Report on Government Services 2020

PART E, SECTION 13: PRESENTATION REVISED ON 25 JUNE 2020, RELEASED ON 31 JANUARY 2020

13 Mental health management

The presentation of this section has been updated since its release on 31 January 2020.

This section is presented in a new online format. Dynamic data visualisations replace the static chapter format used in previous editions. Machine readable data are also available for download. A guide is available on accessing information in the new format.

This section reports on the Australian, State and Territory governments' management of mental health and mental illnesses. Performance reporting focuses on State and Territory governments' specialised mental health services, and mental health services subsidised under the Medicare Benefits Schedule (MBS) (provided by General Practitioners (GPs), psychiatrists, psychologists and other allied health professionals).

The **Indicator Results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator Framework.** The same data are also available in CSV format.

Skip to downloadable Mental health management data tables and supporting material

Context

Objectives for mental health services

Mental health services aim to:

- promote mental health and wellbeing, and where possible prevent the development of mental health problems, mental illness and suicide, and
- when mental health problems and illness do occur, reduce the impact (including the effects of stigma and discrimination), promote recovery and physical health and encourage meaningful participation in society, by providing services that:
  - are high quality, safe and responsive to consumer and carer goals
  - facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
  - are coordinated and provide continuity of care
  - are timely, affordable and readily available to those who need them
  - are sustainable.

Governments aim for mental health services to meet these objectives in an equitable and efficient manner.

Service overview

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 1999). The World Health Organization describes positive mental health as:

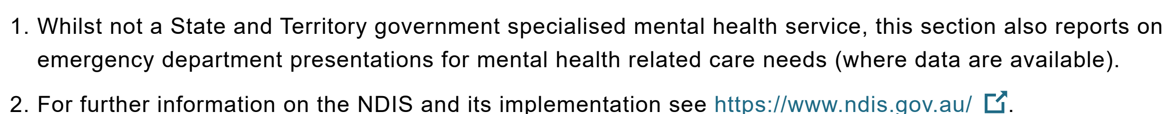
… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

Mental 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.

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

- MBS subsidised mental health specific services that are partially or fully funded under Medicare on a fee-for-service basis and are provided by GPs, psychiatrists, psychologists or other allied health professionals under specific mental health items.
- State and Territory government specialised mental health services (treating mostly low prevalence, but severe, mental illnesses), which include:
    - Admitted patient care in public hospitals — specialised services provided to inpatients in stand-alone psychiatric hospitals or psychiatric units in general acute hospitals[1].
    - Community-based public mental health services, comprising:
        - ambulatory care services and other services dedicated to assessment, treatment, rehabilitation and care, and
        - residential services that provide beds in the community, staffed onsite by mental health professionals.
- Not for profit, non-government organisation (NGO) services, funded by the Australian, State and Territory governments focused on providing well-being, support and assistance to people who live with a mental illness.
- The National Disability Insurance Scheme (NDIS), which began full roll out in July 2016[2]. People with a psychiatric disability who have significant and permanent functional impairment are eligible to access funding through the NDIS. In addition, people with a disability other than a psychiatric disability, may also be eligible for funding for mental health-related services and support if required.

There are also other services (for example, specialist homelessness services) provided and/or funded by governments that make a significant contribution to the mental health treatment of people with a mental illness, but are not specialised or specific mental health services. Information on these services can be found in *Mental Health Services in Australia* (AIHW 2019).



1. Whilst not a State and Territory government specialised mental health service, this section also reports on emergency department presentations for mental health related care needs (where data are available).
2. For further information on the NDIS and its implementation see https://www.ndis.gov.au/ .

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and/or management of specialised mental health services including inpatient/admitted care in hospitals, community-based ambulatory care and community-based residential care.

The Australian Government is responsible for the oversight and funding of a range of mental health services and programs that are primarily provided or delivered by private practitioners or NGOs. These services and programs include MBS subsidised services provided by GPs (under both general and specific mental health items), private psychiatrists and other allied mental health professionals, Pharmaceutical Benefits Scheme (PBS) funded mental health related medications and other programs designed to prevent suicide or increase the level of social support and community-based care for people with a mental illness and their carers. The Australian Government also funds State and Territory governments for health services, most recently through the approaches specified in the National Health Reform Agreement (NHRA) which includes a mental health component.

A number of national initiatives and nationally agreed strategies and plans underpin the delivery and monitoring of mental health services in Australia including:

- the *Mental Health Statement of Rights and Responsibilities* (Australian Health Ministers 1991)
- the *National Mental Health Policy* 2008 (DoH 2009)
- the *National Mental Health Strategy* (DoH 2014)
- five-yearly National Mental Health Plans, with the most recent — the *Fifth National Mental Health and Suicide Prevention Plan* — endorsed in August 2017 (COAG 2017).

Funding

Nationally, real government recurrent expenditure of around $9.4 billion was allocated to mental health services in 2017-18, equivalent to $377.79 per person in the population (table 13A.1 and figure 13.1). State and Territory governments made the largest contribution ($6.0 billion or 64.1 per cent, which includes Australian Government funding under the NHRA), with Australian Government expenditure of $3.4 billion (table 13A.1).

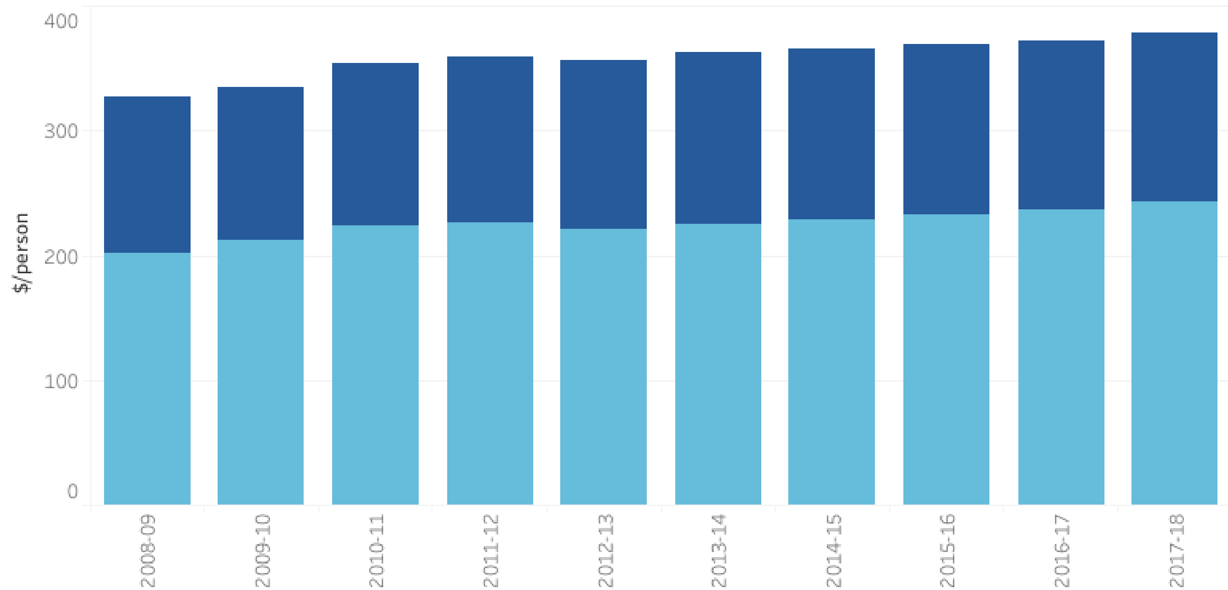
Expenditure on MBS subsidised services was the largest component of Australian Government expenditure on mental health services in 2017-18 ($1.2 billion or 37.0 per cent) (table 13A.2). This comprised MBS payments for psychologists and other allied health professionals (17.4 per cent), consultant psychiatrists (10.7 per cent) and GP services (8.9 per cent) (table 13A.2). Another significant area of Australian Government expenditure on mental health services in 2017-18 was expenditure under the PBS for mental health related medications ($519.9 million) (table 13A.2).

Nationally, expenditure on admitted patient services is the largest component of State and Territory governments' expenditure on specialised mental health services ($2.6 billion or 43.7 per cent) in 2017-18 followed by expenditure on community-based ambulatory services ($2.3 billion or 37.3 per cent) (table 13A.3). State and Territory governments' expenditure on specialised mental health services, by source of funds and depreciation (which is excluded from reporting) are in tables 13A.4 and 13A.5 respectively.

Select year(s):
All

Australian Government
State and Territory Governments'

Figure 13.1 **Real government expenditure per person on mental health services, (2017-18 dollars), by year, by funding source**



Source: table 13A.1

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

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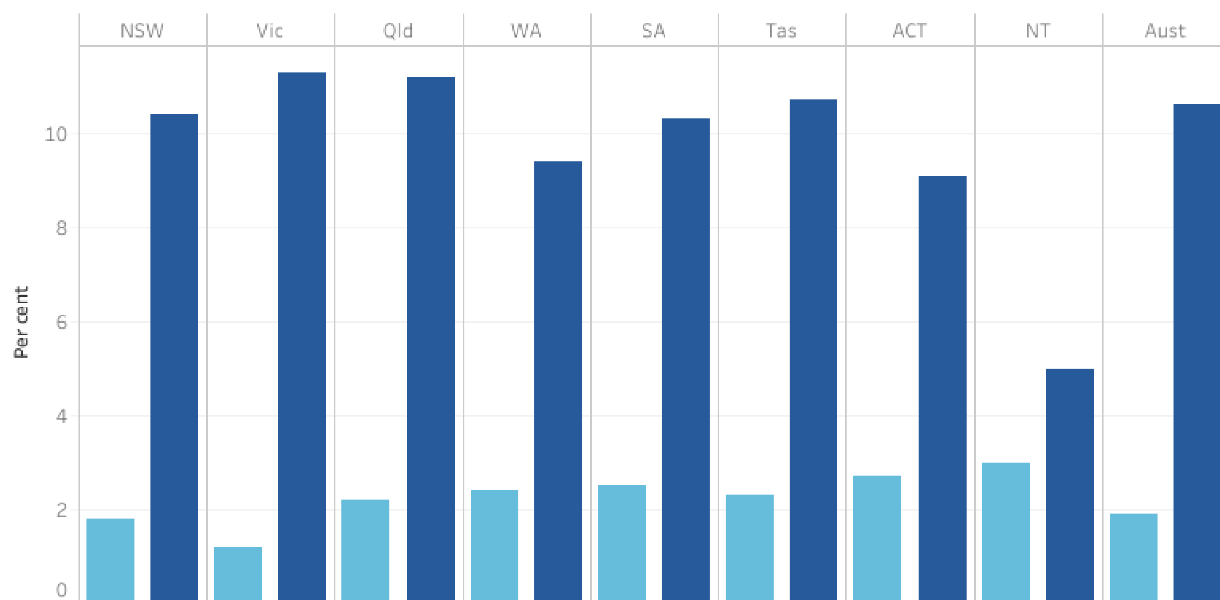
Size and scope

In 2017-18, 1.9 per cent and 10.6 per cent of the total population received State and Territory governments' specialised mental health services and MBS/Department of Veterans' Affairs (DVA) services, respectively (figure 13.2). While the proportion of the population using State and Territory governments' specialised mental health services has remained relatively constant, the proportion using MBS/DVA services has increased steadily over time from 5.9 per cent in 2008-09 to 10.6 per cent in 2017-18 (table 13A.7). Much of this growth has come from greater utilisation of GP mental health-specific services (from 4.4 per cent to 8.7 per cent) and other allied health services (1.7 per cent to 3.3 per cent) over that period (table 13A.7).

