# 12 Mental health management

#### CONTENTS

12.1 Profile of mental health management 12.2

12.2 Framework of performance indicators 12.11

12.3 Key performance indicator results 12.14

12.4 Future directions in performance reporting 12.53

12.5 Definitions of key terms 12.53

12.6 List of attachment tables 12.58

12.7 References 12.62

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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 website at www.pc.gov.au/rogs/2016. |
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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 chapter focuses on State and Territory governments’ specialised mental health services and specific mental health services provided by General Practitioners (GPs), psychiatrists, psychologists and other allied health professionals under the Medicare Benefits Schedule (MBS).

Improvements to the reporting of mental health management in this edition include:

* additional data disaggregations for MBS subsidised services for the ‘New client index’ indicator
* new data on the duration of seclusion events reported as contextual information for the ‘Rate of seclusion’ indicator
* a new measure for the ‘Social and economic inclusion of people with mental illness’ indicator on the social participation of people with mental illness.

All abbreviations used in this Report are available in a complete list in volume A: Approach to performance reporting.

## 12.1 Profile of mental health management

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. 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 the spectrum of services, including prevention, early detection and treatment programs. The appropriate mix of services and of service delivery mechanisms is also important.

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 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 one of the national health priority areas. The national health priority areas represent a large proportion of the total burden of disease and injury in Australia and mental illnesses makes a significant contribution to this total burden (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 (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).

Mental health management is offered across a spectrum of government and non‑government service providers that include promotion, prevention, treatment, management and rehabilitation services. Psychiatric hospitals, general hospitals with psychiatric units, community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice and counsellors all provide specialised mental health care. Mental health care is also provided in non‑specialised settings — for example, GPs, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialised psychiatric units). 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.

This chapter focuses on the performance of State and Territory governments’ specialised mental health services that treat the mostly low prevalence, but severe, mental illnesses and also on the specific mental health services provided by GPs, psychiatrists, psychologists and other allied health professionals under the MBS. It also reports on the interaction and integration arrangements between hospital and community‑based services and on the broad social, economic and physical health outcomes of people with a mental illness.

### Roles and responsibilities

#### National mental health policy context

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). 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 Statement underpins the National Mental Health Strategy (NMHS) endorsed by Australian, State and Territory governments in 1992, but has been reaffirmed by health ministers a number of times since then (Department of Health 2014). 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 that describes its broad aims and objectives and the National Mental Health Plan that outlines the approach to implementing these aims and objectives. The National Mental Health Policy was revised in 2008 and the Fourth National Mental Health Plan was released in November 2009. The Fourth Plan (2009–2014) has now expired and a Fifth Plan is currently being developed.

#### Service roles and responsibilities

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

The Australian Government is responsible for the oversight and funding of a range of mental health services and programs that are primarily provided or delivered by private practitioners or NGOs. These services and programs include MBS subsidised services provided by GPs (under both general and specific mental health items), private psychiatrists and allied mental health professionals, Pharmaceutical Benefits Scheme (PBS) funded mental health‑related medications and other programs designed to prevent suicide or increase the level of social support and community‑based care for people with a mental illness and their carers. The Australian Government also funds State and Territory governments for health services, most recently through the approaches specified in the National Health Reform Agreement (NHRA), but the mental health component of this funding is not separately identified for this Report.

### Funding

Real government recurrent expenditure of around $7.7 billion was allocated to mental health services in 2013‑14 (table 12A.4). State and Territory governments made the largest contribution ($4.8 billion, or 62.4 per cent, which includes Australian Government funding under the NHRA), with Australian Government expenditure of $2.9 billion or 37.6 per cent of total government recurrent expenditure on mental health services (table 12A.4).

Real recurrent government expenditure per person on mental health services increased from $255.44 in 2005‑06 to $330.28 in 2013‑14 (figure 12.1). The average annual growth rate for Australian Government real expenditure over this period was 5.7 per cent, which was slightly higher than the 4.7 per cent for State and Territory governments (table 12A.4).

Expenditure on MBS subsidised services was the largest component of Australian Government expenditure on mental health services in 2013‑14 ($971.0 million or 33.5 per cent) (table 12A.1). This comprised MBS payments for psychologists and other allied health professionals (15.0 per cent), consultant psychiatrists (11.1 per cent) and GP services (7.5 per cent) (table 12A.1). Another significant area of Australian Government expenditure on mental health services in 2013‑14 was expenditure under the PBS for mental‑health related medications ($735.0 million) (table 12A.1).

Nationally, expenditure on admitted patient services is the largest component of State and Territory governments’ expenditure on specialised mental health services ($2.1 billion or   
43.4 per cent in 2013‑14), followed by expenditure on community‑based ambulatory services ($1.9 billion or 38.3 per cent) (figure 12.2). State and Territory governments’ expenditure on specialised mental health services, by source of funds and depreciation (which is excluded from reporting) are in tables 12A.3 and 12A.5 respectively.

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| Figure 12.1 Real recurrent governments’ expenditure on mental health services, by funding source (2013‑14 dollars)**a** |
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| a See table 12A.4 for detailed footnotes and caveats. |
| *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. |
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| Figure 12.2 **Recurrent expenditure on State and Territory governments’ specialised mental health services, by service category, 2013‑14**a, b |
| |  | | --- | | Figure 12.2 Recurrent expenditure on State and Territory governments’ specialised mental health services, by service category, 2013-14  More details can be found within the text surrounding this image. | |
| a Queensland does not have any in‑scope community residential services. b See table 12A.6 for detailed footnotes and caveats. |
| *Source*: AIHW (unpublished) MHE NMDS; table 12A.6. |
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### Size and scope of sector

#### Prevalence of mental illness and psychological distress

According to the National Survey of Mental Health and Wellbeing (SMHWB), in 2007, 1 in 5 people aged 16–85 years (20.0 per cent, or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder/illness and had symptoms in the previous 12 months, and a further 25.5 per cent of people in this age group had experienced a mental disorder at some point in their life (table 12A.76).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services (ABS 2012). Higher levels of psychological distress are reported for:

* females compared to males (figure 12.3)
* people with disability compared to those without (table 12A.9)
* people in lower socioeconomic areas compared to those in higher areas (table 12A.9)
* Aboriginal and Torres Strait Islander Australians compared to non‑Indigenous Australians (table 12A.15).

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| Figure 12.3 Adults with very high levels of psychological distress, by gender, 2011‑12**a** |
| |  | | --- | | Figure 12.3 Adults with very high levels of psychological distress, by gender, 2011-12  More details can be found within the text surrounding this image. | |
| a See table 12A.8 for detailed footnotes and caveats. |
| *Source*:ABS (unpublished) *Australian Health Survey* (AHS) *2011–13* (2011‑12 National Health Survey (NHS) component), Cat. no. 4364.0; table 12A.8. |
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There is also a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders, and people with a mental illness are overrepresented in the population who had high/very high levels of psychological distress (ABS 2012 and table 12A.7).

Tables 12A.8–16 contain additional data on high/very high levels of psychological distress.

#### Mental health services ― overview

There are a range of Australian, State or Territory governments’ provided or funded services that are specifically designed to meet the needs of people with mental health issues; the key services are:

* MBS subsidised mental health specific services that are partially or fully funded under Medicare on a fee for service basis and are provided by GPs, psychiatrists, psychologists or other allied health professionals under specific mental health items.
* Admitted patient care in public hospitals — specialised services provided to inpatients in stand‑alone psychiatric hospitals or psychiatric units in general acute hospitals.
* Community‑based public 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 assessment, treatment, rehabilitation and care
* residential services that provide beds in the community, staffed onsite by mental health professionals
* Not‑for‑profit, NGO services, funded by the Australian, State and Territory governments to provide community‑based 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).

There are also other health services provided and/or funded by governments that make a significant contribution to the mental health treatment of people with a mental illness, but are not specialised or specific mental health services. Tables 12A.30–32 provide information on these non‑specialised services provided in hospitals.

#### MBS subsidised mental health services

GPs are often the first type of service accessed by people seeking help when suffering from a mental illness (AIHW 2014). GPs can diagnose, manage and treat mental illnesses and they also refer patients to more specialised service providers such as psychiatrists and psychologists.

