



Australian Government

NATIONAL MENTAL HEALTH REPORT

2010

national
mental
health
strategy

National Mental Health Report 2010

**Summary of 15 Years of reform in
Australia's Mental Health Services under the
National Mental Health Strategy
1993-2008**



11th Report

Paper-based version

© Commonwealth of Australia 2010

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>.

Internet version

© Commonwealth of Australia 2010

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

ISBN: 978-1-74241-310-5

Online ISBN: 978-1-74241-311-2

Publication Approval Number: D0012

This report is available for screen reading or free downloading from the internet site of the Australian Government Department of Health and Ageing at the website address listed below. The tables presented in the Appendices, including all data covering the years 1992-93 to 2007-08, are also available on the website: www.health.gov.au/mentalhealth

Additional hard copies of this report are available from the mental health branches of each state and territory health department. Contact addresses are provided at Appendix 15 of this document. Copies may also be obtained by contacting the Department of Health and Ageing publications phone order service (telephone 1800 020 103, facsimile 1800 020 103), or via email at health@nationalmailing.com.au.

Prepared by the Mental Health Reform Branch, Mental Health and Chronic Disease Division, Department of Health and Ageing, Canberra.

Suggested citation for this report:

Department of Health and Ageing (2010) *National Mental Health Report 2010: Summary of 15 Years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008*. Commonwealth of Australia, Canberra.

FOREWORD

The National Mental Health Strategy was endorsed by all Australian Health Ministers in 1992 and committed all governments to a reform process aimed at achieving major improvements in the quality and range of mental health services available to the community. Through various changes in government at the federal, state and territory levels, the National Mental Health Strategy has continued as a bipartisan reform agenda and the National Mental Health Report series has been maintained as the principal vehicle for monitoring reform progress.

This report is the eleventh in the National Mental Health Report series released by the Australian Government. It summarises the progress of mental health reform undertaken over the fifteen years of the National Mental Health Strategy, and provides a view of trends and performance at the national and state and territory levels over the period spanning the First, Second and Third Mental Health Plans from 1993 to 2008.

There has been significant change during the past fifteen years of mental health reform. All governments have increased their reform efforts in recent times with significant investments in clinical and community support services. Several governments have appointed Ministers with specific responsibility for mental health reform, highlighting their strengthened commitment to mental health as a national health priority area.

However, as stakeholders have emphasised, the system needs an overhaul to build a modern system of mental health care in Australia.

One in five Australians will experience mental illness this year, and nearly one in two Australians will experience some form of mental illness at some stage during their life. It is the largest cause of non-fatal disability of any disease in the country. It is a bigger barrier to workforce participation than any other illness in the country. People living with mental illness need access to a range of services from across government – health and clinical care services, but also stable accommodation, community support and education and training opportunities. And while improvements have been made in many areas, we know that access to services remains uneven across Australia, and key service gaps are evident across all states and territories.

Community advocacy for a renewed focus on mental health reform has reached unprecedented levels in recent times. As a community, we need to do better.

In December 2008, all Australian Health Ministers renewed their commitment to the National Mental Health Strategy by endorsing a new National Mental Health Policy (the Policy). The Policy provides an overarching vision and intent for the mental health system in Australia and embeds a whole of government approach to mental health reform that formed the centrepiece of the Council of Australian Governments (COAG) National Action Plan on Mental Health (2006-2011). The plan takes a whole of government approach, based on recognition that many of the determinants of good mental health are influenced by factors beyond the health system. It also recognises that effective services to support consumers and their families towards recovery require coordination between the health system and other areas of government service delivery, including housing, disability services, family services, education and workforce training and development.

In this context, it is important to note that, as part of its April 2010 agreement on broader national health reforms, COAG agreed to undertake further work on the scope for additional mental health service reform for report back in 2011.

I am pleased to endorse this eleventh National Mental Health Report that describes progress in mental health reform up to 2008. The National Mental Health Report series, along with other national reports such as the Mental Health Services in Australia series produced by the Australian Institute of Health and Welfare, has been an important element of the National Mental Health Strategy to date.

This report is the last in the present format of National Mental Health Reports. From 2011, these reports will be redesigned to focus on monitoring progress against the new outcome oriented set of

indicators identified in the Fourth National Mental Health Plan. Importantly, future National Mental Health Reports will incorporate independent commentaries from stakeholders on the progress of reform. The newly designed report will form a key component of a broader approach to strengthen the accountability and transparency of the national mental health reform process. In addition to changes in national reporting, the new arrangements will include the requirements for service providers - Medicare Locals and Locals Hospital Networks - to report on the performance of local mental health services.

These National Mental Health Reports have entailed considerable work by many people including consumers, carers, service providers and the mental health units of various state and territory health administrations. I wish to extend my thanks to all who have contributed to this report.



Mark Butler
Minister for Mental Health and Ageing

Contents

PART A: Highlights of progress under the National Mental Health Strategy 1993-2008	1
PART B: Monitoring the National Mental Health Strategy	11
1. Overview of the Strategy.....	12
2. Council of Australian Governments National Action Plan on Mental Health 2006-2011.....	15
3. Estimating Australia's needs for mental health care.....	16
4. The role of the National Mental Health Report.....	19
PART C: Progress in reform of Australia's mental health services	23
5. National spending on mental health.....	24
6. Reform of state and territory mental health services.....	35
7. Private sector mental health services.....	62
8. Consumers and carers in mental health care.....	70
PART D: Profiles of state and territory reform progress	75
New South Wales.....	78
Victoria.....	80
Queensland.....	82
Western Australia.....	84
South Australia.....	86
Tasmania.....	88
Australian Capital Territory.....	90
Northern Territory.....	92
PART E: Appendices	95
APPENDIX 1 Sources for state and territory data.....	96
APPENDIX 2 State and territory expenditure on mental health services.....	100
APPENDIX 3 State and territory inpatient service data.....	118
APPENDIX 4 State and territory community based residential services data.....	128
APPENDIX 5 State and territory staffing data.....	135
APPENDIX 6 State and territory ambulatory care services data.....	142
APPENDIX 7 Consumer and carer participation arrangements in public sector mental health service organisations.....	143
APPENDIX 8 Implementation of National Standards for Mental Health Services.....	147
APPENDIX 9 Explanatory notes on data analysis approach used for state and territory profiles.....	149
APPENDIX 10 Private psychiatric hospital data.....	154
APPENDIX 11 Australian Government mental health expenditure.....	158
APPENDIX 12 Medicare Benefits Schedule data for Consultant Psychiatrists.....	164
APPENDIX 13 Australian Government Pharmaceutical Benefits Scheme data.....	168
APPENDIX 14 Population data.....	169
APPENDIX 15 Contacts for information about mental health services.....	170

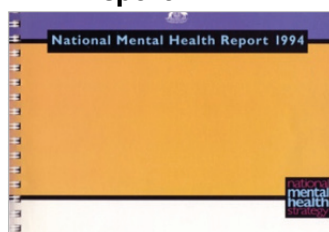
Guide to the National Mental Health Report Series

National Mental Health Report 1993



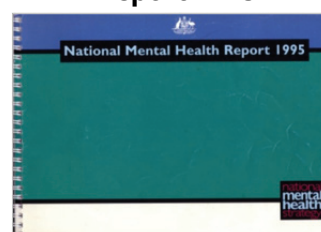
Released: March 1994
Coverage: 1992-93 'baseline year'

National Mental Health Report 1994



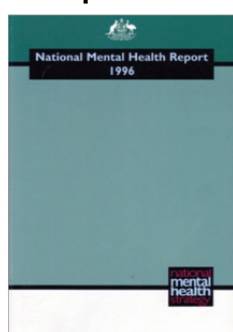
Released: May 1995
Coverage: Progress in 1993-94

National Mental Health Report 1995



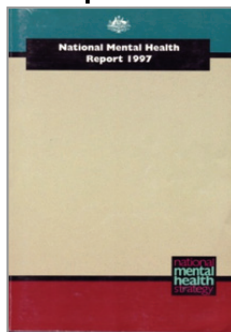
Released: July 1996
Coverage: Progress to 1994-95

National Mental Health Report 1996



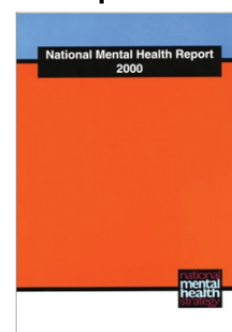
Released: March 1998
Coverage: Progress to 1995-96

National Mental Health Report 1997



Released: March 1999
Coverage: Progress to 1996-97

National Mental Health Report 2000



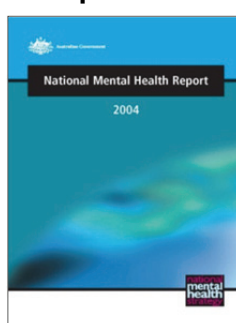
Released: November 2000
Coverage: Progress to 1997-98

National Mental Health Report 2002



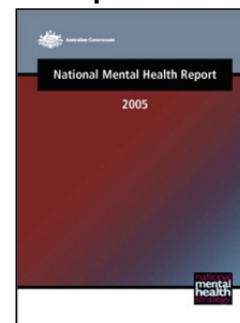
Released: October 2002
Coverage: Progress to 1999-2000

National Mental Health Report 2004



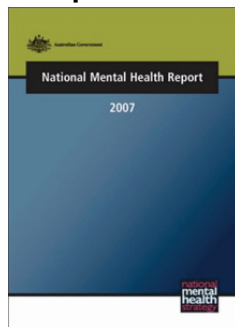
Released: November 2004
Coverage: Progress to 2001-02

National Mental Health Report 2005



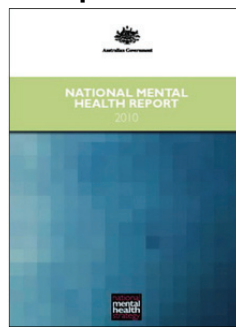
Released: December 2005
Coverage: Progress to 2002-03

National Mental Health Report 2007



Released: February 2008
Coverage: Progress to 2004-05

National Mental Health Report 2010



Released: December 2010
Coverage: Progress to 2007-08

ACKNOWLEDGEMENTS

This report has been produced by the Mental Health Reform Branch of the Department of Health and Ageing. It uses information that could not have been presented without the cooperation of many people and organisations throughout Australia.

These include:

- the Australian Health Ministers' Advisory Council National Mental Health Standing Committee Information Strategy Subcommittee, which oversees the data collection instruments and methodology;
- the management and staff of all specialised mental health services, who provided data for the National Minimum Data Set – Mental Health Establishments;
- the various mental health branches within each state and territory health department, in association with other relevant areas of their organisations that coordinated the annual data collections;
- the Australian Institute of Health and Welfare, which managed data validation of the 2005-06, 2006-07 and 2007-08 collections of the National Minimum Data Set – Mental Health Establishments.
- Strategic Data Pty Ltd, which provided the technical services to enable data processing and web based validation of the National Minimum Data Set – Mental Health Establishments.
- the Australian Bureau of Statistics, which provided information on private psychiatric hospitals;
- Australian Government departments and the various areas of the Department of Health and Ageing that provided information on mental health initiatives and services;
- staff within the Medicare Statistics and Analysis Section, Medicare Benefits Branch and Pharmaceutical Access and Quality Branch of the Department of Health and Ageing, who provided the analyses of data relating to the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme, respectively; and
- Buckingham and Associates Pty Ltd, who assisted the Australian Government in data analysis and drafting of the report.

Whilst responsibility for conclusions drawn in this report is held by the Department of Health and Ageing, the contribution and assistance of all persons and organisations that contributed to its production are gratefully acknowledged.

Conventions used in this report

Several conventions are used to improve the readability of this report.

- Financial years are occasionally abbreviated by referring to the last calendar year of the pair. For example, 2007-08 is abbreviated as 2008, the period 1992-93 to 1997-98 is abbreviated as 1993-98 and so forth.
- Unless otherwise stated, all expenditure and revenue reported in the body of the report are expressed in constant 2008 prices. Tabulated expenditure data presented in the Appendices indicate specifically whether current or constant prices are used.
- All population-based indicators are expressed as crude (non age standardised) rates.
- Frequent reference is made to the terms: 'First National Mental Health Plan', 'Second National Mental Health Plan', 'Third National Mental Health Plan' and 'National Mental Health Strategy'. Occasionally, they are referred to, respectively, as the 'First Plan', 'Second Plan', 'Third Plan', and 'the National Strategy' or 'the Strategy'.
- The Fourth National Mental Health Plan 2009-2014 is referred to as the 'Fourth Plan'.

PART A

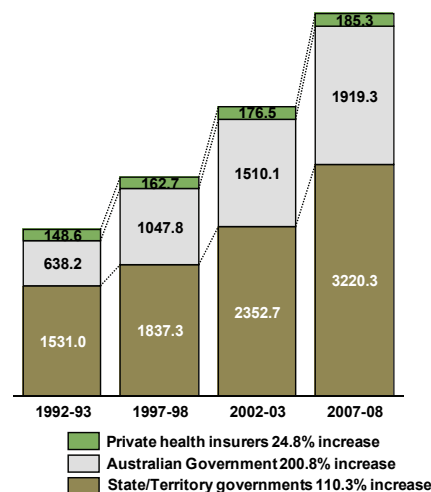
**Highlights of progress
under the National
Mental Health Strategy
1993-2008**

GOVERNMENT SPENDING ON MENTAL HEALTH

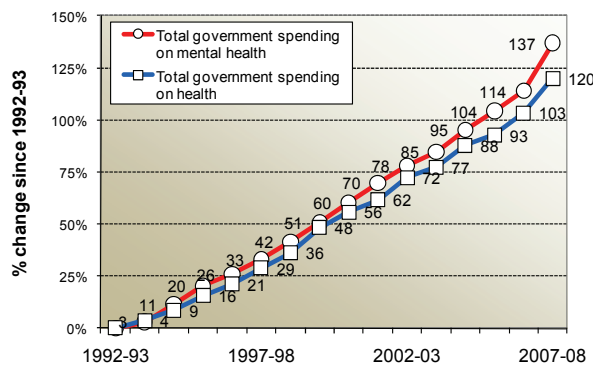
Public reporting on the level of spending on mental health services has been a central function of the National Mental Health Report since its first release in 1994. All governments agreed under the National Mental Health Strategy to maintain expenditure on specialised mental health services and to regularly monitor whether this is occurring through an annual data collection of all publicly funded mental health services.

- Mental health care is financed from a number of sources, including ‘third party’ funders (governments and private health insurers) and ‘out-of-pocket’ payments by people who use services. The information presented in this report is focused on third party funders, particularly the role of governments.
- Spending on mental health in 2008 was \$5.32 billion, 10% higher in real terms than the previous year, the largest annual increase since the commencement of the Strategy. Australian Government spending was \$1.92 billion, states and territories \$3.22 billion and private health insurers \$185 million.
- Mental health accounted for 7.0% of health care expenditure in 2008 and 7.5% of government health spending. These proportions have remained relatively stable over the course of the National Mental Health Strategy.
- Total government spending on mental health increased by 137% between 1993 and 2008, equivalent to \$2.97 billion or \$119 more per head of population per year.
- This growth kept mental health in step with expenditure in the overall health sector. However, when judged by the long term trends, the mental health sector has only maintained its relative position in the health industry rather than increasing its share of the health dollar.
- State and territory hospital services accounted for the largest share of national mental health spending (28%), followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Scheme (14%).

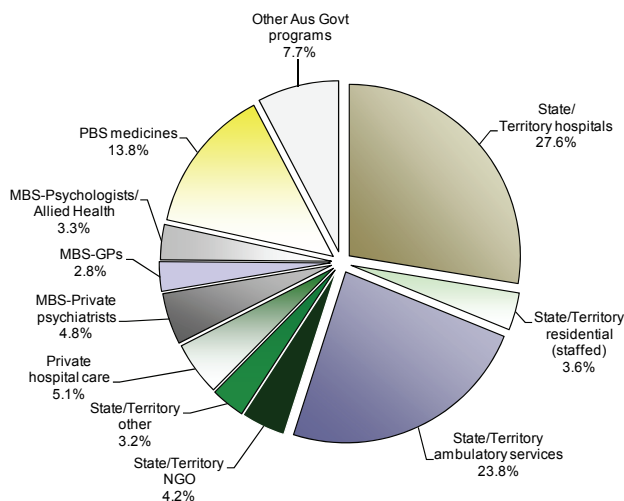
National expenditure on mental health by the three main funders (\$ Millions)



Growth in government mental health spending compared with overall health expenditure



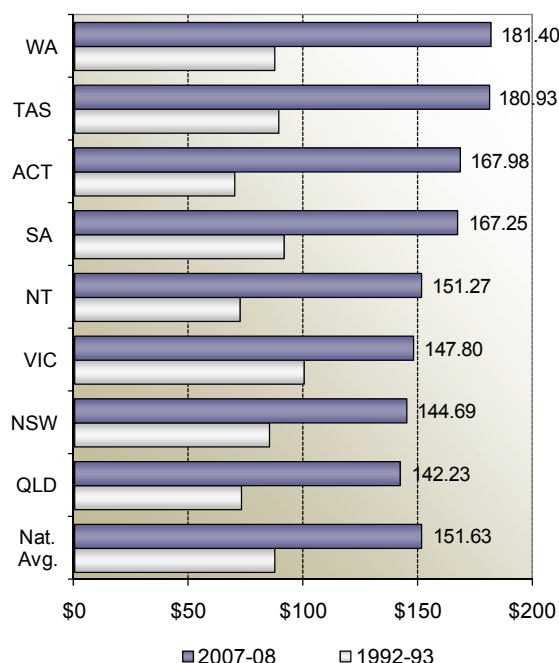
How 2007-08 spending was distributed



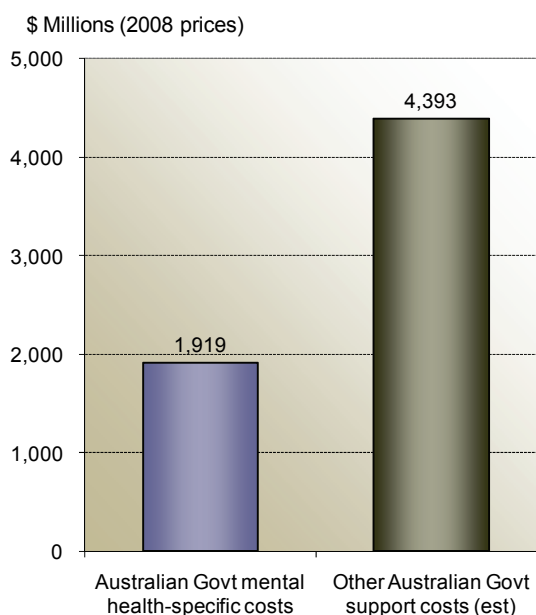
GOVERNMENT SPENDING ON MENTAL HEALTH

- All states and territories have met their commitments to protect mental health resources over the course of the National Mental Health Strategy.
- Combined spending by state and territory governments on running their public mental health systems has increased by 110%, equivalent to \$1.7 billion more in annual spending compared with 1993.
- Growth at the national level masks differences between the states and territories. The gap between the highest and the lowest spending jurisdiction increased over the 1993-2008 period. While some variation between state and territory expenditure can be expected due to the different needs of their populations, the variation is too large for this to be the full explanation.
- Beyond specialist mental health care, a wide range of other health and welfare services is needed to support people with mental illness. The Australian Government funds a number of assistance programs, including income support, housing services, domiciliary care and employment and training opportunities. Conservative estimates of Australian Government spending alone suggest that, for every dollar allocated to specialised mental health care, an additional \$2.30 is spent providing other support services to assist people with mental illness. This is equivalent to \$4.4 billion in 2008 prices.
- It is not known how much spending on mental health services is required to meet the priority needs of the Australian population. However, surveys conducted of the extent of mental illness in the population have found a high level of need. Similar findings have been reported in other countries, but reliable international benchmarks are not available for determining what is the right level of funding to allocate to mental health.

Per capita spending on mental health by state and territory governments



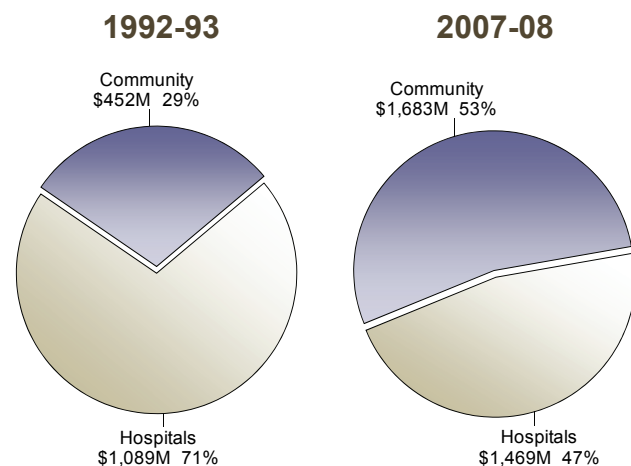
Estimated direct and indirect costs to the Australian Government of mental illness, 2007-08



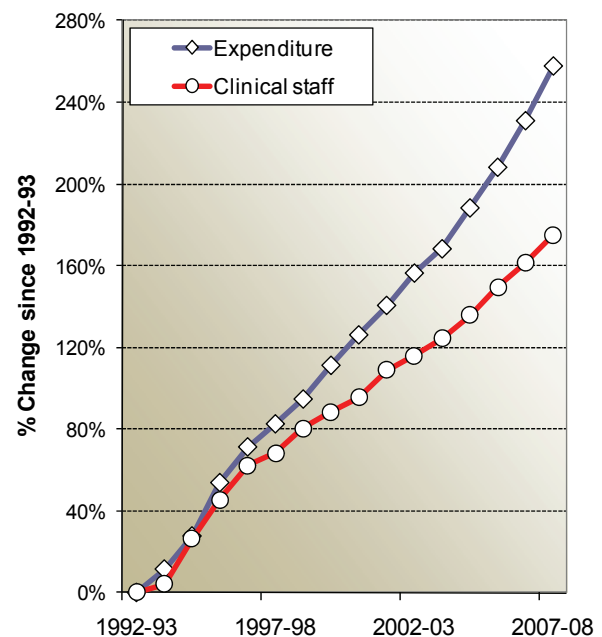
PROGRESS TOWARDS A COMMUNITY BASED SYSTEM OF CARE

The expansion of treatment and support services to assist people affected by mental illness living in the community is a central aim of the National Mental Health Strategy. These services include clinical care provided by health professionals working outside hospital settings (referred to as ‘ambulatory care services’), residential services and a range of support programs provided by non government organisations (NGOs). Monitoring the extent to which growth in these areas has occurred is an important role of the National Mental Health Report.

- Annual spending by states and territories on community based mental health services increased by 272% or \$1.2 billion between 1993 and 2008. All states and territories have expanded services, but to varying degrees.
- At the commencement of the Strategy, 29% of state and territory mental health spending was dedicated to caring for people in the community. By 2008, the community share of total mental health expenditure had increased to 53%.
- Ambulatory services accounted for three quarters of the growth in community based mental health care over the 1993-2008 period. Annual spending on ambulatory care services increased by 258%, or \$914 million.
- Changes in the number of health professionals employed to provide treatment and care in the community give the best indication of the expansion of ambulatory care services. Nationally, the number of clinical staff providing ambulatory mental health care increased by 175% between 1993 and 2008. Growth in the clinical workforce has not kept up with growth in spending.
- In 2008, there were 5,880 more health professionals employed in state and territory funded ambulatory care mental health services than in 1993.



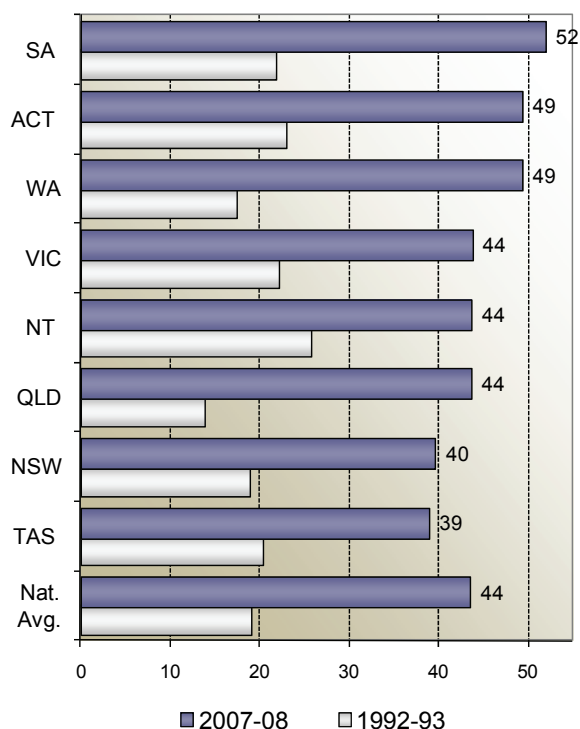
Growth in ambulatory mental health care clinical staffing and spending



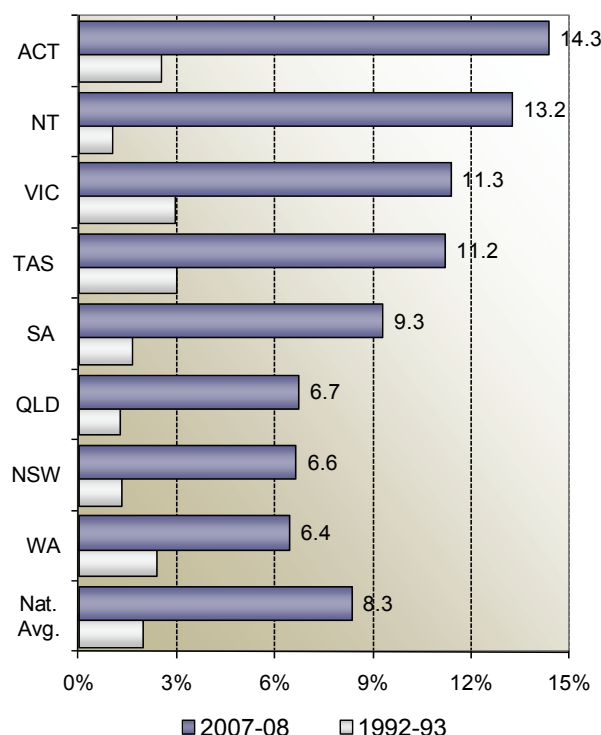
PROGRESS TOWARDS A COMMUNITY BASED SYSTEM OF CARE

- The scale and pace of change has not been uniform across the jurisdictions. While all states and territories have made substantial progress in strengthening their community mental health workforce, differences remain in the extent to which health professionals are employed to provide community care.
- Funding to non government organisations (NGOs) to provide mental health services has increased more than seven fold since the start of the National Mental Health Strategy, equivalent to \$232 million growth in annual spending. From the outset, the Strategy called for an increased role for the NGO sector in providing community support services for people with mental illness.
- The high percentage growth of the sector mainly reflects the fact that relatively little funding was allocated to non government organisations when the Strategy began. Only 2% of state and territory mental health funding was directed to the sector in 1993, rising to 8.3% in 2008. Most of the growth occurred between 2003 and 2008.
- Approximately 400 non government organisations were involved in delivering services in 2008. The organisations range from very small entities, employing only a few workers, to complex, multi-million dollar organisations.
- States and territories vary in the degree to which they call on the non government sector to provide mental health services. This reflects differences in the way services are organised and delivered, as well as variable funding investment. In some jurisdictions, services provided by NGOs substitute for those formerly provided by the government sector 'clinical services'. In others, NGOs are engaged to provide a number of innovative services, designed to complement rather than replace the government sector.

Clinical staff employed in ambulatory care mental health services per 100,000 population



Funding to non government organisations as a percent of total state and territory spending on mental health services

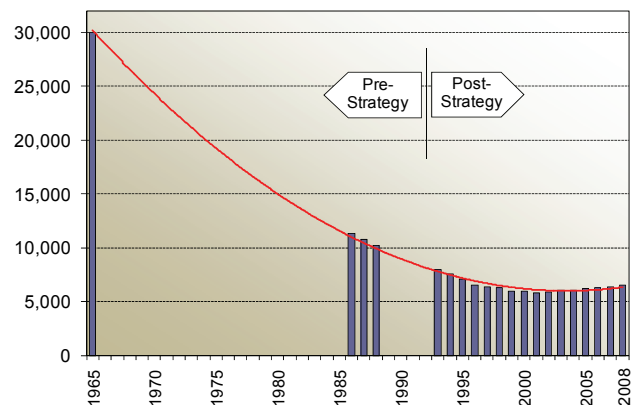


TRENDS IN THE LEVEL AND MIX OF PSYCHIATRIC BEDS

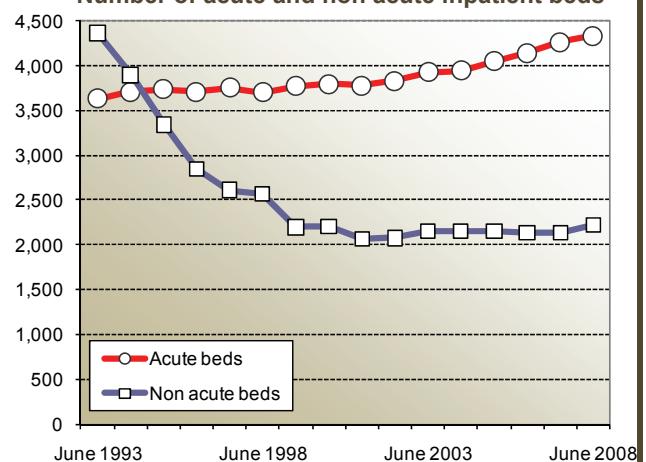
The National Mental Health Strategy entails a commitment by states and territories to reduce the size of stand alone psychiatric hospitals and develop most of their inpatient services within general hospitals. The Strategy calls for each jurisdiction to develop a mix of services appropriate to local population needs. This includes sufficient acute inpatient beds as well as residential services, located in the community, for those who require more intensive or longer term care.

- Extensive reductions in the size of stand alone psychiatric hospitals occurred in the 30 years preceding the National Mental Health Strategy, decreasing the number of beds by about 22,000. Few alternative services were developed to replace the role of the hospitals during this period.
- Reductions in the size of stand alone hospitals continued under the Strategy, with the number of beds decreasing by 63% between 1993 and 2008. By June 2008, stand alone psychiatric hospital beds accounted for only 33% of Australia's total psychiatric inpatient capacity, compared with 73% in June 1993.
- The impact of the reductions has been the loss of about half of the non acute beds (2,144 beds) that were available in stand alone psychiatric hospitals in 1993. The role of these beds was to provide longer term care to people with severe and persistent mental illness.
- In contrast, the overall number of acute beds has increased over the same period (704 beds). The overall number of inpatient beds in fact increased between 2003 and 2008 (478 beds), but this growth simply kept pace with population growth.
- The main change in the delivery of acute inpatient care has been the transfer of this function from stand alone psychiatric hospitals to general hospitals. The number of psychiatric beds located in general hospitals doubled between 1993 and 2008 (2,206 additional beds). By June 2008, 86% of acute psychiatric beds were located in general hospitals compared with 55% in June 1993.

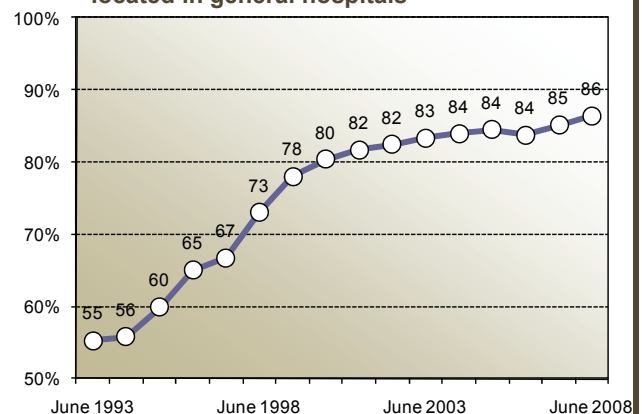
Number of psychiatric inpatient beds:
Pre- and post- National Mental Health Strategy



Number of acute and non acute inpatient beds



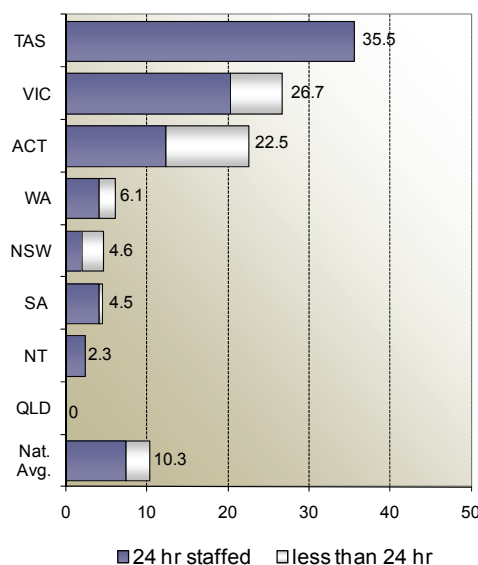
Percentage of acute psychiatric beds
located in general hospitals



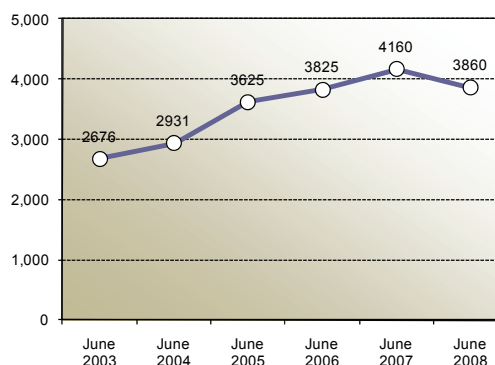
TRENDS IN THE LEVEL AND MIX OF PSYCHIATRIC BEDS

- Development of specialised mental health residential services in the community has not progressed at the same pace.
- These services substitute for the role previously fulfilled by stand alone hospitals. They provide rehabilitation and longer term care in small accommodation units, located in community settings. Residential units are staffed by mental health trained workers, from a few hours up to 24 hours per day.
- 24 hour staffed residential beds have increased by 71% (745 beds) since 1993, equivalent to one third of the reduction in long stay hospital beds. Up to 2005, the growth was mainly the result of initiatives taken by Victoria but more recently, staffed residential services have begun to increase in most other jurisdictions. Alternative models of accommodation support are also being developed by states and territories. For example, the number of supported public housing places increased by 44% between 2003 and 2008.
- When inpatient and residential services are considered together, major disparities are evident between the states and territories in the level and mix of psychiatric beds provided to their populations. At June 2008, there was a three-fold difference across the jurisdictions in the number of available inpatient and 24 hour staffed residential beds.
- Over recent years, all states and territories have experienced increased demand for mental health care right across the health sector, and in particular, for acute inpatient care. Consumers and carers consistently point to these problems as needing urgent attention.
- Difficulties in accessing psychiatric inpatient and residential care is not just a function of the number of beds available. It also depends on the availability of alternative treatment options in the community. These include community crisis services that provide care for people in their own homes, as well as services that assist people after discharge from hospital to reduce the possibility of relapse and readmission.

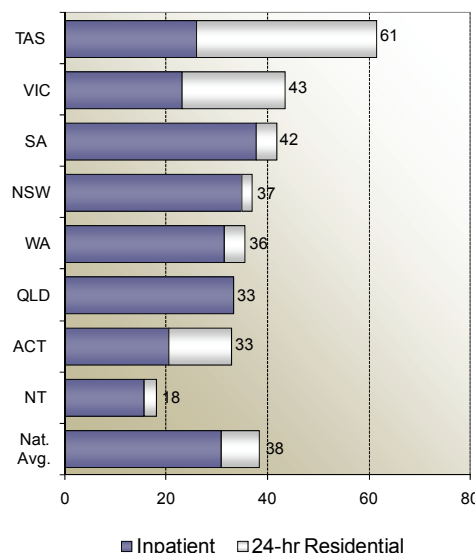
Number of beds in staffed community residential facilities per 100,000 population, June 2008



Number of supported public housing places, June 2003 to June 2008



Total inpatient and 24 hour staffed residential beds per 100,000 population, June 2008

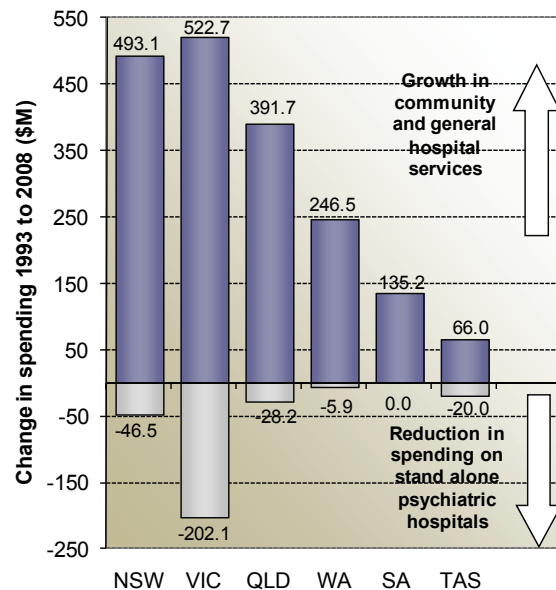


STATE AND TERRITORY INVESTMENT IN SERVICE MIX REFORM

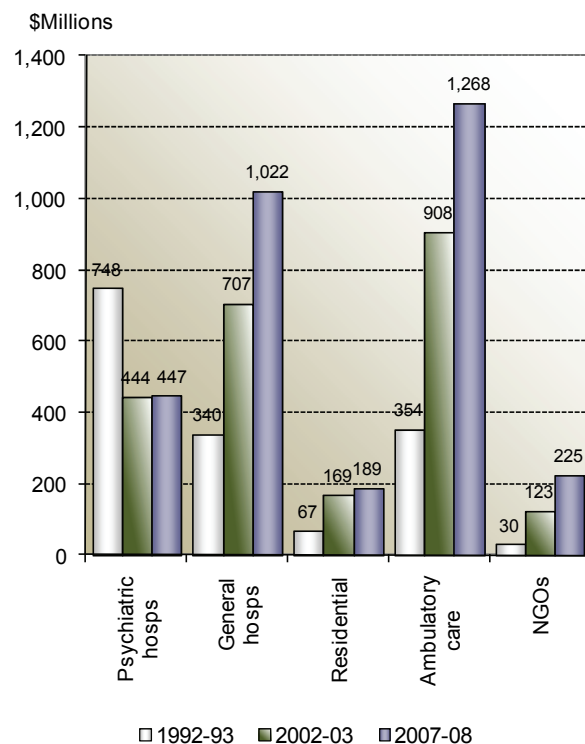
The National Mental Health Strategy has aimed to ensure that savings accrued from the downsizing of stand alone psychiatric hospitals were redirected back to new service development. The National Mental Health Report tracks the progress of each of the states and territories in meeting this commitment.

- The commitment made to re-invest savings from the downsizing of older style psychiatric institutions back into new mental health programs has been met by each of the six states. Stand alone psychiatric hospitals do not exist in the two territories.
- Spending on stand alone psychiatric hospitals in 2008 was \$301 million less than in 1993. These savings have been more than matched by a \$1.9 billion increase in spending on alternative community based and general hospital services.
- Over the life of the Strategy, approximately 15% of the total growth in community based and general hospital services has been funded by savings arising from the reduced spending on stand alone psychiatric hospitals.
- Savings re-invested from the reduction in stand alone hospitals have been backed by significant new state funds, as well as Australian Government funding allocated under the Medicare Agreements (1993-1998) and Australian Health Care Agreements (1998-2003, 2003-2008) to assist in mental health reform.
- About half (48%) of the total increase in spending on new replacement services developed since 1993 was invested in growth of ambulatory care services. Acute inpatient services, located within general hospitals, received approximately one third (36%) of the spending increase, aimed at increasing the number of beds.

Relative change in spending on stand alone psychiatric hospitals and replacement services, 1993-2008



Expenditure on stand alone psychiatric hospitals, community services and general hospital units 1993 and 2008

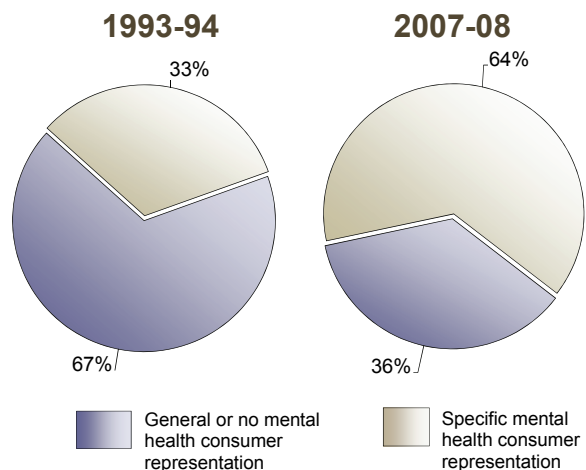


CONSUMER AND CARER PARTICIPATION

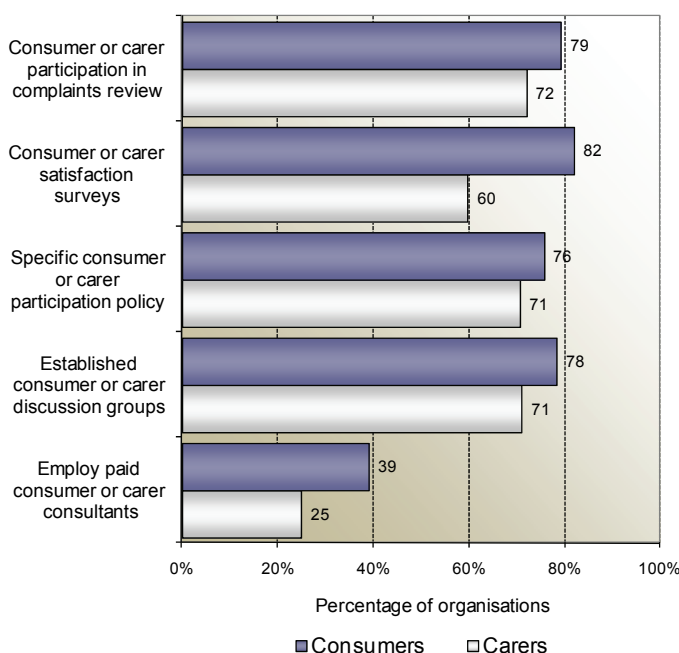
The National Mental Health Strategy advocates the participation of consumers and carers in the planning, delivery and evaluation of mental health services. Accountability to consumers at all levels of the mental health system is necessary to promote improvements in service quality.

- Consumers and carers have been included in all national planning groups established since the Strategy began.
- Commencing in 1994, state and territory mental health service organisations have been surveyed for the National Mental Health Report to determine the extent to which consumers are represented on local decision-making and advisory bodies. By 2008, approximately two-thirds of organisations reported that such arrangements were in place compared with one-third in 1994.
- Beyond this basic requirement, service organisations are more recently being surveyed about other initiatives taken to promote consumer and carer involvement at the service delivery level. The 2008 data suggest that a range of new initiatives is being introduced by organisations throughout Australia.
- Of these, consumers and carers have argued most strongly for the paid employment of people from within their ranks, as consultants to provide support and advocate for their needs. The 2008 data indicates that, across the 221 main service delivery organisations nationally, only 64 consumers and 27 carers (full time equivalents) were employed in this capacity.
- Consumers and carers also argue that, although progress has been made in the structural arrangements for their representation at state and territory and national levels, substantial work remains to create a 'client responsive' culture in mental health services.

Percentage of mental health service organisations with formal consumer participation mechanisms



Percentage of mental health service organisations with other consumer and carer participation mechanisms, 2008

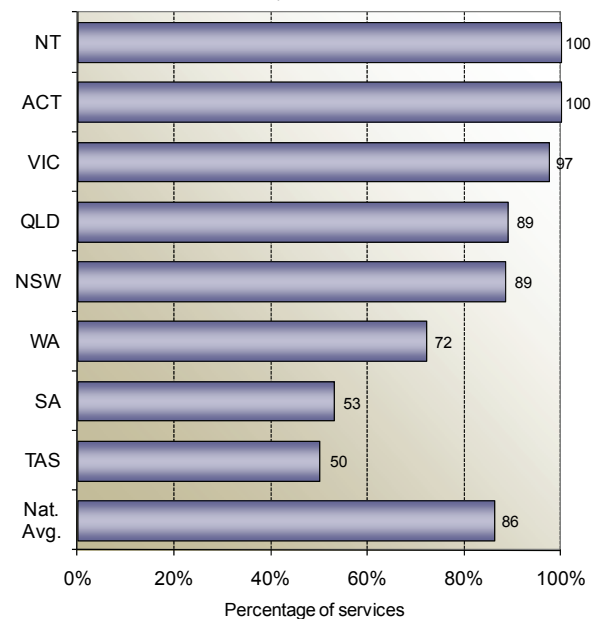


QUALITY AND OUTCOMES IN MENTAL HEALTH CARE

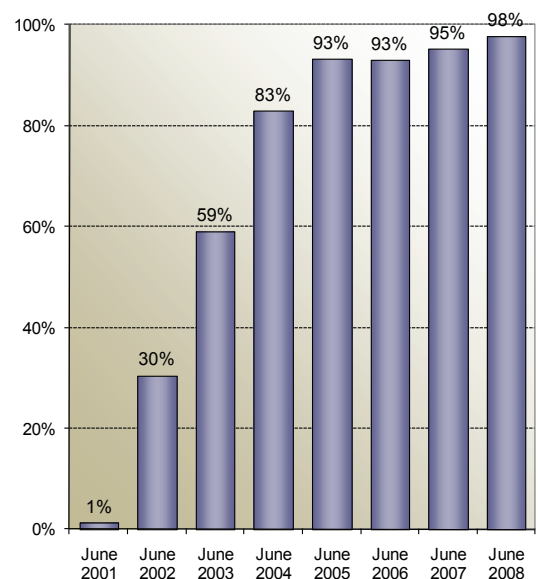
Concern about poor service quality was a major factor leading to the formulation of the original National Mental Health Policy in 1992. The Strategy called for a move from the historical focus on service inputs and structure, to service standards, quality and the outcomes of care. Much of the criticism of mental health services concerns its alleged failures in these areas.

- While much of the effort in the first five years of the Strategy focused on the restructuring of services, developmental work began to lay the foundation for a range of quality improvement activities.
- Two initiatives taken early in the reforms set a course for Australia's mental health services that foreshadowed major change and will take many years to complete – the introduction of service standards and the routine monitoring of consumer outcomes. All jurisdictions have made substantial investments in each of these.
- The National Standards for Mental Health Services were agreed in 1996 as a basis for assessing service quality and continuous quality improvements. All states and territories agreed in 1998 to implement the Standards, but progress was slower than expected. By June 2008, 86% of services had completed the review process. Revised Standards are expected to be implemented over the Fourth National Mental Health Plan.
- Use of standardised measures to regularly monitor the outcomes of care was an objective of the Strategy from the beginning. Australia commenced the process during the Second National Mental Health Plan, by introducing consumer outcome measures into all services and has progressed this work further than any other country.
- By June 2008, 98% of state and territory services had begun collecting and reporting consumer outcomes information.
- In the absence of international precedents, work is ongoing to build use of the information into quality improvement processes that more sharply focuses services on the outcomes achieved with their consumers.

Percentage of mental health service organisations completing external review against the National Standards for Mental Health Services, June 2008



Percentage of public mental health system collecting and reporting consumer outcome measures, 2001 to 2008



PART B

**Monitoring the National
Mental Health Strategy**

1. Overview of the Strategy

At the time of releasing this report, Australia is in its first year of the Fourth National Mental Health Plan, a new five-year plan under the National Mental Health Strategy.

Commencing in April 1992 with the endorsement by Health Ministers of a National Mental Health Policy, the National Mental Health Strategy committed governments to undertake action within their respective jurisdictions, as well as to collaborate on policy and service development issues requiring a national focus. This was the first attempt in Australia to set a common course of action by governments in the development of public mental health services which had been the exclusive responsibility of the eight state and territory governments since Federation.

The National Mental Health Strategy has steered a changing reform agenda over time, reflecting the evolution of mental health policy considerations in Australia.

- The First National Mental Health Plan (1993 to 1998) was developed in parallel with the National Mental Health Policy and focused primarily on state and territory mental health services. The First Plan advocated major structural reform of state and territory service systems, with emphasis on decreasing the reliance on stand alone psychiatric hospitals, expanding community based care alternatives and 'mainstreaming' the delivery of acute inpatient care into general hospitals.
- The Second National Mental Health Plan (1998 to 2003) continued the work of the First Plan toward structural reform but introduced new areas for action, covering mental health promotion, illness prevention and destigmatisation. In contrast to the First Plan's focus on severe and disabling mental illnesses that are principally the responsibility of the states and territories, the Second Plan responded to the growing evidence of the widespread prevalence of more common mental health problems in the community, particularly anxiety disorders and depression. The Second Plan was also instrumental in adding a national policy focus to the need for partnerships within the health sector, between public and private specialist services and primary health care providers, and

between health services and the broader system of human services.

- The Third National Mental Health Plan (2003 to 2008) set out to consolidate the achievements of the previous two plans by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to improve the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Alongside these national activities, states and territories have developed their own mental health plans that have reflected the goals and principles of the national approach, but tailored to meet local requirements.

Both the Second and Third Plans emphasised the importance of cross sectoral partnerships in supporting mental health and wellbeing, and the need to respond to mental illness through a whole of government approach. These themes were elevated as priorities by the agreement in July 2006 of the Council of Australian Governments (COAG) to a *National Action Plan on Mental Health 2006-2011*. The Action Plan (described in next section) was developed between governments to give further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the various National Mental Health Plans.

More recently, the Strategy was extended through a new National Mental Health Policy, endorsed by Health Ministers in December 2008. The new policy carries forward the central tenets of the previous policy but updates elements to more closely align with the whole of government approach articulated within the COAG National Action Plan.

The 2008 policy aims to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- reduce the impact of mental health problems and mental illness, including the effects of

stigma on individuals, families and the community;

- promote recovery from mental health problems and mental illness; and
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

In November 2009, Health Ministers endorsed a Fourth National Mental Health Plan that specifies priorities for collaborative government action over the period 2009 to 2014. The Fourth Plan identifies 32 reform actions to be undertaken across five priority areas over the 2009 to 2014 period (Figure 1).

A summary of key milestones in the life of the National Mental Health Strategy is shown in Figure 2.

Framework for national action

This report is being released at a time of significant reform of the Australian health system that will involve fundamental changes to the responsibilities of governments for the funding and delivery of health services. These changes will be implemented progressively over the next few years and will impact on the delivery of mental health care. In this context, it is important to highlight that the framework described here reflects the arrangements that were in place for the period covered by this report (1993-2008) and may undergo change in coming years arising from the broader health policy reforms.

From its inception, the National Mental Health Strategy has been premised on an understanding of the complementary but different roles of the Australian Government and the states and territories. Traditionally, the states and

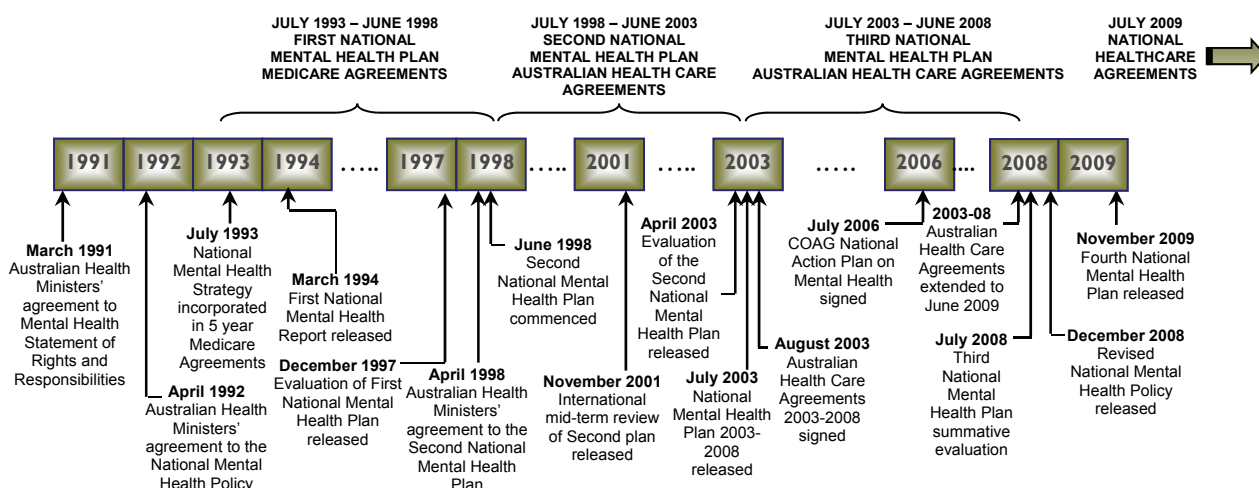
Figure 1: Fourth National Mental Health Plan - priority areas for collaborative government action 2009-2014

Priority Areas identified in the Plan
1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality improvement and innovation
5. Accountability – measuring and reporting progress

territories have been responsible for the funding, delivery and management of specialised public mental health services, including both community based services and hospital care, targeted mainly at people who have severe mental illnesses.

Complementing these services, the Australian Government directly funds a range of services for people with mental illness through the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and programs administered by the Department of Health and Ageing and the Department of Veterans' Affairs. The role of the Commonwealth in funding mental health care expanded substantially as a result of the COAG National Action Plan on Mental Health, following an investment of \$1.9 billion over the 2006-11 period. New programs and services introduced include access to Medicare subsidised primary mental health care and a range of community support programs managed through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). The impact of this expansion in Commonwealth funded services began to take effect in 2006-07, towards the end of the Third National Mental Health Plan.

Figure 2: Milestones in the development of the National Mental Health Strategy



In addition, a range of mainstream programs and services is also funded by the Australian Government, which provides essential support for people with a mental illness. These include income support, social and community support services, disability services, workforce participation programs, and housing assistance.

A key role of the Australian Government is to provide leadership in guiding mental health reform activities identified under the Strategy. The Australian Government also monitors the reform process and disseminates information that will contribute to national goals. Preparation of the National Mental Health Report has been the central mechanism for this to be achieved.

As the main source of both funding and service delivery over the period covered by this report, the states and territories have occupied the central position in Australia's mental health system. Accordingly, much of the focus of the report is on their activities in implementing the agreed reforms.

In setting up the National Mental Health Strategy, Australian Health Ministers required that the reform process be progressed in partnership between all governments by the establishment of a National Mental Health Standing Committee, reporting through the Australian Health Ministers' Advisory Council.

The Standing Committee acts as a forum to provide direction on the implementation of the Strategy. Each state and territory and the Australian Government is represented, as are consumers and carers. Membership has also been expanded to include representatives of the Mental Health Council of Australia, the Private Mental Health Alliance (previously known as the Strategic Planning Group for Private Psychiatric Services), and the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs and the Department of Veterans' Affairs. The New Zealand Ministry of Health is represented as an official observer.

Funding under the National Mental Health Strategy

The Australian Health Care Agreements (1998-2003 and 2003-2008) and previously, the Medicare Agreements (1993-1998), have provided the main funding vehicle for implementing the National Mental Health Strategy. Bilaterally negotiated between the

Australian Government and each of the state and territory governments, the Agreements required the states and territories to commit to undertake reform of their mental health services in the directions advocated by the Strategy, in return for funding.

Under the Agreements covering the period 1993 to 2008, the Australian Government allocated \$856 million (in 2008 prices) to the states and territories specifically tagged to assist in their reform efforts.

2. Council of Australian Governments National Action Plan on Mental Health 2006-2011

In July 2006, the Council of Australian Governments agreed to the National Action Plan on Mental Health 2006-2011, recognising the need for a change in the way governments respond to mental illness. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non government providers, aimed at building a more connected system of health care and community supports for people affected by mental illness.¹

The Action Plan represented an important milestone in the development of mental health services in Australia. For the first time, heads of governments focused on the issue of mental health and agreed to a national plan of action to reform mental health services. Backing this agreement, a total of \$4.1 billion was committed to a wide range of initiatives over the 2006-11 period.

The Action Plan outlined a series of initiatives to be implemented between 2006 and 2011, described in Individual Implementation Plans prepared by each government. A total of 145 separate initiatives were described in the implementation plans. A network of state-based mental health groups was established to coordinate the work, both across sectors and between governments.

While most of the Action Plan initiatives represented additional commitments to expand ongoing programs, many were new and took the delivery of services for people with mental

illness into areas beyond the boundaries of traditional health care. Key human service programs operating outside the health system with major responsibilities under the Plan include housing, employment, education and correctional services. Additionally, the initiatives funded under the Plan emphasised the role of the non government sector in the delivery of a wide range of community support services. These provide the services needed by many people affected by mental illness, complementing the role of health services.

The Plan identified five 'action areas' for combined government action, with specific policy directions within each area. The action areas provide an organising framework for grouping and understanding the relative investments by governments. Governments also committed to four outcomes by which the success of the Plan can be assessed. The action areas and outcomes are summarised below (Figure 3).

Heads of governments agreed to annual reporting and monitoring of the implementation of the Action Plan with responsibility for this function assigned to Health Ministers. Copies of the most recent annual reports can be found on the COAG website (address below).

As part of the April 2010 agreement on national health system reforms, COAG committed to further consider mental health reforms in 2011, including the allocation of roles and responsibilities in the mental health sector.

Figure 3: COAG National Action Plan on Mental Health - agreed action areas and outcomes

Action areas agreed in the COAG Plan	Agreed outcomes
<ul style="list-style-type: none"> Promotion, prevention and early intervention 	<ul style="list-style-type: none"> Reducing the prevalence and severity of mental illness in Australia
<ul style="list-style-type: none"> Integrating and improving the care system 	<ul style="list-style-type: none"> Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent long term recovery
<ul style="list-style-type: none"> Participation in the community and employment, including accommodation 	<ul style="list-style-type: none"> Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention
<ul style="list-style-type: none"> Increasing workforce capacity 	<ul style="list-style-type: none"> Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation
<ul style="list-style-type: none"> Coordinating care ('Coordinating care' and 'Governments working together') 	<ul style="list-style-type: none"> Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

¹ The Action Plan is available at <http://www.coag.gov.au>

3. Estimating Australia's needs for mental health care

Planning services, allocating resources and evaluating the overall effectiveness of the Strategy require knowledge about the extent of mental health problems in the Australian population. Information is also required about how these problems affect peoples' lives, particularly in terms of their need for mental health care.

Measures of the extent and impact of mental disorders in Australia were not available at the commencement of the Strategy. Recognising the importance of this information, a series of major epidemiological surveys was undertaken in 1997 and 1998. These comprised three studies – one for adult Australians from the age of 18 years, one for children and adolescents within the 4 to 17 year age range, and one in relation to 'low prevalence disorders', such as schizophrenia and bipolar illness. The survey of adults - referred to as the National Survey of Mental Health and Wellbeing (NSMHW) – was repeated in 2007 to gather an updated picture on Australia's mental health, and covered the 16 to 85 year age range.

The findings from these surveys highlighted that mental health issues reach into the fabric of Australian society, and for many, into our own families. As in other Western countries, mental illness is common in the Australian population.

Prevalence of mental illness in the population

'Mental illness' is a term describing a diverse range of behavioural and psychological conditions. The most common illnesses are anxiety, affective (mood) and substance use disorders. Results from the 2007 survey, conducted by the Australian Bureau of Statistics (ABS), indicated that one in five (20%) Australians aged 16-85 years experienced one of these more common mental illnesses in the preceding 12 months, equivalent to 3.2 million people.

One-quarter experience two or more conditions at the same time. These results are broadly comparable to the findings from the first ABS survey conducted in 1997, pointing to the

relative stability in patterns of mental illness in the Australian community over the decade.^{2,3}

Prevalence rates vary across the lifespan and are highest in the early adult years, the period during which people are usually establishing families and independent working lives. The 2007 ABS survey found that the prevalence of mental illness for people in the 16 to 24 year age range (26%) is one third higher than the average for the overall adult population. This finding is consistent with 1997 results, and highlights the need to strengthen early intervention services that target younger Australians.

Mental illness also includes 'low prevalence' conditions. In addition to schizophrenia, bipolar disorder and other psychoses, the low prevalence conditions include a range of other conditions such as eating disorders, and severe personality disorder. These were not specifically counted in either the 1997 or 2007 ABS surveys of adults but are estimated to affect another 2-3% of the adult population.⁴

Within this group, an estimated 0.7% of the population have a psychotic illness, based on the 1998 survey of low prevalence disorders. The survey found that in each month, approximately 58,000 adults were in contact with mental health services because of psychotic illness. Of these, about 40,000 were diagnosed with schizophrenia, with most of the remainder having a severe mood disorder.⁵ Psychotic illnesses are frequently very disabling, extending over long periods of the person's life. For a high proportion of people covered in the 1998 survey, their psychotic illnesses had been

² Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing: Summary of Results*. ABS Catalogue No. 4326.0. ABS, Canberra.

³ Slade, T, Johnston A, Teesson, M et al (2009) *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Department of Health and Ageing, Canberra.

⁴ Andrews G, Henderson S, Hall W (2001) Prevalence, comorbidity, disability and service utilisation. Overview of the Australian National Mental Health Survey, *British Journal of Psychiatry*, 178, 145-153.

⁵ Jablensky A, McGrath J, Herrman H, et al (2000) Psychotic disorders in urban areas: an overview of the study on low prevalence disorders, *Australian and New Zealand Journal of Psychiatry*, 34, 221-236.

continuous, without remission, for an average of 15 years since the first onset of symptoms. Psychotic illnesses are the traditional focus of state and territory mental health services and account for most of the costs of specialised mental health care in Australia.

The Australian child and adolescent survey conducted in 1998 found that 14% of children and young people (or 500,000 persons) are affected by mental disorders within any six month period. This includes about 93,000 with anxiety or depression, 200,000 with aggressive behaviour and another 93,000 with attention disorders.^{6,7,8}

For most people, the mental illness they experience in adult life has its onset in childhood or adolescence. The ABS 2007 survey of adults found that, of those in the 16-85 age range who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age.⁹

Services for people with a mental illness

Mental health care is delivered by a mixture of health service agencies, covering primary health care and specialised service sectors, and public and private providers.

The 2007 ABS survey found that only 35% of people aged 16 to 85 years experiencing a mental illness seek assistance from a health service. The proportion of Australians experiencing mental illness who access care has been estimated to be half that of comparable physical disorders.¹⁰ Similar estimates have been reported in overseas studies.¹¹

⁶ Sawyer M, Arney FM, Baghurst PA et al, (2000) *The Mental Health of Young People in Australia*, Australian Government Publishing Service, Canberra.

⁷ Rey J M (2001), The mental health of young Australians, *Medical Journal of Australia*, 174, 380-381.

⁸ The Australian survey of children and adolescents estimated prevalence rates over a 6 month period.

⁹ Australian Health Ministers Conference (2009) *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*. Commonwealth of Australia, Canberra.

¹⁰ Andrews et al (2006) Evidence-based medicine is affordable: The cost effectiveness of current and optimal treatment for rheumatoid arthritis and osteoarthritis. *Journal of Rheumatology*, 33, 671-680.

¹¹ Kessler RC et al (1994), Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States, *Archives of General Psychiatry*, 51, 8-19.

When the ABS survey findings are scaled to the total population, they suggest that 2.1 million adult Australians experienced the symptoms of a mental illness in 2007 but received no health care for their conditions. These rates are similar to those observed in 1997 and highlight that the potential demand for mental health care is high and not being met by either the specialist or general health system.

Treatment rates varied according to the severity of the person's condition and type of disorder. Approximately two thirds (64%) of those with disorders classified as severe according to the ABS methodology received some level of health care. About 39% of people with moderately severe disorders and only 17% of people with milder (but still clinically significant) disorders were found to receive mental health care. People with an affective disorder (mainly depression) were more likely to have received services for their condition than those affected by one of the various anxiety disorders (59% and 38% respectively).

Of those who seek help for a mental disorder, the majority (71%) consult their general practitioner. Recent data suggest that mental health problems account for approximately 8% of all problems managed by general practitioners and are a presenting feature in about 11% of all attendances.¹² Most of those consulting a GP for a mental health problem also saw a mental health professional (psychologist, psychiatrist or another allied health professional). The proportion of those with a mental illness who saw a mental health professional in 2007 was almost double that found in the 1997 survey, reflecting the increased availability of mental health care within primary care settings.

The burden of mental illness

Recognition of the extent to which mental illness contributes to overall ill health and its economic implications have increased substantially in recent years. Although mental disorders account for only 1% of deaths, they are responsible for an estimated 11% of disease burden worldwide. The World Health Organisation projected that this will rise to 15%

¹² Australian Institute of Health and Welfare (2009), *Mental Health Services in Australia 2006-07, Mental health series no.11. Cat no. HSE 74. Canberra: AIHW*

by the year 2020.¹³ Within Australia, the Australian Institute of Health and Welfare reported that mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability). This has major impact on youth and people in their prime adult working years.¹⁴

The 2007 ABS National Survey of Mental Health and Wellbeing also provided evidence of the extent to which mental disorders are associated with overall disability in Australian adults. Forty two per cent of the approximate half a million Australians who have a profound or severe disability were found to have a current mental illness. These figures are consistent with data reported by the Department of Families, Housing, Community Services and Indigenous Affairs, which indicate that, of the 732,000 people on Disability Support Pensions (DSP) in June 2008, 28% (approximately 202,000 people) had a psychiatric or psychological condition recorded as their primary condition.¹⁵ This group has been growing in number by an annual average of 5% since 2001, at more than twice the rate of overall growth in DSP recipients. Based on the June 2008 data, for every 1,000 adults of working age, 13 are on a disability pension due to mental illness.