Select year:
2017-18

State and Territory governments' specialised
MBS/DVA subsidised

Figure 13.2 **Population receiving mental health services, 2017-18**
by service type, by jurisdiction



Source: table 13A.7

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Information on the proportion of new consumers who accessed State and Territory governments' specialised and MBS subsidised mental health services are available in tables 13A.8–9.

MBS subsidised mental health services

In 2017-18, 8.0 million MBS subsidised mental health services were provided by; psychologists (5.2 million), psychiatrists (2.4 million) and other allied health professionals (0.4 million). Service usage rates varied across states and territories (table 13A.10).

A further 3.6 million MBS subsidised specific mental health services were provided by GPs (table 13A.10). GPs are often the first service accessed by people seeking help when suffering from a mental illness (AIHW 2019). They can diagnose, manage and treat mental illnesses and refer patients to more specialised service providers. A recent report from the Royal Australian College of General Practitioners found that mental health issues are the most common single reason patients are visiting their GP (RACGP 2019). Data from the now decommissioned Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity showed an estimated 18.0 million GP visits in 2016-17 included management of mental health related problems (12.4 per cent of all GP encounters) (table 13A.11).

State and Territory governments' specialised mental health services

Across states and territories, the mix of admitted patient and community-based services and care types can differ. As the unit of activity varies across these three service types, service mix differences can be partly understood by considering items which have comparable measurement such as expenditure (table 13A.3), numbers of full time equivalent (FTE) direct care staff (table 13A.12), accrued mental health patient days (table 13A.13) and mental health beds (table 13A.14).

Additional data are also available on the most common principal diagnosis for admitted patients, community-based ambulatory contacts by age group and specialised mental health care by Indigenous status in *Mental*

Health Services in Australia (AIHW 2019).

National Disability Insurance Scheme

By 2019-20, the number of participants in the NDIS with a significant and enduring primary psychosocial disability is estimated to be approximately 64 000 (NDIA 2017). In 2018-19, there were 25 192 NDIS participants (active with an approved plan) with a psychosocial disability (9 per cent of all participants) (NDIA 2019).

Nationally in 2018-19, payments for active participants (with an approved plan) for people with a primary disability of psychosocial disability totalled $550.8 million (table 13A.15).

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WHO (World Health Organization) 2001, *Strengthening mental health promotion* , Fact sheet no. 220, Geneva.

Indicator Framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health services.

The performance indicator framework shows which data are complete and comparable in this Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a Report-wide perspective. In addition to the service area's Profile information, the Report’s statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

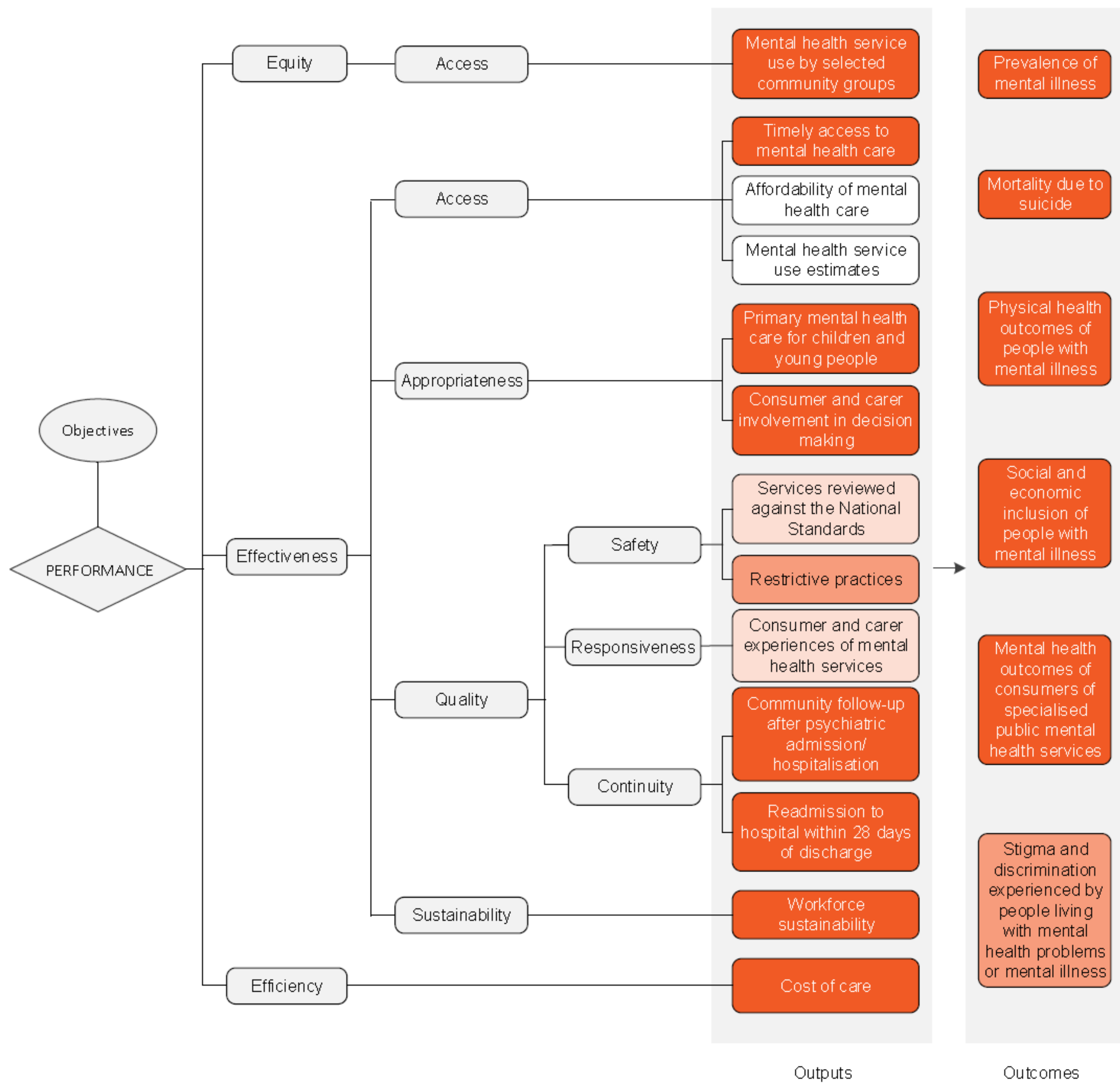
Improvements to performance reporting for mental health services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see section 1). Output information is also critical for equitable, efficient and effective management of government services.

Outcomes

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



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 section

Indicator Results

An overview of the mental health services performance indicator results are presented. Different delivery contexts, locations and types of consumers can affect the equity, effectiveness and efficiency of mental health services.

Information to assist the interpretation of these data can be found in the mental health services supporting interpretative material and data tables. Data tables are identified by a ‘13A’ prefix (for example, table 13A.1).

All data are available for download as an excel spreadsheet and as a CSV dataset — refer to Download supporting material. Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

Mental health service use by selected community groups is an indicator of governments' objective to provide mental health services in an equitable manner. It is defined by two measures.

Measure 1: The proportion of the population in a selected community group using State and Territory governments' specialised public mental health services, compared to the proportion of the population outside the selected community group.
Measure 2: The proportion of the population in a selected community group using Medicare Benefits Schedule (MBS)/Department of Veterans' Affairs (DVA) subsidised mental health services, compared to the proportion of the population outside the selected community group.

The selected community groups reported are Aboriginal and Torres Strait Islander Australians, people from outer regional, remote and very remote locations and people residing in low socioeconomic areas (Socio Economic Indexes for Areas (SEIFA) quintiles 1 and 2).

Guidance: 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 are comparable (subject to caveats) across jurisdictions and over time (from 2011-12 onwards by geographic location and SEIFA for Measure 2).

■ Data are complete (subject to caveats) for the current reporting period.

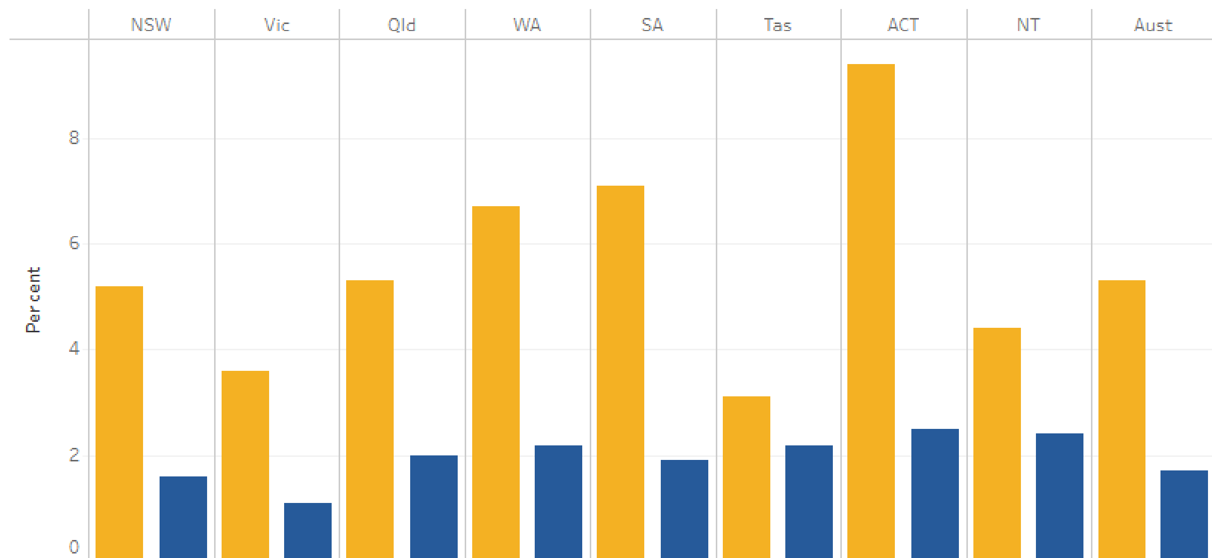
Select year:
2017-18

Select measure (service type):
◉ State and Territory governments' specialised
○ MBS/DVA subsidised

Select community group:
Indigenous status

Aboriginal and Torres Strait Islander
Non-Indigenous

Figure 13.3 **Public Mental health service use by selected community groups, 2017-18 (a), (b)**
by jurisdiction, by Indigenous status



Source: tables 13A.16, 13A.17, 13A.18

(a) See data tables 13A.16-18 for information on non-publication of data on Indigenous status, remoteness or SEIFA for individual jurisdictions.
(b) Data by Indigenous status are not available for DVA subsidised mental health services. MBS/DVA data by Indigenous status only include MBS subsidised services.