In 2013‑14, an estimated 12.8 per cent of GP encounters included management of mental health‑related problems (equivalent to an estimated 17.1 million encounters) (table 12A.18). Data on GP mental‑health related encounters by patient demographics are in table 12A.19.

A GP can manage more than one problem at a single encounter, hence the number of mental health problems can be greater than the number of mental‑health related encounters. In 2013‑14, 13.7 mental health‑related problems were managed per 100 encounters (table 12A.20). Depression was the most frequently reported mental health‑related problem managed (4.3 per 100 GP encounters), representing around one third of all mental health‑related problems managed (table 12A.20).

In 2013‑14, GPs provided 2.7 million MBS subsidised specific mental health items. A further 6.4 million MBS subsidised mental health services were provided by psychiatrists (2.2 million), psychologists (3.9 million) and allied health professionals (0.3 million) (table 12A.17). Service usage rates varied across states and territories (figure 12.4).

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| Figure 12.4 MBS subsidised mental‑health related services, by provider type, 2013‑14**a** |
| |  | | --- | | Figure 12.4 MBS subsidised mental health related services, by provider type, 2013-14  More details can be found within the text surrounding this image. | |
| a See table 12A.17 for detailed footnotes and caveats. |
| *Source*:AIHW (2015) *Mental Health Services in Australia* (available at http://mhsa.aihw.gov.au/home/); table 12A.17. |
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#### State and Territory governments’ specialised mental health services

State and Territory governments’ specialised mental health services (covering the three service types of: admitted patient, community‑based ambulatory and community‑based residential) tend to treat people with the lower prevalence, but severe, mental illnesses. The proportion of the total Australian population treated in these public services remained below 2 per cent between 2007‑08 and 2013‑14 (table 12A.42 and figure 12.5).

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| Figure 12.5 Population using State and Territory governments’ specialised mental health services**a, b** |
| |  | | --- | | Figure 12.5 Population using State and Territory governments’ specialised mental health services  More details can be found within the text surrounding this image. | |
| a Victorian 2011‑12 and 2012‑13 data are not available. b See table 12A.42 for detailed footnotes and caveats. |
| *Source*:AIHW (unpublished), derived from data provided by State and Territory governments; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period); table 12A.42. |
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Across states and territories, the mix of admitted patient and community‑based services and care types can differ. As the unit of activity varies across these three service types (table 12A.25), service mix differences can be partly understood by considering items which have comparable measurement across service types such as expenditure (figure 12.2), numbers of full time equivalent (FTE) direct care staff (figure 12.6), accrued mental health patient days (figure 12.7) and mental health beds (figure 12.8).

Additional data are also available on the most common principal diagnosis for admitted patients (tables 12A.22 and 12A.33) and community‑based ambulatory contacts by age group (table 12A.24).

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| Figure 12.6 FTE health professional direct care staff, by service type, 2013‑14**a, b** |
| |  | | --- | | Figure 12.6 FTE health professional direct care staff, by service type, 2013-14  More details can be found within the text surrounding this image. | |
| a Queensland does not have any in scope residential services. b See table 12A.28 for detailed footnotes and caveats. |
| *Source*: AIHW (unpublished) MHE NMDS; table 12A.28. |
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| Figure 12.7 Accrued mental health patient days, by service type, 2013‑14**a, b, c** |
| |  | | --- | | Figure 12.7 Accrued mental health patient days, by service type, 2013-14  More details can be found within the text surrounding this image. | |
| a Queensland does not have any in‑scope residential services. b The ACT and the NT do not have non‑acute hospital units. c See table 12A.21 for detailed footnotes and caveats. |
| *Source*:AIHW (unpublished) MHE NMDS; table 12A.21. |
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| Figure 12.8 Mental health beds in public hospitals and community‑based residential units, 2013‑14**a, b, c** |
| |  | | --- | | Figure 12.8 Mental health beds in public hospitals and community- based residential units, 2013-14  More details can be found within the text surrounding this image. | |
| aQueensland does not have any in‑scope residential services. b Tasmania, the ACT and the NT do not have public psychiatric hospitals. c See table 12A.26 for detailed footnotes and caveats. |
| *Source*:AIHW (unpublished) MHE NMDS; table 12A.26. |
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#### Government funded not‑for‑profit, NGO services

There are limited data available on the size and scope of the mental health services provided by the Australian, State and Territory governments’ funded not‑for‑profit, NGO sector. The targeted community care (Mental Health) program is one exception. In 2013‑14, there were 157 670 participants in the program across three service types: 18 539 for Personal Helpers and Mentors (PHaMs), 98 664 for Family Mental Health Support Services and 40 467 for Mental Health Respite: Carer Support (table 12A.29).

## 12.2 Framework of performance indicators

The framework of performance indicators for mental health services draws on governments’ broad objectives as expressed in the *National Mental Health Policy 2008* (box 12.1).

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| Box 12.1 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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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). It covers a number of service delivery types (MBS subsidised, admitted patient and community‑based services) and includes outcome indicators of system‑wide performance. The performance indicator framework shows which data are complete and comparable in the 2016 Report. Chapter 1 discusses data comparability from a Report‑wide perspective (see chapter 1, section 1.6).

In addition to section 12.1, 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 (chapter 2).

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| Figure 12.9 Mental health management performance indicator framework |
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## 12.3 Key performance indicator results

Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of mental health management services.

Data Quality Information (DQI) is included where available for performance indicators in this Report. The purpose of DQI is to provide structured and consistent information about quality aspects of data used to report on performance indicators, in addition to material in the chapter or sector overview and attachment tables. All DQI for the 2016 Report can be found at www.pc.gov.au/rogs/2016.

### 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). Output information is also critical for equitable, efficient and effective management of government services.

#### **Equity**

#### Access — new client index

‘New client index’ is an indicator of governments’ objective to provide mental health services in an equitable manner (box 12.2). Where population treatment rates are relatively low it may be difficult for a new client to access services if already used by existing clients.

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| Box 12.2 New client index |
| ‘New client index’ is defined by two measures, the proportions of total clients under the care of:   * State and Territory governments’ specialised public mental health services, who were new — clients include all people who received one or more community‑based ambulatory contact or had one or more day of admitted patient or community‑based residential care. * MBS subsidised mental health services provided by private psychiatrists, GPs and allied health providers, who were new.   A new client is a consumer who has not received a mental health service in the five years preceding the initial contact with a service in the relevant reference period. |
| (continued next page) |
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| Box 12.2 (continued) |
| A high or increasing proportion of total clients who are new might be desirable, as it can suggest better access for new clients. However, results are difficult to interpret as the appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown. In addition, a significant increase in the proportion of new clients accessing services might be the result of an increase in the prevalence of mental illness.  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 the proportions of total clients under the care of State and Territory governments’ specialised public mental health services who were new are:   * comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data reported for the proportions of total clients under the care of MBS subsidised mental health services who were new are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally, the proportion of State and Territory governments’ specialised mental health services clients who are new remained relatively stable over time (figure 12.10). These proportions tend to be higher than for clients of MBS subsidised mental health services nationally and for all jurisdictions, except the NT (figure 12.11).

For Aboriginal and Torres Strait Islander Australians, the proportion of clients who are new tend to be lower than for non‑Indigenous Australians for State and Territory governments’ specialised mental health services. By contrast, for MBS subsidised mental health services, the proportion of Aboriginal and Torres Strait Islander Australian clients who are new tends to be slightly higher than for non‑Indigenous Australians (tables 12A.34 and 12A.36). Data are also reported by age, gender and remoteness in tables 12A.34 and 12A.36 and Socio‑Economic Indexes for Areas (SEIFA) quintiles in table 12A.34.

