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

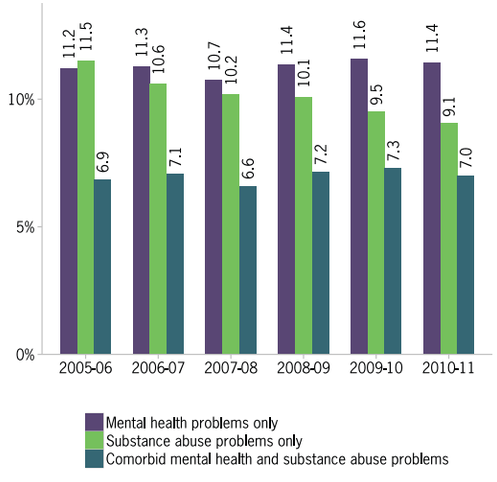
Quantifying the prevalence of mental illness among homeless populations is difficult, and estimates have varied considerably. *Australia's Welfare 2011*, published by the Australian Institute of Health and Welfare (AIHW), reviewed the evidence and observed that while some studies estimated the prevalence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

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

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

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

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



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

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

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

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

KEY MESSAGES:

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

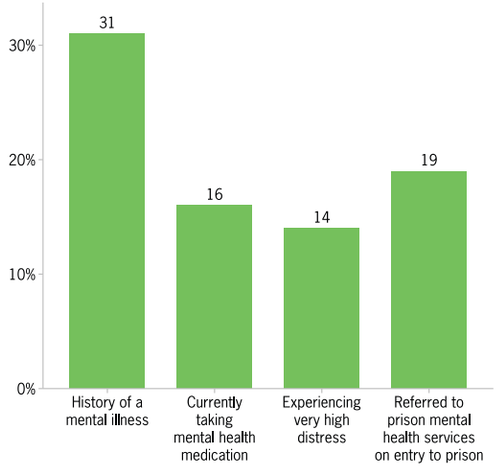
Prisoners are more likely to have poor mental health than members of the general population. The relationship between incarceration and mental illness is a complex one and can operate in both directions. Mental health problems may interact with other forces like drug use and poverty, and act as a risk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

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

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

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

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



3.5 Priority area 4: Quality improvement and innovation

Progress of actions under this priority area

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

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

KEY MESSAGES:

- Nationally, in 2010-11, 4.6 per 1,000 (or 0.5%) of the total full-time equivalent (FTE) mental health workforce was accounted for by consumer and carer workers. This represents an increase of 33% since the 2002-03 level of 3.5 FTE per 1,000 (0.3%). This growth is due to an almost fourfold increase in the number of FTE carer workers per 1,000, compared to a slight decrease in FTE consumer workers per 1,000.
- There is substantial variation across jurisdictions, with the highest proportions in South Australia (6.3 per 1,000 in 2010-11, or 0.6%) and Victoria (6.1 per 1,000, 0.6%), and the lowest rates in the Australian Capital Territory and the Northern Territory (0.0 per 1,000, or 0.0%).

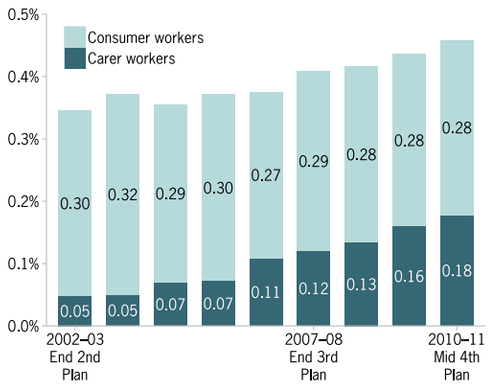
Since its inception, the National Mental Health Strategy has promoted the participation of consumers and carers in the planning, delivery and evaluation of mental health services. The availability of paid consumer and carer worker positions is an index of the opportunities available for, and an organisation's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

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

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

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

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



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

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

KEY MESSAGES:

- In 2010-11, 84% of specialised mental health services in Australia had undertaken external accreditation and been judged to meet all standards set out in the National Standards for Mental Health Services (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4).
- In two jurisdictions (the Australian Capital Territory and the Northern Territory) 100% of services met the standards set for Level 1. Three others (Queensland, Victoria and South Australia) came close to this, with at least 96% of their services achieving Level 1. In other states the proportion of services achieving Level 1 was lower. In New South Wales (79% at Level 1) and Tasmania (48% at Level 1), the balance of services had undertaken external review and reached threshold for Level 2, whereas in Western Australia (49% at Level 1), the balance had not completed external review and were graded as Levels 3 or 4.
- Ongoing effort is required to ensure more uniform levels of accreditation across jurisdictions.

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

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

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

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

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

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

Table 12
National Standards for Mental Health Services (2010)

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

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

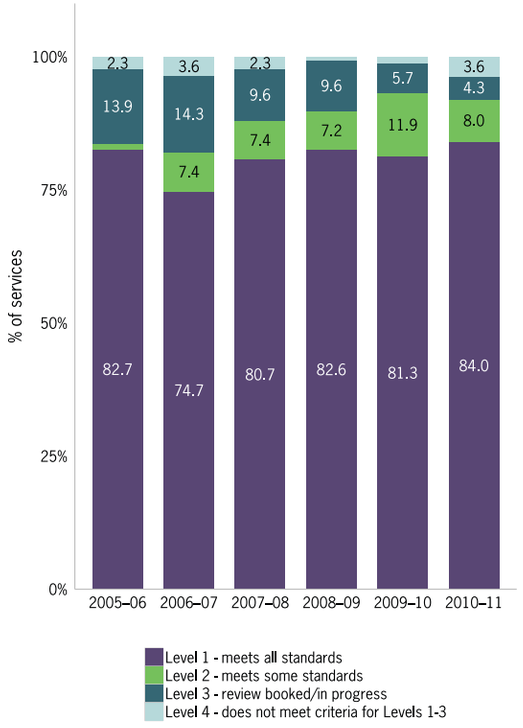


Figure 66 shows that nationally, in 2010-11, 84% of services met all standards (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4). Several jurisdictions reported at 100% or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

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

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

KEY MESSAGES:

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

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

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

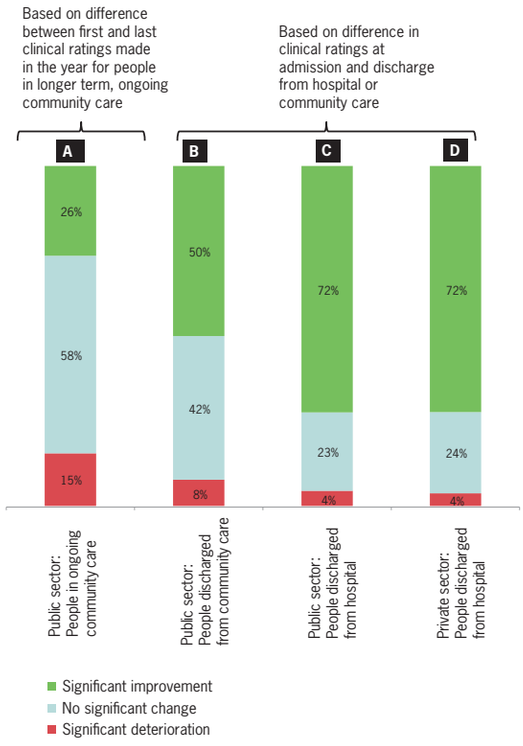
Today, 85% of state and territory public sector inpatient and community mental health services collect data that can be used to assess outcomes, as do 98% of private hospitals. Over 12,000 clinicians have received training in the use of outcome measures. Systems have also been established to enable pooling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

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

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

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

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



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

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

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

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

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

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

3.6 Priority area 5: Accountability: Measuring and reporting progress

Progress of actions under this priority area

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

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

Part 4: Profiles of state and territory reform progress

4.1 Introduction

KEY MESSAGES:

