12 Mental health management

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Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the Australian, State and Territory governments' management of mental health and mental illnesses through a variety of service types and delivery settings.

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

- a case study on how follow-up community care can influence psychiatric inpatient hospital readmission within 28 days has been included

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

12.1 Framework for measuring health management performance

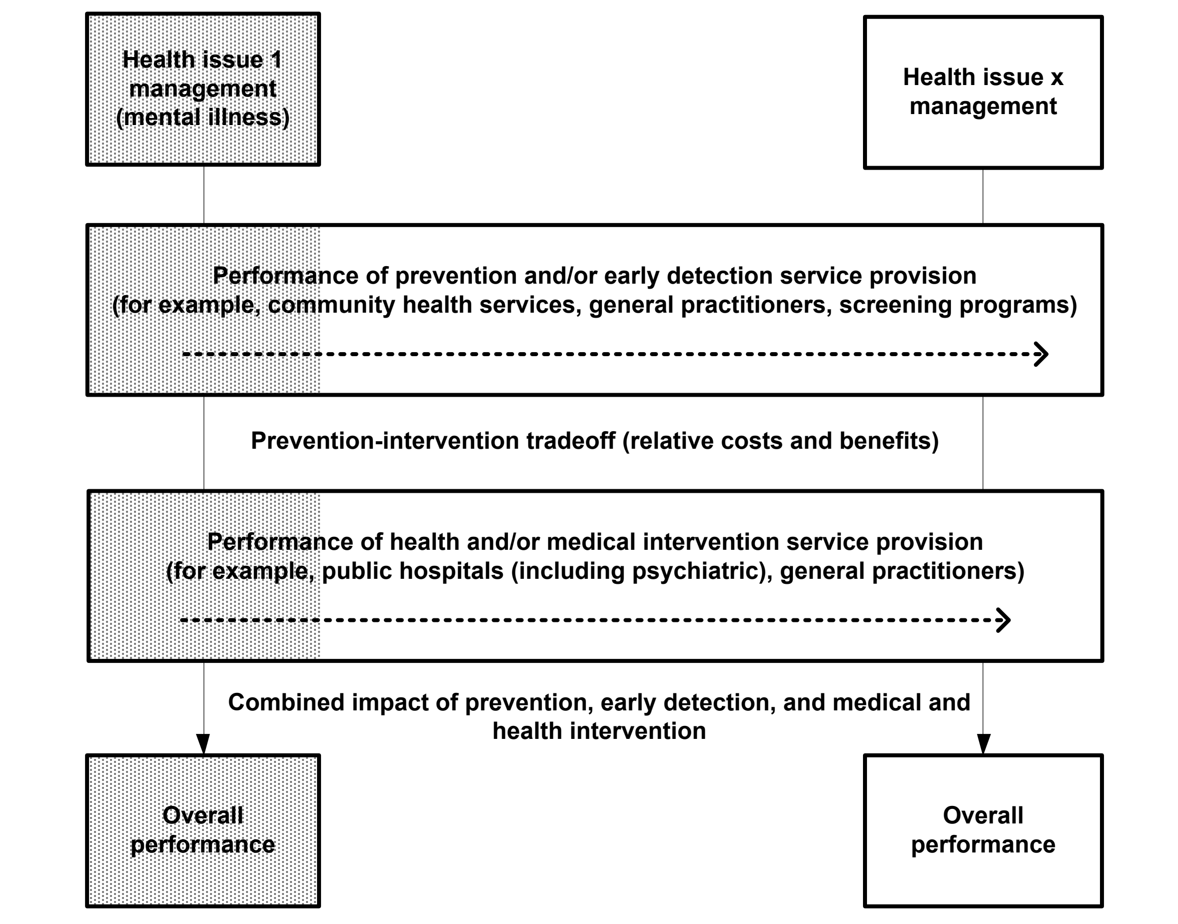
Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral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

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

The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue. The Health sector overview in this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular

service delivery mechanisms. The mental health management performance framework provides information on the interaction and integration arrangements between General Practitioners (GPs) (as the key providers of primary health), community-based and hospital-based providers in meeting the needs of people with a mental illness.

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



12.2 Profile of mental health management

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

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

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

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

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

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

This chapter focuses on the performance of State and Territory specialised public mental health services that treat the mostly low prevalence, but severe, mental

illnesses. It also includes performance data on the mental health services provided by GPs, psychiatrists and other allied health professionals under the Medicare Benefits Schedule (MBS).

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

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

Roles and responsibilities

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

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

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

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

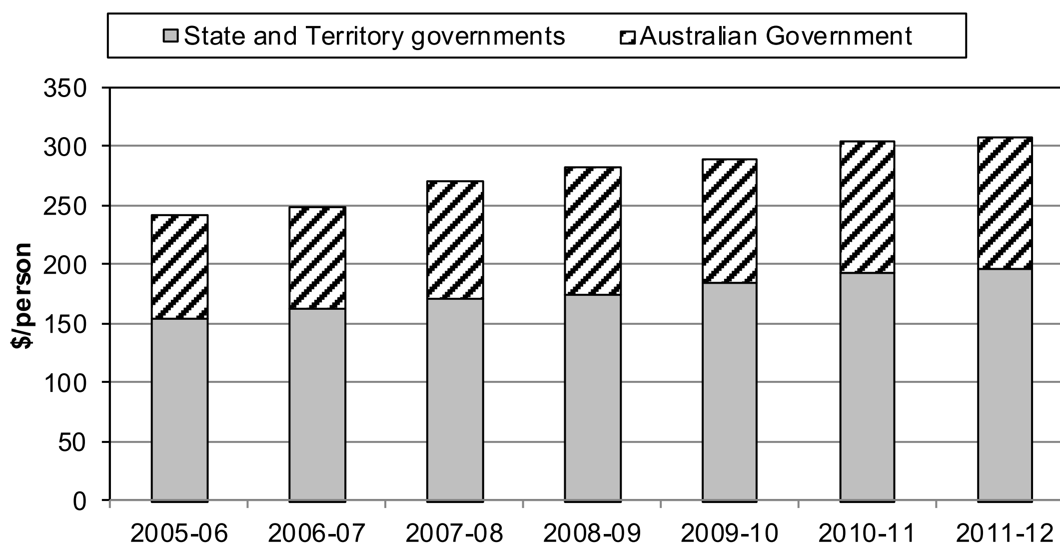
The Australian Government also provides a specific purpose payment (SPP) to State and Territory governments for health services under the National Healthcare Agreement (NHA). According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory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

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

Funding

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

Figure 12.2 **Real recurrent governments' expenditure on mental health services, by funding source (2011-12 dollars)[a, b, c]**



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

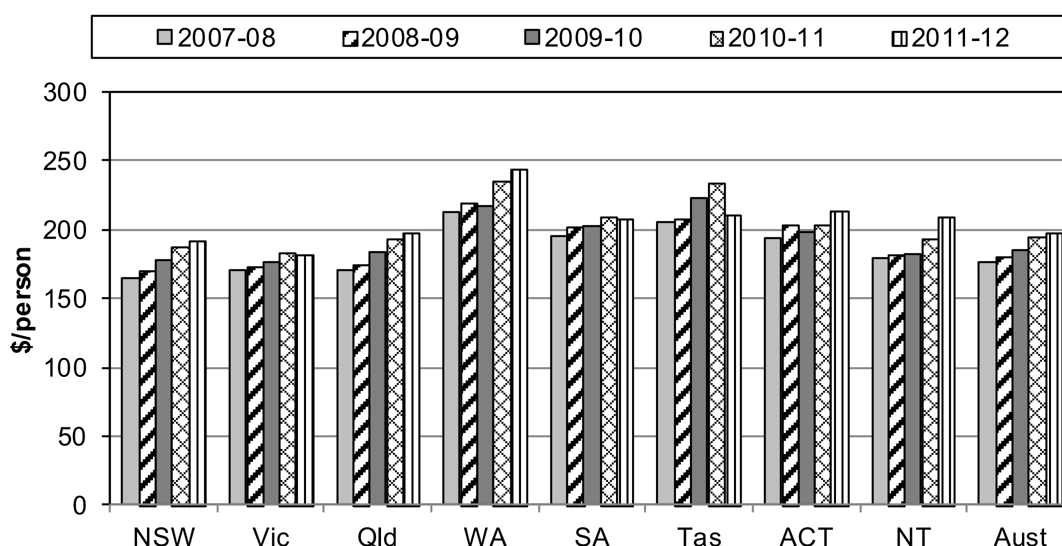
Source: Department of Health (unpublished); Australian Institute of Health and Welfare (AIHW) (unpublished) Mental Health Establishments (MHE) National Minimum Data Set (NMDS); table 12A.4.

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

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

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

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

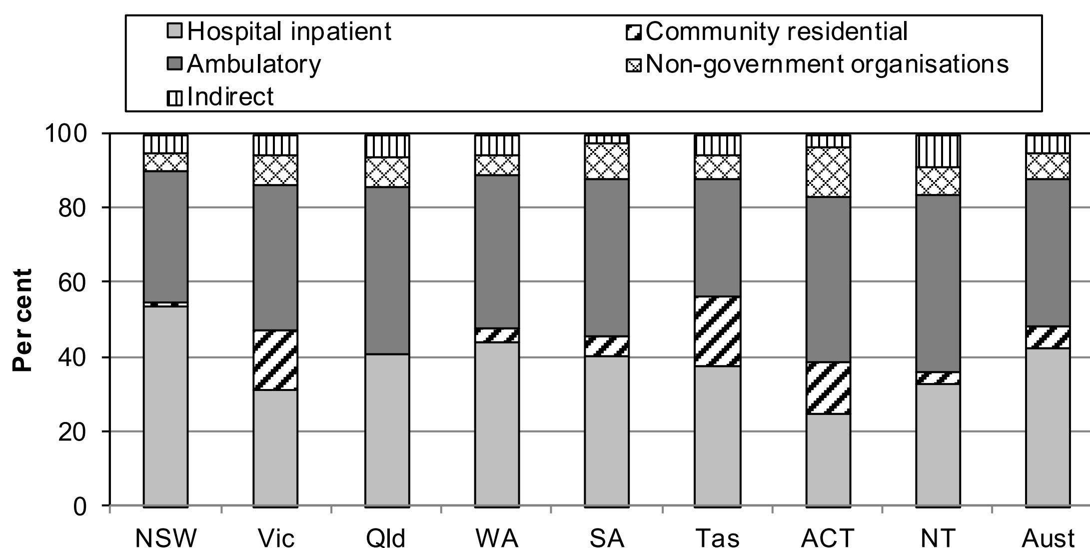


[a] Real expenditure (2011-12 dollars), using State and Territory implicit price deflators for general government final consumption on hospitals and nursing homes (table 12A.73). [b] Estimates of State and Territory governments' spending include funding from other revenue (including patient fees and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

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

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

Figure 12.4 **Recurrent expenditure on State and Territory governments' specialised public mental health services, by service category, 2011-12**[a, b, c, d, e]



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

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

Size and scope of sector

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

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

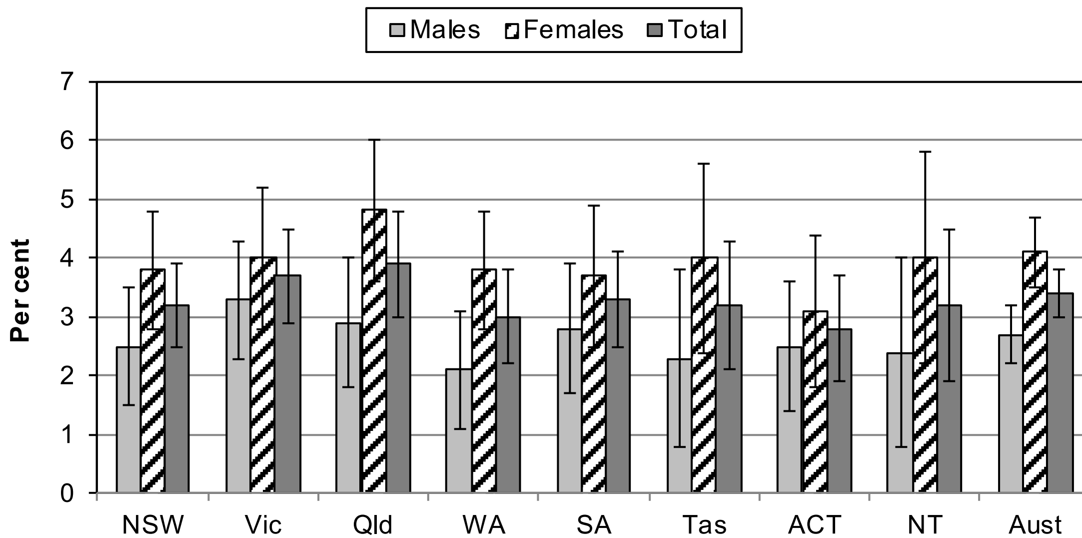
A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMHWB show

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

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

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

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



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

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

Mental health services

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

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

people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy (DoHA 2010).

MBS-subsidised GP mental health services

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

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

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

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

Other MBS-subsidised services

In 2011-12, 5.7 million other MBS-subsidised mental health-related services were provided by psychiatrists, psychologists and other allied health professionals

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

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

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

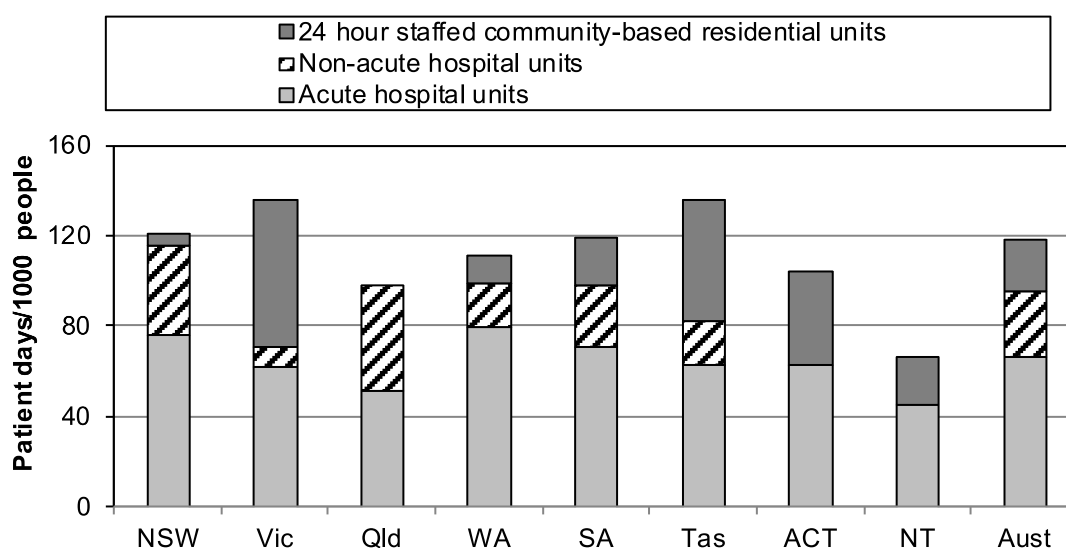
There were 86 669 separations with specialised psychiatric care in public acute hospitals and 9561 specialised psychiatric care separations in public psychiatric hospitals in 2010-11 (table 12A.19). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public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

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

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

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

Figure 12.6 **Accrued mental health patient days, 2011-12**[a, b, c]



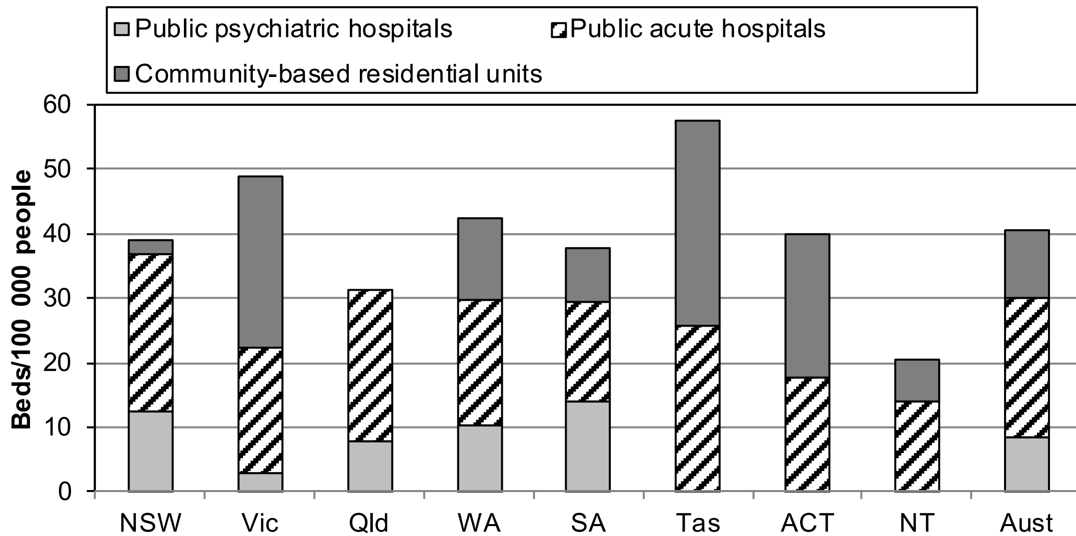
[a] Hospital patient days include those funded by government, but provided by services managed and operated by private and non-government entities. [b] Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended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

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

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

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

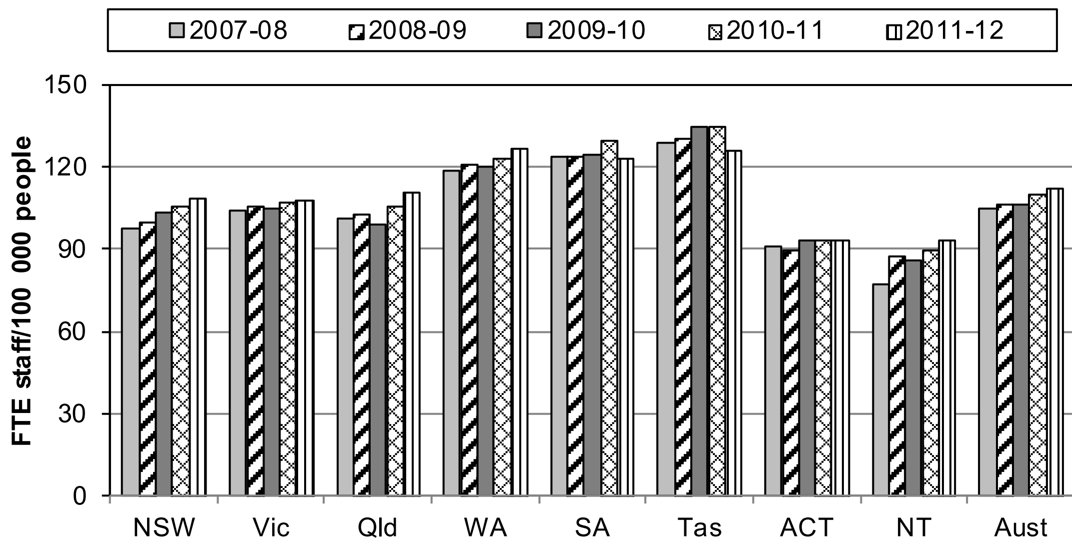
Figure 12.7 **Mental health beds in public hospitals and community-based residential units, 2011-12**[a, b, c, d]



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

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

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



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

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

Case study

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

Box 12.1 **Reducing psychiatric inpatient hospital readmission within 28 days, influenced by seven day follow-up contact**

Readmissions following a recent discharge from an acute psychiatric inpatient episode can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. The relationship between acute psychiatric inpatient readmission and contact with mental health services post-discharge (follow-up care) has been explored in the ACT. Results indicate that reduction in readmissions is influenced by the amount, the quality and the type of follow-up community contact including who, beyond the consumer, is involved.

The ACT provides a high level of follow-up care, including high frequency contact over a number of days to weeks — this is possible due, in part, to the size of the jurisdiction, service accessibility and system attributes.

- Mental health services in the ACT are provided by one central organisation.
- Public mental health service provision is captured in a centralised electronic system, covering both inpatient and community services — this enables service providers to coordinate and be aware of clinical care within inpatient services and across the community.

Follow-up community care that engages consumers' family and carers is another key factor in reducing the need for further inpatient care. Follow-up contact that includes direct face-to-face contact and involves significant others in the consumer's life appears to improve the likelihood of the consumer remaining in the community for longer and reduces the possibility of relapse to a degree requiring an inpatient readmission.

Community follow-up within seven days of discharge

In the ACT, rates of community follow-up within seven days of discharge have improved progressively over the period 2005-06 to 2012-13 and are relatively high compared to the national average. The ACT rate exceeded the *indicative* national target agreed under the *Measurement Strategy for the Fourth National Mental Health Plan* (75 per cent) from 2010-11.

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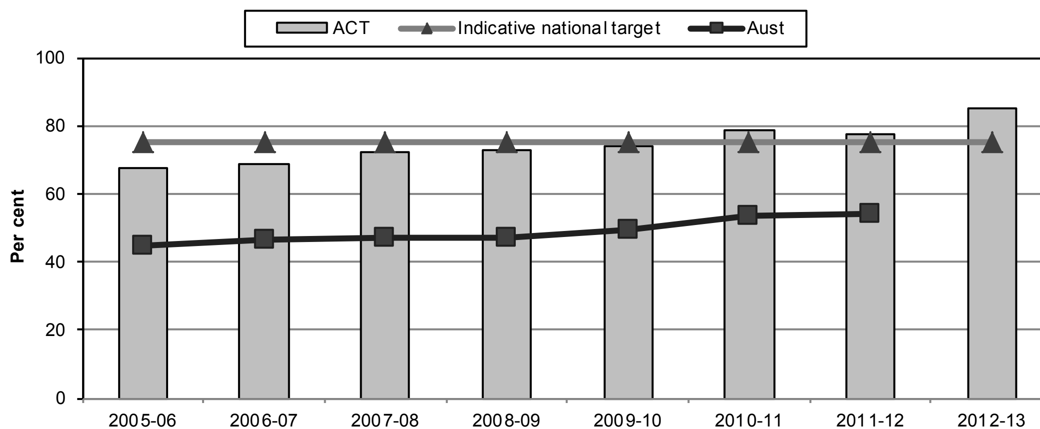
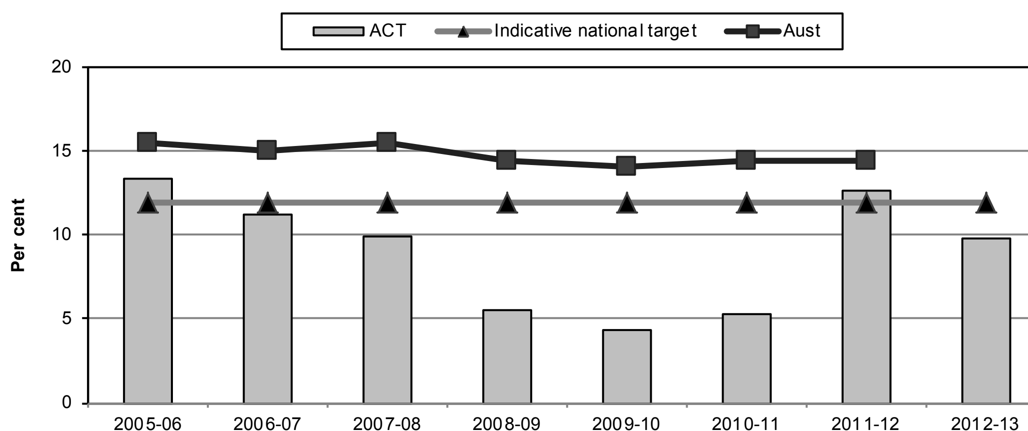
Box 12.1 **(continued)**



Readmission within 28 days of discharge from an initial inpatient episode

Rates of psychiatric inpatient hospital readmission within 28 days have decreased and are trending lower compared to the national average. The ACT rate has been below the indicative national target agreed under the Measurement Strategy for the Fourth National Mental Health Plan since 2006-07 until 2010-11. In 2011-12, the trend was reversed creating a spike in that year, but the rate decreased again in 2012-13.



The relationship between community follow-up and readmission is complex and influenced by a range of factors not directly related to the two indicators shown here. Between 2010 and 2012 a number of changes were introduced in the ACT, this included, an increase in the number of available beds for inpatient admissions (a new inpatient unit), implementation of a Mental Health Assessment Unit in the Emergency Department and the introduction of Step-Up-Step-Down community 'placements' pre- and post-admission (the reduction in the readmissions rate may be partly due to these additional services diverting the need for an inpatient admission, however their use is not included in the data provided for this indicator). These services continue to emphasise maintaining people in the community for longer, offering pre-admission inpatient assessment and early treatment, and offering alternative options to inpatient admission where appropriate.

(Continued next page)

Box 12.1 **(continued)**

These changes have caused adjustments to the inpatient casemix. A greater share of consumers admitted to hospital are now more likely to require a subsequent hospital admission due to the complexity, co-morbidity and nature of their longer term mental illnesses and their longer more variable recovery phase due to the influence of substance use. An improved understanding of the interplay of these indicators would benefit from further analysis of case-mix — particularly co-morbidity, complexity of presentations and the effect of substance use/abuse.

Results for 2012-13 indicate a period of adjustment to the changes made to services available and management of those services for the types of case-mix consumers most in need of inpatient care and more intense community follow-up from 2011-12.

The consumer's engagement with other community support services and family and friends where possible, also influences their degree of acuity and coping ability and prolongs their functional capacity to minimise their need for further acute inpatient care.

Source: ACT Government (unpublished).

12.3 Framework of performance indicators for mental health management

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

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

Box 12.2 **Broad objectives and policy directions of National Mental Health Policy**

The *National Mental Health Policy 2008* has an emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. The key broad objectives are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The key policy directions are summarised as follows:

- Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected.
- Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community.
- The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced.
- Emerging mental health problems or mental illnesses will receive early intervention to minimise the severity and duration of the condition and to reduce its broader impacts.
- People will receive timely access to high quality, coordinated care appropriate to their conditions and circumstances.
- People with mental health problems and mental illness will enjoy full social, political and economic participation in their communities.
- The crucial role of carers will be acknowledged and respected and they will be provided with appropriate support to enable them to fulfil their role.
- The mental health workforce will be appropriately trained and adequate in size and distribution to meet the need for care.
- Across all sectors, mental health services should be monitored and evaluated to ensure they are of high quality and achieving positive outcomes.
- Research and evaluation efforts will generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions.

National Mental Health Strategy

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

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

COAG National Healthcare Agreement

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

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

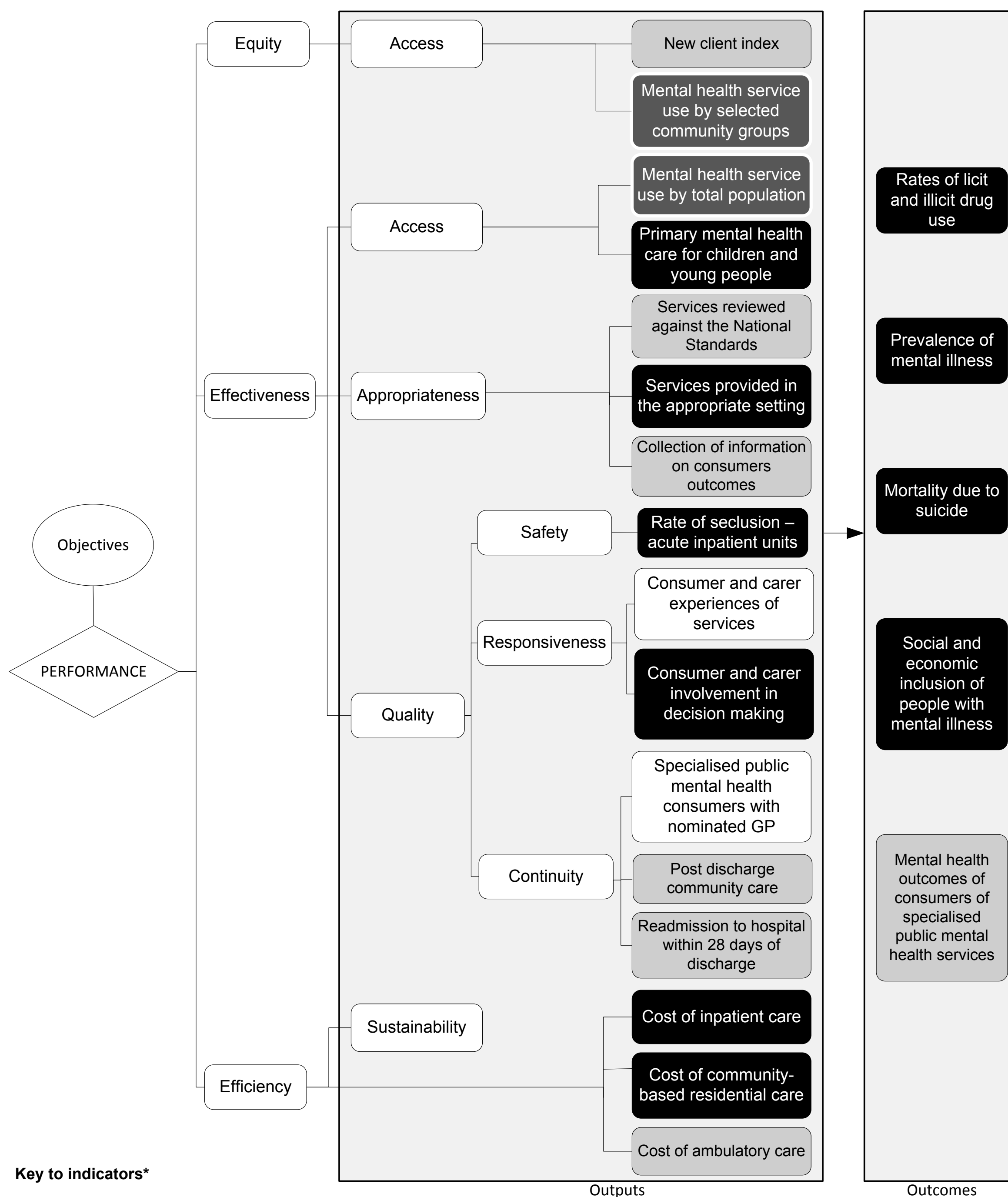
Performance indicator framework

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

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

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

Figure 12.9 **Mental health management performance indicator framework**



Key to indicators*

Text	Most recent data for all measures are comparable and complete
Text	Most recent data for at least one measure are comparable and complete
Text	Most recent data for all measures are either not comparable and/or not complete
Text	No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the chapter

12.4 Key performance indicators for mental health management

Outputs

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

Equity — access — new client index

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

Box 12.3 **New client index**

'New client index' is defined as the proportion of total clients under the care of State and Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period.

A high or increasing proportion of total clients who are new might be desirable, as it suggests it is easier for new clients to access specialised public mental health services. However, results are difficult to interpret. The appropriate balance between providing ongoing care to existing clients who have continuing needs and meeting the needs of new clients is unknown.

This indicator does not provide information on whether the services are appropriate or adequate for the needs of the people receiving them (new or existing clients), or correctly targeted to those clients who are most in need.

Data reported for this indicator are:

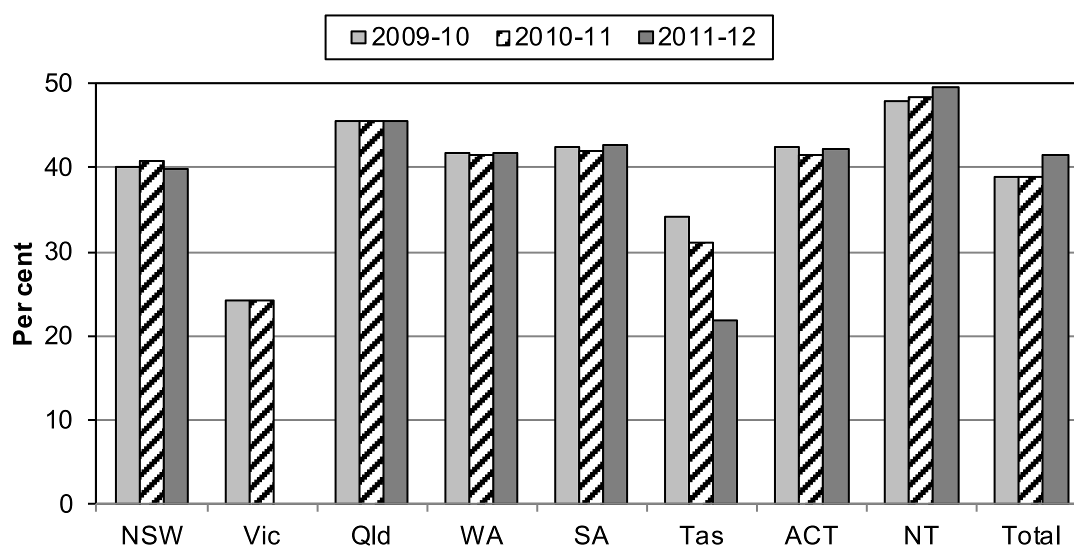
- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2011-12 data are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The proportions of total clients of specialised public mental health services who are new are reported in figure 12.10. Data for 2011-12 are not available for Victoria due to service level collection gaps resulting from protected industrial action during this

period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. Victoria has requested no substitute or proxy data be included at the jurisdictional level or to fill the gap in calculation of the national results. The total includes only those states and territories that have provided data.

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



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

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

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

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

Box 12.4 **Mental health service use by selected community groups**

'Mental health service use by selected community groups' is defined by two measures:

- proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services
- proportion of the population in a selected community group using MBS-subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS-subsidised ambulatory mental health services.

The selected community groups reported are Indigenous Australians, people from outer regional, remote and very remote locations and people residing in low socio-economic areas. For MBS-subsidised ambulatory mental health services, data by socio-economic status are reported by decile at the national level only.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community group. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for the 'proportion of the population in a selected community group using State and Territory specialised public mental health services' measure are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011-12 by geographic location and Socio Economic Indexes for Areas (SEIFA) are not comparable to previous years' data
- incomplete for the current reporting period (subject to caveats). All required 2011-12 data are not available for Victoria.

Data reported for the 'proportion of the population in a selected community group using MBS-subsidised ambulatory mental health services' measure are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011-12 by geographic location and SEIFA are not comparable to previous years' data
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The proportions of the population using State and Territory specialised public mental health services in 2011-12, by selected community groups are reported in figure 12.11. The results are not available for Victoria or at the national level.

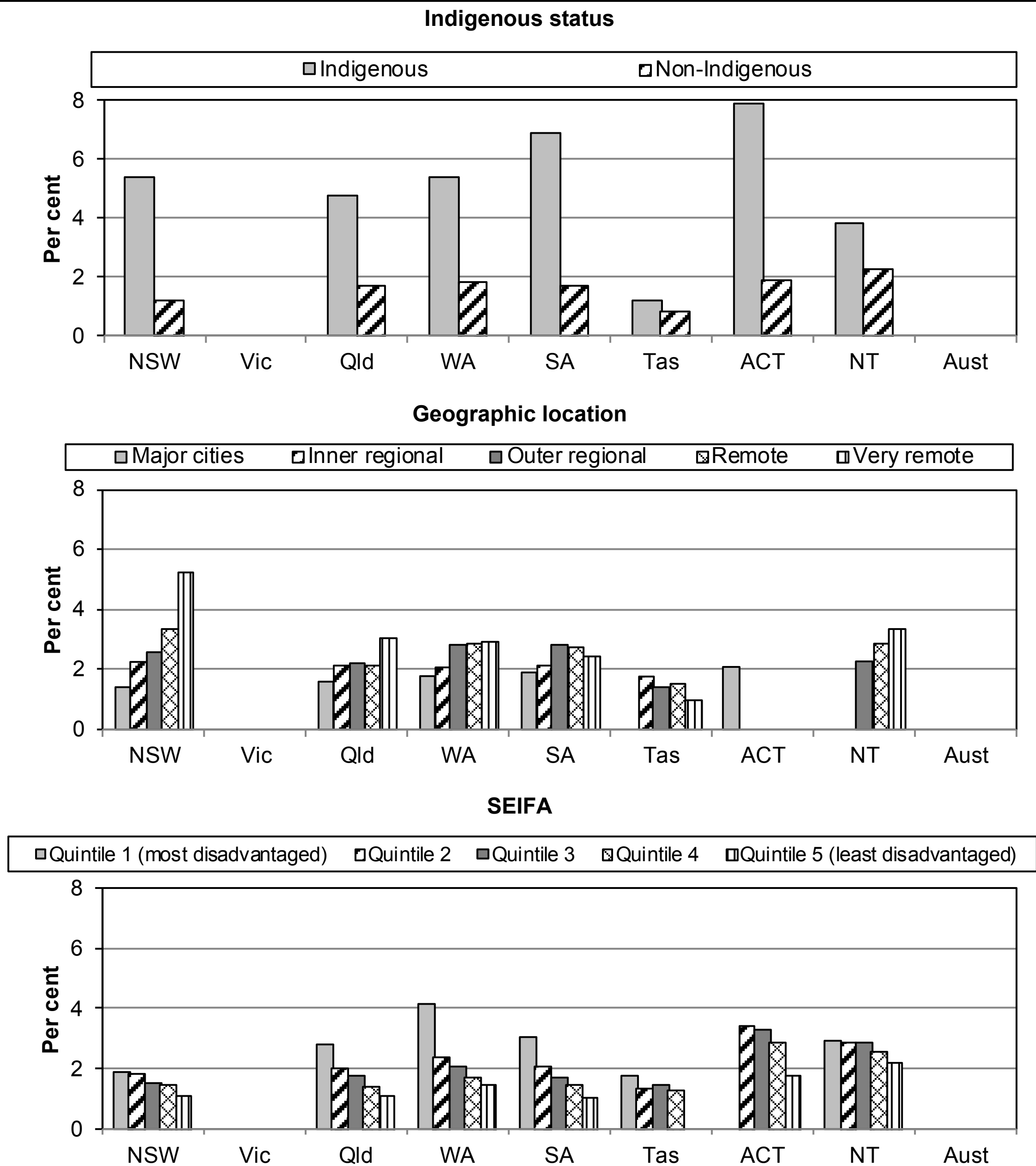
These results, which are derived using community-based ambulatory care data, should be interpreted with care, as:

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

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

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

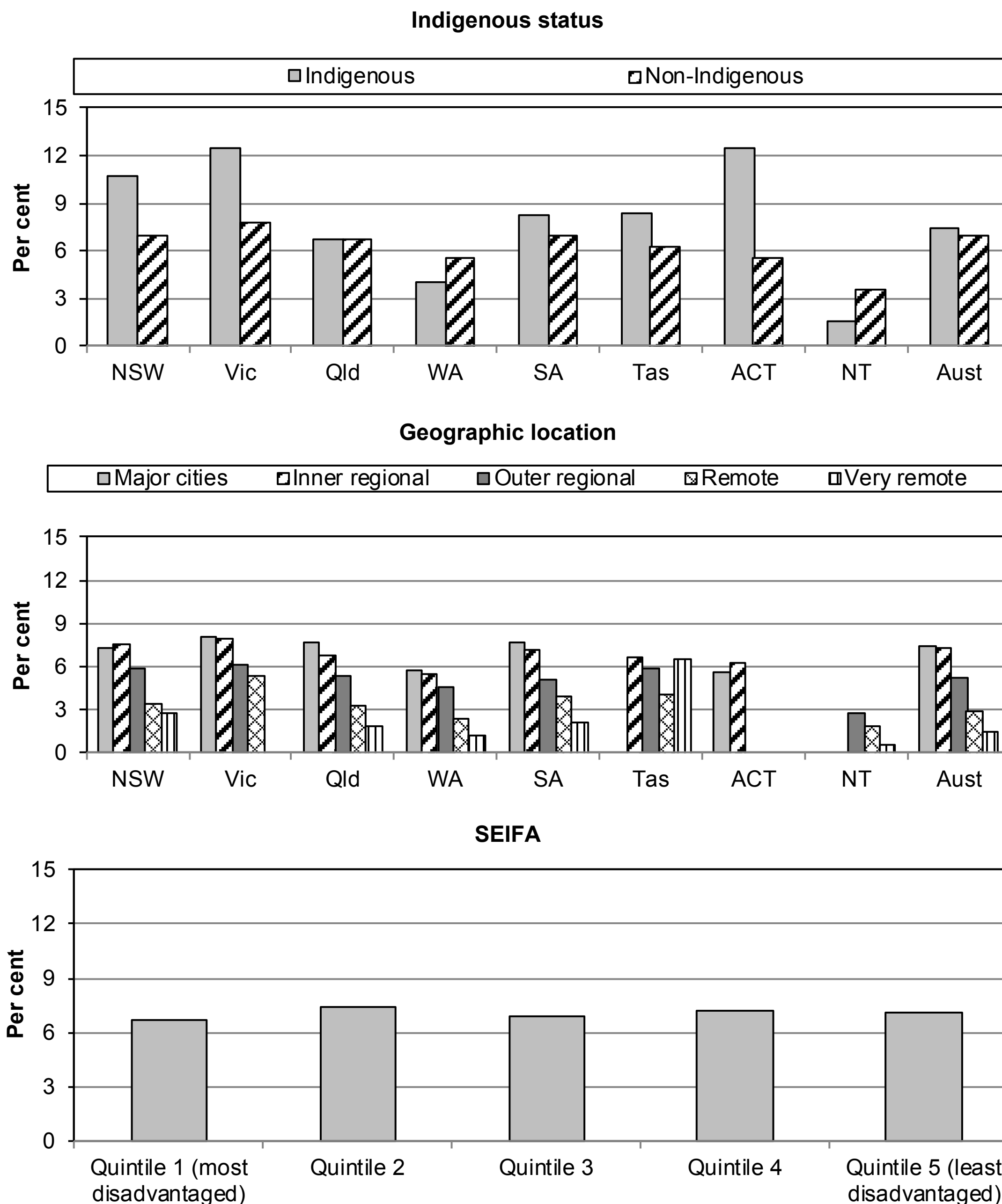
Figure 12.11 **Population using State and Territory specialised public mental health services, by selected community group, 2011-12[a, b, c, d, e, f, g, h]**



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

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

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



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

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

Effectiveness — access — mental health service use by total population

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

Box 12.5 **Mental health service use by total population**

'Mental health service use by total population' is defined as the proportion of the population using a State and Territory specialised public mental health service or a MBS-subsidised service. Data are reported separately for State and Territory specialised public mental health services and MBS-subsidised services. Data from the 2007 SMHWB on the proportion of people who had a lifetime mental disorder with symptoms in the 12 months before the survey who used any service for mental health are also reported in tables 12A.31–32.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

This indicator does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need. People with a mental illness can have low rates of service use due to them choosing not to access services, appropriate services are unavailable, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Data reported for the 'proportion of the population using State and Territory specialised public mental health services' measure are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period (subject to caveats). All required 2011-12 data are not available for Victoria.

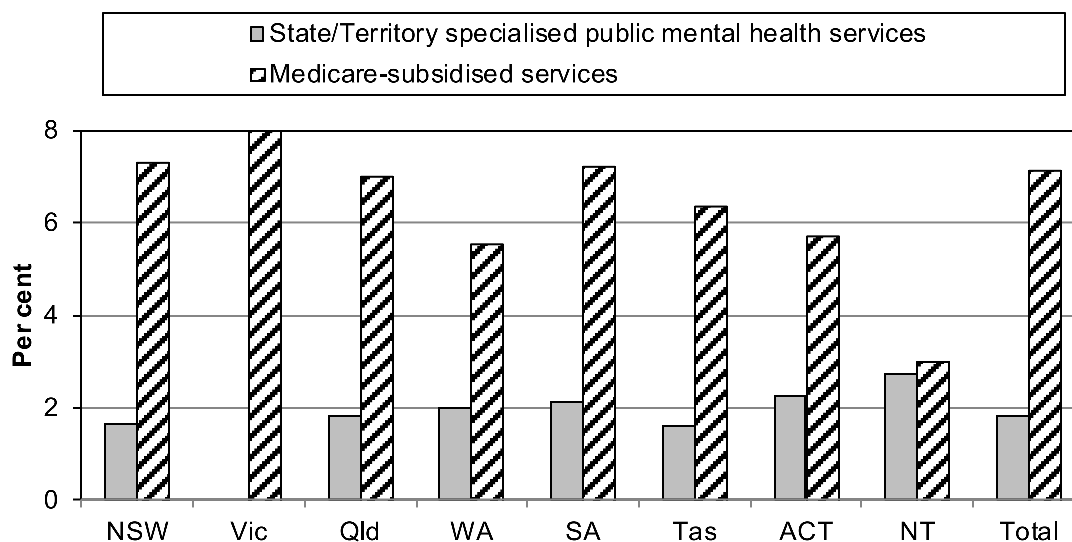
Data reported for the 'proportion of the population using MBS-subsidised ambulatory mental health services' measure are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

In 2011-12, 1.8 per cent and 7.1 per cent of the total population received State and Territory specialised public mental health services and MBS-subsidised (MBS general and DVA), respectively (figure 12.13).

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



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

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

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

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

Box 12.6 **Primary mental health care for children and young people**

'Primary mental health care for children and young people' is defined as the proportion of young people aged under 25 years who received a primary mental health care service subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

High or increasing proportions of young people who had contact with primary mental health care services subsidised through the MBS is desirable.

This indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. It also does not measure access according to need, that is, according to the prevalence of mental illness across jurisdictions. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness.

Data reported for this indicator are:

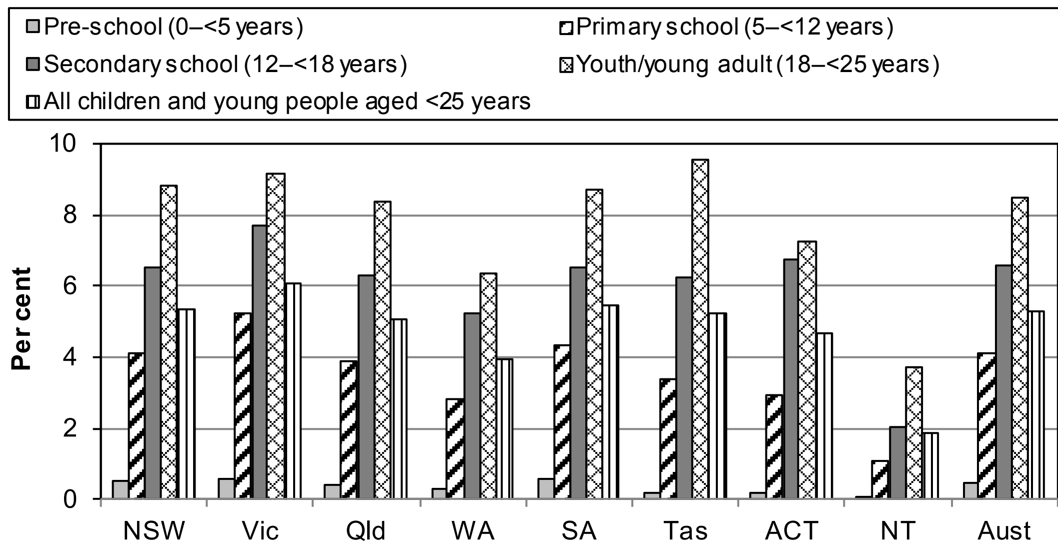
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2012-13 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Results for this indicator should be interpreted with caution. Primary mental health care for children and young people can be accessed from services other than those that are MBS subsidised. Other providers of primary mental health care to young people include community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses and university and Technical and Further Education counselling services. A component of the mental health care provided by State and Territory specialised public mental health services could also be considered primary mental health care for young people, but this cannot be reliably differentiated from other care types (NMHPSC 2011a).

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

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



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

Effectiveness — appropriateness — services reviewed against the National Standards

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

Box 12.7 **Services reviewed against the National Standards**

'Services reviewed against the National Standards' is defined as the proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — services reviewed by an external accreditation agency and judged to have met all National Standards.

(Continued next page)

Box 12.7 **(continued)**

- *Services at level 2* — services reviewed by an external accreditation agency and judged to have met some but not all National Standards.
- *Services at level 3* — services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency.
- *Services at level 4* — services that do not meet criteria detailed under levels 1 to 3.

A high or increasing proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Revised *National Standards for Mental Health Services* (NSMHS) were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The standards have been broadened to include non-government community mental health services and private office-based services as well as specialised public mental health services. Implementation guidelines have also been released.

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

Box 12.8 **The 2010 National Standards for Mental Health Services**

The first NSMHS were developed under the *First National Mental Health Plan 1993–1998*. Revised NSMHS were released in September 2010 and provide a blueprint for new and existing services to guide quality improvement and service enhancement activities. The 2010 NSMHS comprise 10 overarching standards:

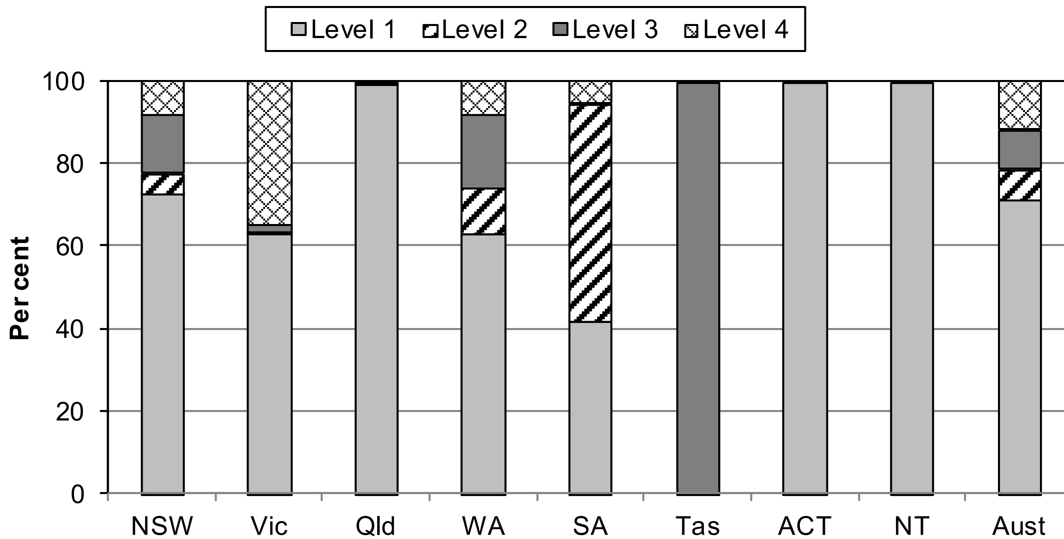
1. Rights and responsibilities
2. Safety
3. Consumer and carer participation
4. Diversity responsiveness
5. Promotion and prevention
6. Consumers
7. Carers
8. Governance, leadership and management
9. Integration
10. Delivery of care.

In future, services will be required to undergo accreditation against the ten new national safety and quality health service standards mandated by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and the revised 2010 NSMHS. Reaccreditation against the 2010 NSMHS was to be undertaken by 2014. However, services indicated their preference to undertake NSMHS reaccreditation in conjunction with the accreditation against the ACSQHC standards which were implemented from January 2013 onwards.

Source: AHMC (2010) and Department of Health (unpublished).

Figure 12.15 shows the proportion of expenditure on specialised public mental health services that had completed an external review against the NSMHS and were assessed as meeting ‘all standards’ (level 1) or as meeting ‘some but not all standards’ (level 2). Figure 12.15 also shows the proportion of expenditure on specialised public mental health services that were either in the process of being reviewed by an external accreditation agency but the outcomes were not known, or that had booked for review by an external accreditation agency (level 3); and those that did not meet criteria detailed under levels 1 to 3 (level 4).

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



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

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

Effectiveness — appropriateness — services provided in the appropriate setting

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

Box 12.9 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is defined as the proportion of State and Territory governments' recurrent expenditure on specialised mental health services (excluding aged care community residential expenditure) that was on community-based services. Community-based services are defined as ambulatory care, adult residential services and non-government organisations. Aged residential care is excluded to improve comparability.

A high or increasing proportion of recurrent expenditure spent on community-based services is desirable, reflecting a greater reliance on services that are based in community settings.

Data reported for this indicator are:

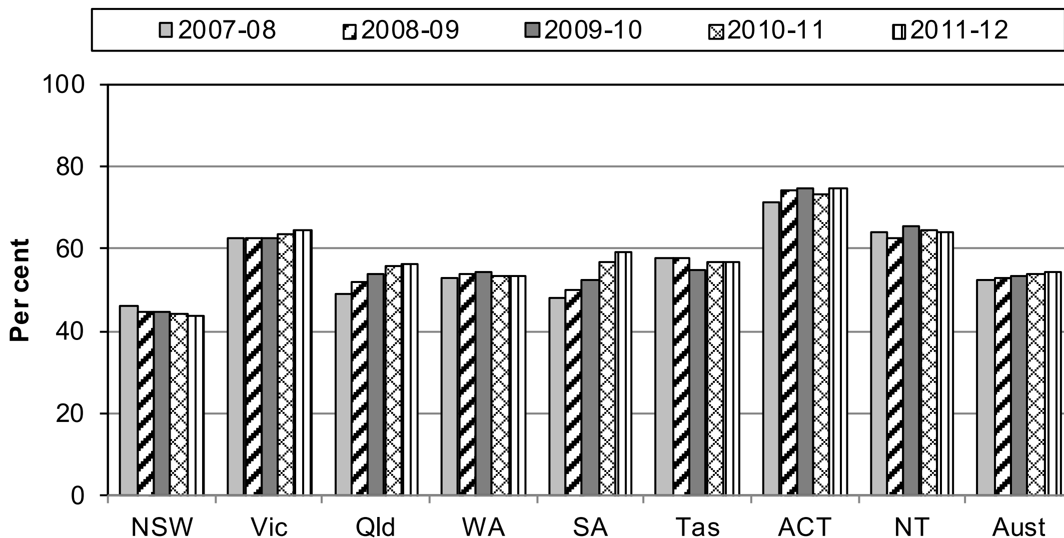
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. More appropriate mental health treatment options can be provided by encouraging the treatment of patients in community-based settings, rather than in stand-alone psychiatric hospitals and public (non-psychiatric) hospitals.

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

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



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

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

Effectiveness — appropriateness — collection of information on consumers' outcomes

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

Box 12.10 **Collection of information on consumers' outcomes**

'Collection of information on consumers' outcomes' is defined as the proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by client type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital).

High or increasing proportions of episodes for which information on consumers' mental health outcomes is collected is desirable.

This indicator monitors the uptake of the routine National Outcomes Casemix Collection. It does not provide information on whether consumers had appropriate outcomes.

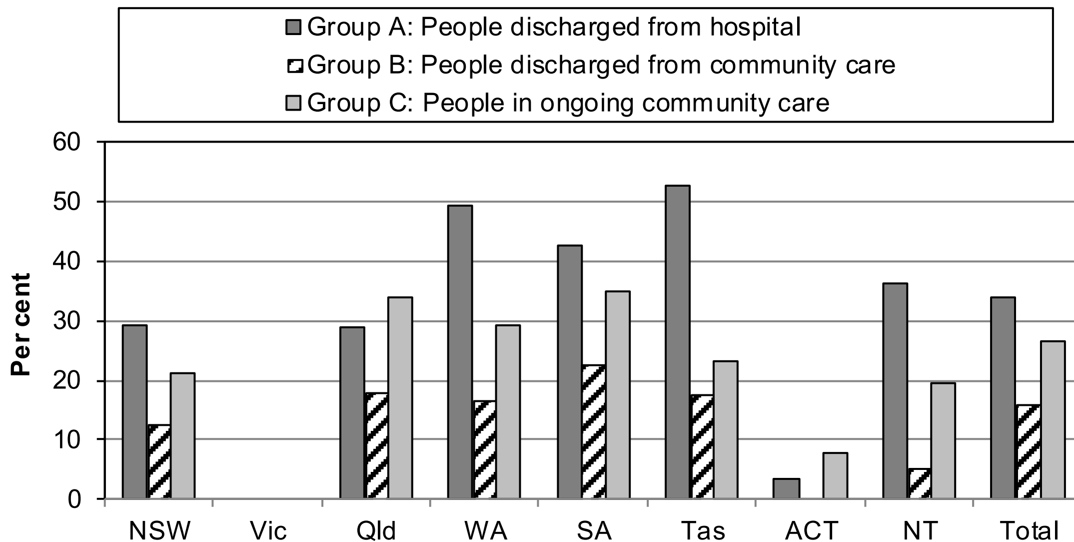
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

The estimated proportions of specialised public mental health service episodes for which information on consumers' mental health outcomes is collected are shown in figure 12.17.

Figure 12.17 **Estimated proportion of episodes for which 'complete' consumer outcome measures were collected, 2011-12**[a, b, c, d]



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

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

Quality — safety — rate of seclusion — acute inpatient units

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

Box 12.11 **Rate of seclusion — acute inpatient units**

'Rate of seclusion — acute inpatient units' is defined as the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units. Seclusion involves a patient being confined at any time of the day or night alone in a room or area from which it is not within their control to leave (NMHWG 2005; NMHPSC 2011b). See section 12.6 for further details on seclusion and how 'seclusion events' are defined.

A low or decreasing number of seclusion events per 1000 patient days (or where possible none) in specialised public mental health inpatient units is desirable.

The indicator does not provide any information on the duration of seclusion events. Information on the duration of seclusion events if reported alongside this indicator would provide a better understanding of performance in relation to the use and management of seclusion in inpatient units.

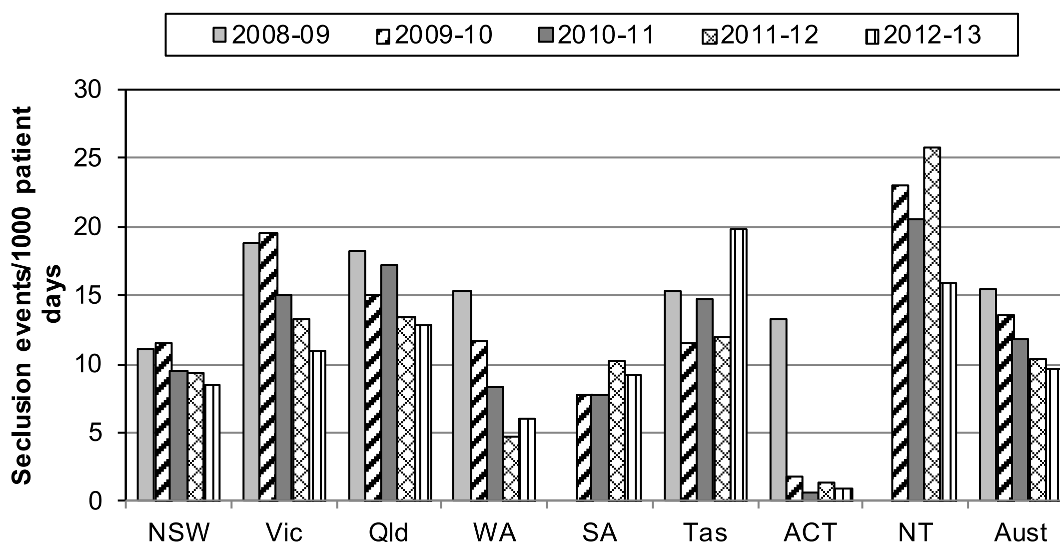
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required data for 2012-13 are available for all jurisdictions.

Data quality information for this indicator is under development.

Data on the number of seclusion events per 1000 patient days in specialised public mental health acute inpatient units are shown in figure 12.18. Legislation (a Mental Health Act or equivalent) or mandatory policy governs the use of seclusion in each State and Territory and the definition of 'seclusion' can vary across jurisdictions (NMHPSC 2011b).

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



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

Source: AIHW (2013); table 12A.37.

Quality — responsiveness — consumer and carer experiences of services

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

Box 12.12 **Consumer and carer experiences of services**

'Consumer and carer experiences of services' is yet to be defined.

Data for this indicator were not available for the 2014 Report.

Quality — responsiveness — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective that consumers and carers are involved at the service delivery level, where they have the opportunity to influence the services they

receive (box 12.13). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.13 Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is defined by two measures:

- the number of paid FTE consumer staff per 1000 FTE direct care, consumer and carer staff
- the number of paid FTE carer staff per 1000 FTE direct care, consumer and carer staff.

High or increasing proportions of paid FTE direct care, consumer and carer staff who are consumer/carer staff implies better opportunities for consumers and carers to be involved at the service delivery level, where they can influence the services received.

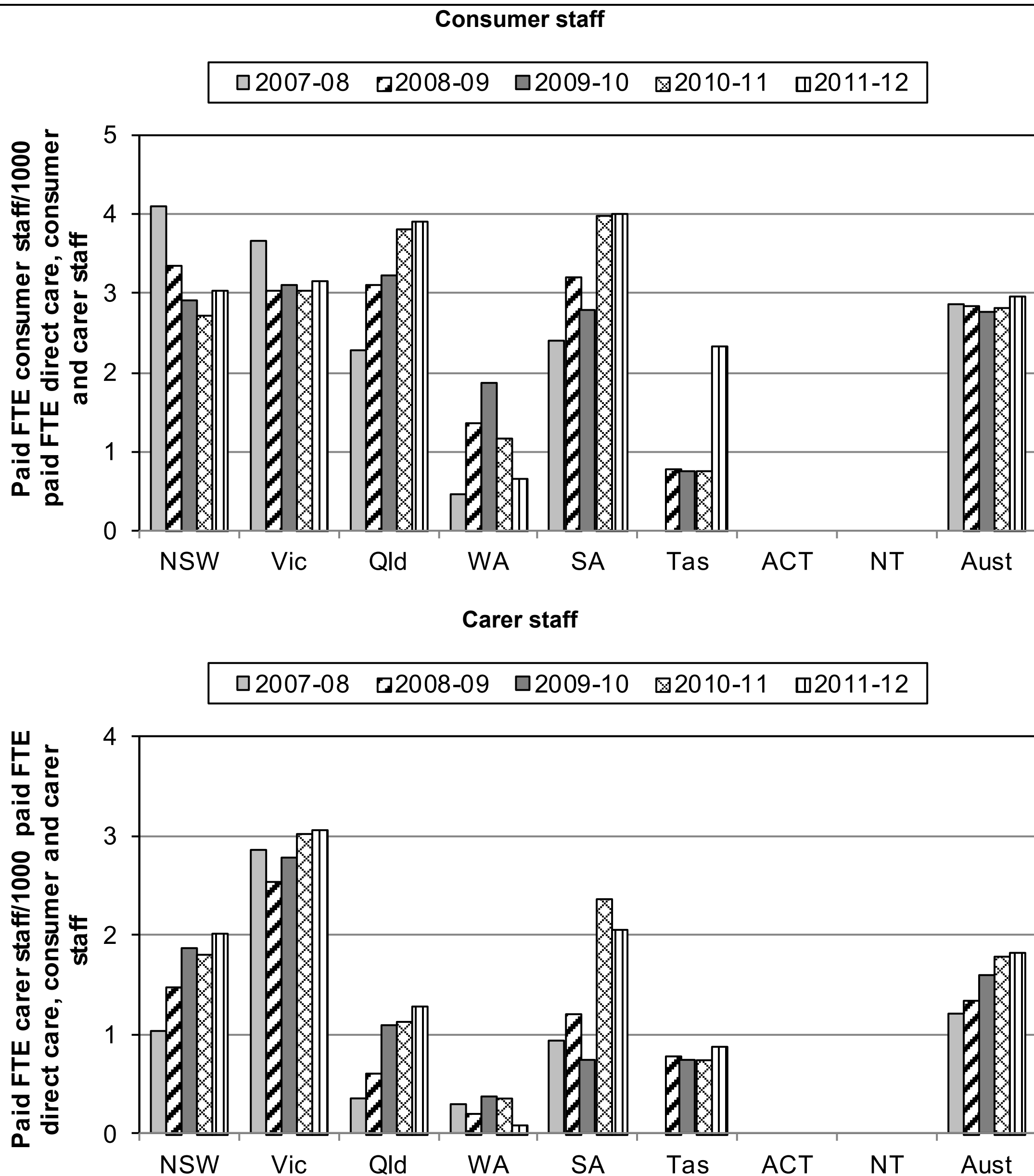
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data before 2010-11 are not comparable to data from that year
- complete for the current reporting period (subject to caveats). All required data for 2011-12 are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Figure 12.19 reports the number of paid FTE consumer and carer staff per 1000 paid FTE direct care, consumer and carer staff.

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



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

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

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

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

Box 12.14 **Specialised public mental health service consumers with nominated GP**

'Proportion of specialised public mental health service consumers with nominated GP' is yet to be defined.

Data for this indicator were not available for the 2014 Report.

Quality — continuity — post discharge community care

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

Box 12.15 **Post discharge community care**

'Post discharge community care' is defined as the proportion of admitted patient overnight acute separations from psychiatric inpatient services for which a community-based ambulatory mental health care contact was recorded in the seven days following separation.

A high or increasing rate of community follow up within the first seven days of discharge from hospital is desirable.

This indicator does not measure the frequency of contacts recorded in the seven days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts. Only community-based ambulatory contact made by State and Territory specialised public mental health services are included. Where clinical follow up is managed outside these services (for example, by private psychiatrists or GPs), these contacts are not included.