The economic cost of mental illness in the community is high. As presented later in this report, outlays in 2007–08 by governments and health insurers on mental health services totalled \$5.32 billion, and represented 7.5% of all government health spending. These figures reflect only the cost of operating the mental health service system. An additional \$4.63 billion was spent by the Australian Government in providing other support services for people with mental illness, including income support, housing assistance, community and domiciliary care, and employment and training opportunities.

¹³ World Health Organisation (2001) *The World Health Report 2001: Mental Health – New Understanding, New Hope*. World Health Organisation: Geneva.

¹⁴ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD (2007). *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: AIHW.

¹⁵ Department of Families, Housing, Community Services and Indigenous Affairs (2009), *Characteristics of disability support pension customers*, June 2008, Commonwealth of Australia, Canberra.

What the information means for Australia's mental health strategy

These estimates provide the context for reviewing the progress of governments in improving mental health care of the Australian population. The personal, social and financial costs associated with mental illness are substantial and unlikely to be reduced by treatment interventions alone. Integrated, whole of government strategies are needed that embrace both prevention and treatment concepts.

The COAG National Action Plan on Mental Health, and the more recent revised National Mental Health Policy and Fourth National Mental Health Plan, were developed to respond to the whole of government challenge. Through each of these documents, governments have committed to a series of individual and collaborative actions over the next two to five years.

Arguably, the most striking finding to emerge from the various population surveys is the gap between the level of mental illness in the community and the proportion of the population who receive help from the health system. The COAG Action Plan recognised that improving rates of treatment for people with mental illness will require concerted action and substantial additional funding to increase the capacity of current services. New funding was allocated by the Australian Government under the initiative *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Scheme* to provide Medicare subsidised access to services delivered by psychologists and clinical psychologists, along with other changes to strengthen the role of GPs in mental health care. This initiative commenced in November 2006. Early results are covered in this report (see Section 7).

Additional population surveys are necessary to build a strong evidence base to inform future mental health policy. To this end, a second national survey of 'low prevalence' mental illnesses commenced in 2009 with findings expected to be available in 2011. Planning work has also commenced for a second national survey of the child and adolescent population.

4. The role of the National Mental Health Report

In agreeing to the National Mental Health Strategy, Health Ministers recognised that an important aspect of the reform process was to ensure that progress is monitored and publicly reported. This has been achieved through two mechanisms:

- the development of nationally agreed measures of performance in relation to the objectives of the Strategy and continued reporting of progress against these in the National Mental Health Report; and
- independent evaluations of each five-year National Mental Health Plan.

The National Mental Health Report was prescribed as one of the responsibilities of the Australian Government under the First and Second National Mental Health Plans and is prepared by the Department of Health and Ageing. Its purpose is to:

- present relevant information about the resources that underpin mental health service delivery (human and financial), their funding sources and how those resources are being applied to achieve the national reform aspirations;
- monitor changes that have taken place in the provision of specialised mental health services;
- act as an information resource on the state of mental health services in Australia, for use by a range of interested parties; and
- improve community understanding of the reform of Australia's mental health services.

Few national policy areas in Australia are subject to an equivalent level of reporting and accountability as required under the National Mental Health Strategy.

The first National Report covered the 1992-93 financial year and presented 'baseline' data against which progress of the Strategy could be evaluated. Subsequently, 10 further reports were released, presenting updated data in each issue to monitor progress under the Strategy.

With each edition, the ability to define, count and report mental health information improves. Accordingly, the current report updates

information from previous editions, particularly with respect to financial reporting. As each report is intended to supersede earlier versions, content from previous years has been retained in the current report where it is appropriate and accurate.

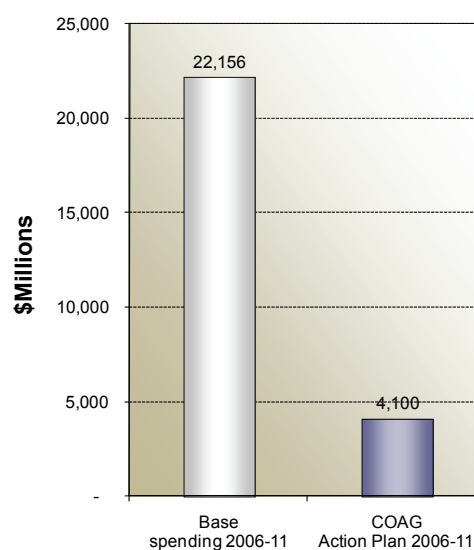
Relationship to COAG National Action Plan monitoring

As noted earlier, heads of governments agreed to annual reporting on progress of the COAG Action Plan. The COAG annual reports chart progress made under the Plan, and monitor the extent to which the agreed initiatives are taking place. The COAG annual reports are tied specifically to the initiatives announced by governments under the Plan.

The National Mental Health Report predates the new COAG reporting arrangements and plays a different role. It tracks spending across the full range of specialised mental health services and covers base spending in programs, along with expenditure on new initiatives or expansion of base programs.

The relative scope of the COAG Action Plan and the National Mental Health Report is shown in Figure 4. Projected over the five year period

Figure 4: Cumulative projected 'base' spending and COAG Action Plan expenditure on mental health, 2006-2011



Note:

1. 'Base spending' is projected on the basis of total 2005-06 spending on mental health.
2. COAG Action Plan: \$4.1 billion represents the combined value of all commitments included in the COAG National Action Plan when signed by heads of government on 14 July 2006, and does not include additional commitments that have been subsequently announced by most jurisdictions.

2006-11, the COAG Action Plan initiatives (\$4.1 billion) will represent approximately 16% of total spending on mental health (projected at \$22.1 billion). While the COAG National Action Plan annual reports will monitor the progress of the new initiatives that make up the \$4.1 billion over the 5 years, the key function of the National Mental Health Report is to monitor the extent to which base commitments pre-dating the Action Plan are maintained.

Reporting period

This publication is the eleventh in the National Mental Health Report series and incorporates the most recently available data, covering the 2007-08 year. The focus of the report is on progress of the Strategy across the period 1993 to 2008, covered by the First, Second and Third National Mental Health Plans. As such, it completes 15 years of reporting on progress of the National Mental Health Strategy.

Methodology

Data collection methodology was substantially the same as for previous years. Information was obtained from five sources, summarised in Figure 5. Each of these is described below.

The emphasis in data collection is on *specialised mental health services*, defined as those which have as their primary function the provision of treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability. A wide range of general health and community support services used by people with mental illness are not included in the data analysis. The only exception to this principle is that estimates are included in Australian Government expenditure of the extent to which mental health services are provided by general practitioners.

State and territory mental health services – National Minimum Data Set Mental Health Establishments collection

The National Minimum Data Set (NMDS) – Mental Health Establishments collection commenced in 2005-06, continuing a data collection that had been in place for state and territory mental health services since 1994 (the National Survey of Mental Health Services). The former national survey was undertaken by the Commonwealth Department of Health and Ageing through a paper-based collection system distributed to all state and territory funded mental health services. It was replaced in

2005-06 by the new NMDS, reported electronically by states and territories. All data processing of the Mental Health Establishments data was undertaken by the Australian Institute of Health and Welfare, under contract to the Department of Health and Ageing.

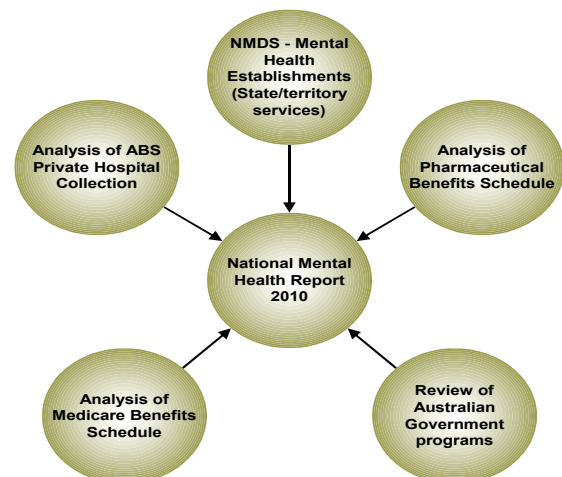
The former national survey and more recent Mental Health Establishments collection provide the primary means for monitoring state and territory government progress. While some differences were introduced as part of the transition from the former survey to the new NMDS, the collections are largely comparable and allow continuous time series monitoring.

The collection requires each state and territory funded mental health service organisation to report a wide range of information about the services it provided over the preceding year. Information collected includes expenditure, service mix, workforce, activity levels including patients treated, and arrangements for consumer and carer participation. Additionally, state and territory central and regional administrative offices are required to separately submit information on their mental health expenditure, including grants made to non government organisations. The data collected is at a level of detail that is designed specifically to accommodate variations in the organisational arrangements existing in the public mental health sector. It has few international counterparts.

Approximately 220 public sector health organisations provided data to the 2008 Mental Health Establishments collection.

For all years, detailed validation processes were applied to the national data to ensure accuracy

Figure 5: National Mental Health Report 2010 - Information sources



of the information presented in the National Mental Health Report. The validation entails two broad steps:

- *Cross-sectional analysis:* Data submitted by each organisation for any given year was reviewed against three criteria: compliance (the extent to which instructions and definitions have been followed), consistency (the degree to which the organisation's data returns are internally consistent) and credibility (the face validity of each organisation's data in the context of the types of services and programs reported).
- *Longitudinal analysis:* Longitudinal validation aimed to ensure consistency in the methods of counting and reporting across data collection years. The main focus was on expenditure, to distinguish genuine growth in spending from differences that simply result from changes in accounting or reporting methods. To achieve this, all data submitted by each organisation were compared with data reported in previous years to identify anomalies or possible changes in accounting methods.

For the current report, as in previous years, where the validation process identified expenditure growth to be attributable to changed accounting practices, or found errors in the previous years' data submitted by organisations, adjustments have been made to the historical time series. In all cases where apparent expenditure growth could be attributed to better recording practices, data for earlier years has been updated. The figures reported in this report may therefore differ from those published previously.

Details about the former National Survey of Mental Health Services validation approach used are available in Appendix I of the 2007 National Mental Health Report. Further information about the NMDS – Mental Health Establishments collection is provided in the AIHW Mental Health Services in Australia report¹⁶.

Analysis of Medicare Benefits Schedule data

Information about Medicare benefits paid by the Australian Government for Consultant Psychiatrist services, general practitioners and

allied health professionals was prepared by the Department of Health and Ageing. The information builds upon baseline figures first reported in the 1994 National Report and, for Consultant Psychiatrists, provides trends over the 22 year period 1984-85 (the year of commencement of Medicare arrangements) to 2007-08. Data for allied health professionals is more recent and begins in 2006-07, the commencement year for the *Better access to psychiatrists, psychologists and general practitioners* initiative.

Analysis of Pharmaceutical Benefits Scheme data

Similarly, information about Australian Government outlays for psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme was prepared by the Department of Health and Ageing.

Analysis of the Australian Bureau of Statistics Survey of Private Hospitals

The Australian Bureau of Statistics provided information extracted from its 2006 and 2007 Private Hospitals Establishments Collection. This was used to compile a picture of psychiatric services provided through the private hospital sector. Details of the approach used are provided in Appendix 10.

Review of other Australian Government programs and related activities

Australian Government departments responsible for services to assist people affected by mental illness also provided information about their activities. This included, in particular, the Department of Veterans' Affairs in relation to the health care programs it funds for war veterans and their families, and the Department of Families, Housing, Community Services and Indigenous Affairs.

Structure of the Report

The report is presented in five parts.

- Part A provides a high level overview of the main trends over the course of the National Mental Health Strategy between 1993 and 2008.
- Part B sets the context by describing the National Mental Health Strategy and the role of the National Mental Health Report.
- Part C comprises the main body of the report and provides the 2008 update on

¹⁶ www.aihw.gov.au/publications/index.cfm/title/10686

trends in national spending on mental health, structural changes within state and territory public sector mental health services, developments in the private sector and updated information on the participation of consumers and carers in the mental health system.

- Part D presents summary information covering expenditure, workforce, service mix and levels for each of the states and territories.
- Part E contains the Appendices that provide the detailed source data used for this report.

PART C

**Progress in reform of
Australia's mental
health services**

5. National spending on mental health

Public reporting on the level of spending on mental health services has been a central function of the National Mental Health Report since its first release in 1994. All governments agreed under the First National Mental Health Plan to maintain expenditure on specialised mental health services at least at the level it was at the beginning of the Strategy, and to review annually whether this is occurring. This commitment was last renewed under the Australian Health Care Agreements 1998-2003, covering the period of the Second National Mental Health Plan.

Regular monitoring of the relative contributions of the main funding authorities responsible for mental health services also serves as a check against the possibility that the reform process may simply lead to shifts of financial responsibility from one funder to another, rather than any overall growth in services. This was a concern expressed by advocacy groups at the outset of the Strategy.

This section of the report provides an overview of 2007-08 spending on mental health services within the context of information about spending patterns since the National Strategy began.

Total spending on mental health services 2007-08

Total spending on mental health services by the major funders in Australia in 2007-08 was \$5.32 billion, a 10% increase in real terms above the previous year. Spending on mental health services and related activity represented approximately 7.0% of national (government and

other) total gross recurrent expenditure on health services, and 7.5% of government health spending.¹⁴ These figures have remained relatively stable over the course of the National Mental Health Strategy.

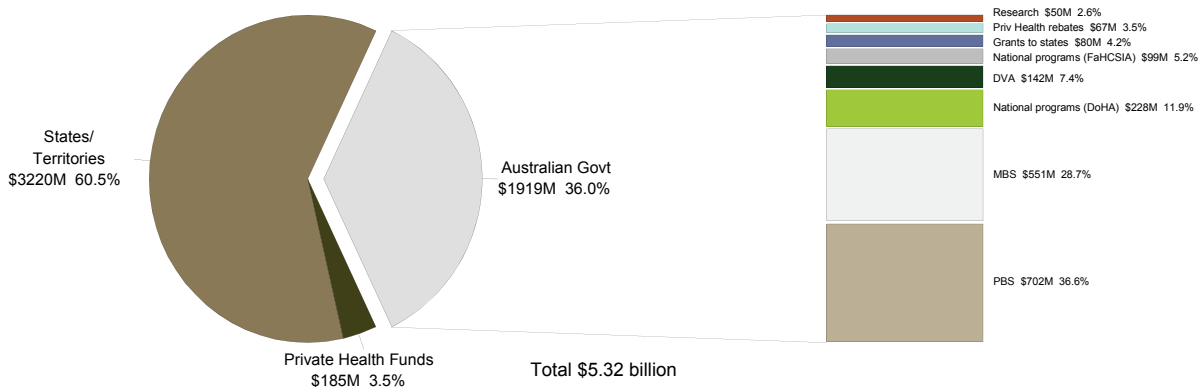
The major funders are the Australian Government, state and territory governments and private health insurers. Their contributions are summarised in Figure 6. Collectively, state and territory governments continue to play the largest role in specialised mental health service delivery, as they are primarily responsible, either directly or indirectly, for the delivery and management of most services. They are the main focus of this report.

The Australian Government is the largest single funder and was responsible for more than one-third (36%) of total spending in 2007-08. It provides funding for a range of services and programs but does not manage these services directly. Figure 6 also provides a breakdown of Australian Government funding streams.

How Australia's 2007-08 spending was invested

Hospital services administered by state and territory governments accounted for the largest share of total national spending (28%). This was followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Schemes (14%). Figure 7 summarises the national pattern of mental health spending in 2007-08.

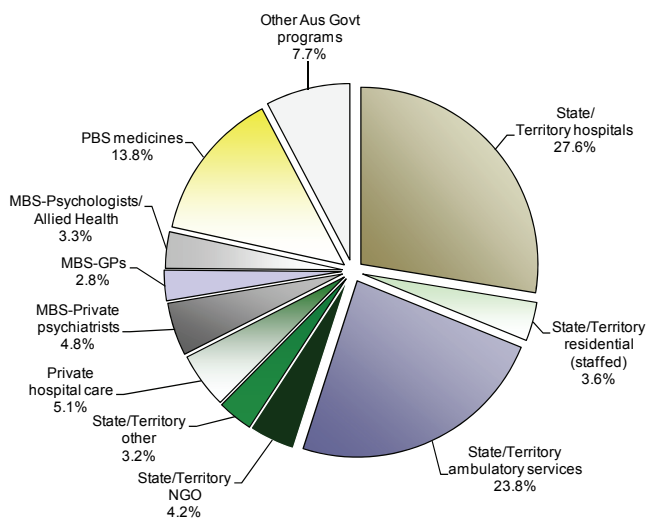
Figure 6: Distribution of recurrent spending on mental health, 2007-08



¹⁴ Based on Australian Government analysis of data published in *Health Expenditure in Australia 2007-08*, Australian Institute of Health and Welfare, September 2009, Cat No. HWE 46

The calculation of the proportion of total health expenditure directed to mental health includes only government and private health insurance revenue sources.

Figure 7: National spending on mental health, 2007-08



National spending trends 1993-2008

Annual recurrent expenditure on mental health services by the major funding authorities has increased by 130% over the course of the Strategy between 1993 and 2008. Growth occurred in the three funding streams to varying extents (Figure 8).

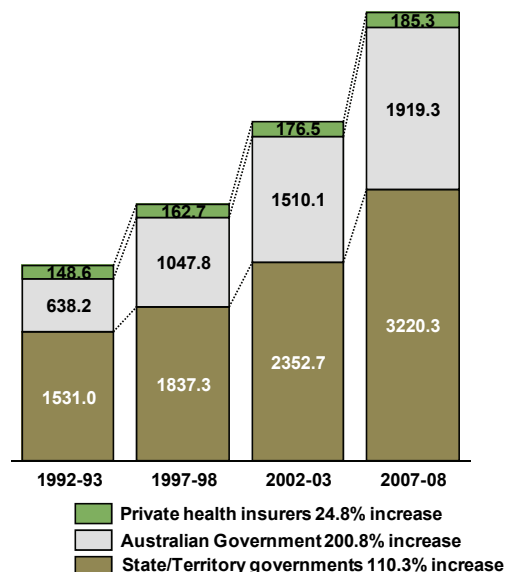
- Combined state and territory funding increased by 110% or \$1.7 billion.
- Australian Government expenditure increased by 201% or \$1.3 billion.
- Spending by private health funds increased by 25% or \$37 million.

Annual growth in overall mental health expenditure has averaged 5.7% over the course of the Strategy, and been relatively even over the three 5-year periods of each National Mental Health Plan (Table 1). Growth in 2007-08 (10.3%) was the largest annual increase over the 15 year period, driven largely by the commencement of new and expanded services

Table 1: Average annual percentage growth in mental health spending over the course of the National Mental Health Strategy 1993-2008

First National Mental Health Plan 1993-1998	5.6%
Second National Mental Health Plan 1998-2003	5.8%
Third National Mental Health Plan 2003-2008	5.7%
All Plans 1993-2008	5.7%

Figure 8: National expenditure on mental health by source of funds, 1992-93 to 2007-08 (\$millions)



committed by governments under the 2006 COAG National Action Plan on Mental Health.

In per capita terms, national spending on mental health increased from \$132 per head of population to \$251 over the 15 year period (Table 2).

Looking at government spending only (Australian Government, states and territories), recurrent expenditure on mental health increased by 137% between 1992-93 and 2007-08, averaging 5.9% growth per year (Figure 9). This has kept mental health expenditure in step with increases in government health spending as a whole. Government expenditure on all health services increased by 120% over the same period, averaging 5.4% per year. In this respect, mental health has increased its position in terms of relative spending within the overall health sector, but only marginally.

Table 2: Total per capita spending on mental health by funding source, 1992-93 to 2007-08 (dollars)

	1992-93	1997-98	2002-03	2007-08
State and territory governments	87.08	98.73	119.00	151.63
Australian Government	36.30	56.31	76.38	90.37
Private health insurers	8.45	8.74	8.93	8.73
Total	131.83	163.78	204.31	250.73

Figure 9: Percentage growth in government recurrent health expenditure and mental health expenditure, 1992-93 to 2007-08

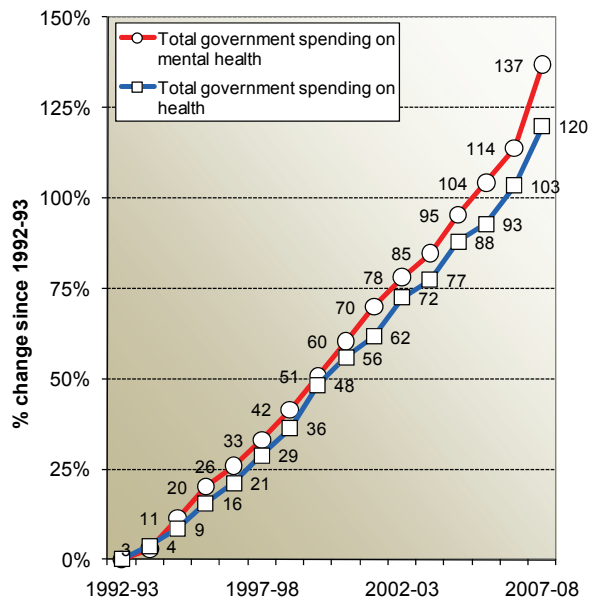
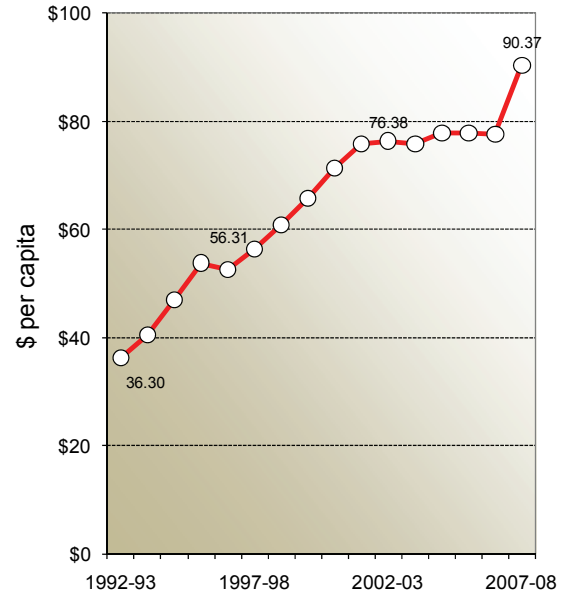


Figure 10: Australian Government per capita expenditure on mental health, 1992-93 to 2007-08 (dollars)



Australian Government expenditure

The Australian Government share of national spending on mental health increased from 27% to 36% over the 1993-2008 period, due to a combination of growth in new activities and programs and increases in existing services. Following a 137% increase in annual spending in the first decade of the Strategy, growth slowed during the early part of Third National Mental Health Plan, but then increased sharply in the

final year (2007-08), driven by the commencement of new Commonwealth programs funded as part of the COAG Action Plan on Mental Health (Figure 10).

Expenditure on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme (PBS) was the main driver of growth in the first ten years of the National Mental Health Strategy, accounting for nearly two thirds of the

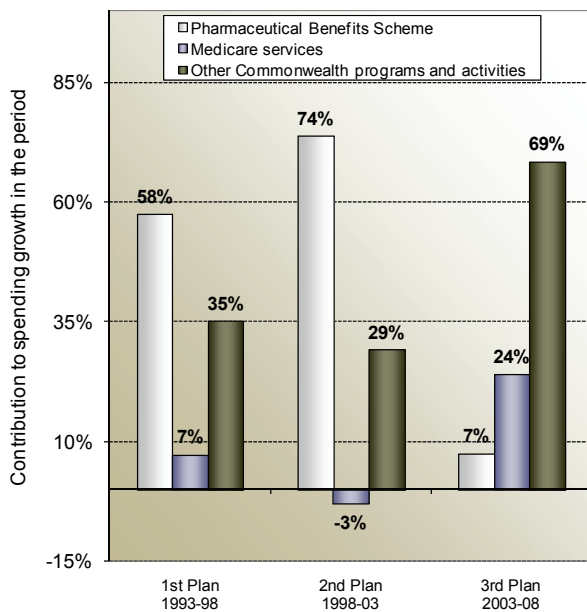
Table 3: Growth in Australian Government spending on mental health, 1992-93 to 2007-08

Expenditure by category (Millions)	Expenditure by category (Millions)			
	1992-93	1997-98	2002-03	2007-08
Health Care Agreements - Grants to states and territories	3.7	72.8	87.9	80.3
National programs and initiatives (DoHA managed)	13.6	34.9	39.5	209.6
National programs and initiatives (FaHCSIA managed)	0.0	0.0	0.0	99.0
National programs and initiatives (DVA managed)	80.4	100.2	159.9	142.1
National Suicide Prevention Program	0.0	13.3	12.5	18.7
Medicare Benefits Schedule – Psychiatrists	254.1	265.3	244.3	240.6
Medicare Benefits Schedule – GPs	182.5	201.1	208.5	133.4
Medicare Benefits Schedule – Psychologists/Allied health	0.0	0.0	0.0	177.0
Pharmaceutical Benefits Scheme	94.2	330.0	671.2	701.7
Private Health Insurance Premium Rebates	0.0	13.0	57.8	66.8
Research	9.8	17.2	28.6	50.0
Total	638.2	1,047.8	1,510.1	1,919.3

Notes: (1) Caution is needed when interpreting trends in GP expenditure. The reduction in 2007-08 is due to a change in counting methods used rather than reflecting decreased service delivery. See Appendix 11 for details.

(2) DoHA refers to Department of Health and Ageing; FaHCSIA refers to the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs; DVA refers to Department of Veterans' Affairs.

Figure 11: Drivers of growth in Australian Government mental health expenditure under the National Mental Health Plans 1993-2008



growth in Commonwealth spending in that period. Over the course of the Strategy, expenditure on psychiatric drugs has increased more than six-fold (645%, Table 3), three and a half times the growth rate of overall PBS expenditure (183%) in the period. Outlays on medicines for the treatment of depression and psychoses accounted for 39% and 53% respectively of the total spending increase.

The impact of psychiatric medicines on Australian Government mental health spending growth reduced markedly between 2003 and 2008 (Figure 11), caused by a combination of factors. In particular, several commonly prescribed antidepressant drugs came off patent in the period, allowing new lower cost generic products into the Australia market. The costs of these products fell below the PBS subsidy threshold, or required significantly less Commonwealth subsidisation than the patented products. Additionally, new programs funded under the COAG Action Plan began to be rolled out between 2006 and 2008, including the introduction of new Medicare funded 'talking therapies' provided by psychologists and allied health providers. Each of these factors moderated the previous role of the PBS as the main driver of Commonwealth mental health spending.

Appendix 11 provides a breakdown of Australian Government mental health expenditure. Details of PBS expenditure by drug category are presented in Appendix 13.

State and territory government 'maintenance of expenditure'

The commitment by state and territory governments to some form of budget protection was part of the original National Mental Health Policy. This was reinforced through the Australian Health Care Agreements 1998-2003, which covered the period of the Second National Mental Health Plan. The commitment was intended to serve three purposes.

Firstly, the Australian Government required a guarantee that the benefits of additional funds provided under the National Mental Health Strategy would not be negated by a reduction in state and territory funding for mental health. Secondly, the commitment recognised that existing service levels in Australia were struggling to meet even the highest priority needs and could not be further reduced without serious consequences. Finally, it acted as a safeguard against erosion of resources that was believed to be occurring with the downsizing of state managed psychiatric hospitals and incorporation of mental health services into mainstream health care.

The First National Mental Health Report established the baseline for measuring change in state and territory mental health resources and documented the gross recurrent expenditure by each jurisdiction in the 1992-93 year. It revealed substantial differences in the investments made by the various state and territory governments, with a 45% gap in per capita spending between the highest spending jurisdiction and the lowest.

This report uses the same approach to assessing 'maintenance of expenditure' by state and territory governments as used in previous reports. The approach makes a distinction between what was spent **within** a particular state and spending **by** the respective state or territory government. In brief, the method deducts specific Australian Government payments from the total spending reported by each state and territory to reduce the impact of growth in state and territory expenditure caused by:

- mental health specific grants made by the Australian Government under the Australian Health Care Agreements; and

Table 4: Recurrent expenditure on mental health services by state and territory governments, 1992-93 to 2007-08 (\$millions)

	1992-93	1997-98	2002-03	2007-08	Change since 1992-93	Average annual growth
New South Wales	508.0	586.5	787.5	1,004.7	98%	4.7%
Victoria	446.5	469.7	601.2	777.8	74%	3.8%
Queensland	222.8	313.9	397.5	603.4	171%	6.9%
Western Australia	145.5	213.9	269.8	387.9	167%	6.8%
South Australia	133.5	162.2	183.7	266.5	100%	4.8%
Tasmania	41.8	48.3	53.2	89.6	114%	5.4%
Australian Capital Territory	20.7	24.9	40.0	57.5	178%	7.3%
Northern Territory	12.3	17.9	19.8	32.9	168%	7.0%
Total	1,531.0	1,837.3	2,352.7	3,220.3	110%	5.1%

- payments provided by the Department of Veterans' Affairs for the mental health care of veterans by state and territory services.

The intent of this approach is to focus on health funding that is under the discretionary control of the various state and territory governments – that is, it may or may not be spent on mental health. As a result of these exclusions, expenditure attributed in this report to each state and territory government is less than what was actually spent by the relevant government on mental health services. Further details of the method used in handling expenditure data are given in Appendix 2.

Table 4 shows the summary picture of expenditure by state and territory governments, comparing 'baseline' spending in 1992-93 with spending at the close of each of three National Mental Health Plans.

All state and territory governments met their commitment to maintain mental health spending over the first ten years of the Strategy, with average annual expenditure growth of 4.4% between 1993 and 2003. By the end of decade, state and territory mental health expenditure had increased by a total of 54%.

Spending growth by states and territories increased under the Third National Mental Health Plan, averaging 6.5% per year. Combined state and territory mental health expenditure in 2007-08 was 37% more than 2002-03 and 110% above the pre-strategy baseline, equivalent to \$1.7 billion. All but two jurisdictions (New South Wales and Victoria) more than doubled their expenditure between 1993 and 2008.

Per capita spending by state and territory governments

Different population sizes and rates of growth need to be taken into account when reviewing trends in resourcing of mental health services. Higher population growth in some jurisdictions places greater demands upon the resources available for mental health care. Adjusting for the growth is necessary given that this report covers a 15 year period during which significant population shifts occurred.

Figure 12 summarises the relative positions of the states and territories in 2007-08. Trends over the 15 reporting years are shown in Figure 13.

Figure 12: Per capita expenditure on specialised mental health services by states and territories, 1992-93 and 2007-08 (dollars)

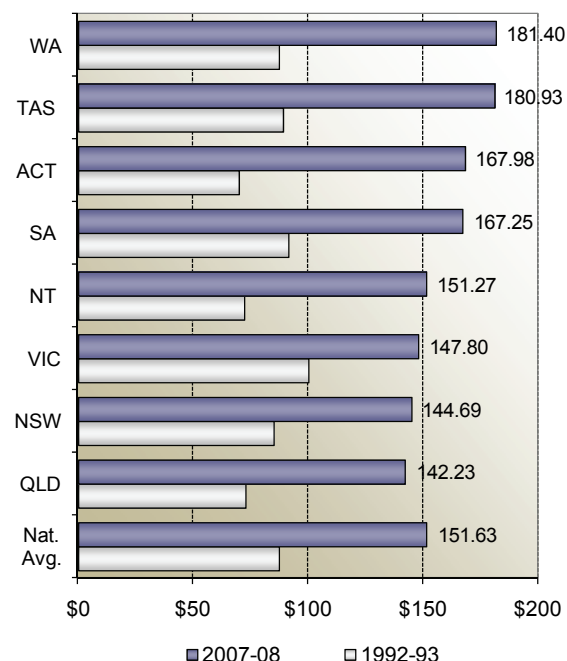
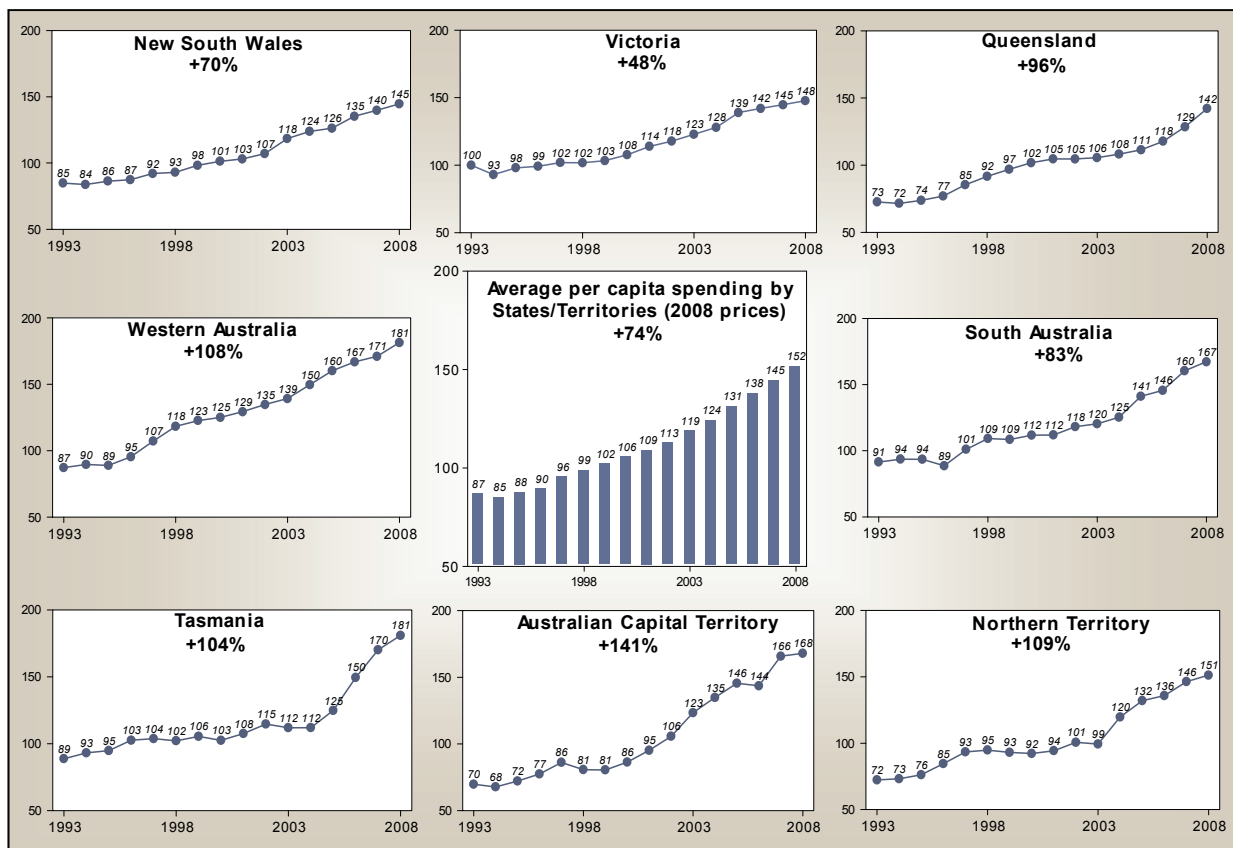


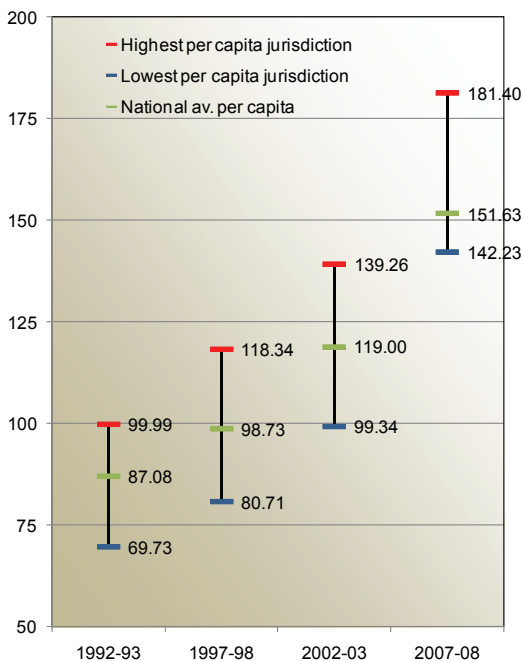
Figure 13: Per capita expenditure by state and territory governments (dollars)



When population growth is taken into account, growth in mental health spending becomes more conservative than the 110% suggested in Table 4. Per capita adjusted growth over the 15 years was 74%, or an annual average of 3.8%. The largest increases were reported by the

Australian Capital Territory (141%), the Northern Territory (109%) and Western Australia (108%), the latter jurisdiction maintaining top per capita ranking in 2007-08, a position that it has held since 1996-97. Rapid growth by Tasmania over the 2004-08 period, equivalent to 62%, has taken that jurisdiction to Western Australian levels of spending. When judged on 2007-08 mental health expenditure, Western Australia and Tasmania stand out from all other jurisdictions, with both states spending 20% above the national per capita average.

Figure 14: Range of per capita spending by states and territories, 1992-93 to 2007-08 (dollars)



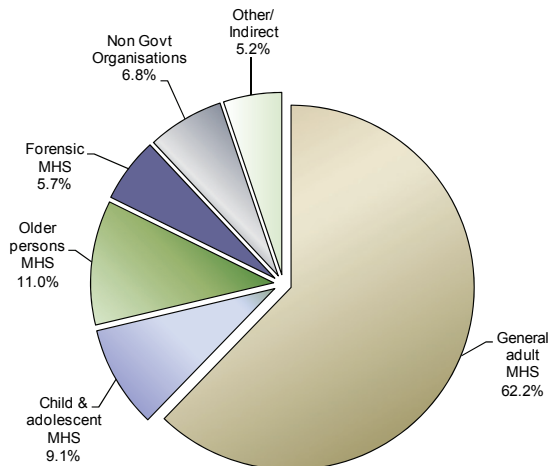
The considerable variation between the states and territories that existed at the commencement of the Strategy continued to be evident across its full 15 year course. The gap between the highest spending and the lowest spending jurisdiction has in fact increased over the 1993-2008 period (Figure 14). While some variation between state and territory expenditure can be expected due to the different needs of their populations, the variation in spending is too large for this to be the full explanation and points to significant inequity in levels of access to state and territory mental health services.

State and territory investment in programs for age-specific populations¹⁷

These perspectives give only a global picture of the relative investments by each of the states and territories in providing mental health services to their populations. Recent public interest in mental health is demanding more detailed information about how mental health funding is distributed across specific program areas and to populations across the lifespan. The data gathered from the 2008 Mental Health Establishments annual collection provide a basis for such analysis.

Distribution of funds in each state and territory jurisdiction is organised into programs and services dedicated to specific populations (i.e., general adult, older persons, child and adolescent and forensic mental health programs). Figure 15 provides the national summary of how funding in states and territories was distributed across the major program areas in 2007-08. It shows about two thirds of expenditure to be directed to general mental health services, primarily serving the adult population (ages 18-64) and the remainder

Figure 15: National summary of state and territory government mental health expenditure by program type, 2007-08



Total State and Territory services expenditure 2007-08 = \$3.32 billion

Note: Non government organisation expenditure excludes residential services managed by the NGO sector. This expenditure is apportioned mainly to the general adult MHS category.

¹⁷ The analysis presented in this section includes all public sector expenditure within state and territory jurisdictions, regardless of funding source. Totals are therefore greater than those presented in the earlier 'maintenance of expenditure' analysis which excluded Australian Government funds.

distributed across specialist child and adolescent, older persons, forensic and non government programs (NGOs).

Substantial differences exist in both the extent to which mental health services are differentiated according to age-specific programs and the level at which the programs are funded. Figure 16 to Figure 18 explore differences between the states and territories in their per capita allocations to general adult, child and adolescent and older persons programs.

By this analysis the relative positions of the 'rich' and the 'poor' jurisdictions alter depending on which age-related program is considered. For example, while Queensland spends less overall on mental health services than all other jurisdictions, its expenditure on child and adolescent mental health services in 2007-08 was 19% above the national average and the third highest of the states and territories. Tasmania on the other hand, the second top spending jurisdiction overall, holds this position in part through significantly above average spending on general adult services, but spends 25% less than the national average on child and adolescent mental health services.

The analysis highlights that, while mental health services are not provided uniformly across Australia, the greatest variation is in the availability of specialist child and adolescent and older persons services, with a two and a half - fold difference between the highest and lowest providing jurisdictions.

It should also be noted that general mental health services are just that, providing services not only to the adult population but also for child and adolescent and older persons. Indeed, where such services do not exist or are less well developed (such as in the Northern Territory), general adult services substitute. The net impact is that in some jurisdictions, estimates of the total expenditure on adults are overstated because a proportion of the resources is necessarily used to provide services to children or elderly people.

The data presented in the figures represent a relatively crude attempt to map Australia's mental health resources to different levels of need. Differences between the jurisdictions may reflect different population needs, different ways of organising services, or a combination of both. At this stage, there is no national agreement on how mental health budgets should be split across age-specific programs.

Figure 16: Per capita expenditure by states and territories on general adult mental health services 2007-08 (dollars)

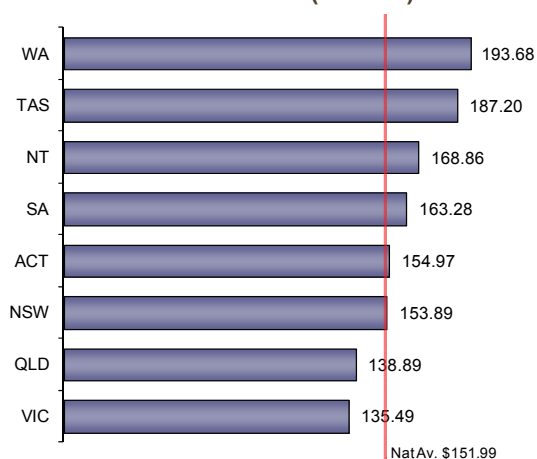


Figure 17: Per capita expenditure by states and territories on child and adolescent mental health services 2007-08 (dollars)

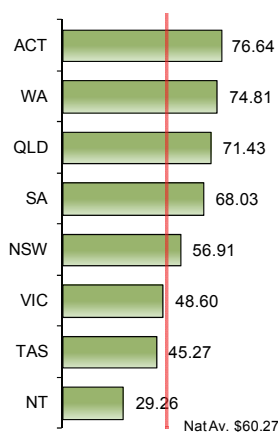
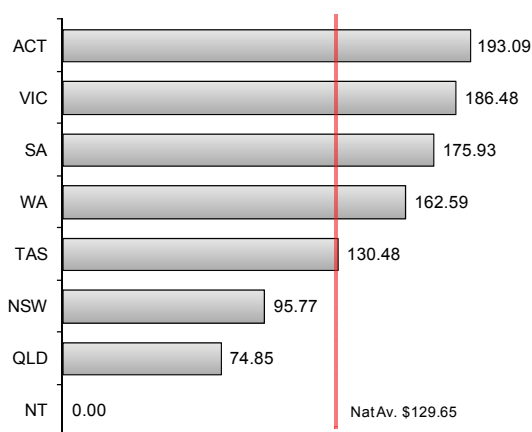


Figure 18: Per capita expenditure by states and territories on older persons mental health services 2007-08 (dollars)



Notes to above Figures:

1. Estimated expenditure for each age-specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Data Set, not the age of consumers treated.
2. Analysis excludes NGO grants and expenditure on services classified as Forensic Psychiatry.
3. Per capita rates based on age-specific populations.
4. Specialised older persons' mental health services are not available in the Northern Territory (Figure 15)
5. Source data and further details are provided in Appendix 2, Table A-10.

Australia's mental health spending in the international context

Mental health reforms in Australia have been occurring in parallel with similar developments in other Western nations. In this context, it is appropriate to ask whether Australia's spending on mental health is comparable to other countries, or matches international standards.

The National Mental Health Report 2005 presented the most recent authoritative analysis of the issue, and identified three obstacles that limit the extent to which mental health spending can be compared between countries.

- Firstly, there are no reliable international benchmarks available to assess whether the 'right' level of funding is allocated for a given population's mental health needs.
- Second, significant differences exist between countries in how mental health is defined, how expenditure is reported and what is included as 'health expenditure', making comparisons of available data both unreliable and potentially misleading.
- Thirdly, of those countries that have published potentially comparable data, differences in the costing methods used to estimate mental health spending prevent direct comparison.

Noting these problems, the report reviewed the available evidence and concluded that, while international comparisons of mental health spending are desirable, they remain elusive. The available data do not provide a reasonable basis to evaluate the investment of any particular country in providing mental health care to its population and contribute little to the monitoring of Australian endeavours under the National Mental Health Strategy.

Substantial collaboration between countries will be required for any future international comparisons of mental health spending to be valid.

Indirect costs of mental illness

The figures presented in the preceding sections only count the cost of providing specialist mental health services and do not reflect the full economic impact on the community and costs to government arising from mental illness in the Australian population.

Table 5: Estimated cost to the Australian Government of support services for people with mental illness, 2003-04

	\$ Millions
Income support payments	3,219.8
Workforce participation programs	114.8
Housing and accommodation programs	115.6
Disability support services	45.5
War veteran's disability compensation	192.1
Home and community care	10.6
Total	3,698.4

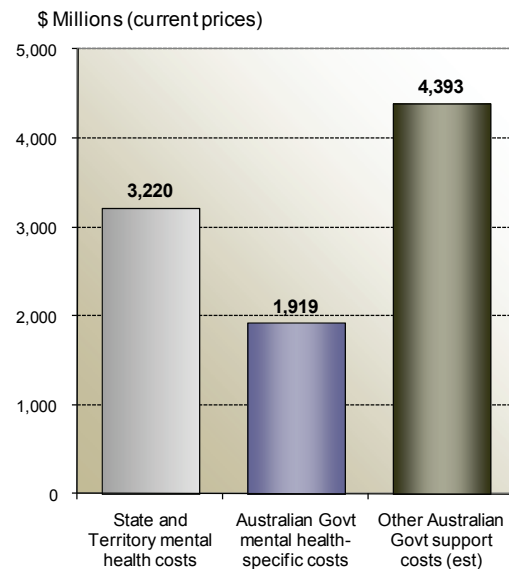
Source: Based on methodology used Australian Government submission to the 2005 Senate Inquiry into the Provision of Mental Health Services in Australia, updated by Department of Health and Ageing in collaboration with other Commonwealth departments. See footnote 18.

Many people with a mental illness depend on government for assistance that extends beyond specialist mental health treatment. They require access to a complex array of community services including housing assistance, community and domiciliary care, income support and employment and training opportunities. The costs associated with all these services represent a major component of total government outlays that are attributable to mental illness.

Early National Mental Health Reports estimated 'indirect' costs to be significant and likely to outweigh the cost of providing specialised mental health care, but routinely collected information was not available to quantify the claims. Analysis of spending patterns by Commonwealth departments, completed in response to the 2005 Senate Inquiry into the Provision of Mental Health Services in Australia, represented an important step toward filling this gap. The analysis estimated the 2001-02 cost of providing income, housing, aged care, employment and other services for people with mental disorders to be in excess of \$3 billion.¹⁸ Updates to these estimates prepared by the Department of Health and Ageing in collaboration with other Commonwealth departments estimated the total indirect costs for 2003-04 at \$3.7 billion (Table 5).

¹⁸ Australian Government (2005) *The Contribution of the Australian Government to Mental Health in Australia*. Submission to Senate Inquiry into the Provision of Mental Health Services in Australia. Available at: www.aph.gov.au/Senate/committee/mentalhealth_ctte/index.htm

Figure 19: Comparing direct and estimated 'indirect' government costs of mental disorders – 2007-08 estimates (\$million)



Notes:

1. Estimate of 'Other Australian Government support costs' for 2007-08 is based 2003-04 data, converted to 2008 prices.
2. Information on state and territory 'other government support costs' is not available but known to be substantial. It includes contributions from a number of human services, including housing, disability support, juvenile justice, child protection, police and corrective services.

More up-to-date data are not available for the current report, although there are reasonable grounds to assume that the spending patterns have been maintained. When scaled to 2008 prices, the estimated Australian Government support costs rise to \$4.4 billion, compared with a total of \$5.14 billion spent by all governments on providing specialised mental health services (Figure 19).

These estimates are conservative, using available information that allow reasonable attribution of costs to mental illness. Comparable information on state and territory government outlays is not available, further emphasising that this figure is likely to be a significant underestimate.

The analysis confirms that government outlays for mainstream support services accessed by people with mental illness approximate, and possibly exceed, the total funding allocated by all governments for specialist mental health services.

For the Australian Government, the implication is significant. For every dollar allocated to mental health services in the specialised sector, an additional \$2.30 is spent on providing support services to people who require such

assistance due to their mental illness. Income support payments through the Disability Support Pension (DSP) are the single largest outlay, accounting for an estimated \$2.5 billion in 2007-08. Of the 732,000 individuals receiving the DSP in June 2008, 28% (approximately 202,000) had a psychiatric or psychological condition recorded as their primary condition. This group has been growing by an annual average of 5% since 2001, more than twice the overall DSP growth rate.

In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and productivity. Mental illness creates barriers for many who would be capable of productive employment if appropriate treatment and employment assistance programs were available. Recent analysis by the Productivity Commission suggests that of six major health conditions (cancer, cardiovascular, major injury, mental disorder, diabetes, arthritis), mental illness is associated with the lowest likelihood of being in the labour force.¹⁹

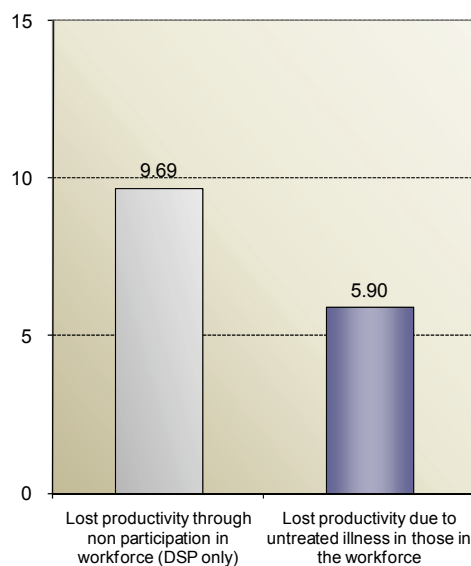
Lost productivity arising from workforce non participation by people on disability pensions alone is estimated at \$9.7 billion annually (Figure 20). Additionally, for those in the employed workforce, international and Australian studies consistently point to impaired employment functioning associated with untreated mental illness as a leading cause of lost productivity. Productivity losses are due to both absenteeism, and reduced functioning while at work. Based on recent Australian and overseas evidence, the cost of reduced productivity associated with mental illness in the employed workforce is \$5.9 billion annually.

Conclusions about mental health spending trends

Several conclusions can be drawn from the analysis of mental health spending trends over the course of the National Mental Health Strategy between 1993 and 2008, covering three 5-year National Mental Health Plans.

- The commitments made by all governments to protect mental health resources during a period of change were met. Total

Figure 20: Estimated cost of lost productivity per year due to mental illness, 2007-08 (\$billion)



Notes:

1. Estimate of lost productivity attributable to DSP recipients is calculated on the assumption that the average recipient, if in employment, would attract 75% of the average national wage.
2. Source for lost productivity due to untreated illness in the employed workforce: Hilton MF, Scuffham PA, Vecchio N, Whiteford HA. Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity. *Aust N Z J Psychiatry*, 2010, 44 (2):151-61.

government expenditure on mental health increased by 137% in real terms between 1993 and 2008. In 2008, Australia spent \$2.97 billion more of public funds on mental health services, or \$119 more per person per year, than it did at the commencement of the Strategy. As discussed in the next chapter, most of this increase has gone to expanding community services.

- Growth in mental health spending has mirrored overall health expenditure trends. Although the growth is important in dollar terms, mental health has not significantly increased its share of the overall health resource allocation.
- Australian Government spending has increased at a much greater rate than the states and territories (201% compared with 110%), increasing the Australian Government share of total national spending on mental health from 27% in 1992-93 to 36% in 2007-08. Most of the increase in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently, other Commonwealth funded activities have overtaken as the main drivers of increased mental health.

¹⁹ Laplagne P, Glover M, Shomos A (2007) *Effects of health and education on labour force participation*. Staff Working Paper, Productivity Commission, Melbourne.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy in 1993 continued to be evident 15 years later, at the conclusion of the Third National Mental Health Plan. The gap between the highest spending and the lowest spending jurisdiction increased over the 1993-2008 period. The disparity between the jurisdictions points to wide variation in the level of mental health services available to their populations.
- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.
- The cost to the Australian Government of providing the income and support services needed to allow people affected by mental illness to participate in community life is more than double its outlays on mental health specific programs. This highlights the need to look beyond investment only in specialised mental health programs when considering both the options and scope for improving national mental health reform arrangements.

These conclusions need to be interpreted in the context of two reminders about the limitations of an exclusive focus on health spending.

The first concerns the fact that spending patterns do not tell us about what is actually delivered, in terms of either the volume and quality of services, or the outcomes achieved. In the context of the National Mental Health Strategy, understanding how resources are allocated is necessary, but not sufficient to judge whether the policy directions are achieving the intended benefits for the community. Simply put, more dollars do not necessarily produce more or better services.

Recognising this, all governments have agreed on a range of supplementary information to assess the extent to which services are meeting needs. These include the introduction of systems for the regular monitoring and reporting of consumer outcomes (see page 56) and additional information compiled for annual reporting on the COAG National Action Plan, and the Fourth National Mental Health Plan. Additionally, all states and territories have

agreed to a set of national performance indicators aimed at providing a basis for monitoring 'value for money' in mental health service delivery.²⁰

The second limitation concerns the relationship between resources and needs. Measuring growth over the past 15 years informs us about changes since the commencement of the Strategy. It does not tell us whether the original 1993 funding levels were adequate to meet community need, or indeed, whether the growth that has taken place has been sufficient to meet new demands that have emerged since the Strategy began. The 2007 National Survey of Mental Health and Wellbeing, described in the previous chapter, highlights the continuing and substantial level of unmet need for mental health care that exists nearly 15 years after the commencement of the National Mental Health Strategy.

The implication is that current funding levels may not be enough to meet priority needs of the Australian population. These concerns underpinned many of the new initiatives announced under the Council of Australian Governments 2006 National Action Plan on Mental Health, described in Chapter 1, and the more recent Fourth National Mental Health Plan. In this context, it is important to note that the Fourth National Mental Health Plan includes a commitment by states and territories to develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.

²⁰ National Mental Health Information Strategy Committee (2005), *Key Performance Indicators for Australian Public Mental Health Services*. Information Strategy Committee Discussion Paper No. 5. Commonwealth Department of Health and Ageing, Canberra.

6. Reform of state and territory mental health services

Monitoring the progress of states and territories in the restructuring of their mental health services has been a central component of all National Mental Health Reports. The National Mental Health Strategy, through each of the three five-year National Mental Health Plans covering the 1993-2008 period, advocated fundamental change in the balance of services, focused on overhauling the institutional-centred systems of care that prevailed at the beginning of the 1990s.

The First National Mental Health Report documented the 'baseline' situation in 1992-93 and pointed to the scale of the task ahead. At the commencement of the Strategy:

- 73% of specialist psychiatric beds were located in stand alone institutions;
- only 29% of mental health resources were directed toward community based care;
- stand alone hospitals consumed half of the total mental health spending by states and territories; and
- less than 2% of resources were allocated to non government programs aimed at supporting people in the community.

Agreement to a national approach to mental health reform committed state and territory governments to both expand their community based services and devolve management from separate 'head office' administrations to the mainstream health system. In those jurisdictions

where decentralisation had occurred prior to 1992, the First National Mental Health Plan promoted the integration of inpatient and community services into a cohesive mental health program. The Second and Third National Mental Health Plans continued this direction, but expanded the focus of reform to additional activities to complement development of the specialist mental health service system.

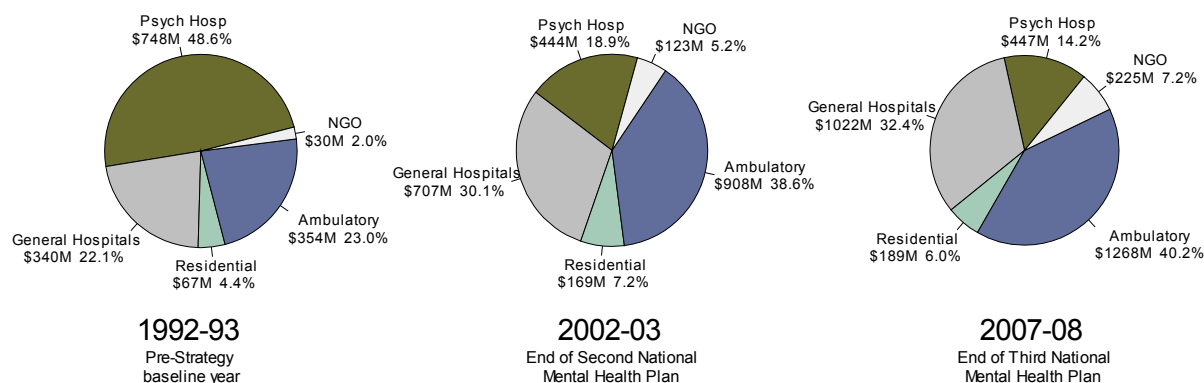
The series of National Mental Health Reports published prior to this current edition provided evidence of significant change in the direction advocated by the Strategy, although variable across the eight jurisdictions. National trends in the first five years were largely dominated by extensive structural changes in Victoria. The restructuring of services in other jurisdictions became more prominent in the early part of the Second National Mental Health Plan.

This section of the report updates previous published information and presents a summary of progress to 2007-08, the final year of the Third National Mental Health Plan.

Investment in service mix reform

Information collected through the annual Mental Health Establishments collection, and its predecessor (the National Survey of Mental Health Services) provides the basis for assessing changes in the structure of the mental health service systems administered by state and territory governments.

Figure 21: Distribution of total states and territories expenditure on mental health services, 1992-93, 2002-03 and 2007-08



Note: NGO estimates exclude staffed residential services managed by non government organisations for 2002-03 and 2007-08. These amounts are reported in the residential services category. If added to the NGO category, the NGO share of total expenditure would increase by 1-1.2%.

Over the 1993-2008 period:

- annual spending on stand-alone psychiatric hospitals decreased by 40% (\$301 million), taking their share of total spending on services from 49% to 14%; and
- annual spending on services provided in general hospitals and the community grew by 241%, equivalent to \$1.9 billion in real terms.

The impact has been to reduce Australia's reliance on institutional care and strengthen community alternatives that address the inadequacies of service systems that were the focus of the original National Mental Health Policy. The extent of Australia's structural changes in mental health services is illustrated in Figure 21.

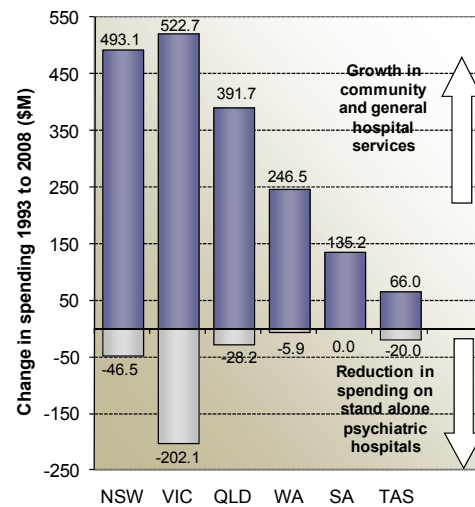
An issue of concern in the original design of the Strategy was to ensure that savings accrued from the planned downsizing of stand alone psychiatric hospitals were redirected back to new service development. Monitoring progress against this commitment is an important function of the National Mental Health Report.

The approach used in the current report follows that used in previous years and compares changes in spending on stand alone institutions between 1993 and 2008 with changes in spending across the same period for all other services, including general hospital-based inpatient units, ambulatory care services, community residential units and non government organisations.

Figure 22 summarises the results for each of the six state jurisdictions (the territories are excluded from this analysis because they do not have stand alone hospitals). Collectively, annual spending on stand alone hospitals decreased by \$301 million relative to 1992-93 and was accompanied by a larger increase (\$1.9 billion) in the resources invested in other mental health services. For all six states, the increased expenditure on new and expanded services was substantially higher than reductions in institutional spending.

On this basis, it can be concluded that the savings stemming from the reduction in stand alone psychiatric hospitals have been returned to the mental health sector. This provides some reassurance that concerns expressed at the commencement of the Strategy about 'leakage' of mental health resources did not eventuate over the past 15 years of national reform.

Figure 22: Have savings from the reduction of state government's stand alone psychiatric hospitals been matched by growth in alternative services?



Notes:

1. 'New service development' includes ambulatory care, residential and non government services and general hospital inpatient services.
2. Only the six state jurisdictions are shown above because the ACT and Northern Territory do not have stand alone psychiatric hospitals.

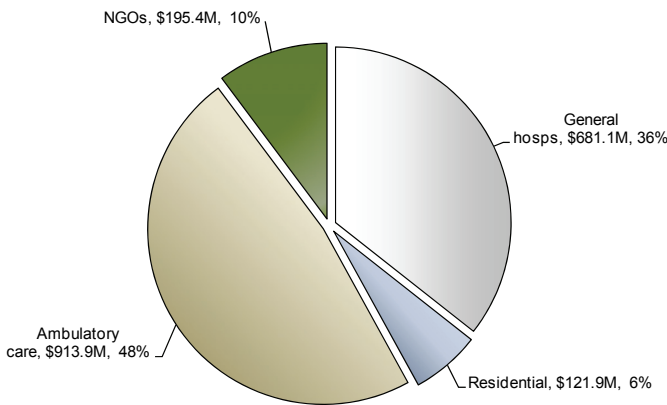
The national summary masks important differences between the jurisdictions in the extent to which resource transfer has taken place, and the rate of change across the National Mental Health Plans.

Most (71%) of the savings redirected from institutions to new services took place during the first five years of the Strategy. The national picture was dominated by extensive structural changes in Victoria. By June 1999, Victoria had virtually completed the closure of all its stand alone psychiatric hospitals (apart from a new forensic service) and reduced spending on these facilities by 83%. Over the Second Plan, reforms in Queensland and Tasmania were the main driver of the national picture, with these jurisdictions reducing their spending on stand alone hospitals by 41% and 100% respectively.

Subsequently, over the period 2003-2008, total annual spending on stand alone psychiatric hospitals remained relatively stable, the net result of three states (Victoria, Queensland and Western Australia) increasing their expenditure, offset by reductions in New South Wales and South Australia.

Over the 15 years of the Strategy, South Australia is the only state that did not decrease its spending on stand alone psychiatric hospitals relative to 1993. Expenditure in 2007-08 by South Australia on these services was 2% higher than 1993.

Figure 23: How the \$1.9 billion growth in annual spending on non institutional services is invested



Notes:

- \$1.9 billion represents the difference between 2007-08 and 1992-93 in total state and territory annual spending on community-based and general hospital mental health services.
- NGO estimates exclude staffed residential services managed by non government organisations for 2002-03 and 2007-08. These amounts are included in the residential services category.