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

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

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

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

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

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

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

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

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

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

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

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

Table 13
Purpose of jurisdiction level indicators presented in charts

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

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

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

4.2 New South Wales

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

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

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

Figure NSW1
Overall spending on mental health

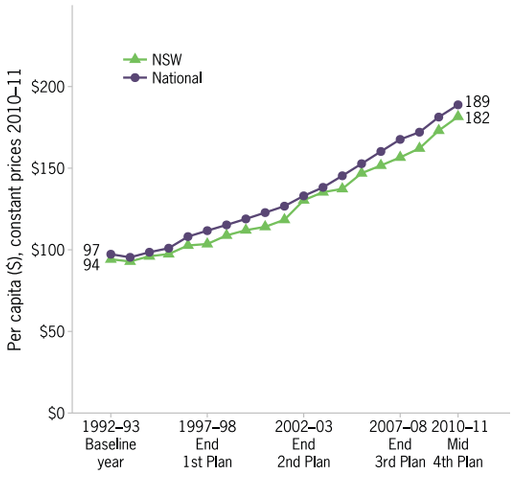


Figure NSW2
Change in spending mix

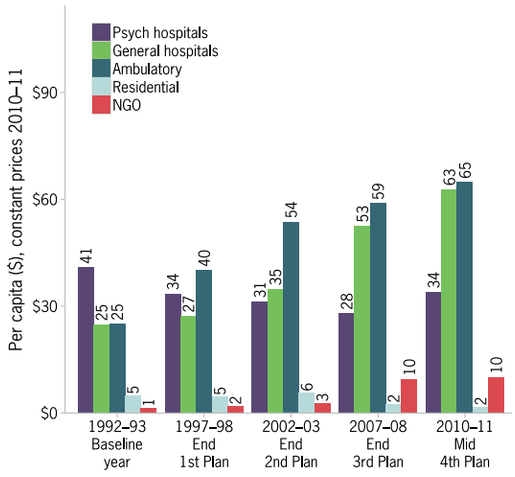


Figure NSW3
Changes in inpatient services

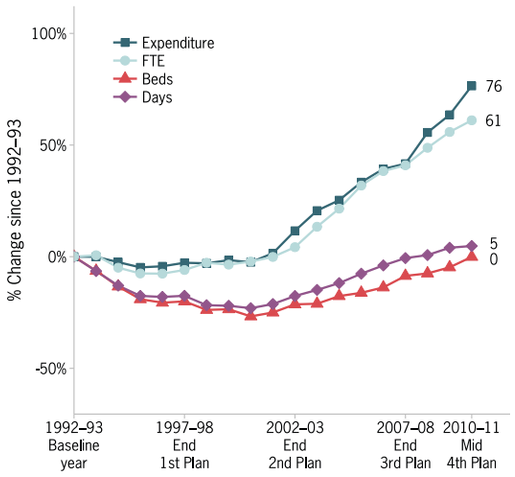


Figure NSW4
Changes in ambulatory care

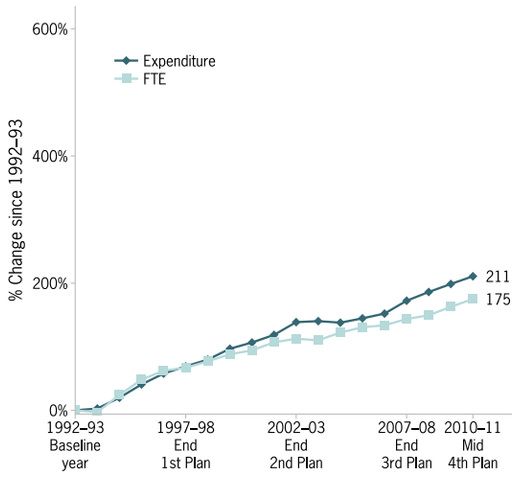


Figure NSW5
Direct care workforce

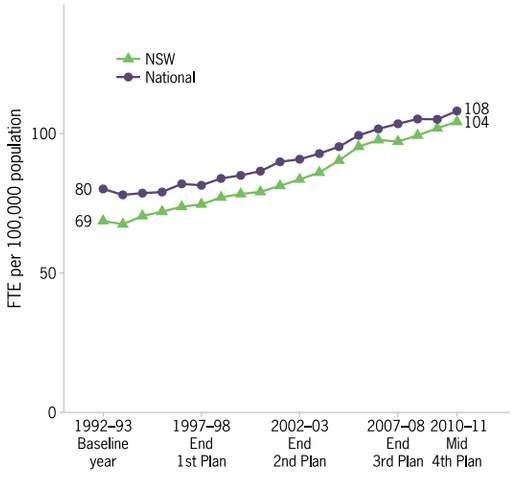


Figure NSW6
Inpatient and residential beds

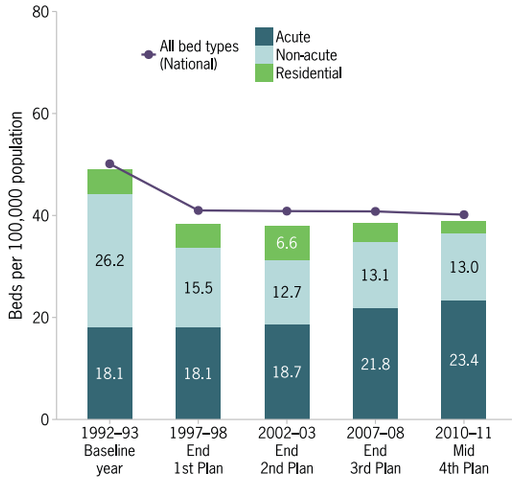


Figure NSW7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

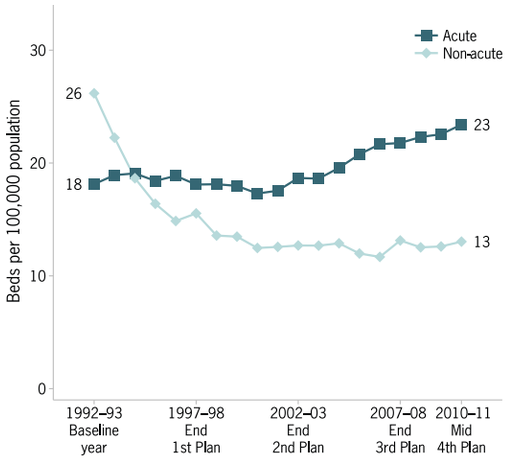


Figure NSW8
Readmission to hospital within 28 days of discharge

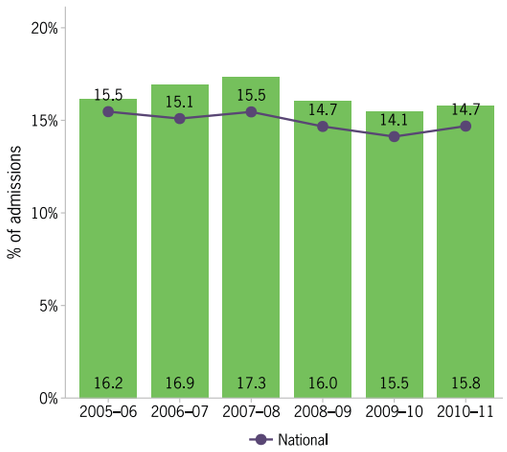


Figure NSW9
Rates of pre-admission community care

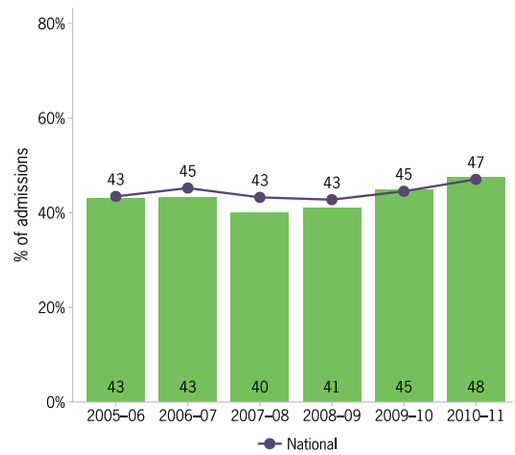


Figure NSW10
Rates of post-discharge community care

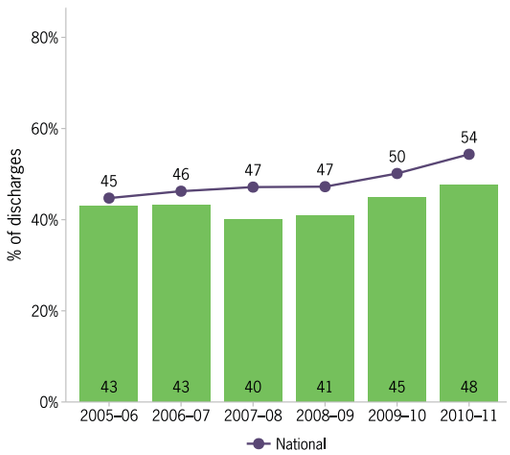


Figure NSW11
Average treatment days per three month community care period

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

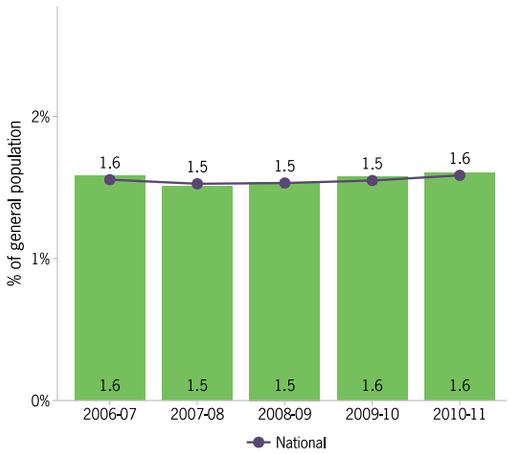


Figure NSW13
Percentage of population receiving MBS-subsidised mental health services

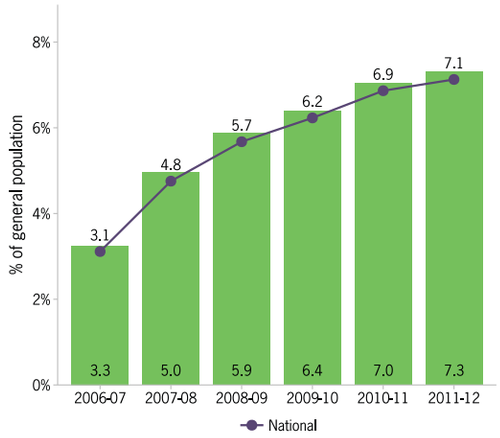


Figure NSW14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

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

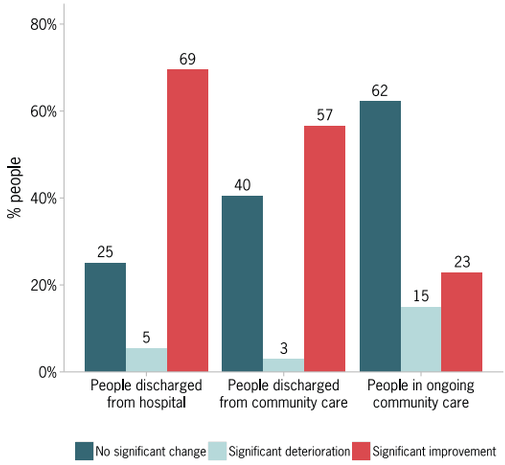


Figure NSW16
Proportion of total mental health workforce accounted for by consumer and carer workers

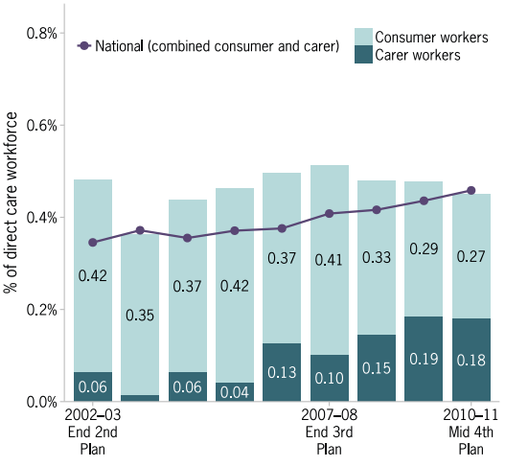


Figure NSW17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

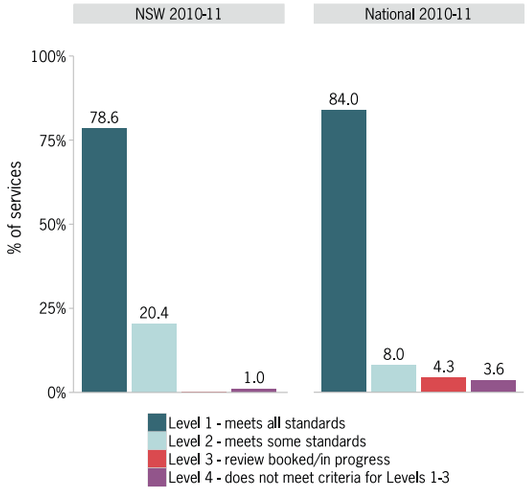
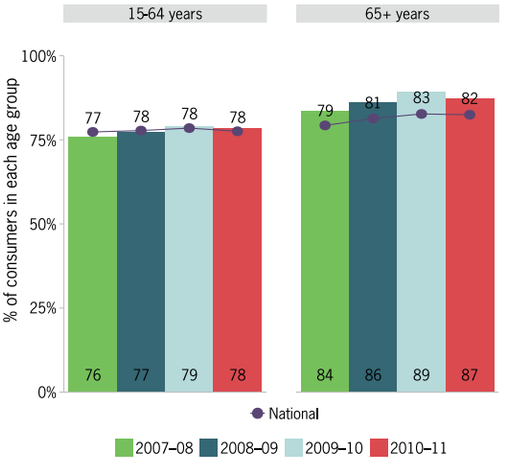


Figure NSW18
Percentage of mental health consumers living in stable housing



4.3 Victoria

Table VIC1
Indicators of mental health reform in Victoria[a,b,c]

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

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

Figure VIC1
Overall spending on mental health

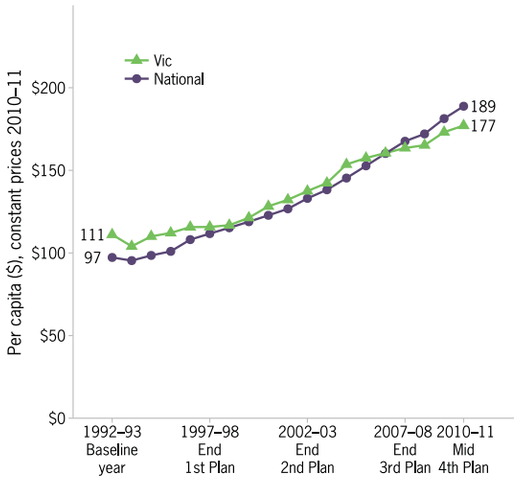


Figure VIC2
Change in spending mix

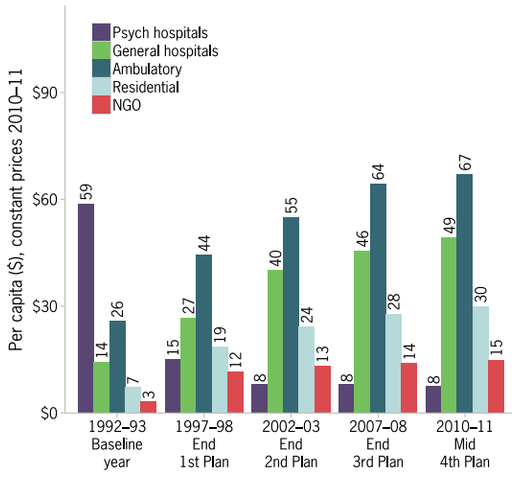


Figure VIC3
Changes in inpatient services

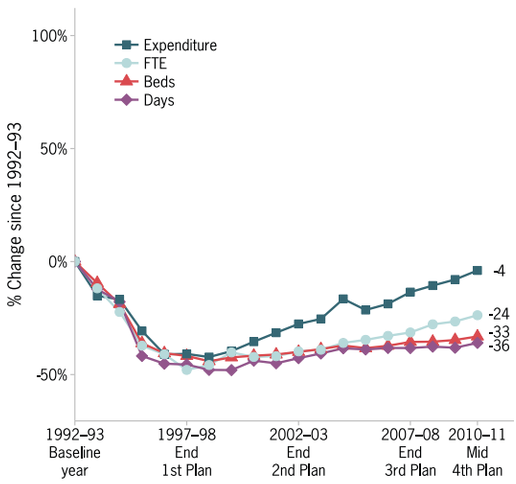


Figure VIC4
Changes in ambulatory care

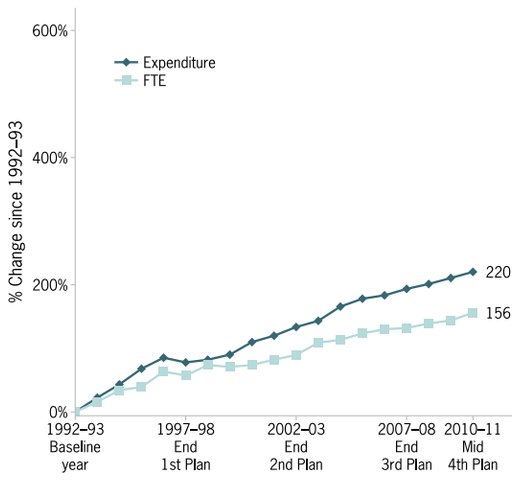


Figure VIC5
Direct care workforce

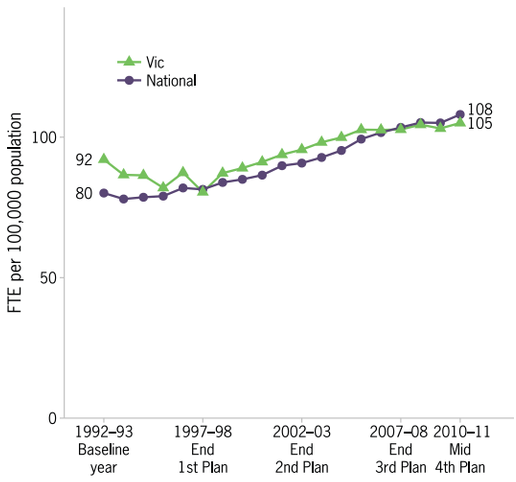


Figure VIC6
Inpatient and residential beds

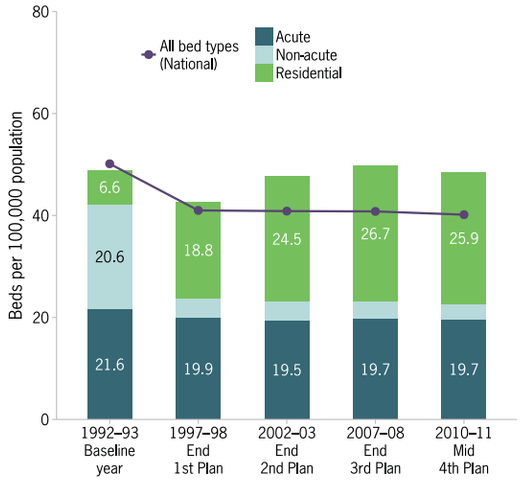


Figure VIC7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

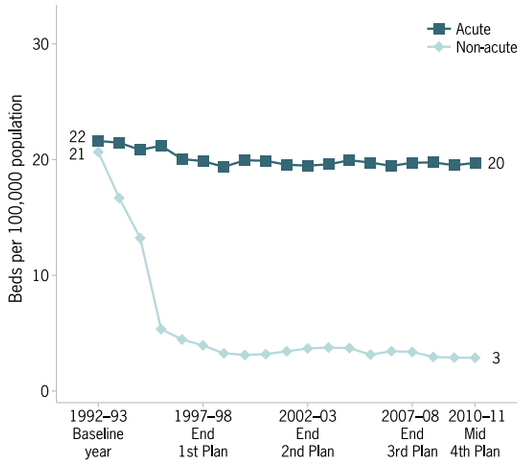


Figure VIC8
Readmission to hospital within 28 days of discharge

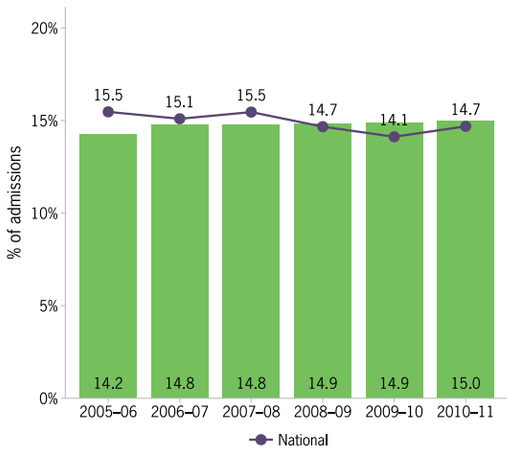


Figure VIC9
Rates of pre-admission community care

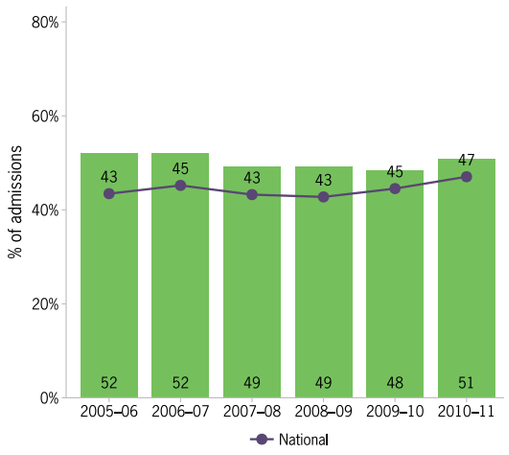


Figure VIC10
Rates of post-discharge community care

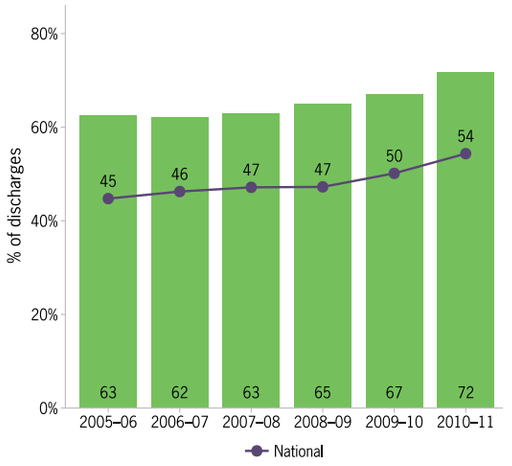


Figure VIC11
Average treatment days per three month community care period

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

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

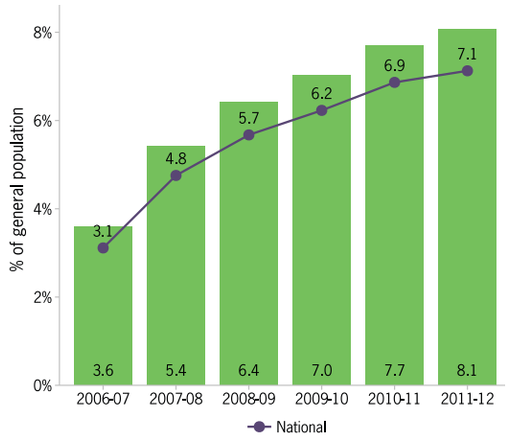


Figure VIC14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

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

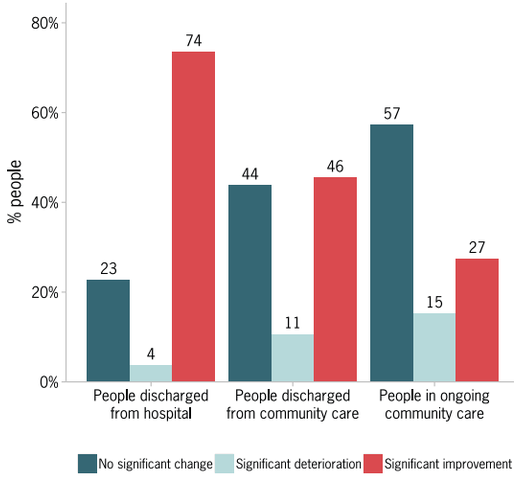


Figure VIC16
Proportion of total mental health workforce accounted for by consumer and carer workers