Data reported for this indicator are:

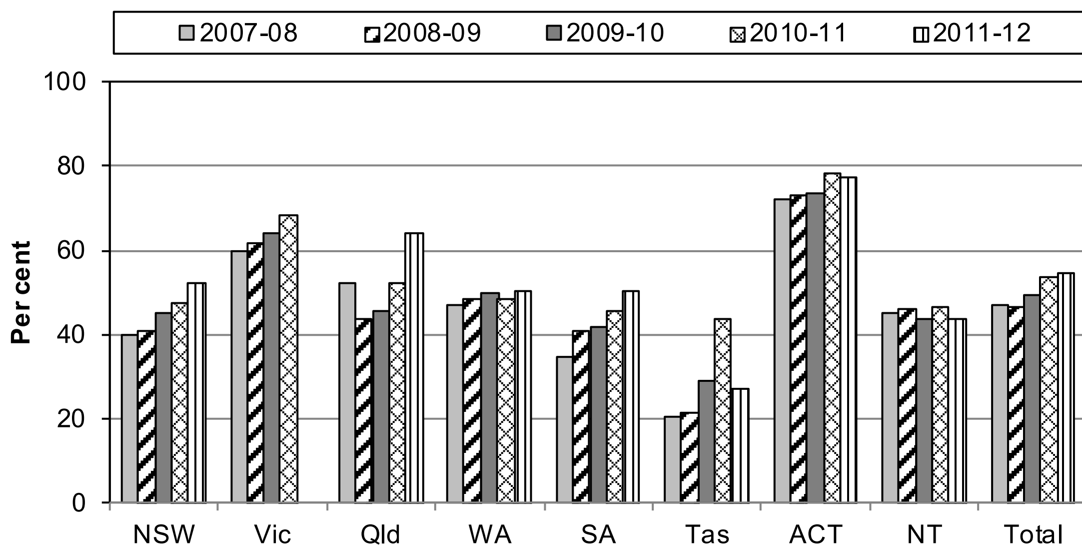
- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required 2011-12 data are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2012). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability and to minimise the need for hospital readmission (NMHPSC 2011a).

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

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



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

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

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

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

Box 12.16 **Readmissions to hospital within 28 days of discharge**

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospital is desirable. Readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain people out of hospital (NMHPSC 2011a).

Readmission rates are affected by factors other than deficiencies in specialised public mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG Information Strategy Committee Performance Indicator Drafting Group 2005).

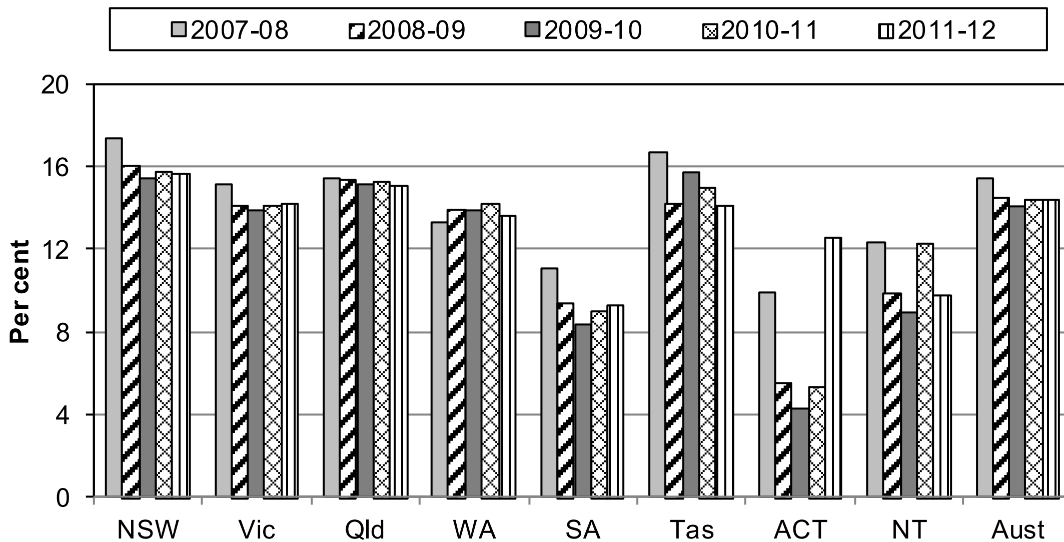
Data reported for this indicator are:

- comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.21.

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



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

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

Efficiency — Sustainability

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

Efficiency — cost of inpatient care

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

Box 12.17 **Cost of inpatient care**

'Cost of inpatient care' is defined by two measures:

- 'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day — data are disaggregated by hospital and care type (psychiatric hospitals [acute units and non-acute units] and general hospitals [acute and non-acute units]) and by inpatient target population (acute units only).
- 'Average length of stay' is defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Patient days for clients who separated in the reference period (2011-12) that were during the previous period (2010-11) are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

These measures are considered together for the inpatient acute units by target population to provide a 'proxy' measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care.

A low or decreasing cost per inpatient bed day combined with similar or shorter average lengths of stay can indicate more efficient service delivery, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

This indicator does not account for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More suitable measures for mental health services would be cost per casemix adjusted separation, for which cost is adjusted to take into account the type and complexity of cases, and the relative stay index (that also adjusts for casemix) similar to those presented for public hospitals (chapter 10). Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data reported for the two measures for this indicator are:

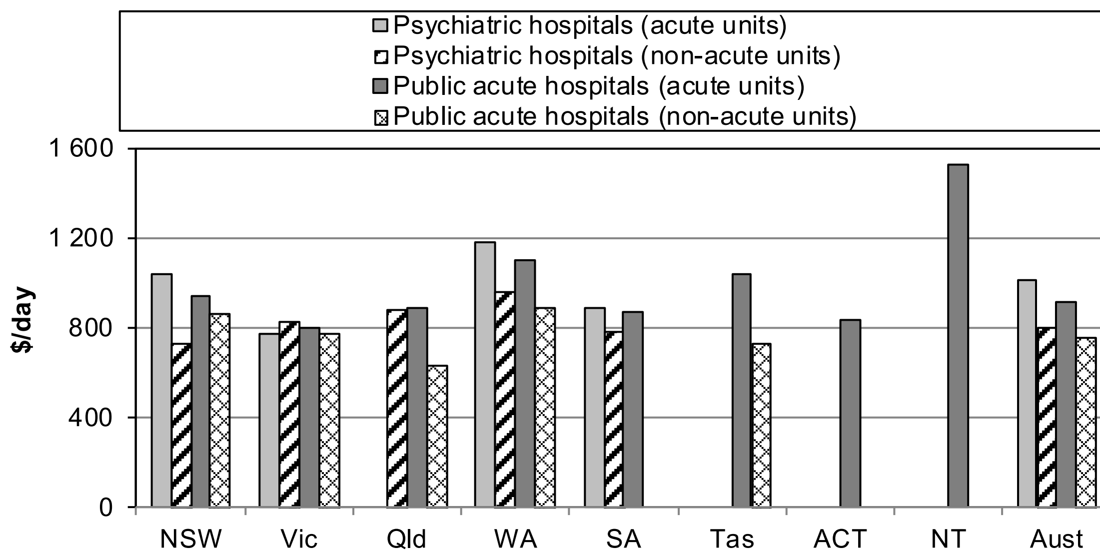
- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Data on average recurrent cost per inpatient bed day by hospital (psychiatric and public acute) and care type (acute or non-acute) are reported in figure 12.22. Costs per inpatient bed day and average length of stay data for acute units by inpatient target population (for psychiatric and public acute hospitals combined) are presented in figure 12.23. Data for forensic services are included for costs per inpatient bed day only as the length of stay is dependent on factors outside the

control of the specialised public mental health services. Data for cost per inpatient bed day for all units by target population are included in table 12A.42.

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



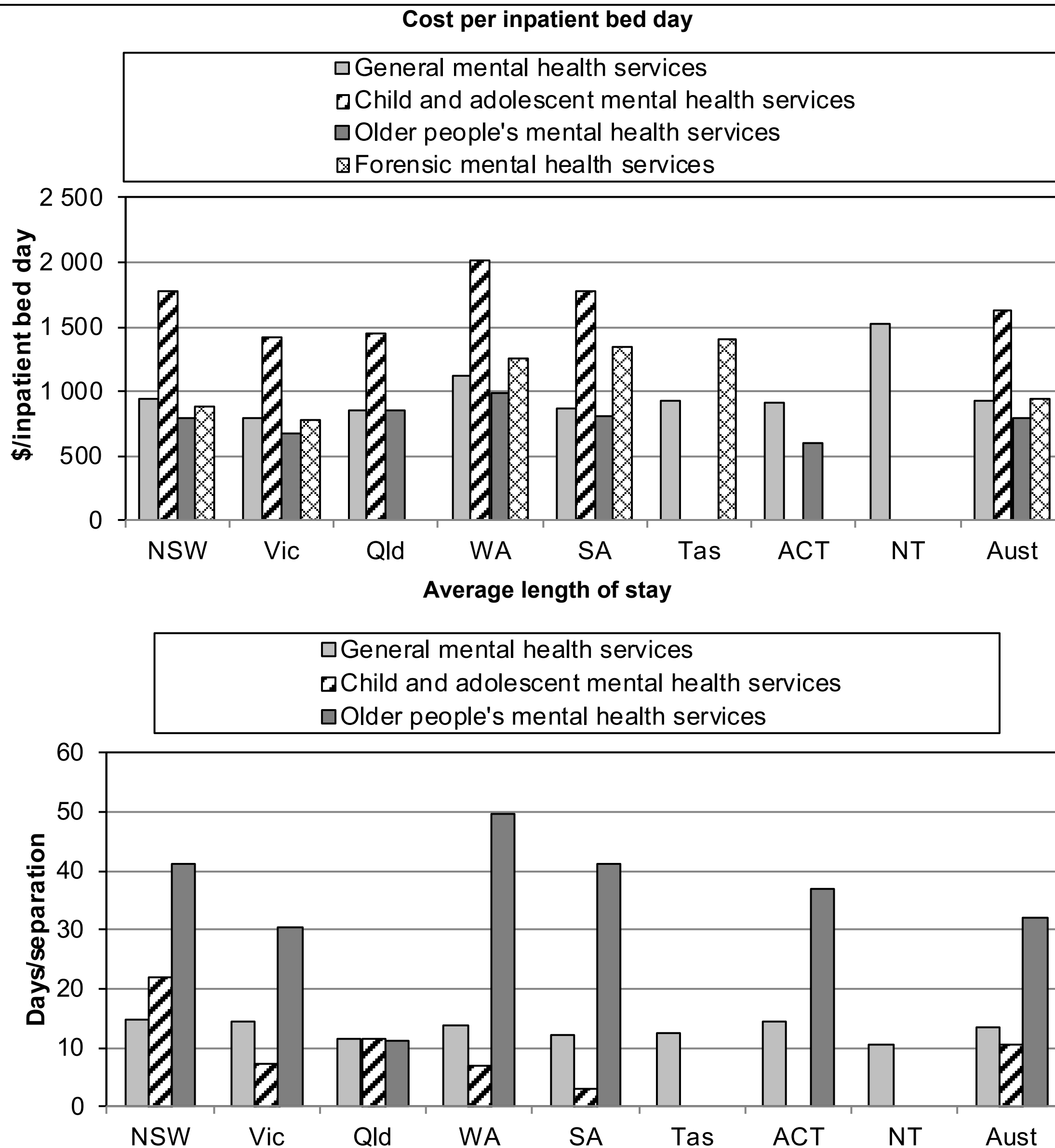
[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Mainstreaming has occurred at different rates across jurisdictions.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

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

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

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

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



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

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

Efficiency — cost of community-based residential care

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

Box 12.18 **Cost of community-based residential care**

'Cost of community-based residential care' is defined as the average cost per day for specialised public mental health services of providing community-based residential care.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions providing the services.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community-based residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

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

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

	NSW[c]	*Vic*[c]	*Qld*[d]	*WA*[e]	*SA*[e]	*Tas*	*ACT*[c]	*NT*[e]	*Aust*
General adult units									
24 hour staffed	225	488	..	368	484	490	650	308	447
Non-24 hour staffed	178	158	..	148	331	198	133	..	163
Older people's care units									
24 hour staffed	234	347	..	..	..	682	249	..	358

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

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

Efficiency — cost of ambulatory care

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

Box 12.19 **Cost of ambulatory care**

'Cost of ambulatory care' is defined by two measures:

- average cost per treatment day of ambulatory care provided by community-based specialised public mental health services
- average number of community treatment days per episode of ambulatory care provided by community-based specialised public mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

(Continued next page)

Box 12.19 **(continued)**

An episode of ambulatory care is a three month period of ambulatory care for an individual registered consumer where the consumer was under ‘active care’ (one or more treatment days in the period). Community-based periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

Low or decreasing average cost or fewer community treatment days can indicate greater efficiency although, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The measures do not account for differences in the consumer mix. The consumer mix in community-based services can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of consumers with more complex conditions in community-based ambulatory settings.

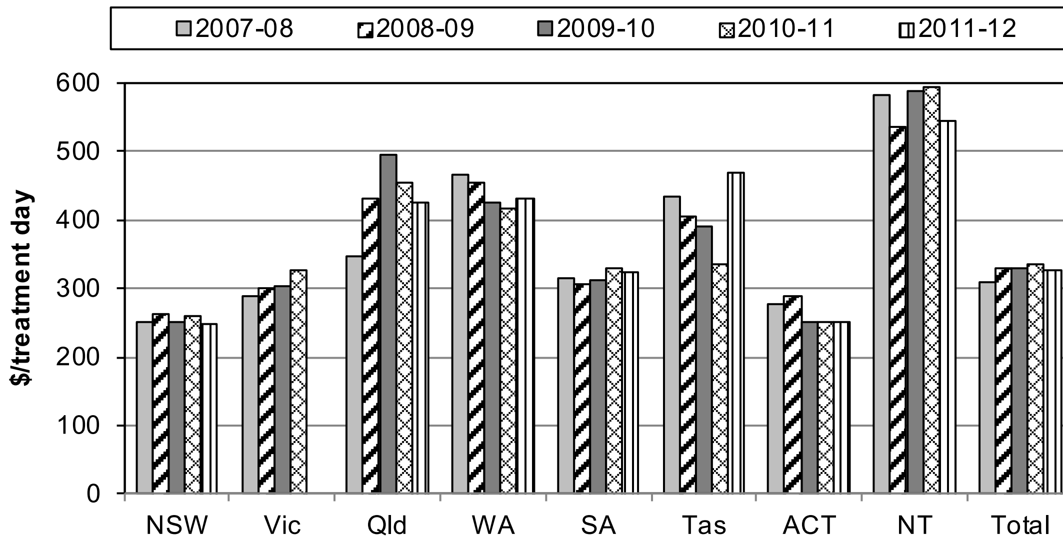
Data reported for the two measures are:

- comparable (subject to caveats) within most jurisdictions over time, but are not comparable across jurisdictions or over time for Tasmania
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Average recurrent cost per treatment day of ambulatory care data are shown in figure 12.24 and average treatment days per episode of ambulatory care data are shown in figure 12.25.

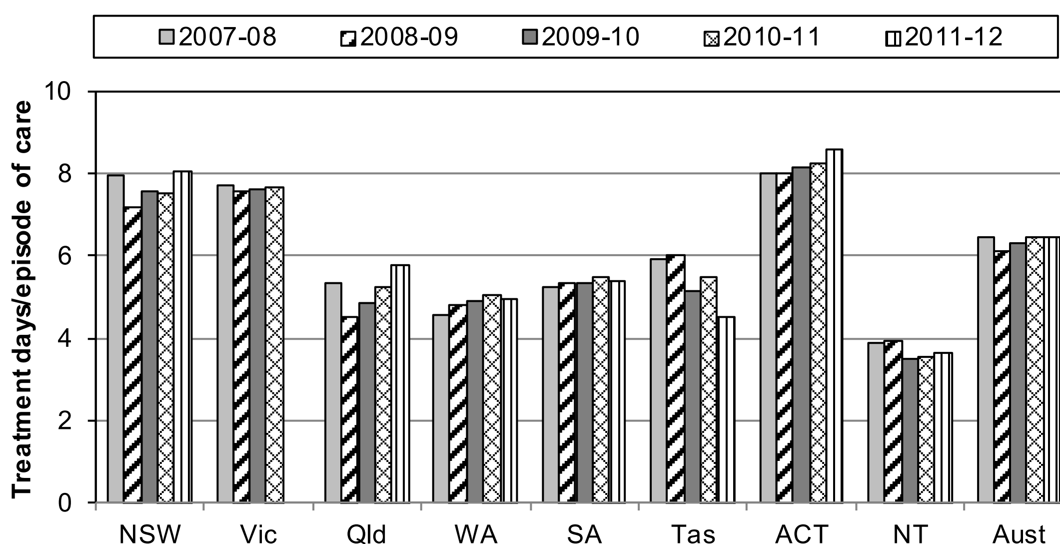
Figure 12.24 **Average recurrent cost per treatment day of ambulatory care (2011-12 dollars)**[a, b, c, d, e, f]



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

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

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



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

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

Outcomes

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

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

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

Rates of licit and illicit drug use

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

Box 12.20 **Rates of licit and illicit drug use**

‘Rates of licit and illicit drug use’ is defined as the proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months. The specific drugs are: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin.

A low or decreasing proportion of people aged 14 years or over using specific licit and illicit drugs is desirable. It suggests a reduction in the risk factors that contribute to the onset of mental illness and prevent longer term recovery.

Many of the risk and protective factors that impact on a person’s propensity to use licit or illicit drugs lie outside the ambit of the mental health system. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of substance abuse. A reduction in the prevalence of drugs use, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data for 2010 are not comparable to data for 2007
- complete for the current reporting period (subject to caveats). All required 2010 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Alcohol is the substance most commonly used and abused, and is a major cause of death, injury and illness in Australia (AHMC 2012). In 2010, of people aged 14 years or over, 80.5 per cent drank alcohol over the last 12 months and 20.1 per cent drank alcohol at levels considered ‘risky’ for developing long-term health problems (table 12A.48). Data from the 2007 *National Drug Strategy Household Survey Report* on alcohol use and risk status are in table 12A.52.

Cannabis, ecstasy, cocaine and meth/amphetamines are the most widely used illicit drugs in Australia (table 12A.49). Younger people’s usage of cannabis and

meth/amphetamines is of particular concern for their associated mental health problems (AHMC 2012). Cannabis use can precipitate schizophrenia in people who have a family history, increase the risk of psychosis symptoms and also exacerbate the schizophrenia symptoms (AHMC 2012). Psychosis symptoms are also associated with meth/amphetamine use and dependent meth/amphetamine users can also suffer from a range of co-morbid mental health problems (AHMC 2012). Table 12A.50 shows the rates of use of cannabis and meth/amphetamines by young people.

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

Prevalence of mental illness

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

Box 12.21 **Prevalence of mental illness**

'Prevalence of mental illness' is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

(Continued next page)

Box 12.21 **(continued)**

A reduction in the prevalence of mental illness can be brought about by preventative activities to stop an illness occurring, or by increasing access to effective treatments for those who have an illness (AHMC 2012). Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system, in sectors that affect the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions
- complete for the current reporting period (subject to caveats). All required 2007 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Prevalence of mental illness data are from the 2007 SMHWB, the latest prevalence estimates available. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at the State and Territory level; however, jurisdictional data are available in table 12A.56. National data on the prevalence of mental illness by disorder, age and sex are reported in tables 12A.57-58.

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

Mortality due to suicide

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

Box 12.22 **Mortality due to suicide**

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, Indigenous and non-Indigenous Australians.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non-government organisations and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.

Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions but a break in series means that data are not comparable across time periods for some dissagregations (see the attachment tables 12A.60–63 for details)
- complete for the current reporting period (subject to caveats). All required 2011 data are available for all jurisdictions.

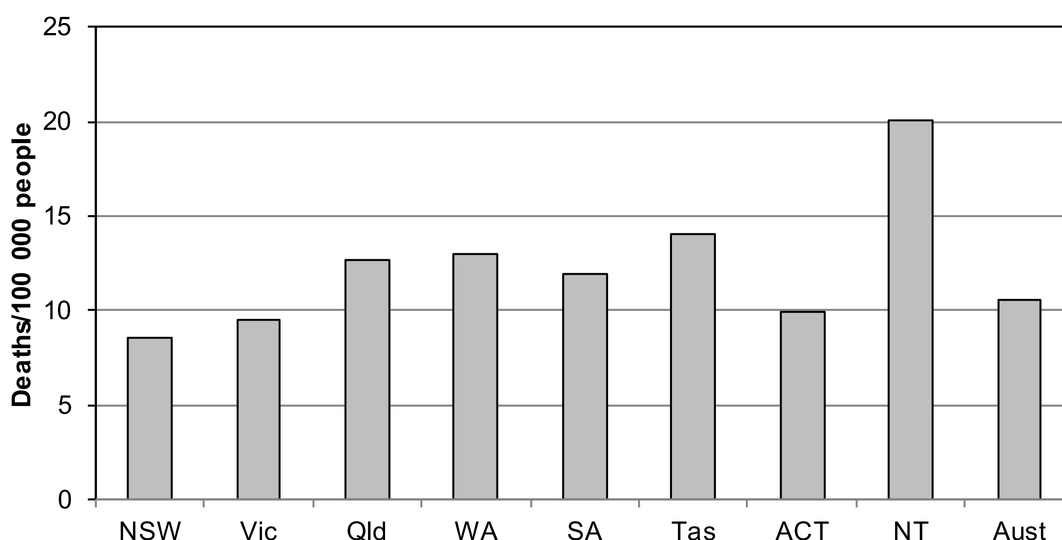
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

People with a mental illness are at a higher risk of suicide than are the general population. They are also at a higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007; Lawrence et al. 2013).

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

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

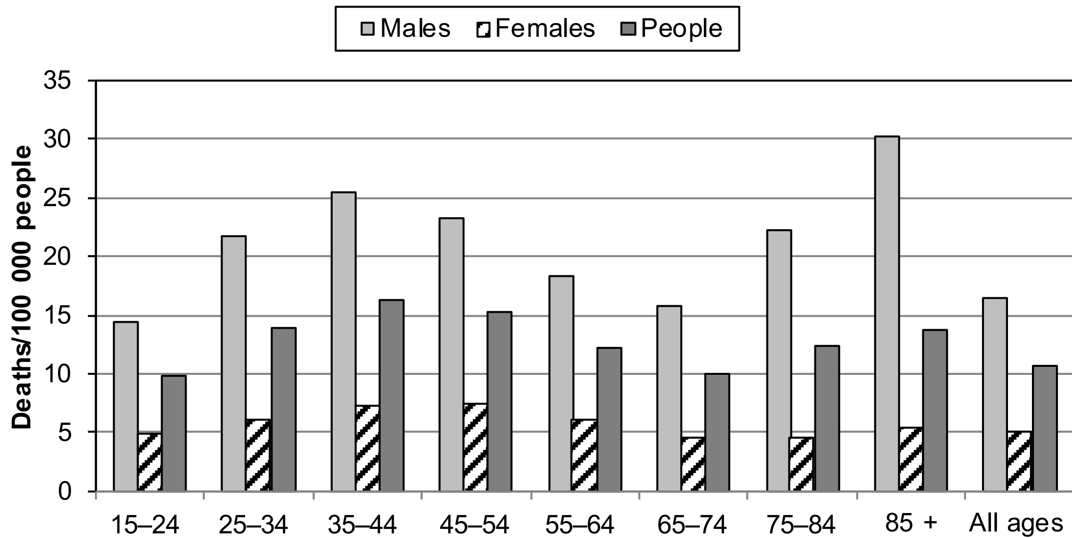
Figure 12.26 **Suicide rates, 5 year average, 2007–2011**[a, b, c]



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

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

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



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

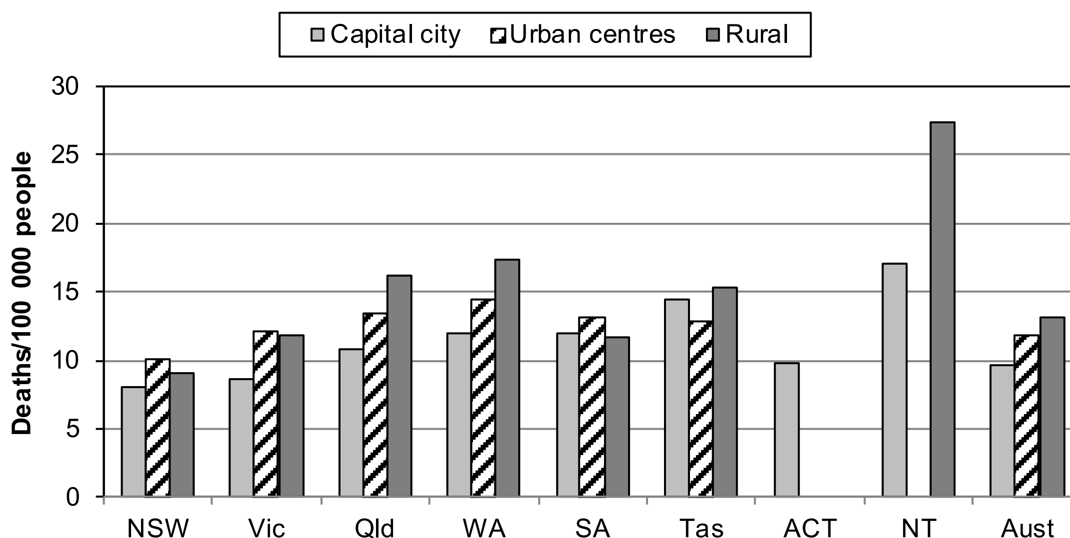
Source: ABS (unpublished) *Causes of Deaths, Australia*, Cat. no. 3303.0; table 12A.60.

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

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

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

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

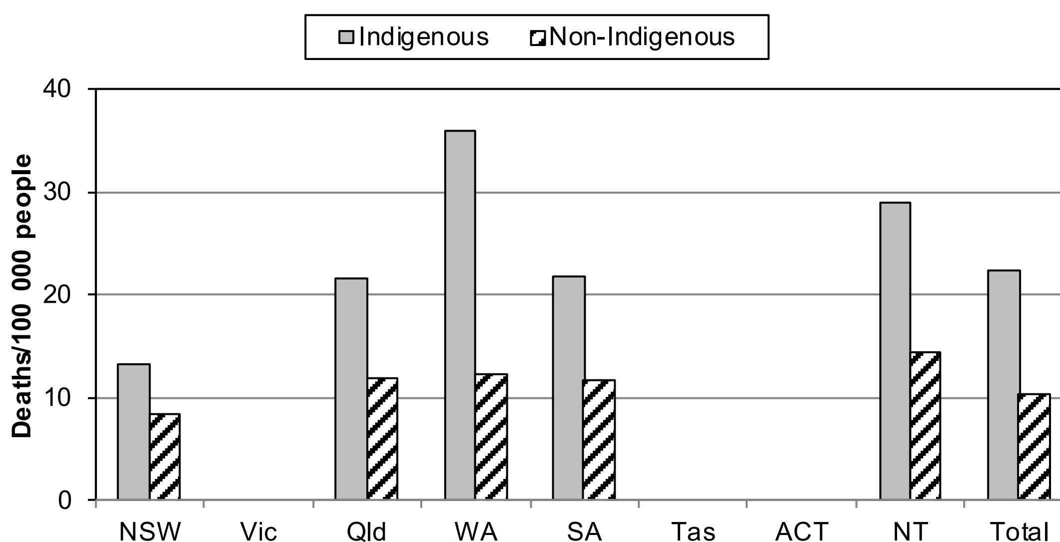


[a] The capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities comprise Statistical Area 2s classified as capital cities. Urban centres comprise all Statistical Area 2s within a state which are classified as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

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

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

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



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

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

Social and economic inclusion of people with a mental illness

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

Box 12.23 **Social and economic inclusion of people with a mental illness**

'Social and economic inclusion of people with a mental illness' is defined by two measures:

- proportion of people aged 16–64 years with a mental illness who are employed, compared with the equivalent proportion for people without a mental illness
- proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time), compared with the equivalent proportion for people without a mental illness.

A high or increasing proportion of people with a mental illness aged 16–64 years who are employed is desirable. A high or increasing proportion of people aged 16–30 years with a mental illness who are employed and/or are enrolled for study is also desirable.

This indicator measures employment participation relative to the total population aged 16–64 years, as distinct from the labour force (that is, people who are employed or unemployed, but actively looking for work). Some people can choose not to participate in the labour force (that is, they are not working or actively looking for work). Data on the proportion of people aged 16–64 years who are unemployed or not in the labour force (by mental illness status) are in table 12A.65. It also does not provide information on whether for those employed or enrolled for study, their jobs/studies are appropriate or meaningful.

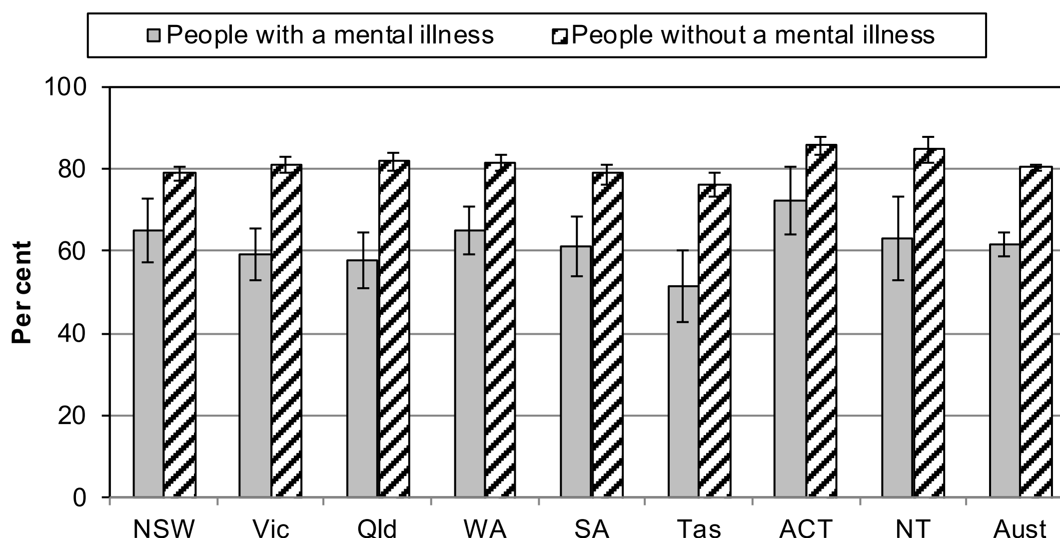
Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and overtime depending on the source, that is 2011-12 NHS data are comparable to 2007-08 NHS data, but not to 2007 SMHWB data
- complete for the current reporting period (subject to caveats). All required 2011-12 data are available for all jurisdictions.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2012). Nationally, in 2011-12, the proportion of all Australians with a mental illness who were employed was 61.7 ± 3.1 per cent, compared to 80.3 ± 0.9 per cent for those without a mental illness (figure 12.30).

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



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

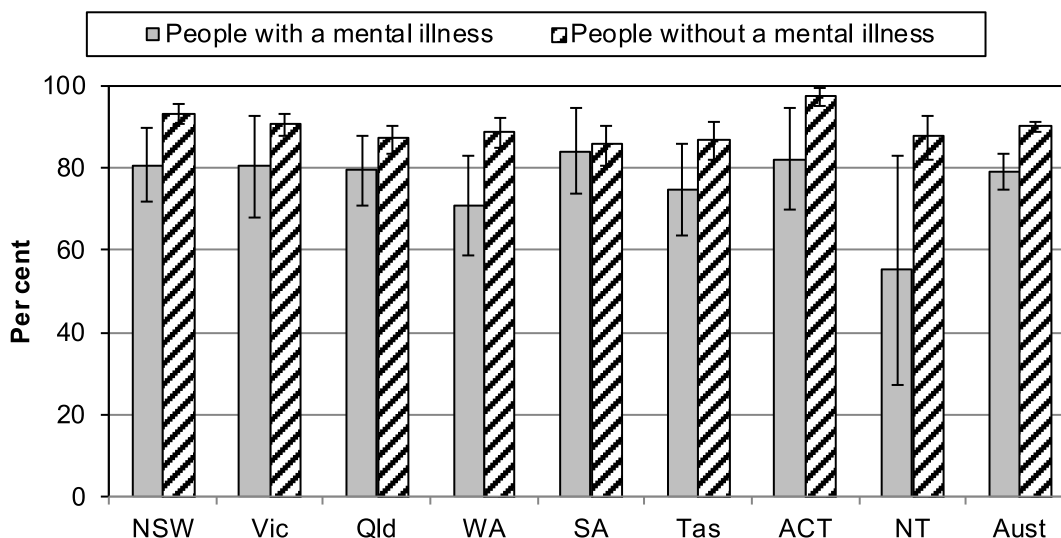
Source: ABS (unpublished) *AHS 2011–13* (2011-12 NHS component), Cat. no. 4364.0; table 12A.65.

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

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

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

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



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

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

Mental health outcomes of consumers of specialised public mental health services

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

Box 12.24 **Mental health outcomes of consumers of specialised public mental health services**

'Mental health outcomes of consumers of specialised public mental health services' is defined as the proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by three consumer types: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

(Continued next page)

Box 12.24 **(continued)**

Results are difficult to interpret as there are a range of mental health clinical outcomes for people treated in specialised public mental health services and 'best practice' outcomes are unknown (AHMC 2012). A high or increasing proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (AHMC 2012). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre- and post- scores to the standard deviation of the pre-score (AHMC 2012). Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between -0.5 and zero; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).

This indicator has many technical and conceptual issues. The outcome measurement tool is imprecise. A single 'average score' does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods (AHMC 2012). The approach separates a consumer's care into segments (hospital versus the community) rather than tracking the person's overall outcomes across treatment settings. In addition, consumers' outcomes are measured from the clinician's perspective and not as the 'lived experience' from the consumer's viewpoint (AHMC 2012).

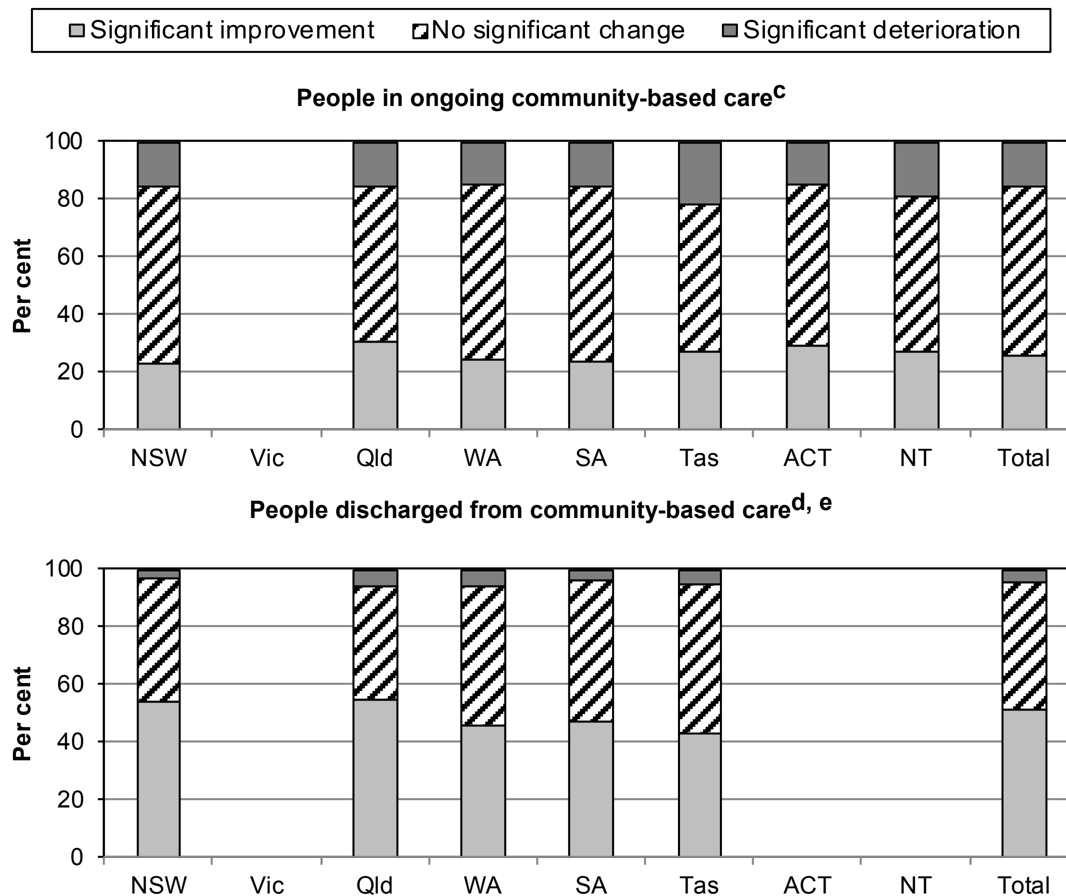
Data reported for this indicator are:

- not comparable across jurisdictions or over time due to differences in the quality of the data and the proportion of episodes for which completed outcomes data are available
- incomplete for the current reporting period. All required data for 2011-12 are not available for Victoria.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014.

Nationally, in 2011-12, 26.0 per cent of people in ongoing community-based care, 51.5 per cent of people discharged from community-based care and 70.8 per cent of people discharged from a hospital psychiatric inpatient unit showed a significant improvement in their mental health clinical outcomes (figures 12.32-33). Caution is required in interpreting results across states and territories. Data are of variable quality and there are different levels of coverage across states and territories (AHMC 2012).

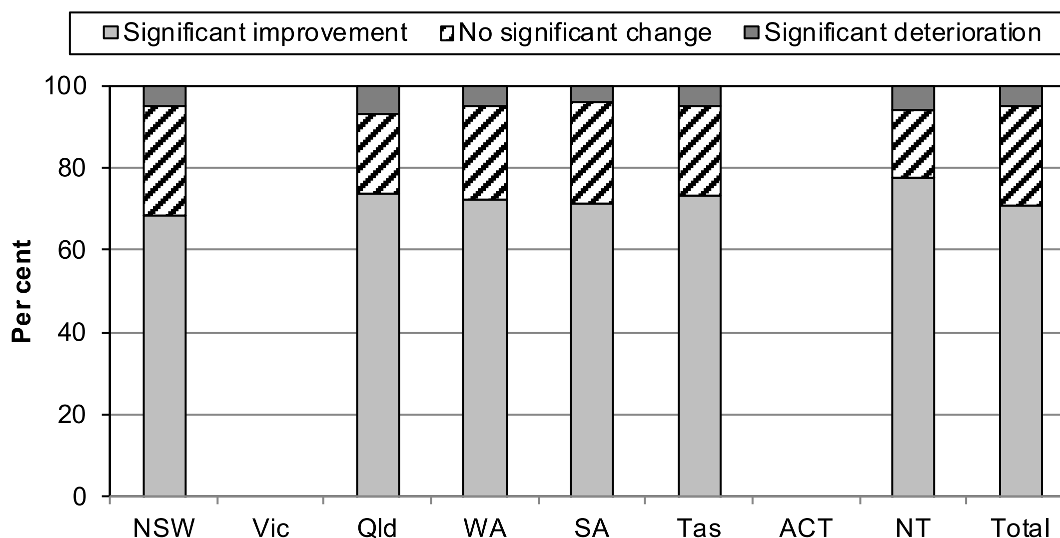
Figure 12.32 **Mental health outcomes of consumers of State and Territory community-based specialised public mental health services, 2011-12**[a, b]



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

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

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



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

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

12.5 Future directions in performance reporting

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

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

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

12.6 Definitions of key terms

General terms

General practice — The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.

Health management — The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.

Incidence rate — Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).

Separation — An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Mental health

Acute services — Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can:

- focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms
- target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.

Accrued mental health patient days — Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, that is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

The key basic rules to calculate the number of accrued mental health care days are as follows:

- For a patient admitted and discharged on different days, all days are counted as mental health care days except the day of discharge and any leave days.
- Admission and discharge on the same day are equal to one patient day.
- Leave days involving an overnight absence are not counted.
- A patient day is recorded on the day of return from leave.

Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Average available beds	The number of beds available to provide overnight accommodation for patients admitted to hospital (other than neonatal cots [non-special-care] and beds occupied by hospital-in-the-home patients) or to specialised residential mental health care, averaged over the counting period. Beds are available only if they are suitably located and equipped to provide care and the necessary financial and human resources can be provided.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.

Forensic mental health services Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.

General mental health services Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, youth, older people's or forensic services.

General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).

Mental illness A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.

Mental health The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.

Mental health problems Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.

Mental health promotion Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.

Mental illness prevention Interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.

Mortality rate from suicide The proportion of the population who die as a result of suicide.

Non-acute services Non-acute services are defined by two categories:

- Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.
- Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Non-government organisations Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of

providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

Older people's mental health services — Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.

Outpatient services — community-based — Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.

Outpatient services — hospital-based — Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.

Percentage of facilities accredited — The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.

Prevalence — The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).

Preventive interventions — Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.

Psychiatrist — A medical practitioner with specialist training in psychiatry.

Public health — The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.

Public (non-psychiatric) hospital — A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional services.

Schizophrenia — A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.

Seclusion — Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement (NMHPSC 2011b).

The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does

not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2013).

Seclusion event	An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a non-24 or 24-hour basis.
Staffing categories (mental health)	Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis. Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry. Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation. Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses. Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states). Diagnostic and health professionals (allied health professionals): qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

Stand-alone psychiatric hospitals

Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital
- a single employer covers the staff of the acute care hospital and the psychiatric hospital
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Substance use disorders

Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).

Youth mental health services

Services principally targeting children and young people generally aged 16-25 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

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12.8 References

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12A Mental health management — attachment

Definitions for the indicators and descriptors in this attachment are in section 12.6 of the chapter. Unsourced information was obtained from the Australian, State and Territory governments.

Data in this Report are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

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	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Mental health specific payments to states and territories (d)	85 032	84 023	89 233	87 296	3 738	6 557	18 550
National programs and initiative (DOHA managed) (e)	113 607	127 400	247 401	232 183	229 205	270 592	311 737
National programs and initiative (FaHCSIA managed) (f)	–	9 935	92 537	154 211	145 463	144 906	151 238
National programs and initiative (DVA managed) (g)	149 589	161 222	160 676	169 751	163 416	160 839	157 482
National Suicide Prevention Program (h)	10 307	19 829	20 819	22 153	22 522	24 762	51 568
MBS — Psychiatrists (i)	262 908	264 324	266 916	268 158	268 944	276 689	282 976
MBS — General practitioners (j)	277 400	172 613	150 151	187 319	203 732	234 750	198 100
MBS — Psychologists/Allied Health (k)	2 858	63 976	196 628	263 557	313 334	361 400	369 570
Pharmaceutical Benefits Schedule (l)	757 454	760 443	779 721	798 931	801 106	828 666	830 424
Private Health Insurance Premium Rebates (m)	69 094	73 857	82 637	79 020	96 782	96 077	96 905
Research (n)	32 766	35 535	42 450	50 036	55 425	59 893	61 040
National Mental Health Commission (o)	..	..	..	..	..	..	2 661
TOTAL	**1 761 014**	**1 773 157**	**2 129 169**	**2 312 614**	**2 303 667**	**2 465 131**	**2 532 249**
Per cent							
Mental health specific payments to states and territories (d)	4.8	4.7	4.2	3.8	0.2	0.3	0.7
National programs and initiative (DOHA managed) (e)	6.5	7.2	11.6	10.0	9.9	11.0	12.3
National programs and initiative (FaHCSIA managed) (f)	0.0	0.6	4.3	6.7	6.3	5.9	6.0
National programs and initiative (DVA managed) (g)	8.5	9.1	7.5	7.3	7.1	6.5	6.2
National Suicide Prevention Program (h)	0.6	1.1	1.0	1.0	1.0	1.0	2.0
MBS — Psychiatrists (i)	14.9	14.9	12.5	11.6	11.7	11.2	11.2
MBS — General practitioners (j)	15.8	9.7	7.1	8.1	8.8	9.5	7.8
MBS — Psychologists/Allied Health (k)	0.2	3.6	9.2	11.4	13.6	14.7	14.6
Pharmaceutical Benefits Schedule (l)	43.0	42.9	36.6	34.5	34.8	33.6	32.8

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*
Private Health Insurance Premium Rebates (m)	3.9	4.2	3.9	3.4	4.2	3.9	3.8
Research (n)	1.9	2.0	2.0	2.2	2.4	2.4	2.4
National Mental Health Commission (o)	..	..	..	..	..	..	0.1
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Detailed notes on how estimates specific to Commonwealth mental health specific expenditure are derived are provided in the AIHW *Mental Health Services in Australia* on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/.

(b) Estimated Australian Government expenditure shown in the table covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, both directly and indirectly related to provision of support for people affected by mental illness, is not covered in the table.

(c) Constant price expenditure for all years expressed in 2011-12 prices using the general government final consumption expenditure on hospital and nursing home services. Details provided in table 12A.74.

(d) *Mental health specific payments to states and territories:* For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993–1998, and Australian Health Care Agreements 1998–2003 and 2008-09. From July 2009, the Australian Government provided special purpose payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan — Payments to States; and from 2011-12, National Partnership — Supporting Mental Health Reform. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement – Improving Public Hospital Services, which will total $175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.

(e) *National programs and initiatives (Department of Health and Ageing [from September 2013 it is the Department of Health] managed):* This category of expenditure includes the expenditure groups described in the AIHW Mental Health Services in Australia on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/.

(f) *National programs and initiatives (Families, Housing, Community Services and Indigenous Affairs [FaHCSIA] [from September 2013 it is the Department of Social Services] managed)*: Expenditure on FaHCSIA-managed COAG Action Plan programs refers to funding outlays on three initatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness).

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12

(g) *National programs and initiatives (Department of Veterans' Affairs [DVA] managed)*: This category of expenditure includes the groups described in the AIHW *Mental Health Services in Australia* on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/

(h) *National Suicide Prevention Program*: Expenditure reported includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan and the 2010-11 and 2011-12 Federal Budgets.

(i) *Medicare Benefits Schedule – Psychiatrists*: Expenditure reported refers to benefits paid for services by consultant psychiatrists processed in each of the index years. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.

(j) *Medicare Benefits Schedule – General Practitioners (GP)*: Prior to 2006-07, General Practitioner mental health-related expenditure was based on a crude estimate of 6.1 per cent of total MBS benefits paid for GP attendances, and derived from data and assumptions as detailed in the National Mental Health Report 2007. This estimate was historical and aimed to recognise that, although few mental health specific items were available in the MBS to accurately monitor GP mental health service provision, GPs are a significant provider of services to people with mental illness. Commencing November 2006, new mental health specific GP items were introduced under the Better Access to Mental Health Care initiative. To incorporate these changes, GP expenditure reported for 2006-07 is based on total MBS benefits paid against these new mental health specific items, plus an additional 6.1 per cent of total GP Benefits paid in the period preceding the introduction of the new items (July and November 2006).
From 2007-08 onwards, expenditure on GP mental health care is based solely on benefits paid against MBS mental health specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. This method provides a significantly lower expenditure figure than obtained using the 6.1 per cent estimate of previous years because it is conservative and does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific mental health item. Comparisons of GP mental health related expenditure reported pre- and post-2006-07 are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services.

(k) *Medicare Benefits Schedule – Psychologists/Allied Health*: Expenditure refers to MBS benefits paid for Clinical Psychologists, Psychologists, Social Workers and Occupational Therapists under the new items introduced through the Better Access to Mental Health Care initiative on 1 November 2006, plus a small number of Psychologist/Allied health items that were created under the Enhanced Primary Care program in the years preceding the introduction of the Better Access initiative.

(l) *Pharmaceutical Benefits Scheme*: Expenditure under the Pharmaceutical Benefits Scheme refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics (except prochloperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. Expenditure on Clozapine, funded under the Highly Specialised Drugs Program, has been included for all years, including Clozapine dispensed through public hospitals. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.

Table 12A.1 **Real estimated Australian Government expenditure on mental health services (2011-12 dollars) ($'000) (a), (b), (c)**

	2005-06	*2006-07*	*2007-08*	*2008-09*	*2009-10*	*2010-11*	*2011-12*

(m) *Private Health Insurance Premium Rebates*: Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals. The methodology undepinning these estimates is described in the AIHW Mental Health Services in Australia on-line publication. See mhsa.aihw.gov.au/resources/expenditure/data-source/

(n) *Research*: Research funding represents the value of mental health related grants administered by the National Health and Medical Research Council (NHMRC) during the relevant year. Data were sourced from the NHMRC website: www.nhmrc.gov.au/grants/research-funding-statistics-and-data/mental-health-1, accessed 15 September 2013.

(o) *National Mental Health Commission:* The Commission commenced operation in January 2012

.. Not applicable.

Source: Department of Health (Australian Government), unpublished.

Table 12A.2 Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2011-12 dollars) (a), (b), (c), (d)

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Real recurrent expenditure ($'000)									
2005-06	1 039 194.4	824 857.5	561 987.6	396 709.9	264 295.9	83 236.3	55 130.9	33 204.1	3 258 616.6
2006-07	1 084 168.0	852 054.0	627 022.5	416 401.4	293 222.2	94 789.3	64 048.7	36 348.1	3 468 054.1
2007-08	1 133 485.3	883 648.6	708 215.7	452 982.7	308 762.1	101 584.8	66 578.4	38 715.0	3 693 972.7
2008-09	1 189 574.4	915 938.5	748 092.4	483 604.9	322 794.5	103 885.0	71 371.7	40 541.8	3 875 803.3
2009-10	1 258 338.4	954 764.5	804 363.6	490 268.3	328 712.3	113 000.9	71 005.5	41 637.6	4 062 091.2
2010-11	1 344 068.2	1 002 421.7	857 340.2	544 567.5	340 799.2	119 267.5	74 380.2	44 493.5	4 327 338.1
2011-12	1 393 410.2	1 013 624.3	891 259.6	581 463.6	342 489.2	107 510.4	79 209.9	48 650.0	4 457 617.1
Real expenditure per person ($)									
2005-06	155	164	142	195	171	171	165	160	160
2006-07	160	167	155	200	188	193	189	172	168
2007-08	165	170	170	212	196	205	193	179	176
2008-09	170	172	175	219	202	207	203	182	180
2009-10	177	176	184	217	203	223	198	183	186
2010-11	187	182	193	235	209	234	204	193	195
2011-12	192	182	197	244	208	210	214	209	198

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.73).

(b) Estimates of expenditure on State and Territory governments specialised mental health services include revenue from other sources (including patient fees and reimbursement by third party compensation insurers), Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP), ‘other Australian Government funds’, Australian Government mental health specific payments to states and territories and funding provided through the Department of Veterans’ Affairs.

(c) Depreciation is excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

Table 12A.2 **Real estimated recurrent expenditure on State and Territory governments specialised mental health services (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

Source: Australian Institute of Health and Welfare (AIHW) unpublished, Mental Health Establishments National Minimum Data Set (MHE NMDS); Australian Government unpublished; ABS (various issues), *Australian Demographic Statistics, December* (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
2005-06									
State/Territory funds	974 115.3	774 987.1	531 711.5	382 072.6	249 163.4	77 609.4	52 368.2	31 415.5	3 073 443.0
Australian Government funds									
Mental health specific payments to states and territories (g)	25 926.0	20 551.7	16 934.3	8 820.7	6 581.3	2 554.4	1 844.9	1 724.9	84 938.1
Department of Veterans' Affairs (h)	10 280.9	9 850.5	1 103.5	2 013.9	3 741.3	184.3	179.9	–	27 354.3
Total Australian Government funds	36 206.8	30 402.2	18 037.8	10 834.6	10 322.6	2 738.7	2 024.8	1 724.9	112 292.4
Other revenue	28 872.2	19 468.2	12 238.3	3 802.7	4 809.9	2 888.3	737.9	63.6	72 881.2
Total funds	**1 039 194.4**	**824 857.5**	**561 987.6**	**396 709.9**	**264 295.9**	**83 236.3**	**55 130.9**	**33 204.1**	**3 258 616.6**
2006-07									
State/Territory funds	1 027 254.8	789 613.6	595 711.9	400 839.2	279 212.4	89 174.3	61 357.2	34 529.6	3 277 693.0
Australian Government funds									
Mental health specific payments to states and territories (g)	27 214.3	19 465.9	16 544.2	8 502.1	6 745.4	1 984.2	1 741.4	1 771.4	83 968.9
Department of Veterans' Affairs (h)	8 427.7	8 923.3	3 281.7	3 176.9	3 461.8	501.5	165.6	16.5	27 955.1
Total Australian Government funds	35 642.1	28 389.2	19 825.9	11 679.0	10 207.2	2 485.7	1 907.0	1 787.9	111 924.0
Other revenue	21 271.1	34 051.1	11 484.8	3 883.1	3 802.7	3 129.3	784.5	30.6	78 437.2
Total funds	**1 084 168.0**	**852 054.0**	**627 022.5**	**416 401.4**	**293 222.2**	**94 789.3**	**64 048.7**	**36 348.1**	**3 468 054.1**
2007-08									
State/Territory funds	1 077 417.1	829 545.6	677 800.5	437 834.3	293 292.4	95 192.7	63 380.4	36 161.1	3 510 624.0
Australian Government funds									
Mental health specific payments to states and territories (g)	27 928.4	21 108.7	17 598.1	9 005.1	6 646.1	2 433.2	2 415.1	2 092.0	89 226.7
Department of Veterans' Affairs (h)	8 346.5	6 890.9	2 546.0	2 669.6	4 010.7	333.9	247.4	36.7	25 081.7
Total Australian Government funds	36 274.8	27 999.6	20 144.1	11 674.7	10 656.8	2 767.1	2 662.6	2 128.7	114 308.4

Table 12A.3 **Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)**

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Other revenue	19 793.4	26 103.4	10 271.2	3 473.7	4 812.9	3 625.0	535.4	425.3	69 040.2
Total funds	**1 133 485.3**	**883 648.6**	**708 215.7**	**452 982.7**	**308 762.1**	**101 584.8**	**66 578.4**	**38 715.0**	**3 693 972.7**
2008-09									
State/Territory funds	1 137 966.6	855 329.8	715 536.1	468 206.3	303 853.7	95 767.6	68 433.7	38 750.8	3 683 844.6
Australian Government funds									
Mental health specific payments to states and territories (g)	27 594.5	20 690.9	17 645.2	8 977.5	6 419.8	2 125.2	2 059.1	1 783.9	87 296.0
Department of Veterans' Affairs (h)	8 477.1	10 604.6	3 853.2	3 934.0	4 873.3	603.3	55.5	2.6	32 403.7
Total Australian Government funds	36 071.6	31 295.5	21 498.5	12 911.4	11 293.1	2 728.5	2 114.7	1 786.5	119 699.7
Other revenue	15 536.2	29 313.2	11 057.8	2 487.2	7 647.7	5 389.0	823.3	4.5	72 259.0
Total funds	**1 189 574.4**	**915 938.5**	**748 092.4**	**483 604.9**	**322 794.5**	**103 885.0**	**71 371.7**	**40 541.8**	**3 875 803.3**
2009-10									
State/Territory funds	1 236 515.2	911 210.4	788 907.7	484 610.8	319 033.3	108 192.1	69 708.4	41 432.6	3 959 610.6
Australian Government funds									
Mental health specific payments to states and territories (g)	1 018.7	871.1	629.3	485.1	269.9	158.5	142.5	162.2	3 737.4
Department of Veterans' Affairs (h)	9 336.5	9 376.5	4 070.0	2 431.8	3 850.1	567.8	364.0	42.8	30 039.5
Total Australian Government funds	10 355.2	10 247.6	4 699.3	2 917.0	4 120.0	726.3	506.5	205.0	33 776.9
Other revenue	11 468.0	33 306.5	10 756.6	2 740.5	5 558.9	4 082.5	790.6	–	68 703.7
Total funds	**1 258 338.4**	**954 764.5**	**804 363.6**	**490 268.3**	**328 712.3**	**113 000.9**	**71 005.5**	**41 637.6**	**4 062 091.2**
2010-11									
State/Territory funds	1 305 947.5	952 397.8	840 139.0	539 317.2	332 827.5	116 286.4	72 750.7	44 214.6	4 203 880.6
Australian Government funds									
Mental health specific payments to states and territories (g)	1 845.8	1 525.9	1 301.5	816.1	456.5	211.1	181.5	217.6	6 556.0

Table 12A.3 Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)
Department of Veterans' Affairs (h)	9 766.3	10 187.8	3 547.9	2 090.5	4 307.9	404.5	321.4	–	30 626.4
Total Australian Government funds	11 612.1	11 713.7	4 849.4	2 906.6	4 764.4	615.6	502.9	217.6	37 182.3
Other revenue	26 508.7	38 310.2	12 351.9	2 343.7	3 207.3	2 365.6	1 126.6	61.2	86 275.2
Total funds	**1 344 068.2**	**1 002 421.7**	**857 340.2**	**544 567.5**	**340 799.2**	**119 267.5**	**74 380.2**	**44 493.5**	**4 327 338.1**
2011-12									
State/Territory funds	1 361 630.0	956 499.6	868 857.5	570 698.7	332 477.3	104 104.7	77 551.8	48 105.3	4 319 924.8
Australian Government funds									
Mental health specific payments to states and territories (g)	6 082.8	3 997.1	3 252.8	2 601.6	1 326.5	340.6	552.6	395.7	18 549.6
Department of Veterans' Affairs (h)	9 506.2	9 010.6	2 859.2	1 719.6	3 849.0	461.9	275.2	43.3	27 725.1
Total Australian Government funds	15 589.0	13 007.7	6 112.0	4 321.2	5 175.5	802.4	827.8	439.0	46 274.7
Other revenue	16 191.2	44 116.9	16 290.1	6 443.6	4 836.4	2 603.3	830.3	105.7	91 417.6
Total funds	**1 393 410.2**	**1 013 624.3**	**891 259.6**	**581 463.6**	**342 489.2**	**107 510.4**	**79 209.9**	**48 650.0**	**4 457 617.1**

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services (table 12A.73).

(b) Estimates of State and Territory government funds include Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP).

(c) Depreciation excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) The Australian total for mental health specific payments to states and territories differ slightly to those in table 12A.1 as in that table the deflator for Australia is used, whereas in this table State or Territory specific deflators are used and the Australian total is the sum of states and territories.

Table 12A.3 Real estimated expenditure on State and Territory governments' specialised mental health services, by funding source (2011-12 dollars) ($000s) (a), (b), (c), (d)

	NSW (e)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (f)

(g) Mental health specific payments to states and territories: For years up to 2008-09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98, and Australian Health Care Agreements 1998-2003 and 2008-09. From July 2009 the Australian Government provided special purpose payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA. From 2008-09 onwards, the amounts include: National Perinatal Depression Plan – Payments to States; and from 2011-12, National Partnership — Supporting Mental Health Reform. Note that the expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement – Improving Public Hospital Services, which will total $175 million over the period 2010-11 to 2013-14. Mental-health specific payments for 2010-11 cannot be separately identified from payments for other categories of subacute beds made to states and territories.

(h) Department of Veterans' Affairs: refers to payments for mental health care provided in public hospitals for veterans. Non admitted costs are not included as relevant data sets are incomplete or unavailable. There were no mental health related public hospital services claimed in the Northern Territory in 2010-11 or 2005-06.

– Nil or rounded to zero.

Source: AIHW unpublished, MHE NMDS; Department of Health (Australian Government), unpublished.

Table 12A.4 Real Australian, State and Territory governments expenditure on specialised mental health services (2011-12 dollars) ($000s), (a), (b), (c), (d)

	Aust
Real expenditure ($'000)	
State and Territory governments	
2005-06	3 146 324.2
2006-07	3 356 130.2
2007-08	3 579 664.3
2008-09	3 756 103.6
2009-10	4 028 314.3
2010-11	4 290 155.8
2011-12	4 411 342.4
Australian Government	
2005-06	1 761 014.4
2006-07	1 773 157.2
2007-08	2 129 169.4
2008-09	2 312 614.0
2009-10	2 303 667.3
2010-11	2 465 130.8
2011-12	2 532 249.3
Total	
2005-06	**4 907 338.6**
2006-07	**5 129 287.4**
2007-08	**5 708 833.6**
2008-09	**6 068 717.7**
2009-10	**6 331 981.5**
2010-11	**6 755 286.6**
2011-12	**6 943 591.7**
Expenditure per person	
State and Territory governments	
2005-06	155
2006-07	163
2007-08	170
2008-09	175
2009-10	184
2010-11	193
2011-12	196
Australian Government	
2005-06	87
2006-07	86
2007-08	101
2008-09	108

Table 12A.4 **Real Australian, State and Territory governments expenditure on specialised mental health services (2011-12 dollars) ($000s), (a), (b), (c), (d)**

	Aust
2009-10	105
2010-11	111
2011-12	113
Total	
2005-06	**242**
2006-07	**249**
2007-08	**272**
2008-09	**283**
2009-10	**290**
2010-11	**305**
2011-12	**309**
Proportion of expenditure	
State and Territory governments	
2005-06	64.1
2006-07	65.4
2007-08	62.7
2008-09	61.9
2009-10	63.6
2010-11	63.5
2011-12	63.5
Australian Government	
2005-06	35.9
2006-07	34.6
2007-08	37.3
2008-09	38.1
2009-10	36.4
2010-11	36.5
2011-12	36.5

(a) Constant price expenditure expressed in 2011-12 prices using the State and Territory and Australian total implicit price deflators for general government final consumption expenditure on hospital and nursing home services (tables 12A.73 and 12A.74).

(b) Estimates of State and Territory government funds include other revenue and Australian government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments (SPP).

(c) Depreciation excluded for all years.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

Source: AIHW unpublished, MHE NMDS; Department of Health (Australian Government), unpublished; ABS (various issues), *Australian Demographic Statistics, December* (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.5 **Depreciation (current prices) ($'000s) (a), (b)**

	NSW (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06	15 282	7 350	8 453	4 282	53	–	287	–	35 706
2006-07	12 392	7 234	9 656	4 059	46	–	–	–	33 387
2007-08	13 805	11 344	9 108	3 546	438	–	–	543	38 784
2008-09	8 993	12 888	8 214	4 126	3 245	–	–	–	37 466
2009-10	14 367	19 661	7 739	4 265	2 506	–	–	–	48 537
2010-11	13 425	29 586	9 248	4 341	1 493	–	–	–	58 093
2011-12	13 562	26 260	9 134	4 799	1 063	–	–	–	54 818

(a) See the *AIHW Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year.

– Nil or rounded to zero.

Source: AIHW unpublished, MHE NMDS.

