# 12 Mental health management

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘12A’ prefix (for example, table 12A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp. |
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Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the Australian, State and Territory governments’ management of mental health and mental illnesses through a variety of service types and delivery settings.

The following improvements have been made to the chapter this year:

* a case study on how follow‑up community care can influence psychiatric inpatient hospital readmission within 28 days has been included
* a new indicator on seclusion events has been added to the framework ― this is the first mental health management safety indicator to be included
* ‘average cost per community treatment day’ has replaced the ‘average cost per three month community care period’ measure to provide a better measure of unit costs
* the ‘services reviewed against the National Standards’ indicator has been revised to weight the results for expenditure, to provide a better understanding of the share of activity covered by the different assessment levels
* time series data reporting in some attachment tables has been expanded, in particular, seven years are now reported for most data for State and Territory governments’ specialised mental health services
* data quality information (DQI) is available for the first time for the indicators ‘new client index’, ‘primary mental health care for children and young people’, ‘collection of outcomes information’, ‘readmissions to hospital within 28 days of discharge’, ‘rates of illicit and licit drug use’ and ‘mental health outcomes of consumers of specialised public mental health services’.

## 12.1 Framework for measuring health management performance

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers in specific settings, and the overall management of diseases, illnesses and injuries across a spectrum of services, including prevention, early detection and treatment programs. The measurement approach is summarised in figure 12.1.

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue. The Health sector overview in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The mental health management performance framework provides information on the interaction and integration arrangements between General Practitioners (GPs) (as the key providers of primary health), community‑based and hospital‑based providers in meeting the needs of people with a mental illness.

Figure 12.1 **The Australian health system — measurement approach**

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| Figure 12.1 The Australian health system - measurement approach.  More details can be found within the text surrounding this image. |

## 12.2 Profile of mental health management

Mental health relates to an individual’s ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

… a state of well‑being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental health is identified by governments as a national health priority area as are cancer, asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions, and obesity. The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003 and mental illnesses contribute significantly to this total burden (13.3 per cent) (Begg et al. 2007). The total burden comprises the number of ‘years’ lost due to fatal events (years of life lost due to premature death) and   
non‑fatal events (years of ‘healthy’ life lost due to disability). Mental illness is the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non‑fatal burden in 2003) (Begg et al. 2007).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual’s mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common mental illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes low prevalence conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010). While of lower prevalence, these conditions can severely affect people’s ability to function in their daily lives (Morgan et al. 2011).

Specialised mental health management services offered by a range of government and non‑government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non‑specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health and other, services. The performance of public hospitals is reported in chapter 10 and the performance of primary and community health services is reported in chapter 11.

This chapter focuses on the performance of State and Territory specialised public mental health services that treat the mostly low prevalence, but severe, mental illnesses. It also includes performance data on the mental health services provided by GPs, psychiatrists and other allied health professionals under the Medicare Benefits Schedule (MBS).

Other health and related services are also important for people with a mental illness, including alcohol and drug treatment services (chapter 11), public hospitals   
(chapter 10) and aged care services (chapter 13). This Report does not include specific performance information on these services’ treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 (School education), chapter 8 (Corrective services), chapter 9 (Fire and ambulance services), chapter 14 (Services for people with disability) and chapter 18 (Homelessness services).

Some key terms used in mental health management are outlined in   
section 12.6.

### Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of specialised public mental health services including admitted patient care in hospitals, community‑based ambulatory care services and community‑based residential care (for further details see the sector scope section later in this chapter). Some of these services are provided by non‑government organisations, for example governments’ can fund private and non‑government entities to provide admitted patient hospital care. State and Territory governments also fund not‑for‑profit,   
non‑government organisations (NGOs) to provide a range of support services for people with psychiatric disability arising from a mental illness.

The Australian Government is responsible for the funding of the following mental health services and related programs:

* MBS‑subsidised services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers)
* Pharmaceutical Benefits Scheme (PBS) funded mental health‑related medications
* other specific programs, including those provided by the non‑government sector, designed to increase the level of social support and community‑based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health‑related services through the Medicare Safety Net, the Department of Veterans’ Affairs (DVA) and the Private Health Insurance Premium Rebates.

The Australian Government also provides a specific purpose payment (SPP) to State and Territory governments for health services under the National Healthcare Agreement (NHA). According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have budget flexibility to allocate funds within that sector as they deem appropriate. Consequently, specific mental health funding cannot be separately identified in the Australian Government funding provided to State and Territory governments under the NHA.

The Australian, State and Territory governments also fund and/or provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

### Funding

Real government recurrent expenditure of around $7.0 billion was allocated to mental health services in 2011‑12 (table 12A.4). State and Territory governments made the largest contribution ($4.4 billion, or 63.5 per cent), although this includes Australian Government funding under the NHA SPP. The Australian Government spent $2.5 billion or 36.5 per cent of total government recurrent expenditure on mental health services (table 12A.4). Real average governments’ expenditure per person on specialised mental health services in 2011‑12 was $309, an increase from $242 in 2005‑06 (figure 12.2).

Figure 12.2 Real recurrent governments’ expenditure on mental health services, by funding source (2011‑12 dollars)**a, b, c**

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| Figure 12.2 Real recurrent governments' expenditure on mental health services, by funding source - 2011-12 dollars.  More details can be found within the text surrounding this image. |

a Real expenditure for all years (2011‑12 dollars), using the implicit price deflators for general government final consumption expenditure on hospitals and nursing homes (tables 12A.73 and 12A.74). b State and Territory governments’ expenditure includes expenditure sourced from ‘other revenue’ that includes patient fees and reimbursement by third party compensation insurers and from Australian Government funding provided under the Australian Health Care Agreement base grants/NHA SPP. c Australian Government expenditure includes funding provided for State and Territory governments’ specialised mental health services, see table 12A.3 for details.

*Source*: Department of Health (unpublished); Australian Institute of Health and Welfare (AIHW) (unpublished) Mental Health Establishments (MHE) National Minimum Data Set (NMDS); table 12A.4.

One of the largest components of Australian Government expenditure on mental health services in 2011‑12 was expenditure under the PBS for mental health‑related medications ($830.4 million) (table 12A.1). Real expenditure on PBS mental   
health‑related medications increased by an annual average rate of 1.5 per cent between 2005‑06 and 2011‑12. This average annual growth rate was lower than the overall Australian Government mental health services average annual expenditure growth rate of 6.2 per cent. Expenditure on PBS mental health‑related medications decreased as a share of real expenditure from 43.0 per cent in 2005‑06 to   
32.8 per cent in 2011‑12 (table 12A.1).

In 2011‑12, another significant component of Australian Government expenditure for mental health services was MBS payments for psychologists and other allied health professionals (social workers and occupational therapists) (14.6 per cent). Consultant psychiatrists also accounted for a significant share of expenditure at   
11.2 per cent (table 12A.1). For details on the remainder of the Australian Government’s expenditure for mental health services see table 12A.1.

Real expenditure per person on State and Territory governments’ specialised public mental health services has increased over time (figure 12.3). Recurrent expenditure on State and Territory governments’ specialised public mental health services includes expenditure funded from all sources, including the Australian Government. Expenditure on State and Territory governments’ specialised public mental health services by source of funding is in table 12A.3.

Figure 12.3 **Real recurrent expenditure on State and Territory governments’ specialised public mental health services  
(2011‑12 dollars)a, b, c, d, e**

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| Figure 12.3 Real recurrent expenditure on State and Territory governments’ specialised public mental health services 2011-12 dollars.  More details can be found within the text surrounding this image. |

**a** Real expenditure (2011‑12 dollars), using State and Territory implicit price deflators for general government final consumption on hospitals and nursing homes (table 12A.73). **b** Estimates of State and Territory governments’ spending include funding from other revenue (including patient fees and reimbursement by third party compensation insurers) and Australian Government funds. **c** Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.5. **d** Expenditure data on State and Territory governments’ specialised public mental health services by source of funding are presented in table 12A.3. **e** The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year.

*Source*: Department of Health (unpublished); State and Territory governments (unpublished); AIHW (unpublished) MHE NMDS; table 12A.2.

Figure 12.4 shows how recurrent expenditure on State and Territory governments’ specialised public mental health services was distributed across the different service types in 2011‑12.

Figure 12.4 Recurrent expenditure on State and Territory governments’ specialised public mental health services, by service category,   
2011‑12a, b, c, d, e

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| Figure 12.4 Recurrent expenditure on State and Territory governments’ specialised public mental health services, by service category, 2011-12.  More details can be found within the text surrounding this image. |

a Includes all State and Territory governments’ expenditure on specialised public mental health services, regardless of source of funds. b Depreciation is excluded. Depreciation estimates are reported in table 12A.5. c The differential reporting of clinical service providers and NGOs artificially segregates the mental health data. Given that the role of NGOs varies across states and territories, the level of expenditure on NGOs does not necessarily reflect the level of community support services available. d Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non‑government entities. e Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.6.