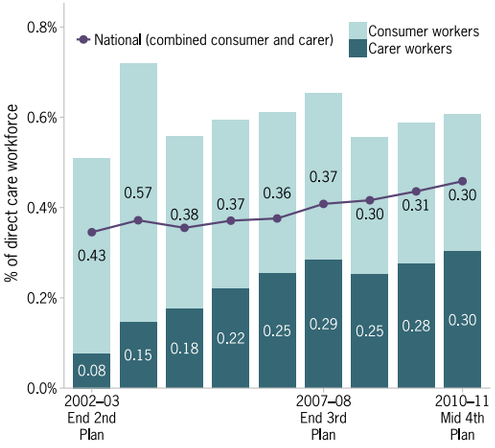


Figure VIC17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

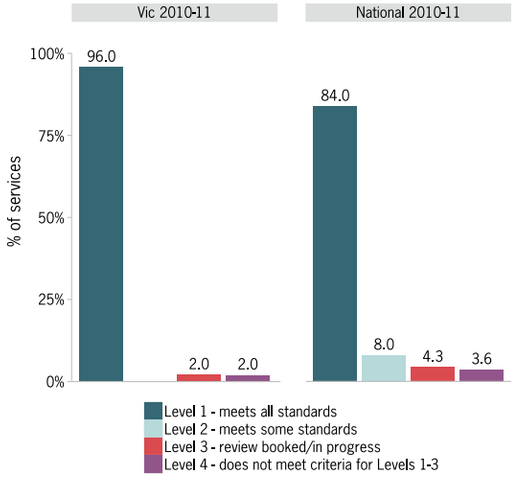
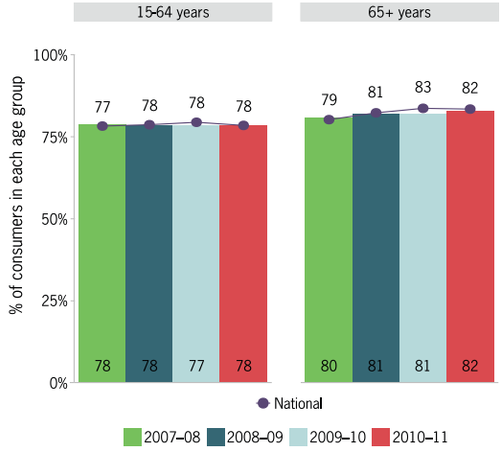


Figure VIC18
Percentage of mental health consumers living in stable housing



4.4 Queensland

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

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

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

Figure QLD1
Overall spending on mental health

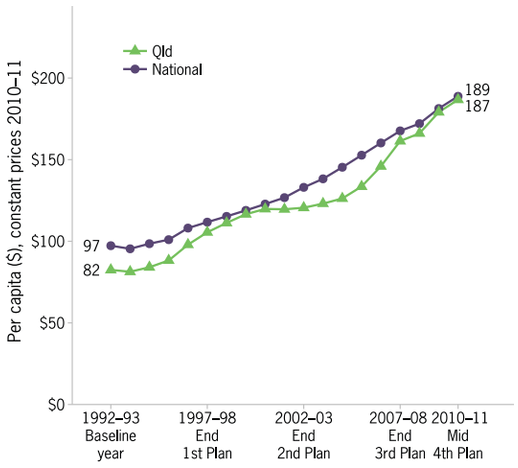


Figure QLD2
Change in spending mix

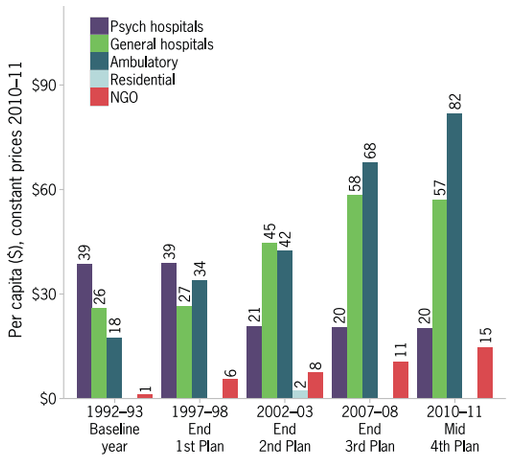


Figure QLD3
Changes in inpatient services

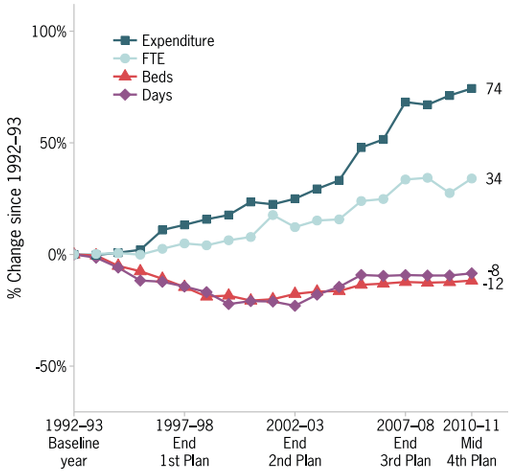


Figure QLD4
Changes in ambulatory care

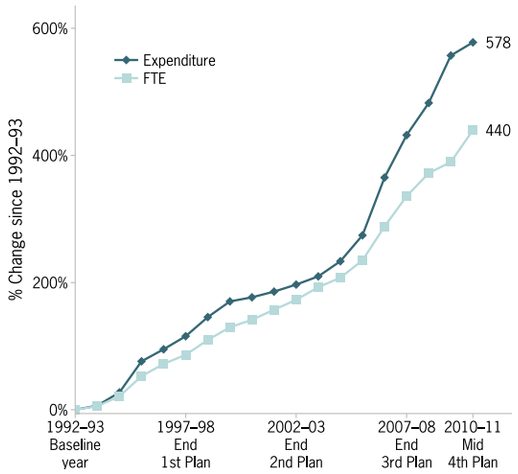


Figure QLD5
Direct care workforce

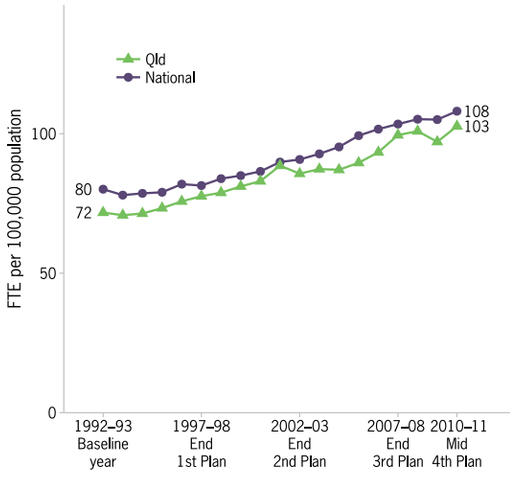


Figure QLD6
Inpatient and residential beds

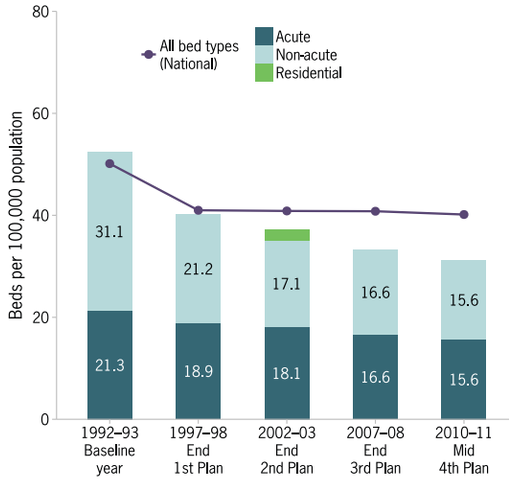


Figure QLD7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

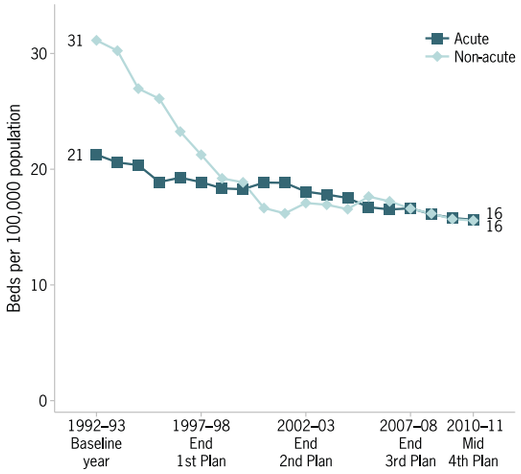


Figure QLD8
Readmission to hospital within 28 days of discharge

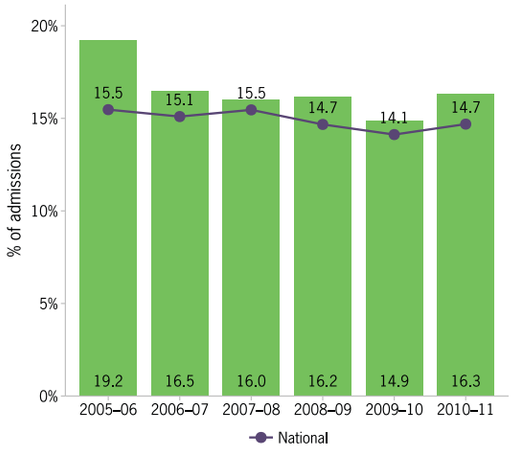


Figure QLD9
Rates of pre-admission community care

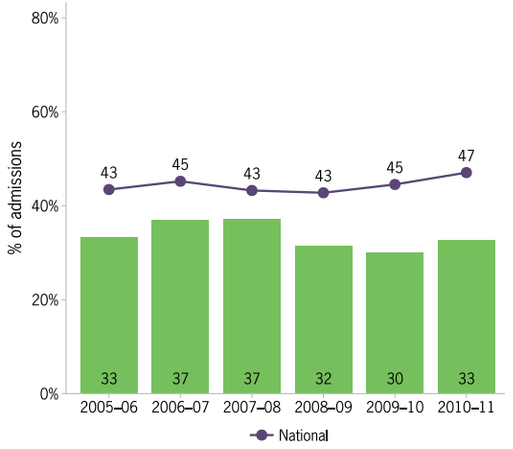


Figure QLD10
Rates of post-discharge community care

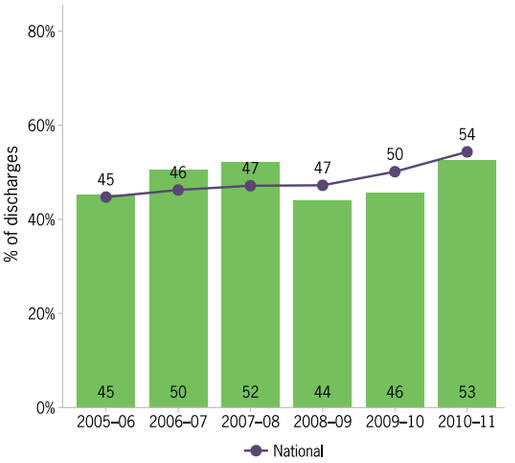


Figure QLD11
Average treatment days per three month community care period

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

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

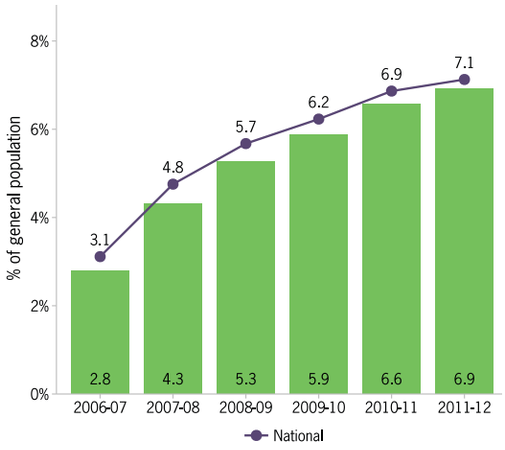


Figure QLD14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

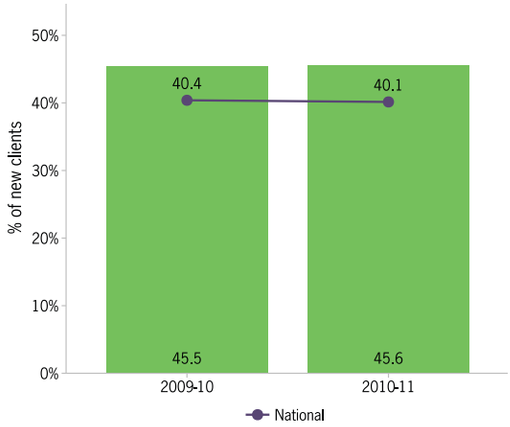


Figure QLD15
Mental health outcomes for people who receive treatment from state or territory services

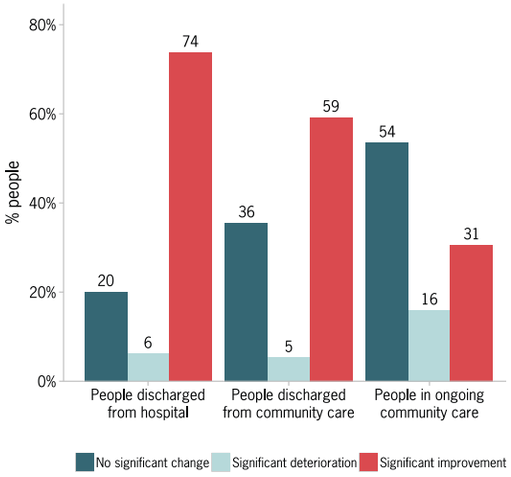


Figure QLD16
Proportion of total mental health workforce accounted for by consumer and carer workers

