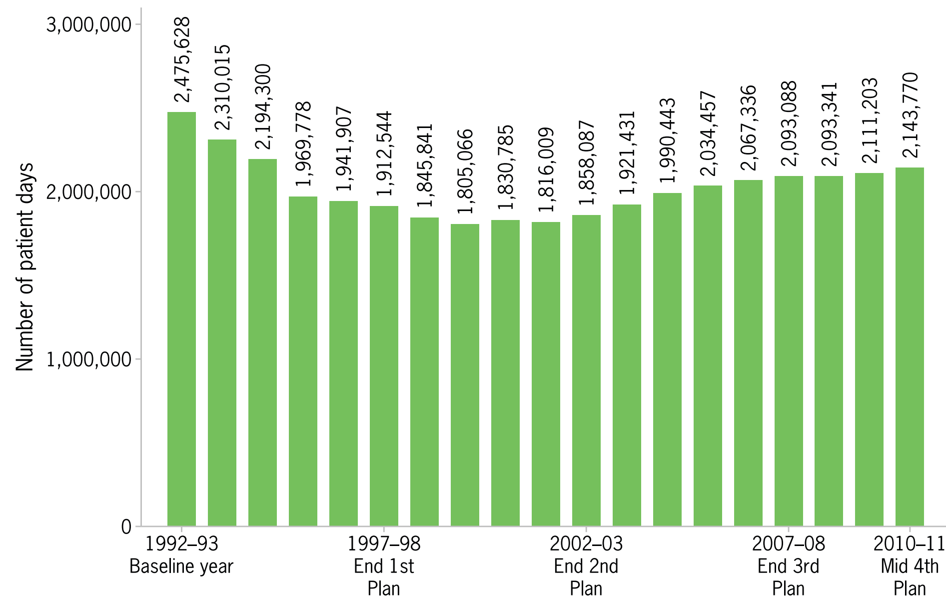


Figure 33
Total number of patient days in psychiatric inpatient settings, 1992-93 to 2010-11



2.5 Trends in private sector mental health services

KEY MESSAGES:

- There was significant growth in mental health care activity in private hospitals between 1992-93 and 2010-11. Bed numbers in specialist psychiatric units in private hospitals increased by 40%, the number of patient days increased by 106%, and the number of full-time equivalent staff increased by 87%. Expenditure by private hospital psychiatric units grew by 142% between 1992-93 and 2010-11.

- Medicare Benefits Schedule (MBS) expenditure on mental health services increased significantly with the introduction of the Better Access program. Better Access provided a rebate on the MBS for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists. In 2006-07, MBS expenditure on mental health services had reached a low of $474 million. In 2007-08, the first full year of Better Access, there was a sharp increase to $583 million, and by 2010-11 the overall MBS mental health specific expenditure figure rose to $852 million, accounting for 35% of overall Australian Government mental health spending.

- In 1992-93, services provided by psychiatrists and general practitioners accounted for all of the MBS expenditure on mental health services. By 2010-11, MBS-subsidised services provided by medical practitioners were complemented by services delivered by clinical psychologists, registered psychologists and other allied health professionals who accounted for 41% of MBS mental health specific expenditure.

- In 2011-12, 1.6 million people received mental health services subsidised by the Medicare system, some from several providers. In total, 7.9 million mental health services were provided in that year.

Reform of public sector mental health services was the principal focus of the National Mental Health Strategy in its first five years. Services provided outside the public sector were not originally considered within scope, but governments have become increasingly aware of the importance of partnerships with service providers operating in Australia's private sector.

The private sector plays a key role in overall service delivery. In 2010-11, the sector:

- provided 20% of total psychiatric beds;
- engaged or employed approximately 17% of Australia's health professional workforce delivering mental health services; and
- provided services to eight out of every 10 people who were recorded as receiving mental health specific health services.

This section reviews the provision of services provided through the private sector, both in private hospital settings and through services primarily funded under the Australian Government Medicare Benefits Schedule (MBS).

Private hospital care

Private psychiatric hospitals have focused primarily on the provision of inpatient care. This reflects both the history of mental health services in Australia and the predominant way in which health insurance funds have paid benefits for mental health care. More recently, innovative community models of service delivery are being established that either substitute for or complement inpatient care. The datasets used for the *National Mental Health Report* do not currently contain accurate data on these, so, apart from acknowledging the emergence of these new services, little other information can be provided.

This section summarises information compiled by the Australian Bureau of Statistics (ABS) over key years in the National Mental Health Strategy, using data from its Private Health Establishments collection (PHEC). The ABS did not conduct a private hospital survey in 2007-08, the final year of the *Third National Mental Health Plan*. It also draws on an alternative source of private hospital data, auspiced by the Private Mental Health Alliance (PMHA) to supplement the information compiled from the ABS collection.[30]

Table 6 describes the activity in private hospitals from 1992-93 to 2010-11. The number of private hospitals reporting a specialist psychiatric unit has increased steadily over the course of the Strategy. Forty nine private hospitals providing psychiatric services in 2010-11 reported to the ABS PHEC compared with 33 in 1992-93.[E]

There has been growth in the number of psychiatric beds in private hospitals over time. In 1992-93 there were 1,260 beds and in 2010-11 there were 1,768, an increase of 40%. In per capita terms, these figures equate to 7.2 beds per 100,000 in the former year and 7.9 per 100,000 in the latter.

The number of patient days spent in private psychiatric units has also increased. In 1992-93, 328,100 patient days were recorded. In 2010-11, this figure had risen by 61% to 676,654. In population terms, these figures translate to 19 patient days per 100,000 in 1992-93 and 30 patient days per 100,000 in 2010-11.

Staffing of private hospital psychiatric units has increased alongside bed numbers and patient days. In the baseline year, there were 1,222 full-time equivalent staff working in psychiatric units in private hospitals Australia-wide (seven per 100,000). By 2010-11, there were 2,290 (10 per 100,000). This represents an increase of 87% in absolute terms.

[E] Data from the PMHA collection (see www.pmha.com.au) suggests that this may be a slight undercount. The PMHA's Annual Statistical Report suggests that there were 53 private hospitals with specialised psychiatric units operating in 2010-11.

Table 6
Activity in private hospitals with psychiatric units, 1992-93 to 2010-11

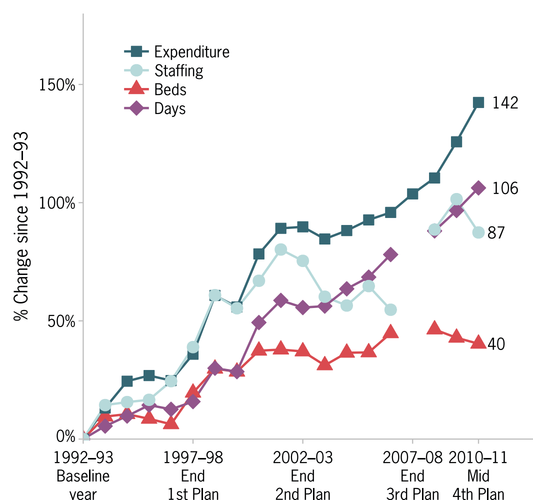
	1992-93 (Baseline year)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)
Hospitals	33	39	46	n.a.	49
Beds	1,260	1,507	1,727	n.a.	1,768
Beds per 100,000	7.2	8.1	8.7	n.a.	7.9
Patient days	328,100	380,117	510,634	n.a.	676,654
Patient days per 100,000	18.7	20.4	25.8	n.a.	30.1
Staff (FTE)	1,222	1,697	2,143	n.a.	2,290
Staff (FTE) per 100,000	7.0	9.1	10.8	n.a.	10.2

About one third of the growth (31%) in patient days in private psychiatric hospitals was accounted for by a substantial rise in same-day admissions, which increased nearly twelve fold between 1992-93 and 2010-11. Same-day admissions accounted for 78% of all discharges from private psychiatric hospital units in 2010-11 and represent the most frequent type of service provided. Same-day admissions across the broader private hospital sector have also increased significantly, but at a much lesser rate than in the psychiatric units that form part of the sector. Total same-day admissions increased approximately four fold in all private hospitals (including freestanding day facilities) between 1992-93 and 2010-11 and accounted for 64% of total separations in 2006-07.

Same-day care in the general health field refers to patients admitted to hospital for a medical, surgical or diagnostic procedure who are discharged on the day of admission. In the mental health field, most same-day admissions to private hospitals represent individual days of care that fall within planned episodes of ambulatory mental health care. In its Annual Statistical Report Series, the PMHA reported that Australia's private hospital psychiatric units delivered 13.335 episodes of ambulatory mental health care in 2010-11, with an average of 11 days of care per episode.[30] These episodes typically involve participation by consumers in structured, group-based psychotherapeutic programs, run by allied health professionals or nurses with formal training in these forms of therapy. A relatively small proportion of same-day admissions to psychiatric hospital units are for electroconvulsive therapy, most usually provided to consumers with recurrent severe major depression.

Activity data relating to private hospital psychiatric units are considered in the context of expenditure data in Figure 34. Estimated recurrent expenditure by private psychiatric units in 2010-11 was $307 million, an increase of 142% since 1992-93. This increase in expenditure outweighs the increases in beds, patient days and staffing, described above.

Figure 34
Selected indicators of change in the private psychiatric hospital sector, 1992-93 to 2010-11



Medicare Benefits Schedule funded private mental health care

Most previous *National Mental Health Reports* confined their coverage of Medicare Benefits Schedule (MBS) funded services to the activities of consultant psychiatrists working in the private sector. The 2010 report extended this scope to incorporate new MBS-subsidised services provided by general practitioners and allied health professionals that were introduced through Australian Government initiatives under the 2006 *National Action Plan on Mental Health*.

These services became available through the initiative known as Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access), which was introduced in November 2006 in response to low treatment rates for common mental disorders (for example, anxiety, depression and substance use disorders). Better Access introduced a series of new item numbers on the Medicare Benefits Schedule to provide a rebate for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists.

Figure 35 shows that MBS expenditure on mental health services has increased significantly in line with the introduction of Better Access. In 1992-93, an estimated $521 million was spent on MBS-funded services, accounted for by services provided by GPs and consultant psychiatrists. This figure rose incrementally until the mid-1990s, reaching $576 million in 1995-96, and then dipped into the mid-2000s. In 2007-08, the first full year of Better Access, expenditure rose to $583 million and by 2010-11 the overall MBS mental health specific expenditure figure reached $852 million, accounting for 35% of overall Australian Government mental health spending.

Figure 35
MBS expenditure on mental health services ($millions), 1992-93 to 2010-11

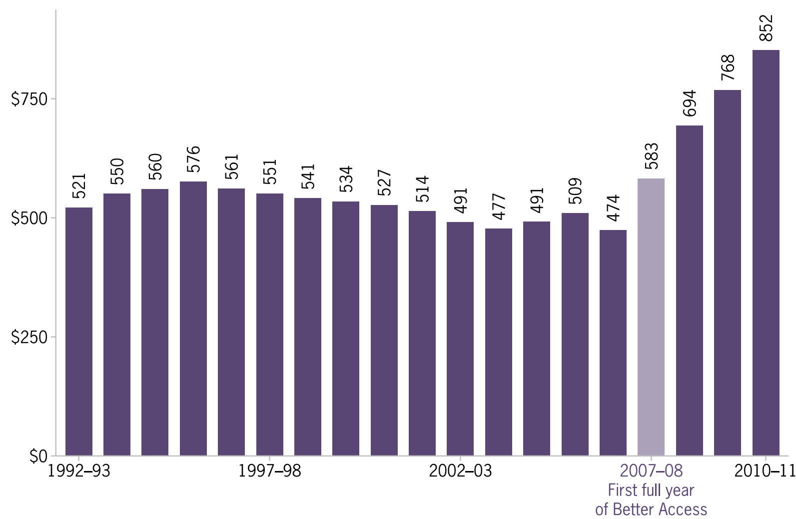
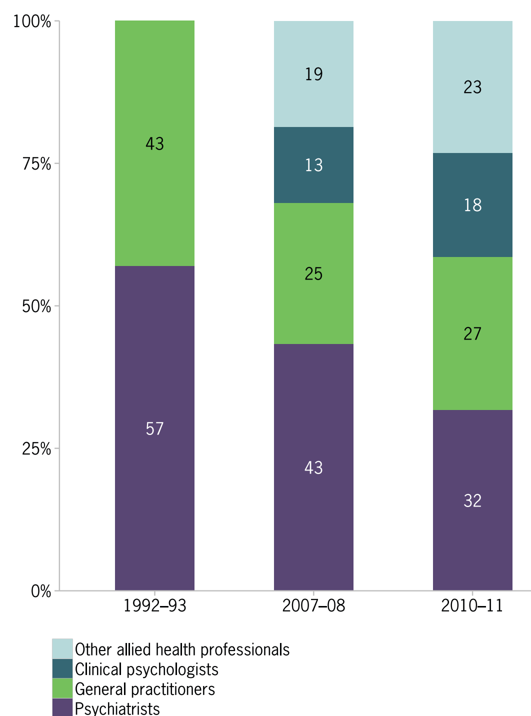


Figure 36 shows the distribution of expenditure across the different provider groups over time. In 1992-93, services provided by psychiatrists and general practitioners accounted for 57% and 43% of overall MBS expenditure on mental health services, respectively. As Better Access was rolled out in 2007-08, the share of expenditure on services delivered by psychiatrists and general practitioners in that year reduced, with the former accounting for 43% and the latter tallying 25%. In that year, 13% of expenditure covered services delivered by clinical psychologists, and 19% covered services delivered by registered psychologists and other allied health professionals. The proportion of expenditure dedicated to services delivered by each of these groups has continued to grow, and in 2010-11 it collectively made up 41% of all expenditure on MBS-funded mental health services.

Figure 36
Distribution of MBS expenditure on mental health services, 1992-93 to 2010-11



In total, one million people received mental health services subsidised by the Medicare system in 2007-08 (see Figure 37). This number climbed steadily during the first five full years of Better Access, and reached 1.6 million in 2011-12.

Figure 38 provides a breakdown of the number of people seen by psychiatrists, general practitioners, clinical psychologists and other allied health professionals in 2011-12. Some of the individuals treated by MBS-subsidised mental health service providers in 2011-12 received services from more than one kind of provider, so the total exceeds 1.6 million. General practitioners saw the largest number of people (1.2 million), which reflects the fact that they not only provide mental health services themselves but also act as the referral conduit to other providers under the rules of Better Access. Registered psychologists and other allied health professionals saw nearly 500,000 people.

In total, 7.9 million mental health services were provided through Medicare in 2011-12, compared with 3.3 million provided in 2006-07 (an increase of 141%). Figure 39 shows the number of services provided by each of the four provider types, and demonstrates significant growth for services provided by general practitioners (0.6 million to 2.2 million), clinical psychologists (0.2 million to 1.4 million) and other allied health professionals (0.5 million to 2.3 million). Figure 39 suggests that in all three cases the growth is beginning to attenuate and that for other allied health professionals it may be beginning to reverse. An evaluation of Better Access suggested that the significant initial uptake of these new services reflected the high levels of previously unmet need for mental health care in the community.[31]

Figure 37
Number of people treated by MBS-subsidised mental health service providers, 2006-07 to 2011-12

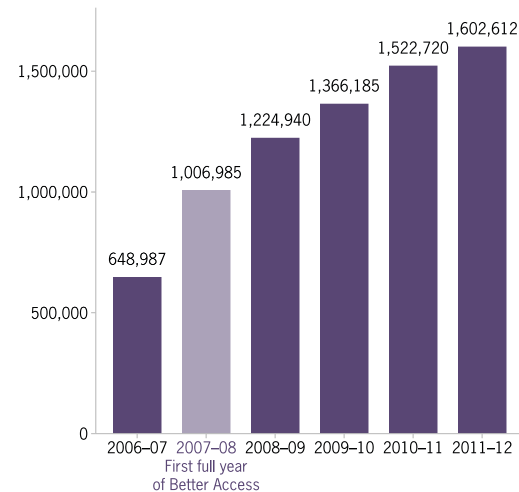


Figure 38
Number of people treated by MBS-subsidised mental health service providers, by provider type, 2011-12

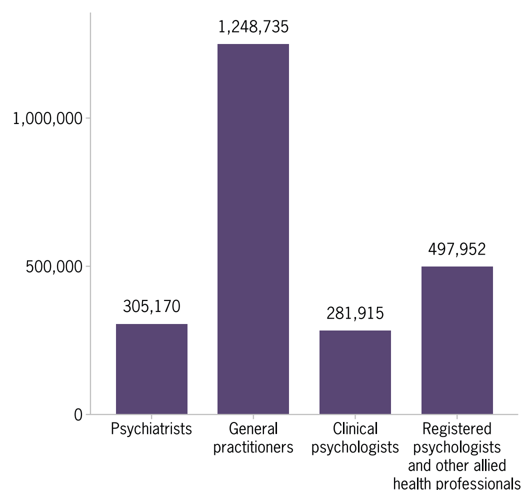
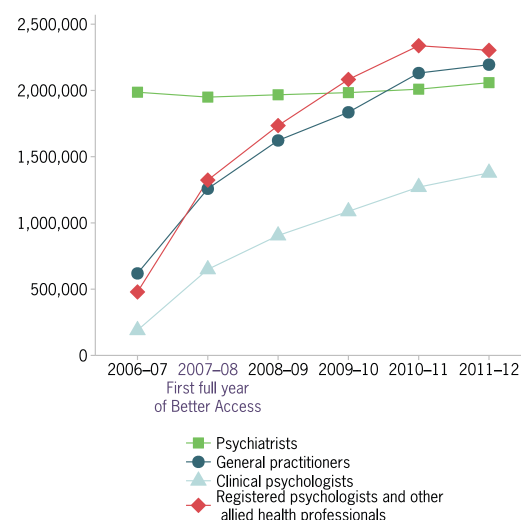


Figure 39
Number of MBS-subsidised mental health services provided, by provider type, 2006-07 to 2011-12



2.6 Consumer and carer participation in mental health care

KEY MESSAGES:

- In 2010-11, about half of Australia's state and territory mental health services had either appointed a person to represent the interests of mental health consumers on their organisational management committees or had a specific Mental Health Consumer/Carer Advisory Group established to advise on all aspects of service delivery. However, one quarter had no structural arrangements in place for consumer and carer participation.

- Significant proportions of state and territory mental health services also had some other arrangements in place for consumer and carer participation, although the extent to which organisations had established particular initiatives varied. Mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

- In 2010-11, there were 4.6 consumer and carer workers employed for every 1,000 full-time equivalent staff in the mental health workforce. This figure has risen by 33% since 2002-03, when it was 3.5 per 1,000.

- In recent times, there have been a number of consumer and carer developments that have had an increased emphasis on social inclusion and recovery. For example, the recently established National Mental Health Commission has produced its first *Report Card*, identifying and reporting on several areas that are important to consumers' ability to lead a contributing life. Moves are also underway to establish a new national mental health consumer organisation, auspiced by the Mental Health Council of Australia, that will ensure that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform.

Consumer and carer participation in Australian mental health services underwent rapid maturation over the course of the *First National Mental Health Plan*. Inquiries conducted in the period preceding the National Mental Health Strategy pointed to abuses of the rights of consumers and advocated forcefully on their behalf for action to correct these. Governments responded with a number of proposals for change and, more importantly, consumers began to speak for themselves.

Initial concerns driving the Strategy revolved around concepts of protection from human rights abuses, but these concerns progressively evolved to incorporate more contemporary concepts of consumer empowerment and participation. This required that consumers and carers be given a place in discussions about the planning, delivery and evaluation of services designed to meet their needs.

The Strategy has advocated strongly for this position. Underpinning this is a view that such participation can empower and inform consumers and carers, destigmatise mental illness and ultimately improve mental health outcomes by promoting a recovery orientation in service delivery. Additionally, accountability to consumers at all levels of the mental health system provides an avenue to identify and resolve deficiencies in service quality that, historically, compromised the rights of people with a mental illness.

The early steps taken to promote consumer and carer participation are regarded as one of the hallmarks of the National Mental Health Strategy. Under the *First* and *Second National Mental Health Plans,* states and territories were required to establish advisory groups to provide direct consumer and carer input to mental health policy and service development. The *Third National*

Mental Health Plan promoted further development of opportunities for consumers and carers to take meaningful roles in building a better service system. The *Fourth National Mental Health Plan* has continued this direction.

At the national level, consumers and carers were included in all planning and advisory groups established under the Strategy. Considerable funds were allocated to strengthening their voice in mental health planning, policy and evaluation through representation on bodies such as the Mental Health Council of Australia.

Many other groups play important roles throughout Australia in representing consumers and carers in mental health. They have undertaken a substantial amount of work to increase participation by, and awareness of, the roles of consumers and carers in the mental health reform agenda.

The current report does not detail the contributions of all the individual parties, but focuses on updating previously published data on the extent to which mechanisms for consumer and carer participation have been established at the local service delivery level.

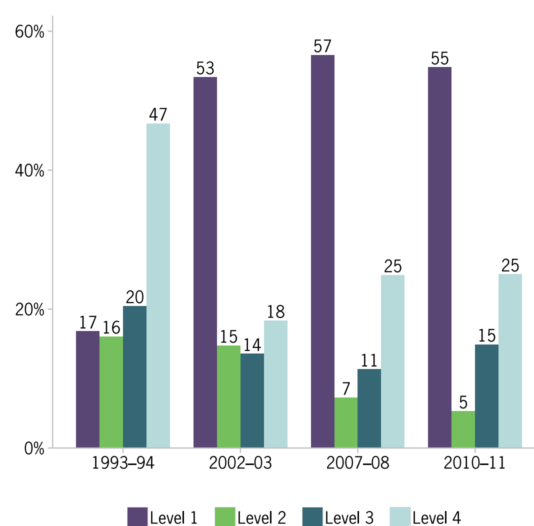
Consumer committee representation at the local service delivery level

The extent to which consumers are involved at the 'coalface' level of service delivery, where they have opportunities to influence the services they receive, is an important indicator of whether the National Mental Health Strategy has made a difference for consumers.

The principle of consumer participation in local services is reflected in the National Standards for Mental Health Services (National Standards). The National Standards set expectations that each service will involve consumers in the planning, implementation and evaluation of services, and that consumers will be active participants in the assessment and treatment planning that directly affects them. All states and territories are committed to full implementation of the Standards within the services under their control.

The annual data collection reported by states and territories has provided the means to monitor trends in the type of local arrangements in place for consumers to contribute to service planning and delivery. As in previous years, the 2010-11 collection required each organisation to describe its structural arrangements for involving consumers. Analysis of the survey data assigns each organisation into one of four levels, ranging from Level 1 (agencies where consumers were given a formal place in the local executive decision making structures or where a specific consumer group had been established to advise on all aspects of service delivery) to Level 4 (agencies with no specific arrangements for consumer participation).

Figure 40
Consumer committee representation within mental health service organisations, 1993-94 to 2010-11[a]



(a) Level 1: Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers. Alternatively, specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation.
Level 2: Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation.
Level 3: Consumers participate on a broadly based advisory committee that includes a mixture of organisations and groups representing a wide range of interests.
Level 4: Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required. Alternatively, no specific arrangements exist for consumer participation in planning and evaluation of services.

The results for 2010-11 are shown in Figure 40 and compared with the situations at the beginning of the National Mental Health Strategy, and at the end of the *Second* and *Third National Mental Health Plans*. They illustrate the considerable progress made over the first 10-year period. Between 1993-94 and 2002-03, the proportion of organisations with some formal mechanism in place for consumer participation (Levels 1 to 3) increased from 53% to 82%. However, the data also reveal that, at the national summary level, little advance has been made since then.

Eighteen years into national mental health reform, about half of Australia's mental health service organisations have consumer representation at the higher level (Level 1). One quarter remain without any basic structural arrangements for consumer participation.

Other local arrangements for consumer and carer participation

States and territories have expressed concern in previous years that exclusive reliance on the 'formal committees' approach to the assessment of consumer participation – the basis of Figure 40 – does not adequately describe the range of initiatives that can be taken to enable participation within mental health service structures and processes. Consumers and carers themselves have articulated similar views.

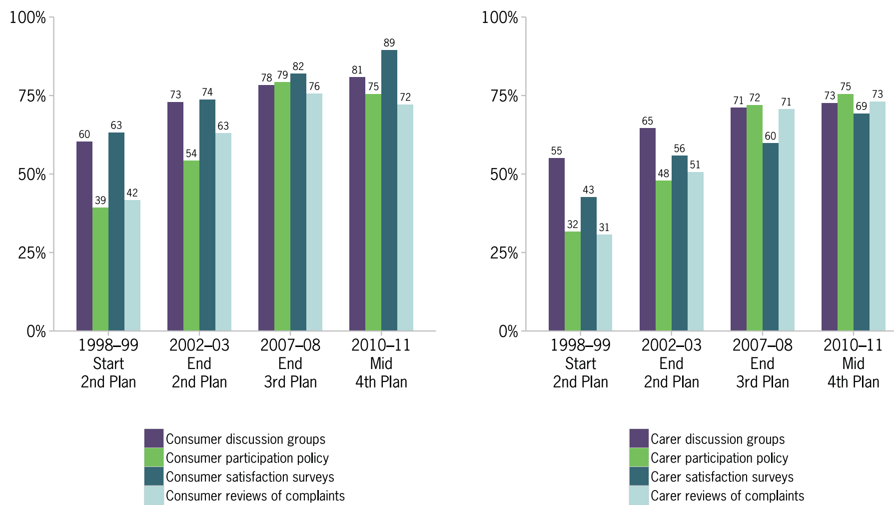
Commencing in 1998-99, the annual state and territory data collection was modified to explore a fuller range of options being pursued by local services, and requested that each mental health service organisation indicate whether such arrangements were in place. The options assessed in the survey are summarised in Table 7.

Figure 41 considers the extent to which mental health service organisations have implemented the last four of these strategies (the first strategy is considered separately below). Taken at face value, the data suggest considerable innovation by service providers in the approaches to building a consumer and carer oriented culture, although the extent to which organisations have established particular initiatives varies. As noted in previous reports, mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

Table 7
Additional consumer and carer participation strategies assessed in annual state and territory reporting

	Additional consumer and carer participation strategies
1.	Consumer/carer consultants are employed on a paid basis to represent the interests of primary consumers/carers and advocate for their needs.
2.	The organisation holds regular discussion groups to seek the views of primary consumers/carers about the mental health services.
3.	The organisation has developed a formal (documented policy) on participation by primary consumers/carers.
4.	The organisation periodically conducts consumer/carer satisfaction surveys.
5.	The organisation has a formal internal complaints mechanism in which complaints made by primary consumers/carers are regularly reviewed by a committee that includes primary consumers/carers.

Figure 41
Other participation arrangements for consumers and carers, 1998-99 to 2010-11



Employment of consumer and carer workers

Arguably, a stronger indicator of services' investment in consumer and carer participation is employing them in a paid role. In the early stages of the National Mental Health Strategy, consumer and carer consultants were employed as consultants to represent the interests of consumers and carers respectively, and to advocate for their needs. These consumer and carer consultants took on a variety of roles, including: investigating areas for improvement to local services, policy and procedures and advocating for change; participating in the selection of staff employed in local services; presenting consumer and carer perspectives in the evaluation of local services; and contributing to training programs for service delivery staff.

Consumers and carers valued this strategy as a means to promote services that are responsive to their needs, but argued that they had more to offer. As time went by, new roles for consumers and carers emerged. Some consumer and carer consultants had played a role in developing relationships with individual consumers and carers and communicating their needs to professional staff, and the new consumer and carer workers took this further. 'Recovery workers' and 'peer support workers' emerged, and the people who took on these roles began to work directly with consumers and carers, offering them support and guidance based on their own lived experience of mental illness. Today, the consumer and carer workforce includes both consumer and carer consultants and the newer type of consumer and carer workers.

Since 2002-03, mental health service organisations have been required to quantify the investments they have made in employing consumers and carers. To do this, organisations reporting that consumer and/or carer workers were employed in their organisations were required to provide substantiation, by reporting supplementary information on salary expenditure and numbers of full-time equivalent staff employed. This was designed to avert the situation where mental health service organisations might, for example, report they had employed a paid consumer consultant if a consumer was given a one-off payment for attending a meeting.

Figure 42 shows the national full-time equivalent tally for consumer and carer workers employed in state and territory mental health services from the end of the *Second National Mental Health Plan* to the middle of the *Fourth National Mental Health Plan* (i.e., between 2002-03 and 2010-11). The number of full-time equivalent consumer workers has fluctuated over time, but was at its lowest at 54 in 2002-03 and reached a peak at 69 in 2010-11. The number of carer workers began at a lower base rate but has risen steadily and, in 2010-11, reached about two thirds of the number of consumer workers. In absolute terms, the numbers of consumer and carer workers is still very low.

Another way of thinking about this is to consider the proportion of the total direct care workforce (clinical staff and consumer and carer workers) in state and territory mental health services that is accounted for by consumer and carer workers. Figure 43 shows that the number of consumer and carer workers employed in 2002-03 was 3.5 per 1,000 full-time equivalent direct care staff. By 2010-11, this had risen to 4.6 per 1,000. Although this represents a 33% increase, the penetration of consumer and carer workers into the overall workforce remains small.

The *Fourth National Mental Health Plan* advocates for substantial growth in the consumer and carer workforce and includes a specific indicator to monitor the extent to which this is occurring (Indicator 21). More detail about this indicator is provided in Part 3 of the current report.

Figure 42
Number of full-time equivalent consumer and carer workers employed in state and territory mental health services, 2002-03 to 2010-11

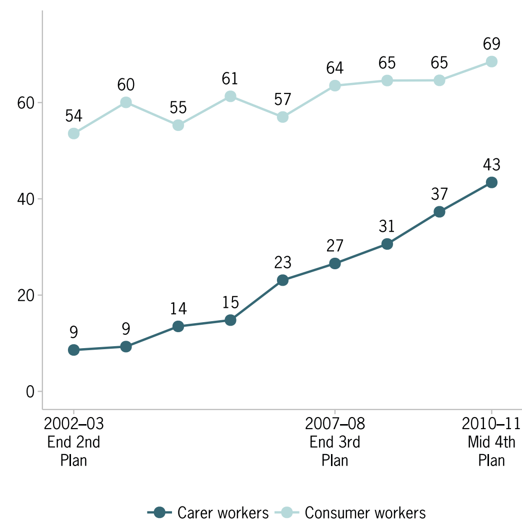
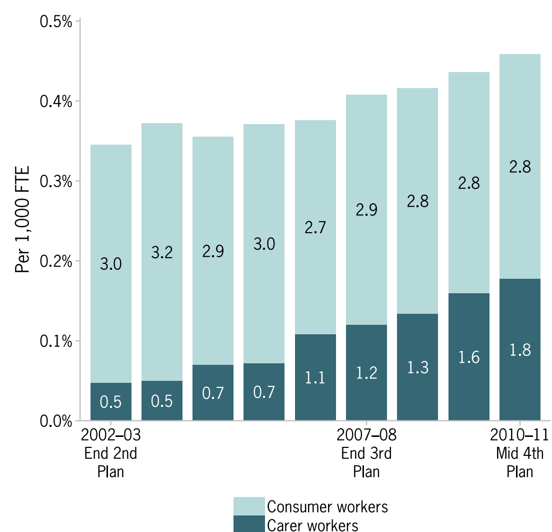


Figure 43
Consumer and carer workers employed per 1,000 full-time equivalent direct care staff, 2002-03 to 2010-11



Ongoing consumer and carer developments

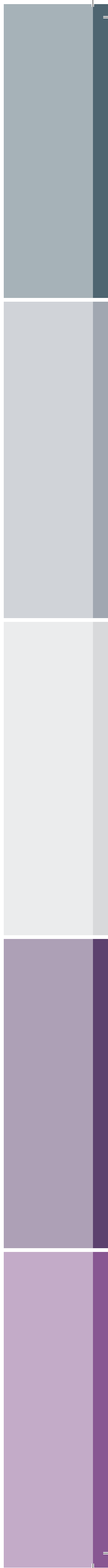
The above indicators suggest that while some progress has been made in providing formal mechanisms for consumer and carer participation, a great deal remains to be done. The *Fourth National Mental Health Plan* reiterates the importance of continuing initiatives to build mental health service systems that are truly consumer and carer responsive.

Over and above this, there is a question about whether the kind of indicators described above are focusing on the issues that are of concern to consumers and carers. In its first *Report Card*,[28] the recently established National Mental Health Commission has identified and reported on six areas that stakeholders have indicated are important to consumers' ability to lead a contributing life. These are: the physical health of people with mental illness; approaches to care which are inclusive of carers; access to timely, appropriate, high quality care; participation in employment and community activities; having a safe, stable and secure home; and preventing suicide.

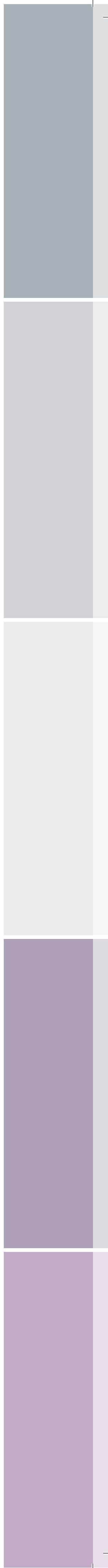
These concerns extend the newer emphases that distinguish the *Fourth National Mental Health Plan* from its predecessors, particularly the focus on social inclusion and recovery themes. A number of the *Fourth Plan* indicators described in Part 2 of this report address these areas and aim to measure progress. The Australian National Mental Health Outcomes and Classification Network is also developing a new measure of social inclusion known as the Living in the Community Questionnaire (LCQ). Funded by the Australian Government, this measure focuses on the consumer's participation in various life domains (for example, employment, education, housing and social activities) and is being designed for use by state and territory mental health services as part of the current arrangements in place for the regular collection of standardised data on consumer outcomes. Routine collection of data from this measure will allow changes in consumers' levels of social inclusion to be systematically tracked.

There are also other broader developments designed to ensure that the participation of people with lived experience of mental illness is central to mental health reform. At the national level, Australian Government funding ($4 million over the period 2011 to 2016) was provided to establish a new mental health consumer-led peak body. The national mental health consumer organisation will involve diverse mental health consumer groups, organisations and individuals, and represent a wide cross-section of experiences and views, in particular those views which are often under-represented. The new organisation will work towards a shared vision so that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform. This will include the work of the National Mental Health Commission that is assessing system performance, described above.

The new organisation is being auspiced by the Mental Health Council of Australia to ensure it has the best possible chance of long term success and sustainability. A Mental Health Consumer Reference Group is advising the Council on planning and implementation of the new organisation, to ensure the voices and views of consumers are front and centre in informing this project. The Council and the Consumer Reference Group are working together to establish a diverse and inclusive membership base and are arranging mechanisms to ensure mental health consumers are involved fully throughout the process. The ultimate aim is to have an independent organisation built upon strong organisational governance and sustainable structures.



Part 3: Monitoring progress and outcomes under the *Fourth National Mental Health Plan*



3.1 Introduction

As noted in Part 1, the current *National Mental Health Report* can be distinguished from its predecessors by the inclusion of new outcome oriented indicators agreed for monitoring progress of the *Fourth National Mental Health Plan*. Part 3 presents the most current quantitative data on the *Fourth Plan* indicators, and draws on qualitative information about the progress of the actions agreed under the *Plan*. Part 3 is organised around the five priority areas of the *Fourth Plan*, namely:

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

Quantitative indicators

The development of indicators under the *Fourth National Mental Health Plan* was underpinned by a number of principles. The 25 indicators were selected to be inclusive of all components of the mental health sector, including public, private and non-government agencies in both the primary care and the specialist mental health sector. They were also designed to go beyond this, and consider key intersections in cross-sectoral reform. There was a commitment to using existing national data wherever possible, and to specify the indicators in a manner consistent with currently recognised quality frameworks. Eleven of the 25 indicators were taken directly from the 12 indicators specified by the COAG *National Action Plan on Mental Health*, to ensure their continued publication given that reporting on the *National Action Plan* has now been completed. The need for extensive work to develop suitable data sources to populate some indicators was recognised, along with the fact that proxy indicators might need to be used in the interim where preferred data were not available.

As a preliminary exercise to reporting the *Fourth Plan* indicators in future *National Mental Health Reports*, work was undertaken to develop detailed specifications and identification of data sources through the then National Mental Health Information Strategy Subcommittee (now Standing Committee), which acts as an inter-governmental group and operates under the auspices of the Australian Health Ministers Standing Council on Health. The resulting document, *The Fourth National Mental Health Plan Measurement Strategy 2011*,[32] has guided the presentation of all indicators in the current report.

Table 8 provides an overview of the indicators. Three indicators (1, 2 and 20) are split because they require data from two different sources. This effectively means that the total number of indicators is 28, rather than 25. Data sources and specifications (including proxy measures) have been developed for 19 of these (1a, 2a, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 19, 20a, 21, 22 and 23, highlighted by a green traffic light symbol in the table). No current data sources are available for the nine remaining indicators, but work is in progress for seven of these (1b, 2b, 5, 17, 18, 24 and 25, highlighted by an amber traffic light symbol), and there is no foreseeable data source for two indicators (10 and 20b, highlighted by a red traffic light symbol). The first 19 are reported in Part 3 and will continue to be reported for the rest of the *Fourth National Mental Health Plan*. No further detail is provided on the remainder in the current report.

Data sources and explanatory notes for quantitative data presented in Part 3 are provided in Appendix 2.

Table 8
Overview of indicator status

Priority Area	Indicator		Indicator status
Priority area 1: Social inclusion and recovery	1a	Participation rates by people with mental illness of working age in employment: General population	●
	1b	Participation rates by people with mental illness of working age in employment: Public mental health service consumers	⊖
	2a	Participation rates by young people aged 16–30 with mental illness in education and employment: General population	●
	2b	Participation rates by young people aged 16–30 with mental illness in education and employment: Public mental health service consumers	⊖
	3	Rates of stigmatising attitudes within the community	●
	4	Percentage of mental health consumers living in stable housing	●
	5	Rates of community participation by people with mental illness	⊖
Priority area 2: Prevention and early intervention	6	Proportion of primary and secondary schools with mental health literacy component included in curriculum	●
	7	Rates of contact with primary mental health care by children and young people	●
	8	Rates of use of licit and illicit drugs that contribute to mental illness in young people	●
	9	Rates of suicide in the community	●
	10	Proportion of front line workers within given sectors who have been exposed to relevant education and training	⦶
	11	Rates of understanding of mental health problems and mental illness in the community	●
	12	Prevalence of mental illness	●
Priority area 3: Service access, coordination and continuity of care	13	Percentage of population receiving mental health care	●
	14	Readmission to hospital within 28 days of discharge	●
	15	Rates of pre-admission community care	●
	16	Rates of post-discharge community care	●
	17	Proportion of specialist mental health sector consumers with nominated GP	⊖
	18	Average waiting times for consumers with mental health problems presenting to emergency departments	⊖
	19	Prevalence of mental illness among homeless populations	●
	20a	Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities	●
	20b	Prevalence of mental illness among people who are remanded or newly sentenced to juvenile correctional facilities	⦶
Priority area 4: Quality improvement and innovation	21	Proportion of total mental health workforce accounted for by consumer and carer workers	●
	22	Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	●
	23	Mental health outcomes for people who receive treatment from state and territory services and the private hospital system	●
	24	Proportion of consumers and carers with positive experiences of service delivery	⊖
Priority area 5: Accountability: Measuring and reporting progress	25	Proportion of services publicly reporting performance data	⊖

Key to indicator status: ● – Data sources and specifications developed; ⊖ – No current data sources available (including proxy measures) but work is in progress; ⦶ – No foreseeable data source

Qualitative data sources

The *Fourth National Mental Health Plan* committed governments to collaborative action in 34 areas designed to achieve reform at a national level in each of the five priority areas. Twenty three of these actions are examined in the current *National Mental Health Report*, on the grounds that they are being pursued independently of broader national reforms (see 1.3). Each action is being led by a lead agency (generally a jurisdiction, or a working group established under the auspices of the Australian Health Ministers' Standing Council on Health). Each priority area has an overall lead which is required to report on the *Fourth Plan's* implementation process, and these reports are collated in the *Fourth Plan's Second Progress Report of Implementation Activity.* For the purposes of the current report, the most recent progress report to 2010-11, as endorsed by the Mental Health Drug and Alcohol Principal Committee, has been used as the primary source of information on progress of the specific actions of the *Fourth Plan*.

3.2 Priority area 1: Social inclusion and recovery

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to social inclusion and recovery. Progress has been made on five of these (see Appendix 3). By way of example, considerable activity has occurred in relation to Action Area 4, which involves adopting a recovery oriented culture within mental health services that is underpinned by appropriate values and service models. A National Mental Health Recovery Framework that is designed to support implementation of a recovery oriented culture in all mental health services is being finalised. In addition, a National Recovery Forum was held in June 2012 at which three international experts gave keynote addresses. This enabled exchange about the implementation of a recovery oriented culture, and provided an opportunity to promote the development of the National Mental Health Recovery Framework.

Indicator 1a: Participation rates by people with mental illness of working age in employment: General population

KEY MESSAGES:

- In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness.
- Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory.
- Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62% in 2011-12.

Mental illness can reduce participation in the workforce in two broad ways. For those in employment, untreated mental illness can diminish engagement and activity in the workplace. Annual losses to national productivity caused by untreated mental illness in the Australian workforce have been estimated at $5.9 billion.[33]

For those not in the workforce, mental illness can act as a barrier to gaining or holding a job. Additionally, the absence of meaningful vocational roles can compromise recovery from mental illness through the associated impacts of social exclusion, welfare dependency, unstable housing and long term poverty.

An increasing body of evidence is accumulating that suggests that vocational outcomes for people affected by mental illness can be improved substantially, leading to better health outcomes.

Using data from the 2011-2012 National Health Survey (NHS) component of the Australian Health Survey (AHS),[34] Figure 44 shows that the 2011-12 employment rate for Australians aged 16-64 years with a self-reported mental illness[D] was 62%, only three quarters of the rate for people without a mental illness (80%). Employment rates for people with mental illness varied across states and territories, ranging from 52% in Tasmania to 73% in the Australian Capital Territory.

Lower employment rates should not be taken as an indicator that people with a mental illness cannot or do not wish to work. Additional 2011-13 AHS data indicate that 6% of people with a self-reported mental illness are unemployed (that is, they are not currently working but actively searching for work). This is double the percentage of people without a mental illness who are unemployed (3%).

Figure 44
Percentage of people aged 16-64 years who are employed, nationally and in each state and territory, by mental illness status, 2011-12

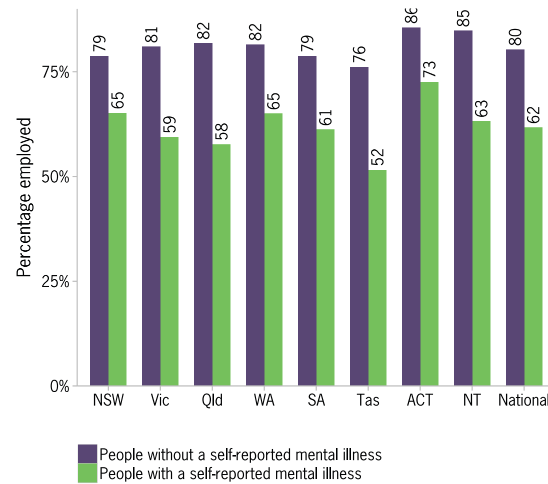
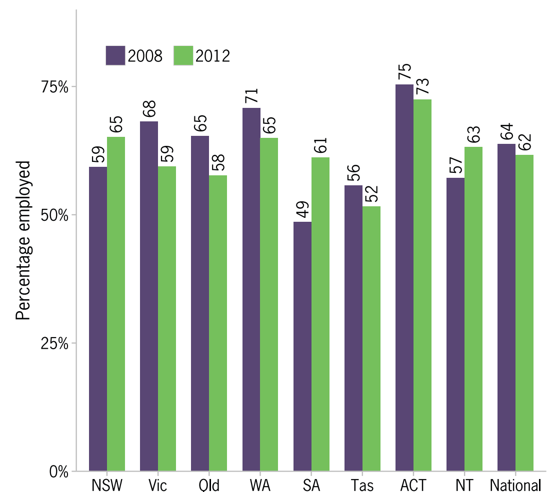


Figure 45
Percentage of people with a mental illness aged 16-64 years who are employed, nationally and in each state and territory, 2007-08 and 2011-12



The data also show that many working age Australians with a self-reported mental illness (32%) are not participating in the labour force (that is, they are neither employed nor looking for work), compared to 17% without a mental illness. Reasons for this are many, but include impaired capacity to work arising from the mental illness. In 2011, people with a mental illness comprised the largest proportion (30%) of the 820,000 Australians receiving a Disability Support Pension (DSP).[35] This equates to 16 in every 1,000 adults of working age being on a DSP due to mental illness. Rates vary across the states and territories.

[D] The approach to identifying mental illness used in the National Health Survey is based on the respondent self-reporting that he or she has a mental or behavioural problem that has lasted, or is likely to last, for six months or more. This approach yields lower prevalence estimates of mental illness than methods that rely on independent assessment against objective criteria (14% in 2011 compared with 20% found in the National Survey of Mental Health and Wellbeing of the adult population), because it does not include people who experience milder forms of mental illness that resolve within a six month period. See Appendix 2 for further details.