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| Figure 12.10 Proportion of State and Territory governments’ specialised mental health service clients who are new**a, b** |
| |  | | --- | | Figure 12.10 Proportion of State and Territory governments’ specialised mental health service clients who are new  More details can be found within the text surrounding this image. | |
| a Victorian 2011‑12 and 2012‑13 data are not available. b See box 12.2 and table 12A.33 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) derived from State and Territory governments’ data; table 12A.33. |
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| Figure 12.11 Proportion of MBS subsidised mental health service clients who are new**a** |
| |  | | --- | | Figure 12.11 Proportion of MBS subsidised mental health service clients who are new  More details can be found within the text surrounding this image. | |
| a See box 12.2 and table 12A.35 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Government Department of Health (unpublished); table 12A.35. |
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#### 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 Aboriginal and Torres Strait Islander Australians (box 12.3).

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| Box 12.3 Mental health service use by selected community groups |
| ‘Mental health service use by selected community groups’ is defined by two measures:   * the proportion of the population in a selected community group using the service, compared to the proportion of the population outside the selected community group, for each of: * State and Territory governments’ specialised public mental health services * MBS subsidised mental health services.   The selected community groups reported are Aboriginal and Torres Strait Islander Australians, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas.  This indicator is difficult to interpret. 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 State and Territory governments’ specialised public mental health services measure:   * may not be comparable (subject to caveats) within jurisdictions over time and may not be comparable across jurisdictions (see caveats in DQI and attachment tables for details) * are complete (subject to caveats) for the current reporting period (subject to caveats). All required 2013‑14 data are available.   Data reported for the MBS subsidised mental health services measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data from 2011‑12 onwards by geographic location and SEIFA are not comparable to data for previous years’ (see caveats in DQI and attachment tables for details) * complete (subject to caveats) for the current reporting period (subject to caveats). All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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While a higher proportion of the population access MBS subsidised mental health services than State and Territory governments’ specialised mental health services, the pattern of service use across the selected community groups differs.

For State and Territory governments specialised public mental health services, across all the selected community groups, higher proportions of people within these groups (Aboriginal and Torres Strait Islander Australians, people from outer regional, remote and very remote areas and people residing in low socioeconomic areas) access these services than those outside these groups (figures 12.12‑13 and table 12A.39).

For MBS subsidised mental health services the results are mixed. Nationally, a similar proportion of Aboriginal and Torres Strait Islander Australians accessed these services to non‑Indigenous Australians (figure 12.12), likewise for people across different socioeconomic areas (table 12A.39). Results varied across states and territories. However, for people in outer regional, remote and very remote areas, the proportions accessing MBS subsidised services were lower than for people in inner regional and major cities both nationally and across all states (figure 12.13).

Additional data on the use of State and Territory governments’ specialised and MBS subsidised mental health services by community groups are in tables 12A.40–41. Data on the use of private hospital mental health services are also contained in tables 12A.37–39 and 12A.41–42.

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| Figure 12.12 Population using mental health services, by Indigenous status and service type, 2013‑14**a** |
| |  | | --- | | **State and Territory governments’ specialised public mental health services** | | Figure 12.12 Population using mental health services, by Indigenous status and service type, 2013-14  State and Territory governments’ specialised public mental health services  More details can be found within the text surrounding this image. | | **MBS subsidised mental health services** | | Figure 12.12 Population using mental health services, by Indigenous status and service type, 2013-14  MBS subsidised mental health services  More details can be found within the text surrounding this image. | |
| a See box 12.3 and table 12A.37 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished), derived from data provided by State and Territory governments and the Australian Government Department of Health and Department of Veterans’ Affairs (DVA); ABS (unpublished) Estimated Residential Population, 30 June 2013; table 12A.37. |
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| Figure 12.13 Population using mental health services, by geographic location and service type, 2013‑14**a, b, c** |
| |  | | --- | | **State and Territory governments’ specialised public mental health services** | | Figure 12.13 Population using mental health services, by geographic location and service type, 2013-14  State and Territory governments’ specialised public mental health services  More details can be found within the text surrounding this image. | | **MBS subsidised mental health services** | | **Figure 12.13 Population using mental health services, by geographic location and service type, 2013-14  MBS subsidised mental health services  More details can be found within the text surrounding this image.** | |
| a See box 12.3 and table 12A.38 for detailed definitions, footnotes and caveats. b 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. c ACT data are not published for inner regional areas. |
| *Source*: AIHW (unpublished), derived from data provided by State and Territory governments and the Australian Government Department of Health and DVA; ABS (unpublished) Estimated Residential Population, 30 June (prior to relevant period); table 12A.38. |
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#### **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 12.4).

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| Box 12.4 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 mental health service. Data are reported separately for State and Territory specialised public mental health services and MBS subsidised mental health services.  This indicator is difficult to interpret. As a robust estimate of the population who need mental health services is not available, the indicator is reported as a proportion of the total population. 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 State and Territory governments’ specialised public mental health services measure are:   * comparable (subject to caveats) within most jurisdictions over time but are not comparable across jurisdictions or over time for Tasmania (see caveats in DQI and attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available.   Data reported for the MBS subsidised mental health services measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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In 2013‑14, 1.8 per cent and 8.4 per cent of the total population received State and Territory governments’ specialised mental health services and MBS subsidised services, respectively (figure 12.14). While the proportion of the population using State and Territory governments’ specialised mental health services has remained relatively constant (figure 12.5), the proportion using MBS subsidised services has increased steadily over time from 4.9 per cent in 2007‑08 to 8.4 per cent in 2013‑14 (table 12A.42). Much of this growth has come from greater utilisation of GP mental health specific services (from 3.5 to 6.7 per cent) and other allied health services (1.3 per cent to 2.5 per cent) over that period (table 12A.42). Data from the 2007 SMHWB on the proportion of people with an mental illness who did/did not use services for their mental health are reported in table 12A.43.

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| Figure 12.14 Population receiving mental health services, by service type, 2013‑14**a** |
| |  | | --- | | Figure 12.14 Population receiving mental health services, by service type, 2013-14  More details can be found within the text surrounding this image. | |
| a See box 12.4 and table 12A.42 for detailed definitions, footnotes and caveats. |
| *Source*:AIHW (unpublished) derived from data provided by State and Territory governments and Australian Government, Department of Health and DVA; ABS (unpublished) *Estimated Residential Population*, 30 June (prior to relevant period); table 12A.42. |
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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.42–43.

#### 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 12.5).

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| Box 12.5 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 mental health care service subsidised through the MBS from a GP, psychologist or an allied health professional.  High or increasing proportions of young people who had contact with MBS subsidised primary mental health care services is desirable. |
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| Box 12.5 (continued) |
| 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. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.  Results for this indicator should be interpreted with caution as some primary mental health services for children and young people are excluded; for example, community health centres, school and university counsellors and health nurses and some mental health care provided by State and Territory governments’ specialised mental health services (NMHPSC 2011a).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2014‑15 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The proportion of all children and young people who receive MBS subsidised primary mental health care services has increased gradually over time (table 12A.45). The proportion increases as age increases, with the highest proportion for young people aged 18−24 years (10.2 per cent of this population receiving these primary mental health care services nationally in 2014‑15) (figure 12.15).

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| Figure 12.15 Children and young people who received MBS subsidised primary mental health care, by age group, 2014‑15**a** |
| |  | | --- | | Figure 12.15 Children and young people who received MBS subsidised primary mental health care, by age group, 2014-15  More details can be found within the text surrounding this image. | |
| a See table 12A.45 for detailed definitions, footnotes and caveats. |
| *Source*: Australian Government Department of Health (unpublished); table 12A.45. |
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Data on the proportion of young people who had received MBS subsidised primary mental health care services by Indigenous status, SEIFA, gender and service type are also available in tables 12A.46–47, with the pattern of results reflecting those for the total population (all ages).

#### 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 12.6).

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| Box 12.6 Services reviewed against the National Standards |
| ‘Services reviewed against the National Standards’ is defined as the proportion of expenditure on State and Territory governments’ specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and were assessed at level 1. The assessment levels are defined as:   * *Services at level 1* — services reviewed by an external accreditation agency and judged to have met all National Standards. * *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 mental health services that had completed a review by an external accreditation agency and had been assessed against the NSMHS as level 1 is desirable.  This is a process indicator of appropriateness, reflecting progress made in meeting the NSMHS. It 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 (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The first NSMHS were developed under the *First National Mental Health Plan   
1993–1998* and revised NSMHS were released in September 2010 (box 12.7).