While a higher proportion of the population access MBS/DVA subsidised mental health services than State and Territory governments' specialised public mental health services, the pattern of service use across the selected community groups differs.

For State and Territory governments' specialised public mental health services, a higher proportion of Aboriginal and Torres Strait Islander people access these services than non-Indigenous people. This is similar nationally for people residing in lower socioeconomic areas (SEIFA quintiles 1 and 2) compared to people residing in higher socioeconomic areas (SEIFA quintiles 4 and 5) and for people in remote and very remote areas compared to other areas.

For MBS subsidised mental health services nationally, a similar proportion of Aboriginal and Torres Strait Islander people and non-Indigenous Australians accessed these services, but results varied across jurisdictions. Nationally in 2017-18, a higher proportion of people residing in higher socioeconomic areas accessed MBS/DVA services compared to people residing in lower socioeconomic areas. By remoteness area, the proportion of people accessing MBS/DVA subsidised services generally decreased as remoteness increased, though results varied across jurisdictions.

Data on the use of private hospital mental health services are also contained in tables 13A.16–18 and 13A.7.

Timely access to mental health care is an indicator of governments' objective to provide services in a timely manner.

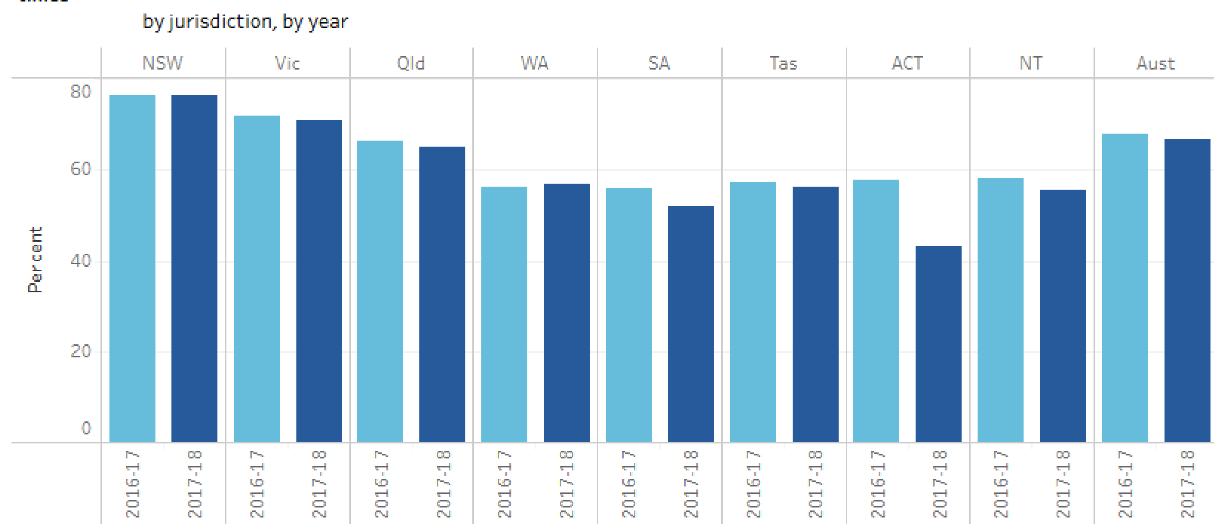
Measure: The proportion of people who present to an emergency department with a mental health related care need (principal diagnosis of F00–F99) seen within clinically recommended waiting times.

Guidance: High or increasing proportions of patients seen within the recommended waiting times is desirable. This is a partial measure for this indicator as emergency departments are only one of many services that provide access to mental health care.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):
(All)

Figure 13.4 **Proportion of mental health related emergency department presentations seen within clinically recommended waiting times**



Source: table 13A.19

Nationally in 2017-18, 66.8 per cent of people who presented to an emergency department with a mental health related care need were seen within clinically recommended waiting times.

Affordability of mental health care is an indicator of governments' objective to provide services that are affordable. It is defined by three measures.

Measure 1: The proportion of people with a mental health condition who delayed seeing or did not see a GP for their mental health condition due to cost.
Measure 2: The proportion of people with a mental health condition who delayed filling or did not fill a prescription for their mental health condition due to cost.
Measure 3: The proportion of people with a mental health condition who delayed seeing or did not see a psychologist, psychiatrist or other allied mental health professional for their mental health condition due to cost.

Guidance: A low or decreasing proportion for each measure is desirable.

Data are not yet available for reporting against this indicator.

Mental health service use estimates is an indicator of governments' objective to provide services that are readily available to those who need them.

***Measure*:** The estimated proportion of the population with a mental health condition receiving a mental health service.

***Guidance*:** A high or increasing proportion of the population with a mental health condition receiving mental health services suggests greater access to treatment. However, not all people with a mental health condition will want or need treatment. Furthermore, accessing a service does not guarantee that the service will be effective.

An agreed method for reporting against this indicator is not yet available.

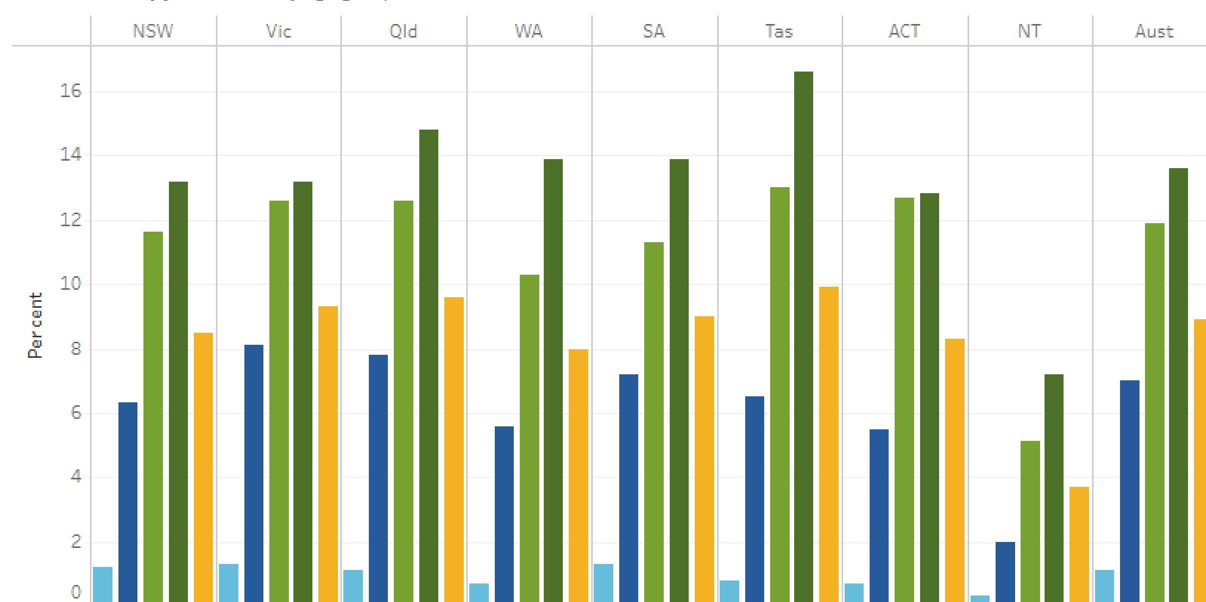
Primary mental health care for children and young people is an indicator of governments' objective to facilitate early detection of mental health issues and mental illness, followed by appropriate intervention.

Measure: The proportion of young people aged under 25 years who received a mental health care service subsidised through the MBS from a GP, psychologist or other allied health professional.

Guidance: High or increasing proportions of young people who had contact with MBS subsidised primary mental health care services is desirable. Results for this indicator should be interpreted with caution. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. In addition, 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.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Figure 13.5 **Children and young people who received MBS subsidised primary mental health care, 2018-19**
by jurisdiction, by age group



Source: table 13A.20

The proportion of all children and young people who receive MBS subsidised primary mental health care services has more than doubled over the past 10 years, from 3.8 per cent in 2009-10 to 8.9 per cent in 2018-19. The proportion increases as age increases; with the highest proportion for young people aged 18–24 years (13.6 per cent nationally in 2018-19).

Proportions are higher for females compared to males, and for major cities and inner regional areas compared to other areas (table 13A.21). Data by Indigenous status and service type are available in tables 13A.21–22 respectively.

Consumer and carer involvement in decision making is an indicator of governments' objective to provide universal access to services that are responsive to consumer and carer goals. It is defined by two measures.

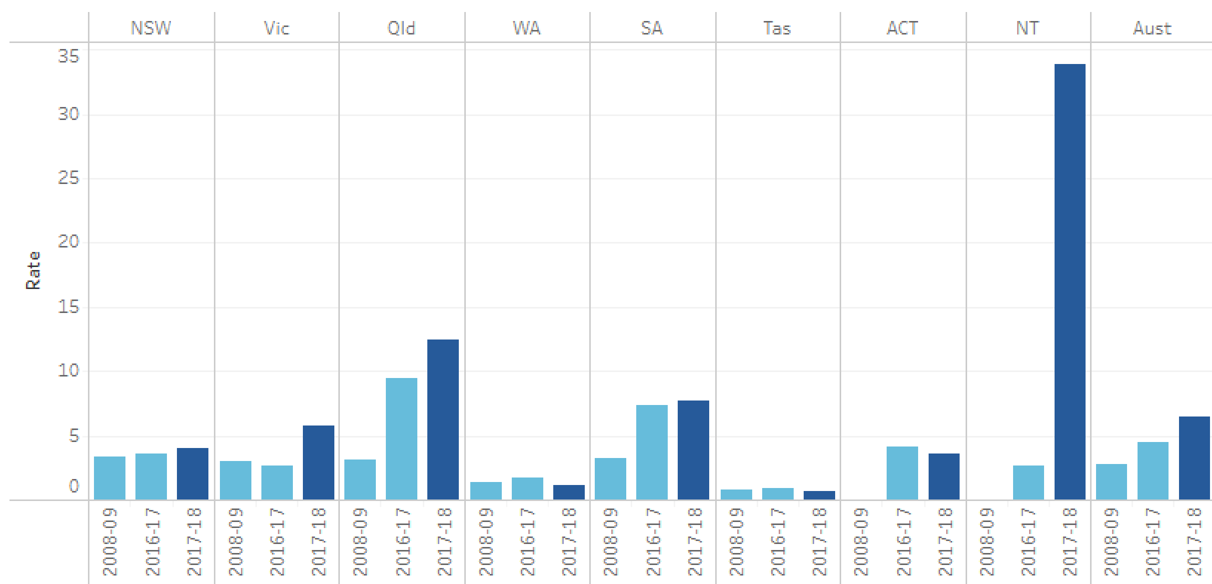
Measure 1: The number of paid FTE consumer workers per 1000 FTE direct care staff.
Measure 2: The number of paid FTE carer workers per 1000 FTE direct care staff.