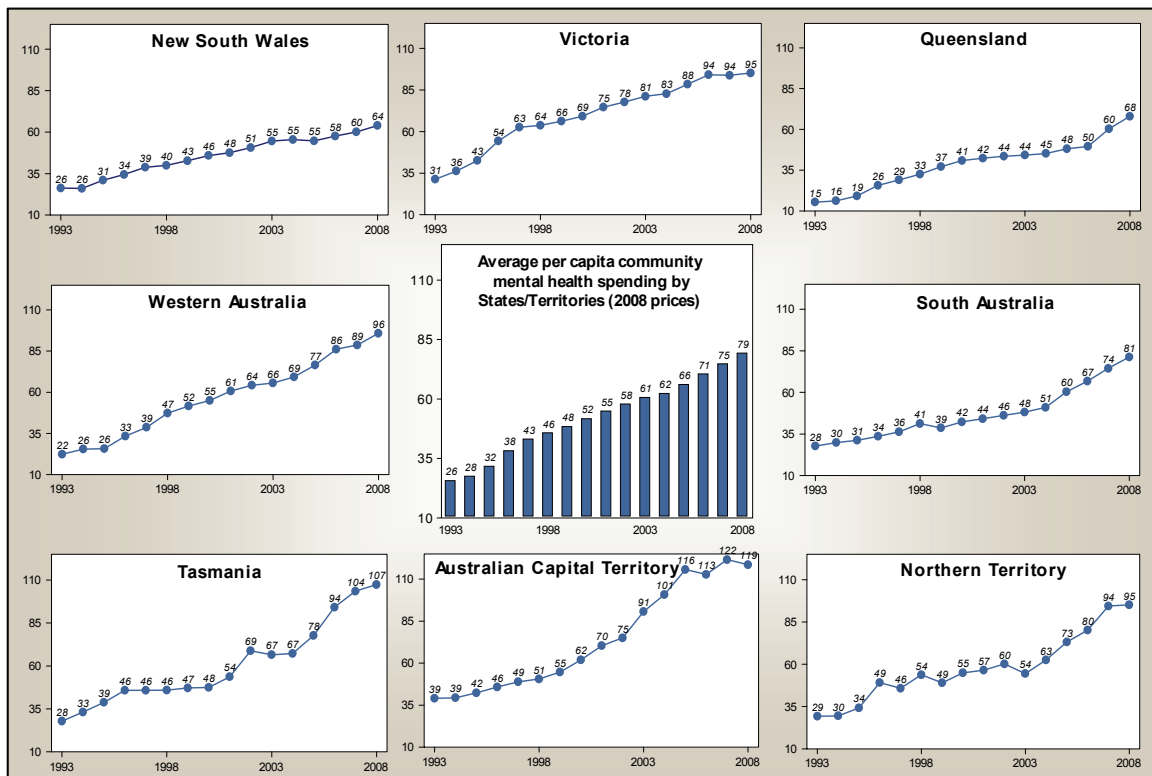
At the national level, about half (48%) of the \$1.9 billion growth in annual spending on non institutional services has been invested in expansion of ambulatory care services, and one third (36%) in development of new psychiatric units located in general hospitals (Figure 23).

Expansion of community based services

Three broad types of services are included in this service category.

- ‘Ambulatory care services’ comprising outpatient clinics (hospital and clinic based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care of people affected by mental illness or psychiatric disability who live in the community.
- Specialised residential services that provide beds in the community, staffed on-site by mental health professionals. These services, designed for people with significant disability or sub acute disorders, aim to replace some of the functions traditionally performed by long stay psychiatric hospitals. They include residential services established as specialised psychogeriatric nursing homes for older people with mental illness or dementia with severe behavioural disturbance.
- Services provided by not-for-profit, non government organisations (NGOs), funded by governments to provide support for

Figure 24: Per capita spending by states and territories on community based mental health services (dollars)



Note: Community mental health expenditure includes all three components – ambulatory, residential and non government services.

people with a psychiatric disability arising from a mental illness. The NGO sector provides a wide range of services including accommodation, outreach to support people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy.

By 2007-08, 53% of total state and territory mental health spending was directed to community based services compared with 29% at the beginning of the Strategy. All jurisdictions reported increases in spending in this area since 1993.

Previous National Reports described wide variation between the jurisdictions in the level of community services available per capita. Figure 24 presents this comparison, as well as illustrating growth at the individual state and territory level. It shows that significant discrepancies in resourcing of community services continued to be evident in 2007-08, with the highest spending jurisdiction (ACT) investing nearly double the lowest (New South Wales).

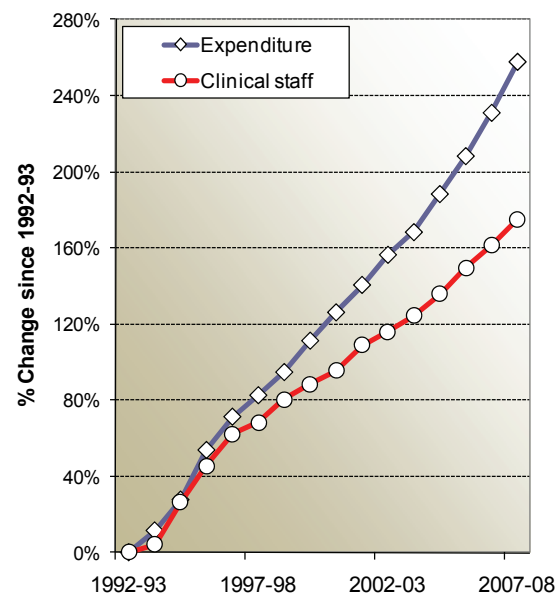
Growth of community based services has occurred across all three service categories. Specific details on ambulatory care and non government organisations are provided in the sections that follow. Details on community residential services are discussed later in this chapter in the context of developments in bed-based services.

Development of ambulatory care services

Significant growth in the resources directed to ambulatory care services occurred in the first ten years of the National Mental Health Strategy. Between 1993 and 2003, expenditure increased by 156% and the clinical workforce by 116%. Three-quarters of the growth in community based services in that period was directed to ambulatory care.

This pattern continued during the Third National Mental Health Plan, with a further 40% increase in expenditure and a 27% increase in the clinical workforce (Figure 25). By 2007-08, the size of the clinical workforce engaged in the delivery of ambulatory mental health care was 175% greater than the pre-Strategy baseline year (1992-93). This is equivalent to the employment of 5,880 additional health professionals.

Figure 25: Changes in resourcing of ambulatory care services, 1993 to 2008



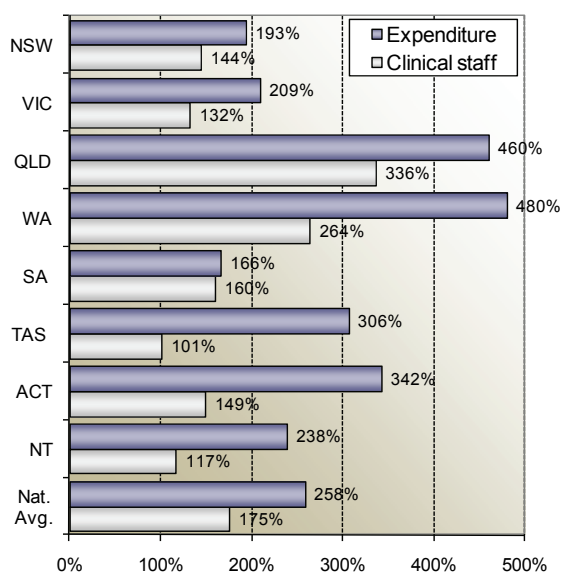
All jurisdictions have more than doubled their ambulatory care workforce over the course of the Strategy. Two states (Queensland and Western Australia) have more than tripled the size of their clinical workforce.

Figure 25 reveals that growth in expenditure has outstripped growth in the clinical workforce, even when health inflation is accounted for. The implication is that more dollars have not proportionately translated to increased staffing levels in state and territory ambulatory services. Nationally, the purchasing power of the mental health dollar in 2008 was 30% less than in 1993 when measured by the number of staff employed in ambulatory care. As noted later in this report, similar cost increases have occurred in inpatient services.

This may be due to a number of factors, including employment of clinical staff with higher qualifications (and salaries), a greater overall increase in costs in mental health relative to overall health care, or higher administrative overhead costs associated with the process of managing an increasingly complex service system.

The gap between growth in spending on ambulatory services and growth in clinical staffing is not the same for all jurisdictions. For several, the gap is minimal with the rate of staffing increases closely matching growth in spending. For others, the gap is substantial (Figure 26).

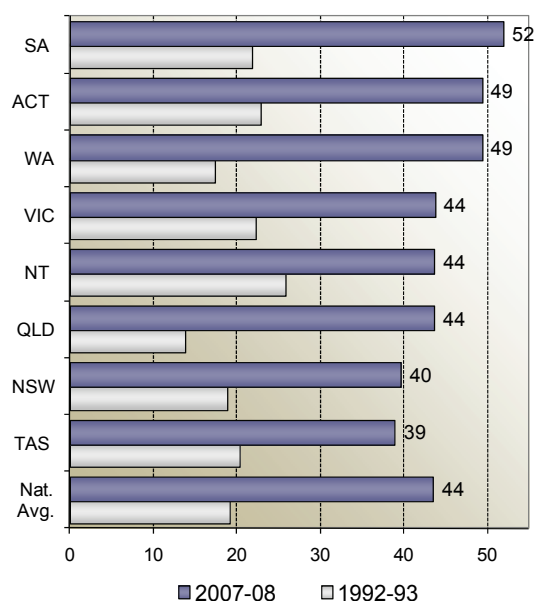
Figure 26: Growth in ambulatory expenditure compared with growth in full-time equivalent clinical staff (FTE), 1993-2008



Comparative per capita staffing levels are summarised in Figure 27. The figure shows the progress made, as well the continuing disparity between the jurisdictions, in the level of clinical staffing employed in delivering ambulatory mental health care.

These indicators provide a simplified view of the relative progress by states and territories. However, they do not tell us about the workforce levels required to meet priority

Figure 27: Full-time equivalent clinical staff (FTE) per 100,000 population employed in ambulatory care mental health services 1992-93 and 2007-08



community needs, nor the amount of care actually provided. A consensus model to guide future state and territory planning of ambulatory care services has not yet been developed under the National Mental Health Strategy. As noted in the previous chapter, the Fourth National Mental Health Plan includes a commitment by states and territories to develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services.

Expansion of the non government community support sector

From the outset, the National Mental Health Strategy advocated the expansion of the role of non government organisations in providing support services to consumers and carers whose lives are affected by mental illness.

The work conducted by the sector has its origins in the 'voluntary movement' that was initiated by charitable organisations in the 19th century to fill gaps in human services provided by government departments. In the decade running up to the commencement of the Strategy, these organisations progressively attracted government funding to develop new and innovative services for people affected by mental illness.

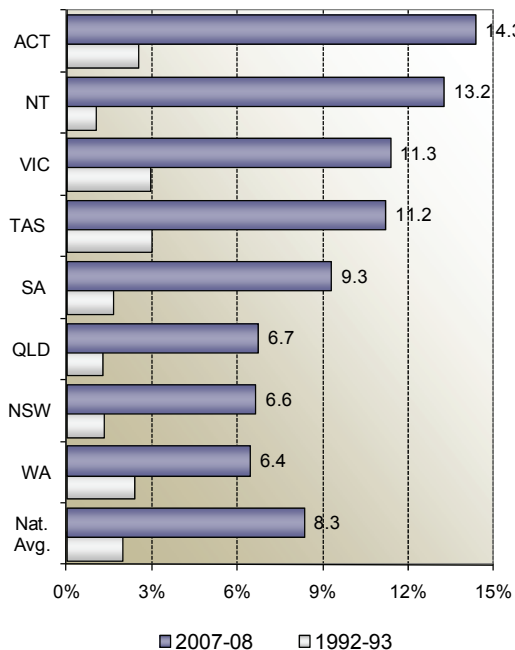
Expansion of the sector was promoted as a means to strengthen community support and develop service approaches that complement the clinical services provided by hospitals and community mental health centres. More recently, the COAG National Action Plan on Mental Health renewed the call to elevate the priority of the sector, foreshadowing major expansion of funding by most jurisdictions.²¹

The first National Report described funding to non government organisations as limited, with most of the needed support services poorly developed or nonexistent in all jurisdictions. Only 2% of state and territory mental health budgets was directed to the sector in 1993.

Moderate improvement in the funding base occurred over the 1993-2003 period, increasing from \$30 million to \$123 million nationally, taking the sector to 6.2% of total state and territory expenditure on specialist mental health services.

²¹ For example, approximately 45% of the Australian Government's \$1.9 billion commitment under the COAG Action Plan is delivered by the NGO sector.

Figure 28: Percentage of total mental health services expenditure allocated to non government organisations, 1992-93 and 2007-08



Note: Includes expenditure reported by staffed community residential services managed by non government organisations. See footnote 22.

Growth over the 2003-08 period accelerated with the sector increasing its share of annual mental health expenditure to 8.3%. Four jurisdictions (New South Wales, South Australia, Tasmania and Northern Territory) more than tripled their annual NGO funding in the period. Total state and territory funds allocated to the sector in 2007-08 was \$262 million, distributed to about 400 organisations involved in delivering services. The organisations ranged from very small entities, employing only a few workers, to complex, multi-million dollar organisations.²²

Despite the significant recent growth during the final years of the Third National Mental Health

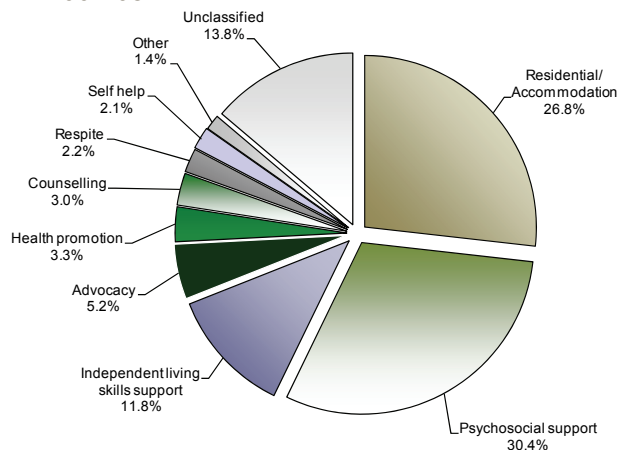
²² Prior to 1999-00, all services provided by non government organisations were reported only in terms of total funds allocated by state and territory governments. Commencing in 1999-00, staffed community residential units managed by the sector began to report separately and were grouped with 'government managed' residential services in previous National Mental Health Reports. For the purpose of the analysis in this section, funding to NGO-managed staffed residential services (approximately \$37 million in 2007-08) has been combined with non-residential NGO programs to ensure better consistency in monitoring the 15 year spending trends. The 2007-08 estimate of 8.3% expenditure allocated to NGOs described in this section differs from the 7.2% shown in Figure 21 because, in the latter, NGO-managed residential programs are grouped with other residential services.

Plan, differences between the jurisdictions remain prominent (Figure 28). By 2008, the 'NGO share' was strongest in the ACT (14.3%), followed by the Northern Territory (13.2%), and most limited in Western Australia (6.4%). For the first time in the history of the Strategy, Victoria lost its top ranking position in NGO funding in 2004-05, and was overtaken by the ACT and the Northern Territory. However, in terms of the number and range of services, Victoria continues to dominate the national picture, accounting for one third of total state and territory NGO funding in 2007-08.

Previous National Reports observed that the role played by NGOs varied across the jurisdictions, reflecting differences in the extent to which states and territories funded the organisations to take on functions that substituted for those traditionally provided by the government sector, or to develop complementary services.

In this environment, a diverse array of services has been developed by the NGO sector to meet varied needs. Figure 29 shows the national profile of NGO services funded by states and territories in 2007-08. Residential/accommodation services and psychosocial support services each accounted for about one quarter of the funding.

Figure 29: Types of services funded by state and territory grants to non government service organisations, 2007-08



Total state and territory grants to NGOs – \$262 million

Notes:

1. The \$262 million amount differs from the \$225 million shown in Figure 21 because NGO staffed residential services are included.
2. 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 NMDS – Mental Health Establishments collection.
3. 'Other' combines prevocational and recreational programs.

Changes in inpatient and community residential services

Substantial change in both the level and mix of inpatient services occurred over the first ten years of the Strategy. By the end of the Second National Mental Health Plan (June 2003), Australia had 24% fewer public sector beds (1,918 beds) available than ten years earlier. Non acute inpatient services located in separate psychiatric hospitals were the main target for the service reductions. Consistent with the original intent of the Strategy, the majority of acute services had been relocated to general hospital units.

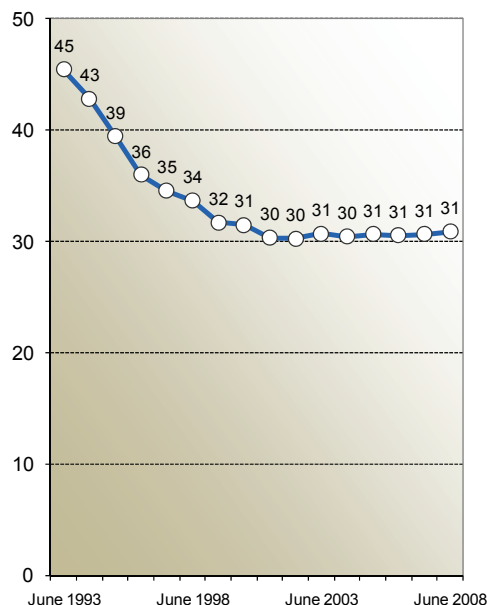
By June 2003, stand alone hospitals had reduced in size by 59% (3,442 beds). No jurisdiction other than Victoria had developed a significant number of alternative beds in staffed, community residential services. This was despite an expectation that such services were needed to cater for people who required longer term care and rehabilitation, a function previously provided by stand alone psychiatric hospitals.

Early editions of the National Mental Health Report series described separately the changes within inpatient and community based residential services. The current report takes a different approach, based on the recognition that an incomplete picture is presented when one service category is considered in isolation of the other. In the sections that follow, developments in hospital-based inpatient services and residential services continue to be presented separately, but are brought together in a consolidated view of changes in the overall bed capacity of specialised mental health services (see page 50).

Overall number of psychiatric inpatient beds²³

The reduction in the number of public sector psychiatric beds plateaued towards the end of the Second National Mental Health Plan. Between 2003 and 2008, bed numbers increased by 478 but when adjusted for population growth, remained relatively stable in per capita terms (Figure 30). By June 2008, 6,551

Figure 30: Total public sector inpatient beds per 100,000, June 1993 to June 2008



psychiatric beds were available in the public sector, 18% fewer than at the commencement of the Strategy (1,440 bed reduction).

Specialised psychiatric beds comprised 12% of the 56,493 public sector hospital beds available in Australia in 2007-08.²⁴ A total of 157 public hospitals (141 colocated, 16 stand alone) provided a specialised psychiatric inpatient unit.

Inpatient service reductions have not been uniform across the jurisdictions. Tasmania and Victoria's changes have been the most significant, with bed numbers decreasing by 48% and 36% respectively since 1993. The two States with the highest per capita bed numbers at the commencement of the Strategy (South Australia and Queensland) have reduced bed numbers by 23% and 12% respectively.

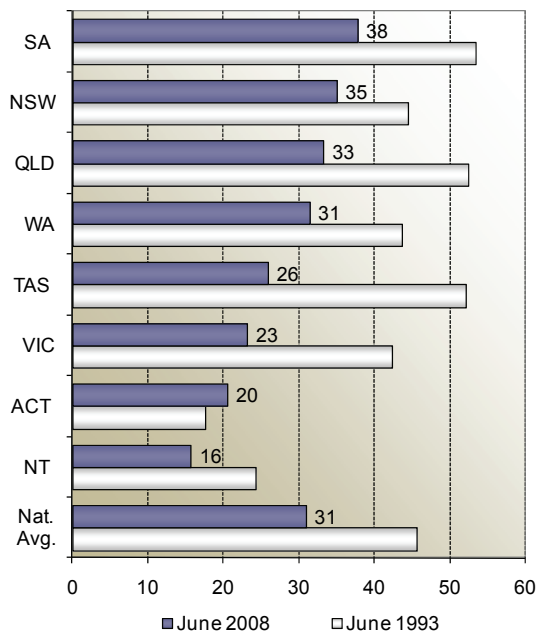
Figure 31 compares the states and territories on beds per capita at June 1993 and June 2008 and shows considerable variation in the availability of psychiatric inpatient services. The differences between jurisdictions are only partially counterbalanced by community residential services, described later in this section.

The reduction in psychiatric inpatient services needs to be viewed within a longer term context. Like other developed countries,

²³ Changes in the reporting of residential services in Queensland and New South Wales contribute to the growth in general hospital beds from 2006 onwards. June 2008 bed counts include approximately 180 beds previously reported as community residential services. See Appendix 2 Table A-3 for details.

²⁴ Source for total public hospital beds: Australian Institute of Health and Welfare 2009. *Australian hospital statistics 2007-08*. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW.

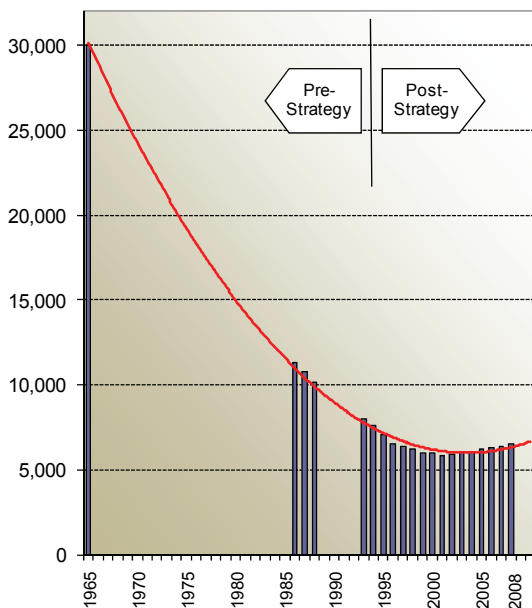
Figure 31: Total public sector inpatient beds per 100,000 at June 1993 and June 2008, by state and territory



downsizing of large psychiatric institutions commenced within Australia’s public mental health system in the mid 1960s, when the number of beds peaked at 30,000. By the commencement of the National Mental Health Strategy, approximately 22,000 beds had been closed (Figure 32), despite the fact that the national population doubled over the preceding three decades.

The 1960s peak in bed numbers represented the

Figure 32: Reduction in psychiatric bed numbers, pre- and post-National Mental Health Strategy



final stage of a long period in Australia’s history in which the isolation and custody of people with mental illness dominated the treatment culture. Many beds were located in rural asylums, located far from families and social networks. Overcrowding and other inhumane conditions were the norm. Wards built in facilities based on European 19th century models to cater for 25 people often housed up to 100 patients. At that time, the only form of care provided to people affected by mental illness was a long stay, sometimes for life, in an institution located far from home.²⁵

The reduction in size of hospitals prior to the Strategy was driven by both new discoveries in treatment and a growing concern for human rights. However, it occurred in a policy environment that provided few safeguards to ensure that alternative community services were developed to replace the functions of the shrinking institutions. As beds were closed, the freed resources were usually re-directed back to the hospitals to improve staffing levels and rarely used to open new community services, or inpatient services elsewhere.

The National Mental Health Strategy was conceived in part to respond to the legacy created by bed reductions and set a coherent direction to guide future reform.

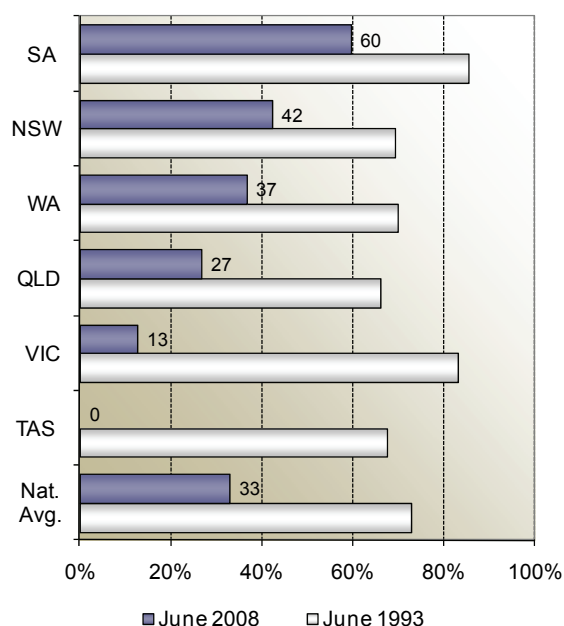
Reduction in stand alone psychiatric hospitals

Stand alone psychiatric hospitals continued to be the focus of bed reductions during the National Mental Health Strategy. Between 1993 and 2003, beds in these hospitals decreased by 59% (3,442 beds). Bed numbers reduced a further 9% (204 beds) between 2003 and 2008, attributable primarily to reductions in South Australia.

In order of their contribution to the national change, closure of separate psychiatric hospital beds in Victoria (1,411 beds), New South Wales (815 beds), and Queensland (683 beds) have accounted for 80% of the reduction. Developments in Western Australia (264 beds), South Australia (308 beds) and Tasmania (165 beds) make up the balance.

²⁵ National Health Strategy (1993) *Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness*. Issues Paper No. 5, Commonwealth of Australia, Canberra.

Figure 33: Beds in stand alone hospitals as a percentage of total psychiatric inpatient beds at June 1993 and 2008

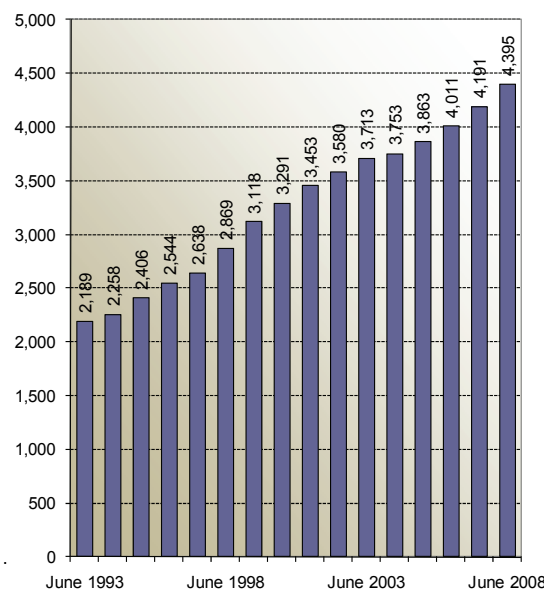


By June 2008, 16 of the 32 stand alone hospitals operating at the commencement of the Strategy remained functional, but most at a substantially reduced size. Beds in these hospitals accounted for 33% of Australia's total psychiatric inpatient capacity, reduced from 73% in June 1993.

Figure 33 charts the progress of each of the States in reducing their reliance on separate psychiatric hospitals. Victoria and Tasmania achieved the greatest change relative to their 1993 baselines, the latter closing its only freestanding psychiatric hospital in 2001. By contrast, South Australia remains substantially dependent upon its stand alone hospitals.

Differences in the starting points of the six states are important to take into account when interpreting the changes. At the commencement of the Strategy, South Australia and Victoria had the highest proportion of their beds located in separate psychiatric hospitals and Queensland the lowest. Clearly, states which had closed or relocated a greater proportion of their separate hospitals, or had fewer beds prior to the commencement of the Strategy, had less work to complete. Conversely, greater movement of beds could reasonably be expected of states such as South Australia and Victoria.

Figure 34: Growth in psychiatric beds located in general hospitals June 1993 to June 2008



Growth of general hospital acute inpatient services

The National Mental Health Strategy committed states and territories to the replacement of most acute inpatient services previously provided in separate psychiatric facilities with units located in general hospitals. Such 'mainstreaming' of acute services was aimed at both reducing the stigma associated with psychiatric care, as well as stimulating improvements in service quality.

Fifty five percent of acute psychiatric beds were located in general hospitals when the Strategy began, increasing to 83% at the close of the Second National Mental Health Plan. By June 2008, this had increased marginally (to 86%) due to the commissioning of new units in most jurisdictions. Over the life of the Strategy, the number of beds located in general hospitals has doubled (2,206 additional beds, Figure 34).

Leaving aside the two territories, which do not maintain stand alone psychiatric hospitals, Tasmania, Queensland and Victoria provided the greatest proportion of mainstreamed acute beds by June 2008 (Figure 35). South Australia continues as the state with the lowest proportion of acute beds located in general hospitals, but expanded its general hospital-based services substantially in the latter part of the Third National Mental Health Plan.

Figure 35: Percentage of acute psychiatric beds located in general hospitals by state and territory, June 1993 and June 2008



Note: Excludes forensic psychiatry services

By June 2008, 96% of Australia’s major public hospitals with 200 or more beds had a specialised psychiatric unit (Figure 36).

Development of psychiatric units in these larger hospitals, which have sufficient size and diversity to support specialist units, has been the main focus of ‘mainstreaming’.

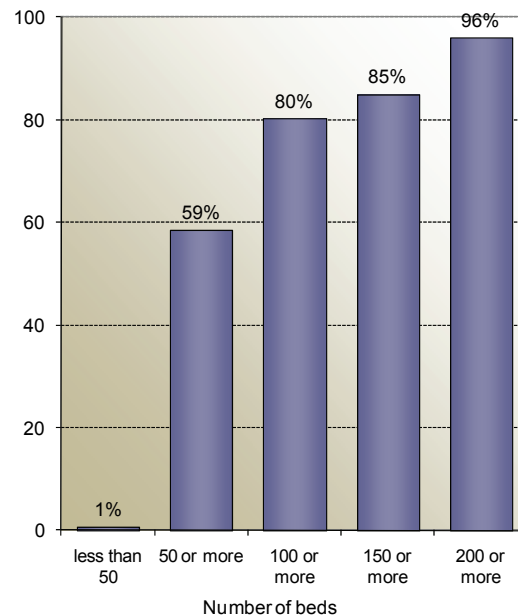
Changes in the inpatient program mix

The decrease in hospital beds numbers has been accompanied by changes in the mix of inpatient services. Reductions during the Strategy have been selectively targeted at non acute units – that is, hospital wards that provide medium to longer term care. The number of non acute units has halved (2,144 beds), whilst places in acute inpatient units have increased by 19% (704 beds).

The emphasis on maintaining acute services and reducing non acute beds is relatively consistent across all jurisdictions. The most significant reductions in non acute beds have been made in Tasmania and Victoria (81% in both states). Figure 37 charts the changes in acute and non acute service provision within each of the states and territories.

The National Mental Health Strategy does not stipulate an optimum level or mix of inpatient services. When agreed in 1992, this was intended to acknowledge the different histories and circumstances of each jurisdiction, and the need for plans to be based on local population

Figure 36: Percentage of general hospitals with a specialised psychiatric unit as a function of size of hospital, 2007-08



Note: Based on Department of Health and Ageing analysis of data presented Australian Institute of Health and Welfare 2009. *Australian hospital statistics 2007-08*. Health services series no. 33. Cat. no. HSE 71. Canberra: AIHW..

needs. It was expected that the final balance of services might differ substantially between the states and territories.

Previous National Mental Health Reports noted a convergence between jurisdictions for an acute bed provision level of around 20 beds per 100,000 population. Two states (Western Australia and South Australia) entered the Strategy with levels 15% or more above this and have maintained them over the past 15 years. The Northern Territory and, until recently years, the ACT have managed their service system with 15-25% less. The remaining jurisdictions have maintained their inpatient services throughout the Strategy close to the 20 acute beds per 100,000 level.

Similar consensus on provision of non acute beds has not yet emerged. Disparities between the jurisdictions are marked, with a five-fold difference between the highest providing state (Queensland) and the lowest (Victoria). Interpretation of these differences needs to take account of the differing levels of community residential services that provide longer term care. This is discussed later in this chapter.

Just as the downsizing of psychiatric hospitals primarily focused on non acute inpatient care, most of the reductions have been within adult

Figure 37: Acute and non acute inpatient beds per 100,000, June 1993 to June 2008

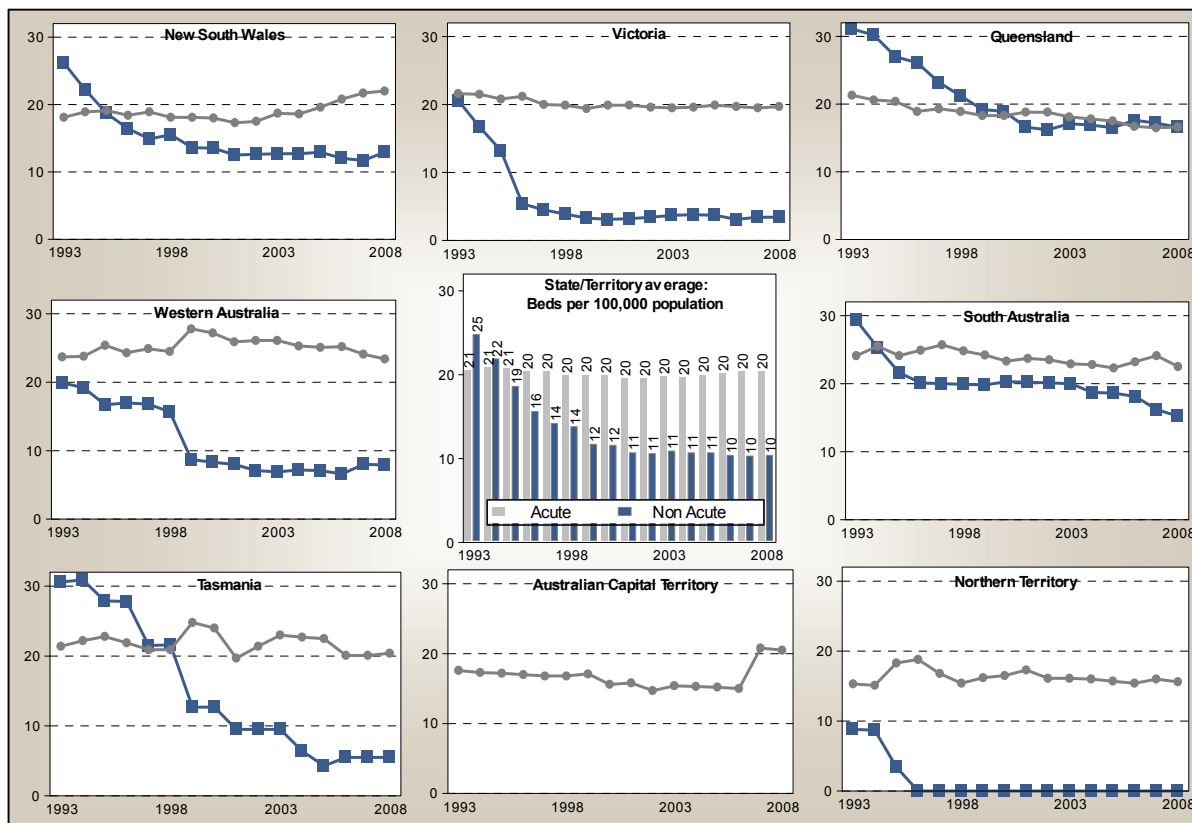
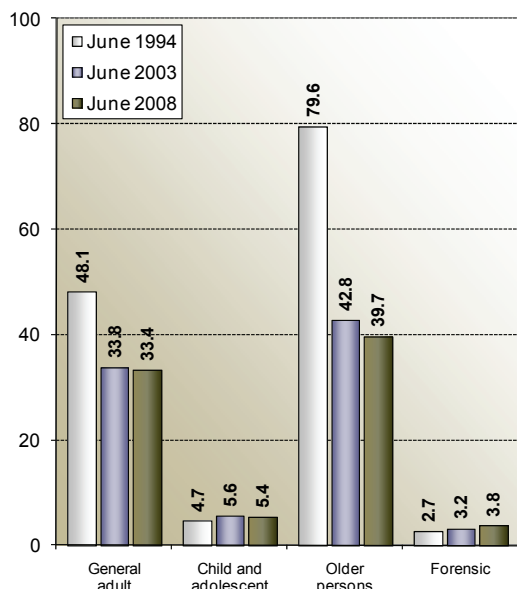


Figure 38: Psychiatric beds per 100,000 by target population, June 1994 to June 2008



Notes:

1. Estimation of per capita rates is based on age-specific populations for each target group:

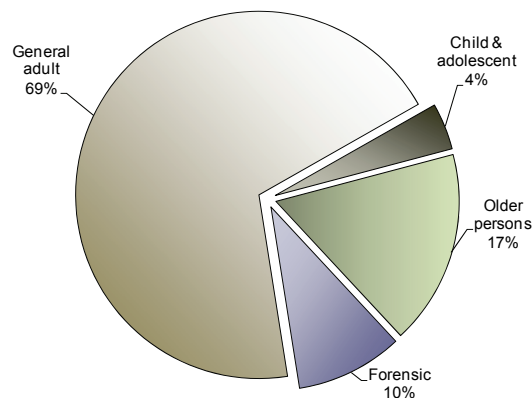
- *General adult*: Based on population aged 18-64 years.
- *Child and adolescent*: Based on population aged 0-17 years.
- *Older persons*: Based on population aged 65 years and over.
- *Forensic*: Based on total population aged 18 years and over.

2. Data only available from June 1994.

and older persons' mental health programs. The number of general adult beds has reduced by 31% in per capita terms and older persons' beds by 50% (Figure 38). Specialist beds dedicated to child and adolescent and forensic mental health have both increased in per capita terms by 15% and 41% respectively, although these figures reflect the low 1993 starting points of each of these programs.

Figure 39 shows the distribution of beds across the four major program categories at June 2008.

Figure 39: Distribution of psychiatric beds across the major mental health programs, June 2008



Changes in inpatient unit costs

A concern expressed at the outset of the National Mental Health Strategy was that the transfer of inpatient services to general hospitals would lead to increased bed day costs and absorb much of the savings potentially available to expand community care.

Analysis of the data collected over the 1993-2008 period confirms that significant movement in unit costs has been associated with the re-configuration of inpatient services. The greatest unit cost increase has been in the separate psychiatric hospitals. Over the 15 years, average bed day costs in stand alone hospitals increased by 58% in constant price terms compared with 38% in general hospitals (Figure 40). The average cost per patient day in stand alone hospitals moved from 22% below, to approximately equal the average patient day cost in general hospitals by 2002-03. Most of this gain occurred in the first five years of the Strategy. Increases in unit costs in the remaining stand alone hospitals slowed during the Third National Mental Health Plan while general hospitals continued to grow at about the same rate as the preceding decade (3% average annual growth above the health inflation rate).

Both economic and clinical factors underlie the increase in the costs of hospital care.

From the economic perspective, the costs of running freestanding hospitals does not reduce in proportion to bed reductions because fixed costs are only released when whole wards or hospitals close. Despite the 63% reduction in

Figure 40: Average cost per day in psychiatric inpatient units, 1993-2008

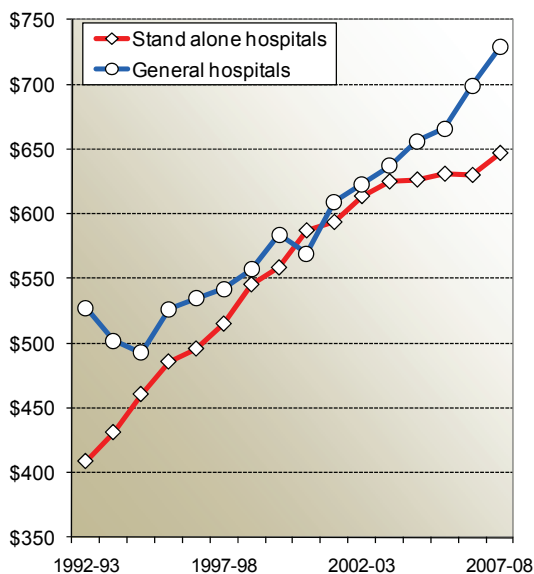
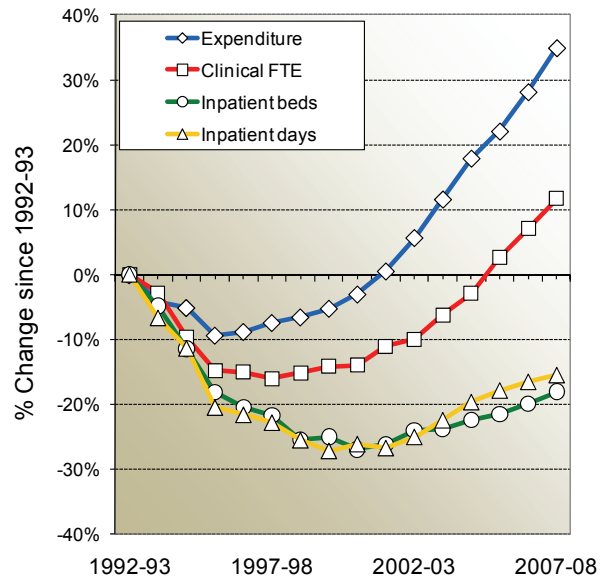


Figure 41: Changes in inpatient bed numbers, patient days, expenditure and clinical staffing relative to 1992-93



beds in stand alone hospitals, few large hospitals have been fully decommissioned other than in Victoria and Tasmania.

Figure 41 provides an insight to the resource shifts within Australia’s psychiatric inpatient services over the 1993-2008 period. It shows that, at the national level, reduced bed numbers have not translated to reduced overall spending. While beds and days spent in hospital have reduced by 18% and 16% respectively, spending on hospital services has increased by 35%. Staffing levels in inpatient units have increased by 12%, about one third the rate of the growth in overall expenditure on inpatient services. The implication is that inpatient services are substantially more costly overall than at the beginning of the Strategy. When measured in terms of days in hospital, 2008 funding would buy 37% less services than the same level of funding 15 years earlier.

Jurisdictions differ in the extent to which the decrease in inpatient beds has been accompanied by reduced spending. Table 6 compares the states and territories and shows that only Victoria has succeeded in aligning the direction of spending savings with inpatient bed reductions. In all other jurisdictions, expenditure and bed numbers have moved in opposite directions and at very different growth rates for some.

Clinical factors contributing to increased costs include the changing role of the separate psychiatric hospitals. These services have developed specialised roles as they have

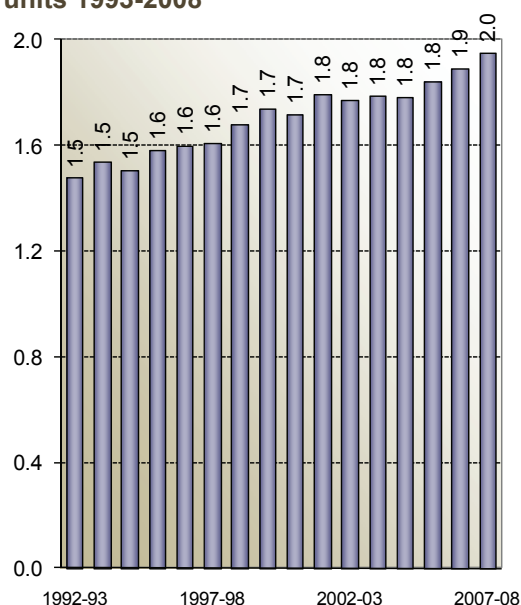
Table 6: Comparison of 2007-08 inpatient bed numbers, patient days, expenditure and clinical staffing relative to 1992-93

	Inpatient Expenditure	Inpatient Beds	Patient Days	Inpatient Clinical FTE
	Percentage change since 1992-93			
NSW	43.4	-8.6	-0.6	45.4
VIC	-13.5	-35.6	-38.3	-31.4
QLD	68.9	-12.3	-9.2	33.6
WA	68.1	-8.0	-8.8	18.3
SA	51.7	-23.0	-13.2	-0.9
TAS	20.9	-47.8	-53.7	9.6
ACT	89.1	34.6	6.1	12.4
NT	72.6	-17.1	7.3	-9.2
Nat. Avg.	34.9	-18.0	-15.5	11.7

reduced in size, treating consumers with more complex conditions that require increased staff-patient ratios. Specific efforts have also been made to bring overall staffing within these hospitals to an acceptable level, commensurate with that provided in general hospital psychiatric units. The data reported by the states and territories over the course of the Strategy provides some support for this view, and suggests that average clinical staffing levels within psychiatric inpatient units have increased by 32% (Figure 42).

Overall, the relative contributions of economic and clinical factors to the cost increases within inpatient units is not known, but it is likely that both have played a part.

Figure 42: Average number of clinical staff (FTE) per patient day, psychiatric inpatient units 1993-2008



Growth of community residential services

The National Mental Health Strategy recognised the central place of accommodation in promoting quality of life and recovery of functioning for people living with a mental illness. A wide spectrum of accommodation services is needed, including tenured housing, supervised community residential units, crisis and respite places and flexible support systems that provide assistance to people living in independent settings.

Deficiencies in accommodation options to replace the former role of large stand alone institutions have been linked to the failure of mental health reform initiatives overseas and were the focus of criticism in Australia by the Human Rights and Equal Opportunity Commission in the period immediately preceding the Strategy. Reporting on the results of its inquiry into human rights and mental illness, the Commission concluded that "... all the evidence considered by the Inquiry established that the policy of deinstitutionalisation cannot succeed unless it is complemented by appropriate policies on housing and a commensurate allocation of resources".²⁶

Similar themes have been voiced by consumer advocacy groups over the course of the Strategy.

The approach taken by the National Mental Health Report to monitoring community accommodation under the Strategy has focused mainly on the extent to which each state and territory has developed specialised community residential services, staffed by mental health professionals, that provide alternative care to that previously available in longer term psychiatric institutions. Before 1999-2000, the monitoring only focused on 24 hour staffed facilities. This was expanded to include units less intensively staffed (less than 24 hours) in order to provide a more comprehensive picture of specialised residential services.

Although this approach does not assess the extent to which the full range of accommodation options are in place, monitoring trends in the growth of staffed residential services has provided a useful point by which to compare the reduction in inpatient services.

²⁶ Human Rights and Equal Opportunity Commission (1993), *Human Rights and Mental Illness*, Australian Government Publishing Service, Canberra.

Commencing in 2002-03, states and territories agreed to augment this information by also reporting on the development of supported public housing places. These are defined as public sector accommodation places, specifically provided for people with mental illness, under an agreement between the relevant state/territory housing and health authorities. This information, presented for the first time in the 2005 National Mental Health Report, adds a new ingredient for understanding each jurisdiction's residential and accommodation services development strategy.

Figure 43 shows the growth in general adult and older persons' residential beds between 1993 and 2008.²⁷ By June 2008, a total of 1,569 24 hour staffed beds were available, 90% above 1993 service levels. Residential beds for older persons' accounted for 43% of the total and about one in three of all new 24 hour staffed beds commissioned since 1993.

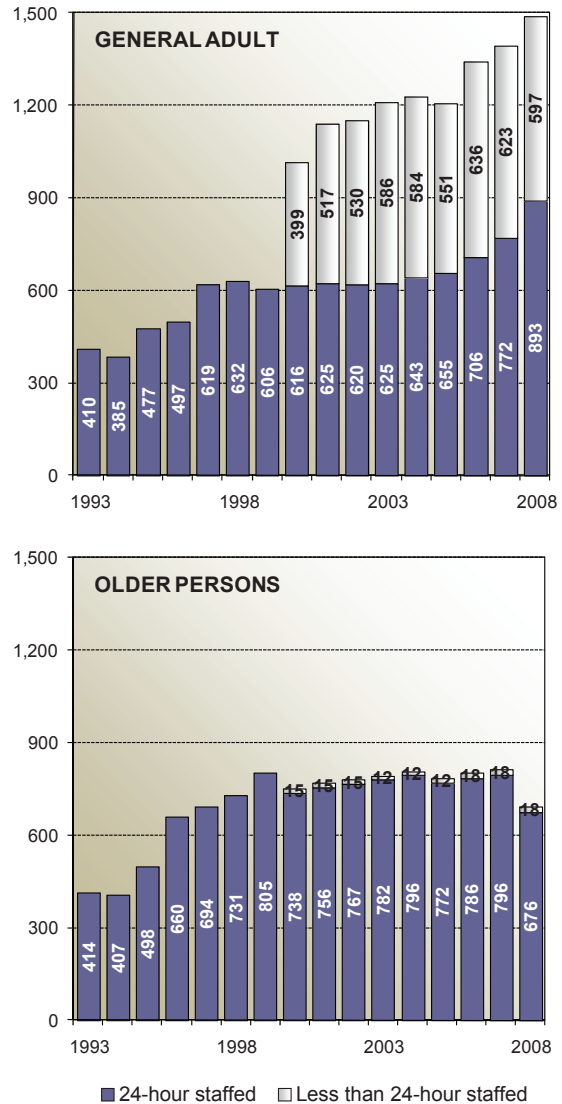
At the national level, the growth in 24 hour staffed residential services (745 beds) is equivalent to only about one third of the reduction in long stay beds in psychiatric hospitals (2,144 beds). The additional 615 beds staffed on less than a 24 hour basis available in 2008 provides partial compensation, but it is not possible to chart how these have developed over the full 15-year period. They have almost exclusively been developed for general adult rather than aged clients and provide varying levels of on-site supervision, ranging from six hours per day to units staffed up to 18 hours.

Development of staffed community residential services has been patchy with much variation between jurisdictions. Up until 2005, the vast majority (85%) of the growth in 24 hour staffed services was undertaken by Victoria. More recently, jurisdictions with very limited development previously have begun investing in

²⁷ Interpretation of trends in residential services needs to take account of changes in reporting of services for Queensland and New South Wales. Approximately 80 adult beds in Queensland included in the residential category for the years 1999-2000 to 2004-05 are classified as non acute adult inpatient beds from 2005-06. In New South Wales, approximately 100 residential beds reported as older persons services for years up to 2006-07 have been reclassified as non acute inpatient services in the 2007-08 data. See Appendix 2, Table A-3, note (6) for details.

Additionally, a revised definition of staffed residential services was implemented from 2005-06 that required minimum on site staffing hours to be 50 hours per week, with at least 6 hours on any single day. No minimum staffing hours criterion was applied in earlier years.

Figure 43: Total beds in general adult and older persons staffed residential services, June 1993 to June 2008

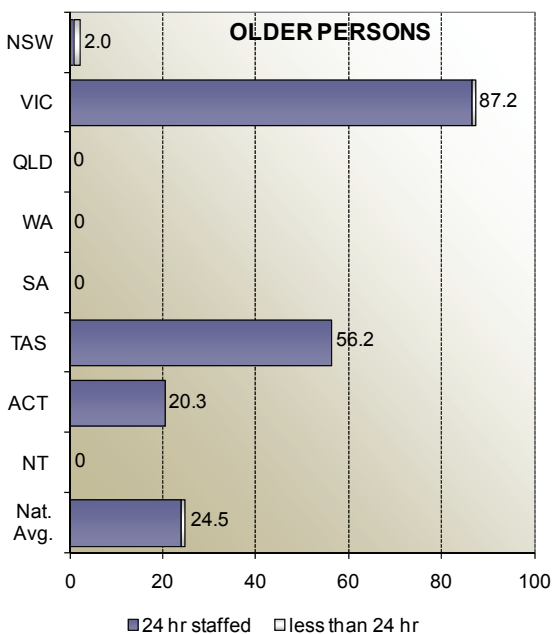
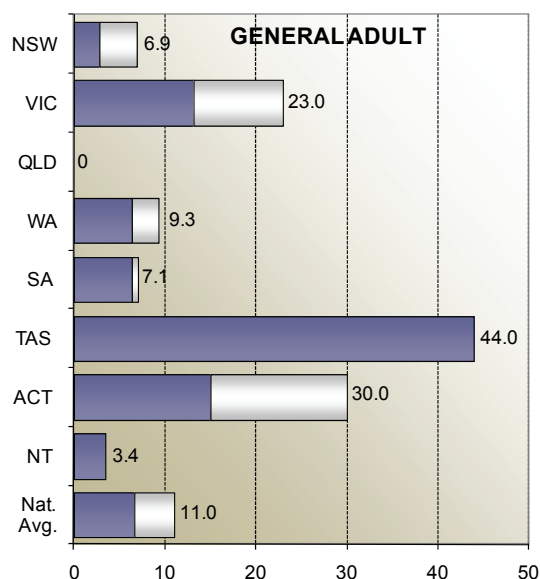


Note: Data on 'less than 24 hour staffed' beds not available prior to 1999-00.

staffed residential services for adult consumers to fill a widely acknowledged service gap. Victoria has also continued to expand its general residential services, increasing the number of general adult beds by a further 30% since 2005.

Figure 44 compares the jurisdictions on adult and older persons residential services available at June 2008. For general services, three jurisdictions – Tasmania, ACT and Victoria – were the leading providers and stand well above other jurisdictions. For older persons residential services, there is greater variability but Tasmania, ACT and Victoria again are marked by their service provision levels relative to other jurisdictions. Victoria in particular is unusual when compared to other jurisdictions in

Figure 44: Number of beds in general adult and older persons staffed residential services per 100,000, June 2008



Notes:

- Estimation of per capita rates is based on age-specific populations for each target group:
 - General adult: Based on population aged 18-64 years.
 - Older persons: Based on population aged 65 years and over.
- Approximately 80 general adult beds in Queensland meet criteria for 24 hour staffed residential services but are reported by Queensland as adult non acute inpatient services.

terms of its investment in specific residential services for older consumers. Nine out of ten residential beds for older persons available in Australia at June 2008 were provided by Victoria.

Table 7: Number of supported public housing places, June 2003 and June 2008

	Number of places		Places per 100,000	
	2003	2008	2003	2008
NSW	987	1,516	14.8	21.8
VIC	1,179	1,397	24.1	26.5
QLD	-	68	0.0	1.6
WA	358	659	18.5	30.8
SA	59	112	3.9	7.0
TAS	0	27	0.0	5.5
ACT	75	48	23.1	14.0
NT	18	33	9.0	15.2
Total	2,676	3,860	13.5	18.2

Note: Number of places refers to the number of persons who can be accommodated, not the number of houses.

Table 7 summarises the data on the availability of supported public housing places within each of the jurisdictions. It shows that 3,860 such places were available in June 2008, 44% more than in 2003. Although supported housing places were reported by all jurisdictions in 2007-08, Table 7 suggests that Western Australia and Victoria lead development in this area.

The concept of 'supported places' signifies the purpose of these services, designed to assist people to live as independently as possible through the provision of ongoing clinical and disability support, including outreach services in their homes. They are seen by consumer advocates as essential components of a recovery oriented service system.

Consensus has not emerged between the states and territories on planning benchmarks for provision of community residential services. However, demand pressures on acute inpatient units have highlighted the lack of bed-based acute and subacute options that might be used by consumers with severe conditions requiring specialist care, but who do not need the intensity of treatment provided in acute hospital units. Lack of development of such services by most jurisdictions has been noted in previous National Mental Health Reports as a significant issue in relation to the commitment by all states and territories to develop a full range of community services to replace the historical functions of the stand alone psychiatric hospitals. Developments over the closing years of the Third National Mental Health Plan indicate that most jurisdictions are beginning the service development needed to fill the gaps.

Summary of comparative inpatient and 24 hour community residential service levels

This section brings together the inpatient and community residential services data to give a fuller comparison of the service levels in each of the states and territories. Such a summary is necessary given the different emphases across the jurisdictions on inpatient and residential components.

Figure 45 compares the jurisdictions on available inpatient and 24 hour staffed residential beds per 100,000 population. Community residential beds staffed on a 24 hour basis comprised 19% of the total beds available nationally at 30 June 2008, but differences between the jurisdictions in the mix of services are significant. At the upper end of the range, Tasmania provides 58% of its bed-based services in 24 hour staffed community residential services, followed by Victoria (44%) and ACT (38%). These contrast with an average of 13% for the other jurisdictions. The between-jurisdiction relativities in inpatient bed numbers shown in Figure 31 (see page 42) are shifted substantially when residential services are added to the equation. For example, Tasmania ranks fifth in terms of inpatient bed provision, but moves to the top position when both inpatient and 24 hour residential beds are taken into account.

Figure 45: Total inpatient and 24 hour staffed residential beds per 100,000, June 2008

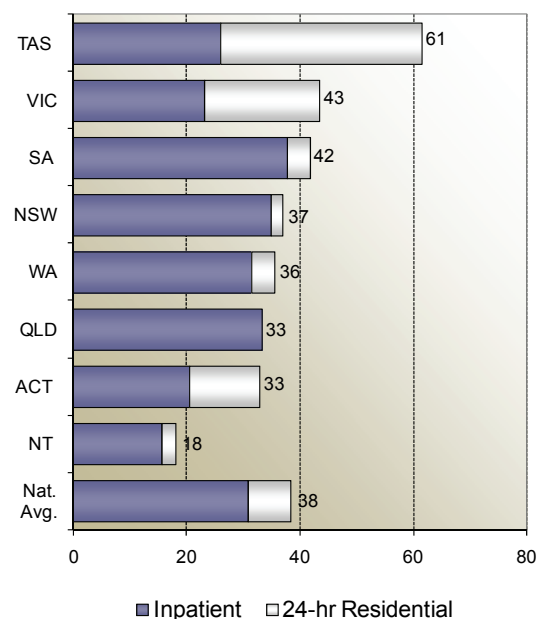


Table 8 provides a more detailed view of the inpatient and residential service mix available for specific target populations in each jurisdiction at June 2008. Greater divergence between states and territories is evident in the provision of older persons services than for other target populations.

Table 8: Inpatient and 24 hour residential beds per 100,000 by target population, June 2008

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
General adult									
Acute inpatient	27.6	20.1	22.1	26.0	25.9	26.6	21.4	23.2	24.2
Non acute inpatient	12.3	3.0	14.3	8.0	8.3	8.9	0.0	0.0	9.2
24 hour staffed residential	2.8	13.1	0.0	6.3	6.4	44.0	15.0	3.4	6.6
<i>Total General adult</i>	<i>42.7</i>	<i>36.1</i>	<i>36.5</i>	<i>40.3</i>	<i>40.5</i>	<i>79.4</i>	<i>36.4</i>	<i>26.6</i>	<i>39.9</i>
Child and adolescent									
Acute inpatient	3.3	5.5	5.0	3.9	3.4	0.0	0.0	0.0	4.1
Non acute inpatient	2.5	0.0	1.4	1.5	0.0	0.0	0.0	0.0	1.3
<i>Total Child and adolescent beds</i>	<i>5.9</i>	<i>5.5</i>	<i>6.4</i>	<i>5.4</i>	<i>3.4</i>	<i>0.0</i>	<i>0.0</i>	<i>0.0</i>	<i>5.4</i>
Older persons									
Acute inpatient	16.7	29.9	9.7	38.7	31.7	0.0	58.0	0.0	22.1
Non acute inpatient	21.3	0.0	26.2	11.6	51.7	0.0	0.0	0.0	17.7
24 hour staffed residential	0.7	86.3	0.0	0.0	0.0	56.2	20.3	0.0	23.9
<i>Total Older persons beds</i>	<i>38.7</i>	<i>116.3</i>	<i>35.9</i>	<i>50.3</i>	<i>83.4</i>	<i>56.2</i>	<i>78.4</i>	<i>0.0</i>	<i>63.6</i>
Forensic									
Acute inpatient	1.8	1.9	0.0	1.1	0.6	5.3	0.0	0.0	1.3
Non acute inpatient	2.1	1.9	5.0	1.1	2.6	0.0	0.0	0.0	2.4
<i>Total Forensic beds</i>	<i>3.8</i>	<i>3.8</i>	<i>5.0</i>	<i>2.3</i>	<i>3.2</i>	<i>5.3</i>	<i>0.0</i>	<i>0.0</i>	<i>3.8</i>
All beds									
All Inpatient	34.9	23.1	33.2	31.3	37.7	25.8	20.5	15.6	30.8
All 24 hour staffed residential	1.9	20.2	0.0	4.1	4.0	35.5	12.3	2.3	7.4
<i>Total beds</i>	<i>36.8</i>	<i>43.3</i>	<i>33.2</i>	<i>35.5</i>	<i>41.7</i>	<i>61.4</i>	<i>32.7</i>	<i>17.9</i>	<i>38.2</i>

Note:

Estimation of per capita rates is based on age-specific populations for each program type:

- *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.
- *Forensic*: Based on total population aged 18 years and over.
- *'All beds'* based on total beds and population.

Workforce changes associated with the shift in service mix

The wide ranging changes that have occurred in the financing and structure of Australia's public mental health services over the 1993-2008 period are also reflected in shifts in the composition, size and distribution of the workforce. These are summarised below.

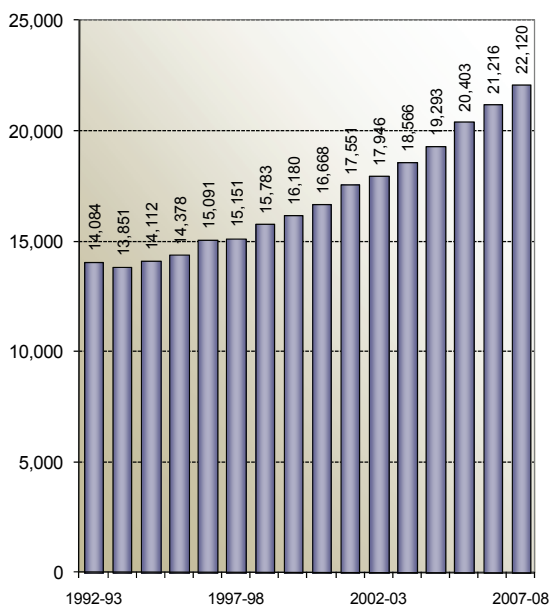
Changes in workforce size and distribution

The direct care workforce employed in public sector mental health services increased by 57% between 1993 and 2008, equivalent to approximately 8,036 full-time staff (Figure 48). Approximately half the total growth occurred over the period of the Third National Mental Health Plan.

Changes in both the settings in which people are employed and the staffing mix have accompanied the growth in workforce numbers. A greater proportion of direct care staff is now working outside of hospitals and providing treatment in community settings. Since the commencement of the Strategy:

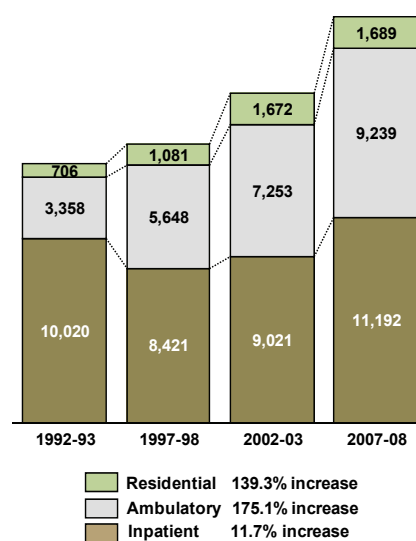
- staffing in inpatient services has increased by 12% and accounted for 50% of the service delivery workforce in 2007-08 compared with 71% in 1992-93; and
- combined staffing in ambulatory care and residential services has grown by 169% (Figure 46).

Figure 48: Number of direct care staff (FTE) employed in state and territory mental health services 1992-93 to 2007-08



Note: Direct care staff refers to the total number of staff employed in inpatient, ambulatory and residential services in the following occupational categories: Nursing; Medical; Allied Health; Other Personal Care

Figure 46: Change in the distribution of direct care staff (FTE) by service setting, 1992-93 to 2007-08



Change in clinical workforce composition

Data on the composition of the clinical workforce are only available from 1993-94. Figure 47 summarises the information and shows the growth in each of the major clinical provider groups between 1994 and 2008.

More detailed information about the subgroups that make up each of the major occupational categories is available from 1994-95. Table 9 presents that data.

All clinical service provider groups have expanded under the Strategy, but there has been a shift in the professional staffing mix. Medical and allied health staff have increased the

Figure 47: Distribution of direct care staff (FTE) by broad occupational group, 1993-94 and 2007-08

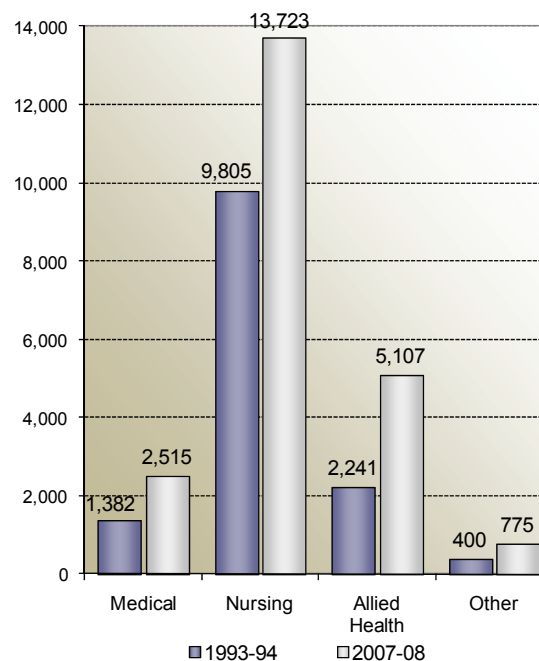


Table 9: Change in the mental health clinical workforce (FTE), 1994-95 to 2007-08

	1994-95	1997-98	2002-03	2007-08	Change since 1994-95	Average annual growth
MEDICAL						
Consultant psychiatrists	560	657	753	1,094	95%	5.4%
Psychiatry registrars	568	659	882	1,086	91%	5.2%
Other medical officers	273	303	284	336	23%	2.5%
<i>Total Medical</i>	<i>1,401</i>	<i>1,619</i>	<i>1,920</i>	<i>2,516</i>	<i>80%</i>	<i>4.6%</i>
ALLIED HEALTH						
Psychologists	696	1,024	1,417	1,741	150%	7.5%
Occupational therapists	525	548	697	859	64%	4.0%
Social workers	759	975	1,233	1,592	110%	5.9%
Other allied health	546	624	779	920	68%	4.5%
<i>Total Allied Health</i>	<i>2,527</i>	<i>3,171</i>	<i>4,125</i>	<i>5,112</i>	<i>102%</i>	<i>5.6%</i>
NURSING						
Registered nurses	8,318	8,504	9,649	11,518	38%	2.6%
Non registered nurses	1,262	1,323	1,663	2,209	75%	4.6%
<i>Total Nursing</i>	<i>9,580</i>	<i>9,827</i>	<i>11,312</i>	<i>13,727</i>	<i>43%</i>	<i>2.8%</i>

Note: Minor discrepancies with 2007-08 estimates shown in Figure 47 are due to conflicting data reported by a small number of organisations.

most and grown to 34% of the clinical workforce in 2007-08 compared with 26% in 1993-94. The move to develop multi-disciplinary community services has underpinned these changes.