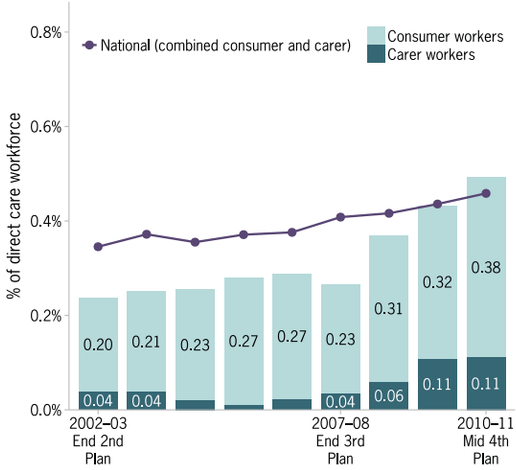


Figure QLD17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

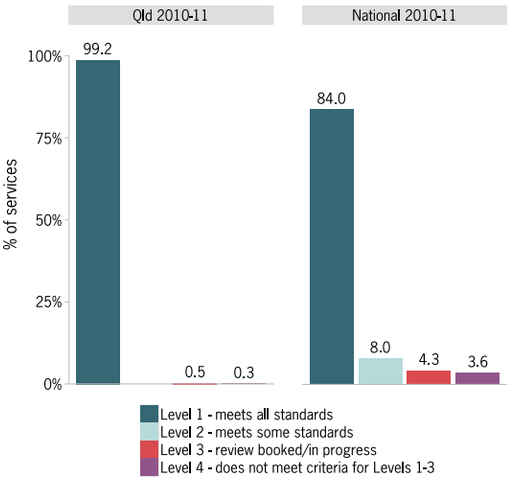
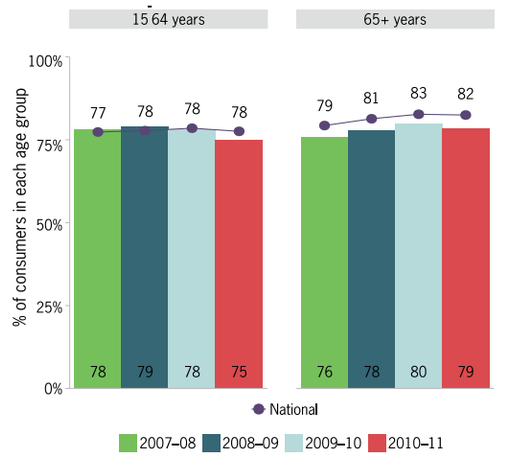


Figure QLD18
Percentage of mental health consumers living in stable housing



4.5 Western Australia

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

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

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

Figure WA1
Overall spending on mental health

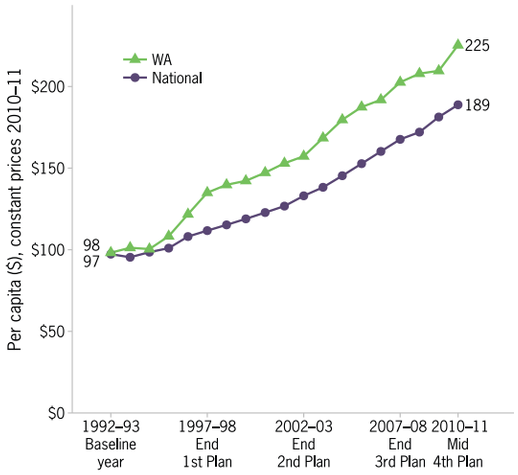


Figure WA2
Change in spending mix

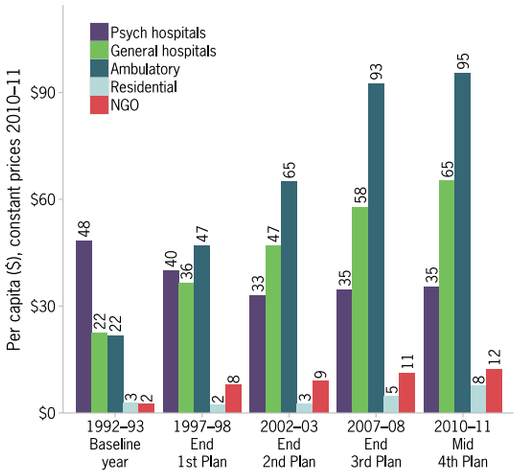


Figure WA3
Changes in inpatient services

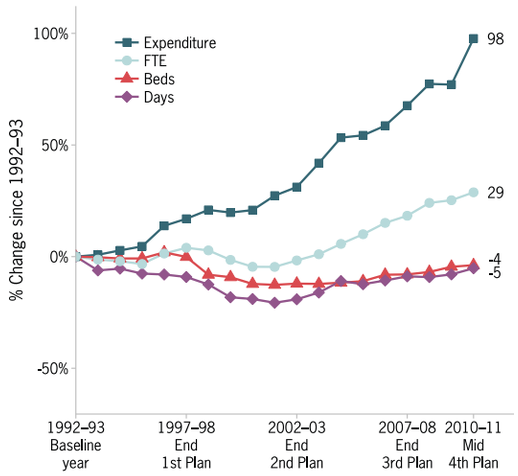


Figure WA4
Changes in ambulatory care

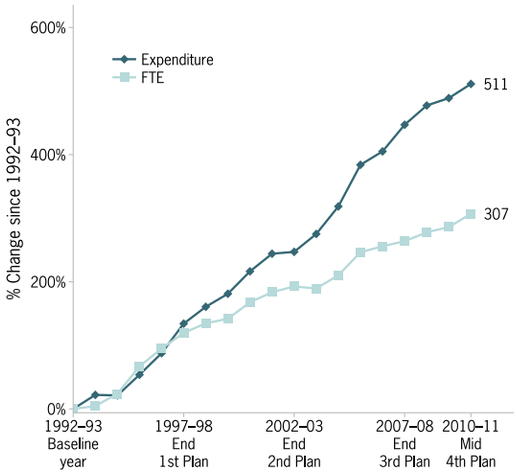


Figure WA5
Direct care workforce

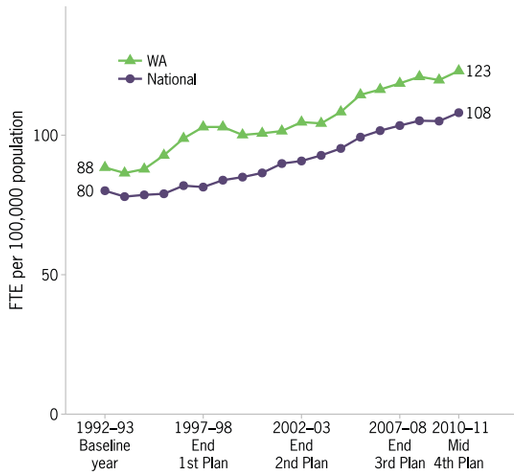


Figure WA6
Inpatient and residential beds

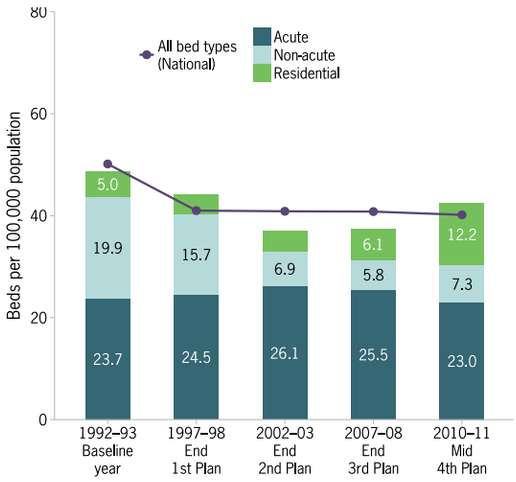


Figure WA7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

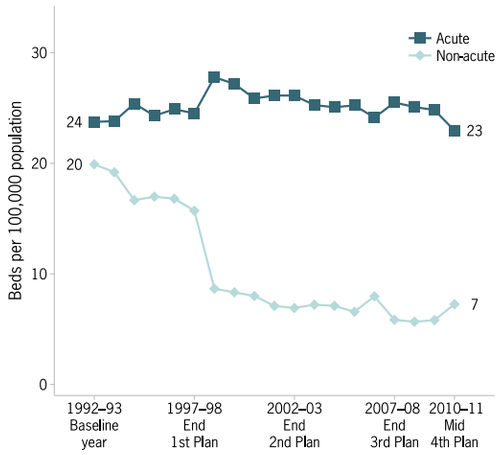


Figure WA8
Readmission to hospital within 28 days of discharge

Figure WA9
Rates of pre-admission community care

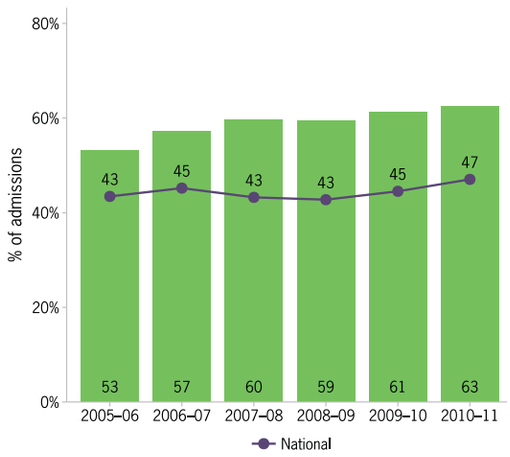


Figure WA10
Rates of post-discharge community care

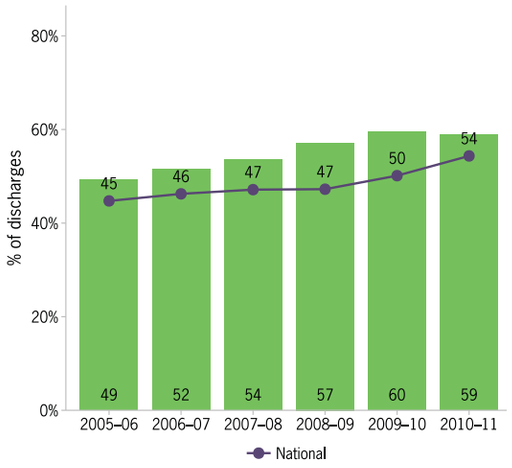


Figure WA11
Average treatment days per three month community care period

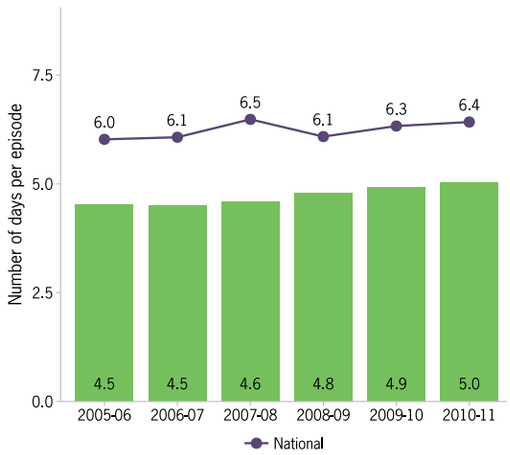


Figure WA12
Percentage of population receiving state or territory mental health services

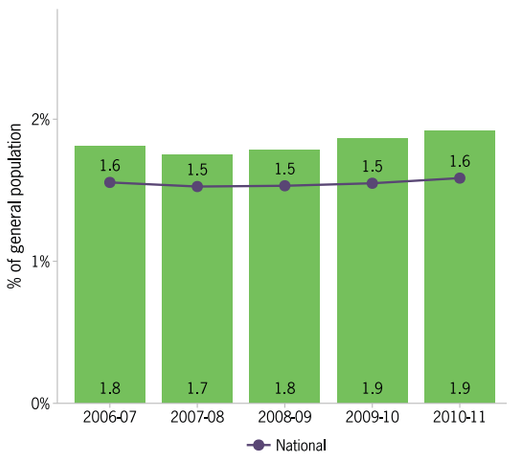


Figure WA13
Percentage of population receiving MBS-subsidised mental health services

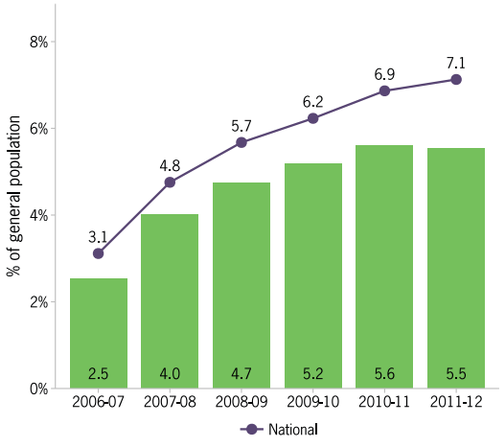


Figure WA14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

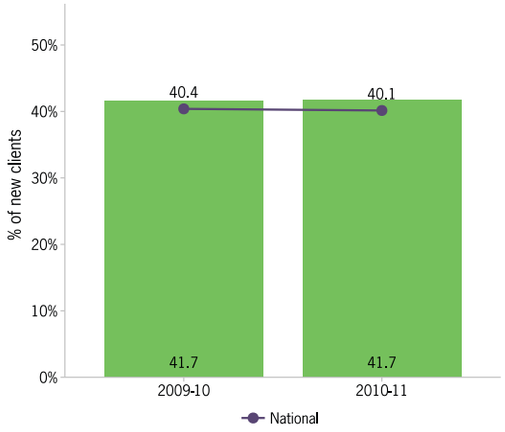


Figure WA15
Mental health outcomes for people who receive treatment from state or territory services

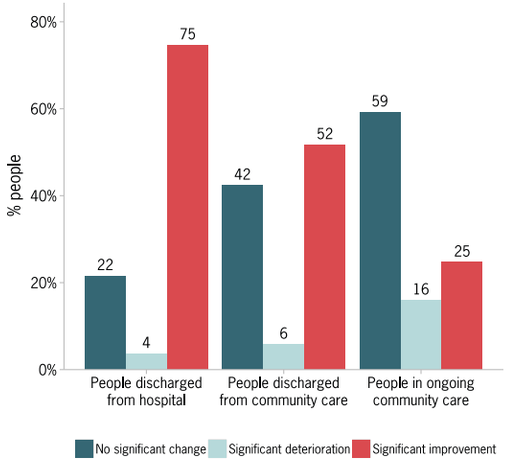


Figure WA16
Proportion of total mental health workforce accounted for by consumer and carer workers