Guidance: High or increasing proportions of paid FTE direct care workers who are consumer or carer staff implies better opportunities for consumers and carers to influence the services received.

- Data are comparable (subject to caveats) across jurisdictions and (from 2010-11) over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year (applies to figures 13.6a and 13.6b):
(Multiple values)

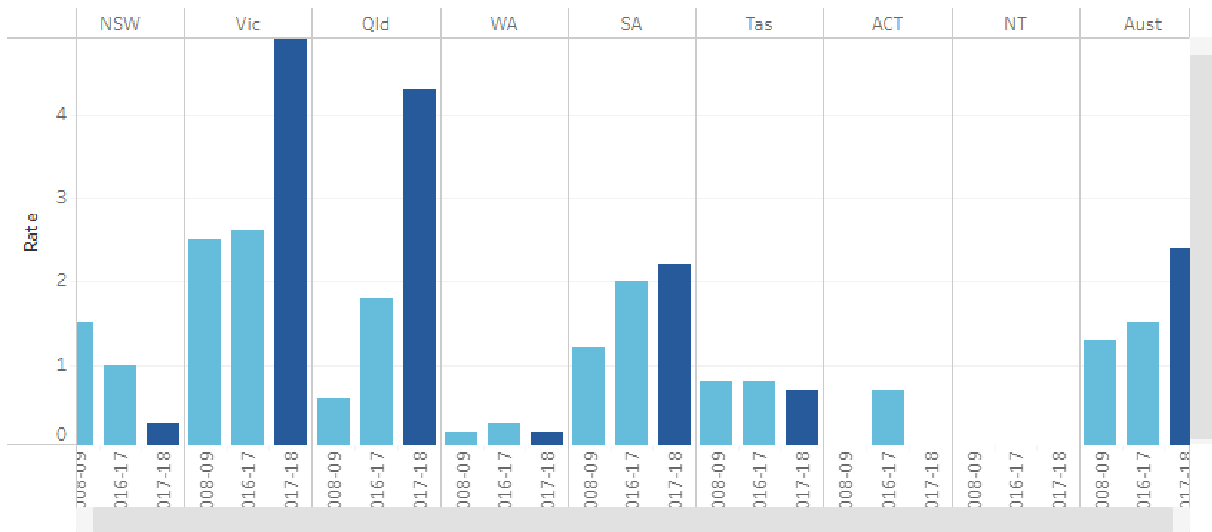
Figure 13.6a Measure 1: **Paid consumer workers (FTE) per 1000 paid direct care staff (a)** by jurisdiction, by year



Source: table 13A.23
(a) Consumer and carer staff could not be separately identified in the ACT for 2013-14 to 2015-16. The Australian total excludes the ACT for these years.

Nationally in 2017-18, there were 6.4 paid FTE consumer workers per 1000 paid FTE direct care staff.

Figure 13.6b Measure 2: **Paid carer workers (FTE) per 1000 paid direct care staff (b)**
by jurisdiction, by year



Source: table 13A.2

(b) WA did not employ carer staff in 2013-14. The NT did not employ carer staff in 2013-14 or in 2016-17 to 2017-18. Consumer and carer sta
could not be separately identified in the ACT for 2013-14 to 2015-16. The Australian total excludes the ACT for 2013-14 to 2015-16. The ACT di
not employ any carer staff in 2017-1

Nationally in 2017-18, there were 2.4 paid FTE carer workers per 1000 paid FTE direct care staff.

Services reviewed against the National Standards is an indicator of governments' objective to provide universal access to services that are high quality.

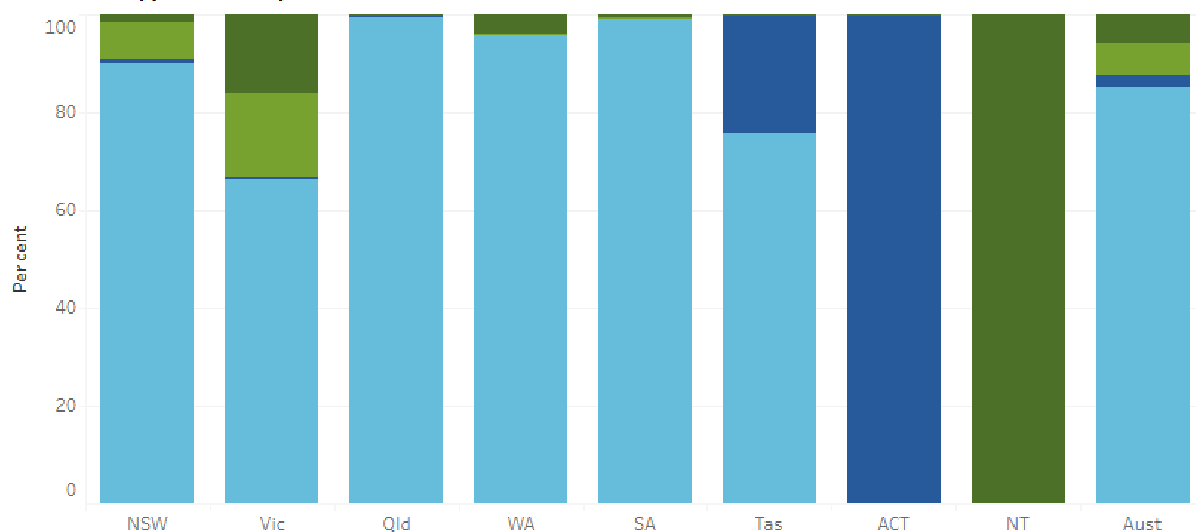
Measure: The proportion of expenditure on State and Territory governments' specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and met 'all standards' (level 1).

Guidance: A high or increasing proportion of expenditure on specialised mental health services that had completed a review by an external accreditation agency and had been assessed against the NSMHS as level 1 is desirable. Supporting data on the duration of seclusion events are provided in table 13A.25. These data, when considered with the rate of seclusion, provide information on the use and management of seclusion within each jurisdiction. A low rate of seclusion events combined with shorter average durations is desirable.

Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.

Data are complete (subject to caveats) for the current reporting period.

Figure 13.7 **Share of Expenditure on State and Territory governments' specialised public mental health services reviewed against the National Standards for Mental Health Services level (NSMHS), 2018**
by jurisdiction, by NSMHS level



Source: table 13A.24

Nationally, as at 30 June 2018, 85.1 per cent of expenditure on specialised public mental health services that had completed an external review against the NSMHS was on services that met 'all standards' (level 1).

Services reviewed against the National Standards is an indicator of governments' objective to provide universal access to services that are high quality.

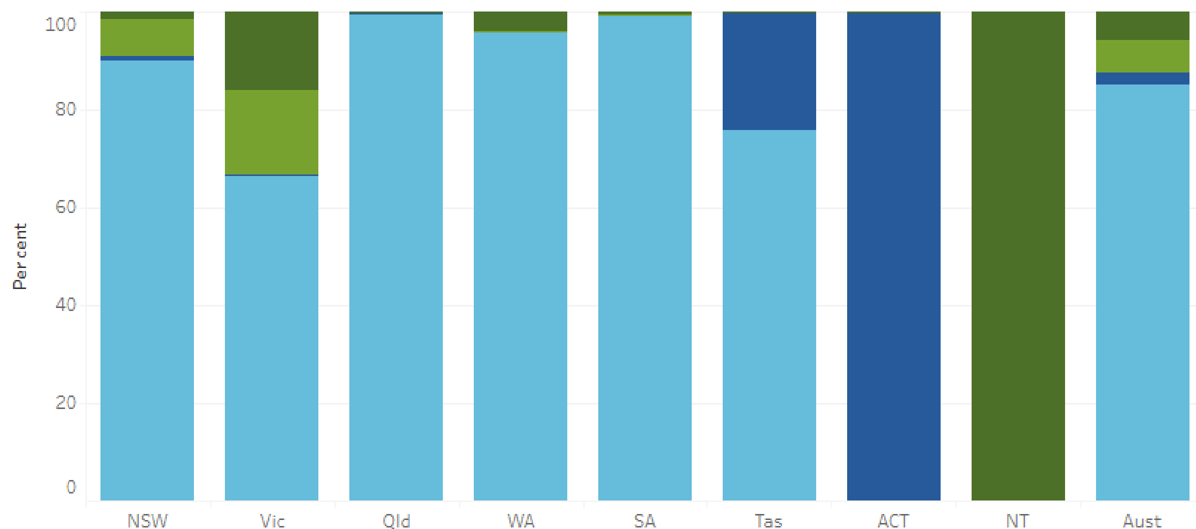
Measure: The proportion of expenditure on State and Territory governments' specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and met 'all standards' (level 1).

Guidance: A high or increasing proportion of expenditure on specialised mental health services that had completed a review by an external accreditation agency and had been assessed against the NSMHS as level 1 is desirable. Supporting data on the duration of seclusion events are provided in table 13A.25. These data, when considered with the rate of seclusion, provide information on the use and management of seclusion within each jurisdiction. A low rate of seclusion events combined with shorter average durations is desirable.

Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.

Data are complete (subject to caveats) for the current reporting period.