### Size and scope of sector

#### Prevalence of mental illness and high/very high levels of psychological distress

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey (table 12A.56). A further   
25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months   
(table 12A.56).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMHWB show that people with a lifetime mental disorder who had symptoms in the previous   
12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (table 12A.7). Analysis of the 1997 SMHWB showed a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders (ABS 2012). According to the ABS, which uses the K10 instrument in the SMHWB and National Health Surveys (NHS), the K10:

… is a scale designed to measure non‑specific psychological distress, based on questions about negative emotional states experienced in the past 30 days. … it is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may signify a need for professional help. It is also useful for estimating population need for mental health services (ABS 2012).

Females had higher proportions of very high levels of psychological distress than males in 2011‑12 (figure 12.5). People with disability or restrictive long‑term health condition and people in low socio‑economic areas also reported higher proportions of very high levels of psychological distress than other community groups   
(table 12A.9). In 2012‑13, 29.4 ± 2.1 per cent of Indigenous Australians aged 18 years or over reported high/very high levels of psychological distress   
(table 12A.15). After adjusting for age, this was 2.7 times the rate for   
non‑Indigenous adults. Tables 12A.8–16 contain additional data on high/very high levels of psychological distress from NHSs conducted in 2004‑05, 2007‑08 and 2011‑12.

Figure 12.5 Adults with very high levels of psychological distress, by sex, 2011‑12**a, b**

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| Figure 12.5 Adults with very high levels of psychological distress, by sex, 2011-12.  More details can be found within the text surrounding this image. |

a Adults are defined as people aged 18 years and over. b Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population.

*Source*: ABS (unpublished) *Australian Health Survey (AHS) 2011–13* (2011‑12 NHS component); table 12A.8.

#### Mental health services

There are a range of government provided or funded mental health services; the key services are the following:

* MBS‑subsidised mental health services — services provided by GPs, psychiatrists, psychologists or another allied health professionals on a fee‑for‑service basis that are partially or fully funded under Medicare.
* Admitted patient care in hospitals — services provided to admitted patients in stand‑alone psychiatric hospitals or in specialised psychiatric units in acute hospitals.
* Community‑based mental health services, comprising:
* ambulatory care services provided by outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care
* specialised residential services that provide beds in the community, staffed onsite (24 hour and non‑24 hour) by mental health professionals
* not‑for‑profit, non‑government organisations’ (NGO) services, funded by the Australian, State and Territory governments to provide community support for people with psychiatric disability, including accommodation, outreach to people living in their own homes, residential rehabilitation units, recreational programs, self‑help and mutual support groups, carer respite services and system‑wide advocacy (DoHA 2010).

##### MBS‑subsidised GP mental health services

GPs are often the first type of service accessed by people seeking help when suffering from a mental illness (AIHW 2012). GPs can diagnose, manage and treat mental illnesses and they also refer patients to more specialised service providers such as psychiatrists and psychologists (see other MBS‑subsidised services below).

According to the *Bettering the Evaluation and Care of Health* (BEACH) (an annual survey collected from a sample of approximately 1000 GPs), 12.1 per cent of   
GP encounters (an estimated 15.0 million MBS‑subsidised services) were mental health‑related in 2011‑12 (AIHW 2013). Under the BEACH, a mental health‑related encounter is defined as one at which a mental health‑related problem is managed. Problems managed reflect the GP’s understanding of the health problem presented by the patient. These encounters comprise those billed as general surgery consultations and those billed under specific mental health MBS items.

A GP can manage more than one problem at a single encounter. In 2011‑12,   
13.0 mental health‑related problems were managed per 100 encounters. Depression was the most frequently reported mental health‑related problem managed   
(4.4 per 100 GP encounters) and of all problems was the fifth most frequently managed (Britt et al*.* 2012). Anxiety (1.9 per 100 GP encounters) and sleep disturbance (1.5 per 100 GP encounters) were the next most common mental health‑related problems. The most common form of GP management for a mental health‑related problem was the prescription, supply or recommendation of a medication (AIHW 2013).

Another measure of GP mental‑health related activity is the number of services provided under specific mental health MBS items (GP Mental Health Treatment Plan, Focussed Psychological Strategies and Family Group Therapy). In 2011‑12, 2.2 million MBS‑subsidised specific mental health MBS items (97.6 per   
1000 people) were provided by GPs and Other Medical Practitioners (OMPs) (table 12A.17).

##### Other MBS‑subsidised services

In 2011‑12, 5.7 million other MBS‑subsidised mental health‑related services were provided by psychiatrists, psychologists and other allied health professionals (AIHW 2013). This comprised 3.4 million provided by psychologists, 2.1 million services provided by psychiatrists, and 231 182 services provided by other allied health professionals (table 12A.17). This was equivalent to 153.4 psychologist services, 91.6 psychiatrist services, and 10.3 other allied health services   
per 1000 people (table 12A.17).

##### Admitted patient care and community‑based mental health services — service use, patient days, beds and staffing

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community‑based mental health services, is problematic as the way activity is measured differs across the service types. Service activity is reported by separations for admitted patient care, episodes for community‑based residential care and contacts for community‑based ambulatory care. Service use data for the NGO sector are not available.

There were 86 669 separations with specialised psychiatric care in public acute hospitals and 9561 specialised psychiatric care separations in public psychiatric hospitals in 2010‑11 (table 12A.19). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (21.0 per cent in public acute hospitals and 22.4 per cent in public psychiatric hospitals)   
(table 12A.19). Ambulatory equivalent specialised psychiatric care is also provided in public hospitals. In 2009‑10, the latest year for which data are published, there were 5193 of these separations from public acute hospitals and 132 in public psychiatric hospitals (AIHW 2013).

There were 4234 episodes of community‑based residential care in 2010‑11   
(table 12A.21). Schizophrenia, schizotypal and delusional disorders (F20‑29) as a principal diagnosis accounted for the largest proportion of these episodes   
(61.5 per cent) (AIHW 2013). There were 7.2 million community‑based ambulatory care patient contacts, equivalent to 326.8 contacts per 1000 people, in 2010‑11 (table 12A.21). For those contacts, the largest proportion was for the principal diagnosis of schizophrenia (25.6 per cent) (AIHW 2013).

Data on service use by the Indigenous status of patients are available, but comparisons are not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous Australians, and differences in the complexity, incidence and prevalence of illnesses between Indigenous and non‑Indigenous Australians. Table 12A.21 contains information on use of these services by Indigenous status.

Activity can also be measured across specialised public mental health services by accrued mental health patient days, mental health beds and full time equivalent (FTE) direct care staff. Admitted patient care and community‑based residential   
(24 hour staffed) accrued patient days per 1000 people for 2011‑12 are included in figure 12.6.

Figure 12.6 Accrued mental health patient days, 2011‑12**a, b, c**

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| Figure 12.6 Accrued mental health patient days, 2011-12.  More details can be find within the text surrounding this image. |

a Hospital patient days include those funded by government, but provided by services managed and operated by private and non‑government entities. b Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services. c The ACT and the NT do not have non‑acute hospital units.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.18.

Beds are counted as those that can provide overnight accommodation for patients admitted to hospital or residential services (see section 12.6 for more details). Figure 12.7 presents the number of beds per 100 000 people by service setting, in 2011‑12. These data show the differences in service mix across states and territories.

Figure 12.8 reports FTE direct care staff per 100 000 people employed across the admitted patient and community‑based services (ambulatory and residential). Nursing staff comprise the largest FTE component of direct care staff employed in specialised public mental health services. Across Australia in 2011‑12, there were 68.2 nurses per 100 000 people, compared with 25.2 allied health care staff,   
13.1 medical staff and 5.1 other personal care staff (table 12A.23). FTE direct care staff employed in specialised public mental health services, by service setting, are reported in table 12A.24.

Figure 12.7 Mental health beds in public hospitals and community‑based residential units, 2011‑12**a, b, c, d**

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| Figure 12.7 Mental health beds in public hospitals and community-based residential units - 2011-12.  More details can be found within the text surrounding this image. |

a Includes beds in public hospitals and publicly funded community‑based residential units. b Hospital beds can include government funded beds managed and operated by private and non‑government entities.  
c Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services. d Tasmania, the ACT and the NT do not have public psychiatric hospitals.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.22.

Figure 12.8 FTE health professional direct care staff**a, b**

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| Figure 12.8 FTE health professionals direct care staff.  More details can be found within the text surrounding this image. |

a Includes staff within the health professional categories of ‘medical’, ‘nursing’, ‘allied health’ and ‘other personal care’. Section 12.6 provides detailed definitions for these staffing categories. b The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.23.

### Case study

Box 12.1 contains a case study on the influence of community follow‑up contact on reducing psychiatric inpatient hospital readmissions within 28 days.