Table 12A.6 Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
2005-06									
Recurrent expenditure ($'000)									
Public psychiatric hospital	191 193	30 160	65 653	63 095	81 328	..	..	..	431 429
Public acute hospital	266 130	193 649	177 088	92 132	36 614	22 545	9 026	10 374	807 557
Total inpatient expenditure (i)	457 324	223 809	242 741	155 226	117 942	22 545	9 026	10 374	1 238 986
Community residential	24 448	121 861	..	4 913	2 815	16 039	5 941	268	176 285
Ambulatory	307 723	269 596	159 795	142 248	79 311	25 173	23 878	12 446	1 020 171
Non-government organisations	31 744	61 087	25 347	16 474	14 686	1 690	5 136	3 088	159 251
Indirect	64 155	32 200	26 764	7 234	5 140	4 971	2 219	2 048	144 731
Total expenditure	885 394	708 553	454 648	326 096	219 894	70 418	46 200	28 223	2 739 425
Per cent									
Public psychiatric hospital	21.6	4.3	14.4	19.3	37.0	..	..	..	15.7
Public acute hospital	30.1	27.3	39.0	28.3	16.7	32.0	19.5	36.8	29.5
Total inpatient expenditure (i)	51.7	31.6	53.4	47.6	53.6	32.0	19.5	36.8	45.2
Community residential	2.8	17.2	..	1.5	1.3	22.8	12.9	0.9	6.4
Ambulatory	34.8	38.0	35.1	43.6	36.1	35.7	51.7	44.1	37.2
Non-government organisations	3.6	8.6	5.6	5.1	6.7	2.4	11.1	10.9	5.8
Indirect	7.2	4.5	5.9	2.2	2.3	7.1	4.8	7.3	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2006-07									
Recurrent expenditure ($'000)									
Public psychiatric hospital	189 191	32 916	70 375	66 936	80 028	..	..	..	439 446
Public acute hospital	310 228	206 207	190 034	98 566	55 009	29 785	14 186	10 297	914 311
Total inpatient expenditure (i)	499 419	239 123	260 409	165 502	135 036	29 785	14 186	10 297	1 353 758
Community residential	27 812	124 657	..	6 485	2 985	18 475	6 906	349	187 669

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Ambulatory	332 867	283 885	208 876	154 482	88 466	27 721	27 418	15 240	1 138 956
Non-government organisations	40 539	64 265	32 539	18 025	21 803	3 266	5 283	4 093	189 812
Indirect	63 188	42 990	29 264	10 696	4 760	4 263	1 866	2 117	159 143
Total expenditure	963 825	754 920	531 088	355 190	253 051	83 509	55 658	32 095	3 029 337
Per cent									
Public psychiatric hospital	19.6	4.4	13.3	18.8	31.6	..	..	..	14.5
Public acute hospital	32.2	27.3	35.8	27.8	21.7	35.7	25.5	32.1	30.2
Total inpatient expenditure (i)	51.8	31.7	49.0	46.6	53.4	35.7	25.5	32.1	44.7
Community residential	2.9	16.5	..	1.8	1.2	22.1	12.4	1.1	6.2
Ambulatory	34.5	37.6	39.3	43.5	35.0	33.2	49.3	47.5	37.6
Non-government organisations	4.2	8.5	6.1	5.1	8.6	3.9	9.5	12.8	6.3
Indirect	6.6	5.7	5.5	3.0	1.9	5.1	3.4	6.6	5.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2007-08									
Recurrent expenditure ($'000)									
Public psychiatric hospital	181 465	39 731	77 752	67 508	80 601	..	..	..	447 057
Public acute hospital	340 701	221 090	221 511	113 050	60 245	34 203	16 006	11 663	1 018 467
Total inpatient expenditure (i)	522 166	260 821	299 262	180 558	140 846	34 203	16 006	11 663	1 465 524
Community residential	15 109	131 314	..	9 137	6 337	19 325	7 400	456	189 077
Ambulatory	372 671	303 441	249 240	174 580	98 702	29 171	27 051	16 399	1 271 255
Non-government organisations	60 362	65 625	39 436	21 079	24 487	4 690	6 117	3 843	225 639
Indirect	66 831	42 036	33 167	13 723	5 662	4 748	3 281	2 444	171 892
Total expenditure	1 037 139	803 237	621 105	399 078	276 033	92 137	59 854	34 805	3 323 388
Per cent									
Public psychiatric hospital	17.5	4.9	12.5	16.9	29.2	..	..	..	13.5

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Public acute hospital	32.9	27.5	35.7	28.3	21.8	37.1	26.7	33.5	30.6
Total inpatient expenditure (i)	50.3	32.5	48.2	45.2	51.0	37.1	26.7	33.5	44.1
Community residential	1.5	16.3	..	2.3	2.3	21.0	12.4	1.3	5.7
Ambulatory	35.9	37.8	40.1	43.7	35.8	31.7	45.2	47.1	38.3
Non-government organisations	5.8	8.2	6.3	5.3	8.9	5.1	10.2	11.0	6.8
Indirect	6.4	5.2	5.3	3.4	2.1	5.2	5.5	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2008-09									
Recurrent expenditure ($'000)									
Public psychiatric hospital	181 514	37 200	80 643	74 273	80 738	..	..	..	454 368
Public acute hospital	405 641	240 976	227 751	124 447	66 018	35 893	16 401	12 983	1 130 110
Total inpatient expenditure (i)	587 156	278 176	308 394	198 720	146 756	35 893	16 401	12 983	1 584 478
Community residential	13 905	142 206	..	12 876	9 146	19 079	9 867	877	207 956
Ambulatory	401 855	323 484	285 218	193 361	113 267	32 060	31 380	17 219	1 397 845
Non-government organisations	57 706	70 004	46 100	23 673	24 020	4 676	6 213	3 635	236 026
Indirect	54 010	45 281	41 801	14 352	6 686	5 320	2 656	3 192	173 299
Total expenditure	1 114 631	859 150	681 512	442 982	299 876	97 029	66 518	37 907	3 599 606
Per cent									
Public psychiatric hospital	16.3	4.3	11.8	16.8	26.9	..	..	..	12.6
Public acute hospital	36.4	28.0	33.4	28.1	22.0	37.0	24.7	34.2	31.4
Total inpatient expenditure (i)	52.7	32.4	45.3	44.9	48.9	37.0	24.7	34.2	44.0
Community residential	1.2	16.6	..	2.9	3.0	19.7	14.8	2.3	5.8
Ambulatory	36.1	37.7	41.9	43.6	37.8	33.0	47.2	45.4	38.8
Non-government organisations	5.2	8.1	6.8	5.3	8.0	4.8	9.3	9.6	6.6
Indirect	4.8	5.3	6.1	3.2	2.2	5.5	4.0	8.4	4.8

Table 12A.6 Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2009-10									
Recurrent expenditure ($'000)									
Public psychiatric hospital	221 217	43 821	86 884	75 391	72 841	..	..	..	500 154
Public acute hospital	416 798	252 140	244 112	131 455	74 835	43 090	16 636	12 931	1 191 998
Total inpatient expenditure (i)	638 015	295 961	330 997	206 846	147 676	43 090	16 636	12 931	1 692 152
Community residential	11 918	152 333	..	14 900	9 047	20 249	10 630	1 271	220 350
Ambulatory	434 303	344 622	338 363	206 557	123 367	34 007	30 945	19 395	1 531 558
Non-government organisations	68 310	74 657	50 254	25 777	30 192	5 495	7 908	3 748	266 340
Indirect	65 525	56 640	46 945	14 126	6 925	6 318	2 473	2 793	201 744
Total expenditure	1 218 072	924 212	766 558	468 206	317 207	109 159	68 591	40 139	3 912 145
Per cent									
Public psychiatric hospital	18.2	4.7	11.3	16.1	23.0	..	..	..	12.8
Public acute hospital	34.2	27.3	31.8	28.1	23.6	39.5	24.3	32.2	30.5
Total inpatient expenditure (i)	52.4	32.0	43.2	44.2	46.6	39.5	24.3	32.2	43.3
Community residential	1.0	16.5	..	3.2	2.9	18.6	15.5	3.2	5.6
Ambulatory	35.7	37.3	44.1	44.1	38.9	31.2	45.1	48.3	39.1
Non-government organisations	5.6	8.1	6.6	5.5	9.5	5.0	11.5	9.3	6.8
Indirect	5.4	6.1	6.1	3.0	2.2	5.8	3.6	7.0	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11									
Recurrent expenditure ($'000)									
Public psychiatric hospital	243 983	42 208	90 406	82 134	66 809	..	..	..	525 539
Public acute hospital	451 426	271 298	254 034	151 114	74 959	44 492	18 564	14 301	1 280 190
Total inpatient expenditure (i)	695 410	313 506	344 440	233 247	141 768	44 492	18 564	14 301	1 805 729

Table 12A.6 **Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Community residential	11 773	164 361	..	17 747	11 754	21 040	10 014	1 458	238 147
Ambulatory	465 525	368 771	364 375	221 445	135 670	36 229	32 348	20 929	1 645 293
Non-government organisations	72 596	80 406	65 576	28 472	36 494	7 677	8 633	3 382	303 238
Indirect	69 195	58 336	60 658	24 596	6 252	6 966	2 961	3 267	232 230
Total expenditure	1 314 499	985 381	835 049	525 508	331 938	116 405	72 521	43 337	4 224 637
Per cent									
Public psychiatric hospital	18.6	4.3	10.8	15.6	20.1	..	..	..	12.4
Public acute hospital	34.3	27.5	30.4	28.8	22.6	38.2	25.6	33.0	30.3
Total inpatient expenditure (i)	52.9	31.8	41.2	44.4	42.7	38.2	25.6	33.0	42.7
Community residential	0.9	16.7	..	3.4	3.5	18.1	13.8	3.4	5.6
Ambulatory	35.4	37.4	43.6	42.1	40.9	31.1	44.6	48.3	38.9
Non-government organisations	5.5	8.2	7.9	5.4	11.0	6.6	11.9	7.8	7.2
Indirect	5.3	5.9	7.3	4.7	1.9	6.0	4.1	7.5	5.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12									
Recurrent expenditure ($'000)									
Public psychiatric hospital	236 006	40 821	97 368	88 757	63 841	..	..	..	526 794
Public acute hospital	511 470	274 569	267 483	167 242	73 621	40 559	19 437	16 004	1 370 386
Total inpatient expenditure (i)	747 476	315 390	364 851	255 999	137 463	40 559	19 437	16 004	1 897 180
Community residential	11 664	164 144	..	21 556	18 442	19 837	11 014	1 486	248 143
Ambulatory	497 775	394 360	401 463	240 252	144 506	34 302	35 444	23 286	1 771 390
Non-government organisations	68 051	83 643	69 410	31 796	33 460	6 507	10 529	3 571	306 967
Indirect	68 445	56 086	55 536	31 860	8 618	6 304	2 785	4 302	233 937
Total expenditure	1 393 410	1 013 624	891 260	581 464	342 489	107 510	79 210	48 650	4 457 617

Table 12A.6 Total state and territory recurrent expenditure on specialised mental health services (current prices) (a), (b), (c), (d), (e)

	NSW (f)	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas* (h)	*ACT*	*NT*	*Aust*
Per cent									
Public psychiatric hospital	16.9	4.0	10.9	15.3	18.6	..	..	..	11.8
Public acute hospital	36.7	27.1	30.0	28.8	21.5	37.7	24.5	32.9	30.7
Total inpatient expenditure (i)	53.6	31.1	40.9	44.0	40.1	37.7	24.5	32.9	42.6
Community residential	0.8	16.2	..	3.7	5.4	18.5	13.9	3.1	5.6
Ambulatory	35.7	38.9	45.0	41.3	42.2	31.9	44.7	47.9	39.7
Non-government organisations	4.9	8.3	7.8	5.5	9.8	6.1	13.3	7.3	6.9
Indirect	4.9	5.5	6.2	5.5	2.5	5.9	3.5	8.8	5.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Expenditure is current prices for all years and includes all spending, regardless of source of funds.

(b) Depreciation is excluded for all years.

(c) See the AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(d) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(e) Totals may not add due to rounding

(f) The quality of the NSW 2010-11 *MHE NMDS* data has been affected by the reconfiguration of the service system during the year.

(g) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day seven days a week. In addition, Queensland have advised that funding to non-government services for psychiatric disability support services is administered either by Queensland Health or Disability Services Queensland (DSQ).

(h) For Tasmania, in 2005-06, non-government organisations (NGOs) providing residential services were included for the first time in the community residential category. As these NGOs are now categorised as residential services, NGO funding has decreased from previous years. Indirect/residual expenditure represents State indirect/residual expenditure. If organisational indirect expenditure were included this expenditure would have been $10 719 100.

(i) Includes expenditure on public hospital services managed and operated by private and non-government entities.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS; State and Territory governments unpublished.

Table 12A.7 **Functioning and quality of life measures, by 12-month mental disorder status, 2007 (per cent) (a)**

	Any 12-month mental disorder (b)	*No 12-month mental disorder*	*Total*
Level of psychological distress (c)			
Low	10.9 ± 1.1	89.1 ± 1.0	100.0
Moderate	32.0 ± 2.6	68.0 ± 2.5	100.0
High	57.1 ± 5.1	42.9 ± 5.1	100.0
Very high	79.6 ± 7.2	20.4 ± 7.1	100.0
Disability status (d)			
Profound/severe	42.9 ± 8.2	57.1 ± 8.2	100.0
Moderate/mild	32.1 ± 5.5	67.9 ± 5.6	100.0
Schooling/employment restriction only	43.4 ± 7.1	56.6 ± 7.1	100.0
No disability/no specific limitations or restrictions	16.6 ± 1.1	83.4 ± 1.1	100.0
Days out of role (e)			
0 days	14.7 ± 1.3	85.3 ± 1.3	100.0
1 to 7 days	28.5 ± 2.5	71.5 ± 2.5	100.0
More than 7 days	42.0 ± 5.2	58.0 ± 5.2	100.0
Suicidal behaviour			
Ideation (f)	71.7 ± 8.7	28.3 ± 8.7	100.0
Plans	77.5 ± 12.6	22.5*± 12.6	100.0
Attempts	94.2 ± 9.0	5.8** ± 8.9	100.0
No suicidal behaviours	18.7 ± 1.1	81.3 ± 1.1	100.0
Total people aged 16–85 years	20.0 ± 1.1	80.0 ± 1.1	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) Level of psychological distress is measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.

(d) Disability status relates to whether a person has disability, a core-activity limitation (mild, moderate, severe or profound), or a schooling or employment restriction.

(e) People who were unable to carry out or had to cut down on their usual activities in the 30 days prior to interview. Total includes 'not stated'.

(f) Suicidal ideation refers to the presence of serious thoughts about committing suicide.

Source: ABS 2008, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0.

Table 12A.8 Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion					
Males	%	2.5	3.3	2.9	2.1	2.8	2.3*	2.5	2.4*	2.7
Females	%	3.8	4.0	4.8	3.8	3.7	4.0	3.1	4.0	4.1
Total	**%**	**3.2**	**3.7**	**3.9**	**3.0**	**3.3**	**3.2**	**2.8**	**3.2**	**3.4**
					Relative standard errors					
Males	%	20.2	15.5	18.6	23.9	20.3	32.2	22.1	34.5	9.5
Females	%	13.4	15.7	13.2	14.1	16.8	20.7	20.7	23.0	7.1
Total	**%**	**12.0**	**11.7**	**12.1**	**13.0**	**12.7**	**17.7**	**15.4**	**20.1**	**5.9**
					95 per cent confidence intervals					
Males	±	1.0	1.0	1.1	1.0	1.1	1.5	1.1	1.6	0.5
Females	±	1.0	1.2	1.2	1.0	1.2	1.6	1.3	1.8	0.6
Total	**±**	**0.7**	**0.8**	**0.9**	**0.8**	**0.8**	**1.1**	**0.9**	**1.3**	**0.4**

(a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component),* Cat. no. 4364.0.

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 (a), (b), (c), (d)

	Age standardised proportion (%)	*Relative standard error (%)*	*95 % confidence interval (±)*
Remoteness of residence			
Major cities	3.3	8.0	0.5
Inner regional	3.8	12.8	0.9
Outer regional	3.5	19.2	1.3
Remote	2.9*	42.1	2.4
Very remote (e)	..	..	..
SEIFA of residence (quintiles) (f)			
Quintile 1	5.4	12.6	1.3
Quintile 2	4.1	8.8	0.7
Quintile 3	3.5	12.7	0.9
Quintile 4	2.8	13.3	0.7
Quintile 5	1.9	17.2	0.6
SEIFA of residence (deciles) (f)			
Decile 1	5.7	15.9	1.8
Decile 2	5.2	17.4	1.8
Decile 3	3.9	14.8	1.1
Decile 4	4.2	14.5	1.2
Decile 5	4.1	17.5	1.4
Decile 6	2.9	15.8	0.9
Decile 7	3.0	18.8	1.1
Decile 8	2.7	21.5	1.1
Decile 9	2.0	23.8	1.0
Decile 10	1.7*	25.3	0.9
Disability status			
With disability or restrictive long-term health condition	8.2	6.7	1.1
No disability or restrictive long-term health condition	1.1	9.4	0.2

SEIFA = Socio-Economic Indexes for Areas

(a) Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS.

(f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage

.. Not applicable.

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 (a), (b), (c), (d)**

	Age standardised proportion (%)	*Relative standard error (%)*	*95 % confidence interval (±)*

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Age standardised proportion					
Remoteness of residence										
Major cities	%	10.6	10.7	10.6	10.3	10.5	..	9.1	..	10.6
Inner regional	%	9.9	13.1	11.9	13.3	11.0*	8.8	–	..	11.4
Outer regional/remote	%	8.3*	13.2*	9.9	9.8	16.8	10.4	..	9.0	10.8
Very remote (e)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles) (f)										
Quintile 1	%	15.9	16.4	19.6	16.5	17.6	11.2	np	11.1	16.7
Quintile 2	%	14.0	13.0	11.9	13.4	12.5	9.3	11.4*	6.8*	12.9
Quintile 3	%	11.0	11.6	11.3	10.3	8.2	10.2	11.0*	10.0*	10.9
Quintile 4	%	8.3	9.6	7.7	6.7	5.9*	6.7*	10.6	9.1*	8.1
Quintile 5	%	5.7	7.8	8.1	8.3	10.1	5.9*	7.3	6.8*	7.4
Disability status										
With disability or restrictive long-term health condition	%	21.2	26.6	21.4	22.1	24.3	17.4	17.5	20.4	22.7
No disability or restrictive long-term health condition	%	5.2	4.8	5.1	4.7	5.1	3.8	4.4	3.8	5.0
Total	%	**10.4**	**11.4**	**10.8**	**10.6**	**11.4**	**9.1**	**9.1**	**9.0**	**10.8**
					Relative standard errors					
Remoteness of residence										
Major cities	%	6.5	6.9	8.4	8.0	8.5	–	9.7	..	3.4
Inner regional	%	16.9	13.4	13.7	22.4	29.3	10.5	–	..	7.3
Outer regional/remote	%	44.2	31.7	22.0	19.2	19.2	16.9	..	15.0	11.5
Very remote (e)	%	..	..	..	..	..	..	..	..	..

Table 12A.10 Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)

	unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
SEIFA of residence (quintiles) (f)										
Quintile 1	%	12.7	11.9	17.3	13.4	13.1	14.2	np	23.5	7.8
Quintile 2	%	12.2	12.6	11.9	15.2	11.9	17.4	34.7	36.8	5.2
Quintile 3	%	17.6	12.2	10.6	17.4	21.2	16.5	26.4	30.6	6.1
Quintile 4	%	17.1	15.9	16.1	16.5	29.7	28.7	15.9	25.6	9.6
Quintile 5	%	19.8	20.9	16.4	19.2	24.7	47.7	16.9	28.4	9.0
Disability status										
With disability or restrictive long-term health condition	%	9.5	7.1	7.7	8.1	8.5	11.5	13.1	15.3	3.7
No disability or restrictive long-term health condition	%	11.0	10.6	11.7	14.2	12.6	18.7	16.1	21.8	4.8
Total	%	**6.7**	**6.2**	**6.3**	**7.2**	**7.3**	**8.8**	**9.7**	**15.0**	**3.2**
					95 per cent confidence intervals					
Remoteness of residence										
Major cities	±	1.4	1.4	1.7	1.6	1.8	..	1.7	..	0.7
Inner regional	±	3.3	3.4	3.2	5.8	6.3	1.8	–	..	1.6
Outer regional/remote	±	7.2	8.2	4.3	3.7	6.3	3.5	..	2.7	2.4
Very remote (e)	±	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles) (f)										
Quintile 1	±	4.0	3.8	6.6	4.3	4.5	3.1	np	5.1	2.5
Quintile 2	±	3.3	3.2	2.8	4.0	2.9	3.2	7.7	4.9	1.3
Quintile 3	±	3.8	2.8	2.4	3.5	3.4	3.3	5.7	6.0	1.3
Quintile 4	±	2.8	3.0	2.4	2.1	3.4	3.8	3.3	4.5	1.5
Quintile 5	±	2.2	3.2	2.6	3.1	4.9	5.5	2.4	3.8	1.3

Table 12A.10 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2011-12 (a), (b), (c), (d)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Disability status										
With disability or restrictive long-term health condition	±	3.9	3.7	3.2	3.5	4.1	3.9	4.5	6.1	1.7
No disability or restrictive long-term health condition	±	1.1	1.0	1.2	1.3	1.3	1.4	1.4	1.6	0.5
Total	±	**1.4**	**1.4**	**1.3**	**1.5**	**1.6**	**1.6**	**1.7**	**2.7**	**0.7**

SEIFA = Socio-Economic Indexes for Areas

(a) Total includes a small number of persons for whom levels of psychological distress were unable to be determined

(b) Adults are defined as persons aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data was not collected in the 2011-12 component of the 2011-13 AHS.

(f) Socioeconomic Index for Areas, Index of relative disadvantage. Quintile/decile 1 contains areas of most disadvantage

.. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 12A.11 **Age standardised rate of adults with very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion (c), (d)					
Males	%	3.2	3.0	2.0	2.3	3.5	*2.5	np	np	2.8
Females	%	4.8	4.0	4.1	3.3	3.5	*4.0	np	np	4.1
Total	**%**	**4.0**	**3.5**	**3.1**	**2.8**	**3.5**	**3.3**	**3.4**	**np**	**3.5**
					Relative standard errors (d)					
Males	%	18.0	23.0	20.3	22.1	19.8	31.4	np	np	9.2
Females	%	16.1	16.0	15.5	17.8	18.6	26.0	np	np	9.3
Total	**%**	**11.9**	**13.3**	**13.5**	**13.6**	**13.8**	**20.0**	**17.6**	**np**	**6.7**
					95 per cent confidence intervals					
Males	±	1.1	1.3	0.8	1.0	1.4	1.5	np	np	0.5
Females	±	1.5	1.2	1.2	1.2	1.3	2.0	np	np	0.8
Total	**±**	**0.9**	**0.9**	**0.8**	**0.8**	**1.0**	**1.3**	**1.2**	**np**	**0.5**

(a) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(b) Adults are defined as people aged 18 years and over.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimates with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

np Not published.

Source: ABS unpublished, *2007-08 National Health Survey*, Cat. no. 4364.0.

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 (a), (b)

	Proportion (c), (d)	*Relative standard error (%)* (d)	*95 % confidence interval (±)*
Remoteness of residence			
Major cities	3.6	8.0	0.6
Inner regional	3.3	11.5	0.8
Outer regional	3.0	14.7	0.9
Remote	*3.2	32.5	2.0
Very remote (e)	..	..	..
SEIFA of residence (quintiles)			
Quintile 1	6.5	9.5	1.2
Quintile 2	3.7	12.7	0.9
Quintile 3	3.3	15.1	1.0
Quintile 4	2.1	16.1	0.7
Quintile 5	2.3	19.0	0.9
SEIFA of residence (deciles)			
Decile 1	8.1	12.2	1.9
Decile 2	5.1	12.3	1.2
Decile 3	4.1	16.1	1.3
Decile 4	3.2	19.3	1.2
Decile 5	3.7	23.7	1.7
Decile 6	2.7	17.0	0.9
Decile 7	2.1	22.6	0.9
Decile 8	2.2	22.1	1.0
Decile 9	*2.9	25.2	1.4
Decile 10	*1.5	27.0	0.8
Disability status			
With disability or restrictive long-term health condition	7.3	6.4	0.9
No disability or restrictive long-term health condition	1.0	16.4	0.3
Total	**3.5**	**6.7**	**0.5**

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

(e) Very remote data were not collected in the 2007-08 NHS.

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 (a), (b)**

	Proportion (c), (d)	*Relative standard error (%)* (d)	*95 % confidence interval (±)*

.. Not applicable.

Source: ABS unpublished, *2007-08 National Health Survey*, Cat. no. 4364.0.

Table 12A.13 Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)

	unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Age standardised proportion (c)					
Remoteness of residence										
Major cities	%	13.4	11.9	11.2	9.7	12.3	..	10.9	..	12.1
Inner regional	%	12.1	11.7	11.9	10.9	*13.3	11.6	–	..	11.9
Outer regional/remote	%	*12.2	8.5	13.0	*9.6	14.2	9.9	..	*13.4	11.8
Very remote (d)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	%	20.1	18.6	15.8	19.3	20.4	15.9	np	np	18.6
Quintile 2	%	13.2	14.0	12.4	9.3	13.8	8.7	np	np	12.6
Quintile 3	%	11.4	11.5	11.4	14.3	13.1	9.0	*20.5	np	11.9
Quintile 4	%	9.8	8.5	*7.8	8.2	9.0	*6.7	12.4	np	8.9
Quintile 5	%	10.1	10.0	9.5	*3.9	9.9	*9.4	7.1	*23.4	9.2
Disability status										
With disability or restrictive long-term health condition	%	23.4	21.0	18.7	17.9	24.8	19.9	19.4	np	21.0
No disability or restrictive long-term health condition	%	6.3	5.3	6.8	5.1	5.2	4.8	4.6	np	5.9
Gender										
Males	%	10.2	8.5	9.0	8.6	12.2	9.0	9.8	np	9.6
Females	%	15.4	15.0	14.0	11.4	13.8	12.5	12.0	15.1	14.4
Total	**%**	**12.8**	**11.8**	**11.5**	**10.0**	**13.0**	**10.8**	**10.9**	***13.4**	**12.0**
					Relative standard errors (e)					
Remoteness of residence										
Major cities	%	6.6	7.9	10.1	8.7	8.3	..	9.3	..	3.6
Inner regional	%	14.9	15.8	14.1	22.3	26.3	12.6	–	..	7.0

Table 12A.13 **Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)**

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Outer regional/remote	%	26.4	24.4	12.2	27.4	19.8	14.0	..	36.8	7.3
Very remote (d)	%	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	%	8.2	12.6	11.3	13.7	12.9	12.6	np	np	5.1
Quintile 2	%	15.3	14.3	11.6	16.9	18.5	16.9	np	np	7.0
Quintile 3	%	15.5	13.7	12.0	16.3	17.0	24.2	29.9	np	6.9
Quintile 4	%	13.6	17.8	25.7	17.0	22.1	28.8	15.9	np	8.6
Quintile 5	%	15.2	17.6	21.5	29.8	16.6	32.4	16.1	44.5	7.8
Disability status										
With disability or restrictive long-term health condition	%	6.7	7.8	9.2	8.5	8.0	11.8	9.4	np	3.9
No disability or restrictive long-term health condition	%	9.4	12.5	14.5	14.0	15.5	19.6	17.4	np	5.5
Gender										
Males	%	9.6	11.3	12.9	10.8	12.1	14.3	14.3	np	4.5
Females	%	7.2	8.0	7.8	9.3	9.9	14.1	10.4	18.3	4.0
Total	**%**	**5.7**	**6.6**	**7.7**	**7.2**	**8.3**	**9.3**	**9.4**	**36.8**	**3.1**
					95 per cent confidence intervals					
Remoteness of residence										
Major cities	±	1.7	1.8	2.2	1.6	2.0	..	2.0	..	0.9
Inner regional	±	3.5	3.6	3.3	4.7	6.9	2.8	–	..	1.6
Outer regional/remote	±	6.3	4.1	3.1	5.2	5.5	2.7	..	9.7	1.7
Very remote (d)	±	..	..	..	..	..	..	..	..	..
SEIFA of residence (quintiles)										
Quintile 1	±	3.2	4.6	3.5	5.2	5.2	3.9	np	np	1.8

Table 12A.13 Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, 2007-08 (a), (b)

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Quintile 2	±	4.0	3.9	2.8	3.1	5.0	2.9	np	np	1.7
Quintile 3	±	3.5	3.1	2.7	4.6	4.4	4.3	12.0	np	1.6
Quintile 4	±	2.6	3.0	3.9	2.7	3.9	3.8	3.9	np	1.5
Quintile 5	±	3.0	3.5	4.0	2.3	3.2	5.9	2.2	20.4	1.4
Disability status										
With disability or restrictive long-term health condition	±	3.1	3.2	3.4	3.0	3.9	4.6	3.6	np	1.6
No disability or restrictive long-term health condition	±	1.2	1.3	1.9	1.4	1.6	1.8	1.6	np	0.6
Gender										
Males	±	1.9	1.9	2.3	1.8	2.9	2.5	2.7	np	0.8
Females	±	2.2	2.4	2.1	2.1	2.7	3.4	2.4	5.4	1.1
Total	**±**	**1.4**	**1.5**	**1.7**	**1.4**	**2.1**	**2.0**	**2.0**	**9.7**	**0.7**

SEIFA = Socio-Economic Indexes for Areas

(a) Adults are defined as people aged 18 years and over.

(b) Psychological distress levels derived from the K10. Denominator includes a small number of people for whom levels of psychological distress were unable to be determined.

(c) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (5 year ranges from 18 for adults).

(d) Very remote data were not collected in the 2007-08 NHS.

(e) Estimate with a "*" have a relative standard error between 25 per cent and 50 per cent and should be used with caution.

– Nil or rounded to zero. .. Not applicable. **np** Not published.

Source: ABS unpublished, *2007-08 National Health Survey*, Cat. no. 4364.0.

Table 12A.14 Level of psychological distress K10, 2007-08 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
Males									
18–64 years									
Low (10–15)	70.6 ± 3.4	72.4 ± 3.4	70.2 ± 4.2	68.3 ± 3.8	67.9 ± 4.4	75.2 ± 5.3	69.3 ± 3.6	np	70.5 ± 1.7
Moderate (16–21)	19.1 ± 2.7	18.7 ± 3.4	19.9 ± 3.5	22.8 ± 4.0	19.2 ± 2.4	15.7 ± 4.5	20.6 ± 3.2	np	19.6 ± 1.6
High (22–29) & Very high (30–50)	10.3 ± 2.1	8.9 ± 2.3	9.9 ± 2.5	8.9 ± 2.1	12.9 ± 3.5	9.1 ± 2.7	10.1 ± 2.8	np	9.9 ± 1.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years or over									
Low (10–15)	77.1 ± 5.2	83.7 ± 4.8	75.2 ± 6.7	82.8 ± 7.0	74.0 ± 6.4	73.1 ± 8.5	74.2 ± 10.8	np	78.7 ± 2.8
Moderate (16–21)	12.6 ± 4.2	9.5 ± 4.1	19.3 ± 6.0	10.7* ± 6.0	16.4 ± 5.9	15.6 ± 6.7	18.5* ± 12.3	np	13.3 ± 2.4
High (22–29) & Very high (30–50)	10.3 ± 4.1	6.8 ± 2.7	5.5*± 3.1	6.5* ± 4.5	9.6* ± 4.7	11.3* ± 6.8	7.4* ± 6.3	np	8.0 ± 1.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	71.7 ± 3.2	74.1 ± 2.8	71.0 ± 3.9	70.4 ± 3.3	69.0 ± 3.5	74.8 ± 4.8	69.8 ± 3.7	63.9 ± 17.1	71.8 ± 1.6
Moderate (16–21)	18.1 ± 2.4	17.3 ± 2.8	19.8 ± 3.2	21.1 ± 3.5	18.7 ± 2.0	15.7 ± 4.1	20.3 ± 3.6	23.9* ± 14.1	18.6 ± 1.4
High (22–29) & Very high (30–50)	10.3 ± 1.9	8.6 ± 1.9	9.2 ± 2.3	8.6 ± 1.8	12.3 ± 3.1	9.5 ± 2.7	9.8 ± 2.7	12.3* ± 12.2	9.6 ± 0.9
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Females									
18–64 years									
Low (10–15)	60.9 ± 3.0	61.4 ± 3.5	58.4 ± 3.9	68.1 ± 3.3	62.1 ± 4.0	65.0 ± 4.8	61.0 ± 3.7	np	61.4 ± 1.5
Moderate (16–21)	23.7 ± 2.9	22.7 ± 2.9	26.6 ± 3.8	19.7 ± 3.2	23.0 ± 3.1	21.3 ± 4.0	27.4 ± 3.5	np	23.6 ± 1.5
High (22–29) & Very high (30–50)	15.4 ± 2.4	15.8 ± 2.4	15.1 ± 2.5	12.2 ± 2.4	14.8 ± 3.1	13.7 ± 4.0	11.6 ± 2.5	np	15.0 ± 1.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over									
Low (10–15)	65.1 ± 5.1	70.7 ± 7.2	75.1 ± 6.2	75.4 ± 5.6	76.5 ± 5.2	70.4 ± 7.2	67.7 ± 8.4	np	70.5 ± 3.0
Moderate (16–21)	19.5 ± 5.1	18.1 ± 5.6	16.6 ± 5.2	16.5 ± 5.2	15.6 ± 4.3	22.4 ± 6.5	18.3 ± 7.4	np	18.1 ± 2.6

Table 12A.14 Level of psychological distress K10, 2007-08 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
High (22–29) & Very high (30–50)	15.4 ± 3.7	11.2* ± 5.5	8.3 ± 3.8	8.1 ± 3.5	7.8 ± 3.4	7.2* ± 3.9	14.0 ± 6.7	np	11.5 ± 2.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	61.7 ± 2.6	63.1 ± 3.3	61.0 ± 3.7	69.3 ± 2.8	65.0 ± 3.5	66.0 ± 3.9	61.9 ± 3.4	59.0 ± 19.6	63.0 ± 1.4
Moderate (16–21)	23.0 ± 2.6	21.9 ± 2.5	25.0 ± 3.4	19.2 ± 2.6	21.6 ± 2.8	21.5 ± 3.6	26.2 ± 3.2	26.6 ± 14.5	22.7 ± 1.4
High (22–29) & Very high (30–50)	15.4 ± 2.2	15.0 ± 2.4	14.0 ± 2.1	11.5 ± 2.2	13.4 ± 2.6	12.4 ± 3.2	11.9 ± 2.4	14.4* ± 9.7	14.4 ± 1.1
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
People									
18–64 years									
Low (10–15)	65.8 ± 2.2	66.9 ± 2.2	64.2 ± 2.9	68.2 ± 2.8	65.0 ± 3.2	70.0 ± 3.4	65.1 ± 2.6	np	66.0 ± 1.1
Moderate (16–21)	21.4 ± 1.9	20.7 ± 2.1	23.3 ± 2.6	21.3 ± 2.7	21.1 ± 1.9	18.5 ± 2.6	24.0 ± 2.4	np	21.6 ± 1.1
High (22–29) & Very high (30–50)	12.8 ± 1.5	12.4 ± 1.7	12.5 ± 1.9	10.5 ± 1.7	13.8 ± 2.5	11.5 ± 2.2	10.9 ± 2.1	np	12.4 ± 0.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
65 years and over									
Low (10–15)	70.7 ± 3.7	76.7 ± 4.6	75.2 ± 4.9	78.9 ± 4.5	75.4 ± 4.0	71.6 ± 5.5	70.7 ± 6.1	np	74.3 ± 2.3
Moderate (16–21)	16.3 ± 3.5	14.1 ± 3.3	17.9 ± 4.2	13.7 ± 4.1	16.0 ± 3.4	19.3 ± 4.4	18.4 ± 6.2	np	15.9 ± 1.9
High (22–29) & Very high (30–50)	13.0 ± 3.0	9.2 ± 3.4	6.9 ± 2.7	7.3 ± 2.7	8.6 ± 3.0	9.1 ± 3.7	10.9 ± 4.8	np	9.9 ± 1.4
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	np	100.0
Total									
Low (10–15)	66.6 ± 2.0	68.5 ± 2.0	65.9 ± 2.7	69.8 ± 2.4	67.0 ± 2.6	70.3 ± 3.0	65.8 ± 2.5	61.6 ± 15.4	67.3 ± 1.0
Moderate (16–21)	20.5 ± 1.8	19.6 ± 1.8	22.4 ± 2.3	20.1 ± 2.3	20.2 ± 1.6	18.7 ± 2.2	23.3 ± 2.4	25.1 ± 12.0	20.7 ± 1.0
High (22–29) & Very high (30–50)	12.9 ± 1.4	11.9 ± 1.5	11.6 ± 1.7	10.0 ± 1.4	12.9 ± 2.1	11.0 ± 1.9	10.9 ± 2.0	13.3* ± 8.1	12.0 ± 0.7
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 12A.14 **Level of psychological distress K10, 2007-08 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*

(a) Derived from the Kessler Psychological Distress Scale–10 items (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks prior to interview. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50.

(b) A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use. These estimates are not published.

(c) Separate estimates for the NT are not available for some estimates from this survey, but the NT contributes to national estimates.

(d) Totals include not stated.

np Not published.

Source: ABS unpublished, *2007-08 National Health Survey*, Cat. no. 4364.0.

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 (a), (b), (c), (d)

	unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
					Age standardised proportion (%)					
Indigenous	rate	30.5	31.5	30.3	28.5	32.8	26.3	30.9	21.6	29.4
Non-Indigenous	rate	9.9	11.3	11.5	10.9	12.2	9.9	8.9	8.2	10.8
					Relative standard errors					
Indigenous	%	8.2	7.8	7.0	5.9	7.4	10.4	16.8	8.8	3.6
Non-Indigenous	%	6.8	6.1	6.5	7.8	7.4	9.0	9.1	13.2	3.0
					95 per cent confidence intervals					
Indigenous	±	4.9	4.8	4.1	3.3	4.8	5.4	10.2	3.7	2.1
Non-Indigenous	±	1.3	1.3	1.5	1.7	1.8	1.8	1.6	2.1	0.6

(a) Levels of psychological distress are derived from the Kessler Psychological Distress Scale (K5). Denominator includes a small number of persons for whom levels of psychological distress were unable to be determined.

(b) Rates are age standardised by State and Territory, to the 2001 Estimated Resident Population (10 year ranges from 18 years).

(c) Adults are defined as persons aged 18 years and over.

(d) Totals for Indigenous persons exclude a small number of persons for whom responses were provided by proxy but who were not present at interview.

Source: ABS unpublished, *National Aboriginal and Torres Strait Islander Health Survey, 2012-13* and ABS unpublished, *Australian Health Survey 2011-13* (2011-12 NHS component), Cat. no. 4362.0.

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
2004-05									
Males									
18–64 years									
Low (10–15)	65.9	64.8	64.5	68.1	64.7	68.9	65.8	na	65.6
Moderate (16–21)	23.3	23.8	23.4	22.1	24.5	19.7	24.8	na	23.3
High (22–29) & Very high (30–50)	10.7	11.1	11.9	9.8	10.5	11.1	9.4	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	71.4	73.9	66.0	80.9	76.1	74.4	65.5	na	72.4
Moderate (16–21)	17.7	15.7	19.8	13.0	18.5	15.7	25.4	na	17.2
High (22–29) & Very high (30–50)	10.9*	9.8*	14.0*	6.0	5.3*	9.9*	9.1	na	10.2
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	66.8	66.2	64.7	69.9	66.7	69.8	65.8	na	66.6
Moderate (16–21)	22.4	22.6	22.9	20.9	23.5	19.0	24.8	na	22.4
High (22–29) & Very high (30–50)	10.8	10.9	12.2	9.2	9.6	10.9	9.4	na	10.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Females									
18–64 years									
Low (10–15)	58.6	55.0	58.1	63.3	58.4	63.8	55.5	na	58.1
Moderate (16–21)	26.6	28.2	25.1	21.2	26.1	21.0	29.2	na	26.0
High (22–29) & Very high (30–50)	14.6	16.5	16.8	15.4	15.5	15.3	15.3	na	15.8
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	65.0	63.8	61.9	75.1	69.5	68.3	60.9	na	65.4

Table 12A.16 **Level of psychological distress K10, 2004-05 (per cent) (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*
Moderate (16–21)	21.8	26.4	23.8	16.7	19.3	21.5	29.0	na	22.8
High (22–29) & Very high (30–50)	13.1	9.3	14.1	8.1	11.2	10.2	10.1	na	11.6
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	59.8	56.6	58.7	65.2	60.6	64.6	56.2	na	59.4
Moderate (16–21)	25.8	27.9	24.9	20.5	24.7	21.1	29.2	na	25.5
High (22–29) & Very high (30–50)	14.4	15.2	16.4	14.3	14.6	14.3	14.6	na	15.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
People									
18–64 years									
Low (10–15)	62.3	59.9	61.3	65.7	61.6	66.3	60.6	na	61.8
Moderate (16–21)	25.0	26.0	24.3	21.7	25.3	20.4	27.0	na	24.7
High (22–29) & Very high (30–50)	12.7	13.8	14.4	12.6	13.0	13.2	12.4	na	13.4
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
65 years and over									
Low (10–15)	67.9	68.4	63.8	77.8	72.5	71.1	63.0	na	68.6
Moderate (16–21)	20.0	21.6	21.9	15.0	18.9	18.9	27.3	na	20.2
High (22–29) & Very high (30–50)	12.1	9.5	14.1	7.2*	8.6	10.0*	9.7	na	11.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0
Total									
Low (10–15)	63.2	61.3	61.6	67.5	63.6	67.2	60.9	na	62.9
Moderate (16–21)	24.1	25.3	23.9	20.7	24.1	20.1	27.0	na	24.0
High (22–29) & Very high (30–50)	12.6	13.1	14.3	11.8	12.2	12.6	12.1	na	13.0
Total (d)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	na	100.0

(a) Psychological distress as measured by the Kessler 10 scale.

Table 12A.16 Level of psychological distress K10, 2004-05 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT* (c)	*Aust*

(b) A '*' indicates that an estimate has a relative standard error (RSE) of between 25 per cent and 50 per cent and should be used with caution.

(c) Separate estimates for the NT are not available for this survey, but the NT contributes to national estimates.

(d) Totals include not stated.

na Not available (small numbers not reported for privacy reasons).

Source: ABS 2006, *National Health Survey 2004-05*, Cat. no. 4362.0, Canberra.

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2007-08									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	28 805	23 009	16 671	7 022	7 423	1 513	1 182	317	85 942
Patient attendances (d)	546 004	585 193	327 045	114 737	162 878	36 725	18 471	3 547	1 794 600
Group psychotherapy	15 850	18 137	2 898	870	567	2 877	146	15	41 360
Interview with non-patient	1 982	1 987	1 601	439	433	126	48	18	6 634
Telepsychiatry	643	92	334	15	9	2	11	19	1 125
Case conferencing	80	763	41	42	47	38	4	–	1 015
Electroconvulsive therapy (e)	5 280	5 327	4 886	1 480	1 216	790	45	2	19 026
Total psychiatrist services	**598 644**	**634 508**	**353 476**	**124 605**	**172 573**	**42 071**	**19 907**	**3 918**	**1 949 702**
GP mental health specific services									
GP mental health care plans	407 865	335 835	209 549	106 349	80 756	23 307	14 934	5 095	1 183 690
Focussed psychological strategies	13 254	10 350	7 051	1 474	4 168	414	376	46	37 133
Total GP mental health specific services	**421 119**	**346 185**	**216 600**	**107 823**	**84 924**	**23 721**	**15 310**	**5 141**	**1 220 823**
Psychologist services									
Psychological therapy — clinical psychologists	208 032	174 404	69 774	114 269	49 556	20 361	11 577	1 404	649 377
Focussed psychological strategies — psychologists	402 284	431 801	237 281	54 998	48 985	22 620	19 001	3 699	1 220 669
Enhanced primary care — psychologists	3 056	2 213	1 731	263	356	127	28	14	7 788
Total psychologist services	**613 372**	**608 418**	**308 786**	**169 530**	**98 897**	**43 108**	**30 606**	**5 117**	**1 877 834**

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	5 830	3 826	1 999	1 563	1 642	494	3	82	15 439
Focussed psychological strategies — social worker	26 594	25 519	12 119	5 505	5 052	1 571	135	375	76 870
Enhanced Primary Care — mental health worker (f)	1 045	599	323	37	375	18	3	–	2 400
Total allied health services	**33 469**	**29 944**	**14 441**	**7 105**	**7 069**	**2 083**	**141**	**457**	**94 709**
Rate per 1000 people (g)									
Psychiatrist services	86.4	120.9	83.6	58.5	108.4	84.9	58.4	18.0	92.1
GP mental health specific services	60.8	66.0	51.2	50.6	53.3	47.8	44.9	23.6	57.6
Psychologist services	88.5	116.0	73.0	79.6	62.1	87.0	89.8	23.5	88.7
Other allied health services	4.8	5.7	3.4	3.3	4.4	4.2	0.4	2.1	4.5
2008-09									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	31 484	25 495	17 220	8 055	7 418	1 785	1 266	306	93 029
Patient attendances (d)	543 800	583 020	330 605	117 929	162 032	37 344	17 961	3 831	1 796 522
Group psychotherapy	20 082	17 924	2 479	678	574	3 106	201	30	45 074
Interview with non-patient	2 848	2 594	1 948	439	552	112	73	15	8 581
Telepsychiatry	752	78	447	26	8	1	15	29	1 356
Case conferencing	190	734	97	44	37	31	9	2	1 144
Electroconvulsive therapy (e)	5 425	6 326	5 462	1 852	1 628	589	103	6	21 391
Assessment and treatment of pervasive developmental disorder	32	65	22	5	–	–	–	1	125

Table 12A.17 Mental health care specific MBS items processed (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total psychiatrist services	**604 613**	**636 236**	**358 280**	**129 023**	**172 254**	**42 968**	**19 628**	**4 220**	**1 967 222**
GP mental health specific services									
GP mental health care	520 403	434 383	290 904	138 410	111 352	28 783	19 020	6 688	1 549 943
Focussed psychological strategies	13 238	10 693	6 037	1 115	3 261	249	345	226	35 164
Family group therapy	6 696	6 144	1 000	274	560	161	85	16	14 936
Total GP mental health specific services	**540 337**	**451 220**	**297 941**	**139 799**	**115 173**	**29 193**	**19 450**	**6 930**	**1 600 043**
Psychologist services									
Psychological therapy — clinical psychologists	298 137	226 729	111 728	145 385	77 824	28 968	14 297	1 767	904 835
Focussed psychological strategies — psychologists	517 849	550 951	315 067	76 491	59 519	23 591	25 367	4 963	1 573 798
Enhanced primary care — psychologists	2 705	1 858	1 413	267	178	88	68	14	6 591
Assessment and treatment of pervasive developmental disorder	1 180	2 196	399	348	244	101	87	20	4 575
Total psychologist services	**819 871**	**781 734**	**428 607**	**222 491**	**137 765**	**52 748**	**39 819**	**6 764**	**2 489 799**
Other allied health services									
Focussed psychological strategies — occupational therapist	9 207	7 689	3 373	1 951	2 956	519	182	10	25 887
Focussed psychological strategies — social worker	42 707	41 722	17 111	9 107	7 860	2 451	449	133	121 540
Enhanced Primary Care — mental health worker (f)	1 059	742	298	39	169	13	–	2	2 322
Total allied health services	**52 973**	**50 153**	**20 782**	**11 097**	**10 985**	**2 983**	**631**	**145**	**149 749**
Rate per 1000 people (g)									
Psychiatrist services	85.9	118.6	82.4	58.5	106.9	85.9	56.4	19.0	90.9

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
GP mental health specific services	76.7	84.1	68.5	63.4	71.4	58.4	55.9	31.3	73.9

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Psychologist services	116.4	145.7	98.5	100.9	85.5	105.4	114.5	30.5	115.0
Other allied health services	7.5	9.3	4.8	5.0	6.8	6.0	1.8	0.7	6.9
2009-10									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	34 265	26 289	17 780	8 249	7 264	1 902	1 385	366	97 511
Patient attendances (d)	543 765	577 090	338 197	124 506	160 934	36 999	17 554	3 822	1 802 867
Group psychotherapy	22 013	16 144	2 504	669	563	3 190	135	21	45 239
Interview with non-patient	4 238	3 093	2 613	428	593	131	59	18	11 173
Telepsychiatry	733	117	697	29	107	8	19	9	1 719
Case conferencing	302	884	93	93	36	21	5	–	1 434
Electroconvulsive therapy (e)	5 715	6 320	6 642	2 217	1 565	720	123	24	23 326
Assessment and treatment of pervasive developmental disorder	50	69	68	np	16	np	–	–	212
Total psychiatrist services	**611 081**	**630 006**	**368 594**	**136 206**	**171 078**	**42 976**	**19 280**	**4 260**	**1 983 481**
GP mental health specific services									
GP mental health care	581 755	343 420	492 773	154 864	127 135	32 634	8 789	20 543	1 761 913
Focussed psychological strategies	13 609	9 101	6 078	1 289	3 135	451	285	318	34 266
Family group therapy	6 080	895	5 833	244	516	92	13	97	13 770
Total GP mental health specific services	**601 444**	**353 416**	**504 684**	**156 397**	**130 786**	**33 177**	**9 087**	**20 958**	**1 809 949**
Psychologist services									
Psychological therapy — clinical psychologists	343 733	277 745	146 601	168 215	97 566	33 247	17 445	2 617	1 087 169

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Focussed psychological strategies — psychologists	614 418	640 812	390 393	93 016	68 990	27 300	28 131	6 143	1 869 203
Enhanced primary care — psychologists	2 968	1 834	1 322	358	239	95	58	28	6 902
Assessment and treatment of pervasive developmental disorder	1 863	3 323	1 170	555	441	93	117	155	7 717
Total psychologist services (h)	**962 998**	**923 714**	**539 486**	**262 144**	**167 236**	**60 735**	**45 751**	**8 959**	**2 971 023**
Other allied health services									
Focussed psychological strategies — occupational therapist	13 062	9 474	np	3 940	2 267	1 075	259	np	34 194
Focussed psychological strategies — social worker	51 896	58 436	24 164	11 255	10 964	4 001	1 073	292	162 081
Enhanced Primary Care — mental health worker (f)	np	np	680	120	78	8	np	7	2 669
Total allied health services (h)	**65 889**	**68 753**	**28 960**	**13 351**	**15 273**	**5 084**	**1 336**	**307**	**198 953**
Rate per 1000 people (g)									
Psychiatrist services	85.0	114.6	82.4	60.0	104.7	85.0	54.3	18.7	89.5
GP mental health specific services	83.6	64.3	112.8	68.9	80.0	65.6	25.6	92.0	81.7
Psychologist services	133.9	168.1	120.6	115.5	102.4	120.2	128.9	39.3	134.1
Other allied health services	9.2	12.5	6.5	5.9	9.3	10.1	3.8	1.3	9.0
2010-11									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	35 803	27 131	19 866	8 591	7 099	1 741	1 582	312	102 125

Table 12A.17 Mental health care specific MBS items processed (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Patient attendances (d)	557 867	576 962	344 504	124 555	154 924	35 592	18 856	3 945	1 817 205
Group psychotherapy	22 572	15 306	2 411	557	400	2 818	242	68	44 374
Interview with non-patient	5 953	3 915	4 219	475	668	152	173	16	15 571
Telepsychiatry	941	149	1 184	127	182	18	14	18	2 633
Case conferencing	517	956	209	145	160	22	10	7	2 026
Electroconvulsive therapy (e)	12 621	13 809	15 951	4 404	4 350	2 268	275	72	53 750
Assessment and treatment of pervasive developmental disorder	55	69	54	3	12	4	1	–	198
Total psychiatrist services	**636 329**	**638 297**	**388 398**	**138 857**	**167 795**	**42 615**	**21 153**	**4 438**	**2 037 882**
GP mental health specific services									
GP mental health care	676 154	579 248	397 898	175 073	147 956	38 433	24 211	8 728	2 047 701
Focussed psychological strategies	17 504	10 485	8 606	1 512	3 332	716	424	326	42 905
Family group therapy	5 626	4 755	769	212	603	147	95	15	12 222
Total GP mental health specific services	**699 284**	**594 488**	**407 273**	**176 797**	**151 891**	**39 296**	**24 730**	**9 069**	**2 102 828**
Psychologist services									
Psychological therapy — clinical psychologists	399 144	333 786	184 361	175 818	116 009	35 023	23 066	3 043	1 270 250
Focussed psychological strategies — psychologists	694 950	693 592	445 505	111 650	73 850	36 235	28 534	6 933	2 091 249
Enhanced primary care — psychologists	2 844	1 889	1 312	430	217	125	61	9	6 887
Assessment and treatment of pervasive developmental disorder	2 065	3 626	1 367	726	414	39	144	64	8 445
Total psychologist services (h)	**1 099 029**	**1 032 894**	**632 552**	**288 627**	**190 492**	**71 422**	**51 805**	**10 049**	**3 376 870**

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	18 101	10 304	3 672	2 584	5 407	939	350	9	41 366
Focussed psychological strategies — social worker	57 507	71 410	26 016	12 796	12 061	4 478	1 464	259	185 991
Enhanced Primary Care — mental health worker (f)	1 222	1 143	744	341	141	12	4	3	3 610
Total allied health services (h)	**76 832**	**82 857**	**30 434**	**15 721**	**17 609**	**5 429**	**1 818**	**272**	**230 972**
Rate per 1000 people (g)									
Psychiatrist services	87.5	114.3	85.4	59.9	101.7	83.7	58.4	19.3	90.7
GP mental health specific services	96.2	106.4	89.5	76.3	92.0	77.2	68.3	39.5	93.6
Psychologist services	151.1	184.9	139.1	124.6	115.4	140.2	143.1	43.7	150.2
Other allied health services	10.6	14.8	6.7	6.8	10.7	10.7	5.0	1.2	10.3
2011-12									
Number of services									
Psychiatrist services									
Initial consultations new patient (c)	37 346	29 634	21 864	9 406	7 124	1 651	1 536	290	108 877
Patient attendances (d)	561 520	590 523	368 265	124 548	154 032	33 233	17 079	3 465	1 852 665
Group psychotherapy	26 936	14 018	3 005	580	254	1 470	208	105	46 576
Interview with non-patient	6 079	5 614	5 411	374	895	150	174	24	18 721
Telepsychiatry	872	148	1 122	55	47	28	21	8	2 301

Table 12A.17 Mental health care specific MBS items processed (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Case conferencing	966	1 716	378	161	159	20	15	6	3 421
Electroconvulsive therapy (e)	5 350	7 020	8 094	2 366	2 004	980	139	33	25 986
Assessment and treatment of pervasive developmental disorder	68	78	61	16	np	np	np	np	230
Total psychiatrist services	**639 137**	**648 751**	**408 200**	**137 511**	**164 522**	**37 536**	**19 182**	**3 938**	**2 058 777**
GP mental health specific services									
GP mental health care	699 492	605 877	417 905	167 758	150 998	39 415	25 166	9 506	2 116 117
Focussed psychological strategies	15 866	10 090	7 387	1 428	2 709	817	266	129	38 692
Family group therapy	5 217	4 321	712	137	661	125	58	7	11 238
Electroconvulsive therapy (i)	6 964	6 987	8 406	2 753	2 094	1 084	163	32	28 483
Total GP mental health specific services	**727 541**	**627 275**	**434 410**	**172 076**	**156 462**	**41 441**	**25 653**	**9 674**	**2 194 532**
Clinical psychologist services									
Total clinical psychologist services	**428 948**	**365 900**	**214 421**	**174 908**	**127 577**	**35 887**	**27 315**	**3 133**	**1 378 089**
Other psychologist services									
Focussed psychological strategies — psychologists	677 689	673 360	442 712	111 347	76 946	36 903	24 859	7 086	2 050 902
Enhanced primary care — psychologists	4 119	2 770	1 920	578	410	104	85	42	10 028
Assessment and treatment of pervasive developmental disorder	2 642	4 659	1 660	789	509	90	132	113	10 594
Total other psychologist services (h)	**684 502**	**680 798**	**446 365**	**112 717**	**77 865**	**37 097**	**25 076**	**7 277**	**2 071 697**

Table 12A.17 Mental health care specific MBS items processed (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Other allied health services									
Focussed psychological strategies — occupational therapist	17 266	10 666	4 116	2 354	6 168	770	275	32	41 647
Focussed psychological strategies — social worker	55 398	73 476	26 691	11 812	12 393	4 085	1 709	269	185 833
Enhanced Primary Care — mental health worker (f)	1 128	1 246	659	328	np	np	np	np	3 614
Total allied health services (h)	**73 801**	**85 465**	**31 466**	**14 495**	**18 800**	**4 863**	**1 991**	**301**	**231 182**
Rate per 1000 people (g)									
Psychiatrist services	88.2	116.4	90.4	57.6	100.0	73.4	51.7	16.9	91.6
GP mental health specific services	100.4	112.5	96.3	72.1	95.1	81.0	69.2	41.6	97.6
Clinical psychologist services	59.2	65.6	47.5	73.3	77.6	70.1	73.7	13.5	61.3
Other psychologist services	94.4	122.1	98.9	47.2	47.3	72.5	67.6	31.3	92.1
Other allied health services	10.2	15.3	7.0	6.1	11.4	9.5	5.4	1.3	10.3

(a) State and territory is based on the postcode of the mailing address of the patient as recorded by Medicare Australia. Provider type is based on the MBS item numbers claimed.

(b) A listing of the MBS items associated with each of the categories is available in the Medicare Benefits Schedule and General practice data source sections of the *Mental Health Services in Australia* (various issues), (mhsa.aihw.gov.au/home/).

(c) Includes consultations in consulting room, hospital and home visits.

(d) Includes attendances in consulting room, hospital and other locations.

(e) Data for electroconvulsive therapy may include services provided by medical practitioners other than psychiatrists.

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

(g) Crude rates based on the preliminary Australian estimated resident population as at 31 December mid-point of financial year.

(h) Totals for other psychologist and other allied health services include specific services for Indigenous Australians that were introduced on 1 November 2008.

(i) This item is for the initiation of management of anaesthesia for electroconvulsive therapy and includes data for services provided by medical practitioners other than GPs.

Table 12A.17 **Mental health care specific MBS items processed (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

– Nil or rounded to zero. **np** Not published.

Source: AIHW various issues, *Mental Health Services in Australia* (various years) (available at mhsa.aihw.gov.au/home/).

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*
Patient days									
Acute units									
2005-06	468 925	325 855	216 029	167 257	117 148	30 681	15 342	11 266	1 352 503
2006-07	502 521	328 817	216 505	165 365	120 755	28 219	16 419	11 854	1 390 455
2007-08	501 388	322 087	222 006	183 741	119 808	30 924	18 539	10 990	1 409 483
2008-09	525 512	334 711	224 395	181 426	115 412	31 291	19 884	11 517	1 444 148
2009-10	531 649	332 677	226 762	182 647	114 605	29 615	21 484	10 877	1 450 316
2010-11	536 310	345 369	228 406	177 733	117 123	29 249	22 941	11 518	1 468 649
2011-12	547 250	343 809	230 274	188 644	115 761	32 148	23 163	10 489	1 491 538
Nonacute units									
2005-06	256 893	55 745	225 242	44 800	90 200	9 074	..	..	681 954
2006-07	252 391	56 837	222 783	50 751	84 637	9 482	..	..	676 881
2007-08	279 349	63 428	219 026	36 838	77 836	7 128	..	..	683 605
2008-09	265 820	54 667	215 715	38 357	65 509	9 125	..	..	649 193
2009-10	285 494	53 712	213 343	40 061	59 746	8 531	..	..	660 887
2010-11	287 011	54 293	216 365	51 600	56 073	9 779	..	..	675 121
2011-12	287 810	51 032	209 993	47 013	46 036	10 011	..	..	651 895
24-hour staffed community residential									
2005-06	73 112	321 675	..	11 380	8 635	34 155	13 981	..	462 938
2006-07	73 773	338 377	..	12 006	9 232	34 697	14 023	..	482 108
2007-08	42 051	352 741	..	14 888	15 277	27 194	13 599	1 737	467 487
2008-09	37 375	344 623	..	24 725	20 649	28 727	14 262	3 550	473 911
2009-10	35 355	351 719	..	33 008	20 187	30 172	15 416	3 841	489 698
2010-11	34 503	353 996	..	17 605	22 529	29 958	14 961	4 144	477 696
2011-12	40 567	363 985	..	30 073	34 397	27 333	15 367	4 828	516 550

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*
Patient days per 1000 people									
Acute units									
2005-06	69.8	64.9	54.5	82.4	75.8	62.9	46.0	54.3	66.6
2006-07	74.1	64.4	53.4	79.6	77.3	57.4	48.5	56.2	67.4
2007-08	72.8	61.9	53.4	86.1	75.9	62.4	53.9	50.7	67.1
2008-09	75.1	63.0	52.5	82.1	72.2	62.4	56.6	51.8	67.2
2009-10	74.9	61.4	51.9	80.7	70.8	58.5	60.0	47.8	66.3
2010-11	74.7	62.8	51.5	76.6	71.7	57.3	62.9	50.0	66.2
2011-12	75.5	61.7	51.0	79.0	70.4	62.8	62.5	45.1	66.3
Nonacute units									
2005-06	38.2	11.1	56.8	22.1	58.4	18.6	..	..	33.6
2006-07	37.2	11.1	54.9	24.4	54.2	19.3	..	..	32.8
2007-08	40.6	12.2	52.7	17.3	49.3	14.4	..	..	32.5
2008-09	38.0	10.3	50.5	17.4	41.0	18.2	..	..	30.2
2009-10	40.2	9.9	48.8	17.7	36.9	16.8	..	..	30.2
2010-11	40.0	9.9	48.8	22.3	34.3	19.2	..	..	30.4
2011-12	39.7	9.2	46.5	19.7	28.0	19.6	..	..	29.0
24-hour staffed community residential									
2005-06	10.9	64.0	..	5.6	5.6	70.0	41.9	..	22.8
2006-07	10.9	66.3	..	5.8	5.9	70.6	41.4	..	23.4
2007-08	6.1	67.8	..	7.0	9.7	54.8	39.5	8.0	22.2
2008-09	5.3	64.9	..	11.2	12.9	57.3	40.6	16.0	22.1
2009-10	5.0	64.9	..	14.6	12.5	59.6	43.1	16.9	22.4
2010-11	4.8	64.4	..	7.6	13.8	58.7	41.0	18.0	21.5
2011-12	5.6	65.3	..	12.6	20.9	53.4	41.5	20.8	23.0

Table 12A.18 **Mental health patient days (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas*	*ACT* (h)	*NT* (h)	*Aust*

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of patient day estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Hospital patient days include those provided in services funded by government, but managed and operated by private and non-government entities.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) Queensland does not fund community residential services; however, it funds a number of campus based and non-campus based extended treatment services. Data from these services are included as non-acute units.

(g) Caution is required when interpreting WA data. Several residential services that reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010–11. In addition, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010–11 collection, to more accurately reflect the function of these services.

(h) The ACT and the NT did not have non-acute hospital units.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS; ABS (various issues), *Australian Demographic Statistics*, December (various years), Cat. no. 3101.0.