Figure 13.7 **Share of Expenditure on State and Territory governments' specialised public mental health services reviewed against the National Standards for Mental Health Services level (NSMHS), 2018**
by jurisdiction, by NSMHS level



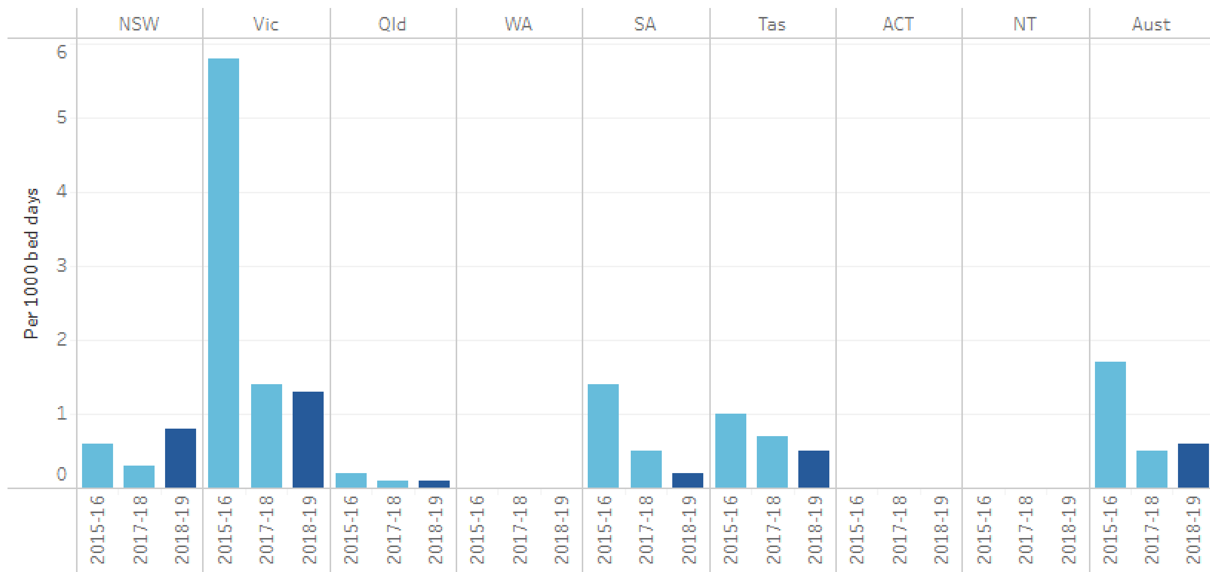
Source: table 13A.24

Nationally, as at 30 June 2018, 85.1 per cent of expenditure on specialised public mental health services that had completed an external review against the NSMHS was on services that met 'all standards' (level 1).

Select year(s) (applies to figure 13.8b):
(Multiple values)

Select restraint type:
- Mechanical restraint (selected)
- Physical restraint

Figure 13.8b Measure 2: **Restrictive practices - Mechanical restraint (a)**
by jurisdiction, by year



Source: table 13A.27

(a) See data table 13A.27 for information on non-publication of data on mechanical and physical restraint for individual jurisdictions.

Nationally for mechanical restraint, the number of events per 1000 bed days has decreased from 1.7 in 2015-16 to 0.5 in 2017-18, with a slight increase to 0.6 in 2018-19. For physical restraint nationally, the numbers have remained relatively stable.

For both seclusion and restraint, results varied across target populations (tables 13A.26 and 13A.28). In 2018-19, the lowest seclusion, physical and mechanical restraint rates were in Older persons units and the highest were in Forensic units (tables 13A.26 and 13A.28). In 2018-19, there was an increase for both seclusion and physical restraint in Child and adolescent units (for seclusion it is the highest rate since 2012-13) (tables 13A.26 and 13A.28).

Consumer and carer experiences of mental health services is an indicator of governments' objective to provide access to services that are responsive to consumer and carer goals. It is defined by two measures.

Measure 1: The proportion of mental health service consumers reporting positive experiences of mental health services.
Measure 2 : The proportion of carers of mental health service consumers reporting positive experiences of mental health services.

Guidance: A high or increasing proportion of mental health consumers and carers with positive experiences of service is desirable.

(Measure 1) Data are not comparable across jurisdictions, but are comparable within jurisdictions over time.

(Measure 1) Data are incomplete for the current reporting period.

(Measure 2) Data are not available for the measure of carers experience.

Select Year(s):
(All)

Table 13.1 **Proportion of mental health service consumers reporting positive experiences of mental health services** by type of service, by jurisdiction, by year

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Admitted Care	2017-18	68.7	50.4	47.1	na	na	na	na	na	na
	2016-17	67.6	53.9	51.4	na	na	na	na	na	na
	2015-16	67.0	52.6	46.4	na	na	na	na	na	na
Ambulatory Care	2017-18	77.9	73.8	79.1	na	na	na	na	na	na
	2016-17	79.1	68.9	81.2	na	na	na	na	na	na
	2015-16	78.9	69.0	79.5	na	na	na	na	na	na
Residential Care	2017-18	na	77.6	78.9	na	na	na	na	na	na
	2016-17	na	72.3	na	na	na	na	na	na	na
	2015-16	na	77.9	na	na	na	na	na	na	na

Source: table 13A.29
na Not available.

In 2017-18, for jurisdictions where data are available, a higher proportion of respondents reported positive experiences of service in residential and ambulatory care (non-admitted care) than in admitted care.

Community follow-up after psychiatric admission/hospitalisation is an indicator of governments' objective to provide services that are coordinated and provide continuity of care.

Measure: The proportion of State and Territory governments' specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

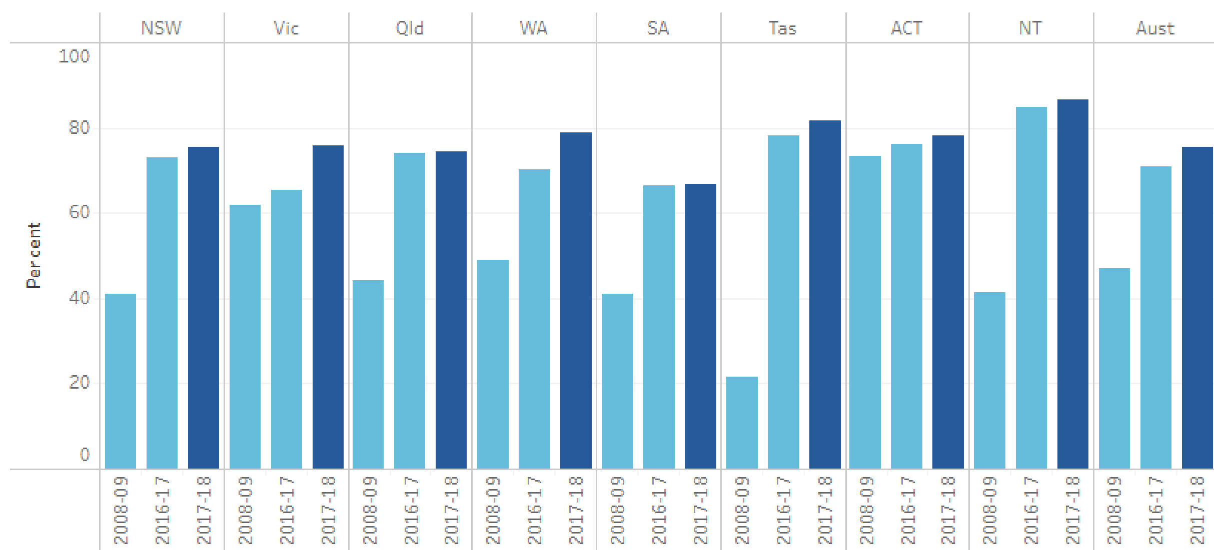
Guidance: A high or increasing rate of community follow-up within the first seven days of discharge from hospital is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):
(Multiple values)

Figure 13.9 **Overnight separations from acute psychiatric inpatient services with community mental health contact recorded in the seven days following separation**

by jurisdiction, by year



Source: table 13A.32

Nationally, the rate of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit has increased each year over the 10 years of data in this Report, from 46.9 per cent in 2008-09 to 75.2 per cent in 2017-18. Community follow-up rates by Indigenous status, remoteness areas, SEIFA, age groups and sex are in tables 13A.30-31.

Readmissions to hospital within 28 days of discharge is an indicator of governments' objective to provide services that are coordinated and provide continuity of care.

Measure: The proportion of State and Territory governments' admitted patient overnight separations from psychiatric acute inpatient units that were followed by readmission to the same type of unit within 28 days of discharge.

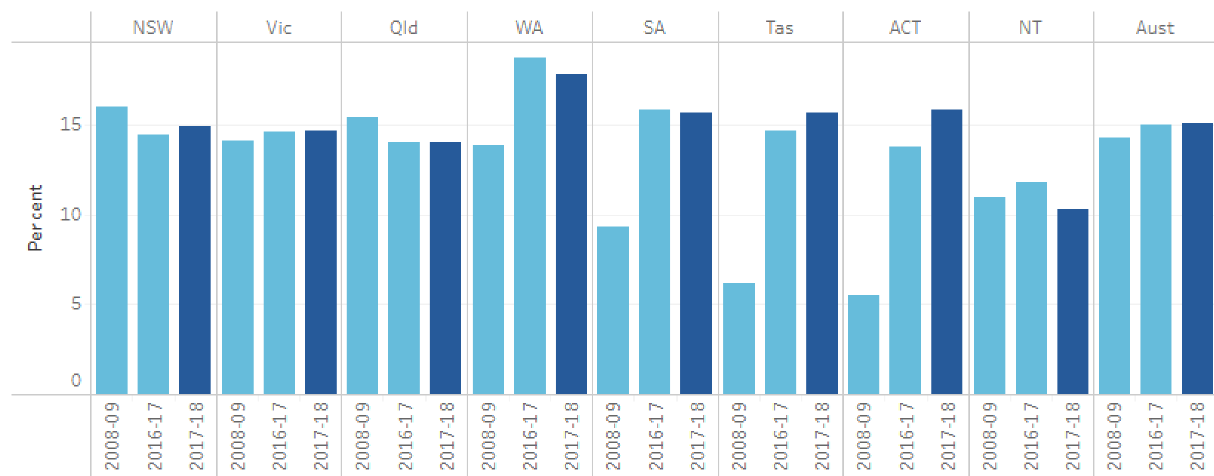
Guidance: A low or decreasing rate of readmissions to hospital within 28 days of discharge is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):

(Multiple values)

Figure 13.10 **Readmissions to hospital within 28 days of discharge**
by jurisdiction, by year



Source: table 13A.34

Nationally in 2017-18, the rate of readmission to hospital acute psychiatric units within 28 days of discharge was 15.1 per cent, with rates remaining relatively stable over the 10 years of data in this Report. Data by Indigenous status, remoteness areas, SEIFA, age group and sex are in table 13A.33.