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| Box 12.1 Reducing psychiatric inpatient hospital readmission within  28 days, influenced by seven day follow‑up contact |
| Readmissions following a recent discharge from an acute psychiatric inpatient episode can indicate that inpatient treatment was either incomplete or ineffective, or that  follow‑up care was inadequate to maintain the person out of hospital. The relationship between acute psychiatric inpatient readmission and contact with mental health services post‑discharge (follow‑up care) has been explored in the ACT. Results indicate that reduction in readmissions is influenced by the amount, the quality and the type of follow‑up community contact including who, beyond the consumer, is involved.  The ACT provides a high level of follow‑up care, including high frequency contact over a number of days to weeks — this is possible due, in part, to the size of the jurisdiction, service accessibility and system attributes.   * Mental health services in the ACT are provided by one central organisation. * Public mental health service provision is captured in a centralised electronic system, covering both inpatient and community services ― this enables service providers to coordinate and be aware of clinical care within inpatient services and across the community.   Follow‑up community care that engages consumers’ family and carers is another key factor in reducing the need for further inpatient care. Follow‑up contact that includes direct face‑to‑face contact and involves significant others in the consumer’s life appears to improve the likelihood of the consumer remaining in the community for longer and reduces the possibility of relapse to a degree requiring an inpatient  readmission.  Community follow‑up within seven days of discharge  In the ACT, rates of community follow‑up within seven days of discharge have improved progressively over the period 2005‑06 to 2012‑13 and are relatively high compared to the national average. The ACT rate exceeded the *indicative* national target agreed under the *Measurement Strategy for the Fourth National Mental Health Plan* (75 per cent) from 2010‑11. |
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| Box 12.1 (continued) |
| **Box 12.1 Reducing psychiatric inpatient hospital readmission within 28 days, influenced by seven day follow-up contact.  More details can be found within the text surrounding this image.**  **Readmission within 28 days of discharge from an initial inpatient episode**  Rates of psychiatric inpatient hospital readmission within 28 days have decreased and are trending lower compared to the national average. The ACT rate has been below the indicative national target agreed under the Measurement Strategy for the Fourth National Mental Health Plan since 2006‑07 until 2010‑11. In 2011‑12, the trend was reversed creating a spike in that year, but the rate decreased again in 2012‑13.  Box 12.1 (cont'd) Readmission within 28 days of discharge from an initial inpatient episode.  More details can be found within the text surrounding this image.  The relationship between community follow‑up and readmission is complex and influenced by a range of factors not directly related to the two indicators shown here. Between 2010 and 2012 a number of changes were introduced in the ACT, this included, an increase in the number of available beds for inpatient admissions (a new inpatient unit), implementation of a Mental Health Assessment Unit in the Emergency Department and the introduction of Step‑Up‑Step‑Down community ‘placements’  pre‑ and post‑admission (the reduction in the readmissions rate may be partly due to these additional services diverting the need for an inpatient admission, however their use is not included in the data provided for this indicator). These services continue to emphasise maintaining people in the community for longer, offering pre‑admission inpatient assessment and early treatment, and offering alternative options to inpatient admission where appropriate. |
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| Box 12.1 (continued) |
| These changes have caused adjustments to the inpatient casemix. A greater share of consumers admitted to hospital are now more likely to require a subsequent hospital admission due to the complexity, co‑morbidity and nature of their longer term mental illnesses and their longer more variable recovery phase due to the influence of substance use. An improved understanding of the interplay of these indicators would benefit from further analysis of case‑mix ― particularly co‑morbidity, complexity of presentations and the effect of substance use/abuse.  Results for 2012‑13 indicate a period of adjustment to the changes made to services available and management of those services for the types of case‑mix consumers most in need of inpatient care and more intense community follow‑up from 2011‑12.  The consumer’s engagement with other community support services and family and friends where possible, also influences their degree of acuity and coping ability and prolongs their functional capacity to minimise their need for further acute inpatient care. |
| *Source*:ACT Government (unpublished). |
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## 12.3 Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

The framework of performance indicators for mental health services draws on governments’ broad objectives for national mental health policy, as encompassed in the *National Mental Health Policy 2008* (box 12.2). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS‑subsidised, admitted patient and community‑based services) and includes outcome indicators of   
system‑wide performance.

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| Box 12.2 Broad objectives and policy directions of National Mental Health Policy |
| The *National Mental Health Policy 2008* has an emphasis on whole‑of‑government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia’s mental health system. The key broad objectives are to:   * promote the mental health and well‑being of the Australian community and, where possible, prevent the development of mental health problems and mental illness * reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community * promote recovery from mental health problems and mental illness * assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.   The key policy directions are summarised as follows:   * Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected. * Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community. * The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced. * Emerging mental health problems or mental illnesses will receive early intervention to minimise the severity and duration of the condition and to reduce its broader impacts. * People will receive timely access to high quality, coordinated care appropriate to their conditions and circumstances. * People with mental health problems and mental illness will enjoy full social, political and economic participation in their communities. * The crucial role of carers will be acknowledged and respected and they will be provided with appropriate support to enable them to fulfil their role. * The mental health workforce will be appropriately trained and adequate in size and distribution to meet the need for care. * Across all sectors, mental health services should be monitored and evaluated to ensure they are of high quality and achieving positive outcomes. * Research and evaluation efforts will generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions. |
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### National Mental Health Strategy

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the National Mental Health Strategy (NMHS) endorsed by Australian, State and Territory governments in 1992   
(AIHW 2008). During 2011‑12, the Statement was updated to align with the *National Mental Health Policy 2008* and Australia’s international obligations with respect to the United Nations Convention on the Rights of Persons with Disabilities and the United Nations Convention on the Rights of the Child.

The NMHS was established to guide the reform agenda for mental health in Australia across the whole‑of‑government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan. The National Mental Health Policy describes the broad aims and objectives of the NMHS. The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. The fourth plan aims to strengthen the accountability framework with Australian, State and Territory governments by developing targets and data sources for a set of indicators and to provide annual progress reports to Council of Australian Governments (COAG) (AHMC 2009). These indicators will be the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

### COAG National Healthcare Agreement

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations).

The NHA covers the areas of health and aged care services. The NHA includes sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council. Performance indicators reported in this chapter are aligned with the mental health‑related performance indicators in the NHA. The NHA was reviewed in 2011, 2012 and 2013 resulting in changes that have been reflected in this Report, as relevant.

### Performance indicator framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.9). The performance indicator framework shows which data are complete and comparable in the 2014 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report‑wide perspective (section 1.6).

The Report’s statistical context chapter contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (chapter 2).

Data quality information is being progressively introduced for all indicators in the Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators. DQI in this Report cover the seven dimensions in the ABS’ data quality framework (institutional environment, relevance, timeliness, accuracy, coherence, accessibility and interpretability) in addition to dimensions that define and describe performance indicators in a consistent manner, and key data gaps and issues identified by the Steering Committee. All DQI for the 2014 Report can be found at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 12.9 Mental health management performance indicator framework

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| Figure 12.9 Mental health management performance indicator framework.  More details can be found within the text surrounding this image. |

## 12.4 Key performance indicators for mental health management

### Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

#### Equity — access — new client index

‘New client index’ is an indicator of governments’ objective to provide mental health services in an equitable manner (box 12.3). Population treatment rates are relatively low and it might be difficult for a new client to access specialised public mental health services if resources are already utilised by existing clients.

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| Box 12.3 New client index |
| ‘New client index’ is defined as the proportion of total clients under the care of State and Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.  A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access specialised public mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.  This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.  Data reported for this indicator are:   * comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania * incomplete for the current reporting period. All required 2011‑12 data are not available for Victoria.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10. Data for 2011‑12 are not available for Victoria due to service level collection gaps resulting from protected industrial action during this period. This affects all data collected in community‑based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. Victoria has requested no substitute or proxy data be included at the jurisdictional level or to fill the gap in calculation of the national results. The total includes only those states and territories that have provided data.

Figure 12.10 Proportion of total clients of State and Territory specialised public mental health services who are new**a, b, c, d, e**

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| Figure 12.10 Proportion of total clients of State and Territory specialised public mental health services who are new.  More details can be found within the text surrounding this image. |

a Clients in receipt of services include all people who received one or more community‑based ambulatory service contact or had one or more day of inpatient or community‑based residential care in the data period.   
b A new client is a consumer who had not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service. c The approach to identifying unique clients differs across jurisdictions. Some have a State‑wide unique patient identifier, others use a statistical linkage key. For SA, the client counts are not unique, but are an aggregation of three separate databases. d Victorian 2011‑12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. e Industrial action in Tasmania has limited the available data quality and quantity of data for 2011‑12.

*Source*: State and Territory governments (unpublished); table 12A.25.

#### Equity — access — mental health service use by selected community groups

‘Mental health service use by selected community groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by selected community groups such as Indigenous Australians (box 12.4).

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| Box 12.4 Mental health service use by selected community groups |
| ‘Mental health service use by selected community groups’ is defined by two measures:   * proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services * proportion of the population in a selected community group using MBS‑subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS‑subsidised ambulatory mental health services.   The selected community groups reported are Indigenous Australians, people from outer regional, remote and very remote locations and people residing in low  socio‑economic areas. For MBS‑subsidised ambulatory mental health services, data by socio‑economic status are reported by decile at the national level only.  This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community group. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.  Data reported for the ‘proportion of the population in a selected community group using State and Territory specialised public mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011‑12 by geographic location and Socio Economic Indexes for Areas (SEIFA) are not comparable to previous years’ data * incomplete for the current reporting period (subject to caveats). All required 2011‑12 data are not available for Victoria.   Data reported for the ‘proportion of the population in a selected community group using MBS‑subsidised ambulatory mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011‑12 by geographic location and SEIFA are not comparable to previous years’ data * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The proportions of the population using State and Territory specialised public mental health services in 2011‑12, by selected community groups are reported in   
figure 12.11. The results are not available for Victoria or at the national level.