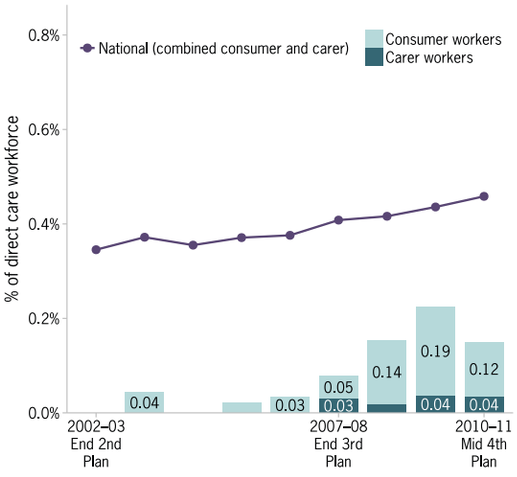


Figure WA17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

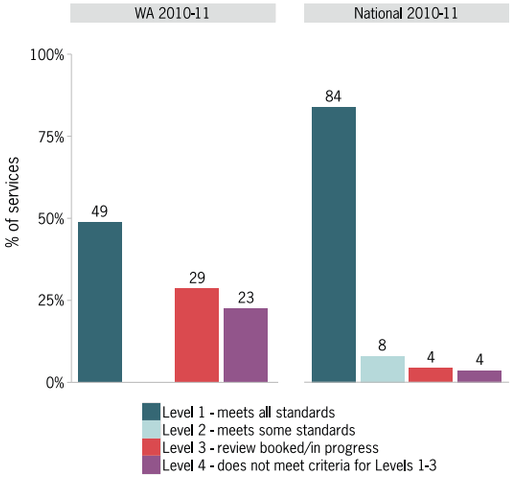
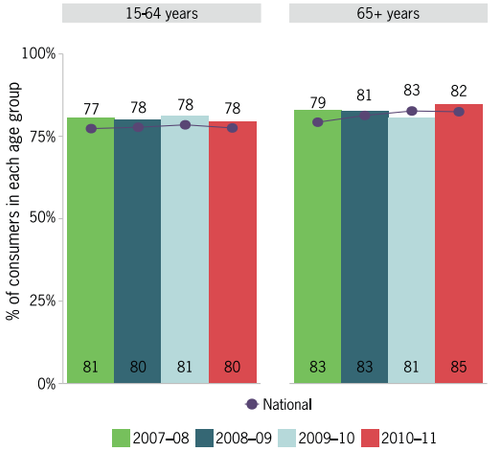


Figure WA18
Percentage of mental health consumers living in stable housing



4.6 South Australia

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

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

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

Figure SA1
Overall spending on mental health

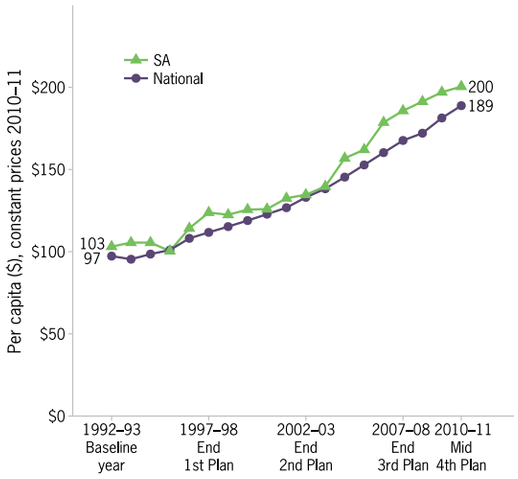


Figure SA2
Change in spending mix

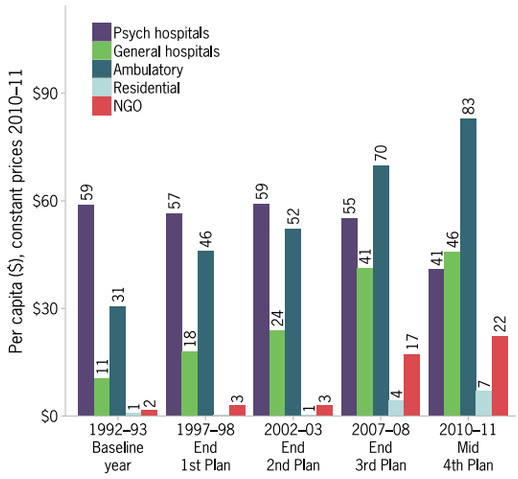


Figure SA3
Changes in inpatient services

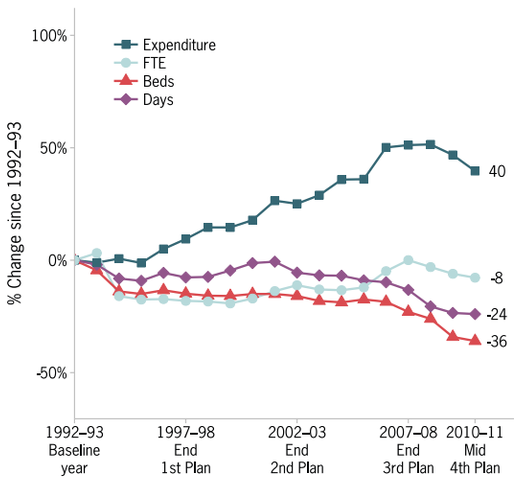


Figure SA4
Changes in ambulatory care

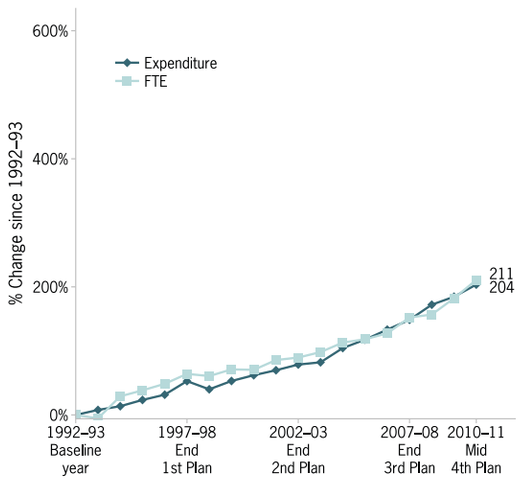


Figure SA5
Direct care workforce

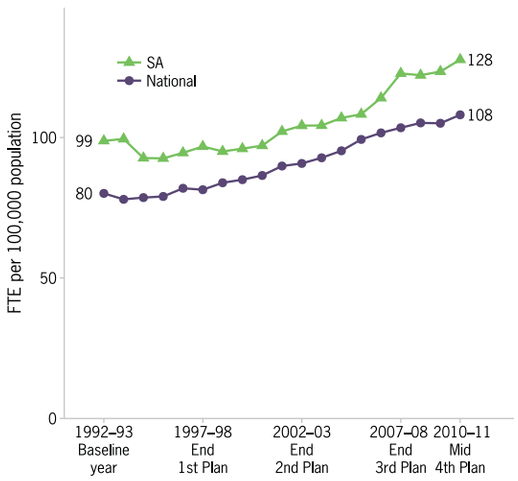


Figure SA6
Inpatient and residential beds

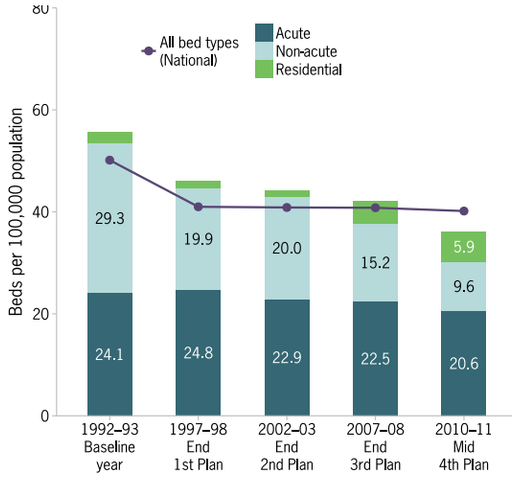


Figure SA7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

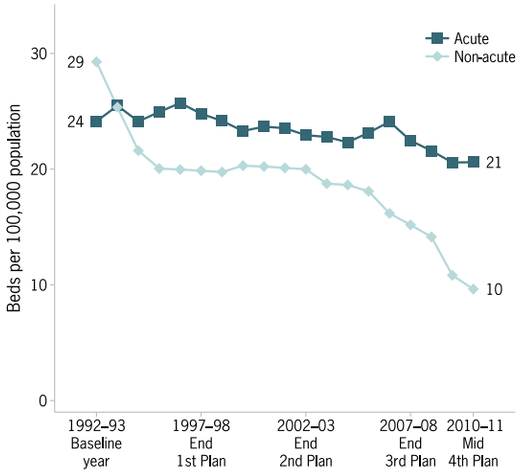


Figure SA8
Readmission to hospital within 28 days of discharge

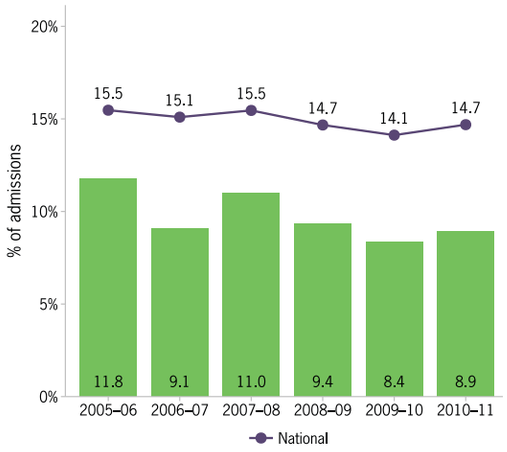


Figure SA9
Rates of pre-admission community care

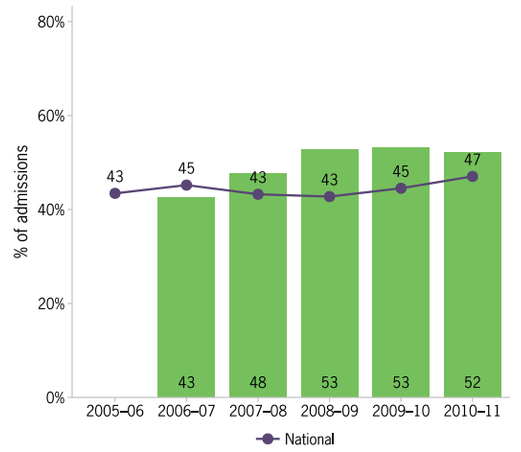


Figure SA10
Rates of post-discharge community care

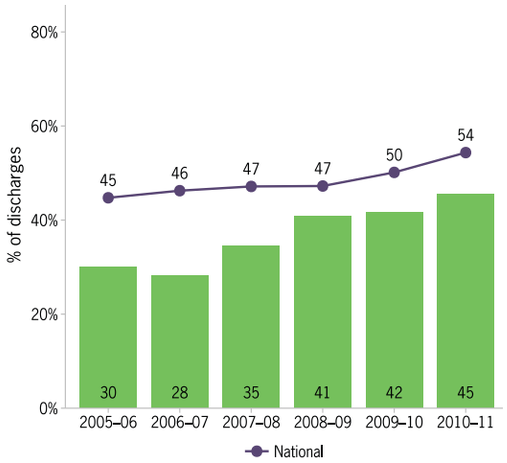


Figure SA11
Average treatment days per three month community care period

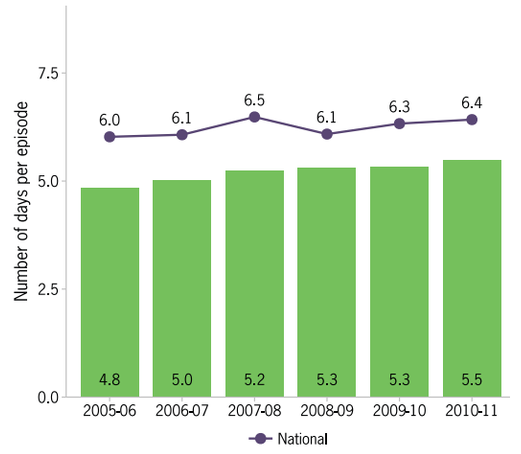


Figure SA12
Percentage of population receiving state or territory mental health services

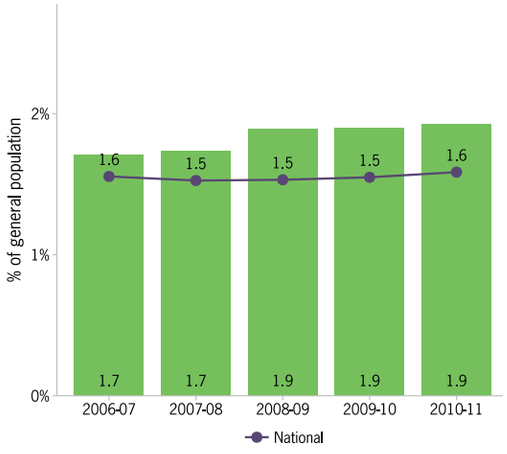


Figure SA13
Percentage of population receiving MBS-subsidised mental health services

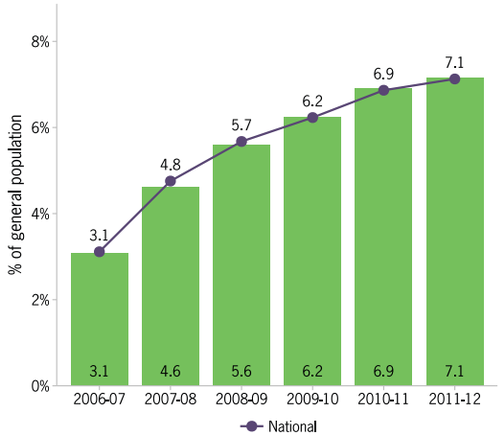


Figure SA14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

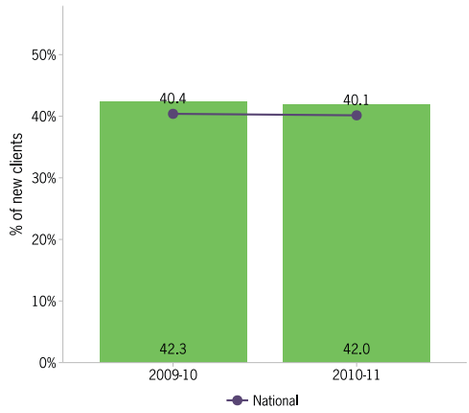


Figure SA15
Mental health outcomes for people who receive treatment from state or territory services

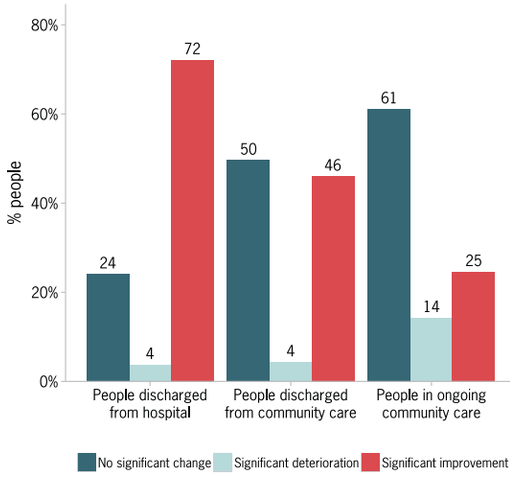


Figure SA16
Proportion of total mental health workforce accounted for by consumer and carer workers