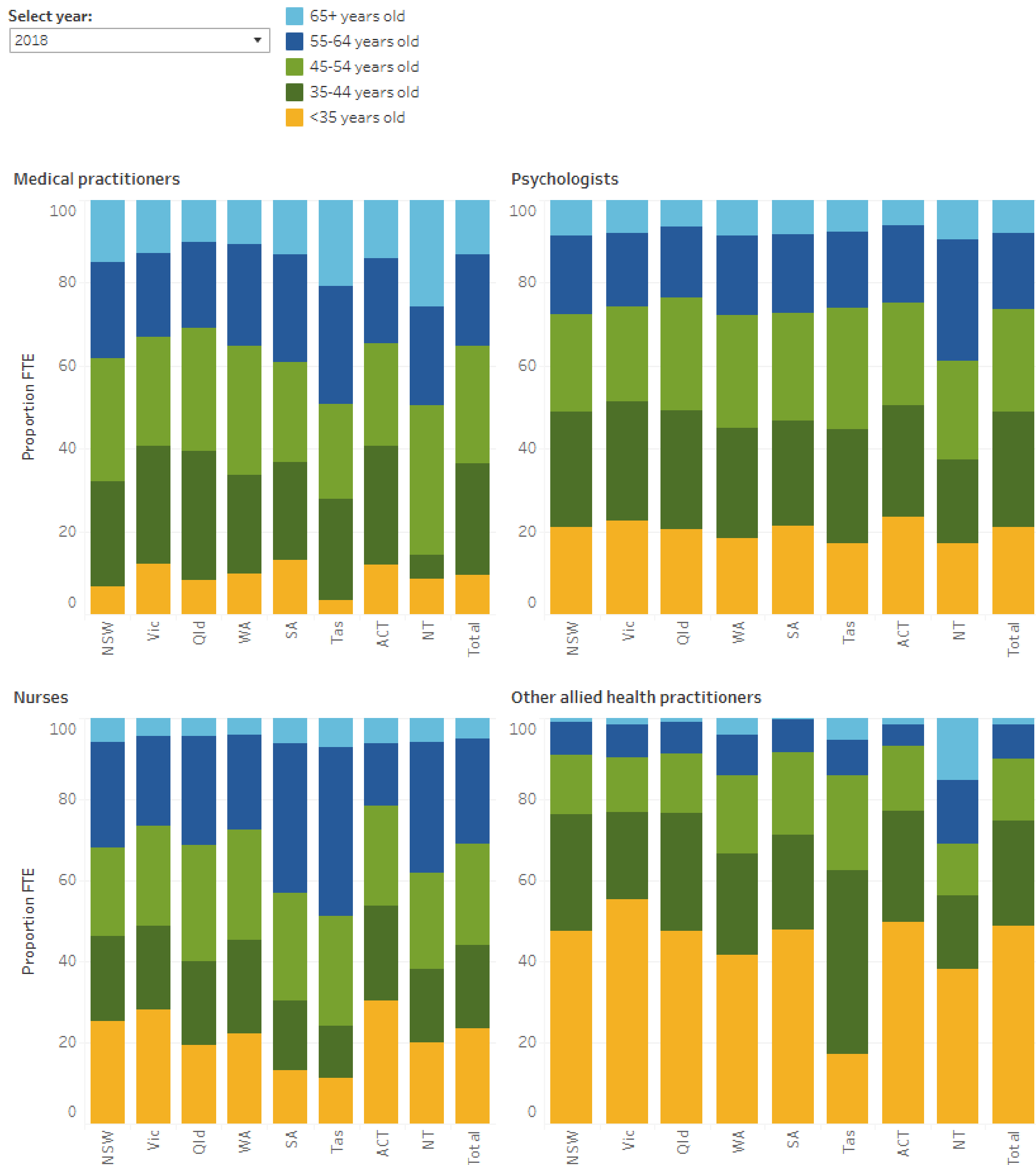
Workforce sustainability is an indicator of governments' objective to provide sustainable mental health services.

Measure: The proportion of full-time equivalent (FTE) medical practitioners (including psychiatrists), mental health nurses, registered psychologists and other allied mental health practitioners in ten year age brackets, by jurisdiction.

Guidance: A high or increasing proportion of the workforce that has newly entered the workforce and/or a low or decreasing proportion of the workforce that is close to retirement is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Figure 13.11 **Mental health workforce, 2018**
by jurisdiction, by age



Source: table 13A.35

Nationally in 2018, allied mental health practitioners had the highest proportion of FTEs who were aged less than 35 years, followed by nurses, psychologists and medical practitioners (including psychiatrists). The medical practitioner (including psychiatrist) workforce had the highest proportion of FTEs aged 65 years or over.

Cost of care is an indicator of governments' objective that mental health services are delivered in an efficient manner. It is defined by three measures.

Measure 1: Cost of inpatient care, defined by two sub measures:
- cost per inpatient bed day — expenditure on inpatient services divided by the number of inpatient bed days
- average length of stay — the number of inpatient patient days divided by the number of separations in the reference period.

Measure 2: Cost of community-based residential care — the average cost per patient day.
Measure 3: Cost of ambulatory care, defined by two sub measures:
- average cost per treatment day
- average number of treatment days per episode.

Guidance: For each measure a low or decreasing cost per input is desirable as this might indicate more efficient service delivery. However, efficiency data need to be interpreted with care as they do not provide information on service quality or patient outcomes.

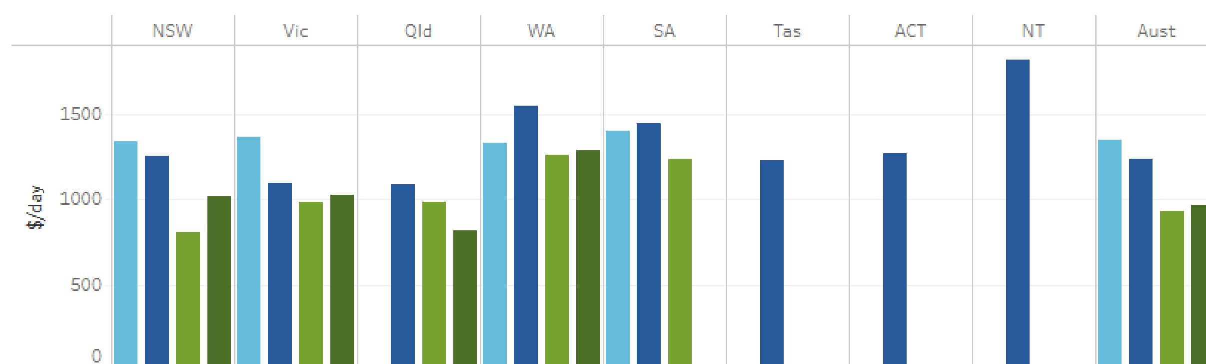
■ Data are comparable (subject to caveats) across jurisdictions and over time.

■ Data are complete (subject to caveats) for the current reporting period.

Select year (applies to figure 13.12a):
2017-18

Psychiatric hospitals (acute units)
General acute hospitals (acute units)
Psychiatric hospitals (non-acute units)
General acute hospitals (non-acute units)

Figure 13.12a Measure 1a: **Average recurrent cost per inpatient bed day, 2017-18 (a)**
by jurisdiction, by hospital and care type



Source: table 13A.36

(a) Queensland does not provide acute services in psychiatric hospitals. Tasmania, the ACT and the NT do not have psychiatric hospitals. SA, Tasmania, the ACT and the NT do not have non-acute units in general hospitals.

Nationally in 2017-18, the average cost per inpatient bed day was higher in acute than non-acute units.

Older persons units have lower costs per inpatient day (table 13A.37), but have considerably longer lengths of stay than general adult or child and adolescent units (table 13A.39). Data on the average cost per inpatient bed day by target population for all care types are reported in tables 13A.37–38.

Nationally in 2017-18, the average cost for 24-hour staffed residential care is higher for general adult units ($576.89 per patient day) compared to older persons care units ($535.74 per patient day). Nationally and for all relevant jurisdictions, the costs for general adult units were higher for those staffed 24 hours a day compared to those that were not staffed 24 hours a day (table 13A.40).

Select year(s) (applies to figure 13.12b and 13.12c):

(Multiple values)

Figure 13.12b Measure 3a: **Average cost per treatment day of ambulatory care**

by jurisdiction, by year

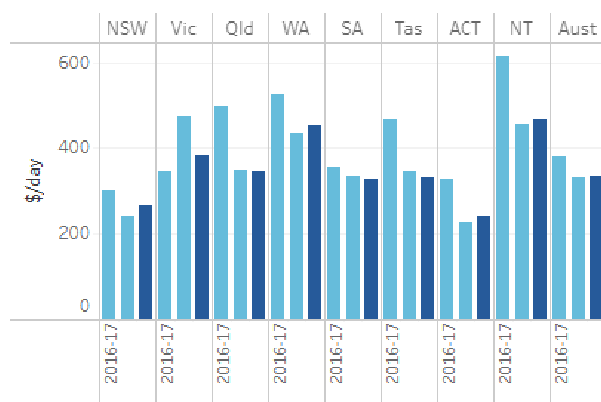
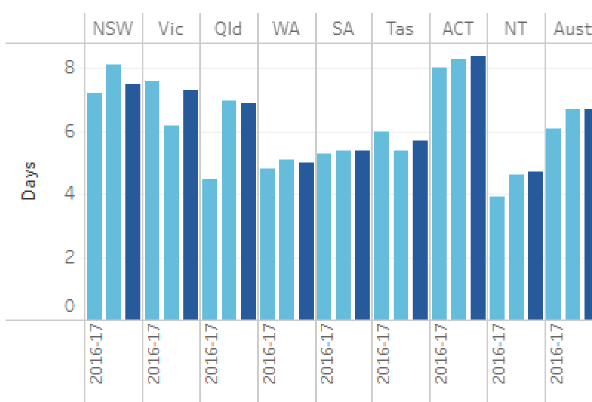


Figure 13.12c Measure 3b: **Average treatment days per episode of ambulatory care**

by jurisdiction, by year



Source: table 13A.41

Nationally in 2017-18, the average recurrent cost per treatment day of ambulatory care was $334.37, and the average number of treatment days per episode of ambulatory care was 6.7 days.

Prevalence of mental illness is an indicator of governments' objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

Measure: The proportion of the total population who have a mental illness.

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

■ Data are comparable (subject to caveats) across jurisdictions and over time.

■ Data are complete (subject to caveats) for the current reporting period. A new ABS survey of mental health and wellbeing is scheduled for 2020-2021 with data anticipated to be available in 2021-2022.

Table 13.2 **Proportion of people with lifetime mental disorders (with symptoms in the previous 12 months) among adults aged 16-85 years, 2007**

by jurisdiction

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
%	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

Source: tables 13A.42-13A.4

np Not publishe

Percentages reported in these tables include 95 per cent confidence intervals (for example, 80 per cent ± 2.7 per cent

Adult prevalence data are now more than 10 years old. Nationally in 2007, the prevalence of a mental illness was 20.0 per cent for people aged 16–85 years, with a further 25.5 per cent reported as having a mental illness at some point in their life (table 13A.42). Data by disorder, age and sex are reported in tables 13A.42–44.

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

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

Nationally in 2017-18, the age standardised proportion of adults with high/very high levels of psychological distress was 13.0 per cent (table 13A.46), and for those with very high levels was 4.0 per cent (table 13A.45). Proportions are higher for:

- females compared to males (table 13A.45)
- people with disability compared to those without (tables 13A.46–47)
- people in lower compared to higher socioeconomic areas (tables 13A.46–47)
- Aboriginal and Torres Strait Islander (2018-19) compared to non-Indigenous Australians (2017-18) (table 13A.48).