These results, which are derived using community‑based ambulatory care data, should be interpreted with care, as:

* people receiving only admitted and/or community‑based residential services are not included in the proportion of people accessing services or in rates of service use
* there is no identifier to distinguish ‘treatment’ versus ‘non‑treatment’ service contacts in the community mental health care data set
* jurisdictions differ in their collection and reporting of community‑based ambulatory care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS‑subsidised ambulatory mental health services, by selected community groups, are reported in figure 12.12. Data are not available at the State and Territory level for Socio Economic Indexes for Areas (SEIFA) quintiles.

Data on the use of State and Territory community‑based specialised public mental health services and MBS‑subsidised ambulatory mental health services by SEIFA deciles are in table 12A.29. Data on the use of private hospital mental health services are also contained in tables 12A.26–29.

Figure 12.11 Population using State and Territory specialised public mental health services, by selected community group, 2011‑12**a, b, c, d, e, f, g, h**

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| **Indigenous status** |
| Figure 12.11 Population using State and Territory specialised public mental health services, by selected community group 2011-12 (by Indigenous status)  More details can be found within the text surrounding this image. |
| **Geographic location** |
| Figure 12.11 Population using State and Territory specialised public mental health services, by selected community group 2011-12 (by geographic location)  More details can be found within the text surrounding this image. |
| **SEIFA** |
| Figure 12.11 Population using State and Territory specialised public mental health services, by selected community group 2011-12 (by SEIFA)  More details can be found within the text surrounding this image. |

SEIFA = Socio‑Economic Indexes for Areas. a Proportions are age‑standardised to the Australian population as at 30 June 2001. b State and Territory specialised public mental health services are counts of people receiving one or more service contact provided by community‑based ambulatory services. c Data are not available for Victoria or at the national level. d SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. e Disaggregation by remoteness area is based on a person’s usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. f Tasmania does not have major cities. SEIFA Quintile 5 is not applicable for Tasmania. g The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. h The NT does not have major cities or inner regional locations.

*Source*: State and Territory governments (unpublished) Community Mental Health Care (CMHC) data; tables 12A.26–28.

Figure 12.12 Population using MBS‑subsidised ambulatory mental health services, by selected community group, 2011‑12**a, b, c, d, e**

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| **Indigenous status** |
| Figure 12.12 Population using MBS- subsidised ambulatory mental health services, by selected community group 2011-12 (by Indigenous status)  More details can be found within the text surrounding this image. |
| **Geographic location** |
| Figure 12.12 Population using MBS-subsidised ambulatory mental health services, by selected community group 2011-12 (by Geographic location)  More details can be found within the text surrounding this image. |
| **SEIFA** |
| Figure 12.12 Population using MBS-subsidised ambulatory mental health services, by selected community group 2011-12 (by SEIFA)  More details can be found within the text surrounding this image. |

SEIFA = Socio‑Economic Indexes for Areas. a Proportions are age‑standardised to the Australian population as at 30 June 2001. b MBS‑subsidised services are those mental health‑specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in table 12A.30.   
c Disaggregation by remoteness area is based on a person’s usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. d Victoria does not have very remote areas. Tasmania does not have major cities. The ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. e Data for SEIFA quintiles are not available by state or territory.

*Source*: Department of Health (unpublished) MBS Statistics data; DVA (unpublished); tables 12A.26–28.

#### Effectiveness — access — mental health service use by total population

‘Mental health service use by total population’ is an indicator of governments’ objective to provide equitable access to mental health services for all people who need them (box 12.5). An estimate of the population who need mental health services is not available, so the indicator is reported as a proportion of the total population.

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| Box 12.5 Mental health service use by total population |
| ‘Mental health service use by total population’ is defined as the proportion of the population using a State and Territory specialised public mental health service or a MBS‑subsidised service. Data are reported separately for State and Territory specialised public mental health services and MBS‑subsidised services. Data from the 2007 SMHWB on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported in tables 12A.31−32.  This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.  This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. People with a mental illness can have low rates of service use due to them choosing not to access services, appropriate services are unavailable, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).  Data reported for the ‘proportion of the population using State and Territory specialised public mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period (subject to caveats). All required 2011‑12 data are not available for Victoria.   Data reported for the ‘proportion of the population using MBS‑subsidised ambulatory mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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In 2011‑12, 1.8 per cent and 7.1 per cent of the total population received   
State and Territory specialised public mental health services and MBS‑subsidised (MBS general and DVA), respectively (figure 12.13).

Figure 12.13 Population receiving mental health services, by service type, 2011‑12**a, b, c, d**

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| Figure 12.13 Population receiving mental health services by service type, 2011-12.  More details can be found within the text surrounding this image. |

a Rates are age‑standardised to the Australian population as at 30 June 2001. b Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community‑based ambulatory services (most people who have received an inpatient service or residential care service have also received a service contact with a community‑based ambulatory service).   
c MBS‑subsidised services are those specific mental health services provided under the general MBS and DVA by psychiatrists, clinical psychologists, GPs and other allied health services. The specific MBS items included are detailed in table 12A.30. People seen by more than one provider type are counted only once.   
d Data for State and Territory specialised public mental health services are not available for Victoria for   
2011‑12 due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

*Source*: State and Territory governments (unpublished) CMHC data; Department of Health (unpublished)   
MBS Statistics data; DVA (unpublished); table 12A.30.

#### Effectiveness — access — primary mental health care for children and young people

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to prevent, where possible, the development of mental health problems and mental illness and undertake early intervention for mental health problems and mental illness (box 12.6). Early identification of and intervention in mental illnesses for children and young people can result in better outcomes.

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| Box 12.6 Primary mental health care for children and young people |
| ‘Primary mental health care for children and young people’ is defined as the proportion of young people aged under 25 years who received a primary mental health care service subsidised through the MBS. Data are also reported by four age cohorts: pre‑school (0–<5 years), primary school (5–<12 years), secondary school  (12–<18 years) and youth/young adult (18–<25 years).  High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable.  This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2012‑13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses and university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011a).

In 2012‑13, 5.2 per cent of all children and young people aged under 25 years had contact with MBS‑subsidised primary mental health care services (figure 12.14).

Figure 12.14 **Children and young people who received MBS‑subsidised primary mental health care, 2012‑13**

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| Figure 12.14 Children and young people who received MBS subsidised primary mental health care, 2012-13.  More details can be found within the text surrounding this image. |

*Source*: Department of Health (unpublished); table 12A.33.

#### Effectiveness — appropriateness — services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.7). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care (see box 12.8 for details on the relevant standards). This indicator has been revised for this year’s Report to weight the results by expenditure. This provides a better understanding of the share of activity covered by the different assessment levels.

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| Box 12.7 Services reviewed against the National Standards |
| ‘Services reviewed against the National Standards’ is defined as the proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:   * *Services at level 1* — services reviewed by an external accreditation agency and judged to have met all National Standards. |
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| Box 12.7 (continued) |
| * *Services at level 2* — services reviewed by an external accreditation agency and judged to have met some but not all National Standards. * *Services at level 3* — services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency. * *Services at level 4* — services that do not meet criteria detailed under levels 1 to 3.   A high or increasing proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.  The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self‑assessment preparation.  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The standards have been broadened to include non‑government community mental health services and private office‑based services as well as specialised public mental health services. Implementation guidelines have also been released.

Box 12.8 outlines the 2010 NSMHS against which public mental health services are now assessed. External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

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| Box 12.8 The 2010 National Standards for Mental Health Services |
| The first NSMHS were developed under the *First National Mental Health Plan  1993–1998*. Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The 2010 NSMHS comprise 10 overarching standards:  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.  In future, services will be required to undergo accreditation against the ten new national safety and quality health service standards mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the revised  2010 NSMHS. Reaccreditation against the 2010 NSMHS was to be undertaken by 2014. However, services indicated their preference to undertake NSMHS reaccreditation in conjunction with the accreditation against the ACSQHC standards which were implemented from January 2013 onwards. |
| *Source*: AHMC (2010) and Department of Health (unpublished). |
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Figure 12.15 shows the proportion of expenditure on specialised public mental health services that had completed an external review against the NSMHS and were assessed as meeting ‘all standards’ (level 1) or as meeting ‘some but not all standards’ (level 2). Figure 12.15 also shows the proportion of expenditure on specialised public mental health services that were either in the process of being reviewed by an external accreditation agency but the outcomes were not known, or that had booked for review by an external accreditation agency (level 3); and those that did not meet criteria detailed under levels 1 to 3 (level 4).

Figure 12.15 Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level,   
30 June 2012**a, b**

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| Figure 12.15 Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level, 30 June 2012   More details can be found within the text surrounding this image. |

a Data are based on expenditure on individual service units within mental health organisations, not at the whole organisation level. However, there is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to a service unit. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the organisation's units are ‘counted’ at that assessment level. In other jurisdictions, service units are ‘counted’ individually at assessment levels and assessment levels may or may not be consistent across the units within an organisation. The approach can also vary across organisations within a single jurisdiction. b Box 12.7 contains definitions of the assessment levels.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.34.

#### Effectiveness — appropriateness — services provided in the appropriate setting

‘Services provided in the appropriate setting’ is an indicator of governments’ objective to provide mental health services in mainstream or community‑based settings wherever possible (box 12.9).