Comparison of data from the 2007-08 NHS[36] and 2011-12 NHS in Figure 45 shows that, nationally, employment rates for working age people with a mental illness decreased slightly from 64% in 2007-08 to 62% in 2011-12. However, the amount and direction of change varied across states and territories, with employment rates increasing in New South Wales, South Australia and the Northern Territory.

A major driver of employment participation rates among people with a mental illness is severity of disorder. A report by the Organisation for Economic Cooperation and Development (OECD) showed that 49% of people with a severe disorder were employed, compared to 72% with a moderate disorder, and 81% with a mild or no mental disorder.[37]

Mental disorders make the largest contribution of all the major health conditions (cancer, cardiovascular, major injury, mental disorder, diabetes, arthritis) to health-related labour force non-participation rates. Averting the impact of mental illness has the greatest potential to lift labour force participation rates.[38] A body of evidence is now available to show that vocational outcomes for people with mental illness can be improved through the introduction of models of supported employment.[39] The optimal model of such interventions is an evolving science currently being debated by employment specialists.

Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population

KEY MESSAGES:

- In 2011-12, 79% of Australians aged 16–30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, compared to 90% of their same age peers.
- Employment and education participation rates for this group for most states and territories were within 10% of the national average.
- Nationally, employment and education participation rates for this group remained stable between 2007-08 and 2011-12.

Participation in employment and formal education provide important opportunities for social inclusion. Mental illnesses are particularly prevalent during early adulthood. Many disorders emerge during the late adolescent and early adult years, a period coinciding with important developmental milestones such as the completion of education or training and the commencement of employment. The onset of mental illness, particularly severe mental illness, often involves a decline in functioning leading to compromised academic performance, premature drop out from school or training, and failed or delayed transition between education and employment. These disruptions in education can negatively affect a person's career prospects, increase the risk of long term unemployment or reliance of welfare as their primary income source, and limit opportunities for social inclusion in the broader community.[40] Evidence from Australian studies shows that, among people with a mental illness, previous educational attainment is associated with current employment regardless of type of diagnosis.[41]

Using data from the 2011-12 National Health Survey (NHS),[34] Figure 46 indicates that, in 2011-12, 79% of people aged 16-30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, one eighth lower than for people without a mental illness (90%). Employment and education participation rates for people with a mental illness varied across states and territories, being highest for South Australia and lowest for Western Australia, but all were within 10% of the national average. Data for the Northern Territory should be interpreted with caution due to small numbers in the 'self-reported mental illness' category.

Comparison of data from the 2011-12 NHS with the 2007-08 NHS[36] in Figure 47 shows that, nationally, the rate of participation in employment and education for people aged 16-30 years with a mental illness remained stable between 2007-08 (80%) to 2011-12 (79%). However, the amount and direction of change varied across states and territories. There were relatively large increases in South Australia and Tasmania, compared to a relatively large decrease in Western Australia. Again, small numbers in the Northern Territory mean that 2011-12 data should be interpreted with caution and 2007-08 data are unavailable.

Work and education play an important role in recovery from mental illness. There is increasing evidence that supported employment and education programs can improve employment outcomes and reduce welfare reliance among young people with mental illness.[42]

Figure 46
Percentage of people aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, by mental illness status, 2011-2012

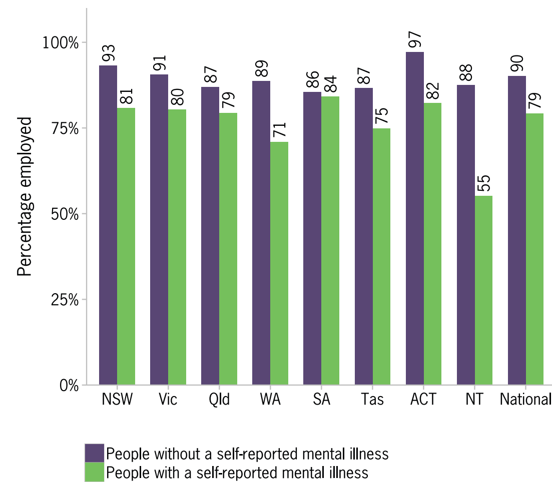
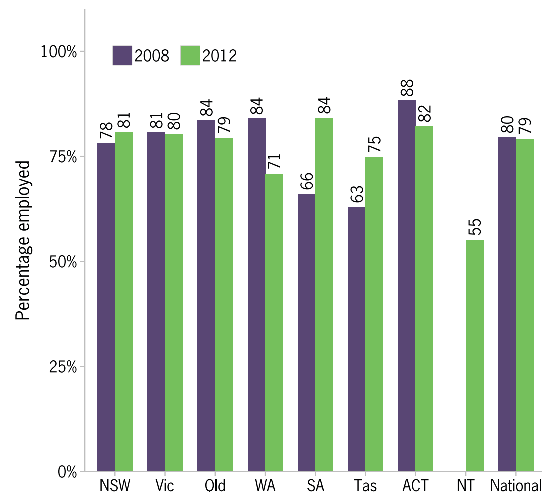


Figure 47
Percentage of people with a mental illness aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, 2007-08 and 2011-12



Indicator 3: Rates of stigmatising attitudes within the community

KEY MESSAGES:

- Social distance is a term used to indicate the willingness of people to interact with people experiencing mental illness. In 2011, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to interact socially with people with a mental illness. Stigmatising attitudes varied across the different types of mental illness, with the average desire for social distance being highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.

- Comparing the 2011 results with equivalent data from 2003-04, Australians' desire for social distance from people with depression with suicidal thoughts had decreased. However, their desire for social distance from people with depression without suicidal thoughts, early schizophrenia and chronic schizophrenia remained relatively unchanged.

- There is evidence that the efforts of organisations like *beyondblue* may have contributed to this improvement, at least in the case of depression.

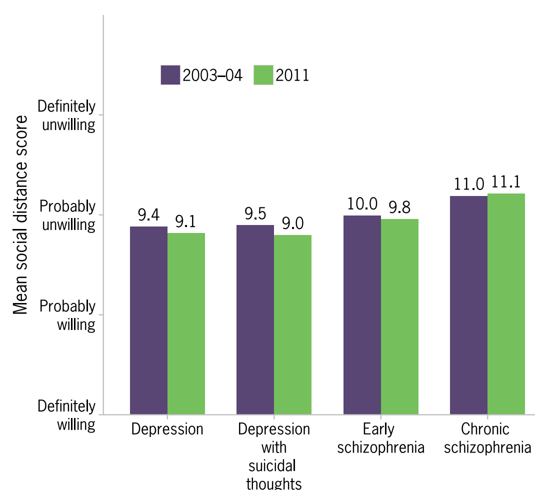
Stigma is often nominated as the issue of most concern by people who live with a mental illness. Stigmatising attitudes have the potential to inhibit help seeking, increase the experience of psychological distress and adversely impact upon the recovery process and achievement of educational and vocational goals.[43 44]

Data for this indicator are taken from the *National Surveys of Mental Health Literacy and Stigma*, conducted in 1995, 2003-04 and 2011.[45] These surveys assessed rates of stigmatising attitudes in Australia using measures of social distance, which are indicators of the willingness of Australians to interact with people suffering from a range of mental illnesses, in a variety of situations. Figure 48 provides data on social distance from the 2003-04 and 2011 surveys.

Data from the 2011 survey suggest that, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to socially interact with people with a mental illness. In 2011, the average desire for social distance was highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.[45 46]

Comparing these results with those from the 2003-04 survey, there is evidence that the Australian public has become more willing to interact with people showing symptoms of depression (with suicidal thoughts). People's willingness to interact with people with depression (without suicidal thoughts) and early schizophrenia also showed improvement in the right direction, but this did not reach statistical significance. Their willingness to interact with people with chronic schizophrenia remained the same across the two years.[45 46]

Figure 48
Average desire for social distance from the person described in the vignette, 2003-04 and 2011



There may be a range of reasons for the improvements observed above. Over the last decade Australia has invested considerable resources in reducing stigmatising attitudes in the community. For example, beyondblue: the national d*epression initiative* has been funded by the Australian Government and state and territory governments since 2000 with the goal of improving the Australian community's awareness of and response to depression and related disorders. Similarly, initiatives such as the federally funded MindMatters and Kidsmatter (described in more detail under Indicator 6) have promoted mental health literacy in schools. States and territories have also invested in their own anti-stigma campaigns.

Indicator 4: Percentage of mental health consumers living in stable housing

KEY MESSAGES:

- Nationally, the percentage of adult consumers of state and territory mental health services (aged 15-64) with no significant problems with their living conditions has been stable from 2007-08 to 2010-11 (sitting at around 78%). Consumers in the Australian Capital Territory were the least likely to report problems and those in the Northern Territory were the most likely to do so.
- The percentage of older adult consumers (aged 65+) with no significant problems with their living conditions has shown a slight improvement over time, rising from 79% in 2007-08 to 83% in 2010-11. Older consumers in New South Wales were the least likely to report problems, and those in Tasmania were the most likely to do so.
- Safe, secure and affordable accommodation is critical to recovery for people with living with a mental illness.

Mental illness can act as a risk factor for homelessness, and, in turn, unstable housing can exacerbate symptoms of mental illness. Good collaboration between mental health services, housing providers and accommodation support services can improve the housing prospects of people with mental illness and contribute to their overall wellbeing.

Proxy information on this indicator is available for consumers of state and territory mental health services. For adult consumers (aged 15-64) it is derived from the Health of the Nation Outcome Scales (HoNOS) and for older adult consumers (aged 65+) it is taken from the HoNOS65+. These measures are administered routinely at selected points during episodes of care in state and territory mental health services. Item 11 on the HoNOS and the HoNOS65+ requires the treating clinician to rate the consumer's problems with living conditions and is scored from 0 (no problem) to 4 (severe to very severe problem). These data provide an indicator of the housing status of consumers but should be interpreted with caution for several reasons. Item 11 on the HoNOS and HoNOS65+ relies on the clinician knowing the living circumstances of the consumer and is not optimally completed.

Figure 49 provides national and jurisdiction-level data on the percentage of adult consumers who, on admission to care, had no significant problems with their living conditions. Nationally, the percentage has been stable from 2007-08 to 2010-11 at around 78%. Of all states and territories, the Australian Capital Territory performs the best, with figures close to 90% in the latter years of the period. Consumers in the Northern Territory are most likely to have difficulties in this area, with only 69% having no

significant problems with their living conditions in 2010-11, down from 81% in 2007-08.

Figure 50 provides equivalent data for older adult consumers. The total includes data from all states and territories, but individual figures for the Australian Capital Territory and the Northern Territory are not presented because of small numbers. Nationally, the percentage of older adult consumers with no significant problems with their living conditions has shown a slight increase over time, rising from 79% in 2007-08 to 83% in 2009-10 and 82% in 2010-11. Consumers in New South Wales appear to be the most likely to be rated as having no problems, peaking at 89% in 2009-10.

Governments have acknowledged the crucial role played by stable housing in promoting recovery from mental illness. The *Fourth National Mental Health Plan* emphasised the importance of developing integrated programs between mental health support services and housing agencies to provide tailored assistance to people living with a mental illness. The Council of Australian Governments (COAG) reinforced this in its recent endorsement of the *Roadmap for National Mental Health Reform*, 2012–2022.[1]

Figure 49
Percentage of state and territory mental health services consumers aged 15-64 years who are recorded at admission as having no significant problems with their living conditions

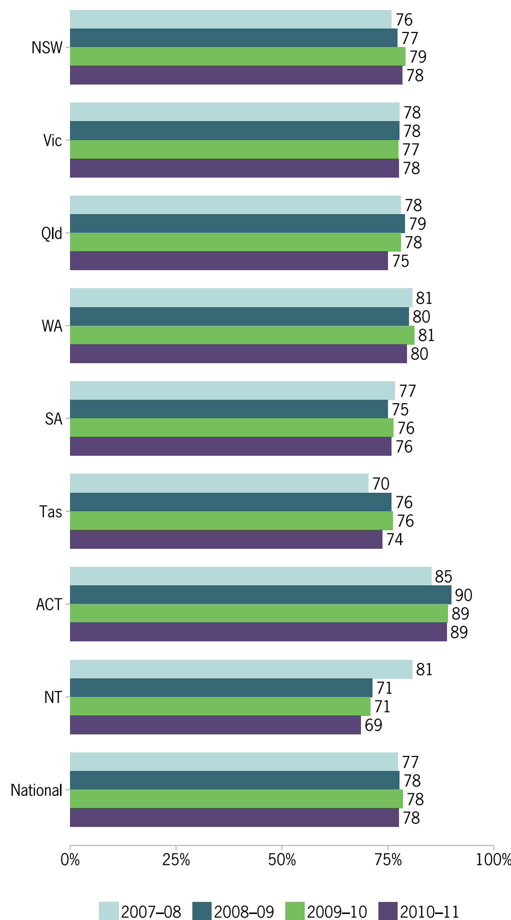
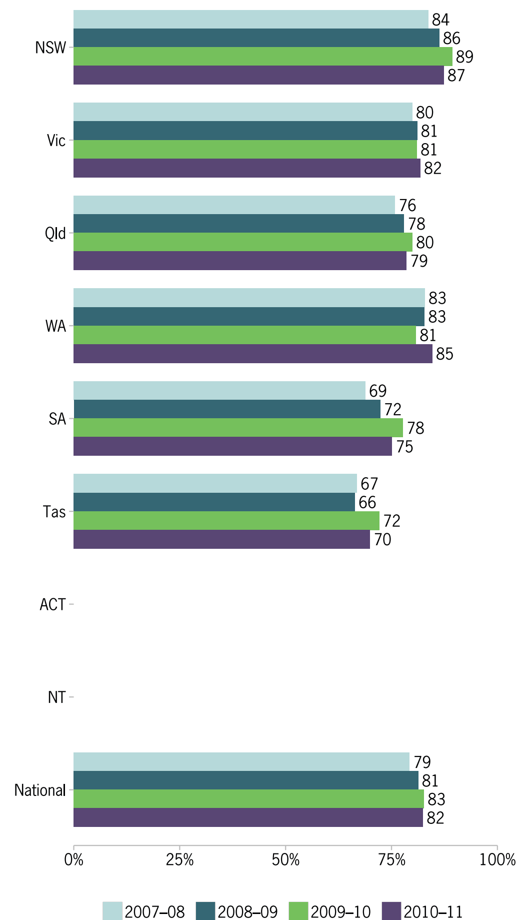


Figure 50
Percentage of state and territory mental health services consumers aged 65+ years who are recorded at admission as having no significant problems with their living conditions



3.3 Priority area 2: Prevention and early intervention

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists eight actions that relate to prevention and early intervention. Progress has been made on five of these (see Appendix 3). A key example is the activity that has occurred in relation to Action Area 10, which involves expanding community based youth mental health services which are accessible and combine primary health care, mental health services and alcohol and other drug services. Funding was provided in the 2011-12 Federal Budget for 90 fully sustainable *headspace* sites across Australia by 2014-15. Seventy sites have been announced, and 40 are currently operational. When fully established, these sites will help up to 72,000 young people each year.

Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum

KEY MESSAGES:

- Australia has invested significant resources in programs that promote mental health literacy in schools – notably MindMatters in secondary schools and Kidsmatter in primary schools.
- In 2011, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources.

There is a growing body of evidence that suggests that school-based mental health literacy programs can boost resilience in children and adolescents, assist school staff in identifying and intervening with students showing early signs of mental health problems, and encourage help seeking among students themselves.[47]

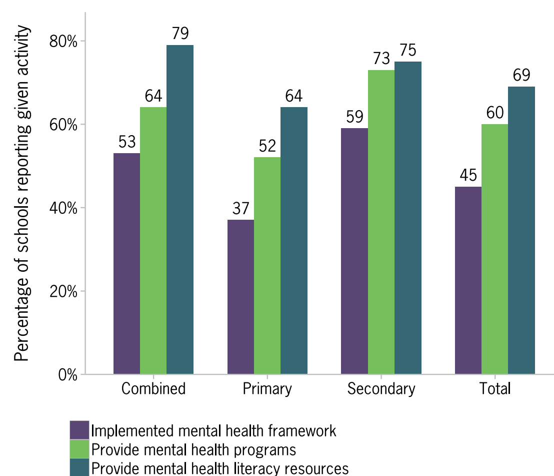
Commencing with the introduction of MindMatters in secondary schools in 1997-98, Australia has invested significant resources in organising frameworks that guide whole-of-school approaches to mental health issues. MindMatters provides a broad framework to assist secondary schools in promoting mental health and identifying and responding to mental health issues where they are present in the school community. Kidsmatter, which followed in 2006 and commenced with an initial pilot, provides a mental health and wellbeing framework specifically designed for primary schools and early childhood education and care services. Both support schools in promoting and protecting the mental health and social and emotional wellbeing of students and other members of the school community. Both have been evaluated positively by students and teachers.[48 49] In addition to MindMatters and Kidsmatter, a range of other mental health frameworks are in use by Australian primary and secondary schools.

Figure 51 shows the percentage of schools that include mental health literacy components in their curricula, using data from Principals Australia's National Market Research Survey which was conducted in 2011.[50] It shows that, in total, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources. 'Combined' schools (i.e., those which cater for both primary and secondary grade levels) generally fell somewhere in between primary and

secondary schools, except in the case of the provision of mental health literacy resources where their uptake rates were the highest.

The uptake of mental health literacy initiatives in schools is positive, but there is still scope for further expansion, particularly in primary schools. Schools appear to perform relatively well in terms of providing resources and offering relevant programs, but are perhaps less successful in embedding these activities within an overarching mental health framework. These activities are less likely to be effective if they are conducted in relative isolation, and should be integral to the school's ethos and environment and woven through its curriculum.[51]

Figure 51
Percentage of schools reporting implementation of mental health frameworks, programs and literacy resources, by school type



Indicator 7: Rates of contact with primary mental health care by children and young people

KEY MESSAGES:

- There was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177). This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so.
- The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).
- This improvement is largely due to the introduction of the Better Access initiative in 2006.

Primary mental health care services have a central role to play in identifying and treating children and young people who are showing signs of mental illness. Childhood, adolescence and young adulthood are crucial developmental periods, and appropriate treatment at these life stages can not only have positive outcomes in the immediate term but can also help to avert or ameliorate problems in later life.

Medicare-funded mental health services provide the main vehicle for delivering mental health services in primary health care settings. Table 9 shows the number and percentage of children and young people making contact with Medicare-funded primary mental health care services from 2006-07 to 2011-12, broken down by age group. It shows that the absolute number of children and young people (aged 0-24) receiving these services has risen substantially over time, from a low of 79,139 in 2006-07 to a high of 337,177 in 2011-12. This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so. The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).

This improvement is largely due to the introduction of the Better Access initiative in 2006. Better Access introduced a suite of new Medicare-funded services (provided by eligible allied health professionals) and expanded the existing range of services provided by GPs and psychiatrists. Annually, children, adolescents and young adults account for slightly over 20% of all users of Better Access.[52]

Several other primary mental health care initiatives of relevance to this group have been implemented under the National Mental Health Strategy. The most notable of these is *headspace*, which was first funded in 2006 and provides youth-friendly access to 12-25 year olds who may be developing, or are already experiencing, mental and/or substance use disorders. *headspace* operates through integrated service hubs and networks. Another example is Access to Allied Psychological Services (ATAPS) which offers similar services to those provided by Better Access, but is funded by the Commonwealth through Medicare Locals rather than via the Medicare Benefits Schedule fee for service system. ATAPS has been running since 2002, and in 2010 an initiative was added which specifically targets children and their parents and offers interventions like family therapy, training in behaviour management, and play therapy.

A range of other providers (for example, community health centres, school counsellors and health nurses, and university and TAFE counselling services) also offer primary mental health care services for children and young people. In addition, child and adolescent specialist public mental health services deliver some primary mental health care services, for example, in their work in school settings.

Taking into account *headspace*, ATAPS and relevant services provided in educational, community health and specialist mental health settings would boost the figures in Table 9, but their specific contribution is unknown. It is likely that there is considerable overlap between those who receive Medicare-funded services and those who see providers in these other settings. For example, a significant proportion of *headspace* clients are referred on to GPs or allied health professionals providing care under Better Access. Similarly, individuals who see an allied health professional through ATAPS require a referral from a GP, and the GP would typically bill Medicare using a Better Access item number.

Without a system of identifying unique individuals accessing all primary mental health care across service streams, it is not possible to include the broader group of services in the counts shown in Table 9. These numbers should therefore be regarded as a conservative estimate, but one which probably does account for the majority of children and young people in contact with primary mental health care.

Table 9
Number and percentage of children and young people receiving relevant Medicare-funded mental health services, 2006-07 to 2011-12 , by age group

		0-4 (Preschool)	5-11 (Primary school)	12-17 (Secondary school)	18-24 (Youth/young adult)	All children and young people aged <25 years
2006-07	Number	1,479	12,298	18,941	46,421	79,139
	%	0.1%	0.7%	1.1%	2.2%	1.1%
2007-08	Number	2,791	28,238	38,984	89,011	159,024
	%	0.2%	1.5%	2.3%	4.2%	2.2%
2008-09	Number	3,931	40,126	55,246	114,458	213,761
	%	0.3%	2.1%	3.2%	5.2%	3.0%
2009-10	Number	4,643	50,434	70,850	130,896	256,823
	%	0.3%	2.7%	4.2%	5.9%	3.5%
2010-11	Number	5,320	60,852	83,671	153,412	303,255
	%	0.4%	3.2%	4.9%	7.0%	4.2%
2011-12	Number	5,862	70,156	94,032	167,127	337,177
	%	0.4%	3.6%	5.5%	7.5%	4.6%

Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people

KEY MESSAGES:

- Data from the National Drug Strategy Household Survey show that use of both licit and illicit drugs has decreased over time.
- In 2001, 47% of 14-29 year olds engaged in risky drinking in the previous year. This had reduced to 42% by 2010, the lowest figure recorded to date.
- In 1998, 36% of 14-29 year olds used cannabis. By 2010, this figure had halved (19%), although the latter figure represented a rise from 2007.
- Ten per cent of 14-29 year olds used amphetamines in 1998 compared with 4% in 2010. As with alcohol, these are the lowest figures recorded to date.

Agreement to this indicator in the *Fourth National Mental Health Plan* reflected concern at the level of government and at the broader community level about substance abuse in young people and its perceived contribution to increased rates of mental illness and associated demand upon health services. While national programs have been initiated under the National Drug Strategy, further targeted efforts were acknowledged as necessary to reduce substance abuse, particularly the use of illicit drugs that may contribute to mental illness, and to deal with the challenge of providing services to people presenting with comorbid mental health and substance abuse problems.

Regular updates on the level of substance abuse in young people are provided through the National Drug Strategy Household Survey. This survey is conducted every three years by the Australian Institute of Health and Welfare, and provides insights into whether patterns of drug and alcohol misuse by young people have changed over time. Three substances of major priority are considered below, namely alcohol, cannabis and amphetamines. Usage rates for each of these drugs by younger people are of particular concern due to the mental health problems often associated with them. Data on alcohol consumption are available from the National Drug Strategy Household Survey from 2001 to 2010, and data on use of cannabis and amphetamines are available from 1998 to 2010.

Alcohol is the most commonly used and abused substance in the Australian community, and is a major cause of death, injury and illness. Figure 52 profiles 'risky drinking' of alcohol by young people. 'Risky drinking' is defined as drinking any amount on a daily basis over the course of the previous year, or drinking at risky levels (i.e., more than four standard drinks on one occasion) at least once per month during that year. The percentage of young people aged 14-29 engaging in risky drinking dropped from 47% in 2001 to 42% in 2010. In each year, the proportion of 'risky drinkers' was higher among 20-29 year olds than among 14-19 year olds.

Cannabis is the most commonly used illicit drug in the community, across all age groups. Research evidence is accumulating that cannabis use may precipitate psychotic symptoms or the onset of schizophrenia in people who have a family history or other vulnerability to psychosis. Cannabis use may also exacerbate the symptoms of schizophrenia, but it remains unclear whether or not cannabis causes additional cases of schizophrenia. Cannabis use also poses a moderate risk for later depression, with heavy cannabis use also possibly conferring a small additional risk for suicide.

Figure 53 shows the 12 month prevalence of cannabis use for young people. In 1998, 36% of 14-29 year olds indicated that they had used cannabis in the past 12 months; by 2010 this figure had halved (19%). The drop was greater for 14-19 year olds (35% in 1998 to 16% in 2010) than for 20-29 year olds (37% in 1998 to 21% in 2010). In each group, 2007 was the lowest prevalence year.

Growth in the use of methamphetamines in the 1990s has been associated with a range of mental health and related problems. Symptoms of psychosis are one of the particularly troubling consequences of methamphetamine use and dependent methamphetamine users also suffer from a range of comorbid mental health problems.

Figure 54 shows the use of amphetamines by young people. As with alcohol use and cannabis use, there is evidence of a downward trend in the use of this class of drugs. In 1998, 10% of 14-29 year olds reported using amphetamines, whereas in 2010 only 4% did so. Again, the relative decline in use was greater for 14-19 year olds (from 6% in 1998 to 2% in 2010) than for 20-29 year olds (from 12% in 1998 to 6% in 2010).

The three substances selected here represent a range of licit and illicit drugs that contribute to mental illness in young people. It is positive to note that the use of all three substances has shown an overall decline over time in young people, although it should be acknowledged that use of ecstasy, not reported here, has increased. Various national programs that have been initiated under the National Drug Strategy may have played a role in this decline. Further targeted efforts are required to ensure that the downward trajectory continues.

Figure 52
Percentage of 14-29 year olds engaging in 'risky drinking' in the past 12 months, 2001-10

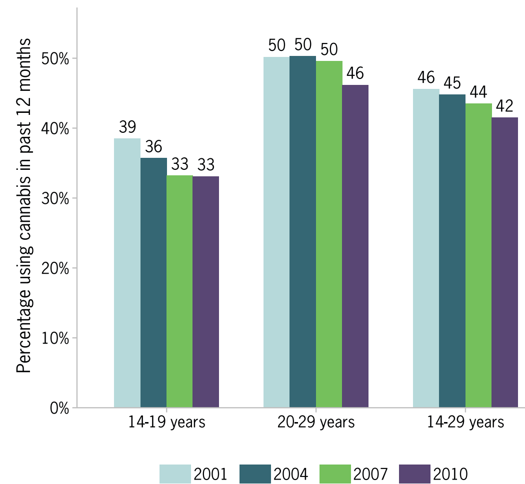


Figure 53
Percentage of 14-29 year olds using cannabis in the past 12 months, 1998-2010

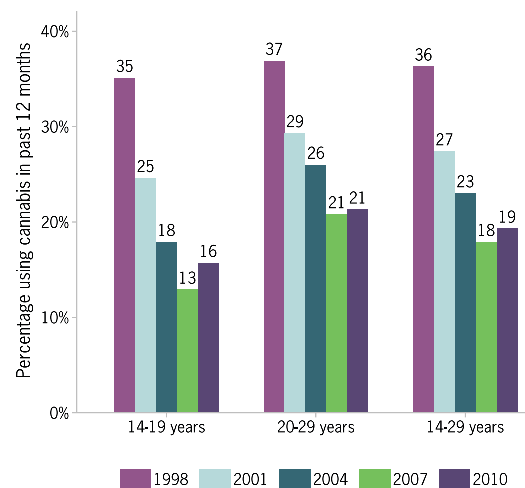
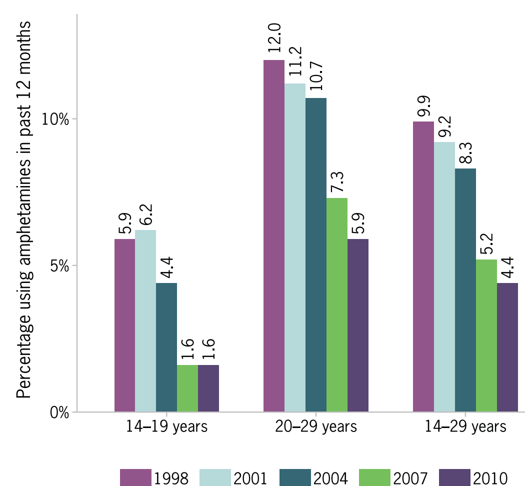


Figure 54
Percentage of 14-29 year olds using amphetamines in the past 12 months, 1998-2010



Indicator 9: Rates of suicide in the community

KEY MESSAGES:

- In 2011, there were 2,273 suicides in Australia, 76% of which were by males.
- Nationally, the average annual suicide rate for the period 2007-11 was 10.6 per 100,000 (16.3 per 100,000 for males; 4.9 per 100,000 for females). The Northern Territory stood out as having particularly high rates.
- The average suicide rate has remained stable since 2003-07. The rate is considerably lower than it was before Australia began its concerted efforts to address suicide through strategic national action.

Arguably, suicides are the starkest indicator of the mental health of the nation. In Australia, suicide ranks as the 15th leading cause of death overall, but it is the leading cause of death for younger people.[53] Suicide is a devastating event for the bereaved; it has been estimated that for every suicide at least six people suffer intense grief and between 80 and 100 more may be affected.[54]

In 2011, there were 2,273 suicides (see Table 10). Three quarters of these suicides (76%) were by males.[53]

Some caution should be exercised in interpreting suicide trends. The number of suicides can fluctuate considerably, and increases in a given year can be matched by commensurate decreases in the following year. These year-on-year changes can sometimes be misinterpreted as significant, when in fact the underlying trend may be relatively flat. This situation may be exacerbated in states and territories with relatively small numbers of suicides.
A common way of reducing the impact of temporal fluctuations in suicides is to convert them to age standardised rates and average them across several years. This allows for more meaningful interpretation of patterns across jurisdictions and over time.

Table 10
Number of suicides by state and territory, 2003-2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2003	640	540	466	227	193	69	35	44	2,214
2004	587	521	453	194	178	88	26	51	2,098
2005	549	506	459	203	231	74	35	45	2,102
2006	577	485	494	245	180	72	32	33	2,118
2007	611	474	520	266	205	66	32	55	2,229
2008	620	545	553	300	175	73	36	38	2,341
2009	623	576	525	279	185	79	32	37	2,337
2010	639	536	583	315	197	64	41	45	2,420
2011	566	483	559	306	209	73	34	43	2,273

Figure 55 compares the average annual age standardised suicide rates in states and territories for the period 2006-10, using five year averages. In all states and territories, the rate for males was over three times higher than that for females. The Northern Territory stands out as having the highest rate, almost double the national figure (19.3 per 100,000 compared with 10.6 per 100,000). Tasmania's rate (14.1 per 100,000) was 33% higher than the national average, Western Australia's (13.1 per 100,000) was 24% higher, Queensland's (12.4 per 100,000) was 17% higher, and South Australia's (12.0 per 100,000) was 13% higher. Lower than average suicide rates were recorded in New South Wales (8.6 per 100,000), Victoria (9.6 per 100,000) and the Australian Capital Territory (9.9 per 100,000).[53] Relative numbers of Indigenous people and people living in rural and remote areas may contribute to these jurisdictional differences.

Figure 55
Average annual age standardised suicide rates (per 100,000 population) by state and territory, 2007-11

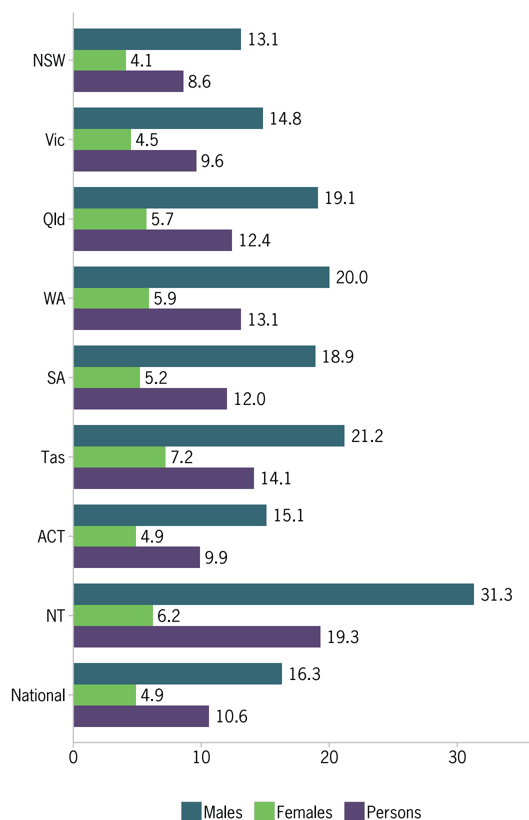
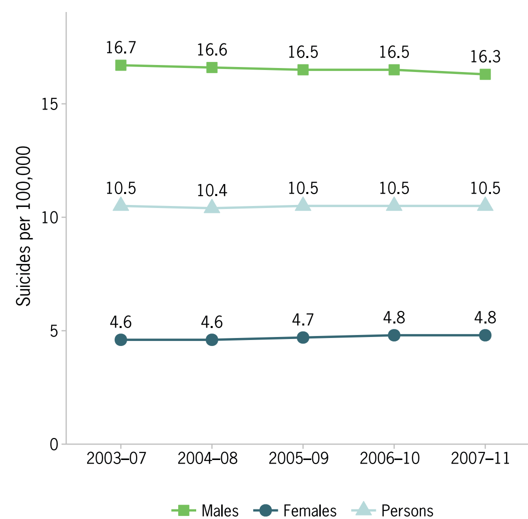


Figure 56 uses unpublished figures from the Australian Bureau of Statistics (ABS) and shows the national trend in suicide rates from 2003-07 to 2007-11, again using five year averages. The overall rate has been stable at 10.5 per 100,000, the male rate has declined slightly (from 16.7 to 16.3 per 100,000) and the female rate has increased slightly (from 4.6 to 4.8 per 100,000).

Figure 56
Average annual suicide rates (per 100,000 population) by five year period, 2003-07 to 2007-11[a]



(a) These figures are based on recent unpublished data provided by the Australian Bureau of Statistics. The 2007-11 figures vary slightly from those presented in Figure 55 due to a different upper age group being used in the calculation of each rate.

The ABS has drawn attention to significant data quality problems that impact on the apparent fluctuation in suicide rates, arising primarily from the increasing number of 'open cases' that are the subject of coronial inquiry. Commencing with its 2008 Causes of Death publication[55] (released in March 2010), the ABS introduced changes to its coding and reporting practices to reduce the impact of these problems and improve the accuracy of overall statistics on causes of death in Australia. These changes particularly affect suicide statistics. They include revisions to historical data back to 2007. The ABS has cautioned that, as a result of these changes, care should be taken when comparing recent data with earlier years.

Australia was one of the first countries to establish a national suicide prevention strategy, and the above suicide statistics should be considered in that context. In 1995, Australia

put in place the National Youth Suicide Prevention Strategy (Here for Life), which was broadened in 1999 with the introduction of the National Suicide Prevention Strategy to consider suicide and suicidal behaviours across the life span. The National Suicide Prevention Strategy has continued since that time, and it aims to: build individual resilience and capacity for self-help; improve community strength, resilience and capacity in suicide prevention; provide targeted suicide prevention activities; implement standards and quality in suicide prevention; take a coordinated approach to suicide prevention; and improve the evidence base and understanding of suicide prevention. The National Suicide Prevention Strategy comprises several components, most notably the Living Is For Everyone (LIFE) Framework which sets out an evidence-based strategic policy framework for suicide prevention that has been agreed to by the Australian Government and all states and territories. In 1998, the year before the National Suicide Prevention Strategy began, the age standardised suicide rate sat at 14.3 per 100,000.[56]

Australia's suicide prevention efforts are continuing. In late 2010, against the background of the National Suicide Prevention Strategy, the Australian Government invested an additional $274m over four years to reduce suicide via its *Taking Action to Tackle Suicide* package. The funding was directed at four key action areas, namely boosting frontline services to support those at risk, investing more in direct suicide prevention and crisis intervention, targeting men who are at heightened risk of suicide but unlikely to seek help, and promoting good mental health and resilience in young people.

Indicator 11: Rates of understanding of mental health problems and mental illness in the community

KEY MESSAGES:

- In 2011, nearly three quarters (74%) of Australian adults could recognise depression. This figure was even higher (86%) for depression accompanied by suicidal thoughts.
- Rates of recognition of early and chronic schizophrenia and post-traumatic stress disorder were lower, with only about one third of the population being able to recognise these disorders. Rates of recognition of social phobia were the worst at 9%.
- Rates of recognition of depression have improved since 1995, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since. Recognition of post-traumatic stress disorder and social phobia were only assessed in 2011, so no comparison data are available.

Mental health literacy can be thought of as the knowledge and beliefs about mental illnesses which aid their recognition, management and/or prevention. Accurately recognising the symptoms of a mental illness is a necessary first step in the process of seeking professional help, with failure to identify the problem leading to delays in treatment.[57] Research has demonstrated an association between extended duration of untreated mental illness and poorer outcomes in terms of response to treatment,[58,59] and suicidality.[60]

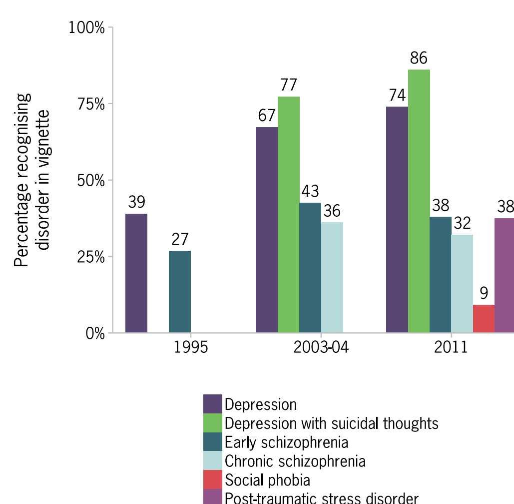
Data for this indicator come from the National Surveys of Mental Health Literacy and Stigma, conducted in 1995, 2003-04 and 2011, the same source as used for Indicator 3 (Rates of stigmatising attitudes within the community).

These surveys have used a vignette-based approach to investigate the ability of the Australian population to accurately identify a variety of mental disorders, namely depression and early schizophrenia (assessed in all years), depression with suicidal thoughts and chronic schizophrenia (assessed in 2003-04 and 2011), and social phobia and post-traumatic stress disorder (assessed in 2011).[46]

Figure 57 shows that in 2011, recognition rates for depression with and without suicidal thoughts were high (86% and 74%, respectively). Recognition rates for early schizophrenia and chronic schizophrenia were lower; 38% identified the former correctly, and 32% identified the latter. Recognition rates for post-traumatic stress disorder were similar to those for schizophrenia at 38%, and recognition rates for social phobia were the lowest at 9%.[46] Rates of recognition of depression have improved over time, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since.[46]

Australian initiatives such as *beyondblue*, MindMatters and Kidsmatter have focused considerable attention on improving the mental health literacy of the Australian population. Future efforts in this area might benefit from a focus on disorders other than depression. There is clearly still some way to go in terms of improving community understanding of schizophrenia, and other disorders – like anxiety disorders – might also be targeted. In addition, further monitoring is necessary to explore whether improvements in understanding of mental health problems translate into help seeking and, ultimately, whether they lead to gains in population mental health.

Figure 57
Recognition of the mental disorder experienced by the person described in the vignette, 1995, 2003-04 and 2011



Indicator 12: Prevalence of mental illness

KEY MESSAGES:

- In 1997, 18% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders) in the past 12 months. In 2007, the figure was slightly higher at 20% but this may be explained by methodological differences in the way in which these prevalence figures were gathered.
- In both 1997 and 2007, young adults experienced higher rates of mental illness than older adults.
- In 1998, 14% of children and adolescents were affected by a clinically significant mental health problem. More current data will be collected in 2013.

Mental illness affects the lives of individuals, those close to them, and the wider community. The prevalence of mental illness provides a global indicator of the mental health of Australians.

As noted in Part 1, several major cross-sectional prevalence surveys have been conducted during the course of the National Mental Health Strategy. These include the National Surveys of Mental Health and Wellbeing (conducted in 1997 and 2007) which provide a picture of the prevalence of common mental disorders in adults,[4 8 9] and the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (conducted in 1998) which profiles mental health problems among children and adolescents.[6]

Figure 58 summarises the findings from the National Surveys of Mental Health and Wellbeing at the two points in time. It shows that in 1997, 18% of adults experienced a common mental disorder (anxiety disorders, affective disorders and substance use disorders) in the 12 months prior to the survey. In 2007, this figure was slightly higher at 20%. Some caution should be exercised in comparing findings from the two surveys because they sampled from slightly different age ranges and used somewhat different approaches to gauge the presence of mental illness in the past 12 months. It may be the case that these methodological differences account for the small increase in overall prevalence over time.[9]

In both 1997 and 2007, rates of mental disorders diminished with age. Rates were highest in the early adult years, the period in which many people experience their first episode of mental illness. In 2007, the prevalence of mental disorders among 18-24 year olds (26%) was one third higher than the average for the total adult population. A similar pattern was evident from the 1997 figures.

Figure 58
Prevalence of common mental disorders in the Australian population, 1997/1998 and 2007

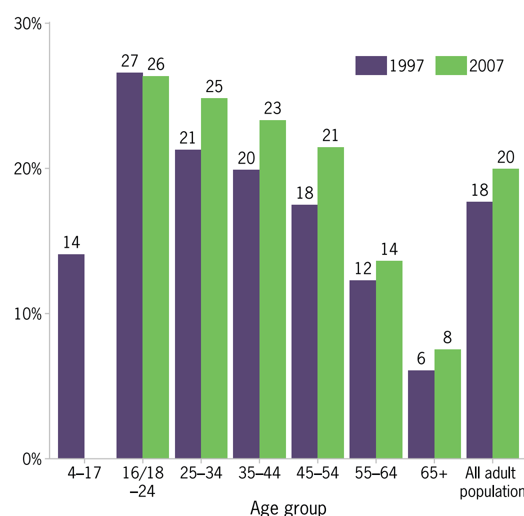


Figure 58 also provides a prevalence estimate from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing. It shows that 14% of children and adolescents aged 4-17 years were affected by a clinically significant mental health problem. Updated figures are not yet available, but a new study of children and adolescents has been commissioned and will be conducted in 2013.

The available evidence indicates that we can protect individuals against mental illness by building resilience, particularly in young people. Steps can also be taken to minimise the impact of mental illness on the individual and his or her family and friends, by ensuring that high quality treatment and support is readily available. Evidence-based interventions are also available to minimise the likelihood of relapse following an initial episode by fostering coping strategies. Australian experiences also suggest that we can continue to work with the community to reduce the stigma surrounding mental illness, and put in place initiatives to promote social inclusion and recovery. The National Mental Health Strategy's population health approach encompasses all of these directions.

3.4 Priority area 3: Service access, coordination and continuity of care

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to service access, coordination and continuity of care. Progress has been made on two of these (see Appendix 3). By way of example, substantial progress has been made on Action Area 16 which involves better targeting services and addressing service gaps through cooperative and innovative service models for the delivery of primary mental health care. The 2011-12 Federal Budget allocated resources to address service gaps in the delivery of primary mental health care, including doubling the funding for the Access to Allied Psychological Services (ATAPS) initiative and providing new funding for the Partners in Recovery program. ATAPS offers access to psychological services for people with common mental disorders like depression and anxiety, employing a service delivery model that is managed by Medicare Locals. Partners in Recovery aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by encouraging collaboration between the multiple services with which they come into contact.

Indicator 13: Percentage of population receiving mental health care

KEY MESSAGES:

- The percentage of the population seen by state and territory community mental health services from 2006-07 to 2010-11 remained relatively stable at around 1.5%.
- The percentage of the population receiving mental health specific Medicare-funded services rose from 3.1% in 2006-07 to 6.9% in 2010-11. This increase was largely due to the introduction and uptake of services provided through the Better Access initiative.
- Targets for population coverage by mental health services are yet to be agreed but are expected to be advanced as part of the continuing development of the *Roadmap for Mental Health Reform*[1] agreed by the Council of Australian Governments (COAG) in December 2012.

Widespread concern about access to mental health care was a key factor that underpinned the COAG *National Action Plan on Mental Health* endorsed by governments in 2006, and was reinforced in the commitments made under the various *National Mental Health Plans*. The *Third* and *Fourth National Mental Health Plans* in particular have emphasised the need to improve access to primary mental health care, especially for people with common mental illnesses. For consumers, having access to the right services at the right time is of paramount importance.

First insights into the gap between need for mental health services and services actually delivered were provided by the National Surveys of Mental Health and Wellbeing undertaken in 1997 and 1998. The surveys revealed that only 38% of adults and one quarter of children and younger people with a mental illness received treatment from a health service. Of those who received services, the majority (77%) consulted their general practitioner, although about half also attended another health service. The implication is that, 15 years ago, about two

thirds of the one in five adult Australians who were experiencing a recent mental illness received no treatment for that illness from any part of the health system.

An updated picture on the extent of unmet need for mental health care in the adult population became available from the 2007 National Survey of Mental Health and Wellbeing. Conducted by the Australian Bureau of Statistics (ABS) in 2007, results released in October 2008 suggested that little change had occurred over the preceding decade in the overall rates of treatment for people with mental disorders, with approximately two thirds (65%) continuing to receive no treatment. Similar rates of treatment for mental illness have been reported in all population surveys conducted in other developed countries.