High rates of substance use and abuse can contribute to the onset of, and poor recovery from, mental illness. Information on rates of licit and illicit drug use can be found in tables 13A.49–51 and the National Drug Strategy Household Survey (AIHW 2017).

Mortality due to suicide is an indicator of governments' objective to, where possible, prevent the development of mental health problems, mental illness and suicide.

Measure: The suicide rate per 100 000 people.

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

■ Data are comparable (subject to caveats) across jurisdictions and over time for some years and disaggregations, but not comparable for other years and disaggregations.

■ Data are complete (subject to caveats) for the current reporting period.

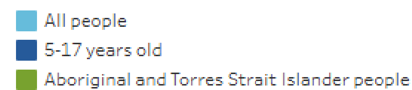
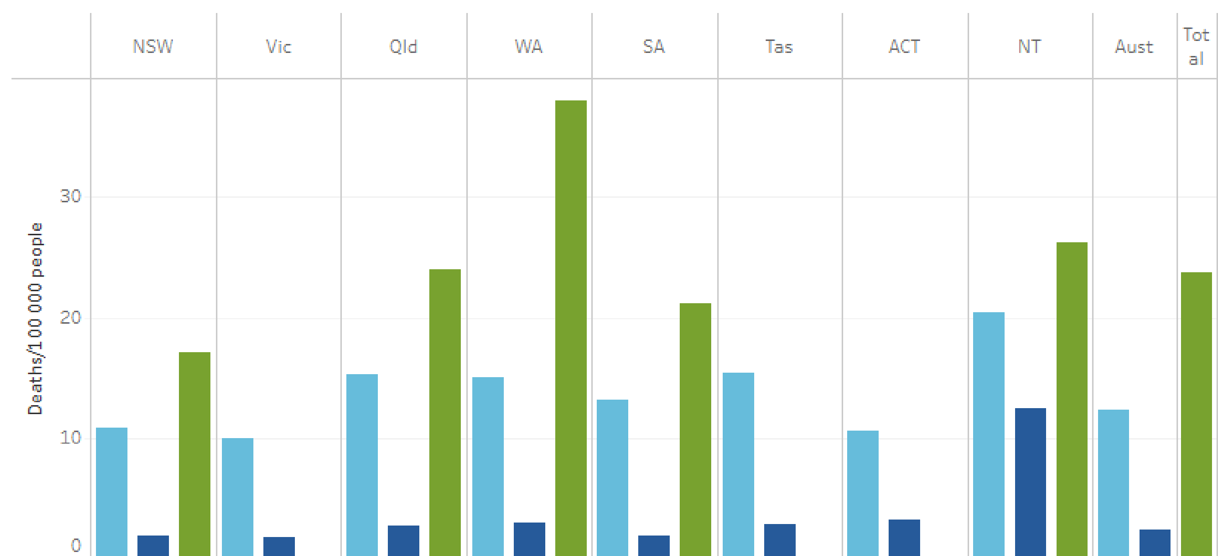


Figure 13.13 **Mortality due to suicide, Suicide rate per 100 000, All people, 5-17 years old, Aboriginal and Torres Strait Islander people, 5-year aggregate, 2014-2018**
by jurisdiction



Source: tables 13A.52, 13A.53, 13A.55

People with a mental illness are at a higher risk of suicide compared to the general population. For the period 2014–2018, 15 100 suicides were recorded in Australia — equivalent to 12.4 deaths per 100 000 people. The rate for people aged 5–17 years was 2.4 deaths per 100 000 population and the rate for Aboriginal and Torres Strait Islander people was 23.7 deaths per 100 000 population.

Nationally, suicide rates per 100 000 population for 2018 show that rates are lower for females compared to males (5.7 deaths compared to 18.6 deaths, ABS 2019), lower in capital cities compared to other areas (10.3 deaths compared to 15.9 deaths, table 13A.54) and (for 2014–2018) lower for non-Indigenous compared to Aboriginal and Torres Strait Islander people (12.3 deaths compared to 23.7 deaths, table 13A.55).

Physical health outcomes for people with a mental illness is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

Measure: The proportion of adults with a mental illness (compared to those without a mental illness) who experienced a long term physical health condition: cancer, diabetes, arthritis, cardiovascular disease and asthma.

Guidance: Low or decreasing proportions of people with a mental illness who experience a long term physical health condition are desirable.

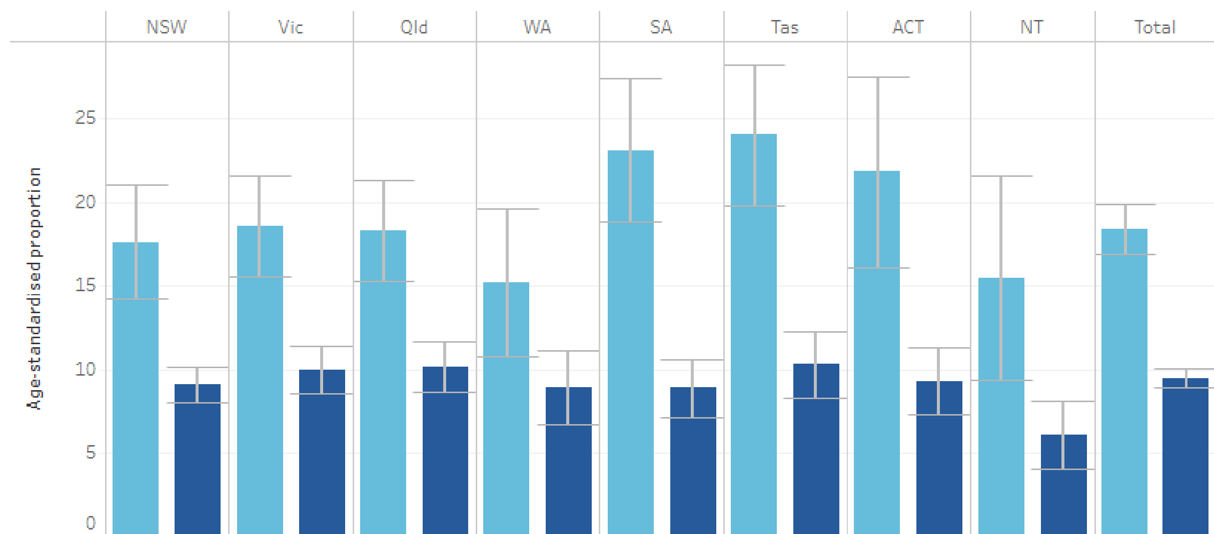
- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year:
2017-18

Select condition:
- (selected) Asthma
- Arthritis
- Cancer
- Cardiovascular disease
- Diabetes

People with a mental illness
People without a mental illness

Figure 13.14 **Adults with long-term health conditions, Asthma, 2017-18 (a)**
by jurisdiction, by mental illness status



Source: table 13A.57
(a) Data were not published for adults with cancer in the ACT (2014-15) and NT (2017-18 and 2014-15).

A higher proportion of adults with a mental illness had long term health conditions compared to adults without a mental illness. Nationally in 2017-18, the age standardised proportions of adults with a mental illness who had arthritis (25.9 per cent) and asthma (18.4 per cent) were higher than those without a mental illness (15.3 per cent and 9.5 per cent respectively) (table 13A.57).

Social and economic inclusion of people with a mental illness is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society. It is defined by two measures.

Measure 1: The proportion of people aged 16–64 years with a mental illness who are employed, compared with the proportion for people without a mental illness.
Measure 2: The proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the past week, compared with the proportion for people without a mental illness.

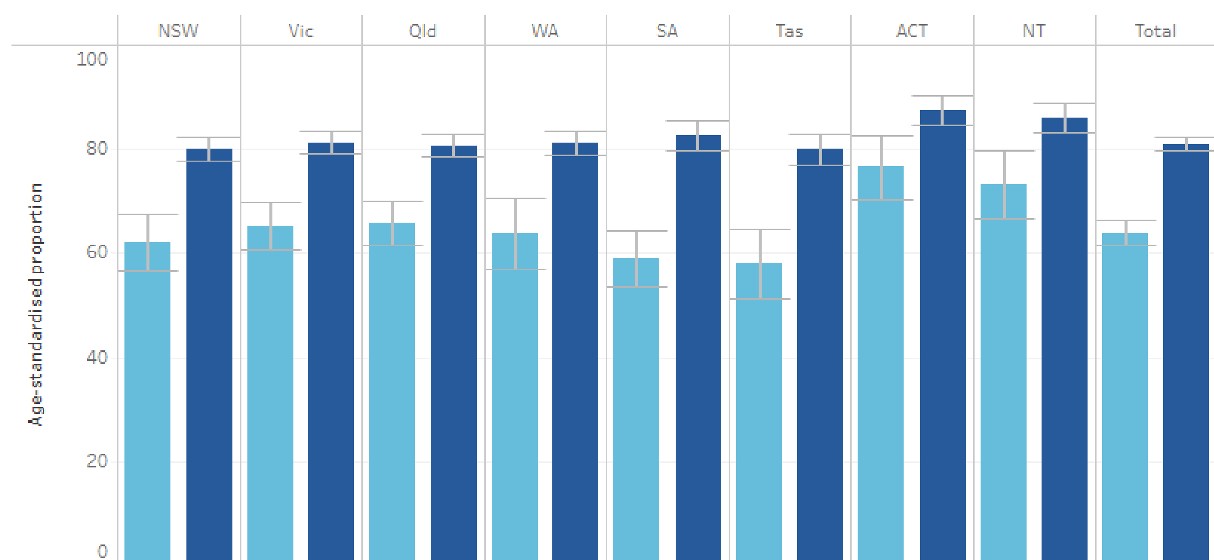
Guidance: High or increasing proportions of people with a mental illness who are employed, or who had face-to-face contact with family or friends, are desirable.

- Data are comparable (subject to caveats) across jurisdictions and, (for measure 1) over time (no time series reported for measure 2).
- Data are complete (subject to caveats) for the current reporting period.

Select year (applies to figure 13.15):
2017-18

People with a mental illness
People without a mental illness

Figure 13.15 Measure 1: **People Aged 16-64 years who are employed, 2017-18**
by jurisdiction, by mental illness status



Source: table 13A.59

Nationally in 2017-18, the age-standardised proportion of 16–64 year olds with a mental illness who were employed was lower (63.9 per cent) than the proportion of the same age without a mental illness who were employed (81.0 per cent).

The significantly higher proportion of people with a mental illness who do not participate in the labour force, compared to those without a mental illness, is a major contributing factor (30.4 per cent compared to 15.5 per cent) (table 13A.59).