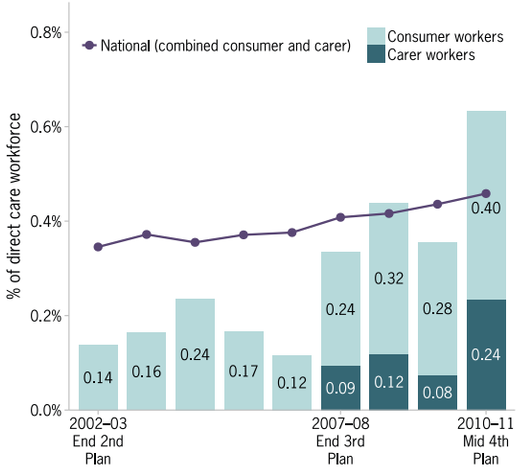


Figure SA17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

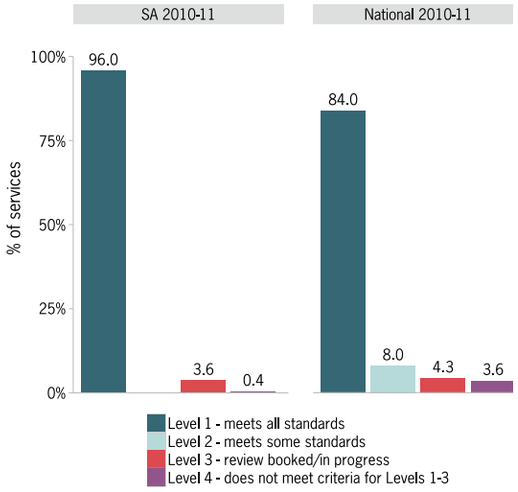
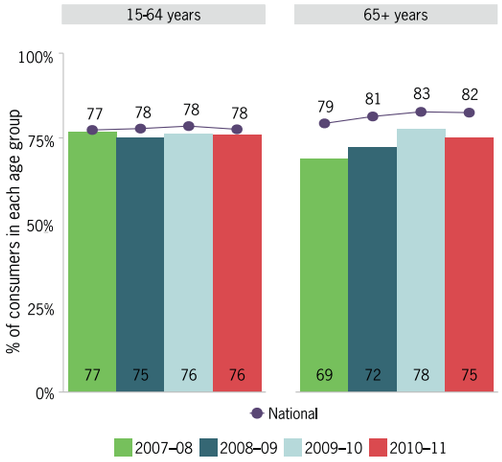


Figure SA18
Percentage of mental health consumers living in stable housing



4.7 Tasmania

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

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

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

Figure TAS1
Overall spending on mental health

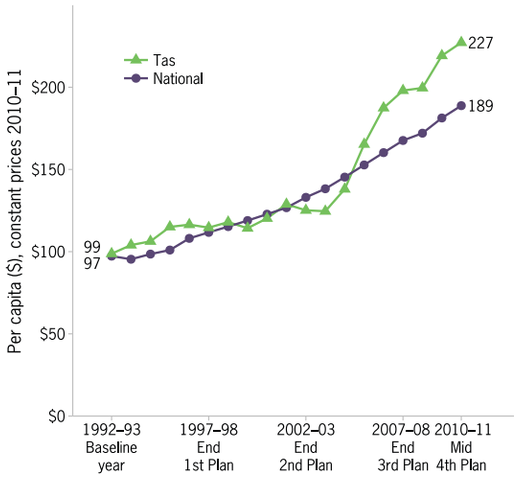


Figure TAS2
Change in spending mix

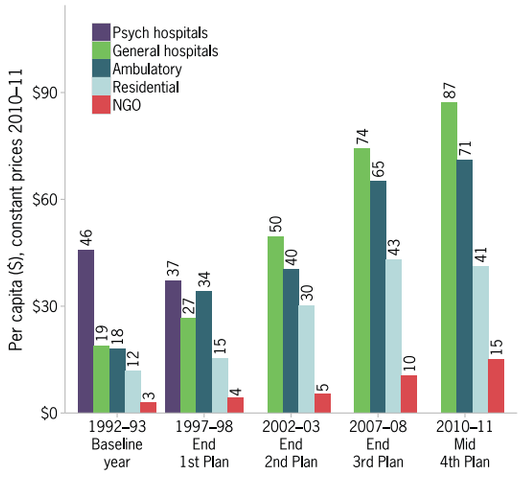


Figure TAS3
Changes in inpatient services

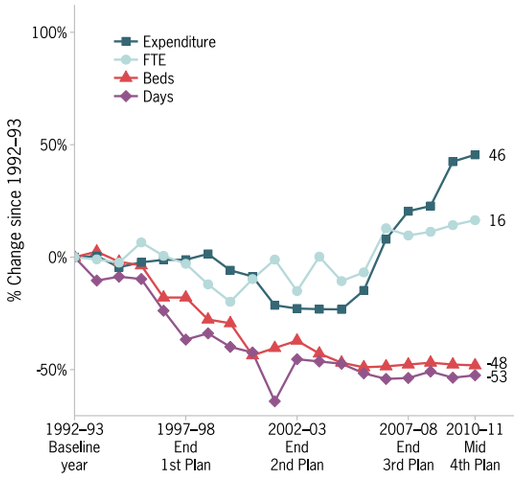


Figure TAS4
Changes in ambulatory care

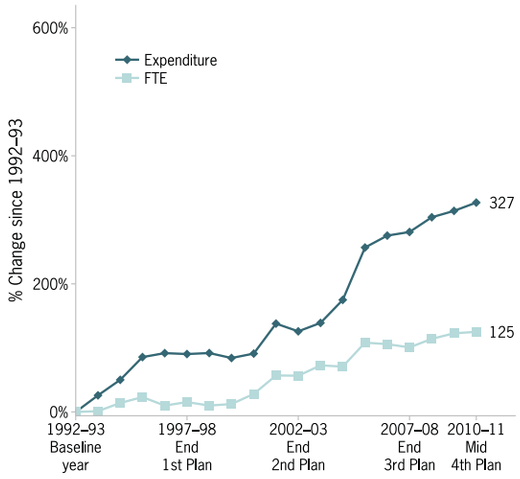


Figure TAS5
Direct care workforce

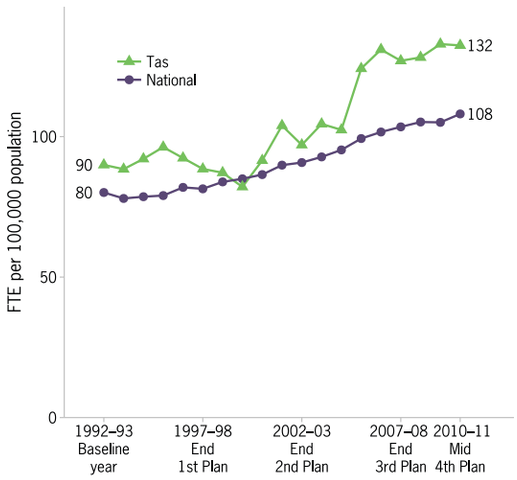


Figure TAS6
Inpatient and residential beds

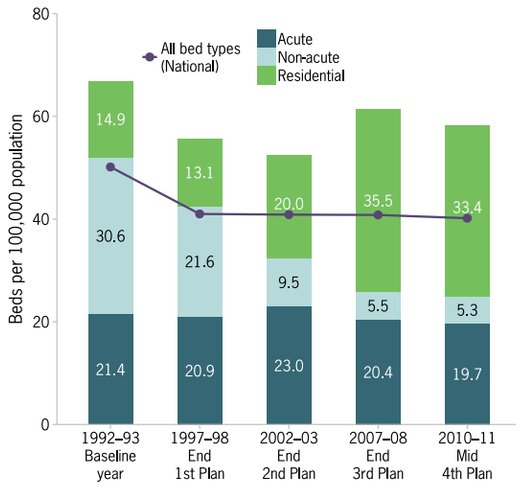


Figure TAS7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

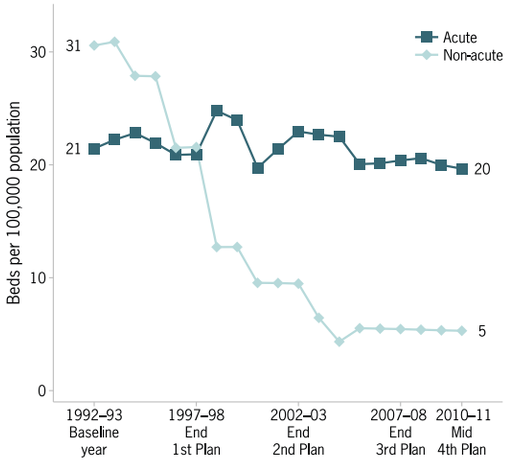


Figure TAS8
Readmission to hospital within 28 days of discharge

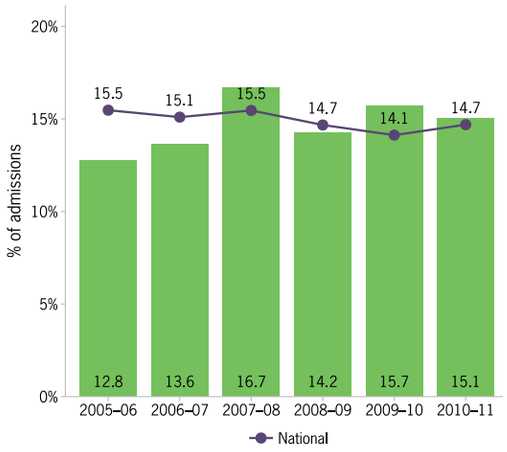


Figure TAS9
Rates of pre-admission community care

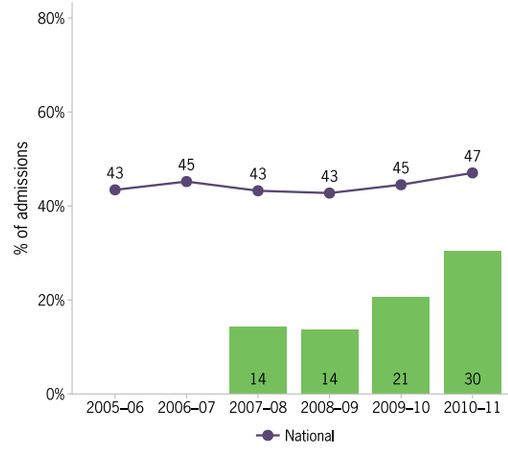


Figure TAS10
Rates of post-discharge community care

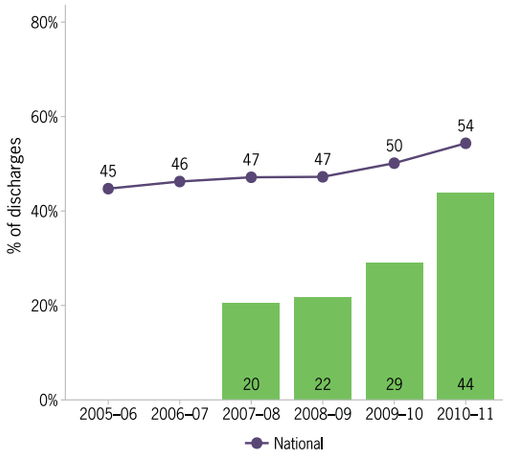


Figure TAS11
Average treatment days per three month community care period

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

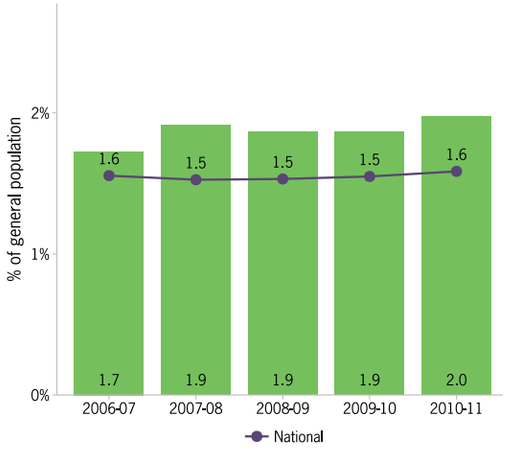


Figure TAS13
Percentage of population receiving MBS-subsidised mental health services

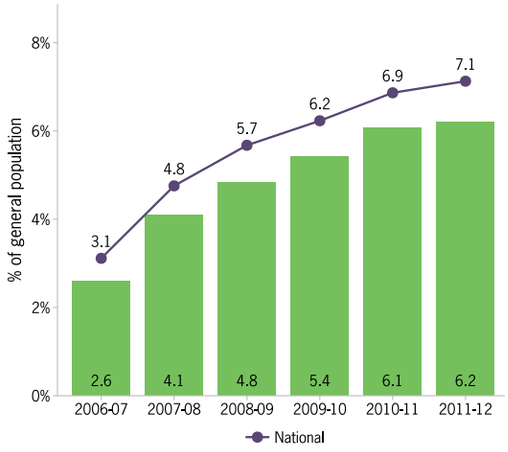


Figure TAS14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

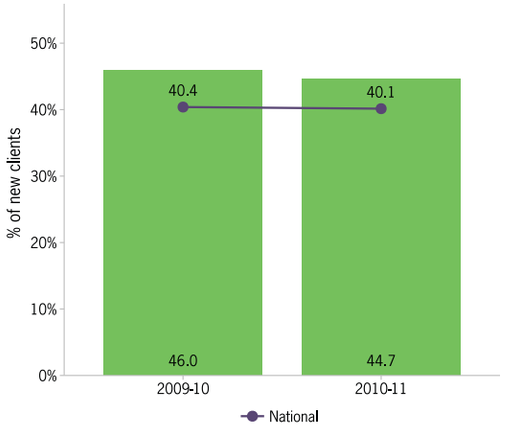


Figure TAS15
Mental health outcomes for people who receive treatment from state or territory services

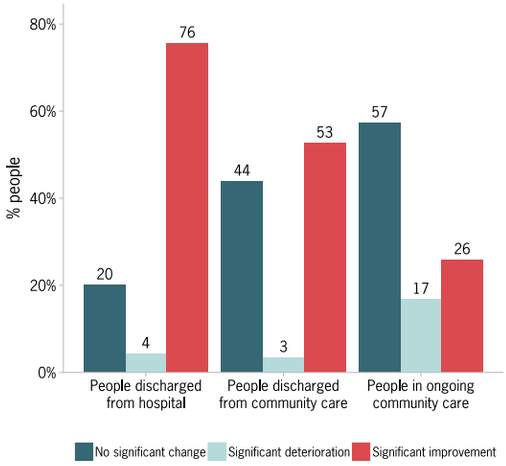


Figure TAS16
Proportion of total mental health workforce accounted for by consumer and carer workers