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
		no.	no.	no.	%
2005-06					
F00–F03	Dementia	609	188	797	0.9
F04–F09	Other organic mental disorders	599	146	745	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 623	542	2 165	2.4
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 464	878	4 342	4.9
F20	Schizophrenia	17 402	3 231	20 633	23.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 505	260	1 765	2.0
F22	Persistent delusional disorders	787	163	950	1.1
F23	Acute and transient psychotic disorders	1 309	217	1 526	1.7
F25	Schizoaffective disorders	5 078	1 028	6 106	6.8
F30	Manic episode	449	71	520	0.6
F31	Bipolar affective disorders	7 331	1 157	8 488	9.5
F32	Depressive episode	10 844	1 068	11 912	13.3
F33	Recurrent depressive disorders	3 761	251	4 012	4.5
F34	Persistent mood (affective) disorders	910	109	1 019	1.1
F38, F39	Other and unspecified mood (affective) disorders	143	41	184	0.2
F40	Phobic anxiety disorders	62	14	76	0.1
F41	Other anxiety disorders	994	57	1 051	1.2

Table 12A.19	**Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**				
ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	239	22	261	0.3
F43	Reaction to severe stress and adjustment disorders	7 232	1 402	8 634	9.7
F44	Dissociative (conversion) disorders	124	13	137	0.2
F45, F48	Somatoform and other neurotic disorders	79	10	89	0.1
F50	Eating disorders	604	15	619	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	169	24	193	0.2
F60	Specific personality disorders	3 642	542	4 184	4.7
F61–F69	Disorders of adult personality and behaviour	189	45	234	0.3
F70–F79	Mental retardation	139	53	192	0.2
F80–F89	Disorders of psychological development	168	31	199	0.2
F90	Hyperkinetic disorders	114	11	125	0.1
F91	Conduct disorders	291	53	344	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	170	61	231	0.3
F99	Mental disorder not otherwise specified	251	22	273	0.3
G30	Alzheimer's disease	509	134	643	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	224	357	581	0.7
	Other specified mental health-related principal diagnosis (c)	209	17	226	0.3

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Other (d)	4 796	1 022	5 818	6.5
	Total	**76 019**	**13 255**	**89 274**	**100.0**
2006-07					
F00–F03	Dementia	557	178	735	0.8
F04–F09	Other organic mental disorders	569	133	702	0.8
F10	Mental and behavioural disorders due to use of alcohol	1 980	621	2 601	2.8
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 606	981	4 587	5.0
F20	Schizophrenia	17 610	3 014	20 624	22.3
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 456	248	1 704	1.8
F22	Persistent delusional disorders	776	130	906	1.0
F23	Acute and transient psychotic disorders	1 395	211	1 606	1.7
F25	Schizoaffective disorders	5 359	1 021	6 380	6.9
F30	Manic episode	559	69	628	0.7
F31	Bipolar affective disorders	7 935	1 089	9 024	9.8
F32	Depressive episode	11 103	1 065	12 168	13.2
F33	Recurrent depressive disorders	3 701	314	4 015	4.3
F34	Persistent mood (affective) disorders	998	118	1 116	1.2
F38, F39	Other and unspecified mood (affective) disorders	133	30	163	0.2
F40	Phobic anxiety disorders	54	6	60	0.1
F41	Other anxiety disorders	1 160	102	1 262	1.4

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	226	24	250	0.3
F43	Reaction to severe stress and adjustment disorders	8 141	1 274	9 415	10.2
F44	Dissociative (conversion) disorders	116	8	124	0.1
F45, F48	Somatoform and other neurotic disorders	81	8	89	0.1
F50	Eating disorders	575	7	582	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	193	12	205	0.2
F60	Specific personality disorders	3 744	531	4 275	4.6
F61–F69	Disorders of adult personality and behaviour	163	33	196	0.2
F70–F79	Mental retardation	156	44	200	0.2
F80–F89	Disorders of psychological development	175	31	206	0.2
F90	Hyperkinetic disorders	112	9	121	0.1
F91	Conduct disorders	298	32	330	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	190	58	248	0.3
F99	Mental disorder not otherwise specified	267	86	353	0.4
G30	Alzheimer's disease	497	85	582	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	218	324	542	0.6
	Other specified mental health-related principal diagnosis (c)	235	36	271	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Other (d)	5 400	839	6 239	6.7
	Total	**79 738**	**12 771**	**92 509**	**100.0**
2007-08					
F00–F03	Dementia	592	221	813	0.9
F04–F09	Other organic mental disorders	596	172	768	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 128	690	2 818	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 155	779	3 934	4.3
F20	Schizophrenia	17 250	2 834	20 084	21.9
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 609	260	1 869	2.0
F22	Persistent delusional disorders	817	136	953	1.0
F23	Acute and transient psychotic disorders	1 432	168	1 600	1.7
F25	Schizoaffective disorders	5 354	949	6 303	6.9
F30	Manic episode	532	60	592	0.6
F31	Bipolar affective disorders	7 628	1 157	8 785	9.6
F32	Depressive episode	11 051	1 121	12 172	13.3
F33	Recurrent depressive disorders	2 997	554	3 551	3.9
F34	Persistent mood (affective) disorders	938	116	1 054	1.2
F38, F39	Other and unspecified mood (affective) disorders	145	25	170	0.2
F40	Phobic anxiety disorders	79	11	90	0.1
F41	Other anxiety disorders	1 089	99	1 188	1.3

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F42	Obsessive-compulsive disorders	236	19	255	0.3
F43	Reaction to severe stress and adjustment disorders	8 501	1 098	9 599	10.5
F44	Dissociative (conversion) disorders	112	11	123	0.1
F45, F48	Somatoform and other neurotic disorders	106	8	114	0.1
F50	Eating disorders	523	6	529	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	155	9	164	0.2
F60	Specific personality disorders	3 834	614	4 448	4.9
F61–F69	Disorders of adult personality and behaviour	197	73	270	0.3
F70–F79	Mental retardation	147	56	203	0.2
F80–F89	Disorders of psychological development	199	42	241	0.3
F90	Hyperkinetic disorders	106	17	123	0.1
F91	Conduct disorders	262	29	291	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	172	58	230	0.3
F99	Mental disorder not otherwise specified	167	101	268	0.3
G30	Alzheimer's disease	491	150	641	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	191	247	438	0.5
	Other specified mental health-related principal diagnosis (c)	296	10	306	0.3
	Other (d)	5 832	823	6 655	7.3

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**78 919**	**12 723**	**91 642**	**100.0**
2008-09					
F00–F03	Dementia	565	163	728	0.7
F04–F09	Other organic mental disorders	600	101	701	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 365	572	2 937	3.0
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 827	558	3 385	3.4
F20	Schizophrenia	18 127	2 270	20 397	20.7
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 966	174	2 140	2.2
F22	Persistent delusional disorders	803	108	911	0.9
F23	Acute and transient psychotic disorders	1 338	137	1 475	1.5
F25	Schizoaffective disorders	6 239	733	6 972	7.1
F30	Manic episode	577	51	628	0.6
F31	Bipolar affective disorders	8 622	1 080	9 702	9.9
F32	Depressive episode	14 406	1 105	15 511	15.8
F33	Recurrent depressive disorders	3 433	342	3 775	3.8
F34	Persistent mood (affective) disorders	821	93	914	0.9
F38, F39	Other and unspecified mood (affective) disorders	117	24	141	0.1
F40	Phobic anxiety disorders	65	7	72	0.1
F41	Other anxiety disorders	1 386	107	1 493	1.5
F42	Obsessive-compulsive disorders	210	15	225	0.2

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	8 863	931	9 794	10.0
F44	Dissociative (conversion) disorders	108	7	115	0.1
F45, F48	Somatoform and other neurotic disorders	73	10	83	0.1
F50	Eating disorders	635	6	641	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	180	8	188	0.2
F60	Specific personality disorders	3 979	550	4 529	4.6
F61–F69	Disorders of adult personality and behaviour	211	58	269	0.3
F70–F79	Mental retardation	190	np	190	0.2
F80–F89	Disorders of psychological development	236	28	264	0.3
F90	Hyperkinetic disorders	85	–	85	0.1
F91	Conduct disorders	311	np	311	0.3
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	381	25	406	0.4
F99	Mental disorder not otherwise specified	189	64	253	0.3
G30	Alzheimer's disease	452	100	552	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	235	np	235	0.2
	Other specified mental health-related principal diagnosis (c)	349	11	360	0.4
	Other (d)	6 853	1 047	7 900	8.0

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**87 797**	**10 562**	**98 359**	**100.0**
2009-10					
F00–F03	Dementia	534	126	660	0.7
F04–F09	Other organic mental disorders	645	119	764	0.8
F10	Mental and behavioural disorders due to use of alcohol	2 235	560	2 795	3.1
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	2 626	530	3 156	3.4
F20	Schizophrenia	17 155	2 436	19 591	21.4
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 707	221	1 928	2.1
F22	Persistent delusional disorders	770	79	849	0.9
F23	Acute and transient psychotic disorders	1 303	145	1 448	1.6
F25	Schizoaffective disorders	5 376	750	6 126	6.7
F30	Manic episode	511	51	562	0.6
F31	Bipolar affective disorders	7 726	976	8 702	9.5
F32	Depressive episode	11 932	1 139	13 071	14.3
F33	Recurrent depressive disorders	2 631	348	2 979	3.3
F34	Persistent mood (affective) disorders	790	72	862	0.9
F38, F39	Other and unspecified mood (affective) disorders	131	20	151	0.2
F40	Phobic anxiety disorders	71	10	81	0.1
F41	Other anxiety disorders	1 442	131	1 573	1.7
F42	Obsessive-compulsive disorders	230	23	253	0.3

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	8 528	964	9 492	10.4
F44	Dissociative (conversion) disorders	128	13	141	0.2
F45, F48	Somatoform and other neurotic disorders	69	7	76	0.1
F50	Eating disorders	576	9	585	0.6
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	158	10	168	0.2
F60	Specific personality disorders	3 599	578	4 177	4.6
F61–F69	Disorders of adult personality and behaviour	171	31	202	0.2
F70–F79	Mental retardation	144	51	195	0.2
F80–F89	Disorders of psychological development	243	38	281	0.3
F90	Hyperkinetic disorders	80	19	99	0.1
F91	Conduct disorders	331	49	380	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	352	21	373	0.4
F99	Mental disorder not otherwise specified	199	81	280	0.3
G30	Alzheimer's disease	518	88	606	0.7
	Other factors related to mental and behavioural disorders and substance use (b)	227	232	459	0.5
	Other specified mental health-related principal diagnosis (c)	364	7	371	0.4
	Other (d)	7 004	1 063	8 067	8.8

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**80 506**	**10 997**	**91 503**	**100.0**
2010-11					
F00–F03	Dementia	443	61	504	0.5
F04–F09	Other organic mental disorders	618	90	708	0.7
F10	Mental and behavioural disorders due to use of alcohol	2 318	487	2 805	2.9
F11–F19	Mental and behavioural disorders due to other psychoactive substances use	3 517	600	4 117	4.3
F20	Schizophrenia	18 164	2 137	20 301	21.1
F21, F24, F28, F29	Schizotypal and other delusional disorders	1 978	202	2 180	2.3
F22	Persistent delusional disorders	802	97	899	0.9
F23	Acute and transient psychotic disorders	1 318	99	1 417	1.5
F25	Schizoaffective disorders	6 031	792	6 823	7.1
F30	Manic episode	625	47	672	0.7
F31	Bipolar affective disorders	8 147	896	9 043	9.4
F32	Depressive episode	11 874	917	12 791	13.3
F33	Recurrent depressive disorders	2 625	170	2 795	2.9
F34	Persistent mood (affective) disorders	752	69	821	0.9
F38, F39	Other and unspecified mood (affective) disorders	165	13	178	0.2
F40	Phobic anxiety disorders	72	9	81	0.1
F41	Other anxiety disorders	1 612	67	1 679	1.7
F42	Obsessive-compulsive disorders	249	10	259	0.3

Table 12A.19 **Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)**

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
F43	Reaction to severe stress and adjustment disorders	9 446	928	10 374	10.8
F44	Dissociative (conversion) disorders	149	4	153	0.2
F45, F48	Somatoform and other neurotic disorders	96	2	98	0.1
F50	Eating disorders	616	11	627	0.7
F51–F59	Other behavioural syndromes associated with physiological disturbances and physical factors	174	16	190	0.2
F60	Specific personality disorders	4 146	420	4 566	4.7
F61–F69	Disorders of adult personality and behaviour	162	23	185	0.2
F70–F79	Mental retardation	177	30	207	0.2
F80–F89	Disorders of psychological development	243	23	266	0.3
F90	Hyperkinetic disorders	75	3	78	0.1
F91	Conduct disorders	396	10	406	0.4
F92–F98	Other and unspecified disorders with onset in childhood or adolescence	393	8	401	0.4
F99	Mental disorder not otherwise specified	352	–	352	0.4
G30	Alzheimer's disease	511	51	562	0.6
	Other factors related to mental and behavioural disorders and substance use (b)	199	70	269	0.3
	Other specified mental health-related principal diagnosis (c)	271	3	274	0.3
	Other (d)	7 953	1 196	9 149	9.5

Table 12A.19 Admitted patient mental health-related separations with specialised psychiatric care, by principal diagnosis in ICD-10-AM and hospital type (a)

ICD–10		*Public acute hospitals*	*Public psychiatric hospitals*	*Total*	*Per cent*
	Total	**86 669**	**9 561**	**96 230**	**100.0**

(a) Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded.

(b) Includes ICD-10-AM codes Z00.4, Z03.2, Z04.6, Z09.3, Z13.3, Z54.3, Z63.1, Z63.8, Z63.9, Z65.8, Z65.9, Z71.4, Z71.5 and Z76.0.

(c) Includes separations for which the principal diagnosis was any other mental health-related principal diagnosis.

(d) Includes all other codes not included as a mental health principal diagnosis.

– Nil or rounded to zero. **np** Not published.

Source: AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2005-06									
Number									
Males									
Less than 15 years	39 242	61 978	65 976	27 955	23 046	2 652	8 294	1 534	230 677
15–24	135 686	152 875	83 386	30 460	25 441	2 531	28 628	3 871	462 878
25–34	252 587	252 055	108 586	47 572	34 707	4 812	32 443	6 435	739 197
35–44	199 198	194 510	91 381	45 952	32 112	4 062	16 903	4 290	588 408
45–54	113 329	119 193	57 663	32 580	22 076	4 822	12 055	2 162	363 880
55–64	51 652	65 399	33 349	21 487	9 102	1 782	4 657	1 212	188 640
65 years and over	29 325	106 367	26 531	22 786	10 204	5 496	5 092	794	206 595
Total males (a)	821 019	952 377	466 872	228 792	156 688	26 157	108 072	20 298	2 780 275
Females									
Less than 15 years	30 780	38 115	45 103	18 043	13 925	2 195	9 272	649	158 082
15–24	112 548	150 119	79 990	38 489	19 770	4 416	30 477	3 038	438 847
25–34	129 122	153 943	80 377	44 052	21 971	4 023	19 210	4 221	456 919
35–44	121 075	160 153	77 948	44 759	25 206	3 916	14 329	3 616	451 002
45–54	92 416	129 707	64 160	45 469	19 741	4 136	11 232	2 817	369 678
55–64	57 219	74 678	36 751	24 617	12 383	3 048	6 025	1 228	215 949
65 years and over	46 767	174 060	41 180	48 247	22 129	9 058	11 660	488	353 589
Total females (a)	589 927	880 775	425 509	263 676	135 125	30 792	102 205	16 057	2 444 066
People									
Less than 15 years	70 129	100 093	111 085	45 998	37 020	4 864	17 599	2 184	388 972
15–24	248 456	303 005	163 378	68 949	45 224	6 949	59 160	6 909	902 030
25–34	382 257	405 998	188 965	91 624	56 678	8 847	51 733	10 656	1 196 758
35–44	320 939	354 663	169 330	90 711	57 321	7 989	31 307	7 906	1 040 166
45–54	206 402	248 900	121 823	78 049	41 817	8 993	23 311	4 979	734 274

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
55–64	109 218	140 079	70 101	46 103	21 487	4 831	10 691	2 440	404 950
65 years and over	75 010	271 201	67 638	70 777	32 275	14 672	14 202	1 268	547 043
Total (b)	**1 832 177**	**1 833 205**	**892 393**	**492 468**	**302 400**	**65 576**	**210 833**	**36 356**	**5 665 408**
Rate (per 1,000 population) (c)									
Males									
Less than 15 years	57.4	124.0	155.3	132.9	157.0	53.3	260.4	57.8	111.2
15–24	288.7	425.5	287.0	202.1	235.9	77.1	1 037.5	231.8	318.0
25–34	523.7	687.2	382.7	329.6	341.7	168.8	1 215.8	355.3	509.0
35–44	401.5	513.6	308.8	295.2	283.4	119.8	684.2	244.7	388.1
45–54	245.9	346.9	208.6	223.3	201.6	137.5	531.0	146.5	258.3
55–64	141.1	244.0	148.1	192.2	103.2	61.1	275.0	122.4	169.1
65 years and over	72.1	353.6	118.0	208.7	99.1	173.5	362.9	157.9	172.8
Total males (a)	246.3	378.9	232.4	223.8	208.2	111.2	624.3	185.0	274.1
Females									
Less than 15 years	47.4	80.5	111.9	91.6	99.2	46.7	301.5	26.1	80.4
15–24	249.6	435.0	286.1	273.5	192.8	138.9	1 164.8	196.3	315.1
25–34	265.5	417.6	283.4	314.7	222.2	135.6	713.6	238.6	314.7
35–44	241.3	414.3	258.0	292.1	222.7	111.5	565.2	222.3	294.1
45–54	197.9	370.4	230.1	315.2	176.1	115.5	463.4	207.5	259.2
55–64	157.2	274.2	167.9	231.8	136.3	104.2	348.1	156.3	195.1
65 years and over	92.6	463.9	157.3	373.8	168.4	232.0	675.5	110.4	241.7
Total females (a)	173.7	336.1	210.6	259.5	171.8	120.5	594.4	158.6	235.4
Total people									
Less than 15 years	52.6	102.8	134.1	113.0	128.9	50.3	281.1	42.4	96.3
15–24	269.8	430.2	286.5	236.6	215.0	107.5	1 100.5	214.7	316.7
25–34	394.6	552.1	333.1	322.2	282.7	152.1	965.1	297.7	412.1

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
35–44	321.7	463.4	283.1	293.7	253.1	115.8	625.4	233.9	341.1
45–54	222.5	358.8	219.4	269.0	188.7	126.9	496.6	175.7	259.0
55–64	149.6	259.2	157.9	211.5	120.0	82.7	312.2	137.4	182.2
65 years and over	82.3	401.2	139.0	297.1	137.7	207.5	453.8	134.2	205.8
Total (b)	**265.1**	**357.3**	**221.5**	**242.2**	**195.6**	**130.5**	**616.3**	**170.8**	**274.9**
2006-07									
Number									
Males									
Less than 15 years	52 850	65 142	68 238	29 023	26 869	6 118	8 058	1 715	258 013
15–24	157 769	146 075	99 033	35 453	26 836	4 085	26 355	3 735	499 341
25–34	293 437	255 661	136 745	52 831	48 005	6 654	31 352	6 857	831 542
35–44	242 766	200 969	110 867	50 402	44 058	6 020	18 745	5 352	679 179
45–54	147 155	125 412	68 829	35 713	29 942	6 840	11 414	1 893	427 198
55–64	70 202	69 302	37 575	23 399	12 528	2 566	4 170	1 148	220 890
65 years and over	38 374	88 736	31 958	22 163	9 776	6 580	3 974	679	202 240
Total males (a)	1 003 086	955 935	553 343	249 098	198 083	38 926	104 893	21 384	3 124 748
Females									
Less than 15 years	34 800	42 273	49 801	17 356	17 002	4 062	7 953	992	174 239
15–24	127 370	150 159	94 250	44 259	24 824	7 897	28 382	2 767	479 908
25–34	145 183	156 335	92 550	46 035	27 152	5 230	19 528	4 533	496 546
35–44	153 131	161 996	96 595	50 486	34 278	6 774	16 953	3 732	523 945
45–54	121 441	131 390	74 283	48 786	27 710	6 065	11 262	2 825	423 762
55–64	71 887	77 097	43 412	28 175	16 460	3 867	5 556	1 185	247 639
65 years and over	68 461	152 440	46 652	46 821	21 430	15 554	11 044	362	362 764
Total females (a)	722 696	874 196	497 571	282 028	168 894	49 474	102 205	16 401	2 713 465
People									

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Less than 15 years	87 685	107 415	118 065	46 379	43 871	10 183	16 055	2 707	432 360
15–24	285 537	296 287	193 287	79 712	51 660	12 014	54 772	6 502	979 771
25–34	439 120	412 062	229 296	98 868	75 157	11 886	50 910	11 390	1 328 689
35–44	396 346	362 993	207 463	100 888	78 348	12 830	35 718	9 084	1 203 670
45–54	269 194	256 802	143 112	84 499	57 653	12 973	22 694	4 718	851 645
55–64	142 214	146 399	80 987	51 574	28 989	6 485	9 726	2 333	468 707
65 years and over	106 985	241 176	78 610	68 984	31 206	22 166	15 018	1 041	565 186
Total (b)	**1 828 468**	**1 830 278**	**1 050 960**	**535 809**	**382 304**	**93 186**	**207 487**	**37 785**	**5 966 277**
Rate (per 1,000 population) (c)									
Males									
Less than 15 years	77.3	129.7	158.8	136.2	183.0	123.3	253.0	64.7	123.8
15–24	331.2	397.0	332.9	229.5	244.3	123.0	955.1	215.2	336.3
25–34	610.1	695.6	477.2	362.0	475.1	237.6	1 174.9	378.4	571.4
35–44	490.4	526.6	369.1	317.5	388.6	179.5	758.8	303.3	445.2
45–54	315.9	359.3	244.4	240.6	270.4	193.2	502.8	126.1	298.9
55–64	187.2	251.3	161.3	201.5	137.9	85.0	246.3	111.5	192.3
65 years and over	92.1	286.4	137.0	195.1	92.9	202.6	283.2	126.1	164.2
Total males (a)	299.2	375.2	271.2	238.1	262.6	165.0	605.3	188.8	304.5
Females									
Less than 15 years	53.5	88.7	122.2	86.9	121.2	87.0	258.6	39.6	88.1
15–24	277.5	424.8	328.1	306.8	237.4	246.6	1 084.7	174.6	337.3
25–34	300.0	426.1	325.5	328.1	276.3	179.2	725.5	254.5	343.0
35–44	304.8	414.6	315.0	325.5	302.9	194.3	668.7	226.5	339.1
45–54	255.9	368.4	259.7	331.3	244.5	166.7	464.6	202.4	291.7
55–64	191.4	272.9	190.4	253.8	174.7	127.6	321.0	142.6	215.7
65 years and over	133.2	398.1	172.9	351.7	160.4	391.0	639.8	76.5	242.5

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total females (a)	209.9	330.0	241.6	271.7	214.8	191.9	594.5	155.2	258.1
Total people									
Less than 15 years	65.7	109.8	141.1	112.3	152.8	105.7	256.4	52.5	106.4
15–24	305.3	410.7	330.6	266.8	240.9	184.2	1 018.9	195.8	337.0
25–34	455.1	561.0	401.7	345.4	377.1	207.8	949.8	317.0	457.7
35–44	397.4	470.0	341.8	321.4	345.9	187.5	713.6	266.3	392.0
45–54	286.3	363.9	252.1	285.8	257.3	180.7	483.5	162.9	295.5
55–64	189.5	262.2	175.7	227.0	156.7	107.2	284.0	125.4	204.1
65 years and over	114.9	348.1	156.3	279.6	130.7	306.8	479.9	102.9	207.2
Total (b)	**269.7**	**353.3**	**256.7**	**257.9**	**249.3**	**189.2**	**602.9**	**172.3**	**288.0**
2007-08									
Number									
Males									
Less than 15 years	54 762	54 125	76 331	29 163	29 505	9 447	8 265	1 640	263 238
15–24	184 734	137 121	108 312	36 359	29 943	7 412	24 591	3 215	531 687
25–34	355 111	236 320	153 452	56 300	56 261	11 232	27 680	7 053	903 409
35–44	292 683	197 867	127 742	51 256	51 794	10 167	17 279	4 889	753 677
45–54	183 155	126 146	81 201	37 727	37 971	10 928	10 690	2 409	490 227
55–64	83 938	67 908	42 359	25 594	15 663	4 931	4 259	909	245 561
65 years and over	45 786	82 281	35 607	24 218	11 745	8 410	5 444	528	214 019
Total males (a)	1 200 743	906 012	625 063	260 826	232 893	62 527	98 692	20 646	3 407 402
Females									
Less than 15 years	36 288	36 896	52 758	16 990	16 432	7 796	10 379	778	178 317
15–24	132 106	144 876	100 645	46 955	27 868	11 066	29 435	3 007	495 958
25–34	163 717	141 706	101 403	46 049	33 118	8 750	17 649	4 138	516 530
35–44	174 214	158 411	106 223	56 335	44 022	11 435	16 781	3 644	571 065

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
45–54	132 986	128 081	80 389	48 451	34 139	11 326	12 871	2 556	450 799
55–64	70 774	78 566	44 263	30 097	20 837	6 149	6 496	1 005	258 187
65 years and over	74 591	139 767	51 659	43 517	23 763	19 503	13 565	368	366 733
Total females (a)	785 095	830 400	537 415	288 596	200 195	76 035	108 200	15 500	2 841 436
People									
Less than 15 years	91 158	91 021	129 090	46 156	45 937	17 244	18 646	2 418	441 670
15–24	317 087	281 997	208 957	83 315	57 812	18 478	54 093	6 222	1 027 961
25–34	519 221	378 026	254 855	102 350	89 379	19 982	45 451	11 191	1 420 455
35–44	467 790	356 307	233 965	107 592	95 845	21 603	34 102	8 533	1 325 737
45–54	316 282	254 232	161 590	86 178	72 135	22 255	23 573	4 965	941 210
55–64	154 799	146 484	86 622	55 693	36 500	11 081	10 772	1 914	503 865
65 years and over	120 459	222 048	87 266	67 735	35 508	27 914	19 031	896	580 857
Total (b)	**2 072 440**	**1 736 456**	**1 162 557**	**554 558**	**456 942**	**147 701**	**207 467**	**36 146**	**6 374 267**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	80.1	106.5	173.4	134.1	199.9	189.5	255.5	61.2	125.0
15–24	378.3	361.5	353.3	228.7	269.3	222.5	879.9	181.2	349.0
25–34	730.6	631.2	520.6	370.7	553.2	403.9	1 002.3	377.2	609.2
35–44	590.4	513.6	415.7	315.2	457.8	307.7	683.8	276.6	489.3
45–54	387.5	355.1	281.8	248.4	339.2	305.8	465.1	157.3	337.1
55–64	217.7	238.9	176.0	212.4	167.7	158.2	236.9	84.8	207.3
65 years and over	107.0	258.1	147.5	205.9	109.2	251.8	357.1	91.3	168.8
Total males (a)	353.1	346.3	297.8	241.8	305.1	265.7	558.8	175.8	324.9
Females									
Less than 15 years	55.8	76.4	126.5	83.3	116.3	166.0	331.4	30.8	89.2
15–24	283.6	403.3	341.4	317.6	263.3	347.2	1 122.1	184.9	342.5

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
25–34	335.3	380.6	348.1	318.9	333.8	302.8	641.3	225.7	351.3
35–44	345.2	401.1	339.7	356.4	389.0	330.3	650.8	218.3	365.9
45–54	275.6	352.2	273.6	322.3	297.9	307.3	525.9	178.9	304.4
55–64	182.3	268.5	187.1	259.9	214.4	195.8	346.6	114.4	217.1
65 years and over	142.3	357.3	186.1	318.1	175.2	482.3	729.0	72.7	239.8
Total females (a)	225.8	307.3	255.0	270.5	252.1	293.6	619.6	141.3	265.6
Total people									
Less than 15 years	68.3	91.8	150.6	109.5	159.0	178.1	292.9	46.4	107.6
15–24	332.3	381.8	347.5	271.6	266.3	283.4	998.4	182.9	345.9
25–34	532.9	506.2	434.9	345.4	444.8	352.4	824.3	302.2	480.9
35–44	467.6	456.7	377.4	335.5	423.5	319.2	667.9	248.3	427.5
45–54	331.1	353.6	277.7	285.2	318.4	306.6	496.7	167.7	320.7
55–64	200.1	253.9	181.5	235.7	191.5	177.1	293.3	98.1	212.3
65 years and over	126.5	312.7	168.2	266.2	146.0	378.0	562.2	82.6	207.6
Total (b)	**289.8**	**327.1**	**276.7**	**256.6**	**279.4**	**280.9**	**591.8**	**158.6**	**295.7**
2008-09									
Number									
Males									
Less than 15 years	53 539	57 020	69 564	34 115	33 837	9 406	8 128	1 975	267 584
15–24	171 329	133 507	84 433	38 255	35 906	10 491	25 270	4 347	503 538
25–34	313 446	216 375	125 107	60 557	59 071	13 937	27 686	7 559	823 738
35–44	282 427	193 192	105 837	58 506	59 530	14 136	20 277	4 831	738 736
45–54	186 573	125 183	68 080	41 871	42 059	12 907	10 206	2 541	489 420
55–64	84 909	72 207	35 777	25 053	18 046	8 227	5 549	1 236	251 004
65 years and over	58 257	79 146	29 029	26 172	13 837	8 911	6 658	455	222 465
Total males (a)	1 156 291	876 648	517 871	285 039	262 412	78 015	103 779	22 955	3 303 010

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Females									
Less than 15 years	37 897	37 270	48 266	21 148	19 012	7 034	10 011	1 028	181 666
15–24	136 950	142 510	83 923	53 375	33 094	13 786	31 795	3 405	498 838
25–34	153 624	142 334	81 922	51 410	41 034	10 557	22 738	4 362	507 981
35–44	172 520	155 971	83 097	59 040	51 147	14 705	18 509	3 805	558 794
45–54	137 339	125 192	64 417	52 783	39 505	12 354	13 842	2 274	447 706
55–64	74 183	78 068	35 652	32 153	24 338	7 722	7 771	1 265	261 152
65 years and over	89 167	131 117	43 626	49 024	26 211	20 078	13 861	221	373 305
Total females (a)	805 354	812 501	441 009	319 368	234 382	86 247	118 527	16 371	2 833 759
People									
Less than 15 years	91 569	94 290	117 847	55 269	52 849	16 440	18 141	3 005	449 410
15–24	308 462	276 021	168 356	91 631	69 000	24 277	57 215	7 752	1 002 714
25–34	467 566	358 709	207 029	111 989	100 105	24 494	50 567	11 921	1 332 380
35–44	455 922	349 275	188 938	117 553	110 687	28 912	38 911	8 636	1 298 834
45–54	324 932	250 377	132 497	94 658	81 568	25 305	24 133	4 815	938 285
55–64	159 347	150 275	71 430	57 209	42 386	15 949	13 338	2 501	512 435
65 years and over	147 707	210 324	72 655	75 203	40 059	28 989	20 657	676	596 270
Total (b)	**2 051 579**	**1 689 328**	**958 921**	**609 276**	**525 217**	**173 788**	**223 328**	**39 328**	**6 270 765**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	77.9	110.8	154.6	152.6	227.7	187.8	247.3	72.9	125.3
15–24	345.0	344.6	268.3	234.2	320.5	312.7	901.8	240.7	324.1
25–34	633.6	563.0	411.2	376.7	568.7	497.8	969.5	395.6	540.6
35–44	569.4	496.7	337.7	350.9	528.3	432.5	792.8	271.2	475.3
45–54	389.5	346.4	231.3	268.6	372.2	358.5	439.3	163.3	331.0
55–64	215.0	246.9	144.6	200.9	188.7	257.7	299.3	111.0	206.3

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
65 years and over	132.3	241.1	116.1	214.4	125.6	258.4	419.9	73.8	170.2
Total males (a)	336.2	330.2	241.4	256.3	340.6	329.3	583.8	189.6	309.9
Females									
Less than 15 years	58.0	76.2	113.1	100.7	133.7	148.6	316.0	40.5	89.7
15–24	289.0	387.7	278.3	352.0	309.4	431.3	1 213.5	207.6	337.9
25–34	309.5	373.9	273.8	343.0	406.0	365.8	812.2	231.5	338.0
35–44	341.5	391.6	261.9	367.8	454.4	426.9	709.3	225.5	355.6
45–54	280.7	338.3	214.3	344.0	342.3	332.4	562.2	156.6	297.4
55–64	185.8	258.6	145.9	266.9	243.8	238.0	402.2	136.1	212.9
65 years and over	166.6	327.9	152.7	347.9	190.0	485.9	718.9	41.0	238.4
Total females (a)	227.9	296.4	205.1	292.4	293.9	333.1	673.0	144.4	260.7
Total people									
Less than 15 years	68.3	93.9	134.4	127.4	181.7	168.7	281.1	57.2	108.0
15–24	317.9	365.6	273.2	290.9	315.1	370.6	1 055.2	224.9	330.9
25–34	471.8	468.9	343.1	360.5	488.4	430.8	894.2	314.1	440.2
35–44	455.3	443.6	299.6	359.2	491.4	430.7	753.1	248.9	415.5
45–54	335.6	342.3	222.7	306.1	357.1	345.8	504.3	160.1	314.5
55–64	200.7	252.8	145.3	233.3	216.9	247.8	352.3	122.4	209.7
65 years and over	151.4	288.9	135.6	286.0	161.4	382.4	587.9	58.5	207.5
Total (b)	**294.8**	**313.6**	**223.5**	**277.1**	**335.5**	**351.5**	**632.5**	**167.4**	**291.9**
2009-10									
Number									
Males									
Less than 15 years	55 617	58 865	64 050	36 263	36 458	11 539	10 502	2 894	276 188
15–24	194 198	136 613	75 322	43 713	37 083	14 725	23 932	4 080	529 666
25–34	360 216	212 696	112 225	68 442	59 549	20 832	30 156	6 456	870 572

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
35–44	321 520	198 512	96 721	64 902	61 150	17 384	21 995	5 110	787 294
45–54	203 206	128 415	62 759	47 702	46 587	15 444	12 722	2 666	519 501
55–64	95 362	72 427	34 715	28 721	21 436	8 458	7 146	1 171	269 436
65 years and over	66 302	81 070	27 779	31 519	13 287	10 247	11 291	401	241 896
Total males (a)	1 300 584	888 610	473 593	321 343	275 600	98 681	117 749	22 779	3 498 939
Females									
Less than 15 years	42 034	38 740	43 742	25 000	18 535	9 827	11 446	1 187	190 511
15–24	138 723	153 599	78 342	58 934	32 183	16 731	36 918	3 382	518 812
25–34	156 345	146 349	73 952	55 207	44 709	14 281	25 806	4 465	521 114
35–44	183 051	160 410	76 764	63 702	52 955	19 542	20 050	3 716	580 190
45–54	144 038	134 412	59 620	59 271	41 185	16 258	14 457	1 984	471 225
55–64	88 349	80 891	34 718	35 638	25 366	10 308	10 017	1 131	286 418
65 years and over	95 084	132 732	42 704	53 999	25 146	19 118	20 162	336	389 281
Total females (a)	849 771	847 150	409 855	351 908	240 123	106 109	138 868	16 205	2 959 989
People									
Less than 15 years	97 709	97 605	107 792	61 263	54 993	21 423	21 948	4 081	466 814
15–24	333 043	290 216	153 672	102 649	69 267	31 571	60 938	7 462	1 048 818
25–34	516 863	359 201	186 179	123 674	104 258	35 213	56 025	10 921	1 392 334
35–44	505 271	358 974	173 485	128 624	114 176	37 026	42 091	8 826	1 368 473
45–54	347 565	262 865	122 379	106 975	87 781	31 772	27 213	4 650	991 200
55–64	184 322	153 318	69 433	64 362	46 803	18 801	17 163	2 302	556 504
65 years and over	161 548	213 802	70 483	85 522	38 453	29 400	31 453	737	631 398
Total (b)	**2 242 034**	**1 736 010**	**883 458**	**680 134**	**543 348**	**212 599**	**257 497**	**38 984**	**6 594 064**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	80.4	113.1	139.4	159.3	244.5	230.1	314.0	106.0	127.9

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
15–24	377.6	336.5	229.9	256.0	323.8	430.7	842.1	216.5	328.0
25–34	699.3	526.1	354.3	403.0	556.5	739.1	1 016.4	323.2	547.2
35–44	643.8	504.7	304.2	385.2	545.4	535.3	849.8	281.4	502.1
45–54	419.7	350.5	209.2	300.5	408.5	428.2	541.9	168.5	346.6
55–64	236.6	241.6	137.1	223.9	219.2	260.1	375.8	101.6	216.4
65 years and over	146.0	239.5	106.6	248.6	117.6	287.2	683.5	61.0	178.9
Total males (a)	369.9	325.7	215.1	281.2	352.6	419.0	661.2	182.1	320.5
Females									
Less than 15 years	63.9	78.5	100.5	116.7	129.7	206.9	357.5	46.3	93.0
15–24	285.5	404.7	250.8	375.6	295.9	518.1	1 394.4	201.1	341.5
25–34	303.9	367.5	236.6	349.7	429.4	488.6	886.7	226.9	332.9
35–44	358.6	397.8	238.3	389.8	471.3	569.1	759.8	214.6	364.9
45–54	290.4	357.3	194.1	378.0	354.1	434.8	584.1	134.3	308.1
55–64	215.8	260.4	138.1	285.7	248.8	311.1	504.8	115.3	227.1
65 years and over	173.5	323.7	144.2	372.0	178.6	452.6	1 008.8	58.8	242.1
Total females (a)	235.5	302.5	185.6	312.9	298.4	416.6	780.0	140.4	266.4
Total people									
Less than 15 years	72.4	96.3	120.5	138.6	188.3	219.4	335.3	77.1	110.9
15–24	333.0	369.5	240.1	313.3	310.2	474.9	1 110.0	209.2	334.7
25–34	502.0	447.6	295.8	377.4	493.8	613.4	953.3	275.4	441.1
35–44	500.3	450.6	271.1	387.6	508.6	554.2	805.2	248.8	433.4
45–54	354.6	354.0	201.6	339.0	381.1	432.5	564.3	152.0	327.3
55–64	226.9	251.2	137.6	254.4	234.3	286.4	441.7	107.9	222.0
65 years and over	161.2	285.6	126.6	314.5	151.5	377.3	861.6	60.0	213.3
Total (b)	**312.1**	**315.7**	**197.5**	**299.7**	**332.4**	**420.7**	**725.4**	**171.0**	**297.7**
2010-11									

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number									
Males									
Less than 15 years	53 036	57 824	72 813	42 776	32 021	7 000	8 900	2 339	276 709
15–24	206 312	147 891	92 363	54 328	38 495	9 058	27 770	4 397	580 614
25–34	374 096	211 602	128 045	74 158	63 636	14 058	26 754	7 325	899 674
35–44	351 095	204 707	111 891	70 991	65 026	13 116	20 986	5 535	843 347
45–54	214 607	133 645	73 858	51 986	47 926	11 299	14 007	2 788	550 116
55–64	103 602	73 148	38 367	31 831	23 731	5 281	5 971	1 255	283 186
65 years and over	67 449	86 616	31 531	31 509	14 623	8 192	8 124	418	248 462
Total males (a)	1 378 280	915 441	548 876	357 783	285 478	68 048	112 834	24 061	3 690 801
Females									
Less than 15 years	42 780	35 815	51 300	28 703	20 137	6 107	10 502	827	196 171
15–24	161 084	169 999	96 151	70 234	34 661	11 384	39 911	3 040	586 464
25–34	173 977	149 064	82 701	60 239	45 294	9 033	21 600	5 224	547 132
35–44	202 688	171 229	88 749	67 465	54 097	12 340	21 573	4 208	622 349
45–54	158 044	136 234	68 181	65 891	41 782	12 316	13 965	2 163	498 576
55–64	93 863	84 995	41 885	38 616	26 114	8 260	10 058	1 291	305 082
65 years and over	101 540	138 036	45 582	54 456	28 308	15 615	11 783	404	395 724
Total females (a)	938 018	885 380	474 560	385 808	250 423	75 100	129 900	17 160	3 156 349
People									
Less than 15 years	95 881	93 665	124 113	71 479	52 158	13 132	19 402	3 166	472 996
15–24	367 518	317 934	188 540	124 570	73 160	20 501	67 706	7 437	1 167 366
25–34	548 366	360 809	210 754	134 403	108 930	23 157	48 373	12 549	1 447 341
35–44	554 048	376 073	200 640	138 490	119 130	25 645	42 569	9 743	1 466 338
45–54	373 577	269 912	142 067	117 887	89 718	23 660	27 974	4 951	1 049 746
55–64	197 940	158 143	80 256	70 453	49 849	13 570	16 029	2 546	588 786

Table 12A.20 **Community mental health service contacts, by sex and age group**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
65 years and over	169 546	224 652	77 113	85 985	42 937	23 838	19 907	822	644 800
Total (b)	**2 408 488**	**1 994 752**	**1 023 502**	**752 186**	**560 498**	**150 689**	**242 857**	**41 221**	**7 174 193**
Rate (per 1000 population) (c)									
Males									
Less than 15 years	76.2	112.1	160.5	187.9	216.6	141.5	263.3	86.7	128.6
15–24	418.9	375.4	290.8	319.6	339.4	264.7	926.7	225.6	369.5
25–34	734.7	521.2	409.1	420.3	590.1	481.0	875.6	346.0	564.4
35–44	707.1	525.3	355.8	414.8	586.6	402.0	789.3	298.3	540.4
45–54	440.9	365.3	246.8	320.8	421.1	309.1	591.5	172.8	365.7
55–64	252.2	241.3	151.4	243.2	240.1	156.3	311.2	104.4	224.3
65 years and over	143.9	250.4	118.7	243.7	127.0	218.5	474.7	62.2	179.3
Total males (a)	395.2	337.3	252.2	307.8	366.3	283.1	611.8	186.5	339.1
Females									
Less than 15 years	65.0	73.2	119.3	131.6	142.3	132.0	327.5	32.8	96.1
15–24	342.8	454.1	313.4	440.8	322.3	354.9	1 403.9	184.0	392.3
25–34	342.9	371.5	266.4	363.7	430.9	305.1	717.6	266.3	348.7
35–44	398.7	425.5	276.8	403.0	488.5	362.0	801.5	242.0	391.9
45–54	319.0	361.3	223.0	410.8	361.1	330.3	559.4	145.9	325.5
55–64	225.1	269.1	165.1	295.7	254.3	244.6	501.0	128.0	237.6
65 years and over	181.4	329.9	150.9	361.1	199.0	360.7	567.1	70.0	240.8
Total females (a)	262.2	316.1	216.1	334.4	311.9	290.3	708.3	148.2	284.6
Total people									
Less than 15 years	70.8	93.2	140.4	160.3	180.3	137.2	294.6	60.6	112.8
15–24	381.9	413.8	301.9	378.3	331.1	309.2	1 159.5	206.5	380.7
25–34	539.5	447.0	338.1	392.9	511.6	393.6	797.5	307.7	457.6
35–44	551.3	474.7	316.0	409.1	537.6	384.4	795.6	271.1	465.7

Table 12A.20 Community mental health service contacts, by sex and age group

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
45–54	380.4	363.3	234.8	365.6	390.9	320.4	575.0	159.9	345.8
55–64	239.1	255.5	158.3	269.4	247.4	200.9	408.3	115.2	231.2
65 years and over	164.8	294.0	135.8	307.0	166.8	295.1	525.3	65.8	212.8
Total (b)	**341.4**	**362.1**	**234.3**	**325.4**	**354.8**	**301.9**	**659.9**	**168.1**	**326.8**

(a) Includes service contacts for which age group was not reported.

(b) Includes service contacts for which sex and/or age group was not reported.

(c) Rates were directly age-standardised, with the exception of age which is a crude rate, as detailed in Technical information — Technical notes section of *Mental Health Services in Australia* online.

Source: AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2005-06										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	23	11	..	np	8	16	np	..	64
Non-Indigenous	no.	403	778	..	172	130	565	48	..	2 096
Not reported	no.	10	2	..	–	2	160	11	..	185
Total	no.	436	791	..	177	140	741	60	..	2 345
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	2.0	3.7	..	np	3.6	18.5	np	..	1.9
Non-Indigenous	per 10 000 people	0.6	1.6	..	0.9	0.9	15.4	1.8	..	1.1
Rate ratio (f)		3.3	2.3	..	0.8	4.0	1.2	1.2	..	1.7
Total	per 10 000 people	0.6	1.6	..	0.9	1.0	14.1	1.8	..	1.1
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	97 430	21 682	49 225	23 006	11 255	950	5 275	10 654	219 477
Torres Strait Islander	no.	1 697	2 146	5 314	171	158	22	39	27	9 574
Both Aboriginal and Torres Strait Islander	no.	9 518	2 474	2 704	1 953	762	7	412	382	18 212
Indigenous (d)	no.	108 645	26 302	57 243	25 130	12 175	979	5 726	11 063	247 263
Neither Aboriginal nor Torres Strait Islander	no.	1 040 517	1 800 406	832 841	440 820	271 101	47 412	135 872	24 807	4 593 776
Not reported	no.	683 015	6 497	2 309	26 518	19 124	17 185	69 235	486	824 369
Total	**no.**	**1 832 177**	**1 833 205**	**892 393**	**492 468**	**302 400**	**65 576**	**210 833**	**36 356**	**5 665 408**
Rate per 10 000 people (e)										
Indigenous (d)	per 1 000 people	822.1	936.6	435.5	375.9	446.3	153.5	1138.6	187.2	531.7

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Non-Indigenous (h)	per 1 000 people	254.2	356.4	216.6	239.5	191.4	133.0	612.6	168.4	270.3
Rate ratio (f)		3.2	2.6	2.0	1.6	2.3	1.2	1.9	1.1	2.0
Total	**per 1 000 people**	**265.1**	**357.3**	**221.5**	**242.2**	**195.6**	**130.5**	**616.3**	**170.8**	**274.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 709	316	1 007	623	328	np	np	np	4 478
Separation rate (e)	per 1 000 people	13.6	10.9	8.2	9.3	12.2	np	np	np	10.4
Patient days	no.	30 049	4506	22 285	14 339	4 641	np	np	np	80 616
Psychiatric care days	no.	29 549	4502	22 167	14 288	4 641	np	np	np	79 907
Average length of stay (overnight)	no.	18.0	14.5	22.5	23.3	15.0	np	np	np	18.5
Non-Indigenous (h)										
Separations	no.	36 704	25 380	25 438	10 976	9 990	np	np	np	109 139
Separation rate (e)	per 1 000 people	5.5	5.0	6.6	5.6	6.4	np	np	np	5.7
Patient days	no.	790 150	466 353	458 231	205 605	236 494	np	np	np	2 162 881
Psychiatric care days	no.	766 667	465 514	454 165	202 744	236 494	np	np	np	2 131 599
Average length of stay (overnight)	no.	23.0	19.4	21.3	19.9	27.2	np	np	np	21.7
Rate ratio (f)		2.5	2.2	1.2	1.7	1.9	np	np	np	1.8
2006-07										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	15	26	..	np	2	10	np	np	60
Non-Indigenous	no.	377	968	..	178	115	627	73	6	2 344

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Not reported	no.	1	9	..	np	4	106	7	np	127
Total	no.	393	1 003	..	181	121	743	81	9	2 531
Rate per 10 000 people										
Indigenous (d)	per 10 000 people	1.8	10.3	..	np	0.8	15.4	1.6	np	1.8
Non-Indigenous	per 10 000 people	0.6	1.9	..	0.9	0.8	12.8	2.1	0.5	1.2
Rate ratio (f)		3.0	5.4	..	np	1.0	1.2	0.8	np	1.5
Total	per 10 000 people	0.6	2.0	..	0.9	0.8	14.7	2.3	0.5	1.2
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	114 468	25 636	65 117	23 967	14 042	2 598	3 710	10 897	260 435
Torres Strait Islander	no.	2 402	1 681	7 514	123	166	31	8	62	11 987
Both Aboriginal and Torres Strait Islander	no.	12 137	1 760	4 299	1 335	763	23	199	297	20 813
Indigenous (d)	no.	129 007	29 077	76 930	25 425	14 971	2 652	3 917	11 256	293 235
Neither Aboriginal nor Torres Strait Islander	no.	1 288 558	1 789 065	970 751	489 271	333 057	77 479	177 633	24 799	5 150 613
Not reported	no.	410 903	12 136	3 279	21 113	34 276	13 055	25 937	1 730	522 429
Total	**no.**	**1 828 468**	**1 830 278**	**1 050 960**	**535 809**	**382 304**	**93 186**	**207 487**	**37 785**	**5 966 277**
Rate per 1000 people (e)										
Indigenous	per 1 000 people	996.3	1 022.1	595.3	359.7	528.9	181.3	902.5	180.8	629.3
Non-Indigenous (h)	per 1 000 people	255.4	349.3	245.8	253.3	243.1	189.4	596.8	167.2	279.8
Rate ratio (f)		3.9	2.9	2.4	1.4	2.2	1.0	1.5	1.1	2.2
Total	**per 1 000 people**	**269.7**	**353.3**	**256.7**	**257.9**	**249.3**	**189.2**	**602.9**	**172.3**	**288.0**

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 915	361	1 219	607	362	np	np	440	4 904
Separation rate (e)	per 1 000 people	15.1	12.6	10.1	8.4	13.5	np	np	7.0	11.3
Patient days	no.	37 458	6 008	40 405	14 216	6 833	np	np	5 369	110 289
Psychiatric care days	no.	36 981	5 997	40 265	14 134	6 833	np	np	5 339	109 549
Average length of stay (overnight)	no.	19.7	16.7	34.9	23.6	19.5	np	np	12.8	23.0
Non-Indigenous (h)										
Separations	no.	37 344	27 095	24 791	11 389	10 775	np	np	544	111 938
Separation rate (e)	per 1 000 people	5.6	5.2	6.2	5.6	6.8	np	np	3.3	5.7
Patient days	no.	808 262	536 843	481 912	226 377	207 442	np	np	5 957	2 266 793
Psychiatric care days	no.	782 915	536 176	477 831	223 946	207 442	np	np	5 886	2 234 196
Average length of stay (overnight)	no.	22.6	20.6	23.4	21.3	22.3	np	np	11.2	22.0
Rate ratio (f)		2.7	2.4	1.6	1.5	2.0	np	np	2.1	1.8
2007-08										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	np	np	..	np	np	np	np	np	87
Non-Indigenous	no.	np	np	..	np	np	np	np	np	2 962
Not reported	no.	np	np	..	np	np	np	np	np	np
Total	no.	305	1 498	..	240	192	907	75	5	3 222

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Rate per 10 000 people										
Indigenous (d)	per 10 000 people	np	np	..	np	np	np	np	np	1.9
Non-Indigenous (h)	per 10 000 people	np	np	..	np	np	np	np	np	1.4
Rate ratio (f)		np	np	..	np	np	np	np	np	1.4
Total	per 10 000 people	0.4	2.8	..	1.1	1.3	17.3	2.1	0.3	1.5
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	154 648	25 248	81 047	27 339	19 616	3 371	4 399	10 788	326 456
Torres Strait Islander	no.	3 088	1 516	7 942	98	248	41	24	37	12 994
Both Aboriginal and Torres Strait Islander	no.	12 511	2 646	5 164	1 394	817	113	–	334	22 979
Indigenous (d)	no.	170 247	29 410	94 153	28 831	20 681	3 525	4 423	11 159	362 429
Neither Aboriginal nor Torres Strait Islander	no.	1 602 002	1 691 539	1 066 035	508 389	388 682	120 633	179 059	21 081	5 577 420
Not reported	no.	300 191	15 507	2 369	17 338	47 579	23 543	23 985	3 906	434 418
Total		**2 072 440**	**1 736 456**	**1 162 557**	**554 558**	**456 942**	**147 701**	**207 467**	**36 146**	**6 374 267**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1228.5	940.5	678.2	412.4	729.0	193.7	1077.2	172.0	735.7
Non-Indigenous (h)	per 1 000 people	262.9	302.5	253.5	231.6	261.1	254.1	552.0	151.1	271.6
Rate ratio (f)		4.7	3.1	2.7	1.8	2.8	0.8	2.0	1.1	2.7
Total	**per 1 000 people**	**289.8**	**327.1**	**276.7**	**256.6**	**279.4**	**280.9**	**591.8**	**158.6**	**295.7**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	1 940	362	1 227	590	302	np	np	404	4 825
Separation rate (e)	per 1 000 people	14.1	11.9	9.3	8.3	11.3	np	np	5.9	10.5

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Patient days	no.	38 573	6 463	45 785	14 307	4 984	np	np	5 074	115 186
Psychiatric care days	no.	37 795	6 351	45 011	14 171	4 984	np	np	5 050	113 362
Average length of stay (overnight)	no.	20.0	18.2	39.1	24.4	16.7	np	np	12.9	24.3
Non-Indigenous										
Separations	no.	38 256	28 910	24 429	12 494	9 549	np	np	553	114 191
Separation rate (e)	per 1 000 people	5.6	5.5	5.9	6.0	6.0	np	np	3.4	5.7
Patient days	no.	874 557	537 322	469 727	238 391	188 967	np	np	5 376	2 314 340
Psychiatric care days	no.	856 734	536 505	465 016	235 522	188 967	np	np	5 343	2 288 087
Average length of stay (overnight)	no.	24.0	19.5	22.7	21.9	22.7	np	np	10.2	22.2
Rate ratio (f)		2.5	2.2	1.6	1.4	1.9	np	np	1.7	1.8
2008-09										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	13	34	..	5	11	9	–	9	81
Non-Indigenous	no.	200	1 685	..	249	219	822	45	40	3 260
Total	no.	213	1 730	..	254	237	968	46	49	3 497
Rate per 10 000 people (e)										
Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.7
Non-Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.5
Rate ratio (f)		np	np	..	np	np	np	np	np	1.1
Total	per 10 000 people	0.3	3.2	..	1.1	1.6	18.4	1.3	2.2	1.6

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	155 180	26 648	67 758	32 355	26 639	3 645	5 332	12 100	329 657
Torres Strait Islander	no.	3 647	1 755	7 181	81	417	48	33	70	13 232
Both Aboriginal and Torres Strait Islander	no.	12 899	2 570	4 419	1 469	890	641	–	348	23 236
Indigenous (d)	no.	171 726	30 973	79 358	33 905	27 946	4 334	5 365	12 518	366 125
Neither Aboriginal nor Torres Strait Islander	no.	1 441 593	1 643 674	872 221	557 448	434 958	142 697	191 895	21 500	5 305 986
Not reported	no.	438 260	14 681	7 342	17 923	62 313	26 757	26 068	5 310	598 654
Total		**2 051 579**	**1 689 328**	**958 921**	**609 276**	**525 217**	**173 788**	**223 328**	**39 328**	**6 270 765**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 224	975.0	556.7	482.7	943.6	269.5	1108.3	188.1	731.2
Non-Indigenous	per 1 000 people	211.5	308.8	212.1	264.5	283.8	300.5	549.2	131.3	254.0
Rate ratio (f)		5.8	3.2	2.6	1.8	3.3	0.9	2.0	1.4	2.9
Total	per 1 000 people	**294.8**	**313.6**	**223.5**	**277.1**	**335.5**	**351.5**	**632.5**	**167.4**	**291.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	4 951
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 255
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	6.0
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2009-10										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	18	27	..	8	19	16	–	33	121
Non-Indigenous	no.	196	2 200	..	215	190	780	55	49	3 685
Total	no.	214	2 240	..	223	219	929	57	82	3 964
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.5
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.7
Rate ratio (f)		np	np	np	np	np	np	np	np	1.5
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.8
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	190 299	25 973	67 059	38 366	27 363	18 496	7 632	14 483	389 671
Torres Strait Islander	no.	3 227	2 091	6 382	202	310	587	172	107	13 078
Both Aboriginal and Torres Strait Islander	no.	16 017	4 138	4 633	1 552	860	527	–	418	28 145
Indigenous (d)	no.	209 543	32 202	78 074	40 120	28 533	19 610	7 804	15 008	430 894
Neither Aboriginal nor Torres Strait Islander	no.	1 604 984	1 681 351	803 254	617 936	446 762	178 757	226 842	23 514	5 583 400
Not reported	no.	427 507	22 457	2 130	22 078	68 053	14 232	22 851	462	579 770
Total		**2 242 034**	**1 736 010**	**883 458**	**680 134**	**543 348**	**212 599**	**257 497**	**38 984**	**6 594 064**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 459.1	971.2	530.2	554.4	941.3	1211.1	1767.0	217.4	841.8
Non-Indigenous (h)	per 1 000 people	231.7	309.4	190.6	284.5	288.8	380.4	649.0	141.6	262.0

Table 12A.21 Specialised mental health care reported, by Indigenous status

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Rate ratio (f)		6.3	3.1	2.8	1.9	3.3	3.2	2.7	1.5	3.2
Total	**per 1 000 people**	**315.5**	**314.4**	**200.5**	**300.5**	**343.1**	**434.2**	**724.8**	**161.9**	**299.9**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	5 075
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 489
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.9
Rate ratio (f)		np	np	np	np	np	np	np	np	1.8
2010-11										
Episodes of community-based residential mental health care (a), (b), (c)										
Number										
Indigenous (d)	no.	17	27	..	6	15	14	np	np	121
Non-Indigenous	no.	215	2 425	..	231	323	656	np	np	3 969
Total (h)	no.	232	2 475	..	237	369	760	75	86	4 234
Rate per 10 000 people (e)										
Indigenous (d)	per 10 000 people	np	np	np	np	np	np	np	np	2.6
Non-Indigenous	per 10 000 people	np	np	np	np	np	np	np	np	1.8
Rate ratio (f)		np	np	np	np	np	np	np	np	1.4
Total	per 10 000 people	np	np	np	np	np	np	np	np	1.9
Community-based ambulatory mental health service contacts (g)										
Number										
Aboriginal	no.	200 879	26 355	82 921	49 083	28 886	3 580	9 173	16 098	416 975
Torres Strait Islander	no.	3 186	1 741	7 777	135	451	392	157	71	13 910

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Both Aboriginal and Torres Strait Islander	no.	16 143	2 128	6 327	1 592	54	978	–	461	27 683
Indigenous (d)	no.	220 208	30 224	97 025	50 810	29 391	4 950	9 330	16 630	458 568
Neither Aboriginal nor Torres Strait Islander	no.	1 755 783	1 731 303	924 592	679 170	461 470	121 216	211 748	24 296	5 909 578
Not reported	no.	432 497	233 225	1 885	22 206	69 637	24 523	21 779	295	806 047
Total		**2 408 488**	**1 994 752**	**1 023 502**	**752 186**	**560 498**	**150 689**	**242 857**	**41 221**	**7 174 193**
Rate per 1000 people (e)										
Indigenous (d)	per 1 000 people	1 511.5	892.2	634.1	676.6	968.8	289.2	1807.5	242.4	870.9
Non-Indigenous (h)	per 1 000 people	254.4	317.5	220.2	306.1	297.7	251.3	587.8	142.9	276.7
Rate ratio (f)		5.9	2.8	2.9	2.2	3.3	1.2	3.1	1.7	3.1
Total	**per 1 000 people**	**341.4**	**362.1**	**234.3**	**325.4**	**354.8**	**301.9**	**659.9**	**168.1**	**326.8**
Admitted patient mental health-related separations with specialised psychiatric care (i), (j), (k), (l)										
Indigenous (d)										
Separations	no.	np	np	np	np	np	np	np	np	6 109
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	12.9
Non-Indigenous (h)										
Separations	no.	np	np	np	np	np	np	np	np	122 610
Separation rate (e)	per 1 000 people	np	np	np	np	np	np	np	np	5.8
Rate ratio (f)		np	np	np	np	np	np	np	np	2.2

(a) Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions.

(b) Queensland does not have any government-operated residential mental health services. Tasmanian information contains data for government-funded residential units operated by the non-government sector in that state, being the only jurisdiction providing this level of reporting. The NT did not have any community residential units in 2005-06.

Table 12A.21 **Specialised mental health care reported, by Indigenous status**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total

(c) For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards. Comparison of NSW data over time therefore should be approached with caution.

(d) Includes patients identified as being either of Aboriginal but not Torres Strait Islander origin, Torres Strait Islander but not Aboriginal origin, Aboriginal and Torres Strait Islander origin and patients identified as of Aboriginal or Torres Strait Islander origin.

(e) The rates were directly aged standardised against the Australian Estimated Resident Population as at 30 June 2001.

(f) The rate ratio is equal to the service use (episodes, contacts or separations) rate for Indigenous Australians divided by the service use rate for non-Indigenous Australians.

(g) Data for community mental health service contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. See *Mental Health Services in Australia* (mhsa.aihw.gov.au/home) for further information.

(h) Includes data for people where Indigenous status was missing or not reported.

(i) Admitted patient separations refers to those non-ambulatory separations when a patient undergoes a hospital's formal admission process, completes an episode of care and 'separates' from the hospital, excluding ambulatory-equivalent separations. Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded. Comprises separations with and without mental health-related principal diagnoses but with specialised psychiatric care.

(j) Interpretation of differences between jurisdictions needs to be undertaken with care as they may reflect different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals.

(k) Includes only public hospital separations for the NT.

(l) Indigenous status data for NSW, Victoria, Queensland, WA, SA and the NT public hospitals are considered to be of acceptable quality for analytical purposes. Indigenous identification is likely to be incomplete and to vary among jurisdictions. Total includes data for these jurisdictions only.

– Nil or rounded to zero. **np** Not published. .. Not applicable.

Source: AIHW various issues, *Mental Health Services in Australia* (various years), (available at mhsa.aihw.gov.au/home/).

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
No. of beds									
Public psychiatric hospitals									
2005-06	1 072	116	375	245	455	..	..	..	2 263
2006-07	1 060	134	375	254	388	..	..	..	2 211
2007-08	1 024	154	376	245	357	..	..	..	2 156
2008-09	911	154	375	246	343	..	..	..	2 029
2009-10	967	150	375	243	267	..	..	..	2 002
2010-11	1 064	152	375	246	247	..	..	..	2 083
2011-12	902	150	345	246	230	..	..	..	1 873
Public acute hospitals with psychiatric units or wards									
2005-06	1 151	1 048	1 014	403	188	125	50	32	4 011
2006-07	1 227	1 050	1 022	415	247	126	70	34	4 191
2007-08	1 400	1 062	1 033	425	243	128	70	34	4 395
2008-09	1 542	1 064	1 029	432	233	130	63	34	4 527
2009-10	1 558	1 082	1 033	452	246	128	63	34	4 597
2010-11	1 586	1 110	1 044	454	252	127	65	33	4 672
2011-12	1 747	1 091	1 057	463	250	131	65	32	4 836
Publicly funded community-based residential units									
2005-06	440	1 319	..	80	43	174	80	10	2 146
2006-07	437	1 359	..	85	63	176	75	5	2 200
2007-08	251	1 404	..	130	71	176	77	5	2 114
2008-09	196	1 456	..	178	99	165	83	13	2 190
2009-10	195	1 430	..	260	89	169	83	13	2 239
2010-11	175	1 448	..	283	97	170	83	15	2 271
2011-12	176	1 476	..	303	138	162	82	15	2 352
Proportion of all beds in different settings (%)									
Public psychiatric hospitals									
2005-06	40.3	4.7	27.0	33.7	66.3	..	..	..	26.9
2006-07	38.9	5.3	26.8	33.7	55.6	..	..	..	25.7
2007-08	38.3	5.9	26.7	30.6	53.2	..	..	..	24.9
2008-09	34.4	5.8	26.7	28.7	50.8	..	..	..	23.2
2009-10	35.6	5.6	26.6	25.4	44.3	..	..	..	22.7
2010-11	37.7	5.6	26.4	25.0	41.4	..	..	..	23.1
2011-12	31.9	5.5	24.6	24.3	37.2	..	..	..	20.7
Public acute hospitals with psychiatric units or wards									
2005-06	43.2	42.2	73.0	55.4	27.4	41.8	38.5	76.2	47.6
2006-07	45.0	41.3	73.2	55.0	35.4	41.7	48.3	87.2	48.7
2007-08	52.3	40.5	73.3	53.1	36.2	42.1	47.6	87.2	50.7
2008-09	58.2	39.8	73.3	50.5	34.5	44.1	43.2	72.3	51.8
2009-10	57.3	40.6	73.4	47.3	40.9	43.1	43.2	72.3	52.0
2010-11	56.1	41.0	73.6	46.2	42.3	42.8	43.9	68.9	51.8

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
2011-12	61.8	40.2	75.4	45.8	40.5	44.7	44.2	68.1	53.4
Publicly funded community-based residential units									
2005-06	16.5	53.1	..	11.0	6.3	58.2	61.5	23.8	25.5
2006-07	16.0	53.4	..	11.3	9.0	58.3	51.7	12.8	25.6
2007-08	9.4	53.6	..	16.3	10.6	57.9	52.4	12.8	24.4
2008-09	7.4	54.5	..	20.8	14.7	55.9	56.8	27.7	25.0
2009-10	7.2	53.7	..	27.2	14.8	56.9	56.8	27.7	25.3
2010-11	6.2	53.4	..	28.8	16.3	57.2	56.1	31.1	25.2
2011-12	6.2	54.3	..	29.9	22.3	55.3	55.8	31.9	26.0
Beds per 100 000 people									
Public psychiatric hospitals									
2005-06	16.0	2.3	9.5	12.1	29.5	..	..	..	11.1
2006-07	15.6	2.6	9.2	12.2	24.9	..	..	..	10.7
2007-08	14.9	3.0	9.0	11.5	22.6	..	..	..	10.3
2008-09	13.0	2.9	8.8	11.1	21.5	..	..	..	9.4
2009-10	13.6	2.8	8.6	10.7	16.5	..	..	..	9.2
2010-11	14.8	2.8	8.5	10.6	15.1	..	..	..	9.4
2011-12	12.4	2.7	7.6	10.3	14.0	..	..	..	8.3
Public acute hospitals with psychiatric units or wards									
2005-06	17.1	20.9	25.6	19.9	12.2	25.6	15.0	15.4	19.7
2006-07	18.1	20.6	25.2	20.0	15.8	25.6	20.7	16.1	20.3
2007-08	20.3	20.4	24.8	19.9	15.4	25.8	20.3	15.7	20.9
2008-09	22.0	20.0	24.1	19.6	14.6	25.9	17.9	15.3	21.1
2009-10	21.9	20.0	23.7	20.0	15.2	25.3	17.6	14.9	21.0
2010-11	22.1	20.2	23.5	19.6	15.4	24.9	17.8	14.5	21.1
2011-12	24.1	19.6	23.4	19.4	15.2	25.6	17.5	13.8	21.5
Publicly funded community-based residential units									
2005-06	6.5	26.3	..	3.9	2.8	35.6	24.0	4.8	10.6
2006-07	6.4	26.6	..	4.1	4.0	35.8	22.2	2.4	10.7
2007-08	3.6	27.0	..	6.1	4.5	35.5	22.4	2.3	10.1
2008-09	2.8	27.4	..	8.1	6.2	32.9	23.6	5.8	10.2
2009-10	2.7	26.4	..	11.5	5.5	33.3	23.2	5.7	10.2
2010-11	2.4	26.3	..	12.2	6.0	33.3	22.8	6.5	10.2
2011-12	2.4	26.5	..	12.7	8.4	31.7	22.1	6.5	10.5
Total									
2005-06	39.6	49.4	35.0	35.9	44.4	61.3	39.0	20.3	41.5
2006-07	40.1	49.8	34.4	36.3	44.7	61.4	42.9	18.5	41.7
2007-08	38.9	50.4	33.9	37.5	42.5	61.3	42.7	18.0	41.2
2008-09	37.8	50.3	32.8	38.8	42.2	58.8	41.6	21.1	40.7
2009-10	38.3	49.1	32.2	42.2	37.2	58.6	40.8	20.6	40.4
2010-11	39.3	49.3	32.0	42.4	36.5	58.2	40.6	21.0	40.7

Table 12A.22 **Available beds in specialised mental health services (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f)	*WA* (g)	*SA*	*Tas* (h), (i)	*ACT* (i)	*NT* (i)	*Aust*
2011-12	39.0	48.7	31.1	42.4	37.6	57.3	39.7	20.2	40.3

(a) Bed numbers represent the average number of beds which are immediately available for use by an admitted patient or resident within the establishment. See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the bed estimates. Available beds are counted as the average of monthly available bed numbers. Available beds counts exclude beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only).

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Hospital bed can include government funded beds managed and operated by private and non-government entities.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) Queensland does not fund community residential services, however, it funds a number of campus based and non-campus based extended treatment services. These services are reported either as wards of public acute hospitals or beds in public psychiatric hospitals. Furthermore, limiting the classification of all inpatient beds to either co-located or standalone results in the reporting of some psychogeriatric beds co-located with nursing homes being reported as ‘standalone’ which results in the reporting of these beds as psychiatric hospital beds in this report. In 2005-06, there was temporary closure of acute beds in one Queensland hospital and some transitional extended treatment beds were permanently closed. In addition, Queensland did not change its method for counting beds until 2007-08 (see 2011 Report for details of previous method).

(g) Beds numbers in WA include publicly funded mental health beds in private hospitals for all years. Bed numbers in WA include emergency department observation beds in one hospital for all years prior to 2010-11.

(h) In Tasmania, for 2005-06, non-government organisations’ residential beds funded by government were included for the first time in the publicly funded community residential facilities category.

(i) Tasmania, the ACT and the NT do not have public psychiatric hospitals.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS; ABS (various issues), *Australian Demographic Statistics*, December (various years), Cat. no. 3101.0; table 12A.75.