Since 1993-94:

- Medical staff have increased by 82% and made up 11% of the clinical workforce in 2007-08. Growth within the medical category has been achieved through increases in all categories. Both the consultant psychiatrist and psychiatry registrar training category have nearly doubled between 1994-95 and 2007-08.
- Allied health staff – psychologists, social workers and occupational therapists and other categories of therapists – have increased by 128%, accounting for 23% of the clinical workforce in 2007-08. Growth has occurred across all provider categories. Psychologists and social workers, the groups with the greatest percentage growth, each comprised about one third of the category in 2007-08, and occupational therapy 17%.
- Nursing staff numbers have increased by 40% and represented 62% of the 2007-08 clinical workforce. The growth has been primarily through an increase in registered nurses rather than non registered nurses. While the nursing profession has experienced the smallest percentage change of all the labour categories, nurses account for about 47% of the overall workforce growth.

State and territory comparative workforce levels

Nationally, the 57% growth in the direct care workforce is equivalent to a 30% increase when population size is taken into account. The growth pattern has been uneven across and within jurisdictions. Figure 50 summarises the trends for each of the states and territories.

All jurisdictions have increased the overall size of their workforce in per capita terms when compared with 1992-93 levels. Relative to individual baselines, most growth occurred in New South Wales, where the direct care workforce increased by 44% in per capita terms.

Figure 49: Comparison of states and territories on number of direct care staff (FTE) per 100,000, 1992-93 and 2007-08

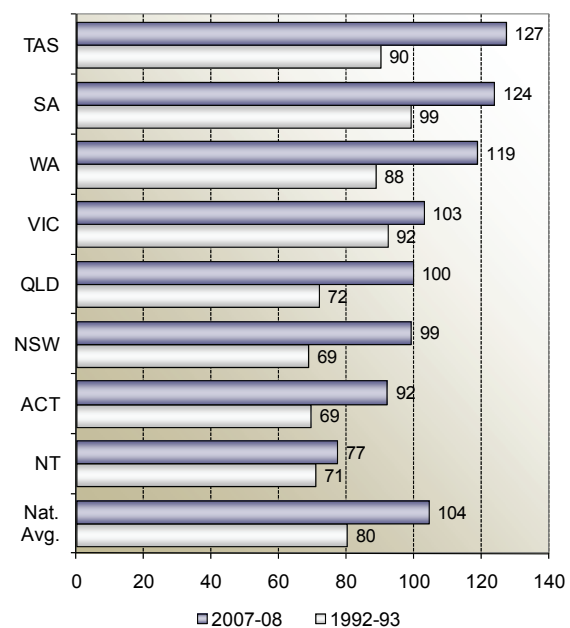
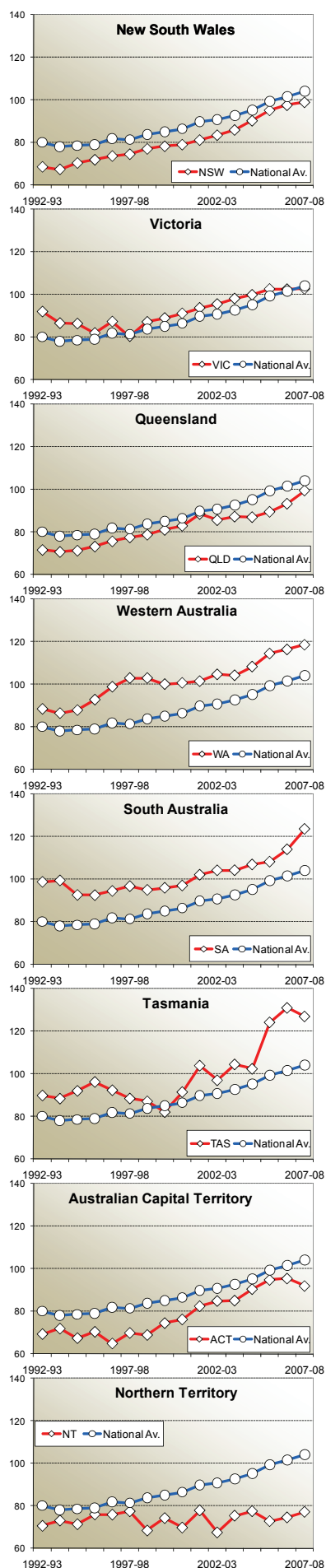


Figure 50: Number of direct care staff (FTE) employed in mental health services per 100,000, 1993 to 2008



Per capita growth in workforce levels in Tasmania (41%) and Queensland (39%) has closely followed New South Wales.

Inequities continue between the states and territories in the number of mental health professionals employed (Figure 49). By 2007-08, Tasmania reported the highest per capita number of health professionals in its mental health workforce, with a level 22% above the national average, followed by South Australia. Workforce levels were the lowest in the Northern Territory.

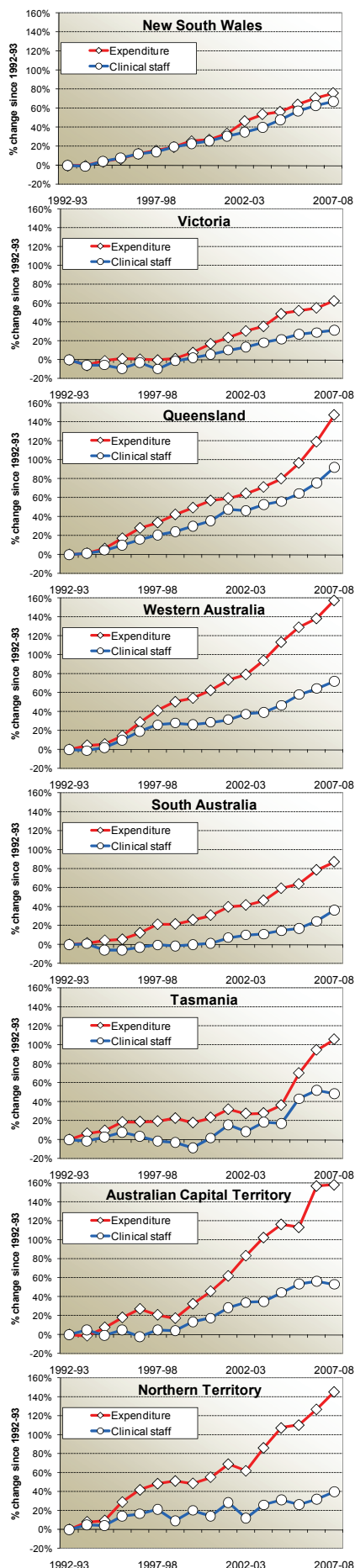
As could be expected, most jurisdictions with more than average per capita expenditure also provide workforce levels higher than the national average. However, the relationship between expenditure and workforce is not straightforward. At the national level, the increase in the clinical workforce was only two thirds the size of the growth in service related expenditure over the 1993-2008 period. Two jurisdictions with close to, or above, national average spending in 2007-08 (Northern Territory, ACT) provided a clinical workforce at less than the national average level. Conversely, three jurisdictions with lower than average spending in 2007-08 (Queensland, New South Wales and Victoria) reported clinical workforce levels that approximated the national average.

For all jurisdictions except New South Wales, increases in spending on mental health were significantly higher than overall workforce growth. For most other jurisdictions, the 15 year growth in service related spending has more than doubled the growth in clinical workforce. Figure 51 summarises the 15 year trends for each jurisdiction.²⁸

The extent to which higher spending translates into more staff is affected by differences between the jurisdictions in labour costs and differential movement in wages. Increased overhead and infrastructure costs (including training and support) have also contributed. Other factors are also relevant, including the higher costs incurred in recruiting and maintaining sufficient numbers of skilled staff in jurisdictions with significant rural populations. These problems have continued throughout the course of the National Mental Health Strategy.

²⁸ Growth in service expenditure shown in Figure 51 is based on expenditure reported for inpatient, ambulatory and residential services and excludes indirect and non residential NGO spending.

Figure 51: Growth in service expenditure compared with growth in direct care staff (FTE), 1993 to 2008



Progress towards quality improvement in state and territory services

Concerns about poor service quality were a major factor leading to the formulation of the National Mental Health Policy in 1992. The reform agenda was ambitious and not all objectives were progressed at an equal pace. Much of the effort over the first five years focused on structural change, targeted at addressing inadequacies in state and territory mental health service systems. Alongside this focus, the Strategy called for a move from the historical focus on service inputs and structure, to service standards, quality and outcomes. Most criticism of mental health services over recent years has focused on its alleged failures in these areas.

Developmental work was initiated under the First National Mental Health Plan to lay the groundwork for a range of quality improvement activities within the public sector. By 1998, most of that work had been completed, but had not been translated into specific initiatives at the service delivery level. The evaluation of the First Plan noted this and concluded:

*"... current services fall far short of the Strategy vision for Australia ... many initiatives taken, particularly those focusing on service quality and outcomes, will not deliver results for several years and will need the momentum to be maintained."*²⁹

The Second Plan added emphasis to the drive for quality improvement by incorporating 'quality and effectiveness' as one of its three priority themes. The Plan advocated a range of measures with a particular focus on improving consumer outcomes across the lifespan.

The Australian Health Care Agreements 1998-2003 provided the funding vehicle for implementing the Second National Health Plan. Under the Agreements, all states and territories committed to the introduction of two service quality initiatives: the implementation of the *National Standards for Mental Health Services*; and the introduction of *routine consumer outcome measurement*. States and territories committed

²⁹ AHMAC National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy: Final Report*, Australian Health Ministers' Advisory Council, Department of Health and Ageing, Canberra.

to continuing implementation of both initiatives under the Third National Mental Health Plan.

This section summarises progress to June 2008 on each of these initiatives.

Implementation of National Standards for Mental Health Services 1996

The *National Standards for Mental Health Services* were developed under the First National Mental Health Plan for use in assessing service quality, and as a guide for continuous quality improvement in all Australian public mental health services.³⁰ The standards are the equivalent of accreditation systems in general hospitals. They were designed to give confidence to the public that their local mental health services are equipped to provide care that is in keeping with modern practice.

The standards cover eleven major criteria, organised in three categories (Figure 52). Standards 1 to 7 relate to the universal issues of human rights, dignity, safety, uniqueness and community acceptance. Standards 8 to 10 address mental health service organisational structures and links between parts of the mental health sector. Standard 11 describes the process of delivering care on a continuum and the types of treatment and support that should be available to consumers.

The state and territory agreement to implement the National Standards was slow to begin, with several jurisdictions delaying action until midway through the Second Plan.

Figure 53 summarises the progress achieved by each of the jurisdictions by the close of the Third National Mental Health Plan, measured in terms of the percentage of services that had completed the external review processes by June 2008. Nationally, 86% of services had reached this stage in implementing the Standards, rising from 78% since last reported for June 2005.

Comprehensive implementation of the National Standards was expected to be completed by the

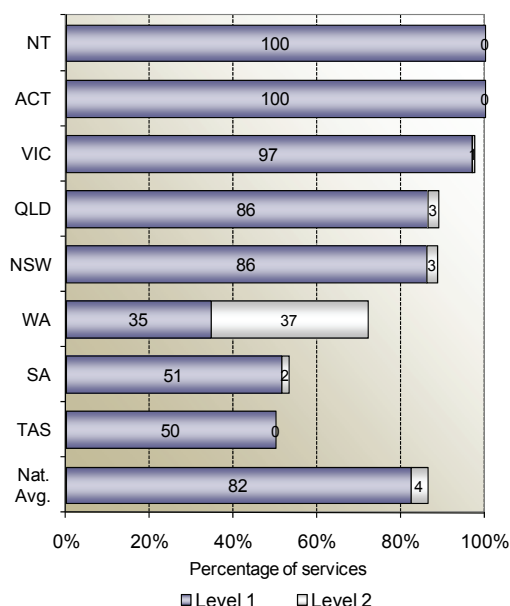
Figure 52: The National Standards for Mental Health Services 1996

1. Consumer rights
2. Safety
3. Consumer and carer participation
4. Promoting community acceptance
5. Privacy and confidentiality
6. Prevention and mental health promotion
7. Cultural awareness
8. Integration
9. Service development
10. Documentation
11. Delivery of care

end of the Third National Mental Health Plan in 2008. While this was substantially achieved by five jurisdictions, three (Western Australia, South Australia and Tasmania) fell significantly below the 100% completion target.

Two limitations of the current approach to monitoring implementation of the National Service Standards that became apparent during the course of the Third National Mental Health Plan need to be taken into account when comparing the jurisdictions' performance. Firstly, states and territories report implementation progress on a different basis,

Figure 53: Percentage of state and territory mental health services that completed external review under the 1996 National Standards for Mental Health Services, June 2008



Notes:

1. Level 1 – services have been reviewed and assessed as meeting all Standards.
2. Level 2 - services have been reviewed and assessed as meeting some but not all Standards.

³⁰ The 1996 National Service Standards were developed by a consortium comprising the Australian Council on Healthcare Standards (ACHS), the Community Health Accreditation Standards Program (CHASP) of the Australian Community Health Association (ACHA) and the Area Integrated Mental Health Service Standards (AIMHS). See Department of Health and Family Services (1996) *National Standards for Mental Health Services*, Commonwealth of Australia, Canberra.

with some reporting a single 'score' for whole organisations and others reporting at the level of individual service units. This is the result of the way in which the National Service Standard have been incorporated in the overall health accreditation process. External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require an individual mental health service unit (for example, a community mental health centre managed by the hospital) to be separately assessed against the National Standards. Rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Secondly, because the assessment is based on a periodic review, usually only conducted every three to five years, achievement of the Standards does not reflect the quality of actual services delivered, nor the extent to which service delivery organisations use the Standards as a tool for ongoing quality improvement beyond getting across the initial accreditation hurdle.

Improved reporting of the implementation of National Service Standards is a challenge to be addressed under the Fourth National Mental Health Plan.

The 1996 National Service Standards are soon to be replaced by a revised set. A review of the Standards was completed in 2008 with a view to better align them with developments in mental health reform, current legislation and to strengthen the focus on provision of services that are evidence-based, integrated and

recovery-focused. Revised standards have been developed (Figure 54) and are expected to be introduced progressively during the Fourth National Mental Health Plan period.

Implementation of routine consumer outcomes measurement

Establishing a system for the routine monitoring of consumer outcomes has been an objective of Australia's National Mental Health Strategy since it was first agreed by Health Ministers in 1992. The National Mental Health Policy included as one of its original objectives:

"To institute regular review of client outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery."

The goal was to develop standard measures of a consumer's clinical status and functioning and apply these at entry and exit from care to enable change to be measured. For consumers who require longer term care, the measures were envisaged to be applied at regular review points. The original intent was for outcome measurement to be introduced in a way that provided both clinician and consumer perspectives on the extent to which services are effective in achieving improvements.

The concept was simple but ambitious in the context of the poor status of information in mental health services in the early 1990s. Most services did not routinely collect basic clinical and service delivery data, nor have systems capable of timely analysis and reporting of such data to inform clinical care. Instruments for measuring consumer outcomes on a routine basis were not available at the commencement of the Strategy, nor was a set of candidate measures evident. More significantly, there were few precedents to follow, as no other country had established routine consumer outcome measures comprehensively across their publicly funded mental health services.

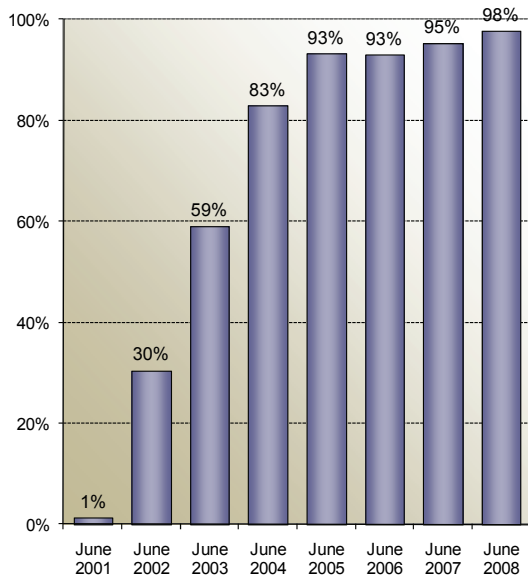
In response, a research and development program was initiated early in the Strategy to identify outcome measures that were feasible for use in routine clinical practice with adult consumers. This resulted in the selection of a small set of standard measures that were put to trial. Similar work was undertaken in relation to outcome measures for use in child and adolescent mental health services.

Implementation of the selected measures in state and territory mental health services

Figure 54: The revised 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 (Supporting recovery; Access; Entry; Assessment and review; Treatment and support; Exit and re-entry)

Figure 55: Percentage of public mental health system collecting and reporting consumer outcome measures



Sources: June 2001 to June 2003, National Mental Health Report 2007; June 2004-2010, Report on Government Services 2010.

commenced under the Second National Mental Health Plan, supported by \$38 million of Australian Government funds provided under the Australian Health Care Agreements. Further outcomes targeted funding of \$22 million was provided to states and territories under the Agreements covering the period 2003-2008.

Implementation of the 'simple concept' articulated in 1992 has taken the mental health sector into a period of major industry re-development and involved all public mental health services. By June 2008, routine measurement of consumer outcomes is now in place in an estimated 98% of public mental health services (Figure 55). Information systems in each state and territory have been overhauled to accommodate the new requirements. Over 12,000 clinicians have received training.

To support developments at the state and territory level, systems have also been established nationally to enable pooling and analysis of the information as well as being made available via the internet to support clinical staff in assessing the progress of individual consumers (see www.amhocn.org). States and territories are contributing to the national data pool approximately 420,000 de-identified records annually for which outcome data are collected.

In parallel, regular assessment of consumer outcomes has been comprehensively

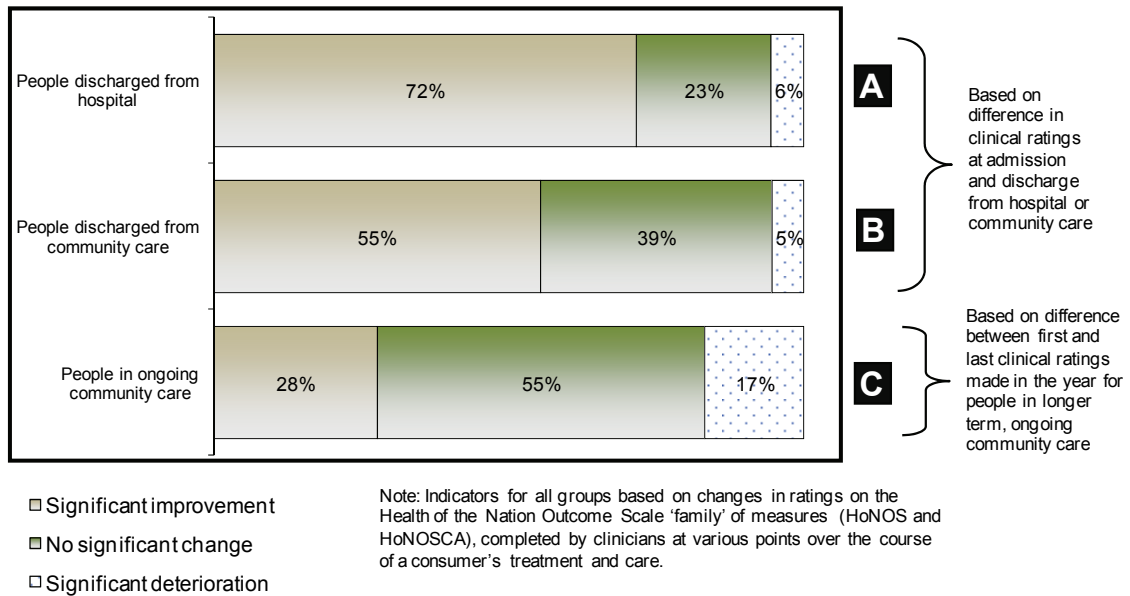
implemented in the private hospital sector, with 98% of hospitals with a psychiatric unit participating in the national data collection.

The information gathered to date has provided important insights, summarised in Figure 56.

- For people admitted to state and territory managed psychiatric inpatient units (Group A in Figure 56), 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 (6%), their clinical condition is worse at discharge than at admission. About one in five (23%) are discharged with no significant change in their clinical condition.
- The picture for people treated in the community by state and territory mental health services is more complex because it covers a wide range of people with varying conditions. Some people receive relatively short term care in the community, entering and exiting care within the year (Group B in Figure 56). For this group, approximately half (55%) experience significant clinical improvement, 5% deteriorate and about 40% (39%) experience no significant clinical change.
- A second group of consumers of state and territory community care are in longer term ongoing care (Group C in Figure 56). 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 (55%) experience no significant change in their clinical condition, compared with approximately one quarter (28%) who improve and 17% who undergo 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 undergone a worsening of symptoms.

These results are both complex and difficult to distil to a single message. The data suggest that consumers of state and territory mental health care have a range of clinical outcomes that

Figure 56: Clinical outcomes of people receiving various types of mental health care, 2006-07



Sources: Australian Health Ministers' Conference. Council of Australian Governments National Action Plan for Mental Health 2006-2011 Second Progress Report covering implementation to 2007-08. September 2009. (2006-07 is the latest published data)

cannot be described by a simple average statistic. They also raise questions about what 'best practice' outcomes should be expected by consumers treated in Australia's public mental health system.

The picture derived from Australia's investment in routine outcome measurement represents 'work in progress' that is both imperfect and incomplete. 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 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 vs community) rather than tracking the person's overall outcomes across treatment settings.

Australia's introduction of routine outcome assessment in mental health services is a major undertaking that will require a long term effort. Continued government collaboration will be required to support the further development of a national approach to measuring and reporting on consumer outcomes. As there are no

international precedents to guide the work, Australia needs to continue 'growing the evidence' from which any quantitative indicators will emerge.

All jurisdictions have committed to continuing the implementation over the course of the Fourth National Mental Health Plan.

Conclusions about 15 years of reform in state and territory mental health services

The most recent data submitted by states and territories for this report completes 15 years of reporting under the National Mental Health Strategy, covering the First, Second and Third National Mental Health Plans. The significance of the structural changes made to service systems was acknowledged in the evaluations of all three plans, along with the limitations of the achievements. The conclusions drawn from the evaluations provide useful insights for looking back over the indicators of progress presented in the current National Mental Health Report.

The evaluation of the First Plan observed that *"... the direction set by the Strategy has led to changes in the structure and mix of mental health services that are unparalleled in Australia's history*

*... Where new community services have been established, these are especially valued and seen as the 'backbone' of the service."*³¹

The evaluation concluded that the extent of change achieved in the first five years was not sufficient. *"Beneath the national level, the scale and pace of change is not uniform across the jurisdictions. Development in several States is slow, and considerable disparity exists between regions with services in most rural areas being particularly undeveloped ... For many, the Strategy vision of accessible, responsive and integrated services has little resemblance to current reality. National groups responding to the evaluation most frequently identified service mix issues as the highest priority for future attention"*.³¹

These comments summarised the situation as Australia entered the Second National Mental Health Plan. Further reforms of the specialised public mental health system remained on the agenda for the years ahead. However, the Second Plan introduced the additional expectation that the states and territories would pursue these in parallel with the new themes of prevention and promotion, partnerships and service quality.

The direction and rate of change that took place under the Second National Mental Health Plan were consistent with the developments of the preceding five years. Ambulatory services continued to grow, both in expenditure and workforce terms. Stand alone psychiatric hospitals continued to be reduced in size with savings re-invested in new services by all jurisdictions. The reduction in bed numbers that was a feature of the First National Mental Health Plan slowed considerably in the majority of jurisdictions.

By 2003, many of the major structural reforms proposed at the outset of the Strategy ten years earlier had been followed through by all jurisdictions, and were near completion in some cases. All states and territories had transferred the management of public mental health services to the mainstream health system.

The evaluation conducted at the conclusion of the Second National Mental Health Plan echoed similar views to those made in the earlier evaluation and observed that:

"... Australia has continued to pursue and make progress implementing the objectives of the National Mental Health Strategy ... However, the extent and pace of progress has not universally been viewed as satisfactory ... national community consultations reveal a high level of dissatisfaction.

... progress has been constrained by the level of resources available for mental health and by varying commitment to mental health care reform. While the aims of the Second Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment.

... Despite the considerable progress made towards community care, the consultations revealed that community treatment options are perceived to be unavailable or inadequate.

*... The aims of the National Mental Health Strategy have not yet been fully translated into the expected benefits for consumers and carers or the general population."*³²

³¹ AHMAC National Mental Health Strategy Evaluation Steering Committee (1997) *Evaluation of the National Mental Health Strategy: Final Report*, Australian Health Ministers' Advisory Council, Department of Health and Ageing, Canberra.

³² AHMAC Steering Committee for the Evaluation of the Second National Mental Health Plan (2003) *Evaluation of the Second National Mental Health Plan*, Australian Health Ministers' Advisory Council, March 2003.

The Third National Mental Health Plan, developed after a decade of previous reform, established the framework for further development of mental health services over the period 2003 to 2008. The data presented in this report shows that progress continued in the same direction and at roughly the same pace in most indicators, with three notable exceptions.

- The pattern of steady decline in inpatient bed numbers that characterised the First and Second National Mental Health Plans reversed under the Third Plan. Inpatient bed numbers increased by 8% between 2003 and 2008.
- Growth of the clinical workforce accelerated. About half of the total increase in the size of the clinical workforce achieved over the 15 years of the National Mental Health Strategy occurred between 2003 and 2008.
- Similarly, funding provided by state and territory governments to NGOs for mental health services accelerated. Sixty percent of the total growth in NGO funding over the course of the National Mental Health Strategy took place between 2003 and 2008.

While all jurisdictions reported significant spending increases over the course of the Strategy, a common pattern that continued under all three national plans was that growth in expenditure significantly outstripped growth of the clinical workforce and services delivered. At the national summary level, the purchasing power of the mental health dollar in 2008 was 20-30% less than in 1993 when measured in terms of workforce or services purchased.

The implication is that misleading conclusions about expansion of mental health resources will be drawn if judged on spending alone. Workforce growth, the key factor for a labour-intensive health sector, suggests the gains in state and territory mental health have been more modest than suggested by spending growth.

Differences between jurisdictions continue to be prominent to the extent that a summary of the 'national picture' does not provide an accurate reflection of any specific state or territory.

At the end of 15 years of reform, the mental health service system is faced with a different set of challenges, arising from both the new demands of community service delivery and higher community expectations for better

access to, and better quality of, mental health care.

The key question is whether the service reform efforts have brought Australia closer to an optimal mix of services to meet the population's needs for mental health care. The absence of international benchmarks that define the right mix of services to meet a given population's needs makes it difficult to reach a definitive conclusion. However, a range of information suggests that the task is far from complete.

- Major disparities continue between jurisdictions in the mix and level of services. Development of longer term residential and non government support services continues to be uneven despite the original commitment that these are fundamental to a community oriented service system.
- All states and territories experienced over the period of the Third Plan increased demand pressures for mental health care right across the health sector, particularly for acute and emergency care. Consumers and carers consistently point to these problems as needing urgent attention.
- Workforce shortages are reported by all jurisdictions and are particularly critical in nursing, affecting both the quantity and quality of care.

The evaluation of the Third National Mental Health Plan acknowledged the continuing progress made between 2003 and 2008 but, like previous evaluations, identified areas of ongoing concern.

"... this summative evaluation shows that progress was made in all the key areas and stated outcomes of the National Mental Health Plan 2003-2008 ... (but) ... there was a level of dissatisfaction expressed on the part of a range of constituents that not enough progress was made."

The evaluation highlighted the need to give greater focus to quantifiable reform targets and actions.

"The frustration expressed in the interviews included that the current Plan did not give specific guidance towards actionable and measurable items. Many of those interviewed viewed the Plan as somewhat too broad by trying to 'be all things to all people'."

Of the reform areas needing continuing effort, the evaluation highlighted the pivotal role of workforce.

“The challenges across the entire mental health workforce pose the greatest current challenge to the sustainability of a viable mental health system of care. A clear forward looking plan is required in the near future, which specifies the numbers of staff needed, with their defined skills and competences, up to 10 years ahead and across all sectors providing services for people with mental illness. Indeed many have told us that the provision of a sufficient workforce is a fundamental precondition for the successful implementation of a further Plan.”³³

The Council of Australian Governments *National Action Plan on Mental Health* in July 2006, represented an acceptance by all governments that more needs to be done. The Plan provided much needed impetus to accelerate reforms and focus on areas that had not progressed sufficiently under the National Mental Health Strategy. Under the Plan, all governments reiterated their commitment to mental health as a priority and foreshadowed substantial funding increases. As noted in the previous chapter, the impact of these began to be visible in the final year of the Third National Mental Health Plan and are expected to be more apparent in future reports.

Recent commitments by all governments to the revised National Mental Health Policy and a Fourth National Mental Health Plan have given greater emphasis to the need for whole of government approaches to mental health reform. Responding to the call for sharper reform focus, the Fourth Plan outlines specific areas will be targeted over the 2009-14 period, and reported on through new progress indicators in a revised future National Mental Health Report structure.

³³ Curie C and Thornicroft G (2009), *Summative Evaluation of the National Mental Health Plan 2003-2008*. Department of Health and Ageing, Commonwealth of Australia.

7. Private sector mental health services

Reform in the public sector was the principal focus of the National Mental Health Strategy in its first five years. Services provided outside the public sector were not originally considered within scope, but governments have become increasingly aware of the importance of partnerships with service providers operating in Australia's private health sector.

The private sector plays a key role in overall service delivery. By 2007-08, the sector:

- provided 22% of total psychiatric beds; and
- employed approximately 20% of Australia's mental health workforce.

This section reviews the provision of services provided through the private sector, both in private hospital settings and through services funded under the Medicare Benefits Schedule (MBS).³⁴

Medicare subsidised private sector mental health services

Previous National Mental Health Reports confined their coverage of MBS-funded services to the activities of Consultant Psychiatrists working in the private sector. The current report extends the scope to incorporate new MBS subsidised services provided by General Practitioners and allied health professionals that were introduced through Commonwealth Government initiatives under the 2006 COAG National Action Plan on Mental Health.

Commencing in November 2006, the initiative known as *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS*, (or more briefly, 'Better Access') introduced a range of Medicare subsidised services not previously available to people experiencing a mental illness. These included new Medicare items delivered by GPs, designated allied health professionals and Consultant Psychiatrists. As a package, the Better Access initiative was explicitly aimed at

increasing treatment rates for people affected by mental illness by opening up primary mental health care services to the public in a manner comparable to the availability of Medicare-funded services for those with physical illnesses.

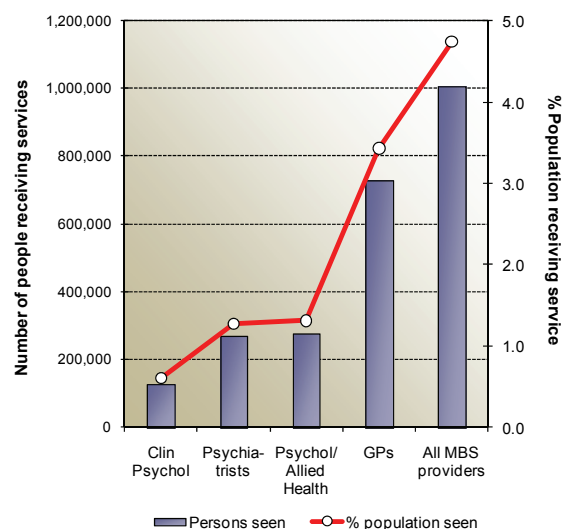
Approximately one million people received specific mental health services subsidised by the Medicare system in 2007-08, or 4.7% of the Australian population (Figure 57). As 2007-08 was the first full year of operation of the Better Access initiative, the data presented here only describe the early impact of the program. The overall number of people receiving mental health specific services subsidised by the MBS was about four times the number of people treated by Consultant Psychiatrists. GPs were the main provider group and provided services to seven out of every ten people seeking help from Medicare subsidised health professionals.

Further details and updated data on growth in use of Medicare funded mental health services are documented in the AIHW publication *Mental Health Services in Australia 2007-08*.

Consultant Psychiatrist services

In 2007-08, MBS payments to privately employed Consultant Psychiatrists represented 13% of Australian Government mental health expenditure, 44% of MBS benefits paid on mental health specific items and 5% of spending

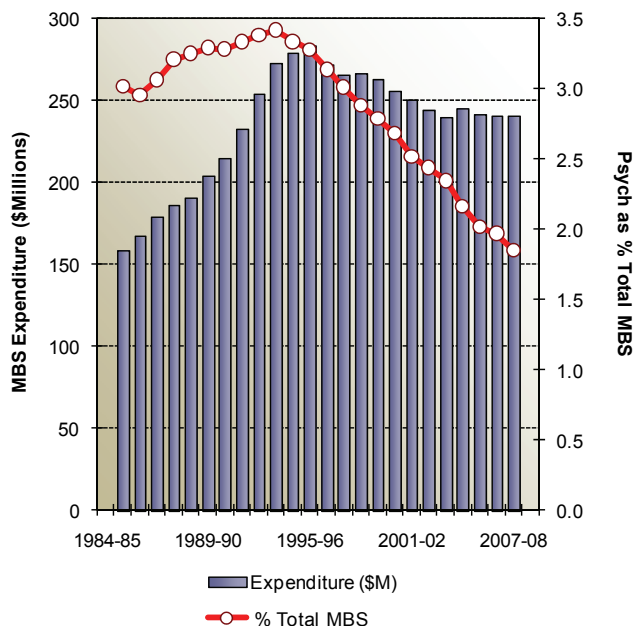
Figure 57: Number of people treated by Medicare subsidised mental health service providers, 2007-08



Note: 'All MBS providers' is less than the sum of people seen by individual provider groups because people may consult more than one type of health professional.

³⁴ The term 'private sector' is sometimes used to refer to all services that operate independently of government, including the range of 'not for profit', community managed non government organisations described in the previous chapter. This chapter does not cover these organisations but is instead focused on private 'for profit' service providers.

Figure 58: MBS expenditure on Consultant Psychiatrist services in constant prices and as a percentage of total MBS Benefits, 1984-85 to 2007-08



by all governments' on specialised mental health services.

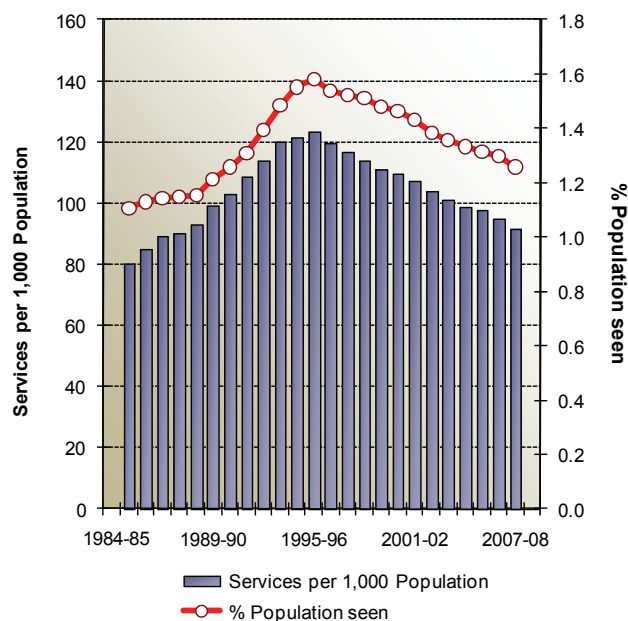
Information presented in early editions of the National Mental Health Report highlighted much variation across Australia in the access of local populations to Consultant Psychiatrists. The reports also documented the considerable growth in MBS-funded services provided by Consultant Psychiatrists in the ten years following its introduction in 1984-85.

Subsequent reports confirmed that a slowing down in the rate of growth that began in the mid 1990s continued through to the mid 2000s.

The MBS data to 2007-08 expand the time series and provide the basis for reviewing the long term picture of Consultant Psychiatrists' activities within the Medicare funded health system.

- Following a decade of 5.6% annual average growth in spending on private psychiatrists, MBS expenditure decreased annually from 1996-97 to 2003-04. Subsequently, total annual benefits have remained relatively constant to 2007-08 (Figure 58).
- Benefits paid for Consultant Psychiatrists as a proportion of total MBS expenditure has been decreasing annually since reaching a peak of 3.4% in 1994-95. Benefits paid for Consultant Psychiatrists accounted for 1.8%

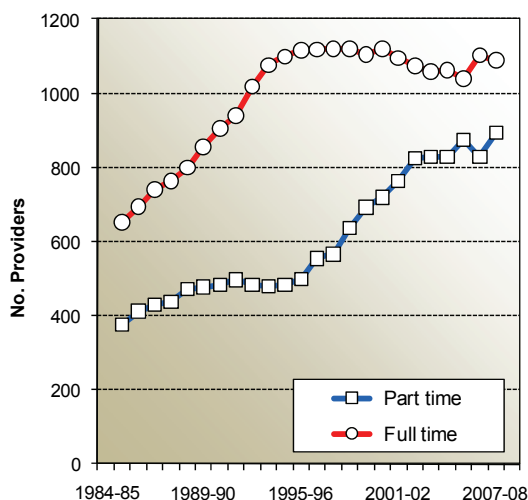
Figure 59: Number of services per 1,000 population and percentage population seen by MBS funded Consultant Psychiatrists, 1984-85 to 2007-08



of total MBS outlays on medical and related services in 2007-08 (Figure 58).

- Similarly, the proportion of the population seen by Consultant Psychiatrists and services delivered through the MBS subsidised health system have declined annually since reaching a peak in the mid 1990s (Figure 59). In 2007-08, 1.3% of the Australian community had at least one consultation with a private psychiatrist subsidised by Medicare.
- The average number of patients seen by MBS-funded consultant psychiatrists in 2007-08 was 136. Since reaching a peak in 1995-96, patients seen per provider has been decreasing at an annual average rate of 2.3%.
- In contrast to the reduction in activity by private psychiatrists, the number of psychiatrists billing against the MBS has continued to grow but at a reduced rate. In parallel, there has been a strong trend towards a lower proportion of psychiatrists earning full time income through the MBS arrangements (Figure 60). The number of providers billing against Medicare has grown by an annual average of 1.7% since 1995-96, compared with 4.2% over the preceding decade. A total of 1,983 practitioners billed against the MBS in 2007-08. Of these, 55% were in full time MBS-funded practice compared with 69% in 1995-96.

Figure 60: Number of Consultant Psychiatrists billing under the MBS, 1984-85 to 2007-08



Although 1.3% of Australians see a private psychiatrist at least once a year, access is uneven. Little change in the distribution of services has occurred since the commencement of the National Mental Health Strategy.

At the state and territory level, the imbalance continues to favour those living in Victoria and South Australia. Both states were substantially above the national per capita average in 2007-08 on MBS benefits per capita paid for Consultant Psychiatrists (Figure 61), the proportion of the population treated (Figure 62) and number of Consultant Psychiatrists providing services through Medicare.

Within individual states and territories, there is differential access to private psychiatrists. Like

Figure 62: Percentage of population seen by Consultant Psychiatrists billing under MBS by state and territory, 2007-08

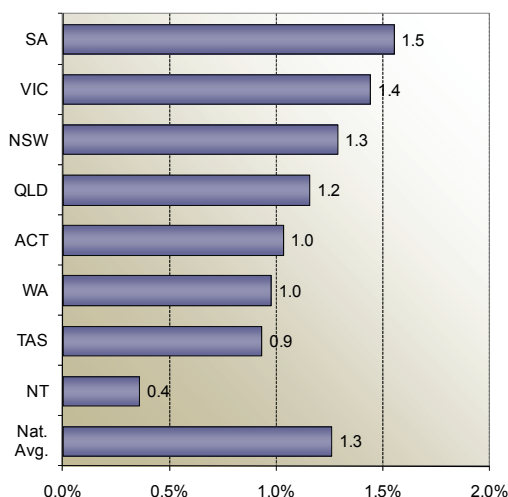
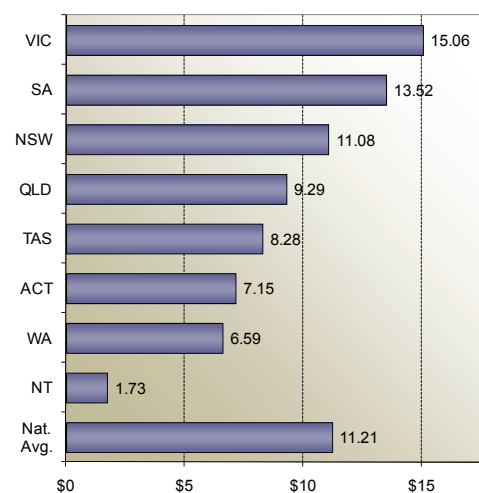


Figure 61: MBS per capita benefits paid for Consultant Psychiatrists by state and territory, 2007-08



most medical specialists, Consultant Psychiatrists are concentrated in the capital cities (particularly Melbourne, Adelaide and Sydney) and tend to attract the majority of their clientele from metropolitan populations.

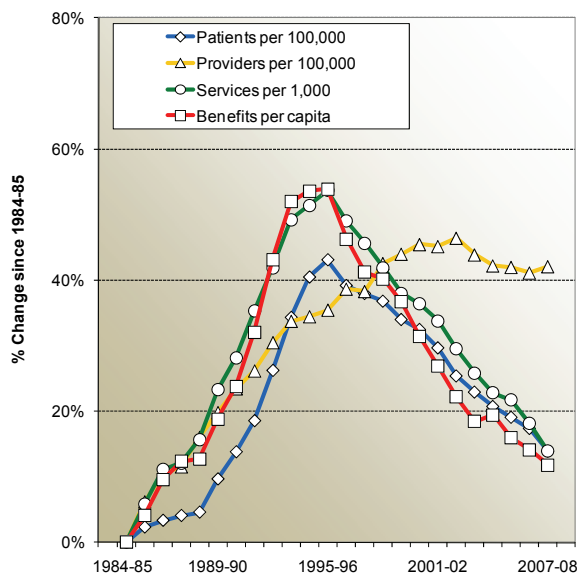
Table 10 compares the pattern of servicing in 1992-93 and 2007-08 of MBS-funded psychiatrists in capital cities, other metropolitan areas and non metropolitan regions of Australia. People resident in non-metropolitan areas, particularly those in rural and remote communities, continue to have least access, and are half as likely to receive services from a private psychiatrist than people residing in capital cities. When people in rural and remote areas do see private psychiatrists, they are likely to have about one-third less consultations.

Figure 63 summarises the key indicators of change in the activities of private psychiatrists since the commencement of the Medicare

Table 10: Comparison of percentage of population seen, MBS services provided and number of consultant psychiatrist providers by area of residence, 1992-93 to 2007-08

Region	Year	% Population seen	Benefits per capita (\$)	Attendances per patient
Capital city	1992-93	1.7	19.11	8.8
	2007-08	1.6	14.82	7.6
Other metro	1992-93	1.3	10.48	6.6
	2007-08	1.2	8.00	5.7
Rest of state	1992-93	0.8	4.90	5.6
	2007-08	0.7	4.09	5.3
Total	1992-93	1.4	14.34	8.1
	2007-08	1.3	11.21	7.2

Figure 63: MBS consultant psychiatrists – percentage change in patients seen, number of providers, services and benefits per capita, 1984-85 to 2007-08



Benefits Schedule in 1984-85. With the exception of number of providers, all indicators highlight that the rapid growth occurring between the mid-80s and the mid-90s has almost fully reversed.

It is important to note that in contrast to the reducing levels of private sector activity, medical staffing in the public mental health sector has increased by 80% between 1994 and 2008, with most growth occurring in the Psychiatric Registrar and Consultant Psychiatrist categories (see Table 9, page 52). Since the outset of the Strategy, all jurisdictions have taken steps to improve their recruitment and retention of psychiatrists, including development of more flexible employment options and greater provision for mixed public and private practice. The growth towards part-time psychiatrists billing against the MBS suggests that these initiatives have been successful in improving the distribution of psychiatrists across the public and private sectors.

General Practitioner mental health services

General Practitioners are often described as the 'first port of call' for people seeking help with mental health problems. The National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics in 2007, supported this view of GPs by its finding that more than two thirds (71%) of those who

consulted a health provider for a mental health problem saw their GP.³⁵ A similar result was found when a comparable mental health survey of the Australian population was undertaken in 1997.

Indicators derived from the annual BEACH (Bettering the Evaluation and Care for Health) Survey further support the central role of GPs in mental health care. Based on a sample of 100 consecutive consultations by approximately 1,000 randomly selected GPs, the BEACH data for 2007-08 suggest that mental health-related problems accounted for 7.6% of all problems managed by GPs and at least one was managed at 10.8% of all GP encounters.³⁶

The National Mental Health Report approach to estimating the quantum of mental health related work undertaken by GPs has changed following the introduction of the Better Access initiative in November 2006. Prior to Better Access, GP mental health service provision could not be estimated reliably from MBS item numbers because few items claimable by GPs could be specifically tagged as mental health related. The approach taken in previous reports was to estimate GP mental health work as a percentage of total MBS related expenditure paid for GP services. The standard applied was to deem 6.1% of MBS payments for GP services as a reasonable estimate of GP mental health related costs. This was based on early findings from the predecessor to the BEACH survey that found 6.1% of GP consultations were *primarily* for mental health reasons.³⁷

The introduction of the Better Access initiative created new and additional Medicare items for GP provided mental health care. All estimates of GP mental health service provision and related costs from November 2006 are based on these items, combined with a small number of items that existed prior to the Better Access initiative. The implication of this new approach is that estimates of GP mental health expenditure and activity from 2006-07 onward

³⁵ Slade T, Johnston A et al, (2009) *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*. Department of Health and Ageing, Canberra.

³⁶ Australian Institute of Health and Welfare (2009), *Mental Health Services in Australia 2006-07*, Mental health series no. 11. Cat. no. HSE 74. Canberra: AIHW

³⁷ Bridges-Webb C, Britt H, Miles D et al (1992) Morbidity and treatment in General Practice in Australia 1990-1991, *Medical Journal of Australia*, Supplement, October 1992.

are not directly comparable to those made for previous years.

Data presented in Appendix 11 provide the estimates of expenditure for GP mental health related services derived from these two methods and highlight the break in the time series. Based on the new MBS mental health items claimed by GPs, a total of \$133 million in benefits was paid in 2007-08, accounting for 7% of total Commonwealth mental health spending and 24% of MBS benefits paid for mental health care. General Practitioners provided mental health services to approximately 730,000 people, representing 3.4% of the population.

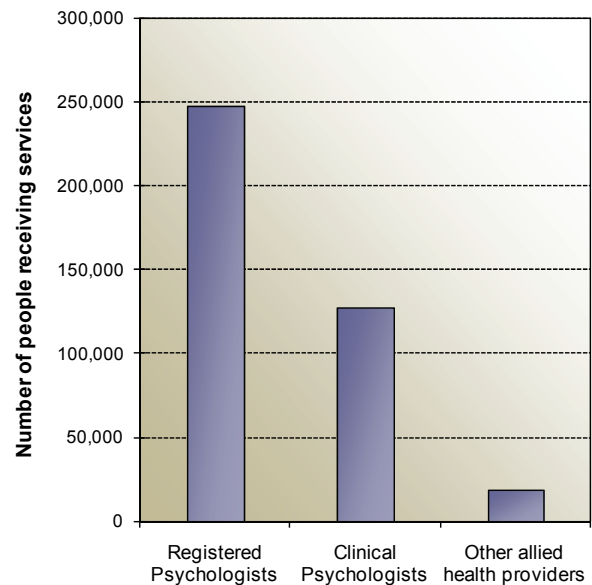
It is important to acknowledge that the revised approach to estimating GP mental health activity does not count services rendered by GPs that are not billed against a specific mental health item – for example, where a mental health problem is managed as part of a general consultation. Recent results from the BEACH survey suggest that this ‘hidden’ aspect of GP mental health care may be considerable and possibly more significant than services which are billed against specific MBS mental health items. Further information can be found in the AIHW publication *Mental Health Services in Australia 2007-08*.

Mental health services delivered by allied health professionals through Medicare

Access to Medicare MBS funded mental health services by allied health professionals commenced in a limited way from July 2004 with the expansion of the Enhanced Primary Care Program. This program, later incorporated into the MBS Chronic Disease Management items, enabled subsidised services to allied health professionals for people with chronic and complex needs who require multidisciplinary care. Subsequent initiatives, particularly the introduction of Better Access in November 2006, provided access to a designated set of health providers (Clinical and Registered Psychologists, Social Workers, Occupational Therapists) specifically for people affected by a mental illness on referral by a GP, Consultant Psychiatrist or Paediatrician.

Allied health professionals delivered a total of 1.97 million services to approximately 400,000 people in 2007-08, the first full year of operation of the Better Access initiative (Figure 64). Together, these services accounted for about one third (32%) of all MBS benefits paid for mental health services, and 37% of persons

Figure 64: Allied health delivered mental health care – Number of persons seen through MBS subsidised services, 2007-08



Note: The sum of people seen by individual provider groups is greater than the total number seen because people may consult more than one type of health professional.

receiving mental health care through Medicare arrangements. Allied health providers are a key component of Australian Government initiatives to increase treatment rates for people affected by mental illness. Further growth in service coverage is expected.

Private hospital psychiatric services

Private psychiatric hospitals have focused on the provision of inpatient care. This reflects both the history of mental health services in Australia and the predominant way in which health insurance funds pay benefits for mental health care.

This section summarises information compiled by the Australian Bureau of Statistics, using data from its Private Health Establishments (PHE) Collection.^{38, 39} As the ABS did not conduct a private hospital survey in 2007-08, the update provided in this report draws on the 2006-07 PHE collection and where required, extrapolates to 2007-08 to estimate trends.

³⁸ Australian Bureau of Statistics (2008) *Private Hospitals, Australia, 2006-07*, Commonwealth of Australia, Canberra (ABS Cat. No. 4390.0).

³⁹ Summary data on trends in private hospitals over the period 1993-2007 are provided at Appendix 10.

Trend in number of hospitals

The number of private hospitals reporting a specialist psychiatric unit has increased over the course of the National Mental Health Strategy. Forty two private hospitals provided specialist psychiatric services in 2006-07, compared with 33 in 1992-93. Twenty four of these were stand alone psychiatric hospitals, defined for these purposes as those hospitals where the number of psychiatric beds made up more than 75% of total beds.

By 2006-07, 16% of private hospitals in Australia provided a specialist psychiatric inpatient unit compared with 10% in 1992-93.

Growth in number of psychiatric beds

A total of 1,824 psychiatric beds were reported by private hospitals in 2006-07, 45% more than were available at the commencement of the National Mental Health Strategy. Private hospitals accounted for 22% of all psychiatric beds available in Australia in 2006-07, rising from 14% in 1992-93. A combination of growth in the number of private beds and reduction in the public sector has contributed to the increased private sector share. Three quarters (76%) of private beds in 2006-07 were located in facilities defined as stand alone psychiatric hospitals.

Indicators of private hospital activity

The number of patient days spent in private psychiatric units in 2006-07 was 65% above 1992-93 activity levels. However, the accuracy of this estimate is confounded by substantial growth in same day separations and variable reporting of these over the years of the Private Hospital Establishment Collection.

Separations from private sector psychiatric units have increased at a substantially greater rate, with nearly five times (4.7) more reported in 2006-07 than in 1992-93. Same day separations accounted for 80% of the growth. As with the trend data on patient days, the accuracy of this estimate is compromised by variable reporting over the course of the private hospital survey collection.

Same day separations in the general health field refer to patients admitted to hospital for a medical, surgical or diagnostic procedure who are discharged on the day of admission. In the mental health field, the only comparable procedure is same day admission to hospital for electroconvulsive therapy, a relatively low

frequency form of treatment for depression. More commonly, same day separations primarily involve participation by consumers in group based day hospital programs.

Based on the data, same day separations in the private hospital sector increased more than eight fold between 1992-93 and 2006-07 and accounted for 72% of all separations in 2006-07, rising from 39% in 1992-93. While the various contributions to the growth cannot be determined accurately, evidence drawn from other sources suggests that same day psychiatric treatment has increased disproportionately in private sector hospitals and represents the most common type of service now provided.

- Five years into the National Mental Health Strategy, the Australian Casemix Clinical Committee (now known as the Clinical Casemix Committee of Australia) observed in 1996 that there was 'exponential growth' of these services, particularly in the private psychiatric sector. At that time, the committee estimated that same day care accounted for over 40% of psychiatric separations.⁴⁰
- Same day separations across the broader private hospital sector have increased significantly, but at a lesser rate than in the psychiatric units that form part of the sector. Total same day separations increased approximately three fold (323%) in private hospitals (including freestanding day facilities) between 1992-93 and 2006-07 and accounted for 64% of total separations in 2006-07.
- Data reported by the Australian Institute of Health and Welfare from the National Hospital Morbidity database, a separate collection from that used to derive estimates in the current report, also indicates that same day separations accounted for approximately 75% of all separations in private psychiatric units during 2006-07.⁴¹

Caution is needed therefore when using crude separation counts as a measure of activity trends in the private psychiatric sector, for deriving

⁴⁰ Australian Casemix Clinical Committee (1996) *Report on the Clinical Review of the Third Version of the AN-DRG Classification*. Commonwealth of Australia, Canberra.

⁴¹ Australian Institute of Health and Welfare (AIHW) 2009. *Mental health services in Australia 2006-07*. Canberra: AIHW cat no. HSE 74 (Mental Health Series no. 11).

indicators such as length of stay and when making comparisons between the private and public sectors.⁴² At a minimum, it is reasonable to conclude that service provision when measured by separations involving overnight care, or by overnight patient days, has increased roughly in line with the increased capacity of the sector, as judged by growth in available beds.

It is also evident that the pattern of care has moved significantly towards a greater proportion of services delivered on a same day basis, a pattern consistent with general trends within the broader private hospital sector. This reflects efforts by health insurers and private hospital providers to broaden the range of services offered to people with mental illness beyond the historical focus on overnight inpatient care.

Changes in private hospital staffing

An estimated total of 1,683 full-time equivalent staff were employed by private hospitals to provide psychiatric care in 2006-07, increasing by 38% since 1992-93. Of these, 61% were employed in health professional categories with the balance made up by administration and support staff. Nurses made up 81% of the clinical service delivery workforce. Staffing estimates do not include private medical practitioners with admitting rights, who are funded on a fee-for-service basis through the Medicare Benefits Schedule.

Revenue and expenditure

Estimated total revenue in 2006-07 for private sector psychiatric units was \$271 million, an increase of 82% since 1992-93.⁴³ Growth in revenue has been driven largely by the increased

activity of the sector rather than increased prices. Revenue from psychiatric services represents approximately 4% of total private hospital sector income (excluding freestanding day hospital facilities).

As noted in previous reports, the introduction of the Australian Government Private Health Insurance Rebate in 1997-98 brought a new funding source to the sector. The estimated value for private hospitals of the 'mental health share' of the rebate in 2006-07 was \$52 million.⁴⁴ This represents 22% of the total revenue of the hospitals, decreasing the outlays required by private health insurance sources.

Estimated recurrent expenditure by private sector psychiatric units in 2006-07 was \$210 million, an increase of 81% since 1992-93.⁴⁵

Conclusions about the private hospital sector

Despite the limitations of the data, several observations can be made about changes in the place of private hospitals in Australia's mental health services.

There has been substantial growth in the private psychiatric hospital sector over the course of the National Mental Health Strategy. The number of hospital providers and total inpatient bed capacity have increased by 39% and 45% respectively, and revenue by 82% between 1992-93 and 2006-07. These increases have occurred in parallel with reductions in the size of the public sector inpatient system, elevating the relative role of the private sector in providing psychiatric care in Australia.

Alongside these changes, the sector has shifted its overall pattern of care to one of providing a significantly greater proportion of services to its consumers on a same day care basis. Same day admissions have increased from 39% of total admissions in 1992-93 to 72% in 2006-07.

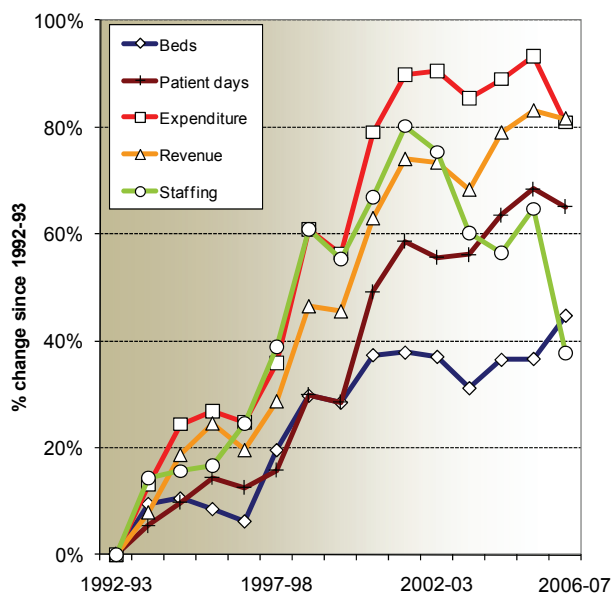
⁴² Same day separations in specialised psychiatric inpatient units in the public sector are estimated to account for approximately 23% of total separations reported to the National Hospital Morbidity Database in 2006-07 (Source: See footnote 41). It is important to note these are excluded in the public sector data presented earlier in this report as, under the state and territory reporting arrangements, they are classed as ambulatory care mental health services.

⁴³ Revenue and expenditure estimates presented in this section are higher from those reported by the Australian Institute of Health and Welfare in its publication *Mental Health Services in Australia 2006-07*. While AIHW estimates are also drawn from the ABS Private Hospital Establishment Collection, they cover only those private hospitals deemed to primarily care for patients with psychiatric or behavioural disorders, defined as hospitals for which 50% or more of total patient days were for psychiatric patients. By contrast, the current report estimates incorporate all psychiatric units in the private hospital sector.

⁴⁴ This differs from the total estimated value of the Private Health Insurance rebate in 2006-07 of \$59 million, identified in Table A-46, Appendix 11. The difference is due to payments for private patients treated in public hospitals.

⁴⁵ In interpreting this figure, it should be noted that the majority of expenditure on medical staff treating private psychiatric patients is not included in the estimate. Payments for consultant psychiatrists attending patients in private hospitals are, in general, covered under the Medicare Benefits Schedule (MBS) described earlier in this chapter.

Figure 65: Selected indicators of change in the private psychiatric hospital sector, 1992-93 to 2006-07



These changes have occurred in the context of increasing collaboration between the hospitals, insurers and the Australian Government, to develop a greater range of services that extend the role of private hospitals to community based care. For example, 'hospital in the home' programs and similar schemes have been introduced by several private health insurance funds that enable treatment in the consumer's home environment and avert admission to hospital where this is not clinically necessary.

Figure 65 provides a summary of selected indicators of change in the private psychiatric hospital sector.

8. Consumers and carers in mental health care

Consumer and carer participation in Australian mental health services underwent rapid maturation over the course of the First National Mental Health Plan. Inquiries conducted in the period preceding the Strategy pointed to abuses of the rights of consumers and advocated forcefully on their behalf for action to correct these. Governments responded with a number of proposals for change, and more importantly, consumers began to speak for themselves.

Initial concerns driving the Strategy revolved around concepts of protection from human rights abuses, but progressively, these concerns evolved to incorporate more contemporary concepts of consumer empowerment and participation. This requires that consumers and carers be given a place in discussions about the planning, delivery and evaluation of services designed to meet their needs.

The National Strategy has advocated strongly for this position. Underpinning this is a view that such participation can empower and inform consumers and carers, destigmatise mental illness and ultimately improve mental health outcomes by promoting a recovery orientation in service delivery. Additionally, accountability to consumers at all levels of the mental health system provides an avenue to identify and resolve deficiencies in service quality that, historically, compromised the rights of people with a mental illness.

The early steps taken to promote consumer and carer participation are regarded as one of the hallmarks of the National Mental Health Strategy. Under the First and Second National Mental Health Plans, states and territories were required to establish consumer advisory groups to provide direct consumer and carer input to mental health policy and service development. The Third National Mental Health Plan promoted further development of opportunities for consumers and carers to take meaningful roles in building a better service system.

At the national level, consumers and carers were included in all planning and advisory groups established since the Strategy began. Considerable funds were allocated to strengthening their voice in mental health planning, policy and evaluation. Consumer and carer representatives currently represent approximately one quarter of the membership

of the Mental Health Council of Australia, the peak, non government organisation established in 1997 to represent and promote the interests of the Australian mental health sector.

Many other groups play important roles throughout Australia in representing consumer and carers in mental health. They have undertaken a substantial amount of work to increase participation by, and awareness of, the roles of consumers and carers in the mental health reform agenda.

The current report does not detail the contributions of all the individual parties, but instead, focuses on updating previously published data on the extent to which mechanisms for consumer and carer participation have been established by at the local service delivery level.

Consumer and carer groups at the local service delivery level

Monitoring the extent to which consumers and carers are involved at the 'coalface' level of service delivery, where they have opportunities to influence the services they receive, is an important indicator of whether the National Mental Health Strategy has made a difference for consumers and carers.

The principle of consumer and carer participation in their local services is reflected strongly throughout both the original National Standards for Mental Health Services (1996) and the revised standards expected to be introduced during the Fourth National Mental Health Plan. The Standards set expectations that each service will involve consumers and carers in the planning, implementation and evaluation of services, and that consumers as well as carers will be active participants in the assessment and treatment planning that directly affect them. As noted in Chapter 5, all states and territories committed to full implementation of the Standards within the services under their management control.

The annual data collection reported by states and territories has provided the means to monitor trends in the type of local arrangements in place for consumers and carers to contribute to service planning and delivery. As in previous years, the 2007-08 collection required each organisation to describe its

structural arrangements for involving consumers and carers. Analysis of the survey data assigns each organisation into one of four levels, ranging from Level 1 (agencies where consumers and carers were given a formal place in the local executive decision making structures or a specific consumer and carer group was established to advise on all aspects of service delivery) to Level 4 (agencies with no specific arrangements for carer and consumer participation).

The results for 2007-08 are shown in Figure 66 and compared with the situation existing at the beginning of the Strategy and at the close of the Second National Mental Health Plan in 2002-03. They illustrate the considerable progress made over first 10 year period. Between 1994 and 2003, the proportion of organisations with some type of formal mechanism in place for consumer participation (Level 1 to Level 3) increased from 53% to 82%. But the data also reveal that, at the national summary level, little advance was made in this area over the course of the Third National Mental Health Plan.

Fifteen years into national mental health reform, about half of Australia’s mental health service organisations have established consumer and carer representation at the higher level (Level 1). About one quarter remain without any basic structural arrangement for consumer and carer participation.

Other local arrangements for consumer and carer participation

States and territories have expressed concern in previous years that exclusive reliance on the ‘formal committees’ approach to the assessment of consumer participation, the basis of Figure 66, does not adequately describe the range of initiatives that can be taken to enable participation at the ‘grass roots’ level.

Figure 66: Structural arrangements for consumer participation within mental health service organisations

Level 4
Other arrangements / No arrangements.

Level 3
Mental health consumers/carers invited to participate on broadly based committees.

Level 2
Specific Mental Health Consumer/Carer Advisory Group established to advise on *some* aspects of service delivery.

Level 1
Appointment of person to represent the interests of mental health consumers and carers on organisation management committee OR Specific Mental Health Consumer/Carer Advisory Group established to advise on *all* aspects of service delivery.