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| Box 12.7 The 2010 NSMHS |
| The 2010 NSMHS comprise 10 overarching standards:   |  |  | | --- | --- | | 1. Rights and responsibilities | 6. Consumers | | 1. Safety | 7. Carers | | 1. Consumer and carer participation | 8. Governance, leadership and management | | 1. Diversity responsiveness | 9. Integration | | 1. Promotion and prevention | 10. Delivery of care | |
| *Source*:Australian Health Ministers’ Conference (2010) *National Standards for Mental Health Services 2010*, Canberra. |
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Figure 12.16 shows the proportion of expenditure on specialised public mental health services that had completed an external review against the NSMHS and met ‘all standards’ (level 1).

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| Figure 12.16 Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level, 30 June 2014**a** |
| |  | | --- | | Figure 12.16 Share of expenditure on specialised public mental health services reviewed against the NSMHS, by assessment level, 30 June 2014  More details can be found within the text surrounding this image. | |
| a See box 12.6 and table 12A.48 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) MHE NMDS; table 12A.48. |
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#### 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 community‑based settings wherever possible (box 12.8).

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| Box 12.8 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 public mental health services that was on community‑based services. Community‑based services expenditure comprises that on ambulatory care, adult residential services, and NGOs. Older people’s residential expenditure 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 (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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State and Territory governments’ expenditure on community‑based services as a proportion of total expenditure on specialised mental health services has remained stable over time (figure 12.17).

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| Figure 12.17 State and Territory governments’ expenditure on community‑based services as a proportion of total expenditure on specialised mental health services**a** |
| |  | | --- | | Figure 12.17 State and Territory governments’ expenditure on community-based services as a proportion of total expenditure on specialised mental health services  More details can be found within the text surrounding this image. | |
| a See box 12.8 and table 12A.49 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) MHE NMDS; table 12A.49. |
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#### 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 12.9).

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| Box 12.9 Collection of information on consumers’ outcomes |
| ‘Collection of information on consumers’ outcomes’ is defined as the proportion of State and Territory governments’ specialised public mental health service episodes (by client type) with completed clinical mental health outcome measures.  High or increasing proportions of episodes for which information on consumers’ mental health outcomes is collected is desirable.  This is a process indicator and 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 * complete (subject to caveats) for the current reporting period. All required data for 2013‑14 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The estimated proportions of specialised mental health service episodes for which ‘complete’ consumers’ mental health outcomes are collected are shown in figure 12.18.

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| Figure 12.18 Estimated proportion of episodes for which ‘complete’ outcome measures were collected, by client type 2013‑14**a, b** |
| |  | | --- | | Figure 12.18 Estimated proportion of episodes for which ‘complete’ outcome measures were collected, by client type 2013-14  More details can be found within the text surrounding this image. | |
| a See box 12.9 and table 12A.50 for detailed definitions, footnotes and caveats. b ACT data for consumers discharged from ambulatory care are not published. |
| *Source*: AIHW (unpublished) from data provided by the Australian Mental Health Outcomes and Classification Network; table 12A.50. |
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#### Quality — safety — rate of seclusion ― acute inpatient units

‘Rate of seclusion ― acute inpatient units’ is an indicator of governments’ objective that services are safe and of a high quality (box 12.10). The reduction, and where possible elimination of, seclusion in specialised mental health services is a national safety priority.

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| Box 12.10 Rate of seclusion ― acute inpatient units |
| ‘Rate of seclusion ― acute inpatient units’ is defined as the number of seclusion events per 1000 bed days in State and Territory governments’ specialised 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 (see section 12.5 for further details on seclusion and ‘seclusion events’). Legislation or mandatory policy governs the use of seclusion in each State and Territory and may result in exceptions to the definition of a seclusion event and variations in the data collected across jurisdictions (NMHPSC 2011b). |
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| Box 12.10 (continued) |
| A low (or nil) or decreasing number of seclusion events per 1000 bed days in specialised public mental health inpatient units is desirable.  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required data for 2014‑15 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016.  Supporting data on the duration of seclusion events are provided in table 12A.51. These data when considered with the rate of seclusion provide information on the use and management of seclusion within each jurisdiction. A low rate of seclusion events combined with shorter average durations is desirable. |
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Nationally, the number of seclusion events per 1000 bed days has decreased steadily from 11.8 in 2010‑11 to 7.8 in 2014‑15 (figure 12.19). This downward trend was reflected across most jurisdictions (figure 12.19) and target population groups (table 12A.52). The lowest seclusion rates were in older people’s units and the highest were in children and adolescent units (table 12A.52).

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| Figure 12.19 Rate of seclusion**a** |
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| a See box 12.10 and table 12A.51 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2015) *Mental Health Services in Australia Online*, mhsa.aihw.gov.au/home/ (accessed 16 December 2015); table 12A.51. |
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#### 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 12.11).

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| Box 12.11 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 2016 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 12.12).

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| Box 12.12 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 staff * carer staff per 1000 FTE direct care staff.   High or increasing proportions of paid FTE direct care staff who are consumers or carers 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 from 2010‑11 are not comparable to data for previous years * complete (subject to caveats) for the current reporting period. All required data for 2013‑14 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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The number of paid FTE consumer and carer staff per 1000 paid FTE direct care staff are reported in figures 12.20 and 12.21 respectively.

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| Figure 12.20 Paid FTE consumer staff per 1000 paid FTE direct care staff **a, b, c, d** |
| |  | | --- | | Figure 12.20 Paid FTE consumer staff per 1000 paid FTE direct care staff  More details can be found within the text surrounding this image. | |
| a See box 12.12 and table 12A.53 for detailed definitions, footnotes and caveats. b Tasmania did not employ consumer staff in 2012‑13. c The ACT do not employ consumer staff. d The NT did not employ consumer staff in 2010‑11 and 2011‑12. |
| *Source*:AIHW (unpublished) MHE NMDS; table 12A.53. |
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| Figure 12.21 Paid FTE carer staff per 1000 paid FTE direct care staff**a, b** |
| |  | | --- | | Figure 12.21 Paid FTE carer staff per 1000 paid FTE direct care staff  More details can be found within the text surrounding this image. | |
| a See box 12.12 and table 12A.53 for detailed definitions, footnotes and caveats. b WA did not employ carer staff in 2013‑14 and the ACT and the NT do not employ carer staff. |
| *Source*:AIHW (unpublished) MHE NMDS; table 12A.53. |
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#### 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 12.13).

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| Box 12.13 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 2016 Report. |
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#### Quality — continuity — community follow-up after psychiatric admission/hospitalisation

‘Community follow-up after psychiatric admission/hospitalisation’ is an indicator of governments’ objective to provide continuity of care in the delivery of mental health services (box 12.14).

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| Box 12.14 Community follow-up after psychiatric admission/hospitalisation |
| ‘Community follow-up after psychiatric admission/hospitalisation’ is defined as the proportion of State and Territory governments’ specialised public admitted patient overnight acute separations from psychiatric units for which a community‑based ambulatory 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 the mode of contact. Only follow-up contacts made by State and Territory governments’ specialised public mental health services are included.  Data reported for this indicator are:   * comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in DQI and attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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For people who are discharged from hospital after an acute psychiatric episode, it is essential to have prompt community follow-up in the vulnerable period following discharge in order to maintain clinical and functional stability and minimise the need for hospital readmission (NMHPSC 2011a). Nationally, the rate of community follow‑up for people within the first seven days of discharge from an acute inpatient psychiatric unit has increased from 49.6 per cent in 2009‑10 to 66.4 in 2013‑14 (figure 12.22). Community follow‑up rates data by Indigenous status, remoteness areas, SEIFA, age groups and gender are in tables 12A.55–56.

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| Figure 12.22 Community follow-up for people within the first seven days of discharge from acute inpatient psychiatric units**a, b** |
| |  | | --- | | Figure 12.22 Community follow-up for people within the first seven days of discharge from acute inpatient psychiatric units  More details can be found within the text surrounding this image. | |
| a See box 12.14 and table 12A.54 for detailed definitions, footnotes and caveats. b Victorian data are not available for 2011‑12 and 2012‑13. |
| *Source*: AIHW (unpublished), from data provided by State and Territory governments; table 12A.54. |
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#### 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 and continuous care in mental health services (box 12.15).