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| Box 12.9 Services provided in the appropriate setting |
| ‘Services provided in the appropriate setting’ is defined as the proportion of State and Territory governments’ recurrent expenditure on specialised mental health services (excluding aged care community residential expenditure) that was on community‑based services. Community‑based services are defined as ambulatory care, adult residential services and non‑government organisations. Aged residential care is excluded to improve comparability.  A high or increasing proportion of recurrent expenditure spent on community‑based services is desirable, reflecting a greater reliance on services that are based in community settings.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the treatment of patients in community‑based settings, rather than in stand‑alone psychiatric hospitals and public (non‑psychiatric) hospitals.

Figure 12.16 shows recurrent expenditure on community‑based services as a proportion of total expenditure on specialised public mental health services.

Figure 12.16 Recurrent expenditure on community‑based services as a proportion of total expenditure on specialised public mental health services**a, b, c, d**

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| Figure 12.16 Recurrent expenditure on community-based services as a proportion of total expenditure on specialised public mental health services.  More details can be found with the text surrounding this image. |

a Community‑based expenditure includes expenditure on ambulatory, NGO grants andadult residential services. Aged care residential expenditure is excluded to improve comparability. b Total expenditure on specialised public mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. c Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services. d The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.35.

#### Effectiveness — appropriateness — collection of information on consumers’ outcomes

‘Collection of information on consumers’ outcomes’ is an indicator of governments’ objective that consumer outcomes be monitored (box 12.10). It is a process indicator, reflecting the capability of services in establishing systems to collect information on consumers’ mental health outcomes.

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| Box 12.10 Collection of information on consumers’ outcomes |
| ‘Collection of information on consumers’ outcomes’ is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community‑based care, people discharged from community‑based care and people discharged from hospital).  High or increasing proportions of episodes for which information on consumers’ mental health outcomes is collected is desirable.  This indicator monitors the uptake of the routine National Outcomes Casemix Collection. It does not provide information on whether consumers had appropriate outcomes.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period. All required data for 2011‑12 are not available for Victoria.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The estimated proportions of specialised public mental health service episodes for which information on consumers’ mental health outcomes is collected are shown in figure 12.17.

Figure 12.17 Estimated proportion of episodes for which ‘complete’ consumer outcome measures were collected, 2011‑12**a, b, c, d**

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| Figure 12.17 Estimated proportion of episodes for which complete consumer outcome measures were collected, 2011-12.  More details can be found with the text surrounding this image. |

a These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government (Department of Health). To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a ‘matching pair’ — that is, a beginning and end rating are needed to enable an outcome score to be determined. b Victorian 2011‑12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. c Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011‑12. d For the ACT the proportion of matched pairs for people discharged from a community episode of care (Group B) was below the statistical threshold for a meaningful comparison.

*Source*: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.36.

#### Quality — safety — rate of seclusion ― acute inpatient units

‘Rate of seclusion ― acute inpatient units’ is an indicator of governments’ objective that services are of a high quality and safe (box 12.11). The reduction, and where possible elimination of, seclusion and restraint in specialised public mental health services is a national safety priority for specialised public mental health services(NMHWG 2005).

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| Box 12.11 Rate of seclusion ― acute inpatient units |
| ‘Rate of seclusion ― acute inpatient units’ is defined as the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units. Seclusion involves a patient being confined at any time of the day or night alone in a room or area from which it is not within their control to leave (NMHWG 2005;  NMHPSC 2011b). See section 12.6 for further details on seclusion and how ‘seclusion events’ are defined.  A low or decreasing number of seclusion events per 1000 patient days (or where possible none) in specialised public mental health inpatient units is desirable.  The indicator does not provide any information on the duration of seclusion events. Information on the duration of seclusion events if reported alongside this indicator would provide a better understanding of performance in relation to the use and management of seclusion in inpatient units.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required data for 2012‑13 are available for all jurisdictions.   Data quality information for this indicator is under development. |
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Data on the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units are shown in figure 12.18. Legislation (a Mental Health Act or equivalent) or mandatory policy governs the use of seclusion in each State and Territory and the definition of ‘seclusion’ can vary across jurisdictions (NMHPSC 2011b).

Figure 12.18 Rate of seclusion**a, b, c, d**

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| Figure 12.18 Rate of seclusion.  More details can be found with the text surrounding this image. |

a Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee of the Mental Health, Drug and Alcohol Principal Committee, in partnership with the relevant state and territory authorities.  
b Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should be made with caution. c Detailed notes on jurisdictions’ seclusion collections are in table 12A.37. d SA and the NT data for 2008‑09 are not available.

*Source*: AIHW (2013); table 12A.37.

#### Quality — responsiveness — consumer and carer experiences of services

‘Consumer and carer experiences of services’ is an indicator of governments’ objective that services are of a high quality and responsive to the needs of consumers and their carers (box 12.12). Consumers and their carers should have positive experiences in all mental health service areas with clinicians and services provided. Both are important aspects of the NMHS.

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| Box 12.12 Consumer and carer experiences of services |
| ‘Consumer and carer experiences of services’ is yet to be defined.  Data for this indicator were not available for the 2014 Report. |
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#### Quality — responsiveness — consumer and carer involvement in decision making

‘Consumer and carer involvement in decision making’ is an indicator of governments’ objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.13). Consumer and carer involvement is an important aspect of the NMHS.

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| Box 12.13 Consumer and carer involvement in decision making |
| ‘Consumer and carer involvement in decision making’ is defined by two measures:   * the number of paid FTE consumer staff per 1000 FTE direct care, consumer and carer staff * the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.   High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carer staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data before 2010‑11 are not comparable to data from that year * complete for the current reporting period (subject to caveats). All required data for 2011‑12 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Figure 12.19 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff.

Figure 12.19 Paid FTE consumer or carer staff per 1000 paid FTE direct care, consumer and carer staff**a, b, c, d, e**

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| **Consumer staff** |
| Figure 12.19 Paid FTE consumer or carer staff per 1000 paid FTE direct care, consumer and carer staff (consumer staff)  More details can be found with the text surrounding this image. |
| **Carer staff** |
| Figure 12.19 Paid FTE consumer or carer staff per 1000 paid FTE direct care, consumer and carer staff (Carer staff)  More details can be found with the text surrounding this image. |

a Data up to 2009‑10 were restricted to consumer/carer consultants. From 2010‑11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. Comparisons between data up to 2009‑10 with data from 2010‑11 should not be made b The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year. c WA has advised that this information does not represent the full range of consumer and carer participation (see table 12A.38 for further details). d Tasmania did not employ consumer and carer staff in 2007-08. e The ACT and the NT do not employ consumer and carer staff.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.38.

#### Quality — continuity — specialised public mental health service consumers with nominated GP

‘Specialised public mental health service consumers with nominated GP’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services. GPs can be an important point of contact for those with a mental illness (box 12.14).

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| Box 12.14 Specialised public mental health service consumers with nominated GP |
| ‘Proportion of specialised public mental health service consumers with nominated GP’ is yet to be defined.  Data for this indicator were not available for the 2014 Report. |
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#### Quality — continuity — post discharge community care

‘Post discharge community care’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.15).

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| Box 12.15 Post discharge community care |
| ‘Post discharge community care’ is defined as the proportion of admitted patient overnight acute separations from psychiatric inpatient services for which a  community‑based ambulatory mental health care contact was recorded in the seven days following separation.  A high or increasing rate of community follow up within the first seven days of discharge from hospital is desirable.  This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face‑to‑face community contacts. Only community‑based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.  Data reported for this indicator are:   * comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania * incomplete for the current reporting period. All required 2011‑12 data are not available for Victoria.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011a).

Data on the rates of community follow up for people within the first seven days of discharge from an acute inpatient psychiatric unit are reported in figure 12.20.

Figure 12.20 Community follow up for people within the first seven days of discharge from acute inpatient psychiatric units**a, b, c, d, e**

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| Figure 12.20 Community follow up for people within the first seven days of discharge from acute inpatient psychiatric units.  More details can be found with the text surrounding this image. |

a Community‑based ambulatory mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the effect on the indicator is immaterial). Contacts made on the day of discharge are also excluded. b Due to data supply issues, totals for 2011‑12 should be interpreted with caution.The total only includes those jurisdictions that have provided data. c Victorian data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. d Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011‑12. e Data are not comparable across jurisdictions. States and territories vary in their capacity to accurately track post‑discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers. Three jurisdictions — WA, SA and Tasmania — indicated that the data submitted were not based on unique patient identifiers. Results for these jurisdictions could appear ‘lower’ relative to jurisdictions that are able to track utilisation across services.

*Source*: State and Territory unpublished, admitted patient and community mental health care data;   
table 12A.39.

#### Quality — continuity — readmissions to hospital within 28 days of discharge

‘Readmissions to hospital within 28 days of discharge’ is an indicator of governments’ objective to provide effective care and continuity of care in the delivery of mental health services (box 12.16).

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| Box 12.16 Readmissions to hospital within 28 days of discharge |
| ‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.  A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospital is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow‑up care was inadequate to maintain people out of hospital (NMHPSC 2011a).  Readmission rates are affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG Information Strategy Committee Performance Indicator Drafting Group 2005).  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.21.