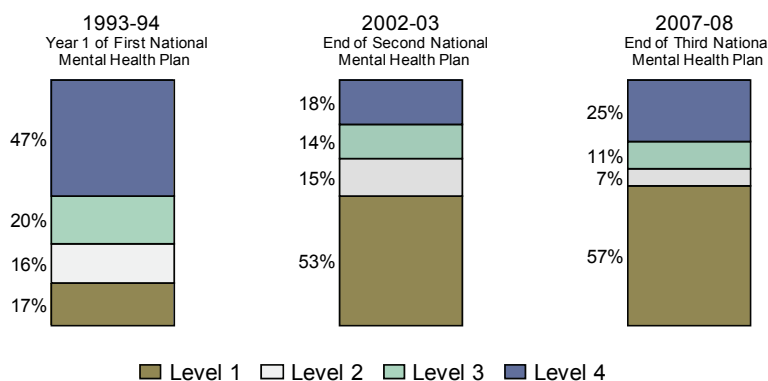


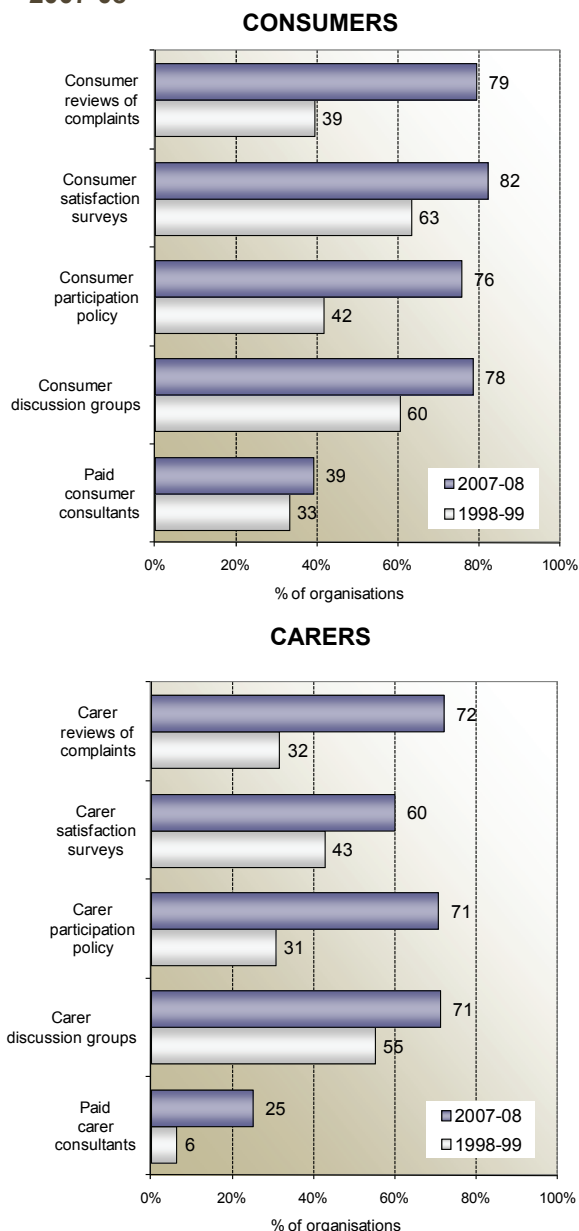
Table 11: Additional consumer and carer participation strategies assessed in annual state and territory reporting

- Consumer/carer consultants are employed on a paid basis to represent the interests of primary consumers/carers and advocate for their needs.
- The organisation holds regular discussion groups to seek the views of primary consumers/carers about the mental health services.
- The organisation has developed a formal (documented) policy on participation by primary consumers/carers.
- The organisation periodically conducts consumer/carer satisfaction surveys.
- The organisation has a formal internal complaints mechanism in which complaints made by primary consumers/carers are regularly reviewed by a committee that includes primary consumers/carers.

Commencing in 1998-99, the annual state and territory collection was modified to explore a fuller range of options being pursued by local services, and requested each mental health service organisation to indicate whether such arrangements were in place. The options assessed in the survey are summarised in Table 11.

Figure 67 presents the results separately for consumers and carers. Taken at face value, they suggest considerable innovation by service providers in the approaches to build a consumer and carer oriented culture, although the extent to which organisations have established initiatives of this type varies. As noted in previous reports, mechanisms for carer participation have been less developed than those for consumers but the gap is closing.

Figure 67: Other participation arrangements for consumers and carers, 1998-99 and 2007-08



Employment of consumer and carer consultants

Reviewing the information presented in previous reports, consumer and carer representatives have suggested that the extent of development reported by states and territories did not match their perceptions of 'what is happening on the ground'. They expressed particular concern at the rates of employment of paid consumer and carer consultants and pointed out that the indicator does not provide information of the extent of commitment of an organisation in employing consultants. For example, a single 'one off' payment for attending a meeting may

have been interpreted by some organisations as constituting a 'paid consumer consultant'.

Consumer and carer consultants are defined as individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs. Use of this strategy within a mental health service is valued by consumers and carers as a means to promote services that are responsive to their needs. They take on a variety of roles, including:

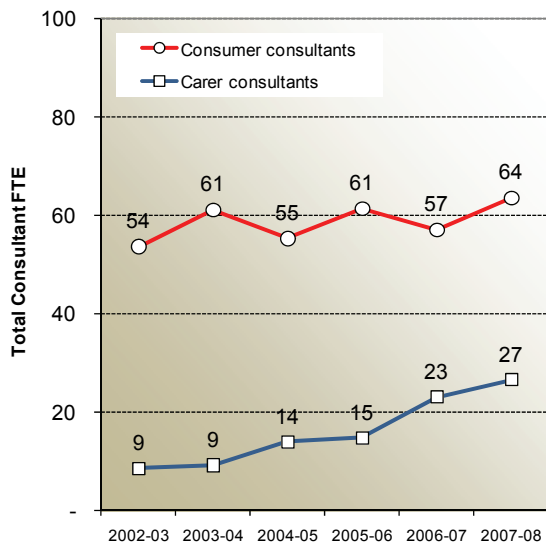
- building relationships with individual consumers and carers and communicating their needs to health professional staff;
- investigating and advocating areas for improvement to local services, policy and procedures;
- participating in the selection of staff employed in the local services;
- advocating consumer and carer perspectives in the evaluation of local services; and
- contributing to training programs for service delivery staff.

Since 2002-03, the annual state and territory data collection has required additional information to quantify the investments made by mental health services in employing consumers and carers. To do this, organisations reporting that consumer and/or carer consultants were employed within their workforce were required to provide substantiation, by reporting supplementary information on salary expenditure and numbers of full-time equivalent staff employed.

The results give a more realistic picture. Nationally, a total of only 64 full time equivalent consumer consultants and 27 carer consultants were employed across the 221 mental health service organisations funded by state and territory governments in 2007-08. Combined expenditure on consumer and carer consultants in 2007-08 was \$5.1 million, or 0.15% of total spending on state and territory mental health services.

Figure 68 shows the national FTE tally for consumer and carer consultants employed in state and territory services over the 2003 to 2008 period. The number of consumer consultants fluctuated between 54 to 64, while carer consultants showed a steady rise from a very low base and reaching about half the level

Figure 68: Number of consumer and carer consultants employed (full time equivalent) in state and territory mental health services, 2003-2008



of employment of consumer consultants by 2007-08. The implication is that, apart from modest growth in carer consultants employed in state and territory services, little progress was made over the Third National Mental Health Plan in expanding the consumer and carer workforce.

This national summary is not equally true for all jurisdictions. The states and territories entered the Third National Mental Health Plan with variable investment in their consumer and carer workforce. With few exceptions, most simply maintained 2002-03 levels over the Third Plan. Two jurisdictions (ACT and Northern Territory) reported no consumer consultants employed within their workforce in the final year of the Third Plan.

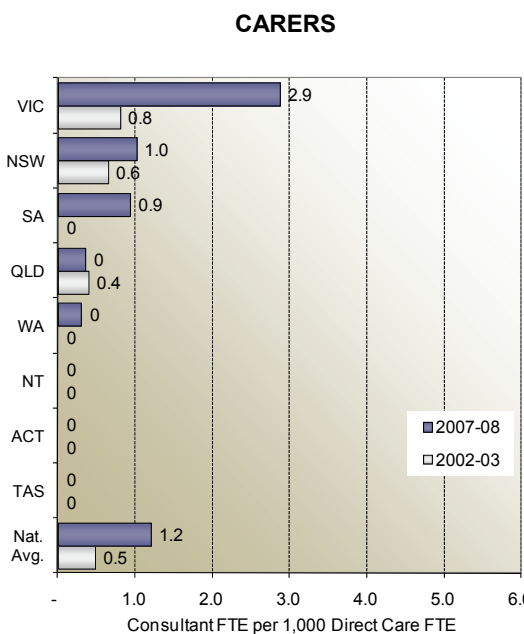
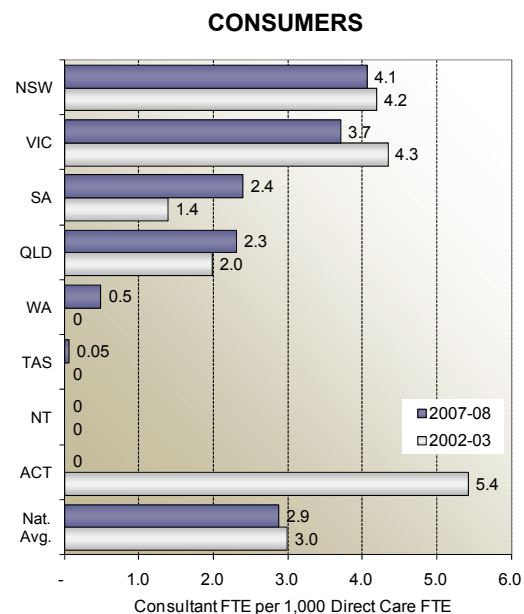
Figure 69 compares the states and territories in terms of the number of consumer and carer consultant FTE employed per 1,000 clinical staff.

Conclusions about consumer and carer developments

Mid way through the Second National Mental Health Plan, an evaluation conducted by international expert reviewers observed that:

“The comments of many consumers and carers emphasised that great progress has been made since 1993 in terms of consumer and carer involvement in many aspects of mental health service and policy planning and provision.”

Figure 69: Consumer and carer consultants employed per 1,000 direct care staff (Full-time equivalents - FTE)



However, the reviewers added a cautionary note to this observation.

“Both groups are still not fully satisfied with the rate of progress as their expectations of service responsiveness and quality still outstrip their direct experience ... In a sense, consumer and carer involvement is now on the cusp between the early (and sometimes) tokenistic systems of the past, and

their increasingly meaningful, respected and affirmed role in their expected future.”⁴⁶

The final evaluation of the Plan reached a similar mixed conclusion.

“Progress has been made towards improving consumer rights and consumer and carer participation but ... full and meaningful participation for consumers and carers has not yet been achieved

While the information provided by states and territories regarding consumer participation shows that there are formal mechanisms available for participation, the nature of this participation is far from the meaningful and affirmed role that consumers and carers desire. Furthermore, there is variable commitment across jurisdictions, and service provider organisations differ in their acceptance and support of consumer and carer participation.

Regarding consumer and carer involvement in individual treatment decisions, there is substantial need for improvement. Participants in the community consultations agreed that consumers and carers were not yet actively involved in individual treatment decisions.

Importantly, carer support is lacking and the role of carers is perceived to be disregarded at local, regional and State/Territory levels.”⁴⁷

These conclusions remained relevant at the close of the Third National Mental Health Plan. In commenting on progress on consumer and carer participation, the evaluators of the Plan observed that:

“... while we heard that some progress has been made during the current National Mental Health Plan, the successful further maturation of these forms of involvement can be further consolidated by ensuring clear and transparent reimbursement structures for consumer and carer participation and appropriate budget allocations and by extended employment opportunities including consumer consultants, peer support workers and advocates.

As the consumer and carer movements mature, more diverse voices and perceptions emerge, more pathways for communication need to be developed.

There is a concern that if the Commonwealth or State and Territory Governments rely on primarily one mechanism to gain a consumer perspective, plans will not have the ‘buy-in’ of a wide range of impacted individuals and groups.⁴⁸

It is clear that, while some progress has been made in providing formal mechanisms for consumer and carer participation, a great deal remains to be done. The Fourth National Mental Health Plan 2009-2014 reiterates the importance of continuing initiatives to build mental health service systems that are truly consumer and carer responsive.

⁴⁶ Thornicroft G and Betts V (2002) *International Mid-Term Review of the Second National Mental Health Plan for Australia*. Commonwealth of Australia, Canberra.

⁴⁷ AHMAC Steering Committee for the Evaluation of the Second National Mental Health Plan (2003). See footnote 32.

⁴⁸ Curie C and Thornicroft G. *Summative Evaluation of the National Mental Health Plan 2003-2008*. Department of Health and Ageing, Commonwealth of Australia, 2009.

PART D

**Profiles of state and
territory reform
progress**

9. Profiles of state and territory reform progress

This section of the report 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.

The section 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 was positioned throughout the Strategy, in relation to other jurisdictions and the goals it set itself.

The comparisons emerging from the data highlight differences in service levels and mix, as well as identifying common ground between the various mental health service systems in Australia. In interpreting relative progress, it is important to consider that, although the National Mental Health Strategy sets directions for reform, specific targets or benchmarks were not imposed on states and territories. This approach was agreed at the beginning of the Strategy to recognise the different histories, circumstances and priorities of each jurisdiction, and the requirement for plans 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 each jurisdiction in relation to:

- overall state and territory government expenditure;

- investment in service mix reform;
- provision of inpatient and community residential beds;
- level of investment in ambulatory care services and non government services;
- specialist mental health workforce levels;
- arrangements for consumer and carer participation; and
- implementation of the National Standards for Mental Health Services.

Summary indicators are also presented for each jurisdiction about services provided through the Medicare Benefits Schedule, and expenditure on drugs for the treatment of mental illness subsidised through the Pharmaceutical Benefits Scheme.

The information presented includes a summary table of key indicators detailing the state or territory position:

- at the beginning of the Strategy (1992-93);
- at the close of the Second National Mental Health Plan (2002-03) representing the 10-year mark of national reform; and
- at the close of the Third National Mental Health Plan (2007-08).

Explanatory notes outlining the approach used in preparation of the quantitative information presented in the tables are provided in Appendix 9.

Each jurisdiction is also presented in six figures, selected to convey a graphical summary of progress over the 1993-2008 period. The purpose of each of the figures is described below.

Overall spending on mental health

These figures show the 15-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 1993, and to the national average?*” Expenditure is expressed in 2008 constant per capita prices and adjusted to remove Australian Government contributions made through National Mental Health Strategy

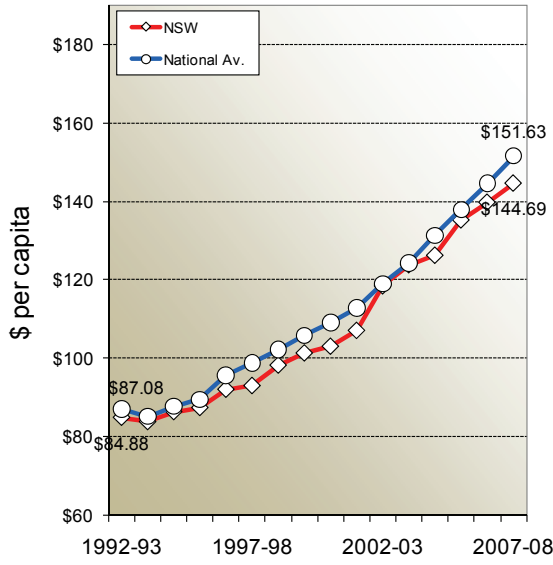


New South Wales

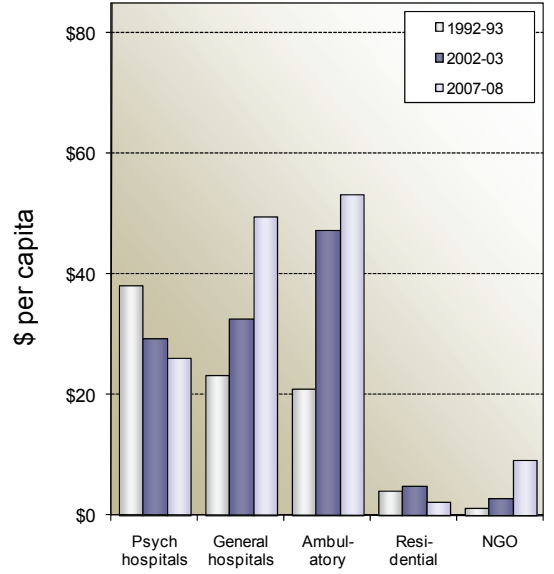
Table 12: Indicators of mental health reform in New South Wales

INDICATOR	NEW SOUTH WALES			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
• State spending on mental health services (\$Millions)	508.0	787.5	1,004.7	3,220.3
• State spending per capita (\$)	84.88	118.44	144.69	151.63
• Per capita spending rank	5	5	7	
• Average annual spending growth during prior National Mental Health Plan(s)		4.5	6.1	5.1
SERVICE MIX				
• % total service expenditure – Community services	30.0	46.9	45.8	53.4
– Stand alone psychiatric hospitals	43.6	25.1	18.7	14.2
– Colocated general hospitals	26.5	28.0	35.5	32.4
INPATIENT SERVICES				
• Total hospital beds	2,652	2,086	2,424	6,551
• Per capita expenditure on inpatient care (\$)	61.32	61.84	75.78	69.16
• Inpatient beds per 100,000	44.3	31.4	34.9	30.8
• Acute inpatient beds per 100,000	18.1	18.7	22.0	20.4
• Non acute inpatient beds per 100,000	26.2	12.7	12.9	10.4
• % acute inpatient beds located in general hospitals	62.7	71.6	76.3	86.4
• Stand alone psychiatric hospitals as % of total beds	69.3	52.6	42.2	32.9
• Average cost per patient day (\$)	467	635	674	702
COMMUNITY SERVICES				
• Ambulatory care – % total service expenditure	24.0	40.6	38.0	40.2
– Per capita expenditure (\$)	21.04	47.26	53.16	59.72
• NGOs – % total service expenditure	1.3	2.5	6.6	8.3
– Per capita expenditure (\$)	1.14	2.94	9.27	12.35
• Residential services – % total service expenditure	4.6	4.3	1.6	6.0
– Per capita expenditure (\$)	4.07	4.97	2.19	8.91
– Adult beds per 100,000:				
24-hour staffed	4.6	2.7	2.8	6.6
Non-24 hour staffed	n.a	4.5	4.0	4.4
– Older persons beds per 100,000:				
24-hour staffed	15.3	14.7	0.7	23.9
Non-24 hour staffed	n.a	1.4	1.2	0.6
• Supported public housing places per 100,000	n.a	14.8	21.8	18.2
DIRECT CARE WORKFORCE				
• Number Full Time Equivalent (FTE) staff	4,108	5,555	6,875	22,120
• FTE per 100,000	68.6	83.5	99.0	104.2
• FTE per 100,000 – ambulatory services	18.8	36.0	39.6	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
• % services Level 1 implementation of Standards	..	50	86	82
• % service expenditure covered by Level 1 services	..	56	85	81
CONSUMER AND CARER PARTICIPATION				
• % services with Level 1 consumer participation arrangements	19	48	61	57
• Consumer consultants employed per 1000 clinical FTE	n.a	4.2	4.1	2.9
• Carer consultants employed per 1000 clinical FTE	n.a	0.6	1.0	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
• % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	5.0	4.7
• % population seen – GPs	..	..	3.6	3.4
• % population seen – Consultant Psychiatrists	1.4	1.4	1.3	1.3
• % population seen – Psychologists and Clinical Psychologists	..	..	1.8	1.8
• % population seen – Other allied health professionals	..	..	0.1	0.1
• Total MBS mental health related benefits paid per capita	..	..	26.09	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
• Total PBS/RPBS benefits paid per capita	5.83	32.57	32.93	34.34

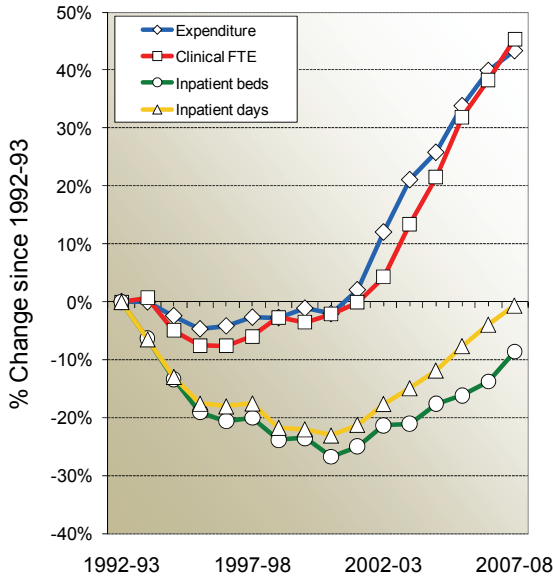
Overall spending on mental health



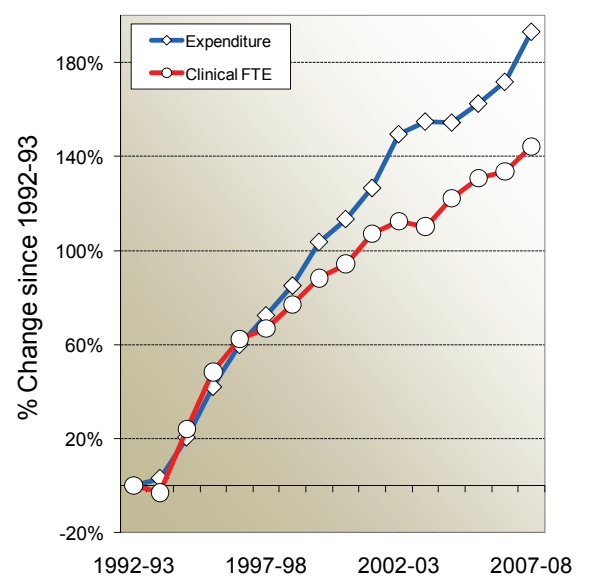
Change in spending mix



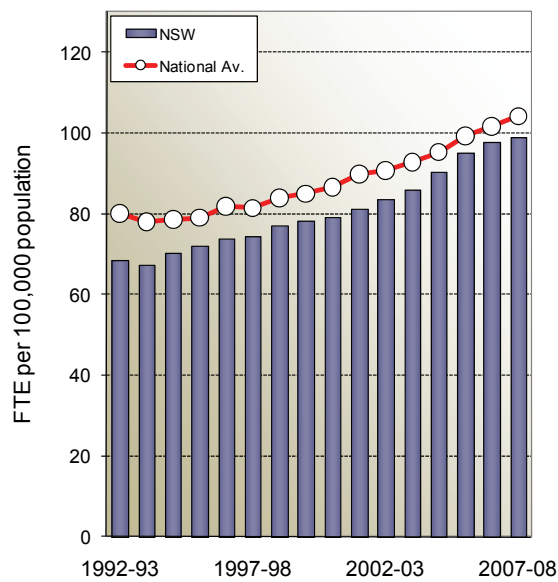
Changes in inpatient services



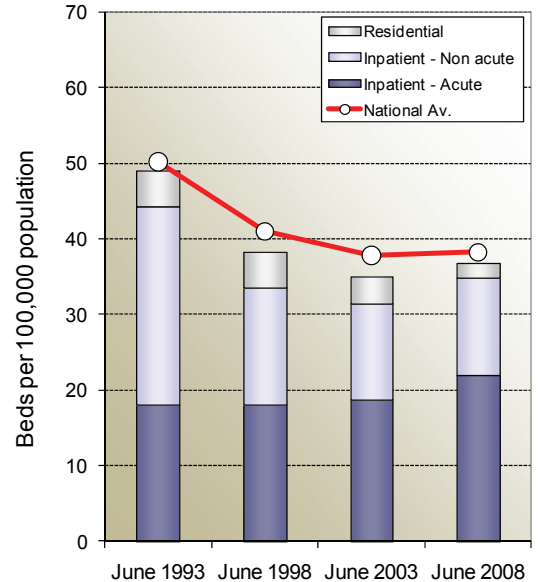
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



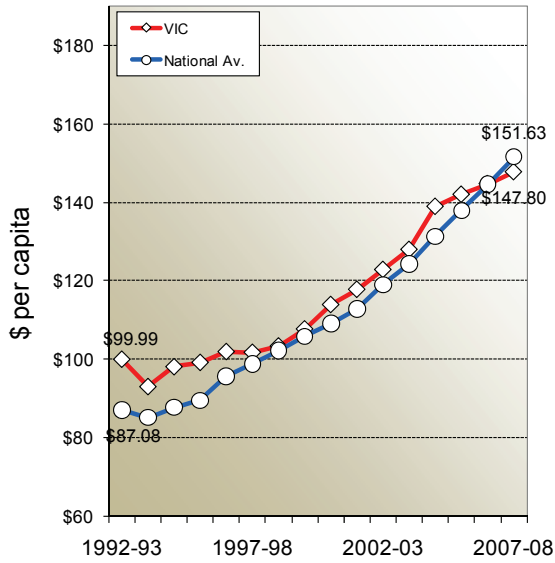


Victoria

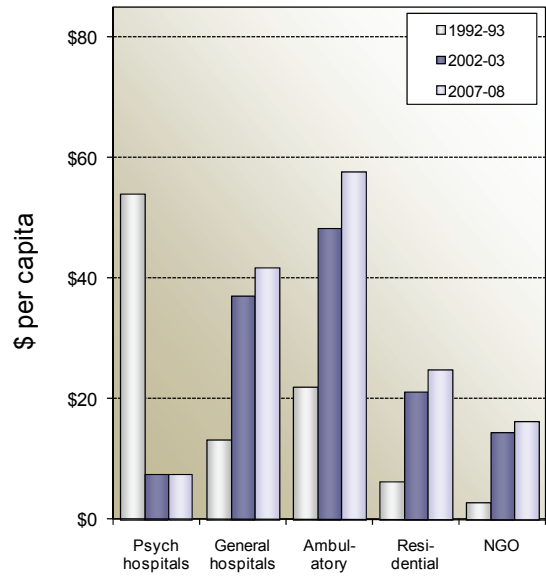
Table 13: Indicators of mental health reform in Victoria

INDICATOR	VICTORIA			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
• State spending on mental health services (\$Millions)	446.5	601.2	777.8	3,220.3
• State spending per capita (\$)	99.99	122.88	147.80	151.63
• Per capita spending rank	1	3	6	
• Average annual spending growth during prior National Mental Health Plan(s)		3.1	5.4	5.1
SERVICE MIX				
• % total service expenditure – Community services	31.8	64.5	65.8	53.4
– Stand alone psychiatric hospitals	54.9	6.0	5.2	14.2
– Colocated general hospitals	13.4	29.4	29.0	32.4
INPATIENT SERVICES				
• Total hospital beds	1,887	1,133	1,216	6,551
• Per capita expenditure on inpatient care (\$)	67.35	44.63	49.43	69.16
• Inpatient beds per 100,000	42.3	23.2	23.1	30.8
• Acute inpatient beds per 100,000	21.6	19.5	19.7	20.4
• Non acute inpatient beds per 100,000	20.6	3.7	3.4	10.4
• % acute inpatient beds located in general hospitals	34.7	96.9	100	86.4
• Stand alone psychiatric hospitals as % of total beds	82.9	12.6	12.7	32.9
• Average cost per patient day (\$)	482	611	675	702
COMMUNITY SERVICES				
• Ambulatory care – % total service expenditure	22.4	38.4	39.9	40.2
– Per capita expenditure (\$)	22.06	48.33	57.75	59.72
• NGOs – % total service expenditure	2.9	11.5	11.3	8.3
– Per capita expenditure (\$)	2.91	14.51	16.41	12.35
• Residential services – % total service expenditure	6.4	16.9	17.3	6.0
– Per capita expenditure (\$)	6.36	21.30	24.97	8.91
– Adult beds per 100,000:				
24-hour staffed	1.5	10.5	13.1	6.6
Non-24 hour staffed	n.a	9.2	9.9	4.4
– Older persons beds per 100,000:				
24-hour staffed	47.5	90.5	86.3	23.9
Non-24 hour staffed	n.a	-	0.8	0.6
• Supported public housing places per 100,000	n.a	24.1	26.5	18.2
DIRECT CARE WORKFORCE				
• Number Full Time Equivalent (FTE) staff	4,111	4,676	5,405	22,120
• FTE per 100,000	92.1	95.6	102.7	104.2
• FTE per 100,000 – ambulatory services	22.2	38.4	43.7	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
• % services Level 1 implementation of Standards	..	40	97	82
• % service expenditure covered by Level 1 services	..	33	99	81
CONSUMER AND CARER PARTICIPATION				
• % services with Level 1 consumer participation arrangements	19	68	55	57
• Consumer consultants employed per 1000 clinical FTE	n.a	4.3	3.7	2.9
• Carer consultants employed per 1000 clinical FTE	n.a	0.8	2.9	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
• % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	5.4	4.7
• % population seen - GPs	..	..	3.8	3.4
• % population seen – Consultant Psychiatrists	1.6	1.6	1.4	1.3
• % population seen – Psychologists and Clinical Psychologists	..	..	2.2	1.8
• % population seen – Other allied health professionals	..	..	0.1	0.1
• Total MBS mental health related benefits paid per capita	..	..	32.91	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
• Total PBS/RPBS benefits paid per capita	5.64	39.73	38.42	34.34

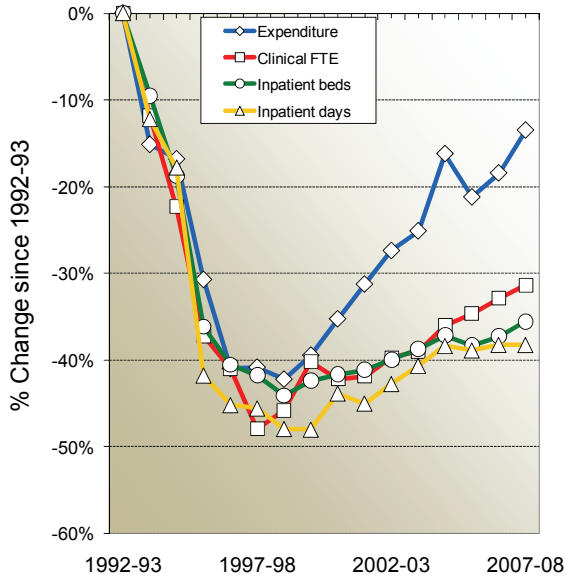
Overall spending on mental health



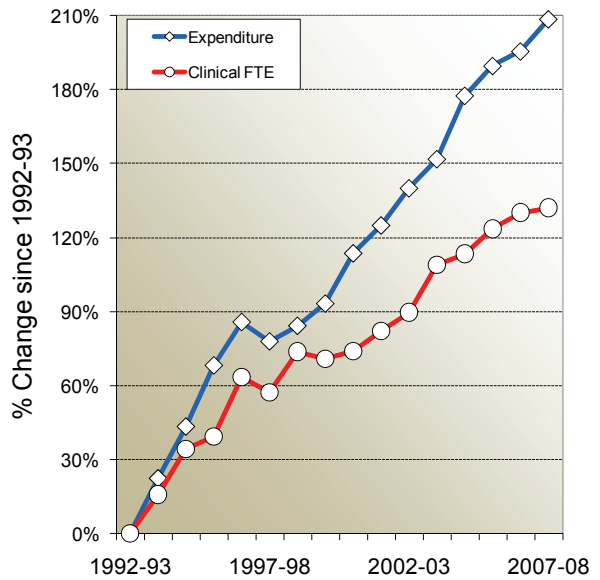
Change in spending mix



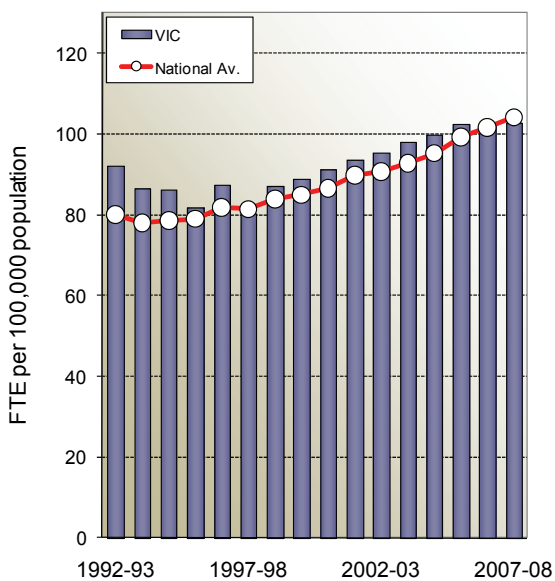
Changes in inpatient services



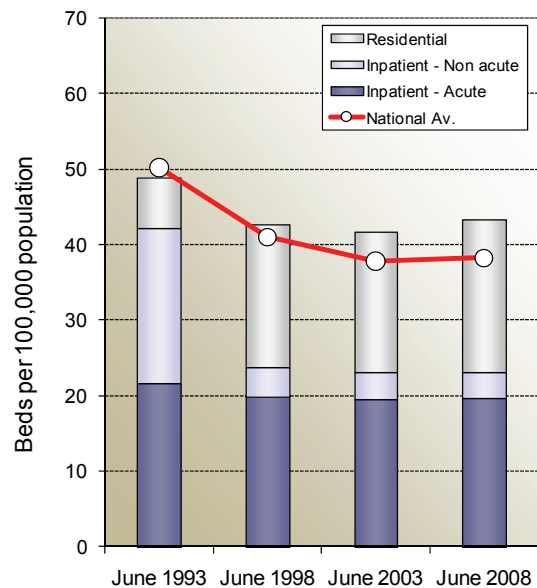
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



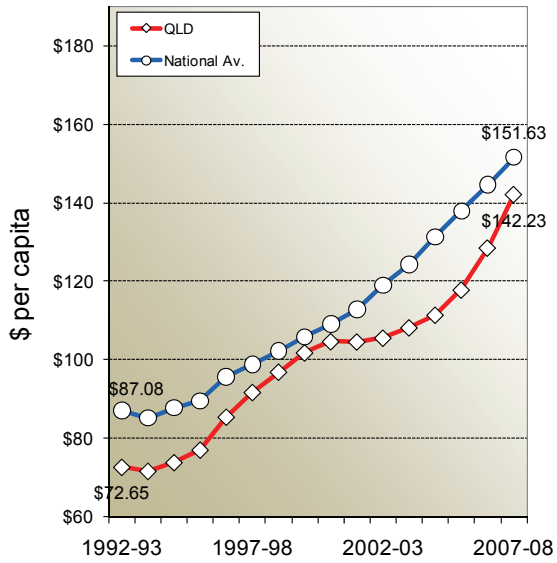


Queensland

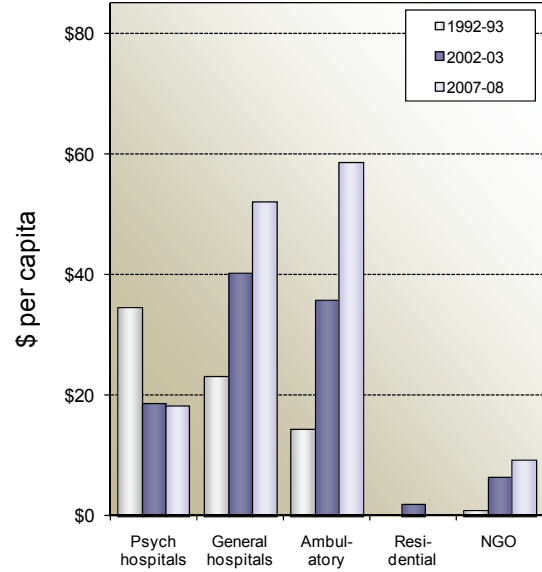
Table 14: Indicators of mental health reform in Queensland

INDICATOR	QUEENSLAND			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
• State spending on mental health services (\$Millions)	222.8	397.5	603.4	3,220.3
• State spending per capita (\$)	72.65	105.59	142.23	151.63
• Per capita spending rank	6	7	8	
• Average annual spending growth during prior National Mental Health Plan(s)		6.0	7.9	5.1
SERVICE MIX				
• % total service expenditure – Community services	21.1	42.9	49.1	53.4
– Stand alone psychiatric hospitals	47.2	18.2	13.2	14.2
– Colocated general hospitals	31.7	39.0	37.7	32.4
INPATIENT SERVICES				
• Total hospital beds	1,607	1,323	1,409	6,551
• Per capita expenditure on inpatient care (\$)	57.76	59.04	70.53	69.16
• Inpatient beds per 100,000	52.4	35.1	33.2	30.8
• Acute inpatient beds per 100,000	21.3	18.1	16.6	20.4
• Non acute inpatient beds per 100,000	31.1	17.1	16.6	10.4
• % acute inpatient beds located in general hospitals	84.0	100	100	86.4
• Stand alone psychiatric hospitals as % of total beds	65.9	29.9	26.7	32.9
• Average cost per patient day (\$)	365	594	679	702
COMMUNITY SERVICES				
• Ambulatory care – % total service expenditure	19.8	34.6	42.4	40.2
– Per capita expenditure (\$)	14.51	35.79	58.74	59.72
• NGOs – % total service expenditure	1.3	6.3	6.7	8.3
– Per capita expenditure (\$)	0.92	6.49	9.29	12.35
• Residential services – % total service expenditure	-	1.9	-	6.0
– Per capita expenditure (\$)	-	2.00	-	8.91
– Adult beds per 100,000: 24-hour staffed	-	3.3	-	6.6
Non-24 hour staffed	n.a	-	-	4.4
– Older persons beds per 100,000: 24-hour staffed	-	-	-	23.9
Non-24 hour staffed	n.a	-	-	0.6
• Supported public housing places per 100,000	n.a	-	1.6	18.2
DIRECT CARE WORKFORCE				
• Number Full Time Equivalent (FTE) staff	2,200	3,225	4,222	22,120
• FTE per 100,000	71.7	85.7	99.5	104.2
• FTE per 100,000 – ambulatory services	13.8	30.8	43.6	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
• % services Level 1 implementation of Standards	..	29	86	82
• % service expenditure covered by Level 1 services	..	35	97	81
CONSUMER AND CARER PARTICIPATION				
• % services with Level 1 consumer participation arrangements	27	49	70	57
• Consumer consultants employed per 1000 clinical FTE	n.a	2.0	2.3	2.9
• Carer consultants employed per 1000 clinical FTE	n.a	0.4	0.4	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
• % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	4.3	4.7
• % population seen - GPs	..	..	3.1	3.4
• % population seen – Consultant Psychiatrists	1.5	1.5	1.2	1.3
• % population seen – Psychologists and Clinical Psychologists	..	..	1.6	1.8
• % population seen – Other allied health professionals	..	..	0.1	0.1
• Total MBS mental health related benefits paid per capita	..	..	21.42	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
• Total PBS/RPBS benefits paid per capita	6.11	36.08	32.89	34.34

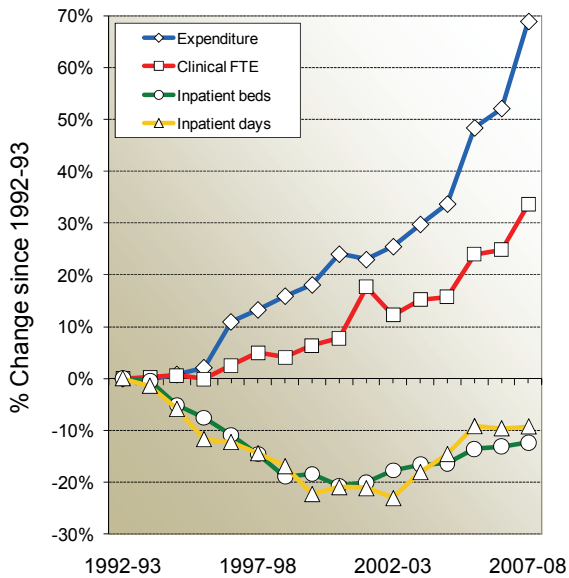
Overall spending on mental health



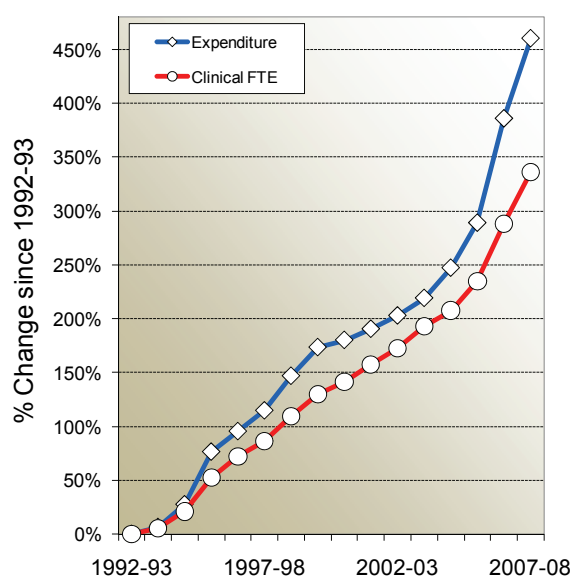
Changes in spending mix



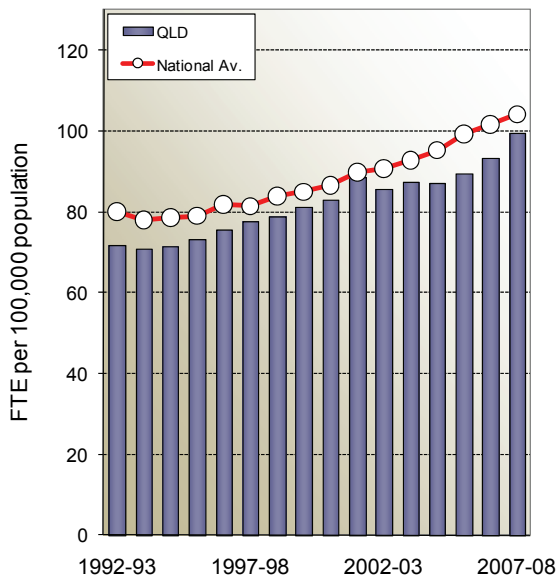
Changes in inpatient services



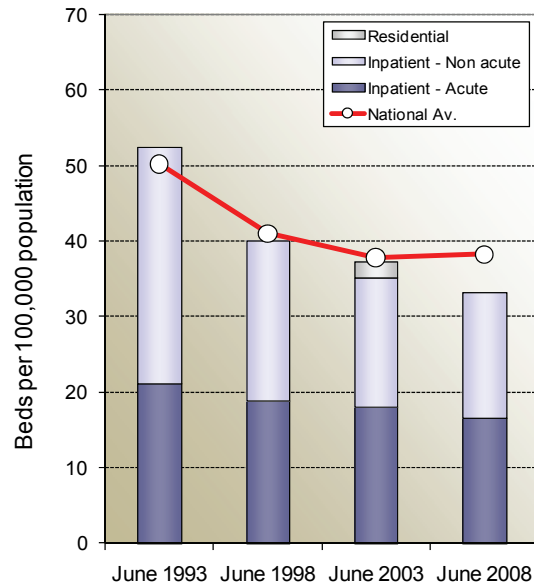
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



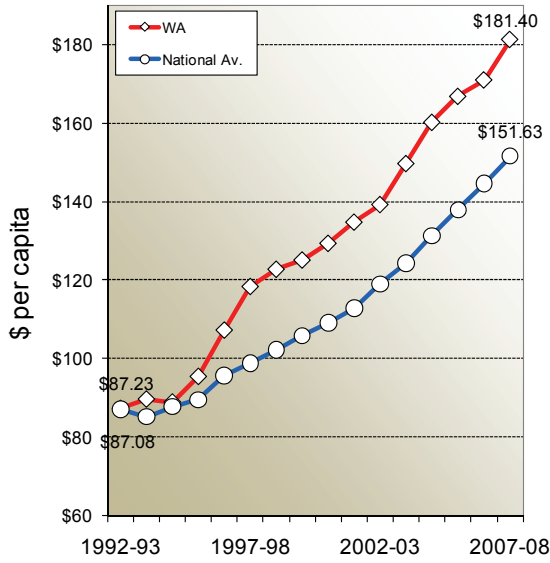


Western Australia

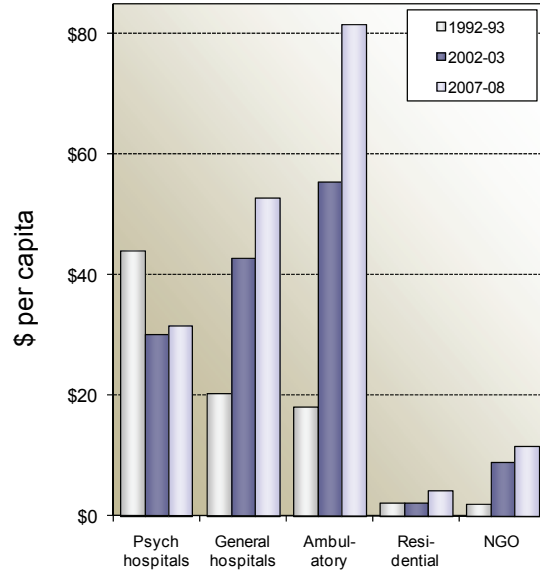
Table 15: Indicators of mental health reform in Western Australia

INDICATOR	WESTERN AUSTRALIA			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
• State spending on mental health services (\$Millions)	145.5	269.8	387.9	3,220.3
• State spending per capita (\$)	87.23	139.26	181.40	151.63
• Per capita spending rank	4	1	1	
• Average annual spending growth during prior National Mental Health Plan(s)		6.4	7.1	5.1
SERVICE MIX				
• % total service expenditure – Community services	25.8	47.3	53.1	53.4
– Stand alone psychiatric hospitals	50.7	21.7	17.5	14.2
– Colocated general hospitals	23.5	30.9	29.3	32.4
INPATIENT SERVICES				
• Total hospital beds	728	640	670	6,551
• Per capita expenditure on inpatient care (\$)	64.39	72.97	84.45	69.16
• Inpatient beds per 100,000	43.7	33.0	31.3	30.8
• Acute inpatient beds per 100,000	23.7	26.1	23.4	20.4
• Non acute inpatient beds per 100,000	19.9	6.9	7.9	10.4
• % acute inpatient beds located in general hospitals	40.2	80.9	77.0	86.4
• Stand alone psychiatric hospitals as % of total beds	69.9	38.4	36.6	32.9
• Average cost per patient day (\$)	444	722	819	702
COMMUNITY SERVICES				
• Ambulatory care – % total service expenditure	20.8	40.1	45.3	40.2
– Per capita expenditure (\$)	18.06	55.54	81.65	59.72
• NGOs – % total service expenditure	2.4	6.5	6.4	8.3
– Per capita expenditure (\$)	2.05	9.02	11.58	12.35
• Residential services – % total service expenditure	2.6	1.6	2.4	6.0
– Per capita expenditure (\$)	2.30	2.27	4.27	8.91
– Adult beds per 100,000:				
24-hour staffed	8.0	1.7	6.3	6.6
Non-24 hour staffed	n.a	4.5	3.0	4.4
– Older persons beds per 100,000:				
24-hour staffed	-	-	-	23.9
Non-24 hour staffed	n.a	-	-	0.6
• Supported public housing places per 100,000	n.a	18.5	30.8	18.2
DIRECT CARE WORKFORCE				
• Number Full Time Equivalent (FTE) staff	1,475	2,029	2,536	22,120
• FTE per 100,000	88.4	104.7	118.6	104.2
• FTE per 100,000 – ambulatory services	17.4	43.8	49.3	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
• % services Level 1 implementation of Standards	..	51	35	82
• % service expenditure covered by Level 1 services	..	54	39	81
CONSUMER AND CARER PARTICIPATION				
• % services with Level 1 consumer participation arrangements	6	33	37	57
• Consumer consultants employed per 1000 clinical FTE	n.a	-	0.5	2.9
• Carer consultants employed per 1000 clinical FTE	n.a	-	0.3	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
• % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	4.0	4.7
• % population seen - GPs	..	..	3.0	3.4
• % population seen – Consultant Psychiatrists	0.9	0.9	1.0	1.3
• % population seen – Psychologists and Clinical Psychologists	..	..	1.5	1.8
• % population seen – Other allied health professionals	..	..	0.1	0.1
• Total MBS mental health related benefits paid per capita	..	..	20.47	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
• Total PBS/RPBS benefits paid per capita	4.53	33.66	29.99	34.34

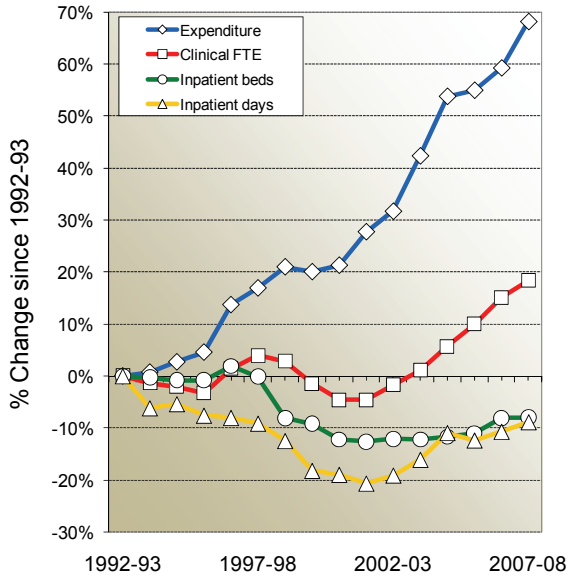
Overall spending on mental health



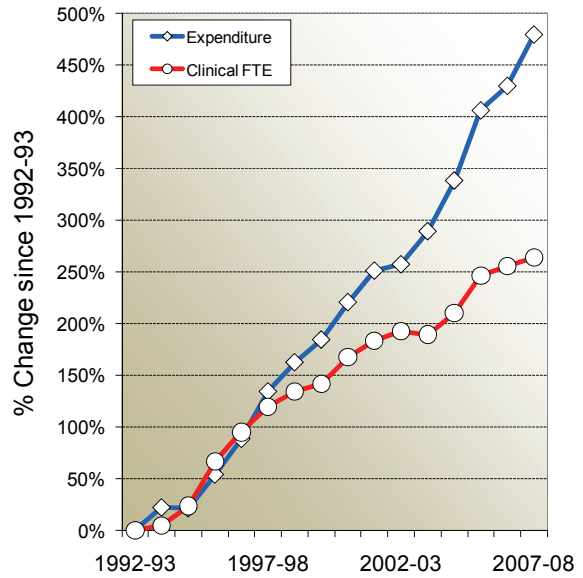
Change in spending mix



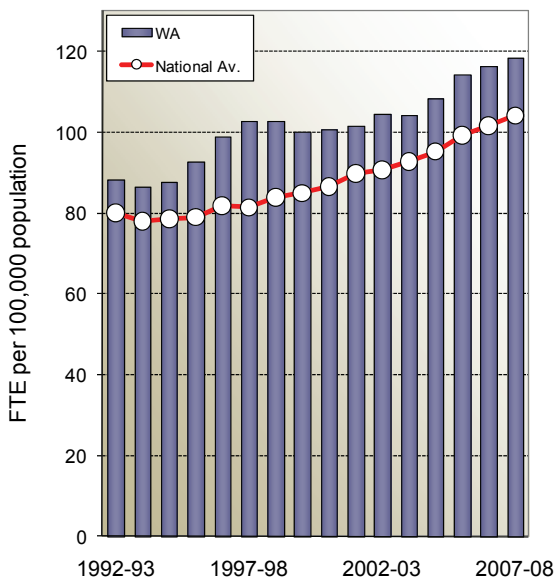
Changes in inpatient services



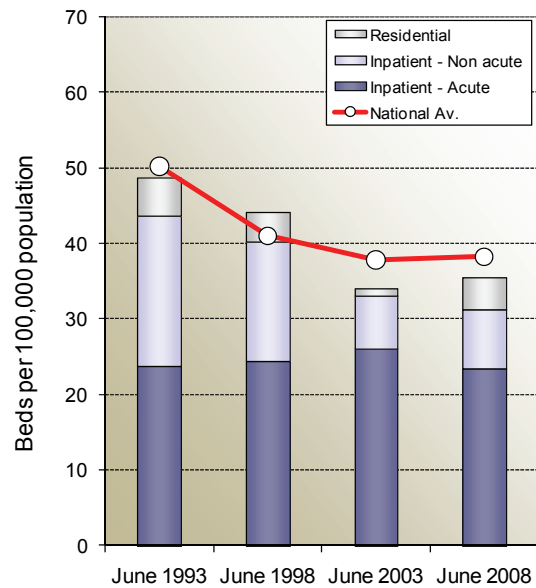
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



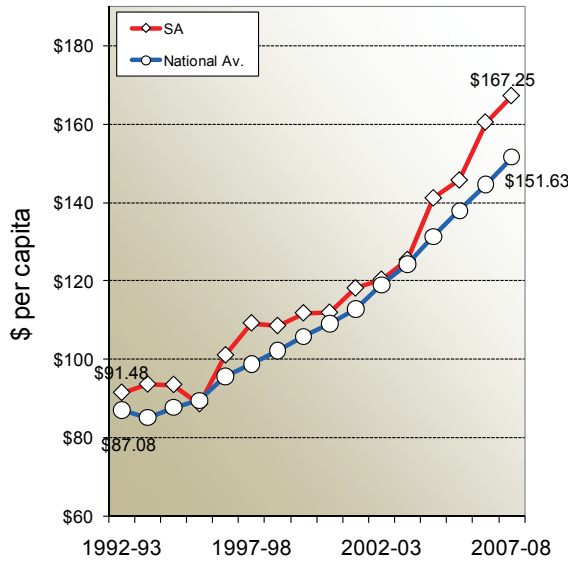


South Australia

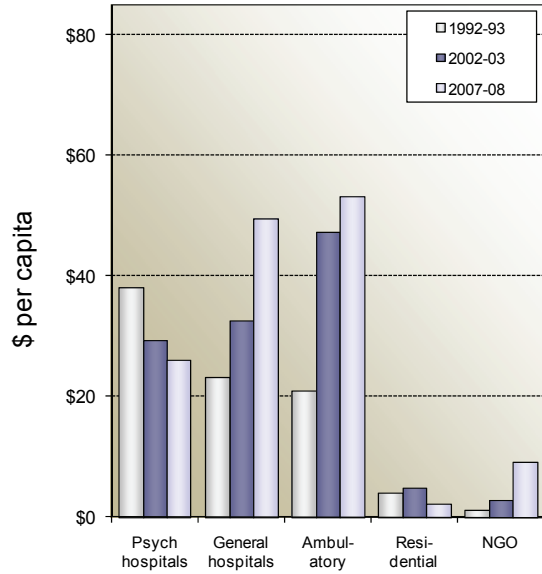
Table 16: Indicators of mental health reform in South Australia

INDICATOR	SOUTH AUSTRALIA			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
• State spending on mental health services (\$Millions)	133.5	183.7	266.5	3,220.3
• State spending per capita (\$)	91.48	120.36	167.25	151.63
• Per capita spending rank	2	4	4	
• Average annual spending growth during prior National Mental Health Plan(s)		3.4	6.9	5.1
SERVICE MIX				
• % total service expenditure – Community services	30.4	38.7	47.9	53.4
– Stand alone psychiatric hospitals	59.1	43.7	29.8	14.2
– Colocated general hospitals	10.6	17.7	22.3	32.4
INPATIENT SERVICES				
• Total hospital beds	779	655	600	6,551
• Per capita expenditure on inpatient care (\$)	63.64	76.38	88.39	69.16
• Inpatient beds per 100,000	53.4	42.9	37.7	30.8
• Acute inpatient beds per 100,000	24.1	22.9	22.5	20.4
• Non acute inpatient beds per 100,000	29.3	20.0	15.2	10.4
• % acute inpatient beds located in general hospitals	33.1	51.8	69.4	86.4
• Stand alone psychiatric hospitals as % of total beds	85.4	73.0	59.5	32.9
• Average cost per patient day (\$)	408	542	713	702
COMMUNITY SERVICES				
• Ambulatory care – % total service expenditure	27.9	36.2	36.5	40.2
– Per capita expenditure (\$)	25.46	45.02	61.94	59.72
• NGOs – % total service expenditure	1.6	2.1	9.3	8.3
– Per capita expenditure (\$)	1.49	2.67	15.75	12.35
• Residential services – % total service expenditure	0.9	0.4	2.3	6.0
– Per capita expenditure (\$)	0.80	0.45	3.98	8.91
– Adult beds per 100,000: 24-hour staffed	3.5	2.1	6.4	6.6
Non-24 hour staffed	n.a	-	0.7	4.4
– Older persons beds per 100,000: 24-hour staffed	-	-	-	23.9
Non-24 hour staffed	n.a	-	-	0.6
• Supported public housing places per 100,000	n.a	3.9	7.0	18.2
DIRECT CARE WORKFORCE				
• Number Full Time Equivalent (FTE) staff	1,441	1,590	1,970	22,120
• FTE per 100,000	98.8	104.2	123.6	104.2
• FTE per 100,000 – ambulatory services	21.8	39.6	51.9	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
• % services Level 1 implementation of Standards	..	12	51	82
• % service expenditure covered by Level 1 services	..	21	43	81
CONSUMER AND CARER PARTICIPATION				
• % services with Level 1 consumer participation arrangements	15	53	49	57
• Consumer consultants employed per 1000 clinical FTE	n.a	1.4	2.4	2.9
• Carer consultants employed per 1000 clinical FTE	n.a	-	0.9	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
• % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	4.6	4.7
• % population seen - GPs	..	..	3.1	3.4
• % population seen – Consultant Psychiatrists	1.5	1.7	1.5	1.3
• % population seen – Psychologists and Clinical Psychologists	..	..	1.4	1.8
• % population seen – Other allied health professionals	..	..	0.1	0.1
• Total MBS mental health related benefits paid per capita	..	..	25.41	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
• Total PBS/RPBS benefits paid per capita	6.17	41.81	39.97	34.34

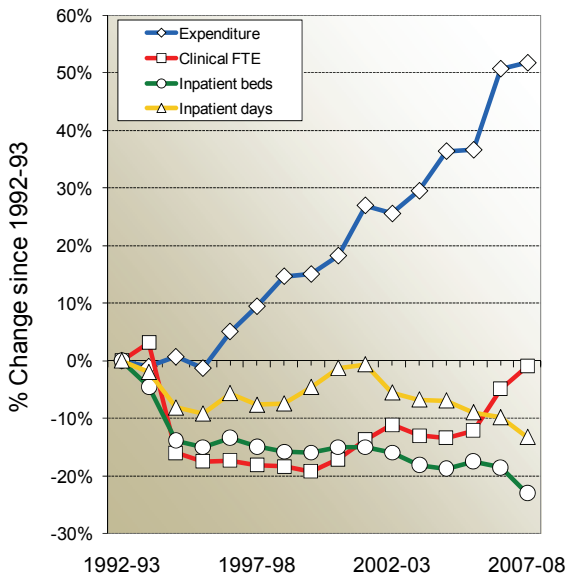
Overall spending on mental health



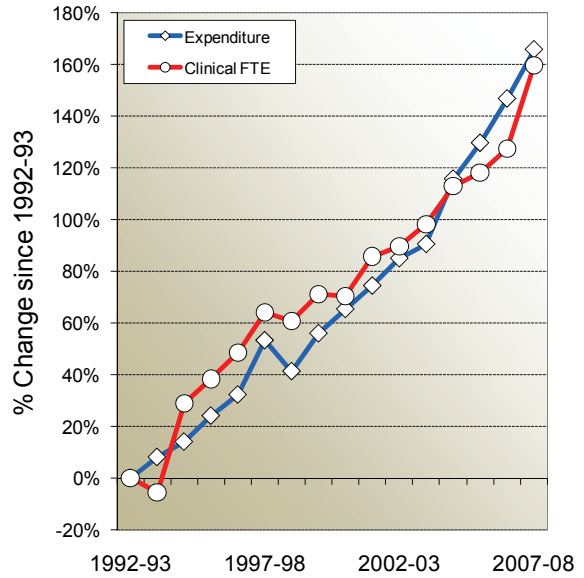
Changes in spending mix



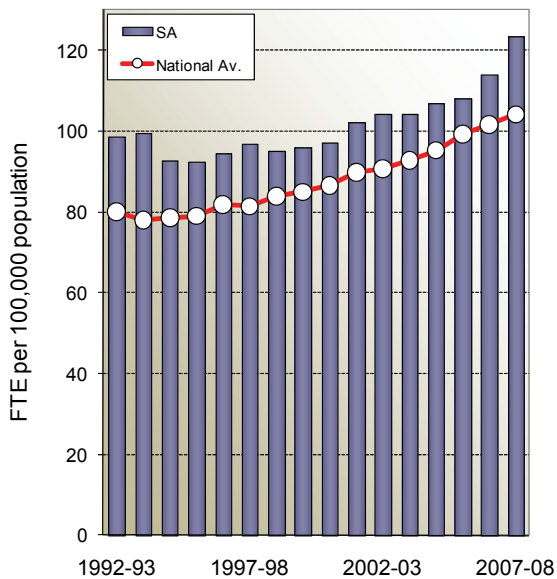
Changes in inpatient services



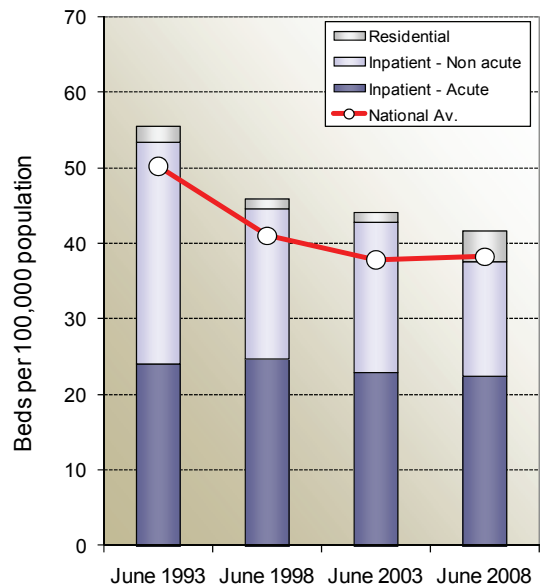
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



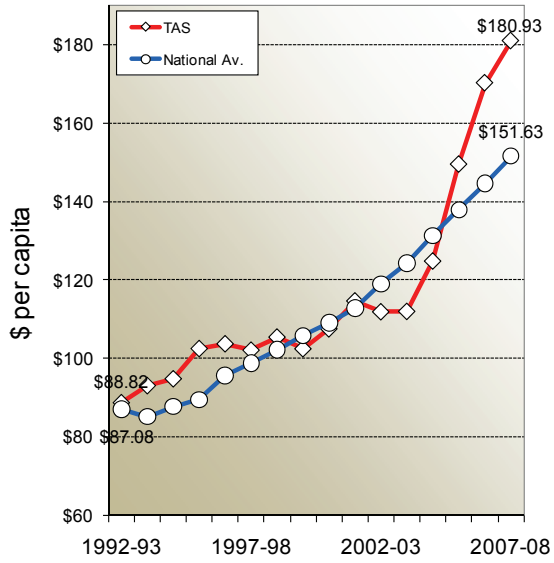


Tasmania

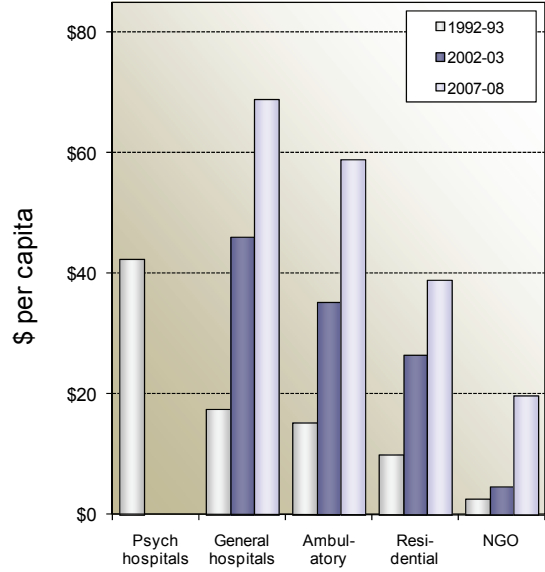
Table 17: Indicators of mental health reform in Tasmania

INDICATOR	TASMANIA		AUSTRALIA	
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
* State spending on mental health services (\$Millions)	41.8	53.2	89.6	3,220.3
* State spending per capita (\$)	88.42	111.94	180.40	151.63
* Per capita spending rank	3	6	2	
* Average annual spending growth during prior National Mental Health Plan(s)		2.5	9.0	5.1
SERVICE MIX				
* % total service expenditure – Community services	31.7	59.0	60.9	53.4
– Stand alone psychiatric hospitals	48.3	-	-	14.2
– Colocated general hospitals	20.0	41.0	39.1	32.4
INPATIENT SERVICES				
* Total hospital beds	245	154	128	6,551
* Per capita expenditure on inpatient care (\$)	60.07	46.13	69.04	69.16
* Inpatient beds per 100,000	52.0	32.4	25.8	30.8
* Acute inpatient beds per 100,000	21.4	23.0	20.4	20.4
* Non acute inpatient beds per 100,000	30.6	9.5	5.5	10.4
* % acute inpatient beds located in general hospitals	87.0	100	100	86.4
* Stand alone psychiatric hospitals as % of total beds	67.3	-	-	32.9
* Average cost per patient day (\$)	344	488	899	702
COMMUNITY SERVICES				
* Ambulatory care – % total service expenditure	17.4	31.3	33.4	40.2
– Per capita expenditure (\$)	15.26	35.25	58.89	59.72
* NGOs – % total service expenditure	3.0	4.2	11.2	8.3
– Per capita expenditure (\$)	2.61	4.79	19.72	12.35
* Residential services – % total service expenditure	11.4	23.5	22.1	6.0
– Per capita expenditure (\$)	9.99	26.49	39.01	8.91
– Adult beds per 100,000:				
24-hour staffed	7.7	13.0	44.0	6.6
Non-24 hour staffed	n.a	-	-	4.4
– Older persons beds per 100,000:				
24-hour staffed	83.2	84.7	56.2	23.9
Non-24 hour staffed	n.a	-	-	0.6
* Supported public housing places per 100,000	n.a	-	5.5	18.2
DIRECT CARE WORKFORCE				
* Number Full Time Equivalent (FTE) staff	424	461	629	22,120
* FTE per 100,000	89.9	97.0	127.0	104.2
* FTE per 100,000 – ambulatory services	20.4	31.6	38.9	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
* % services Level 1 implementation of Standards	..	15	41	82
* % service expenditure covered by Level 1 services	..	22	52	81
CONSUMER AND CARER PARTICIPATION				
* % services with Level 1 consumer participation arrangements	-	67	43	57
* Consumer consultants employed per 1000 clinical FTE	n.a	-	0.05	2.9
* Carer consultants employed per 1000 clinical FTE	n.a	-	-	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
* % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	4.1	4.7
* % population seen - GPs	..	..	3.1	3.4
* % population seen – Consultant Psychiatrists	1.2	1.1	0.9	1.3
* % population seen – Psychologists and Clinical Psychologists	..	..	1.8	1.8
* % population seen – Other allied health professionals	..	..	0.1	0.1
* Total MBS mental health related benefits paid per capita	..	..	22.01	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
* Total PBS/RPBS benefits paid per capita	6.21	37.70	38.25	34.34