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| Box 12.15 Readmissions to hospital within 28 days of discharge |
| ‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of State and Territory governments’ admitted patient overnight separations from psychiatric acute inpatient units that were followed by readmission to a State and Territory governments’ psychiatric acute inpatient unit within 28 days of discharge. |
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| Box 12.15 (continued) |
| A low or decreasing rate of readmissions to hospital within 28 days of discharge is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up community care was inadequate to maintain people out of hospital (NMHPSC 2011a).  Readmission rates can be affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses (National Mental Health Working Group Information Strategy Committee Performance Indicator Drafting Group 2005).  Data reported for this indicator are:   * comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in DQI or attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally, the rates of readmission to hospital acute psychiatric units within 28 days of discharge have remained relatively stable since 2009‑10 (figure 12.23). Rates of readmission to hospital within 28 days of discharge by Indigenous status, remoteness areas, SEIFA, age group and sex are in table 12A.58.

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| Figure 12.23 Readmissions to hospital acute psychiatric units within 28 days**a** |
| |  | | --- | | Figure 12.23 Readmissions to hospital acute psychiatric units within 28 days  More details can be found within the text surrounding this image. | |
| a See box 12.15 and table 12A.57 for detailed definitions, footnotes and caveats. |
| *Source*:AIHW (unpublished), from data provided by State and Territory governments; table 12A.57. |
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### Efficiency

The efficiency indicators reported are for State and territory governments’ specialised mental health services. Mainstreaming has occurred at different rates across states and territories, with some treating a greater proportion of clients with severe mental illnesses in community‑based services than other jurisdictions. This can create differences across states and territories in the mix of clients, and therefore the costs, within service types.

#### 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 mental health services are delivered in an efficient manner (box 12.16).

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| Box 12.16 Cost of inpatient care |
| ‘Cost of inpatient care’ has two measures:   * ‘Cost per inpatient bed day’ is defined as expenditure on inpatient services divided by the number of inpatient bed days — data are disaggregated by hospital type (psychiatric and general hospitals) and care type (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 (2013‑14) that were during the previous period (2012‑13) 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. Measures that adjust to take into account the type and complexity of cases would be more appropriate but the data needed are not yet available. |
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| Box 12.16 (continued) |
| Data reported for the two measures for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions providing the services.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2013‑14, the average cost per inpatient bed day was higher in acute than non‑acute units and slightly higher in psychiatric hospitals than in general hospitals for both acute and non‑acute units (figure 12.24).

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| Figure 12.24 Average recurrent cost per inpatient bed day, by public hospital and care type, 2013‑14**a, b, c, d** |
| |  | | --- | | Figure 12.24 Average recurrent cost per inpatient bed day, by public hospital and care type, 2013-14  More details can be found within the text surrounding this image. | |
| a See box 12.16 and table 12A.62 for detailed definitions, footnotes and caveats. b Queensland does not provide acute services in psychiatric hospitals. c Tasmania, the ACT and the NT do not have psychiatric hospitals. d SA, the ACT and the NT do not have non‑acute units in general hospitals. |
| *Source*:AIHW (unpublished) MHE NMDS; table 12A.62. |
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Older people’s units have lower costs per inpatient day, but have considerably longer lengths of stay than general adult or child and adolescent units (figure 12.25). 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 these services. Data on the average cost per inpatient bed day by target population for all care types are reported in table 12A.59.

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| Figure 12.25 Inpatient care in acute units of public hospitals, by target population, 2013‑14**a, b, c, d, e** |
| |  | | --- | | **Cost per inpatient bed day** | | Figure 12.25 Inpatient care in acute units of public hospitals, by target population, 2013-14  Cost per inpatient bed day  More details can be found within the text surrounding this image. | | **Average length of stay** | | Figure 12.25 Inpatient care in acute units of public hospitals, by target population, 2013-14  Average length of stay  More details can be found within the text surrounding this image. | |
| a See box 12.16 and tables 12A.60–61 for detailed definitions, footnotes and caveats. b Queensland does not report any acute forensic services. c Tasmania does not provide, or cannot separately identify, child and adolescent mental health services or older people’s mental health services. d The ACT does not have separate forensic or child and adolescent mental health inpatient services. e The NT has general mental health services only. |
| *Source*:AIHW (unpublished) MHE NMDS; tables 12A.60–61. |
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#### Efficiency — cost of community‑based residential care

‘Cost of community‑based residential care’ is an indicator of governments’ objective that specialised mental health services be delivered in an efficient manner (box 12.17).

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| Box 12.17 Cost of community‑based residential care |
| ‘Cost of community‑based residential care’ is defined as the average cost per patient day. Data are reported for both the care of adults and older people.  A low or decreasing average cost per patient day 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 and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2013‑14 data are available for all jurisdictions providing the services.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2013‑14, the average cost for 24 hour staffed residential care is higher for general adult units ($535.58 per patient day) compared to older people’s care units ($397.86 per patient day), those this varied across states and territories (table 12A.63). Nationally and for all relevant jurisdictions, the costs for general adults units were higher for those staffed 24 hours compared to those that were non‑24 hours staffed (table 12A.63).

#### Efficiency — cost of ambulatory care

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

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| Box 12.18 Cost of ambulatory care |
| ‘Cost of ambulatory care’ is defined by two measures:   * average cost per treatment day * average number of treatment days per episode — this measure is provided, along with average costs, as frequency of servicing is the main driver of variation in care costs.   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. |
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| Box 12.18 (continued) |
| Low or decreasing average cost and/or fewer treatment days can indicate greater efficiency. Efficiency data need to be interpreted with care as they do not provide information on the quality of services provided.  The measures do not account for differences in the consumer mix. The consumer mix in community‑based services can differ across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services) — for example, some State and Territory governments treat a higher proportion of consumers with more complex conditions in ambulatory care.  Data reported for the two measures are:   * comparable (subject to caveats) within some jurisdictions over time but are not comparable across jurisdictions or over time for other jurisdictions (see caveats in attachment tables for specific jurisdictions) * complete (subject to caveats) for the current reporting period. All required data for 2013‑14 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally, the average recurrent cost per treatment day of ambulatory care declined slightly over the period 2009‑10 to 2013‑14 (figure 12.26), whereas the average treatment days per episode of ambulatory care increased slightly (figure 12.27).

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| Figure 12.26 Average recurrent cost per treatment day of ambulatory care (2013‑14 dollars)**a, b** |
| |  | | --- | | Figure 12.26 Average recurrent cost per treatment day of ambulatory care (2013-14 dollars)  More details can be found within the text surrounding this image. | |
| a See box 12.18 and table 12A.64 for detailed definitions, footnotes and caveats. b Victorian 2011‑12 and 2012‑13 data are not available. |
| *Source*:AIHW (unpublished) Community Mental Health Care (CMHC) NMDS; AIHW (unpublished) MHE NMDS; table 12A.64. |
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| Figure 12.27 Average treatment days per episode of ambulatory  care**a, b** |
| |  | | --- | | Figure 12.27 Average treatment days per episode of ambulatory  care   More details can be found within the text surrounding this image. | |
| a See box 12.18 and table 12A.64 for detailed caveats. b Victorian 2011‑12 and 2012‑13 data are not available. |
| *Source*:AIHW (unpublished) CMHC NMDS; AIHW (unpublished) MHE NMDS; table 12A.64. |
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### Outcomes

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

#### Rates of licit and illicit drug use

‘Rates of licit and illicit drug use’ is an indicator of governments’ objective 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 12.19).

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| Box 12.19 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 used alcohol at ‘risky’ levels and illicit drugs in the preceding 12 months. ‘Risky’ alcohol use is defined as more than two standard drinks per day on average. The specific illicit drugs include: cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma hydroxybutyrate (GHB), inhalants, and heroin.  A low or decreasing proportion of people using alcohol at risky levels or using illicit drugs is desirable.  Many of the risk and protective factors that affect a person’s propensity to consume these drugs lie outside the control of the mental health system. These include environmental, sociocultural and economic factors.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2013 and 2010 are not comparable to data for earlier years * complete (subject to caveats) for the current reporting period. All required 2013 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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In 2013, 18.2 per cent of people aged 14 years or over drank alcohol at levels considered ‘risky’ for developing long‑term health problems (figure 12.28).