When the 2007 survey findings were scaled to the total population, they suggested that 2.1 million adult Australians experienced the symptoms of a mental illness but received no health care for their conditions. Treatment rates varied according to the severity of the person's condition and type of disorder. Approximately two thirds (64%) of those with disorders classified as severe according to the ABS methodology received some level of health care. About 39% of people with moderately severe disorders and only 17% of people with milder (but still clinically significant) disorders were found to receive mental health care. People with an affective disorder (mainly depression) were more likely to have received services for their mental health condition than those affected by one of the various anxiety disorders (59% and 38% respectively). These rates were similar to those observed in 1997.

Large scale population surveys like the National Surveys of Mental Health and Wellbeing provide snapshots of the level of mental illness in the community but cannot provide routine and regularly available information to monitor this indicator over time. To complement the periodic population surveys, for the purposes of this and related reports, health administrations within each jurisdiction agreed to pool data on the number of people receiving services through government-funded clinical mental health care streams. The Private Mental Health Alliance, covering private hospitals and other providers of mental health care, also agreed to contribute data on people treated in private hospitals.

Results at the national level over the period 2006-07 to 2010-11 are presented in Figure 59. Assuming minimal overlap between state and territory and Medicare-funded person counts, the data suggest that approximately 1.9 million people, or 8.5% of the population, received clinical mental health care in 2010-11, compared with 970,000 in the 2006-07.

Overall, the percentage of people seen by state and territory mental health services has remained relatively stable, fluctuating between 1.5% and 1.6%. Growth in the number of people seen by Medicare-funded mental health services, rising from 3.1% of the population in 2006-07 to 6.9% in 2010-11, is the sole driver of overall growth in treatment rates over the five year period.

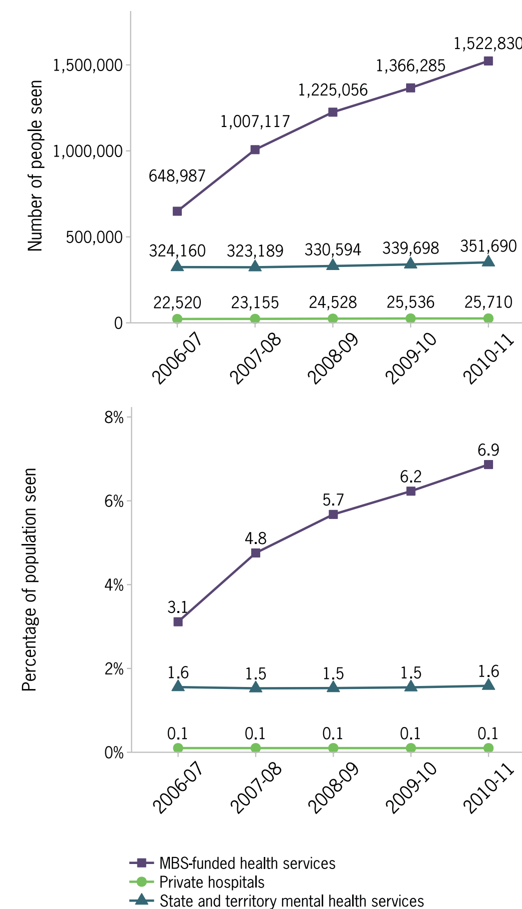
These figures highlight that the ABS estimates made in 2007 of access to mental health care are unlikely to reflect the population's current use of services. Analysis was undertaken by the Australian Government Department of Health and Ageing as part of the national evaluation of the Better Access program, and factored in the growth in the number of persons treated by Medicare-funded Better Access services and incorporated estimates from other service utilisation data.[31] The analysis suggested that the percentage of the population with a current mental illness who received care in 2009-10 was 46%, substantially higher than the 35% estimate found by the ABS in 2007. The growth occurring in 2010-11 evident in Figure 59 will have further increased treatment rates beyond those found in 2007.

Data on relative access figures across each of states and territories are provided in Part 4 of this report. Several caveats need to be considered when interpreting the data. First, assessing progress against this indicator is not as simple as adding together the percentages in Figure 59 for any given year due to the possibility that a sub-group of service users access both state and territory mental health services and Medicare-funded mental health services. Without a unique identifier that permits individuals to be 'tracked' across service sectors, all that can be said is that a minimum of 3.1% of the population received mental health care in 2006-07 and a minimum of 6.9% did so in 2010-11. The figures are likely to be higher than this, but the true percentages cannot be accurately ascertained. However, the trend is certainly in the right direction.[E]

Secondly, comparisons of relative coverage between state and territory mental health services and Medicare-funded services need to take account of differences in the type and intensity of services provided across these sectors, with states and territories having their main focus on treating people with severe mental disorders. Thirdly, the growth in Medicare-funded services is, in part, a function of the fact that the Better Access initiative commenced in the first year of the period examined in Figure 59. Fourthly, comparisons between state and territory services need to be made cautiously because jurisdictions differ in the way in which they count the number of people under care. Victoria in particular undercounts patients seen by clinical services when compared to other jurisdictions because it only reports people who are seen and accepted for case management.

[E] Work is underway by the Australian Institute of Health and Welfare to use data linkage to more accurately estimate the extent of duplication in consumer counts between state and territory services and MBS-subsidised mental health care. This work is progressing with the assistance of jurisdictions and in compliance with ethical requirements.

Figure 59
Number of people and percentage of population seen by each of the major mental health service streams, 2006-07 to 2010-11



A final cautionary note is needed to guide interpretation of data on use of mental health services. Most people who meet diagnostic criteria for mental illness do not experience a need for professional assistance of any kind. The 2007 National Survey of Mental Health and Wellbeing reported that nine out of ten of those experiencing mental illness symptoms in the previous 12 months who were not receiving mental health care reported having no need for any of a range of services, including counselling, medication and information (see Table 11).[9 14] The implication is that the lack of health service use by people with mental illness may be more related to their perception of personal needs than to the actual availability of services. Further work is needed to tease out the extent to which this finding is a function of factors such as lack of recognition by the person that they have an illness, lack of awareness that effective treatments are available, negative experiences of previous service use, and continuing stigma associated with mental illness.

Deciding on an appropriate target for population coverage by mental health services remains a challenge for all governments. The recent *Roadmap for Mental Health Reform* agreed by COAG in December 2012 foreshadowed the developments of targets in this area. As a broad indication of the scope of a possible target, lifting treatment rates for people with mental illness from the 35% found in the 2007 survey to 66% would require 12% of the population receiving mental health care each year.

Table 11
Percentage of people with a current mental illness who received no health services reporting no need for services, 2007

Type of service	% reporting no need
Information	94%
Medication	97%
Talking therapy	89%
Social intervention	94%
Skills training	96%
Any of the above	86%

Indicator 14: Readmission to hospital within 28 days of discharge

KEY MESSAGES:

- In 2010-11, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 15% nationally. This figure has been stable since 2005-06.
- Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%). South Australia's figures should be interpreted with caution because they may represent an undercount.
- There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

Internationally, readmission rates are often used as a litmus test of the performance of mental health systems. High rates may point to deficiencies in hospital treatment or community follow up care, or a combination of the two. Of course, other factors may also be implicated in rapid readmissions, with some reflecting the episodic nature of mental illness. Notwithstanding the complexity of the indicator, it is used by many countries to monitor health system performance. It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is that, while multiple hospital admissions may be necessary over the course of a lifetime for some people with ongoing illness, a high proportion of unplanned readmissions occurring shortly after discharge largely reflects failures in the care system.

This indicator focuses on admissions to acute psychiatric inpatient units run by state and territory mental health services; comparable data for the private hospital sector are not available. Figure 60 presents the national average for each year from 2005-06 to 2010-11, and shows that with the exception of one year (2009-10) when it dropped to 14%, it has consistently sat at 15-16%.

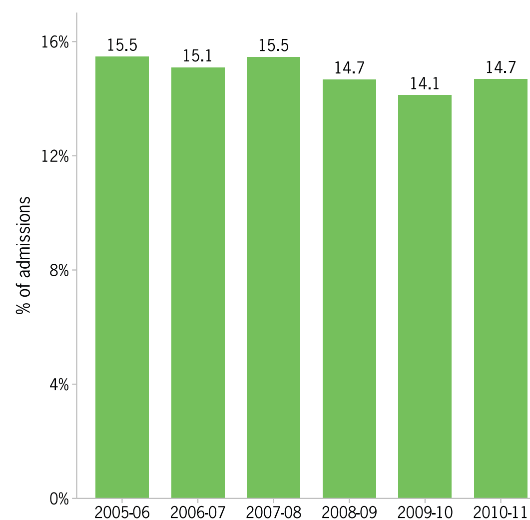
More detailed jurisdiction-level information is available in Part 4. Variation between jurisdictions is evident, with 28 day readmission rates in 2010-11 being below 10% for the Australian Capital Territory (5%) and South Australia (9%). Within jurisdictions, there has been little movement over time except in the Australian Capital Territory where the rate has more than halved since 2005-06.

It should be noted that the estimates from some jurisdictions are more accurate than others. This is because accurate monitoring of 28 day readmission rates depends on a unique identifier information system that tracks the movement of people between hospitals. True readmission rates are likely to be underestimated in the absence of such a system, because a person who is discharged from one hospital and readmitted to another within 28 days will not be represented in the figures. In 2005-06, all jurisdictions except South Australia and Tasmania had such a system. Tasmania developed this capacity in 2007-08, but South Australia has not yet done so.

Considerable attention has been devoted to identifying ways of reducing readmission rates. For example, eight mental health services from around the country considered this issue when they participated in the National Mental Health Benchmarking Project, which began in 2005.

Representatives from these services used a combination of methods to identify positive practices in this area. They concluded that seamless provision of care across inpatient and ambulatory services is required to improve readmission rates, as are good discharge planning and proactive community follow up. They also emphasised good governance, and consumer and carer engagement across the continuum of care.[61]

Figure 60
Percentage of admissions to state and territory acute inpatient units followed by a readmission within 28 days, 2005-06 to 2010-11



Indicator 15: Rates of pre-admission community care

KEY MESSAGES:

- In 2010-11, 47% of admissions to state and territory acute inpatient psychiatric units were preceded by community care in the seven days before the admission. This figure represents a small improvement over recent years.
- There is considerable cross-jurisdictional variability. The Australian Capital Territory is the only jurisdiction to have achieved rates above 70%, with 76% of its acute inpatient admissions in 2010-11 being preceded by community care in the seven days prior to admission.
- The 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

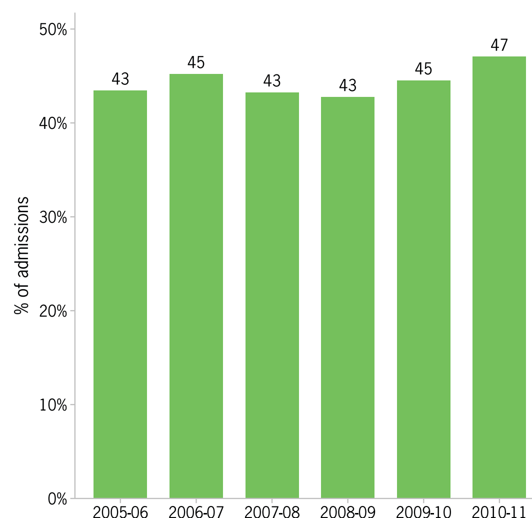
Much of the reform effort in the early years of the National Mental Health Strategy was aimed at creating integrated public sector mental health services, in which hospital and community-based services operate as a single service characterised by continuity of care, particularly when consumers move between treatment settings. Continuity of care has special relevance for the mental health sector because the enduring nature of many mental illnesses often means that care needs to be provided on an ongoing basis or intermittently over a considerable period of a person's life.

This indicator focuses on one aspect of continuity of care and looks at the extent to which consumers who require admission for inpatient care receive community care by clinical teams in the seven days leading up to the hospital admission. The indicator is complemented by Indicator 16 which looks at continuity of care following discharge from hospital.

Monitoring pre-admission community care rates is based on the fact that many consumers who are admitted to an acute inpatient unit are known to the local community mental health service, and the expectation that, where the person is a registered consumer of the service, community teams should be involved in their care in the period prior to admission. Contact by the community team is appropriate to assess the consumer's situation and ensure that admission is the most appropriate treatment option. Community mental health teams that have established a good relationship with the consumer are likely to be able to identify signs of deterioration in his or her condition, and, where required, smooth the way to an inpatient admission.

Figure 61 shows that in 2010-11, 47% of admissions were preceded by community care. Although this represents a small improvement over recent years, the contact rate remains relatively low.

Figure 61
Percentage of admissions to state and territory acute inpatient units where contact was provided by a community mental health team in the 7 days prior to admission, 2005-06 to 2010-11



Equivalent figures are provided for each state and territory in Part 4. The Australian Capital Territory had the highest pre-admission contact rates, with 76% of all its acute inpatient admissions in 2010-11 being preceded by community care, compared with 60% in 2005-06. The Australian Capital Territory is the only jurisdiction with rates above 70%; the 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

Estimates from some jurisdictions are more likely to reflect the true picture than those from others. This is because some states and territories (notably Tasmania and South Australia) only have the capacity to determine whether an individual received pre-admission community care from the community team within the inpatient unit's catchment. Some people may receive community care from elsewhere and be referred from there to the inpatient unit, which means the rates in these jurisdictions may represent an undercount.

As a measure of performance this indicator cannot be looked at in isolation from other services (including non-government services or general practitioners). If people receive care from these services or providers prior to an admission, this will not be reflected in the above figures.

As with other related indicators, deciding on an appropriate target for pre-admission community contact rates remains a challenge for all governments. While 100% is not feasible, given that a proportion of admissions to hospital will continue to be unexpected and accounted for by people not known to the local community mental health team, the current national rate of 47% falls short of reasonable expectations. The *Roadmap for Mental Health Reform*,[1] agreed by the Council of Australian Governments in December 2012, foreshadows the development of targets in this area.

Indicator 16: Rates of post-discharge community care

KEY MESSAGES:

- In 2010-11, 54% of Australian admissions to state and territory acute psychiatric inpatient units were followed by community care (in the seven days after discharge). This percentage has been improving incrementally since 2005-06.

- There is substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory).

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. The post-discharge period is also a period of great stress and uncertainty for families and carers.

Evidence gathered in recent years from a number of consultations around Australia suggests that the transition from hospital to home is often not well managed. The inclusion of this indicator as a measure of progress of the *Fourth National Mental Health Plan* targeted the performance of the overall health system in providing continuity of care, recognising the need for substantial improvement in this area. The standard underlying the measure is that continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital.

Figure 62 shows that in 2010-11, 54% of hospital episodes were followed by community care in the week after discharge. This percentage has been improving incrementally since 2005-06, when it was 45%.

Figure 62
Percentage of discharges from state and territory acute inpatient units in which contact was provided by a community mental health team in the 7 days after discharge, 2005-06 to 2010-11

Equivalent figures are provided for each state and territory in Part 4. They reveal substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory). For most jurisdictions, follow up rates show gradual but small improvement over the six years for

which data are available, although greater improvement is evident in two jurisdictions with relatively low baseline rates (Tasmania and South Australia).

Work undertaken as part of the Australian Government-funded National Mental Health Benchmarking Project provided insights about the reasons organisations and jurisdictions may vary on seven day post-discharge follow up rates.[62] Accuracy of information systems in tracking the movement of people between hospital and community care, particularly across organisations, is critical. For example, two jurisdictions (Tasmania and South Australia) can only confidently determine whether community care was provided in the same area as the hospital from which the consumer was discharged. This is likely to lead to an undercount, because some people may receive community care from elsewhere once they are discharged. Lower follow up rates may also be the result of some consumers being managed outside the state and territory public system (for example, by general practitioners, private psychiatrists or, in the Northern Territory, by Aboriginal/remote health services). These activities are not captured by existing mental health information systems.

Overall, the variation in post-discharge follow up rates suggests important differences between mental health systems in terms of their practices. An observation made by organisations engaged in the benchmarking work was that, although there may be legitimate reasons for non-follow up of some consumers in the week after discharge (for example, perhaps in circumstances where there is follow up by general practitioners, private psychiatrists, non-government organisations etc.), this group is small and routine follow up should be the norm. The implication is that the current national rate of 54% is well below what would be expected from best practice services.

Setting a national target for this indicator is expected to be explored as part of the work to be progressed under the *Roadmap for Mental Health Reform*,[1] agreed by the Council of Australian Governments in December 2012.

Indicator 19: Prevalence of mental illness among homeless populations

KEY MESSAGES:

- Routinely collected data from the former Supported Accommodation Assistance Program (SAAP) suggests that, in 2010-11, 11% of SAAP clients sought accommodation because of mental health problems, 9% did so because of substance use problems, and 7% did so because of comorbid mental health and substance use problems.

- These figures are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral.

- From July 2011, the Special Homelessness Services (SHS) collection will enable more accurate estimates of mental illness among homeless populations to be calculated.

There is a substantial body of evidence that suggests that homeless people are more likely to experience mental illness than those whose accommodation needs are met. Mental illness featured prominently among stakeholder concerns during the consultation process leading up to the release in 2008 of *The Road Home*, the Australian Government White Paper on homelessness.[63]

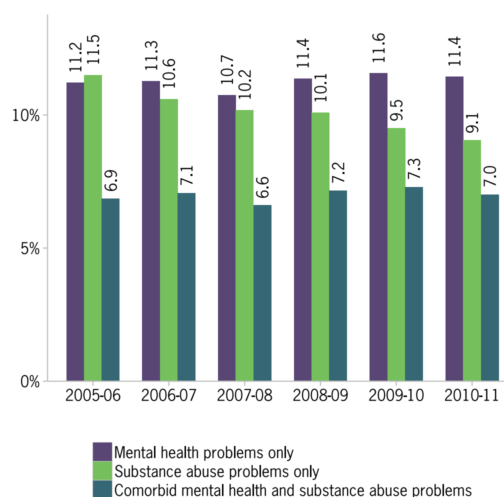
Quantifying the prevalence of mental illness among homeless populations is difficult, and estimates have varied considerably. *Australia's Welfare 2011*, published by the Australian Institute of Health and Welfare (AIHW), reviewed the evidence and observed that while some studies estimated the prevalence of mental illness in the homeless population to be between 72% and 82%, others have found it to be between 12% and 44%. A key study cited by the AIHW, based on a review of approximately 4,300 case histories, found that 31% experienced a mental health problem. Of these, about half (47%) had a mental health problem prior to becoming homeless, and the remainder developed mental health problems following homelessness.[64]

For the purposes of this indicator, estimates are taken from data collected on clients of the former Supported Accommodation Assistance Program (SAAP), a cost-shared program funded by the Australian Government and state and territory governments and providing crisis accommodation and related support services to people who are homeless or at imminent risk of becoming homeless. Information on all SAAP clients was collected via a national minimum dataset, and included data on whether they sought assistance because of mental health problems, substance use problems or comorbid mental health and substance use problems.

Figure 63 shows the percentage of SAAP clients in each group from 2005-06 to 2010-11. In 2010-11, 11% of SAAP's 142,500 clients were deemed to have sought assistance due to mental health issues. These included clients who were referred from a psychiatric unit, reported psychiatric illness and/or mental health issues as a reason for seeking assistance, were in a psychiatric institution before or after receiving assistance, and/or needed, were provided with or were referred on for support in the form of psychological or psychiatric services. An additional 9% were identified with problematic drug, alcohol and/or substance use as reasons for seeking assistance. A further 7% of clients were considered to have both mental health and substance use problems (comorbidity). The figures for mental health problems and comorbid mental health and substance use problems have remained fairly consistent over time, but those for substance use problems have dropped from 12% in 2005-06.

The difficulty with using routinely collected SAAP data is that it only provides part of the picture. It provides an indication of the percentage of clients whose referral to the program has been associated with the above problems, but does not take into account clients who may have underlying conditions that are not directly responsible for the referral. For this reason, a special census was conducted in June 2008 which aimed to gather more accurate data on the proportion of SAAP clients with complex needs. The results of this census confirmed that mental health problems are more prevalent among SAAP clients than the routinely collected data would suggest. The census found that 34% of the survey sample identified as having mental health issues. Of these, more than half (56%) had a known diagnosis of a mental illness and almost a third (31%) were identified as current users of specialist mental health services. The latter figure equates to about 10% of all SAAP clients.

Figure 63
Supported Accommodation Assistance Program (SAAP) clients with mental health, substance use and comorbid problems, 2005-06 to 2010-11



Further evidence that the routinely collected SAAP data underestimates the true prevalence of mental illness among homeless populations comes from the National Survey of Mental Health and Wellbeing. This survey, conducted in 2007, found that over half (54%) of the people who had ever been homeless had a current mental illness, defined by their having a mood disorder, an anxiety disorder or a substance use disorder in the previous 12 months. This was almost three times the rate for those who had never been homeless.[9 65]

On July 2011, the SAAP data collection was replaced by the Special Homelessness Services (SHS) collection. SHS will provide better information about clients of homelessness assistance services, and is likely to enable more accurate estimates of mental illness among homeless populations to be calculated.

For now, it is reasonable to conclude that mental illness is a significant problem for many homeless people, and the two issues often occur together; mental illness may jeopardise people's chances of securing or retaining stable accommodation, and homelessness takes a toll on people's emotional wellbeing. As noted in the discussion of Indicator 4, governments have acknowledged the vital role that stable housing plays in promoting recovery from mental illness.

Indicator 20a: Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities

KEY MESSAGES:

- In 2010, 31% of new entrants to adult prisons reported having been told by a health professional that they had a mental illness, 16% reported that they were currently taking mental health related medication, and 14% reported very high levels of psychological distress.
- These figures indicate that new prisoners have poorer mental health than the general population.
- Ongoing collaborative efforts between the health and justice sectors are required to reduce the prevalence of mental illness among prisoners.

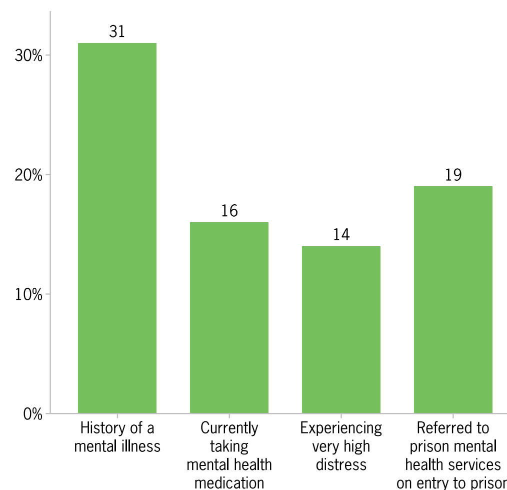
Prisoners are more likely to have poor mental health than members of the general population. The relationship between incarceration and mental illness is a complex one and can operate in both directions. Mental health problems may interact with other forces like drug use and poverty, and act as a risk factor for offending. Once an individual is in prison, the prison environment can have a further deleterious effect on his or her mental health.[66]

Data from the 2010 National Prisoner Health Census sheds some light on the prevalence of mental illness among those remanded or newly sentenced to adult prisons (no equivalent information is available for their counterparts from juvenile correctional facilities).[67 68] Figure 64 shows that almost one third (31%) of new prison entrants reported having been told by a health professional that they had a mental illness (including depression, anxiety and drug and alcohol abuse). Sixteen per cent reported that they were currently taking mental health related medication. Fourteen per cent reported that they were experiencing very high levels of psychological distress according to the Kessler-10 (K-10).[69] On entry to prison, almost one fifth (19%) of prison entrants were referred to prison mental health services for observation and further assessment following the reception assessment.

Data on the general adult population from the 2007 National Survey of Mental Health and Wellbeing provide a point of comparison to gauge how prison entrants fare relative to the broader community. The National Survey of Mental Health and Wellbeing shows, for example, that 3% of the general adult population experience very high levels of psychological distress.[70] This means that the rate for prison entrants is around five times greater than that for the general population.

Ongoing efforts are required to reduce the prevalence of mental illness among prisoners. The National Statement of Principles for Forensic Mental Health provides a framework for these efforts, stressing that prisoners are entitled to have the same access to mental health care that others in the community have, and calling for improved collaboration between the health and justice sectors. The National Statement of Principles for Forensic Mental Health also highlights the need to minimise the detrimental impact on mental health of the incarceration process itself, suggesting that community diversion programs and other relevant initiatives should be used in preference to detention wherever possible.[71]

Figure 64
Percentage of prison entrants showing some evidence of mental illness, including substance use disorders, 2010



3.5 Priority area 4: Quality improvement and innovation

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists eight actions that relate to quality improvement and innovation. Progress has been made on seven of these (see Appendix 3). The efforts invested in progressing Action Area 9 provide an example. Action Area 9 involves the development of a national mental health research strategy to drive collaboration and inform the research agenda. The National Health and Medical Research Council held two workshops on 'developing a more evidence-based mental health system' which informed the 2011-12 Federal Budget allocation of $26.2 million over five years across three areas: (1) a targeted call for research focusing on prevention and early intervention in mental illness in children and young people; (2) three mental health centres of research excellence focusing on suicide prevention, substance abuse and better mental health planning; and (3) and the new John Cade Fellowship in Mental Health Research.

Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers

KEY MESSAGES:

- Nationally, in 2010-11, 4.6 per 1,000 (or 0.5%) of the total full-time equivalent (FTE) mental health workforce was accounted for by consumer and carer workers. This represents an increase of 33% since the 2002-03 level of 3.5 FTE per 1,000 (0.3%). This growth is due to an almost fourfold increase in the number of FTE carer workers per 1,000, compared to a slight decrease in FTE consumer workers per 1,000.

- There is substantial variation across jurisdictions, with the highest proportions in South Australia (6.3 per 1,000 in 2010-11, or 0.6%) and Victoria (6.1 per 1,000, 0.6%), and the lowest rates in the Australian Capital Territory and the Northern Territory (0.0 per 1,000, or 0.0%).

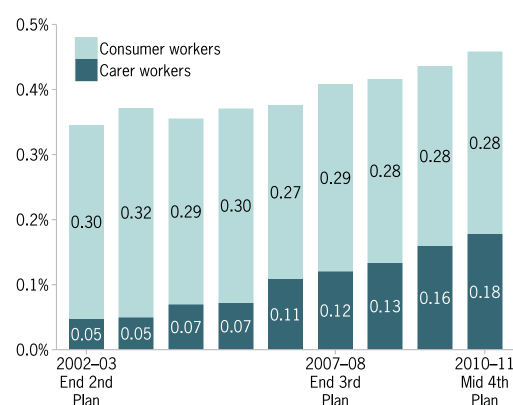
Since its inception, the National Mental Health Strategy has promoted the participation of consumers and carers in the planning, delivery and evaluation of mental health services. The availability of paid consumer and carer worker positions is an index of the opportunities available for, and an organisation's commitment to, enabling consumer and carers to influence service delivery. Information about the consumer and carer workforce was presented in Section 2.6 of Part 2, and is reiterated here in the context of Indicator 21.

Information about the mental health workforce, including consumer and carer workers, is available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection. The NMDS – MHE defines mental health consumer and carer workers as individuals who are employed by a mental health organisation on a full-time or part-time salaried basis, and who are specifically employed for the expertise developed from their lived experience of mental illness (consumer workers), or their experience as a mental health carer (carers). Consumer and carer workers may work under a range of job titles and undertake a variety of roles, including mental health service planning, policy development, service evaluation, training and education, mentoring, advocacy, liaison, client support and client/peer support (consumer workers) or carer support (carer workers).

This indicator uses the number of consumer and carer workers as its numerator, and the number of direct care clinical staff and consumer and carer workers as its denominator. Figure 65 shows that nationally, in 2010-11, 0.46% of the full-time equivalent (FTE) mental health care workforce was accounted for by consumer and carer workers. Figure 65 also shows that the proportion of consumer and carer workers has increased by one third since the 2002-03 level of 0.35%. This growth is due to an almost fourfold increase in the percentage of carer workers.

There is wide variation between jurisdictions on this indicator. In 2010-11, the jurisdictions with highest proportion of consumer and carer workers were South Australia (0.63% of direct

Figure 65
Consumer and carer workers as a proportion of the total mental health care workforce, 2002-03 to 2010-11



care staff) and Victoria (0.61%); jurisdictions with the lowest proportions were the Australian Capital Territory and the Northern Territory. Only limited comparisons across jurisdictions can be made regarding change over time, because not all have had consumer and/or carer workers in all years since 2002-03. Of the four jurisdictions with complete time series data, the overall proportion of consumer and carer workers has increased since 2002-03 in South Australia, Queensland and Victoria, but has decreased marginally in New South Wales. As with the national data, the available state and territory data indicated that although consumer workers still outnumber carer workers, the proportion of carer workers is moving in a positive direction and the change in this proportion is of a greater magnitude than that for consumer workers. More detailed jurisdiction-level data is available in Part 4.

Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

KEY MESSAGES:

- In 2010-11, 84% of specialised mental health services in Australia had undertaken external accreditation and been judged to meet all standards set out in the National Standards for Mental Health Services (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4).

- In two jurisdictions (the Australian Capital Territory and the Northern Territory) 100% of services met the standards set for Level 1. Three others (Queensland, Victoria and South Australia) came close to this, with at least 96% of their services achieving Level 1. In other states the proportion of services achieving Level 1 was lower. In New South Wales (79% at Level 1) and Tasmania (48% at Level 1), the balance of services had undertaken external review and reached threshold for Level 2, whereas in Western Australia (49% at Level 1), the balance had not completed external review and were graded as Levels 3 or 4.

- Ongoing effort is required to ensure more uniform levels of accreditation across jurisdictions.

The implementation of the National Standards for Mental Health Services (National Standards) was agreed by all jurisdictions in 1998, as a basis for assessing service quality and guiding continuous quality improvements. The first National Standards were released in 1996, and focused on improving the quality of state and territory funded specialist clinical mental health services. They included eleven standards grouped into three categories: 1-7, universal issues of human rights, dignity, safety, uniqueness and community acceptance; 8-10, mental health service organisational structures and links between parts of the mental health sector; and 11, service delivery processes and types of treatment and support.

Revised National Standards[72] were endorsed in 2010. They have a greater emphasis on recovery and are intended for use within the full range of mental health services, including public sector mental health services, non-government organisations, private hospitals and private clinic-based providers. The revised National Standards comprise ten standards covering aspects of service delivery, compliance with policy directions, standards of communication and consent, and monitoring and

governance (see Table 12). Each standard is supported by a set of criteria. All of the standards are designed to be assessed, except the consumer standard which comprises criteria included under other standards.

Services undertake accreditation against the National Standards via an external review process. Information about the proportion of services assessed as reaching threshold standards of accreditation under the National Standards is available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection. The indicator grades services according to four categories reflecting their status with respect to external review and, if reviewed, the extent to which they have met the standards:

- Level 1: Services that have been reviewed by an external accreditation agency and judged to have met all National Standards for Mental Health Services.
- Level 2: Services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- Level 3: Services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known; or are booked for review by an external accreditation agency.
- Level 4: Services that do not meet the criteria detailed under levels 1 to 3.

A high proportion of services graded at Level 1 is desirable, and may be interpreted as an index of service quality.

Table 12
National Standards for Mental Health Services (2010)

1. Rights and responsibilities
2. Safety
3. Consumer and carer participation
4. Diversity responsiveness
5. Promotion and prevention
6. Consumers
7. Carers
8. Governance, leadership and management
9. Integration
10. Delivery of care

Figure 66
Percentage of services reaching threshold standards of accreditation under the National Mental Health Standards

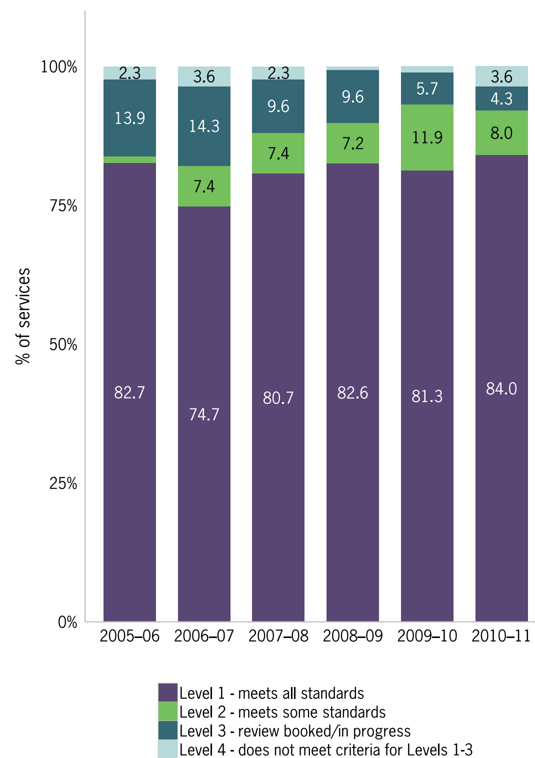


Figure 66 shows that nationally, in 2010-11, 84% of services met all standards (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4). Several jurisdictions reported at 100% or nearly 100% of services at Level 1, namely the Australian Capital Territory (100%), the Northern Territory (100%), Queensland (99%), Victoria (96%), and South Australia (96%). In New South Wales and Tasmania, 79% and 48% of services respectively had achieved Level 1, with all or virtually all of the balance of services having completed external review and graded as Level 2. In Western Australia, 49% of services were graded Level 1, with the balance of services having not completed external review and graded at Level 3 (29%) or Level 4 (23%). More detailed jurisdiction-level information is provided in Part 4.

Ongoing effort is required to ensure comprehensive implementation of the National Standards across all jurisdictions and service sectors.

Indicator 23: Mental health outcomes for people who receive treatment from state and territory services and the private hospital system

KEY MESSAGES:

- Around three quarters of consumers admitted to state and territory public sector mental health inpatient services improve significantly, just under one quarter show no change, and a small percentage deteriorate. This pattern also holds true in private psychiatric hospital units.
- In state and territory community services, the picture depends on the nature of the episode of care. Fifty per cent of those who receive relatively short term care and are then discharged improve significantly, 42% show no change, and 8% deteriorate. Twenty six per cent of those who receive longer term, ongoing care show significant improvement, 58% show no change, and 15% deteriorate.
- This picture is complex and requires careful interpretation in light of the goals of care within each setting and for each type of episode and the limitations of the measurement process. Further work needs to be done to determine what outcomes are consistent with a service system offering 'best practice' care across the board.

The ultimate arbiter of success of the mental health service system is whether it leads to improved outcomes for consumers. Improving the quality and effectiveness of mental health services has been firmly on the agenda in Australia since the inception of the National Mental Health Strategy in 1992.

One of the specific objectives of the original *National Mental Health Policy*, released in the first year of the Strategy, was *'to institute regular review of … outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery.'* Since that time, Australia has invested heavily in establishing a standardised system for the routine monitoring of consumer outcomes that has been the focus of extensive activity in state and territory mental health services and the private hospital sector, with support from the Australian Government. The goal has been to develop standard measures of consumers' clinical status and functioning and apply these at entry to and exit from care to enable change to be measured. For consumers who require longer term care, the measures are applied at review points every three months. A number of different measures are used, some of which are completed by clinicians and some of which are completed by consumers themselves. These repeated assessments allow changes in consumers' clinical status to be monitored over time from different perspectives. The approach taken by Australia to developing a comprehensive system of outcome measurement is well regarded internationally.

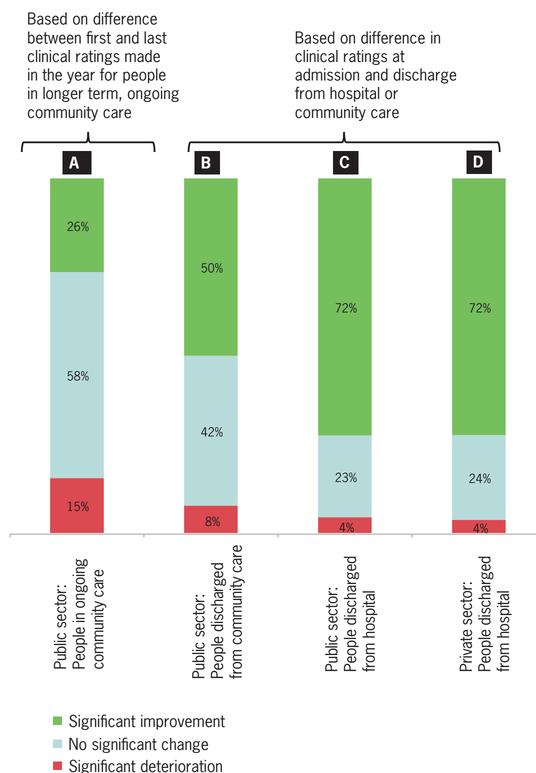
Today, 85% of state and territory public sector inpatient and community mental health services collect data that can be used to assess outcomes, as do 98% of private hospitals. Over 12,000 clinicians have received training in the use of outcome measures. Systems have also been established to enable pooling and analysis of information at the national level, and to provide feedback and support to clinical staff in assessing the progress of individual consumers (see www.amhocn.org).

One of the key measures used to assess change is the Health of the Nation Outcome Scales (HoNOS),

and its equivalents for children and adolescents (HoNOSCA) and older people (HoNOS65+). All three comprise items that collectively cover the main types of problems that may be experienced by people with a mental illness. Each item is rated from 0 (no problem) to 4 (very severe problem), resulting in individual item scores, subscale scores and a total score.

Figure 67 uses the most current data from the HoNOS family of measures to indicate the proportions of consumers who show significant improvement, no significant change and significant deterioration during episodes of care in different mental health care settings.

Figure 67
Clinical outcomes for people receiving various types of mental health care, 2010-11[a]



(a) Totals do not always add to 100% due to rounding.

The picture is complex, and can be summarised as follows:

- For people admitted to state and territory managed psychiatric inpatient units (Group C in Figure 67), approximately three quarters (72%) have a significant reduction in the symptoms that precipitated their hospitalisation. Notwithstanding the changes in symptoms for this group, most remain symptomatic at discharge, pointing to the need for continuing care in the community. For a small percentage (4%), their clinical condition is worse at discharge than at admission. About one in four (23%) are discharged with no significant change in their condition.
- Similar patterns are evident for consumers admitted to private psychiatric hospital units (Group D in Figure 67). Seventy two percent show significant improvement, 24% show no significant change, and 4% show significant deterioration.
- In state and territory community services, the picture is more complicated. This is because consumers in the community are more diverse than those in inpatient settings in terms of their conditions, needs and trajectories of recovery. Some receive relatively short term care in the community, entering and exiting care within the year (Group B in Figure 67). Fifty per cent of this group experience significant improvement, 42% experience no change, and 8% deteriorate.
- A second group of consumers of state and territory community care are in longer term, ongoing care (Group A in Figure 67). This group, representing a significant proportion of people treated by state and territory community mental health services, are affected by illnesses that are persistent or episodic in nature. More than half of this group (58%) experience no significant change in their clinical condition, compared with approximately one quarter (26%) who improve and 15% who experience clinical deterioration. An important caveat to understand for this group is that, for many, ‘no clinical change’ can be a good result because it indicates that the person has maintained their current level and not experienced a worsening of symptoms.

These results are both complex and challenging to policy makers who prefer to distil health outcome indicators into a single message. The data suggest that consumers of state and territory and private hospital sector mental health care have a range of clinical outcomes that require careful interpretation. It makes sense that the proportion of people who show significant improvement is greatest in acute inpatient episodes. Those who are admitted to these settings in both the state and territory and private hospitals are often very unwell, but their symptoms can often be treated quite effectively and reasonably quickly. It also makes sense that those who have relatively short episodes of care with state and territory community mental health services are less likely to show significant improvement than their counterparts in inpatient care, with many demonstrating no change. Many of these people will only be seen in the community, or will be discharged from inpatient units to community care once their symptoms have begun to abate. Either way, their level of severity at the beginning of the episode is lower than that of those admitted to inpatient settings, which means that they may have less room to demonstrate improvement. The observed pattern for those in ongoing community care is also intuitively sensible. This group is mixed – for some the focus of care is further reductions in symptoms and increases in functioning, but for others the focus is more about helping the person maintain their current state of wellness and averting deterioration. The finding that some people improve but that many remain stable is arguably consistent with these treatment goals.

The picture derived from Australia's investment in routine outcome measurement represents 'work in progress' that is both imperfect and incomplete. Further work needs to be done to determine what outcomes are consistent with a service system offering 'best practice' care across the board. The main outcome measurement tools being used describe the condition of the consumer from the clinician's perspective and do not address the 'lived experience' from the consumer's viewpoint. Although consumer rated measures are included in Australia's approach to outcome measurement, uptake by public sector services has been poor to date. Additionally, there are many technical and conceptual issues that are the source of extensive debate. Foremost among these is the fact that the outcome measures are imprecise measurement tools. There is also concern that the approach used to report outcomes separates a consumer's care into segments (hospital versus community) rather than tracking the person's overall outcomes across treatment settings.

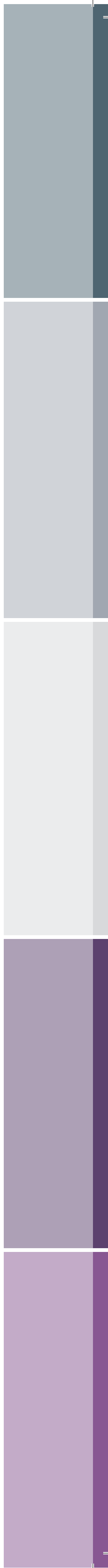
Continued government collaboration will be required to support the further development of the national approach to measuring and reporting on mental health consumer outcomes.

3.6 Priority area 5: Accountability: Measuring and reporting progress

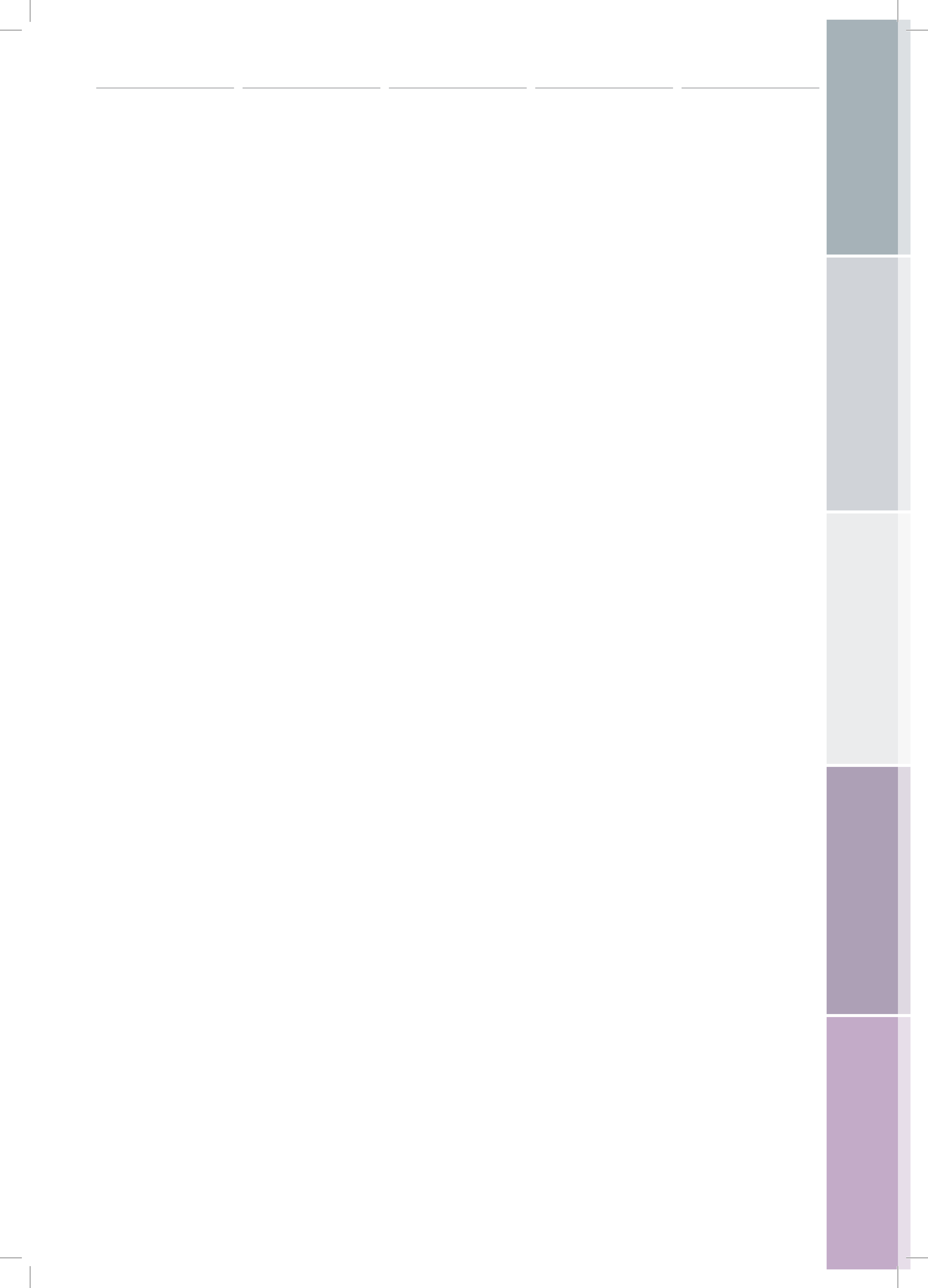
Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists four actions that relate to accountability, and progress has been made on all of these. By way of example, extensive efforts have been made in regard to Action 33, which focuses on the further development of mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting. Highlights of progress in this area include:

- **Mental Health Non-Government Organisation Establishments National Minimum Data Set (MH NGOE NMDS) Project:** In February 2011, the Australian Institute of Health and Welfare (AIHW) commenced the MH NGOE NMDS Project, which aims to collect nationally consistent information about the mental health NGO sector. The AIHW, in collaboration with the MH NGOE NMDS Working Group, has developed a draft specifications and data collection manual which includes, for example, a mental health NGO service taxonomy and definitions of service types in the taxonomy. The AIHW is now consulting with relevant funders to confirm that the MH NGOE NMDS is 'fit for purpose' and that jurisdictions are able to map their MH NGO activities to the NGO service taxonomy.
- **Development of a carer (family inclusiveness) measure:** The Australian Mental Health Outcomes and Classification Network (AMHOCN) commenced work to develop a measure of carers' experiences of the family inclusiveness of mental health care. A literature review identified that the carer version of the Victorian Consumer and Carer Experiences Questionnaires (C&CEQ) was suitable for trialing but required some modification. AMHOCN's next step is to modify the C&CEQ and pilot the revised measure.
- **Development of the Living in the Community Questionnaire:** AMHOCN, in collaboration with a Technical Advisory Group, commenced work to develop a consumer self-report measure that focuses on the social inclusion aspects of recovery. A draft of instrument known as the Living in the Community Questionnaire (LCQ) was produced and underwent 'proof of concept' testing during 2011. Further development of the LCQ occurred on the basis of feedback in early 2012, and field trials of the latest instrument began in early 2013.
- **Measuring consumers' experiences of their care:** Under the auspices of the Mental Health Information Strategy Standing Committee (MHISSC), the Victorian Department of Health commenced work on a project to develop a mental health Consumer Experiences of Care (CEoC) tool suitable for national adoption, to measure the degree to which consumers are involved and engaged in their care as well as the quality of that care. A draft CEoC tool has been completed and a national 'proof of concept' trial and an evaluation of the tool were completed in the second half of 2012. Further work to test the reliability of the instrument will be completed by June 2013. This work builds on a number of initiatives taken by individual states and territories (notably New South Wales and Queensland) which have developed their own consumer experiences of services measures and/or established systems for regular monitoring of consumers' experiences.
- **Mental Health Intervention Classification:** The AIHW developed and conducted a pilot study of a mental health interventions classification to be used in specialist mental health services. The classification was endorsed by MHISSC for voluntary implementation by jurisdictions.
- **Review of the National Outcomes and Casemix Collection (NOCC):** A review of the data collected by Australian public sector mental health services under NOCC commenced in 2012. Known as the NOCC Strategic Directions 2014-24 Project, this review will document the implementation of NOCC to date and develop recommendations for further development of NOCC.