Figure 12.21 Readmissions to hospital within 28 days of discharge from acute psychiatric units**a**

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| Figure 12.21 Readmissions to hospital within 28 days of discharge from acute psychiatric units.  More details can be found within the text surrounding this image. |

a No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital.

*Source*: Department of Health unpublished, from data provided by State and Territory governments’ health authorities; table 12A.41.

#### Efficiency — Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

*Efficiency — cost of inpatient care*

‘Cost of inpatient care’ is an indicator of governments’ objective that specialised public mental health services are delivered in an efficient manner (box 12.17).

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| Box 12.17 **Cost of inpatient care** |
| ‘Cost of inpatient care’ is defined by two measures:   * ‘Cost per inpatient bed day’ is defined as the cost of providing inpatient services per inpatient bed day — data are disaggregated by hospital and care type (psychiatric hospitals [acute units and non‑acute units] and general hospitals [acute and  non‑acute units]) and by inpatient target population (acute units only). * ‘Average length of stay’ is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Patient days for clients who separated in the reference period (2011‑12) that were during the previous period (2010‑11) are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.   These measures are considered together for the inpatient acute units by target population to provide a ‘proxy’ measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.  A low or decreasing cost per inpatient bed day combined with similar or shorter average lengths of stay can indicate more efficient service delivery, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.  This indicator does not account for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More suitable measures for mental health services would be cost per  casemix adjusted separation, for which cost is adjusted to take into account the type and complexity of cases, and the relative stay index (that also adjusts for casemix) similar to those presented for public hospitals (chapter 10). Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.  Data reported for the two measures for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions providing the services.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Data on average recurrent cost per inpatient bed day by hospital (psychiatric and public acute) and care type (acute or non‑acute) are reported in figure 12.22. Costs per inpatient bed day and average length of stay data for acute units by inpatient target population (for psychiatric and public acute hospitals combined) are presented in figure 12.23. Data for forensic services are included for costs per inpatient bed day only as the length of stay is dependent on factors outside the control of the specialised public mental health services. Data for cost per inpatient bed day for all units by target population are included in table 12A.42.

Figure 12.22 **Average recurrent cost per inpatient bed day, public hospitals, by hospital and care type, 2011‑12a, b, c, d, e, f, g**

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| Figure 12.22 Average recurrent cost per inpatient bed day, public hospitals by hospital and care type, 2011-12.  More details can be found within the text surrounding this image |

**a** Depreciation is excluded. **b** Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). **c** Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. **d** Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non‑government entities. **e** Queensland data for public acute hospitals include costs associated with extended treatment services (campus‑based and   
non‑campus‑based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. **f** Tasmania, the ACT and the NT do not have psychiatric hospitals. **g** SA, the ACT and the NT do not have non‑acute units in general hospitals.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.45.

Data on ‘average length of stay’ should be considered with caution. The quality of the separations data used to derive them is variable across jurisdictions. Until recently, these separations data were not subject to in‑depth scrutiny. It is expected that the quality of these data will improve over time.

The ‘average length of stay’ data reported here may not match data reported elsewhere (such as the AIHW’s *Mental Health Services in Australia* publication) due to differences in scope, for example these data include separations and days within the reference period only.

Figure 12.23 **Costs for inpatient care in acute units of public hospitals, by target population, 2011‑12a, b, c, d, e, f, g**

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| **Cost per inpatient bed day** |
| **Figure 12.23 Costs per inpatient care in acute units of public hospitals, by target population, 2011-12 (cost per inpatient bed day)  More details can be found within the text surrounding this image** |
| **Average length of stay** |
| Figure 12.23 Costs per inpatient care in acute units of public hospitals, by target population, 2011-12 (average length of stay)  More details can be found within the text surrounding this image |

a Depreciation is excluded. b Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). c Hospital inpatient expenditure can include expenditure on government funded public hospital services managed and operated by private and non‑government entities. d Queensland provides older persons’ mental health inpatient services using a number of different service models, however the majority of older persons’ acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Additionally, Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units, which may also impact on the comparability of both cost and length of stay data. e Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people’s mental health services.   
f The ACT does not have separate forensic or child and adolescent mental health inpatient services. g The NT has general mental health services only.

*Source*: AIHW (unpublished) MHE NMDS; tables 12A.43‑44.

#### Efficiency — cost of community‑based residential care

‘Cost of community‑based residential care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner   
(box 12.18).

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| Box 12.18 Cost of community‑based residential care |
| ‘Cost of community‑based residential care’ is defined as the average cost per day for specialised public mental health services of providing community‑based residential care.  A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.  The indicator does not account for differences in the client mix. The client mix in community‑based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community‑based residential settings.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions providing the services.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community‑based residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost per patient day for community‑based residential care services is presented in table 12.1. For general adult units in 2011‑12, the average cost per patient day for 24 hour staffed community‑based residential care was an estimated $447 nationally. For non‑24 hour staffed community‑based residential units, the average cost per patient day was $163 nationally. For State or Territory governments that had community‑based older people’s residential care units in 2011‑12, the average recurrent cost per patient day for 24 hour staffed services was $358 nationally (table 12.1).

Table 12.1 Average recurrent cost per inpatient day for community‑based residential services, by target population and staffing provided, 2011‑12**a, b**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSWc | Vicc | Qldd | WAe | SAe | Tas | ACTc | NTe | Aust |
| General adult units | | | |  |  |  |  |  |  |
| 24 hour staffed | 225 | 488 | .. | 368 | 484 | 490 | 650 | 308 | 447 |
| Non‑24 hour staffed | 178 | 158 | .. | 148 | 331 | 198 | 133 | .. | 163 |
| Older people’s care units | | | | |  |  |  |  |  |
| 24 hour staffed | 234 | 347 | .. | .. | .. | 682 | 249 | .. | 358 |

a Depreciation is excluded. b Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). c NSW, Victoria and the ACT do not have any community‑based residential services that are non‑24 hour older people’s units. d Queensland does not report any in‑scope government‑operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non‑campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non‑acute admitted patient services. e WA, SA and the NT do not have any community‑based residential services that are older people’s units. .. Not applicable.

*Source*: AIHW (unpublished) MHE NMDS; table 12A.46.

#### Efficiency — cost of ambulatory care

‘Cost of ambulatory care’ is an indicator of governments’ objective that mental health services be delivered in an efficient manner (box 12.19).

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| Box 12.19 Cost of ambulatory care |
| ‘Cost of ambulatory care’ is defined by two measures:   * average cost per treatment day of ambulatory care provided by community‑based specialised public mental health services * average number of community treatment days per episode of ambulatory care provided by community‑based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the ‘length of stay’ efficiency measure for public hospitals. |
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| Box 12.19 (continued) |
| An episode of ambulatory care is a three month period of ambulatory care for an individual registered consumer where the consumer was under ‘active care’ (one or more treatment days in the period). Community‑based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.  Low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.  The measures do not account for differences in the consumer mix. The consumer mix in community‑based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of consumers with more complex conditions in community‑based ambulatory settings.  Data reported for the two measures are:   * comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania * incomplete for the current reporting period. All required data for 2011‑12 are not available for Victoria.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Average recurrent cost per treatment day of ambulatory care data are shown in   
figure 12.24 and average treatment days per episode of ambulatory care data are shown in figure 12.25.

Figure 12.24 Average recurrent cost per treatment day of ambulatory care  
(2011‑12 dollars)**a, b, c, d, e, f**

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| Figure 12.24 Average recurrent cost per treatment day of ambulatory care (2011-12 dollars).   More details can be found within the text surrounding this image |

a Real expenditure (2011‑12 dollars), using State and Territory implicit price deflators for general government final consumption on hospital and nursing home services (table 12A.73). b Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the   
CMHC NMDS that were defined as ‘non‑uniquely identifiable consumers’. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. c ‘Non‑uniquely identifiable consumers’ have been excluded from the episodes of ambulatory care. d The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year. e Victorian 2011‑12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. f Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011‑12.

*Source*: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.47.

Figure 12.25 Average treatment days per episode of ambulatory care**a, b, c, d**

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| Figure 12.25 Average treatment days per episode of ambulatory care.  More details can be found within the text surrounding this image |

a ‘Non‑uniquely identifiable consumers’ have been excluded from the episodes of ambulatory care and treatment days data. b The quality of the NSW MHE NMDS 2010‑11 data has been affected by the reconfiguration of the service system during the year. c Data are not available for Victoria for 2011‑12 due to an industrial dispute leading to reduced collection rates. Victoria requested no substitute or proxy data be included to fill the gap at the jurisdiction level or in the calculation of the national results. The total only includes those jurisdictions that have provided data. d Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011‑12.

*Source*: AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.47.

### Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see chapter 1, section 1.5).

The output indicators reported above focus on specialised public mental health services provided by State and Territory governments (although the indicators ‘mental health service use by selected community groups’, ‘mental health service use by total population’ and ‘primary mental health care for children and young people’ include measures of access to MBS‑subsidised services). The outcome indicators identified and/or reported here reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole‑of‑government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

#### Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible, by reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery (box 12.20). High rates of substance use and abuse in young people can contribute to the onset of, and poor recovery from, mental illness (NMHPSC 2011a).