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| Figure 12.28 Use of alcohol in last 12 months by people aged 14 years or over, lifetime risk status, 2013**a** |
| |  | | --- | | Figure 12.28 Use of alcohol in last 12 months by people aged 14 years or over, lifetime risk status, 2013  More details can be found within the text surrounding this image. | |
| a See box 12.19 and table 12A.65 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra; table 12A.65. |
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The proportion of people who drank at these ‘risky’ levels slightly decreased between 2007 and 2013, a trend that was consistent across both males and females and most age groups (table 12A.71). Further data on alcohol use, and lifetime and single occasion risk status for 2013, 2010 and 2007, and by Indigenous status and remoteness areas are in tables 12A.66 and 12A.69–72.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (table 12A.67). Data across the 2007, 2010 and 2013 surveys show that people using illicit drugs had higher levels of psychological distress and a higher proportion of people with a mental illness used illicit drugs than those without a mental illness (table 12A.74). Data by Indigenous status and remoteness areas are in table 12A.75.

Younger people’s use of cannabis and meth/amphetamines is of particular concern. Cannabis 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). Since 2001, the proportions of younger people aged 14−19 years and 20−29 years who used these drugs decreased (figure 12.29). Cannabis use in 2013 by state and territory and age group are reported in table 12A.68.

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| Figure 12.29 Young people’s use of cannabis and meth/amphetamines, by age group**a** |
| |  | | --- | | Figure 12.29 Young people’s use of cannabis and meth/amphetamines, by age group  More details can be found within the text surrounding this image. | |
| a See box 12.19 and table 12A.73 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Drug statistics series no. 28, Cat. no. PHE 183, Canberra; table 12A.73. |
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#### Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective to prevent the development of mental health problems and mental illness where possible (box 12.20).

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| Box 12.20 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 by sex, age group and disorder type.  A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.  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, of which some can increase the risk of mental illness whilst others can support good mental health.  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 (no time series data are reported) * complete (subject to caveats) for the current reporting period. All required 2007 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2007, the prevalence of a mental illness (with symptoms in the previous 12 months) was 20.0 per cent for people aged 16−85 years, with a further 25.5 per cent reported as having a mental illness at some point in their life (no symptoms in the last 12 months) (table 12A.76). National data on the prevalence of mental illness by disorder, age, sex and social characteristics are reported in tables 12A.76–78. These prevalence estimates are for the mental disorders that are considered to have the highest incidence rates in the population, but not 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 psychotic illnesses. In 2010, there were an estimated 3.1 cases of psychotic illness per 1000 adult population (aged 18–64 years) (Morgan et al. 2011).

The prevalence of mental illness among children and young people aged 4−17 years was an estimated 13.9 per cent in 2013‑14 (Lawrence et al. 2015). Attention deficit/hyperactivity disorder (ADHD) was the most common mental illness overall for this age group, with 7.4 per cent assessed as having ADHD in the previous 12 months, followed by anxiety disorders (6.9 per cent) (Lawrence et al. 2015).

#### Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.21).

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| Box 12.21 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 by sex, age group, Indigenous status and significant urban areas. Deaths from suicide are defined as causes of death with the International Classification of Diseases (ICD)‑10 codes X60−X84 and Y87.0.  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, NGOs and other special interest groups.  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. 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 and over time for some years and disaggregations but not comparable for other years and disaggregations (see the DQI and attachment tables 12A.82–84 for details) * complete (subject to caveats) for the current reporting period. All required 2013 or  2009–2013 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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People with a mental illness are at a higher risk of suicide than are the general population. For the period 2009–2013, 12 306 deaths by suicide were recorded in Australia (table 12A.81) — equivalent to 10.9 deaths per 100 000 people (figure 12.30). Nationally, the suicide rate increased as remoteness increased (ranging from 9.6 suicides per 100 000 people in capital cities to 14.8 suicides per 100 000 people in rural areas), with a similar pattern in most states and territories (table 12A.84).

Suicide data disaggregated by Indigenous status are available for NSW, Queensland, WA, SA and the NT only (figure 12.31). For the period 2009–2013, after adjusting for differences in population age structures, the rate of deaths for Aboriginal and Torres Strait Islander Australians due to suicide was almost twice the rate for non‑Indigenous Australians (figure 12.31).

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| Figure 12.30 Suicide rates, 5 year average, 2009–2013**a** |
| |  | | --- | | Figure 12.30 Suicide rates, 5 year average, 2009–2013  More details can be found within the text surrounding this image. | |
| a See box 12.21 and table 12A.82 for detailed definitions, footnotes and caveats. |
| *Source*:ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.82. |
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| Figure 12.31 Suicide rates, by Indigenous status, 2009–2013**a** |
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| a See box 12.21 and table 12A.85 for detailed definitions, footnotes and caveats. |
| *Source*:ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.85. |
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National data available by age and sex show that the rate for males (16.8 per 100 000 males) was over three times that for females (5.3 per 100 000 females) — a ratio that was relatively constant over all age groups, except for those aged 85 years or over where the male suicide rate was around six times the female rate (table 12A.81).

Historical data are available by sex in table 12A.80 and by state and territory in tables 12A.82–84.

#### Physical health outcomes for people with a mental illness

‘Physical health outcomes for people with a mental illness’ is an indicator of governments’ objective to promote the recovery of people with a mental illness and to provide high quality co‑ordinated services that are appropriate to the conditions and circumstances of people with a mental illness (box 12.22).

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| Box 12.22 Physical health outcomes for people with a mental illness |
| ‘Physical health outcomes for people with a mental illness’ is defined by two measures, the proportion of adults with a mental illness (compared with the proportion of adults without a mental illness):   * who are exposed to particular health risk factors: obese/overweight, daily smokers and at risk of long term harm from alcohol. * who experienced a long‑term physical health condition: cancer, diabetes, arthritis, cardiovascular disease and asthma.   Low or decreasing proportions of people with a mental illness who are subject to particular health risk factors and who experience a long‑term physical health condition are desirable.  People with a mental illness have worse physical health outcomes than people without mental illness (Coghlan et al. 2001; Happell et al. 2015; Joukamaa et al. 2001; Sartorius 2007; Lawrence, Hancock and Kisely 2013). However, the relationship between a physical and mental health is complex. Poor physical health can exacerbate mental health problems and poor mental health can lead to poor physical health. In addition, some psychiatric medications that are prescribed to treat mental health conditions are known to lead to worse physical health outcomes.  Data for these measures include 95 per cent confidence intervals (in the form of error bars in figures).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions (no time series data are reported) * complete (subject to caveats) for the current reporting period. All required 2011‑12 data are available for all jurisdictions.   The total and non-Indigenous components of the *2011-13 AHS* does not include people living in discrete Aboriginal and Torres Strait Islander communities and very remote areas, which affects the comparability of the NT results.  Data quality information for this indicator is under development. |
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Greater exposure to particular health risk factors can contribute to poorer physical health. In 2011‑12, people with a mental illness had significantly higher daily smoking rates (26.1 per cent) compared to people without a mental illness (14.7 per cent) (figure 12.32). The proportions of people who are obese/overweight or at risk of long term harm from alcohol are similar for those with and without a mental illness (table 12A.86).

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| Figure 12.32 Adults who are daily smokers, by mental illness status, 2011‑12**a** |
| |  | | --- | | Figure 12.32 Adults who are daily smokers, by mental illness status, 2011-12  More details can be found within the text surrounding this image. | |
| a See box 12.22 and table 12A.86 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) *AHS 2011–13 (2011‑12 NHS component)*, Cat. no. 4364.0; table 12A.86. |
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A higher proportion of people with a mental illness had long‑term health conditions compared to people without mental illness. Nationally in 2011‑12, the proportions of people with a mental illness who had arthritis (26.9 per cent) and cardiovascular disease (9.5 per cent) were higher than those without mental illness (16.7 per cent and 5.2 per cent respectively) (figure 12.33). Table 12A.87 provides data for cancer, asthma and diabetes.