Part 4: Profiles of state and territory reform progress



4.1 Introduction

KEY MESSAGES:

- State and territory data are provided on a range of indicators of resourcing levels, outputs and outcomes.
- The comparisons emerging from the data highlight differences in service levels and mix, outputs and outcomes, as well as identifying common ground between the various mental health service systems in Australia.
- In interpreting relative progress, it is important to recognise the different histories, circumstances and priorities of each jurisdiction, and the requirement for mental health service planning to be based on local population needs.

Part 4 brings together relevant information for each jurisdiction and summarises the situation in relation to:

- the progress of the state or territory in several key policy areas as gauged by performance indicators developed specifically to monitor changes under the National Mental Health Strategy; and
- the state or territory position on each of these indicators relative to national averages.

Part 4 provides a convenient reference point for readers seeking information about a particular jurisdiction. Assembling the data in this way is not intended to substitute for assessment of service quality within each jurisdiction, or the strengths and problems experienced at a local level. The emphasis is upon presenting the factual information as a basis to assess where each state and territory is positioned throughout the Strategy, in relation to other jurisdictions and the goals it sets itself.

In interpreting relative progress, it is important to recognise the different histories, circumstances and priorities of each jurisdiction, and the requirement for mental health service planning to be based on local population needs. As such, the Strategy created scope for the balance of services to differ substantially between the jurisdictions. The *National Mental Health Report* can therefore only make broad comparisons between states and territories, and over time, chart their progress against their own baselines.

A consistent structure is used in the pages that follow, providing details on a range of indicators of resourcing levels, outputs and outcomes at state or territory level, including services administered by the Australian Government. These include some of the indicators reported in previous *National Mental Health Reports* and selected new indicators that align with the directions of the Fourth Plan. There are variations in the length of the time series shown for each indicator, depending on the availability of data and its comparability over time. For some indicators, the complete time series from 1992-93 to 2010-11 was available, for others a shorter time series was available, while for others only a single year of data was available.

The information presented includes a summary table of key indicators detailing the state or territory position in each of three milestone years:

- at the beginning of the *National Mental Health Strategy* (1992-93);
- at the end of the *Third National Mental Health Plan* (2007-08); and
- at the mid-point of the *Fourth National Mental Health Plan* (2010-11).

Each jurisdiction is also presented in 18 figures, selected to convey a graphical summary of progress over the 1992-93 to 2010-11 period. Of these figures:

- seven are based on resourcing indicators on the provision of mental health services, a reduced set of those presented in previous *National Mental Health Reports*;
- nine are based on selected *Fourth Plan* indicators, considered to be relevant for reporting at jurisdiction level; and
- two are based on indicators selected from the 15 Key Performance Indicators for Australian Public Mental Health Services.

The purpose of each of the figures is described in Table 13. For all figures, 'n.a.' signifies that the indicator is not available. Where there is no data point shown, this signifies that the indicator is zero.

Data sources and explanatory notes for data presented in Part 4 are provided in Appendix 4.

Table 13
Purpose of jurisdiction level indicators presented in charts

Indicator	Purpose	Source of indicator
Figure 1. Overall spending on mental health	These figures show the 18 year trends in expenditure on mental health services. They are designed to answer the question: '*To what extent has the jurisdiction increased its expenditure on mental health services relative to 1992-93, and to the national average?*' Expenditure has been adjusted to remove Australian Government contributions made through National Mental Health Strategy grants and payments by the Department of Veteran's Affairs.	A
Figure 2. Change in spending mix	These figures are designed to answer the question: *'To what extent has the jurisdiction's relative investment in inpatients and community services changed over the course of the National Mental Health Strategy?'*	A
Figure 3. Changes in inpatient services	These figures show the 18 year trends within inpatient services and aim to answer the question: *'Have changes in the resources allocated to inpatient care (staff and money) been matched by equivalent changes in the number of beds and activity levels?'*	A
Figure 4. Changes in ambulatory care	These figures summarise the 18 year trends within ambulatory care services and aim to answer the question: *'Has increased spending on ambulatory services been matched by an equivalent growth in clinical staffing?'*.	A
Figure 5. Direct care workforce	These figures show the trends in the overall direct care mental health workforce and aim to answer the question: *'To what extent has the number of clinical staff employed in mental health services increased since 1992-93, and relative to the national average?'* Direct care staffing levels are expressed as the number of full-time equivalents (FTEs) per 100,000 population.	A
Figure 6. Inpatient and residential beds	These figures summarise the trends in the number of inpatient and community residential beds (the latter category combines 24 hour staffed and less than 24 hour staffed beds) and are designed to answer the question: *'To what extent has the jurisdiction decreased the number of specialist psychiatric beds (inpatient and community residential) since 1992-93, and relative to the national average?'* Bed numbers are expressed per 100,000 population.	A
Figure 7. Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000	These figures show the trends in the number of public sector specialised mental health beds and are designed to answer the question: *'To what extent has the relative mix of acute and non-acute psychiatric beds changed since the jurisdiction since 1992-93?'* Bed numbers are expressed per 100,000 population.	A
Figure 8. Readmission to hospital within 28 days of discharge	These figures summarise trends in the percentage of readmissions (i.e., admissions to public acute psychiatric units that occur within 28 days of the original discharge), and aim to answer the question: *'To what extent have readmissions decreased since 2005-06?'*	B
Figure 9. Rates of pre-admission community care	These figures show trends in the percentage of admissions to state/territory acute psychiatric units that are preceded by community care (in the seven days before admission). They are designed to answer the question: *'To what extent have rates of pre-admission community care increased since 2005-06?'*	B
Figure 10. Rates of post-discharge community care	These figures show trends in the percentage of discharges from state/territory acute psychiatric units that are followed by community care (in the seven days after discharge). They are designed to answer the question: '*To what extent have rates of post-discharge community care increased since 2005-06?*'	B

Indicator	Purpose	Source of indicator
Figure 11. Average treatment days per three month community care period	These figures are designed to answer the question: *'To what extent has the average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services changed since 2005-06?'* A 'treatment day' is any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.	C
Figure 12. Percentage of population receiving state or territory community mental health services	These figures show trends in the numbers of people seen by state or territory community mental health services. They contribute to answering the question: '*To what extent has the percentage of population receiving mental health care increased since 2006-07?'*	B
Figure 13. Percentage of population receiving MBS-subsidised mental health services	These figures show trends in the numbers of people seen by MBS subsidised mental health services. They contribute to answering the question: '*To what extent has the percentage of population receiving mental health care increased since 2006-07?'*	B
Figure 14. New clients as a proportion of total clients under the care of state or territory specialised public mental health services	These figures aim to answer the question: *'To what extent has the percentage of new clients changed since 2009-10?'* 'New' is defined as not having been seen in the five years preceding the first contact with a state or territory specialised public mental health service in the data period.	C
Figure 15. Mental health outcomes for people who receive treatment from state or territory services	These figures are designed to answer the question: *'In 2010-11, what percentage of consumers showed significant improvement, no significant change and significant deterioration, taking into account the mental health care setting in which they received care?'* Data on outcomes from the private sector were not available at jurisdiction level.	B
Figure 16. Proportion of total mental health workforce accounted for by consumer and carer workers	These figures aim to answer the question: *'To what extent has the percentage of state/territory mental health workforce accounted for by consumer and carer workers increased since 2002-03?'* Consumer and carer worker percentages are shown separately. Levels are expressed as the percentage of full-time equivalent (FTE) direct care staff accounted for by consumer and carer full-time FTE.	B
Figure 17. Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	These figures are designed to answer the question: '*What percentage of mental health services met each of the four levels of accreditation under the National Mental Health Standards in 2010-11?'* The four levels are: 1, meets all standards; 2, meets some standards; 3, review booked/in progress; and 4, does not meet criteria for levels 1-3.	B
Figure 18. Percentage of mental health consumers living in stable housing	These figures show the percentage of adult and older adult consumers who, on admission to care, had no significant problems with their living conditions. They aim to answer the question: *'To what extent has the proportion of consumers living in stable housing improved since 2007/08?'* The percentages shown are of consumers in each age specific population group.	B

Source of indicator: A - Resource indicator reported in previous *National Mental Health Reports*; B - Fourth Plan Indicator; C - Key Performance Indicators for Australian Public Mental Health Services.

4.2 New South Wales

Table NSW1
Indicators of mental health reform in New South Wales[a,b,c]

INDICATOR			NEW SOUTH WALES			AUSTRALIA
			1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE						
State spending on mental health services ($millions)			564	1,085	1,303	4,188
State spending per capita ($)			94	157	182	189
Per capita spending rank (1=highest to 8=lowest)			5	8	7	
Average annual per capita spending growth since preceding milestone year (%)				3.5	5.1	4.1
B. SERVICE MIX						
% total service expenditure	– Community services		32	47	44	55
	– Stand-alone psychiatric hospitals		42	18	20	13
	– Colocated general hospitals		26	35	36	32
C. INPATIENT SERVICES						
Total hospital beds			2,652	2,424	2,650	6,755
Per capita expenditure on inpatient care ($)			66	81	97	81
Inpatient beds per 100,000			44	35	36	30
Acute inpatient beds per 100,000			18	22	23	20
Non acute inpatient beds per 100,000			26.2	13.1	13.0	9.7
Stand-alone psychiatric hospitals as % of total beds			69	42	40	31
Average cost per patient day ($)			502	715	845	842
D. COMMUNITY SERVICES						
Ambulatory care	– % total service expenditure		26	39	37	41
	– Per capita expenditure ($)		25	59	65	74
NGOs	– % total service expenditure		1.4	6.7	6.0	9.3
	– Per capita expenditure ($)		1	10	10	17
Residential services	– % total service expenditure		5.0	1.6	0.9	6.0
	– Per capita expenditure ($)		5	2	2	11
	– Adult beds per 100,000:	24 hour staffed	4.6	2.6	2.3	6.0
		Non-24 hour staffed	n.a.	1.8	0.5	5.0
	– Older persons' beds per 100,000:	24 hour staffed	16	2	2	23
		Non-24 hour staffed	n.a.	1.3	1.2	0.4
Supported public housing places per 100,000			n.a.	23	22	22
E. DIRECT CARE WORKFORCE						
Number Full-time Equivalent (FTE) staff			4,108	6,743	7,576	24,292
FTE per 100,000			69	97	104	108
FTE per 100,000 – ambulatory services			19	40	43	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
% service expenditure covered by Level 1 services			..	85	79	84
G. CONSUMER AND CARER PARTICIPATION						
% services with Level 1 consumer committee representation			19	61	53	55
% total mental health workforce accounted for by consumer workers			n.a.	0.41	0.27	0.28
% total mental health workforce accounted for by carer workers			n.a.	0.10	0.18	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES						
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)			n.a.	5.0	7.0	6.9
% population seen – GPs			n.a.	3.7	5.5	5.4
% population seen – Consultant Psychiatrists			1.4	1.3	1.4	1.3
% population seen – Clinical Psychologists			-	0.6	1.1	1.1
% population seen – Registered Psychologists and Other allied health professionals			-	1.3	2.2	2.1
Total MBS mental health related benefits paid per capita ($)			n.a.	25	39	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)						
Total PBS/RPBS benefits paid per capita ($)			4	33	37	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure NSW1
Overall spending on mental health

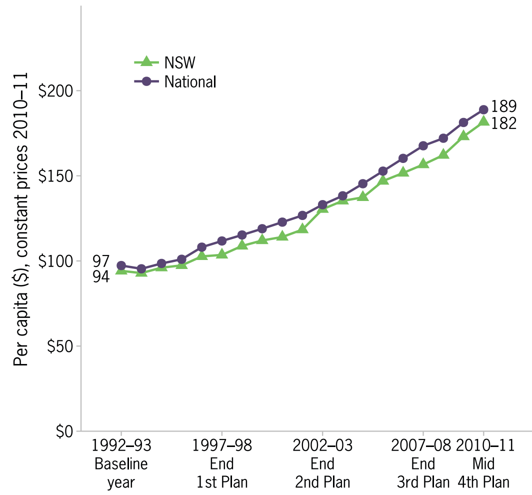


Figure NSW2
Change in spending mix

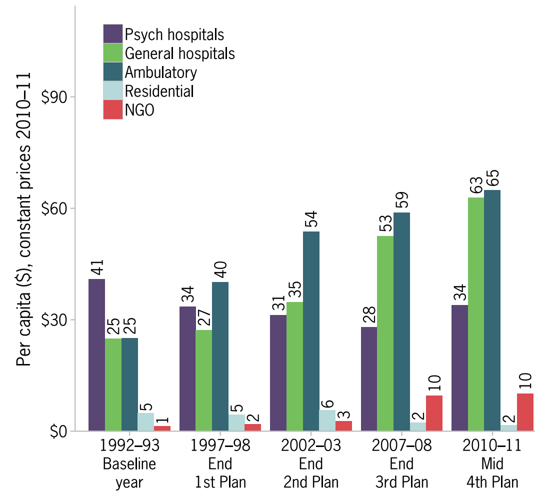


Figure NSW3
Changes in inpatient services

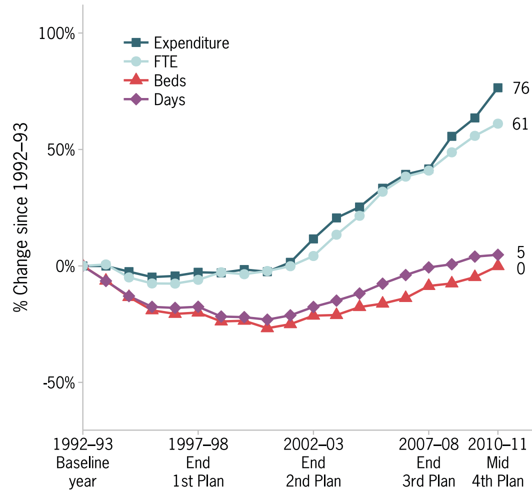


Figure NSW4
Changes in ambulatory care

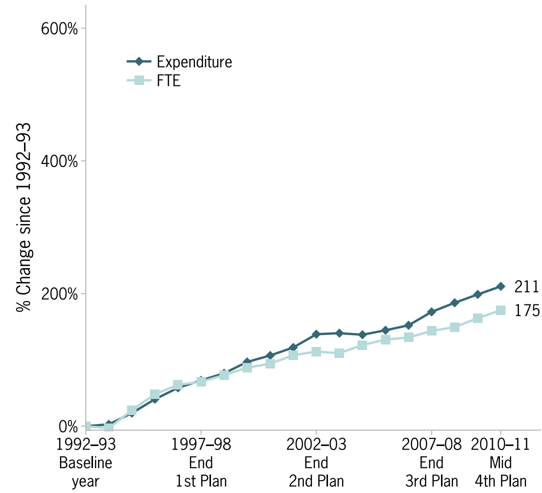


Figure NSW5
Direct care workforce

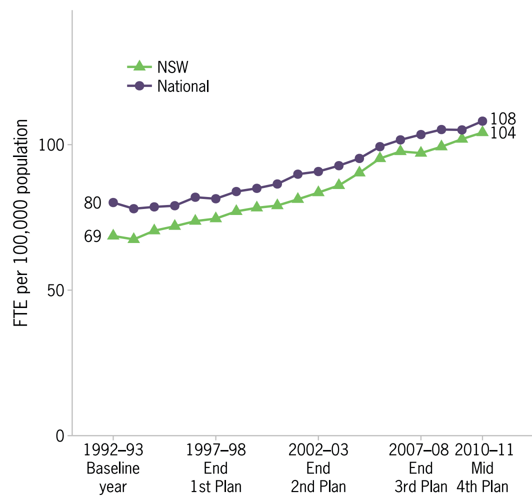


Figure NSW6
Inpatient and residential beds

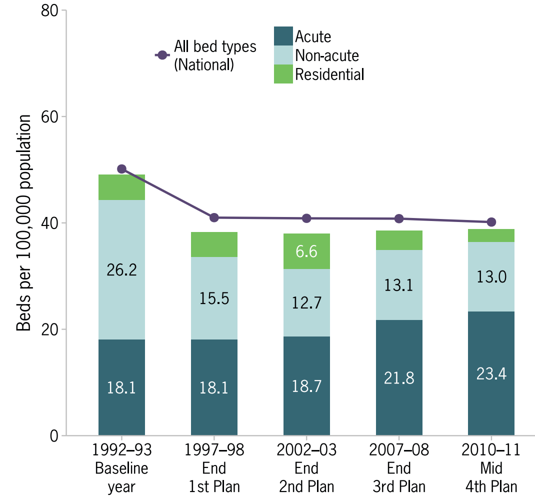


Figure NSW7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

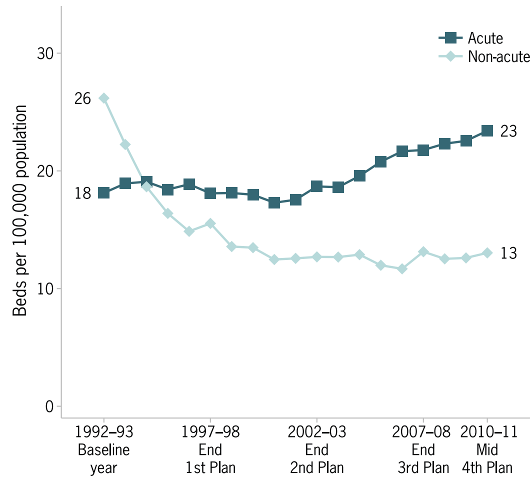


Figure NSW8
Readmission to hospital within 28 days of discharge

Figure NSW9
Rates of pre-admission community care

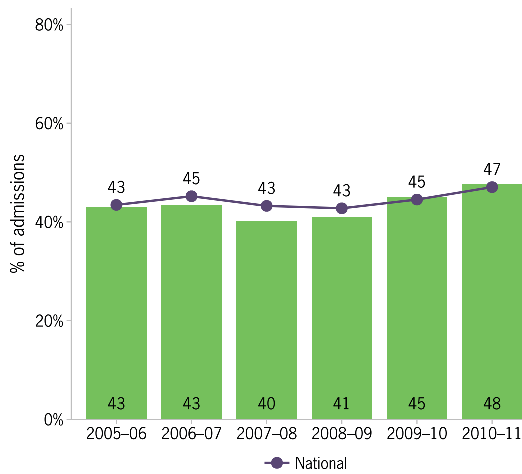


Figure NSW10
Rates of post-discharge community care

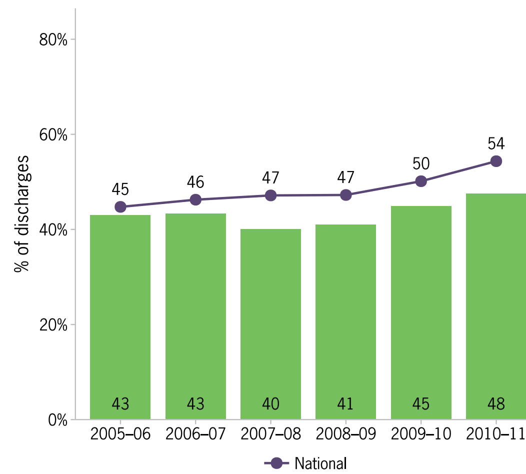


Figure NSW11
Average treatment days per three month community care period

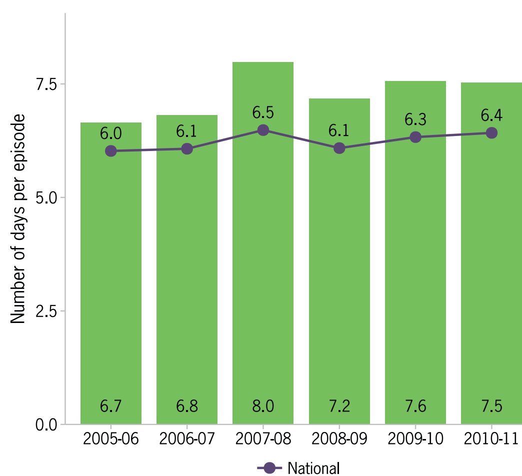


Figure NSW12
Percentage of population receiving state or territory community mental health services

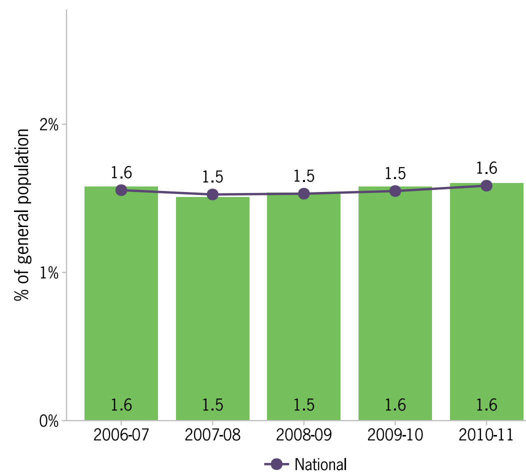


Figure NSW13
Percentage of population receiving MBS-subsidised mental health services

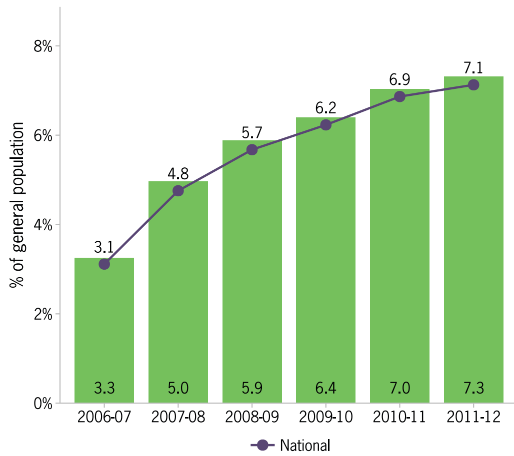


Figure NSW14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

Figure NSW15
Mental health outcomes for people who receive treatment from state or territory services

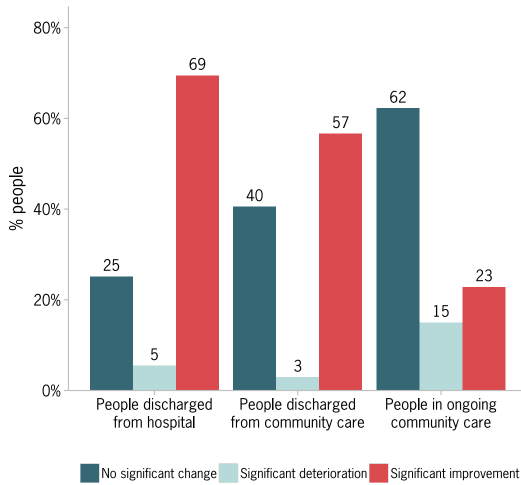


Figure NSW16
Proportion of total mental health workforce accounted for by consumer and carer workers

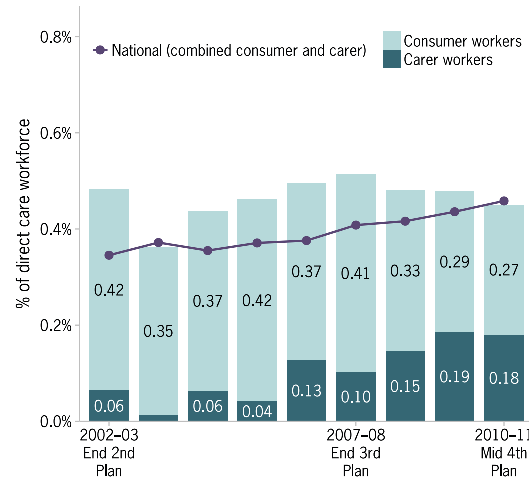


Figure NSW17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

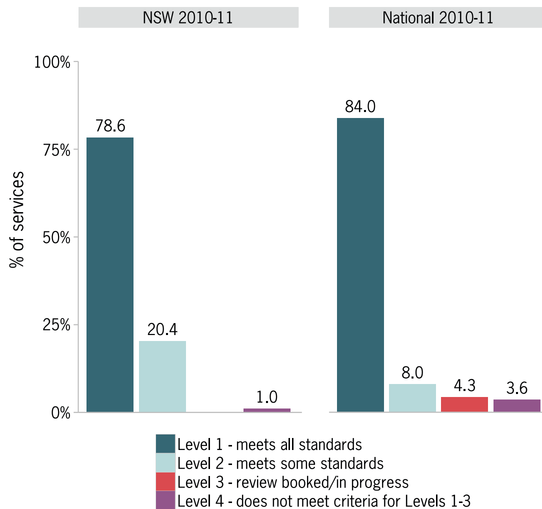
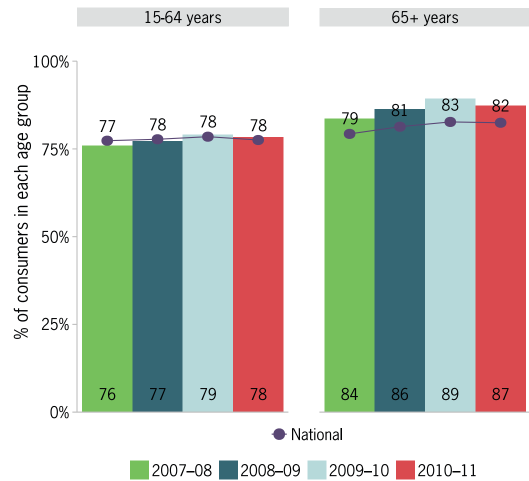


Figure NSW18
Percentage of mental health consumers living in stable housing



4.3 Victoria

Table VIC1

Indicators of mental health reform in Victoria[a,b,c]

INDICATOR	VICTORIA			AUSTRALIA
	1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE				
State spending on mental health services ($millions)	496	857	974	4,188
State spending per capita ($)	111	164	177	189
Per capita spending rank (1=highest to 8=lowest)	1	6	8	
Average annual per capita spending growth since preceding milestone year (%)		2.7	2.7	4.1
B. SERVICE MIX				
% total service expenditure – Community services	33	66	66	55
– Stand-alone psychiatric hospitals	54	5	5	13
– Colocated general hospitals	13	28	29	32
C. INPATIENT SERVICES				
Total hospital beds	1,887	1,216	1,262	6,755
Per capita expenditure on inpatient care ($)	73	54	57	81
Inpatient beds per 100,000	42	23	23	30
Acute inpatient beds per 100,000	22	20	20	20
Non acute inpatient beds per 100,000	20.6	3.4	2.9	9.7
Stand-alone psychiatric hospitals as % of total beds	83	13	12	31
Average cost per patient day ($)	523	732	784	842
D. COMMUNITY SERVICES				
Ambulatory care – % total service expenditure	24	40	40	41
– Per capita expenditure ($)	26	64	67	74
NGOs – % total service expenditure	3.1	11.7	12.8	9.3
– Per capita expenditure ($)	3	19	22	17
Residential services – % total service expenditure	6.8	17.4	17.7	6.0
– Per capita expenditure ($)	7	28	30	11
– Adult beds per 100,000: 24 hour staffed	1.5	13.1	13.7	6.0
Non-24 hour staffed	n.a.	10.2	9.7	5.0
– Older persons beds per 100,000: 24 hour staffed	49	88	82	23
Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000	n.a.	27	23	22
E. DIRECT CARE WORKFORCE				
Number Full-time Equivalent (FTE) staff	4,111	5,405	5,868	24,292
FTE per 100,000	92	103	105	108
FTE per 100,000 – ambulatory services	22	44	45	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
% service expenditure covered by Level 1 services	..	99	96	84
G. CONSUMER AND CARER PARTICIPATION				
% services with Level 1 consumer committee representation	19	55	55	55
% total mental health workforce accounted for by consumer workers	n.a.	0.37	0.30	0.28
% total mental health workforce accounted for by carer workers	n.a.	0.29	0.30	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	n.a.	5.4	7.7	6.9
% population seen – GPs	n.a.	3.9	6.0	5.4
% population seen – Consultant Psychiatrists	1.6	1.5	1.5	1.3
% population seen – Clinical Psychologists	-	0.6	1.1	1.1
% population seen – Registered Psychologists and Other allied health professionals	-	1.8	2.7	2.1
Total MBS mental health related benefits paid per capita ($)	n.a.	36	47	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)				
Total PBS/RPBS benefits paid per capita ($)	4	39	41	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure VIC1
Overall spending on mental health

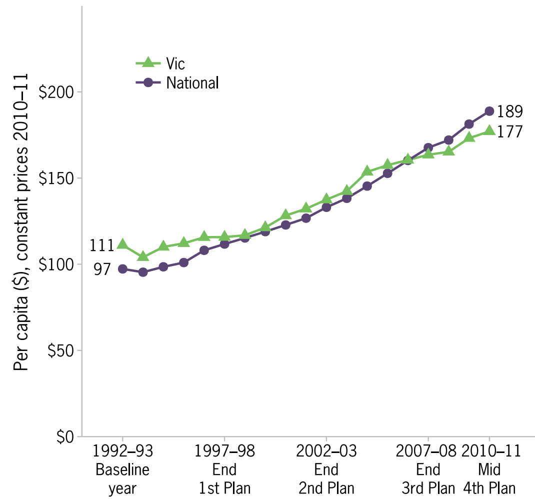


Figure VIC2
Change in spending mix

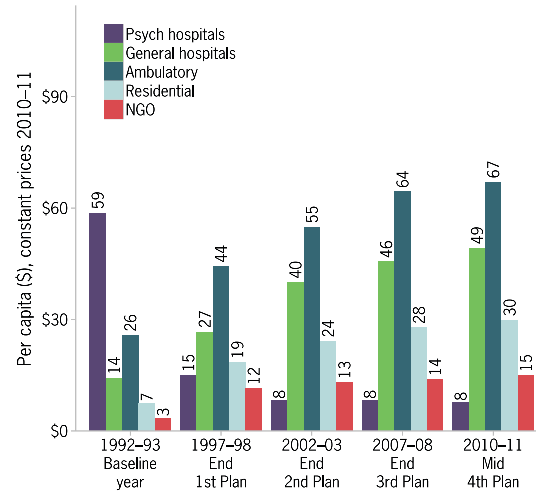


Figure VIC3
Changes in inpatient services

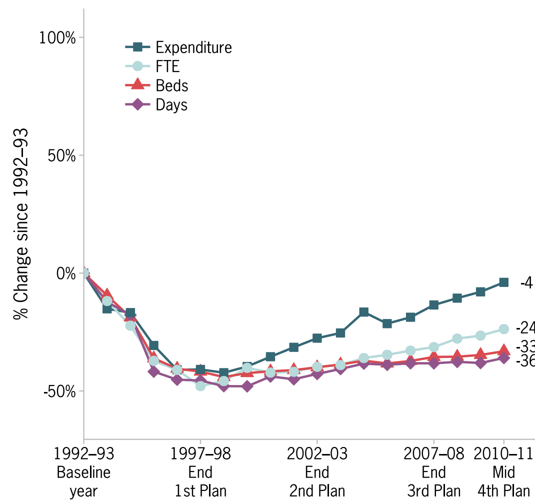


Figure VIC4
Changes in ambulatory care

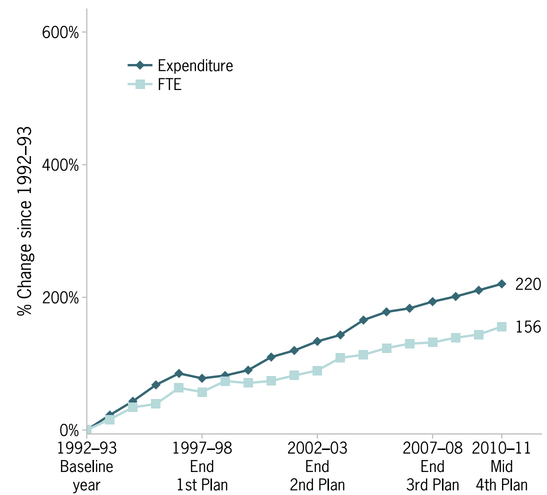


Figure VIC5
Direct care workforce

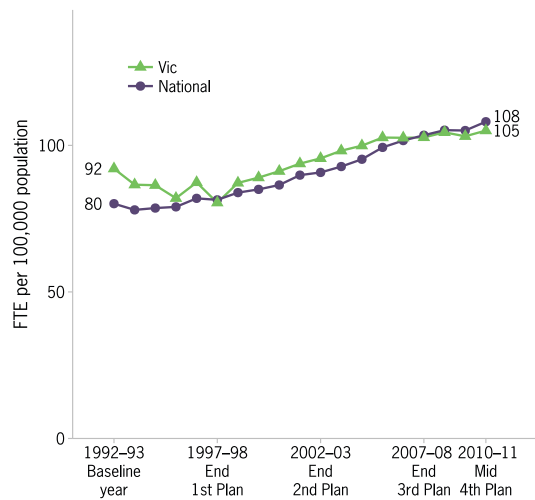


Figure VIC6
Inpatient and residential beds

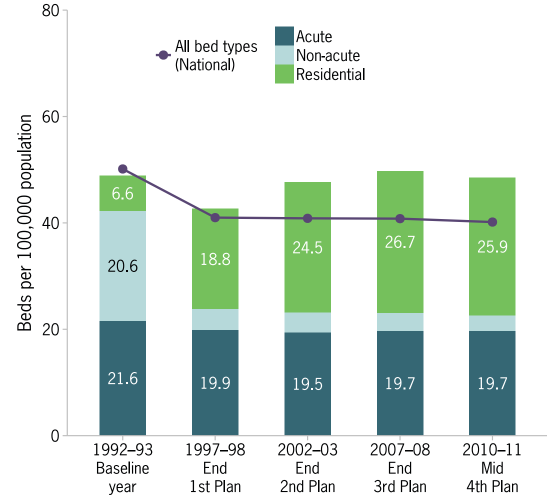


Figure VIC7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

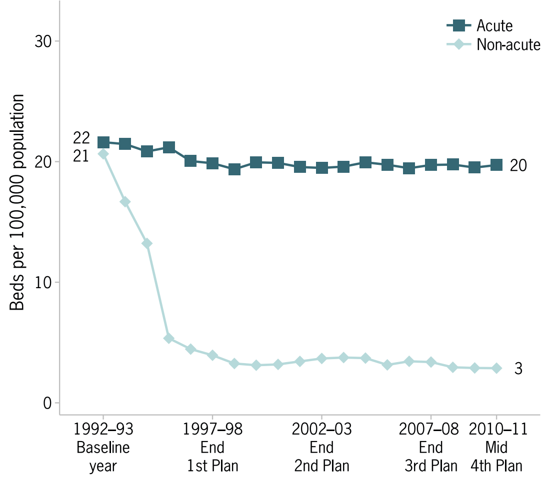


Figure VIC8
Readmission to hospital within 28 days of discharge

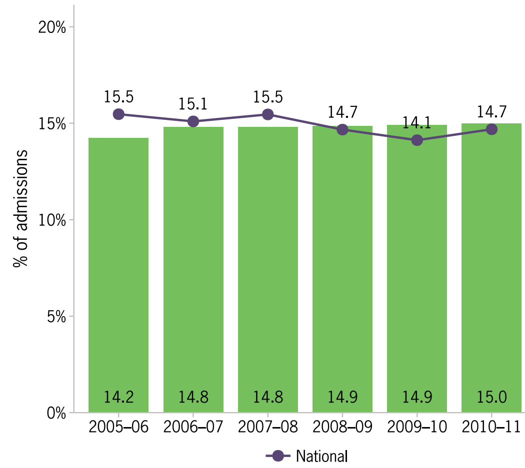


Figure VIC9
Rates of pre-admission community care

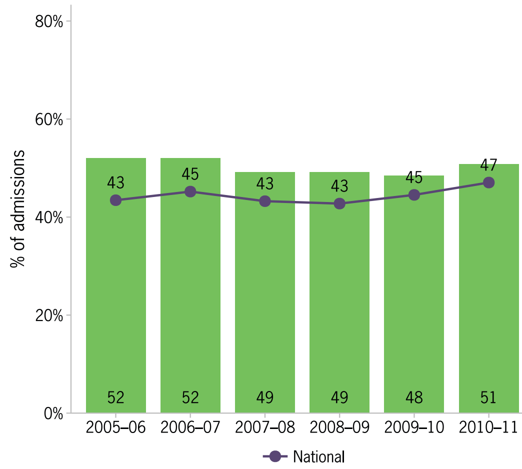


Figure VIC10
Rates of post-discharge community care

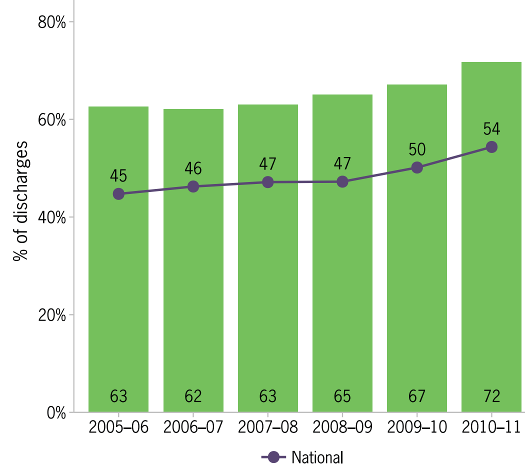


Figure VIC11
Average treatment days per three month community care period

Figure VIC12
Percentage of population receiving state or territory community mental health services

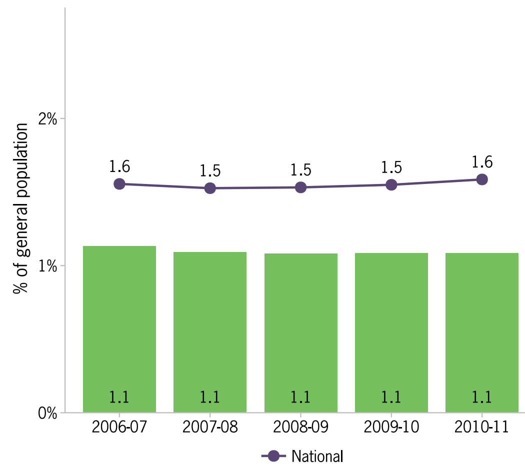


Figure VIC13
Percentage of population receiving MBS-subsidised mental health services

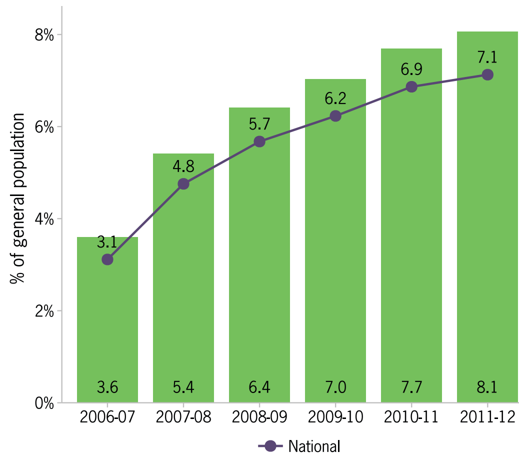


Figure VIC14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

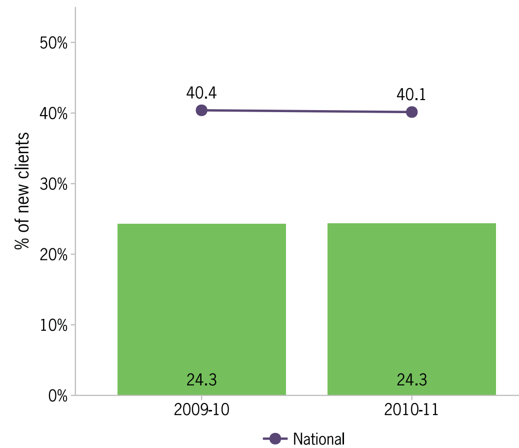


Figure VIC15
Mental health outcomes for people who receive treatment from state or territory services

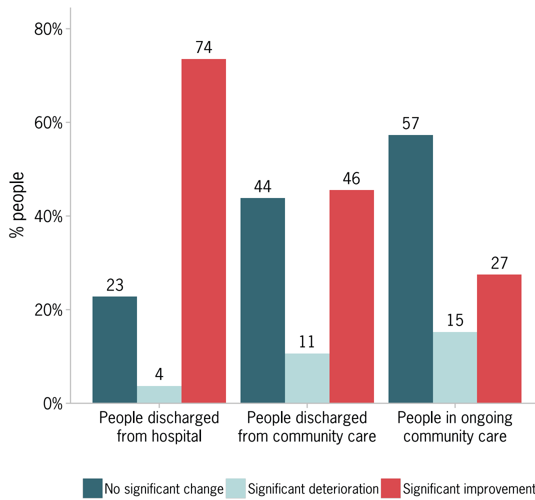


Figure VIC16
Proportion of total mental health workforce accounted for by consumer and carer workers

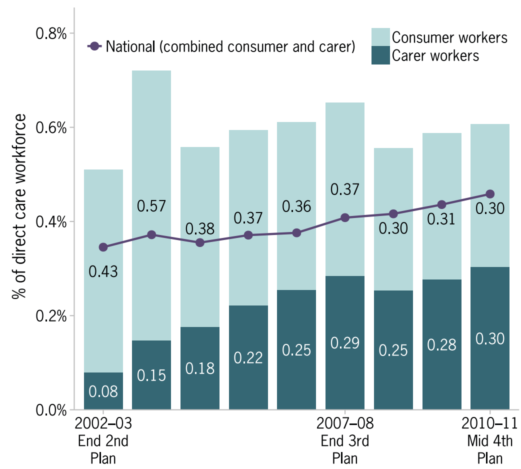


Figure VIC17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

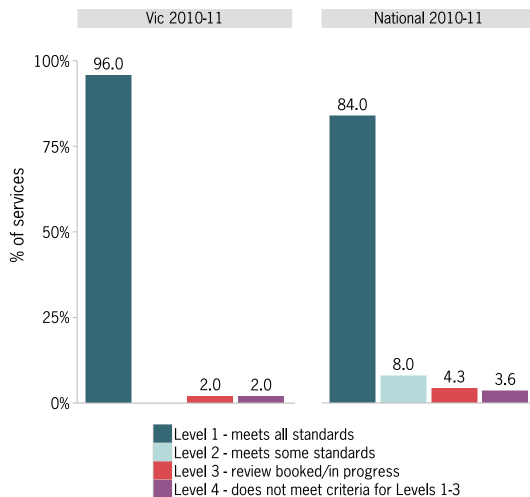
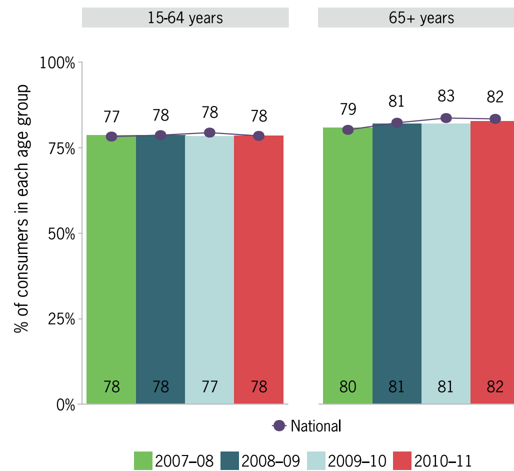