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| Box 12.20 Rates of licit and illicit drug use |
| ‘Rates of licit and illicit drug use’ is defined as the proportion of people aged  14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs are: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma‑hydroxybutyrate (GHB), inhalants, and heroin.  A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.  Many of the risk and protective factors that impact on a person’s propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drugs use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2010 are not comparable to data for 2007 * complete for the current reporting period (subject to caveats). All required 2010 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2012). In 2010, of people aged   
14 years or over, 80.5 per cent drank alcohol over the last 12 months and 20.1 per cent drank alcohol at levels considered ‘risky’ for developing long‑term health problems (table 12A.48). Data from the 2007 *National Drug Strategy Household Survey Report* on alcohol use and risk status are in table 12A.52.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (table 12A.49). Younger people’s usage of cannabis and meth/amphetamines is of particular concern for their associated mental health problems (AHMC 2012). Cannabis use can precipitate schizophrenia in people who have a family history, increase the risk of psychosis symptoms and also exacerbate the schizophrenia symptoms (AHMC 2012). Psychosis symptoms are also associated with meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co‑morbid mental health problems (AHMC 2012).   
Table 12A.50 shows the rates of use of cannabis and meth/amphetamines by young people.

Data on self‑reported health conditions including mental illness and level of psychological distress by whether a person had used an illicit drug in the previous   
12 months are included in table 12A.51. Data from the 2007 *National Drug Strategy Household Survey Report* on illicit drug use are in tables 12A.53–55.

#### Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.21).

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| Box 12.21 Prevalence of mental illness |
| ‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.  A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective. |
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| Box 12.21 (continued) |
| A reduction in the prevalence of mental illness can be brought about by preventative activities to stop an illness occurring, or by increasing access to effective treatments for those who have an illness (AHMC 2012). Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system, in sectors that affect the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions * complete for the current reporting period (subject to caveats). All required 2007 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Prevalence of mental illness data are from the 2007 SMHWB, the latest prevalence estimates available. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level; however, jurisdictional data are available in table 12A.56. National data on the prevalence of mental illness by disorder, age and sex are reported in tables 12A.57‑58.

The SMHWB provided prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders, affective disorders and substance use disorders, but did not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder. The *National Survey of Psychotic Illness 2010* provides information on the   
one‑month treated prevalence of these and other psychotic illnesses. In 2010, there were an estimated 3.1 cases of psychotic illness per 1000 adult population (aged 18−64 years), for which there was a contact with public specialised mental health services. Males had a higher treated prevalence rate than females (3.7 cases compared to 2.4 cases per 1000 adult population). Males aged 25−34 years had the highest rate at 5.2 cases per 1000 population (Morgan et al. 2011).

#### Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.22).

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| Box 12.22 Mortality due to suicide |
| ‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non‑Indigenous Australians.  A low or decreasing suicide rate per 100 000 people is desirable.  While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non‑government organisations and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.  Many factors outside the control of mental health services can influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data are not comparable across time periods for some dissagregations (see the attachment tables 12A.60–63 for details) * complete for the current reporting period (subject to caveats). All required 2011 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan et al*.* 2001; Joukamaa et al*.* 2001; Sartorius 2007; Lawrence et al. 2013).

All Coroner certified deaths registered after 1 January 2006 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD‑10 codes over time (ABS 2010). Each year of data is now released as preliminary, revised and final. For further information on this revisions process see the DQI for this indicator.

In the period 2007–2011, 11 600 deaths by suicide were recorded in Australia   
(table 12A.61) — equivalent to 10.6 deaths per 100 000 people (figure 12.26). The rate for males (16.5 per 100 000 males) was around three times that for females   
(4.9 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged 75–84 years and aged 85 years or over where the male suicide rate was around five or six times the female rate, respectively (figure 12.27). Table 12A.62 shows suicide death rates per 100 000 people aged   
15–24 years for all jurisdictions.

Figure 12.26 Suicide rates, 5 year average, 2007–2011**a, b**, **c**

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| Figure 12.26 Suicide rates, 5 year average, 2007-2011.  More details can be found within the text surrounding this image |

a Suicide deaths include ICD‑10 codes X60‑X84 and Y87.0. b The death rate is age standardised to the   
mid‑year 2001 population. c Causes of death data for 2007, 2008 and 2009 have undergone revision/s and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process.

*Source*: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.61.

Figure 12.27 Suicide rates, by age and sex, 2007–2011**a, b, c**

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| Figure 12.27 Suicide rates, by age and sex, 2007-2011.  More details can be found within the text surrounding this image |

a Suicide deaths include ICD‑10 codes X60‑X84 and Y87.0. b Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period   
2007–2011. c Causes of death data for 2007, 2008 and 2009 have undergone revision/s and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process.

*Source*: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.60.

Nationally the suicide rate in the period 2007–2011 was higher in rural areas. There were 9.6 suicides per 100 000 people in capital cities and 11.8 suicides   
per 100 000 people in urban centres, compared with 13.1 suicides per 100 000 people in rural areas in Australia (figure 12.28).

Tables 12A.59 and 12A.61–63 contain time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and   
the NT (figure 12.29). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous Australians during the period   
2007–2011, for the reported jurisdictions, was higher than the corresponding rate for non‑Indigenous Australians.

Figure 12.28 Suicide rates, by area, 2007–2011**a, b, c, d, e**

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| Figure 12.28 Suicide rates, by area, 2007-2011.  More details can be found within the text surrounding this image. |

a The capital city, urban centres and rural groupings are based on the ABS’ Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities comprise Statistical Area 2s classified as capital cities. Urban centres comprise all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10 000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. b The suicide rate is directly age standardised to the mid‑year 2001 population. c Suicides are reported by year of registration of death. d Causes of death data for 2007, 2008 and 2009 have undergone revisions and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process. e The ACT did not have any ‘urban centres’. Data for ACT ‘rural’ areas and NT ‘urban centres’ are not published.

*Source*: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.63.

Care needs to be taken when interpreting these data because data for Indigenous Australians are incomplete and data for some jurisdictions are not published. Indigenous Australians are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

Figure 12.29 Suicide rates, by Indigenous status, 2007–2011**a, b, c, d, e, f**

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| Figure 12.29 Suicide rates, by Indigenous status, 2007-2011.  More details can be found within the text surrounding this image. |

a Deaths from suicides are deaths with ICD‑10 codes X60–X84 and Y87.0. b Suicide rates are  
age‑standardised. c Data on deaths of Indigenous Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non‑Indigenous data. d Deaths with a ‘not stated’ Indigenous status are included in the data for   
non‑Indigenous. e Causes of death data for 2007, 2008 and 2009 have undergone revisions and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process. f Total data are for NSW, Queensland, WA, SA, and the NT combined, based on the state or territory of usual residence. Data for the Indigenous mortality analysis are excluded for Victoria, Tasmania and the ACT due to insufficient levels of identification or numbers of deaths.

*Source*: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.64.

#### Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is an indicator of governments’ objective to improve mental health and facilitate recovery from illness through encouraging meaningful participation in recreational, social, employment and other activities in the community (box 12.23).

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| Box 12.23 Social and economic inclusion of people with a mental illness |
| ‘Social and economic inclusion of people with a mental illness’ is defined by two measures:   * proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness * proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part‑time), compared with the equivalent proportion for people without a mental illness.   A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged  16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.  This indicator measures employment participation relative to the total population  aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). Data on the proportion of people aged 16–64 years who are unemployed or not in the labour force (by mental illness status) are in table 12A.65. It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and overtime depending on the source, that is 2011‑12 NHS data are comparable to 2007‑08 NHS data, but not to 2007 SMHWB data * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Mental illness can act as a barrier to gaining and maintaining employment   
(AHMC 2012). Nationally, in 2011‑12, the proportion of all Australians with a mental illness who were employed was 61.7 ± 3.1 per cent, compared to 80.3 ± 0.9 per cent for those without a mental illness (figure 12.30).

Figure 12.30 People aged 16–64 years who are employed, by mental illness status, 2011‑12**a, b**

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| Figure 12.30 People aged 16-64 years who are employed, by mental illness status, 2011-12.  More details can be found within the text surrounding this image |

a People with a mental illness are defined as those who self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. b Estimates have been age standardised to the 2001 estimated resident population.

*Source*: ABS (unpublished) *AHS 2011–13* (2011‑12 NHS component)*,* Cat. no.4364.0;table 12A.65.

Data from the 2007‑08 National Health Survey and the 2007 SMHWB on the labour force and employment participation of people who had a mental illness/disorder are in tables 12A.69 and 12A.71.

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2012). The effect of these disruptions can be long term, restricting the person’s ability to participate in a range of social and vocational activities over their lifetime (AHMC 2012).

Nationally, in 2011‑12, the proportion of people aged 16−30 years with a mental illness who were employed and/or are enrolled for study in a formal secondary or tertiary qualification was 79.2 ± 4.2 per cent, compared to 90.2 ± 1.2 per cent for those without a mental illness (figure 12.31). Data from the 2007‑08 NHS and the 2007 SMHWB on the participation of people aged 16–30 years in the labour force and/or in education or training are in tables 12A.68 and 12A.70‑71.

Figure 12.31 People aged 16–30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2011‑12**a, b**

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| Figure 12.31 People aged 16–30 years who were employed and/or are enrolled for study in a formal secondary or tertiary qualification, by mental illness status, 2011-12.  More details can be found within the text surrounding this image. |

a People with a mental illness are defined as those who self‑reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions. b Estimates have been age standardised to the 2001 estimated resident population.