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| Figure 12.33 Adults with long‑term health conditions, by mental illness status, 2011‑12**a** |
| |  | | --- | | **Arthritis** | | Figure 12.33 Adults with long term health conditions, by mental illness status, 2011-12  Arthritis  More details can be found within the text surrounding this image. | | **Cardiovascular disease** | | **Figure 12.33 Adults with long term health conditions, by mental illness status, 2011-12  Cardiovascular disease  More details can be found within the text surrounding this image.** | |
| a See box 12.22 and table 12A.87 for detailed definitions, footnotes and caveats. |
| *Source*:ABS (unpublished) *AHS 2011–13 (2011‑12 NHS component)*, Cat. no. 4364.0; table 12A.87. |
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#### 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 three measures, the proportion of people:   * aged 16–64 years with a mental illness who are employed, compared with the proportion for people without a mental illness * 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 proportion for people without a mental illness * aged 15 years or over with a mental illness who had face‑to‑face contact with family or friends living outside the household in the last week, compared with the proportion for people without a mental illness.   High or increasing proportions for people with a mental illness, and proportions that are similar to those without a mental illness, of people who are employed, who had face‑to‑face contact with family or friends and who are employed and/or are enrolled for study are desirable.  This indicator measures employment participation relative to the total population, as distinct from the labour force. Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). It also does not provide information on whether the employment, education or social activities participated in were appropriate or meaningful.  Data for these measures include 95 per cent confidence intervals (in the form of error bars in figures).  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions for all surveys and over time for the 2011‑12 and 2007‑08 NHS data * complete (subject to caveats) for the current reporting period. All required 2011‑12 data and 2014 data are available for all jurisdictions.   The total and non-Indigenous components of the *2011-13 AHS* and the *2014 General Social Survey* does not include people living in discrete Aboriginal and Torres Strait Islander communities and very remote areas, which affects the comparability of the NT results.  Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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While employment is recognised as important in supporting good mental health, having a mental illness can act as a barrier to gaining and maintaining employment (AHMC 2012). Nationally in 2011‑12, the proportion of people employed was lower for those with a mental illness (61.7 per cent) compared to those without a mental illness (80.3 per cent) (figure 12.34). The significantly higher proportion of people with a mental illness who do not participate in the labour force, compared to those without a mental illness, is a major contributing factor (32.0 per cent compared to 16.7 per cent). Historical data are available in tables 12A.90, 12A.92 and 12A.94.

Mental illness in early adult years can lead to disrupted and premature exit from education or disrupt the transition from school to work. These disruptions can have long term effects on the person’s ability to participate in a range of vocational activities (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 per cent, compared to 90.2 per cent for those without a mental illness (table 12A.89). Historical data are available in tables 12A.91 and 12A.93−94.

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| Figure 12.34 People aged 16–64 years who are employed, by mental illness status, 2011‑12**a** |
| |  | | --- | | Figure 12.34 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 See box 12.23 and table 12A.88 for detailed definitions, footnotes and caveats. |
| *Source*: ABS (unpublished) *AHS 2011–13 (2011‑12 NHS component)*, Cat. no. 4364.0; table 12A.88. |
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Contact with immediate household, extended family, friends, and neighbours is related to lower levels of psychological distress and therefore can protect against the onset and adverse course of mental illnesses (Berry et al. 2007). Nationally in 2014, the proportion of people aged 15 years or over with a mental illness who had face‑to‑face contact with family or friends living outside the household in the last week (76.5 per cent) was similar to the proportion for people without a mental illness (77.1 per cent) (figure 12.35).

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| Figure 12.35 People who had face‑to‑face contact with family or friends living outside the household in the last week, by mental illness status, 2014**a** |
| |  | | --- | | Figure 12.35 People who had face to face contact with family or friends living outside the household in the last week, by mental illness status, 2014  More details can be found within the text surrounding this image. | |
| a See box 12.23 and table 12A.95 for detailed definitions, footnotes and caveats. |
| *Source*:ABS (unpublished) *General Social Survey 2014*, Cat. no. 4159.0 (derived using Table Builder product); table 12A.95. |
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#### 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 who had a significant improvement in their clinical mental health outcomes. See section 12.5 for information on how the consumer outcomes average score is derived. 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 ambulatory care, people discharged from community‑based ambulatory care and people discharged from a hospital psychiatric unit. |
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| Box 12.24 (continued) |
| A high or increasing proportion of people receiving care in State and Territory governments’ specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.  This indicator has a number of 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, ambulatory 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:   * may not be comparable (subject to caveats) within jurisdictions over time and may not be comparable across jurisdictions due to differences in the quality of the data and the proportion of episodes for which completed outcomes data are available * are complete (subject to caveats) for the current reporting period. All required data for 2013‑14 are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/rogs/2016. |
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Nationally in 2013‑14, 26.6 per cent of people in ongoing ambulatory care, 48.4 per cent of people discharged from ambulatory care and 72.4 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figure 12.36). Across age groups and over the reporting years from 2007‑08, for those discharged from hospital and community care, a larger proportion of people aged 18–64 years old showed a significant improvement compared to those in other age groups. Whereas, for those in ongoing community care, younger people aged   
0–17 years had the highest proportion who showed a significant improvement compared to other age groups (table 12A.97).

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| Figure 12.36 Mental health outcomes of consumers of State and Territory governments’ specialised mental health services, 2013‑14**a** |
| |  | | --- | | **People in ongoing community‑based ambulatory care** | | Figure 12.36 Mental health outcomes of consumers of State and Territory governments’ specialised mental health services, 2013-14  People in ongoing community-based ambulatory care  More details can be found within the text surrounding this image. | | **People discharged from community‑based ambulatory care**b | | Figure 12.36 Mental health outcomes of consumers of State and Territory governments’ specialised mental health services, 2013-14  People discharged from community-based ambulatory care  More details can be found within the text surrounding this image. | | **People discharged from hospital** | | Figure 12.36 Mental health outcomes of consumers of State and Territory governments’ specialised mental health services, 2013-14  People discharged from hospital  More details can be found within the text surrounding this image. | |
| a See box 12.24 and table 12A.96 for detailed definitions, footnotes and caveats. b The ACT and NT data are not published due to insufficient observations. |
| *Source*:AIHW (unpublished) from data provided by the Australian Mental Health Outcomes and Classification Network; table 12A.96. |
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## 12.4 Future directions in performance reporting

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

* 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
* further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

## 12.5 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 Aboriginal and Torres Strait Islander 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. |
| **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. |
| **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. |
| **Comparability** | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| **Completeness** | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| **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, postnatal 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. |
| **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 (NGOs)** | 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 NGOs 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. |
| **Outcomes measurement — calculating the consumers ‘score’.** | 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). 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. 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 ‑0.5; and ‘significant deterioration’ if the effect size index is less than or equal to ‑0.5 (AHMC 2012) |
| **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 2015). |
| **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. |
| **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. |