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Medical									
Consultant psychiatrist	5.5	4.6	4.3	4.9	5.1	5.0	3.2	3.7	4.9
Psychiatry registrar	4.7	4.7	5.0	4.4	5.7	3.0	5.1	3.1	4.8
Other medical officers	0.8	1.9	0.8	2.9	1.6	0.8	1.3	2.7	1.4
Total	11.0	11.2	10.1	12.2	12.4	8.8	9.7	9.5	11.0
Nursing									
Registered nursing	53.1	53.7	47.8	63.2	56.9	60.4	37.8	40.6	53.3
Non-registered	8.3	12.0	7.6	7.9	14.5	10.3	7.0	3.9	9.5
Total	61.4	65.7	55.4	71.1	71.4	70.7	44.8	44.4	62.8
Allied health									
Occupation therapist	3.2	4.4	3.6	5.9	3.0	1.8	2.1	0.5	3.8
Social worker	5.3	7.9	6.9	8.4	12.5	4.0	7.4	2.4	7.1
Psychologist	8.5	7.8	7.7	7.1	5.4	5.6	21.9	5.8	7.9
Other allied health staff	5.1	2.2	2.9	5.7	3.6	5.9	4.1	8.2	3.9
Total	22.1	22.3	21.1	27.2	24.6	17.3	35.5	16.9	22.7
Other personal care	1.8	5.1	4.7	4.4	0.9	27.7	8.9	2.4	4.1
Total	**96.2**	**104.3**	**91.4**	**114.9**	**109.3**	**124.5**	**98.9**	**73.2**	**100.6**
2006-07									
Medical									
Consultant psychiatrist	5.5	4.6	4.6	4.8	5.8	4.5	3.8	3.9	5.0
Psychiatry registrar	5.4	4.5	5.6	4.8	6.1	2.8	4.5	4.0	5.1
Other medical officers	0.7	1.6	0.8	3.4	1.6	1.0	0.5	2.2	1.3
Total	11.6	10.7	11.1	12.9	13.5	8.4	8.8	10.1	11.4
Nursing									
Registered nursing	54.4	52.0	50.1	61.6	61.1	65.0	41.7	41.8	54.1
Non-registered	8.2	14.1	7.5	8.7	13.8	10.6	8.4	4.5	10.0
Total	62.5	66.1	57.6	70.3	74.9	75.6	50.1	46.3	64.1
Allied health									
Occupation therapist	3.3	4.7	3.5	6.3	3.6	3.0	1.8	0.5	3.9
Social worker	5.2	8.2	7.0	9.5	12.7	6.1	5.9	3.4	7.3
Psychologist	8.3	8.3	8.1	8.1	5.1	5.5	17.9	5.9	8.1
Other allied health staff	5.4	1.7	2.9	5.3	3.9	5.8	2.0	5.7	3.8
Total	22.2	22.9	21.6	29.3	25.3	20.3	27.7	15.4	23.2
Other personal care	2.4	4.2	5.0	4.3	1.5	29.2	8.5	3.3	4.2
Total	**98.7**	**103.9**	**95.3**	**116.8**	**115.2**	**133.5**	**95.1**	**75.1**	**102.9**
2007-08									
Medical									
Consultant psychiatrist	5.6	4.3	5.7	4.8	6.1	5.4	4.3	4.0	5.2

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Psychiatry registrar	5.4	4.8	5.6	4.8	6.6	3.2	4.8	4.1	5.2
Other medical officers	1.2	2.2	0.9	3.6	1.1	0.2	0.4	2.3	1.6
Total	12.1	11.3	12.1	13.2	13.8	8.9	9.5	10.4	12.0
Nursing									
Registered nursing	54.4	51.0	52.2	61.1	63.8	59.2	40.6	42.7	54.3
Non-registered	8.1	14.4	8.3	8.8	15.0	11.0	8.6	4.2	10.3
Total	62.5	65.4	60.4	70.0	78.7	70.2	49.2	46.9	64.6
Allied health									
Occupation therapist	3.3	4.5	3.9	6.8	4.4	2.2	2.2	0.8	4.1
Social worker	4.7	8.4	7.7	9.5	14.3	5.6	6.8	3.8	7.4
Psychologist	8.7	7.5	9.5	7.4	6.9	5.0	14.2	5.8	8.3
Other allied health staff	5.6	2.2	3.1	5.7	4.4	5.9	0.2	6.1	4.1
Total	22.3	22.6	24.2	29.5	30.0	18.7	23.4	16.5	23.9
Other personal care	1.0	4.7	4.8	6.2	1.5	31.2	9.4	3.6	4.1
Total	**97.9**	**104.0**	**101.5**	**118.8**	**124.0**	**129.0**	**91.4**	**77.3**	**104.6**
2008-09									
Medical									
Consultant psychiatrist	6.2	4.8	5.7	5.3	6.1	4.6	5.8	5.8	5.6
Psychiatry registrar	5.8	5.1	5.9	4.7	7.1	2.8	4.5	4.3	5.5
Other medical officers	0.9	1.5	0.5	3.5	0.2	2.7	0.8	2.7	1.3
Total	12.9	11.4	12.1	13.5	13.4	10.1	11.1	12.8	12.4
Nursing									
Registered nursing	56.0	50.9	52.7	61.9	62.3	60.2	37.4	46.6	54.9
Non-registered	8.2	15.4	8.4	9.3	15.3	11.0	9.3	2.4	10.7
Total	64.2	66.2	61.1	71.2	77.6	71.2	46.6	48.9	65.5
Allied health									
Occupation therapist	3.9	4.6	4.5	6.8	4.2	3.3	4.2	1.0	4.5
Social worker	5.7	8.8	7.8	9.2	14.7	5.9	5.9	5.2	7.9
Psychologist	8.3	7.8	9.3	7.9	5.6	4.6	13.5	4.5	8.1
Other allied health staff	4.0	1.7	3.7	6.2	3.0	4.5	0.4	5.0	3.5
Total	22.0	22.9	25.3	30.0	27.5	18.3	24.0	15.7	24.0
Other personal care	0.8	4.8	4.1	6.0	4.7	30.2	7.7	9.4	4.2
Total	**99.9**	**105.5**	**102.7**	**120.7**	**123.2**	**129.9**	**89.4**	**86.9**	**106.1**
2009-10									
Medical									
Consultant psychiatrist	6.1	5.4	5.6	5.6	6.2	5.4	6.8	5.8	5.8
Psychiatry registrar	6.6	4.7	5.8	4.5	6.8	2.8	5.2	4.6	5.6
Other medical officers	0.4	1.7	0.7	3.5	0.4	2.2	0.5	2.3	1.1
Total	13.1	11.9	12.1	13.7	13.4	10.4	12.5	12.7	12.6

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Nursing									
Registered nursing	59.3	50.3	50.0	60.5	62.9	58.3	40.9	45.5	55.1
Non-registered	7.3	15.3	7.5	9.7	14.6	11.1	8.5	3.3	10.2
Total	66.6	65.6	57.5	70.3	77.6	69.4	49.4	48.8	65.3
Allied health									
Occupation therapist	4.1	4.8	4.1	6.4	4.7	2.9	3.2	1.4	4.5
Social worker	6.0	8.6	8.6	8.8	15.0	6.2	6.0	4.2	8.1
Psychologist	8.4	7.6	8.7	7.2	5.6	4.7	14.4	4.7	7.9
Other allied health staff	4.1	1.6	3.6	6.4	2.5	6.6	0.4	5.7	3.5
Total	22.5	22.5	25.1	28.8	27.8	20.4	24.0	16.0	24.0
Other personal care	0.9	4.6	4.8	7.4	5.9	34.3	7.6	8.7	4.6
Total	**103.1**	**104.6**	**99.4**	**120.1**	**124.7**	**134.5**	**93.5**	**86.2**	**106.5**
2010-11									
Medical									
Consultant psychiatrist	6.4	5.5	6.0	6.0	7.6	6.4	6.0	4.5	6.1
Psychiatry registrar	6.8	5.0	5.8	4.3	5.8	2.5	5.1	5.6	5.7
Other medical officers	0.5	1.5	1.0	3.8	0.3	1.9	0.2	2.1	1.2
Total	13.7	12.0	12.9	14.1	13.7	10.7	11.3	12.2	13.0
Nursing									
Registered nursing	61.0	51.7	53.2	59.6	65.7	59.1	40.4	45.1	56.8
Non-registered	6.6	15.3	7.3	9.7	14.9	10.5	7.6	3.3	9.9
Total	67.6	67.0	60.5	69.3	80.6	69.6	48.0	48.3	66.7
Allied health									
Occupation therapist	4.2	5.2	4.5	6.4	4.7	3.0	3.3	1.2	4.7
Social worker	6.2	8.7	8.9	9.0	14.6	6.4	6.1	5.9	8.3
Psychologist	8.5	7.7	9.2	7.4	5.8	4.3	16.8	7.2	8.2
Other allied health staff	4.7	1.9	3.9	6.1	2.5	7.2	0.2	4.2	3.8
Total	23.6	23.4	26.6	28.9	27.6	20.9	26.4	18.5	24.9
Other personal care	0.6	4.5	5.3	10.7	7.2	33.2	7.1	10.1	5.0
Total	**105.5**	**106.9**	**105.3**	**123.0**	**129.1**	**134.5**	**92.8**	**89.1**	**109.7**
2011-12									
Medical									
Consultant psychiatrist	6.0	5.2	6.2	6.2	7.1	5.8	8.2	6.7	6.0
Psychiatry registrar	6.1	5.3	6.6	4.8	6.2	3.0	4.6	6.3	5.8
Other medical officers	0.9	1.7	0.8	3.6	0.3	1.1	0.2	0.4	1.3
Total	13.0	12.3	13.6	14.6	13.6	10.0	13.0	13.4	13.1
Nursing									
Registered nursing	63.5	52.0	56.0	60.5	62.6	56.8	38.7	47.7	58.0
Non-registered	7.0	15.6	8.0	10.0	13.4	9.2	7.6	3.7	10.1

Table 12A.23 **Full time equivalent (FTE) direct care staff employed in specialised mental health services by staff type (per 100 000 people) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total	70.5	67.5	64.0	70.5	76.0	66.0	46.4	51.3	68.2
Allied health									
Occupation therapist	3.8	5.6	4.5	5.9	4.5	2.5	3.6	1.6	4.6
Social worker	6.2	8.6	9.2	9.0	14.8	6.1	6.8	6.9	8.3
Psychologist	8.9	7.6	9.7	7.4	5.9	3.9	16.1	5.7	8.3
Other allied health staff	5.3	1.9	3.9	7.2	0.9	6.0	0.2	4.6	4.0
Total	24.1	23.6	27.4	29.6	26.0	18.5	26.6	18.7	25.2
Other personal care	0.8	4.4	5.0	11.5	7.4	31.6	7.0	9.5	5.1
Total	**108.5**	**107.8**	**110.0**	**126.3**	**123.1**	**126.0**	**93.1**	**93.0**	**111.6**

(a) Professional categories are defined by profession rather than role. See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of staffing estimates.

(b) Total FTE figures presented in this table can differ from those in table 12A.24. In addition, totals may not add due to rounding.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland implemented a new method to calculate FTE from the 2009-10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

Source: AIHW unpublished, derived from the MHE NMDS; ABS (various issues), *Australian Demographic Statistics,* December (various years), Cat. no. 3101.0.

Table 12A.24 **Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld* (f), (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06									
Inpatient services	53.5	37.0	55.5	62.5	62.9	48.8	25.4	30.6	50.6
Ambulatory mental health services	38.7	44.1	35.9	49.5	45.0	40.9	50.0	40.6	41.3
Community residential services	4.0	22.9	..	2.9	1.4	34.6	19.2	1.9	8.6
Total	**96.2**	**103.9**	**91.4**	**114.9**	**109.3**	**124.3**	**94.5**	**73.2**	**100.4**
2006-07									
Inpatient services	55.6	37.3	54.7	63.9	67.4	58.6	28.2	32.3	52.0
Ambulatory mental health services	38.8	44.7	40.6	49.7	46.4	40.2	50.5	41.3	42.5
Community residential services	4.3	21.9	..	3.3	1.4	32.3	16.4	1.4	8.3
Total	**98.7**	**103.9**	**95.3**	**116.8**	**115.2**	**131.1**	**95.1**	**75.0**	**102.9**
2007-08									
Inpatient services	55.8	37.5	57.0	63.9	70.1	56.5	28.3	31.9	52.7
Ambulatory mental health services	39.9	44.2	44.5	49.4	50.9	38.9	49.0	43.8	43.8
Community residential services	2.3	22.2	..	5.5	3.0	31.6	14.0	1.7	8.0
Total	**97.9**	**104.0**	**101.5**	**118.8**	**124.0**	**126.9**	**91.4**	**77.4**	**104.6**
2008-09									
Inpatient services	57.9	38.6	55.8	64.8	67.1	56.6	26.4	38.0	53.4
Ambulatory mental health services	40.1	44.6	46.9	49.6	51.2	40.9	48.7	42.8	44.6
Community residential services	1.8	22.2	..	6.4	5.0	30.3	14.2	6.1	8.1
Total	**99.9**	**105.5**	**102.7**	**120.7**	**123.2**	**127.8**	**89.4**	**86.9**	**106.0**
2009-10									
Inpatient services	59.8	38.5	51.8	63.8	64.2	57.6	28.5	36.6	52.9
Ambulatory mental health services	41.7	44.6	47.6	49.4	55.5	42.2	50.1	43.1	45.6
Community residential services	1.6	21.5	..	6.9	5.0	32.9	14.9	6.4	8.0
Total	**103.1**	**104.6**	**99.4**	**120.1**	**124.7**	**132.6**	**93.5**	**86.1**	**106.4**
2010-11									
Inpatient services	61.2	39.4	53.6	64.1	62.5	58.3	29.8	38.0	53.8
Ambulatory mental health services	43.1	46.2	51.6	50.9	60.6	42.3	48.9	44.2	47.8
Community residential services	1.2	21.3	..	8.1	6.0	31.6	14.1	6.8	8.0
Total	**105.5**	**106.9**	**105.3**	**123.0**	**129.1**	**132.2**	**92.7**	**89.1**	**109.6**

Table 12A.24 Full time equivalent (FTE) direct care staff employed in specialised mental health services, by service setting (per 100 000 people) (a), (b), (c)

	NSW (d), (e)	*Vic*	*Qld* (f), (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2011-12									
Inpatient services	65.1	39.9	56.2	65.7	55.5	54.9	26.9	37.2	55.3
Ambulatory mental health services	42.3	46.9	53.9	51.8	57.7	40.1	51.6	49.2	48.1
Community residential services	1.1	21.0	..	8.8	9.9	26.8	14.1	6.6	8.1
Total	**108.5**	**107.8**	**110.0**	**126.2**	**123.1**	**121.8**	**92.6**	**93.0**	**111.5**

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of staffing estimates.

(b) Total FTE figures in this table can differ from those in table 12A.23. In addition, totals may not add due to rounding.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(f) The apparent absence of community residential services in Queensland reflects Queensland's preference to describe such facilities as 'extended inpatient care'.

(g) Queensland implemented a new method to calculate FTE from the 2009–10 data. The new method is associated with the reduction in reported FTE so caution should be exercised when conducting time series analysis.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.25 New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, (a), (b)

	Unit	*NSW* (c), (d), (e)	*Vic* (f)	*Qld* (g)	*WA* (h), (i), (j)	*SA* (k)	*Tas* (l)	*ACT*	*NT* (m)	*Aust* (f)
2009-10										
New clients	no.	46 853	14 985	33 457	17 748	13 206	3 593	3 254	2 657	135 753
Total clients	no.	116 653	61 636	73 550	42 600	31 186	10 498	7 657	5 544	349 324
Proportion of total clients who are new	%	40.2	24.3	45.5	41.7	42.3	34.2	42.5	47.9	38.9
2010-11										
New clients	no.	49 018	15 015	35 372	18 700	13 302	3 658	3 352	2 821	141 238
Total clients	no.	119 792	61 687	77 638	44 839	31 689	11 711	8 079	5 817	361 252
Proportion of total clients who are new	%	40.9	24.3	45.6	41.7	42.0	31.2	41.5	48.5	39.1
2011-12										
New clients	no.	48 389	na	37 341	19 673	14 557	2 428	3 548	3 264	129 200
Total clients	no.	121 703	na	82 042	47 238	34 092	11 112	8 407	6 579	311 173
Proportion of total clients who are new	%	39.8	na	45.5	41.6	42.7	21.9	42.2	49.6	41.5

(a) Clients in receipt of services include all people who received one or more community service contacts or had one or more days of inpatient or residential care in the data period.

(b) A new client is defined as a consumer who has not been seen in the five years preceding the first contact with a State or Territory specialised public mental health service in the data period.

(c) NSW has implemented a Statewide Unique Patient Identifier (SUPI) for mental health care. The identification of prior contacts for MH clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level for 2009-10, 2010-11 and 2011-12 is 99.8 per cent. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which may include some duplicates of those who attended multiple facilities).

(d) For NSW, residential clients are not included because their data are manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW MH residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients and 243 total residential MH clients with 130 potential new clients in 2011-12).

Table 12A.25 **New clients as a proportion of total clients under the care of State or Territory specialised public mental health services, (a), (b)**

	Unit	*NSW* (c), (d), (e)	*Vic* (f)	*Qld* (g)	*WA* (h), (i), (j)	*SA* (k)	*Tas* (l)	*ACT*	*NT* (m)	*Aust* (f)

(e) NSW data have been revised for all years, to include all inpatient and ambulatory clients who received mental health services as recorded in NSW State Health Information Exchange (HIE). One large Local Health District (LHD), has incomplete community data (June 2012 data are missing) in the NSW State HIE in 2011-12. Processes are currently underway to rectify the problem. The 2011-12 rate will be revised/updated for the next Report.

(f) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

(g) For Qld, a linkage program is utilised to link between admitted and community activity and patients.

(h) For WA, the matching of mental health community contacts to inpatient episodes is now done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result. Data before 2011-12 are based on data submitted for the NMDS and have not been revised.

(i) Unlike previous reports, mental health community contacts and acute separations are now sourced from two different data collection systems. Each system has different unique patient identifier and requires the use of linkages to allow unique tracking of consumers across all public mental health services in WA. This could result to an under-estimate in the proportion of new clients

(j) Community/ambulatory, community residential and inpatient mental health activity are entered and collected in different systems. An attempt is made to uniquely identify patients across the WA Health system through data linkage, however mental health patients use alias information, lag in clinical coding and quality assurance processes and additional information can become available for that person and unique identifiers can be updated.

(k) For SA, the new client (numerator) count is not unique: it is an aggregation of three separate databases with no linkage between them. Similarly, the total client (denominator) count is not unique: it is an aggregation of three separate databases with no linkage between them. However, impact on the result should be minimal due to populations being relatively stable within the three respective catchments.

(l) For Tasmania, the information has been extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients. For 2009-10, the new and total client count includes Mental Health Service Helpline contacts with individuals who received a one off contact through the 24 hour telephone helpline. Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12.

(m) For the NT, for 2009-10, the count of all clients will not be exactly the same as provided in other reported collections due to non-availability of 'snapshot' or archived annual data sets.

Source: State and Territory governments, unpublished.

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
	Age standardised proportion (%) (a)									no.
2007-08										
Public (b), (c)										
Indigenous	4.5	3.1	3.9	3.5	5.0	1.5	5.1	2.9	3.8	19 187
Non-Indigenous	1.2	1.1	1.7	1.6	1.5	2.0	1.6	1.9	1.3	276 005
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	np	np	np	np	np	np	np	np	np	np
Non-Indigenous	np	np	np	np	np	np	np	np	np	np
2008-09										
Public (b), (c)										
Indigenous	4.7	3.2	3.8	3.8	5.7	1.3	5.6	3.1	4.0	20 616
Non-Indigenous	1.2	1.1	1.6	1.6	1.6	1.3	1.7	1.9	1.3	277 321
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	7.2	9.2	4.5	2.7	5.5	6.5	7.8	1.0	5.1	24 603
Non-Indigenous	5.9	6.4	5.3	4.9	5.6	5.0	4.6	2.7	5.7	1 200 337
2009-10										
Public (b), (c)										
Indigenous	4.9	3.2	4.0	4.2	5.7	np	5.8	3.7	4.3	22 930
Non-Indigenous	1.2	1.0	1.6	1.7	1.6	1.3	1.8	2.0	1.3	282 620

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	8.1	10.2	4.7	3.0	6.1	7.2	8.6	1.3	5.6	28 303
Non-Indigenous	6.3	7.0	5.9	5.3	6.3	5.6	5.1	3.2	6.2	1 337 882
2010-11										
Public (b), (c)										
Indigenous	4.8	3.1	4.4	4.8	5.8	1.9	6.4	3.7	4.4	24 250
Non-Indigenous	1.2	1.0	1.6	1.7	1.6	1.6	1.8	2.0	1.4	291 381
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	10.1	11.3	5.9	4.0	7.8	8.9	11.5	1.5	6.9	36 044
Non-Indigenous	6.9	7.6	6.6	5.7	6.9	6.3	5.5	3.4	6.8	1 486 676
2011-12										
Public (b), (c)										
Indigenous	5.4	na	4.8	5.4	6.9	1.2	7.9	3.8	na	na
Non-Indigenous	1.2	na	1.7	1.8	1.7	0.8	1.9	2.3	na	na
Private (d)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous	na	na	na	na	na	na	na	..	na	na
MBS and DVA (e)										
Indigenous	10.7	12.5	6.7	4.0	8.2	8.4	12.5	1.5	7.4	39 632

Table 12A.26 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Non-Indigenous	7.0	7.8	6.7	5.5	7.0	6.2	5.6	3.6	6.9	1 522 735

(a) Rates are age-standardised to the Australian population as at 30 June 2001.

(b) Excludes people for whom Indigenous status was missing or not reported, for example, in 2011-12 for Tasmania Indigenous status was missing or not reported for 46 per cent of people receiving services. The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions.

(c) SA submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data in 2011-12. Therefore caution needs to be taken when making inter-jurisdictional comparisons.

(d) Indigenous information is not collected for private psychiatric hospitals.

(e) DVA data not available by Indigenous status. MBS data are not published for 2007-08. Medicare data presented by Indigenous status have been adjusted for under-identification in the Department of Human Services (DHS) Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.

na Not available. .. Not applicable. **np** Not published.

Source: State and territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; Department of Health (DoH) unpublished, MBS statistics; Department of Veterans' Affairs (DVA) unpublished data; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, 30 June (prior to relevant period)*, Series B, Cat. no. 3238.0.

Table 12A.27 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
	Age standardised proportion (%) (b)									no.
2007-08										
Public (c), (d)										
Major cities	1.2	0.9	1.5	1.3	1.6	..	1.8	..	1.2	173 288
Inner regional	2.6	1.7	2.5	3.9	1.7	np	np	..	2.2	85 003
Outer regional	3.5	2.2	2.2	2.2	2.6	np	..	2.0	2.3	43 447
Remote	4.4	4.3	1.9	0.9	2.0	np	..	2.2	1.9	5 744
Very remote	13.0	..	3.9	4.8	2.1	np	..	2.2	3.6	6 297
Private (c), (e)										
Major cities	0.1	0.1	0.1	0.1	np	..	np	..	0.1	19 261
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	2 973
Outer regional	–	–	–	–	np	np	..	..	–	579
Remote	–	–	–	–	np	np	..	..	–	69
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	5.3	5.8	5.1	4.6	5.2	..	4.0	..	5.3	764 089
Inner regional	5.1	5.3	4.6	3.7	4.5	4.8	4.6	..	4.9	192 134
Outer regional	3.7	3.7	3.1	3.6	3.2	3.4	..	2.4	3.3	62 986
Remote	2.5	4.7	1.9	1.4	2.5	2.1	..	0.9	1.8	5 668
Very remote	2.6	..	1.2	0.7	2.7	5.5	..	1.2	1.3	2 070
2008-09										
Public (c), (d)										
Major cities	1.2	0.9	1.4	1.3	1.9	..	1.9	..	1.2	180 087
Inner regional	2.7	1.5	2.4	4.0	2.0	np	np	..	2.2	85 135
Outer regional	4.0	2.1	2.2	2.3	2.6	np	..	2.0	2.4	44 963

Table 12A.27 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Remote	5.8	1.5	1.6	0.9	2.5	np	..	2.5	2.0	6 193
Very remote	16.2	..	3.1	5.1	2.3	np	..	2.2	3.7	6 544
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.1	np	..	np	..	0.1	20 251
Inner regional	0.1	–	0.1	0.1	np	np	np	..	0.1	3 205
Outer regional	–	–	–	–	np	np	..	..	–	645
Remote	0.1	–	–	–	np	np	..	..	–	98
Very remote	–	..	–	–	np	np	..	..	–	30
MBS and DVA (c)										
Major cities	6.2	6.7	6.1	5.3	6.3	..	4.8	..	6.2	916 074
Inner regional	6.2	6.6	5.7	4.7	5.5	5.6	5.7	..	6.0	239 453
Outer regional	4.7	4.5	4.0	4.4	4.1	4.2	..	3.0	4.2	80 394
Remote	3.0	6.1	2.5	1.9	3.4	2.7	..	1.3	2.4	7 460
Very remote	4.3	..	1.6	0.8	2.4	6.3	..	1.6	1.5	2 557
2009-10										
Public (c), (d)										
Major cities	1.4	0.9	1.6	1.3	1.8	..	2.0	..	1.3	198 917
Inner regional	2.2	1.6	1.8	4.3	2.1	1.4	np	..	2.0	81 749
Outer regional	2.6	2.1	1.8	2.3	2.5	1.2	..	2.0	2.1	39 579
Remote	3.8	1.0	1.5	1.0	2.6	–	..	2.8	1.9	5 798
Very remote	5.5	..	2.4	5.8	2.1	0.7	..	2.6	3.5	6 416
Private (c), (e)										
Major cities	0.1	0.1	0.2	0.2	np	..	np	..	0.1	21 149
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 416
Outer regional	–	–	–	–	np	np	..	..	–	674

Table 12A.27 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Remote	0.1	0.1	–	–	np	np	..	..	–	105
Very remote	–	..	–	–	np	np	..	..	–	31
MBS and DVA (c)										
Major cities	6.6	7.3	6.7	5.7	6.9	..	5.2	..	6.7	1 011 181
Inner regional	6.8	7.4	6.3	5.2	6.5	6.3	6.4	..	6.7	270 641
Outer regional	5.2	5.4	4.7	4.9	4.6	4.8	..	3.4	4.8	93 109
Remote	3.2	6.3	2.8	2.3	4.4	2.8	..	1.6	2.7	8 759
Very remote	4.9	..	1.7	1.0	2.3	4.9	..	2.0	1.7	2 963
2010-11										
Public (c), (d)										
Major cities	1.4	0.9	1.7	1.8	1.8	..	2.1	..	1.4	214 072
Inner regional	2.2	1.6	1.8	1.6	2.1	1.9	np	..	1.9	76 427
Outer regional	2.5	2.0	1.9	2.5	2.4	1.6	..	2.0	2.1	40 932
Remote	3.5	1.2	1.9	3.0	2.6	0.6	..	2.7	2.6	8 115
Very remote	5.1	..	2.9	2.0	2.5	0.7	..	3.1	2.5	4 820
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.1	22 910
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	3 950
Outer regional	–	–	–	–	np	np	..	..	–	858
Remote	0.1	0.1	–	0.1	np	np	..	..	–	115
Very remote	–	..	–	–	np	np	..	..	–	45
MBS and DVA (c)										
Major cities	7.3	7.9	7.4	6.1	7.6	..	5.6	..	7.3	1 124 293
Inner regional	7.6	8.1	6.9	5.9	7.1	6.9	6.4	..	7.4	301 981
Outer regional	5.7	6.3	5.3	5.5	5.1	5.5	..	3.6	5.4	104 578

Table 12A.27 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Remote	3.2	5.8	3.6	2.6	4.0	3.4	..	1.8	3.0	9 668
Very remote	4.4	..	1.9	1.2	2.3	7.4	..	2.0	1.8	3 314
2011-12										
Public (c), (d)										
Major cities	1.4	na	1.6	1.8	1.9	..	2.1	..	na	na
Inner regional	2.2	na	2.1	2.0	2.1	1.7	np	..	na	na
Outer regional	2.6	na	2.2	2.8	2.8	1.4	..	2.3	na	na
Remote	3.3	na	2.1	2.8	2.7	1.5	..	2.8	na	na
Very remote	5.2	..	3.0	2.9	2.4	0.9	..	3.3	na	na
Private (c), (e)										
Major cities	0.1	0.2	0.2	0.2	np	..	np	..	0.2	25 188
Inner regional	0.1	0.1	0.1	0.1	np	np	np	..	0.1	4 112
Outer regional	–	–	0.1	0.1	np	np	..	..	0.1	1 104
Remote	0.1	0.2	–	0.1	np	np	..	..	–	122
Very remote	–	..	0.1	–	np	np	..	..	–	75
MBS and DVA (c)										
Major cities	7.3	8.1	7.7	5.7	7.7	..	5.6	..	7.4	1 166 357
Inner regional	7.6	8.0	6.8	5.5	7.1	6.6	6.3	..	7.3	287 388
Outer regional	5.8	6.1	5.3	4.5	5.1	5.8	..	2.8	5.2	101 572
Remote	3.4	5.3	3.3	2.3	3.9	4.0	..	1.8	2.9	8 947
Very remote	2.7	..	1.8	1.2	2.1	6.5	..	0.6	1.4	2 766

(a) Not all remoteness areas are represented in each State or Territory. Where a state/territory does not have a particular remoteness category a rate cannot be calculated. Excludes contacts for which demographic information was missing and/or not reported.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

Table 12A.27 Proportion of people receiving clinical mental health services by service type and remoteness area (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust

(c) For 2007-08 and 2008-09, disaggregation by remoteness area is based on a person's usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate remoteness area varied across jurisdictions. For 2009-10 to 2011-12 data, disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. State/territory is the state/territory of the service provider.

(d) Caution needs to be taken when making inter-jurisdictional comparisons. SA submitted data that were not based on unique patient identifier or data matching approaches. Due to system-related issues impacting data quality, Tasmania was unable to provide data by remoteness area for 2007-08 and 2008-09. Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data.

(e) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons, but are included in the Australia figures.

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Source: State and Territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; DoHA unpublished, MBS statistics; DVA unpublished data; ABS unpublished, Estimated Resident Population, 30 June (prior to relevant period).

Table 12A.28 Proportion of people receiving clinical mental health services by service type and SEIFA (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
	Age standardised proportion (b)									no.
2007-08										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.8	1.5	1.9	2.0	2.9	2.0	np	1.5	1.9	76 635
Quintile 2	1.9	1.4	2.6	1.4	1.2	2.9	4.3	6.1	1.8	74 505
Quintile 3	1.5	1.2	2.0	2.1	1.0	1.3	3.7	3.8	1.6	67 420
Quintile 4	1.4	0.9	1.7	2.0	1.3	0.9	2.3	0.6	1.4	55 904
Quintile 5 (least disadvantaged)	1.2	0.7	1.2	1.4	2.0	..	1.5	2.5	1.2	48 530
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	0.1	2 556
Quintile 2	–	–	0.1	–	np	np	np	np	0.1	2 351
Quintile 3	0.1	–	0.1	0.1	np	np	np	np	0.1	3 572
Quintile 4	0.1	0.1	0.2	0.1	np	np	np	np	0.1	5 383
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 074
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	4.4	4.9	4.3	2.3	4.5	3.8	3.7	0.7	4.3	176 364
Quintile 2	5.3	5.2	4.1	3.9	4.8	3.9	4.2	2.0	4.9	200 248
Quintile 3	5.2	5.4	4.6	3.9	4.5	4.2	3.9	1.6	4.8	202 268
Quintile 4	5.3	5.5	4.9	3.9	5.0	6.1	4.0	1.7	5.0	206 586
Quintile 5 (least disadvantaged)	5.4	6.3	4.9	4.8	5.4	..	3.9	1.4	5.4	231 002
2008-09										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	1.7	2.2	2.7	np	np	1.6	1.8	72 356
Quintile 2	2.0	1.4	2.7	1.5	1.3	np	4.6	6.2	1.9	77 089
Quintile 3	1.5	1.2	2.3	2.1	1.3	np	3.8	4.0	1.7	71 113

Table 12A.28 Proportion of people receiving clinical mental health services by service type and SEIFA (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Quintile 4	1.4	0.8	1.3	2.0	0.8	np	2.4	0.6	1.2	51 399
Quintile 5 (least disadvantaged)	1.2	0.7	1.0	1.4	3.5	..	1.6	2.4	1.2	50 798
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 036
Quintile 2	–	–	0.1	0.1	np	np	np	np	0.1	2 578
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 888
Quintile 4	0.1	0.2	0.2	0.1	np	np	np	np	0.1	6 212
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.2	np	..	np	np	0.2	9 553
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	5.3	5.8	5.4	2.7	5.6	4.6	4.6	0.9	5.2	218 084
Quintile 2	6.3	6.2	5.1	4.7	5.9	4.7	4.8	2.5	5.9	244 695
Quintile 3	6.1	6.5	5.7	4.8	5.7	4.9	4.8	2.2	5.8	247 895
Quintile 4	6.1	6.5	5.8	4.5	5.7	6.7	4.9	2.0	5.9	250 106
Quintile 5 (least disadvantaged)	6.3	7.2	5.6	5.5	6.3	..	4.6	1.8	6.2	270 901
2009-10										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.6	2.2	2.7	1.0	np	2.6	2.0	85 633
Quintile 2	1.9	1.4	1.8	1.5	2.1	4.2	4.8	2.4	1.8	75 384
Quintile 3	1.5	1.2	1.7	2.2	1.7	1.3	3.8	3.3	1.6	69 386
Quintile 4	1.4	0.8	1.4	2.1	1.2	1.0	2.5	1.6	1.3	56 689
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.7	1.0	45 247
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	0.0	0.1	0.0	0.1	np	np	np	np	–	1 939
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	2 864
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 121

Table 12A.28 Proportion of people receiving clinical mental health services by service type and SEIFA (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	5 993
Quintile 5 (least disadvantaged)	0.2	0.2	0.2	0.3	np	..	np	np	0.2	10 565
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	5.9	6.5	6.0	3.1	6.4	5.2	5.2	1.1	5.8	246 684
Quintile 2	6.8	6.9	5.7	5.1	6.6	5.1	5.3	3.0	6.5	274 627
Quintile 3	6.6	7.2	6.4	5.2	6.2	5.6	5.2	2.5	6.4	277 661
Quintile 4	6.5	7.1	6.4	4.9	6.2	7.5	5.3	2.3	6.4	278 258
Quintile 5 (least disadvantaged)	6.7	7.6	6.1	5.8	6.9	..	5.0	2.1	6.6	293 715
2010-11										
Public (c), (d)										
Quintile 1 (most disadvantaged)	1.9	1.5	2.9	3.5	2.7	2.0	np	2.9	2.2	93 565
Quintile 2	1.9	1.4	1.9	2.2	2.1	1.4	4.4	2.5	1.9	79 324
Quintile 3	1.6	1.2	1.7	1.9	1.7	1.2	3.7	3.0	1.6	69 526
Quintile 4	1.4	0.8	1.3	1.6	1.3	1.7	2.6	1.7	1.3	55 664
Quintile 5 (least disadvantaged)	1.1	0.7	1.0	1.4	1.0	..	1.7	1.8	1.0	45 973
Private (c), (e), (f)										
Quintile 1 (most disadvantaged)	–	0.1	–	0.1	np	np	np	np	–	2 179.0
Quintile 2	0.1	0.1	0.1	0.1	np	np	np	np	0.1	3 217.0
Quintile 3	0.1	0.1	0.1	0.1	np	np	np	np	0.1	4 752.0
Quintile 4	0.1	0.1	0.2	0.2	np	np	np	np	0.1	6 743.0
Quintile 5 (least disadvantaged)	0.2	0.3	0.2	0.3	np	..	np	np	0.2	10 987.0
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	6.5	7.2	6.6	3.7	7.0	5.9	5.8	1.2	6.5	277 164
Quintile 2	7.6	7.6	6.5	5.5	7.3	5.6	5.9	3.4	7.2	309 010
Quintile 3	7.1	7.9	7.2	5.5	6.7	6.3	5.4	2.8	7.0	307 839

Table 12A.28 **Proportion of people receiving clinical mental health services by service type and SEIFA (a)**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
Quintile 4	7.2	7.7	7.2	5.3	6.9	8.0	5.7	2.4	7.0	312 702
Quintile 5 (least disadvantaged)	7.2	8.1	6.6	6.2	7.6	..	5.5	2.2	7.1	319 001
2011-12										
Public (c), (d), (g)										
Quintile 1 (most disadvantaged)	1.9	na	2.8	4.1	3.1	1.7	np	2.9	na	na
Quintile 2	1.9	na	2.0	2.4	2.1	1.3	3.5	2.9	na	na
Quintile 3	1.5	na	1.8	2.1	1.7	1.4	3.3	2.9	na	na
Quintile 4	1.5	na	1.4	1.7	1.5	1.3	2.9	2.6	na	na
Quintile 5 (least disadvantaged)	1.1	na	1.1	1.5	1.1	..	1.8	2.2	na	na
Private (c), (e)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	0.1	2 394
Quintile 2	na	na	na	na	na	na	na	na	0.1	3 524
Quintile 3	na	na	na	na	na	na	na	na	0.1	5 461
Quintile 4	na	na	na	na	na	na	na	na	0.2	7 354
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	0.3	11 868
MBS and DVA (c)										
Quintile 1 (most disadvantaged)	na	na	na	na	na	na	na	na	6.7	291 207
Quintile 2	na	na	na	na	na	na	na	na	7.4	322 586
Quintile 3	na	na	na	na	na	na	na	na	6.9	307 367
Quintile 4	na	na	na	na	na	na	na	na	7.2	324 458
Quintile 5 (least disadvantaged)	na	na	na	na	na	..	na	na	7.1	320 937

(a) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Excludes people for whom demographic information was missing and/or not reported.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

Table 12A.28 Proportion of people receiving clinical mental health services by service type and SEIFA (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(c) For 2007-08 and 2008-09, disaggregation by SEIFA is based on a person’s usual residence, the location of the service provider or a combination of both. For these years, the public data should be interpreted with caution as the methodology used to allocate SEIFA varied across jurisdictions. From 2009-10 onwards, disaggregation by SEIFA is based on a person’s usual residence, not the location of the service provider. Due to system-related issues impacting data quality, Tasmania was unable to provide data by SEIFA for 2008-09.

(d) SA submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Therefore caution needs to be taken when making inter-jurisdictional comparisons.

(e) Disaggregation by SEIFA is based on a person’s usual residence, not the location of the service provider.

(f) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia figures.

(g) For public sector community mental health services, Victorian data for 2011-12 are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data. Therefore caution needs to be taken when making inter-jurisdictional comparisons and comparisons over time.

na Not available. .. Not applicable. – Nil or rounded to zero. **np** Not published.

Table 12A.29 Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)

	Public (d)	*Private*	*MBS and DVA*
2007-08			
Decile 1	1.9	0.1	4.1
Decile 2	1.9	–	4.5
Decile 3	1.9	0.1	4.8
Decile 4	1.8	0.1	5.0
Decile 5	1.6	0.1	4.8
Decile 6	1.6	0.1	4.9
Decile 7	1.3	0.1	4.9
Decile 8	1.5	0.1	5.1
Decile 9	1.2	0.2	5.5
Decile 10	1.1	0.2	5.3
2008-09			
Decile 1	1.7	–	5.0
Decile 2	1.8	–	5.5
Decile 3	1.8	0.1	5.8
Decile 4	1.9	0.1	5.9
Decile 5	1.7	0.1	5.8
Decile 6	1.6	0.1	5.9
Decile 7	1.2	0.1	5.7
Decile 8	1.2	0.1	6.0
Decile 9	1.2	0.2	6.4
Decile 10	1.2	0.2	6.0
2009-10			
Decile 1	2.1	–	5.6
Decile 2	2.0	–	6.1

Table 12A.29 Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)

	Public (d)	*Private*	*MBS and DVA*
Decile 3	1.8	0.1	6.4
Decile 4	1.7	0.1	6.5
Decile 5	1.6	0.1	6.3
Decile 6	1.6	0.1	6.4
Decile 7	1.4	0.1	6.2
Decile 8	1.2	0.1	6.5
Decile 9	1.1	0.2	6.8
Decile 10	1.0	0.2	6.5
2010-11			
Decile 1	2.2	–	6.3
Decile 2	2.2	0.1	6.7
Decile 3	1.8	0.1	7.2
Decile 4	1.9	0.1	7.2
Decile 5	1.7	0.1	6.9
Decile 6	1.4	0.1	7.0
Decile 7	1.3	0.1	6.9
Decile 8	1.2	0.2	7.1
Decile 9	1.1	0.2	7.3
Decile 10	1.0	0.3	6.9
2011-12			
Decile 1	na	–	6.6
Decile 2	na	0.1	6.8
Decile 3	na	0.1	7.3
Decile 4	na	0.1	7.5
Decile 5	na	0.1	6.8

Table 12A.29 **Proportion of people receiving clinical mental health services, by service type and SEIFA IRSD deciles (age-standardised rate) (a), (b), (c)**

	Public (d)	*Private*	*MBS and DVA*
Decile 6	na	0.1	6.9
Decile 7	na	0.1	7.2
Decile 8	na	0.2	7.2
Decile 9	na	0.2	7.2
Decile 10	na	0.3	7.1

(a) SEIFA deciles are based on the ABS Index of Relative Socio-economic Disadvantage (IRSD), with decile 1 being the most disadvantaged and decile 10 being the least disadvantaged. SEIFA deciles represent approximately 10 per cent of the national population, but do not necessarily represent 10 per cent of the population in each State or Territory. Excludes people for whom information was missing and/or not reported.

(b) Disaggregation by SEIFA is based on a person's usual residence, not the location of the service provider.

(c) Rates are age-standardised to the Australian population as at 30 June 2001.

(d) Victoria did not submit data for 2011–12 due to significantly reduced collection rates arising from industrial action during the period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data.

na Not available. – Nil or rounded to zero.

Source: State and Territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management Service data; Health unpublished, MBS Statistics; DVA unpublished, data; ABS unpublished, Estimated Resident Population, 30 June 2011.

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2007-08										
Public (b)										
Number	no.	108 755	57 197	75 541	37 566	27 793	9 499	6 801	4 721	327 873
Rate	%	1.6	1.1	1.9	1.8	1.8	2.0	1.9	2.2	1.6
Private (c)										
Number	no.	7 256	6 170	4 791	2 183	np	np	np	..	23 044
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	349 679	287 210	189 005	87 638	75 116	20 527	14 163	3 981	1 027 330
Rate: Total MBS and DVA (d)	%	5.1	5.5	4.6	4.1	4.8	4.3	4.0	1.8	4.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4
Rate: Clinical psychologist (f)	%	0.6	0.6	0.4	1.0	0.7	0.9	0.6	0.1	0.6
Rate: GP (g)	%	3.7	4.0	3.2	3.0	3.2	3.2	2.8	1.4	3.5
Rate: Other allied health (h)	%	1.4	1.8	1.4	0.6	0.9	1.1	1.2	0.4	1.3
2008-09										
Public (b)										
Number	no.	113 759	57 860	72 989	39 547	30 423	9 362	7 348	5 008	336 296
Rate	%	1.7	1.1	1.7	1.8	2.0	1.9	2.1	2.2	1.6
Private (c)										
Number	no.	7 575	6 308	5 270	2 629	np	np	np	..	24 348
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS and DVA										
Number: Total MBS and DVA (d)	no.	419 027	346 064	235 222	107 077	91 841	24 501	17 119	5 104	1 247 142
Rate: Total MBS and DVA (d)	%	6.0	6.6	5.6	4.9	5.8	5.1	4.8	2.3	5.9
Rate: Psychiatrist (e)	%	1.4	1.5	1.3	1.1	1.6	1.0	1.1	0.4	1.4

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Rate: Clinical psychologist (f)	%	0.8	0.8	0.6	1.2	1.1	1.2	0.7	0.2	0.8
Rate: GP (g)	%	4.6	4.9	4.2	3.7	4.2	3.9	3.4	1.9	4.4
Rate: Other allied health (h)	%	1.7	2.3	1.8	0.8	1.1	1.3	1.5	0.5	1.7
2009-10										
Public (b)										
Number	no.	113 875	59 080	72 232	42 271	30 818	7 425	7 639	5 830	339 170
Rate	%	1.6	1.1	1.7	1.9	2.0	1.5	2.1	2.5	1.6
Private (c)										
Number	no.	8 145	6 544	5 392	3 047	np	np	np	..	25 536
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		460 708	385 085	265 357	119 533	103 225	27 741	18 871	6 146	1 387 297
Rate: Total MBS and DVA (d)		6.6	7.2	6.1	5.3	6.5	5.7	5.2	2.7	6.4
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.7	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.0	1.0	0.7	1.4	1.3	1.3	0.9	0.3	1.0
Rate: GP (g)		5.0	5.4	4.7	4.0	4.7	4.3	3.7	2.2	4.8
Rate: Other allied health (h)		2.0	2.6	2.1	1.0	1.2	1.5	1.7	0.7	2.0
2010-11										
Public (b)										
Number	no.	115 090	59 696	77 036	44 493	31 434	8 923	8 076	5 840	350 588
Rate	%	1.6	1.1	1.8	2.0	2.0	1.8	2.2	2.4	1.6
Private (c)										
Number	no.	8 354	7 692	5 673	3 250	np	np	np	..	27 924
Rate	%	0.1	0.1	0.1	0.1	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		511 672	426 982	300 311	131 892	115 088	31 175	20 838	6 775	1 544 744

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Rate: Total MBS and DVA (d)		7.2	7.8	6.8	5.7	7.1	6.4	5.6	2.9	7.0
Rate: Psychiatrist (e)		1.4	1.5	1.3	1.1	1.6	1.1	1.2	0.4	1.4
Rate: Clinical psychologist (f)		1.1	1.1	0.9	1.4	1.7	1.4	1.2	0.3	1.1
Rate: GP (g)		5.6	6.1	5.4	4.4	5.4	5.0	4.2	2.4	5.5
Rate: Other allied health (h)		2.3	2.8	2.3	1.2	1.4	1.9	1.7	0.7	2.2
2011-12										
Public (b)										
Number	no.	116 194	na	81 228	46 907	33 791	7 841	8 385	6 580	300 926
Rate	%	1.6	na	1.8	2.0	2.1	1.6	2.2	2.7	1.8
Private (c)										
Number	no.	9 537	8 301	6 578	3 616	np	np	np	..	30 640
Rate	%	0.1	0.1	0.1	0.2	np	np	np	..	0.1
MBS										
Number: Total MBS and DVA (d)		522 941	442 667	311 834	130 752	116 679	31 016	21 466	6 992	1 584 399
Rate: Total MBS and DVA (d)		7.3	8.0	7.0	5.5	7.2	6.3	5.7	3.0	7.1
Rate: Psychiatrist (e)		1.4	1.5	1.4	1.1	1.6	1.1	1.1	0.4	1.4
Rate: Clinical psychologist (f)		1.2	1.3	1.0	1.5	1.9	1.5	1.5	0.4	1.3
Rate: GP (g)		5.4	5.9	5.1	4.0	5.2	4.6	4.1	2.4	5.2
Rate: Other allied health (h)		2.3	2.9	2.4	1.2	1.5	2.0	1.6	0.7	2.3

(a) Rates are age-standardised to the Australian population as at 30 June 2001.

(b) Caution needs to be taken when making inter-jurisdictional comparisons. South Australia submitted data that were not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of the 2011-12 data. Australian totals for 2011-12 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 should not be compared to previous years.

(c) Private psychiatric hospital figures are not published for SA, Tasmania, and the ACT due to confidentiality reasons but are included in the Australia totals.

Table 12A.30 **Proportion of people receiving clinical mental health services by service type (a)**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust

(d) MBS and DVA services are those provided under any of the Medicare/DVA-funded service types described at (e) to (h). People seen by more than one provider type are counted only once in the total.

(e) Consultant psychiatrist services are MBS items 134, 136, 138, 140, 142, 289, 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326, 328, 330, 332, 334, 336, 338, 342, 344, 346, 348, 350, 352, 353, 355, 356, 357, 358, 359, 361, 364, 366, 367, 369, 370, 855, 857, 858, 861, 864, 866, 14224 (as relevant across years).

(f) Clinical psychologist services are MBS items 80000, 80005, 80010, 80015, 80020 and and DVA items US01, US02, US03, US04, US05, US06, US07, US08, US50, US51, US99.

(g) GP services are MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727, 20104 (as relevant across years).

(h) Other allied health services are MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015 and DVA items CL20, CL25, CL30, US11, US12, US13, US14, US15, US16, US17, US18, US21, US22, US23, US24, US25, US26, US27, US31, US32, US33, US34, US35, US36, US37, US52, US53, US96, US97, US98 (as relevant across years).

.. Not applicable. **np** Not published.

Source: State and territory unpublished, community mental health care data; Private Mental Health Alliance unpublished; Centralised Data Management Service data; Department of Health unpublished, DVA unpublished; MBS Statistics; ABS unpublished, Estimated Residential Population, 30 June (prior to relevant period).

Table 12A.31 Services used for mental health problems, Australia, 2007 (per cent) (a), (b)

	With lifetime mental disorder		*No lifetime mental disorder* (e)	*Total*
	Symptoms in previous 12 months (c)	*No symptoms in previous 12 months* (d)		
GP	24.7 ± 2.4	6.2 ± 1.5	2.8 ± 0.9	8.1 ± 0.7
Psychiatrist	7.9 ± 2.7	1.4 ± 0.7	0.6 ± 0.3	2.3 ± 0.6
Psychologist	13.2 ± 2.1	1.8 ± 0.6	0.8 ± 0.3	3.5 ± 0.5
Other mental health professional	7.7 ± 1.6	1.5 ± 0.5	np	2.2 ± 0.4
Other health professional	6.6 ± 1.6	2.1 ± 1.0	1.0 ± 0.4	2.4 ± 0.5
Hospitalisation	2.6 ± 1.1	np	np	0.7 ± 0.3
Total who used health services	34.9 ± 3.1	9.2 ± 1.8	4.7 ± 1.1	11.9 ± 0.9
Total who did not use services for mental health	65.1 ± 3.1	90.8 ± 1.8	95.2 ± 1.1	88.1 ± 0.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.32 Services used for mental health, by mental disorder status, 2007 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Total who used services for mental health in previous 12 months (c)									
Any 12-month mental disorder (d)	32.5 ± 6.4	37.0 ± 7.1	34.4 ± 7.0	35.8 ± 10.5	35.2 ± 9.1	np	np	np	34.9 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	7.6 ± 2.0	11.5 ± 4.0	9.0 ± 3.3	7.4 ± 3.6	np	np	np	np	9.2 ± 1.8
No lifetime mental disorder (f)	np	4.6 ± 1.8	5.6 ± 1.8	4.8 ± 2.3	np	np	np	np	4.7 ± 1.1
Total	**10.9 ± 1.8**	**13.1 ± 2.2**	**12.1 ± 2.0**	**12.0 ± 2.5**	**11.0 ± 2.7**	**np**	**np**	**np**	**11.9 ± 0.9**
Total who did not use services for mental health in previous 12 months									
Any 12-month mental disorder (d)	67.5 ± 6.4	63.0 ± 7.1	65.6 ± 7.0	64.2 ± 10.5	64.8 ± 9.1	65.5 ± 23.2	np	np	65.1 ± 3.1
Lifetime mental disorder, with no 12-month symptoms (e)	92.4 ± 2.0	88.5 ± 4.0	91.0 ± 3.3	92.6 ± 3.6	90.3 ± 5.7	87.8 ± 13.3	np	np	90.8 ± 1.8
No lifetime mental disorder (f)	95.4 ± 2.3	95.4 ± 1.8	94.4 ± 1.8	95.2 ± 2.3	96.1 ± 2.8	95.2 ± 7.1	np	np	95.2 ± 1.1
Total	**89.1 ± 1.8**	**86.9 ± 2.2**	**87.9 ± 2.0**	**88.0 ± 2.5**	**88.6 ± 2.8**	**88.7 ± 6.9**	**81.6 ± 12.2**	**95.3 ± 6.2**	**88.1 ± 0.9**

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) Includes hospitalisations.

(d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.33 Young people who had contact with MBS-subsidised primary mental health care services, by age group

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2010-11										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	1 824	1 627	825	415	496	65	46	17	5 320
Primary school (5-<12 years)	no.	19 915	17 630	11 791	4 700	4 745	1 092	734	199	60 850
Secondary school (12-<18 years)	no.	27 156	23 230	16 698	6 884	6 218	1 837	1 275	331	83 670
Youth/young adult (18-<25 years)	no.	49 329	41 811	29 956	13 691	11 617	3 745	2 489	726	153 416
All children and young people aged <25 years	**no.**	**98 224**	**84 298**	**59 269**	**25 690**	**23 076**	**6 739**	**4 545**	**1 274**	**303 256**
Number of people (g)										
Pre-school (0-<5 years)	no.	473 653	350 919	303 288	154 374	97 349	32 145	23 886	18 489	1 454 240
Primary school (5-<12 years)	no.	622 167	459 508	406 343	203 932	133 261	44 144	29 797	24 270	1 923 685
Secondary school (12-<18 years)	no.	542 161	407 788	356 207	180 515	122 233	40 625	26 481	19 513	1 695 748
Youth/young adult (18-<25 years)	no.	686 620	558 154	441 439	237 447	158 157	45 750	44 598	26 121	2 198 653
All children and young people aged <25 years	**no.**	**2 324 601**	**1 776 369**	**1 507 277**	**776 268**	**511 000**	**162 664**	**124 762**	**88 393**	**7 272 326**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.4	0.5	0.3	0.3	0.5	0.2	0.2	0.1	0.4
Primary school (5-<12 years)	%	3.2	3.8	2.9	2.3	3.6	2.5	2.5	0.8	3.2
Secondary school (12-<18 years)	%	5.0	5.7	4.7	3.8	5.1	4.5	4.8	1.7	4.9
Youth/young adult (18-<25 years)	%	7.2	7.5	6.8	5.8	7.3	8.2	5.6	2.8	7.0
All children and young people aged <25 years	**%**	**4.2**	**4.7**	**3.9**	**3.3**	**4.5**	**4.1**	**3.6**	**1.4**	**4.2**
2011-12										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	2 038	1 792	914	462	484	81	63	20	5 858
Primary school (5-<12 years)	no.	22 528	20 999	13 806	5 219	5 232	1 257	801	257	70 153
Secondary school (12-<18 years)	no.	30 360	26 529	18 755	7 650	6 830	2 114	1 354	394	94 039
Youth/young adult (18-<25 years)	no.	53 711	45 944	33 039	14 392	12 588	3 811	2 734	851	167 143

Table 12A.33 **Young people who had contact with MBS-subsidised primary mental health care services, by age group**

	Unit	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
All children and young people aged <25 years	**no.**	**108 638**	**95 264**	**66 514**	**27 724**	**25 134**	**7 263**	**4 953**	**1 523**	**337 193**
Number of people (g)										
Pre-school (0-<5 years)	no.	473 835	354 162	307 175	158 723	98 116	31 867	24 406	18 474	1 466 902
Primary school (5-<12 years)	no.	622 766	462 730	411 074	207 812	132 686	43 470	30 182	24 261	1 935 222
Secondary school (12-<18 years)	no.	541 296	407 143	358 149	182 726	121 664	40 415	26 165	19 397	1 697 163
Youth/young adult (18-<25 years)	no.	686 756	557 458	446 308	241 859	157 848	45 271	44 566	25 660	2 206 069
All children and young people aged <25 years	**no.**	**2 324 653**	**1 781 493**	**1 522 706**	**791 120**	**510 314**	**161 023**	**125 319**	**87 792**	**7 305 356**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.4	0.5	0.3	0.3	0.5	0.3	0.3	0.1	0.4
Primary school (5-<12 years)	%	3.6	4.5	3.4	2.5	3.9	2.9	2.7	1.1	3.6
Secondary school (12-<18 years)	%	5.6	6.5	5.2	4.2	5.6	5.2	5.2	2.0	5.5
Youth/young adult (18-<25 years)	%	7.8	8.2	7.4	6.0	8.0	8.4	6.1	3.3	7.6
All children and young people aged <25 years	**%**	**4.7**	**5.3**	**4.4**	**3.5**	**4.9**	**4.5**	**4.0**	**1.7**	**4.6**
2012-13										
Number of contacts with MBS-subsidised primary mental health services (a), (b), (c), (d), (e), (f)										
Pre-school (0-<5 years)	no.	2 374	2 139	1 203	468	557	66	43	17	6 877
Primary school (5-<12 years)	no.	25 922	24 797	16 465	6 065	5 852	1 464	911	263	81 837
Secondary school (12-<18 years)	no.	35 434	31 391	22 701	9 662	7 909	2 486	1 760	396	111 839
Youth/young adult (18-<25 years)	no.	60 738	51 252	38 012	15 759	13 677	4 300	3 193	954	187 991
All children and young people aged <25 years	**no.**	**124 469**	**109 579**	**78 381**	**31 954**	**27 995**	**8 316**	**5 907**	**1 630**	**388 544**
Number of people (g)										
Pre-school (0-<5 years)	no.	476 842	364 084	312 021	165 094	99 518	31 469	25 615	18 749	1 493 548
Primary school (5-<12 years)	no.	637 143	476 560	424 047	217 047	135 270	43 817	31 283	24 597	1 990 004
Secondary school (12-<18 years)	no.	542 580	407 250	361 375	185 460	121 123	39 945	26 219	19 521	1 703 688
Youth/young adult (18-<25 years)	no.	692 623	559 619	455 615	248 338	157 643	45 028	44 104	25 825	2 229 099

Table 12A.33 Young people who had contact with MBS-subsidised primary mental health care services, by age group

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
All children and young people aged <25 years	**no.**	**2 349 188**	**1 807 513**	**1 553 058**	**815 939**	**513 554**	**160 259**	**127 221**	**88 692**	**7 416 339**
Proportion of population who had contact with MBS-subsidised primary mental health services										
Pre-school (0-<5 years)	%	0.5	0.6	0.4	0.3	0.6	0.2	0.2	0.1	0.5
Primary school (5-<12 years)	%	4.1	5.2	3.9	2.8	4.3	3.3	2.9	1.1	4.1
Secondary school (12-<18 years)	%	6.5	7.7	6.3	5.2	6.5	6.2	6.7	2.0	6.6
Youth/young adult (18-<25 years)	%	8.8	9.2	8.3	6.3	8.7	9.5	7.2	3.7	8.4
All children and young people aged <25 years	**%**	**5.3**	**6.1**	**5.0**	**3.9**	**5.5**	**5.2**	**4.6**	**1.8**	**5.2**

(a) Totals do not equal the sum of all MBS-subsidised mental health service providers as data excludes psychiatrists

(b) Data are based on the date the claim was processed.

(c) Age of the patient is based on age at 30 June of the reference period.

(d) A person is counted if any mental health item has been used in the reference period, excluding psychiatrists.

(e) A patient is allocated to a state/territory based on their location as at the last service in the reference period.

(f) The allocation to the state or territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.

(g) The population data represent the mid-point of the relevant financial year. For 2012-13 data, the mid-point is December 2012. Estimated Resident Populations (ERPs) used to derive the 2010-11 rates (December 2010) are revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details

Source: Department of Health unpublished; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 12A.34 Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a), (b)

		NSW (c)	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Expenditure on services assessed at level 1										
2006	$'000	641 641	574 931	380 642	129 288	153 479	32 236	36 950	22 820	1 971 986
2007	$'000	556 183	586 248	410 814	95 750	190 360	33 997	46 838	25 537	1 945 727
2008	$'000	770 511	635 893	526 682	134 530	104 592	42 635	48 458	28 062	2 291 362
2009	$'000	880 733	681 385	586 763	187 961	100 433	50 559	54 558	30 202	2 572 592
2010	$'000	851 044	714 515	611 262	178 483	270 545	16 252	54 835	32 326	2 729 262
2011	$'000	920 824	762 949	699 580	212 630	276 680	45 469	57 536	35 230	3 010 898
2012	$'000	904 272	525 579	759 987	299 748	124 058	–	62 122	39 291	2 715 056
Expenditure on services assessed at level 2										
2006	$'000	–	–	602	12 993	2 013	11 126	–	–	26 734
2007	$'000	18 413	–	236	168 105	1 409	3 363	–	–	191 526
2008	$'000	33 962	190	1 770	170 831	1 594	–	–	–	208 347
2009	$'000	44 946	70	1 234	171 349	1 175	6 171	–	–	224 946
2010	$'000	217 392	4 117	1 671	174 807	–	–	–	–	397 987
2011	$'000	236 547	86	–	–	–	49 232	–	–	285 866
2012	$'000	60 110	272	1 330	53 701	157 099	–	–	–	272 511
Expenditure on services assessed at level 3										
2006	$'000	94 363	18 628	14 377	147 659	42 422	14 212	–	–	331 661
2007	$'000	220 311	13 383	51 891	45 173	31 781	8 970	–	–	371 509
2008	$'000	63 334	148	16 771	38 271	135 413	18 753	–	–	272 689
2009	$'000	71 549	21 630	1 772	16 283	164 555	21 880	–	–	297 669
2010	$'000	486	23 010	52 296	38 423	2 116	74 572	–	–	190 903
2011	$'000	490	16 128	3 692	124 290	10 518	–	–	–	155 119
2012	$'000	174 141	15 709	–	84 463	–	88 003	–	–	362 317
Expenditure on services assessed at level 4										
2006	$'000	46 246	1 073	4 326	–	1 418	2 328	–	–	55 391
2007	$'000	61 105	1 107	3 694	–	2 180	24 165	–	–	92 252
2008	$'000	37 887	4 911	462	2 220	3 507	16 235	–	–	65 223
2009	$'000	3 107	4 143	655	6 304	2 220	2 653	–	–	19 082
2010	$'000	12 602	8 940	815	7 927	6 611	–	–	–	36 895
2011	$'000	12 111	15 616	1 971	98 024	1 124	–	–	–	128 846
2012	$'000	101 544	287 982	926	38 667	16 194	–	–	–	445 313
Expenditure on specialised public mental health services										
2006	$'000	782 250	594 633	399 947	289 939	199 332	59 901	36 950	22 820	2 385 771
2007	$'000	856 012	600 739	466 636	309 027	225 730	70 494	46 838	25 537	2 601 014
2008	$'000	905 693	641 143	545 686	345 852	245 106	77 623	48 458	28 062	2 837 621
2009	$'000	1 000 336	707 227	590 424	381 897	268 383	81 263	54 558	30 202	3 114 289
2010	$'000	1 081 524	750 582	666 043	399 640	279 273	90 824	54 835	32 326	3 355 046
2011	$'000	1 169 972	794 780	705 243	434 944	288 323	94 701	57 536	35 230	3 580 728
2012	$'000	1 240 067	829 543	762 243	476 579	297 351	88 003	62 122	39 291	3 795 198
Per cent of expenditure on services assessed at level 1										
2006	%	82.0	96.7	95.2	44.6	77.0	53.8	100.0	100.0	82.7

Table 12A.34 **Specialised public mental health services reviewed against National Standards for Mental Health Services, 30 June (a), (b)**

		NSW (c)	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2007	%	65.0	97.6	88.0	31.0	84.3	48.2	100.0	100.0	74.8
2008	%	85.1	99.2	96.5	38.9	42.7	54.9	100.0	100.0	80.7
2009	%	88.0	96.3	99.4	49.2	37.4	62.2	100.0	100.0	82.6
2010	%	78.7	95.2	91.8	44.7	96.9	17.9	100.0	100.0	81.3
2011	%	78.7	96.0	99.2	48.9	96.0	48.0	100.0	100.0	84.1
2012	%	72.9	63.4	99.7	62.9	41.7	–	100.0	100.0	71.5
Per cent of expenditure on services assessed at level 2										
2006	%	–	–	0.2	4.5	1.0	18.6	–	–	1.1
2007	%	2.2	–	0.1	54.4	0.6	4.8	–	–	7.4
2008	%	3.7	–	0.3	49.4	0.7	–	–	–	7.3
2009	%	4.5	–	0.2	44.9	0.4	7.6	–	–	7.2
2010	%	20.1	0.5	0.3	43.7	–	–	–	–	11.9
2011	%	20.2	–	–	–	–	52.0	–	–	8.0
2012	%	4.8	–	0.2	11.3	52.8	–	–	–	7.2
Per cent of expenditure on services assessed at level 3										
2006	%	12.1	3.1	3.6	50.9	21.3	23.7	–	–	13.9
2007	%	25.7	2.2	11.1	14.6	14.1	12.7	–	–	14.3
2008	%	7.0	–	3.1	11.1	55.2	24.2	–	–	9.6
2009	%	7.2	3.1	0.3	4.3	61.3	26.9	–	–	9.6
2010	%	–	3.1	7.9	9.6	0.8	82.1	–	–	5.7
2011	%	–	2.0	0.5	28.6	3.6	–	–	–	4.3
2012	%	14.0	1.9	–	17.7	–	100.0	–	–	9.5
Per cent of expenditure on services assessed at level 4										
2006	%	5.9	0.2	1.1	–	0.7	3.9	–	–	2.3
2007	%	7.1	0.2	0.8	–	1.0	34.3	–	–	3.5
2008	%	4.2	0.8	0.1	0.6	1.4	20.9	–	–	2.3
2009	%	0.3	0.6	0.1	1.7	0.8	3.3	–	–	0.6
2010	%	1.2	1.2	0.1	2.0	2.4	–	–	–	1.1
2011	%	1.0	2.0	0.3	22.5	0.4	–	–	–	3.6
2012	%	8.2	34.7	0.1	8.1	5.4	–	–	–	11.7

(a) Data for all years (other than 2012) have been revised as this indicator is reported for the first time in this Report weighted by expenditure.

(b) There is variation across jurisdictions in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some jurisdictions, if an organisation with multiple service units is assessed at a particular level all the expenditure on the organisation's units is 'counted' at that assessment level. In other jurisdictions, assessment levels are assigned at the service unit and this may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.