Information on 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 can be found in table 13A.58.

Table 13.3 Measure 2: **Proportion of people who had face-to-face contact with family or friends living outside the household in the past week, aged 15 years old or over, 2014**

by jurisdiction, by mental illness status

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
People with a mental illness	%	75.4 ± 7.3	79.0 ± 5.3	72.5 ± 5.2	77.0 ± 6.6	81.7 ± 8.1	78.1 ± 5.2	76.3 ± 5.9	54.8 ± 11.5	76.5 ± 3.1
People without a mental illness	%	75.1 ± 2.8	77.9 ± 3.1	75.6 ± 3.3	77.4 ± 3.1	85.1 ± 2.1	86.5 ± 2.8	75.8 ± 2.6	69.6 ± 4.6	77.1 ± 1.4

Source: table 13A.60

Percentages reported in these tables include 95 per cent confidence intervals (for example, 80 per cent ± 2.7 per cent).

Nationally in 2014, the proportion of people aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the last week (76.5 per cent) was similar to the proportion for people without a mental illness (77.1 per cent).

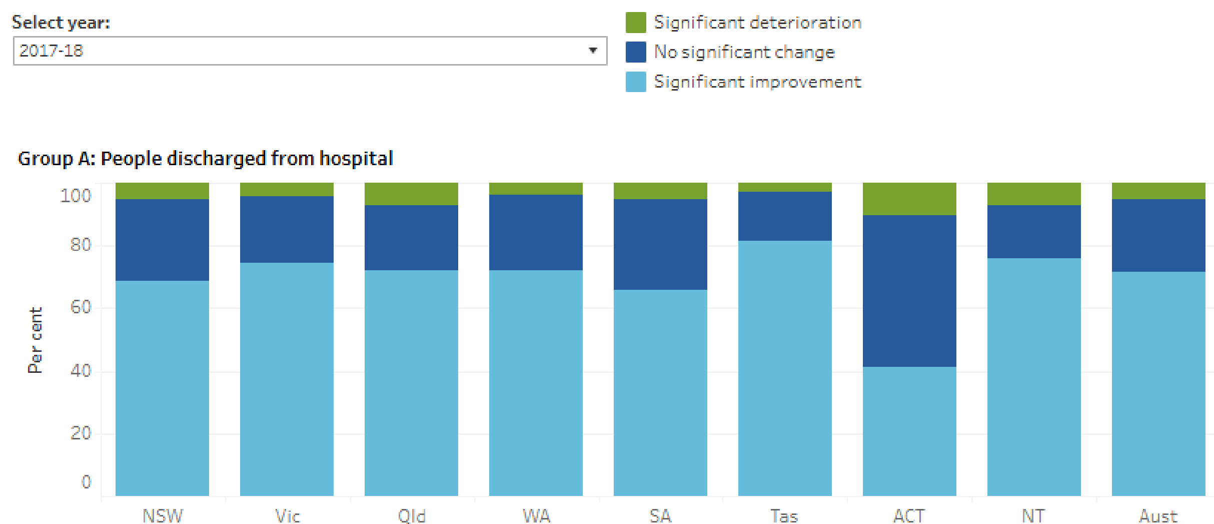
Mental health outcomes of consumers of specialised public mental health services is an indicator of governments' objective to promote recovery and physical health and encourage meaningful participation in society.

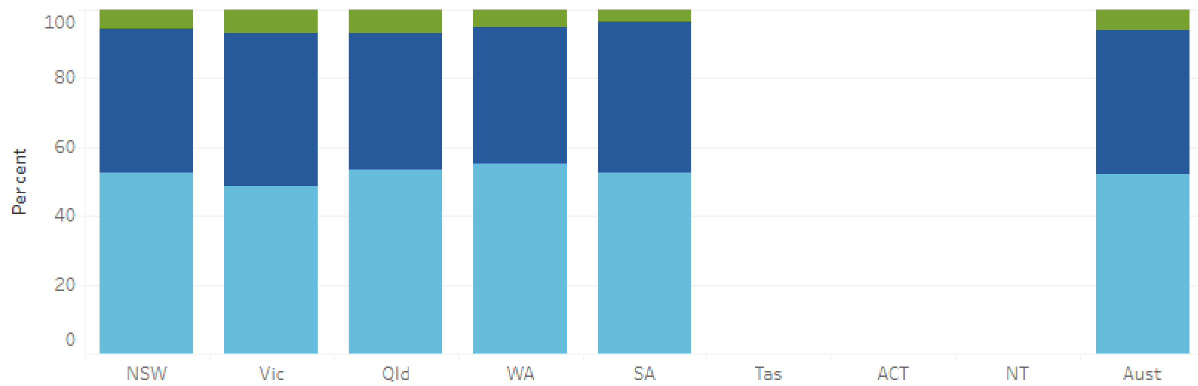
Measure: The proportion of people receiving care who had a significant improvement in their clinical mental health outcomes, by service type.

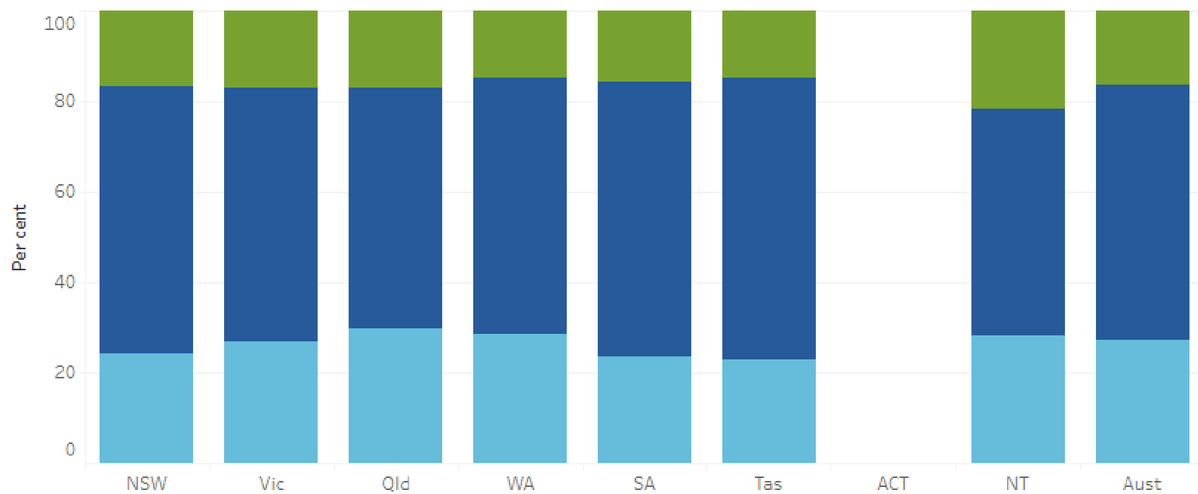
Guidance: A high or increasing proportion of people receiving care in State and Territory governments' specialised public mental health services who had a significant improvement in their clinical mental health outcomes is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Figure 13.16 **Mental health outcomes of consumers of specialised public mental health services, 2017-18 (a)** by jurisdiction, by type of mental health care service







Source: table 13A.63

(a) Some Tasmanian, ACT and NT data are not published but are included in Australian totals.

Nationally in 2017-18, 71.6 per cent of people discharged from a hospital psychiatric inpatient unit, 52.1 per cent of people discharged from community-based ambulatory care, 27.2 per cent of people in ongoing community-based ambulatory care showed a significant improvement in their mental health clinical outcomes.

Over the 10 years of data in this Report, for those in ongoing community-based ambulatory care, younger people aged 0–17 years had the highest proportion of people who showed a significant improvement compared to other age groups (table 13A.62).

Stigma and discrimination experienced by people living with mental health problems or mental illness is an indicator of governments' objective to reduce the impact of mental illness (including the effects of stigma and discrimination). It is defined by two measures.

Measure 1: The proportion of people with a mental health condition who have experienced discrimination or been treated unfairly.
Measure 2: The proportion of people with a mental health condition who have experienced discrimination or been treated unfairly because of their mental health condition.

Guidance: A low or decreasing proportion of people experiencing discrimination or being treated unfairly is desirable.

- (Measure 1) Data are comparable within jurisdictions over time and across jurisdictions.
- (Measure 1) Data are complete (subject to caveats) for the current reporting period.

(Measure 2) Data are not yet available for reporting against this measure.

Table 13.4 **Proportion of people with a mental health condition who have experience discrimination of been treated unfairly, 2014** by jurisdiction

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
%	29.6 ±6.5	24.9 ±6.6	31.7 ±6.5	36.2 ±8.3	25.0 ±5.7	23.7 ±5.2	29.3 ±6.8	31.0 ±9.6	29.1 ±3.2

Source: table 13A.6
Percentages reported in these tables include 95 per cent confidence intervals (for example, 80 per cent ± 2.7 per cent

In 2014, 29.1 per cent of people with a mental illness reported having experienced discrimination or been treated unfairly. These data do not distinguish whether the discrimination was perceived to be due to a person's mental illness.

Refer to the interpretative material for detailed indicator interpretation, definitions and caveats. www.pc.gov.au/rogs

Data tables are referenced above by a '13A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Indigenous Data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section are available in the data tables listed below. Contextual data and further supporting information can be found in the section.

Mental health data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 13A.17	Proportion of people receiving clinical mental health services by service type and Indigenous status
Table 13A.21	Proportion of young people (aged < 25 years) who had contact with MBS subsidised primary mental health care services, by selected characteristics (per cent)
Table 13A.30	Rates of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status and remoteness
Table 13A.33	Readmissions to hospital within 28 days of discharge, by selected characteristics
Table 13A.48	Age-standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status
Table 13A.55	Suicide deaths, by Indigenous status

Download supporting material

13 Mental health management interpretative material (PDF - 850 Kb)

13 Mental health management interpretative material (Word - 60 Kb)

13 Mental health management data tables (XLSX - 1907 Kb)

13 Mental health management dataset (CSV - 1897 Kb)

See the interpretative material and corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).

Note: an errata was released for section 13 Mental health services.

Errata

The following data have changed for section 13 Mental health data tables:

- Table 13A.11: Amended year labels for all years.

- Table 13A.37: Amended data for general mental health services for 2008-09 to 2011-12 for the ACT, NT and Australia; Child and adolescent mental health services for 2008-09 to 2011-12 for Vic, SA and Australia; Older persons mental health services for 2008-09 to 2011-12 for Vic, ACT and Australia; Forensic mental health services for 2008-09 to 2011-12 for Queensland, Tasmania and Australia.
- Table 13A.38: Amended data for acute forensic mental health services for the period of 2008-09 for Australia.
- Table 13A.61: Amended data for group A and group C proportions for the period of 2008-09 for all jurisdictions.