Figure VIC18
Percentage of mental health consumers living in stable housing



4.4 Queensland

Table QLD1
Indicators of mental health reform in Queensland[a,b,c]

	QUEENSLAND			AUSTRALIA
INDICATOR	1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE				
State spending on mental health services ($millions)	253	681	830	4,188
State spending per capita ($)	82	161	187	189
Per capita spending rank (1=highest to 8=lowest)	6	7	6	
Average annual per capita spending growth since preceding milestone year (%)		4.6	5.0	4.1
B. SERVICE MIX				
% total service expenditure – Community services	22	50	56	55
– Stand-alone psychiatric hospitals	46	13	12	13
– Colocated general hospitals	31	37	33	32
C. INPATIENT SERVICES				
Total hospital beds	1,607	1,409	1,419	6,755
Per capita expenditure on inpatient care ($)	64	79	77	81
Inpatient beds per 100,000	52	33	31	30
Acute inpatient beds per 100,000	21	17	16	20
Non acute inpatient beds per 100,000	31.1	16.6	15.6	9.7
Stand-alone psychiatric hospitals as % of total beds	66	27	26	31
Average cost per patient day ($)	407	754	774	842
D. COMMUNITY SERVICES				
Ambulatory care – % total service expenditure	21	43	47	41
– Per capita expenditure ($)	18	68	82	74
NGOs – % total service expenditure	1.3	6.8	8.5	9.3
– Per capita expenditure ($)	1	11	15	17
Residential services – % total service expenditure	-	-	-	6.0
– Per capita expenditure ($)	-	-	-	11
– Adult beds per 100,000: 24 hour staffed	-	-	-	6.0
Non-24 hour staffed	n.a.	-	-	5.0
– Older persons beds per 100,000: 24 hour staffed	-	-	-	23
Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000	n.a.	2	6	22
E. DIRECT CARE WORKFORCE				
Number Full-time Equivalent (FTE) staff	2,200	4,222	4,671	24,292
FTE per 100,000	72	100	103	108
FTE per 100,000 – ambulatory services	14	44	50	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
% service expenditure covered by Level 1 services	..	97	99	84
G. CONSUMER AND CARER PARTICIPATION				
% services with Level 1 consumer committee representation	27	70	74	55
% total mental health workforce accounted for by consumer workers	n.a.	0.23	0.38	0.28
% total mental health workforce accounted for by carer workers	n.a.	0.04	0.11	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	n.a.	4.3	6.6	6.9
% population seen – GPs	n.a.	3.1	5.2	5.4
% population seen – Consultant Psychiatrists	1.5	1.2	1.2	1.3
% population seen – Clinical Psychologists	-	0.4	0.8	1.1
% population seen – Registered Psychologists and Other allied health professionals	-	1.4	2.2	2.1
Total MBS mental health related benefits paid per capita ($)	n.a.	23	34	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)				
Total PBS/RPBS benefits paid per capita ($)	4	33	37	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure QLD1
Overall spending on mental health

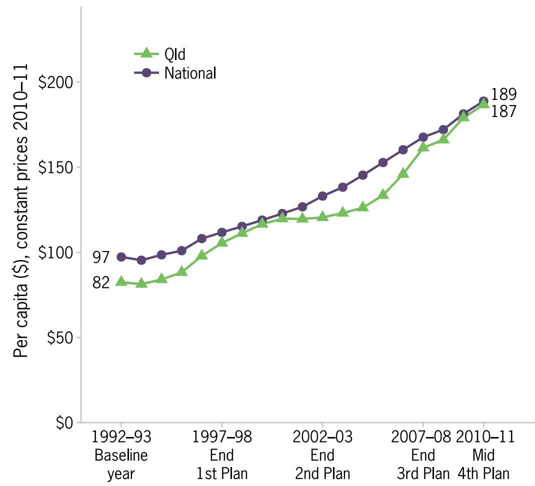


Figure QLD2
Change in spending mix

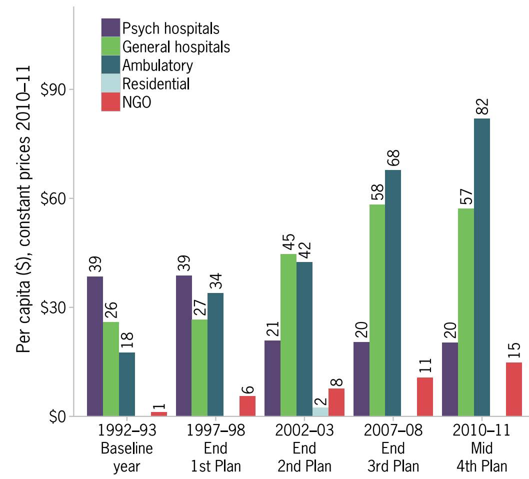


Figure QLD3
Changes in inpatient services

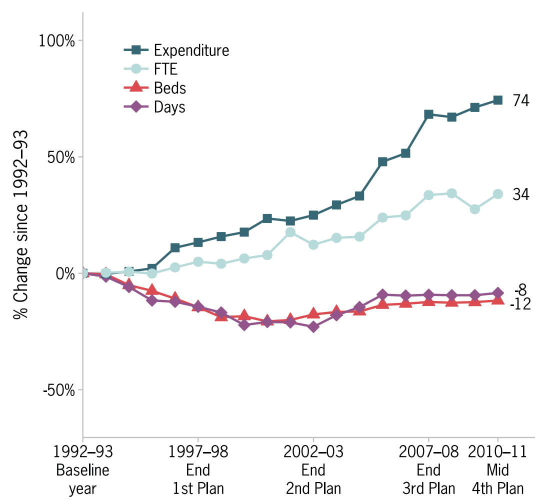


Figure QLD4
Changes in ambulatory care

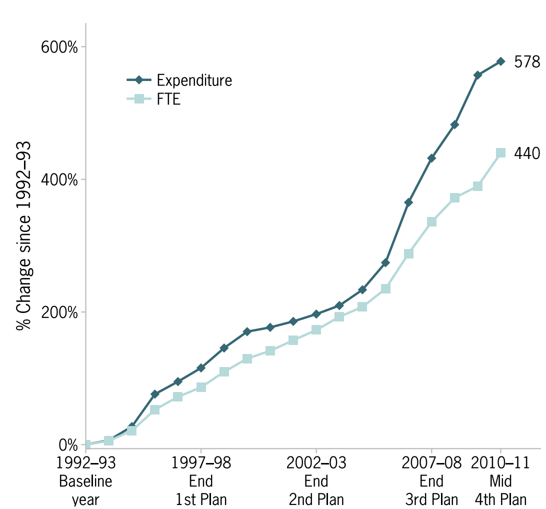


Figure QLD5
Direct care workforce

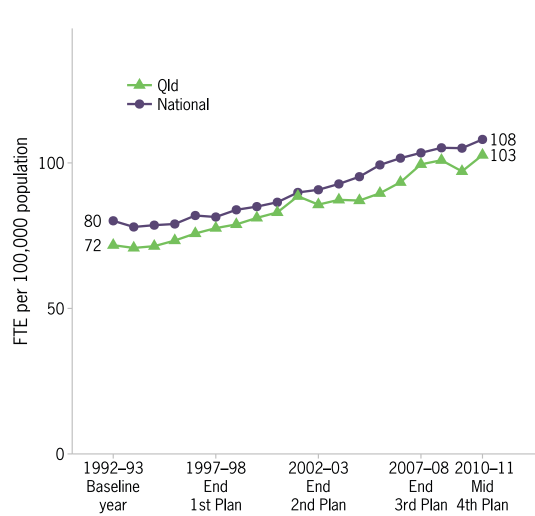


Figure QLD6
Inpatient and residential beds

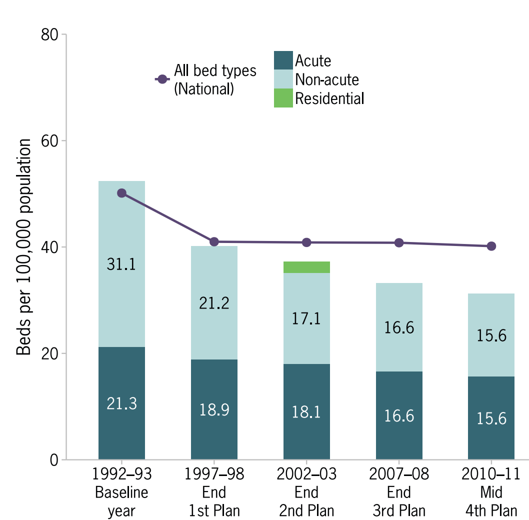


Figure QLD7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

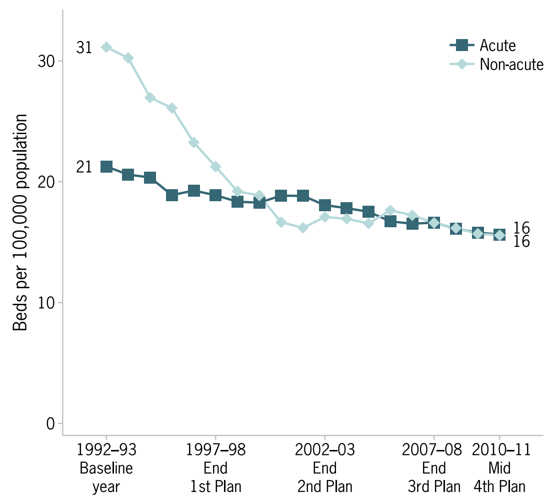


Figure QLD8
Readmission to hospital within 28 days of discharge

Figure QLD9
Rates of pre-admission community care

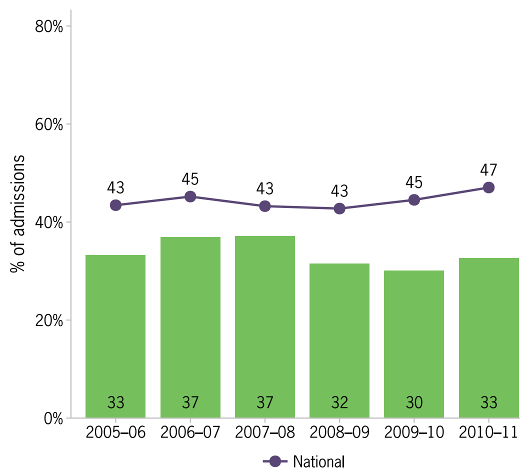


Figure QLD10
Rates of post-discharge community care

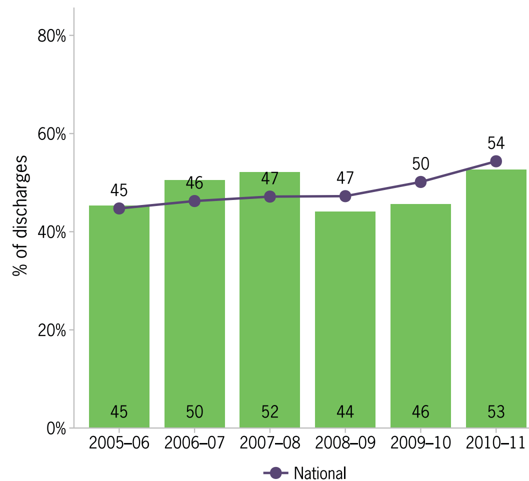


Figure QLD11
Average treatment days per three month community care period

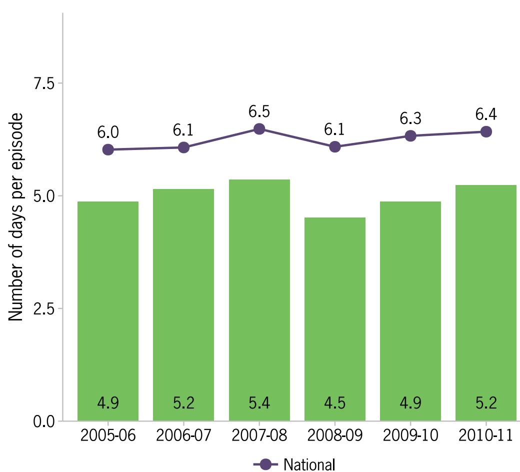


Figure QLD12
Percentage of population receiving state or territory community mental health services

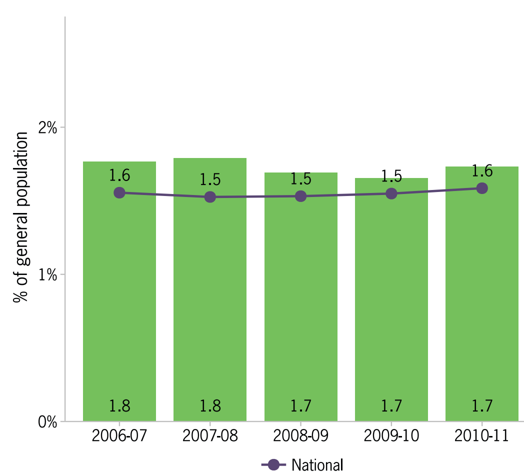


Figure QLD13
Percentage of population receiving MBS-subsidised mental health services

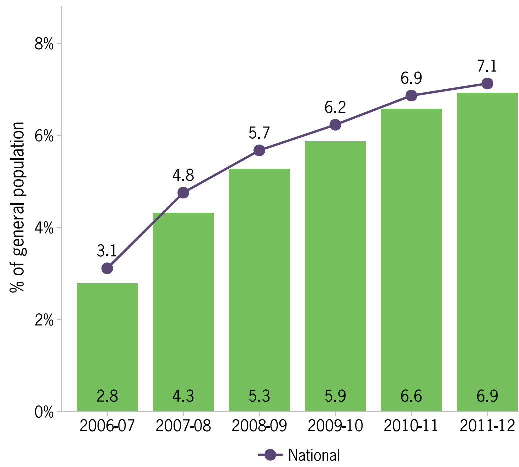


Figure QLD14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

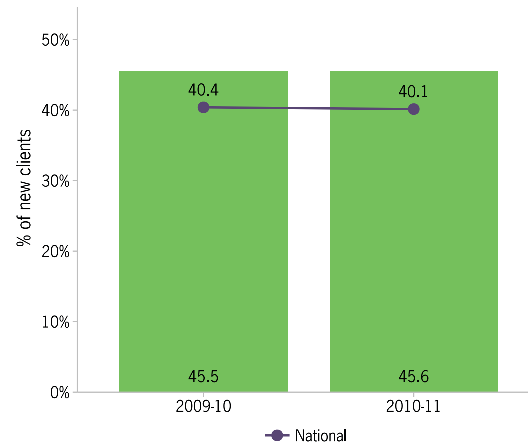


Figure QLD15
Mental health outcomes for people who receive treatment from state or territory services

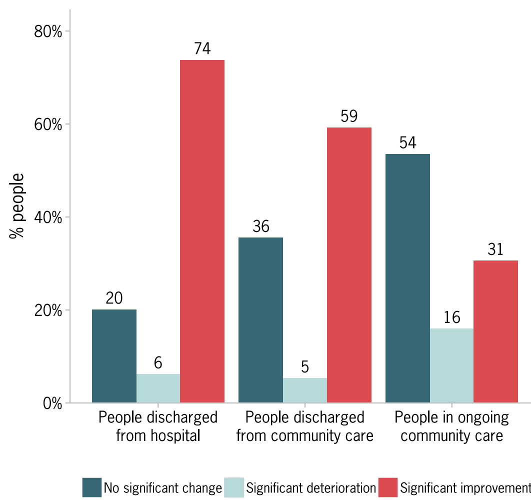


Figure QLD16
Proportion of total mental health workforce accounted for by consumer and carer workers

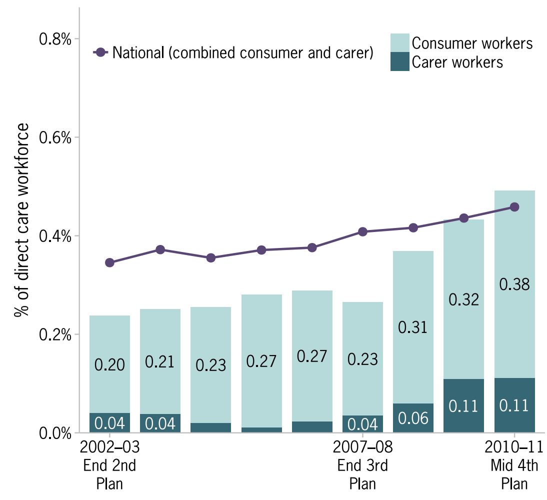


Figure QLD17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

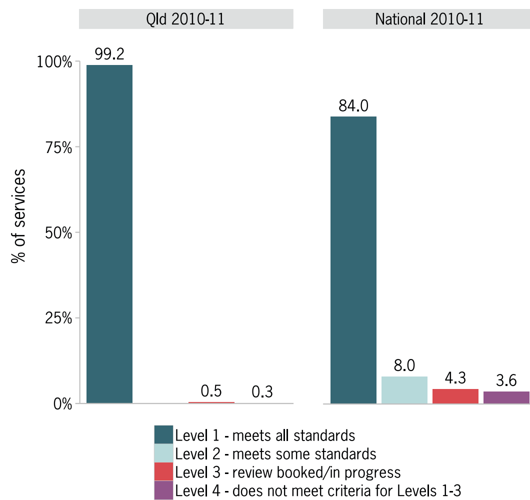
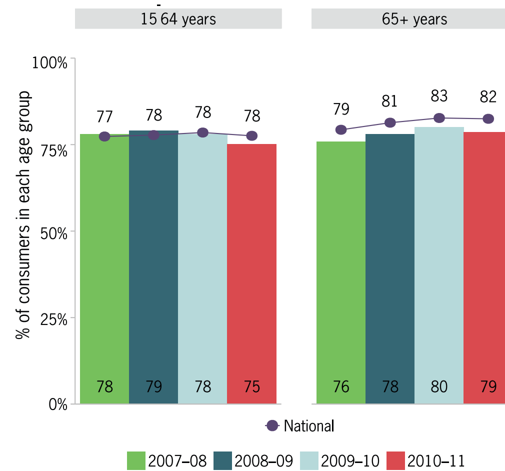


Figure QLD18
Percentage of mental health consumers living in stable housing



4.5 Western Australia

Table WA1
Indicators of mental health reform in Western Australia[a,b,c]

INDICATOR			WESTERN AUSTRALIA 1992-93	WESTERN AUSTRALIA 2007-08	WESTERN AUSTRALIA 2010-11	AUSTRALIA 2010-11
A. STATE GOVERNMENT EXPENDITURE						
State spending on mental health services ($millions)			164	434	523	4,188
State spending per capita ($)			98	203	225	189
Per capita spending rank (1=highest to 8=lowest)			4	1	2	
Average annual per capita spending growth since preceding milestone year (%)				5.0	3.6	4.1
B. SERVICE MIX						
% total service expenditure	– Community services		28	54	53	55
	– Stand-alone psychiatric hospitals		50	17	16	13
	– Colocated general hospitals		23	29	30	32
C. INPATIENT SERVICES						
Total hospital beds			728	670	700	6,755
Per capita expenditure on inpatient care ($)			71	92	101	81
Inpatient beds per 100,000			44	31	30	30
Acute inpatient beds per 100,000			24	25	23	20
Non acute inpatient beds per 100,000			19.9	5.8	7.3	9.7
Stand-alone psychiatric hospitals as % of total beds			70	37	35	31
Average cost per patient day ($)			488	897	1,017	842
D. COMMUNITY SERVICES						
Ambulatory care	– % total service expenditure		22	46	44	41
	– Per capita expenditure ($)		22	93	95	74
NGOs	– % total service expenditure		2.5	6.5	8.7	9.3
	– Per capita expenditure ($)		2	13	19	17
Residential services	– % total service expenditure		2.8	2.4	3.5	6.0
	– Per capita expenditure ($)		3	5	8	11
	– Adult beds per 100,000:	24 hour staffed	8.1	3.8	4.9	6.0
		Non-24 hour staffed	n.a.	5.6	14.0	5.0
	– Older persons' beds per 100,000:	24 hour staffed	-	-	-	23
		Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000			n.a.	31	62	22
E. DIRECT CARE WORKFORCE						
Number Full-time Equivalent (FTE) staff			1,475	2,536	2,852	24,292
FTE per 100,000			88	119	123	108
FTE per 100,000 – ambulatory services			17	49	51	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
% service expenditure covered by Level 1 services			..	39	49	84
G. CONSUMER AND CARER PARTICIPATION						
% services with Level 1 consumer committee representation			6	37	29	55
% total mental health workforce accounted for by consumer workers			n.a.	0.05	0.12	0.28
% total mental health workforce accounted for by carer workers			n.a.	0.03	0.03	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES						
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)			n.a.	4.0	5.6	6.9
% population seen – GPs			n.a.	3.0	4.4	5.4
% population seen – Consultant Psychiatrists			0.9	1.0	1.0	1.3
% population seen – Clinical Psychologists			-	1.0	1.4	1.1
% population seen – Registered Psychologists and Other allied health professionals			-	0.6	1.1	2.1
Total MBS mental health related benefits paid per capita ($)			n.a.	23	30	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)						
Total PBS/RPBS benefits paid per capita ($)			3	30	32	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure WA1
Overall spending on mental health

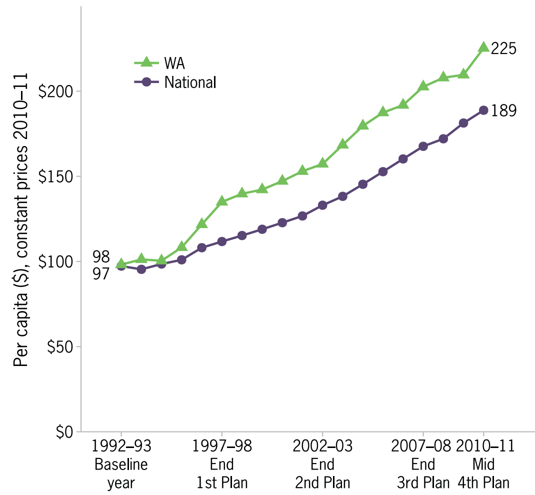


Figure WA2
Change in spending mix

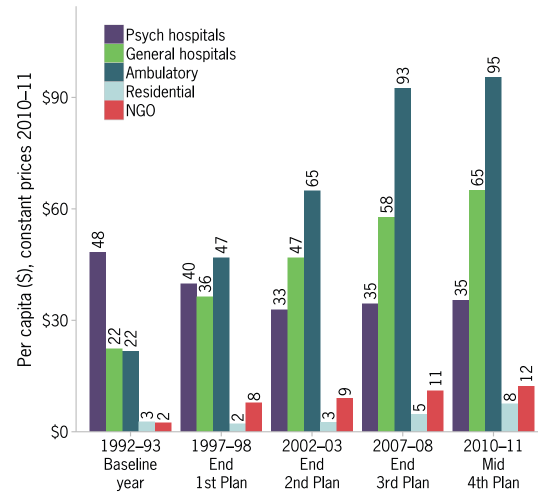


Figure WA3
Changes in inpatient services

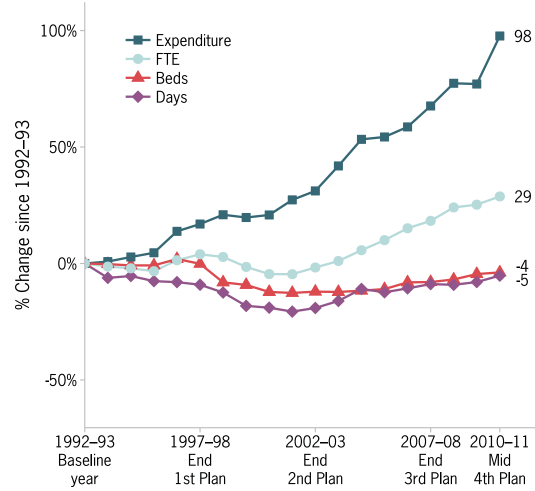


Figure WA4
Changes in ambulatory care

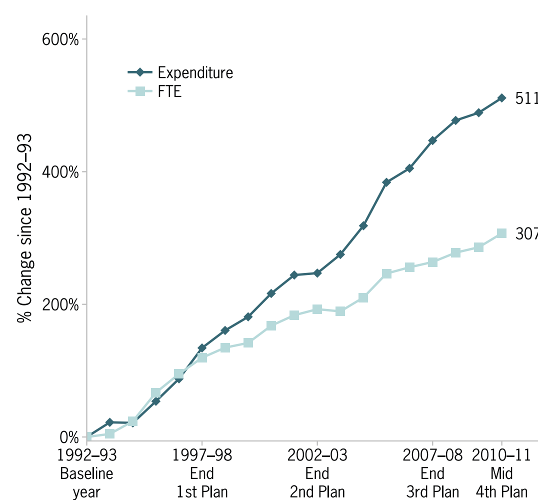


Figure WA5
Direct care workforce

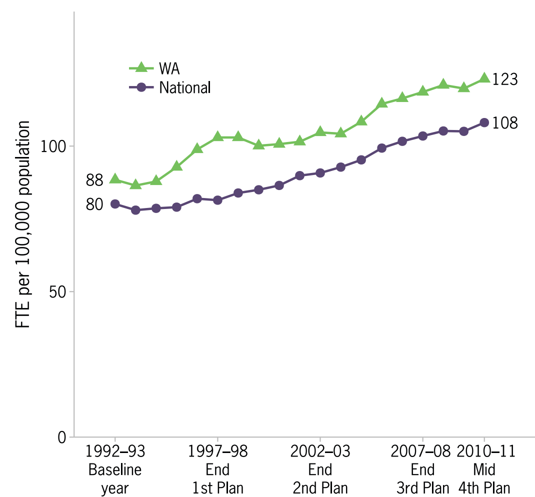


Figure WA6
Inpatient and residential beds

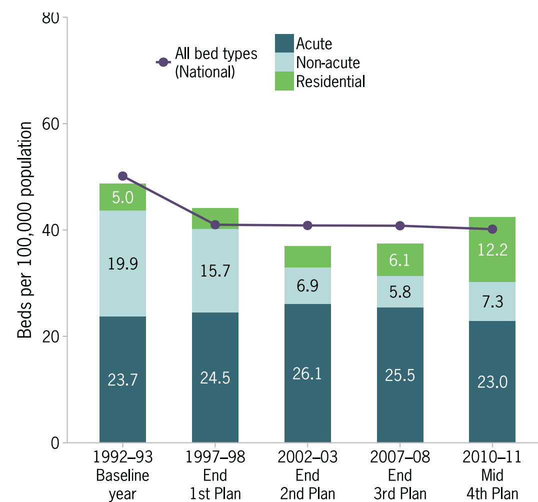


Figure WA7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

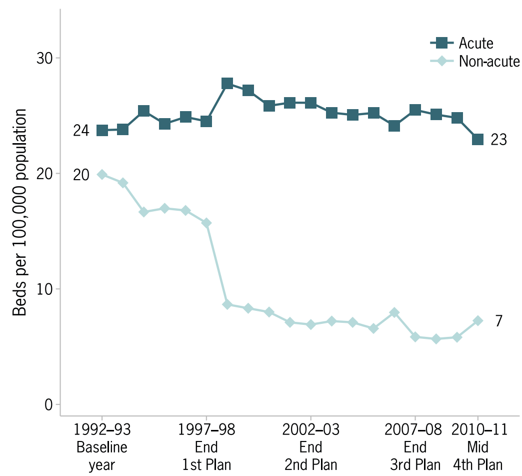


Figure WA8
Readmission to hospital within 28 days of discharge

Figure WA9
Rates of pre-admission community care

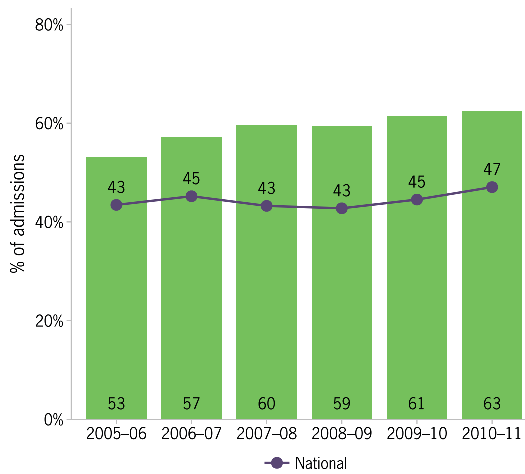


Figure WA10
Rates of post-discharge community care

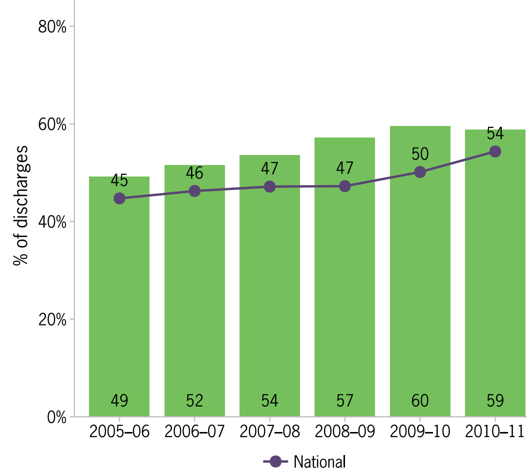


Figure WA11
Average treatment days per three month community care period

Figure WA12
Percentage of population receiving state or territory mental health services

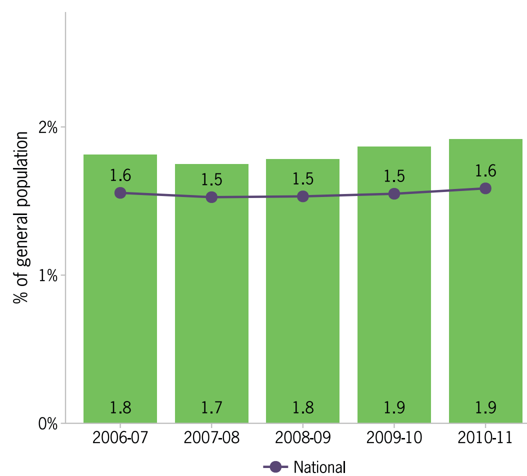


Figure WA13
Percentage of population receiving MBS-subsidised mental health services

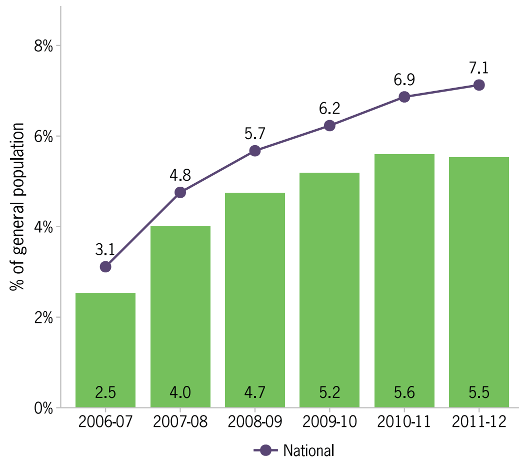


Figure WA14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

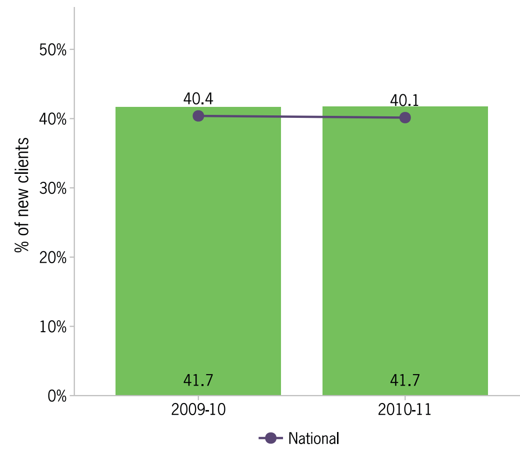


Figure WA15
Mental health outcomes for people who receive treatment from state or territory services

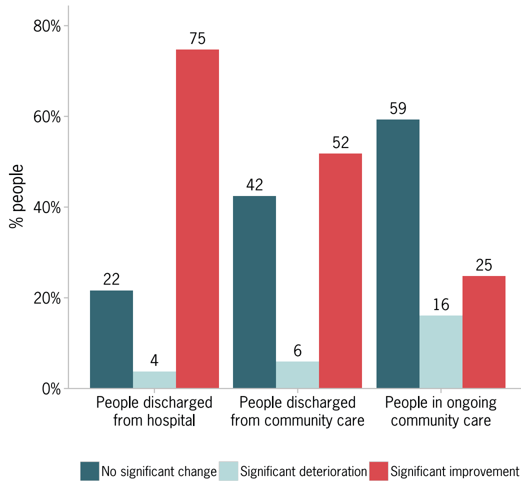


Figure WA16
Proportion of total mental health workforce accounted for by consumer and carer workers

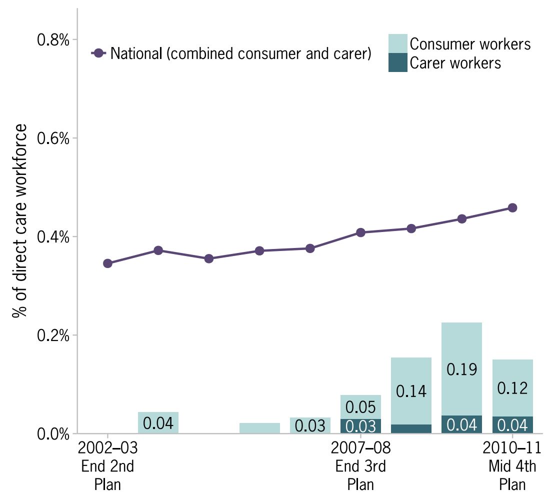
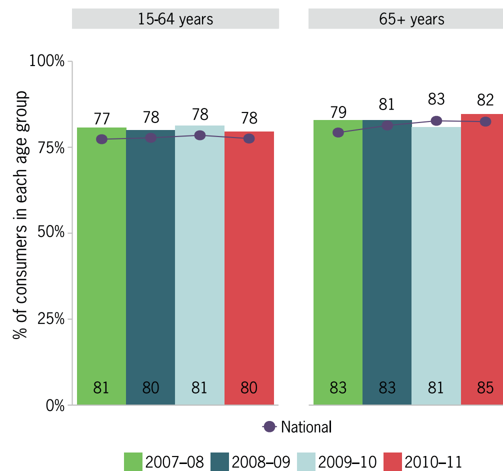


Figure WA17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

Figure WA18
Percentage of mental health consumers living in stable housing



4.6 South Australia

Table SA1
Indicators of mental health reform in South Australia[a,b,c]

INDICATOR			SOUTH AUSTRALIA			AUSTRALIA
			1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE						
State spending on mental health services ($millions)			150	295	327	4,188
State spending per capita ($)			103	186	200	189
Per capita spending rank (1=highest to 8=lowest)			2	3	3	
Average annual per capita spending growth since preceding milestone year (%)				4.1	2.6	4.1
B. SERVICE MIX						
% total service expenditure	– Community services		32	49	56	55
	– Stand-alone psychiatric hospitals		57	29	21	13
	– Colocated general hospitals		10	22	23	32
C. INPATIENT SERVICES						
Total hospital beds			779	600	499	6,755
Per capita expenditure on inpatient care ($)			70	97	87	81
Inpatient beds per 100,000			53	38	30	30
Acute inpatient beds per 100,000			24	22	21	20
Non acute inpatient beds per 100,000			29.3	15.2	9.6	9.7
Stand-alone psychiatric hospitals as % of total beds			85	60	49	31
Average cost per patient day ($)			446	776	819	842
D. COMMUNITY SERVICES						
Ambulatory care	– % total service expenditure		30	37	42	41
	– Per capita expenditure ($)		31	70	83	74
NGOs	– % total service expenditure		1.7	9.5	11.5	9.3
	– Per capita expenditure ($)		2	18	18	17
Residential services	– % total service expenditure		0.9	2.4	3.6	6.0
	– Per capita expenditure ($)		1	4	7	11
	– Adult beds per 100,000:	24 hour staffed	3.5	6.4	7.7	6.0
		Non-24 hour staffed	n.a.	0.7	1.8	5.0
	– Older persons' beds per 100,000:	24 hour staffed	-	-	-	23
		Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000			n.a.	7	15	22
E. DIRECT CARE WORKFORCE						
Number Full-time Equivalent (FTE) staff			1,441	1,957	2,108	24,292
FTE per 100,000			99	123	128	108
FTE per 100,000 – ambulatory services			22	50	60	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
% service expenditure covered by Level 1 services			..	43	96	84
G. CONSUMER AND CARER PARTICIPATION						
% services with Level 1 consumer committee representation			15	49	73	55
% total mental health workforce accounted for by consumer workers			n.a.	0.24	0.40	0.28
% total mental health workforce accounted for by carer workers			n.a.	0.09	0.24	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES						
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)			n.a.	4.6	6.9	6.9
% population seen – GPs			n.a.	3.1	5.3	5.4
% population seen – Consultant Psychiatrists			1.5	1.6	1.6	1.3
% population seen – Clinical Psychologists			-	0.7	1.6	1.1
% population seen – Registered Psychologists and Other allied health professionals			-	0.9	1.3	2.1
Total MBS mental health related benefits paid per capita ($)			n.a.	27	37	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)						
Total PBS/RPBS benefits paid per capita ($)			4	40	44	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure SA1
Overall spending on mental health

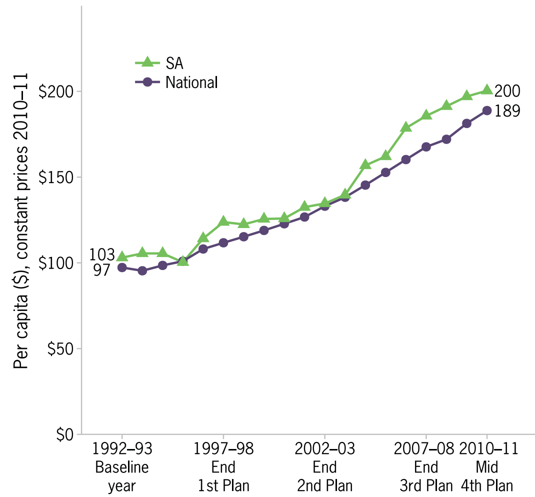


Figure SA2
Change in spending mix

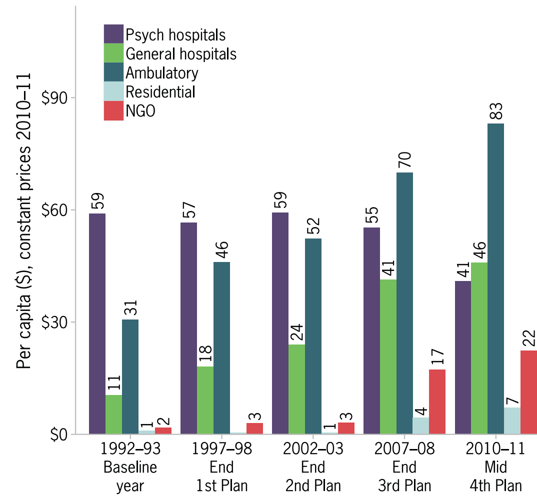


Figure SA3
Changes in inpatient services

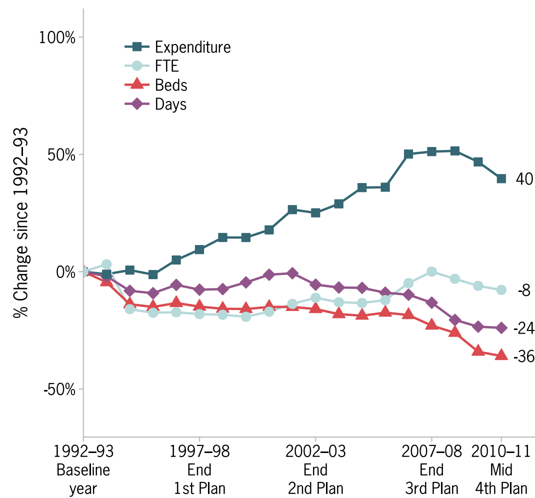


Figure SA4
Changes in ambulatory care

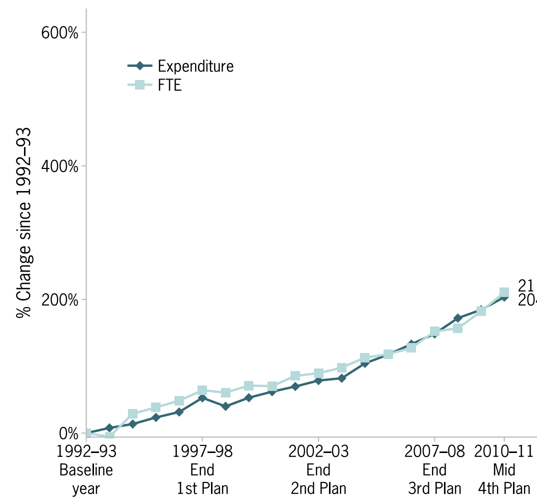


Figure SA5
Direct care workforce

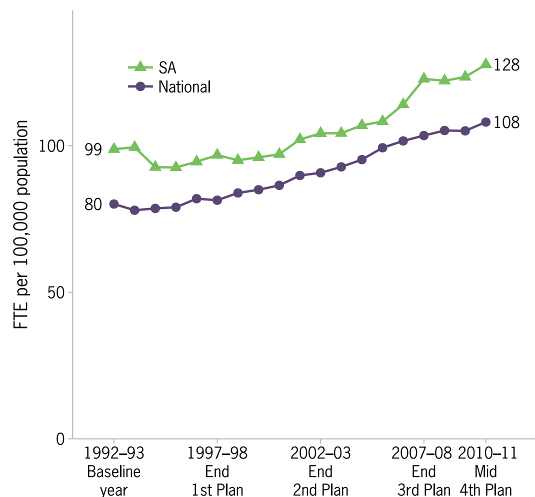


Figure SA6
Inpatient and residential beds

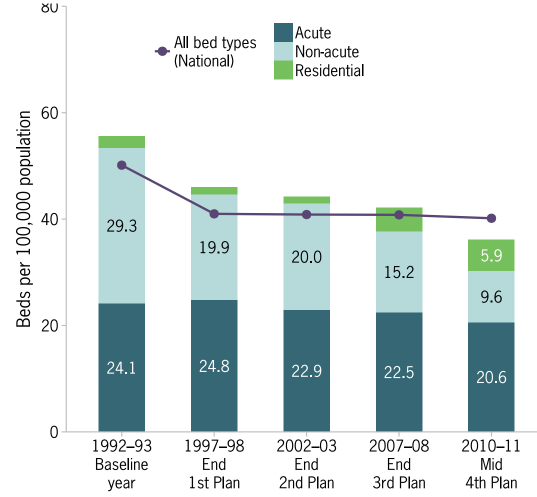


Figure SA7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

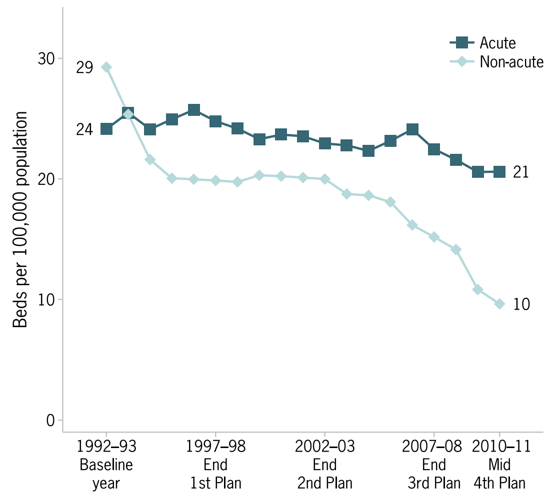


Figure SA8
Readmission to hospital within 28 days of discharge

Figure SA9
Rates of pre-admission community care

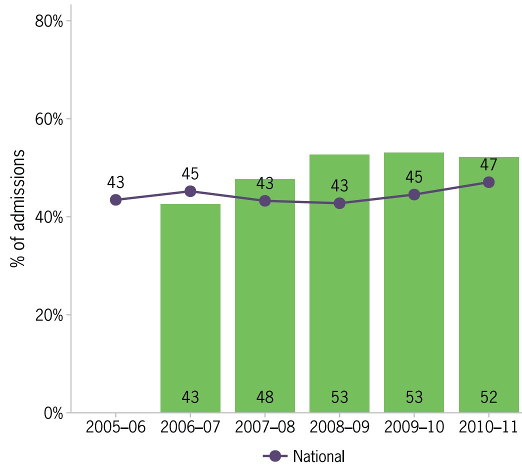


Figure SA10
Rates of post-discharge community care

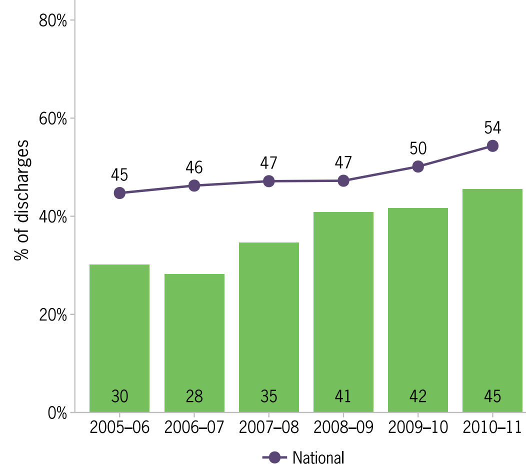


Figure SA11
Average treatment days per three month community care period

Figure SA12
Percentage of population receiving state or territory mental health services