(c) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

– Nil or rounded to zero.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.35 **Recurrent expenditure on community-based services as a proportion of total spending on mental health services (per cent) (a), (b), (c)**

	NSW (d)	*Vic*	*Qld* (e)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2005-06	43.5	63.5	43.3	51.3	45.1	62.4	79.2	60.4	51.0
2006-07	43.7	63.3	48.1	52.0	45.6	59.3	73.3	65.7	51.5
2007-08	46.1	62.6	49.1	53.1	47.9	57.8	71.5	64.0	52.4
2008-09	44.5	62.6	51.8	53.6	49.9	57.7	74.2	62.6	52.7
2009-10	44.6	62.8	54.0	54.4	52.4	54.8	74.7	65.4	53.4
2010-11	44.1	63.2	55.5	53.4	56.5	56.5	73.2	64.3	53.8
2011-12	43.5	64.2	56.3	53.4	58.8	56.8	74.4	63.9	54.2

(a) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure estimates.

(b) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(c) Recurrent expenditure exclude indirect and aged care residential expenditure.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

(e) Queensland does not fund community-based residential services, but funds extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.36 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

	Unit	*NSW*	*Vic* (c)	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT*	*NT*	*Aust* (c)
2007-08										
Group A: People discharged from hospital (d)										
	no.	5 989	3 740	4 419	2 564	2 657	324	40	92	19 825
	%	29.7	28.0	42.0	43.0	50.4	19.7	4.6	16.1	34.0
Group B: People discharged from community care (e)										
	no.	2 126	3 938	6 065	1 196	1 457	366	–	51	15 199
	%	12.0	33.9	39.5	21.5	30.4	22.3	–	6.2	25.7
Group C: People in ongoing community care (f)										
	no.	5 073	5 307	5 917	2 760	3 097	705	159	305	23 323
	%	16.5	27.4	31.5	26.1	39.7	19.3	5.6	23.3	24.8
2008-09										
Group A: People discharged from hospital (d)										
	no.	5 605	6 350	2 205	2 944	2 360	321	46	104	19 935
	%	27.8	47.8	20.6	47.9	46.3	20.2	4.9	18.2	34.0
Group B: People discharged from community care (e)										
	no.	1 985	6 804	3 577	1 162	1 420	305	–	25	15 278
	%	10.3	62.3	19.3	18.8	27.2	21.2	–	3.3	23.7
Group C: People in ongoing community care (f)										
	no.	5 108	6 472	5 759	3 558	3 340	712	175	383	25 507
	%	16.1	34.0	34.0	30.9	37.7	21.3	5.6	25.0	27.1
2009-10										
Group A: People discharged from hospital (d)										
	no.	6 146	7 845	1 736	2 945	2 490	316	67	146	21 691
	%	30.2	55.7	16.2	44.4	46.9	np	7.6	26.3	36.5
Group B: People discharged from community care (e)										
	no.	2 024	8 618	2 706	1 329	1 510	291	–	48	16 526
	%	9.9	77.3	17.7	20.6	28.9	24.0	–	6.0	27.0
Group C: People in ongoing community care (f)										
	no.	5 943	7 895	6 544	4 064	3 201	685	335	396	29 063
	%	17.5	44.1	32.0	35.0	36.3	30.1	10.0	23.8	29.4
2010-11										
Group A: People discharged from hospital (d)										
	no.	5 937	8 249	2 515	3 236	2 288	443	87	200	22 955
	%	30.1	57.1	22.6	45.3	39.3	30.8	8.9	34.6	37.5
Group B: People discharged from community care (e)										
	no.	2 309	10 243	3 537	1 351	1 473	583	–	50	19 546
	%	11.0	80.4	21.7	18.4	25.2	39.2	–	6.6	28.6
Group C: People in ongoing community care (f)										
	no.	6 020	8 165	7 146	4 453	3 150	703	466	354	30 457
	%	18.1	45.7	35.1	36.3	36.3	31.8	13.8	20.3	30.8

Table 12A.36 Specialised public mental health services episodes with completed consumer outcomes measures collected (a), (b)

	Unit	NSW	Vic (c)	Qld	WA	SA	Tas (c)	ACT	NT	Aust (c)
2011-12 (c)										
Group A: People discharged from hospital (d)										
	no.	6 095	na	3 377	3 614	2 307	774	33	223	16 423
	%	29.4	na	28.8	49.5	42.5	52.8	3.3	36.2	34.0
Group B: People discharged from community care (e)										
	no.	2 501	na	3 227	1 332	1 438	294	–	48	8 840
	%	12.7	na	18.1	16.7	22.6	17.7	–	5.1	15.9
Group C: People in ongoing community care (f)										
	no.	7 498	na	7 133	3 651	3 200	541	276	402	22 701
	%	21.1	na	34.1	29.1	34.8	23.3	7.8	19.7	26.5

(a) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. To be counted as an episode for which consumer outcome measures are collected, data need to be completed correctly (a specified minimum number of items completed) and have a 'matching pair' — that is, a beginning and end rating are needed to enable an outcome score to be determined.

(b) Estimates of the number of episodes with complete outcome data for state and territory mental health services for all years are based on a revised analytic approach that compares the number of episodes with 'matched pairs' outcomes data to data submitted for the various mental health National Minimum Data Sets. This approach provides more robust estimates than published in previous years.

(c) Data are not available for Victoria for 2011-12. All totals for 2011-12 exclude Victoria. Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 data.

(d) Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

(e) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.

(f) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

na Not available. – Nil or rounded to zero. **np** Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.37 **Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days) (a), (b)**

	NSW (c)	*Vic* (d)	*Qld*	*WA* (e)	*SA* (f), (g)	*Tas* (h)	*ACT* (i), (j), (k)	*NT* (l)	*Aust*
2008-09	11.0	18.8	18.2	15.3	na	15.4	13.3	na	15.5
2009-10	11.5	19.4	15.0	11.6	7.6	11.5	1.7	22.9	13.5
2010-11	9.4	15.1	17.2	8.3	7.7	14.7	0.7	20.6	11.8
2011-12	9.2	13.3	13.3	4.7	10.1	11.9	1.3	25.7	10.4
2012-13	8.5	10.9	12.7	6.0	9.1	19.7	0.9	15.8	9.6

(a) Data are from a number of ad hoc seclusion data collections for specialised mental health public acute hospital services conducted by the Safety and Quality Partnership Standing Committee (SQPSC), of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC), in partnership with the relevant state and territory authorities for presentation at benchmarking forums. State and territory governments have agreed to the report these data because of their importance to the consumers, carers, policy makers, stakeholders and the general public (AIHW 2013).

(b) Variation in jurisdictional legislation may result in differences in the definition of a seclusion event. Data reported by jurisdictions may therefore vary and comparisons should therefore be made with caution.

(c) NSW does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors. Seclusion rates are a Key Performance Indicator (KPI) in regular performance reporting to NSW Local Health Districts.

(d) For Victoria, both the National Beacon Projects and the Creating Safety Project supported Victorian services to review their use of seclusion and employ different strategies to support reduction, with targets set in the Statement of Priorities to support health services reduce seclusion events. In Victoria, variation between health services will improve over time, with a new Mental Health Act being developed and a reduction in the use of restrictive practices.

(e) For WA, it does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases.

(f) For SA, data reporting improvements over the past few years will affect SA data. Importantly, the number of bed days is an estimate which affects the rate of seclusion reported for South Australia and fluctuations in bed numbers related to new infrastructure projects. During 2010-11, a substantial number of seclusion events in one particular hospital were for a single patient and over half of those were patient-requested events. This may have impacted on the overall seclusion rate reported for the state for 2010-11.

(g) For 2008-09, SA was unable to supply seclusion data.

(h) The increase in the state-wide Tasmanian seclusion rate for 2012-13 data is due to a small number of clients having an above average number of seclusion events.

(i) For the ACT, when interpreting these data, the relative small size of the Australian Capital Territory should be noted, with a total of between 60 and 65 acute inpatient beds reported between 2008-09 and 2011-12.

(j) ACT activities initiated as part of the Beacon Site project included the implementation of a clinical review committee inclusive of clinical staff, consumers and carer representation to review episodes of seclusion for systemic issues on a case-by-case basis. This has led to a number of reforms over several years that have had a direct impact on the use of seclusion and its reduction to the low levels now reported.

(k) In the ACT, work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.

(l) The NT, was unable to supply seclusion data for 2008-09.

Table 12A.37 **Rate of seclusion in public specialised mental health acute inpatient units (per 1000 patient days) (a), (b)**

	NSW (c)	*Vic* (d)	*Qld*	*WA* (e)	*SA* (f), (g)	*Tas* (h)	*ACT* (i), (j), (k)	*NT* (l)	*Aust*

na Not available.

Source: AIHW 2013, *Mental Health Services in Australia* Online, mhsa.aihw.gov.au/home/ (accessed 16 September and 28 November 2013).

Table 12A.38 Consumer and carer participation (a), (b), (c)

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*
Number of consumer and carer consultants (h)									
Number of paid consumer workers (FTE)									
2005-06	27.3	19.6	9.8	0.5	2.8	–	1.3	–	61.3
2006-07	24.8	19.0	10.3	0.8	2.1	–	–	–	57.0
2007-08	27.9	20.0	9.7	1.2	4.7	–	–	–	63.5
2008-09	23.5	17.1	13.6	3.6	6.3	0.5	–	–	64.6
2009-10	21.5	17.7	14.1	5.1	5.7	0.5	–	–	64.6
2010-11	20.5	17.9	17.8	3.3	8.4	0.5	–	–	68.5
2011-12	23.9	19.1	19.5	2.0	8.2	1.5	–	–	74.2
Number of paid carer workers (FTE)									
2005-06	2.7	11.7	0.4	–	–	–	–	–	14.8
2006-07	8.6	13.6	0.9	–	–	–	–	–	23.1
2007-08	7.0	15.5	1.5	0.8	1.8	–	–	–	26.6
2008-09	10.3	14.3	2.7	0.5	2.4	0.5	–	–	30.6
2009-10	13.7	15.8	4.8	1.0	1.5	0.5	–	–	37.3
2010-11	13.7	17.9	5.3	1.0	5.0	0.5	–	–	43.4
2011-12	15.9	18.5	6.4	0.2	4.2	0.6	–	–	45.8
Number of paid direct care, consumer and carer worker positions (FTE)									
2005-06	6 494.5	5 270.0	3 633.8	2 332.3	1 691.3	607.7	331.3	151.9	20 512.8
2006-07	6 732.0	5 338.0	3 875.8	2 427.1	1 800.9	656.2	321.8	158.5	21 310.3
2007-08	6 777.3	5 440.8	4 233.4	2 537.7	1 963.3	639.7	314.7	167.5	22 074.4
2008-09	7 025.6	5 634.4	4 405.7	2 670.5	1 977.3	652.6	313.8	193.3	22 873.2
2009-10	7 357.2	5 703.9	4 361.7	2 724.8	2 025.3	682.5	334.5	196.3	23 386.1
2010-11	7 610.2	5 912.7	4 694.2	2 856.0	2 121.6	687.3	338.4	205.3	24 425.6
2011-12	7 903.9	6 049.5	4 991.9	3 017.4	2 037.6	646.8	345.1	216.1	25 208.1

Table 12A.38 **Consumer and carer participation (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*
Paid consumer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (g)									
2005-06	4.2	3.7	2.7	0.2	1.7	–	3.9	–	3.0
2006-07	3.7	3.6	2.7	0.3	1.2	–	–	–	2.7
2007-08	4.1	3.7	2.3	0.5	2.4	–	–	–	2.9
2008-09	3.3	3.0	3.1	1.4	3.2	0.8	–	–	2.8
2009-10	2.9	3.1	3.2	1.9	2.8	0.7	–	–	2.8
2010-11	2.7	3.0	3.8	1.2	4.0	0.7	–	–	2.8
2011-12	3.0	3.2	3.9	0.7	4.0	2.3	–	–	2.9
Paid carer workers (FTE) per 1000 paid direct care, consumer and carer staff (FTE) (g)									
2005-06	0.4	2.2	0.1	–	–	–	–	–	0.7
2006-07	1.3	2.5	0.2	–	–	–	–	–	1.1
2007-08	1.0	2.9	0.4	0.3	0.9	–	–	–	1.2
2008-09	1.5	2.5	0.6	0.2	1.2	0.8	–	–	1.3
2009-10	1.9	2.8	1.1	0.4	0.8	0.7	–	–	1.6
2010-11	1.8	3.0	1.1	0.4	2.4	0.7	–	–	1.8
2011-12	2.0	3.1	1.3	0.1	2.1	0.9	–	–	1.8

(a) Non-government organisations are included only where they provide staffed residential services.

(b) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of relevant items.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) NSW advised that the government has no authority to require consumer participation in services delivered through the primary care program.

(e) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year.

Table 12A.38 **Consumer and carer participation (a), (b), (c)**

	NSW (d), (e)	*Vic*	*Qld*	*WA* (f)	*SA*	*Tas*	*ACT* (g)	*NT* (g)	*Aust*

(f) WA has advised that this information does not represent the full range of consumer and carer participation. Genuine engagement with consumers and carers is one of the key principles of the Mental Health Commission's Strategic Policy document Mental Health 2020. The Commission has allocated funding to establish and support Consumers of Mental Health WA Inc., a peak body that provides systemic advocacy and is run for and by consumers. Other examples include provision of funding to develop the capacity of non government organisations to employ people with a lived experience of mental illness and awarding scholarships to people with a lived experience to complete approved university and polytechnic studies in mental health. Several key consumer and carer advisory groups are supported and provided with financial assistance and collectively, these groups provide advice and representations on consumer and carer issues. The Commission funds Carers Association of WA for the provision of systemic advocacy services and the Mental Health Carers ARAFMI (WA) for a range of services including individual advocacy.

(g) Consumer and carer workers are not employed in the ACT (except in 2005-06) and the NT.

(h) Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 with data from 2010-11 should not be made.

– Nil or rounded to zero.

Source : AIHW unpublished, derived from the MHE NMDS.

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
2005-06										
Overnight separations from acute psychiatric inpatient services	no.	24 891	14 957	14 326	6 275	5 352	2 617	1 136	1 092	70 646
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 695	8 938	6 488	2 715	1 611	na	769	370	31 586
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.0	59.8	45.3	43.3	30.1	na	67.7	33.9	44.7
2006-07										
Overnight separations from acute psychiatric inpatient services	no.	26 656	15 602	13 534	6 051	5 430	2 381	1 100	997	71 751
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 539	9 303	6 833	2 772	1 532	na	759	447	33 185
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	43.3	59.6	50.5	45.8	28.2	na	69.0	44.8	46.3
2007-08										
Overnight separations from acute psychiatric inpatient services	no.	27 103	16 400	13 600	5 902	5 590	2 116	1 148	946	72 805
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	10 856	9 803	7 094	2 789	1 941	433	827	429	34 172

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	40.1	59.8	52.2	47.3	34.7	20.5	72.0	45.3	46.9
2008-09										
Overnight separations from acute psychiatric inpatient services	no.	27 035	16 429	14 147	6 318	5 435	2 121	1 233	894	73 612
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 078	10 132	6 228	3 064	2 222	461	901	414	34 500
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	41.0	61.7	44.0	48.5	40.9	21.7	73.1	46.3	46.9
2009-10										
Overnight separations from acute psychiatric inpatient services	no.	26 403	16 552	14 061	6 503	5 509	2 011	1 184	837	73 060
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	11 864	10 591	6 417	3 248	2 301	584	873	365	36 243
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	44.9	64.0	45.6	49.9	41.8	29.0	73.7	43.6	49.6
2010-11										
Overnight separations from acute psychiatric inpatient services	no.	26 932	17 156	14 634	7 584	5 825	1 747	1 185	855	75 918

Table 12A.39 Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	12 811	11 730	7 696	3 705	2 662	765	932	400	40 701
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	47.6	68.4	52.6	48.9	45.7	43.8	78.6	46.8	53.6
2011-12										
Overnight separations from acute psychiatric inpatient services	no.	27 432	na	15 324	7 884	5 997	1 936	1 306	898	60 777
Overnight acute separations with community mental health contact recorded in the seven days following separation	no.	14 363	na	9 872	3 997	3 031	531	1 015	396	33 205
Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation	%	52.4	na	64.4	50.7	50.5	27.4	77.7	44.1	54.6

(a) Data are based on all ‘in scope’ separations from state and territory psychiatric acute inpatient units, where ‘in scope’ is defined as those separations for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death.

(b) Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or ‘indirect’ (for example, by telephone), but not contacts delivered ‘on behalf of the client’ in which they did not participate. (The exception is the NT, where data includes all contacts — NT has advised that the impact on the indicator is marginal.) Contacts made on the day of discharge are also excluded.

(c) States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers. Three jurisdictions — WA, SA and Tasmania — indicated that the data submitted were not based on unique patient identifier (see also relevant notes below). This factor can contribute to an appearance of lower follow-up rates for these jurisdictions.

Table 12A.39 **Rates of community follow up for people within the first seven days of discharge from hospital (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f)	*WA* (g), (h)	*SA* (i)	*Tas* (j)	*ACT*	*NT* (k)	*Aust* (e)

(d) For NSW, the indicator is dependent on Statewide Unique Patient Identifier (SUPI) coverage both in the inpatient and community data for the calculation of post-discharge community contact rate. The NSW implementation of the SUPI for mental health care is in a robust state with coverage of above 99.9 per cent in all LHDs in both community and inpatient (except one LHD with 99 per cent coverage) data.

(e) Victorian data have been revised, for all years from 2005-06 to 2010-11 due to a number of in-scope separations from Aged and Specialist acute units previously being excluded from the calculations. For public sector community mental health services, Victorian data is unavailable due to service level collection gaps resulting from protected industrial action during this period. Due to data supply issues, Australian totals for 2011-12 should be interpreted with caution.

(f) For Qld, a linkage program is utilised to link between admitted and community activity and patients.

(g) For WA, the data source for admissions was changed to a more robust and reliable source. All years of data have been revised. The denominator for acute in-scope separations excludes publically funded patients in private hospitals. Figures reported in previous reports are not comparable. The source of acute admissions is now using separations data from the Inpatient Data Collection. The source for Community Contacts remains the same as previous reports, however the methodology in linking acute separations and community contacts has changed.

(h) For WA, unlike previous reports, mental health community contacts and acute separations are now sourced from two different data collection systems. Each system has different unique patient identifiers and requires the use of linkages to allow unique tracking of consumers across all public mental health services in WA. The timing of making the linkages and delays in the time it takes to link records could result in not making a match between the two data sources, when one should be possible. This could result to an under-estimate in the proportion of post-discharge contacts.

(i) For SA, whilst the a state-wide unique identifier does not exist, the data are reliable for the majority of services in SA, being metropolitan-based services. However some under-counting occurs where discharge from ward to community is across catchment/database boundaries.

(j) Industrial action in Tasmania has limited the available data quality and quantity of community data for 2011-12.

(k) For the NT, data filters for mode of separation were reviewed for the whole of the data series and corrected per specification. This resulted in a small reduction in the denominator values. In addition, the time-series data have been reviewed and revised as a result of an audit of actual records indicating significant undercounting in the reported data. A technical error in the reporting system settings limiting the number of rows provided was found and corrected.

na Not available.

Source: State and territory unpublished, admitted patient and community mental health care data.

Table 12A.40 Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status, remoteness, 2011-12 (a), (b)

	Unit	*NSW*	*Vic* (c)	*Qld*	*WA*	*SA* (d)	*Tas* (e)	*ACT*	*NT*	*Aust*
Indigenous status										
Indigenous	%	45.9	na	61.0	39.9	45.2	22.8	87.9	34.7	na
Non-Indigenous	%	53.0	na	65.0	51.8	52.0	27.7	78.2	55.5	na
Remoteness										
Major cities	%	52.9	na	62.8	52.6	52.9	26.5	79.5	70.0	na
Inner regional	%	54.0	na	69.7	50.8	41.2	24.3	51.9	50.0	na
Outer regional	%	51.7	na	67.1	43.9	41.1	37.2	100.0	58.1	na
Remote	%	40.0	na	65.7	48.7	34.4	24.9	100.0	45.8	na
Very remote	%	41.7	na	62.2	26.3	30.5	–	..	26.3	na

(a) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Excludes people for whom demographic information was missing or not reported.

(b) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. State/territory is the state/territory of the service provider. Excludes people for whom demographic information was missing or not reported.

(c) For public sector community mental health services, Victorian data are unavailable due to service level collection gaps resulting from protected industrial action during this period.

(d) South Australia submitted data that was not based on unique patient identifier or data matching approaches.

(e) Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data.

na Not available. .. Not applicable. – Nil or rounded to zero.

Source: State and Territory governments unpublished, admitted patient and community mental health care data.

Table 12A.41 Readmissions to hospital within 28 days of discharge (a), (b), (c)

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*
2005-06										
Overnight separations from psychiatric acute inpatient services	no.	25 087	14 957	14 211	6 645	5 352	2 617	1 136	1 092	71 097
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 057	2 098	2 696	933	629	334	152	132	11 031
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.2	14.0	19.0	14.0	11.8	12.8	13.4	12.1	15.5
2006-07										
Overnight separations from psychiatric acute inpatient services	no.	26 767	15 602	13 432	6 476	5 430	2 381	1 100	997	72 185
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 526	2 309	2 110	822	491	325	123	126	10 832
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.9	14.8	15.7	12.7	9.0	13.6	11.2	12.6	15.0
2007-08										
Overnight separations from psychiatric acute inpatient services	no.	27 202	16 400	13 296	6 446	5 590	2 116	1 148	946	73 144

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 716	2 484	2 059	856	617	353	114	117	11 316
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	17.3	15.1	15.5	13.3	11.0	16.7	9.9	12.4	15.5
2008-09										
Overnight separations from psychiatric acute inpatient services	no.	27 101	16 429	13 827	6 889	5 435	2 121	1 233	894	73 929
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 344	2 317	2 124	959	510	302	68	88	10 712
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	16.0	14.1	15.4	13.9	9.4	14.2	5.5	9.8	14.5
2009-10										
Overnight separations from psychiatric acute inpatient services	no.	26 447	16 552	13 928	7 329	5 509	2 011	1 184	837	73 797
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 094	2 300	2 106	1 015	461	316	51	75	10 418

Table 12A.41 **Readmissions to hospital within 28 days of discharge (a), (b), (c)**

	Unit	NSW (d)	Vic (e)	Qld (f), (g)	WA (h)	SA (i)	Tas	ACT	NT (j)	Aust
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.5	13.9	15.1	13.8	8.4	15.7	4.3	9.0	14.1
2010-11										
Overnight separations from psychiatric acute inpatient services	no.	27 083	17 156	14 457	8 446	5 825	1 747	1 185	855	76 754
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 274	2 427	2 207	1 205	523	263	63	105	11 067
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.8	14.1	15.3	14.3	9.0	15.1	5.3	12.3	14.4
2011-12										
Overnight separations from psychiatric acute inpatient services	no.	27 463	17 910	15 192	8 754	5 997	1 907	1 306	898	79 427
Overnight acute separations that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	no.	4 298	2 554	2 294	1 199	560	269	165	88	11 427
Proportion of overnight separations from psychiatric acute inpatient services that were followed by a readmission to a psychiatric acute inpatient service within 28 days of discharge	%	15.7	14.3	15.1	13.7	9.3	14.1	12.6	9.8	14.4

Table 12A.41 Readmissions to hospital within 28 days of discharge (a), (b), (c)

	Unit	*NSW* (d)	*Vic* (e)	*Qld* (f), (g)	*WA* (h)	*SA* (i)	*Tas*	*ACT*	*NT* (j)	*Aust*

(a) Data are based on all ‘in scope’ separations from State and Territory psychiatric inpatient units, defined as those for which it is meaningful to examine readmission rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge — type change; left against medical advice/discharge at own risk and death.

(b) For the purposes of this indicator, a readmission for any of the separations identified as ‘in-scope’ is defined as an admission to any other public psychiatric acute unit within the jurisdiction that occurs within 28 days of the date of the original separation. States and territories vary in their capacity to accurately track readmissions statewide across hospitals. SA have indicated that data are not derived using unique patient identifiers and Tasmania indicated that data for 2005-06 and 2006-07 are not calculated using unique identifiers. This can lead to the appearance of lower re-admission rates.

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

(d) For NSW, the construction of this indicator complies with the calculation conditions outlined in the *Key Performance Indicators for Australian Public Mental Health Services,* Second Ed. 2011. These conditions specify the exclusion of separations where the procedure code is ECT and the stay is one day or less. These data are calculated using a Statewide Unique Patient Identifier (SUPI) for Mental Health care. The inpatient SUPI coverage was above 99.9 per cent in all Local Health Districts except one where the coverage was at 99 per cent.

(e) Victorian data have been revised, for all years from 2005-06 to 2010-11 due to a number of in-scope separations from Aged and Specialist acute units previously being excluded from the calculations.

(f) For Qld, data have been recalculated across all years to exclude episodes of one night only where an electroconvulsive therapy procedure was recorded. The rate of readmission for 2011-12 is higher than was published for the 2011-12 Queensland Health Service Delivery Statements and Annual Report. This is due to recent improvements in the method used to identify readmissions, which has been used to calculate readmission for more recent data.

(g) For Qld, inpatient identifiers are unique at a hospital level. A routine linkage program is utilised to create a unique identifier for reporting purposes.

(h) For WA, data from previous reports are not comparable to these figures due to change in data source. Data for this report are from a more robust and reliable source as data is subjected to rigorous quality assurance processes. Data for previous financial years have been revised. Within the single data source for inpatient mental health separations there is a unique identifier for clients.

(i) For SA, data have been revised for 2006-07 to 2010-11. Lack of unique identifier in numerous hospital systems means that only readmissions to same inpatient service unit can be identified — not readmission to a different service unit / hospital.

(j) For NT, data filters for mode of separation were reviewed for the whole of the data series and corrected per specification. This resulted in a small reduction in the denominator values.

Source: Department of Health unpublished, from data provided by State and Territory health authorities.

Table 12A.42 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*
General mental health services									
2005-06	754	653	651	896	726	698	702	1 085	727
2006-07	763	670	666	909	827	867	921	987	752
2007-08	752	720	740	961	857	894	959	1 180	783
2008-09	788	757	733	1 003	942	846	859	1 206	810
2009-10	793	771	775	995	931	1 037	850	1 233	825
2010-11	840	783	775	1 098	891	1 013	892	1 275	854
2011-12	883	796	806	1 099	897	872	910	1 526	881
Child and adolescent mental health services									
2005-06	1 370	1 398	1 377	1 239	1 202	..	..	..	1 361
2006-07	1 399	1 401	1 473	1 515	1 521	..	..	..	1 434
2007-08	1 406	1 412	1 553	1 140	2 035	..	..	..	1 429
2008-09	1 381	1 544	1 640	1 530	1 829	..	..	..	1 503
2009-10	1 615	1 510	1 577	1 523	1 977	..	..	..	1 583
2010-11	1 892	1 506	1 577	1 976	1 773	..	..	..	1 720
2011-12	1 720	1 416	1 592	2 133	1 774	..	..	..	1 657
Older people's mental health services									
2005-06	617	566	492	769	535	..	..	..	588
2006-07	637	595	538	756	568	..	2 555	..	617
2007-08	627	637	576	759	613	..	968	..	637
2008-09	677	644	580	816	695	..	1 009	..	677
2009-10	684	653	592	789	708	..	618	..	678
2010-11	750	680	606	808	660	..	618	..	703
2011-12	771	680	614	904	677	..	604	..	727

Table 12A.42 Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*
Forensic mental health services									
2005-06	579	832	860	1 144	919	519	..	1 014	780
2006-07	518	843	883	1 022	1 027	1 037	..	697	775
2007-08	526	852	999	981	1 057	1 496	..	..	818
2008-09	777	756	979	1 167	994	1 527	..	..	883
2009-10	840	884	1 031	1 085	993	1 944	..	..	937
2010-11	927	840	1 128	993	971	2 278	..	..	968
2011-12	868	794	1 254	1 154	970	1 404	..	..	937

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(d) Due to the ongoing validation of the NMDS data could differ from previous reports.

(e) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(g) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report ‘older people's care units’ separately.

(h) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(i) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the ACT for 2005-06, and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Forensic mental health services were not provided seperately in the ACT and in the NT from 2007-08.

Table 12A.42 **Average recurrent costs per inpatient bed day, public hospitals, by target population (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f)	*Vic*	*Qld* (g), (h)	*WA*	*SA*	*Tas* (i)	*ACT* (i), (j)	*NT* (i)	*Aust*

(j) ACT average costs for older person's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jursidictions and other years.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.43 Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
General mental health services									
Acute									
2005-06	854	677	733	899	800	691	702	1 085	792
2006-07	871	689	743	907	904	927	921	987	820
2007-08	851	751	851	953	904	888	959	1 180	854
2008-09	863	783	835	1 005	983	886	859	1 206	873
2009-10	876	797	845	1 007	969	1 111	850	1 233	886
2010-11	918	804	848	1 141	910	1 123	892	1 275	914
2011-12	949	800	859	1 123	865	931	910	1 526	921
Non-acute									
2005-06	527	498	523	883	546	718	..	..	557
2006-07	505	544	542	914	589	731	..	..	565
2007-08	522	531	558	1 013	680	916	..	..	579
2008-09	604	588	571	990	766	735	..	..	627
2009-10	606	605	681	924	763	830	..	..	662
2010-11	664	645	677	970	808	738	..	..	705
2011-12	723	770	730	1 016	1 092	725	..	..	769
Child and adolescent mental health services									
Acute									
2005-06	1 543	1 398	1 389	1 239	1 202	..	..	..	1 411
2006-07	1 339	1 401	1 567	1 459	1 521	..	..	..	1 430
2007-08	1 451	1 412	1 561	1 035	2 035	..	..	..	1 429
2008-09	1 483	1 544	1 612	1 431	1 829	..	..	..	1 538
2009-10	1 708	1 510	1 454	1 318	1 977	..	..	..	1 563

Table 12A.43 Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
2010-11	1 855	1 506	1 494	1 783	1 773	..	..	..	1 660
2011-12	1 780	1 416	1 449	2 022	1 774	..	..	..	1 630
Non-acute									
2005-06	1 069	..	1 330	..	..	..	..	..	1 143
2006-07	1 547	..	1 195	1 755	..	..	..	..	1 450
2007-08	1 308	..	1 527	1 923	..	..	..	..	1 426
2008-09	1 169	..	1 751	2 006	..	..	..	..	1 369
2009-10	1 370	..	2 099	2 968	..	..	..	..	1 679
2010-11	2 056	..	1 965	4 456	..	..	..	..	2 148
2011-12	1 545	..	2 375	4 462	..	..	..	..	1 809
Older people's mental health services									
Acute									
2005-06	659	566	712	797	687	..	..	..	661
2006-07	690	595	796	795	787	..	2 555	..	702
2007-08	705	637	875	784	797	..	968	..	725
2008-09	736	644	795	843	778	..	1 009	..	737
2009-10	731	653	827	879	862	..	618	..	750
2010-11	810	680	823	869	780	..	618	..	773
2011-12	801	680	847	982	806	..	604	..	796
Non-acute									
2005-06	560	..	418	629	451	..	..	..	481
2006-07	562	..	447	624	451	..	..	..	493
2007-08	560	..	470	676	506	..	..	..	527
2008-09	619	..	495	723	636	..	..	..	593
2009-10	633	..	504	504	582	..	..	..	571

Table 12A.43 **Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)**

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*
2010-11	686	..	524	446	540	..	..	..	591
2011-12	738	..	528	435	519	..	..	..	609
Forensic mental health services									
Acute									
2005-06	416	923	..	1 168	1 084	519	..	1 014	744
2006-07	466	1 007	..	1 034	1 170	1 037	..	697	786
2007-08	444	907	..	981	1 115	1 496	..	..	769
2008-09	703	824	..	1 167	1 233	1 527	..	..	876
2009-10	847	940	..	1 085	1 307	1 944	..	..	990
2010-11	973	895	..	1 079	1 305	2 278	..	..	1 037
2011-12	886	774	..	1 255	1 342	1 404	..	..	942
Non-acute									
2005-06	653	749	860	1 118	877	..	..	..	794
2006-07	555	699	883	1 009	988	..	..	..	769
2007-08	594	807	999	980	1 041	..	..	..	844
2008-09	849	652	979	1 168	932	..	..	..	888
2009-10	833	792	1 031	1 085	915	..	..	..	891
2010-11	883	750	1 128	646	885	..	..	..	903
2011-12	854	825	1 254	751	876	..	..	..	932

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

Table 12A.43 Average recurrent costs per inpatient bed day, public hospitals, by target population and care type (2011-12 dollars) (a), (b), (c), (d)

	NSW (e), (f)	*Vic* (g)	*Qld* (h), (i), (j)	*WA* (k)	*SA* (g)	*Tas* (g)	*ACT* (g), (l)	*NT* (g)	*Aust*

(d) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(e) Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(g) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Victoria and SA did not have non-acute child and adolescent mental health services units. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT. Older People's Mental Health Services in non-acute units were not available in Victoria and the ACT. Forensic mental health services were not provided seperately in the ACT and in the NT from 2007-08.

(h) Queensland Government has advised that it provides older people's mental health inpatient services using a number of different service models including campus and noncampus based options. All service types are reported as older people's mental health services, which may have the effect of lowering the average patient day costs compared to jurisdictions who report 'older people's care units' separately.

(i) Caution is required when interpreting Queensland data. Several Forensic services reported in 2008-09 were reclassified as General services in 2009-10 to more accurately reflect the function of these services. Forensic mental health services in acute units were not provided seperately in Queensland.

(j) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(k) Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services. In addition, during 2010-11, the child and adolescent non acute inpatient service initiated the closure of beds in order to carry out a complete refurbishment. The service ceased operating in late 2011.

(l) ACT average costs for older people's mental health services are based on a new 20 bed unit opened in March 2007. During 2006-07, only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older people's mental health services relative to other jursidictions and other years.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.44 **Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)**

	NSW (c)	*Vic*	*Qld* (d)	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (e)	*Aust*
2010-11									
General mental health services	14.8	14.5	11.4	14.9	13.4	12.0	15.2	12.6	13.8
Child and adolescent mental health services	21.7	10.4	11.2	8.0	4.2	..	..	..	11.8
Older people's mental health services	35.4	32.6	20.7	51.3	45.6	..	36.3	..	35.5
Total	**16.0**	**16.1**	**11.8**	**17.3**	**15.2**	**12.0**	**17.5**	**12.6**	**15.1**
2011-12									
General mental health services	14.7	14.4	11.6	13.8	12.2	12.6	14.5	10.7	13.6
Child and adolescent mental health services	22.1	7.3	11.5	7.2	3.1	..	..	..	10.5
Older people's mental health services	41.2	30.5	11.3	49.8	41.2	..	36.8	..	31.9
Total	**16.1**	**15.4**	**11.6**	**16.0**	**13.8**	**12.6**	**16.9**	**10.7**	**14.7**

(a) The quality of the separations data used to derive the results in this table is variable across jurisdictions. Until recently, these separations data were not subject to in depth scrutiny. It is expected that the quality of these data will improve over time.

(b) There is a mismatch between the inpatient bed days and the separations used to derive this indicator for the relevant reference period (eg 2010-11).
– Patients days for clients who separated in the reference period that were during the previous period (eg 2009-10) are excluded.
– Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

(c) The quality of the NSW 2010-11 MHE NMDS data has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(d) Data for a small number of *Youth* services have been rolled into the General services category at the request of Queensland Government.

(e) Child and adolescent mental health services were not available, or could not be separately identified, in Tasmania, the ACT and the NT. Tasmanian figures include child and adolescent mental health services within the general mental health services category. Older People's Mental Health Services programs were not available, or could not be separately identified, in Tasmania and the NT.

Table 12A.44 Average length of stay, public hospitals acute units, by target population (no. of days) (a), (b)

	NSW (c)	*Vic*	*Qld* (d)	*WA*	*SA*	*Tas* (e)	*ACT* (e)	*NT* (e)	*Aust*

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.45 **Average recurrent cost per inpatient bed day, by public hospital type (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g)	*Vic* (h)	*Qld* (i)	*WA* (j)	*SA* (k)	*Tas* (l)	*ACT* (k), (l)	*NT* (k), (l)	*Aust*
Psychiatric hospitals (acute units)									
2005-06	806	923	..	901	895	..	..	..	854
2006-07	773	1 007	..	932	1 018	..	..	..	872
2007-08	723	907	..	913	1 100	..	..	..	851
2008-09	735	824	..	976	1 064	..	..	..	875
2009-10	953	940	..	974	1 108	..	..	..	979
2010-11	934	895	..	1 146	930	..	..	..	972
2011-12	1 039	774	..	1 183	889	..	..	..	1 009
Psychiatric hospitals (non-acute units)									
2005-06	566	749	691	923	542	..	..	..	626
2006-07	533	699	703	927	566	..	..	..	619
2007-08	546	807	774	915	634	..	..	..	653
2008-09	628	652	760	978	725	..	..	..	697
2009-10	620	792	780	965	704	..	..	..	698
2010-11	684	750	798	920	705	..	..	..	738
2011-12	723	825	880	954	783	..	..	..	798
Psychiatric hospitals (all units)									
2005-06	648	832	691	910	675	..	..	..	701
2006-07	618	843	703	930	721	..	..	..	701
2007-08	607	852	774	914	784	..	..	..	719
2008-09	658	756	760	977	848	..	..	..	755
2009-10	713	884	780	972	840	..	..	..	787
2010-11	756	840	798	1 037	786	..	..	..	809
2011-12	827	794	880	1 086	826	..	..	..	869
Public acute hospital with a psychiatric unit or ward (acute units)									
2006-07	865	696	787	891	831	952	994	984	811
2007-08	857	751	888	933	815	1 008	960	1 180	849
2008-09	885	782	872	998	907	1 014	885	1 206	876
2009-10	871	797	875	1 005	918	1 267	802	1 233	882
2010-11	942	808	881	1 079	896	1 312	830	1 275	919
2011-12	944	802	891	1 104	871	1 036	839	1 526	918
Public acute hospital with a psychiatric unit or ward (non-acute units)									
2006-07	651	544	517	756	..	731	..	..	569
2007-08	600	531	531	991	..	916	..	..	589
2008-09	758	588	547	949	..	735	..	..	643
2009-10	830	605	597	734	..	830	..	..	679
2010-11	878	645	596	889	..	738	..	..	699
2011-12	864	770	627	888	..	725	..	..	754
Public acute hospital with a psychiatric unit or ward (all units)									
2005-06	823	664	676	877	703	670	702	1 083	741

Table 12A.45 **Average recurrent cost per inpatient bed day, by public hospital type (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g)	*Vic* (h)	*Qld* (i)	*WA* (j)	*SA* (k)	*Tas* (l)	*ACT* (k), (l)	*NT* (k), (l)	*Aust*
2006-07	850	681	699	877	831	897	994	984	777
2007-08	820	728	774	939	815	991	960	1 180	808
2008-09	872	763	772	993	907	951	885	1 206	842
2009-10	867	777	792	973	918	1 169	802	1 233	853
2010-11	935	792	794	1 063	896	1 168	830	1 275	888
2011-12	930	799	811	1 086	871	962	839	1 526	892

(a) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(b) Depreciation is excluded for all years.

(c) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/ resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(d) Due to the ongoing validation of the NMDS data could differ from previous reports.

(e) Includes government expenditure and funded patients days in services managed and operated by private and non-government entities.

(f) Caution is required when interpreting NSW data. Seven residential mental health services in 2006-07 were reclassified as non-acute older person specialised hospital services in 2007-08, reflecting a change in function of those units.

(g) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(h) Mainstreaming has occurred at different rates in different jurisdictions. In Victoria's case, the data for psychiatric hospitals comprises mainly forensic services, since nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means that the client profile and service costs are very different from those of a jurisdiction where general psychiatric treatment still occurs mostly in psychiatric hospitals.

(i) Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals.

(j) Caution is required when interpreting WA data. A review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.

(k) SA, the ACT and the NT do not have non-acute units in public acute hospital with a psychiatric unit or ward.

(l) Tasmania, the ACT and the NT do not have public psychiatric hospitals.

.. Not applicable.

Source: AIHW unpublished, MHE NMDS.

Table 12A.46 Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*
General adult units									
2005-06									
24-hour staffed units	292	470	..	360	258	434	526	..	422
non-24-hour staffed units	95	165	..	133	300	342	84	124	149
2006-07									
24-hour staffed units	289	457	..	469	255	452	581	..	426
non-24-hour staffed units	92	151	..	150	307	227	116	286	143
2007-08									
24-hour staffed units	267	443	..	503	399	519	588	292	428
non-24-hour staffed units	176	148	..	186	490	230	109	..	165
2008-09									
24-hour staffed units	302	474	..	427	402	552	716	264	455
non-24-hour staffed units	228	147	..	170	297	259	104	..	170
2009-10									
24-hour staffed units	259	505	..	332	390	425	681	343	446
non-24-hour staffed units	196	153	..	155	264	235	117	..	166
2010-11									
24-hour staffed units	298	540	..	529	463	480	653	361	502
non-24-hour staffed units	200	158	..	139	269	225	111	..	161
2011-12									
24-hour staffed units	225	488	..	368	484	490	650	308	447
non-24-hour staffed units	178	158	..	148	331	198	133	..	163

Table 12A.46 Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*
Older people's care units									
2005-06									
24-hour staffed units	321	340	..	..	..	480	170	..	342
non-24-hour staffed units	120	..	..	..	..	..	..	..	120
2006-07									
24-hour staffed units	380	317	..	..	..	507	179	..	334
non-24-hour staffed units	313	..	..	..	..	..	..	..	313
2007-08									
24-hour staffed units	211	315	..	..	..	796	184	..	329
non-24-hour staffed units	168	..	..	..	..	..	..	..	168
2008-09									
24-hour staffed units	188	343	..	..	..	528	244	..	349
non-24-hour staffed units	223	..	..	..	..	..	..	..	223
2009-10									
24-hour staffed units	218	337	..	..	..	756	197	..	351
non-24-hour staffed units	216	..	..	..	..	..	..	..	216
2010-11									
24-hour staffed units	231	349	..	..	..	702	211	..	361
non-24-hour staffed units	284	..	..	..	..	..	..	..	284
2011-12									
24-hour staffed units	234	347	..	..	..	682	249	..	358
non-24-hour staffed units	..	..	..	..	..	..	..	..	..

Table 12A.46 **Average recurrent cost per patient day for community residential services (2011-12 dollars) (a), (b), (c), (d), (e)**

	NSW (f), (g), (h)	*Vic*	*Qld* (i)	*WA* (j), (k)	*SA* (k)	*Tas* (l), (m)	*ACT* (h), (m)	*NT* (k), (n)	*Aust*

(a) Depreciation is excluded for all years.

(b) Unit costs are not casemix adjusted.

(c) Constant price expenditure expressed in 2011-12 prices, using the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services (table 12A.73).

(d) See AIHW *Mental Health Services in Australia* on-line publication (mhsa.aihw.gov.au/resources/expenditure/data-source/) for a full description of the derivation of expenditure items.

(e) Due to the ongoing validation of the NMDS data could differ from previous reports.

(f) Caution is required when interpreting NSW data. Seven residential mental health services in 2006–07 were reclassified as non-acute older person specialised hospital services in 2007–08, reflecting a change in function of those units.

(g) The quality of the NSW 2010-11 *MHE NMDS* data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(h) A small number of residential beds reported by NSW and the ACT as Child and adolescent residential mental health service beds were included in the General category at the request of those jurisdictions.

(i) Queensland does not fund community residential services, however, it funds a number of extended treatment services, both campus and non-campus based, which provide longer term inpatient treatment and rehabilitation services with a full clinical staffing 24 hours a day 7 days a week. Queensland does not report these beds as community residential beds as it considers these beds to be substantially different to beds described as such in other states and territories.

(j) Caution is required when interpreting WA data. Several residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010. For 2011-12, a small number of Youth services have been included in the General services category at the request of WA.

(k) WA, SA and the NT do not have any community residential services that are aged care units.

(l) Tasmanian services include both acute and rehabilitation units which have higher unit costs than extended care units.

(m) Tasmania and the ACT do not have any community-based residential services that are non-24 hour staffed older people’s units. From 2011-12, NSW no longer has non-24 hour staffed older people’s units.

(n) General adult 24-hour residential services were not provided in the NT until 2007-08. From 2007-08, general non-24-hour staffed units are not provided.

.. Not applicable.

Source: AIHW unpublished, derived from the MHE NMDS.

Table 12A.47	Average cost, and treatment days per episode, of ambulatory care (a), (b), (c)								
	NSW (d)	*Vic* (e)	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT*	*NT*	*Aust*
Average treatment days per episode of ambulatory care									
2005-06	6.7	7.8	4.9	4.5	4.8	4.7	8.2	4.0	6.0
2006-07	6.8	7.7	5.2	4.5	5.0	4.1	8.0	4.0	6.1
2007-08	8.0	7.7	5.4	4.6	5.2	5.9	8.0	3.9	6.5
2008-09	7.2	7.6	4.5	4.8	5.3	6.0	8.0	3.9	6.1
2009-10	7.6	7.6	4.9	4.9	5.3	5.2	8.2	3.5	6.3
2010-11	7.5	7.7	5.2	5.0	5.5	5.5	8.2	3.6	6.4
2011-12	8.0	na	5.8	5.0	5.4	4.5	8.6	3.6	6.4
Average cost per treatment day of ambulatory care (2011-12 $) (g)									
2005-06	249	265	290	442	407	636	270	451	297
2006-07	260	268	322	437	353	561	295	517	307
2007-08	251	288	345	466	315	434	277	582	310
2008-09	263	300	430	453	305	404	287	535	329
2009-10	250	303	494	424	312	391	252	587	330
2010-11	258	326	455	415	329	335	251	592	333
2011-12	245	na	424	431	324	467	249	543	326

(a) Non-uniquely identifiable consumers' have been excluded from the episodes of ambulatory care and treatment days data.

(b) Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for proportion of clients in the *CMHC NMDS* that were defined as 'non-uniquely identifiable consumers'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere.

(c) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(d) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the DQI for this indicator.

(e) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. The total only includes those jurisdictions that have provided data.

(f) Industrial action in Tasmania has limited the available data quality and quantity of the 2011-12 data.

(g) Real expenditure (2011-12 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.73).

na Not available.

Source: AIHW unpublished, CMHC NMDS and MHE NMDS.

Table 12A.48 **Risk status recent drinkers (in last 12 months) aged 14 years or over, 2010 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Lifetime status									
Abstainers (a)	21.8	20.9	16.8	17.0	19.0	14.4	13.5	13.7	19.5
Low risk (b)	59.6	60.6	60.0	60.3	61.7	66.1	67.0	56.9	60.4
Risky (c)	18.6	18.4	23.2	22.7	19.3	19.4	19.5	29.4	20.1
Single occasion									
Abstainers (a)	21.8	20.9	16.8	17.0	19.0	14.4	13.5	13.7	19.5
Low risk (d)	41.7	41.1	38.3	39.7	42.7	45.1	42.0	35.5	40.7
Risky									
At least yearly (e)	10.6	11.4	11.8	12.3	11.0	11.5	15.1	11.3	11.3
At least monthly (f)	11.0	12.3	15.0	13.2	11.2	13.1	15.9	14.9	12.5
At least weekly (g)	15.0	14.4	18.1	17.9	16.1	15.8	13.6	24.7	15.9
Total risky	36.6	38.0	44.9	43.3	38.4	40.4	44.5	50.8	39.8

(a) Not consumed alcohol in the previous 12 months.

(b) On average, had no more than 2 standard drinks per day.

(c) On average, had more than 2 standard drinks per day.

(d) Never had more than 4 standard drinks on any occasion.

(e) Had more than 4 standard drinks at least once a year, but not as often as monthly.

(f) Had more than 4 standard drinks at least once a month, but not as often as weekly.

(g) Had more than 4 standard drinks at least once a week.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.49 Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2010 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Alcohol	78.2	79.1	83.2	83.0	81.0	85.6	86.5	86.3	80.5
Illicit drugs									
Cannabis	9.3	9.4	11.0	13.4	11.3	8.6	9.5	16.5	10.3
Ecstasy	2.9	3.1	2.7	3.7	3.3	*1.7	*2.3	3.2	3.0
Meth/amphetamines (c)	1.6	2.3	1.9	3.4	2.5	*1.1	*1.2	*2.1	2.1
Cocaine	2.7	2.3	1.3	2.2	1.7	*0.8	*1.8	**0.5	2.1
Hallucinogens	0.8	1.8	1.4	1.9	1.0	*1.0	*1.5	*2.6	1.4
Inhalants	0.6	0.6	0.6	*0.4	*0.6	*0.8	**0.6	*1.5	0.6
Heroin	*0.2	*0.3	*0.1	*0.3	*0.2	**0.1	**0.3	**0.1	0.2
GHB	*0.2	*0.2	*0.1	**0.1	**0.1	–	**<0.1	–	0.1
Any illicit (d)	11.4	11.0	12.3	15.4	12.7	9.6	11.4	18.8	12.0

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

(c) Use for non-medical purposes.

(d) Includes ketamine and injected drugs, but excludes pharmacueticals.

– Nil or rounded to zero.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.50 Selected illicit drug use, by substance and age group, 2010 (per cent) (a), (b)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Cannibis									
14–19 years	13.9	16.0	14.6	23.5	*19.6	**3.1	*12.0	*14.8	15.7
20–29 years	18.3	20.4	23.9	27.6	23.2	17.4	18.3	26.0	21.3
30–39 years	11.5	12.9	15.3	17.0	15.9	14.0	11.4	18.5	13.6
40 years or over	5.0	3.4	4.7	5.6	5.4	6.0	4.6	11.6	4.7
14 years or over	9.3	9.4	11.0	13.4	11.3	8.6	9.5	16.5	10.3
Ecstacy									
14–19 years	*2.3	*3.6	*1.8	*3.5	*4.7	**1.6	**2.8	**3.7	2.8
20–29 years	9.1	9.5	10.1	12.5	11.5	*7.2	*7.7	*8.0	9.9
30–39 years	4.5	3.9	2.8	4.1	*5.5	**2.1	*2.2	*3.1	3.9
40 years or over	0.5	0.5	*0.4	*0.6	**0.1	**0.2	–	*0.9	0.5
14 years or over	2.9	3.1	2.7	3.7	3.3	1.7	2.3	3.2	3.0
Meth/amphetamines									
14–19 years	**1.0	*3.1	*1.3	**0.8	**2.2	–	–	**1.1	1.6
20–29 years	3.9	6.4	5.7	11.7	*7.3	**2.6	**2.6	*5.0	5.9
30–39 years	3.0	3.2	2.9	6.1	*4.2	**2.8	**1.6	**2.9	3.4
40 years or over	0.5	*0.4	*0.5	*0.2	*0.8	**0.5	**0.7	**0.6	0.5
14 years or over	1.6	2.3	1.9	3.4	2.5	1.1	1.2	2.1	2.1
Cocaine									
14–19 years	*1.4	*2.1	**0.8	**0.3	**1.5	–	**1.9	**1.1	1.3
20–29 years	7.6	6.9	4.7	*7.6	*5.1	**4.3	*6.2	**0.7	6.5
30–39 years	5.2	3.7	*1.7	*3.5	*4.3	**0.7	**1.3	**0.9	3.7
40 years or over	0.6	*0.3	*0.2	**0.4	**0.2	**0.1	**0.1	**0.2	0.4
14 years or over	2.7	2.3	1.3	2.2	1.7	*0.8	*1.8	**0.5	2.1

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

– Nil or rounded to zero.

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.51 Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2010 (per cent) (a), (b)

	Not used drug in last 12 months	*Used drug in last 12 months*	*All people (18+)*
Any illicit drug			
Level of psychological distress			
Low	71.8	57.3	69.6
Moderate	19.6	25.8	20.5
High	6.5	12.8	7.4
Very high	2.1	4.1	2.4
Self-reported health condition			
Diabetes	5.7	3.3	5.4
Heart diseases	20.4	10.1	19.1
Asthma	8.3	10.3	8.6
Cancer	3.0	1.4	2.8
Mental illness	10.8	18.7	12.0
Cannabis			
Level of psychological distress			
Low	71.1	56.7	69.6
Moderate	19.8	27.0	20.5
High	6.8	12.7	7.4
Very high	2.3	3.6	2.4
Self-reported health condition			
Diabetes	5.8	2.0	5.4
Heart diseases	20.5	5.9	19.1
Asthma	8.5	10.0	8.6
Cancer	3.0	0.9	2.8
Mental illness	11.3	18.7	12.0
Ecstacy			
Level of psychological distress			
Low	70.1	55.9	69.6
Moderate	20.2	28.9	20.5
High	7.3	12.1	7.4
Very high	2.4	3.0	2.4
Self-reported health condition			
Diabetes	5.5	**1.0	5.4
Heart diseases	19.5	*1.2	19.1
Asthma	8.6	11.0	8.6
Cancer	2.9	**0.2	2.8
Mental illness	11.9	16.2	12.0

Table 12A.51 Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2010 (per cent) (a), (b)

	Not used drug in last 12 months	*Used drug in last 12 months*	*All people (18+)*
Meth/amphetamines			
Level of psychological distress			
Low	70.1	51.2	69.6
Moderate	20.3	28.0	20.5
High	7.3	13.3	7.4
Very high	2.3	7.5	2.4
Self-reported health condition			
Diabetes	5.5	*1.5	5.4
Heart diseases	19.3	4.5	19.1
Asthma	8.6	11.2	8.6
Cancer	2.9	*0.7	2.8
Mental illness	11.7	25.6	12.0
Cocaine			
Level of psychological distress			
Low	70.0	55.0	69.6
Moderate	20.3	27.4	20.5
High	7.3	14.1	7.4
Very high	2.4	3.4	2.4
Self-reported health condition			
Diabetes	5.5	**0.5	5.4
Heart diseases	19.4	*2.3	19.1
Asthma	8.7	6.7	8.6
Cancer	2.9	**0.4	2.8
Mental illness	11.9	17.4	12.0

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of between 25 per cent and 50 per cent should be considered with caution and those with relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " ** " and those with RSEs of between 25 per cent and 50 per cent are marked with " * ".

Source: AIHW 2011, *2010 National Drug Strategy Household Survey Report*, Drug statistics series no. 25, Cat. no. PHE 145, Canberra.

Table 12A.52 **Risk status recent drinkers aged 14 years or over, 2007 (per cent)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Long term harm									
Abstainers (a)	20.1	17.2	15.1	13.7	15.7	14.4	11.8	14.4	17.1
Low risk	69.9	73.7	73.1	74.8	75.1	73.7	78.3	69.1	72.6
Risky (b)	10.0	9.1	11.8	11.5	9.2	12.0	9.9	16.5	10.3
Short term harm									
Abstainers (a)	20.1	17.2	15.1	13.7	15.7	14.4	11.8	14.4	17.1
Low risk	48.1	48.8	47.7	49.2	48.9	46.1	52.1	40.2	48.3
Risky (c)									
At least yearly	13.1	14.5	15.2	14.4	13.8	16.5	15.0	16.9	14.2
At least monthly	11.3	11.8	13.7	14.7	14.6	13.3	13.3	16.3	12.6
At least weekly	7.4	7.6	8.3	8.1	7.0	9.7	7.8	12.1	7.8
Total risky	31.8	33.9	37.2	37.1	35.4	39.6	36.1	45.3	34.6

(a) Not consumed alcohol in the previous 12 months.

(b) For males, consumption of 29 or more standard drinks per week; for females, consumption of 15 or more standard drinks per week. A standard drink is 10 grams (or 12.5 millilitres) of pure alcohol.

(c) For males, consumption of 7 or more standard drinks on one occasion; for females, consumption of 5 or more standard drinks on one occasion. A standard drink is 10 grams (or 12.5 millilitres) of pure alcohol.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey State and territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.53 Recent alcohol and illicit drug use, people aged 14 years or over, by substance, 2007 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Alcohol	79.9	82.8	84.9	86.3	84.3	85.7	88.2	85.6	82.9
Illicit drugs									
Cannabis	8.0	8.8	9.5	10.8	10.2	10.8	9.1	13.8	9.1
Ecstasy	3.4	3.6	3.7	4.1	2.9	2.4	4.7	4.2	3.5
Meth/amphetamines (c)	1.8	2.3	2.0	4.2	2.6	1.7	2.3	2.3	2.3
Cocaine	2.0	1.6	1.4	1.8	1.3	0.8	1.4	0.9	1.6
Hallucinogens	0.5	0.5	0.6	1.0	0.9	1.0	0.8	0.9	0.6
Inhalants	0.4	0.5	0.5	0.3	*0.1	0.6	0.6	*0.1	0.4
Heroin	0.2	0.3	0.2	*0.2	*0.1	*0.3	–	*0.3	0.2
GHB	0.2	*0.1	*< 0.1	*0.1	*0.1	–	*< 0.1	*0.1	0.1
Any illicit	12.1	12.8	13.7	16.2	14.7	14.8	13.8	20.4	13.4

(a) Recent means used in the previous 12 months. For alcohol 'recent use' includes daily, weekly and less than weekly drinkers.

(b) Results subject to relative standard errors greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " * " .

(c) Use for non-medical purposes.

– Nil or rounded to zero.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.54 **Use of cannabis and any illicit drug excluding cannabis, by age group, 2007 (per cent) (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Cannibis									
14–24 years	13.1	17.9	19.4	22.1	17.5	18.3	17.6	19.7	17.0
25–39 years	13.0	14.9	13.9	16.3	16.6	21.0	15.0	17.1	14.5
40 years or over	4.0	2.9	3.9	4.3	5.4	4.6	2.8	8.9	3.9
14 years or over	8.0	8.8	9.5	10.8	10.2	10.8	9.1	13.8	9.1
Any illicit, excluding cannabis (b)									
14–24 years	4.1	2.9	4.6	5.5	4.6	4.2	7.5	10.3	4.2
25–39 years	5.1	4.7	5.1	6.8	5.9	2.2	4.0	6.1	5.2
40 years or over	3.2	3.3	3.2	4.0	3.3	4.1	3.3	4.3	3.3
14 years or over	3.8	3.6	3.9	5.0	4.2	3.7	4.3	6.1	4.0

(a) Recent use means used in the previous 12 months.

(b) Excludes those who have used cannabis in the past 12 months, whether or not they had also used other drugs.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.55 Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2007 (per cent) (a), (b)

	Not used drug in last month	*Used drug in last month*
Any illicit drug		
Level of psychological distress		
Low	70.8	51.2
Moderate	20.5	28.6
High	6.9	14.6
Very high	1.8	5.6
Self-reported health condition		
Diabetes	5.4	2.7
Heart diseases	17.8	8.6
Asthma	8.4	11.1
Cancer	2.6	1.0
Mental illness (c)	10.1	17.6
Cannabis		
Level of psychological distress		
Low	70.1	51.2
Moderate	20.8	27.2
High	7.2	15.7
Very high	1.9	5.8
Self-reported health condition		
Diabetes	5.5	1.6
Heart diseases	17.8	5.8
Asthma	8.6	10.6
Cancer	2.6	0.7
Mental illness (c)	10.4	16.8
Ecstacy		
Level of psychological distress		
Low	69.5	45.4
Moderate	20.9	34.4
High	7.5	16.3
Very high	2.1	3.9
Self-reported health condition		
Diabetes	5.3	* 1.8
Heart diseases	17.4	4.0
Asthma	8.7	9.7
Cancer	2.5	–
Mental illness (c)	10.7	15.5

Table 12A.55 Selected illicit drug use by people aged 18 years or over, by level of psychological distress and mental illness status, 2007 (per cent) (a), (b)

	Not used drug in last month	*Used drug in last month*
Meth/amphetamines		
Level of psychological distress		
Low	69.6	43.5
Moderate	21.0	35.3
High	7.4	15.8
Very high	2.1	5.4
Self-reported health condition		
Diabetes	5.3	* 1.5
Heart diseases	17.4	4.9
Asthma	8.6	9.9
Cancer	2.5	–
Mental illness (c)	10.6	21.0
Cocaine		
Level of psychological distress		
Low	69.3	47.1
Moderate	21.1	30.9
High	7.5	15.3
Very high	2.1	* 6.7
Self-reported health condition		
Diabetes	5.3	* 1.5
Heart diseases	17.2	* 4.1
Asthma	8.7	11.9
Cancer	2.5	* 0.8
Mental illness (c)	10.7	14.7

(a) Recent use means used in the previous 12 months.

(b) Results subject to RSEs of greater than 50 per cent should be considered as unreliable for most practical purposes. Estimates that have RSEs greater than 50 per cent are marked with " * " .

(c) Includes depression, anxiety disorder, schizophrenia, bi-polar disorder, an eating disorder and other form of psychosis.

Source: AIHW 2008, *2007 National Drug Strategy Household Survey, State and Territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102, Canberra.

Table 12A.56 Prevalence of lifetime mental disorders among adults aged 16–85 years, 2007 (per cent) (a), (b)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Any 12-month mental disorder (c)									
Anxiety disorders	14.4 ± 1.7	15.4 ± 2.0	13.1 ± 2.5	15.1 ± 3.7	14.4 ± 3.3	np	np	np	14.4 ± 0.9
Affective disorders	6.4 ± 1.2	6.6 ± 1.7	6.1 ± 1.6	6.2 ± 1.8	6.3 ± 2.3	np	np	np	6.2 ± 0.7
Substance use disorders	4.2 ± 1.1	5.5 ± 1.3	5.8 ± 1.8	6.0 ± 2.2	5.5 ± 2.0	np	np	np	5.1 ± 0.7
Any 12-month mental disorder (c), (d)	20.1 ± 2.2	20.7 ± 2.3	19.2 ± 2.6	21.4 ± 4.1	19.1 ± 3.4	14.1 ± 5.4	np	np	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (e)	23.2 ± 1.9	26.3 ± 2.9	28.1 ± 3.4	23.6 ± 4.1	26.3 ± 4.1	30.7 ± 6.9	np	33.3 ± 12.9	25.5 ± 1.4
Without lifetime mental disorders (f)	56.7 ± 2.2	53.0 ± 3.6	52.6 ± 3.8	55.1 ± 5.2	54.6 ± 4.5	55.2 ± 8.2	53.1 ± 11.9	49.0 ± 18.8	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.57 **Prevalence of lifetime mental disorders among adults aged 16–85 years, by sex, 2007 (per cent) (a)**

	Males	*Females*	*People*
Any 12-month mental disorder (b), (c)			
Anxiety disorders			
Panic disorders	2.3 ± 0.7	2.8 ± 0.6	2.6 ± 0.5
Agoraphobia	2.1 ± 0.7	3.5 ± 0.7	2.8 ± 0.5
Social phobia	3.8 ± 1.0	5.7 ± 0.8	4.7 ± 0.6
Generalised anxiety disorder	2.0 ± 0.7	3.5 ± 0.8	2.7 ± 0.6
Obsessive compulsive disorder	1.6 ± 0.6	2.2 ± 0.5	1.9 ± 0.4
Post traumatic stress disorder	4.6 ± 1.0	8.3 ± 1.0	6.4 ± 0.6
Any anxiety disorder (c)	10.8 ± 1.4	17.9 ± 1.3	14.4 ± 0.9
Affective disorders			
Depression (d)	3.1 ± 0.8	5.1 ± 0.8	4.1 ± 0.6
Dysthymia	1.0 ± 0.4	1.5 ± 0.5	1.3 ± 0.3
Bipolar	1.8 ± 0.6	1.7 ± 0.4	1.8 ± 0.4
Any affective disoder (c)	5.3 ± 1.0	7.1 ± 1.0	6.2 ± 0.7
Substance use disorders			
Alcohol harmful use	3.8 ± 0.8	2.1 ± 0.6	2.9 ± 0.5
Alcohol dependence	2.2 ± 0.7	0.7 ± 0.2	1.4 ± 0.3
Drug use (e)	2.1 ± 0.6	0.8 ± 0.3	1.4 ± 0.3
Any substance use disorder (c), (e)	7.0 ± 1.2	3.3 ± 0.7	5.1 ± 0.7
Any 12-month mental disorder (c)	17.6 ± 1.9	22.3 ± 1.3	20.0 ± 1.1
Lifetime mental disorder, with no 12-month symptoms (f)	30.5 ± 2.2	20.7 ± 1.4	25.5 ± 1.4
No lifetime mental disorder (g)	51.9 ± 2.0	57.0 ± 1.7	54.5 ± 1.4

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(c) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(d) Includes severe depressive episode, moderate depressive episode and mild depressive episode.

(e) Includes harmful use and dependence.