## 12.6 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 website (www.pc.gov.au/rogs/2016).

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| **Table 12A.1** | Real estimated Australian Government expenditure on mental health services (2013‑14 dollars) ($million) |
| **Table 12A.2** | Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2013‑14 dollars) |
| **Table 12A.3** | Real estimated expenditure on State and Territory governments’ specialised mental health services, by funding source (2013‑14 dollars) ($million) |
| **Table 12A.4** | Real Australian, State and Territory governments expenditure on mental health services (2013‑14 dollars) ($million), |
| **Table 12A.5** | Depreciation expenditure on State and Territory governments’ specialised mental health services (current prices) ($million) |
| **Table 12A.6** | Total state and territory recurrent expenditure on specialised mental health services (current prices) |
| **Table 12A.7** | Functioning and quality of life measures, by 12‑month mental disorder status, 2007 (per cent) |
| **Table 12A.8** | Age-standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011‑12 |
| **Table 12A.9** | Age-standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2011‑12 |
| **Table 12A.10** | Age-standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011‑12 |
| **Table 12A.11** | Age-standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007‑08 |
| **Table 12A.12** | Age-standardised rate of adults with very high levels of psychological distress, by remoteness, SEIFA IRSD quintiles, SEIFA IRSD deciles, and disability status, 2007‑08 |
| **Table 12A.13** | Age-standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007‑08 |
| **Table 12A.14** | Level of psychological distress K10, 2007‑08 (per cent) |
| **Table 12A.15** | Age-standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011–13 |
| **Table 12A.16** | Level of psychological distress K10, 2004‑05 (per cent) |
| **Table 12A.17** | Mental health care specific MBS items processed |
| **Table 12A.18** | GP mental health‑related encounters (general and mental health specific) |
| **Table 12A.19** | GP mental health‑related encounters (general and mental health specific), by patient demographics, 2013‑14 |
| **Table 12A.20** | The 10 most frequent GP managed mental health‑related problems, by gender, 2013‑14 |
| **Table 12A.21** | Mental health patient days |
| **Table 12A.22** | Admitted patient mental health‑related separations with specialised psychiatric care, by principal diagnosis in ICD‑10‑AM and hospital type |
| **Table 12A.23** | Ambulatory‑equivalent public mental health‑related separations with specialised psychiatric care, by principal diagnosis, 2012‑13 |
| **Table 12A.24** | Community mental health service contacts, by sex and age group |
| **Table 12A.25** | Specialised mental health care reported, by Indigenous status |
| **Table 12A.26** | Available beds in State and Territory governments’ specialised mental health services |
| **Table 12A.27** | Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) |
| **Table 12A.28** | FTE direct care staff employed in specialised mental health services, by service setting (per 100 000 people) |
| **Table 12A.29** | Targeted Community Care (Mental Health) program participants (number) |
| **Table 12A.30** | Admitted patient mental health‑related separations without specialised psychiatric care, by principal diagnosis in ICD‑10‑AM groupings, 2012‑13 |
| **Table 12A.31** | Ambulatory‑equivalent mental health‑related separations without specialised psychiatric care, by principal diagnosis, 2012‑13 |
| **Table 12A.32** | Mental health‑related emergency department occasions of service in public hospitals, by episode end status, 2012‑13 |
| **Table 12A.33** | New clients as a proportion of total clients under the care of State or Territory specialised public mental health services |
| **Table 12A.34** | New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, by selected characteristics, 2013‑14 |
| **Table 12A.35** | New clients as a proportion of total clients of MBS subsidised mental health services |
| **Table 12A.36** | New clients as a proportion of total clients under the care of MBS subsidised mental health services, by selected characteristics, 2014‑15 |
| **Table 12A.37** | Proportion of people receiving clinical mental health services by service type and Indigenous status |
| **Table 12A.38** | Proportion of people receiving clinical mental health services by service type and remoteness area |
| **Table 12A.39** | Proportion of people receiving clinical mental health services by service type and SEIFA |
| **Table 12A.40** | People receiving clinical public mental health services, by age group and gender, 2013‑14 |
| **Table 12A.41** | Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age‑standardised rate) |
| **Table 12A.42** | Proportion of people receiving clinical mental health services by service type |
| **Table 12A.43** | Services used for mental health problems, Australia, 2007 (per cent) |
| **Table 12A.44** | Services used for mental health, by mental disorder status, 2007 (per cent) |
| **Table 12A.45** | Young people who had contact with MBS subsidised primary mental health care services, by age group |
| **Table 12A.46** | Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent) |
| **Table 12A.47** | Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by service type (per cent) |
| **Table 12A.48** | Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June |
| **Table 12A.49** | Recurrent expenditure on community‑based services as a proportion of total spending on mental health services (per cent) |
| **Table 12A.50** | Specialised public mental health services episodes with completed consumer outcomes measures collected |
| **Table 12A.51** | Rate and duration of seclusion events in public specialised mental health acute inpatient units |
| **Table 12A.52** | Rate and duration of seclusion events in public specialised mental health acute inpatient units (per 1000 patient days), by target population |
| **Table 12A.53** | Consumer and carer participation |
| **Table 12A.54** | Rates of community follow-up for people within the first seven days of discharge from hospital |
| **Table 12A.55** | Rates of community follow-up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness |
| **Table 12A.56** | Rates of community follow-up within first seven days of discharge from a psychiatric admission, by age group, gender and SEIFA quintiles, 2013‑14 |
| **Table 12A.57** | Readmissions to hospital within 28 days of discharge |
| **Table 12A.58** | Readmissions to hospital within 28 days of discharge, by selected characteristics, 2013‑14 |
| **Table 12A.59** | Average recurrent real costs per inpatient bed day, public hospitals, by target population (2013‑14 dollars) |
| **Table 12A.60** | Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2013‑14 dollars) |
| **Table 12A.61** | Average length of stay, public hospitals acute units, by target population (no. of days) |
| **Table 12A.62** | Average recurrent cost per inpatient bed day, by public hospital type (2013‑14 dollars) |
| **Table 12A.63** | Average recurrent cost per patient day for community residential services (2013‑14 dollars) |
| **Table 12A.64** | Average cost, and treatment days per episode, of ambulatory care |
| **Table 12A.65** | Risk status recent drinkers (in last 12 months) aged 14 years or over, 2013 (per cent) |
| **Table 12A.66** | Recent drinkers lifetime and single occasion risk, people aged 14 years or older, by social characteristics, 2013 (per cent) |
| **Table 12A.67** | Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2013 (per cent) |
| **Table 12A.68** | Use of cannabis, by age group, 2013 (per cent) |
| **Table 12A.69** | Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent) |
| **Table 12A.70** | Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent) |
| **Table 12A.71** | Lifetime risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent) |
| **Table 12A.72** | Single occasion risk status recent drinkers (in last 12 months) aged 14 years or over, by age group (per cent) |
| **Table 12A.73** | Selected illicit drug use, by substance and age group (per cent) |
| **Table 12A.74** | Selected illicit drug use by people aged 18 years or over, by level of psychological distress and self‑reported health conditions (per cent) |
| **Table 12A.75** | Illicit drug use, people aged 14 years or older, by social characteristics (per cent) |
| **Table 12A.76** | Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent) |
| **Table 12A.77** | Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent) |
| **Table 12A.78** | Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent) |
| **Table 12A.79** | Prevalence of lifetime mental disorders among adults, by disadvantage and section of state, 2007 (per cent) |
| **Table 12A.80** | Suicides and mortality rate, by sex, Australia |
| **Table 12A.81** | Suicides and mortality rate, by age and sex, Australia |
| **Table 12A.82** | Suicide deaths and death rate |
| **Table 12A.83** | Suicide deaths and death rate of people aged 15–24 years |
| **Table 12A.84** | Suicide deaths and suicide death rate, by area |
| **Table 12A.85** | Suicide deaths, by Indigenous status, 2009–2013 |
| **Table 12A.86** | Age‑standardised proportions of adults by health risk factors and mental illness status, 2011‑12 |
| **Table 12A.87** | Age‑standardised proportions of adults by long‑term health conditions and mental illness status, 2011‑12 |
| **Table 12A.88** | Age-standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011‑12 (per cent) |
| **Table 12A.89** | Age-standardised proportion of the population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part‑time), by mental health status, 2011‑12 (per cent) |
| **Table 12A.90** | Age-standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007‑08 (per cent) |
| **Table 12A.91** | Population aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (full or part‑time), by mental health status, 2007‑08 (per cent) |
| **Table 12A.92** | Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent) |
| **Table 12A.93** | Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) |
| **Table 12A.94** | Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) |
| **Table 12A.95** | Proportion of people who had face‑to‑face contact with family or friends living outside the household in the last week, by mental illness status, 2014 (per cent) |
| **Table 12A.96** | Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) |
| **Table 12A.97** | People who received mental health care provided by State and Territory public mental health services and who significantly improved, by service type and age group (per cent) |
| **Table 12A.98** | Deflators used to calculate real State and Territory mental health expenditure |
| **Table 12A.99** | Estimated resident populations used in mental health per head calculations |

## 12.7 References

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