Figure SA13
Percentage of population receiving MBS-subsidised mental health services

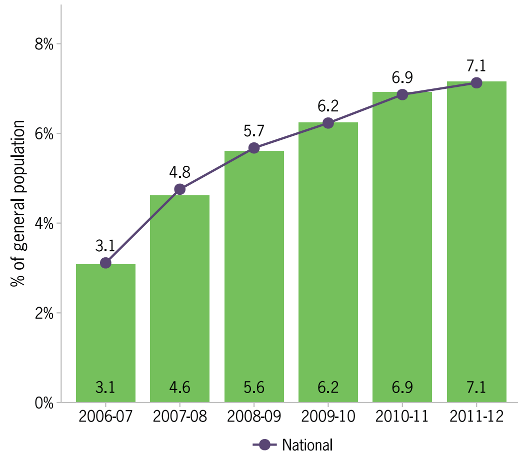


Figure SA14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

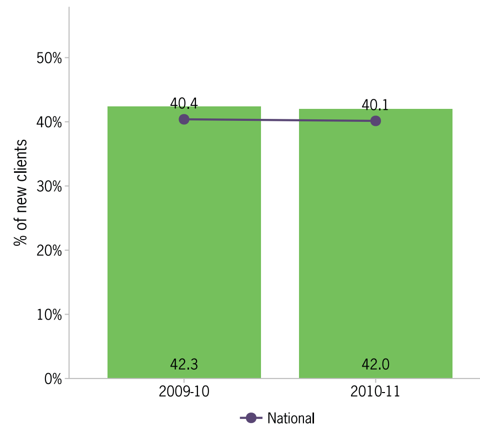


Figure SA15
Mental health outcomes for people who receive treatment from state or territory services

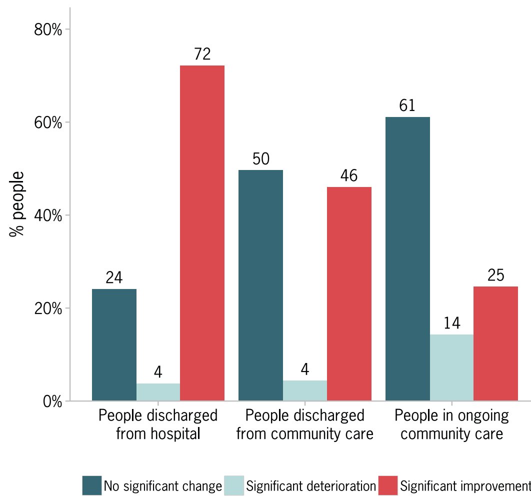


Figure SA16
Proportion of total mental health workforce accounted for by consumer and carer workers

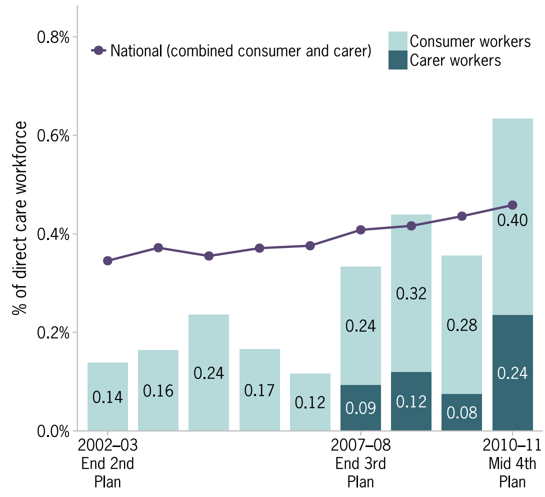


Figure SA17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

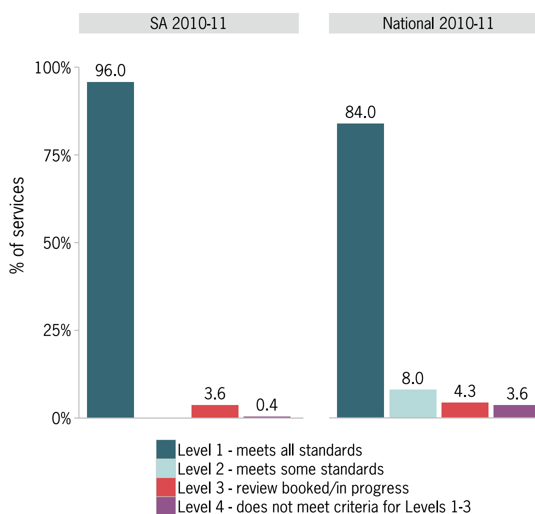
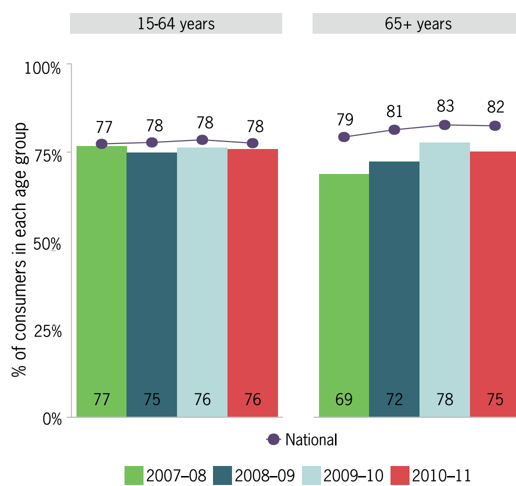


Figure SA18
Percentage of mental health consumers living in stable housing



4.7 Tasmania

Table TAS1
Indicators of mental health reform in Tasmania[a,b,c]

INDICATOR			TASMANIA			AUSTRALIA
			1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE						
State spending on mental health services ($millions)			47	98	116	4,188
State spending per capita ($)			99	198	227	189
Per capita spending rank (1=highest to 8=lowest)			3	2	1	
Average annual per capita spending growth since preceding milestone year (%)				4.9	4.8	4.1
B. SERVICE MIX						
% total service expenditure	– Community services		34	62	59	55
	– Stand-alone psychiatric hospitals		47	-	-	13
	– Colocated general hospitals		19	38	41	32
C. INPATIENT SERVICES						
Total hospital beds			245	128	127	6,755
Per capita expenditure on inpatient care ($)			65	74	87	81
Inpatient beds per 100,000			52	26	25	30
Acute inpatient beds per 100,000			21	20	20	20
Non acute inpatient beds per 100,000			30.6	5.5	5.3	9.7
Stand-alone psychiatric hospitals as % of total beds			67	-	-	31
Average cost per patient day ($)			372	968	1,140	842
D. COMMUNITY SERVICES						
Ambulatory care	– % total service expenditure		18	34	33	41
	– Per capita expenditure ($)		18	65	71	74
NGOs	– % total service expenditure		3.2	11.3	13.5	9.3
	– Per capita expenditure ($)		3	22	29	17
Residential services	– % total service expenditure		12.1	22.4	19.2	6.0
	– Per capita expenditure ($)		12	43	41	11
	– Adult beds per 100,000:	24 hour staffed	7.7	20.0	19.5	6.0
		Non-24 hour staffed	n.a.	23.9	24.6	5.0
	– Older persons' beds per 100,000:	24 hour staffed	85	57	40	23
		Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000			n.a.	5	5	22
E. DIRECT CARE WORKFORCE						
Number Full-time Equivalent (FTE) staff			424	629	675	24,292
FTE per 100,000			90	127	132	108
FTE per 100,000 – ambulatory services			20	39	42	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
% service expenditure covered by Level 1 services			..	55	48	84
G. CONSUMER AND CARER PARTICIPATION						
% services with Level 1 consumer committee representation			-	43	30	55
% total mental health workforce accounted for by consumer workers			n.a.	0.005	0.07	0.28
% total mental health workforce accounted for by carer workers			n.a.	-	0.07	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES						
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)			n.a.	4.1	6.1	6.9
% population seen – GPs			n.a.	3.1	4.7	5.4
% population seen – Consultant Psychiatrists			1.2	0.9	1.0	1.3
% population seen – Clinical Psychologists			-	0.8	1.3	1.1
% population seen – Registered Psychologists and Other allied health professionals			-	1.1	1.8	2.1
Total MBS mental health related benefits paid per capita ($)			n.a.	24	32	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)						
Total PBS/RPBS benefits paid per capita ($)			4	38	44	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure TAS1
Overall spending on mental health

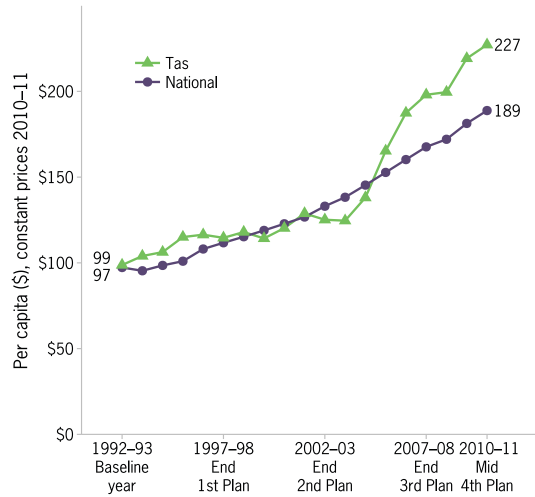


Figure TAS2
Change in spending mix

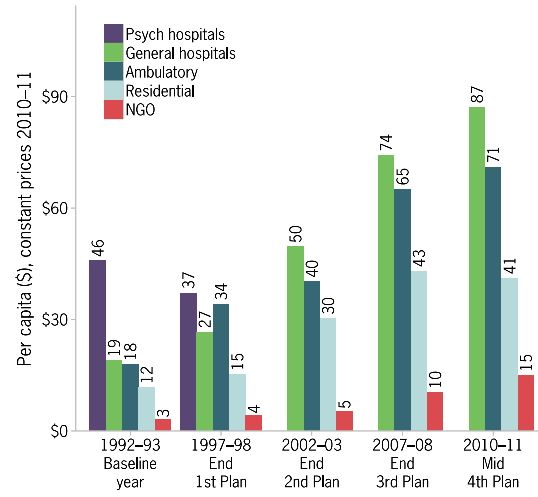


Figure TAS3
Changes in inpatient services

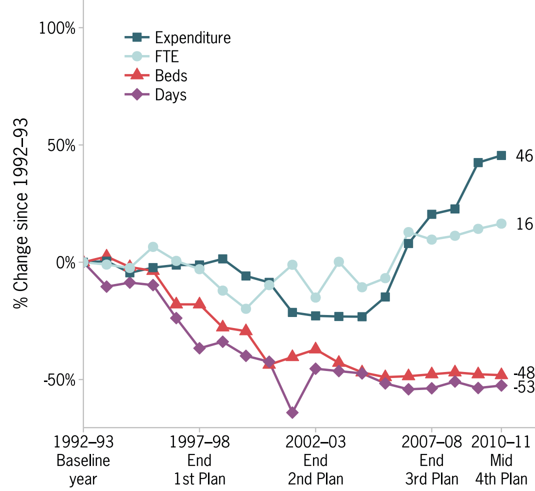


Figure TAS4
Changes in ambulatory care

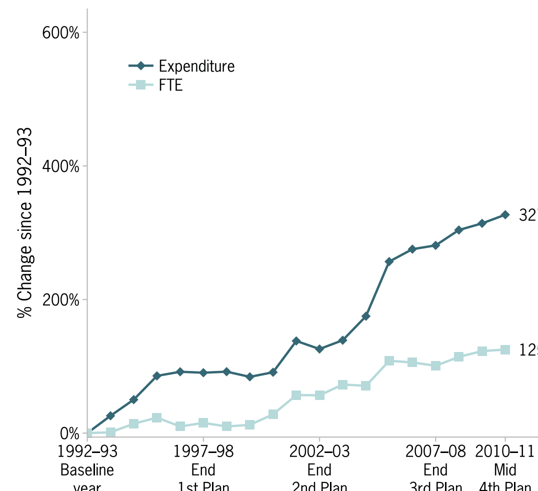


Figure TAS5
Direct care workforce

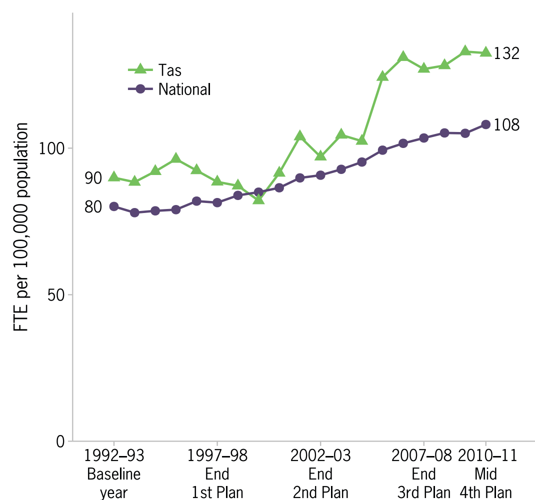


Figure TAS6
Inpatient and residential beds

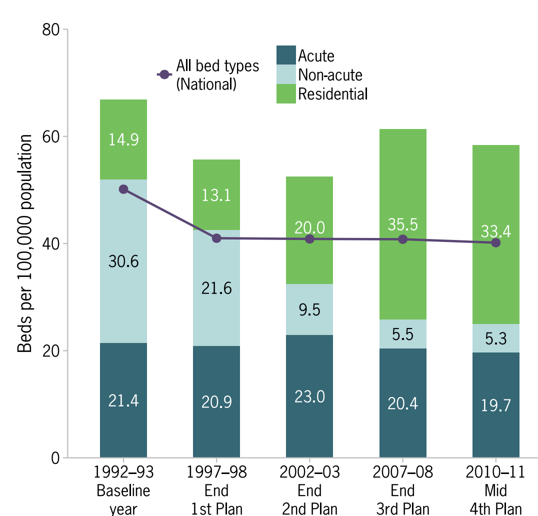


Figure TAS7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

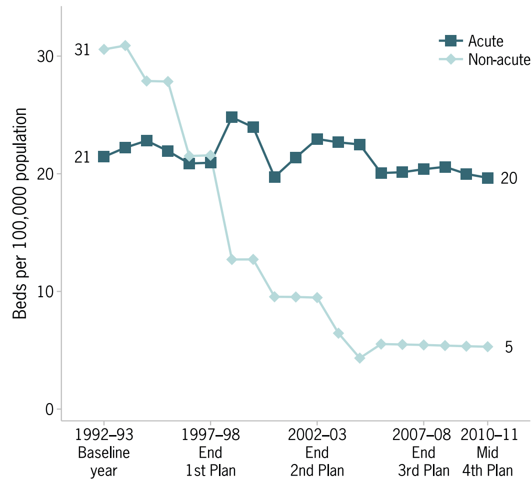


Figure TAS8
Readmission to hospital within 28 days of discharge

Figure TAS9
Rates of pre-admission community care

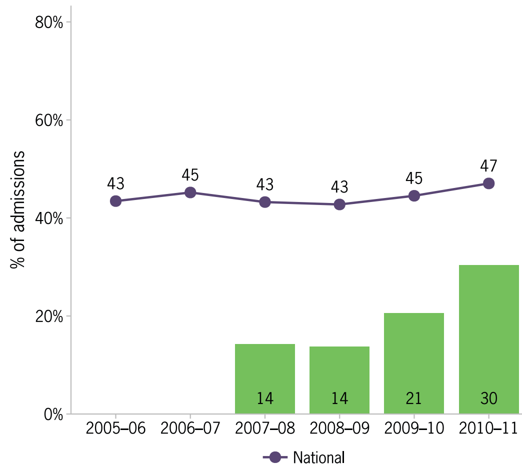


Figure TAS10
Rates of post-discharge community care

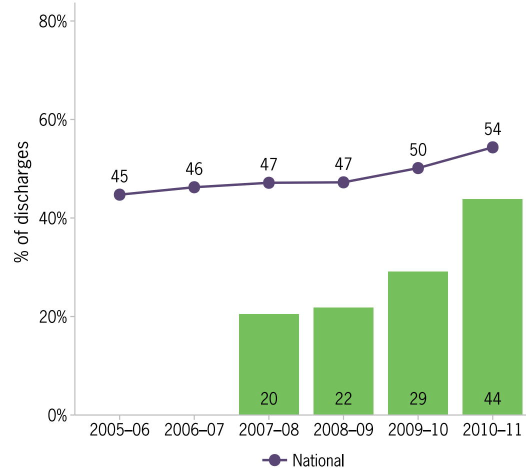


Figure TAS11
Average treatment days per three month community care period

Figure TAS12
Percentage of population receiving state or territory mental health services

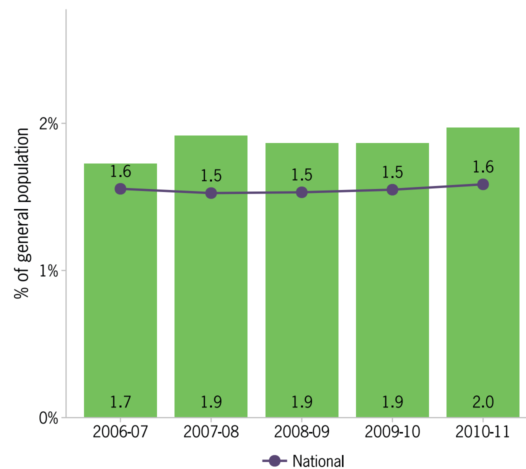


Figure TAS13
Percentage of population receiving MBS-subsidised mental health services

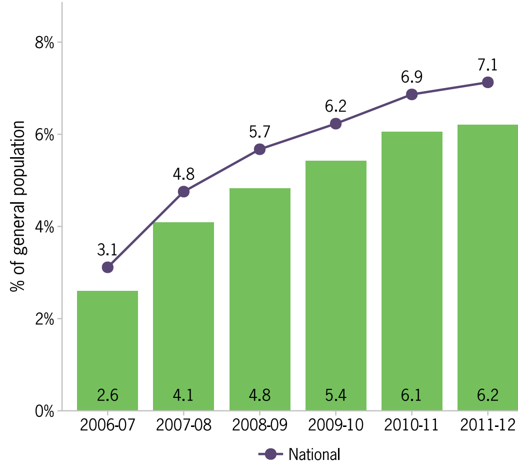


Figure TAS14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

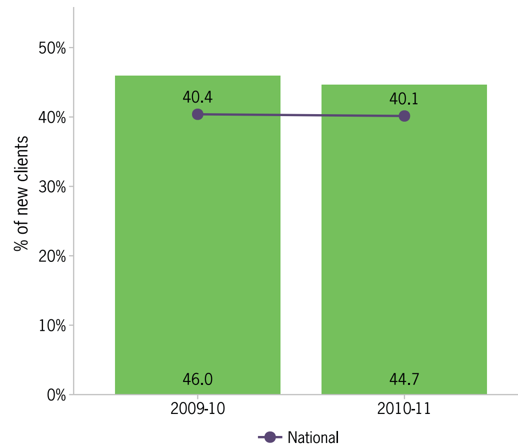


Figure TAS15
Mental health outcomes for people who receive treatment from state or territory services

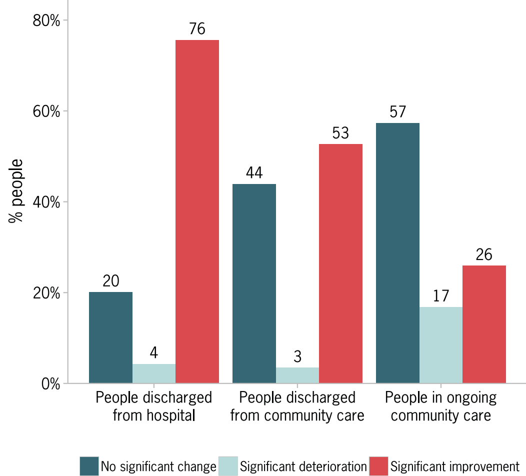


Figure TAS16
Proportion of total mental health workforce accounted for by consumer and carer workers

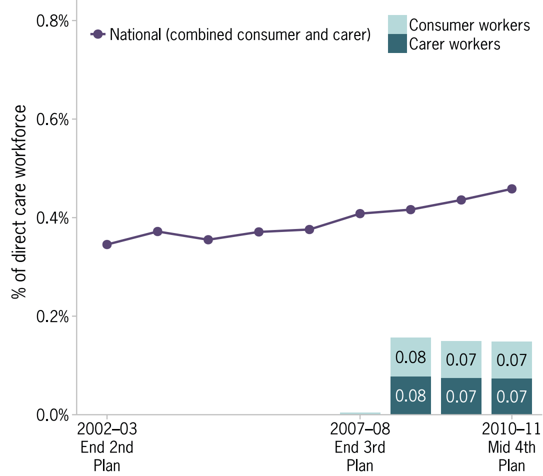


Figure TAS17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

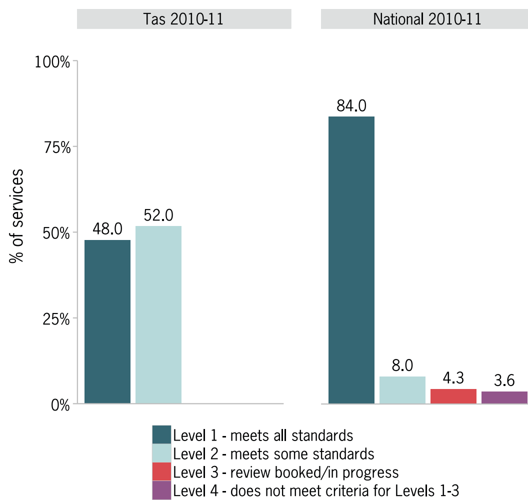
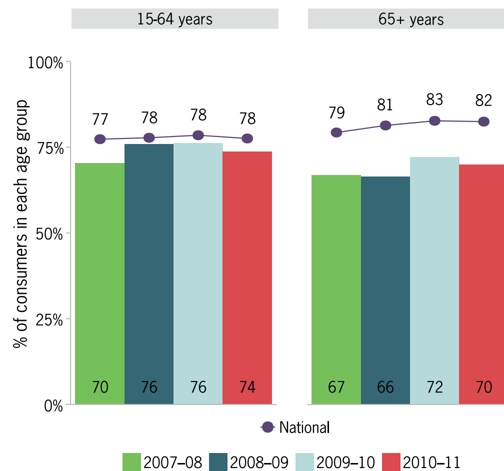


Figure TAS18
Percentage of mental health consumers living in stable housing



4.8 Australian Capital Territory

Table ACT1
Indicators of mental health reform in Australian Capital Territory[a,b,c]

INDICATOR	AUSTRALIAN CAPITAL TERRITORY			AUSTRALIA
	1992-93	2007-08	2010-11	2010-11
A. STATE GOVERNMENT EXPENDITURE				
State spending on mental health services ($millions)	23	63	72	4,188
State spending per capita ($)	79	185	198	189
Per capita spending rank (1=highest to 8=lowest)	8	4	4	
Average annual per capita spending growth since preceding milestone year (%)		6.0	2.3	4.1
B. SERVICE MIX				
% total service expenditure – Community services	59	72	73	55
– Stand-alone psychiatric hospitals	-	-	-	13
– Colocated general hospitals	41	28	27	32
C. INPATIENT SERVICES				
Total hospital beds	52	70	65	6,755
Per capita expenditure on inpatient care ($)	31	51	51	81
Inpatient beds per 100,000	18	20	18	30
Acute inpatient beds per 100,000	18	20	18	20
Non acute inpatient beds per 100,000	-	-	-	9.7
Stand-alone psychiatric hospitals as % of total beds	-	-	-	31
Average cost per patient day ($)	526	936	809	842
D. COMMUNITY SERVICES				
Ambulatory care – % total service expenditure	31	48	47	41
– Per capita expenditure ($)	24	88	89	74
NGOs – % total service expenditure	2.6	14.4	17.3	9.3
– Per capita expenditure ($)	2	26	33	17
Residential services – % total service expenditure	25.4	13.2	14.4	6.0
– Per capita expenditure ($)	19	24	27	11
– Adult beds per 100,000: 24 hour staffed	31.1	13.0	14.2	6.0
Non-24 hour staffed	n.a.	15.1	15.4	5.0
– Older persons' beds per 100,000: 24 hour staffed	-	21	13	23
Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000	n.a.	14	13	22
E. DIRECT CARE WORKFORCE				
Number Full-time Equivalent (FTE) staff	205	315	338	24,292
FTE per 100,000	69	92	93	108
FTE per 100,000 – ambulatory services	23	49	49	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
% service expenditure covered by Level 1 services	..	100	100	84
G. CONSUMER AND CARER PARTICIPATION				
% services with Level 1 consumer committee representation	-	100	100	55
% total mental health workforce accounted for by consumer workers	n.a.	-	-	0.28
% total mental health workforce accounted for by carer workers	n.a.	-	-	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	n.a.	4.0	5.6	6.9
% population seen – GPs	n.a.	2.9	4.2	5.4
% population seen – Consultant Psychiatrists	1.0	1.0	1.1	1.3
% population seen – Clinical Psychologists	-	0.6	1.2	1.1
% population seen – Registered Psychologists and Other allied health professionals	-	1.2	1.8	2.1
Total MBS mental health related benefits paid per capita ($)	n.a.	24	31	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)				
Total PBS/RPBS benefits paid per capita ($)	3	27	29	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure ACT1
Overall spending on mental health

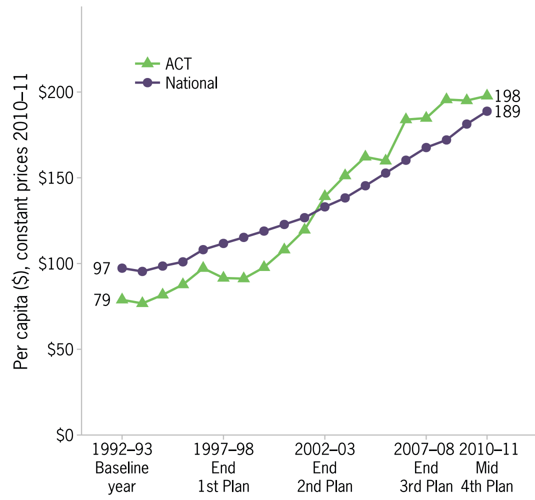


Figure ACT2
Change in spending mix

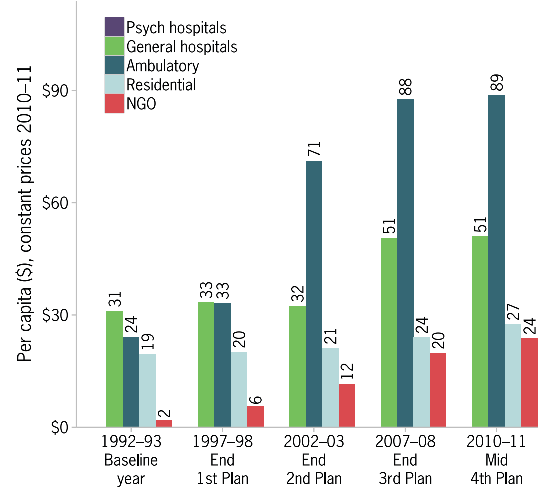


Figure ACT3
Changes in inpatient services

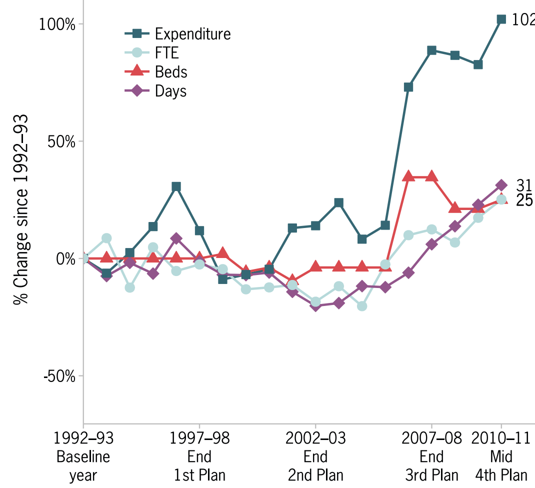


Figure ACT4
Changes in ambulatory care

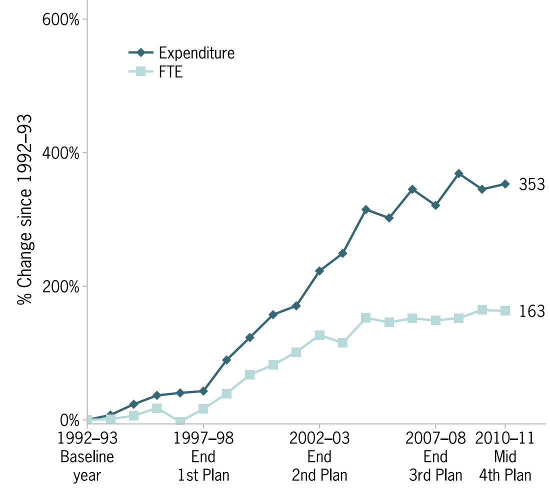


Figure ACT5
Direct care workforce

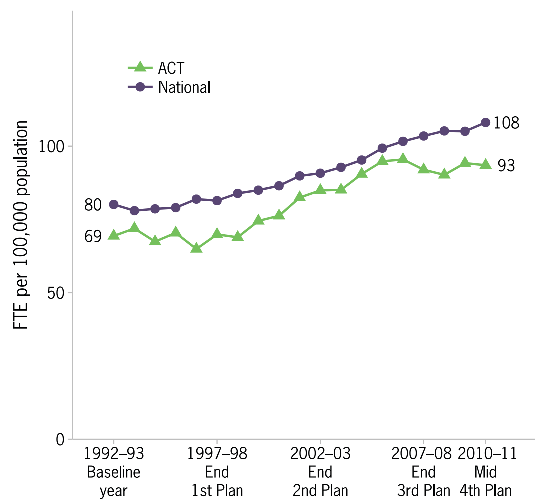


Figure ACT6
Inpatient and residential beds

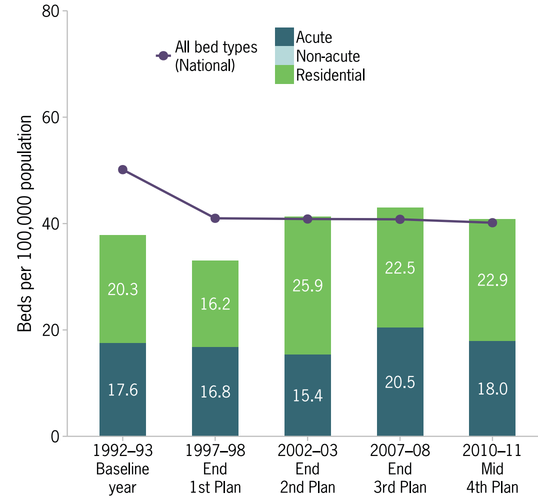


Figure ACT7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

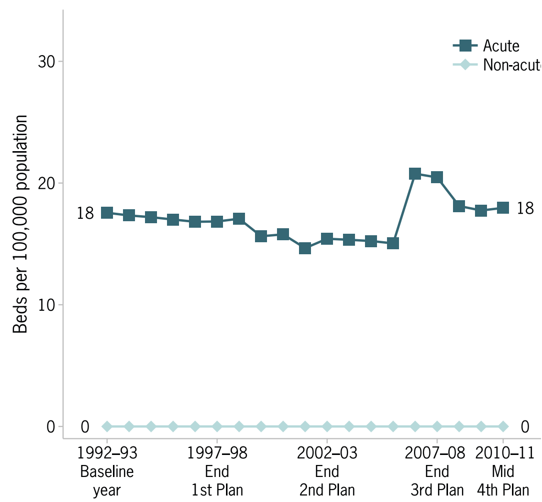


Figure ACT8
Readmission to hospital within 28 days of discharge

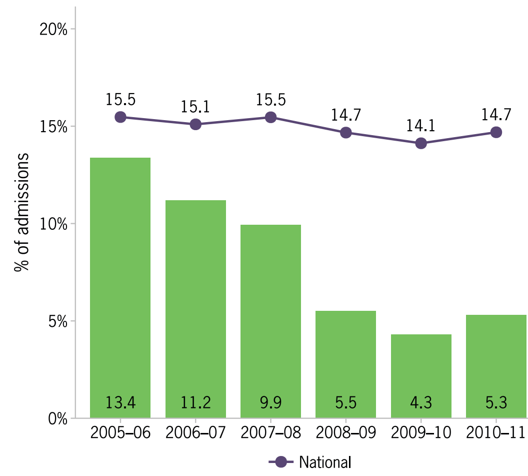


Figure ACT9
Rates of pre-admission community care

Figure ACT10
Rates of post-discharge community care

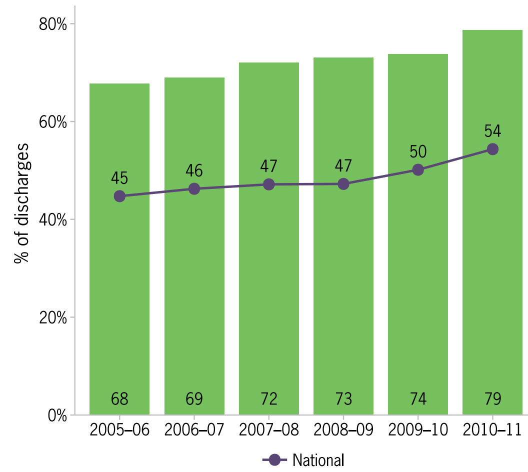


Figure ACT11
Average treatment days per three month community care period

Figure ACT12
Percentage of population receiving state or territory mental health services

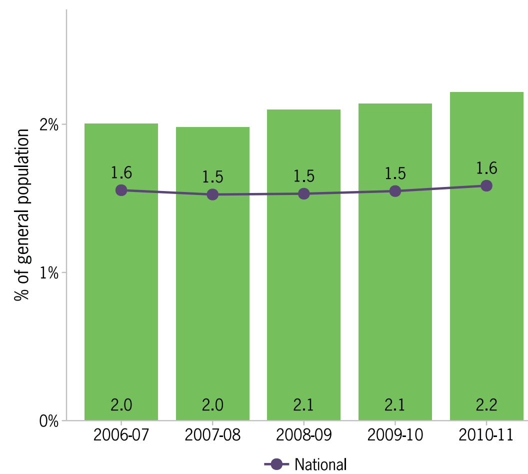


Figure ACT13
Percentage of population receiving MBS-subsidised mental health services

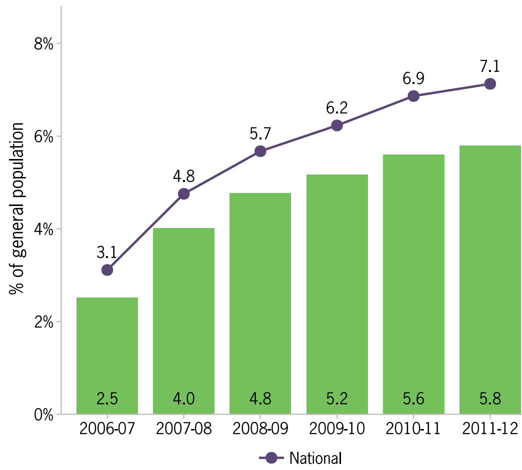


Figure ACT14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

Figure ACT15
Mental health outcomes for people who receive treatment from state and territory services

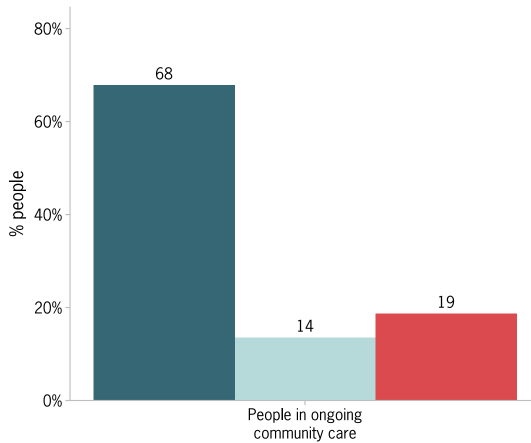


Figure ACT16
Proportion of total mental health workforce accounted for by consumer and carer workers

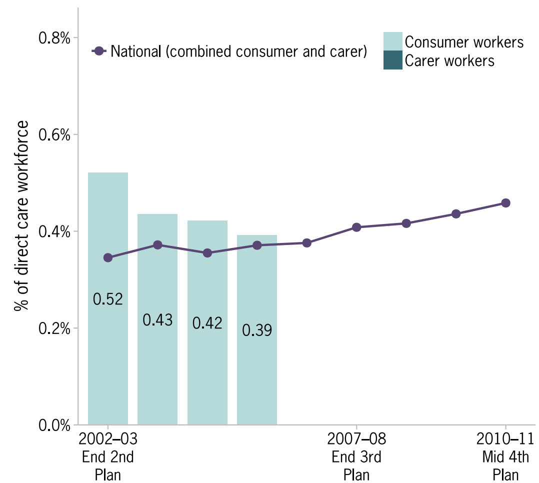


Figure ACT17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

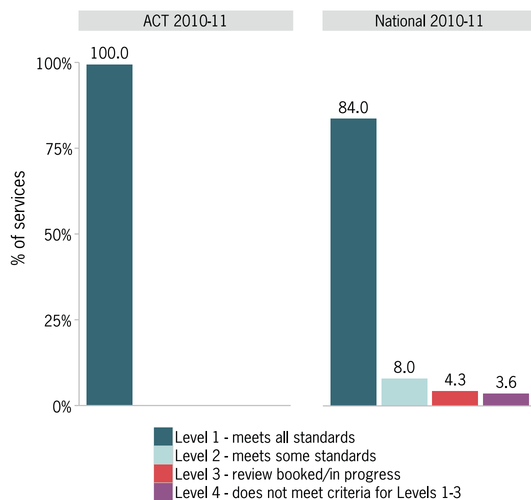
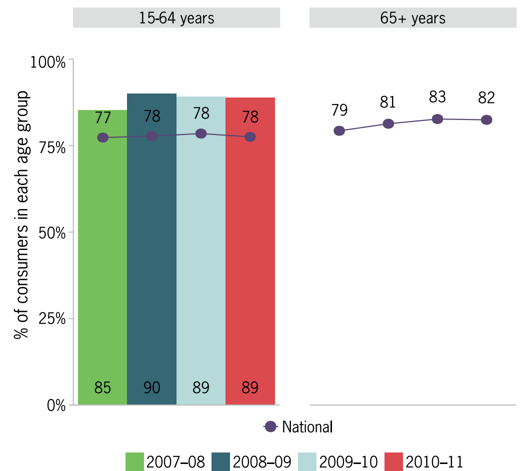


Figure ACT18
Percentage of mental health consumers living in stable housing



4.9 Northern Territory

Table NT1
Indicators of mental health reform in Northern Territory[a,b,c]

INDICATOR			NORTHERN TERRITORY 1992-93	NORTHERN TERRITORY 2007-08	NORTHERN TERRITORY 2010-11	AUSTRALIA 2010-11
A. STATE GOVERNMENT EXPENDITURE						
State spending on mental health services ($millions)			14	36	43	4,188
State spending per capita ($)			82	167	187	189
Per capita spending rank (1=highest to 8=lowest)			7	5	5	
Average annual per capita spending growth since preceding milestone year (%)				5.1	3.8	4.1
B. SERVICE MIX						
% total service expenditure	– Community services		44	65	64	55
	– Stand-alone psychiatric hospitals		-	-	-	13
	– Colocated general hospitals		56	35	36	32
C. INPATIENT SERVICES						
Total hospital beds			41	34	33	6,755
Per capita expenditure on inpatient care ($)			43	58	62	81
Inpatient beds per 100,000			24	16	14	30
Acute inpatient beds per 100,000			15	16	14	20
Non acute inpatient beds per 100,000			8.8	-	-	9.7
Stand-alone psychiatric hospitals as % of total beds			-	-	-	31
Average cost per patient day ($)			717	1,149	1,242	842
D. COMMUNITY SERVICES						
Ambulatory care	– % total service expenditure		43	51	52	41
	– Per capita expenditure ($)		34	85	91	74
NGOs	– % total service expenditure		1.1	13.5	12.1	9.3
	– Per capita expenditure ($)		1	22	21	17
Residential services	– % total service expenditure		-	1.4	3.6	6.0
	– Per capita expenditure ($)		-	2	6	11
	– Adult beds per 100,000:	24 hour staffed	-	3.4	9.6	6.0
		Non-24 hour staffed	n.a.	-	-	5.0
	– Older persons' beds per 100,000:	24 hour staffed	-	-	-	23
		Non-24 hour staffed	n.a.	-	-	0.4
Supported public housing places per 100,000			n.a.	15	25	22
E. DIRECT CARE WORKFORCE						
Number Full-time Equivalent (FTE) staff			120	168	205	24,292
FTE per 100,000			71	77	89	108
FTE per 100,000 – ambulatory services			26	44	44	47
F. IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
% service expenditure covered by Level 1 services			..	100	100	84
G. CONSUMER AND CARER PARTICIPATION						
% services with Level 1 consumer committee representation			-	100	100	55
% total mental health workforce accounted for by consumer workers			n.a.	-	-	0.28
% total mental health workforce accounted for by carer workers			n.a.	-	-	0.18
H. MEDICARE SUBSIDISED MENTAL HEALTH SERVICES						
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)			n.a.	1.8	2.9	6.9
% population seen – GPs			n.a.	1.4	2.4	5.4
% population seen – Consultant Psychiatrists			0.1	0.3	0.4	1.3
% population seen – Clinical Psychologists			-	0.1	0.3	1.1
% population seen – Registered Psychologists and Other allied health professionals			-	0.4	0.7	2.1
Total MBS mental health related benefits paid per capita ($)			n.a.	6	11	38
I. PBS-FUNDED PHARMACEUTICALS (including RPBS)						
Total PBS/RPBS benefits paid per capita ($)			1	13	14	38

(a) 'n.a.' Signifies that the indicator is not available because relevant national data were not collected;
(b) '..' Indicates that the indicator is not applicable for the year on a comparable basis to other reported years;
(c) '–' Indicates zero.