*Source*: ABS (unpublished) *AHS 2011–13* (2011‑12 NHS component)*,* Cat. no.4364.0; table 12A.66.

#### Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to improve the effectiveness and quality of service delivery and outcomes and promote recovery from mental health problems and mental illness (box 12.24).

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| Box 12.24 Mental health outcomes of consumers of specialised public mental health services |
| ‘Mental health outcomes of consumers of specialised public mental health services’ is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three consumer types: people in ongoing community‑based care, people discharged from community‑based care and people discharged from a hospital psychiatric inpatient unit. |
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| Box 12.24 (continued) |
| Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and ‘best practice’ outcomes are unknown (AHMC 2012). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.  The assessment of a consumer’s clinical mental health outcomes is based on the changes reported in a consumer’s ‘score’ on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (AHMC 2012). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre‑ and post‑ scores to the standard deviation of the  pre‑score (AHMC 2012). Individual episodes are classified as ‘significant improvement’ if the effect size index is greater than or equal to positive 0.5; ‘no change’ if the index is between ‑0.5 and zero; and ‘significant deterioration’ if the effect size index is less than or equal to -0.5 (AHMC 2012).  This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single ‘average score’ does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods (AHMC 2012). The approach separates a consumer’s care into segments (hospital versus the community) rather than tracking the person’s overall outcomes across treatment settings. In addition, consumers’ outcomes are measured from the clinician’s perspective and not as the ‘lived experience’ from the consumer’s viewpoint (AHMC 2012).  Data reported for this indicator are:   * not comparable across jurisdictions or over time due to differences in the quality of the data and the proportion of episodes for which completed outcomes data are available * incomplete for the current reporting period. All required data for 2011‑12 are not available for Victoria.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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Nationally, in 2011‑12, 26.0 per cent of people in ongoing community‑based care,  
51.5 per cent of people discharged from community‑based care and 70.8 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.32‑33). Caution is required in interpreting results across states and territories. Data are of variable quality and there are different levels of coverage across states and territories (AHMC 2012).

Figure 12.32 Mental health outcomes of consumers of State and Territory community‑based specialised public mental health services, 2011‑12**a, b**

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| **Figure legend.   More details can be found within the text surrounding this image.** |
| **People in ongoing community‑based care**c |
| Figure 12.32 Mental health outcomes of consumers of State and Territory community based specialised public mental health services, 2011- 12 (people in ongoing community based care).  More details can be found within the text surrounding this image. |
| **People discharged from community‑based care**d, e |
| Figure 12.32 Mental health outcomes of consumers of State and Territory community-based specialised public mental health services, 2011- 12 (people discharged from community based care).  More details can be found within the text surrounding this image. |

a Victorian 2011‑12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.   
b Industrial action in Tasmania has limited the available data quality and quantity of community data for   
2011‑12. c Data comprise people receiving relatively long term community‑based care. Data include people who were receiving care for the whole of 2011‑12, and those who commenced community‑based care sometime after 1 July 2011 who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June 2012). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year. d Data comprise people who received relatively short term community‑based care. The defining characteristic of the group is that the episode of community‑based care commenced, and was completed, within 2011‑12. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge, from community‑based care. People whose episode of community‑based care was completed because they were admitted to hospital are not included. e The ACT and NT data are not published due to insufficient observations.

*Source*: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.72.

Figure 12.33 Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2011‑12**a, b, c**

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| Figure 12.33 Mental health outcomes of consumers discharged from State or Territory inpatient mental health services, 2011-12.   More details can be found within the text surrounding this image |

a Data comprise people who received a discrete episode of inpatient care within a psychiatric unit. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where the length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.   
b Victorian 2011‑12 data are not available due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data. c The ACT data are not published due to insufficient observations.

*Source*: Australian Mental Health Outcomes and Classification Network (unpublished), authorised by the Australian Government Department of Health; table 12A.72.

## 12.5 Future directions in performance reporting

Priorities for future reporting on mental health management include the following:

* improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
* developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
* improving reporting on government funded non‑government entities to include information on their activity and the outcomes of the consumers of these services
* identifying indicators that relate to the performance framework dimension of sustainability
* improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
* further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

## 12.6 Definitions of key terms

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| General terms |  |
| **General practice** | The organisational structure in which one or more GPs provide and supervise health care for a ‘population’ of patients. This definition includes medical practitioners who work solely with one specific population, such as women’s health or Indigenous health. |
| **Health management** | The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies. |
| **Incidence rate** | Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people). |
| **Separation** | An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care. |
| Mental health |  |
| **Acute services** | Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can:   * focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms * target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services. |
| **Accrued mental health patient days** | Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, that is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.  The key basic rules to calculate the number of accrued mental health care days are as follows:   * For a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days. * Admission and discharge on the same day are equal to one patient day. * Leave days involving an overnight absence are not counted. * A patient day is recorded on the day of return from leave. |
| **Affective disorders** | A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia. |
| **Ambulatory care services** | Mental health services dedicated to the assessment, treatment, rehabilitation or care of non‑admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs. |
| **Anxiety disorders** | Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder,  obsessive–compulsive disorder and post‑traumatic stress disorder. |
| **Average available beds** | The number of beds available to provide overnight accommodation for patients admitted to hospital (other than neonatal cots [non‑special‑care] and beds occupied by hospital‑in‑the‑home patients) or to specialised residential mental health care, averaged over the counting period. Beds are available only if they are suitably located and equipped to provide care and the necessary financial and human resources can be provided. |
| **Child and adolescent mental health services** | Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component. |
| **Co‑located services** | Psychiatric inpatient services established physically and organisationally as part of a general hospital. |
| **Community‑based residential services** | Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community‑based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded. |
| **Co‑morbidity** | The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia. |
| **Consumer involvement in decision making** | Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators. |
| **Cost per inpatient  bed day** | The average patient day cost according to the inpatient type. |
| **Depression** | A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected. |
| **Forensic mental health services** | Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes  prison‑based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component. |
| **General mental health services** | Services that principally target the general adult population  (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, youth, older people’s or forensic services.  General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post‑natal depression, anxiety disorders). |
| **Mental illness** | A diagnosable illness that significantly interferes with an individual’s cognitive, emotional and/or social abilities. |
| **Mental health** | The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice. |
| **Mental health  problems** | Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness. |
| **Mental health promotion** | Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the ‘coping’ capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources. |
| **Mental illness prevention** | Interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses. |
| **Mortality rate  from suicide** | The proportion of the population who die as a result of suicide. |
| **Non‑acute  services** | Non‑acute services are defined by two categories:   * Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid‑term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. * Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly. |
| **Non‑government organisations** | Private not‑for‑profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non‑government organisation sector can include supported accommodation services (including community‑based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self‑help services, and support services for families and primary carers. |
| **Older people’s mental health services** | Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service. |
| **Outpatient services  — community‑based** | Services primarily provided to non‑admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base. |
| **Outpatient services  — hospital‑based** | Services primarily provided to non‑admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base. |
| **Percentage of  facilities accredited** | The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services. |
| **Prevalence** | The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence). |
| **Preventive interventions** | Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses. |
| **Psychiatrist** | A medical practitioner with specialist training in psychiatry. |
| **Public health** | The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at‑risk groups) and complements clinical provision of health care services. |
| **Public (non‑psychiatric) hospital** | A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around‑the‑clock, comprehensive, qualified nursing services, as well as other necessary professional services. |
| **Schizophrenia** | A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour. |
| **Seclusion** | Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b).  The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition  (AIHW 2013). |
| **Seclusion event** | An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re‑enters seclusion within a short period of time this would be considered a new seclusion event. The term ‘seclusion event’ is utilised to differentiate it from the different definitions of ‘seclusion episode’ used across jurisdictions  (NMHPSC 2011b). |
| **Specialised mental health inpatient services** | Services provided to admitted patients in stand‑alone psychiatric hospitals or specialised psychiatric units located within general hospitals. |
| **Specialised mental health services** | Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds. |
| **Specialised residential services** | Services provided in the community that are staffed by mental health professionals on a non‑24 or 24‑hour basis. |
| **Staffing categories (mental health)** | Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee‑for‑service basis.  Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.  Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program.  Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists’ Postgraduate Training Program.  Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.  Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.  Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).  Diagnostic and health professionals (allied health professionals): qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.  Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.  Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.  Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.  Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.  Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.  Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. |
| **Stand‑alone psychiatric hospitals** | Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand‑alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the ‘stand‑alone’ category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand‑alone hospitals if the following criteria are not met:   * a single organisational or management structure covers the acute care hospital and the psychiatric hospital * a single employer covers the staff of the acute care hospital and the psychiatric hospital * the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus * the patients of the psychiatric hospital are regarded as patients of the single integrated health service. |
| **Substance use disorders** | Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence). |
| **Youth mental health services** | Services principally targeting children and young people generally aged 16‑25 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component. |

12.7 List of attachment tables

Attachment tables are identified in references throughout this chapter by a ‘12A’ prefix (for example, table 12A.1). Attachment tables are available on the Review website (www.pc.gov.au/gsp).

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## 12.8 References

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