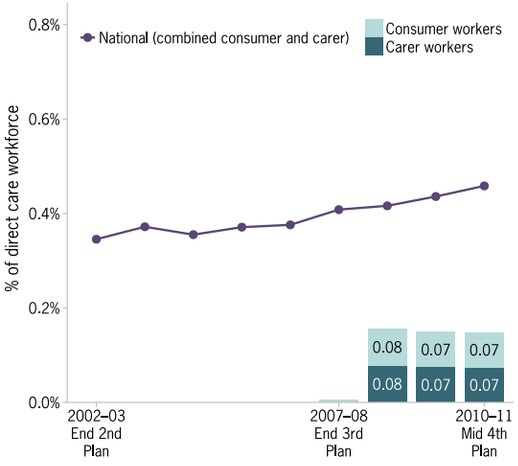


Figure TAS17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

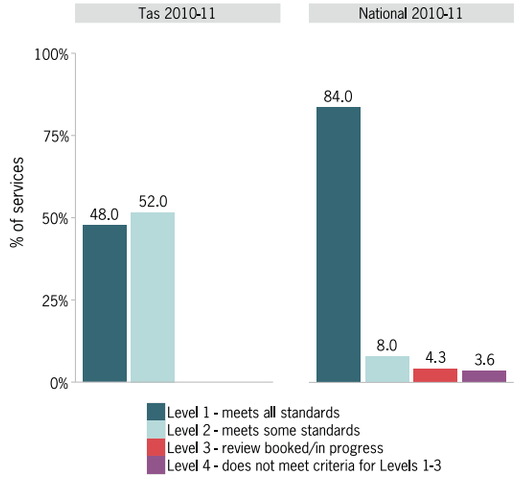
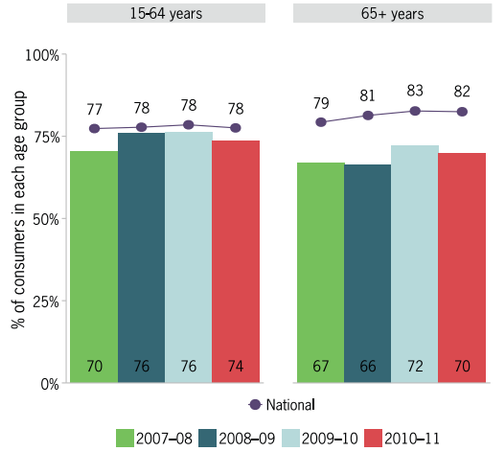


Figure TAS18
Percentage of mental health consumers living in stable housing



4.8 Australian Capital Territory

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

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

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

Figure ACT1
Overall spending on mental health

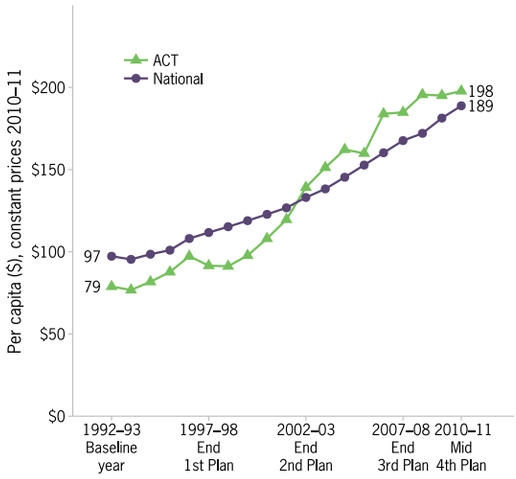


Figure ACT2
Change in spending mix

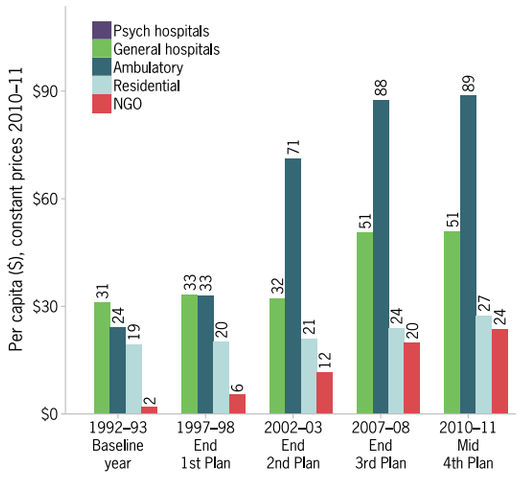


Figure ACT3
Changes in inpatient services

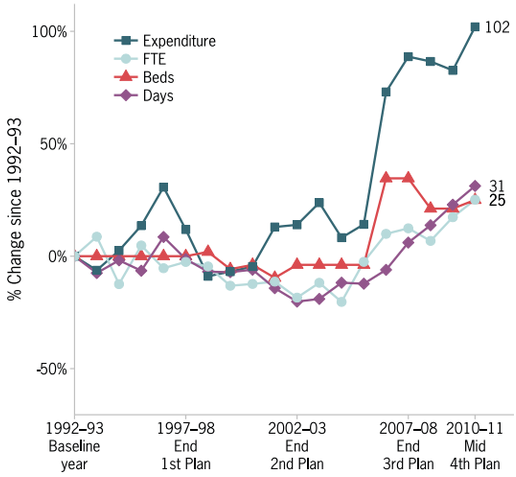


Figure ACT4
Changes in ambulatory care

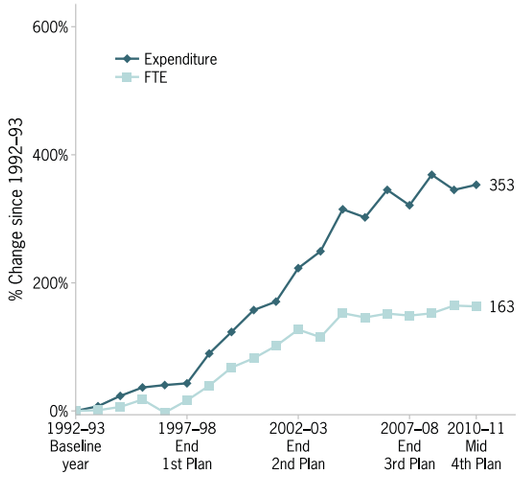


Figure ACT5
Direct care workforce

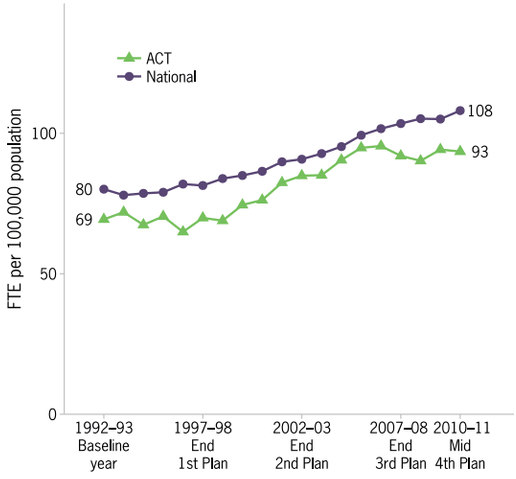


Figure ACT6
Inpatient and residential beds

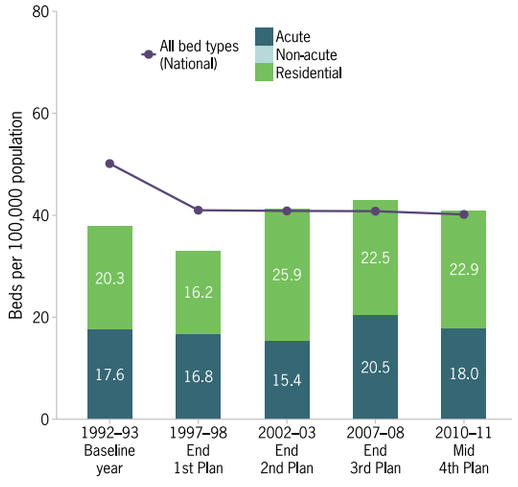


Figure ACT7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

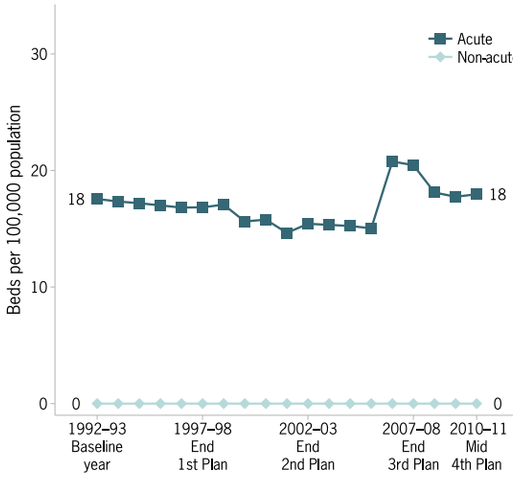


Figure ACT8
Readmission to hospital within 28 days of discharge

Figure ACT9
Rates of pre-admission community care

Figure ACT10
Rates of post-discharge community care

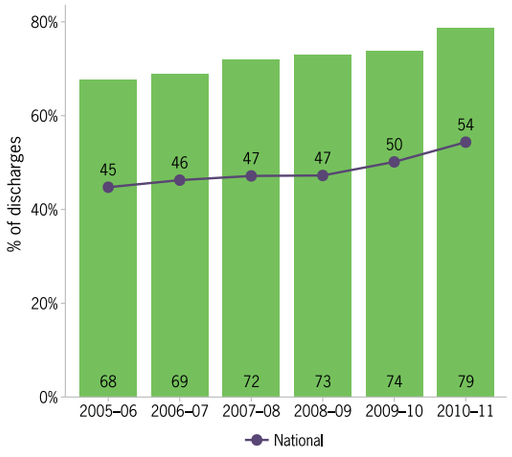


Figure ACT11
Average treatment days per three month community care period

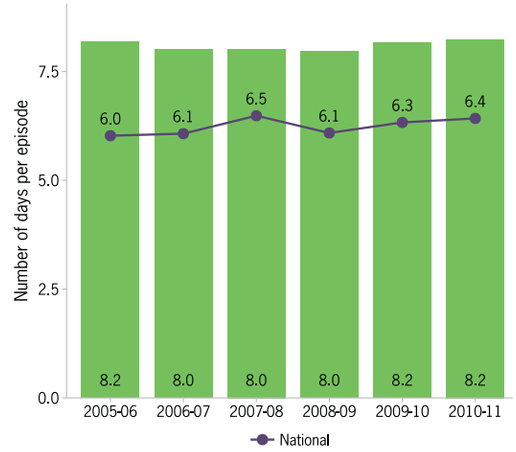


Figure ACT12
Percentage of population receiving state or territory mental health services

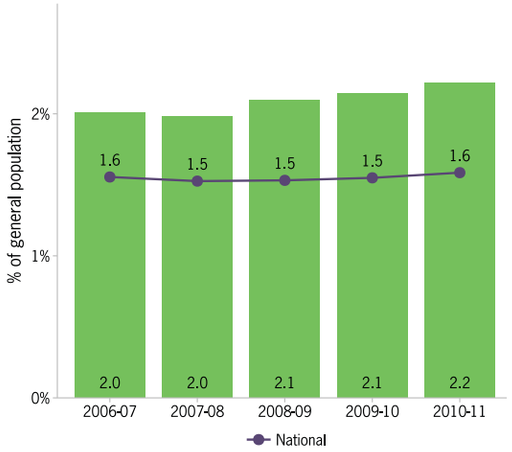


Figure ACT13
Percentage of population receiving MBS-subsidised mental health services

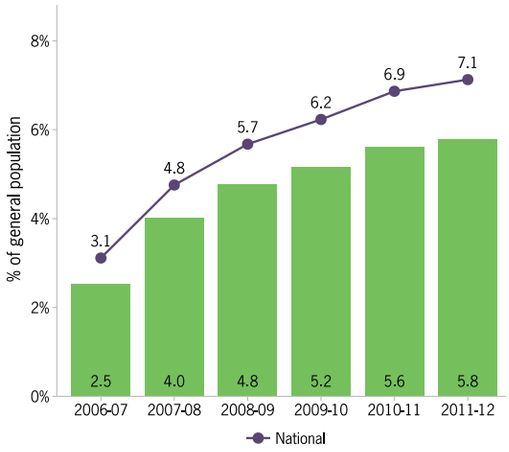


Figure ACT14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

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

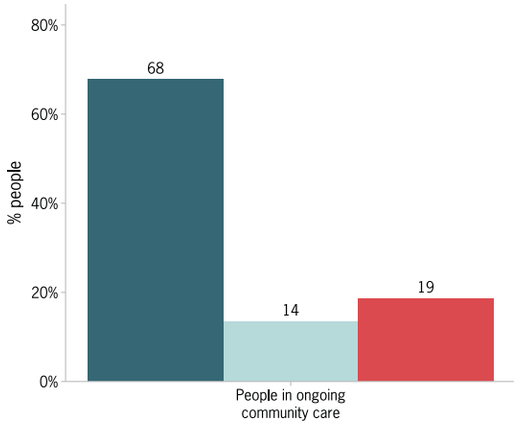


Figure ACT16
Proportion of total mental health workforce accounted for by consumer and carer workers

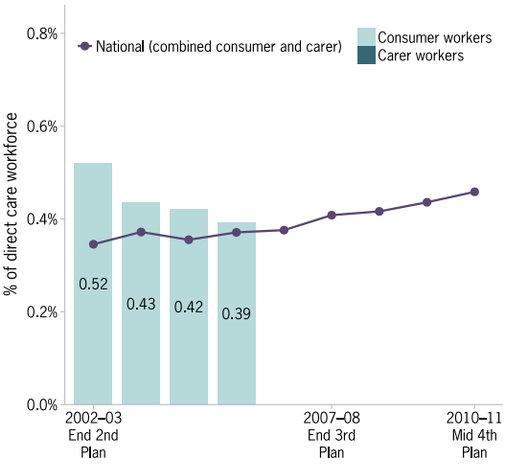


Figure ACT17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

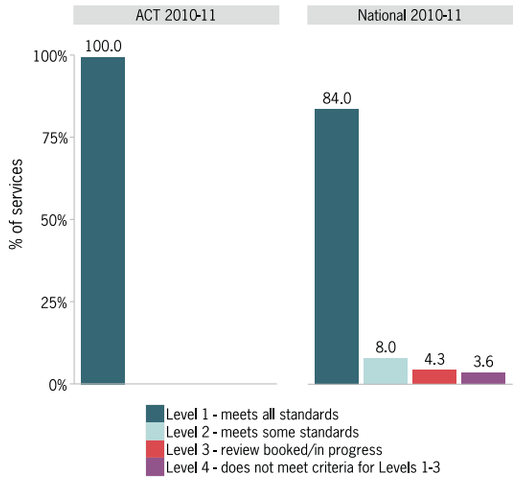
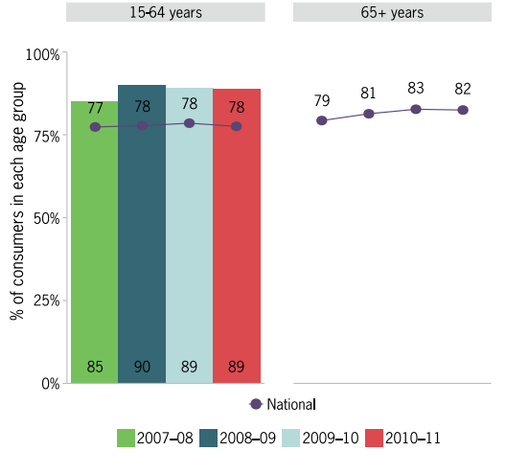