(f) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(g) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.58 Prevalence of lifetime mental disorders among adults, by age, 2007 (per cent) (a), (b)

	16–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–85 years*
Any 12-month mental disorder (c), (d)							
Anxiety disorders	15.4 ± 2.0	16.3 ± 2.8	18.1 ± 3.0	17.6 ± 3.0	11.3 ± 1.9	6.3 ± 1.5	4.0 ± 1.8
Affective disorders	6.3 ± 1.5	7.9 ± 2.1	8.3 ± 2.1	7.1 ± 2.2	4.2 ± 1.3	2.8 ± 1.2	np
Substance use disorders	12.7 ± 2.0	7.3 ± 2.2	4.6 ± 1.6	3.8 ± 1.6	np	np	np
Any 12-month mental disorder (c), (d)	26.4 ± 2.7	24.8 ± 3.2	23.3 ± 3.3	21.5 ± 3.5	13.6 ± 2.1	8.6 ± 1.6	5.9 ± 2.1
Lifetime mental disorder, with no 12-month symptoms (e)	13.2 ± 2.0	29.0 ± 4.4	30.7 ± 3.3	30.4 ± 4.2	27.6 ± 3.6	23.1 ± 2.6	16.2 ± 4.1
No lifetime mental disorder (f)	60.5 ± 3.0	46.2 ± 3.9	46.0 ± 3.3	48.2 ± 4.6	58.8 ± 4.1	68.3 ± 3.0	77.8 ± 4.6

(a) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(b) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person can have had more than one 12-month mental disorder. Therefore, the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.59 Suicides and mortality rate, by sex, Australia (a), (b)

	2002	*2003*	*2004*	*2005*	*2006* (c)	*2007* (c)	*2008* (c)	*2009* (c)	*2010* (d)	*2011* (e)
Suicides (no.)										
Males	1 817	1 737	1 661	1 658	1 624	1 699	1 833	1 785	1 867	1 727
Females	503	477	437	444	494	530	508	552	553	546
People	2 320	2 214	2 098	2 102	2 118	2 229	2 341	2 337	2 420	2 273
Suicide death rate (per 100 000 people) (f)										
Males	18.6	17.6	16.6	16.4	15.8	16.2	17.1	16.3	16.8	15.3
Females	5.1	4.8	4.3	4.3	4.7	5.0	4.7	5.0	4.9	4.8
People	11.8	11.1	10.4	10.3	10.2	10.6	10.9	10.6	10.9	10.0

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2011* (Cat. no. 3303.0) Explanatory Notes 92–95.

(b) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(c) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final. See ABS' *Causes of Death, Australia 2011*, publication for more information.

(d) Data for 2010 have been revised and are subject to further revisions. See ABS' *Causes of Death, Australia 2011*, publication for more information.

(e) Data for 2011 are preliminary and subject to a revisions process. See ABS' *Causes of Death, Australia 2011,* publication for more information.

(f) Crude death rate per 100 000 people using estimated resident populations (ERPs) for Australia (people) at 30 June of relevant year. Rates are derived using ERPs based on the *2006 Census* and cannot be compared with rates derived using ERPs based on the 2011 Census. Details are included in the relevant tables.

Source: ABS 2013, *Causes of Death, Australia 2011,* Cat. no. 3303.0, Canberra.

Table 12A.60 **Suicides and mortality rate, by age and sex, Australia (a), (b)**

	15–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–84 years*	*85 years +*	*All ages* (c)
2011									
Suicides (no.)									
Males	231	332	340	328	222	128	92	47	1 727
Females	90	78	121	94	72	39	21	21	546
People	321	410	461	422	294	167	113	68	2 273
Suicide death rate (per 100 000 people) (d), (e)									
Males	14.7	20.6	21.7	21.8	17.4	15.4	20.5	33.8	15.5
Females	6.0	4.9	7.6	6.1	5.6	4.6	3.8	7.9	4.9
People	10.5	12.8	14.6	13.9	11.5	9.9	11.3	16.8	10.2
2007–2011									
Suicides (no.)									
Males	1 125	1 674	1 973	1 718	1 120	601	483	187	8 911
Females	362	455	564	550	370	176	120	66	2 689
People	1 487	2 129	2 537	2 268	1 490	777	603	253	11 600
Suicide death rate (per 100 000 people) (e)									
Males	14.4	21.7	25.5	23.2	18.4	15.8	22.3	30.2	16.5
Females	4.9	6.0	7.2	7.3	6.0	4.5	4.4	5.4	4.9
People	9.8	13.9	16.3	15.2	12.2	10.1	12.4	13.7	10.7

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data. See ABS *Causes of Death, 2011* (Cat. no. 3303.0) Explanatory Notes 92–95.

(b) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final. Data for 2010 have been revised and are subject to further revisions. Data for 2011 are preliminary and subject to a revisions process. See ABS' Causes of Death, Australia 2011, publication for more information.

(c) All ages includes deaths of people aged under 15 years and age not stated.

(d) Crude death rate per 100 000 estimated resident population as at 30 June 2011 for each age group and sex. Rates are derived using ERPs based on the 2011 Census and cannot be compared with rates derived using ERPs based on the 2006 Census (for example, in table 12A.59).

Table 12A.60 Suicides and mortality rate, by age and sex, Australia (a), (b)

	15–24 years	*25–34 years*	*35–44 years*	*45–54 years*	*55–64 years*	*65–74 years*	*75–84 years*	*85 years +*	*All ages* (c)

(e) Rate per 100 000 estimated resident population at 30 June of the relevant mid point year (for 2007–2011 it is 2009). Rates are derived using ERPs based on the 2011 Census and cannot be compared with rates derived using ERPs based on the 2006 Census.

Source: ABS 2013, *Causes of Death, Australia 2011,* Cat. no. 3303.0, Canberra; ABS unpublished, *Australian Demographic Statistics*, Cat. no. 3101.0.

Table 12A.61 **Suicide deaths and death rate (a), (b)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (c)	*ACT* (c)	*NT* (c)	*Aust*
Suicide deaths (no.)									
2002	692	528	537	242	170	70	26	55	2 320
2003	640	540	466	227	193	69	35	44	2 214
2004	587	521	453	194	178	88	26	51	2 098
2005	549	506	459	203	231	74	35	45	2 102
2006 (d)	577	485	494	245	180	72	32	33	2 118
2007 (d)	611	474	520	266	205	66	32	55	2 229
2008 (d)	620	545	553	300	175	73	36	38	2 341
2009 (d)	623	576	525	279	185	79	32	37	2 337
2010 (e)	639	536	583	315	197	64	41	45	2 420
2011 (f)	566	483	559	306	209	73	34	43	2 273
2007–2011	3 059	2 614	2 740	1 466	971	355	175	218	11 600
Suicide death rate per 100 000 people (g), (h), (i)									
2002	10.4	10.9	14.5	12.6	11.2	14.8	8.1	27.7	11.8
2003	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006 (d)	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007 (d)	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008 (d)	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009 (d)	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010 (e)	8.8	9.7	13.3	13.7	11.8	13.0	11.3	18.8	10.9
2011 (f)	7.7	8.5	12.5	12.8	12.7	13.9	9.5	18.1	10.0
2007–2011 (g)	8.6	9.5	12.7	13.0	12.0	14.1	9.9	20.1	10.6

(a) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide due to limitations of data.

(c) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.

(d) Data for 2006, 2007, 2008 and 2009 have undergone revisions and are now considered final.

(e) Data for 2010 have been revised and are subject to further revisions.

(f) Data for 2011 are preliminary and subject to a revisions process.

(g) Rate per 100 000 estimated resident population at 30 June of the relevant single year or for five year average the mid-point year (2007–2011). 2007–2011 rate includes final 2007, 2008 and 2009 data, revised 2010 data and preliminary 2011 data.

(h) Death rates standardised to the mid-year 2001 population.

(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2007–2011) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

Source: ABS 2013, *Causes of Death, Australia 2011*, Cat. no. 3303.0, Canberra; ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.62 Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (f)	*Aust* (g)
Number of suicide deaths of people aged 15–24 years									
2002	83	58	85	46	23	8	–	12	317
2003	78	64	64	39	27	6	9	13	300
2004	75	66	54	23	22	np	3	np	265
2005	66	61	67	30	37	9	5	15	290
2006	74	61	74	41	25	9	6	8	298
2007	54	74	81	46	19	4	3	21	300
2008	62	63	80	44	21	np	6	9	288
2009	63	60	63	47	21	8	np	11	276
2010	61	77	84	38	22	7	np	11	302
2011	58	62	82	52	36	10	5	16	321
2007–2011	298	336	390	227	119	29	14	68	1 487
Suicide death rate per 100 000 people aged 15–24 years (h), (i)									
2002	9.3	8.8	16.3	16.8	11.5	12.8	–	39.0	11.8
2003	8.7	9.6	12.0	14.0	13.3	9.4	17.4	42.7	10.9
2004	8.3	9.7	9.9	8.2	10.8	np	5.8	np	9.5
2005	7.2	8.9	11.9	10.5	17.9	13.9	9.7	48.1	10.2
2006	8.0	8.5	12.8	13.8	11.7	13.8	11.1	24.5	10.3
2007	5.7	10.1	13.6	15.1	8.8	4.6	3.6	62.6	10.1
2008	6.4	8.3	13.0	14.0	9.6	np	11.0	26.1	9.5
2009	6.5	7.8	10.3	14.5	9.6	12.1	7.0	30.8	9.1
2010	6.3	10.0	13.5	11.6	9.9	10.5	1.7	30.4	9.9
2011	6.0	8.1	13.1	15.7	16.3	15.1	8.5	45.1	10.5
2007–2011 (h)	6.2	8.8	12.7	14.0	10.8	9.4	6.3	38.1	9.8

(a) By year of registration. Year-to-year variation can be influenced by coronial workloads.

(b) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. For further information, see Explanatory Notes 92-95 of Causes of Death, Australia, 2011 (cat. No. 3303.0).

(c) From 2006 data onwards, data cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Rates use the actual count and not the randomly assigned value. Cells with a zero value have not been affected by confidentialisation.

(d) All footnotes and caveats, including this notice, must remain attached to data at all times.

(e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2009 (final), 2010 (revised), 2011 (preliminary). 'See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (cat. 3303.0) and Causes of Death Revisions, 2009 and 2010 in Causes of Death, Australia, 2011 (cat. no. 3303.0).

(f) Low population results in small variations in the number of suicides appearing as large changes across the single year rates.

(g) Includes 'Other Territories'.

Table 12A.62 **Suicide deaths and death rate of people aged 15–24 years (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (f)	*ACT* (f)	*NT* (f)	*Aust* (g)

(h) Rate per 100 000 ERP at 30 June of the relevant single year or for five year average the mid-point year (2007–2011). 2007–2011 rate includes final 2007, 2008 and 2009 data, revised 2010 data and preliminary 2011 data.

(i) The ERPs used to derived these rates differ across years. For data up to 2005 the rates are derived using ERPs based on the 2001 Census. For data up to 2008 the rates are derived using ERPs based on the 2006 Census. For data from 2009 (and for the five year averages 2007–2011) the rates are derived using the ERPs based on the 2011 Census. Rates derived using ERPs based on different Censuses are not comparable.

– Nil or rounded to zero. **np** not published

Source: ABS 2013, Causes of Death, Australia 2011, Cat. no. 3303.0, Canberra; ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.63 Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)

	NSW	Vic	Qld	WA	SA	Tas (k)	ACT	NT	Aust
Number of suicide deaths by area									
2003									
Capital city	379	372	220	164	137	27	35	20	1 354
Other urban	218	111	185	48	39	22	..	12	635
Rural	38	54	55	11	16	19	..	12	205
2004									
Capital city	358	345	194	141	125	29	26	22	1 240
Other urban	192	122	199	38	np	37	..	–	629
Rural	32	50	55	15	21	22	..	16	211
2005									
Capital city	342	332	179	142	173	29	35	23	1 255
Other urban	186	124	204	45	33	31	..	11	634
Rural	19	49	69	14	25	12	..	11	199
2006									
Capital city	340	330	187	157	133	28	32	14	1 221
Urban centres	129	64	171	19	..	20	..	..	403
Rural	108	91	136	69	47	24	..	19	494
2007									
Capital city	393	327	189	180	148	22	32	27	1 318
Urban centres	140	63	191	20	–	25	..	..	439
Rural	76	84	137	65	57	18	..	27	464
2008									
Capital city	362	374	216	219	125	27	36	23	1 382
Urban centres	127	76	215	27	..	26	..	..	471
Rural	131	95	122	54	50	20	..	15	487
2009									
Capital city	326	385	198	194	145	35	32	15	1 330
Urban centres	208	107	198	35	18	22	..	2	591
Rural	87	81	124	44	20	22	–	19	398
2010									
Capital city	348	345	219	227	151	33	41	20	1 384
Urban centres	191	100	225	40	17	15	..	3	592
Rural	97	88	131	45	26	16	–	21	424
2011									
Capital city	309	321	244	193	155	31	33	11	1 297
Urban centres	182	82	209	47	18	25	..	2	567
Rural	70	78	104	65	35	17	2	27	397
2007–2011									
Capital city	1 666	1 726	1 073	1 022	731	147	174	91	6 630
Urban centres	943	471	1 064	184	85	100	..	17	2 864

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (k)	*ACT*	*NT*	*Aust*
Rural	432	405	582	246	149	107	2	108	2 032
Suicide death rate per 100 000 people by area (l)									
2003									
Capital city	9.0	10.5	12.7	11.5	12.2	13.5	10.8	18.5	10.7
Other urban	10.0	10.9	11.7	12.6	16.8	12.0	..	26.1	11.3
Rural	12.2	16.0	11.3	7.9	9.2	20.4	..	26.9	12.9
Total	9.6	11.0	12.3	11.6	12.6	14.5	10.8	21.2	11.1
2004									
Capital city	8.5	9.6	10.9	9.7	11.1	14.3	8.0	20.1	9.7
Other urban	8.8	11.8	12.3	9.9	np	19.9	..	np	11.1
Rural	10.2	14.7	11.1	10.9	12.0	23.4	–	37.1	13.2
Total	8.7	10.5	11.7	9.8	11.6	18.2	8.0	25.5	10.4
2005									
Capital city	7.8	8.9	9.8	9.5	15.0	14.5	10.5	19.6	9.5
Other urban	8.6	12.2	12.3	11.6	14.8	17.0	..	22.2	11.2
Rural	6.5	14.7	13.9	9.6	13.5	12.9	..	27.2	12.5
Total	8.0	9.8	11.6	10.1	14.9	15.8	10.5	21.7	10.3
2006									
Capital city	7.8	8.8	10.3	10.5	11.5	13.8	9.7	np	9.2
Urban centres	10.0	11.0	12.8	np	..	10.9	..	..	11.3
Rural	9.3	11.7	16.6	20.9	11.5	23.8	..	np	13.2
Total	8.4	9.5	12.4	12.1	11.5	14.8	9.7	14.2	10.3
2007									
Capital city	8.8	8.3	10.1	11.4	12.5	10.7	9.1	22.8	9.6
Urban centres	10.8	10.7	12.9	10.3	..	13.9	..	..	11.7
Rural	6.4	10.9	17.0	18.9	13.8	18.5	..	29.1	12.5
Total	8.8	9.0	12.5	12.6	12.9	14.1	9.1	26.5	10.5
2008									
Capital city	8.3	9.5	11.5	14.0	10.6	13.3	10.3	20.2	10.2
Urban centres	9.8	12.9	14.4	13.9	..	13.6	..	..	12.6
Rural	10.9	11.9	15.2	16.5	12.6	22.4	..	np	13.2
Total	8.9	10.3	13.3	14.2	11.0	15.2	10.3	17.9	11.1
2009									
Capital city	7.8	9.6	9.9	11.2	11.9	17.0	8.9	np	9.6
Urban centres	11.1	13.8	12.3	13.7	np	13.9	..	np	12.2
Rural	9.2	12.0	17.5	15.6	8.1	14.7	–	np	12.8
Total	8.7	10.5	12.1	12.3	11.5	15.4	8.9	17.4	10.7
2010									
Capital city	8.2	8.5	10.8	13.1	11.9	16.5	11.4	17.7	9.9
Urban centres	9.9	12.6	14.0	15.3	np	np	..	np	12.1

Table 12A.63 **Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas* (k)	*ACT*	*NT*	*Aust*
Rural	10.0	12.5	17.7	15.5	10.0	np	–	21.1	13.4
Total	8.8	9.7	13.3	13.7	11.8	13.0	11.3	18.8	10.9
2011									
Capital city	7.1	7.7	11.8	10.6	12.4	14.4	9.3	np	9.0
Urban centres	9.4	10.0	12.6	17.2	np	15.9	..	np	11.4
Rural	7.3	11.0	14.4	22.0	13.7	np	np	30.7	12.8
Total	7.7	8.5	12.5	12.8	12.7	13.9	9.5	18.1	10.0
2007–2011									
Capital city	8.0	8.6	10.8	11.9	11.9	14.4	9.8	17.0	9.6
Urban centres	10.0	12.1	13.3	14.4	13.0	12.8	..	np	11.8
Rural	9.0	11.8	16.2	17.4	11.7	15.3	np	27.4	13.1
Total	8.6	9.5	12.7	13.0	12.0	14.1	9.9	20.1	10.6

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Explanatory Notes 92-95, *Causes of Death, Australia*, 2011 (Cat. no. 3303.0).

(b) The total for each state and territory includes deaths registered to that state but which had a usual address which was undefined, overseas, of no fixed abode or off-shore and migratory. Such 'special purpose' Statistical Area 2s are only included in the state total.

(c) The Australian total includes the 'Other Territories' — Jervis Bay, Christmas Island and the Cocos (Keeling) Islands.

(d) Data for 2009, 2010, 2011 and 2007–2011 were supplied this year based on a new method of obtaining Capital City, Urban Centre and Rural data (using SUA from ASGS). Data supplied in previous years also appear in this table (2003–2008), and for these years the geographical breakdown was based on a different method, using the ASGC (see footnotes g, h and i in this table). The total rates data for the 2007–2011 data differ to those in table 12A.60 due to the use of a different population. For years prior to 2008, death rates data are based on the previous year's ERP (i.e. 2007 ERP data for 2008 causes of death). This was necessary because of the change in sub-state statistical geography between years. However, for 2009, 2010, 2011 and 2007-2011 data, when using the ASGS the statistical geography between years is stable and therefore the same year's ERP data was used (that is, 2011 ERP for 2011 *Causes of Death* data).

(e) All causes of death data from 2006 onward are subject to a revisions process — once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised), 2011 (preliminary). See Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2006 in *Causes of Death, Australia, 2010* (Cat. no. 3303.0) and Causes of Death Revisions, 2009 and 2010 in *Causes of Death, Australia, 2011* (Cat. no. 3303.0).

(f) For data from 2006, cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. Cells with a zero value have not been affected by confidentialisation.

Table 12A.63 Suicide deaths and suicide death rate, by area (a), (b), (c), (d), (e), (f), (g), (h), (i), (j)

	NSW	Vic	Qld	WA	SA	Tas (k)	ACT	NT	Aust

(g) For single year data prior to 2006, the categories were as follows: 'capital city' comprises capital city statistical divisions; 'other urban' comprises centres with more than 20 000 people; 'rural' comprises all areas except capital cities and other urban. 'Other urban' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in urban centres, based on Australian Standard Geographical Classification (ASGC) 2001 boundaries. 'Rural' comprises statistical local areas with 50 per cent or greater of their 2001 census enumerated population contained in rural areas. Changes in the population within geographical areas may not be reflected in the rates provided. There is some risk that urban growth areas have been classified as rural as the geography was based on the population in those areas in 2001. Therefore, analysis of data should be undertaken with caution.

(h) For single year 2006, 2007 and 2008, the categories were derived as follows: 'capital cities' — comprising capital city statistical divisions, 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of state, that is all areas other than capital cities and urban centres.

(i) For the single years 2009, 2010, 2011 and the five year sum and averages (2007–2011), the capital city, urban centres and rural groupings are based on the ABS' Significant Urban Areas classification (Cat. no. 1270.0.55.004). Capital cities are comprised of those Statistical Area 2s classified as capital cities. Urban centres are comprised of all Statistical Area 2s within a state which are classified as having or contributing to an urban area with a population of 10,000 or greater, excluding capital cities. Rural areas are those Statistical Area 2s which are not within a capital city or urban centre. For further information, see Cat. no. 1270.0.55.004 - Australian Statistical Geography Standard (ASGS): Volume 4 — Significant Urban Areas, Urban Centres and Localities, Section of State, July 2011. Some Significant Urban Areas cross state boundaries: Canberra – Queanbeyan (ACT/NSW); Albury – Wodonga (NSW/Vic); and Gold Coast – Tweed Heads (Qld/NSW). In these cases, deaths have been included in the Urban Centre category in the relevant state. The exception is Canberra - Queanbeyan: the Canberra portion forms the Capital City area for ACT, while the Queanbeyan portion has been included in the Urban Centres data for NSW.

(j) All footnotes and caveats, including this notice, must remain attached to data at all times.

(k) The three criteria for this data tend to distort the Tasmanian picture due to the low level of urbanisation.

(l) Age-standardised death rates per 100 000 are standardised to Australian 30 June 2001 population.

.. Not applicable. **–** Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *Causes of Death, Australia*, Cat. no. 3303.0.

Table 12A.64 Suicide deaths, by Indigenous status, 2007–2011 (a), (b), (c), (d), (e), (f)

	NSW	*Vic*	*Qld* (g)	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total* (h)
Number									
Indigenous	83	np	168	130	32	np	np	116	529
Non-Indigenous	2 976	np	2 560	1 336	939	np	np	102	7 913
Total	3 059	np	2 728	1 466	971	np	np	218	8 442
Suicide rate per 100 000 (i), (j)									
Indigenous	13.3	np	21.5	35.9	21.7	np	np	29.0	22.3
Non-Indigenous (k)	8.4	np	11.9	12.1	11.6	np	np	14.4	10.3

(a) All causes of death data from 2006 onward are subject to a revisions process - once data for a reference year are 'final', they are no longer revised. Affected data in this table are: 2007-2009 (final), 2010 (revised), 2011 (preliminary). See Technical Notes, Causes of Death Revisions, 2006 in Causes of Death, Australia, 2010 (Cat. no. 3303.0). See also Explanatory Notes 29-33 and Technical Notes, Causes of Death Revisions, 2009 and 2010 in Causes of Death, Australia, 2011 (Cat. no. 3303.0).

(b) See Explanatory Notes 81-99 in Causes of Death, Australia, 2011 (Cat. no. 3303.0) for further information on specific issues relating to 2011 data.

(c) Data are reported by jurisdiction of usual residence for NSW, Qld, WA, SA and the NT only. Only these five states and territories have evidence of a sufficient level of Indigenous identification and sufficient numbers of Indigenous deaths to support mortality analysis. See Explanatory Notes 68-76 of Causes of Death, Australia, 2011 (Cat. no. 3303.0) for further information on interpreting data relating to deaths of Indigenous persons.

(d) Suicide deaths include ICD-10 codes X60-X84 and Y87.0. Care needs to be taken in interpreting figures relating to suicide. For further information, see Explanatory Notes 92-95 of Causes of Death, Australia, 2011 (Cat. no. 3303.0).

(e) Data are presented in a five-year aggregation (2007-2011) due to volatility of the small numbers involved.

(f) All footnotes and caveats, including this notice, must remain attached to data at all times.

(g) Care should be taken when interpreting deaths data for Queensland as they are affected by changes in the timeliness of birth and death registrations. Queensland deaths data for 2010 were adjusted to minimise the impact of late registration of deaths on mortality indicators. See Retrospective deaths by Causes of Death, Queensland, 2010 (Technical Note) in Causes of Death, Australia, 2010 (cat. no. 3303.0) for a more detailed explanation.

(h) Total includes only the five jurisdictions for which data are available: NSW, Qld, WA, SA and NT.

(i) The Indigenous population denominator used for calculating death rates in this table is from ABS Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (cat. no. 3238.0), Series B. These are 2006-census-based population projections. The non-Indigenous denominator has been derived by subtracting the Indigenous population projections from the total persons 2006-census-based population estimates.

(j) Standardised death rate. Deaths per 100,000 of estimated mid-year population. See Glossary of Causes of Death, Australia, 2011 (cat. no. 3303.0) for further information.

(k) Includes deaths where Indigenous status was not stated.

np Not published.

Source: ABS unpublished, *Causes of Death, Australia,* Cat. no. 3303.0.

Table 12A.65 Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	65.2 ± 7.7	59.4 ± 6.4	57.7 ± 6.7	65.0 ± 5.9	61.2 ± 7.2	51.6 ± 8.7	72.5 ± 8.2	63.2 ± 10.3	61.7 ± 3.1
People without mental or behavioural problems	78.7 ± 1.7	81.0 ± 1.8	81.8 ± 2.0	81.5 ± 1.9	78.7 ± 2.4	76.1 ± 2.9	85.6 ± 2.1	84.8 ± 3.1	80.3 ± 0.9
All people	76.6 ± 2.0	77.7 ± 1.8	77.7 ± 2.1	78.7 ± 1.9	76.0 ± 2.5	71.8 ± 3.2	83.4 ± 2.3	81.9 ± 3.1	77.4 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	4.3* ± 2.7	6.0* ± 3.2	9.6 ± 3.3	5.5* ± 3.6	7.0* ± 3.6	8.7* ± 4.6	2.9* ± 2.7	5.6** ± 7.0	6.3 ± 1.4
People without mental or behavioural problems	2.8 ± 0.9	2.8 ± 1.0	3.2 ± 1.0	2.8 ± 1.1	3.8 ± 1.3	3.6 ± 1.2	1.4* ± 0.9	2.0* ± 1.2	3.0 ± 0.4
All people	3.0 ± 0.8	3.4 ± 1.0	4.3 ± 1.0	3.3 ± 1.0	4.3 ± 1.2	4.4 ± 1.3	1.8* ± 0.9	2.4* ± 1.2	3.5 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	69.5 ± 7.3	65.4 ± 6.5	67.3 ± 6.6	70.6 ± 6.2	68.2 ± 7.2	60.3 ± 8.7	75.4 ± 7.9	68.7 ± 11.2	68.0 ± 3.2
People without mental or behavioural problems	81.5 ± 1.6	83.8 ± 1.7	85.1 ± 1.8	84.4 ± 1.8	82.5 ± 2.1	79.6 ± 2.9	87.0 ± 2.0	86.8 ± 2.7	83.3 ± 0.9
All people	79.7 ± 1.8	81.1 ± 1.7	82.0 ± 1.8	81.9 ± 1.6	80.3 ± 2.2	76.2 ± 3.0	85.1 ± 2.0	84.3 ± 2.7	80.8 ± 0.9
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	30.5 ± 7.3	34.6 ± 6.5	32.7 ± 6.6	29.4 ± 6.2	31.8 ± 7.2	39.7 ± 8.8	24.6 ± 7.9	31.3 ± 11.1	32.0 ± 3.2
People without mental or behavioural problems	18.5 ± 1.6	16.2 ± 1.7	14.9 ± 1.8	15.6 ± 1.8	17.5 ± 2.1	20.4 ± 2.9	13.0 ± 2.0	13.2 ± 2.7	16.7 ± 0.9
All people	20.3 ± 1.8	18.9 ± 1.7	18.0 ± 1.8	18.1 ± 1.6	19.7 ± 2.2	23.8 ± 3.0	14.9 ± 2.0	15.7 ± 2.7	19.2 ± 0.9

Table 12A.65 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2011-12 (per cent) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source: ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)*, Cat. no. 4364.0.

Table 12A.66 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) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People with mental or behavioural problems (d), (e)	80.8 ± 9.1	80.4 ± 12.2	79.4 ± 8.3	70.9 ± 11.9	84.2 ± 10.2	74.8 ± 11.0	82.2 ± 12.3	55.2* ± 27.9	79.2 ± 4.2
People without mental or behavioural problems	93.2 ± 2.4	90.5 ± 2.7	87.0 ± 3.4	88.7 ± 3.7	85.5 ± 4.7	86.6 ± 4.8	97.2 ± 2.1	87.5 ± 5.4	90.2 ± 1.2
All people	91.8 ± 2.3	89.2 ± 2.8	85.8 ± 3.3	85.7 ± 4.0	85.4 ± 4.4	84.5 ± 4.3	94.9 ± 2.6	83.2 ± 6.1	88.7 ± 1.1

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) Numerators – number of people 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. Denominators – number of people aged 16–30 years, by mental health status.

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

Source : ABS unpublished, *Australian Health Survey 2011-13 (2011-12 NHS component)* , Cat. no. 4364.0.

Table 12A.67 Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent) (a), (b), (c)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People aged 16–64 years who are employed									
People with mental or behavioural problems (d), (e)	59.3 ± 6.2	68.2 ± 5.8	65.4 ± 6.9	70.8 ± 7.5	48.6 ± 6.9	55.7 ± 8.3	75.4 ± 5.9	57.2 ± 23.7	63.8 ± 3.2
People without mental or behavioural problems	78.0 ± 2.3	79.8 ± 2.0	79.0 ± 2.3	83.1 ± 2.3	79.3 ± 2.6	74.2 ± 3.1	85.9 ± 2.1	83.4 ± 11.1	79.4 ± 1.0
All people	75.6 ± 2.2	78.4 ± 1.8	77.0 ± 2.2	81.3 ± 2.4	75.1 ± 2.6	71.6 ± 3.1	84.5 ± 2.0	83.9 ± 8.8	77.3 ± 1.0
People aged 16–64 years who are unemployed									
People with mental or behavioural problems (d), (e)	7.2 ± 3.3	4.2 ± 2.0	4.2* ± 3.2	3.1* ± 2.5	8.7 ± 3.5	6.6* ± 5.9	3.6* ± 3.5	–	5.3 ± 1.2
People without mental or behavioural problems	2.4 ± 0.8	2.3 ± 0.8	2.9 ± 1.1	2.3 ± 1.1	3.1 ± 1.0	4.1 ± 2.0	np	np	2.5 ± 0.4
All people	3.1 ± 0.8	2.5 ± 0.7	3.1 ± 1.0	2.4 ± 1.0	3.9 ± 1.0	4.3 ± 1.7	np	np	2.9 ± 0.4
People aged 16–64 years who are in the labour force									
People with mental or behavioural problems (d), (e)	66.4 ± 5.7	72.4 ± 6.1	69.6 ± 6.2	73.9 ± 7.2	57.3 ± 7.2	62.3 ± 9.5	79.1 ± 5.9	57.2 ± 23.7	69.1 ± 2.8
People without mental or behavioural problems	80.4 ± 2.2	82.1 ± 2.0	81.9 ± 2.1	85.4 ± 2.1	82.4 ± 2.2	78.3 ± 2.8	87.4 ± 2.0	85.1 ± 10.5	81.9 ± 1.0
All people	78.7 ± 2.1	80.9 ± 1.8	80.1 ± 1.9	83.7 ± 2.2	79.0 ± 2.1	75.9 ± 3.1	86.2 ± 1.9	85.6 ± 8.1	80.2 ± 1.0
People aged 16–64 years who are not in the labour force									
People with mental or behavioural problems (d), (e)	33.6 ± 5.7	27.6 ± 6.1	30.4 ± 6.2	26.1 ± 7.2	42.7 ± 7.2	37.7 ± 9.5	np	np	30.9 ± 2.8
People without mental or behavioural problems	19.6 ± 2.2	17.9 ± 2.0	18.1 ± 2.1	14.6 ± 2.1	17.6 ± 2.2	21.7 ± 2.8	np	np	18.1 ± 1.0
All people	21.3 ± 2.1	19.1 ± 1.8	19.9 ± 1.9	16.3 ± 2.2	21.0 ± 2.1	24.1 ± 3.1	13.8 ± 1.9	14.4* ± 8.1	19.8 ± 1.0

Table 12A.67 **Age standardised proportion of people aged 16–64 years who are employed, by mental illness status, 2007-08 (per cent) (a), (b), (c)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution. A '**' indicates a RSE of greater than 50 per cent. Estimates with RSEs greater than 50 per cent are considered too unreliable for general use.

(b) Numerators — number of people aged 16–64 years who are employed/unemployed/in the labour force/not in the labour force (by mental health status). Denominators — number of people aged 16–64 years in the population (by mental health status).

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

– Nil or rounded to zero. **np** Not published.

Source: ABS unpublished, *National Health Survey 2007-08*, Cat. no. 4364.0.

Table 12A.68 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) (a), (b), (c), (d), (e)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
People with a mental illness	78.1 ± 11.8	80.7 ± 10.0	83.6 ± 11.3	84.0 ± 10.6	66.1 ± 9.8	63.0 ± 17.5	88.3 ± 7.2	np	79.6 ± 5.7
People without a mental illness	89.8 ± 2.9	91.8 ± 2.7	86.9 ± 4.4	89.8 ± 3.9	89.1 ± 3.1	87.0 ± 5.1	94.7 ± 2.3	88.0 ± 24.9	89.7 ± 1.7
All people	88.4 ± 2.8	90.3 ± 2.6	86.4 ± 3.9	88.9 ± 4.0	85.9 ± 3.3	83.3 ± 6.0	93.8 ± 2.1	88.0 ± 24.9	88.4 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). A '*' indicates a relative standard error (RSE) of between 25 per cent and 50 per cent. Estimates with RSEs greater than 25 per cent should be used with caution.

(b) Numerators – number of people 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. Denominators – number of people aged 16–30 years, by mental health status.

(c) As State and Territory comparisons are affected by age, estimates have been age standardised to the 2001 estimated resident population.

(d) People with a mental or behavioural condition are defined as having a current self-reported mental and behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.

(e) Includes organic mental conditions, alcohol and drug conditions, mood conditions and other mental and behavioural conditions.

np Not published.

Source : ABS unpublished, *2007-08 National Health Survey,* Cat. no. 4364.0.

Table 12A.69 Labour force and employment participation among adults aged 16–64 years, by mental disorder status, 2007 (per cent) (a)

	Employed (b)			*Unemployed* (b)	*In labour force*	*Not in the labour force*
	Full-time	*Part-time*	*Total*			
Any 12-month mental disorder (c)						
Anxiety disorders	59.9 ± 5.5	35.4 ± 5.3	95.3 ± 2.0	4.7 ± 2.0	71.0 ± 3.4	29.0 ± 3.4
Affective disorders	57.4 ± 6.8	32.6 ± 7.0	90.0 ± 4.3	10.0 ± 4.3	69.8 ± 4.3	30.2 ± 4.3
Substance use disorders	62.3 ± 6.9	30.8 ± 7.3	93.1 ± 3.3	6.9 ± 3.3	83.0 ± 5.4	17.0 ± 5.4
Any 12-month mental disorder (c), (d)	59.8 ± 4.7	34.7 ± 4.4	94.5 ± 1.7	5.5 ± 1.7	73.6 ± 2.7	26.4 ± 2.7
Lifetime mental disorder, with no 12-month symptoms (e)	68.7 ± 3.8	27.4 ± 3.7	96.1 ± 1.7	3.9 ± 1.7	80.9 ± 2.4	19.1 ± 2.4
No lifetime mental disorder (f)	63.7 ± 2.3	33.1 ± 2.3	96.8 ± 0.9	3.2 ± 0.9	78.4 ± 1.6	21.6 ± 1.6

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) A person may have more than one mental disorder. Therefore the components may not add to the total.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.70 **Education, training and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a), (b)**

	Studying (c)	*Not studying*			*Total*
		Employed	*Unemployed/Not in the labour force*	*Total*	
Any 12-month mental disorder (d)	42.0 ± 4.9	44.3 ± 5.0	13.7 ± 3.0	58.0 ± 4.9	100.0
Lifetime mental disorder, with no 12-month symptoms (e)	29.5 ± 6.6	55.9 ± 7.3	np	70.5 ± 6.6	100.0
No lifetime mental disorder (f)	51.6 ± 3.8	39.2 ± 3.3	9.2 ± 2.2	48.4 ± 3.8	100.0

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent).

(b) Estimates with RSEs greater than 25 per cent are considered unreliable. These estimates are not published.

(c) Includes people studying full-time and part-time and people still at school.

(d) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(e) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(f) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.71 **Labour force and employment participation among adults aged 16–30 years, by mental disorder status, 2007 (per cent) (a)**

	Employed (b)	*Unemployed* (b)	*Not in the labour force*
Any 12-month mental disorder (c)	92.1 ± 3.2	7.9 ± 3.2	19.2 ± 3.4
Lifetime mental disorder, with no 12-month symptoms (d)	92.2 ± 9.0	np	17.6 ± 6.2
No lifetime mental disorder (e)	93.6 ± 1.9	6.4 ± 1.9	22.1 ± 2.9

(a) The rates reported in this table include 95 per cent confidence intervals (for example, X per cent ± X per cent). Estimates with RSEs greater than 25 per cent are not published.

(b) The employed and unemployed rates are as a proportion of those in the labour force.

(c) People who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(d) People who had experienced a mental disorder at some point in their life, but who did not have symptoms in the previous 12 months.

(e) People who did not meet criteria for diagnosis of a lifetime mental disorder.

np Not published.

Source: ABS unpublished, *2007 Survey of Mental Health and Wellbeing*, Cat. no. 4326.0.

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (f)	*Aust* (d)
2007-08									
Group A: People discharged from hospital (g)									
Significant improvement	75.6	76.1	71.3	74.8	66.7	72.2	np	np	73.3
No significant change	20.2	20.5	22.7	20.4	29.0	21.6	np	np	22.1
Significant deterioration	4.2	3.5	6.0	4.8	4.4	6.2	np	np	4.6
Group B: People discharged from community care (h)									
Significant improvement	55.6	53.6	55.1	47.7	47.4	47.0	np	np	53.3
No significant change	42.0	42.5	38.9	44.7	47.0	46.4	np	np	41.7
Significant deterioration	2.4	3.9	6.0	7.6	5.6	6.6	np	np	5.0
Group C: People in ongoing community care (i)									
Significant improvement	24.5	27.9	29.3	28.5	24.9	27.7	np	23.3	27.1
No significant change	60.7	58.0	52.2	56.4	58.7	51.8	np	56.4	56.8
Significant deterioration	14.8	14.0	18.5	15.1	16.4	20.6	np	20.3	16.1
2008-09									
Group A: People discharged from hospital (g)									
Significant improvement	74.7	76.2	73.9	75.8	70.3	76.9	np	np	74.7
No significant change	21.2	20.1	21.2	20.2	25.4	20.2	np	np	21.2
Significant deterioration	4.0	3.7	4.9	4.0	4.4	2.8	np	np	4.0
Group B: People discharged from community care (h)									
Significant improvement	55.9	50.3	57.8	52.9	46.3	45.9	np	np	52.6
No significant change	41.6	44.2	36.3	39.8	48.9	46.9	np	np	42.1
Significant deterioration	2.6	5.5	5.9	7.2	4.8	7.2	np	np	5.3
Group C: People in ongoing community care (i)									
Significant improvement	23.6	29.4	29.4	25.6	27.1	27.2	np	27.2	27.3
No significant change	61.9	56.2	53.3	58.7	57.7	58.0	np	49.9	57.2
Significant deterioration	14.5	14.4	17.3	15.7	15.2	14.7	np	23.0	15.5
2009-10									
Group A: People discharged from hospital (g)									
Significant improvement	68.7	73.5	74.1	72.9	70.0	77.2	np	np	71.7
No significant change	26.2	22.6	21.4	22.5	26.0	19.9	np	np	23.9
Significant deterioration	5.1	3.9	4.5	4.6	4.0	2.8	np	np	4.4
Group B: People discharged from community care (h)									
Significant improvement	54.6	50.0	58.3	52.7	47.7	47.4	np	np	52.0
No significant change	42.1	43.8	35.7	42.3	48.2	48.5	np	np	42.6
Significant deterioration	3.3	6.1	5.9	5.0	4.0	4.1	np	np	5.4
Group C: People in ongoing community care (i)									
Significant improvement	22.6	28.3	31.9	27.2	25.2	27.4	18.5	25.5	27.3
No significant change	61.8	56.8	52.7	58.2	58.7	56.6	68.7	52.0	57.4
Significant deterioration	15.5	14.9	15.4	14.5	16.1	15.9	12.8	22.5	15.3

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (f)	*Aust* (d)
2010-11									
Group A: People discharged from hospital (g)									
Significant improvement	69.4	73.5	73.8	74.7	72.2	75.6	np	77.0	72.5
No significant change	25.1	22.8	20.1	21.6	24.1	20.1	np	19.5	23.1
Significant deterioration	5.4	3.7	6.2	3.7	3.8	4.3	np	3.5	4.5
Group B: People discharged from community care (h)									
Significant improvement	56.6	45.5	59.2	51.7	46.0	52.7	np	np	50.0
No significant change	40.5	43.8	35.5	42.4	49.6	43.9	np	np	42.2
Significant deterioration	2.9	10.7	5.3	5.8	4.3	3.4	np	np	7.7
Group C: People in ongoing community care (i)									
Significant improvement	22.8	27.4	30.6	24.7	24.6	25.9	18.7	28.5	26.4
No significant change	62.2	57.3	53.5	59.3	61.1	57.3	67.8	50.3	58.1
Significant deterioration	15.0	15.3	15.9	16.0	14.3	16.8	13.5	21.2	15.4
2011-12									
Group A: People discharged from hospital (g)									
Significant improvement	68.1	na	73.4	72.1	71.3	73.0	np	77.6	70.8
No significant change	27.0	na	19.7	22.8	24.7	22.1	np	16.1	24.0
Significant deterioration	4.9	na	6.9	5.1	4.0	4.9	np	6.3	5.2
Group B: People discharged from community care (h)									
Significant improvement	54.3	na	54.5	45.7	47.1	43.2	np	np	51.5
No significant change	42.4	na	39.5	48.7	48.8	51.7	np	np	43.7
Significant deterioration	3.3	na	5.9	5.6	4.0	5.1	np	np	4.8
Group C: People in ongoing community care (i)									
Significant improvement	23.0	na	30.4	24.6	23.7	27.5	29.0	27.4	26.0
No significant change	61.1	na	54.0	60.4	60.9	50.8	56.5	53.5	58.3
Significant deterioration	15.8	na	15.6	15.0	15.3	21.6	14.5	19.2	15.7

(a) These data were prepared by the Australian Mental Health Outcomes and Classification Network, using data submitted by State and Territory governments to the Australian Government Department of Health. Assessment of clinical 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 in the case of children and adolescent consumers, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Developed originally in England in the 1990s, these ratings scales comprise standard items that are rated by a clinician to measure the severity of the consumer's symptoms or disability across a range of domains (for example, depressed mood, hallucinations, substance use, suicidality, overactivity, activities of daily living, cognitive impairment). The HoNOS/HoNOSCA form part of small suite of standardised rating scales used to monitor outcomes across state and territory public sector mental health services and private hospitals with a specialised psychiatric unit.
To be considered valid, Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) data needs to be completed correctly (a specified minimum number of items completed) and have a "matching pair" — that is, a beginning and end rating are needed to enable an outcome score to be determined.

Table 12A.72 **Clinical outcomes of people receiving various types of mental health care provided by State and Territory public mental health services (per cent) (a), (b), (c)**

	NSW	*Vic* (d)	*Qld*	*WA*	*SA*	*Tas* (e)	*ACT* (f)	*NT* (f)	*Aust* (d)

(b) Proportions may not add to 100 per cent due to rounding.

(c) For all consumer groups, outcome scores for each episode are classified as either ‘significant improvement’, ‘significant deterioration or ‘no significant change’, based on Effect Size. Effect size is a statistic used to assess the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre- score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 considered medium and 0.8 considered large. Based on this rule, a medium effect size of 0.5 was used to assign outcome scores to the three outcome categories. Thus individual episodes were classified as either: ‘significant improvement’ if the Effect Size index was greater than or equal to positive 0.5; ‘significant deterioration’ if the Effect Size index was less than or equal to negative 0.5; or ‘no change’ if the index was between -0.5 and 0.5.

(d) Victorian 2011-12 data are unavailable due to service level collection gaps resulting from protected industrial action during this period. All national averages for 2011-12 exclude Victoria.

(e) Industrial action in Tasmania has limited the available data quality and quantity of data for 2011-12.

(f) Some data for the ACT and the NT are np (not published) due to insufficient observations. The number of observations of consumer outcomes for some care types is too low to publish because conclusions based on such low numbers are known to have high levels of unreliability. For the purposes of this indicator, the threshold for the minimum number of observations to be reached was set at 200.

(g) Group A covers people who received a discrete episode of inpatient care within a state/territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of inpatient care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission and discharge. The analysis excludes episodes where length of stay was three days or less because it is not meaningful to compare admission and discharge ratings for short duration episodes.

(h) Group B covers people who received relatively short term community care from a state/territory mental health service during the reference year. The defining characteristic of the group is that the episode of community care commenced, and was completed, within the year. Outcome scores were calculated as the difference between the total score recorded at admission to, and discharge from, community care. A subgroup of people whose episode of community care completed because they were admitted to hospital is not included in this analysis.

(i) Group C covers people receiving relatively long term community care from a state/territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June). Outcome scores were calculated as the difference between the total score recorded on the first occasion rated and the last occasion rated in the year.

np Not published.

Source: Australian Mental Health Outcomes and Classification Network, authorised by Australian Government Department of Health.

Table 12A.73 Deflators used to calculate real State and Territory mental health expenditure (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
2005-06	85.2	85.9	80.9	82.2	83.2	84.6	83.8	85.0
2006-07	88.9	88.6	84.7	85.3	86.3	88.1	86.9	88.3
2007-08	91.5	90.9	87.7	88.1	89.4	90.7	89.9	89.9
2008-09	93.7	93.8	91.1	91.6	92.9	93.4	93.2	93.5
2009-10	96.8	96.8	95.3	95.5	96.5	96.6	96.6	96.4
2010-11	97.8	98.3	97.4	96.5	97.4	97.6	97.5	97.4
2011-12	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The deflators used are the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services.

Source: ABS unpublished, *Australian National Accounts: National Income, Expenditure and Product,* Cat. no. 5204.0.

Table 12A.74 **Deflator used to calculate real Australian Government mental health expenditure (a)**

	Aus Gov
2005-06	83.9
2006-07	87.3
2007-08	90.0
2008-09	92.9
2009-10	96.3
2010-11	97.6
2011-12	100.0

(a) The deflators used are the State and Territory implicit price deflators for general government final consumption expenditure on hospital and nursing home services.

Source: ABS unpublished, *Australian National Accounts: National Income, Expenditure and Product*, Cat. no. 5204.0.

Table 12A.75 Estimated resident populations used in mental health per head calculations (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust* (b)
2005-06	6 718 023	5 023 203	3 964 175	2 029 936	1 544 852	488 098	333 505	207 385	20 311 543
2006-07	6 786 160	5 103 965	4 055 845	2 076 867	1 561 300	491 515	338 381	211 029	20 627 547
2007-08	6 883 852	5 199 503	4 159 990	2 135 006	1 578 489	495 858	344 176	216 618	21 016 121
2008-09	7 001 782	5 313 285	4 275 551	2 208 928	1 597 880	501 774	351 101	222 526	21 475 625
2009-10	7 101 504	5 419 249	4 367 454	2 263 747	1 618 578	506 461	357 859	227 783	21 865 623
2010-11	7 179 891	5 495 711	4 436 882	2 319 063	1 632 482	510 219	364 833	230 299	22 172 469
2011-12	7 247 669	5 574 455	4 513 009	2 387 232	1 645 040	511 718	370 729	232 365	22 485 340

(a) The data represent the mid-point of the relevant financial year. For 2011-12 data, the mid-point is 31 December 2011. The Estimated Resident Populations (ERPs) up to 2010-11 have been revised to the ABS' final 2011 Census rebased ERPs. The final ERP replaces the preliminary 2006 Census based ERPs used in the 2013 Report. ERP data from December 2011 (2011-12) are first preliminary estimates based on the 2011 Census. See Chapter 2 (table 2A.1-2) for details.

(b) Includes other territories.

Source: ABS (various issues), *Australian Demographic Statistics, December (various years)*, Cat. no. 3101.0.

Data quality information — Mental health management, chapter 12

Data Quality Information

Data quality information (DQI) provides information against the seven ABS data quality framework dimensions, for a selection of performance indicators in the Mental health management chapter. DQI for additional indicators will be progressively introduced in future reports.

Where the Report on Government Services (RoGS) indicators align with National Agreement indicators, DQI has been sourced from the Steering Committee's reports on National Agreements to the COAG Reform Council.

Technical DQI has been supplied or agreed by relevant data providers. Additional Steering Committee commentary does not necessarily reflect the views of data providers.

DQI are available for the following performance indicators:

New client index 3
Mental health service use by special needs groups and total population 7
Primary mental health care for children and young people 14
Services reviewed against the National Standards 17
Services provided in an appropriate setting 21
Collection of outcomes information 24
Consumer and carer involvement in decision making 28
Post discharge community care 31
Readmissions to hospital within 28 days of discharge 34
Cost of inpatient care — average recurrent cost per inpatient bed day 37
Cost of inpatient care — average length of inpatient stay 41
Cost of community-based residential care 44
Cost of ambulatory care 48
Rates of illicit and licit drug use 52
Prevalence of mental illness 54
Mortality due to suicide 57
Social and economic inclusion of people with a mental illness — participation in employment of working age population 61

Social and economic inclusion of people with a mental illness — participation in education and employment by young people 63
Mental health outcomes of consumers of specialised public mental health services 65

New client index

DQI for this indicator has been sourced from the Australian Government (Department of Health) and State and Territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element	Equity — access
Indicator	New client index
Measure (computation)	Description: Proportion of total clients under the care of State or Territory specialised public mental health services who were new clients. A new client is a consumer who has not been seen by a specialised public mental health service in the five years preceding the initial contact with a service in the relevant reference period. Numerator: Number of new clients — clients who had not been seen by a public mental health service in the five years preceding the initial contact with a service in the relevant reference period. Denominator: Number of total clients under the care of State or Territory specialised public mental health services in the relevant reference period. Computation: Expressed as a proportion: (Numerator ÷ Denominator)*100.
Data source/s	Department of Health using data provided by State and Territory governments from the community mental health care, residential mental health and admitted patients mental health collections.

Data Quality Framework Dimensions

Institutional environment	Department of Health calculated the indicator based on data supplied by state and territory health authorities. The State and Territory health authorities provide these data according to specifications agreed under the *National Key Performance Indicators for Australian Public Mental Health Services*. State and Territory health authorities receive these data from specialised mental health organisations/units in psychiatric and acute hospitals, community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.
Relevance	Estimates are based on all ‘in-scope’ clients (new and total) who are in receipt of services from state and territory public psychiatric inpatient units, residential units and community mental health services. New clients are those who have not been seen by a public specialised mental health service in the five years preceding the initial contact with a service in the relevant reference period. A consumer is not considered to be ‘new’ client if they present with a new condition but have previously received treatment for other conditions. Data for all years reflect full financial year activity — that is, all in scope clients from public specialised mental health services between the period 1 July and

30 June for each financial year.

Only state and territory specialised public mental health services are included. New clients may have been treated in the preceding five years outside the state/territory specialised public mental health system in the primary mental health care or the specialist private mental health sector.

States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems. SA indicated that the data submitted were not based on unique patient identifier or data matching approaches.

For NSW, residential clients are not included because their data is manually collected without a Statewide Unique Patient Identifier (SUPI) assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible.

For WA, the matching of mental health community contacts to inpatient episodes is done for 2011-12 between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result. Data before 2011-12 are based on data submitted for the National Minimum Data Set (NMDS) and have not been revised.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

All states except Victoria count triage and referral patients, that is those who are assessed and referred on.

For Tasmania in 2009-10, the new and total client count includes Mental Health Service Helpline contacts with individuals who received a one off contact through the 24 hour telephone helpline. Industrial action in Tasmania in 2011-12 has limited the quality and quantity of community data.

Timeliness

State and territory governments provide the data to Department of Health for national collation, approximately twelve months after the reference period. The reference period for the latest data is 2011-12.

Accuracy

State and territory governments are primarily responsible for the quality of the data they provide. Department of Health analyses the data, but cannot independently verify them.

Data are subject to ongoing historical validation. Due to this ongoing validation, 2009-10 and 2010-11 data might differ from previous reports.

States and territories differ in their capacity to accurately track clients across organisations or service types, due to the lack of unique patient identifiers or data matching systems. This has led to over/undercounting of clients in some jurisdictions.

- NSW has implemented a SUPI for mental health care. The identification of prior contacts for mental health clients is dependent upon the SUPI, both in coverage (all clients having a SUPI) and in the resolution of possible duplicates. There are differences in the completeness of coverage between the Local Health Districts/Networks and over time. The average SUPI coverage at a State level for 2009-10, 2010-11 and 2011-12 is 99.8 per cent. The numbers provided are a distinct count of individuals using the SUPI (majority) and a count of individuals at the facility level for a small percentage of clients without a SUPI in the reporting period (which

may include some duplicates of those who attended multiple facilities).

- For NSW, residential clients are not included because their data is manually collected without SUPI assigned, thus making the unique counts of the residential clients together with the inpatient and ambulatory clients not possible. The client base of the NSW mental health residential is very small which will have minimal effect on the final result (total residential MH clients in 2010-11 is 185 with 59 potential new clients and 243 total residential MH clients with 130 potential new clients in 2011-12).
- For SA, the client counts are not unique: they are an aggregation of three separate databases with no linkage between them. The impact on the result should be minimal due to populations being relatively stable within the three respective catchments.
- For WA, the matching of mental health community contacts to inpatient episodes for 2011-12 is done between two separate data systems and requires the use of record linkage to be able to identify the same person in both systems. There are delays associated in the use of record linkage and these delays can result in not getting a match between a community contact and a separation when there should be one. The number of unique consumers (both total and new) could be over-estimated as a result.
- For Tasmania, the information has been extracted from three different data sources and linked together with a Statistical Linkage Key (SLK) for each individual present in the extracts for the reporting period. While every attempt has been made to reduce any duplication of identified clients, using an SLK will lead to some duplication and can wrongly identify clients as new clients.

For NSW, one large Local Health District has incomplete community data (June 2012 data is missing) in the NSW State Health Information Exchange in 2011-12.

Coherence

Data are reported for each year from 2009-10 to 2011-12. There has been no major change to the methodology used to collect the data across years except as outlined below for WA.

The Australian total for 2011-12 excludes Victoria and is not comparable to previous years.

Jurisdictions can differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the accuracy dimension).

For WA, data before 2011-12 are based on data submitted for the NMDS and have not been revised. Data from 2011-12 are based on a different method (see relevance dimension).

Accessibility

Data are also available for this indicator in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability

Information for understanding this indicator is available in:

- the *Key* Performance *Indicators for Australian Public Mental Health Services, Second Edition* at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf

- forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- States and territories vary in their capacity to accurately track clients across organisations, due to the lack of unique patient identifiers or data matching systems.
- Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.
- Industrial action in Tasmania in 2011-12 has limited the available data quality and quantity of community data.

Mental health service use by special needs groups and total population

DQI for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Elements	Equity — Access and Effectiveness — Access
Indicators	Mental health service use by special needs groups Mental health service use by total population
Measure (computation)	The *numerator* is the number of people receiving mental health services, separately for three service types. The *denominator* is the Estimated Resident Population (ERP) as at 30 June 2011. *Calculation* is 100 × (Numerator ÷ Denominator), presented as a percentage and age-standardised to the Australian population as at 30 June 2001, using 5-year age groups to 84 years with ages over 84 years combined. Indigenous population data are not available for all states and territories for 5-year age groups beyond 64 years, so Indigenous disaggregations were standardised to 64 years with ages over 64 years combined. These are calculated separately for public, private, Medicare Benefits Scheme- and Department of Veterans' Affairs (DVA)-funded services.
Data source/s	*Numerators*: For Public data: State/Territory community mental health care data. For Private data: Private Mental Health Alliance (PMHA) Centralised Data Management Service (CDMS) data. For Medicare Benefits Schedule (MBS) ata: Australian Government Department of Health (Health) MBS Statistics. For DVA data: Australian Government DVA Statistical Services and Nominal Rolls using the Departmental Management Information System These data are known as Treatment Account System (TAS) data. *Denominator*: Australian Bureau of Statistics (ABS) ERP as at 30 June 2011. ABS Indigenous Experimental Estimates and Projections Series B.

Data Quality Framework Dimensions

Institutional environment	The Australian Institute of Health and Welfare (AIHW) prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. Numerators for this indicator were prepared by State and Territory health authorities, the PMHA, Health and DVA and quality-assessed by the

AIHW.

The AIHW drafted the initial data quality statement. The statement was finalised by AIHW following input from State and Territory health authorities, PMHA, Health and DVA. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator.

Public data

The State and Territory health authorities receive these data from public sector community mental health services. States and territories use these data for service planning, monitoring and internal and public reporting.

Private data

The PMHA's Centralised Data Management Service provided data submitted by private hospitals with psychiatric beds. The data are used by hospitals for activities such as quality improvement.

Health MBS and DVA TAS data

The Department of Human Services (DHS) processes claims made under the *Medicare Australia Act 1973*. These data are then regularly provided to Health. DHS also processes claims for DVA Treatment Card holders made through the MBS under the *Veterans' Entitlements Act 1986*; *Military Rehabilitation and Compensation Act 2004* and *Medicare Australia Act 1973*. All claiming data is regularly provided to DVA as per the Memorandum of Understanding between DHS and DVA.

Relevance

Estimates are based on counts of individuals receiving care within the year, by each service type, where each individual is generally counted once regardless of the number of services received. Persons can receive services of more than one type within the year; a count of persons receiving services regardless of type is not available.

A number of persons receiving mental health treatment are not captured in these data sources. These include:

- individuals receiving only admitted and/or residential services from State and Territory public sector specialised mental health services.
- individuals receiving mental health services (other than as admitted patients in private hospitals) funded through other third party funders (for example, transport accident insurers, workers compensation insurers) or out of pocket sources.

There is likely to be considerable overlap between the Health MBS and DVA TAS data and private data, as most patients accessing private hospital services would also access MBS services.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

Public data

Person counts for State and Territory mental health services are counts of persons receiving one or more service contacts provided by public sector community mental health services. SA submitted data that were not based on unique patient identifier or data matching approaches.

Private data

Private hospital estimates are counts of individuals receiving admitted patient specialist psychiatric care in private hospitals.

Health MBS and DVA TAS data

Data are counts of individuals receiving mental health-specific MBS services for which DHS has processed a claim.

Analyses by state/territory, remoteness and socioeconomic status are based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received.

DVA clients comprised less than 2 per cent of people receiving Australian Government (Medicare Benefits Scheme- and DVA-funded) clinical mental health services.

Timeliness

The reference periods for these data are 2007-08, 2008-09, 2009-10, 2010-11 and 2011-12.

Accuracy

Cells have been suppressed to protect confidentiality (where the presentation could identify a patient or a single service provider).

Public data

State and Territory jurisdictions differ in their capacity to provide accurate estimates of person receiving services (see above). Additionally, jurisdictions differ in their approaches to counting clients under care. For example, people who are assessed for a mental health service but do not go on to be treated for a mental illness are included in the data by some jurisdictions but not others. Therefore, comparisons between jurisdictions should be made with caution.

Indigenous status data should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions. Indigenous status was missing or not reported for more than 11 per cent of all clients.

Private data

Not all private psychiatric hospitals are included in the PMHA's CDMS.

In 2011-12, those that are included account for approximately 98 per cent of all activity in the sector. The data provided are an estimate of overall activity.

Actual counts are multiplied by a factor that accounts for the proportion of data missing from the CDMS collection. That adjustment is performed at the level of State and Territory and also financial year, since non-participation rates varied from state to state and financial year.

Indigenous status information is not collected for these data.

Health MBS and DVA TAS data

As with any administrative system a small degree of error may be present in the data captured.

Data used for statistical purposes are based on enrolment postcode of the patient. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Health MBS data presented by Indigenous status have been adjusted for under-identification in the DHS Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to DHS. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (61 per cent nationally as at August 2012) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. The methodology for this adjustment was developed and verified by the AIHW and Health for assessment of MBS and Pharmaceutical Benefits Scheme (PBS) service use and expenditure for Indigenous Australians. For an explanation of the methodology, see *Expenditure on health for Aboriginal and Torres Strait Islander people 2006-07.*

DVA TAS data are not available by Indigenous status.

Coherence

Following the 2011 Census of Population of Housing, the ABS has rebased the Australian population back to 1991. This rebasing had a significant impact on the population time series, therefore data have been resupplied for previous years using the rebased ERP. The exception is for data presented by Indigenous status. Rebased Indigenous population data are not yet available, thus data presented by Indigenous status uses 2006 based ERP.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the Australian Standard Geographical Classification (ASGC) to the Australian Statistical Geography Standard (ASGS). Also updated at this time were remoteness areas and the Socio-Economic Indices for Areas (SEIFA), based on the 2011 ABS Census of Population and Housing. The new remoteness areas will be referred to as Remoteness Areas (RA) 2011, and the previous remoteness areas as RA 2006. The new SEIFA will be referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006.

Data for 2007-08 through to 2010-11 reported by remoteness are reported for RA 2006. Data for 2011-12 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator, therefore remoteness data for 2010-11 and previous years are not directly comparable to remoteness data for 2011-12 and subsequent years.

Data for 2007-08 through to 2010-11 reported for SEIFA deciles are reported using SEIFA 2006 at the Statistical Local Area (SLA) level. Data for 2011-12 are reported using SEIFA 2011 at the SLA level. The AIHW considers the change from SEIFA 2006 to SEIFA 2011 to be a break in the series, therefore SEIFA data for 2011-12 are not directly comparable with SEIFA data from previous reporting years.

Public data

There has been no major change to the methodology used to collect the data in 2011-12 for the majority of jurisdictions, therefore data is

comparable across years.

However, one large Local Health District in NSW has incomplete data, so 2011-12 data will be updated for the 2015 report.

For public sector community mental health services, Victorian data is unavailable (for 2011-12) due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of data. Australian totals for 2011-12 only include available data and should therefore be interpreted with caution. Australian totals for 2011-12 should not be compared to previous years.

In past years there has been variation in the underlying concept used to allocate remoteness and socioeconomic status across jurisdictions (i.e. location of service provider, location of client or a combination of both). In addition, the underlying concordances used by jurisdictions to allocate remoteness may vary. Since 2009-10, remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011-12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW and the NT used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Comparisons over time for remoteness and socioeconomic status should therefore be interpreted with caution.

Private data

There has been no change to the methodology used to collect the data in 2011-12. Therefore, the data are comparable to previous reporting periods.

Health MBS and DVA TAS data

The same methodology to attribute demographic information to the data has been used in 2011-12 as in previous reporting periods.

For 2010-11 and previous years, remoteness and socioeconomic status for both Health MBS and DVA TAS data were allocated using a postcode concordance. For 2011-12, DVA TAS data were allocated to remoteness using geocoding, and to socioeconomic status using an SLA concordance.

MBS items 81325 and 81355 were added from 1 November 2008. These items relate to mental health or psychological services provided to a person who identified as being of Aboriginal or Torres Strait Islander descent.

On 1 January 2010, a new MBS item (2702) was introduced for patients of GPs who have not undertaken mental health skills training. Changes have been made to the existing MBS item 2710 to allow patients of GPs who have undertaken mental health skills training to access a higher rebate. Both of these items relate to the preparation of a General Practitioner (GP) mental health treatment plan.

On 1 November 2011, MBS items 2715 and 2717 were introduced to cover preparation of a GP mental health treatment plan by a GP who has undertaken mental health skills training. At the same time MBS items 2700 and 2701 were introduced to cover preparation of a GP mental health treatment plan by a GP who has not undertaken mental health skills training.

	MBS item 2719 existed from 1 November 2011 to 30 April 2012. From 2011-12 MBS item 20104 is included to align with other national indicators. Caution should be taken when interpreting Indigenous rates over time. All other data can be meaningfully compared across reference periods. <u>Other publications</u> The AIHW publication series *Mental health services in Australia* contains data that is comparable in coverage (using different MBS item splits) and includes a summary of MBS mental health-related items. *The data used in this indicator is also published in the COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11.* There may be some differences between the data published in these two sources as: • rates may be calculated using different ERPs other than the June ERPs used for this indicator, • MBS numbers are extracted using a different methodology. *The COAG National Action Plan on Mental Health — final progress report covering implementation to 2010-11* counts a patient in each state they resided in during the reference period but only once in the total whereas this indicator counts a patient in only one State/Territory. The indicator specifications and analysis methodology used for this report are equivalent to the *Healthcare 2011-12: comparing performance across Australia.*
Accessibility	MBS statistics are available at: www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1 www.medicareaustralia.gov.au/statistics/mbs_item.shtml Disaggregation of MBS data by SEIFA is not publicly available elsewhere.
Interpretability	Information is available for MBS data from: www.health.gov.au/internet/mbsonline/publishing.nsf/content/medicare-benefits-schedule-mbs-1

<u>Data Gaps/Issues Analysis</u>

Key data gaps/issues	The Steering Committee also notes the following issues: • This is a proxy measure of access to appropriate care. • Data for 2011-12 are not available for Victoria due to significantly reduced collection rates arising from industrial action during the period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. No substitute or proxy data have been included at the jurisdictional level or to fill the gap in calculation of the national results. • Data have been provided according to the State or Territory of service, but at the sub-state level (remoteness area) have been classified by the client's place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated by a service in a major city in Victoria would be classified at the sub-state level as a very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required

to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service.

- Disaggregation of this indicator by Indigenous status for private patients and those recorded in DVA data is a priority.
- Data linkage work is underway to obtain comprehensive and consistent data on people with mental illness across the full scope of service types.

Primary mental health care for children and young people

DQI for this indicator has been sourced from the Australian Government (Department of Health) with additional Steering Committee comments.

Indicator definition and description

Element Effectiveness — access

Indicator Primary mental health care for children and young people

Measure (computation)

Description:

Proportion of young people aged under 25 years who received a primary mental health care services subsidised through the MBS. Data are also reported by four age cohorts: pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

Numerator:

Number of young people aged under 25 years who received a primary mental health care services subsidised through the MBS and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

Denominator:

Estimated Resident Population aged under 25 years and by age cohort (pre-school (0–<5 years), primary school (5–<12 years), secondary school (12–<18 years) and youth/young adult (18–<25 years).

Computation:

Expressed as a proportion: (Numerator/s ÷ Denominator/s)*100.

Calculated for all young people (aged under 25 years) and separately by age cohort.