Figure NT1
Overall spending on mental health

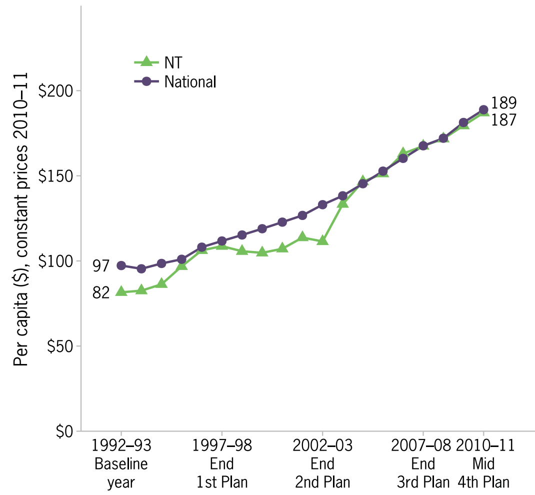


Figure NT2
Change in spending mix

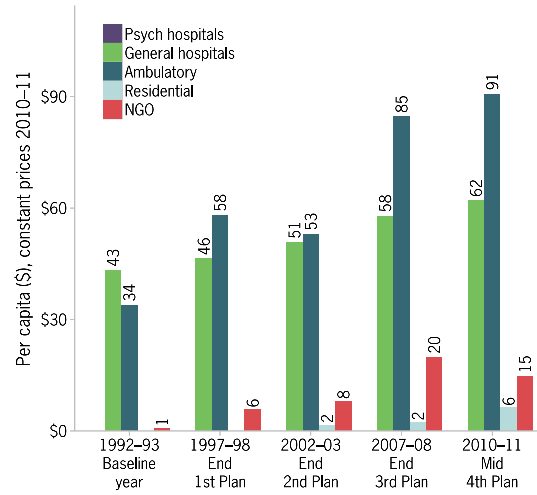


Figure NT3
Changes in inpatient services

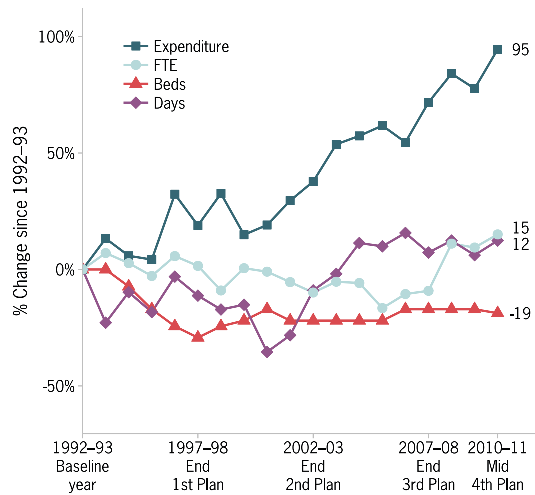


Figure NT4
Changes in ambulatory care

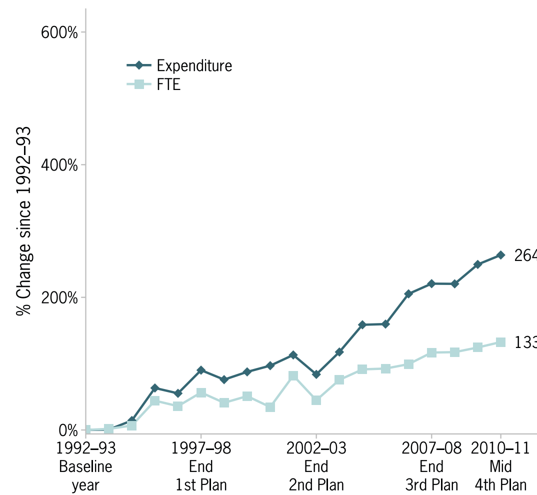


Figure NT5
Direct care workforce

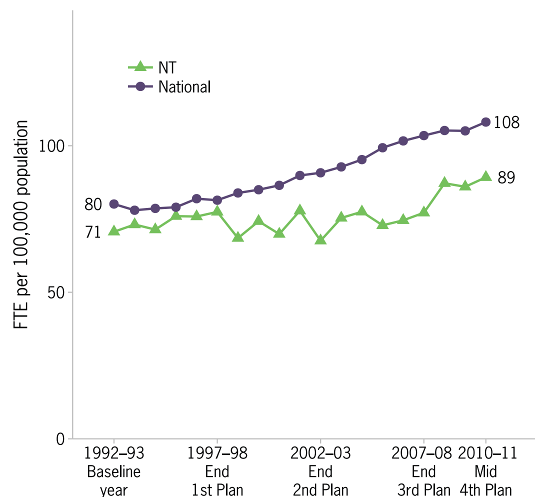


Figure NT6
Inpatient and residential beds

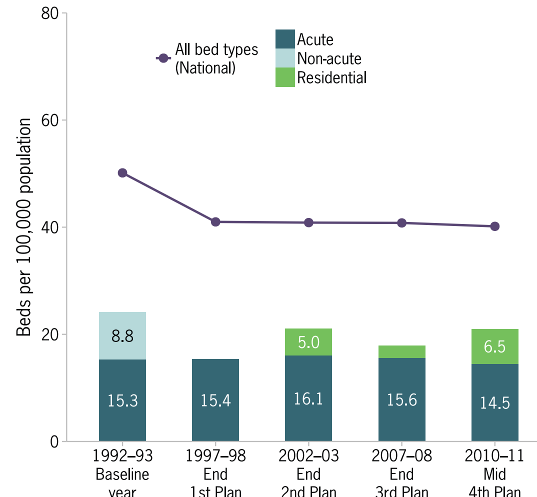


Figure NT7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

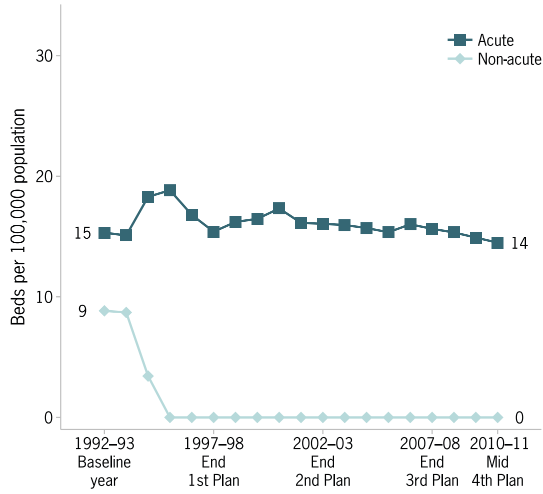


Figure NT8
Readmission to hospital within 28 days of discharge

Figure NT9
Rates of pre-admission community care

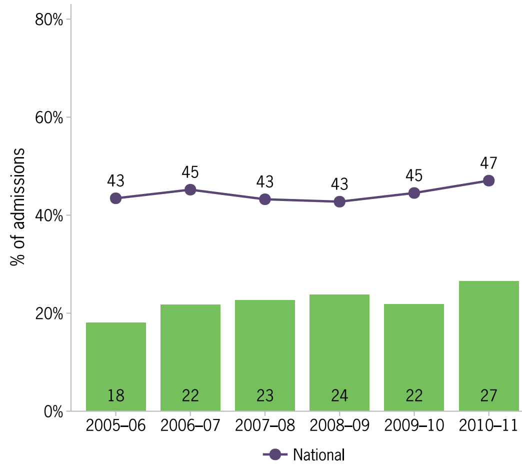


Figure NT10
Rates of post-discharge community care

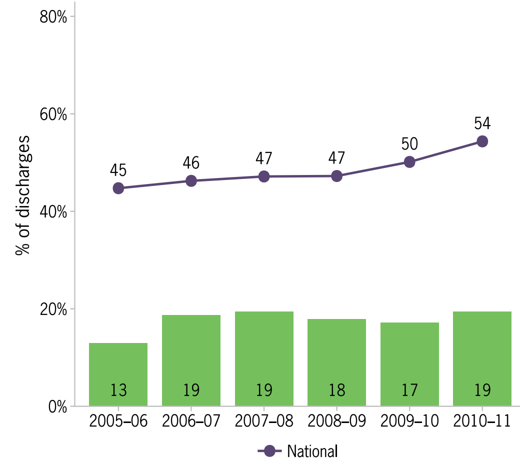


Figure NT11
Average treatment days per three month community care period

Figure NT12
Percentage of population receiving state or territory mental health services

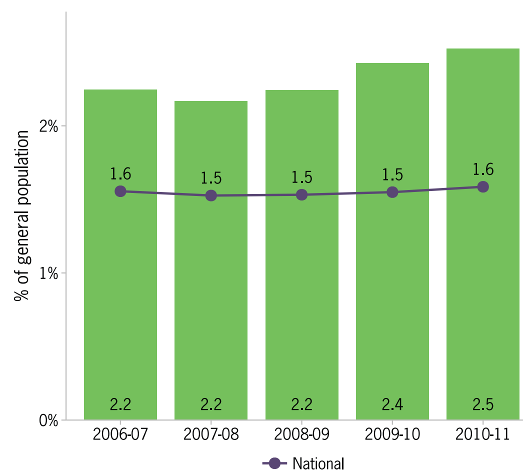


Figure NT13
Percentage of population receiving MBS-subsidised mental health services

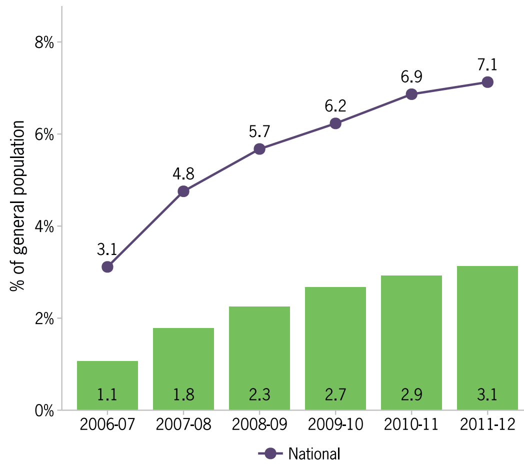


Figure NT14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

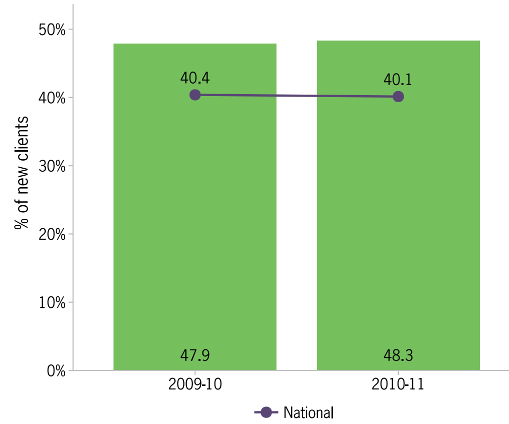


Figure NT15
Mental health outcomes for people who receive treatment from state or territory services

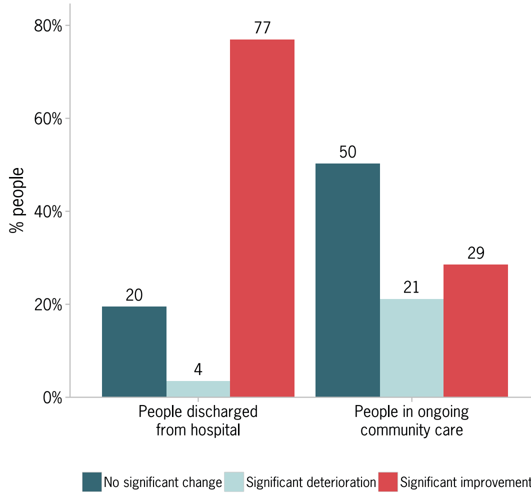


Figure NT16
Proportion of total mental health workforce accounted for by consumer and carer workers

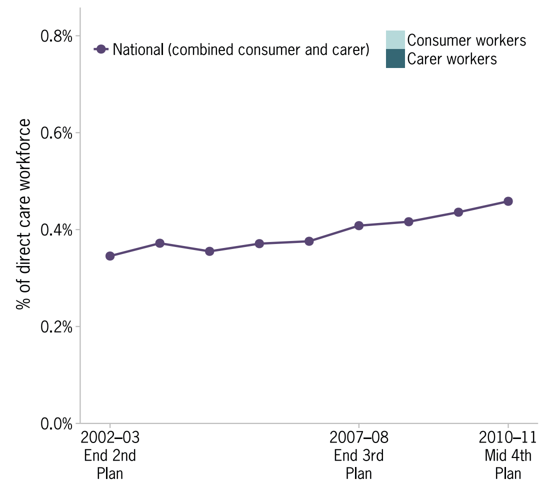


Figure NT17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

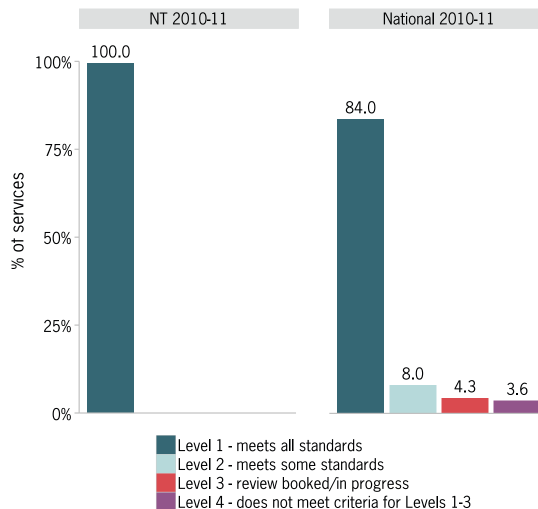
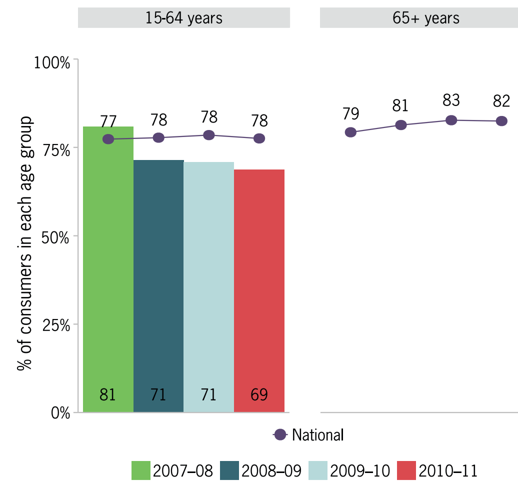
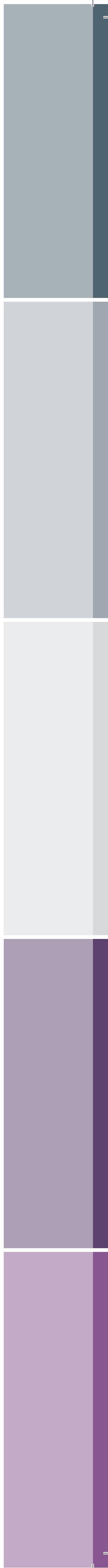
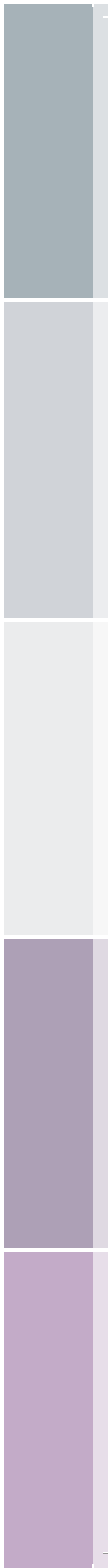


Figure NT18
Percentage of mental health consumers living in stable housing





Appendix 1: Data sources and explanatory notes for Part 2



Introduction

The following notes have been prepared to assist in the interpretation of the figures and tables presented in Part 2 System-level indicators of mental health reform in Australia, 1993 to 2011.

Table A1-1 provides summary information about the data sources used, and which figures and tables are based on each source. Table A1-2 provides further explanatory detail regarding the derivation of the data presented in each figure or table.

The majority of figures and tables presented in Part 2 are derived from data tables published in the Australian Institute of Health and Welfare's Mental Health Services in Australia (MHSiA)22 series of annual mental health reports that describe the activity and characteristics of Australia's mental health care services. MHSiA presents analyses of data from a range of sources including, but not limited to, the Mental Health Care National Minimum Data Sets (NMDSs). These NMDSs cover specialised community and residential mental health care, mental health care for patients admitted to public and private hospitals, and the facilities providing these services. In many cases the data presented in the National Mental Health Report can be extracted directly from the MHSiA tables. In some cases the data have been subject to additional analyses which may have been supplemented by unpublished data.

Data sources and explanatory notes

Table A1-1
Overview of data sources, in alphabetical order

Data source	Description	Relevant figures and tables
Australian Government analyses of jurisdiction data	Analyses undertaken by the Department of Health and Ageing and the Productivity Commission based on data submitted by jurisdictions.	Figures 3-10, 14-20, 22, 24-30, 32-33, 40-43 Tables 2, 3, 5
Australian Government analyses of mental health program data	Analyses undertaken by the Department of Health and Ageing based on data from mental health programs and other published or unpublished material.	Figures 3-9, 34-38 Tables 2, 4, 6
Community Mental Health Care National Minimum Data Set[73]	The Community Mental Health Care National Minimum Data Set includes data about service contacts provided by specialised mental health services 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. It is collated by the Australian Institute of Health and Welfare.	Figure 31
Medicare Benefits Schedule data[74]	Data on the number of people receiving relevant Medicare-funded services are provided by the Australian Government Department of Health and Ageing, based on billing data maintained by Medicare Australia.	Figures 3, 36-39
National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection 2005–06 to 2010–11[75]	The National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) is an annual collection describing the attributes of all specialised mental health services managed or funded by State or Territory health authorities. Data are provided by jurisdictions, and collated by the Australian Institute of Health and Welfare. Data from the NMDS-MHE used in this report cover the period 2005–06 to 2010–11. From 1993-94 to 2004-05, these data were collated as part of the National Survey of Mental Health Services Database maintained by the Australian Government Department of Health and Ageing.	Figures 3-30, 33, 40-43 Tables 2, 3, 5
Private Health Establishments collection[76]	The Private Health Establishments collection is an annual survey which collects information about the activities, staffing and finances of all private hospitals in Australia, conducted by the Australian Bureau of Statistics.	Figures 3-7, 34 Table 6

Table A1-2
Explanatory notes to figures and tables presented Part 2.

Indicator(s)	Notes
National spending on mental health	
Figure 3: Distribution of recurrent spending on mental health, 2010-11 ($millions)	**(a)** Data source: MHSiA Tables 14.31 (national expenditure) and 14.21 (Australian Government expenditure). Calculation of the proportion of total health expenditure directed to mental health includes only government and private health insurance revenue sources.
Figure 4: National spending on mental health, 2010-11	**(b)** Data source: Department of Health and Ageing analysis based on data from MHSiA Tables 14.2 (state and territory expenditure), 14.14 (private hospital services) and 14.28 (Australian Government expenditure).
Figure 5: National expenditure on mental health by source of funds, 1992-93 to 2010-11 ($millions)	**(c)** Data source: MHSiA Table 14.31.
Figure 6: Cumulative growth in government spending on health and mental health, 1992-93 to 2010-11	**(d)** Data source: Department of Health and Ageing analysis based on data from MHSiA Table 14.31. Mental health spending excludes funding administered by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Excludes capital expenditure from national health accounts.
Figure 7: Drivers of growth in expenditure on mental health by the Australian Government under the National Mental Health Plans, 1992-93 to 2010-11	**(e)** Data source: MHSiA Tables 14.31 and 14.28. Percentage growth over each defined period is calculated as: 100 x (Expenditure in final year of period – Expenditure in final year of preceding period)/Expenditure in final year of preceding period.
Table 2: Recurrent expenditure on mental health services by state and territory governments, 1992-93 to 2010-11 ($millions)	**(f)** Data source: MHSiA Table 14.30. Excludes Australian Government dedicated mental health funding to states and territories but includes revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and non-specific Australian Government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments.
Figure 8: Average per capita expenditure by state and territory governments, 1992-93 to 2010-11 ($)	**(g)** Data source: MHSiA Table 14.30.
Figure 9: Per capita expenditure by state and territory governments, 1992-93 and 2010-11 ($)	**(h)** Data source: MHSiA Table 14.30.
Figure 10: National summary of state and territory government mental health expenditure by program type, 2010-11	**(i)** Data source: MHSiA Tables 14.11 (target population expenditure) and 14.2 (Other indirect and NGO expenditure). Youth mental health services (0.2% of total state and territory mental health expenditure) have been included in child and adolescent mental health services. NGO expenditure excludes residential services managed by the NGO sector. This expenditure is targeted mainly at the adult population.
Figure 11: Per capita expenditure by states and territories on general adult mental health services ($), 2010-11	**(j)** Data source: MHSiA Table 14.12. **(k)** Estimated expenditure for each age specific population is based on the classification of services reported to the National Minimum Data Set – Mental Health Establishments collection, not the age of the consumers treated. **(l)** Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry. **(m)** Per capita rates based on age specific population denominators.

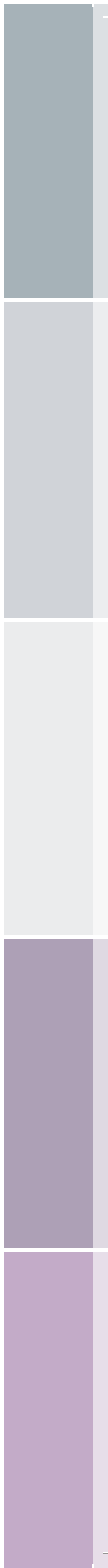
Indicator(s)	Notes
Figure 12: Per capita expenditure by states and territories on child and adolescent mental health services ($), 2010-11	**(n)** Data source: MHSiA Table 14.12. **(o)** As per notes **(k)-(m)** above.
Figure 13: Per capita expenditure by states and territories on older persons' mental health services ($), 2010-11	**(p)** Data source: MHSiA Table 14.12. **(q)** As per notes **(k)-(m)** above. **(r)** Specialised older persons' mental health services are not available in the Northern Territory.
National workforce trends	
Figure 14: Number of direct care staff (FTE) employed in state and territory mental health service delivery, 1992-93 to 2010-11	**(s)** Data source: MHSiA Table 12.40. 'Direct care staff' include those within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'.
Figure 15: Number of direct care staff (FTE) employed in state and territory mental health service delivery per 100,000, 1992-93 to 2010-11	**(t)** Data source: MHSiA Table 12.41.
Table 3: Change in the health professional workforce (FTE) in state and territory mental health services, 1994-95 to 2010-11	**(u)** Data source: MHSiA Table 12.36. **(v)** Totals differ slightly from those in Figure 14 because they do not include other personal care staff and do include a small number of staff employed at the organisational level.
Figure 16: Growth in service expenditure compared with growth in direct care staff (FTE), 1992-93 to 2010-11	**(w)** Data source: MHSiA Tables 12.40 (FTE) and 14.3 (expenditure). Total expenditure is calculated as the sum of expenditure for the following categories: Public Psychiatric Hospital + Specialised psychiatric units or wards in public acute hospitals + Community mental health care services + Residential mental health services. NGO services are out of scope.
Table 4: Health professional direct care workforce (FTE) in Australian Government funded primary mental health care and private hospitals, 2010-11	**(x)** Data source: Australian Government analyses of mental health program data. Analysis based on data describing workforce involved in delivering relevant services under the Medicare Benefits Schedule, Access to Allied Psychological Services (ATAPS) program, and the Mental Health Nurse Incentive Program (MHNIP). Primary mental health care FTE excludes general practitioners because their numbers cannot be accurately estimated. Primary mental health care FTE excludes providers funded through the Department of Veterans Affairs, or providers offering services through headspace, the National Youth Mental Health Foundation. Private hospital FTE excludes psychiatrists and other medical practitioners with admitting rights who work in private hospitals on a fee for service basis through the Medicare Benefits Schedule.
Trends in state and territory mental health services	
Figure 17: Distribution of total state and territory expenditure on mental health services, 1992-93 to 2010-11	**(y)** Data source: MHSiA Table 14.3. **(z)** Prior to 1999-00, all services provided by NGOs were reported only in terms of total funds allocated by state and territory governments. Commencing in 1999-00, staffed residential units managed by the sector began to report separately and were grouped with 'government managed' residential services in previous *National Mental Health Reports*. **(aa)** For this analysis, NGO estimates exclude staffed residential services managed by NGOs for 2002-03, 2007-08 and 2010-11. These amounts are reported in the residential service category. Excludes Other indirect expenditure category shown in MHSiA Table 14.3.

Indicator(s)	Notes
Figure 18: Changes in resourcing of ambulatory care services, 1992-93 to 2010-11	**(ab)** Data source: MHSiA Tables 14.3 (expenditure) and 12.40 (FTE).
Figure 19: Full-time equivalent (FTE) direct care staff per 100,000 population employed in ambulatory mental health care services, 1992-93 to 2010-11	**(ac)** Data source: MHSiA Table 12.41.
Figure 20: Percentage of total mental health services expenditure allocated to non-government organisations, 1992-93 to 2010-11	**(ad)** Data source: MHSiA Tables 14.3 (expenditure) and 14.10 (residential services delivered by NGOs). As per note **(z)** above. For this analysis, funding to NGO-managed staffed residential services has been combined with non-residential NGO programs to ensure greater consistency in monitoring the 18 year spending trends. The estimate of expenditure allocated to NGOs in this figure differs from that in Figure 17 because, in the latter, NGO-managed residential programs are grouped with other residential services. NGO expenditure includes Total grants to NGOs plus expenditure on the component of residential services delivered by NGOs. Total state and territory expenditure is calculated as Total expenditure less Other indirect expenditure. Classification of service types is based on a national taxonomy for funded mental health NGO programs developed in 1999. Service grants are classified by states and territories when reported to the National Minimum Data Set – Mental Health Establishments collection.
Figure 21: Types of services funded by state and territory grants to non-government organisations, 2010-11	**(ae)** Data source: MHSiA Table 14.15.
Figure 22: Total beds in general adult and older persons' residential services, 1992-93 to 2010-11	**(af)** Data source: MHSiA Table 12.19. No graphic is provided for child and adolescent beds because they are very few in number (13). Data on 'less than 24 hour staffed' beds not available prior to 1999-00.
Figure 23: Number of beds per 100,000 in general adult and older persons' residential services by jurisdiction, 2010-11	**(ag)** Data source: MHSiA Table 12.18. No graphic is provided for child and adolescent beds because they are very few in number (13). Estimation of per capita rates is based on age specific populations for each target group: • General adult (based on population aged 18-64 years); and • Older persons (based on population aged 65 years and over). Caution is required when interpreting residential services data for Queensland. A substantial number of general adult beds in Queensland that meet the definition of beds in staffed residential services were reported by Queensland as non-acute inpatient beds. Queensland has foreshadowed that it will review reporting of these beds in future years.
Figure 24: Growth in supported public housing places (absolute and per 100,000), 2002-03 to 2010-11	**(ah)** Data source: MHSiA Table 12.26. **(ai)** Number of places refers to the number of persons who can be accommodated, not the number of houses.
Figure 25: Number of supported public housing places per 100,000 by state and territory, 2010-11	**(aj)** Data source: MHSiA Table 12.26. As per note **(ai)** above.

Indicator(s)	Notes
Figure 26: Acute and non-acute psychiatric inpatient beds per 100,000, 1992-93 to 2010-11	**(ak)** Data source: MHSiA Table 12.14. Acute and non-acute bed totals are calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals.
Figure 27: Total psychiatric inpatient beds per 100,000 by target population, 1993-94 to 2010-11	**(al)** Data source: MHSiA Table 12.17. Estimation of per capita rates is based on age specific populations for each target group: • General adult (based on population aged 18-64 years); • Child and adolescent (based on population aged 0-17 years); • Older persons (based on population aged 65 years and over); and • Forensic (based on target population aged 18 years and over). General adult beds include a small number of youth beds in 2010-11. General adult beds include a small number of youth beds in 2010-11. Data available from 1993-94 onwards.
Figure 28: Average costs per day in psychiatric inpatient units, 1992-93 to 2010-11	**(am)**Data source: MHSiA Table 14.7.
Figure 29: Changes in the number of psychiatric inpatient beds, patient days, expenditure and direct care full-time equivalent staff relative to 1992-93	**(an)** Data source: MHSiA Tables 12.3 (inpatient beds), 12.27 (inpatient days), 12.40 (direct care FTE) and 14.3 (expenditure). Growth in total inpatient services is calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals (Table 14.3). FTE is for Hospital admitted patient services (Table 12.40).
Figure 30: Average number of direct care staff (FTE) per bed, psychiatric inpatient units, 1992-93 to 2010-11	**(ao)** Data source: MHSiA Tables 12.27 (inpatient days) and 12.40 (total inpatient direct care FTE).
Table 5: Inpatient and community residential beds per 100,000 population, 2010-11	**(ap)** Data source: MHSiA Tables 12.14 (total acute and non-acute inpatient beds per capita), 12.17 (inpatient beds per capita by target population), and 12.20 (residential beds). Estimation of per capita rates is based on age specific populations for each target group: • General adult (based on population aged 18-64 years); • Child and adolescent (based on population aged 0-17 years); • Older persons (based on population aged 65 years and over); and • Forensic (based on target population aged 18 years and over). Residential beds includes both 24 hour and Less than 24 hour staffed beds, separately identified.
Figure 31: Number of service contacts provided, 2001-02 to 2010-11, and number of people seen by state and territory community mental health services, 2006-07 to 2010-11	**(aq)** Data source for service contacts: MHSiA Table 4.2. Includes unregistered contacts. Not all jurisdictions report unregistered contacts and reporting practices may have changed over time. **(ar)** Data source for number of people seen by state and territory community mental health services: As provided by states and territories to Department of Health and Ageing for National Mental Health Report purposes. Note that there are small discrepancies for some jurisdictions compared with data provided to the AIHW and published in MHSiA Tables 4.1 and 4.2.
Figure 32: Average number of treatment days per three month period of community mental health care, 2005-06 to 2010-11	**(as)** Data source: Report on Government Services 2013[28] Table 12A.45.

Indicator(s)	Notes
Figure 33: Total number of patient days in psychiatric inpatient settings, 1992-93 to 2010-11	**(at)** Data source: MHSiA Table 12.27.
Trends in private sector mental health services	
Table 6: Activity in private hospitals with psychiatric units, 1992-93 to 2010-11	**(au)** Data source: MHSiA Table 12.25.
Figure 34: Selected indicators of change in the private psychiatric hospital sector, 1992-93 to 2010-11	**(av)** Data source: MHSiA Tables 12.25 (beds, patients days, staffing) and 14.14 (expenditure). Data for 2007-08 describing beds, patients days, and staffing were not available because the Private Health Establishments Collection was not conducted.
Figure 35: MBS expenditure on mental health services ($millions), 1992-93 to 2010-11	**(aw)** Data source: MHSiA Table 14.28.
Figure 36: Distribution of MBS expenditure on mental health services, 1992-93 to 2010-11	**(ax)** Data source: MHSiA Table 14.17. **(ay)** 2007-08 was the first full year of operation of the Better Access program.
Figure 37: Number of people treated by MBS-subsidised mental health service providers, 2006-07 to 2011-12	**(az)** Data source: MHSiA Table 6.3. **(ba)** Data are shown from 2006-07 only, because a significant component of the data includes services provided under Better Access program, which commenced on November 1 2006. As per note **(ay)** above.
Figure 38: Number of people treated by MBS-subsidised mental health service providers, by provider type, 2011-12	**(bb)** Data source: MHSiA Table 6.3. The sum of people seen by individual provider groups will be greater than the total number of people seen MBS-subsidised services shown in Figure 37 because an individual may consult more than one type of provider. As per note **(ay)** above.
Figure 39: Number of MBS-subsidised mental health services provided, by provider type, 2006-07 to 2011-12	**(bc)** Data source: MHSiA Table 6.9. As per notes **(ay)** and **(ba)** above.
Consumer and carer participation in mental health care	
Figure 40: Consumer committee representation within mental health service organisations, 1993-94 to 2010-11	**(bd)** Data source: MHSiA Table 12.8. Data are available from 1993-94.
Figure 41: Other participation arrangements for consumers and carers, 1998-99 to 2010-11	**(be)** Data source: MHSiA Tables 12.9 (consumers) and 12.10 (carers).
Figure 42: Number of full-time equivalent consumer and carer workers employed in state and territory mental health services, 2002-03 to 2010-11	**(bf)** Data source: MHSiA Table 12.36.
Figure 43: Consumer and carer workers employed per 1,000 full-time equivalent direct care staff, 2002-03 to 2010-11	**(bg)** Data source: MHSiA Table 12.36. Calculated as 1000 x Consumer (or carer) worker FTE/ Sum of all staff categories excluding Administrative and clerical staff and Domestic and other staff.

Appendix 2: Data sources and explanatory notes for Part 3



Introduction

The following notes have been prepared to assist in the interpretation of the data measuring each of the *Fourth National Mental Health Plan* indicators presented in Part 3 Monitoring progress and outcomes under the *Fourth National Mental Health Plan*.

Table A2-1 provides summary information about the data sources used, and which indicators are based on each source. Table A2-2 provides further explanatory detail regarding the derivation of each indicator. The table does not include information about indicators that cannot yet be reported.

Data sources and explanatory notes

Table A2-1
Overview of data sources, in alphabetical order

Data source	Description	Relevant indicators, figures and tables
Australian Bureau of Statistics Causes of Death, Australia, 2011, report	The official suicide rate in any given year is produced by the Australian Bureau of Statistics, using data from coroners' courts in all states and territories. Data covering the period 2003 to 2011 are published in the Causes of Death, Australia, 2011, report.[53] Unpublished data are also used. Information about deaths occurring in each state and territory is provided to the Australian Bureau of Statistics (ABS) by individual state and territory Registrars of Births, Deaths and Marriages for coding and compilation into aggregate statistics. In addition, the ABS supplements this data with information from the National Coronial Information System (NCIS).	Indicator 9 (Table 10, Figures 55-56)
Australian Government analyses of jurisdiction data	See Appendix 1, Table A1-1.	Indicators 13-16 (Figures 59-62)
Medicare Benefits Schedule data	See Appendix 1, Table A1-1.	Indicator 7 (Table 9) Indicator 13 (Figure 59)
National Drug Strategy Household Surveys conducted in 2010, 2007, 2004, 2001 and 1998	The National Drug and Alcohol Household Surveys are conducted by the Australian Institute of Health and Welfare every three years.[77] The surveys are designed to provide data on the level, patterns and trends of alcohol and other drug use in Australia, including licit and illicit drug use. The most recent survey – the tenth in the series – was conducted in 2010 and involved over 26,000 participants who were recruited via a household sampling strategy (a response rate of just over 50%).	Indicator 8 (Figures 52-54)
National Health Surveys conducted in 2011-12 and 2007-08	The 2011-12 National Health Survey (NHS)[34] was conducted from March 2011 to March 2012 by the Australian Bureau of Statistics. Previous surveys in this series were conducted in 1989-90, 1995, 2001, 2004-05 and 2007-08. The 2007-08 NHS[36] was conducted between August 2007 to June 2008. The surveys were designed to obtain national benchmarks on a wide range of health issues, and to enable changes in health to be monitored over time. The 2011-12 and 2007-08 NHSs each sampled more than 20,000 people across all age groups from private dwellings in all states and territories. Information was collected via personal interview. The surveys collected information about a broad range of health issues, include mental health status, as well as demographic and socio-economic information.	Indicator 1a (Figures 44-45) Indicator 2a (Figures 46-47)

Data source	Description	Relevant indicators, figures and tables
National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection 2005–06 to 2010–11	See Appendix 1, Table A1-1.	Indicators 21-22 (Figures 65-66)
National Outcomes and Casemix Collection	Data on a range of outcomes for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC).[78] The NOCC was endorsed by all States and Territories in 2003, and all jurisdictions have reported data since 2004-05. Analysis of this data is conducted by the Australian Mental Health Outcomes and Classification Network (AMHOCN), using data submitted annually by states and territories to the Australian Government Department of Health and Ageing. The NOCC protocol prescribes a set of measures to be collected at particular times in the clinical process. The measures are specific to three broad mental health service settings (Inpatient, Residential and Ambulatory) and also to three target populations (i.e., Children and Adolescents, Adults and Older Persons). It is difficult to ascertain definitively the 'coverage' of NOCC reporting, however AMHOCN has previously estimated Inpatient episode coverage at approximately 33% for Completed Episodes of at least 3 days duration and estimated ambulatory episode coverage at approximately 20% for 'Completed Episodes' and 33% for Ongoing Episodes.	Indicator 4 (Figures 49-50) Indicator 23 (Figure 67)
National Prisoner Health Census conducted in 2010	The National Prisoner Health Census[67 68] was conducted in 2010 by the Australian Institute of Health and Welfare. The Census was conducted in October and November 2010 in 44 of the 45 public and private adult correctional facilities from all jurisdictions except New South Wales and Victoria. The survey was developed to help monitor the health of prisoners, and to inform and evaluate the planning, delivery and quality of prisoner health services. Data were collected over a two week period. Individuals were asked a number of questions, including several about their mental health. Data were collected for 610 new prison entrants.	Indicator 20a (Figure 64)
National Survey of Mental Health and Wellbeing, surveys of adult population, conducted in 2007 and 1997	The 2007 National Survey of Mental Health and Wellbeing (NSMHWB)[65], survey of adult population, was conducted between August and December 2007 by the Australian Bureau of Statistics (ABS). The 2007 survey, and its precursor in 1997[4], were designed to provide reliable information about the prevalence of common mental disorders among Australian adults, and the impairment, severity, health care service use and unmet treatment needs associated with these disorders. In both surveys, participants were recruited by a household sampling strategy and interviewed in their homes. The 1997 survey involved 10,641 participants aged 16-85 years and the 2007 survey involved 8,841 participants aged 18-99 years. The response rate was 60% for the 2007 survey and 78% for the 1997 survey.	Indicator 12 (Figure 58) Indicator 13 (Table 11)
National Survey of Mental Health and Wellbeing, survey of children and adolescents, conducted in 1998	The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing[6] was conducted in 1998. This survey recruited 4,509 children and adolescents aged 4-17 through a household sampling strategy. It elicited information from participants and their parents via interview.	Indicator 12 (Figure 58)
National Surveys of Mental Health Literacy and Stigma conducted in 2011, 2003-04 and 1995	The National Surveys of Mental Health Literacy and Stigma[46] are a series of general community surveys designed to assess aspects of the mental health literacy in the Australian population and to monitor trends over time. The surveys were conducted using computer-assisted telephone interviews. The surveys involved the presentation of vignettes describing males or females with symptoms of a mental illness, with subsequent questions eliciting information about respondents' ability to recognise specific mental disorders, their beliefs about treatment, and stigmatising attitudes. The 1995, 2003-04 and 2011 samples consisted of 2,164, 3,998 and 6,019 adults aged 18 years or older respectively. Response rates were 85% in 1995, 34% in 2003-04 and 44% in 2011.	Indicator 3 (Figure 48) Indicator 11 (Figure 57)

Data source	Description	Relevant indicators, figures and tables
Principals Australia's National Market Research Survey conducted in 2011	Australian Government funding was provided to expand the Principals Australia's National Market Research Survey[50] to collect specific information regarding the mental health literacy component of schools' curricula. The Market Research Survey was undertaken in April and May 2011 and included a range of mental health specific questions designed to gather information on the range of mental health related activities undertaken in Australian public and private schools. The survey captured data from a large sample of principals based in all states and territories of Australia, and from all school types, sectors and all locations and is believed to be representative of all schools. Analysis of data for the mental health specific questions was restricted to responses by school principals, numbering 1,285 and covering an estimated 14% of all Australian schools.	Indicator 6 (Figure 51)
Private Mental Health Alliance Centralised Data Management Service	Data on the number of people seen by private hospital-based psychiatric services, and their outcomes, are analysed by the Private Mental Health Alliance's Centralised Data Management Service.[80] Virtually all private hospitals with psychiatric beds in Australia have been routinely collecting and reporting a nationally agreed suite of clinical measures and related data since 2002. The clinical measures to be collected, and the timing of their collection, are guided by a protocol. Valid data for private hospitals in 2009-10 covered 76% of in-scope inpatient episodes.	Indicator 13 (Figure 59) Indicator 23 (Figure 67)
Supported Accommodation Assistance Program (SAAP) National Minimum Data Set 2005-06 to 2009-10	The Supported Accommodation Assistance Program (SAAP) National Minimum Data Set (NMDS) 2005-06 to 2009-10[81] includes information about all clients receiving SAAP support lasting more than one hour. The information is collected throughout the year. The SAAP NMDS is compiled by collating information provided by agencies across Australia and by State and Territory community service departments. Analysis of the SAAP NMDS is conducted by the Australian Institute of Health and Welfare.[81] The SAAP NMDS includes information from three collections: the client collection, the demand collection and the administrative collection. The client collection captures information on all clients receiving ongoing or substantial support under SAAP. It includes basic socio-demographic information and the services required by and provided to each client. Details about accompanying children are also obtained. Additionally, information is collected about the client circumstances before and after receiving SAAP support.	Indicator 19 (Figure 63)

Table A2-2
Explanatory notes to figures and tables presented Part 3.

Indicator(s)	Notes
Priority area 1: Social inclusion and recovery	
Indicator 1a: Participation rates by people with mental illness of working age in employment: General population	**(a)** This indicator estimates the proportion of the Australian population aged 16-64 years with a mental illness who are employed. Data for 2011-12 is derived from the 2011-12 National Health Survey.[34] Data for 2007-08 is derived from the 2007-08 National Health Survey.[36] The 2007-08 and 2011-12 National Health Surveys included questions about the respondent's mental health status and participation in employment. Mental illness was defined as self-reported mental or behavioural problems lasting six months or more, or which the respondent expects to last for six months or more. Persons were classified as employed according to the ABS quarterly Labour Force Survey definition, that is, if they reported in the preceding week that they had worked in a job, business or farm, or if they had a job but were absent during that week. The data collected from these surveys enables comparison between the employment rate for people with and without a mental illness. The data have been age-standardised to enable comparison between 2007-08 and 2011-12. **(b)** Given the relationship between employment and labour force participation and severity of mental illness, methodological aspects of the 2007-08 and 2011-12 National Health Surveys may influence the employment and labour force participation rates reported for people with mental illness. The six month duration criterion used to determine the presence of mental illness is likely to exclude people with milder forms of mental illness that resolve within this period. In addition, as with other household surveys, 2007-08 and 2011-12 National Health Survey samples may underrepresent people with more severe mental illnesses.
Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population	**(c)** This indicator estimates the proportion of the Australian population aged 16-30 years with a mental illness who are employed and/or are enrolled for study towards a formal secondary or tertiary qualification. Data for 2011-12 is derived from the 2011-12 National Health Survey.[34] Data for 2007-08 is derived from the 2007-08 National Health Survey.[36] The 2007-08 and 2011-12 National Health Surveys included questions about the respondent's mental health status and participation in employment and education. Mental illness was defined as self-reported mental or behavioural problems lasting six months or more, or which the respondent expects to last for six months or more. Respondents were classified as employed if they had a job or business, or undertook work without pay in a family business for a minimum of one hour per week, or if they were absent from a job/business. Respondents were classified as participating in education if they were currently enrolled, whether full-time or part-time, in secondary school, university/other higher education, TAFE/technical college, business college, industry skills centre, or other relevant educational institution. Enrolment in adult education courses, hobby and recreation courses were excluded. The data collected from these surveys enables comparison between the employment and education rates for people with and without a mental illness. The data have been age-standardised to enable comparison between 2007-08 and 2011-12. **(d)** As per note **(b)**.

Indicator(s)	Notes
Indicator 3: Rates of stigmatising attitudes within the community	**(e)** This indicator reports average scores on a measure of social distance. Social distance is the degree of closeness people are comfortable with in relation to particular groups, such as individuals with mental disorders. The desire for social distance is recognised as one component of the stigmatising attitudes and beliefs directed towards people with mental disorders.[82] Social distance has been measured in the National Surveys of Mental Health Literacy and Stigma conducted in 2003-04 and 2011. These surveys assessed rates of stigmatising attitudes in Australia using measures of social distance, which are indicators of the willingness of Australians to interact with people suffering from a range of mental disorders, in a variety of situations. In these surveys, respondents were read one of four vignettes describing a male ('John') or female ('Jenny') with depression, depression with suicidal thoughts, early schizophrenia and chronic schizophrenia. In 2011, social phobia and post-traumatic stress disorder were also included. Respondents were asked to rate their willingness to : (1) live next door to John/Jenny; (2) spend the evening socialising with John/Jenny; (3) make friends with John/Jenny; (4) work closely with John/Jenny; and (5) have John/Jenny marry into their family. Each of these five items was rated on a scale ranging 1 ('definitely willing') to 4 ('definitely unwilling'). A 'social distance' score was calculated by summing the ratings for each of the 5 items (maximum score 20).[45 46 83]
Indicator 4: Percentage of mental health consumers living in stable housing	**(f)** Data on a range of outcomes for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC).[78] The majority of the instruments in the NOCC suite assess clinical outcomes like severity of symptoms and level of functioning, but a new measure of social inclusion is currently under development. Known as the Living in the Community Questionnaire (LCQ), this measure will be completed by consumers and will assess participation in various life domains. It will include an emphasis on stability of housing, which will ultimately inform this indicator. For now, proxy data on this indicator are taken from the Health of the Nation Outcome Scales (HoNOS) for adults (aged 15-64) and the HoNOS65+ for older adults (aged 65+). The HoNOS and HoNOS65+ are core clinician-rated instruments in the NOCC suite of measures. These measures are administered routinely at selected points during episodes of care in state and territory public sector mental health services. Item 11 on these instruments is concerned with problems with living conditions and is scored from 0 (no problem) to 4 (severe to very severe problem). The percentage of consumers scoring 0 on admission to episodes of inpatient, ambulatory and residential care is taken as a proxy for the percentage of consumers living in stable housing. These data provide an indicator of the housing status of consumers but should be interpreted with caution for several reasons. Item 11 on the HoNOS and HoNOS65+ relies on the clinician knowing the living circumstances of the consumer and is not optimally completed.
Priority area 2: Prevention and early intervention	
Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum	**(g)** It was originally intended that data from Kidsmatter and MindMatters routinely collected by the Australian Government Department of Health and Ageing (DoHA) could be used to assess progress against this indicator. However, practical and conceptual issues prevented this. Firstly, only relatively basic data is captured on Kidsmatter and MindMatters. Secondly, these programs offer organising frameworks for mental health literacy rather than providing specific curriculum content, making it difficult for routinely collected data regarding these programs to gauge the extent and nature of curriculum developments. More importantly, while MindMatters and Kidsmatter are funded by the Australian Government, there are other mental health frameworks used by schools that would not be captured through DoHA's reporting arrangements. For this reason, Australian Government funding was provided to expand the Principals Australia's National Market Research Survey in 2011[50] to collect specific data to inform this indicator, at least as an interim measure. The mental health questions in the survey included the following filter question which forms the basis of this indicator: "Does your school currently: • Have mental health frameworks implemented and in use (for example, Kidsmatter, MindMatters etc.) – followed with a question on specific details • Provide mental health programs for staff, students or parents – followed with a question on specific details • Have mental health literacy resources that can be accessed by teachers and students (for example,specific printed material, web resources to online services, use computer programs etc.)".