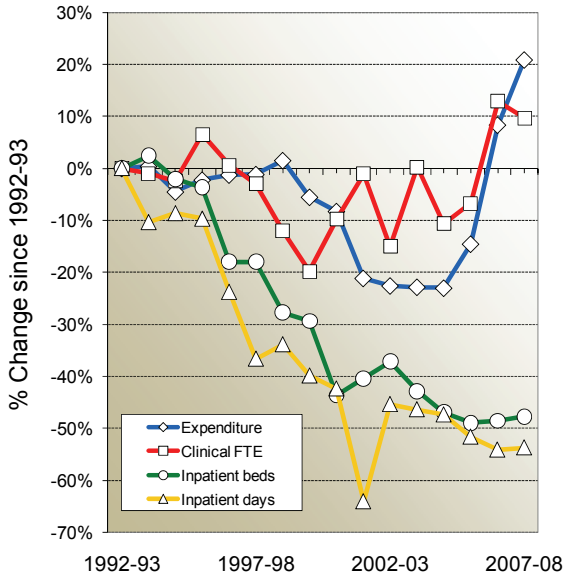
Overall spending on mental health



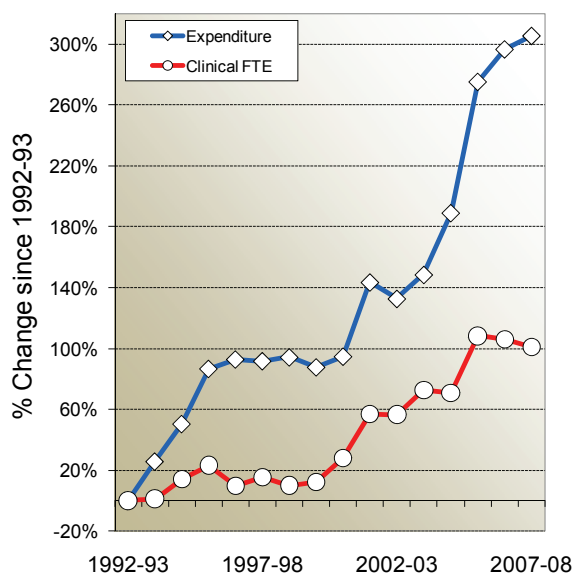
Change in spending mix



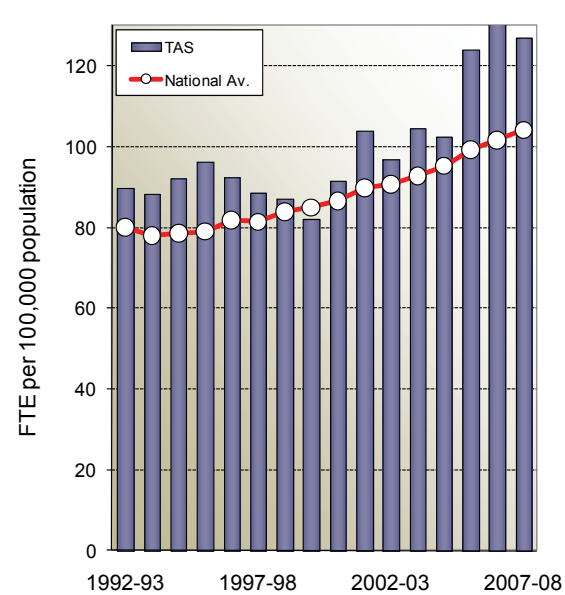
Changes in inpatient services



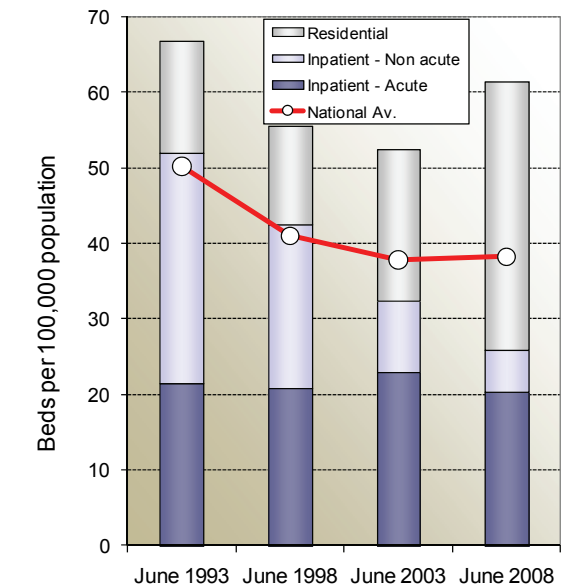
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



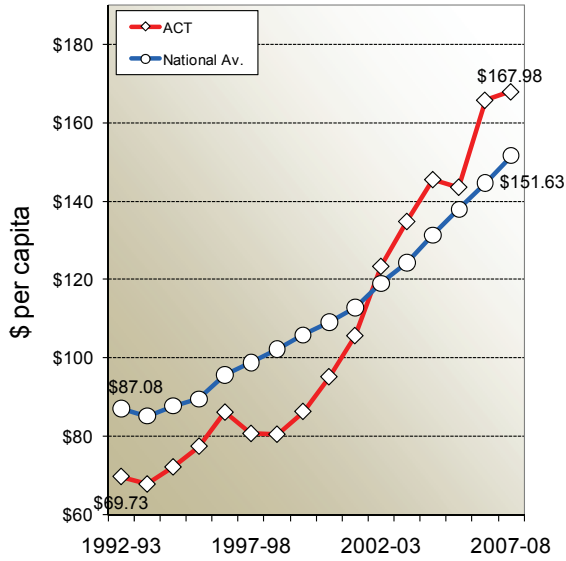


Australian Capital Territory

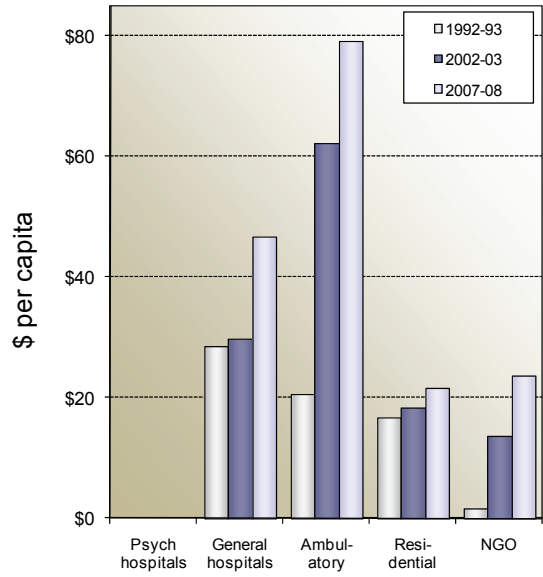
Table 18: Indicators of mental health reform in the Australian Capital Territory

INDICATOR	AUSTRALIAN CAPITAL TERRITORY			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
* State spending on mental health services (\$Millions)	20.7	40.0	57.5	3,220.3
* State spending per capita (\$)	69.73	123.39	167.98	151.63
* Per capita spending rank	8	2	3	
* Average annual spending growth during prior National Mental Health Plan(s)		7.1	9.4	5.1
SERVICE MIX				
* % total service expenditure – Community services	57.7	75.3	71.7	53.4
– Stand alone psychiatric hospitals	-	-	-	14.2
– Colocated general hospitals	42.3	24.7	28.3	32.4
INPATIENT SERVICES				
* Total hospital beds	52	50	70	6,551
* Per capita expenditure on inpatient care (\$)	28.57	29.84	46.79	69.16
* Inpatient beds per 100,000	17.6	15.4	15.4	30.8
* Acute inpatient beds per 100,000	17.6	15.4	20.5	20.4
* Non acute inpatient beds per 100,000	-	-	-	10.4
* % acute inpatient beds located in general hospitals	100	100	100	86.4
* Stand alone psychiatric hospitals as % of total beds	-	-	-	32.9
* Average cost per patient day (\$)	484	693	863	702
COMMUNITY SERVICES				
* Ambulatory care – % total service expenditure	30.6	51.6	47.8	40.2
– Per capita expenditure (\$)	20.67	62.20	79.08	59.72
* NGOs – % total service expenditure	2.5	11.4	14.3	8.3
– Per capita expenditure (\$)	1.69	13.70	23.72	12.35
* Residential services – % total service expenditure	24.7	15.3	13.1	6.0
– Per capita expenditure (\$)	16.69	18.43	21.63	8.91
– Adult beds per 100,000:				
24-hour staffed	30.5	12.8	15.0	6.6
Non-24 hour staffed	n.a	21.1	15.0	4.4
– Older persons beds per 100,000:				
24-hour staffed	-	34.4	20.3	23.9
Non-24 hour staffed	n.a	-	-	0.6
* Supported public housing places per 100,000	n.a	23.1	14.0	18.2
DIRECT CARE WORKFORCE				
* Number Full Time Equivalent (FTE) staff	205	275	315	22,120
* FTE per 100,000	69.4	84.9	92.0	104.2
* FTE per 100,000 – ambulatory services	22.9	47.5	49.3	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
* % services Level 1 implementation of Standards	..	86	100	82
* % service expenditure covered by Level 1 services	..	70	100	81
CONSUMER AND CARER PARTICIPATION				
* % services with Level 1 consumer participation arrangements	-	100	100	57
* Consumer consultants employed per 1000 clinical FTE	n.a	5.4	-	2.9
* Carer consultants employed per 1000 clinical FTE	n.a	-	-	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
* % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	4.1	4.7
* % population seen - GPs	..	..	2.9	3.4
* % population seen – Consultant Psychiatrists	1.0	1.1	1.0	1.3
* % population seen – Psychologists and Clinical Psychologists	..	..	1.7	1.8
* % population seen – Other allied health professionals	..	..	0.04	0.1
* Total MBS mental health related benefits paid per capita	..	..	20.74	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
* Total PBS/RPBS benefits paid per capita	3.76	30.90	26.87	34.34

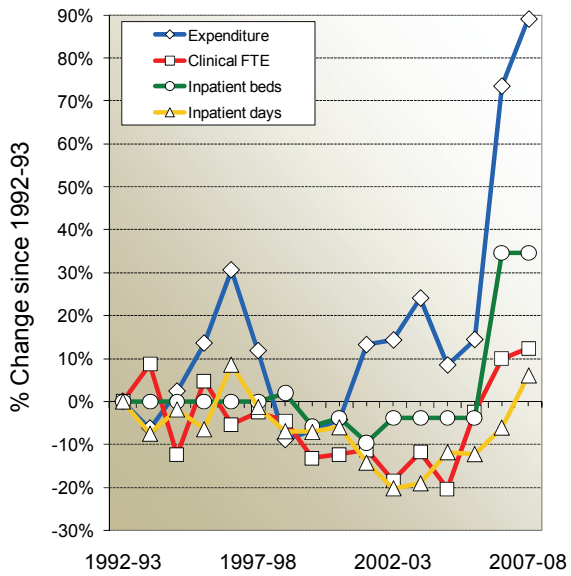
Overall spending on mental health



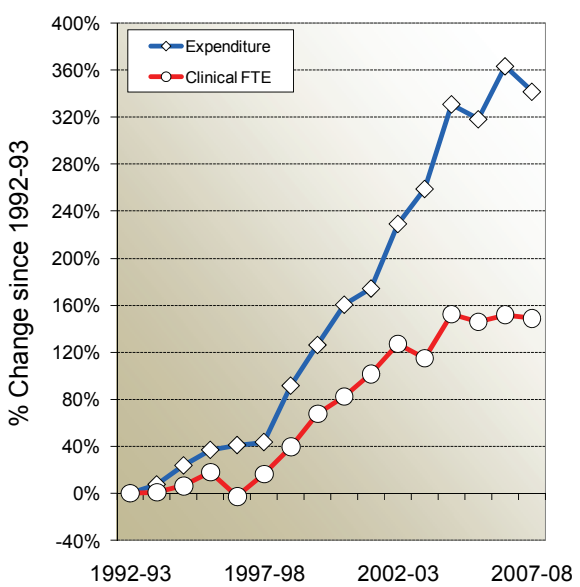
Change in spending mix



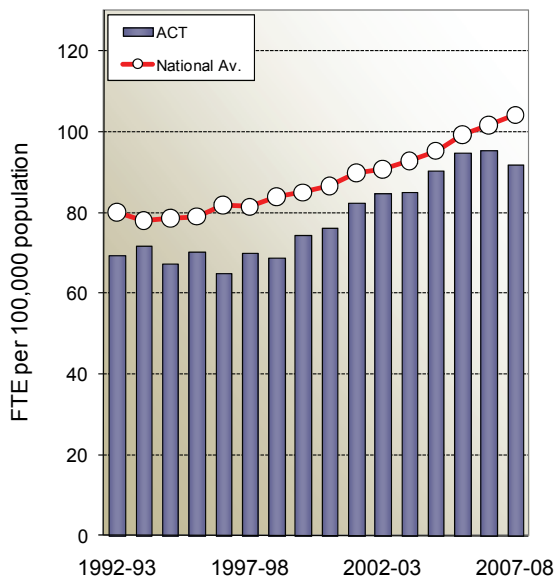
Changes in inpatient services



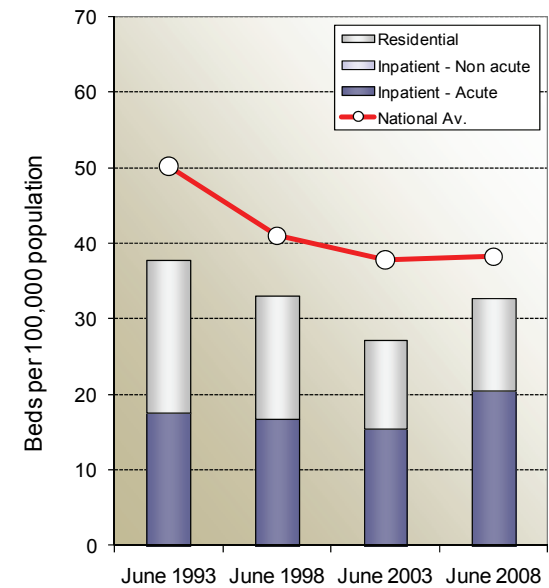
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



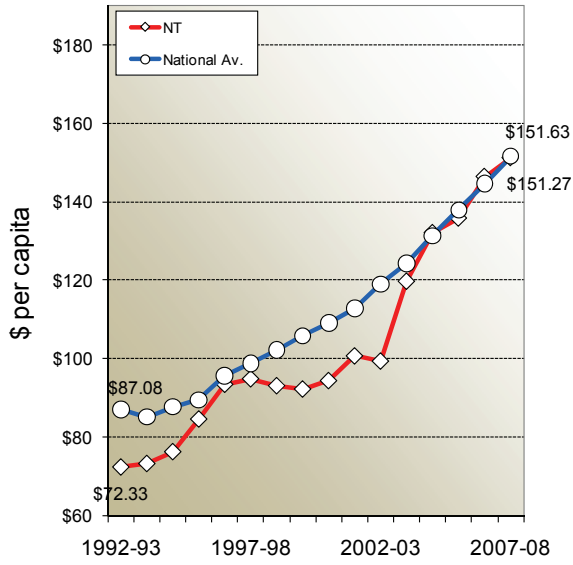


Northern Territory

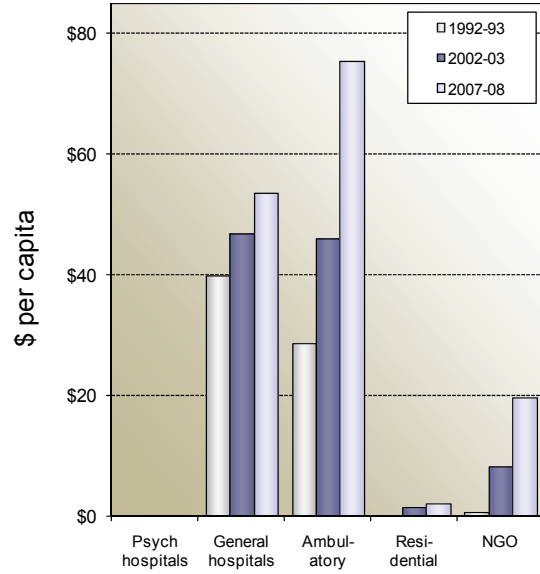
Table 19: Indicators of mental health reform in the Northern Territory

INDICATOR	NORTHERN TERRITORY			AUSTRALIA
	1992-93	2002-03	2007-08	2007-08
STATE GOVERNMENT EXPENDITURE				
* State spending on mental health services (\$Millions)	12.3	19.8	32.9	3,220.3
* State spending per capita (\$)	72.33	99.34	151.27	151.63
* Per capita spending rank	7	8	5	
* Average annual spending growth during prior National Mental Health Plan(s)		5.0	8.9	5.1
SERVICE MIX				
* % total service expenditure – Community services	42.4	53.7	64.0	53.4
– Stand alone psychiatric hospitals	-	-	-	14.2
– Colocated general hospitals	57.6	46.3	36.0	32.4
INPATIENT SERVICES				
* Total hospital beds	41	32	34	6,551
* Per capita expenditure on inpatient care (\$)	39.82	46.91	53.64	69.16
* Inpatient beds per 100,000	24.2	16.1	15.6	30.8
* Acute inpatient beds per 100,000	15.3	16.1	15.6	20.4
* Non acute inpatient beds per 100,000	8.8	-	-	10.4
* % acute inpatient beds located in general hospitals	100	100	100	86.4
* Stand alone psychiatric hospitals as % of total beds	-	-	-	32.9
* Average cost per patient day (\$)	660	1,003	1,061	702
COMMUNITY SERVICES				
* Ambulatory care – % total service expenditure	41.3	45.4	50.7	40.2
– Per capita expenditure (\$)	28.57	45.99	75.42	59.72
* NGOs – % total service expenditure	1.0	8.0	13.2	8.3
– Per capita expenditure (\$)	0.70	8.16	19.71	12.35
* Residential services – % total service expenditure	-	1.4	1.4	6.0
– Per capita expenditure (\$)	-	1.45	2.10	8.91
– Adult beds per 100,000:				
24-hour staffed	-	-	3.4	6.6
Non-24 hour staffed	n.a	7.6	-	4.4
– Older persons beds per 100,000:				
24-hour staffed	-	-	-	23.9
Non-24 hour staffed	n.a	-	-	0.6
* Supported public housing places per 100,000	n.a	9.0	15.2	18.2
CLINICAL WORKFORCE				
* Number Full Time Equivalent (FTE) staff	120	135	168	22,120
* FTE per 100,000	70.6	67.6	77.1	104.2
* FTE per 100,000 – ambulatory services	25.8	31.8	43.6	43.5
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS				
* % services Level 1 implementation of Standards	..	-	94	82
* % service expenditure covered by Level 1 services	..	-	98	81
CONSUMER AND CARER PARTICIPATION				
* % services with Level 1 consumer participation arrangements	-	100	100	57
* Consumer consultants employed per 1000 clinical FTE	n.a	-	-	2.9
* Carer consultants employed per 1000 clinical FTE	n.a	-	-	1.2
MEDICARE SUBSIDISED MENTAL HEALTH SERVICES				
* % population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	..	..	2.2	4.7
* % population seen - GPs	..	..	1.5	3.4
* % population seen – Consultant Psychiatrists	0.1	0.5	0.4	1.3
* % population seen – Psychologists and Clinical Psychologists	..	..	0.5	1.8
* % population seen – Other allied health professionals	..	..	0.02	0.1
* Total MBS mental health related benefits paid per capita	..	..	6.30	25.84
PBS-FUNDED PHARMACEUTICALS (including RPBS)				
* Total PBS/RPBS benefits paid per capita	1.95	12.80	13.20	34.34

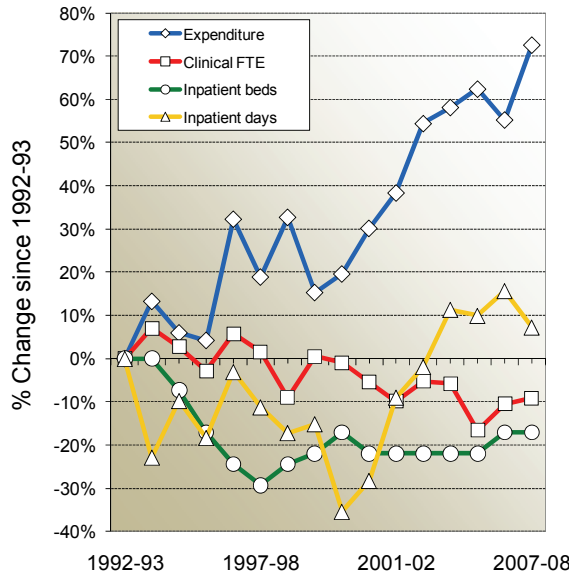
Overall spending on mental health



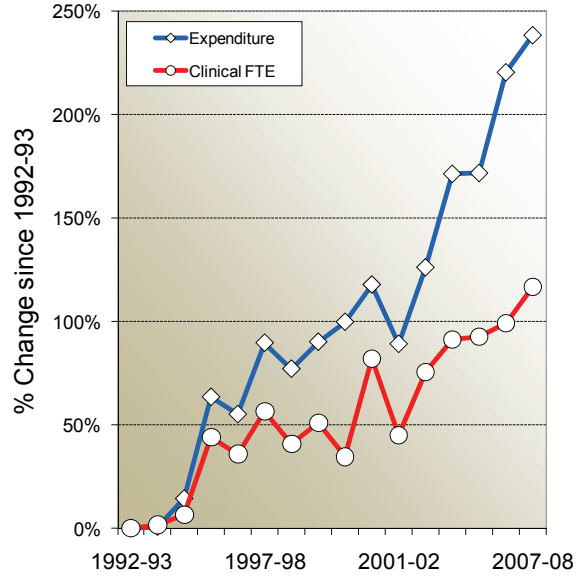
Change in spending mix



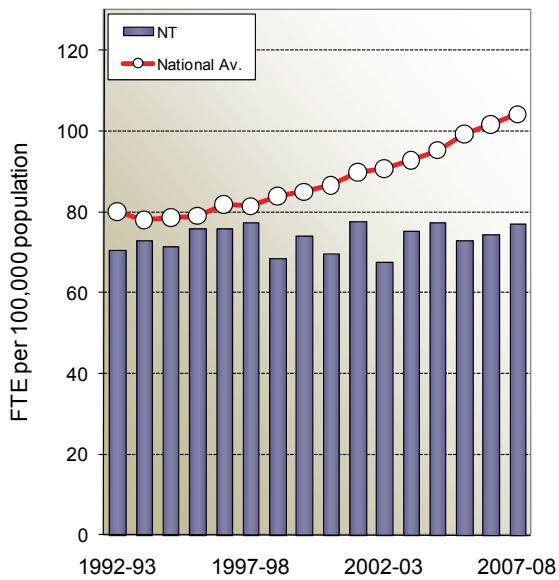
Changes in inpatient services



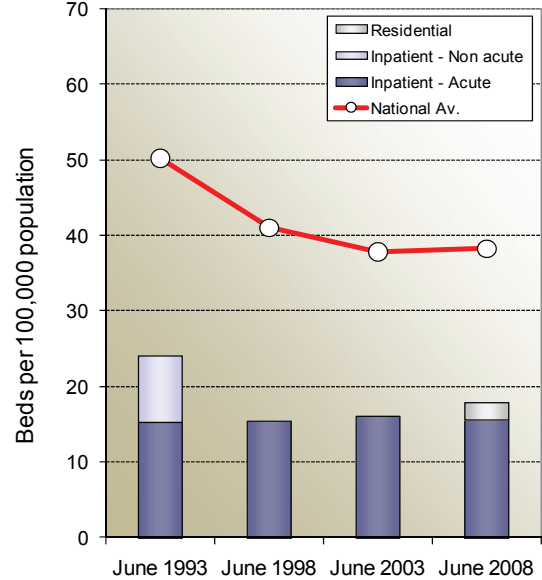
Changes in ambulatory care services



Direct care workforce



Inpatient and 24 hour residential beds



PART E

Appendices

APPENDIX 1

Sources for state and territory data

The origins of national reporting by states and territories

In 1993, the Australian Government, states and territories agreed on a standard data set and performance indicators to monitor progress of the National Mental Health Strategy. The recommended process required each jurisdiction to collect the necessary data elements and provide to the Australian Government aggregated data in the form of a standard set of tables. These covered activity and expenditure in inpatient services, community based services and a range of 'system level' categories such as research and mental health promotion.

The *First National Mental Health Report* was prepared on this basis and provided a national picture of public sector mental health services. However, the Report was compromised by its reliance upon aggregated data sets prepared at central health administration level.

- Difficulties were particularly evident in the quality and range of financial data available on mental health services. In most states and territories, statewide protocols and comprehensive reporting systems were not available to monitor expenditure against the annual budget allocation, preventing accurate analysis of the real cost of providing mental health services.
- Expenditure on specialised mental health services delivered within mainstream health organisations was particularly difficult to identify, usually being absorbed within global reporting arrangements.
- Data routinely collected by central and regional administrative units did not allow the linking of expenditure to activity at the sub-program level, restricting the development of benchmark costs for service components.

The broad information collected limited the extent to which data could be disaggregated beyond the state and territory level, preventing more detailed analysis of service delivery patterns.

Together, these difficulties restricted the extent to which the 1993 data could be used to evaluate mental health services in Australia. Overall, the Report pointed to the need for better quality information to inform policy and planning.

The National Survey of Mental Health Services 1993-94 to 2004-05

The National Survey of Mental Health Services was developed as a joint Australian Government, state and territory initiative to replace the state and territory-level aggregate reporting approach used in the first year of reporting under the National Mental Health Strategy. The National Survey approach was continued through to 2004-05 in various formats and ultimately provided the basis for the current approach to monitoring state and territory mental health services

The Survey constructed the national picture from a 'bottom up' perspective, by directly involving health service organisations in describing their mental health services according to a standard set of data categories and criteria.

Scope of Survey

The Survey covered all specialised mental health services managed or funded by the state and territory health administrations. Specialised mental health services were defined as those in which:

- the primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental disorder or psychiatric disability, with this criterion being applicable regardless of the source of funds; and
- such activities are delivered from a service or facility which is readily identifiable as both specialised and serving a mental health function.

Several aspects of the definition should be noted.

1. The concept of a specialised mental health service was not dependent on inclusion of the service within the state and territory mental health budget. In several jurisdictions, significant public sector health services performing specialist mental health functions are funded from sources other than the mental health appropriation or allocation.
2. A service was not defined as a mental health service simply because its clientele include people affected by mental illness or psychiatric disorder. For example, the definition did not include health or other human services which, as part of a more general role, provided assistance to people affected by mental disorders. These included, for example, services provided by emergency departments, general outpatients and medical/surgical wards of acute hospitals; services provided by primary care health professionals in community health settings; and services delivered by general hospitals without a dedicated psychiatric unit.
3. Finally, the definition excluded specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental illness who also have a drug or alcohol related problem or intellectual disability.

Exclusion of the services described above was not intended to imply that their operation is not relevant to the National Mental Health Strategy. Instead, it reflected the focus of reporting – that is, on those components of the health and community support service industries which specifically operate to provide assessment, treatment, rehabilitation or care to people affected by mental illness or psychiatric disability.

Survey structure

Survey data were collected at three levels of mental health service administration:

- central health departments in each state and territory;
- regional, area and district administrative units; and
- organisations providing specialised mental health services.

Information about mental health services and their associated costs was collected in a series of paper-based forms completed by service delivery organisations. As the survey covered a range of inpatient and non inpatient services, separate reporting formats were required to accommodate the different types of services and allow matching of cost and activity data to service types. Data forms for three major service groupings were based on the taxonomy of mental health services developed by the Information Strategy Subcommittee of the then AHMAC National Mental Health Working Group (now the AHMAC Mental Health Standing Committee).

A hierarchical structure for the reporting and aggregation of data was used in the survey.

- All services (inpatient, ambulatory and community based residential services) were identified against a 'parent' mental health service delivery organisation. This allowed any indirect costs reported by organisations (e.g., superannuation) to be subsequently apportioned to service delivery level.
- All organisations were grouped into their respective health administrative regions. As above, this allowed indirect costs reported at the regional level (e.g., program management expenditure) to be subsequently distributed to services, as well as providing a basis for aggregating all expenditure and service data up to regional level.
- A state and territory level of aggregation was created by combining the regional groupings with relevant data provided by the central health administration.

Organisation level returns

For the purposes of the survey, a mental health service delivery organisation was defined as a health care organisation which carried direct management responsibility for the delivery of one or more public sector specialised mental health services. In most cases, these organisations managed a range of mental health services. For some organisations (e.g., general hospitals), mental health services were only one component of broader health care responsibilities. Mental health organisations covered by the survey included:

- general hospitals which managed a specialised psychiatric inpatient unit and/or psychiatric outpatient services;
- psychiatric hospitals which provided inpatient services and other services such as community mental health centres;
- aged care residential centres which managed psychogeriatric inpatient units, or psychogeriatric community assessment teams;
- community health centres which managed a specialist mental health program or team as part of a broader set of community services;
- community mental health centres or services which were managed independently of a larger health service organisation; and
- regional, area and district health authorities which acted as the management unit directly responsible for mental health services within a particular geographic area.

Although most non government organisations funded to provide community support services for people with psychiatric disability meet this definition, the diversity in range and sizes of these organisations made it impractical to collect standardised information at the agency level. Instead, the survey gathered data from regional and central health administrative units on total grants allocated to non government organisations for the provision of specialised mental health services.

An exception to this approach commenced with the 1999-2000 survey for non government providers of residential services. Where an organisation provided specialised residential services that were staffed for part or all of the day, they were required to complete the survey returns. Surveys prior to 1999-2000 only required specific reporting on 24 hour staffed residential services.

Service organisations were asked to provide a wide range of information about programs, activities, expenditure and funding. The returns included organisation level information in parallel with the state and territory and regional returns, covering:

- expenditure on organisational administration (including indirect expenditure such as training, research and health promotion activities);
- revenue and sources of funds; and
- accounting practices (whether cash or accrual) and procedures for statistical and financial reporting.

In addition, organisations reported:

- workforce profiles for direct care, administrative and other staff; and
- consumer participation in the evaluation and development of mental health services managed by the organisation.

Organisations also reported in detail on their service categories, program mix, activity and expenditure data. Final analyses of the data, presented in the tables in this report, include the distribution of indirect expenditure across all the services provided by each organisation. In this way, hospital and agency reports of expenditure are costed more comprehensively than is possible by reporting unadjusted expenditure totals for each mental health service, program or agency. Details of the approach used are provided in Appendix 2.

Approximately 200 to 250 mental health service organisations provided data annually to the National Survey over the period of its collection. These ranged from organisations which managed single services with funding as low as \$20,000 to large, complex organisations responsible for mental health services with a funding base of over \$60 million.

The National Minimum Data Set – Mental Health Establishments collection, 2005-06 onwards

The National Survey of Mental Health Services was replaced by the Mental Health Establishments (MHE) NMDS in 2005-06. This transition was taken to continue the previous national data collection on a comparable basis but upgrade it to National Minimum Data Set status to ensure sustainability over the longer term. The logic of the previous survey approach was maintained, including the scope and structure of national reporting across the three levels of state and territory mental health service systems (organisation, region, state). To put the national reporting arrangements on a contemporary footing, the former paper based method of reporting was replaced with the requirement for states and territories to provide data in a standardised electronic format over a secure internet connection that allowed much of the data validation process previously undertaken manually to be completed electronically.

The Australian Institute of Health and Welfare are contracted by the Department of Health and Ageing to manage the MHE collection, including the validation of data. Further information on the MHE can be found in the AIHW annual publications *Mental Health Services in Australia* and at the website: <http://meteor.aihw.gov.au>

APPENDIX 2

State and territory expenditure on mental health services

Expenditure data on specialised mental health services reported by states and territories provide the basis for many of the indicators used to monitor progress of the National Mental Health Strategy. Comparisons are made of performance over time to monitor changes in:

- overall expenditure between 1992-93 and 2007-08; and
- the mix of services across years.

Throughout this report, all comparisons across years use amended baseline data.

Standardisation of expenditure data

Expenditure data reported by states and territories were standardised at two levels to ensure consistency between jurisdictions and comparability with data reported for earlier years.

- Expenditure reported as 'indirect' was apportioned to service mix categories.
- Adjustments were made to remove inconsistencies caused by a transfer from cash based to accrual reporting in several jurisdictions.

Details of both aspects of the management of the expenditure are provided below.

Distribution of indirect expenditure

To ensure that no significant expenditure was omitted in state and territory reporting, service delivery organisations and regional and central health administrative units were requested to report a range of indirect expenditure incurred as part of the overall provision of mental health services. There are three types of expenditure that could be reported as 'indirect':

- salary on-costs that can be directly related to specific services (e.g., superannuation, workers' compensation) but may be reported as an aggregate amount;
- expenses indirectly related to service delivery, but which are necessarily incurred in service provision (e.g., information systems, program administration); and
- expenses that cannot be directly or indirectly related to specific mental health services provided by an organisation (e.g., research, education and training).

Indirect expenditure categories are shown in Table A-1. Definitions for each category are provided in the Mental Health Establishments documentation available at <http://meteor.aihw.gov.au>.

Data specifications required that indirect expenditure items only be reported if they were not included elsewhere. For example, if superannuation was not apportioned to specific services, the specifications provided the option of reporting it as an aggregate amount. The approach therefore did not aim to separately assess total expenditure in each of the indirect categories, but instead, acted as a 'safety net' to capture all relevant expenditure.

As in previous years, there was considerable variability in the 2008 data submitted by states and territories in the way organisations used the indirect expenditure categories. Many agencies reported nil amounts, indicating that all relevant expense items had been costed to service level. Other agencies reported large amounts of on-costs or overheads, usually with the comment that these should be apportioned down to service level.

Table A-1: Indirect expenditure items distributed across service mix categories

Expenditure item	Reported by service delivery organisations	Reported by regional administration	Reported by central administration
Program administration	Yes	Yes	No
Organisation-wide support services	Yes	Yes	Not applicable
Education and training	No	No	No
Academic chairs	Yes	Yes	No
Mental health research	No	No	No
Mental health promotion	No	No	No
Superannuation	Yes	Yes	No
Workers compensation	Yes	Yes	No
Insurance	Yes	Yes	No
Mental Health Act	No	No	No
Patient transport services	Yes	Yes	No
Property leasing	Yes	Yes	No
Other indirect expenditures	Yes	Yes	No

A total of \$341 million was reported respectively in indirect expenditure categories in the 2008 survey, representing approximately 10% of total state and territory expenditure. Table A-9 provides details of the indirect expenditure amounts reported by each jurisdiction.

A standard approach was used in distributing indirect expenditure to service mix categories. This involved the following steps:

- Items of indirect expenditure appropriate for apportionment to service mix categories were first identified, as per Table A-1.
- Allocation rules for apportionment of these items were then applied. Apportionment was done in all cases on the basis of total expenditure. Thus, if general acute inpatient services accounted for 30% of an organisation's (or region's) total expenditure, it received 30% of the total indirect expenditure tagged for distribution.
- Non government organisations (NGO) that provided services other than residential services were excluded from the apportioned indirect expenditure on the basis that little if any of these costs could be attributed to the NGO sector.

Following this distribution approach, total unallocated indirect expenditure reduced to approximately 5% of total expenditure. The effect on estimated direct service expenditure for all states and territories was considerable. Table A-2 provides details of state and territory service mix spending pre- and post-distribution of the indirect expenditure for the most recent year.

Adjusting for cash-based versus accrual accounting

Reporting of 1992-93 state and territory expenditure was primarily on a cash basis. In 1993-94, organisations in two states (New South Wales and Tasmania) reported expenditure on a full accrual basis to the national survey. Over the subsequent years, an increasing number of organisations reported expenditure data to the previous National Survey on a full or part accrual basis.

The move to accrual reporting caused problems of consistency across years for those jurisdictions that have made the transfer, and problems of comparability between states and territories within years. The inclusion of depreciation on capital in accrual reporting is the main source of non comparability and typically adds 5% to 8% to health expenditure. As the previous National Survey included a structure that allowed separate enumeration of depreciation where this was included, it was agreed with state and territory representatives to exclude this item from all assessments of recurrent expenditure.

This approach has been continued in the data reported under the Mental Health Establishments collection. The MHE allows depreciation to be specifically enumerated, but to ensure a level playing field, it has been excluded from all data tables and indicators presented in this report.

Maintenance of expenditure analysis

The information presented in Table A-3 provides a picture of what was spent in each state and territory on public sector mental health services. But the concept of 'maintenance of expenditure' requires a distinction between what was spent *in* a state or territory and what was spent *by* the respective state or territory government. Although a simple concept, the monitoring the maintenance of expenditure under the National Mental Health Strategy is a complex process and requires a different level of analysis.

In principle, such an analysis should differentiate between mental health services expenditure on the basis of source of funds, which may include:

- State and territory funds;
- Australian Government contributions in the form of:
 - National Mental Health Strategy grants made under the Australian Health Care Agreements;
 - other health care grants provided under the Australian Health Care Agreements;
 - funds allocated under the Commonwealth/State-Territory Disability Agreement;
 - nursing home and hostel subsidies;
 - grants and payments made by the Department of Veterans' Affairs for mental health care of veterans made as part of the transfer of previously owned Australian Government repatriation hospitals to state ownership;
 - other Australian Government grants for specific mental health purposes; and
- other revenue sources including patient fees and reimbursement by third party compensation insurers.

Ideally, the effect of changes in each of these factors should be isolated to establish a clear basis to evaluate changes in the state and territory government funding components of overall reported expenditure. However, such an analysis demands a level of detail that is impractical in the context of the National Mental Health Strategy monitoring arrangements.

The pragmatic approach adopted in previous reports is also used in the current report. This focuses on the two Australian Government funding sources most likely to affect overall expenditure on mental health services – National Mental Health Strategy funds and grants from the Department of Veterans' Affairs.

National Mental Health Strategy funds

Significant change occurred over the 1993-2008 period in the level of National Mental Health Strategy funds used to support state and territory services. Table A-5 provides the relevant details of National Mental Health Strategy funds allocated to the states and territories for all years.

Department of Veterans' Affairs (DVA)

As a result of agreements between the Australian Government and states and territories in relation to health services to veterans, changes in DVA funding have the potential to distort analysis of state and territory expenditure on mental health services. The major factors here are:

- the transfer of previously Australian Government managed repatriation hospitals to state ownership, bringing significant new mental health expenditure into the state reports. This occurred in New South Wales with the transfer of the Concord Hospital to state ownership in July 1993; in South Australian with the transfer of Daw Park Repatriation Hospital in July 1994; and in Victoria with the transfer of the former Heidelberg Repatriation Hospital in July 1995.
- the closure of the stand alone repatriation 'mental hospitals' previously run by state governments on behalf of the Australian Government. This occurred in Victoria, with the closure of the Bundoora Repatriation Hospital in 1993-94; and
- changing levels of DVA reimbursement to states and territories for provision of mental health services to veterans, consequential to the phasing out of the direct service provider role previously taken by the department.

Each of these factors indicates the need to separately identify DVA funded services that are included in the state and territory reports of gross recurrent expenditure. Table A-5 provides details of the estimated DVA funding across all years of the National Mental Health Strategy.

On the basis of the above details, the maintenance of expenditure analysis used the following logic to calculate an estimate of expenditure by state and territory governments on mental health services in each of the nine years:

Expenditure by the state or territory =

Gross recurrent expenditure reported (adjusted to remove depreciation)
less
Australian Government DVA payments
less
Estimated expenditure for Psychiatric Units in Repatriation Hospitals transferred to state governments
less
National Mental Health Strategy funds

Using this method, state and territory spending on mental health services therefore refers to total recurrent expenditure reported by the state or territory less significant amounts arising from specific Australian Government grants used to supplement mental health services funding.

This approach focuses the analysis on the central element of the 'maintenance of expenditure' agreements – the expenditure by each government relative to its expenditure in the 1992-93 baseline year. The results of this analysis are presented in Table A-5.

Application of mental health services expenditure deflators

Many of the national indicators reported are concerned with the trends in spending patterns to assess the extent of change and the progress of reform within mental health services. As in previous reports, a deflator has been applied to the expenditure data to eliminate the effect of inflation from the analysis of change when making year-on-year comparisons.

There are a number of indicators of price movements that can be applied to deflate various categories of current price expenditure by state, territory and local government authorities in order to produce estimates of expenditure on those categories of goods and services at constant prices. While these are fixed weighted indices, the items included in the indices and weightings given to them are specifically tailored to reflect activities of state and territory government instrumentalities in the particular area to which the deflator(s) are to be applied.

The Australian Institute of Health and Welfare has previously advised that the deflator for Government Final Consumption Expenditure (GFCE) on Hospital and Clinical Services is the most appropriate deflator to apply to mental health expenditure for mental health services in states and territories. This method has been used by the Australian Bureau of Statistics (ABS) since the beginning of the 1990s to derive constant price expenditure on health, social security and welfare.

The deflator for GFCE by state and local authorities on hospital and clinical services is a fixed weighted index incorporating hospital, medical and ancillary staff wage and salary rates and input prices – including drug costs; medical and surgical costs; food costs; domestic service costs; repairs and maintenance; patient transport; fuel, light and power; and other non-salary costs.

The weights applied to those particular components of the index are intended to reflect their relative importance in the provision of hospital and clinical services by government instrumentalities. ABS advise that staff related costs contribute over 70% of the value of the GFCE deflator for hospital and clinical services. As an estimated 75% of expenditure on mental health services is accounted for by salaries and wages, the GFCE deflator is the most appropriate one to use in estimating constant price expenditure on mental health services.

This deflator is applied throughout the current report to express estimates of state and territory expenditure in constant 2007-08 prices (abbreviated for convenience to 'constant prices'). Table A-12 presents final consumption expenditure deflators for each of the jurisdictions covering the financial years 1992-93 to 2007-08, rebased to 2007-08 as unity.

Table A-2: Recurrent expenditure in specialised mental health services, Australian states and territories, current prices, 2007-08 (\$000s)

State/Territory	Stand alone hospitals	Colocated hospitals	Total Inpatient	Community Residential	Ambulatory	NGO (d)	Indirect	Total Expenditure
NSW	Expenditure as reported (a)	321,965.3	484,693.1	14,110.4	340,104.1	60,170.6	138,838.2	1,037,916.5
	Post-distribution (b)	344,431.2	526,199.9	15,201.4	369,118.3	60,170.6	67,226.2	1,037,916.5
VIC	Expenditure as reported (a)	205,680.2	245,411.1	121,876.0	284,624.6	65,624.9	85,695.4	803,232.0
	Post-distribution (b)	220,397.5	260,128.4	131,402.4	304,040.2	65,624.9	42,036.1	803,232.0
QLD	Expenditure as reported (a)	205,680.0	281,550.2	-	235,063.0	39,435.6	65,056.5	621,105.2
	Post-distribution (b)	221,510.6	299,262.4	-	249,240.1	39,435.6	33,167.1	621,105.2
WA	Expenditure as reported (a)	112,996.6	180,504.6	9,137.2	174,187.4	21,079.2	13,227.3	398,135.7
	Post-distribution (b)	113,049.8	180,557.8	9,137.2	174,580.2	21,079.2	12,781.3	398,135.7
SA	Expenditure as reported (a)	58,963.7	137,468.4	6,049.9	94,303.5	24,487.5	13,724.0	276,033.3
	Post-distribution (b)	60,244.8	140,845.6	6,337.0	98,701.6	24,487.5	5,661.7	276,033.3
TAS	Expenditure as reported (a)	32,265.4	32,265.4	18,692.1	27,075.0	4,690.5	9,414.4	92,137.4
	Post-distribution (b)	34,202.8	34,202.8	19,324.7	29,171.0	4,690.5	4,748.4	92,137.4
ACT	Expenditure as reported (a)	13,980.1	13,980.1	6,819.0	24,143.1	6,116.9	8,794.8	59,854.0
	Post-distribution (b)	16,005.6	16,005.6	7,399.6	27,050.6	6,116.9	3,281.3	59,854.0
NT	Expenditure as reported (a)	10,121.0	10,121.0	442.2	14,230.9	3,843.1	6,167.7	34,804.8
	Post-distribution (b)	11,662.5	11,662.5	456.0	16,399.4	3,843.1	2,443.8	34,804.8
Total	Expenditure as reported (a)	961,652.2	1,385,993.9	177,126.8	1,193,731.7	225,448.2	340,918.3	3,323,218.9
	Post-distribution (b)	1,021,504.9	1,468,865.2	189,258.2	1,268,301.5	225,448.2	171,345.8	3,323,218.9

(a) Recurrent expenditure includes all services managed by state and territory agencies, regardless of source of funds.

(b) Post-distribution shows increase in expenditure when indirect costs identified in Table A-1 are apportioned to service categories.

(c) Depreciation excluded from all expenditure categories.

(d) NGO expenditure excludes staffed residential services managed by non government organisations. This is included under the community residential category. Details of the 2007-08 NGO expenditure component included in the residential category are provided in Table A-29.

Source: Australian Government Department of Health and Ageing, Australian Government National Mental Health Establishments Database.

Table A-3: Recurrent expenditure in specialised mental health services, Australian states and territories, current prices, selected years, 1992-93 to 2007-08 (\$'000s)

State/ Territory	Year	Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Indirect	Total Expenditure
NSW	1992-93	146,815.2	89,204.7	236,019.9	15,668.7	80,987.6	4,381.0	3,623.9	340,681.2
	1997-98	141,551.5	114,993.6	256,545.2	17,542.7	155,932.7	7,399.9	17,418.0	454,838.6
	2002-03	159,751.6	177,663.5	337,415.1	27,137.8	257,857.8	12,994.8	42,608.5	678,014.0
	2007-08	181,768.7	344,431.2	526,199.9	15,201.4	369,118.3	60,170.6	67,226.2	1,037,916.5
VIC	1992-93	174,504.9	42,508.8	217,013.7	20,480.2	71,102.6	9,375.9	14,557.1	332,529.5
	1997-98	48,799.0	86,768.9	135,567.9	55,933.9	133,601.5	34,659.5	20,107.0	379,869.7
	2002-03	32,093.3	156,924.5	189,017.8	90,215.3	204,688.1	48,978.5	17,434.4	550,334.1
	2007-08	39,730.9	220,397.5	260,128.4	131,402.4	304,040.2	65,624.9	42,036.1	803,232.0
QLD	1992-93	73,424.3	49,334.7	122,759.0	-	30,842.9	1,947.7	2,883.8	158,433.4
	1997-98	86,774.7	59,492.6	146,267.3	-	69,628.9	11,540.1	9,170.9	236,607.2
	2002-03	58,606.0	125,465.0	184,071.0	6,229.1	111,574.9	20,228.1	23,242.0	345,345.1
	2007-08	77,751.8	221,510.6	299,262.4	-	249,240.1	39,435.6	33,167.1	621,105.2
WA	1992-93	52,058.6	24,113.8	76,172.4	2,720.7	21,361.0	2,427.0	1,598.5	104,279.6
	1997-98	49,235.7	44,895.0	94,130.7	2,445.4	52,905.1	8,797.6	7,855.5	166,134.3
	2002-03	49,803.9	70,938.8	120,742.7	3,764.2	91,904.3	12,914.8	10,243.1	239,569.2
	2007-08	67,508.0	113,049.8	180,557.8	9,137.2	174,580.2	21,079.2	12,781.3	398,135.7
SA	1992-93	54,872.2	9,811.0	64,683.2	817.8	25,879.8	1,509.3	2,471.0	95,361.1
	1997-98	56,760.9	18,201.6	74,962.5	400.0	41,993.7	2,801.9	5,005.4	125,163.5
	2002-03	69,912.6	28,245.3	98,157.9	577.0	57,859.9	3,426.0	4,988.9	165,009.7
	2007-08	80,600.7	60,244.8	140,845.6	6,337.0	98,701.6	24,487.5	5,661.7	276,033.3
TAS	1992-93	13,923.8	5,764.5	19,688.2	3,274.1	5,002.7	856.0	688.5	29,509.5
	1997-98	12,188.5	8,738.6	20,927.1	4,637.5	10,323.4	1,289.0	314.0	37,491.0
	2002-03	-	18,384.6	18,384.6	10,556.2	14,046.2	1,908.0	1,604.0	46,499.0
	2007-08	-	34,202.8	34,202.8	19,324.7	29,171.0	4,690.5	4,748.4	92,137.4

Table A-3: Recurrent expenditure in specialised mental health services, Australian states and territories, current prices, selected years, 1992-93 to 2007-08 (\$'000s)

State/ Territory	Year	Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Indirect	Total Expenditure
ACT	1992-93	-	5,929.8	5,929.8	3,464.2	4,289.0	350.0	538.3	14,571.2
	1997-98	-	7,070.8	7,070.8	3,989.4	6,564.6	1,105.6	1,310.8	20,041.1
	2002-03	-	8,033.7	8,033.7	4,962.7	16,747.2	2,717.3	2,283.9	34,744.8
	2007-08	-	16,005.6	16,005.6	7,399.6	27,050.6	6,116.9	3,281.3	59,854.0
NT	1992-93	-	4,833.3	4,833.3	-	3,467.3	84.7	494.0	8,879.3
	1997-98	-	6,162.4	6,162.4	-	7,048.6	712.0	509.0	14,432.0
	2002-03	-	8,112.2	8,112.2	250.0	7,953.5	1,220.2	1,140.8	18,676.7
	2007-08	-	11,662.5	11,662.5	456.0	16,399.4	3,843.1	2,443.8	34,804.8
Total	1992-93	515,599.0	231,500.6	747,099.6	46,425.7	242,932.9	20,931.6	26,855.2	1,084,244.9
	1997-98	395,310.4	346,323.5	741,633.9	84,948.9	477,998.5	68,305.6	61,690.6	1,434,577.5
	2002-03	370,167.4	593,767.7	963,935.1	143,692.2	762,631.9	104,387.7	103,545.5	2,078,192.5
	2007-08	447,360.3	1,021,504.9	1,468,865.2	189,258.2	1,268,301.5	225,448.2	171,345.8	3,323,218.9

(1) Recurrent expenditure includes all services managed by state and territory agencies, regardless of source of funds, expressed in current prices.

(2) Indirect expenditure apportioned to service categories, except for amounts identified as 'not for distribution' in Table A-1.

(3) Depreciation excluded for all years.

(4) Commencing 1999-2000, NGO expenditure excludes staffed residential services managed by non government organisations. This is included under the community residential category. Details of the 2007-08 NGO expenditure component included in the residential category are provided in Table A-29.

(5) Caution is required when interpreting trends in Queensland for inpatient and community residential services from 1999-2000. Commencing in 1999-2000, Queensland opened a number of facilities that fall within the national definition of community residential services, but reported these facilities as inpatient services. For the years 1999-2000 to 2004-05, under the former National Survey of Mental Health Services (NSMHS), these services were reclassified by the Commonwealth as community residential services to achieve consistency with national definitions and across jurisdictions. Following the introduction in 2005-06 of the NMDS - Mental Health Establishments data collection to replace the NSMHS, Queensland has continued to report these facilities as inpatient services. In contrast to the earlier years' data, no service reclassification has been made and the data for all years from 2005-06 are presented as reported by Queensland. Queensland has foreshadowed that it will review reporting of these facilities in future years.

(6) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. Commencing in 2007-08, the majority of services previously reported as 24 hour staffed older persons residential care were reclassified to non acute inpatient services, reflecting a change in function of those units.

(7) Prior to 1999-2000, community residential services were defined as 24 hour staffed residential units in community settings (external to the campus of a general hospital or psychiatric institution) and funded by government. From 1999-2000, the definition was broadened to incorporate all government funded staffed community-based units, regardless of the number of hours that staff are present. The definition was again amended commencing 2005-06 to restrict residential services reporting to only those that employ mental health trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. Additionally, residential services were defined by function rather than location, and the requirement that they be located external to hospitals was removed.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-4: Recurrent expenditure in specialised mental health services, Australian states and territories, constant prices, selected years, 1992-93 to 2007-08 (\$000s)

State/ Territory	Year	Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Indirect	Total Expenditure
NSW	1992-93	228,294.6	138,711.5	367,006.1	24,364.6	125,934.0	6,812.4	5,635.1	529,752.2
	1997-98	197,049.1	160,078.7	357,127.8	24,420.6	217,068.6	10,301.2	24,247.1	633,165.3
	2002-03	194,676.5	216,504.4	411,180.8	33,070.7	314,230.7	15,835.8	51,923.5	826,241.5
	2007-08	181,768.7	344,431.2	526,199.9	15,201.4	369,118.3	60,170.6	67,226.2	1,037,916.5
	1992-93	241,817.5	58,906.0	300,723.4	28,380.1	98,529.3	12,992.5	20,172.3	460,797.7
	1997-98	64,022.9	113,838.3	177,861.3	73,383.6	175,281.3	45,472.2	26,379.8	498,378.3
	2002-03	37,071.6	181,266.4	218,338.0	104,209.3	236,439.0	56,576.0	20,138.8	635,701.1
	2007-08	39,730.9	220,397.5	260,128.4	131,402.4	304,040.2	65,624.9	42,036.1	803,232.0
QLD	1992-93	105,959.1	71,195.2	177,154.3	-	44,509.6	2,810.7	4,161.6	228,636.3
	1997-98	119,056.6	81,625.0	200,681.6	-	95,532.3	15,833.3	12,582.7	324,629.8
	2002-03	70,768.2	151,502.0	222,270.3	7,521.8	134,729.5	24,425.9	28,065.2	417,012.7
	2007-08	77,751.8	221,510.6	299,262.4	-	249,240.1	39,435.6	33,167.1	621,105.2
	1992-93	73,387.5	33,993.4	107,381.0	3,835.4	30,112.8	3,421.4	2,253.4	147,004.0
	1997-98	65,671.4	59,881.8	125,553.3	3,261.7	70,565.8	11,734.4	10,477.8	221,593.0
	2002-03	58,319.7	83,068.3	141,388.0	4,407.8	107,618.6	15,123.1	11,994.5	280,532.0
	2007-08	67,508.0	113,049.8	180,557.8	9,137.2	174,580.2	21,079.2	12,781.3	398,135.7
SA	1992-93	78,761.0	14,082.2	92,843.2	1,173.8	37,146.6	2,166.4	3,546.8	136,876.8
	1997-98	76,938.7	24,672.0	101,610.7	542.2	56,921.8	3,797.9	6,784.8	169,657.4
	2002-03	83,014.8	33,538.8	116,553.5	685.1	68,703.3	4,068.1	5,923.9	195,933.9
	2007-08	80,600.7	60,244.8	140,845.6	6,337.0	98,701.6	24,487.5	5,661.7	276,033.3
	1992-93	20,010.2	8,284.3	28,294.5	4,705.3	7,189.5	1,230.2	989.5	42,408.9
	1997-98	16,285.8	11,676.2	27,962.0	6,196.5	13,793.7	1,722.3	419.6	50,094.0
	2002-03	-	21,906.2	21,906.2	12,578.2	16,736.7	2,273.5	1,911.2	55,405.8
	2007-08	-	34,202.8	34,202.8	19,324.7	29,171.0	4,690.5	4,748.4	92,137.4
TAS	1992-93	20,010.2	8,284.3	28,294.5	4,705.3	7,189.5	1,230.2	989.5	42,408.9
	1997-98	16,285.8	11,676.2	27,962.0	6,196.5	13,793.7	1,722.3	419.6	50,094.0
	2002-03	-	21,906.2	21,906.2	12,578.2	16,736.7	2,273.5	1,911.2	55,405.8
	2007-08	-	34,202.8	34,202.8	19,324.7	29,171.0	4,690.5	4,748.4	92,137.4

Table A-4: Recurrent expenditure in specialised mental health services, Australian states and territories, constant prices, selected years, 1992-93 to 2007-08 (\$000s)

State/ Territory	Year	Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Indirect	Total Expenditure
ACT	1992-93	-	8,462.9	8,462.9	4,944.0	6,121.1	499.5	768.3	20,795.8
	1997-98	-	9,462.3	9,462.3	5,338.7	8,784.9	1,479.5	1,754.1	26,819.6
	2002-03	-	9,671.2	9,671.2	5,974.2	20,160.8	3,271.1	2,749.4	41,826.8
	2007-08	-	16,005.6	16,005.6	7,399.6	27,050.6	6,116.9	3,281.3	59,854.0
NT	1992-93	-	6,758.3	6,758.3	0.0	4,848.3	118.4	690.8	12,415.8
	1997-98	-	8,036.1	8,036.1	0.0	9,191.7	928.5	663.8	18,820.0
	2002-03	-	9,349.6	9,349.6	288.2	9,166.6	1,406.3	1,314.8	21,525.5
	2007-08	-	11,662.5	11,662.5	456.0	16,399.4	3,843.1	2,443.8	34,804.8
Total	1992-93	748,229.9	340,393.9	1,088,623.7	67,403.1	354,391.3	30,051.5	38,217.8	1,578,687.5
	1997-98	539,024.5	469,270.4	1,008,295.0	113,143.4	647,140.2	91,269.3	83,309.6	1,943,157.5
	2002-03	443,850.8	706,806.8	1,150,657.6	168,735.3	907,785.3	122,979.7	124,021.4	2,474,179.3
	2007-08	447,360.3	1,021,504.9	1,468,865.2	189,258.2	1,268,301.5	225,448.2	171,345.8	3,323,218.9

(1) Recurrent expenditure includes all services managed by state and territory agencies, regardless of source of funds, expressed in current prices.

(2) Indirect expenditure apportioned to service categories, except for amounts identified as 'not for distribution' in Table A-1.

(3) Depreciation excluded for all years.

(4) Commencing 1999-2000, NGO expenditure excludes staffed residential services managed by non government organisations. This is included under the community residential category. Details of the 2007-08 NGO expenditure component included in the residential category are provided in Table A-29.

(5) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

(6) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(7) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-5: Maintenance of expenditure analysis - Gross recurrent expenditure reported by states and territories adjusted for Australian Government funds, current prices, selected years, 1992-93 to 2007-08 (\$000s)

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
1992-93									
Reported recurrent expenditure	340,681.2	332,529.5	158,433.4	104,279.6	95,361.1	29,509.5	14,571.2	8,879.3	1,084,244.9
Deduct Repatriation hospitals transferred to state (a)	5,062.0	3,050.7	-	-	2,087.4	-	-	-	10,200.1
Deduct DVA payments (b)	7,700.0	7,270.0	3,380.0	1,078.4	-	300.0	-	-	19,728.4
Deduct National Mental Health Strategy allocations (c)	1,224.6	-	636.5	-	296.5	100.0	100.0	100.0	2,457.6
1992-93 base for comparison	326,694.6	322,208.8	154,416.9	103,201.2	92,977.2	29,109.5	14,471.2	8,779.3	1,051,858.8
1997-98									
Reported recurrent expenditure	454,838.6	379,869.7	236,607.2	166,134.3	125,163.5	37,491.0	20,041.1	14,432.0	1,434,577.5
Deduct Repatriation hospitals transferred to state (a)	6,761.0	4,451.6	-	-	3,009.0	-	-	-	14,221.6
Deduct DVA payments (b)	8,679.0	1,062.0	1,285.3	134.2	203.0	127.0	-	-	11,490.5
Deduct National Mental Health Strategy allocations (c)	18,106.4	16,320.3	6,543.8	5,641.9	2,294.9	1,207.3	1,420.7	736.7	52,271.9
1997-98 for comparison	421,292.2	358,035.8	228,778.1	160,358.2	119,656.7	36,156.7	18,620.5	13,695.3	1,356,593.5
2002-03									
Reported recurrent expenditure	678,014.0	550,334.1	345,345.1	239,569.2	165,009.7	46,499.0	34,744.8	18,676.7	2,078,192.5
Deduct DVA payments (d)	10,279.3	11,823.1	1,273.0	2,259.5	5,278.8	95.0	54.8	-	31,063.5
Deduct National Mental Health Strategy allocations (e)	21,478.9	18,048.0	14,875.8	6,884.3	5,052.5	1,794.9	1,465.8	1,497.7	71,097.8
2002-03 for comparison	646,255.8	520,463.0	329,196.3	230,425.4	154,678.3	44,609.2	33,224.1	17,179.0	1,976,031.1
2007-08									
Reported recurrent expenditure	1,037,916.5	803,232.0	621,105.2	398,135.7	276,033.3	92,137.4	59,854.0	34,804.8	3,323,218.9
Deduct DVA payments (d)	7,637.0	6,263.8	2,232.9	2,351.9	3,585.5	302.9	222.4	33.0	22,629.5
Deduct National Mental Health Strategy allocations (e)	25,554.5	19,187.8	15,433.5	7,933.5	5,941.6	2,206.9	2,171.2	1,880.7	80,309.7
2007-08 for comparison	1,004,725.0	777,780.4	603,438.8	387,850.3	266,506.1	89,627.6	57,460.3	32,891.1	3,220,279.7

(a) Refers to estimated costs of general hospital psychiatric units transferred from the Departments of Veterans' Affairs to state governments.

(b) Refers to total DVA payments received, as reported by organisations. Funds covered under (a) are excluded.

(c) Refers to actual payments to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98.

(d) Refers to actual payments made to states and territories, as estimated by DVA.

(e) Refers to actual payments to states and territories by the Australian Government for mental health reform under the Australian Health Care Agreements, including Information Development Agreement and Quality Through Outcomes grants.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services database (1993-2005), National Mental Health Establishments Database (2006-2008); Department of Veterans' Affairs.

Note to DVA Payment estimates for 1998-99 to 2004-05

Amounts are the total identified payments made to each State or Territory in the financial year and are based on billing data submitted to the Department by providers in relation to mental health services provided to Veteran clients. Growth is attributed to a combination of factors including: improved identification of Veteran mental health clients by providers for the purpose of payment; improved DVA data matching capacity to identify mental health expenditure in relation to State and Territory Veteran clients; and possible under-reporting in years prior to 2000-01.

For 2007-08, additional costs exist that are not captured in the above table. About \$650,000 is related to price movements in relation to public hospital acute mental health services. A second cost of over \$1.2m exists in relation to public hospital non-acute admitted mental health services, where no Diagnostic Related Group code exists in relation to the admission..

Source: Australian Government Department of Veterans' Affairs.

Table A-6: Summary of gross recurrent expenditure reported by states and territories adjusted for Australian Government funds, current and constant prices, selected years, 1992-93 to 2007-08 (\$000s)

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
CURRENT PRICES									
1992-93	326,694.6	322,208.8	154,416.9	103,201.2	92,977.2	29,109.5	14,471.2	8,779.3	1,051,858.8
1997-98	421,292.2	358,035.8	228,778.1	160,358.2	119,656.7	36,156.7	18,620.5	13,695.3	1,356,593.5
2002-03	646,255.8	520,463.0	329,196.3	230,425.4	154,678.3	44,609.2	33,224.1	17,179.0	1,976,031.1
2007-08	1,004,725.0	777,780.4	603,438.8	387,850.3	266,506.1	89,627.6	57,460.3	32,891.1	3,220,279.7
15 year change	207.5%	141.4%	290.8%	275.8%	186.6%	207.9%	297.1%	274.6%	206.2%
CONSTANT PRICES									
1992-93	508,003.3	446,495.9	222,840.0	145,483.8	133,455.1	41,834.0	20,653.1	12,276.0	1,531,041.3
1997-98	586,466.5	469,732.8	313,888.0	213,888.8	162,192.9	48,311.2	24,918.4	17,859.4	1,837,258.1
2002-03	787,540.4	601,196.5	397,512.6	269,824.7	183,666.4	53,154.0	39,996.2	19,799.4	2,352,690.2
2007-08	1,004,725.0	777,780.4	603,438.8	387,850.3	266,506.1	89,627.6	57,460.3	32,891.1	3,220,279.7
15 year change	97.8%	74.2%	170.8%	166.6%	99.7%	114.2%	178.2%	167.9%	110.3%

(1) Constant prices expressed in 2008 equivalents. See Appendix 2 and Table A-12 for details on deflators used to derive constant prices..

(2) Total per capita expenditure is based on state and territory expenditure adjusted for 'maintenance of expenditure' factors as detailed in Table A-5 and therefore exclude specified Australian Government funding sources (DVA, National Mental Health Strategy).