Figure ACT18
Percentage of mental health consumers living in stable housing



4.9 Northern Territory

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

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

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

Figure NT1
Overall spending on mental health

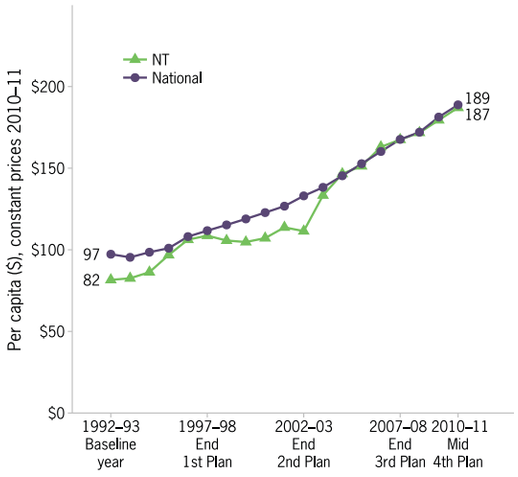


Figure NT2
Change in spending mix

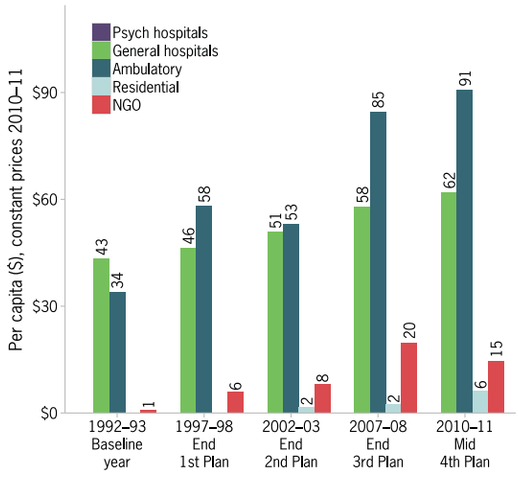


Figure NT3
Changes in inpatient services

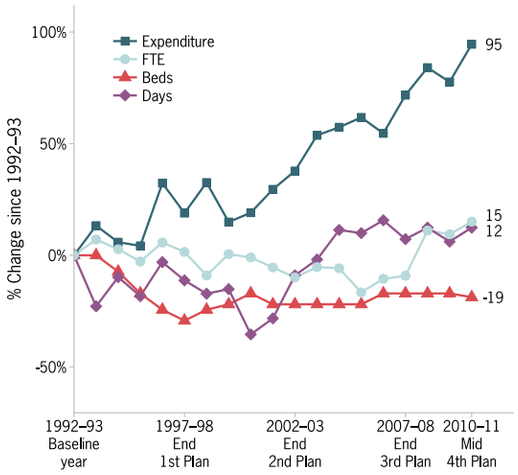


Figure NT4
Changes in ambulatory care

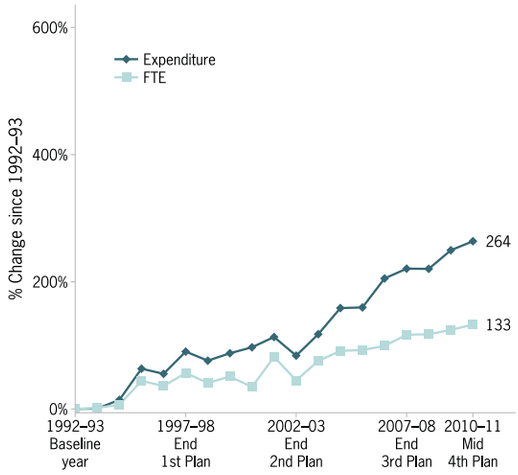


Figure NT5
Direct care workforce

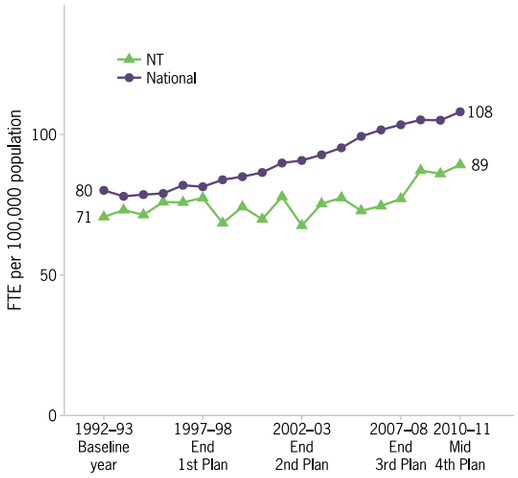


Figure NT6
Inpatient and residential beds

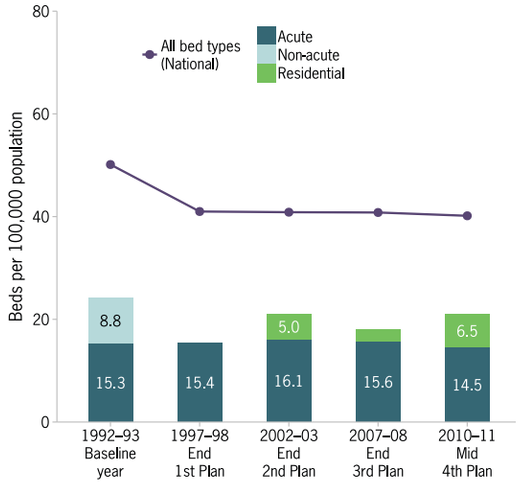


Figure NT7
Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000

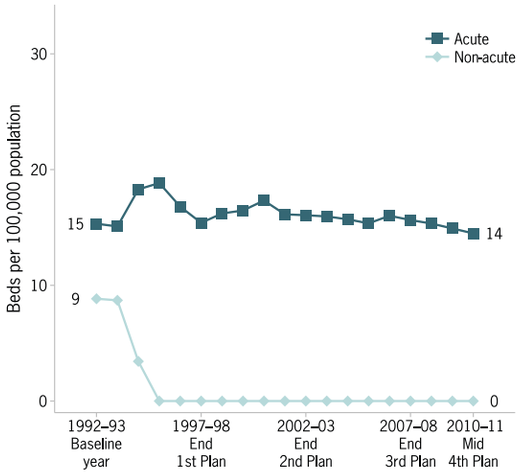


Figure NT8
Readmission to hospital within 28 days of discharge

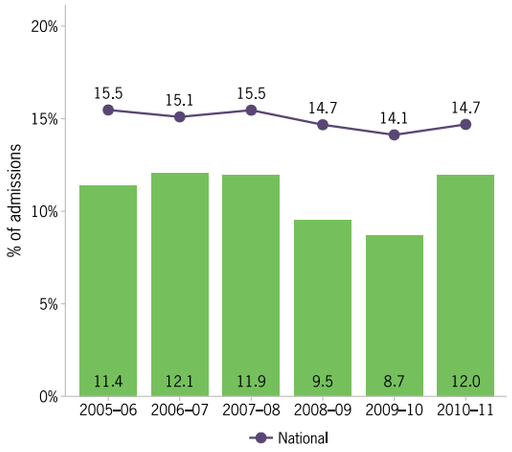


Figure NT9
Rates of pre-admission community care

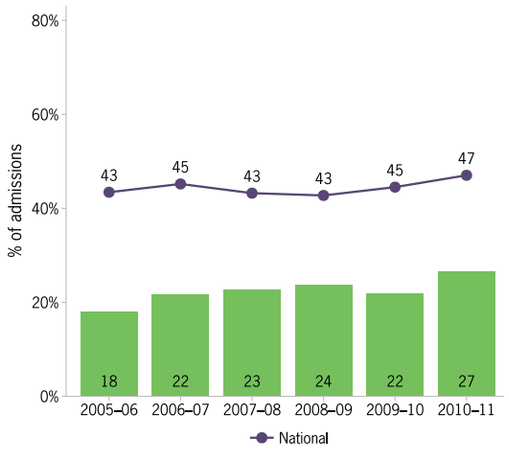


Figure NT10
Rates of post-discharge community care

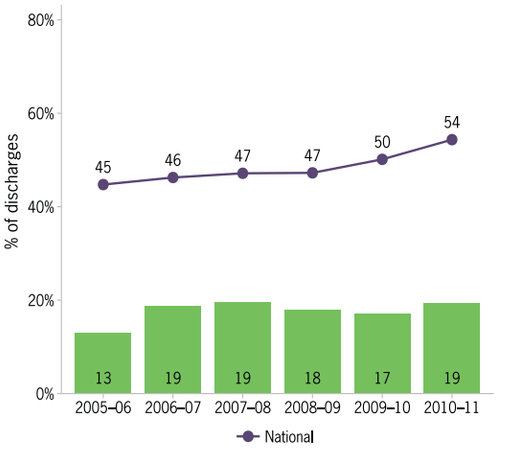


Figure NT11
Average treatment days per three month community care period

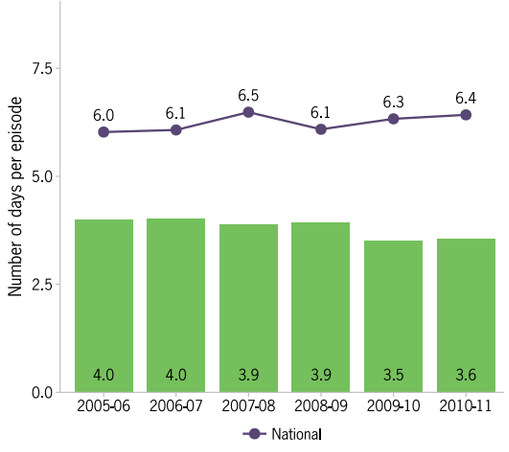


Figure NT12
Percentage of population receiving state or territory mental health services

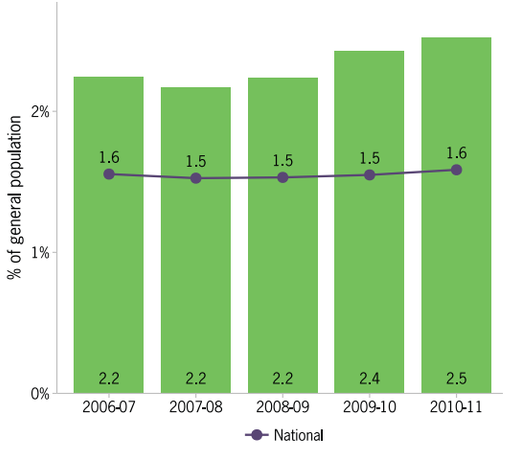


Figure NT13
Percentage of population receiving MBS-subsidised mental health services

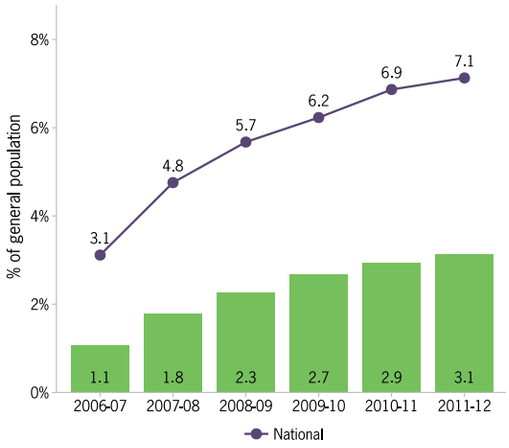


Figure NT14
New clients as a proportion of total clients under the care of state or territory specialised public mental health services

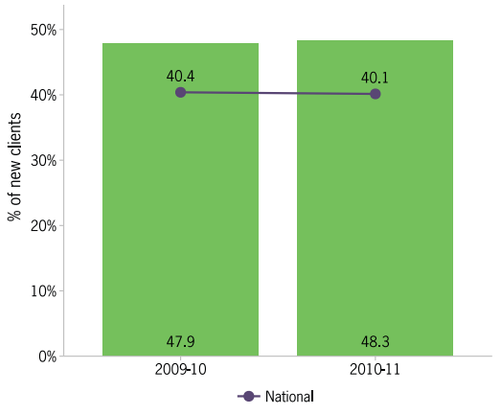


Figure NT15
Mental health outcomes for people who receive treatment from state or territory services

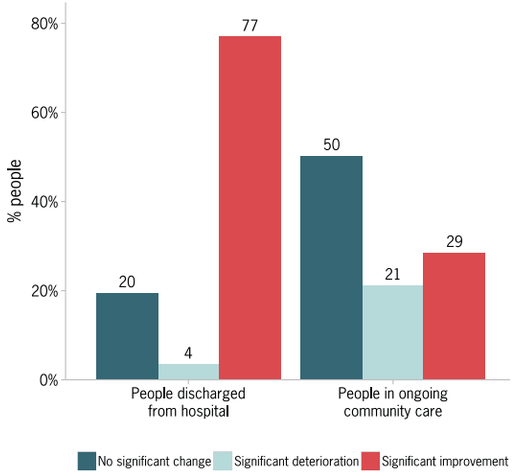


Figure NT16
Proportion of total mental health workforce accounted for by consumer and carer workers

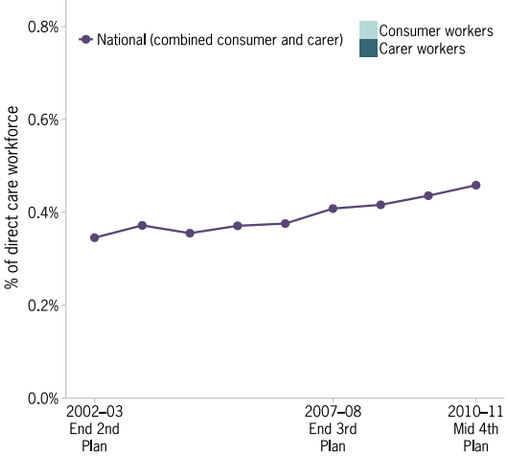


Figure NT17
Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

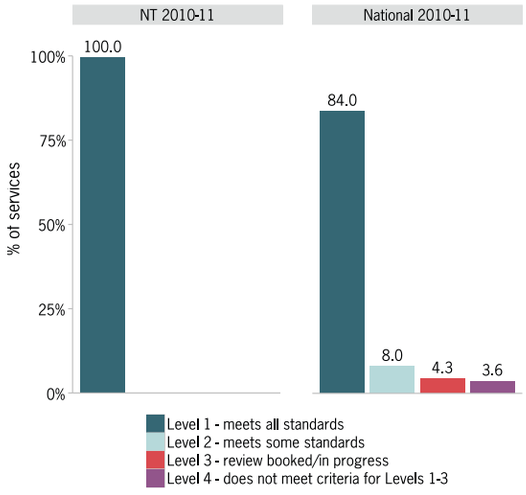
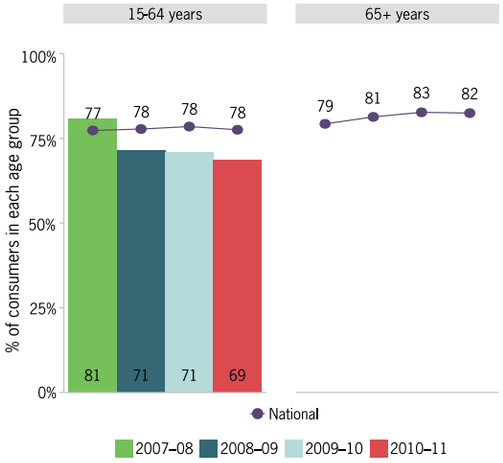


Figure NT18
Percentage of mental health consumers living in stable housing



Appendix 1: Data sources and explanatory notes for Part 2

Introduction

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

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

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

Data sources and explanatory notes

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

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

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

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

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

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

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

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

Appendix 2: Data sources and explanatory notes for Part 3