Indicator(s)	Notes
Indicator 7: Rates of contact with primary mental health care by children and young people	**(h)** Data on the number of children and young people receiving relevant Medicare-funded services are provided by the Australian Government Department of Health and Ageing, based on Medicare Benefits Schedule data.[74] Relevant services relate to Medicare item numbers covering: consultations with private psychiatrists, consultations with GPs for mental health specific services (i.e., GP-related Better Access item numbers and a small number of other relevant item numbers, but not item numbers related to general consultations), and consultations with allied health professionals (i.e., Better Access and Enhanced Primary Care Strategy item numbers covering services provided by psychologists, social workers and occupational therapists). Data are based on the year in which the Medicare claim was processed, not the year in which the service was rendered.
Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people	**(i)** Data for this indicator come from the National Drug Strategy Household Surveys.[77] These surveys provide insights into whether patterns of drug and alcohol misuse by young people have changed over time. The survey has undergone some methodological changes over time with, for example, a computer-assisted telephone interview being dropped in 2010 in favour of self-completion booklets. Data on alcohol use are presented here from all surveys from 2001 onwards, and data on cannabis and amphetamine use are presented from all surveys from 1998 onwards.
Indicator 9: Rates of suicide in the community	**(j)** The data for Figure 55 were sourced from the Australian Bureau of Statistics Causes of Death, Australia, 2011, report. Figure 56 is based on recent unpublished data provided by the Australian Bureau of Statistics. The 2007-11 figures vary slightly from those presented in Figure 55 due to a different upper age group being used in the calculation of each rate.[53] Until recently, the cause of death data for a given year were finalised by the ABS at a particular point in time, and cases that were still under investigation by the coroner in the relevant year were not reflected in the statistics for that year, even if they were subsequently judged by the coroner to be suicides. Recently, this anomaly has been rectified and now when cause-of-death determinations for a given year are forwarded from coroners, the ABS updates data from previous years. However, this improved method will only be applied to deaths registered after 1 January 2006, which means that data in very recent years and data from pre-2007 is likely to represent something of an undercount.[53] The causes of death data reported for 2006, 2007 and 2008 have undergone revisions and are now considered final. Causes of death data for 2009 and 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revision process.[53]
Indicator 11: Rates of understanding of mental health problems and mental illness in the community	**(k)** This indicator reports the percentage of adults who accurately recognise a range of mental disorders. Accurate recognition of individual mental disorders is one indicator of mental health literacy.[57] Data for this indicator come from the National Surveys of Mental Health Literacy and Stigma, conducted in 1995, 2003-04 and 2011.[44] These surveys have used a vignette-based approach to investigate the ability of the Australian population to accurately identify a variety of mental disorders. Respondents were read one of several vignettes describing a male ('John') or female ('Jenny') with depression and early schizophrenia (assessed in all years), and depression with suicidal thoughts and chronic schizophrenia (assessed in 2003-04 and 2011), and social phobia and post-traumatic stress disorder (assessed in 2011). After being presented with the vignette, respondents were asked what, if anything, they thought was wrong with John/Jenny.[45 46 83]

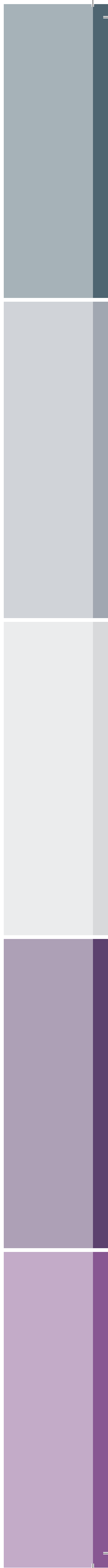
Indicator(s)	Notes
Indicator 12: Prevalence of mental illness	**(l)** Information on the prevalence of common mental disorders among adults comes from the National Surveys of Mental Health and Wellbeing, conducted in 2007[8 9] and 1997.[4] There were several methodological differences between the two surveys which should be taken into account when comparing their findings: • The 1997 survey recruited people aged 18-99, whereas the 2007 survey recruited people aged 16-85. • The 1997 survey had a substantially higher response rate than its 2007 counterpart (78% versus 60%). • The 1997 survey focused on providing prevalence estimates over a 12 month timeframe, whereas the 2007 survey was designed to provide lifetime prevalence estimates and 12 month estimates were derived. • The two surveys used different algorithms to derive diagnoses. **(m)** Information on the prevalence of clinically significant mental health problems among children and adolescents comes from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, conducted in 1998.[6] This survey recruited 4,509 children and adolescents aged 4-17 through a household sampling strategy. It elicited information from participants and their parents via interview. A second child and adolescent survey has been commissioned and will collect data from May to December 2013.
Priority area 3: Service access, coordination and continuity of care	
Indicator 13: Percentage of population receiving mental health care	**(n)** Data on the number of unique individuals seen by state and territory community mental health services are based on Department of Health and Ageing analyses of data submitted by jurisdictions. These data are provided by states and territories as person counts. Person counts are confined to those receiving one or more contacts with a community mental health service. This approach picks up most people seen in inpatient services too, since the majority of these would also be seen by a community team. The submitted service contacts are counted, including those delivered 'on behalf' of the consumer (i.e., where the consumer does not directly participate). This approach ensures that the role of state and territory mental health services in providing back-up specialist services to other health care providers is captured. It should be noted that states and territories differ in their capacity to provide accurate estimates of individuals receiving community mental health services because some (South Australia and Tasmania) do not have comprehensive unique identifier or data matching systems. In addition, jurisdictions differ in their approaches to counting individuals in receipt of services. Most record all individuals seen, but some – most notably Victoria – only count the individual once a clinical decision has been made to accept the person for treatment. **(o)** Data on the number of unique individuals receiving relevant Medicare-funded services are based on Department of Health and Ageing analyses of Medicare Benefits Schedule data.[74] Data are based on the year in which the Medicare claim was processed, not the year in which the service was rendered. **(p)** Data on the number of unique individuals seen by state and territory community mental health services and data on the number of unique individuals receiving relevant Medicare-funded services are converted to percentages using population denominator data taken from the 2006 Census. **(q)** Data on the number of people seen by private hospital-based psychiatric services were provided by the Private Mental Health Alliance Centralised Data Management Service. **(r)** Work is underway by the Australian Institute of Health and Welfare to use data linkage to more accurately identify the extent of duplication in consumer counts between state and territory services and MBS-subsidised mental health care. This work is progressing with the assistance of jurisdictions and in compliance with ethical requirements.

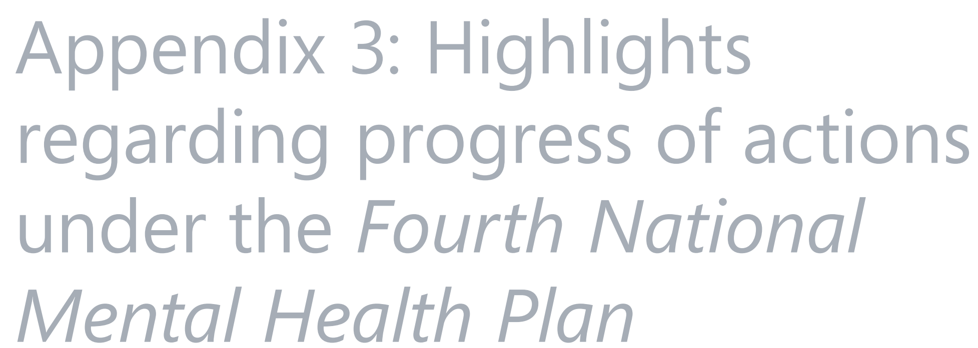
Indicator(s)	Notes
Indicator 14: Readmission to hospital within 28 days of discharge	**(s)** Data on 'in scope' separations from state and territory acute psychiatric inpatient units in each financial year are based on Department of Health and Ageing analyses of data submitted by jurisdictions. 'In scope' separations are defined as those for which it is meaningful to examine readmission rates, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Readmissions are defined as admissions to any public acute psychiatric unit within the given jurisdiction that occur within 28 days of the original discharge. In order to determine whether the same individual was discharged from one unit and readmitted to a different unit, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across sites. Such systems have been available in all states and territories for the full period (2005-06 to 2010-11), with the exception of Tasmania (which introduced such a system in 2007-08) and South Australia (which has not yet introduced such a system). The absence of such a system will lead to an undercount of the true readmission rate. Available data do not yet allow a distinction to be made between planned and unplanned readmissions.
Indicator 15: Rates of pre-admission community care	**(t)** Estimates for this indicator are based on Department of Health and Ageing analyses of data submitted by jurisdictions. Each jurisdiction provides data on 'in scope' separations from their acute psychiatric inpatient units in each financial year. 'In scope' separations are defined as those for which it is meaningful to examine rates of pre-admission community care, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Community mental health contacts are defined as contacts with any public community mental health team within the given jurisdiction that occur within the week before the inpatient admission. Except in the Northern Territory, these contacts are restricted to those in which the consumer participates directly. These may be face-to-face or indirect (for example, by telephone), but do not include those delivered 'on behalf of the consumer'. In order to determine whether the same individual was admitted to an acute inpatient unit and received pre-admission community care, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across service settings. Such systems were available in all states and territories for the full period (2005-06 to 2010-11), with the exception of Tasmania and South Australia. The absence of such a system may underestimate the true rate of pre-admission care. Only contacts with state and territory community mental health services are included here. Contacts with other community-based providers (for example, GPs and private psychiatrists) are excluded.
Indicator 16: Rates of post-discharge community care	**(u)** Estimates for this indicator are based on Department of Health and Ageing analyses of data submitted by jurisdictions. Each jurisdiction provides data on 'in scope' separations from their acute psychiatric inpatient units in each financial year. 'In scope' separations are defined as those for which it is meaningful to examine rates of post-discharge community care, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Community mental health contacts are defined as contacts with any public community mental health team within the given jurisdiction that occur within the week after discharge from the inpatient unit. Except in the Northern Territory, these contacts are restricted to those in which the consumer participates directly. These may be face-to-face or indirect (for example, by telephone), but do not include those delivered 'on behalf of the consumer'. In order to determine whether the same individual was admitted to an acute inpatient unit and received post-discharge community care, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across service settings. Such systems were available in all states/territories for the full period (2005-06 to 2010-11), with the exception of Tasmania and South Australia. The absence of such a system may underestimate the true rate of post-discharge care. Only contacts with state and territory community mental health services are included here. Contacts with other community-based providers (for example, GPs and private psychiatrists) are excluded.

Indicator(s)	Notes
Indicator 19: Prevalence of mental illness among homeless populations	**(v)** Data for this indicator is based on analysis of the Supported Accommodation Assistance Program (SAAP) National Minimum Data Set 2005-06 to 2009-10.[81] For the purpose of this indicator, SAAP clients are categorised into four mutually exclusive groups, based on their reasons for seeking assistance: • Those with mental health problems: This includes clients who were: referred from a psychiatric unit; reported psychiatric illness and/or mental health issues as reasons for seeking assistance; were in a psychiatric facility before or after receiving assistance; and/or needed, were provided with or were referred on for support in the form of psychological or psychiatric services. • Those with substance use problems: This includes clients who: reported problematic drug, alcohol and/or substance use as a reason for seeking assistance; and/or needed, were provided with or were referred on for support in the form of drug and/or alcohol support or intervention. • Those with comorbid mental health and substance use problems: This includes clients who reported at least one of the mental health criteria and at least one of the substance use criteria listed above in the same support period. • Other: This includes clients who reported none of the criteria listed above. A client may have more than one support period within a year and their circumstances might vary between support periods. Routinely collected SAAP data are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral. SAAP data have now been replaced with the Specialist Homelessness Services Collection (SHSC). The SHSC is designed to provide more comprehensive data on clients of specialist homelessness services. Options for using the SHSC to assess the achievement of this indicator in future *National Mental Health Reports* are currently being explored.
Indicator 20a: Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities	**(w)** The data for this indicator come from the 2010 National Prisoner Health Census[67,68] which was conducted by the Australian Institute of Health and Welfare. The Census was conducted over a two week period in 44 adult correctional facilities from all jurisdictions except New South Wales and Victoria. Individuals who entered 44 adult correctional facilities from all jurisdictions except New South Wales and Victoria over a two week census period were asked a number of questions, including several about their mental health. Self-reported information on prison entrants' mental health status was sought across three domains: • Mental health history: This was assessed by a single question – 'Have you ever been told by a doctor, psychiatrist, psychologist or nurse that you have a mental health disorder (including drug and alcohol abuse)?' • Current mental health medication: This was also assessed by a single question – 'Are you currently on medication for a mental health disorder?' • Current psychological distress: This was assessed by the Kessler-10 (K-10), which measures non-specific psychological distress.[69] The K-10 comprises 10 items relating to symptoms of depression and anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All of the time), resulting in a total score that ranges from 10 to 50. Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high).

Indicator(s)	Notes
Priority area 4: Quality improvement and innovation	
Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers	**(x)** This indicator measures the proportion of the state and territory mental health workforce who are consumer and carer workers. The data for this indicator are available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE).[75] The NMDS-MHE captures information about the size and composition of the mental health workforce, including direct care staff. Direct care staff comprises Consultant psychiatrists and psychiatrists, Psychiatry registrars and trainees, Other medical officers, Registered nurses, Enrolled nurses, Psychologists, Social workers, Occupations therapists, Diagnostic and health professionals, Other personal care, Consumer workers, and Carer workers. FTE counts for consumer and carer workers are only available from 2002–03 onwards. The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a broader array of consumer and career roles, and this may impact on the figures reported. It is calculated as the number of full-time equivalent consumer and carer worker positions within Australian state and territory public mental health services, over the number of full-time equivalent clinical positions within Australian state and territory public mental health services. A revision of the current, nationally agreed definition of consumer and carer workers is currently being undertaken to improve consistency in how jurisdictions report the variety of arrangements that exist between organisations and consumer and carer workers. The current data collection does not include mental health services managed by non-government organisations. The development of a Mental Health Non-Government Organisation National Minimum Dataset is currently underway, and is it desirable that data to inform this indicator be included in that collection.
Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	**(y)** The data for this indicator are available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE).[75] The NMDS-MHE captures information about the extent of progress made by specialised mental health service units in implementing the National Standards for Mental Health Services, summarised into categories. The indicator grades services according to four categories: • Level 1—Services that have been reviewed by an external accreditation agency and judged to have met all National Standards for Mental Health Services. • Level 2—Services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards. • Level 3—Services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known; or are booked for review by an external accreditation agency. • Level 4—Services that do not meet the criteria detailed under levels 1 to 3. The indicator is based on the expenditure reported for each of the service units accredited at the various levels. This method takes account of the size of the service unit, and the number of service units per jurisdiction, and is therefore considered a more accurate reflection of the proportion of mental health services meeting each level. The current coverage of this indicator excludes service units that are non-government mental health service units and private hospital service units in receipt of government funding where the National Standards for Mental Health Services do not apply. It also excludes aged care residential services subject to Australian Government residential aged care reporting and service standards requirements.

Indicator(s)	Notes
Indicator 23: Mental health outcomes for people who receive treatment from state and territory services and the private hospital system	**(z)** Data for this indicator come from the National Outcomes and Casemix Collection (NOCC)[78] and the Private Mental Health Alliance.[80] For the purposes of this indicator, assessment of clinical outcomes is based on the clinician-rated Health of the Nation Outcome Scales (HoNOS), and its equivalents for children and adolescents (HoNOSCA) and older people (HoNOS65+). All three comprise items that collectively cover the sorts of problems that may be experienced by people with a mental illness. Each item is rated from 0 (no problem) to 4 (very severe problem), resulting in individual item scores, subscale scores and a total score. HoNOS/HoNOSCA/HoNOS65+ data for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC) and analysed by the Australian Mental Health Outcomes and Classification Network (AMHOCN). Equivalent data for consumers seen in private psychiatric hospital units are collected and analysed by the Private Mental Health Alliance's Centralised Data Management Service. Outcomes according to the HoNOS family of measures are considered for four cohorts of consumers who received episodes of care during 2010-11. Outcome scores are calculated differently for these groups, depending on the setting and the duration of the episode of care: • Those discharged from hospital in both the public and private sector include people who had an inpatient admission that began and ended during the 2010-11 year and lasted at least three days. Outcome scores for these groups are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded at admission to and discharge from inpatient care. • Those discharged from community care in the public sector include people who received an episode of community care that began and ended in 2010-11. Outcome scores for this group are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded at admission to and discharge from community care. • Those in ongoing community care in the public sector include people who were receiving community care for the whole of 2010-11 and those who commenced community care some time after 1 July 2010 and continued to receive care for the rest of the year. The defining characteristic for this group is that all were still in ongoing care when the year ended (30 June 2011). Outcome scores for this group are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded on the first and last occasions rated during the year. In each case, outcome scores are classified based on 'effect size'. 'Effect size' is a statistic used to measure the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre-score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 are considered medium, and 0.8 are considered large. Based on this rule, a medium effect size of 0.5 is used to assign outcome scores to categories – an effect size of greater than or equal to +0.5 equates to 'significant improvement', an effect size of -0.5 to +0.5 equates to 'no change', and an effect size of less than or equal to -0.5 equates to 'significant deterioration'. The denominator in the analysis for each of the four cohorts is 'valid' episodes of care. To be considered valid, the episode had to have sufficiently complete HoNOS/HoNOSCA/HoNOS65+ data that total scores could be calculated at its beginning and end. It has been estimated that valid 2010-11 data were available for 34% of public sector inpatient episodes, 23% of public sector community episodes, and 80% of private sector inpatient episodes. It should be noted that, except in the case of ongoing community episodes, an individual may have had more than one episode during 2010-11 so the data represent episode-counts, rather than person-counts. This means that some individuals may appear more than once within a given group. Data coverage has been estimated at around one third of potential inpatient episodes and around one quarter of community care episodes. Coverage varies widely across jurisdictions. Changes in coverage may change the pattern of results.





Appendix 3: Highlights regarding progress of actions under the *Fourth National Mental Health Plan*

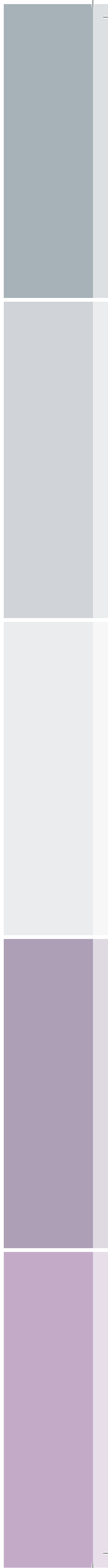


Table A3-1
Highlights of actions under Priority area 1 – Social inclusion and recovery

Action		Summary of highlights of progress
2	Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.	**Stocktake of supported employment and education activities:** A national stocktake of existing supported employment and education activities that are linked to mental health programs is being finalised.
4	Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.	**National Mental Health Recovery Framework:** A project to develop a National Mental Health Recovery Framework is being finalised. The Framework is intended to support implementation of recovery oriented culture in all mental health services. **National Recovery Forum:** An inaugural National Recovery Forum was held in June 2012. Three international experts gave keynote addresses. This enabled exchange about the implementation of a recovery oriented culture, and provided an opportunity to promote the development of the National Mental Health Recovery Framework.
5	Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.	**Intersectoral linkages:** The implementation of Actions 5 and 6 has been combined as a single process. An implementation approach has been endorsed and a Working Group was established in early 2013.
6	Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.	**Intersectoral linkages:** The implementation of Actions 5 and 6 has been combined as a single process. An implementation approach has been endorsed and a Working Group was established in early 2013.
7	Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework.	**Renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework:** A Working Group was established in March 2012 and a request for tender issued to engage a contractor to work with the Working Group to renew the Aboriginal and Torres Strait Islander Social Emotional Wellbeing Framework. The Working Group has begun to review the previous framework to identify gaps, achievements and changes that should be considered in renewing the Framework. A discussion paper will be developed and jurisdictional consultations will occur.

Table A3-2
Highlights of actions under Priority area 2 – Prevention and early intervention

Action		Summary of highlights of progress
9	Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.	**Mapping child mental health services:** Work has commenced to progress the mapping of existing child mental health services and to identify existing links and possible gaps in the service provision.
10	Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.	***headspace*:** Funding was provided in the 2011-12 Federal Budget for 90 fully sustainable headspace sites across Australia by 2014-15. 70 sites have been announced, and 40 are currently operational. When fully established, these sites will help up to 72,000 young people each year.
11	Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.	**Early psychosis youth centres:** In addition to the expansion of the headspace program (see above), the 2011-12 Federal Budget also allocated $222.4 million over five years for up to 12 early psychosis youth centres across the country, based on the Early Psychosis Prevention and Intervention Centre model. This builds on a 2010-11 Budget measure that provided $25.5 million over four years to establish up to four sites, bringing the total number of sites to be funded to 16.

Action		Summary of highlights of progress
12	Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.	**Review of the National Suicide Prevention Working Group:** In May 2012, the Mental Health Standing Committee agreed to review the terms of reference, role and membership of the National Suicide Prevention Working Group, with a view to determining its capacity to progress this action and providing it with direction on priorities for the next 12 months. The National Suicide Prevention Working Group's last meeting was held in October 2012. This action now sits under the remit of the Mental Health Drug and Alcohol Principal Committee.
13	Coordinate state, territory and Australian Government suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.	**Overarching framework for suicide prevention activity:** In September 2011, the Living Is For Everyone (LIFE) Framework was endorsed by the Australian Health Ministers Advisory Council as the national overarching framework for suicide prevention activity in Australia. The LIFE Framework provides evidence based priorities, actions and strategies for suicide prevention in Australia.

Table A3-3
Highlights of actions under Priority area 3 – Service access, coordination and continuity of care

Action		Summary of highlights of progress
16	Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.	**National Mental Health Service Planning Framework:** A project to develop a National Mental Health Service Planning Framework (NMHSPF) commenced in 2011 and is expected to be completed in 2013. Expert working groups comprising service providers, researchers, consumers, carers and people with service planning expertise are informing the development and refinement of a classification of mental health service elements and packages of care.
22	Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.	**Resources for primary mental health care initiatives:** The 2011-12 Federal Budget allocated resources to address service gaps in the delivery of primary mental health care, including doubling funding for the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program, and providing new funding for the Partners in Recovery program.

Table A3-4
Highlights of actions under Priority area 4 – Quality improvement and innovation

Action		Summary of highlights of progress
23	Review the Mental Health Statement of Rights and Responsibilities.	**Review of the Mental Health Statement of Rights and Responsibilities:** Led by the Safety and Quality Partnership Subcommittee, a project to review the Mental Health Statement of Rights and Responsibilities commenced in the first half of 2011. Following national consultation processes, the revised Draft Statement was endorsed by Health Ministers in late 2012 and publicly released in early 2013.
24	Review and where necessary amend mental health and related legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.	**Review of mental health and related legislation:** A working group was formed and an implementation approach and work plan were endorsed but unable to be progressed due to capacity issues.

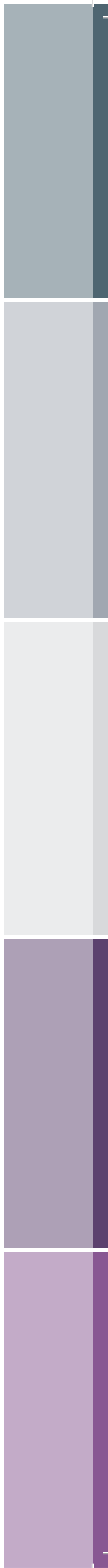
Action		Summary of highlights of progress
25	Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.	**National Mental Health Workforce Strategy and Plan:** The Mental Health Workforce Advisory Committee (MHWAC) progressed the development of the National Mental Health Workforce Strategy and an accompanying National Mental Health Workforce Plan which were endorsed by Australian Health Ministers in September 2011. The Strategy and Plan provide an overarching framework for the ongoing development of the mental health workforce in Australia. A national implementation strategy is currently being developed. **National Practice Standards for the Mental Health Workforce:** MHWAC and Health Workforce Australia commenced a project in early 2012 to review the National Practice Standards for the Mental Health Workforce and to develop mental health core competencies. It is expected that the review of the Practice Standards will be completed in 2013, but that the work on standardised mental health competencies will continue.
27	Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.	**Mapping the National Safety and Quality Health Service Standards to the National Standards form Mental Health Services:** In 2011, the Australian Commission on Safety and Quality in Healthcare (ACSQHC) and the Safety and Quality Partnership Subcommittee mapped the draft National Safety and Quality Health Service Standards (NSQHSS) to the National Standards for Mental Health Services (NSMHS). The work explored ways to facilitate a single review process that avoids duplication and satisfactorily meets both the NSQHSS and the NSMHS accreditation standards. **Accreditation workbook:** Collaborative work continued in 2012 on an accreditation workbook to enable mental health service organisations to focus their quality improvement activities within the NSQHSS and NSMHS frameworks. The workbook was made available for trailing and consultation purposes via the ACSQHC website in January 2013.
28	Further develop and progress implementation of the National Mental Health Performance and Benchmarking Frameworks.	**Key Performance Indicators for Australian Mental Health Services:** Ongoing review of the National Key Performance Indicators for Australian Mental Health Services resulted in a second edition being published in May 2011. The technical specifications of this edition are currently being reviewed and it is anticipated that a third edition will be published in 2013. The focus will remain on public sector mental health services, however, it is envisaged that continued data development over time will enable the National Mental Health Performance Framework to be utilised in the broader mental health sector. ***Fourth National Mental Health Plan* Measurement Strategy:** Extensive collaborative work to describe the underlying technical details of the 25 *Fourth Plan* indicators resulted in the publication of the *Fourth National Mental Health Plan Measurement Strategy* in May 2011. The *Measurement Strategy* provides a high-level overview of the indicators and targets (where appropriate), details on indicator specifications and planned developments. **National support for benchmarking in Australian public mental health services:** A range of concepts for nationally-coordinated benchmarking activities for specialised mental health service organisations are being considered. These include developing a data repository for the reporting of national benchmarks; and establishing online benchmarking forums for unique mental health services (across Australia) that have insufficient critical mass to create relevant peer groups for reviewing and comparing performance. **Development of nationally consistent promotional material for use by states and territories:** A series of 'non-technical' fact sheets is being developed to promote the national key performance indicators and the range of performance measurement information available to the mental health sector. It is anticipated that the first set of fact sheets will be available in 2013.

Action		Summary of highlights of progress
29	Develop a national mental health research strategy to drive collaboration and inform the research agenda.	**Stocktake of mental health research efforts:** A stocktake on current mental health research efforts was completed in mid-2012. National Health and Medical Research Council investment: The National Health and Medical Research Council (NHMRC) held two workshops on 'developing a more evidence-based mental health system' which informed the 2011-12 Federal Budget allocation of $26.2 million over 5 years across three areas: (1) a targeted call for research focusing on prevention and early intervention in mental illness in children and young people; (2) three mental health centres of research excellence focusing on suicide prevention, substance abuse and better mental health planning; and (3) and the new John Cade Fellowship in Mental Health Research.
30	Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.	**Mental health portal:** The 2011-12 Federal Budget included funding for the development of a national mental health portal. Stage 1 of the portal – mindhealthconnect: your pathway to a healthy mind – was launched in July 2012 and provides access to a range of trusted, high quality online information and self-help programs from Australia's leading mental health organisations. The National Health Call Centre Network is hosting the portal. Continued development of the portal will examine the capability to refer to local services through the National Health Call Centre's services directory, along with other functionality. **Stocktake of e-mental health activities:** State and territory governments have also invested in e-mental health activities. A stocktake of e-mental health activities was undertaken in the first half of 2012, with the aim of informing decisions about further effective expansion and innovation of mental health services into the online environment.

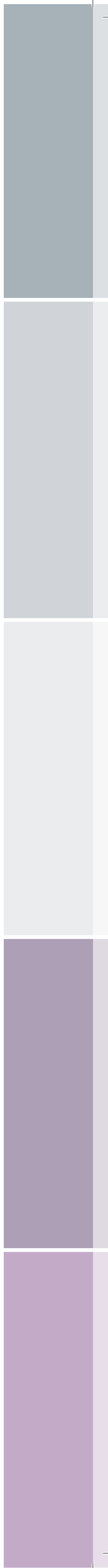
Table A3-5
Highlights of actions under Priority area 5 – Accountability

Action		Summary of highlights of progress
31	Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.	***Fourth National Mental Health Plan Measurement Strategy:*** In May 2011, the first edition of the *Fourth National Mental Health Plan Measurement Strategy* which proposed data sources, specifications and targets for the *Fourth Plan* progress indicators was released. ***COAG National Action Plan on Mental Health Annual Progress Report:*** The *Fourth Progress Report* – covering implementation to 2009-2010 – was published in July 2012. ***Mental Health Services in Australia:*** The Australian Institute of Health and Welfare has sought to make this publication and the data that underlie it more readily accessible. An online version of the report was launched in October 2011 and repeated in October 2012, as was a summary snapshot of the key findings. The data were presented via a range of media, including an interactive data portal. ***National Mental Health Report:*** In June 2012, the revised outline and structure of future *National Mental Health Reports* was endorsed and work began on the production of the current report.
32	Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.	**Public reporting:** The Mental Health Information Strategy Standing Committee (MHISSC) established a Public Reporting Working Group to develop recommendations on how to implement the *Fourth Plan's* commitment to public reporting. In May 2011, a report for this group was finalised. The report included a literature review, recommendations regarding the introduction of public performance reporting by state and territory mental health services, and a broader consultation strategy.

Action		Summary of highlights of progress
33	Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.	**Mental Health Non-Government Organisation Establishments National Minimum Data Set (MH NGOE NMDS) Project:** In February 2011, the Australian Institute of Health and Welfare (AIHW) commenced the MH NGOE NMDS Project, which aims to collect nationally consistent information about the mental health NGO sector. The AIHW, in collaboration with the MH NGOE NMDS Working Group, developed draft specifications and data collection manual which includes a mental health NGO service taxonomy and definitions of service types in the taxonomy. The AIHW is now consulting with relevant funders to confirm that the MH NGOE NMDS is 'fit for purpose' and that jurisdictions are able to map their MH NGO activities to the NGO service taxonomy. **Development of a carer (family inclusiveness) measure:** The Australian Mental Health Outcomes and Classification Network (AMHOCN) commenced work to develop a measure of carers' experiences of the family inclusiveness of mental health care. A literature review identified that the carer version of the Victorian Consumer and Carer Experiences Questionnaires (C&CEQ) was suitable for trialing but required some modification. AMHOCN's next step is to modify the C&CEQ and pilot the revised measure. **Development of the Living in the Community Questionnaire:** AMHOCN, in collaboration with a Technical Advisory Group, commenced work to develop a consumer self-report measure that focuses on the social inclusion aspects of recovery. A draft of instrument known as the Living in the Community Questionnaire (LCQ) was produced and underwent 'proof of concept' testing during 2011. Further development of the LCQ occurred on the basis of feedback in early 2012, and field trials of the latest instrument began in early 2013. **Measuring consumers' experiences of their care:** Under the auspices of the Mental Health Information Strategy Standing Committee (MHISSC), the Victorian Department of Health commenced work on a project to develop a national mental health Consumer Experiences of Care (CEoC) tool, to measure the degree to which consumers are involved and engaged in their care as well as the quality of that care. A draft CEoC tool has been completed and a national 'proof of concept' trial and an evaluation of the tool were completed in the second half of 2012. Further work to test the reliability of the instrument was completed in June 2013. **Mental Health Intervention Classification:** The AIHW developed and conducted a pilot study of a mental health interventions classification to be used in specialist mental health services. The classification was endorsed by MHISSC for voluntary implementation by jurisdictions. **Review of the National Outcomes and Casemix Collection (NOCC):** A review of the data collected by Australian public sector mental health services under NOCC commenced in 2012. Known as the NOCC Strategic Directions 2014-24 Project, this review will document the implementation of NOCC to date and develop recommendations for further development of NOCC.
34	Conduct a rigorous evaluation of the *Fourth National Mental Health Plan.*	**Evaluation Framework for the *Fourth National Mental Health Plan:*** An external contractor was funded to develop an evaluation framework for the evaluation of the *Fourth Plan.*



Appendix 4: Data sources and explanatory notes for Part 4



Introduction

The following notes have been prepared to assist in the interpretation of the tables and figures describing state and territory performance in Part 4 Profiles of state and territory reform progress (Tables NSW1 to NT1, and Figures NSW1 to NT18).

Information about the data sources used is provided in Table A4-1. Further explanatory detail regarding the derivation of each indicator is provided, where necessary, in Table A4-2. The majority of figures and data reported in the tables in Part 4 are derived from tables published in the Australian Institute of Health and Welfare's Mental Health Services in Australia (MHSiA)[22] series of annual mental health reports that describe the activity and characteristics of Australia's mental health care services. MHSiA presents analyses of data from a range of sources including, but not limited to, the Mental Health Care National Minimum Data Sets (NMDSs). These NMDSs cover specialised community and residential mental health care, mental health care for patients admitted to public and private hospitals, and the facilities providing these services. In many cases the data can be extracted directly from component tables of the MHSiA report. In some cases the data have been subject to additional analyses which may have been supplemented by unpublished data.

Data sources and explanatory notes

Table A4-1
Overview of data sources, in alphabetical order.

Data source	Description	Relevant figures and table rows
Australian Government analyses of jurisdiction data	See Appendix 1, Table A1-1.	Figures 1-12, 14, 16 Table sections A-E, G
Australian Government analyses of mental health program data	See Appendix 1, Table A1-1.	Figure 1 Tables sections A, H
Medicare Benefits Schedule data	See Appendix 1, Table A1-1.	Figure 13; Table section H
National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection 2005–06 to 2010–11	See Appendix 1, Table A1-1.	Figures 1-7, 11, 16-17 Table sections A-G
National Outcomes and Casemix Collection	See Appendix 2, Table A2-1.	Figures 15, 18
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).[86]	Table section I

Table A4-2
Explanatory notes to Tables NSW1 to NT1.

Indicator(s)	Notes
A. State and territory government expenditure	
State spending on mental health services State spending per capita Per capita spending rank	**(a)** Data source: MHSiA Table 14.30. State and territory expenditure estimates used for each of these indicators are based on overall spending by the state or territory government, which should be distinguished from spending in the state or territory. Spending by the state or territory is calculated as total spending on mental health services administered by the state or territory government, less Australian Government contributions made through National Mental Health Strategy grants and payments by the Department of Veterans' Affairs. As a result of these exclusions, total state or territory expenditure is in all cases less than the total actual amount spent on mental health services in the state or territory.
Average annual per capita spending growth since preceding milestone year	**(b)** Data source: MHSiA Table 14.30. As per the indicators described in note **(a)** above, average annual per capita spending growth indicators are based on overall spending by the state or territory government and exclude the specified Australian Government contributions. Spending growth is reported for two periods: • 2007-08: Average annual growth presented here refers to growth over the period of the *First, Second* and *Third National Mental Health Plans*, i.e., over the 15 year period 1993-94 to 2007-08. • 2010-11: Average annual growth presented here refers to growth over the period of the *Fourth National Mental Health Plan*, i.e., over the three years 2008-09 to 2010-11.
B. Service mix	
% total service expenditure - community services % total service expenditure – stand-alone psychiatric hospitals % total service expenditure - colocated general hospitals	**(c)** Data source: MHSiA Table 14.3. In contrast to the above indicators, these indicators are based on all recurrent amounts reported by the state or territory government in these service categories, regardless of funding source. The estimates therefore include Australian Government funds which are excluded in the indicators described at note **(a)** above. Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e., indirect expenditure that is not apportioned to services). Estimates of the percentage of service expenditure on community services include three categories of services: Ambulatory care, community residential and non-government services.
C. Inpatient services	
Total hospital beds	**(d)** Data source: MHSiA Table 12.13. Refers to total number of hospital-based psychiatric inpatient beds reported as available at 30 June of each of the respective years.
Per capita expenditure on inpatient care	**(e)** Data source: MHSiA Table 14.4. This indicator is based on total expenditure (constant 2010-11 prices) reported by state and territory-administered psychiatric inpatient services, regardless of source of funds.

Indicator(s)	Notes
Inpatient beds per 100,000 Acute inpatient beds per 100,000 Non-acute inpatient beds per 100,000	**(f)** Data source: MHSiA Table 12.14. Estimates of Acute inpatient beds include acute beds in Public psychiatric hospitals plus Specialised psychiatric units or wards in public acute hospitals. Estimates of Non-acute inpatient beds include non-acute beds in Public psychiatric hospitals plus Specialised psychiatric units or wards in public acute hospitals.
Stand-alone hospitals as % of total beds	**(g)** Data source: MHSiA Table 12.13.
Average cost per patient day	**(h)** Data source: MHSiA Table 14.7. All costs exclude depreciation.
D. Community services	
Ambulatory, NGO and Residential services - % total service expenditure	**(i)** Data sources: MHSiA Table 14.3, supplemented by Table 14.10 (expenditure on residential services used to calculated NGO expenditure). These indicators represent the ambulatory, NGO and residential components of expenditure on community services shown earlier in the table, and described in note **(c)** above. All expenditure reported by services is counted and includes Australian Government funds. Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e., indirect expenditure that is not apportioned to services). **(j)** 'NGO % total service expenditure' includes funding to staffed community residential services managed by non-government organisations, to give a more accurate estimate of non-government allocations by each jurisdiction and to ensure consistency in monitoring the 18 year spending trends. As these amounts are also included in the indicator 'Residential % total service expenditure', the total percentage of expenditure shown for residential, ambulatory and NGO services is greater than the amount shown in the indicator '% total service expenditure – community services' described in note **(c)** above.
Ambulatory, NGO and Residential services - per capita expenditure	**(k)** Data source: MHSiA Table 14.4 with the exception that NGO per capita expenditure includes staffed community residential services managed by non-government organisations (see MHSiA Table 14.10). These amounts are also counted in the indicator 'Residential services per capita expenditure'. As per note **(j)** above.
Residential services - Adult beds (24 hour staffed) per 100,000; Adult beds (non-24 hour) per 100,000 ; Older persons' beds (24 hour staffed) per 100,000; Adult beds (non-24 hour) per 100,000	**(l)** Data source: MHSiA Table 12.20. Estimates of per capita rates are based on age specific populations - Adult beds per 100,000 calculated using population aged 18-64 years; Older persons' beds calculated using population aged 65 years and over.
Supported public housing places per 100,000	**(m)** Data source: MHSiA Table 12.26. Per capita rates are calculated using total populations within each jurisdiction.

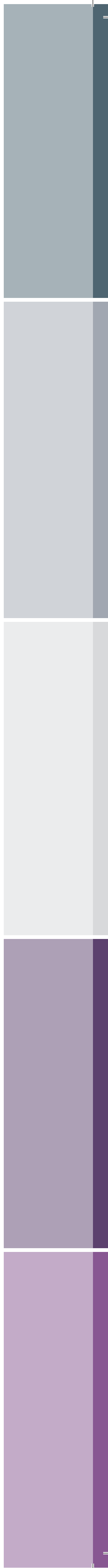
Indicator(s)	Notes
E. Direct care workforce	
Number Full-time Equivalent (FTE) staff FTE per 100,000 FTE per 100,000 - ambulatory services	**(n)** Data source: MHSiA Tables 12.40 and 12.41. FTE indicators presented in the state and territory tables are based on 'direct care' staff, covering the following occupational groups: Nursing, Medical, Diagnostic and Health Professionals and Other Personal Care Staff. FTE reported under the categories of Administrative and Clerical and Domestic and Other are excluded from the analysis. Data used for constructing these indicators are based only on staffing reported for each of the three service settings (inpatient, residential, ambulatory) and therefore exclude staff not reported against a specific service setting.
F. Implementation of National Service Standards	
% service expenditure covered by Level 1 services	**(o)** Data source: MHSiA Table 12.12.
G. Consumer and carer participation	
% services with Level 1 consumer committee representation	**(p)** Data source: MHSiA Table 12.8. As this information only commenced in 1993-94, data for that year is substituted in the 1992-93 column as an approximation of the pre-Strategy baseline.
% total mental health workforce account for by – consumers; carers	**(q)** Data source: MHSiA Table 12.36. Calculation of percentages excludes from the denominator non-direct care staff categories (i.e., Administrative and clerical staff, and Domestic and other staff).
H. Medicare-subsidised mental health services	
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	**(r)** Data source: Medicare Benefits Schedule data. This indicator is based on a unique count of persons receiving one or more services provided under any of the Medicare-funded service streams described at (s) to (v) below. Persons seen by more than one provider stream are counted only once. All Medicare funded data are based on year of processing (i.e., date on which a Medicare claim was processed by Medicare Australia), not when the service was rendered. A significant component of the data includes services provided under the Australian Government Better Access to Mental Health Care initiative, which commenced on 1 November 2006. Comparable full year estimates are not available for years prior to 2007-08.
% population seen – GPs	**(s)** Data source: Medicare Benefits Schedule data. General practitioner data represents a unique count of people who received one or more general practitioner attendance items, billed to Medicare Australia, that are mental health specific. These are predominantly items under the Better Access to Mental Health Care initiative (available 1 November 2006 onwards) plus a small number of other items that were created in years preceding the introduction of the Better Access initiative. A small proportion of this latter group may also be provided by other medical practitioners. The count does not include people receiving GP-based mental health care that was billed as a general consultation.
% population seen – Consultant Psychiatrists	**(t)** Data source: Medicare Benefits Schedule data. Consultant psychiatrist data represents a unique count of people seen who received one or more consultant psychiatrist attendance items billed to Medicare Australia.

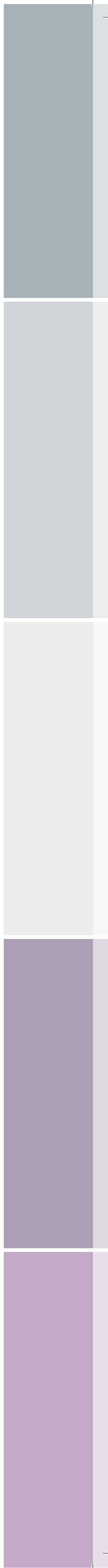
Indicator(s)	Notes
% population seen – Clinical Psychologists	**(u)** Data source: Medicare Benefits Schedule data. Clinical psychologist data represents a unique count of people who received one or more Clinical Psychologist attendance items, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. As noted above, these commenced in 1 November 2006.
% population seen – Registered Psychologists and Other allied health professionals	**(v)** Data source: Medicare Benefits Schedule data. Registered Psychologists and Other allied health data represents a unique count of people who received one or more attendance items provided by Registered Psychologists, Social Workers or Occupational Therapists, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. The person count also includes a small number of services provided by allied health professionals provided under the Enhanced Primary Care Strategy, introduced in the MBS in 2004.
Total MBS mental health related benefits paid per capita	**(w)** Data source: MHSiA Table 14.18. This indicator is based on total MBS rebates paid in relation to Medicare-funded service streams described at (s) to (v) above. 1992-93 is marked 'n.a.' because it is not possible to identify the GP component at state/territory level prior to 2006-07.
I. PBS-funded pharmaceuticals (including RPBS)	
Total PBS/RPBS benefits paid per capita	**(x)** Data source: MHSiA Table 14.27. Indicators of the utilisation of Australian Government-funded psychiatric medicines, subsidised through the Pharmaceutical Benefits Schemes, is included in each table to provide further context for interpreting differences between the states and territories. This indicator counts Australian Government benefits for psychiatric medication in each of the relevant years, in the following classes of the Anatomical Therapeutic Chemical Drug Classification system: antispychotics (except prochloperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, expenditure on Clozapine, funded under the Highly Specialised Drugs program, has been included for all years, requiring adjustment to historical data. This indicator covers both the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme.

Table A4-3
Explanatory notes to Figures NSW1 to NT18.

Indicator	Notes
Figure 1. Overall spending on mental health	**(y)** Data source: MHSiA Table 14.30.
Figure 2. Change in spending mix	**(z)** Data source: MHSiA Table 14.4.
Figure 3. Changes in inpatient services	**(aa)** Data sources: MHSiA Tables 12.13 (inpatient beds), 12.27 (inpatient days), 12.40 (clinical FTE) and 14.3 (expenditure). Growth in total inpatient services is calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals (Table 14.3). FTE is for Hospital admitted patient services (Table 12.40).
Figure 4. Changes in ambulatory care	**(ab)** Data sources: MHSiA Tables 14.3 (expenditure) and 12.40 (clinical FTE).
Figure 5. Direct care workforce	**(ac)** Data source: MHSiA Table 12.41.
Figure 6. Inpatient and residential beds	**(ad)** Data sources: MHSiA Tables 12.14 (total acute and non-acute inpatient beds) and 12.20 (residential beds). **(ae)** Acute and non-acute bed totals are each calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals. Residential beds includes 24 hour and Less than 24 hour staffed beds. Note: Queensland data as presented for 2002-03 is an artifact of changes in reporting by the Commonwealth and is not a reflection of closure of residential services in Queensland. Queensland's residential equivalent services are classified as non-acute inpatient in all other years presented.
Figure 7. Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000	**(af)** Data source: MHSiA Table 12.14. As per note **(ae)** above.
Figure 8. Readmission to hospital within 28 days of discharge	**(ag)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 9. Rates of pre-admission community care	**(ah)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 10. Rates of post-discharge community care	**(ai)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 11. Average treatment days per three month community care period	**(aj)** Data source: Australian Government analyses of jurisdiction data, presented *in Report on Government Services 2013*[28] Table 12A.45.
Figure 12. Percentage of population receiving state or territory community mental health services	**(ak)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 13. Percentage of population receiving MBS-subsidised mental health services	**(al)** Data source: Medicare Benefits Schedule data.
Figure 14. New clients as a proportion of total clients under the care of state or territory specialised public mental health services	**(am)** Data source: *Report on Government Services 2013.*[28] Table 12A.25.

Indicator	Notes
Figure 15. Mental health outcomes for people who receive treatment from state or territory services	**(an)** Data source: National Outcomes and Casemix Collection.
Figure 16. Proportion of total mental health workforce accounted for by consumer and carer workers	**(ao)** Data source: MHSiA Table 12.36.
Figure 17. Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	**(ap)** Data source: MHSiA Table 12.12. Calculation of proportion excludes from the denominator non-direct care staff categories (i.e., Administrative and clerical staff, and Domestic and other staff).
Figure 18. Percentage of mental health consumers living in stable housing	**(aq)** Data source: National Outcomes and Casemix Collection.





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