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-7: Per capita gross recurrent expenditure reported by states and territories adjusted for Australian Government funds, constant and current prices, selected years, 1992-93 to 2007-08 (dollars)

CURRENT PRICES	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
1992-93	54.58	72.16	50.34	61.88	63.74	61.80	48.86	51.73	59.83
1997-98	66.80	77.57	66.86	88.72	80.58	76.47	60.31	72.72	72.90
2002-03	97.19	106.38	87.44	118.92	101.37	93.94	102.50	86.19	99.95
2007-08	144.69	147.80	142.23	181.40	167.25	180.93	167.98	151.27	151.63
15 year change	165.1%	104.8%	182.5%	193.1%	162.4%	192.8%	243.8%	192.4%	153.4%
CONSTANT PRICES	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
1992-93	84.88	99.99	72.65	87.23	91.48	88.82	69.73	72.33	87.08
1997-98	92.99	101.77	91.74	118.34	109.22	102.17	80.71	94.84	98.73
2002-03	118.44	122.88	105.59	139.26	120.36	111.94	123.39	99.34	119.00
2007-08	144.69	147.80	142.23	181.40	167.25	180.93	167.98	151.27	151.63
15 year change	70.5%	47.8%	95.8%	107.9%	82.8%	103.7%	140.9%	109.1%	74.1%

(1) Constant prices expressed in 2008 equivalents. See Appendix 2 and Table A-12 for details on deflators used to derive constant prices.

(2) Total per capita expenditure is based on state and territory expenditure adjusted for 'maintenance of expenditure' factors as detailed in Table A-5 and therefore exclude specified Australian Government funding sources (DVA, National Mental Health Strategy).

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-8: Comparative per capita expenditure on mental health service components in the states and territories, selected years, 1992-93 to 2007-08, constant prices (dollars)

		Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Total Community	Indirect Expenditure	Total
NSW	1992-93	38.14	23.18	61.32	4.07	21.04	1.14	26.25	0.94	88.51
	1997-98	31.24	25.38	56.62	3.87	34.42	1.63	39.92	3.84	100.39
	2002-03	29.28	32.56	61.84	4.97	47.26	2.38	54.61	7.81	124.26
	2007-08	26.18	49.60	75.78	2.19	53.16	8.67	64.01	9.68	149.47
VIC	1992-93	54.15	13.19	67.35	6.36	22.06	2.91	31.33	4.52	103.19
	1997-98	13.87	24.66	38.54	15.90	37.98	9.85	63.73	5.72	107.98
	2002-03	7.58	37.05	44.63	21.30	48.33	11.56	81.19	4.12	129.93
	2007-08	7.55	41.88	49.43	24.97	57.78	12.47	95.22	7.99	152.64
QLD	1992-93	34.54	23.21	57.76	-	14.51	0.92	15.43	1.36	74.54
	1997-98	34.80	23.86	58.65	-	27.92	4.63	32.55	3.68	94.88
	2002-03	18.80	40.24	59.04	2.00	35.79	6.49	44.27	7.45	110.77
	2007-08	18.33	52.21	70.53	-	58.74	9.29	68.04	7.82	146.39
WA	1992-93	44.00	20.38	64.39	2.30	18.06	2.05	22.41	1.35	88.15
	1997-98	36.34	33.13	69.47	1.80	39.04	6.49	47.34	5.80	122.61
	2002-03	30.10	42.87	72.97	2.27	55.54	7.81	65.62	6.19	144.78
	2007-08	31.57	52.87	84.45	4.27	81.65	9.86	95.79	5.98	186.21
SA	1992-93	53.99	9.65	63.64	0.80	25.46	1.49	27.75	2.43	93.83
	1997-98	51.81	16.61	68.42	0.37	38.33	2.56	41.25	4.57	114.25
	2002-03	54.40	21.98	76.38	0.45	45.02	2.67	48.14	3.88	128.40
	2007-08	50.58	37.81	88.39	3.98	61.94	15.37	81.28	3.55	173.23
TAS	1992-93	42.48	17.59	60.07	9.99	15.26	2.61	27.86	2.10	90.04
	1997-98	34.44	24.69	59.14	13.10	29.17	3.64	45.92	0.89	105.94
	2002-03	-	46.13	46.13	26.49	35.25	4.79	66.52	4.02	116.68
	2007-08	-	69.04	69.04	39.01	58.89	9.47	107.37	9.59	185.99

Table A-8: Comparative per capita expenditure on mental health service components in the states and territories, selected years, 1992-93 to 2007-08, constant prices (dollars)

		Stand alone hospitals	Co-located units	Total Inpatient	Community Residential	Ambulatory	NGO	Total Community	Indirect Expenditure	Total
...	continued									
ACT	1992-93	-	28.57	28.57	16.69	20.67	1.69	39.04	2.59	70.21
	1997-98	-	30.65	30.65	17.29	28.45	4.79	50.54	5.68	86.87
	2002-03	-	29.84	29.84	18.43	62.20	10.09	90.72	8.48	129.04
	2007-08	-	46.79	46.79	21.63	79.08	17.88	118.59	9.59	174.97
NT	1992-93	-	39.82	39.82	-	28.57	0.70	29.27	4.07	73.16
	1997-98	-	42.67	42.67	-	48.81	4.93	53.74	3.52	99.94
	2002-03	-	46.91	46.91	1.45	45.99	7.06	54.49	6.60	108.00
	2007-08	-	53.64	53.64	2.10	75.42	17.67	95.19	11.24	160.07
Nat. Avg.	1992-93	42.56	19.36	61.92	3.83	20.16	1.71	25.70	2.17	89.79
	1997-98	28.97	25.22	54.18	6.08	34.78	4.90	45.76	4.48	104.42
	2002-03	22.45	35.75	58.20	8.53	45.92	6.22	60.67	6.27	125.14
	2007-08	21.06	48.10	69.16	8.91	59.72	10.62	79.25	8.07	156.48

(1) Estimates of per capita expenditure in each of the service mix categories refer to all mental health services reported by the state/territory, regardless of source of funds. They are designed to give a comparative picture of spending IN the States/Territories. Expenditure estimates used for these measures are as provided in Table A-4.

(2) Commencing 1999-2000, NGO expenditure excludes staffed residential services managed by non government organisations. This is included under the community residential category. Details of the 2007-08 NGO expenditure component included in the residential category are provided in Table A-29. Information presented in Part D on per capita NGO expenditure by states and territories differs from the above figures because it adds the residential component to give a more accurate picture of each jurisdiction's investment in non government organisations.

(3) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

(4) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-9: Summary of indirect expenditure reported by states and territories for 2007-08 by expenditure category, current prices (\$'000s)

	REPORTED BY STATE CENTRAL										Total
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total		
Program Administration	7,269.0	16,216.5	12,342.8	5,330.3	3,123.0	3,449.3	635.0	1,565.1	49,931.1		
Education and Training	2,106.0	6,751.0	3,376.5	657.5	390.0	44.8	-	17.3	13,343.1		
Academic Chairs	1,399.0	451.0	-	-	-	-	-	-	1,850.0		
Mental Health Research	11,151.2	3,542.9	-	1,072.8	307.0	-	-	-	16,073.9		
Mental Health Promotion	136.0	5,611.0	2,353.4	729.8	-	18.2	1,123.5	-	9,971.8		
Superannuation	1,106.0	1,101.8	-	-	164.0	211.1	100.9	-	2,683.8		
Workers Compensation	92.0	130.6	-	-	-	39.9	19.9	0.4	282.8		
Insurance	16,111.0	219.2	-	-	-	-	-	-	16,330.2		
Mental Health Act	4,754.0	2,559.5	6,518.8	989.2	-	72.4	399.0	338.0	15,630.8		
Transport	-	-	-	-	-	-	-	-	-		
Property Leasing	-	-	-	-	-	41.0	-	-	95.8		
Other indirect	764.0	-	924.1	-	199.4	871.7	927.5	147.9	3,834.5		
Total	44,888.2	36,583.4	25,515.6	8,779.6	4,183.4	4,748.4	3,205.8	2,123.4	130,027.7		
REPORTED BY REGIONS											
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total		
Program Administration	18,293.0	2,446.2	1,977.4	-	601.1	-	-	-	23,317.7		
Region Wide Support	16,762.0	721.3	-	-	3,679.2	-	-	-	21,162.6		
Education & Training	3,023.0	18.4	-	-	523.8	-	-	-	3,565.2		
Academic Chairs	-	-	-	-	-	-	-	-	-		
Mental Health Research	2,100.0	-	-	-	430.6	-	-	-	2,530.6		
Mental Health Promotion	-	-	-	-	238.3	-	-	-	238.3		
Superannuation	595.0	278.4	-	-	-	-	-	-	873.4		
Workers Compensation	189.0	67.7	-	-	-	-	-	-	256.7		
Insurance	-	-	-	-	-	-	-	-	-		
Mental Health Act	-	-	-	-	-	-	-	-	-		
Transport	57.0	-	-	-	-	-	-	-	57.0		
Property Leasing	-	-	-	-	-	-	-	-	-		
Other indirect	1,839.0	92.0	-	-	34.7	-	-	-	1,965.6		
Total	42,858.0	3,624.0	1,977.4	-	5,507.8	-	-	-	53,967.2		
REPORTED BY ORGANISATIONS											
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total		
Program Administration	17,730.0	16,037.9	3,283.2	-	1,784.4	3,116.2	1,016.6	469.3	43,437.6		
Organisation Wide Support	15,229.0	13,177.3	24,422.3	128.1	212.7	1,549.8	1,032.2	2,137.1	57,888.5		
Education & Training	16,600.0	4,732.6	3,126.7	1,560.3	157.6	-	14.6	320.5	26,512.4		
Academic Chairs	-	2,858.0	264.9	-	41.5	-	553.0	-	3,717.4		
Mental Health Research	615.0	424.8	4,185.8	2,441.3	96.6	-	-	-	7,763.6		
Mental Health Promotion	-	276.9	89.6	-	31.3	-	60.9	-	458.7		
Superannuation	629.0	2,282.2	144.9	-	192.1	-	18.5	-	3,266.7		
Workers Compensation	46.0	2,285.1	97.4	-	492.0	-	1,680.9	6.9	4,608.3		
Insurance	-	502.2	309.8	-	5.0	-	1,200.1	-	2,017.1		
Mental Health Act	-	-	249.3	-	-	-	-	-	249.3		
Transport	3.0	54.2	3.4	6.6	12.7	-	-	-	79.9		
Property Leasing	-	2,432.5	-	311.4	354.4	-	-	1,017.5	4,115.8		
Other indirect	240.0	424.2	1,386.3	-	652.6	-	12.1	93.0	2,808.1		
Total	51,092.0	45,488.0	37,563.5	4,447.7	4,032.9	4,666.0	5,589.0	4,044.3	156,923.4		
Grand Total	138,938.2	85,695.4	65,056.5	13,227.3	13,724.0	9,414.4	8,794.8	6,167.7	340,918.3		

(1) The above amounts should not be interpreted as the total costs of each indirect expenditure item, as they only include amounts not reported by organisations in service delivery costs. States and territories differ in the extent to which organisations apportion indirect expenditure to services or report them separately.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database.

Table A-10: Comparative per capita expenditure on specific target populations in the states and territories, 2007-08, current prices (\$000s)

Number of beds	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
General adult mental health services									
Inpatient (\$000s)	399,976.0	166,135.9	204,022.2	132,908.9	87,989.7	25,897.4	12,923.1	11,662.5	1,041,515.8
Community (\$000s)	278,318.2	292,877.9	173,894.3	137,185.4	76,004.0	31,159.6	23,238.6	13,058.7	1,025,736.8
Total (\$000s)	678,294.2	459,013.9	377,916.5	270,094.3	163,993.7	57,057.0	36,161.8	24,721.3	2,067,252.6
Per capita (\$)	153.89	135.49	138.89	193.68	163.28	187.20	154.97	168.86	151.99
Child and adolescent mental health services									
Inpatient (\$000s)	26,713.0	14,939.1	19,696.8	7,479.6	3,098.5	-	-	-	71,927.0
Community (\$000s)	65,131.1	43,767.6	55,061.6	31,290.5	20,940.0	5,343.6	5,958.9	1,821.2	229,314.5
Total (\$000s)	91,844.1	58,706.8	74,758.4	38,770.1	24,038.5	5,343.6	5,958.9	1,821.2	301,241.4
Per capita (\$)	56.91	48.60	71.43	74.81	68.03	45.27	76.64	29.26	60.27
Older persons mental health services									
Inpatient (\$000s)	65,743.5	39,322.4	30,862.0	28,760.0	37,091.2	-	3,082.5	-	204,861.5
Community (\$000s)	16,148.5	68,339.8	11,741.0	1,985.5	1,964.2	8,500.5	2,069.5	1,975.5	112,724.5
Total (\$000s)	81,891.9	107,662.3	42,603.0	30,745.5	39,055.4	8,500.5	5,152.0	1,975.5	317,586.0
Per capita (\$)	85.06	149.91	80.93	118.97	158.97	113.80	149.52	176.79	112.14
Forensic mental health services									
Inpatient (\$000s)	33,767.5	39,730.9	44,681.5	11,409.4	12,666.1	8,305.5	-	-	150,560.9
Community (\$000s)	24,721.9	30,457.1	8,543.2	13,256.1	6,130.4	3,492.0	3,183.1	-	89,783.8
Total (\$000s)	58,489.4	70,188.1	53,224.6	24,665.5	18,796.5	11,797.5	3,183.1	-	240,344.7
Per capita (\$)	10.89	17.09	16.39	14.92	15.04	31.09	11.89	-	14.63

(1) Classification of expenditure into target populations is based on the classification of services as reported to the NMDS - Mental Health Establishments rather than the characteristics of their patient populations. In brief, for a service to be classified as providing a child and adolescent, older persons' or forensic mental health service, it must be recognised by the relevant state or territory funding authority as having a corresponding specialised function and is specifically funded to provide such specialty services.

(2) General adult mental health services provide services not only to the adult population but also for child and adolescent and older persons where such services do not exist or are less well developed. The net impact is that in some jurisdictions, amounts for total expenditure on adults are over-estimated because a proportion of the resources is necessarily used to provide services to children or elderly people.

(3) Calculation of expenditure excludes grants to non residential NGOs (because these cannot be classified by target populations) and residual indirect expenditure (i.e. indirect expenditure that is not apportioned to services).

(4) 'Community' expenditure combines expenditure on ambulatory and community residential services.

(5) Calculation of per capita rates is based on age-specific populations for each target population:

General adult mental health services: Based on population aged 18-64 years.

Older persons' mental health services: Based on population aged 65 years and over.

Child and adolescent mental health services: Based on population aged 0-17 years.

Forensic mental health services: Based on population aged 18 years and over.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database Population data from ABS Catalogue 3201.0 Population by Age and Sex, Australian States and Territories, June 2008.

Table A-11: Source of recurrent funds for specialised public sector mental health services, Australian states and territories, 2007-08, current prices (\$000s)

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
State/Territory funds (a)	986,283.0	728,885.3	589,320.1	383,865.0	259,916.3	84,556.0	55,966.8	31,485.1	3,120,277.6
Australian Government funds									
National Mental Health Strategy funds (b)	25,554.5	19,187.8	15,433.5	7,933.5	5,941.6	2,206.9	2,171.2	1,880.7	80,309.7
Department of Veterans' Affairs funds (c)	7,637.0	6,263.8	2,232.9	2,351.9	3,585.5	302.9	222.4	33.0	22,629.5
Other Australian Government funds	331.0	22,540.7	5,110.9	924.9	2,287.1	1,783.8	1,012.2	1,023.7	35,014.3
<i>Total Australian Government funds</i>	33,522.5	47,992.3	22,777.3	11,210.4	11,814.3	4,293.5	3,405.8	2,937.4	137,953.5
Other revenue (d)	18,111.0	26,354.4	9,007.8	3,060.3	4,302.7	3,287.9	481.3	382.3	64,987.8
Total funds	1,037,916.5	803,232.0	621,105.2	398,135.7	276,033.3	92,137.4	59,854.0	34,804.8	3,323,218.9

(a) Excludes depreciation and specified Australian Government funding sources.

(b) Actual payments to states and territories by the Australian Government for mental health reform under the Australian Health Care Agreements, including Information Development Agreement grants and Quality Through Outcomes Agreements.

(c) Actual payments made to states and territories, as estimated by DVA

(d) Includes patient revenue and recoveries.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database.

Table A-12: Deflators for state and territory mental health services expenditure, selected years 1992-93 to 2007-08

	1992-93	1997-98	2002-03	2007-08	15 year impact
New South Wales	64.31	71.84	82.06	100.00	55.5%
Victoria	72.16	76.22	86.57	100.00	38.6%
Queensland	69.29	72.89	82.81	100.00	44.3%
Western Australia	70.94	74.97	85.40	100.00	41.0%
South Australia	69.67	73.77	84.22	100.00	43.5%
Tasmania	69.58	74.84	83.92	100.00	43.7%
Australian Capital Territory	70.07	74.73	83.07	100.00	42.7%
Northern Territory	71.52	76.68	86.77	100.00	39.8%

State and territory expenditure deflated by state and Local Government Final Consumption Expenditure - Hospital and Clinical Services.

Source: Australian Bureau of Statistics, unpublished data.

APPENDIX 3

State and territory inpatient service data

The tables presented in this Appendix provide details about specialist psychiatric inpatient services managed or funded by the states and territories.

With the following exceptions, all tables focus on the number of beds or patient days in each reporting period:

- Table A-22 links expenditure and activity data provided by mental health organisations responding to the 2008 Mental Health Establishments collection and presents details of 2007-08 average bed day costs in the major inpatient programs. Comparable estimates of bed day costs in psychiatric units based on such a comprehensive collection of hospitals are not readily available in Australia.
- Table A-23 presents a summary of changes in average bed day costs for stand alone and colocated hospital units.
- Table A-24 presents trends in average bed day costs by inpatient target population group.

Caution should be exercised in interpreting the unit costs. Due to the level of aggregation of the data collected, unit cost estimates for individual hospitals could not be confirmed against local financial estimates. Similarly, the data collection is unable to adjust for differences in costing methodologies that may affect the unit cost estimates.

The cost comparisons are therefore offered as an indicative guide only.

Table A-13: Number of available psychiatric beds reported at 30 June by states and territories for colocated and stand alone hospitals, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Stand alone psychiatric hospitals	June 1993	1,839	1,565	1,059	509	665	165	–	–	5,802
	June 1998	1,204	386	799	380	504	123	–	–	3,396
	June 2003	1,098	143	395	246	478	–	–	–	2,360
	June 2008	1,024	154	376	245	357	–	–	–	2,156
Colocated units	June 1993	813	322	548	219	114	80	52	41	2,189
	June 1998	917	713	574	347	159	78	52	29	2,869
	June 2003	988	990	928	394	177	154	50	32	3,713
	June 2008	1,400	1,062	1,033	425	243	128	70	34	4,395
All inpatient units	June 1993	2,652	1,887	1,607	728	779	245	52	41	7,991
	June 1998	2,121	1,099	1,373	727	663	201	52	29	6,265
	June 2003	2,086	1,133	1,323	640	655	154	50	32	6,073
	June 2008	2,424	1,216	1,409	670	600	128	70	34	6,551

(1) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

(2) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(3) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-14: Number of available acute and non acute psychiatric beds reported at 30 June by states and territories, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Acute beds	June 1993	1,085	965	652	396	352	101	52	26	3,629
	June 1998	1,141	917	646	443	368	99	52	29	3,695
	June 2003	1,242	953	680	506	350	109	50	32	3,922
	June 2008	1,526	1,038	705	501	358	101	70	34	4,333
Non acute beds	June 1993	1,567	922	955	332	427	144	–	15	4,362
	June 1998	980	182	727	284	295	102	–	–	2,570
	June 2003	844	180	643	134	305	45	–	–	2,151
	June 2008	898	178	704	169	242	27	–	–	2,218
Total beds	June 1993	2,652	1,887	1,607	728	779	245	52	41	7,991
	June 1998	2,121	1,099	1,373	727	663	201	52	29	6,265
	June 2003	2,086	1,133	1,323	640	655	154	50	32	6,073
	June 2008	2,424	1,216	1,409	670	600	128	70	34	6,551

(1) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

(2) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(3) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-15: Number of patient days reported by states and territories for colocated psychiatric units and stand alone hospitals, selected years 1992-93 to 2007-08

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Stand alone psychiatric hospitals	1992-93	549,673	525,855	331,195	171,561	193,840	58,154	–	–	1,830,278
	1997-98	368,893	122,910	246,043	116,617	160,995	31,250	–	–	1,046,708
	2002-03	335,417	44,449	108,867	79,713	154,962	–	–	–	723,408
	2007-08	326,867	51,308	114,568	83,878	114,953	–	–	–	691,574
Colocated units	1992-93	235,998	98,548	154,686	70,403	33,898	24,089	17,481	10,247	645,350
	1997-98	279,064	216,949	170,068	103,271	49,295	20,838	17,255	9,096	865,836
	2002-03	311,931	313,012	265,354	116,010	60,184	44,910	13,952	9,326	1,134,679
	2007-08	453,870	334,207	326,464	136,701	82,691	38,052	18,539	10,990	1,401,514
All inpatient units	1992-93	785,670	624,403	485,881	241,964	227,738	82,243	17,481	10,247	2,475,628
	1997-98	647,957	339,859	416,111	219,888	210,290	52,088	17,255	9,096	1,912,544
	2002-03	647,348	357,461	374,221	195,723	215,146	44,910	13,952	9,326	1,858,087
	2007-08	780,737	385,515	441,032	220,579	197,644	38,052	18,539	10,990	2,093,088

(1) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(2) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-16: Number of patient days reported by states and territories for acute and non acute inpatient units, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Acute beds	June 1993	340,578	301,543	188,126	125,297	99,105	33,226	17,481	6,653	1,112,009
	June 1998	345,944	289,078	191,255	133,808	113,870	25,305	17,255	9,096	1,125,611
	June 2003	383,917	303,642	197,235	153,202	116,794	33,436	13,952	9,326	1,211,504
	June 2008	506,684	322,087	222,006	169,817	119,808	30,924	18,539	10,990	1,400,855
Non acute beds	June 1993	445,093	322,860	297,755	116,667	128,633	49,017	–	3,594	1,363,619
	June 1998	302,013	50,781	224,856	86,080	96,420	26,783	–	–	786,933
	June 2003	263,431	53,819	176,986	42,521	98,352	11,474	–	–	646,583
	June 2008	274,053	63,428	219,026	50,762	77,836	7,128	–	–	692,233
Total beds	June 1993	785,670	624,403	485,881	241,964	227,738	82,243	17,481	10,247	2,475,628
	June 1998	647,957	339,859	416,111	219,888	210,290	52,088	17,255	9,096	1,912,544
	June 2003	647,348	357,461	374,221	195,723	215,146	44,910	13,952	9,326	1,858,087
	June 2008	780,737	385,515	441,032	220,579	197,644	38,052	18,539	10,990	2,093,088

(1) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(2) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-17: Number of available acute psychiatric beds reported at 30 June by states and territories for colocated psychiatric units and stand alone hospitals, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Stand alone psychiatric hospitals	June 1993	388	643	104	237	238	21	–	–	1,631
	June 1998	338	236	84	158	209	21	–	–	1,046
	June 2003	344	83	–	112	173	–	–	–	712
	June 2008	340	76	–	130	115	–	–	–	661
Colocated units	June 1993	697	322	548	159	114	80	52	26	1,998
	June 1998	803	681	562	285	159	78	52	29	2,649
	June 2003	898	870	680	394	177	109	50	32	3,210
	June 2008	1,186	962	705	371	243	101	70	34	3,672
All inpatient units	June 1993	1,085	965	652	396	352	101	52	26	3,629
	June 1998	1,141	917	646	443	368	99	52	29	3,695
	June 2003	1,242	953	680	506	350	109	50	32	3,922
	June 2008	1,526	1,038	705	501	358	101	70	34	4,333

(1) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-18: Number of available acute psychiatric beds reported at 30 June by states and territories for colocated and stand alone hospitals, excluding forensic and prison-based beds, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Stand alone psychiatric hospitals	June 1993	388	606	104	237	230	12	–	–	1,577
	June 1998	338	203	84	130	201	12	–	–	968
	June 2003	344	28	–	93	165	–	–	–	630
	June 2008	340	–	–	111	107	–	–	–	558
Colocated units	June 1993	651	322	548	159	114	80	52	26	1,952
	June 1998	772	681	562	285	159	78	52	23	2,612
	June 2003	868	870	680	394	177	92	50	24	3,155
	June 2005	1,092	962	705	371	243	81	70	34	3,558
All inpatient units	June 1993	1,039	928	652	396	344	92	52	26	3,529
	June 1998	1,110	884	646	415	360	90	52	23	3,580
	June 2003	1,212	898	680	487	342	92	50	24	3,785
	June 2008	1,432	962	705	482	350	81	70	34	4,116

(1) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-19: Number of psychiatric inpatient beds per 100,000 population reported by states and territories for acute and non acute psychiatric units, selected years 1993 to 2008

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Acute beds	June 1993	18.1	21.6	21.3	23.7	24.1	21.4	17.6	15.3	20.6
	June 1998	18.1	19.9	18.9	24.5	24.8	20.9	16.8	15.4	19.9
	June 2003	18.7	19.5	18.1	26.1	22.9	23.0	15.4	16.1	19.8
	June 2008	22.0	19.7	16.6	23.4	22.5	20.4	20.5	15.6	20.4
Non acute beds	June 1993	26.2	20.6	31.1	19.9	29.3	30.6	–	8.8	24.8
	June 1998	15.5	3.9	21.2	15.7	19.9	21.6	–	–	13.8
	June 2003	12.7	3.7	17.1	6.9	20.0	9.5	–	–	10.9
	June 2008	12.9	3.4	16.6	7.9	15.2	5.5	–	–	10.4
Total beds	June 1993	44.3	42.3	52.4	43.7	53.4	52.0	17.6	24.2	45.5
	June 1998	33.6	23.8	40.1	40.2	44.6	42.5	16.8	15.4	33.7
	June 2003	31.4	23.2	35.1	33.0	42.9	32.4	15.4	16.1	30.7
	June 2008	34.9	23.1	33.2	31.3	37.7	25.8	20.5	15.6	30.8

(1) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

(2) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(3) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-20: Number of psychiatric inpatient beds by target population reported by states and territories at 20 June, selected years 1994 to 2008

		June 1994	June 1998	June 2003	June 2008
General adult	NSW	1,748	1,514	1,526	1,758
	VIC	1,138	735	739	780
	QLD	1,349	997	965	992
	WA	402	395	424	474
	SA	450	383	369	343
	TAS	182	160	137	108
	ACT	52	52	50	50
	NT	41	23	24	34
	Total	5,362	4,259	4,234	4,539
Child & adolescent	NSW	89	85	87	95
	VIC	42	70	72	67
	QLD	28	40	71	67
	WA	37	36	28	28
	SA	20	15	12	12
	TAS	–	–	–	–
	ACT	–	–	–	–
	NT	–	–	–	–
	Total	216	246	270	269
Older persons	NSW	527	381	307	366
	VIC	423	221	207	215
	QLD	149	263	185	189
	WA	265	256	150	130
	SA	252	235	234	205
	TAS	60	32	–	–
	ACT	–	–	–	20
	NT	–	–	–	–
	Total	1,676	1,388	1,083	1,125
Forensic	NSW	120	141	166	205
	VIC	105	73	115	154
	QLD	74	73	102	161
	WA	22	40	38	38
	SA	22	30	40	40
	TAS	9	9	17	20
	ACT	–	–	–	–
	NT	–	6	8	–
	Total	352	372	486	618
Total	NSW	2,484	2,121	2,086	2,424
	VIC	1,708	1,099	1,133	1,216
	QLD	1,600	1,373	1,323	1,409
	WA	726	727	640	670
	SA	744	663	655	600
	TAS	251	201	154	128
	ACT	52	52	50	70
	NT	41	29	32	34
	Total	7,606	6,265	6,073	6,551

(1) Relevant data not available for June 1993.

(2) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005–06, bed counts are based on average available beds.

(3) Caution is required when interpreting changes in 2007–08 inpatient and residential data for New South Wales. See note (6) at Table A-3.

(4) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993–2005); National Mental Health Establishments Database (2006–2008).

Table A-21: Number of acute and non acute psychiatric inpatient beds reported by states and territories at 30 June 2008 by target population and program

Number of beds	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
General adult mental health services									
Acute beds	1,217	680	602	362	260	81	50	34	3,286
Non acute beds	541	100	390	112	83	27	–	–	1,253
Total	1,758	780	992	474	343	108	50	34	4,539
Older persons mental health services									
Acute beds	161	215	51	100	78	–	20	–	625
Non acute beds	205	–	138	30	127	–	–	–	500
Total	366	215	189	130	205	–	20	–	1,125
Child and adolescent mental health services									
Acute beds	54	67	52	20	12	–	–	–	205
Non acute beds	41	–	15	8	–	–	–	–	64
Total	95	67	67	28	12	–	–	–	269
Forensic mental health services									
Acute beds	94	76	–	19	8	20	–	–	217
Non acute beds	111	78	161	19	32	–	–	–	401
Total	205	154	161	38	40	20	–	–	618
Total beds	2,424	1,216	1,409	670	600	128	70	34	6,551
<hr/>									
Beds per 100,000	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
General adult mental health services									
Acute beds	27.6	20.1	22.1	26.0	25.9	26.6	21.4	23.2	24.2
Non acute beds	12.3	3.0	14.3	8.0	8.3	8.9	–	–	9.2
Total	39.9	23.0	36.5	34.0	34.2	35.4	21.4	23.2	33.4
Older persons mental health services									
Acute beds	16.7	29.9	9.7	38.7	31.7	–	58.0	–	22.1
Non acute beds	21.3	–	26.2	11.6	51.7	–	–	–	17.7
Total	38.0	29.9	35.9	50.3	83.4	–	58.0	–	39.7
Child and adolescent mental health services									
Acute beds	3.3	5.5	5.0	3.9	3.4	–	–	–	4.1
Non acute beds	2.5	–	1.4	1.5	–	–	–	–	1.3
Total	5.9	5.5	6.4	5.4	3.4	–	–	–	5.4
Forensic mental health services									
Acute beds	1.8	1.9	–	1.1	0.6	5.3	–	–	1.3
Non acute beds	2.1	1.9	5.0	1.1	2.6	–	–	–	2.4
Total	3.8	3.8	5.0	2.3	3.2	5.3	–	–	3.8

(1) Calculation of per capita rates is based on age-specific populations for each target population:

- General adult mental health services: Based on population aged 18-64 years.
- Older persons' mental health services: Based on population aged 65 years and over.
- Child and adolescent mental health services: Based on population aged 0-17 years.
- Forensic mental health services: Based on population aged 18 years and over.

(2) Data prior to 2005–06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

(3) Population data from ABS Catalogue 3201.0 Population by Age and Sex, Australian states and territories, June 2008.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-22: Average inpatient day costs reported by states and territories for 2007-08, categorised by target population and program type (dollars)

State/Territory	Colocation status	General adult mental health services			Child and adolescent mental health services			Older persons mental health services			Forensic mental health services			Average
		Acute	Other	Total	Acute	Other	Total	Acute	Other	Total	Acute	Other	Total	
NSW	Unadj Bed day cost	737	407	641	1,215	1,115	1,184	610	464	532	376	480	433	621
	Adj Bed day cost	791	459	694	1,315	1,179	1,272	657	513	580	407	545	482	674
VIC	Unadj Bed day cost	635	446	609	1,193	..	1,193	541	..	541	825	734	774	637
	Adj Bed day cost	680	480	653	1,269	..	1,269	579	..	579	825	734	774	675
QLD	Unadj Bed day cost	697	462	608	1,289	1,301	1,292	726	393	480	..	832	832	638
	Adj Bed day cost	746	490	649	1,369	1,339	1,362	767	412	505	..	876	876	679
WA	Unadj Bed day cost	927	551	847	904	1,694	997	691	596	669	1,001	721	864	818
	Adj Bed day cost	927	551	847	912	1,694	1,004	691	596	669	1,001	721	864	819
SA	Unadj Bed day cost	791	594	749	1,635	..	1,635	699	442	537	973	909	922	696
	Adj Bed day cost	809	608	766	1,819	..	1,819	713	453	548	997	931	945	713
TAS	Unadj Bed day cost	747	802	759	..	..	..	..	..	..	1,310	..	1,310	848
	Adj Bed day cost	805	830	811	..	..	..	..	..	..	1,357	..	1,357	899
ACT	Unadj Bed day cost	757	..	757	..	..	..	741	..	741	..	..	..	754
	Adj Bed day cost	862	..	862	..	..	..	870	..	870	..	..	..	863
NT	Unadj Bed day cost	921	..	921	..	..	..	..	..	..	..	..	..	921
	Adj Bed day cost	1,061	..	1,061	..	..	..	..	..	..	..	..	..	1,061
Nat. Avg.	Unadj Bed day cost	738	459	664	1,198	1,220	1,202	623	446	544	688	712	704	662
	Adj Bed day cost	782	495	706	1,277	1,271	1,275	655	473	574	707	748	734	702

(1) All cells represent weighted averages, expressed as current prices.

(2) Unadjusted bed day costs are based on expenditure as reported by hospitals, prior to distribution of indirect expenditure.

(3) Adjusted bed day costs are based on inpatient expenditure following distribution of indirect amounts. See Appendix 2 for details of the approach taken to distribution of indirect expenditure.

(4) Depreciation excluded in all estimates.

(5) '..' indicates not applicable.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database.

Table A-23: Average bed day cost for stand alone and colocated hospitals by state and territory, selected years 1992-93 to 2007-08, constant prices (dollars)

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
Stand alone - all units	1992-93	415	460	320	428	406	344	..	..	409
	1997-98	534	521	484	563	478	521	..	..	515
	2002-03	580	834	650	732	536	..	..	..	614
	2007-08	556	774	679	805	701	..	..	..	647
	% change	34%	68%	112%	88%	73%	..	..	..	58%
Stand alone acute units	1992-93	397	549	289	447	577	354	..	..	478
	1997-98	585	543	509	586	601	1,090	..	..	579
	2002-03	718	845	..	684	701	..	..	..	724
	2007-08	681	825	..	1,049	984	..	..	..	825
	% change	72%	50%	-100%	135%	70%	..	..	..	73%
Stand alone non acute units	1992-93	422	404	323	412	320	342	..	..	381
	1997-98	513	474	481	547	395	426	..	..	485
	2002-03	519	816	650	774	441	..	..	..	564
	2007-08	491	734	679	512	567	..	..	..	565
	% change	17%	82%	110%	24%	77%	..	..	..	48%
Colocated units	1992-93	588	598	460	483	415	344	484	660	527
	1997-98	574	525	480	580	500	560	548	883	542
	2002-03	694	579	571	716	557	488	693	1,003	623
	2007-08	759	659	679	827	729	899	863	1,061	729
	% change	29%	10%	47%	71%	75%	161%	78%	61%	38%
All inpatient units	1992-93	467	482	365	444	408	344	484	660	440
	1997-98	551	523	482	571	483	537	548	883	527
	2002-03	635	611	594	722	542	488	693	1,003	619
	2007-08	674	675	679	819	713	899	863	1,061	702
	% change	44%	40%	86%	84%	75%	161%	78%	61%	60%

(1) All cells represent weighted averages.

(2) Unit costs expressed in constant 2008 prices.

(3) Based on adjusted bed day costs, following distribution of indirect expenditure. See Appendix 2 for details of the approach taken to distribution of indirect expenditure.

(4) Depreciation removed from inpatient expenditure estimates.

(5) '..' indicates not applicable.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-24 Average patient day costs by inpatient target population group by state and territory, selected years 1998-99 to 2007-08, constant prices (dollars)

	1998-99	2002-03	2004-05
General adult mental health services			
NSW	611	649	694
VIC	514	574	653
QLD	494	572	649
WA	603	726	847
SA	574	587	766
TAS	514	489	811
ACT	474	693	862
NT	1,060	1,024	1,061
Nat. Avg.	561	619	706
Child and adolescent mental health services			
NSW	1,078	927	1,272
VIC	919	1,119	1,269
QLD	849	1,026	1,362
WA	1,118	1,140	1,004
SA	837	1,168	1,819
TAS	..	..	..
ACT	..	..	..
NT	..	..	..
Nat. Avg.	959	1,038	1,275
Older persons mental health services			
NSW	500	579	580
VIC	446	542	579
QLD	447	422	505
WA	582	630	669
SA	376	411	548
TAS	736	..	..
ACT	..	..	870
NT	..	..	..
Nat. Avg.	472	512	574
Forensic mental health services			
NSW	396	536	482
VIC	743	799	774
QLD	696	1,011	876
WA	632	821	864
SA	545	744	945
TAS	302	481	1,357
ACT	..	..	..
NT	1,047	934	..
Nat. Avg.	575	719	734

(1) All cells represent weighted averages.

(2) Unit costs expressed in constant 2008 prices.

(3) Based on adjusted bed day costs, following distribution of indirect expenditure. See Appendix 2 for details of the approach taken to distribution of indirect expenditure.

(4) Depreciation removed from inpatient expenditure estimates.

(5) '..' indicates not applicable.

(6) Data not available prior to 1998-99.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

APPENDIX 4

State and territory community based residential services data

Table A-25: Number of available beds in community residential services reported at 30 June by states and territories, selected years 1993 to 2008

		June 1993	June 1998	June 2003	June 2008
General adult residential services					
24 hour staffed	NSW	171	147	112	124
	VIC	41	323	326	443
	QLD	–	–	80	–
	WA	84	70	21	88
	SA	32	20	20	64
	TAS	22	22	38	134
	ACT	60	50	28	35
	NT	–	–	–	5
	<i>subtotal</i>	<i>410</i>	<i>632</i>	<i>625</i>	<i>893</i>
less than 24 hour staffed	NSW	n.a.	n.a.	187	178
	VIC	n.a.	n.a.	287	335
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	56	42
	SA	n.a.	n.a.	–	7
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	46	35
	NT	n.a.	n.a.	10	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>586</i>	<i>597</i>
Total adult		410	632	1,211	1,490
Older persons residential services					
24 hour staffed	NSW	112	146	130	7
	VIC	254	545	585	620
	QLD	–	–	–	–
	WA	–	–	–	–
	SA	–	–	–	–
	TAS	48	40	57	42
	ACT	–	–	10	7
	NT	–	–	–	–
	<i>subtotal</i>	<i>414</i>	<i>731</i>	<i>782</i>	<i>676</i>
less than 24 hour staffed	NSW	n.a.	n.a.	12	12
	VIC	n.a.	n.a.	–	6
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	–	–
	SA	n.a.	n.a.	–	–
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	–	–
	NT	n.a.	n.a.	–	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>12</i>	<i>18</i>
Total older persons'		414	731	794	694

Table A-25: Number of available beds in community residential services reported at 30 June by states and territories, selected years 1993 to 2008

		June 1993	June 1998	June 2003	June 2008
... continued					
All residential services					
24 hour staffed	NSW	283	293	242	131
	VIC	295	868	911	1,063
	QLD	–	–	80	–
	WA	84	70	21	88
	SA	32	20	20	64
	TAS	70	62	95	176
	ACT	60	50	38	42
	NT	–	–	–	5
	<i>subtotal</i>	<i>824</i>	<i>1,363</i>	<i>1,407</i>	<i>1,569</i>
less than 24 hour staffed	NSW	n.a.	n.a.	199	190
	VIC	n.a.	n.a.	287	341
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	56	42
	SA	n.a.	n.a.	–	7
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	46	35
	NT	n.a.	n.a.	10	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>598</i>	<i>615</i>
	Total beds	824	1,363	2,005	2,184

(1) n.a. indicates not available - data were not collected for those years.

(2) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details

(3) Details of the 2007-08 NGO component included in the residential category are provided in Table A-29.

(4) For 2001-02 onwards, a small number of residential beds reported by New South Wales as child and adolescent were reclassified to general adult to protect agency confidentiality. ACT also reported a single Child & Adolescent unit for 2007-08 that was similarly reclassified.

(5) Caution is required when interpreting trends in Queensland for 24 hour staffed general adult community residential services. See note (5) at Table A-3.

(6) Caution is required when interpreting changes in 2007-08 older persons residential data for New South Wales. See note (6) at Table A-3.

(7) Data prior to 2005-06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-26: Number of patient days in community residential services reported by states and territories, selected years 1993 to 2008

		1992-93	1997-98	2002-03	2007-08
General adult residential services					
24 hour staffed	NSW	49,704	42,212	35,364	34,153
	VIC	12,302	99,177	99,369	129,867
	QLD	–	–	22,835	–
	WA	26,061	17,309	7,048	17,157
	SA	7,793	2,535	5,204	15,277
	TAS	4,746	7,037	11,349	39,422
	ACT	21,243	19,777	6,521	11,249
	NT	–	–	–	1,737
	<i>subtotal</i>	<i>121,849</i>	<i>188,047</i>	<i>187,690</i>	<i>248,862</i>
less than 24 hour staffed	NSW	n.a.	n.a.	57,894	51,742
	VIC	n.a.	n.a.	85,801	112,974
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	15,949	13,197
	SA	n.a.	n.a.	–	2,024
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	16,417	10,879
	NT	n.a.	n.a.	3,159	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>179,220</i>	<i>190,816</i>
Total adult		121,849	188,047	366,910	439,678
Older persons residential services					
24 hour staffed	NSW	34,748	47,827	42,480	2,525
	VIC	86,304	179,569	198,977	221,681
	QLD	–	–	–	–
	WA	–	–	–	–
	SA	–	–	–	–
	TAS	16,299	8,597	20,191	8,664
	ACT	–	–	3,650	2,350
	NT	–	–	–	–
	<i>subtotal</i>	<i>137,351</i>	<i>235,993</i>	<i>265,298</i>	<i>235,220</i>
less than 24 hour staffed	NSW	n.a.	n.a.	6,726	3,707
	VIC	n.a.	n.a.	–	1,923
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	–	–
	SA	n.a.	n.a.	–	–
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	–	–
	NT	n.a.	n.a.	–	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>6,726</i>	<i>5,630</i>
Total older persons'		137,351	235,993	272,024	240,850

Table A-26: Number of patient days in community residential services reported by states and territories, selected years 1993 to 2008

		1992-93	1997-98	2002-03	2007-08
... continued					
All residential services					
24 hour staffed	NSW	84,452	90,039	77,844	36,678
	VIC	98,606	278,746	298,346	351,548
	QLD	–	–	22,835	–
	WA	26,061	17,309	7,048	17,157
	SA	7,793	2,535	5,204	15,277
	TAS	21,045	15,634	31,540	48,086
	ACT	21,243	19,777	10,171	13,599
	NT	–	–	–	1,737
	<i>subtotal</i>	<i>259,200</i>	<i>424,040</i>	<i>452,988</i>	<i>484,082</i>
less than 24 hour staffed	NSW	n.a.	n.a.	64,620	55,449
	VIC	n.a.	n.a.	85,801	114,897
	QLD	n.a.	n.a.	–	–
	WA	n.a.	n.a.	15,949	13,197
	SA	n.a.	n.a.	–	2,024
	TAS	n.a.	n.a.	–	–
	ACT	n.a.	n.a.	16,417	10,879
	NT	n.a.	n.a.	3,159	–
	<i>subtotal</i>	<i>n.a.</i>	<i>n.a.</i>	<i>185,946</i>	<i>196,446</i>
	Total beds	259,200	424,040	638,934	680,528

(1) n.a. indicates not available - data were not collected for those years.

(2) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details

(3) Details of the 2007-08 NGO component included in the residential category are provided in Table A-29.

(4) For 2001-02 onwards, a small number of residential beds reported by New South Wales as child and adolescent were reclassified to general adult to protect agency confidentiality. ACT also reported a single Child & Adolescent unit for 2007-08 that was similarly reclassified.

(5) Caution is required when interpreting trends in Queensland for 24 hour staffed general adult community residential services. See note (5) at Table A-3.

(6) Caution is required when interpreting changes in 2007-08 older persons residential data for New South Wales. See note (6) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-27: Average cost per patient day for community residential services by program type and 24 hour staffing status, 2007-08, current prices (dollars)

		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
Adult units										
24 hour staffed	Unadj bed day cost	217	375	..	438	339	321	477	255	351
	Adj Bed day cost	235	405	..	438	357	332	529	263	374
Less than 24 hour staffed	Unadj bed day cost	98	123	..	123	428	..	98	..	118
	Adj Bed day cost	105	130	..	123	438	..	98	..	124
Older persons units										
24 hour staffed	Unadj bed day cost	418	265	..	..	..	697	165	..	281
	Adj Bed day cost	465	287	..	..	..	722	165	..	304
Less than 24 hour staffed	Unadj bed day cost	146	240	..	..	..	..	..	..	178
	Adj Bed day cost	154	284	..	..	..	..	..	..	198

(1) All cells represent weighted averages, expressed as current prices.

(2) Unadjusted bed day costs are based on expenditure as reported by residential services prior to distribution of indirect expenditure.

(3) Adjusted bed day costs are based on residential services expenditure following distribution of indirect amounts. See Appendix 2 for details of the approach taken to distribution of indirect expenditure.

(4) Depreciation excluded in all estimates.

(5) A small number of residential beds reported by New South Wales and ACT as child & adolescent were reclassified as general adult to protect agency confidentiality.

(6) '..' indicates not applicable.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database.

Table A-28: Number of 24 hour staffed community residential beds per 100,000 population reported at 30 June by states and territories, selected years 1993 to 2008

		June 1993	June 1998	June 2003	June 2008
General adult beds	NSW	4.6	3.7	2.7	2.8
	VIC	1.5	11.1	10.5	13.1
	QLD	–	–	3.3	–
	WA	8.0	6.1	1.7	6.3
	SA	3.5	2.2	2.1	6.4
	TAS	7.7	7.7	13.0	44.0
	ACT	30.5	24.3	12.8	15.0
	NT	–	–	–	3.4
	Total adult beds	3.7	5.4	5.0	6.6
Older persons beds	NSW	15.3	18.0	14.7	0.7
	VIC	47.5	92.4	90.5	86.3
	QLD	–	–	–	–
	WA	–	–	–	–
	SA	–	–	–	–
	TAS	83.2	64.5	84.7	56.2
	ACT	–	–	34.4	20.3
	NT	–	–	–	–
	Total older persons' beds	20.1	31.9	30.9	23.9
All 24 hour beds	NSW	4.7	4.6	3.6	1.9
	VIC	6.6	18.8	18.6	20.2
	QLD	–	–	2.1	–
	WA	5.0	3.9	1.1	4.1
	SA	2.2	1.3	1.3	4.0
	TAS	14.9	13.1	20.0	35.5
	ACT	20.3	16.2	11.7	12.3
	NT	–	–	–	2.3
	Total beds	4.7	7.3	7.1	7.4

- (1) Calculation of per capita rates is based on age-specific populations for each program type:
- Adult beds: Based on population aged 18-64 years.
 - Older persons' beds: Based on population aged 65 years and over.
 - All beds: Based on total population.
- (2) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details
- (3) For 2001-02 onwards, a small number of residential beds reported by New South Wales as child and adolescent were reclassified to general adult to protect agency confidentiality. ACT also reported a single Child & Adolescent unit for 2007-08 that was similarly reclassified.
- (4) Caution is required when interpreting trends in Queensland for 24 hour staffed general adult community residential services. See note (5) at Table A-3.
- (6) Caution is required when interpreting changes in 2007-08 older persons residential data for New South Wales. See note (6) at Table A-3.
- (7) Data prior to 2005-06 was sourced from the National Survey of Mental Health Services which reported the total number of beds available as at 30 June. From 2005-06, bed counts are based on average available beds.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Population data from ABS Catalogue 3201.0 Population by Age and Sex, Australian states and territories, June 2008.

Table A-29: Non government organisations contribution to community residential services reported by states and territories, 2007-08

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
24 hour staffed services									
Number of beds	16	104	–	57	12	85	12	5	291
Expenditure reported (\$000s)	804.9	6,789.1	–	2,058.1	618.0	5,075.9	933.6	442.2	16,721.8
Less than 24 hour staffed services									
Number of beds	136	335	–	42	–	–	35	–	548
Expenditure reported (\$000s)	3,422.6	13,946.5	–	1,617.5	–	–	1,064.5	–	20,051.1
All NGO staffed residential services									
Number of beds	152	439	–	99	12	85	47	5	839
Expenditure reported (\$000s)	4,227.5	20,735.6	–	3,675.6	618.0	5,075.9	1,998.1	442.2	36,773.0

- (1) Commencing 1999-2000, grants to NGOs for provision of staffed residential services were reported under the category 'community residential services on the same basis as 'government services', in contrast to previous years in which they were aggregated with NGO expenditure.
- (2) This table is presented to quantify the NGO component included in the residential services category for 2007-08. Expenditure reported in this category is not included in the NGO expenditure presented in the tables in Appendix 2 but is taken into account in state and territory indicators provided in Part D of this report.
- (3) For Victoria, 70% of the expenditure reported by PARC (Prevention and Recovery Care) units has been deemed to be NGO expenditure for the purposes of this analysis. The remaining 30% is attributed to expenditure by the relevant local clinical service organisation.

Source: Australian Government Department of Health and Ageing, National Mental Health Establishments Database.

Table A-30: Number of supported public housing places available at 30 June, by state and territory, 2003 to 2008

		June 2003	June 2004	June 2005	June 2006	June 2007	June 2008
Number of places	NSW	987	1,105	1,565	1,565	1,781	1,516
	VIC	1,179	1,273	1,432	1,343	1,471	1,397
	QLD	–	–	–	134	43	68
	WA	358	358	359	628	659	659
	SA	59	91	112	112	112	112
	TAS	–	–	23	23	23	27
	ACT	75	83	113	–	48	48
	NT	18	21	21	20	23	33
	Total	2,676	2,931	3,625	3,825	4,160	3,860
Places per 100,000 population	NSW	14.8	16.5	23.3	23.1	26.0	21.8
	VIC	24.1	25.7	28.6	26.4	28.4	26.5
	QLD	–	–	–	3.3	1.0	1.6
	WA	18.5	18.2	18.0	30.8	31.6	30.8
	SA	3.9	5.9	7.2	7.2	7.1	7.0
	TAS	–	–	4.7	4.7	4.7	5.5
	ACT	23.1	25.5	34.4	–	14.2	14.0
	NT	9.0	10.5	10.3	9.6	10.8	15.2
Nat. Avg.	13.5	14.6	17.9	18.6	19.9	18.2	

- (1) 'Supported public housing places' refers to the number of accommodation places available in public housing that are targeted to people affected by psychiatric disorder or disability. To be counted, a formal partnership agreement must exist between the state or territory health department and the relevant public housing authority that is designed to facilitate access to public housing places by people affected by mental illness. The concept of 'supported places' indicates that, as a component of the formal partnership arrangement, the Health Department assists the person within their home by providing ongoing clinical and disability support, including outreach services.
- (2) Number of places refers to the number of persons who can be accommodated, not the number of houses. States and territories vary in the extent to which this definition is applied consistently.
- (3) Excludes staffed residential services reported elsewhere in the National Survey of Mental Health Services/Mental Health Establishments
- (4) Collection of this information commenced in the National Survey of Mental Health Services 2003.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

APPENDIX 5

State and territory staffing data

Table A-31: Number of full-time equivalent (FTE) staff employed in specialist mental health services by labour class, 1993-94 to 2007-08

Labour Class	Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Medical	1993-94	385	450	226	119	142	29	20	11	1,382
	1997-98	399	505	278	189	178	38	22	15	1,623
	2002-03	577	515	346	232	185	26	22	17	1,921
	2007-08	813	587	504	281	231	43	33	22	2,515
Nursing	1993-94	2,891	2,648	1,635	1,066	1,067	270	134	93	9,805
	1997-98	3,173	2,297	1,718	1,193	961	271	126	98	9,837
	2002-03	3,473	3,011	2,029	1,242	1,047	299	136	87	11,323
	2007-08	4,456	3,402	2,514	1,494	1,243	344	169	102	13,723
Diagnostic/Allied Health	1993-94	634	622	357	257	244	62	48	18	2,241
	1997-98	970	816	528	437	298	63	49	18	3,179
	2002-03	1,367	1,022	710	513	343	57	96	19	4,127
	2007-08	1,535	1,261	1,005	629	473	87	80	36	5,107
Other Personal Care	1993-94	135	159	10	18	4	57	14	4	400
	1997-98	162	95	131	42	–	46	19	16	512
	2002-03	143	128	141	41	16	78	21	12	580
	2003-04	102	123	134	35	19	81	25	13	533
	2007-08	71	156	199	132	23	155	32	8	775
Administrative/Clerical	1993-94	407	514	211	186	240	59	30	11	1,659
	1997-98	527	444	322	234	180	49	45	14	1,814
	2002-03	1,123	482	385	317	227	41	42	25	2,642
	2007-08	1,048	443	567	450	282	58	44	24	2,915
Domestic and related	1993-94	879	838	397	421	366	132	5	1	3,039
	1997-98	757	181	428	288	171	78	3	–	1,905
	2002-03	948	240	246	216	212	59	11	1	1,933
	2007-08	620	204	235	220	202	41	19	0	1,541
Total	1993-94	5,332	5,231	2,837	2,067	2,063	608	251	138	18,526
	1997-98	5,987	4,337	3,406	2,383	1,788	545	264	159	18,870
	2002-03	7,631	5,398	3,857	2,562	2,029	562	328	160	22,526
	2007-08	8,543	6,052	5,024	3,206	2,453	728	377	192	26,576

(1) Detailed FTE data collection commenced 1993-94.

(2) The majority of organisations report annual average FTE data, but the dataset includes those organisations reporting FTE on a 'snapshot' basis.

(3) Domestic staff are mainly excluded in reports of inpatient FTE by the Northern Territory. However, costs for these staff are included in expenditure data reported in Appendix 2.

(4) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-32: Number of full-time equivalent (FTE) staff employed in specialist mental health services by service setting, selected years 1993-94 to 2007-08

Service setting		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Inpatient services	1993-94	3,873	3,519	2,305	1,668	1,640	408	113	84	13,609
	1997-98	3,486	1,714	2,442	1,583	1,155	342	98	80	10,900
	2002-03	4,084	1,965	2,404	1,432	1,299	253	80	78	11,594
	2007-08	4,918	2,145	2,814	1,672	1,400	310	110	80	13,448
Ambulatory mental health services	1993-94	1,219	1,418	532	361	407	128	78	54	4,197
	1997-98	2,212	1,845	964	760	623	138	107	80	6,728
	2002-03	3,137	2,213	1,371	1,071	722	198	187	80	8,978
	2007-08	3,450	2,601	2,211	1,389	996	233	200	108	11,187
Community residential services	1993-94	239	294	–	38	16	72	61	–	720
	1997-98	290	778	–	40	10	66	59	–	1,243
	2002-03	409	1,221	82	58	8	111	61	3	1,954
	2007-08	176	1,306	–	145	58	186	67	4	1,941
Total	1993-94	5,332	5,231	2,837	2,067	2,063	608	251	138	18,526
	1997-98	5,987	4,337	3,406	2,383	1,788	545	264	159	18,870
	2002-03	7,631	5,398	3,857	2,562	2,029	562	328	160	22,526
	2007-08	8,543	6,052	5,024	3,206	2,453	728	377	192	26,576

- (1) The majority of organisations report annual average FTE data, but the dataset includes organisations reporting FTE on a 'snapshot' basis.
- (2) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details
- (3) Components may not add to totals due to rounding error.
- (4) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.
- (5) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-33: Number of full-time equivalent (FTE) direct care staff employed in specialist mental health services by service setting, selected years 1992-93 to 2007-08

Service setting		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Inpatient services	1992-93	2,727	2,840	1,776	1,153	1,106	255	87	76	10,020
	1997-98	2,565	1,479	1,864	1,199	906	248	85	77	8,421
	2002-03	2,843	1,712	1,993	1,134	983	217	71	69	9,021
	2007-08	3,965	1,949	2,372	1,364	1,096	280	98	69	11,192
Ambulatory mental health services	1992-93	1,127	991	425	290	318	96	68	44	3,358
	1997-98	1,881	1,559	792	636	523	111	79	69	5,648
	2002-03	2,395	1,880	1,158	848	604	150	154	63	7,253
	2007-08	2,751	2,300	1,850	1,054	827	193	169	95	9,239
Community residential services	1992-93	255	279	–	32	17	72	51	–	706
	1997-98	259	675	–	26	9	60	52	–	1,081
	2002-03	317	1,083	74	47	4	94	51	3	1,672
	2007-08	160	1,156	–	117	47	156	48	4	1,689
Total	1992-93	4,108	4,111	2,200	1,475	1,441	424	205	120	14,084
	1997-98	4,704	3,713	2,655	1,861	1,438	418	216	146	15,151
	2002-03	5,555	4,676	3,225	2,029	1,590	461	275	135	17,946
	2007-08	6,875	5,405	4,222	2,536	1,970	629	315	168	22,120

- (1) Direct care FTE includes the following categories: Medical Officers; Nursing; Diagnostic/Allied Health and Other Personal Care staff.
- (2) Direct care FTE for 1992-93 were extrapolated on the basis of the relationship between FTE and expenditure over the subsequent five years.
- (3) The majority of organisations report annual average FTE data, but the dataset includes those organisations reporting FTE on a 'snapshot' basis.
- (4) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details
- (5) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.
- (6) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.
- (7) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-34: Number of full-time equivalent (FTE) direct care staff employed in specialist mental health services per 100,000 population by service setting, selected years 1992-93 to 2007-08

Service setting		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Inpatient services	1992-93	45.6	63.6	57.9	69.2	75.8	54.2	29.3	44.9	57.0
	1997-98	40.7	32.0	54.5	66.3	61.0	52.4	27.4	41.0	45.3
	2002-03	42.8	35.0	52.9	58.5	64.4	45.7	21.8	34.4	45.6
	2007-08	57.1	37.0	55.9	63.8	68.8	56.5	28.5	31.8	52.7
Ambulatory mental health services	1992-93	18.8	22.2	13.8	17.4	21.8	20.4	22.9	25.8	19.1
	1997-98	29.8	33.8	23.1	35.2	35.2	23.4	25.6	36.4	30.4
	2002-03	36.0	38.4	30.8	43.8	39.6	31.6	47.5	31.8	36.7
	2007-08	39.6	43.7	43.6	49.3	51.9	38.9	49.3	43.6	43.5
Community residential services	1992-93	4.3	6.3	–	1.9	1.2	15.4	17.2	–	4.0
	1997-98	4.1	14.6	–	1.4	0.6	12.7	16.9	–	5.8
	2002-03	4.8	22.1	2.0	2.4	0.3	19.7	15.6	1.4	8.5
	2007-08	2.3	22.0	–	5.5	3.0	31.6	14.1	1.7	8.0
Total	1992-93	68.6	92.1	71.7	88.4	98.8	89.9	69.4	70.6	80.1
	1997-98	74.6	80.4	77.6	103.0	96.8	88.5	69.9	77.4	81.4
	2002-03	83.5	95.6	85.7	104.7	104.2	97.0	84.9	67.6	90.8
	2007-08	99.0	102.7	99.5	118.6	123.6	127.0	92.0	77.1	104.2

- (1) Direct care FTE includes the following categories: Medical Officers; Nursing; Diagnostic/Allied Health and Other Personal Care staff.
- (2) Direct care FTE for 1992-93 were extrapolated on the basis of the relationship between FTE and expenditure over the subsequent five years.
- (3) The majority of organisations report annual average FTE data, but the dataset includes those organisations reporting FTE on a 'snapshot' basis.
- (4) The definition of residential services was amended on several occasions over the course of the National Mental Health Strategy. See note (7) Table A-3 for details
- (5) Caution is required when interpreting changes in 2007-08 inpatient and residential data for New South Wales. See note (6) at Table A-3.
- (6) Caution is required when interpreting trends in Queensland for community residential services and inpatient services. See note (5) at Table A-3.
- (7) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-35: Number of medical full time equivalent (FTE) staff employed in specialist mental health services by state and territory, selected years 1994-95 to 2007-08

Number of FTE		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Consultant psychiatrists	1994-95	159	167	84	63	58	16	9	3	560
	1997-98	159	218	105	75	65	20	8	7	657
	2002-03	217	207	129	101	65	16	11	6	753
	2007-08	384	225	235	103	97	27	15	9	1,094
Psychiatry registrars	1994-95	171	169	116	43	51	7	9	2	568
	1997-98	180	171	127	82	77	5	12	6	659
	2002-03	260	227	184	94	93	10	8	7	882
	2007-08	371	251	232	102	89	16	17	9	1,086
Other medical officers	1994-95	57	112	42	14	33	10	1	4	273
	1997-98	59	115	45	30	37	13	2	2	303
	2002-03	99	80	32	38	27	–	4	4	284
	2007-08	58	112	37	77	45	1	1	5	336
Total medical FTE	1994-95	387	448	242	121	142	33	19	9	1,401
	1997-98	398	504	278	187	178	38	22	15	1,619
	2002-03	577	514	346	232	185	26	22	17	1,920
	2007-08	814	587	504	281	231	44	33	22	2,516
Total medical FTE per 100,000 population		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
	1994-95	6.4	10.0	7.5	7.0	9.7	6.9	6.3	5.4	7.8
	1997-98	6.3	10.9	8.1	10.4	12.0	8.1	7.1	7.7	8.7
	2002-03	8.7	10.5	9.2	12.0	12.2	5.5	6.7	8.5	9.7
	2007-08	11.7	11.2	11.9	13.2	14.5	8.9	9.6	10.3	11.8

- (1) Data collected at specific professional category levels is only available from 1994-95.
(2) Minor discrepancies with Table A-31 due to conflicting data reported by some organisations.
(3) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-36: Number of nursing full time equivalent (FTE) staff employed in specialist mental health services by state and territory, selected years 1994-95 to 2007-08

Number of FTE		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Registered nurses	1994-95	2,724	2,435	1,209	752	771	233	115	80	8,318
	1997-98	2,839	2,028	1,386	1,016	797	235	117	87	8,504
	2002-03	2,885	2,620	1,740	1,094	865	241	119	87	9,649
	2007-08	3,857	2,653	2,171	1,305	1,006	294	140	92	11,518
Non registered nurses	1994-95	249	295	320	168	157	52	7	14	1,262
	1997-98	326	269	332	177	165	36	7	11	1,323
	2002-03	575	393	289	149	182	59	17	–	1,663
	2007-08	598	749	343	189	236	55	30	9	2,209
Total nursing FTE	1994-95	2,974	2,729	1,529	920	929	285	122	94	9,580
	1997-98	3,165	2,298	1,718	1,193	961	271	124	98	9,827
	2002-03	3,460	3,013	2,029	1,242	1,047	299	136	87	11,312
	2007-08	4,456	3,402	2,514	1,494	1,243	348	169	102	13,727
Total nursing FTE per 100,000 population		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
	1994-95	48.8	60.6	47.4	53.6	63.3	60.3	40.3	53.4	53.4
	1997-98	50.2	49.8	50.2	66.0	64.7	57.2	40.1	51.8	52.8
	2002-03	52.0	61.6	53.9	64.1	68.6	63.0	41.9	43.5	57.2
	2007-08	64.2	64.6	59.3	69.9	78.0	70.3	49.5	46.7	64.6

- (1) Data collected at specific professional category levels is only available from 1994-95.
(2) Minor discrepancies with Table A-31 due to conflicting data reported by some organisations.
(3) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-37: Number of allied health full time equivalent (FTE) staff employed in specialist mental health services by state and territory, selected years 1994-95 to 2007-08

Number of FTE		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Occupational Therapists	1994-95	185	167	64	68	33	4	3	1	525
	1997-98	156	165	90	87	37	9	4	1	548
	2002-03	201	198	109	128	46	6	7	1	697
	2007-08	229	233	164	145	69	11	7	2	859
Social Workers	1994-95	198	221	113	66	110	26	19	5	759
	1997-98	252	269	161	108	130	24	26	5	975
	2002-03	290	329	229	153	178	18	32	4	1,233
	2007-08	320	464	319	204	226	28	23	8	1,592
Psychologists	1994-95	257	161	118	58	47	26	21	8	696
	1997-98	348	276	176	101	72	27	15	10	1,024
	2002-03	534	352	257	122	72	18	55	6	1,417
	2007-08	601	390	396	159	110	25	49	13	1,741
Other allied health	1994-95	162	121	91	112	49	4	–	8	546
	1997-98	200	108	101	141	59	3	1	11	624
	2002-03	332	141	116	109	46	16	10	9	779
	2007-08	386	174	127	122	69	29	1	13	920
Total allied health FTE	1994-95	802	670	386	304	239	60	44	22	2,527
	1997-98	955	818	528	436	298	63	45	27	3,171
	2002-03	1,357	1,021	710	513	343	57	105	19	4,125
	2007-08	1,535	1,261	1,005	629	473	93	80	36	5,112
Total allied health FTE per 100,000 population		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
	1994-95	13.2	14.9	12.0	17.7	16.3	12.7	14.4	12.6	14.1
	1997-98	15.1	17.7	15.4	24.1	20.1	13.4	14.6	14.3	17.0
	2002-03	20.4	20.9	18.9	26.5	22.4	12.0	32.5	9.7	20.9
	2007-08	22.1	24.0	23.7	29.4	29.7	18.8	23.5	16.4	24.1

- (1) Data collected at specific professional category levels is only available from 1994-95.
- (2) Minor discrepancies with Table A-31 due to conflicting data reported by some organisations.
- (3) Components may not add to totals due to rounding error.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

APPENDIX 6

State and territory ambulatory care services data

Table A-38: Number of patients treated and service contacts by ambulatory care mental health services by state and territory, 2007-08

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Patients treated									
Number of patients	216,171	105,299	91,056	52,787	56,223	8,719	11,283	5,836	547,374
% Services not reporting data or with nil patient care activity	0.0%	11.5%	6.0%	0.0%	2.2%	0.0%	0.0%	0.0%	3.7%
% Ambulatory expenditure covered by non reporting services	0.0%	2.4%	2.0%	0.0%	1.4%	0.0%	0.0%	0.0%	1.1%
% population receiving service	3.1%	2.0%	2.1%	2.5%	3.5%	1.8%	3.3%	2.7%	2.6%
Cost per treated patient (\$)	\$1,708	\$2,819	\$2,682	\$3,307	\$1,731	\$3,346	\$2,397	\$2,810	\$2,292
Service contacts									
Number of contacts	2,242,672	2,134,658	1,140,845	567,784	454,280	94,449	208,066	36,841	6,879,595
% Services not reporting data or with nil patient care activity	0.0%	11.1%	6.0%	0.0%	1.1%	5.9%	0.0%	0.0%	3.5%
% Ambulatory expenditure covered by non reporting services	0.0%	1.9%	2.0%	0.0%	0.1%	1.1%	0.0%	0.0%	0.9%
Cost per contact (\$)	\$165	\$140	\$214	\$307	\$217	\$305	\$130	\$445	\$183
Contacts per patient	10.4	20.3	12.5	10.8	8.1	10.8	18.4	6.3	12.6

- (1) The above data and derived indicators have significant data quality problems and are presented for demonstration purposes only, with the aim of improving the quality of information reported in future years. **The data and indicators are not considered to be of sufficient quality to be used for comparative analysis of the performance of state and territory jurisdictions.** Future work will focus on improving data on service outputs and outcomes to support a range of analyses.
- (2) In the NMDS – Mental Health Establishments, reporting of number of patients treated has a variable level of missing data across jurisdictions, and variable degrees of duplicated person counts. In some jurisdictions, it is not possible to calculate the exact number of patients treated, so a best estimate is provided. Overall, the number of patients treated is likely to be significantly overestimated by most jurisdictions. Furthermore, the extreme difference between jurisdictions suggests that many organisations may be reporting counts of contacts in place of counts of patients treated. Readers are encouraged to refer to the COAG National Action Plan on mental health Annual Progress Reports (www.coag.gov.au) for more accurate data on the number of patients treated by state and territory mental health services.
- (3) Calculation of average unit costs excludes those services with missing data or nil patient care activity.
- (4) Depreciation excluded from ambulatory service expenditure.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services 2005.