Data source/s

Numerator:

Department of Health MBS Statistics data.

Denominator:

ABS *Australian Demographic Statistics*.

Data Quality Framework Dimensions

Institutional environment

MBS data are an administrative by-product of the DHS, Medicare fee-for-service payment systems. DHS, Medicare collects MBS data under the *Human Services (Medicare) Act 1973* and regularly provides the data to Department of Health.

The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.

For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au.

Relevance

Includes primary mental health care covered by the MBS only. Other relevant forms of primary mental health care for young people are not incorporated due to a lack of available data, including community health centres, Aboriginal Community Controlled Health Services, school counsellors and health nurses,

university and Technical and Further Education counselling services and a component of the mental health care provided by state/territory specialised public mental health services.

MBS data are counts of young people receiving mental health-specific MBS services for which DHS has processed a claim, excluding those for psychiatrists. The relevant MBS items are as follows:

- GP and other services include MBS items 170, 171, 172, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2712, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727.
- Clinical psychologist services include MBS items 80000, 80005, 80010, 80015, 80020.
- Other allied health services include MBS items 10956, 10968, 80100, 80105, 80110, 80115, 80120, 80125, 80130, 80135, 80140, 80145, 80150, 80155, 80160, 80165, 80170, 81325, 81355, 82000, 82015.

Analyses by state/territory of MBS data is based on postcode of residence of the client as recorded by DHS at the date of last service processed in the reference period. As clients may receive services in locations other than where they live, these data do not necessarily reflect the location in which services were received. The allocation to the state/territory uses a concordance and splits a person where the postcode covers more than one state/territory, therefore the totals may not equal the sum of the individual cells due to rounding.

MBS data are based on the date the claim was processed. Age of the patient is based on age at 30 June of the reference period, which may differ from their age at the date of the service.

The population data represent the mid-point of the relevant financial year. For 2012-13 data, the mid-point is December 2012. All ERP data are based on the *2011 Census of Population and Housing* (EPRs for 2010-11 have been rebased).

Timeliness

MBS claims data are available within 14 days of the end of a month. The reference period for the latest data is 2012-13.

Accuracy

As with any administrative system a small degree of error may be present in the data captured.

Analyses by state/territory are based on postcode of residence of the client as recorded by DHS, Medicare at the date the last service was received in the reference period. This postcode may not reflect the current postcode of the patient if an address change has not been notified to DHS, Medicare.

The data provided are based on the date on which the claim was processed by DHS, not when the service was rendered. The use of data based on when the claim was processed, rather than when the service was rendered, produces little difference in the total number of persons included in the numerator for the reference period.

People who received more than one type of service are counted once only in the calculations for this indicator.

Coherence

Estimates are compiled the same way across jurisdictions and over time.

The MBS items included can change over time, for example 2700, 2701, 2715 and 2719 were included for the latest year of data.

Proportions in the 2014 RoGS for 2010-11 may differ to those reported in previous reports as the ERPs have been rebased to the 2011 Census.

Accessibility MBS statistics are available at:

- www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1
- www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Interpretability Information for understanding this indicator is available in the:

- *Fourth national mental health plan: measurement strategy*, www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub-plan4-meas
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- Not all relevant forms of primary mental health care for young people are not incorporated due to a lack of available data.
- Annual data are available. The most recent data available are for 2012-13.
- The data are consistent and comparable over time.

Services reviewed against the National Standards

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services reviewed against the *National Standards for Mental Health Services (NSMHS)*
Measure (computation)	Description: Proportion of expenditure on specialised public mental health services that had completed a review by an external accreditation agency against the NSMHS. Numerator/s: Expenditure on service units, by assessed level (level 1, level 2, level 3, level 4). Denominator: Total expenditure on service units in scope for the NSMHS. Computation: Expressed as a proportion: (Numerator/s ÷ Denominator)*100. Calculated separately by assessed level.
Data source/s	AIHW from the Mental Health Establishments (MHE) NMDS

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

The NSMHS were first introduced in 1996 and were adopted by all public specialised mental health services and private psychiatric hospitals. Most non-government community mental health services found it difficult to apply many of the NSMHS to the context within which they operated[1]. Revised standards were endorsed in September 2010 and these are designed to be applied across the broad range of mental health services (where mental health is the main focus of care), including non-government organisations and private office based services (such as GPs). Coverage of all publicly funded mental health services to which the revised NSMHS now apply would improve the relevance of these data to measurement of this indicator for future reports.

Services were assessed as level 1, level 2, level 3, or level 4 where these levels are defined as:

- *Services at level 1* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met all NSMHS.
- *Services at level 2* — the number of specialised public mental health services that have been reviewed by an external accreditation agency and judged to have met some but not all NSMHS.
- *Services at level 3* — the number of specialised public mental health services that are (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* — the number of specialised public mental health services that do not meet criteria detailed under levels 1 to 3, except those for whom the NSMHS do not apply — code 8 in the MHE NMDS.

Assessments against the NSMHS are based on periodic reviews, usually conducted every three to five years. Services assigned a level 1 for the 2011-12 data may have been assessed at this level in a review that was conducted in 2005-06 and therefore this assessed level may not necessary reflect the quality of the actual services delivered in the 2011-12 reference period, nor the extent to which the NSMHS are used for ongoing quality improvement.

The data element '*National standards for mental health service review status'* is collected at the statistical unit of service unit (admitted patient, ambulatory and residential). Specialised mental health service units relate to units in public psychiatric hospitals, designated psychiatric units in acute care hospitals, public community-based ambulatory and residential services and publicly funded private hospital and non-government residential service units. Non-government operated community residential service units are excluded from the analysis. Aged care community residential services in receipt of funding under the *Aged Care Act 1997* are subject to residential aged care reporting and service standard requirements and are therefore excluded from the NSMHS analysis. Ambulatory services managed by non-government organisations are not defined as statistical units for the MHE NMDS and therefore data on this element are not available for these service types.

Timeliness State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy Coverage of the MHE NMDS in-scope services for the '*National standards for*

[1] DoHA 2010, *National Standards for Mental Health Services: Implementation guidelines for Non-government Community Services,* Australian Government, Canberra.

mental health service review status' data element is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

Coherence

Data are reported for each year from 2005-06 to 2011-12.

The data reported from 2005-06 to 2009-10 all relate to specialised mental health services assessed against the old NSMHS. Data from 2010-11 will progressively include larger proportions of services assessed against the revised NSMHS that were endorsed in September 2010.

External accreditation agencies can undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised mental health service units. Accreditation of the parent organisation does not currently require an individual service unit (for example, a community-based ambulatory service managed by the hospital) to be assessed separately against the NSMHS. Assessment against the NSMHS for a service unit must be specifically requested and involves a separate review process. This leads to variation across states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. In some states and territories, if an organisation with multiple service units is assessed at a particular level all the organisation's units are 'counted' at that assessment level. In other jurisdictions, assessments are conducted at the service unit level and the level assigned may or may not be consistent with the other units within the organisation. The approach can also vary across organisations within a single jurisdiction.

The external accreditation agencies such as Australian Council on Healthcare Standards (ACHS) and Quality Improvement Council (QIC) can use differing review methods. In addition, external review is a process of negotiation between a mental health service organisation and the accrediting agency. There may be differences in the extent to which all or some of the NSMHS are considered to be applicable to individual service units.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial

publication

- National Mental Health Reports.

Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell sizes with small numbers may be suppressed.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- There is variation across and within states and territories in the method used to assign an assessment level (1, 2, 3 or 4) to service units. This may affect the comparability of the results across jurisdictions.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Services provided in an appropriate setting

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Services provided in an appropriate setting
Measure (computation)	Description: Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. Numerator: Governments' recurrent expenditure on community-based specialised mental health services. Community-based recurrent expenditure for this indicator includes expenditure on ambulatory care, non-government organisations and adult residential services. Aged residential care expenditure is excluded. Denominator: Total government recurrent expenditure on specialised mental health services, excluding aged residential care expenditure and unapportioned indirect expenditure. Computation: Expressed as a proportion: (Numerator/Denominator)*100.
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment

The AIHW has provided the data for this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance

The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

The data elements on direct and indirect recurrent expenditure and grants to

non-government organisations are collected at levels in the hierarchy used to capture jurisdiction-wide information on mental health services (state/territory, region, organisation and service units). Non-government grants are collected at the regional and state and territory levels. Direct recurrent expenditure comprises salaries and wages and non-salary expenditure, and is collected at the individual service unit level. Indirect recurrent expenditure is additional expenditure associated with the provision of mental health services not incurred or reported at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The estimates do not include residual indirect expenditure incurred at the state and territory level or that unapportioned from the organisational or regional level.

Certain categories of expenditure collected under the MHE NMDS are excluded to derive this indicator and improve the relevance of these data to its measurement.

- Community aged residential care expenditure is excluded from community-based expenditure to improve comparability across states and territories. A significant share of jurisdictions do not have this service type.
- Indirect expenditure at the State and Territory level and indirect expenditure at the organisational or regional level that cannot be apportioned to individual services is also excluded. This indicator is seeking to measure the service mix by showing the proportion of expenditure that is community-based relative to the other categories of service expenditure (admitted patients) and not relative to total expenditure, which includes indirect expenditure at the State or Territory level on areas such as program administration and property leasing costs.

Government expenditure on mental health services that are out of scope of the MHE NMDS, such as Medicare-subsidises for community-based services provided by GPs or the personal helpers and mentors program is not included in the analysis.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation, on an annual basis approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services' recurrent expenditure is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Data are also subject to ongoing historical validation. Due to this ongoing

	validation, 2005-06 to 2010-11 data could differ from previous reports.
Coherence	Data are reported for each year from 2005-06 to 2010-11. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years. For NSW, Confused and Disturbed Elderly (CADE) residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.
Accessibility	The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include: • Mental Health Services in Australia — annual publication • National Mental Health Reports. Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.
Interpretability	Metadata information for the MHE NMDS are published in the AIHW’s online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: • Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Collection of outcomes information

DQI for this indicator has been sourced from the Australian Mental Health Outcomes and Classification Network (AMHOCN), Department of Health, and State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — appropriateness
Indicator	Collection of information on consumers' outcomes. This DQI should be considered in conjunction with the DQI for Mental health outcomes of consumers of specialised public mental health services
Measure (computation)	Description: Proportion of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type (people in ongoing community-based care, people discharged from community-based care and people discharged from hospital). Numerator: Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type. Denominator: Estimated number of specialised public mental health service episodes, by consumer type. Computation: Expressed as a proportion: (Numerator/s ÷ Denominator)*100. Calculated separately by consumer type.
Data source/s	Numerator: State and territory health authorities' data reported to the National Outcomes and Casemix Collection (NOCC) and analysed by the AMHOCN. Denominator: State and territory health authorities' data as reported to Community Mental Health Care (CMHC) NMDS and the Admitted Patient Mental Health Care (APMHC) NMDS and analysed by the Department of Health.

Data Quality Framework Dimensions

Institutional environment	Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation. The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3) training and service development — supports training in the measures and their use for clinical practice, service management and development purposes. The NOCC was endorsed by all State and Territory governments in 2003, and

all jurisdictions have reported data since 2004-05. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.

Relevance

The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities. Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to the collection of data for the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcomes measures are also collected, including those completed by consumers. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32); for children and adolescents, the parent and youth versions of the Strengths and Difficulties Questionnaire (SDQ). The uptake of these measures is not captured by this indicator.

For an episode to be counted as one for which consumer outcome measures are collected, a minimum of two data collection occasions with 'valid' measures within the reference period are required. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Brief ambulatory and inpatient care episodes (defined as follows) are excluded.

- inpatient care — episodes 3 days or less.
- ambulatory — episodes where the consumers had a treatment period between 1 and 14 days inclusive.

The completion of outcomes data are calculated for three consumer groups. Further, the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — measures need to be 'valid' for both the first (either an admission or a review) and last (either an admission or a review) occasions rated during the year
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital) who received an episode of community care that started and ended in the reference period — measures need to be 'valid' for both the admission and discharge occasions rated during the reference period.

Outcomes are measured for consumers discharged from residential mental health care also, but there were too few public mental health service episodes with completed clinical mental health outcome measures data to derive coverage estimates.

The number of 'in-scope' specialised public mental health service episodes, for

which outcomes data should be collected (the denominator) is not provided directly to the NOCC, but is an estimate based on the CMHC or APMHC NMDSs. For determining the denominators for consumers in ongoing ambulatory care and those discharged from ambulatory care the following distinguishing definitions are used:

- ongoing — the estimated unique count of consumers with CMHC treatment periods of greater than 91 days (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care were left censored (that is, commenced in an earlier reporting period by finished within the current reporting periods)
- discharged — the estimated unique count of consumers with CMHC treatment periods of 91 days or less (that is, from their first service contact date to their last service contact date); LESS the estimated number of consumers whose episodes of care resulted in a discharge to an inpatient setting.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness

State and territory health authorities provide the CMHC and APMHC NMDS data to the AIHW for national collation, on an annual basis approximately six months after the reference period.

State and territory health authorities provide the NOCC data to AMHOCN for national collation, on an annual basis and all data are to be submitted approximately six months after the reference period.

The reference period for the latest data is 2011-12.

Accuracy

States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging invalid domain values and/or missing data.

Coherence

Data are available for 2007-08 to 2011-12.

The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the CMHC and APMHC NMDS. Published products available on the AIHW or Department of Health websites include:

- *Mental Health Services in Australia* — annual publication mhsa.aihw.gov.au/home/
- *Australia's Health* — a mental health chapter is included in this biennial publication aihw.gov.au/publication-detail/?id=10737422172
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data

Unpublished NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incurred in gaining access. Cell

sizes with small numbers may be suppressed.

NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:

- web decision support tool
- NOCC Standard Reports
- NOCC Volume and Percentage Clinical Ratings: Australia
- NOCC data are also published in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability

Metadata information for the CMHC and APMHC NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.

Information for understanding this indicator is available in the Key Performance Indicators for Australian Public Mental Health Services, Second Edition at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The numerator and denominator are sourced from different data sets. Estimates of the total number of episodes requiring outcomes assessment is not provided directly to the NOCC, so it is indirectly estimated from the NMDSs (CMHC and APMHC).

Consumer and carer involvement in decision making

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element	Effectiveness — Quality — Responsiveness
Indicator	Consumer and carer involvement in decision making
Measure (computation)	Description: Number of paid full time equivalent (FTE) consumer OR carer staff per 1000 FTE direct care, carer and consumer staff Numerator: 1) Number of paid FTE consumer staff. 2) Number of paid FTE carer staff. Denominator: Number of paid FTE direct care, carer and consumer staff. Computation: Expressed as a proportion per 1000 FTE. Calculation is: (Numerator/Denominator*1000).
Data source/s	Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS. Direct care staff comprise consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, other medical officers, registered nurses, enrolled nurses, occupational therapists, social workers, psychologists, other diagnostic and health professionals and other personal care staff. Other categories of staff

who work in mental health services are collected under the MHE NMDS, such as administrative and clerical staff, but are not included.

Mental health consumer and carer workers are individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs. The person must be employed for the expertise developed from their lived experience of mental illness. The person should also receive a salary or contract fee on a regular basis and it excludes individuals who only received reimbursement of expenses or occasional sitting fees for attendance at meetings.

The MHE NMDS does not collect information on the staffing of, or consumer and carer participation in, specialised ambulatory mental health services managed by government-funded NGOs.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services for direct care staff and consumer and carer workers may not be complete across jurisdictions and years due to the transition from a count of consumer/carer consultants up to 2009-10 to a count of mental health consumer/carer workers from 2010-11.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

WA have advised that data on FTE consumer or carer workers per 1000 direct care, consumer and carer staff for the years 2006-07 to 2008-09 do not accurately represent consumer and carer participation strategies used in WA.

Coherence

Data are reported for each year from 2005-06 to 2011-12. Data up to 2009-10 were restricted to consumer/carer consultants. In 2010-11, the definitions were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- From 2010-11, the definitions of consumer/carer workers were altered to include a broader range of roles in the contemporary mental health environment, transitioning to mental health consumer and carer workers. These improved definitions should promote greater consistency between jurisdictions. Comparisons between data up to 2009-10 and data from 2010-11 should not be made.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Post discharge community care

DQI for this indicator has been sourced from the Steering Committee's report to the COAG Reform Council on the National Healthcare Agreement (data supplied by AIHW) with additional Steering Committee comments.

Indicator definition and description

Element	Quality — Continuity
Indicator	Post discharge care — rate of community follow up within first seven days of discharge from a psychiatric admission.
Measure (computation)	Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation. The numerator is the number of in-scope separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated, was recorded in the seven days following that separation. The denominator is the number of in-scope separations for the mental health service organisation's acute psychiatric inpatient unit(s). Calculation is 100 x (Numerator ÷ Denominator).
Data source/s	State/territory admitted patient and community mental health care data.

Data Quality Framework Dimensions

Institutional environment

The tables for this indicator were prepared by the AIHW prepared the denominator and calculated the indicator based on numerators supplied by other data providers. The AIHW is an independent statutory authority within the Health portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

AIHW drafted the initial data quality statement (including providing input about the methodology used to extract the data and any data anomalies) in consultation with State and Territory health authorities.

The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities receive these data from public sector community mental health services and public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. The AIHW did not have the relevant datasets required to independently verify the data tables for this indicator.

Community mental health services and public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

Relevance

Estimates are based on all 'in scope' separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine community follow-up rates. The following separations were excluded: same day separations; overnight separations that occur through discharge/transfer to another hospital; statistical discharge – type change; left against medical advice/discharge at own risk and death

Data for all years reflect full financial year activity – that is, all in scope separations from public sector acute psychiatric units between the period

1 July and 30 June for each financial year.

Community mental health contacts counted for determining whether follow-up occurred are restricted to those in which the consumer participated. These may be face-to-face or 'indirect' (for example, by telephone), but not contacts delivered 'on behalf of the client' in which they did not participate, with the exception of the NT which includes all contacts, but advised that the impact on the indicator is believed to be marginal. Contacts made on the day of discharge are also excluded for all jurisdictions.

Only community mental health contacts made by state and territory public mental health services are included. Where responsibility for clinical follow-up is managed outside the state/territory mental health system (for example, by private psychiatrists, general practitioners), these contacts are not included.

States and territories vary in their capacity to accurately track post-discharge follow up between hospital and community service organisations, due to the lack of unique patient identifiers or data matching systems. SA indicated that the data submitted were not based on unique patient identifier or data matching approaches. This factor can contribute to an appearance of lower follow-up rates for this jurisdiction.

In 2011, the ABS updated the standard geography used in Australia for most data collections from the ASGC to the ASGS. Also updated at this time were remoteness areas and the SEIFA. The new remoteness areas are referred to as RA 2011. The new SEIFA are referred to as SEIFA 2011, and the previous SEIFA as SEIFA 2006. Data for 2011-12 are reported for RA 2011. Data for 2011-12 are reported using SEIFA 2011 at the Statistical Local Area level (an ASGC substate geographical unit).

Remoteness and socioeconomic status have been allocated using the SLA of the client at last contact. For 2011-12 data all jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

NSW used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Remoteness and socioeconomic status have been allocated using the client's usual residence, not the location of the service provider. State/territory is reported for the state/territory of the service provider.

Timeliness The reference period for these data is 2011-12.

Accuracy State and territory jurisdictions differ in their capacity to accurately track post-discharge follow up between hospital and community service organisations (see Relevance section above for further information).

Coherence Agreement to align with specifications for the nationally agreed key performance indicators for public mental health services. Specifically, the revised indicator focuses on follow up care for people discharged from acute psychiatric units only, rather than discharges from all psychiatric units.

This indicator is currently reported in the Report on government services. It is also equivalent to the Key Performance Indicators for Australian Public Mental Health Services: MHS PI 12 — Rates of post-discharge community care (which this new indicator is based on) and the Fourth National Mental Health Plan: NMHP PI 16 — Rates of post-discharge community care.

There has been no major change to the methodology used to collect the data in 2011-12, therefore data is comparable across years.

However, one large Local Health District in NSW has incomplete community

data, so 2011-12 data will be updated for the 2015 report.

For public sector community mental health services, Victorian data is unavailable (for 2011-12) due to service level collection gaps resulting from protected industrial action during this period. Industrial action over the last 18 months in Tasmania has limited the available data quality and quantity of community data. Australian totals for 2011-12 should therefore be interpreted with caution.

All jurisdictions have used the same concordance and proportionally allocated records to remoteness and SEIFA categories with the following exception:

- NSW used postcode concordance (rather than SLA concordance) to allocate records to remoteness and SEIFA.

Accessibility Report on government services available at: www.pc.gov.au/gsp/rogs.

Interpretability Definitions for this indicator are published in the indicator specifications in METeOR.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- Community mental health care data for 2011-12 are not available for Victoria due to service level collection gaps resulting from protected industrial action during this period. This affects all data collected in community-based ambulatory settings and the National Outcomes Casemix Collection in inpatient settings. No substitute or proxy data have been included at the jurisdictional level or to fill the gap in calculation of the national results.
- Further disaggregation of this indicator by State and Territory, by Indigenous status and Socio Economic Status (SES) is a priority.
- Data have been provided according to the State or Territory of the service, but at the sub-state level (remoteness area) have been classified by the client's place of usual residence. For example, a person who usually resides in a very remote area of the NT and is treated in a service in a major city of Victoria would be classified for remoteness purposes as very remote area of Victoria (even though Victoria itself has no very remote areas under the ABS remoteness classification). Further work is required to determine whether geographic location for this indicator should be based on usual residence of the client (used for most indicators) or location of the service.

Readmissions to hospital within 28 days of discharge

DQI for this indicator has been sourced from state and territory health authorities and Department of Health with additional Steering Committee comments.

Indicator definition and description

Element	Quality— continuity
Indicator	Readmissions to hospital within 28 days of discharge
Measure (computation)	Description: Proportion of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge. Numerator: Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services that were followed by readmission to public psychiatric acute inpatient services within 28 days of discharge. Denominator: Number of 'in-scope' admitted patient overnight separations from public psychiatric acute inpatient services. Computation: Expressed as a proportion: (Numerator ÷ Denominator)*100.
Data source/s	State and territory governments admitted patient mental health care data set.

Data Quality Framework Dimensions

Institutional environment	Department of Health calculated the indicator based on data supplied by state and territory health authorities. The state and territory health authorities receive these data from public hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Public hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.
Relevance	Estimates are based on all 'in scope' overnight separations from state and territory psychiatric acute inpatient units, where 'in scope' is defined as those separations for which it is meaningful to examine readmission after 28 days of discharge rates. The following separations were excluded: same day separations, including index separation and subsequent readmission; statistical and change of care type separations; separations that end by transfer to another acute or psychiatric hospital; separations that end by death, or instances where the person left against medical advice or discharged at own risk. A readmission for any of the separations identified as 'in-scope' is an admission to any other public acute psychiatric unit within the jurisdiction. For this to occur a system of unique client identifiers needs to be in place that allows individuals to be 'tracked' across units. Such systems have been available in all states/territories for the full period (2005-06 to 2011-12), with the exception of Tasmania (which introduced such a system in 2007-08) and SA (which has not yet introduced such a system). Readmissions across state and territory boundaries or movements between

public and private hospitals are not captured.

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

Timeliness

State and territory health authorities provide these data to Department of Health for national collation, on an annual basis approximately twelve months after the reference period.

The latest year of data available is 2011-12.

Accuracy

Coverage of the 'in-scope' separations and readmissions is essentially complete across jurisdictions and years.

States and territories are primarily responsible for the quality of these data. Department of Health analyses the data, but cannot independently verify them.

Undercounting of readmissions may have occurred in SA and Tasmania in the years that the system of unique identifiers is not in place (see the relevance dimension). Additional undercounting of readmissions may have occurred in SA as admitted patient reporting systems only identify mental health activity based on the discharging ward. However, this factor is believed to be immaterial as the majority of admissions to mental health wards end in hospital discharge from there.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

Coherence

Data are available from 2005-06 to 2011-12. There has been no major change to the method used to collect the data or to derive the results across years for the majority of jurisdictions, therefore the data are largely comparable across most jurisdictions and years.

States and territories differ in their capacity to accurately track clients across organisations or service types, this can affect the comparability of the results across jurisdictions (see the relevance and accuracy dimensions).

States and territories differ in the overnight separations that they count as 'in scope'. NSW and Queensland exclude separations where length of stay is one night only and the procedure code for ECT is recorded and the ACT excludes all overnight separations with the procedure code for ECT, whereas the others (Victoria, WA, SA, Tasmania and the NT) include all overnight separations for the procedure code for ECT.

Accessibility

These data are also published in the:

- COAG national action plan on mental health progress reports available at www.coag.gov.au
- National mental health reports available at www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

Interpretability

Further information to understand this indicator are available in:

- the *COAG national action plan on mental health — progress report 2010-11*
- National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data
- the Key Performance Indicators for Australian Public Mental Health Services, Second Edition at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf
- forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- No distinction is made between planned and unplanned readmissions.
- States and territories differ in their capacity to accurately track clients across organisations or service types.
- States and territories differ in the overnight separations that they count as ‘in scope’.

Cost of inpatient care — average recurrent cost per inpatient bed day

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost for inpatient care — average recurrent cost per inpatient bed day

Measure (computation)

Description:

Average recurrent cost per inpatient bed day.

Numerator:

Expenditure on State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.

Denominator:

Number of inpatient bed days in State and Territory funded specialised mental health admitted patient services, by hospital and program type and by target population and program type.

Disaggregations for numerator and denominator are:

By inpatient target population:

- general, by acute and non-acute
- child and adolescent, by acute and non-acute
- older persons' psychiatry, by acute and non-acute
- forensic psychiatry, by acute and non-acute

By hospital type:

- psychiatric hospitals, by acute units and non-acute units
- public acute hospital with a psychiatric unit or ward, by acute and non-acute units

Computation:

Expressed as $ per bed day. Calculation is Numerator/Denominator.

Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:

$$R_t = \frac{D_t}{N_t} \times 100$$

Where:

R_t is real dollars in year t

D_t is nominal dollars in year t

N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator in table 12A.73 for 2011-12 dollars (2011-12=100).

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional The AIHW has provided the data for this indicator. The AIHW is an

environment	independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS. Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator. Expenditure data are for services provided in specialised mental health service units in public psychiatric hospitals, public acute hospitals and publicly funded private hospital units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates. Cost per inpatient bed day data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be casemix adjusted, for which cost is adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.
Timeliness	State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.
Accuracy	Coverage of the MHE NMDS in-scope mental health services for expenditure and bed days is essentially complete across jurisdictions and years. States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The

compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for each year from 2005-06 to 2011-12. Data should be reported consistently across most jurisdiction and across years within most jurisdictions.

Costs per inpatient bed day may not be comparable across jurisdictions. Classification of expenditure into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the cost per patient day for general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria), may not be comparable to the average cost in a jurisdiction that has general services only (for example, NT).

For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including expenditure. Comparison of NSW data over time therefore should be approached with caution.

Caution is required when interpreting historical Queensland data, particularly as several services reported as forensic up to 2008-09 were reclassified as general services in 2009-10 to more accurately reflect the function of these services. For 2010-11 and 2011-12, a small number of Youth services have been included in the General category at the request of Queensland. Queensland public acute hospital data includes costs associated with extended treatment services (campus and non-campus based) reported as non-acute admitted patient services in public acute hospitals. Queensland does not provide any acute services in public psychiatric hospitals. Additionally, Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently. Queensland does not report any acute forensic services, however forensic patients can and do access acute care through general units.

For 2010-11 and 2011-12, a small number of Youth services have been included in the General category at the request of Queensland.

For WA data, a review of services resulted in the reclassification of beds between the acute and non-acute categories for the 2010-11 collection, to more accurately reflect the function of these services.

ACT average costs for older person's mental health services during 2006-07 are based on a new 20 bed unit opened in March 2007, in which only 6–10 beds operated due to issues related to staffing resources. This has artificially inflated the average cost of older persons' mental health services relative to other jurisdictions and other years for the ACT.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The average recurrent cost per inpatient bed day measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of inpatient care — average length of inpatient stay

DQI for this indicator has been sourced from the AIHW and state and territory health authorities, with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost of inpatient care — average length of inpatient stay

Measure (computation)

Description:

Average length of inpatient stay in acute units, by target population.

Numerator:

Number of inpatient bed days in State and Territory funded specialised mental health admitted patient acute units, by target population.

Denominator:

Number of separations from State and Territory funded specialised mental health admitted patient acute units, by target population.

Disaggregations for numerator and denominator are:

By inpatient target population:

- general acute
- child and adolescent acute
- older persons' psychiatry acute
- total acute (excluding forensic)

Computation:

Expressed as number of days per stay. Calculation is Numerator/Denominator.

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment

The AIHW has provided the data for this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance

The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and

episodes). Specialised psychiatric care in non-specialised public mental health inpatient units is not in scope of the MHE NMDS.

Bed days include those for same day admissions, which are counted as one day. Leave days are excluded. Same day admissions are a confounding issue that require the identification of intent of admission (that is, day care or overnight stay). Leave days also present complexities in the mental health area and further work is required to ensure that it does not distort this indicator.

Average length of stay data are not adjusted for differences in the client mix. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. More relevant measures would be relative stay index, for which the length of stay index takes into account the type and complexity of cases. Data for these measures are not yet available, as casemix analysis has not been applied to specialised mental health services.

Patients days for clients who separated in the reference period that were during the previous period (for example, 2009-10), are excluded. Patient days for clients who remain in hospital (that is, are not included in the separations data) are included.

Average length of stay is not calculated for forensic services as the length of stay is determined by factors outside the control of the specialised mental health service. However, the child and adolescent and older persons' psychiatry target population services may include a forensic component.

Average length of stay is not calculated for non-acute inpatient units due to variability across jurisdictions in the models and mix of care (in particular, variability across jurisdiction in mix of non-acute inpatient and community-based residential care units) that would significantly affect the comparability of the average length of stay data.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services bed days and separations is essentially complete across jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

The quality of the separations data used to derive this indicator is variable across jurisdictions. Until recently, these separations data were not subject to the level of in depth scrutiny that has applied to other data elements in the MHE NMDS. Therefore, data is only available from 2010-11. It is expected that the quality of these data will improve over time.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence Data are reported for 2010-11 and 2011-12.

Average length of stay data may not be comparable across jurisdictions. Classification of inpatient days and separations into target populations and program type is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a child and adolescent, older persons' or forensic mental health service for example, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. It is likely that the average length of stay for a general mental health services in a jurisdiction that has separate child and adolescent and older persons services (for example, NSW and Victoria) may not be comparable to the average length of stay that has general services only (for example, NT).

Queensland provides older persons' mental health inpatient services using a number of different service models, however the majority of older persons' acute care is reported through general adult units, which limits comparability with jurisdictions that report these services differently."

A small number of Youth services have been included in the General category at the request of Queensland.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- The average length of stay measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- The quality of the separations data used to derive this indicator is variable across jurisdictions.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of community-based residential care

DQI for this indicator has been sourced from the AIHW and state and territory health authorities with additional Steering Committee comments.

Indicator definition and description

Element Efficiency

Indicator Cost of community-based residential care

Measure (computation)

Description:

Average recurrent cost per patient day for community-based residential care

Numerator:

Expenditure on community-based residential care, by target population and staffing provided

Denominator:

Number of patient days in community-based residential care, by target population and staffing provided.

Disaggregations for the numerator and denominator are:

- General adult units
  - 24 hour staffed
  - Non-24 hour staffed
- Older people's care units
  - 24 hour staffed
  - Non-24 hour staffed

Computation:

Expressed as $ per bed day. Calculation is Numerator/Denominator.

Real expenditure is reported across years. The general formula for applying the deflator (used in the attachment tables) to convert nominal dollars to real dollars is:

$$R_t = \frac{D_t}{N_t} \times 100$$

Where:

R_t is real dollars in year t

D_t is nominal dollars in year t

N_t is the new index based in year t. N_t is sourced from ABS unpublished, government final consumption expenditure on hospitals and nursing homes price deflator in table 12A.X for 2011-12 dollars (2011-12=100).

Data source/s Numerator and Denominator: AIHW from the MHE NMDS.

Data Quality Framework Dimensions

Institutional environment

The AIHW has provided the data for this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website.

The data were supplied to the AIHW by state and territory health authorities.

The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.

Relevance

The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes).

Patient days and expenditure relating to community residential services includes that for publicly funded residential services operated by non-government organisations.

Expenditure data are for services provided in community residential units. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Cost per patient day data are not adjusted for differences in the client mix. The client mix in community residential settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in community residential services. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding has not been applied to specialised mental health services.

Data for child and adolescent community-based residential units are included in the data for general acute units for NSW and the ACT. Other jurisdictions do not have these types of units.

For 2011-12, a small number of Youth services have been included in the General category at the request of WA.

Queensland does not report any in-scope government-operated residential mental health services to the MHE NMDS. However, it funds a number of extended treatment services (campus and non-campus based) with full clinical staffing for 24 hours a day, 7 days a week that are reported as non-acute admitted patient services.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period. The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope mental health services community residential expenditure and bed days is complete across jurisdictions and years.

States and territories are primarily responsible for the quality of the MHE

NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year. Delays caused by this change in completing the NSW 2010-11 MHE NMDS has also meant that the figures provided for the RoGS have not completed full validation and may be different to the finalised data that will be provided for the *National Mental Health Report*.

Coherence Data are reported for each year from 2005-06 to 2011-12. Data should be reported consistently across years within most jurisdictions.

Average cost of community-based residential care may not be comparable across jurisdictions. Classification of expenditure and inpatient days into target populations is based on the classification of services as reported to the MHE NMDS rather than the characteristics of their patient populations. For a service to be classified as providing a general or older persons' mental health service, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services. For NSW and the ACT, some child and adolescent services are reclassified to general adult to protect agency confidentiality.

For NSW, CADE residential mental health services were reclassified as admitted patient hospital services from 1 July 2007. All data relating to these services have been reclassified from 2007-08 onwards, including patient days. Comparison of NSW data over time therefore should be approached with caution.

Several WA residential services reported as 24-hour staffed services in 2009-10 transitioned to a non-24-hour staffed model of care as of 1 July 2010.

Accessibility The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or Department of Health websites include:

- Mental Health Services in Australia — annual publication
- Australia's Health — a mental health chapter is included in this biennial publication
- National Mental Health Reports.

Interpretability Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- The cost of community-based residential care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency.
- Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data.

Cost of ambulatory care

DQI for this indicator has been sourced from the AIHW, state and territory health authorities and Department of Health with additional Steering Committee comments.

Indicator definition and description

Element	Efficiency
Indicator	Cost of ambulatory care
Measure (computation)	Description: Average treatment days per episode of ambulatory care. Average cost per treatment day of ambulatory care Numerator: (1) Number of treatment days in ambulatory care. (2) Adjusted recurrent expenditure on ambulatory care. Denominator: (1) Number of statistical episodes of ambulatory care. (2) Number of treatment days in ambulatory care. Computation: Expressed as treatment days per episode OR cost per episode. Calculation is Numerator (1 OR 2)/Denominator (1 OR 2).
Data source/s	Numerator (1): AIHW from the Community Mental Health Care NMDS. Numerator (2): AIHW from the MHE NMDS Denominator/s: AIHW from the Community Mental Health Care NMDS.

Data Quality Framework Dimensions

Institutional environment	The AIHW has provided the data for this indicator. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health. For further information see the AIHW website. The data were supplied to the AIHW by state and territory health authorities. The state and territory health authorities received these data from specialised mental health organisations/units in psychiatric and acute hospitals, and community-based ambulatory and residential settings. States and territories use these data for service planning, monitoring and internal and public reporting. Organisations may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation. States and territories supplied these data under the auspices of the National Healthcare Agreement and the terms of the National Health Information Agreement.
Relevance	The scope of the MHE NMDS is all specialised mental health services managed by, or in receipt of funds from, state or territory health authorities. The purpose of the MHE NMDS is to collect information on the characteristics of specialised mental health services (for example, program type and target populations) and summary information on their expenditure, staffing and activity (for example, patient days, available beds, separations, contact and episodes). Ambulatory services managed by non-government organisations

are not defined as statistical units for the MHE NMDS and therefore excluded.

The scope of the CMHC NMDS is government-operated community (also termed ambulatory) mental health services. Data collected includes information relating to each individual service contact provided by an in-scope mental health service. Examples of data elements are demographic characteristics of patients, such as age and sex, clinical information, such as principal diagnosis and mental health legal status, and service provision information, such as contact duration and session type. Ambulatory services managed by non-government organisations are not considered in-scope for the CMHC NMDS and are therefore excluded.

All activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers is excluded.

Expenditure data are for services provided in public specialised mental health ambulatory services. Expenditure comprises direct and indirect expenditure incurred at the individual service unit level. Some indirect expenditure reported at the organisational and regional level can be directly linked to the provision of services by service units and is apportioned to individual service units. The residual indirect expenditure incurred at the state and territory level and that unapportioned from the organisational or regional level is not included in the estimates.

Treatment days per episode or expenditure per treatment day are not adjusted for differences in the client mix. The client mix in ambulatory settings can differ — for example, some jurisdictions treat a higher proportion of more complex patients in ambulatory settings as distinct from treating them in hospitals. More relevant measures would be casemix adjusted to take into account the type and complexity of cases. Data for these measures are not yet available, as casemix funding/analysis has not been applied to specialised mental health services.

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. 'One treatment day' episodes are included. These episodes are a confounding issue and a method for accounting for 'one treatment day' ambulatory episodes might provide more relevant measures.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient 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. The three month period used in this indicator to define a treatment episode is arbitrary. Further development of episode-based funding models may enable more meaningful/relevant measures in future.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness

State and territory health authorities provide the MHE NMDS data to the AIHW for national collation on an annual basis, approximately nine months after the reference period.

State and territory health authorities provide the CMHC NMDS data to the AIHW for national collation on an annual basis, approximately six months after the reference period.

The reference period for the most recent data is 2011-12.

Accuracy

Coverage of the MHE NMDS in-scope expenditure is essentially complete

across years. Coverage of the CMHC NMDS in-scope mental health services contacts is variable among the jurisdictions, with coverage issues for both the services in-scope for collection and the reporting of service contacts between clinicians and clients. Work is ongoing to clarify coverage for jurisdictions.

States and territories are primarily responsible for the quality of the MHE NMDS data they provide. However, the Department of Health and the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is overseen by the Department of Health and managed by the AIHW and is concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is managed by the AIHW and is primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues, including invalid values, missing data and historical inconsistency. Potential validation errors are queried with jurisdictions, and corrections and resubmissions are made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

States and territories are primarily responsible for the quality of the CMHC NMDS data they provide. However, the AIHW undertake extensive validation. Validation is conducted in two stages: (1) The compliance stage is concerned with ensuring that the data file supplied is structurally compliant and correctly formatted. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage is series of edit checks to ensure that the data supplied are consistent, logical and with valid values. Potential validation errors are queried with jurisdictions, and where the priority for correction is considered high, resubmissions are requested in response to these edit queries. A series of additional edit checks are conducted by the AIHW including coverage checks, historical validation and state/territory comparisons. The AIHW does not adjust data to account for possible data errors or missing or incorrect values. Jurisdictions are responsible for adjusting any data that is identified as problematic and re-submitting improved data files.

Data are also subject to ongoing historical validation. Due to this ongoing validation, 2005-06 to 2010-11 data could differ from previous reports.

The quality of the NSW 2010-11 MHE NMDS has been affected by the reconfiguration of 10 Area Health Services into 18 Local Health Districts mid the 2010-11 financial year.

Coherence

Data are reported for each year from 2005-06 to 2011-12.

'Non-uniquely identifiable consumers' are defined as those with service contacts for which a unique person identifier was not recorded. The proportion of contacts attributed to these consumers varies across jurisdictions (for example, from zero to 15 per cent) and can vary in one jurisdiction across time (for example, from 76 to 99 per cent). As all activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers are excluded using these proportions, the coherence and comparability of the results across jurisdictions and across time may be affected.

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility

The AIHW and Department of Health provide a variety of products that draw upon the MHE NMDS. Published products available on the AIHW or

	Department of Health websites include: • Mental Health Services in Australia — annual publication • Australia's Health — a mental health chapter is included in this biennial publication • National Mental Health Reports. Unpublished MHE NMDS data are available from the AIHW on request, but clearance for use of these data for a specific purpose needs to be provided by states and territories and there may be costs incur in their provision. Cells may be suppressed for confidentiality reasons or where estimates are based on small numbers, resulting in low reliability.
Interpretability	Metadata information for the MHE NMDS are published in the AIHW's online metadata repository — METeOR and in the National health data dictionary.

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following key data gaps/issues: • The cost of ambulatory care measures are not adjusted for differences in the client mix and this reduces the relevance of these data to the measurement of efficiency. • Data are not provided for the latest reference period (2012-13). Further work is required to ensure availability of more timely data. • The exclusion of activity (treatment days and statistical episodes) and expenditure associated with non-uniquely identified consumers means that the coherence and comparability of the results across jurisdictions and across time may be affected.

Rates of illicit and licit drug use

DQI for this indicator has been sourced from the AIHW with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Rates of illicit and licit drug use
Measure (computation)	Description: Proportion of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type: alcohol, cannabis, ecstasy, cocaine, meth/amphetamine, hallucinogens, Gamma-hydroxybutyrate (GHB), inhalants, and heroin. Numerator: Number of people aged 14 years or over who use specific licit and illicit drugs in the preceding 12 months — by drug type. Denominator: Total population aged 14 years or over. Computation: (Numerator ÷ Denominator)*100 Calculated separately, by drug type.
Data source/s	AIHW 2011, *2010 National Drug Strategy Household Survey* (NDSHS) *Report*, Drug statistics series no. 25, Cat. no. PHE 145. AIHW 2008, *2007 National Drug Strategy Household Survey State and territory supplement*, Drug statistics series no. 21, Cat. no. PHE 102.

Data Quality Framework Dimensions

Institutional environment	The NDSHS data was collected, processed, and published by the AIHW. The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister. For further information see the AIHW website. The NDSHS is one of the key data collections that support the *National Drug Strategy*. The last survey in this program was conducted in 2010, with previous surveys in 1985, 1988, 1991, 1993, 1995, 2001, 2004 and 2007. The data collected from these surveys have contributed to the development of policies for Australia's response to drug-related issues.
Relevance	The estimates are based on information obtained from people aged 12 years or over (or 14 years or over) from all states and territories on their drug use patterns, attitudes and behaviours. It covers people's use of, their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours. Most of the analysis presented is for people aged 14 years or over, so that results can be compared across surveys. The scope of the survey is residential households, and excludes institutional settings, hostels, motels and homeless people.
Timeliness	The NDSHS is conducted every three years. Data are released the year following the reference period. The latest data available are for 2010.
Accuracy	Data were collected from a national stratified random selection of households, using self-completion booklets, using a 'drop and collect' methodology. Estimates based on survey samples are subject to various types of variation, mainly sampling and non-sampling error.

- For sampling errors, estimates that have relative standards errors between 25–50 per cent and greater than 50 per cent are identified and should be used with caution or be considered as unreliable for most practical purposes, respectively.
- Non-sampling errors can arise from errors in reporting of responses, for example:
  - the reported findings are based on self-reported data and not empirically verified by blood tests or other screening measures — respondents might be unwilling to reveal certain information
  - higher levels of non-response can occur from population subgroups.

Response rates are reported in the relevant *National Drug Strategy Household Survey* reports.

Coherence

Data are reported for each year 2007 and 2010. Within the results for each survey, the data are largely comparable across most jurisdictions.

The 2010 survey was built on the design of the 2007 survey. However, the 2010 survey differed to 2007 in the following ways:

- it used the drop and collect method exclusively — in 2007, a combination of computer-assisted telephone interviews and drop and collect was used (this change in methodology does affect the time series data, and users should exercise some degree of caution when comparing data over time).
- the timing of the fieldwork differed
- sampling methodology differed, oversampling was undertake for some states and territories and the coverage of the survey was improved for very remote areas
- some refinements were made to the questionnaire, for example, the standard drinks guide was updated in line with the new Australian alcohol guidelines published in March 2009.

For further details on the differences across these surveys see AIHW 2011, *2010 National Drug Strategy Household Survey report*, Drug statistics series no. 25. Cat. no. PHE 145. Canberra.

Accessibility

Comprehensive data for the 2010 and 2007 National Drug Strategy Household Survey reports and supplementary tables are available on the AIHW’s website.

Data for this indicator are also reported in the National mental health reports www.health.gov.au/internet/main/publishing.nsf/Content/mental-data

Interpretability

Further information to understand this indicator are available in:

- the COAG national action plan on mental health — progress report 2010-11
- National mental health reports www.health.gov.au/internet/main/ publishing.nsf/Content/mental-data.

Data Gaps/Issues Analysis

Key data gaps/issues

The Steering Committee notes the following key data gaps/issues:

- Data are not comparable across the 2010 and 2007 National Drug Strategy Household Survey reports.

Prevalence of mental illness

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Prevalence of mental illness
Measure (computation)	*Numerator*: Number of people aged 16–85 years who had a mental health disorder diagnosed by the World Mental Health Composite Interviewing Diagnostic Instrument (CIDI), with symptoms in last 12 months. *Denominator*: Total population aged 16–85 years. *Computation*: (Numerator ÷ Denominator)*100 Disaggregated by disorder type and age or sex (national only), State and Territory, by disorder type.
Data source/s	ABS unpublished, *2007 National Survey of Mental Health and Wellbeing* (Cat. no. 4326.0).

Data Quality Framework Dimensions

Institutional environment	For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au).
Relevance	The 2007 National Survey of Mental Health and Wellbeing (SMHWB) provides information about the prevalence of selected *high prevalence* mental disorders in the Australian population aged 16–85 years, the level of impairment associated with these disorders, physical conditions, and the use of health services, such as consultations with health practitioners or visits to hospital. The survey also provides information on the strength of social networks, caring responsibilities and a range of socio-economic and demographic characteristics. The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The SMHWB was not designed to measure the prevalence of all mental health conditions, therefore some severe mental disorders, such as schizophrenia, were not collected. The SMHWB is based on an international survey instrument, the CIDI, developed by the World Health Organization (WHO) for use by participants in the World Mental Health Survey Initiative. The 2007 survey was designed to provide data that were internationally comparable, rather than to provide comparisons with the 1997 survey. The survey was also designed to provide estimates of the prevalence of mental disorders at a national rather than a state/territory level.

Timeliness	The SMHWB was conducted in 1997 and 2007. Results from the 2007 survey were released ten months after the completion of enumeration, in the publication *National Survey of Mental Health and Wellbeing: Summary of Results* (cat. no. 4326.0).
Accuracy	Estimates from the 2007 SMHWB are subject to sampling and non-sampling errors. The Relative Standard Error (RSE) is a measure of the size of the sampling error affecting an estimate; that is, the error introduced by basing estimates on a sample of the population rather than the full population. Estimates should be considered with reference to their RSEs. Estimates with an RSE between 25 per cent and 50 per cent should be used with caution, and those with an RSE greater than 50 per cent are considered too unreliable for general use. Non-sampling errors are inaccuracies that occur because of imperfections in reporting by respondents and interviewers, as well as errors made in coding and processing the data. The SMHWB was designed primarily to provide estimates at the national level. Due to the higher than expected non-response rate, RSEs were somewhat larger than originally designed. While broad estimates are available for the larger states, users should exercise caution when using estimates at this level due to relatively high sampling errors.
Coherence	The 2007 SMHWB was the second survey of this type conducted by the ABS, with the previous survey conducted in 1997. Care should be exercised when comparing data between surveys as there have been a number of changes to the scope, design, collection, methodology and content. Supporting documentation released with the survey data can assist in understanding the relationships between data variables within the dataset and in comparisons with data from other sources.
Accessibility	The main products available from this survey are: • *National Survey of Mental Health and Wellbeing: Summary of Results, 2007* (Cat. no. 4326.0) • *National Survey of Mental Health and Wellbeing: Users' Guide, 2007* (Cat. no. 4327.0) • *Microdata: National Survey of Mental Health and Wellbeing, Basic and Expanded Confidentialised Unit Record Files, 2007* (Cat. no. 4326.0.30.001) • *Technical Manual: National Survey of Mental Health and Wellbeing, Confidentialised Unit Record Files* (Cat. no. 4329.0). Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.
Interpretability	The *National Survey of Mental Health and Wellbeing: Summary of Results* (Cat. no. 4326.0) includes explanatory material to aid the interpretation of the survey results. More detailed information is available in the *National Survey of Mental Health and Wellbeing: Users' Guide* (Cat. no. 4327.0).

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issues: • The SMHWB was designed to provide estimates at the national level. Broad estimates are available for the larger states, but users should exercise caution when using estimates at this level due to relatively high sampling errors.

- The SMHWB was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). It does not measure the prevalence of some severe mental disorders, such as schizophrenia (which are the mental illnesses most frequently treated by specialised public mental health services).

Mortality due to suicide

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Mortality due to suicide
Measure (computation)	*Numerator*: Number of people who have died by suicide over the relevant reference period: • five year period (2007–2011) • single reference year (2011) *Denominator*: Estimated resident population. *Computation*: (Numerator ÷ Denominator)*100 000 Expressed as crude, age-specific or age standardised rates. Disaggregated by age and sex (national only), State and territory for all persons, young people (15–24 years), by geographical region and Indigenous status.
Data source/s	*Numerator:* ABS *Causes of Death* collection (Cat. no. 3303.0) *Denominator:* ABS Estimated Resident Population (Cat. no. 3101.0); Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 (Cat. no. 3238.0); ASGC (Cat. no. 1216.0).

Data Quality Framework Dimensions

Institutional environment	Statistics presented in *Causes of Death, Australia, 2011* (Cat. no. 3303.0) are sourced from deaths registrations administered by the various state and territory Registrars of Births, Deaths and Marriages. It is a legal requirement of each state and territory that all deaths are registered. Information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred on a *Death Registration Form*. As part of the registration process, information on the cause of death is either supplied by the medical practitioner certifying the death on a *Medical Certificate of Cause of Death*, or supplied as a result of a coronial investigation. Death records are provided electronically to the ABS by individual Registrars on a monthly basis. Each death record contains both demographic data and medical information from the *Medical Certificate of Cause of Death* where available. Information from coronial investigations are provided to the ABS through the National Coroners Information System (NCIS). For information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance

arrangements, and mechanisms for scrutiny of ABS operations, see ABS Institutional Environment (available www.abs.gov.au).

Relevance

The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS deaths or causes of death statistics.

From the 2007 reference year, the scope of the collection is:

- all deaths registered in Australia for the reference year and are received by the ABS by the end of the March quarter of the subsequent year; and
- deaths registered prior to the reference year but not previously received from the Registrar nor included in any statistics reported for an earlier period.

For example, records received by the ABS during the March quarter of 2011 which were initially registered in 2010 or prior (but not forwarded to the ABS until 2011) are assigned to the 2010 reference year. Any registrations relating to 2010 which are received by the ABS after the end of the March 2011 quarter are assigned to the 2011 reference year.

Data in the Causes of Death collection include demographic items, as well as causes of death information, which is coded according to the International Classification of Diseases (ICD). ICD is the international standard classification for epidemiological purposes and is designed to promote international comparability in the collection, processing, classification, and presentation of causes of death statistics. The classification is used to classify diseases and causes of disease or injury as recorded on many types of medical records as well as death records. The ICD has been revised periodically to incorporate changes in the medical field. The 10th revision of ICD (ICD-10) has been used since 1997.

Non-Indigenous data from the Causes of Death collection do not include death registrations with a ‘not stated’ Indigenous status.

Timeliness

Causes of death data are published on an annual basis.

There is a focus on fitness for purpose when causes of death statistics are released. To meet user requirements for accurate causes of death data it is necessary to obtain information from other administrative sources before all information for the reference period is available (for example, information from finalisation of coronial proceedings to code an accurate cause of death). A balance therefore needs to be maintained between accuracy (completeness) of data and timeliness. ABS provides the data in a timely manner, ensuring that all coding possible can be undertaken with accuracy prior to publication.

In addition, to address the issues which arise through the publication of causes of death data for open coroners cases, these data are subject to a revisions process. This process enables the use of additional information relating to coroner certified deaths either 12 or 24 months after initial processing.

Accuracy

Information on causes of death is obtained from a complete enumeration of deaths registered during a specified period and are not subject to sampling error. However, deaths data sources are subject to non-sampling error which can arise from inaccuracies in collecting, recording and processing the data. Every effort is made to minimise non-sample error by working closely with data providers, running quality checks throughout the

data processing cycle, training of processing staff, and efficient data processing procedures.

Causes of death data for 2006, 2007, 2008, 2009 and 2010 have been subject to revision. All coroner certified deaths registered after 1 January 2006 are subject to a revision process. This is a change from previous years where all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner), less specific ICD codes were assigned as required by the ICD coding rules. The revision process enables the use of additional information relating to coroner certified deaths as it becomes available over time. This results in increased specificity of the assigned ICD-10 codes.

For this year's report, causes of death data for 2009 and 2010 were updated as more information became available. Final data for 2006, 2007, 2008 and revised data for 2009 and 2010 have been published in the *2011 Causes of Death* publication, released in March 2013. 2010 and 2011 causes of death will be revised in the 2012 Causes of Death publication due for release in 2014. Revisions will only affect coroner certified deaths, as further information becomes available to the ABS about the causes of these deaths. See *Causes of Death, Australia* (Cat. no. 3303.0).

Some rates are unreliable due to small numbers of deaths over the reference period. Resultant rates could be misleading for example where the non-Indigenous mortality rate is higher than the Indigenous mortality rate. All rates for this indicator must be used with caution.

Non-Indigenous population estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

Coherence

The methods used to construct the indicator are consistent and comparable with other collections and with international practice.

The completeness or quality of older (unrevised) versus newer data (subject to a revisions process) can affect comparisons across time. The accuracy dimension contains information pertinent to coroner certified deaths affected by the revision process.

The ERPs used to derived rates differ across years and tables. Some are derived using ERPs based on the 2001 Census, 2006 Census or 2011 Census. See particular tables for details. Rates derived using ERPs based on different Censuses are not comparable.

Accessibility

Causes of death data are available in a variety of formats on the ABS website under the 3303.0 product family. ERP data is available in a variety of formats on the ABS website under the 3101.0 and 3201.0 product families. Further information on deaths and mortality may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability

Information on how to interpret and use cause of death data is available

from Explanatory Notes in *Causes of Death, Australia* (Cat. no. 3303.0).

Data Gaps/Issues Analysis

Key data gaps/issues	The Steering Committee notes the following issue: • Causes of death data are subject to a revisions process. Final data for 2006, 2007 and 2008 and revised data for 2009 and 2010 have been published in the 2011 Causes of Death publication. Data for 2010 and 2011 causes of death will be revised in 2014.

Social and economic inclusion of people with a mental illness — participation in employment of working age population

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in employment of working age population.
Measure (computation)	*Numerator*: Number of people aged 16-64 years who are employed (by mental health status) *Denominator*: Number of people aged 16-64 years in the population (by mental health status) *Computation*: (Numerator ÷ Denominator)*100 Note: People with a mental health condition are defined as having a self-reported mental or behavioural problem that has lasted for six months, or which the respondent expects to last for six months or more.
Data source/s	ABS unpublished, *Australian Health Survey (AHS) 2011-13* (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au.
Relevance	Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI. The definitions of employment, unemployment and the labour force are consistent with those used in ABS labour force surveys.
Timeliness	The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released in October 2012.
Accuracy	The AHS is conducted in all States and Territories, excluding very

remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users' Guide on the ABS website.

Coherence The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability Information to aid interpretation of the data is available from the Australian Health Survey: Users' Guide on the ABS website.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following issues:

- The AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the SMHWB that uses a diagnostic tool to identify mental illnesses.

Social and economic inclusion of people with a mental illness — participation in education and employment by young people

DQI for this indicator has been sourced from the ABS with additional Steering Committee comments.

Indicator definition and description

Element	Outcome
Indicator	Social and economic inclusion of people with a mental illness — participation in education and employment by young people.
Measure (computation)	*Numerator*: Number of people aged 16–30 years who are employed and/or are enrolled for study in a formal secondary or tertiary qualification (studying full or part-time) (by mental health status). *Denominator*: Number of people in aged 16–30 years in the population (by mental health status). *Computation*: (Numerator ÷ Denominator)*100 Note: People with a mental health condition are defined as having a self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more.
Data source/s	ABS unpublished, *AHS 2011-13* (2011-12 National Health Survey component).

Data Quality Framework Dimensions

Institutional environment	The AHS was collected, processed, and published by the ABS. The ABS operates within a framework of the Census and Statistics Act 1905 and the Australian Bureau of Statistics Act 1975. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents. For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms for scrutiny of ABS operations, please see ABS Institutional Environment at www.abs.gov.au.
Relevance	Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the ICD. The 2011-12 AHS collected data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. Estimates for people with 'mental illness' will differ to those that are derived under the SMHWB using the CIDI. The definitions of employment are consistent with those used in ABS labour force surveys.
Timeliness	The AHS is conducted every three years over a 12 month period. Results from the 2011-12 NHS component of the AHS were released

in October 2012.

Accuracy The AHS is conducted in all states and territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the NT, where such persons make up a relatively large proportion of the population. The response rate for the 2011-12 NHS component was 85 per cent. Results are weighted to account for non-response.

As it is drawn from a sample survey, the indicator is subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their RSE. Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use. The attachment tables identify those estimates with RSEs between 25 per cent and 50 per cent.

For information on AHS survey design, see the Australian Health Survey: Users’ Guide on the ABS website.

Coherence The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Accessibility See *Australian Health Survey: First Results (cat. no. 4364.0.55.001)* for an overview of results from the NHS component of the AHS. Other information from this survey is also available on request.

Further information may be available on request. The ABS observes strict confidentiality protocols as required by the *Census and Statistics Act (1905)*. This may restrict access to data at a very detailed level.

Interpretability Information to aid interpretation of the data is available from the Australian Health Survey: Users’ Guide on the ABS website.

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Data Gaps/Issues Analysis

Key data gaps/issues The Steering Committee notes the following issues:

- The AHS collects data on self-reported mental and behavioural problems that have lasted for six months, or which the respondent expects to last for six months or more. The data may not be as reliable as or comparable with the data collected under the National Survey of Mental Health and Wellbeing that uses a diagnostic tool to identify mental illnesses.

Mental health outcomes of consumers of specialised public mental health services

DQI for this indicator has been sourced from the AMHOCN and Australian, State and Territory governments with additional Steering Committee comments.

Indicator definition and description

Element Outcome

Indicator Mental health outcomes of consumers of specialised public mental health services. This DQI should be considered in conjunction with DQI for Collection of information on consumers' outcomes.

Measure (computation) Description:

Proportion of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes. Data are also reported on the proportion who experienced no significant change or a significant deterioration in their mental health outcomes. Data are reported by consumer type: people in ongoing community-based care, people discharged from community-based care and people discharged from a hospital psychiatric inpatient unit.

Numerator/s:

Number of people receiving care in specialised public mental health services who had a significant improvement in their clinical mental health outcomes, by consumer type.

Number of people receiving care in specialised public mental health services who had no significant change in their clinical mental health outcomes, by consumer type.

Number of people receiving care in specialised public mental health services who had a significant deterioration in their clinical mental health outcomes, by consumer type.

Denominator:

Number of specialised public mental health service episodes with completed clinical mental health outcome measures data, by consumer type.

Computation:

Expressed as a proportion: (Numerator ÷ Denominator)*100. Calculated separately by consumer type.

Data source/s State and Territory data reported to NOCC and analysed by AMHOCN.

Data Quality Framework Dimensions

Institutional environment Health Ministers adopted the routine measurement of consumer outcomes as a priority under the *National Mental Health Strategy (1992)* and in all subsequent National Mental Health Plans. It is also compatible with State and Territory governments' documented policy emphasis on high quality health services and increased consumer and carer participation.

The AMHOCN prepared this indicator using the NOCC data on the Health of the Nation Outcome Scales (HoNOS) family of measures. The Australian Government (Department of Health) contracts AMHOCN to support the implementation of the NOCC as part of routine clinical practice by undertaking three functions 1) data bureau — receives and processes information 2) analysis and reporting — analyses and reports on the submitted data and 3)

training and service development — supports training in the measures and their use for clinical practice, service management and development purposes.

The NOCC 1.50 was endorsed by all State and Territory governments in 2003, and all jurisdictions have reported data since 2004-05. The NOCC Technical Specification was revised to 1.60 in 2009. All jurisdictions have supplied, or resupplied NOCC data according to 1.60 from 2007-08. The NOCC protocol prescribes a set of standard measures to be collected at particular times (collection occasions) in the clinical process. Under the NOCC protocol, collection of outcomes data is mandatory at admission, review and discharge. Data collected outside of NOCC protocols are excluded from the analysis.

Relevance

The scope of the NOCC is all specialised public mental health services managed by, or in receipt of funds from, state or territory health authorities Australian Government funded aged residential services are excluded.

The purpose of the NOCC is to measure consumer outcomes. This indicator relates only to consumer outcomes data collected through the HoNOS family of measures (HoNOS; HoNOS for Older People (HoNOS 65+) and HoNOS for Children and Adolescents (HoNOSCA). Other consumer outcome measures are also collected. For adults and older persons these include: Kessler 10 (K10+), Behavior and Symptom Identification Scales (BASIS-32), or Mental Health Inventory (MHI-38); for children and adolescents, the parent and youth versions of the SDQ. The uptake of these measures is not captured by this indicator.

Only episodes that have valid measures for two specified data collection occasions are included. 'Valid' measures are those with a correctly completed specified number of items, for the:

- HoNOS/HoNOS 65+ — a minimum of 10 of the 12 items
- HoNOSCA — a minimum of 11 of the first 13 items.

Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect. The effect size is 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.

Outcomes are calculated for each of the following three consumer groups and the calculation varies depending on the setting and the duration of the episode of care:

- people discharged from hospital, episodes for people who were admitted and discharged from inpatient care during the reference period (an individual can have two episodes of care so the data represent episode-counts, rather than person-counts) — the admission and discharge occasions rated during the reference period are used
- people in ongoing community-based care, episodes for people who received community care for the whole of the reference period or who commenced community care sometime after 1 July (beginning of the period) and continued to receive care for the rest of the reference period — the first and last occasions rated during the reference period are used
- people discharged from community-based care, episodes for people who were discharged from community care (not including those discharged to hospital and who received an episode of community care that started and ended in the reference period — the admission and discharge occasions rated during the reference period are used.

Outcomes are measured for consumers discharged from residential mental health care, but there were too few episodes with completed clinical mental

health to derive outcome results.

A single 'average score' by consumer type does not reflect the complex service system in which services are delivered across multiple settings (inpatient, community and residential) and provided as both discrete, short term episodes of care and prolonged care over indefinite periods. 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.

Data are not available for Victoria for 2011-12. All Australian totals for 2011-12 exclude Victoria.

Timeliness State and territory health authorities provide the NOCC data to AMHOCN for national collation on an quarterly/annual basis and all data are to be submitted approximately six months after the reference period.

The latest reference period for this data set is 2011-12.

Accuracy States and territories are primarily responsible for the quality of the NOCC data they provide. However, AMHOCN undertakes extensive validation. Validation is conducted in two stages: (1) The compliance stage, concerned with ensuring that the data file will load and is structurally compliant. A non-compliant file is rejected and a new file needs to be submitted. (2) The data validation stage, primarily concerned with identifying and explaining or fixing inconsistent, anomalous, and exceptional issues in relation to the NOCC protocol as well as flagging , including invalid domain values and/or, missing data.

The proportion of episodes for which 'valid' outcomes data are collected is less than 50 per cent of expected coverage. It is not known if the results for those for whom data are collected are representative of the consumer population.

Coherence Data are available for 2007-08 to 2011-12. The comparability of the outcomes data across jurisdictions and years may be affected by the relatively low proportion of episodes for which 'valid' outcomes data are collected and the degree to which this proportion varies across jurisdictions and years.

The Australian totals for 2011-12 are not comparable to earlier years as they exclude data for Victoria.

Accessibility Data for this indicator are published in the National mental health reports: www.health.gov.au/internet/main/publishing.nsf/Content/mental-data.

NOCC data are available on the AMHOCN website amhocn.org/. The following on-line products are available:

- web decision support tool
- NOCC Standard Reports
- NOCC Volume and Percentage Clinical Ratings: Australia

Interpretability Metadata information for the NOCC are published on the AMHOCN website amhocn.org/.

Information for understanding this indicator is available in the *Key Performance Indicators for Australian Public Mental Health Services, Second Edition* at www.health.gov.au/internet/mhsc/publishing.nsf/Content/99A25CC5B3781660CA257A5D000235B3/$File/kpitech.pdf and forthcoming in 2013 in the *Key Performance Indicators for Australian Public Mental Health Services, Third Edition*

<u>Data Gaps/Issues Analysis</u>

Key data gaps/issues The Steering Committee notes the following key data gaps/issues:

- There are differences in the relative proportions of "matched pair"

HoNOS/CA/65+ ratings.

- NOCC completion rates are for people discharged from hospital and people on ongoing community based care are approximately 85 per cent.
- NOCC completion rates for people discharged from community based care, are lower, at approximately 65 per cent. This pattern has been stable over time and generally consistent for all consumer age groups and jurisdictions, with the exception of ACT where technical issues have not enabled linkage of admission and discharge ratings for this consumer group. It is likely that the overall lower completion rate for this consumer group arises when consumers are administratively discharged from care following a period of no active care in the preceding period.