APPENDIX 7

Consumer and carer participation arrangements in public sector mental health service organisations

Table A-39: Consumer participation arrangements in public sector mental health service organisations, selected years 1993-94 to 2007-08

Number of organisations		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Consumer with a formal position on management committee (LEVEL 1)	1993-94	4	2	2	1	2	–	–	–	11
	1997-98	30	7	3	1	3	–	–	–	44
	2002-03	34	29	11	2	5	2	2	1	86
	2007-08	47	12	11	7	5	3	1	3	89
Mental health consumer advisory committee, all services (LEVEL 1)	1993-94	4	4	4	–	–	–	–	–	12
	1997-98	17	2	7	–	12	1	–	1	40
	2002-03	13	7	7	5	13	–	1	2	48
	2007-08	8	6	5	3	12	–	2	–	36
Mental health consumer advisory committee, some services (LEVEL 2)	1993-94	12	5	4	–	1	–	–	–	22
	1997-98	6	3	12	5	4	–	–	1	31
	2002-03	8	6	7	9	6	1	–	–	37
	2007-08	1	2	1	8	4	–	–	–	16
Consumers on broadly based advisory committee (LEVEL 3)	1993-94	9	6	4	3	4	2	–	–	28
	1997-98	3	3	1	9	4	2	1	1	24
	2002-03	17	3	7	3	4	–	–	–	34
	2007-08	10	4	1	2	4	4	–	–	25
No specific arrangements or 'other arrangements' (LEVEL 4)	1993-94	14	14	8	12	6	1	2	7	64
	1997-98	11	7	7	12	9	–	1	2	49
	2002-03	25	8	5	2	6	–	–	–	46
	2007-08	24	9	5	7	10	–	–	–	55
Total number of organisations	1993-94	43	31	22	16	13	3	2	7	137
	1997-98	67	22	30	27	32	3	2	5	188
	2002-03	97	53	37	21	34	3	3	3	251
	2007-08	90	33	23	27	35	7	3	3	221
Percent of organisations		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Nat. Avg.
LEVEL 1	1993-94	19	19	27	6	15	–	–	–	17
	1997-98	70	41	33	4	47	33	–	20	45
	2002-03	48	68	49	33	53	67	100	100	53
	2007-08	61	55	70	37	49	43	100	100	57
LEVEL 2	1993-94	28	16	18	–	8	–	–	–	16
	1997-98	9	14	40	19	13	–	–	–	16
	2002-03	8	11	19	43	18	33	–	–	15
	2007-08	1	6	4	30	11	–	–	–	7
LEVEL 3	1993-94	21	19	18	19	31	67	–	–	20
	1997-98	4	14	3	33	13	67	50	20	13
	2002-03	18	6	19	14	12	–	–	–	14
	2007-08	11	12	4	7	11	57	–	–	11
LEVEL 4	1993-94	33	45	36	75	46	33	100	100	47
	1997-98	16	32	23	44	28	–	50	40	26
	2002-03	26	15	14	10	18	–	–	–	18
	2007-08	27	27	22	26	29	–	–	–	25

(1) Collection of consumer participation data commenced 1993-94.

(2) LEVELS 1 to 4 reflect the scoring hierarchy developed for monitoring state and territory performance under the Australian Health Care Agreements 1998-2003. See Chapter 4 for discussion.

(3) 'No specific arrangements' and 'other arrangements' includes the responses 'Consumers meet with senior representatives as required', 'No specific arrangements' and 'Other arrangements'.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-40: Number and percentage of public sector mental health service organisations employing Consumer and Carer Consultants, by state and territory, 2007-08

Consumer Consultants	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Number of organisations	90	33	23	27	35	7	3	3	221
Number of organisations employing Consumer Consultants	44	18	11	3	7	3	–	–	86
Percent total organisations	49%	55%	48%	11%	20%	43%	–	–	39%
Total Consumer Consultant FTE	27.9	20.0	9.7	1.2	4.7	–	–	–	63.5
Total wages paid (\$000s)	1,784.0	1,008.3	615.4	74.2	201.2	1.5	–	–	3,684.5
Consumer Consultants per 1000 Clinical FTE	4.1	3.7	2.3	0.5	2.4	–	–	–	2.9
Carer Consultants	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Number of organisations	90	33	23	27	35	7	3	3	221
Number of organisations employing Carer Consultants	26	16	4	2	4	3	–	–	55
Percent total organisations	29%	48%	17%	7%	11%	43%	–	–	25%
Total Carer Consultant FTE	7.0	15.5	1.5	0.8	1.8	–	–	–	26.6
Total wages paid (\$000s)	419.0	836.8	85.1	–	82.1	–	–	–	1,423.1
Carer Consultants per 1000 Clinical FTE	1.0	2.9	0.4	0.3	0.9	–	–	–	1.2

(1) Consumer and Carer Consultants are defined as individuals who are employed on a paid basis to represent the interests of consumers and carers, respectively, and advocate for their needs.

This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where individuals only received reimbursement of expenses or occasional sitting fees for attendance at meetings.

(2) Collection of this information commenced in the National Survey of Mental Health Services 2003.

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-41: Number and percentage of other types of consumer participation arrangements within public sector mental health service organisations 2007-08, by state and territory

Number of organisations					
	Total organisations	Consumer discussion groups	Formal consumer participation policy	Consumer satisfaction surveys	Consumer review of complaints
NSW	90	75	69	77	75
VIC	33	22	21	24	21
QLD	23	19	19	19	15
WA	27	18	21	24	21
SA	35	27	27	25	32
TAS	7	7	5	7	6
ACT	3	3	3	3	3
NT	3	2	2	2	2
Total	221	173	167	181	175

Percent of organisations					
		Consumer discussion groups	Formal consumer participation policy	Consumer satisfaction surveys	Consumer review of complaints
NSW		83	77	86	83
VIC		67	64	73	64
QLD		83	83	83	65
WA		67	78	89	78
SA		77	77	71	91
TAS		10	71	10	86
ACT		10	10	10	10
NT		67	67	67	67
Nat. Avg.		78	76	82	79

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

Table A-42: Number and percentage of other types of carer participation arrangements within public sector mental health service organisations 2007-08, by state and territory

Number of organisations					
	Total organisations	Carer discussion groups	Formal carer participation policy	Carer satisfaction surveys	Carer review of complaints
NSW	90	69	68	61	67
VIC	33	18	20	21	21
QLD	23	18	18	12	15
WA	27	16	15	12	19
SA	35	24	25	21	29
TAS	7	7	5	–	3
ACT	3	3	3	3	3
NT	3	2	2	2	2
Total	221	157	156	132	159

Percent of organisations					
		Carer discussion groups	Formal carer participation policy	Carer satisfaction surveys	Carer review of complaints
NSW		77	76	68	74
VIC		55	61	64	64
QLD		78	78	52	65
WA		59	56	44	70
SA		69	71	60	83
TAS		100	71	–	43
ACT		100	100	100	100
NT		67	67	67	67
Nat. Avg.		71	71	60	72

Source: Australian Government Department of Health and Ageing, National Survey of Mental Health Services Database (1993-2005); National Mental Health Establishments Database (2006-2008).

APPENDIX 8

Implementation of National Standards for Mental Health Services

Table A-43: Implementation of National Standards for Mental Health Services at 30 June 2008 - Number of services by service type by implementation status by state and territory

	Implementation Status Code	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Inpatient services	1	124	58	45	11	7	5	3	2	255
	2	8	–	–	12	–	–	–	–	20
	3	1	–	1	–	–	–	–	–	2
	4	3	–	2	4	13	1	–	–	23
	5	–	1	–	–	–	–	–	–	1
	6	10	–	–	–	–	–	–	–	10
	7	2	–	–	–	–	–	–	–	2
	8	–	–	3	3	–	–	–	–	6
	Total	148	59	51	30	20	6	3	2	319
Residential services	1	10	33	–	2	2	4	1	–	52
	2	–	–	–	1	–	–	–	–	1
	3	–	–	–	–	–	–	–	–	–
	4	3	–	–	–	2	–	–	–	5
	5	–	–	–	–	–	–	–	–	–
	6	–	–	–	–	–	–	–	–	–
	7	–	–	–	–	–	1	–	–	1
	8	–	12	–	–	–	–	–	–	12
	Total	13	45	–	3	4	5	1	–	71
Ambulatory services	1	377	208	111	13	49	5	11	13	787
	2	7	2	5	15	2	–	–	–	31
	3	–	1	2	–	1	–	–	–	4
	4	42	1	13	15	31	5	–	–	107
	5	–	5	–	–	–	4	–	–	9
	6	4	–	2	2	4	3	–	–	15
	7	3	–	–	–	2	–	–	–	5
	8	–	–	–	–	–	–	–	–	–
	Total	433	217	133	45	89	17	11	13	958
All services	1	511	299	156	26	58	14	15	15	1,094
	2	15	2	5	28	2	–	–	–	52
	3	1	1	3	–	1	–	–	–	6
	4	48	1	15	19	46	6	–	–	135
	5	–	6	–	–	–	4	–	–	10
	6	14	–	2	2	4	3	–	–	25
	7	5	–	–	–	2	1	–	–	8
	8	–	12	3	3	–	–	–	–	18
	Total	594	321	184	78	113	28	15	15	1,348

(1) Collection of this information commenced in the National Survey of Mental Health Services 2005.

(2) All data refers to counts of individual services within mental health organisations, not whole organisations.

(3) NGO residential services excluded from analysis.

Key to Implementation Status Codes

- 1 The service had been reviewed by an external accreditation agency and was judged to have met the National Standards.
- 2 The service had been reviewed by an external accreditation agency and was judged to have met some but not all National Standards.
- 3 The service was in the process of being reviewed by an external accreditation agency but the outcomes were not known.
- 4 The service was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review.
- 5 The service was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review (Code 5 includes services that may have submitted an application to the accreditation agency but had not received a formal response by June 2003).
- 6 The service had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future.
- 7 It had not been resolved whether the service would undertake review by an external accreditation agency under the National Standards.
- 8 The National Standards are not applicable to this service (only applicable to Aged care residential services in receipt of funding under the Aged Care Act and subject to Commonwealth residential aged care reporting and service standards requirements).

Table A-44: Implementation of National Mental Health Service Standards at 30 June 2008 - state and territory summary indicators

Implementation Progress Level	Description of level	Percentage of services								Nat. Avg.
		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
Level 1	Met all National Service Standards	86	97	86	35	51	50	100	100	82
Level 2	Met some but not all National Service Standards	3	1	3	37	2	-	-	-	4
Level 3	External review against National Standards commenced and ongoing	8	1	10	25	42	21	-	-	11
Level 4	External review not yet formally arranged	3	2	1	3	5	29	-	-	3
Total		100	100	100	100	100	100	100	100	100

Implementation Progress Level	Description of level	Percentage of service expenditure								Nat. Avg.
		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
Level 1	Met all National Service Standards	85	99	97	39	43	55	100	100	81
Level 2	Met some but not all National Service Standards	4	0	0	49	1	0	0	0	7
Level 3	External review against National Standards commenced and ongoing	7	0	3	11	55	24	0	0	10
Level 4	External review not yet formally arranged	4	1	0	1	1	21	0	0	2
Total		100	100	100	100	100	100	100	100	100

(1) Collection of this information commenced in the National Survey of Mental Health Services 2005.

(2) NGO Residential services excluded from analysis.

Key to Implementation Progress Levels

- Level 1 Includes only services assigned Code 1 on Table A-43.
 Level 2 Includes only services assigned Code 2 on Table A-43.
 Level 3 Includes services assigned Codes 3 and 4 on Table A-43.
 Level 4 Includes only services assigned Codes 5, 6 and 7 on Table A-43.

Services assigned Code 8 excluded from indicators.

APPENDIX 9

Explanatory notes on data analysis approach used for state and territory profiles

The following notes have been prepared to assist in the interpretation of the summary tables of state and territory performance presented in Part 3 (Table 12 to Table 19). Source data used in preparing the indicators are provided elsewhere throughout the Appendices.

All population-based indicators are expressed as crude (non age standardised) rates.

1. State and territory government expenditure

Indicator(s)	Notes
<ul style="list-style-type: none"> • State spending on mental health services • State spending per capita • Per capita spending rank 	<p>(a) State and territory expenditure estimates used for each of these indicators are based on overall spending by the state or territory government, which should be distinguished from spending in the state or territory. Spending by the state or territory is calculated as total spending on mental health services administered by the state or territory government, less Australian Government contributions made through National Mental Health Strategy grants and payments by the Department of Veterans' Affairs. As a result of these exclusions, total state or territory expenditure is in all cases less than the total actual amount spent on mental health services in the state or territory.</p> <p>Expenditure data used to prepare these indicators is provided in Table A-2. Appendix 2 provides further details of the relationship between spending by the state or territory and spending in the state or territory.</p>
<ul style="list-style-type: none"> • Average annual per capita spending growth during National Mental Health Plan(s) 	<p>(b) As per the indicators described in note (a) above, average annual per capita spending growth indicators are based on overall spending by the state or territory government and exclude the specified Australian Government contributions.</p> <p>Indicators are reported for two periods:</p> <p><u>2002-03</u>: Average annual growth presented here refers to growth over the period of the First and Second National Mental Health Plan i.e. over the 10 year period 1993-94 to 2002-03.</p> <p><u>2007-08</u>: Average annual growth presented here refers to growth over the period of the Third National Mental Health Plan i.e. over the five years 2003-04 and 2007-08.</p>

2. Service mix

Indicator(s)	Notes
<ul style="list-style-type: none"> • % total service expenditure - community services • % total service expenditure - stand alone psychiatric hospitals • % total service expenditure - 	<p>(c) In contrast to the above indicators, these indicators are based on all recurrent amounts reported by the state or territory government in these service categories, regardless of funding source. The estimates therefore include Australian Government funds which are excluded in the indicators described at note (a) above.</p>

Indicator(s)	Notes
colocated hospitals	<p>Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e. indirect expenditure that is not apportioned to services).</p> <p>Estimates of the percentage of service expenditure on community services includes three categories of services: Ambulatory care, community residential and non government services.</p> <p>Source data used in preparing indicators of service mix are provided in Table A-4.</p>

3. Inpatient services

Indicator(s)	Notes
<ul style="list-style-type: none"> Total hospital beds 	(d) Refers to total number of hospital-based psychiatric inpatient beds reported as available at 30 June of each of the respective years.
<ul style="list-style-type: none"> Per capita expenditure on inpatient care 	(e) This indicator is based on total expenditure (constant 2008 prices) reported by state and territory-administered psychiatric inpatient services, regardless of source of funds. Source data for expenditure are provided in Table A-4.
<ul style="list-style-type: none"> Inpatient beds per 100,000 Acute inpatient beds per 100,000 Non acute inpatient beds per 100,000 	(f) Source data for total inpatient, acute and non acute beds are provided in Appendix 3.
<ul style="list-style-type: none"> % acute inpatient beds located in general hospitals 	(g) Calculation of the percentage of total acute beds located in general hospital settings excludes acute beds that are provided as part of a Forensic Psychiatry or prison-based medical service. Source data are provided in Table A-18.
<ul style="list-style-type: none"> Stand alone hospitals as % of total beds 	(h) Source data for total stand alone and colocated psychiatric inpatient beds are provided in Table A-13.
<ul style="list-style-type: none"> Average cost per patient day 	(i) Source data are presented in Table A-23. All costs are expressed in 2008 constant prices and exclude depreciation.

4. Community services

Indicator(s)	Notes
<ul style="list-style-type: none"> Ambulatory, NGO and Residential services - % total service expenditure 	<p>(j) These indicators represent the ambulatory, NGO and residential components of expenditure on community services shown earlier in the table, and described in note (c) above. All expenditure reported by services is counted and includes Australian Government funds. Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e. indirect expenditure that is not apportioned to services).</p> <p>(k) 'NGO % total service expenditure' includes funding to staffed community residential services managed by non government organisations, to give a more accurate estimate</p>

Indicator(s)	Notes
	of non government allocations by each jurisdiction and to ensure consistency in monitoring the 15-year spending trends.
	As these amounts are also included in the indicator 'Residential % total service expenditure', the total percentage of expenditure shown for residential, ambulatory and NGO services is greater than the amount shown in the indicator '% total service expenditure – community services' described in note (c) above.
	Expenditure for NGO–managed staffed residential services for each jurisdiction is provided in Table A-29.
<ul style="list-style-type: none"> Ambulatory, NGO and Residential services - per capita expenditure 	(l) Source data are presented in Table A-8 with the exception that NGO per capita expenditure <u>includes</u> staffed community residential services managed by non government organisations. These amounts are also counted in the indicator 'Residential services per capita expenditure'. See note (k) above.
<ul style="list-style-type: none"> Residential services - Adult beds (24 hour staffed) per 100,000; Adult beds (non 24 hour) per 100,000 ; Older persons beds (24 hour staffed) per 100,000; Adult beds (non 24 hour) per 100,000 	(m) Source data are presented in Table A-25 and Table A-38. Estimates of per capita rates are based on age-specific populations - Adult beds per 100,000 calculated using population aged 18-64 years; Older persons beds calculated using population aged 65 years and over.
<ul style="list-style-type: none"> Supported public housing places per 100,000 	(n) Source data are presented in Table A-30. Per capita rates are calculated using total populations within each jurisdiction.

5. Direct care workforce

Indicator(s)	Notes
<ul style="list-style-type: none"> Number Full Time Equivalent (FTE) staff FTE per 100,000 % FTE in community based services FTE per 100,000 - ambulatory services 	(o) FTE indicators presented in the state and territory tables are based on 'direct care' staff, covering the following occupational groups: Nursing, Medical, Diagnostic and Health Professionals and Other Personal Care Staff. FTE reported under the categories of Administrative and Clerical and Domestic and Related are excluded from the analysis. Data used for constructing these indicators are based only on staffing reported for each of the three service settings (inpatient, residential, ambulatory) and therefore exclude staff not reported against a specific service setting. Source data are presented in Table A-33 and Table A-34.

6. Implementation of National Service Standards

Indicator(s)	Notes
<ul style="list-style-type: none"> % services Level I implementation of Standards % service expenditure covered by Level I services 	(p) Source data are presented in Table A-44.

7. Consumer and carer participation

Indicator(s)	Notes
<ul style="list-style-type: none"> % services with Level I consumer participation arrangements 	<p>(q) Source data are presented in Table A-39.</p> <p>As this information only commenced in 1993-94, data for that year is substituted in the 1992-93 column as an approximation of the pre-Strategy baseline.</p>
<ul style="list-style-type: none"> Consumer consultants employed per 1000 clinical FTE Carer consultants employed per 1000 clinical FTE 	<p>(r) Source data are presented in Table A-40.</p>

8. Medicare-subsidised mental health services

Indicator(s)	Notes
<ul style="list-style-type: none"> % population seen – all MBS funded providers (Psychiatrists, GPs, allied health) 	<p>(s) This indicator is based on a unique count of persons receiving one or more services provided under any of the Medicare-funded service streams described at (t) to (w) below. Persons seen by more than one provider stream are counted only once. All Medicare funded data are based on year of processing (i.e. date on which a Medicare claim was processed by Medicare Australia), not when the service was rendered. A significant component of the data includes services provided under the Australian Government Better Access to Mental Health Care initiative, which commenced on 1 November 2006. Comparable full year estimates are not available for years prior to 2007-08. Source data for all person counts is as reported in the <i>COAG National Action Plan for Mental Health Second Annual Progress Report to 2007-08</i>. See www.coag.gov.au</p>
<ul style="list-style-type: none"> % population seen – GPs 	<p>(t) General practitioner data represents a unique count of people who received one or more general practitioner attendance items, billed to Medicare Australia, that are mental health specific. These are predominantly items under the Better Access to Mental Health Care initiative (available 1 November 2006 onwards) plus a small number of other items that were created in years preceding the introduction of the Better Access initiative. A small proportion of this latter group may also be provided by other medical practitioners. The count does not include people receiving GP-based mental health care that was billed as a general consultation.</p>
<ul style="list-style-type: none"> % population seen – Consultant Psychiatrists 	<p>(u) Consultant psychiatrist data represents a unique count of people seen who received one or more consultant psychiatrist attendance items billed to Medicare Australia.</p>
<ul style="list-style-type: none"> % population seen – Psychologists and Clinical Psychologists 	<p>(v) Clinical psychologist data represents a unique count of people who received one or more Registered Psychologist or Clinical Psychologist attendance items, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. As noted above, these commenced on 1 November 2006.</p>

<ul style="list-style-type: none"> • % population seen – Other allied health professionals 	<p>(w) Other allied health data represents a unique count of people who received one or more attendance items provided by Social Workers or Occupational Therapists, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. The person count also includes a small number of services provided by allied health professionals provided under the Enhanced Primary Care Strategy, introduced in the MBS in 2004.</p>
<ul style="list-style-type: none"> • Total MBS mental health related benefits paid per capita 	<p>(x) This indicator is based on total MBS rebates paid in relation to Medicare-funded service streams described at (t) to (w) above.</p>

9. PBS-funded pharmaceuticals (including RPBS)

Indicator(s)	Notes
<ul style="list-style-type: none"> • Total PBS/RPBS benefits paid per capita 	<p>(y) Indicators of the utilisation of Australian Government-funded psychiatric medicines, subsidised through the Pharmaceutical Benefits Schemes, is included in each table to provide further context for interpreting differences between the states and territories.</p> <p>Drugs counted in the preparation of this indicator are detailed in note (i), Appendix II and cover both the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme.</p> <p><i>Source data: Provided by Pharmaceutical Benefits Branch, Department of Health and Ageing.</i></p>

APPENDIX 10

Private psychiatric hospital data

A specific establishment-level collection of psychiatric units provided by the private hospital sector is not available. The closest alternative is the Private Health Establishments Collection (PHEC), a periodic census conducted by the Australian Bureau of Statistics (ABS). Up to 2006-07, PHEC was conducted on an annual basis but subsequently been recast as a biennial collection. As no collection occurred for 2007-08, the data reported here are based on the 2006-07 survey. Estimates of expenditure and revenue for 2007-08 presented in this report are equivalent to 2006-07 data, inflated to 2008 prices.

Data from the PHEC collection is published in *Private Hospitals Australia*. Data released in the ABS publication is designed to describe the overall activity and financial aspects of private hospitals rather than give details relating to the operation of specialised units within the sector.

Using customised tables prepared by the ABS for the Department of Health and Ageing, the PHEC database has provided the basis of all information presented on private hospitals in the National Mental Health Report series. The scope of the analysis covers only those private hospitals that indicated in the PHEC survey that they provide a specialised psychiatric inpatient unit, rather than all hospitals which, as part of a more general service, treated patients for a mental illness. This approach is consistent with the definition of specialised mental health services used in defining relevant services within the public sector.

Data quality issues

Three factors may contribute to inaccuracy of the estimates detailed in this report.

- As the PHEC survey does not specifically target psychiatric units, expenditure, revenue and staffing of those units is reported as part of the total hospital response to the survey. Specific data relating to expenditure, revenue and staffing for private psychiatric units therefore needed to be derived, involving a series of estimates outlined below. These are subject to some degree of error that is not possible to quantify.
- As the ABS can only provide aggregate data that does not identify individual agencies, it was not possible to undertake a data validation exercise in a manner comparable to that used for public mental health services.
- Variable reporting practices over the years of the survey may contribute to the trends observed in the time series data. For example, because of the close relationship of drug and alcohol services with psychiatric services in the private hospital sector, the data presented for some years may include some details relating to drug and alcohol services which it has not been possible to separate out.

Definitional issues

Stand alone and colocated status of hospitals

The PHEC survey distinguishes private acute and private psychiatric hospitals. Private psychiatric hospitals are defined as those hospitals that are licensed or approved by each state or territory health authority and that cater primarily for admitted patients with psychiatric or behavioural disorders. For the purpose of the analysis used in this report, stand alone private psychiatric hospitals were operationalised as those private hospitals in which the number of psychiatric beds made up more than 75% of total beds.

Of the 46 private hospitals reporting a psychiatric unit to the 2006-07 survey, 24 met the stand alone criterion. Ninety three per cent of the total beds reported by these hospitals were located in psychiatric units, indicating that the predominant business of this hospital group was the provision of psychiatric care. Collectively, the stand alone group accounted for 76% of total psychiatric beds and 71% of patient days reported by the private hospital sector in 2006-07.

Beds, patient days and separations

All estimates are based on the standard ABS survey definitions. The PHEC survey requires psychiatric-specific beds, patient days and separations to be separately enumerated by each hospital responding to the survey.

Expenditure, revenue and staffing estimates used in the analysis

Expenditure

Total expenditure is reported to the PHEC survey for each hospital as a whole and not separated into the various health care programs that may be delivered by each hospital. The following approach was used to estimate total psychiatric-related expenditure for the private hospital sector.

Step 1: Estimate psychiatric expenditure for stand alone hospitals.

This was calculated by ABS at the individual hospital level as follows.

$$\begin{array}{l} \text{Estimated total psychiatric} \\ \text{expenditure within stand alone} \\ \text{hospitals} \end{array} = \begin{array}{l} \text{(Total expenditure} \\ \text{reported by the} \\ \text{hospital)} \end{array} \times \frac{\begin{array}{l} \text{(Total psychiatric patient days} \\ \text{reported by the hospital)} \end{array}}{\begin{array}{l} \text{(Total patient days reported} \\ \text{by the hospital)} \end{array}}$$

The individual totals for each of hospital were then summed to give the total psychiatric expenditure for stand alone hospitals.

Step 2: Estimate total psychiatric expenditure of all private hospitals.

This step 'scaled up' the estimated total psychiatric expenditure for stand alone hospital based on the proportion of total private psychiatric patient days provided by those hospitals.

$$\begin{array}{l} \text{Estimated total psychiatric} \\ \text{expenditure of all private} \\ \text{hospitals} \end{array} = \begin{array}{l} \text{(Estimated total} \\ \text{psychiatric expenditure} \\ \text{for stand alone hospitals)} \end{array} \times \frac{\begin{array}{l} \text{(Total psychiatric patient days reported} \\ \text{by all private hospitals)} \end{array}}{\begin{array}{l} \text{(Total psychiatric reported by} \\ \text{stand alone hospitals)} \end{array}}$$

This step assumes that psychiatric patient day costs in colocated units were equivalent to the average patient days cost of all stand alone hospitals.

Revenue

As per expenditure, total revenue is reported to the PHEC survey for each hospital as a whole and not separated into the various health care programs. The following approach was used to estimate total psychiatric-related revenue for the private hospital sector.

Step 1: Estimate psychiatric revenue for stand alone hospitals.

This was calculated at an aggregate level for stand alone hospitals based on the data supplied by ABS.

$$\begin{array}{l} \text{Estimated total psychiatric} \\ \text{revenue within stand alone} \\ \text{hospitals} \end{array} = \begin{array}{l} \text{(Total revenue} \\ \text{reported by stand alone} \\ \text{hospitals)} \end{array} \times \frac{\begin{array}{l} \text{(Estimated total psychiatric} \\ \text{expenditure for stand alone hospitals)} \end{array}}{\begin{array}{l} \text{(Total expenditure reported} \\ \text{by stand alone hospitals)} \end{array}}$$

This method assumes that if psychiatric patient days are x% of expenditure then they are also x% of revenue for the stand alone hospital group as a whole.

Step 2: Estimate total psychiatric revenue of all private hospitals.

This step 'scaled up' the estimated total psychiatric expenditure for stand alone hospital based on the proportion of total private psychiatric patient days provided by those hospitals.

$$\begin{array}{l} \text{Estimated total psychiatric} \\ \text{revenue for all private hospitals} \end{array} = \begin{array}{l} \text{(Estimated total} \\ \text{psychiatric revenue} \\ \text{within stand alone} \\ \text{hospital hospitals)} \end{array} \times \frac{\begin{array}{l} \text{(Estimate total psychiatric} \\ \text{expenditure of all private hospitals)} \end{array}}{\begin{array}{l} \text{(Estimated total expenditure for} \\ \text{stand alone hospitals)} \end{array}}$$

This method assumes that the revenue to expenditure ratio in colocated psychiatric units is the same as that for stand alone hospitals ie the revenue earned per patient day is the same.

Staffing estimates

Staffing profiles are reported to the PHEC for the total hospital establishment rather than separated in to specific programs. The following formulae were used to estimate the psychiatric component of total staffing reported.

Step 1: Estimate psychiatric-specific staffing within stand alone hospitals.

This was calculated as follows.

$$\text{Estimated total psychiatric FTE within stand alone hospitals} = \frac{\text{(Total FTE reported by stand alone hospitals)}}{\text{(Total patient days reported by stand alone hospitals)}} \times \frac{\text{(Total psychiatric patient days reported by stand alone hospitals)}}{\text{(Total patient days reported by stand alone hospitals)}}$$

Step 2: Estimate total psychiatric-specific staffing within all private hospitals.

This step 'scaled up' the estimated psychiatric staffing in stand alone hospitals based on the proportion of total private psychiatric beds located in those hospitals.

$$\text{Estimated total psychiatric FTE within all private hospitals} = \frac{\text{(Estimated total psychiatric FTE within stand alone hospitals)}}{\text{(Total psychiatric beds reported by stand alone hospitals)}} \times \frac{\text{(Total psychiatric beds reported by all private hospitals)}}{\text{(Total psychiatric beds reported by stand alone hospitals)}}$$

This step assumes that staffing numbers in colocated hospitals, expressed as staff per available bed, are equivalent to the average for stand alone hospitals.

Deflator applied to Private Hospital expenditure

Within the main text of this report, private hospital expenditure has been deflated and expressed in 2007-08 constant prices. The rationale for this procedure is equivalent to that used in the adjustment of state and territory expenditure, as outlined in Appendix 2.

The deflator applied for the current report was the same as that used for state and territory mental health services expenditure - the Government Final Consumption Expenditure (GFCE) on Hospital and Clinical Services. Details are provided in Appendix 2.

Table A-45: Summary of activity and expenditure in private hospitals with psychiatric units, selected years 1992-93 to 2007-08, current and constant prices

	1992-93	1997-98	2002-03	2006-07	2007-08 (c)
Number of hospitals	33	39	46	46	n.a
Total psychiatric beds	1,260	1,507	1,727	1,824	n.a
Patient days (include same day)	328,100	380,117	510,634	541,874	n.a
Total separations	25,861	39,338	104,650	122,561	n.a
<i>Overnight</i>	15,716	20,336	24,000	34,031	n.a
<i>Same day</i>	10,145	19,002	80,650	88,530	n.a
Average length of stay (est)					
<i>With same day</i>	12.7	9.7	4.9	4.4	n.a
<i>Excluding same day</i>	20.2	17.8	17.9	13.3	n.a
Staffing (FTE) (a,d)	1,222	1,697	2,143	1,683	n.a
EXPENDITURE AND REVENUE – CURRENT PRICES (a)					
Total recurrent expenditure ('000s)	79,617.8	116,333.2	185,669.8	203,885.8	210,040.0
Total revenue ('000s)	102,605.7	141,999.3	217,611.3	263,751.3	271,712.5
Total revenue less Australian Government sources ('000s) (b)	101,846.7	119,934.1	148,097.1	183,709.6	185,325.5
EXPENDITURE AND REVENUE - CONSTANT PRICES (a)					
Total recurrent expenditure ('000s)	116,128.7	157,782.7	221,298.9	210,040.0	210,040.0
Total revenue ('000s)	149,658.3	192,593.7	259,369.9	271,712.5	271,712.5
Total revenue less Australian Government sources ('000s) (b)	148,551.2	162,666.7	176,516.2	189,254.8	185,325.5

(a) Estimates of expenditure, revenue and staffing are derived and subject to some degree of error. Direct measures are not possible from source data.

- (b) 'Total revenue less Australian Government sources' takes Total revenue and deducts:
- all payments made to hospitals by the Department of Veterans' Affairs; and
 - estimates of the private hospital mental health component of the Australian Government Private Health Insurance Rebate.

The remaining amount is then deemed to represent the payments made by private health insurers in respect of private hospital psychiatric care and is used in the estimates of national spending on mental health presented in Section 3, Part C.

(c) Data not available for 2007-08 as a PHEC survey was not conducted. Estimates of expenditure and revenue are equivalent to 2006-07 data, inflated to 2008 prices.
'n.a' indicates data not available.

(d) Staffing estimates for 2006-07 are not directly comparable to previous years because 'Other personal care staff' were excluded from the staffing categories collected.

Source: Based on Australian Government analysis of data prepared by the Australian Bureau of Statistics from the Private Hospitals Establishments Collection.

APPENDIX 11

Australian Government mental health expenditure

Estimated Australian Government expenditure presented in this Appendix covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, both directly or indirectly related to provision of support for people affected by mental illness and psychiatric disability, is not covered in Table A-46. Expenditure that can be directly linked to specialised mental health service provision but not counted in the table includes:

- nursing home and hostel subsidies provided to psychogeriatric nursing homes managed by states and territories;
- all administrative overheads except for those associated with the National Mental Health Strategy, including the costs of the administrative infrastructure required to provide funding under the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS); and
- general grants provided to states and territories under the Australian Health Care Agreements (1998-2003, and 2003-2008, other than Schedule B of the 1998-2003 Agreements) used to fund public hospitals including psychiatric units within those hospitals.

Accurate costing of these items was not possible for the current National Mental Health Report. In addition, the Australian Government provides significant support to people affected by mental illness through income security provisions and other social and welfare programs.⁴⁹ Consistent with the focus of the National Mental Health Report on specialised mental health services, these costs have been excluded from the analysis.

Explanatory notes to Table A-46

- (a) *Health Care Agreements - Grants to states and territories*: This covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993-98, and Australian Health Care Agreements 1998-2003 and 2003-08. These amounts include grants provided under Information Development Agreements and Quality Through Outcomes funding agreements, sourced from Commonwealth Own Purpose Outlays (COPO) of national mental health reform funding provided under special appropriations linked to the Australian Health Care Agreements.
- (b) *National programs and initiatives (DoHA managed)*: This category of expenditure includes the following programs and activities:
- Initiatives funded through national mental health reform funding provided under special appropriations linked to the Australian Health Care Agreements (excluding amounts reported against item (a) above).
 - DoHA-administered programs funded by the Australian Government under the COAG Action Plan on Mental Health 2006, excluding MBS expenditure through the Better Access to Psychiatrists, Psychologists and General Practitioners initiative (this is reported against items (f) to (h) below) and the National Suicide Prevention Program (reported under (e) below). These include the following programs:
 - Alerting the Community to Links between Illicit Drugs and Mental Illness
 - New Early Intervention Services for Parents, Children and Young People
 - Better Access to Psychiatrists, Psychologists, GPs - Education and Training component
 - New Funding For Mental Health Nurses
 - Mental Health Services in Rural and Remote Areas

⁴⁹ Discussion of the 'indirect' costs can be found in chapter 5, Part C of this report.

- Improved Services for People with Drug and Alcohol Problems and Mental Illness
- Funding for Telephone Counselling, Self-help and Web based Support Programmes
- Mental Health Support for Drought Affected Communities Initiative
- Additional Education Places, Scholarships and Clinical Training in Mental Health - Scholarships and Clinical Training components only
- Mental Health in Tertiary Curricula
- Improving the Capacity of Health Workers in Indigenous Communities

Note: Full details of all expenditure by the Australian Government on the Action Plan initiatives can be found in COAG National Action Plan Progress Reports (www.coag.gov.au).

- National Mental Health Program
 - National Depression Initiative
 - Better Outcomes in Mental Health Care program (including ATAPS)
 - Youth Mental Health Initiative
 - OATSIH Emotional & Social Wellbeing Action Plan (base mental health funding only)
- (c) *National programs and initiatives (FaHCSIA managed)*: This refers to expenditure on three initiatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness).
- (d) *National programs and initiatives (DVA managed)*: DVA provided the following information in respect of its mental health related expenditure in 2007-08.

	2007-08 (\$M)
Private hospitals	27.9
Public hospitals	22.6
Consultant psychiatrists	17.1
Vietnam Veteran's Counselling Service (salaries, contracted providers and programs)	21.2
Pharmaceuticals	34.8
Private psychologists and allied health	1.5
General practitioners	14.3
Australian Centre for Posttraumatic Mental Health	2.7
TOTAL	142.1

Source: Department of Veterans' Affairs (current prices)

DVA provided the following explanatory notes to the 2007-08 data:

"As for the 2008 report on mental health expenditure for FY 2006-07, the figures provided in this report for both private and public hospitals include payments made to hospitals only. While this is the most common way that hospital expenditure is reported, it should be noted that there are various medical and allied health services during a hospital episode which are not paid to the hospital (excluding all provider costs already reported here) but which contribute to the total episode cost. These costs, that are in addition to the amounts reported in the tables above, amount to about \$3.6m for 2007-08.

It should also be noted that additional costs for 2007-08 exist that are not captured by the existing reporting methodology that created the tables above. About \$650,000 is related to price movements in relation to public hospital acute mental health services. A second cost of over \$1.2m exists in relation to public hospital non-acute admitted mental health services, where no Diagnostic Related Group code exists in relation to the admission."

- (e) *National Suicide Prevention Program*: Expenditure reported includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan.
- (f) *Medicare Benefits Schedule – Psychiatrists*: Expenditure reported refers to benefits paid for all services by consultant psychiatrists processed in each of the index years. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.

- (g) *Medicare Benefits Schedule – GPs*: Prior to 2006-07, General Practitioner mental health-related expenditure was based on a crude estimate of 6.1 per cent of total MBS benefits paid for GP attendances. This estimate was historical, based on a 1992 survey that found 6.1% of GP consultations were primarily for mental health reasons⁵⁰, and aimed to recognise that, although few mental health specific items were available in the MBS to accurately monitor their mental health service provision, GPs are a significant provider of services to people with mental illness. While more recent data from the *Bettering the Evaluation and Care of Health* (BEACH) survey suggested that this may understate mental health related GP expenditure, the 6.1 per cent estimate continued to be used in all previous National Mental Health Reports for the purpose of maintaining consistency across the time series.

Commencing November 2006, new mental health specific GP items were introduced under the Better Access to Mental Health Care initiative. To incorporate these changes, GP expenditure reported for 2006-07 is based on total MBS benefits paid against these new mental health specific items, plus an additional 6.1 per cent of total GP Benefits paid in the period preceding the introduction of the new items (July and November 2006).

For 2007-08 and future years, expenditure on GP mental health care is based solely on benefits paid against the MBS mental health-specific GP items, which are predominantly the Better Access GP mental health items plus a small number of other items that were created in years preceding the introduction of the Better Access initiative.⁵¹ This method provides a significantly lower expenditure figure than obtained using the 6.1 per cent estimate of previous years because it is conservative and does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific Better Access item. Comparisons of GP mental health related expenditure reported pre- and post-2006-07 are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services.

- (h) *Medicare Benefits Schedule – Psychologists/Allied Health*: Expenditure refers to MBS benefits paid for Clinical Psychologists, Psychologists, Social Workers and Occupational Therapists under the new items introduced through the Better Access to Mental Health Care initiative on 1 November 2006. Note that comparable items did not exist in preceding years, and that these items were not available for the full 2006-07 period. MBS benefits paid in relation to a small number of Allied Health items introduced in 2004 under the Enhanced Primary Care program are also included, but these represent less than 1% of the overall expenditure reported.
- (i) *Pharmaceutical Benefits Scheme*: Expenditure under the Pharmaceutical Benefits Scheme refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics (except prochlorperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, expenditure on Clozapine, funded under the Highly Specialised Drugs Program, has been included for all years, requiring adjustment to the historical data. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule. These are included under the Department of Veterans' Affairs expenditure.
- (j) *Private Health Insurance Premium Rebates*: Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals.

In 1997, the Australian Government passed the *Private Health Insurance Incentives Act 1997*. This introduced the Private Health Insurance Incentives Scheme (PHIIS) effective from 1 July 1997. Under the PHIIS, fixed-rate rebates were provided to low and middle-income earners with hospital and/or

⁵⁰ Bridges-Webb C, Britt H, Miles D et al (1992) Morbidity and treatment in General Practice in Australia 1990-1991, *Medical Journal of Australia*, Supplement, October 1992.

⁵¹ Details of MBS items used to estimate GP mental health related expenditure are provided in the Australian Institute of Health and Welfare report *Mental health services in Australia 2007-08*, available at <http://www.aihw.gov.au/mentalhealth/index.cfm>

ancillary cover with a private health insurance fund. Those rebates could be taken in the form of reduced premiums (with the health funds being reimbursed by the Australian Government out of appropriations) or as income tax rebates, claimable after the end of the income year. On 1 January 1999, the means-tested PHIS was replaced with a 30% rebate on premiums, which is available to all persons with private health insurance cover. As with the PHISS, the 30% rebate could be taken either as a reduced premium (with the health funds being reimbursed by the Australian Government) or as an income tax rebate.

The combined Australian Government outlays under the two schemes, and the estimated amounts spent on private hospital care for selected years, are as follows (current prices):

	1997-98	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
	\$M	\$M	\$M	\$M	\$M	\$M	\$M
(A) Total Australian Government outlays on private health insurance subsidies	407	2,250	2,387	2,645	2,883	3,073	3,587
(B) Estimated component of Australian Government private health insurance subsidies spent on hospital care	241	1,238	1,376	1,569	1,588	1,695	1,960

Source: *Health Expenditure in Australia 2007-08*, Australian Institute of Health and Welfare, September 2009.

Estimation of the 'mental health share' of the amounts shown at (B) is based on the proportion of total hospital revenue accounted for by psychiatric care. This assumes that if psychiatric care provided by the private hospital sector accounts for x% of revenue, then x% of the component of the Australian Government private health insurance subsidies spent by health insurance funds in paying for private hospital care is directed to psychiatric care. The estimates provided by this approach are shown below (current prices):

	1997-98	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
	\$M	\$M	\$M	\$M	\$M	\$M	\$M
Estimated component of Australian Government private health insurance subsidies spent on hospital care	241	1,238	1,376	1,569	1,588	1,695	1,960
Per cent of total private hospital revenue earned through the provision of psychiatric care	3.88%	3.78%	3.49%	3.61%	3.65%	3.50%	3.41%
Estimated 'mental health share' of Australian Government private health insurance subsidies spent on hospital care	9.3	46.8	48.0	56.6	58.0	59.3	66.8

Details of the estimation of private hospital revenue earned from psychiatric care are provided in Appendix 10. Total private hospital revenue was sourced from *Health Expenditure in Australia 2007-08*, Australian Institute of Health and Welfare, September 2009 and *Private Hospitals Australia 2006-07*, Australian Bureau of Statistics.

- (k) *Research*: Research funding represents the value of mental health related grants administered by the National Health and Medical Research Council (NHMRC) during the relevant year. Data were sourced from the NHMRC website: <http://www.nhmrc.gov.au/grants/dataset/disease/mental.php>.

Deflator applied to Australian Government expenditure

Within the main text of this report, Australian Government expenditure has been deflated and expressed in 2008 constant prices. The rationale for this procedure is equivalent to that used in the adjustment of state and territory expenditure, outlined in Appendix 2.

There are a number of indicators of price movements that can be applied to deflate various categories of Australian Government expenditure. The deflator applied for the current report was the Implicit Price Deflator for Non-Farm GDP, as this index is most commonly applied for Australian Government health spending trends. The deflator is applied throughout the current report to express estimates of Australian Government expenditure in 2007-08 prices.

The details below present the expenditure deflators used for the conversion of current expenditure in the financial years 1992-93 to 2007-08 to constant 2008 prices.

1992-93	66.73
1993-94	67.31
1994-95	68.07
1995-96	69.80
1996-97	70.95
1997-98	71.81
1998-99	72.00
1999-00	73.54
2000-01	76.80
2001-02	78.62
2002-03	80.92
2003-04	84.18
2004-05	87.54
2005-06	91.66
2006-07	95.88
2007-08	100.00

Table A-46: Estimated Australian Government expenditure on mental health services, selected years 1992-93 to 2007-08, current and constant prices (\$000s)

	1992-93	1997-98	2002-03	2007-08
Expenditure in current prices				
Health Care Agreements - Grants to states and territories (a)	2,457.6	52,271.9	71,097.8	80,309.7
National programs and initiatives (DoHA managed) (b)	9,054.3	25,035.1	31,938.8	209,569.7
National programs and initiatives (FaHCSIA managed) (c)	–	–	–	99,025.0
National programs and initiatives (DVA managed) (d)	53,649.9	71,923.7	129,420.0	142,138.4
National Suicide Prevention Program (e)	–	9,577.0	10,105.8	18,736.8
Medicare Benefits Schedule – Psychiatrists (f)	169,530.4	190,529.9	197,663.4	240,587.8
Medicare Benefits Schedule – GPs (g)	121,759.5	144,436.0	168,739.5	133,449.0
Medicare Benefits Schedule – Psychologists/Allied Health (h)	–	–	–	176,965.1
Pharmaceutical Benefits Scheme (i)	62,862.1	237,004.2	543,110.4	701,749.3
Private Health Insurance Premium Rebates (j)	–	9,344.3	46,791.4	66,807.7
Research (k)	6,530.0	12,342.2	23,120.9	49,970.9
Total	425,843.7	752,464.4	1,221,988.0	1,919,309.5
Expenditure in constant prices				
Health Care Agreements - Grants to states and territories	3,682.9	72,789.9	87,861.4	80,309.7
National programs and initiatives (DoHA managed)	13,568.4	34,862.0	39,469.3	209,569.7
National programs and initiatives (FaHCSIA managed)	–	–	–	99,025.0
National programs and initiatives (DVA managed)	80,397.7	100,155.4	159,934.8	142,138.4
National Suicide Prevention Program	–	13,336.2	12,488.5	18,736.8
Medicare Benefits Schedule – Psychiatrists	254,052.0	265,317.3	244,268.9	240,587.8
Medicare Benefits Schedule – GPs	182,464.3	201,130.6	208,525.3	133,449.0
Medicare Benefits Schedule – Psychologists/Allied Health	–	–	–	176,965.1
Pharmaceutical Benefits Scheme	94,202.8	330,033.8	671,166.1	701,749.3
Private Health Insurance Premium Rebates	–	13,012.2	57,824.0	66,807.7
Research	9,785.6	17,186.8	28,572.4	49,970.9
Total	638,153.7	1,047,824.2	1,510,110.8	1,919,309.5
Per capita expenditure in constant prices (dollars)				
	36.30	56.31	76.38	90.37

(1) Table A-46 includes revised estimates for years prior to 2007-08.

(2) Constant price expenditure for all years, expressed in 2008 prices, using Implicit Price Deflator for Non-Farm GDP.

(3) See pages 159-162 for explanatory notes to individual expenditure items.

(4) General Practitioners show a decrease from the 2005-06 report due to the different way in which the estimates were calculated. For all years prior to the introduction of the Better Access initiative (2006-07), the estimate was based on a calculation (6.1% of total MBS benefits paid to GPs). From November 2006, the expenditure is based on actual MBS benefits paid only for specific MBS mental health items.

(5) DoHA refers to Department of Health and Ageing; FaHCSIA refers to the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs; DVA refers to Department of Veterans' Affairs

Source: Australian Government Department of Health and Ageing.

APPENDIX 12

Medicare Benefits Schedule data for Consultant Psychiatrists

Three source data tables are presented in this Appendix to support the MBS information outlined in chapter 7 of the main report. Notes to assist in interpretation are provided below. All tables relate only to benefits paid under the Medicare Benefits Schedule for service provided by consultant psychiatrists. Work performed by consultant psychiatrists funded from other sources (e.g., workers compensation schemes), including the Repatriation Medicare Benefits Schedule, is not included in the tables.

Notes applicable to Table A-47 to Table A-49

- All data presented in Table A-47 to Table A-49 were prepared by Medicare Statistics and Analysis Section, Medicare Benefits Branch of the Department of Health and Ageing.
- Based on consultant psychiatrist attendance items rather than all services provided by consultant psychiatrists. Data also include electroconvulsive therapy services funded under the MBS although in recent years, this item has been transferred out of the MBS category of consultant psychiatrist attendances.
- All data are based on full counts of attendances, providers and benefits paid in respect of each year; and based on date of processing of Medicare accounts rather than the date on which the service was provided.
- The split of providers into full-time and part-time groups is based on the standard Department of Health and Ageing MBS schedule income split.
- Provider counts in each year ignore providers with zero or negative activity within each year. However counts of services, fees charged etc adjust for negative values.

Table A-47: National trends in consultant psychiatrist services funded under the Medicare Benefits Schedule, selected years 1984-85 to 2007-08

PRIMARY DATA	1984-85	1992-93	1997-98	2002-03	2007-08
Number of providers – part time	375	483	566	824	894
Number of providers - full time	653	1,018	1,119	1,074	1,089
No. providers - total	1,028	1,501	1,685	1,898	1,983
Total services (all services by Psychs)	1,268,413	2,014,608	2,189,434	2,071,470	1,962,071
No. patients	174,420	246,340	285,160	275,634	269,582
Total fees charged (All services by Psychs) \$M	73.9	186.7	217.4	236.3	290.4
Total schedule fees (all services by Psychs) \$M	77.5	195.3	220.7	229.4	261.7
Total psych. benefits paid (all services by Psychs) \$M	68.7	169.5	190.5	197.7	240.6
Total MBS benefits \$M - all items	2,279.9	5,018.1	6,333.5	8,115.5	13,006.5
INDICATORS					
Providers per 100,000 - Part time	2.4	2.7	3.0	4.1	4.2
Providers per 100,000 - Full Time	4.1	5.8	6.0	5.4	5.1
Providers per 100,000	6.5	8.5	9.0	9.5	9.3
Patients per 100,000	1,105	1,394	1,524	1,385	1,258
Psych. expenditure as % Total MBS	3.0%	3.4%	3.0%	2.4%	1.8%
Psych. expenditure per capita (\$)	4.35	9.60	10.18	9.93	11.23
Services per 100,000	8,034	11,403	11,701	10,408	9,155
Av. patients per provider	170	164	169	145	136
Av. services per provider	1,234	1,342	1,299	1,091	989
Av. services per patient	7.3	8.2	7.7	7.5	7.3
Av. benefits paid per provider (\$)	66,845	112,945	113,074	104,143	121,325
Av. gross fees per provider (\$)	71,885	124,410	128,993	124,510	146,447

(1) All expenditure data expressed in current prices.

(2) Patient counts based on 10% file sample for years prior to and inclusive of 1999-2000 but based on actual counts for subsequent years. Patient counts are based on Group A8 & MBS Items 855, 857, 858, 861, 864, 866 & 14224.

Source: Australian Government Department of Health and Ageing, Medicare Medicare Estimates and Statistics Section.

Table A-48: Indicators of MBS funded consultant psychiatrist services by state and territory, selected years 1992-93 to 2007-08 – Percentage of population seen, providers per 100,000 population, attendances per 100 population and MBS benefits paid per capita

State/ Territory	% Population seen			
	1992-93	1997-98	2002-03	2007-08
NSW	1.4%	1.6%	1.4%	1.3%
VIC	1.6%	1.7%	1.6%	1.4%
QLD	1.5%	1.4%	1.2%	1.2%
WA	0.9%	1.1%	1.0%	1.0%
SA	1.5%	1.8%	1.7%	1.5%
TAS	1.2%	1.0%	1.1%	0.9%
ACT	1.0%	1.4%	1.1%	1.0%
NT	0.1%	0.4%	0.5%	0.4%
Nat. Av.	1.4%	1.5%	1.4%	1.3%
	Attendances per 100 population			
	1992-93	1997-98	2002-03	2007-08
NSW	11.1	11.1	10.0	8.6
VIC	14.4	15.0	13.6	11.9
QLD	10.6	10.6	9.0	8.2
WA	6.4	6.7	5.7	5.7
SA	13.2	14.8	13.3	10.8
TAS	8.8	8.8	9.8	8.5
ACT	5.7	7.1	6.5	5.8
NT	0.9	2.6	2.4	1.8
Nat. Av.	11.3	11.7	10.4	9.1
	Providers per 100,000			
	1992-93	1997-98	2002-03	2007-08
NSW	8.4	8.6	9.1	8.7
VIC	10.4	11.5	12.2	12.0
QLD	6.9	7.5	8.2	8.0
WA	5.1	5.3	5.7	5.3
SA	11.7	12.8	13.1	13.5
TAS	7.4	7.0	7.5	7.8
ACT	n.a.	7.8	8.3	7.5
NT	n.a.	2.1	3.5	2.3
Nat. Av.	8.5	9.0	9.5	9.3
	Benefits paid per capita (\$)			
	1992-93	1997-98	2002-03	2007-08
NSW	14.31	13.73	12.00	11.08
VIC	18.33	18.56	16.44	15.06
QLD	12.50	12.10	10.02	9.29
WA	7.96	7.94	6.17	6.59
SA	17.59	18.68	16.32	13.52
TAS	10.94	10.22	10.28	8.28
ACT	7.15	7.98	7.55	7.15
NT	0.92	2.53	2.29	1.73
Nat. Av.	14.34	14.16	12.27	11.21

(1) All expenditure data expressed in 2008 constant prices.

(2) Patient counts based on 10% file sample for years prior to and inclusive of 1999-2000 but based on actual counts for subsequent years. Patient counts are based on Group A8 & MBS Items 855, 857, 858, 861, 864, 866 & 14224

Source: Australian Government Department of Health and Ageing, Medicare Medicare Estimates and Statistics Section.

Table A-49: Indicators of MBS funded consultant psychiatrist services by region of patient, selected years 1992-93 to 2007-08 – Percentage of population seen, attendances per 100 population, MBS benefits paid per capita and attendances per patient

Region	Year	Est Population	Patients seen	Benefits (\$'000)	Number of Attendances	% Pop seen	Benefits per capita (\$)	Attendances per 100 pop'n	Attendances per patient
Capital City	1992-93	11,220,543	189,070	214,453	1,661,581	1.7%	19.11	14.8	8.8
	1997-98	11,927,258	224,590	224,400	1,819,491	1.9%	18.81	15.3	8.1
	2002-03	12,653,429	215,873	205,823	1,719,781	1.7%	16.27	13.6	8.0
	2007-08	13,594,290	211,731	201,426	1,609,713	1.6%	14.82	11.8	7.6
Other Metro Centre	1992-93	1,302,811	17,160	13,658	112,556	1.3%	10.48	8.6	6.6
	1997-98	1,441,663	19,520	14,742	125,298	1.4%	10.23	8.7	6.4
	2002-03	1,588,884	20,100	14,237	124,440	1.3%	8.96	7.8	6.2
	2007-08	1,727,297	20,921	13,819	118,581	1.2%	8.00	6.9	5.7
Rest of State	1992-93	5,143,739	40,110	25,181	224,770	0.8%	4.90	4.4	5.6
	1997-98	5,342,350	40,950	25,574	233,595	0.8%	4.79	4.4	5.7
	2002-03	5,653,122	39,661	23,999	220,871	0.7%	4.25	3.9	5.6
	2007-08	6,110,195	41,772	24,981	221,408	0.7%	4.09	3.6	5.3
Nat. Av.	1992-93	17,667,093	246,340	253,298.1	1,998,957	1.4%	14.34	11.3	8.1
	1997-98	18,711,271	285,160	264,912.1	2,179,872	1.5%	14.16	11.7	7.6
	2002-03	19,895,435	275,634	244,059.5	2,065,092	1.4%	12.27	10.4	7.5
	2007-08	21,431,781	269,582	240,225.0	1,949,702	1.3%	11.21	9.1	7.2

(1) All expenditure data expressed in 2008 constant prices.

(2) Patients from unknown/other address omitted from table.

Source: Australian Government Department of Health and Ageing, Medicare Benefits Branch.

APPENDIX 13

Australian Government Pharmaceutical Benefits Scheme data

Table A-50: Australian Government benefits paid on psychiatric medicines subsidised under the Pharmaceutical Benefits Scheme, by drug class, selected years 1992-93 to 2007-08, constant prices (\$000s)

Drug class	1992-93	1997-98	2002-03	2007-08	15 year growth	Contribution to 15 year total PBS growth
Antidepressants	55,154.5	227,456.0	374,100.7	301,143.6	446%	39%
Antipsychotics	8,998.7	55,621.3	254,380.7	342,019.1	3701%	53%
Anxiolytics	17,117.2	21,058.9	20,767.1	16,308.2	-5%	0%
Hypnotics and Sedatives	18,130.7	19,502.2	16,193.9	10,562.3	-42%	-1%
Psychostimulants and Nootropics	224.0	2,809.9	5,015.1	18,204.3	8027%	3%
Highly Specialised Drugs Program (Clozapine)	–	19,779.4	34,619.6	41,026.7	2694%	7%
Total	99,625.1	346,227.7	705,077.1	729,264.4	632%	100%

(1) Includes payments made through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Schemes.

(2) All expenditure data expressed in 2008 constant prices.

Source: Australian Government Department of Health and Ageing, Pharmaceutical Benefits Branch.

Table A-51: Number of prescriptions for psychiatric medicines subsidised by the Australian Government under the Pharmaceutical Benefits Scheme, by drug class, selected years 1992-93 to 2007-08 (000s)

Drug class	1992-93	1997-98	2002-03	2007-08	15 year growth	Contribution to 15 year total PBS growth
Antidepressants	3,919	6,873	11,294	11,657	197%	88%
Antipsychotics	787	962	1,502	2,201	180%	16%
Anxiolytics	3,170	3,292	3,338	3,179	0%	0%
Hypnotics and Sedatives	3,395	3,516	3,155	2,643	-22%	-9%
Psychostimulants and Nootropics	17	163	252	393	2258%	4%
Highly Specialised Drugs Program (Clozapine)	n.a	n.a	n.a	n.a	n.a	n.a
Total	11,287	14,806	19,540	20,073	78%	100%

(1) n.a. Comprehensive data on number of scripts not available.

(2) Includes payments made through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Schemes.

Source: Australian Government Department of Health and Ageing, Pharmaceutical Benefits Branch.

APPENDIX 14

Population data

Table A-52: Mid-year population estimates ('000s), Australian states and territories 1992-93 to 2007-08

Year	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia (a)
Dec 1992	5,985.1	4,465.4	3,067.3	1,667.7	1,458.8	471.0	296.2	169.7	17,581.3
Dec 1993	6,032.8	4,478.8	3,148.1	1,689.0	1,463.6	472.5	299.9	172.3	17,760.0
Dec 1994	6,090.3	4,500.4	3,223.0	1,716.6	1,467.5	473.4	302.4	175.0	17,951.5
Dec 1995	6,168.8	4,539.8	3,303.4	1,749.3	1,471.2	474.1	305.8	180.5	18,196.1
Dec 1996	6,244.0	4,579.4	3,368.0	1,780.4	1,477.4	474.3	309.2	184.6	18,420.3
Dec 1997	6,306.9	4,615.5	3,421.6	1,807.4	1,485.0	472.8	308.7	188.3	18,609.1
Dec 1998	6,373.6	4,661.7	3,472.9	1,836.1	1,493.6	471.9	310.5	191.3	18,814.3
Dec 1999	6,448.0	4,713.2	3,530.8	1,861.8	1,502.4	471.6	313.5	194.3	19,038.3
Dec 2000	6,527.4	4,770.0	3,592.4	1,887.7	1,508.0	471.4	316.8	196.3	19,272.6
Dec 2001	6,605.1	4,833.4	3,670.8	1,914.0	1,516.7	472.3	320.8	198.3	19,534.0
Dec 2002	6,649.5	4,892.5	3,764.7	1,937.6	1,525.9	474.9	324.1	199.3	19,771.0
Dec 2003	6,688.7	4,952.2	3,857.1	1,967.9	1,536.3	480.8	326.0	200.6	20,011.9
Dec 2004	6,728.9	5,014.0	3,946.0	1,998.8	1,545.5	484.6	328.2	203.8	20,252.1
Dec 2005	6,786.4	5,085.5	4,043.8	2,037.3	1,559.4	488.5	332.4	208.4	20,544.1
Dec 2006	6,858.6	5,170.6	4,139.7	2,084.7	1,576.5	491.8	337.1	212.3	20,873.7
Dec 2007	6,943.9	5,262.4	4,242.8	2,138.1	1,593.5	495.4	342.1	217.4	21,237.9

(a) Prior to September quarter 1993, Jervis Bay Territory is included in estimates for the Australian Capital Territory. 'Other Territories' include Christmas Island, the Cocos (Keeling) Islands and Jervis Bay Territory from September quarter 1993. Australia includes 'Other Territories' from September quarter 1993. 'Other Territories' include Christmas Island, the Cocos (Keeling) Islands and Jervis Bay Territory.

Source: Australian Bureau of Statistics. 3101.0 Australian Demographic Statistics, Table 4. Estimated Resident Population, States and Territories, released at 3 Dec 2009.

APPENDIX 15

Contacts for information about mental health services

The following contacts are provided for further information on mental health policy or services in Australia.

AUSTRALIAN GOVERNMENT

Monitoring and Evaluation Section
Mental Health Reform Branch
Mental Health and Chronic Disease Division
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601
Phone: (02) 6289 1555

NORTHERN TERRITORY

Mental Health Policy and Program Management Branch
Department of Health and Community Services
PO Box 40596
CASUARINA NT 0811
Phone: (08) 8999 2916

NEW SOUTH WALES

Mental Health and Drug and Alcohol Office
NSW Health Department
Locked Mail Bag 961
NORTH SYDNEY NSW 2059
Phone: (02) 9391 9307

VICTORIA

Mental Health, Drugs and Regions Division
Department of Health
GPO Box 4057
MELBOURNE VIC 3001
Phone: (03) 9096 0790

QUEENSLAND

Mental Health Branch
Queensland Health
GPO Box 48
BRISBANE QLD 4001
Phone: (07) 3235 9474

WESTERN AUSTRALIA

Mental Health Commission
81 St Georges Terrace
PERTH WA 6000
Phone: (08) 6272 1200

SOUTH AUSTRALIA

Mental Health Unit
Department of Health
PO Box 287
Rundle Mall
ADELAIDE SA 5000
Phone: (08) 8226 6286

TASMANIA

Mental Health Services
Department of Health and Human Services
GPO Box 125
HOBART TAS 7001
Phone: (03) 6230 7711

AUSTRALIAN CAPITAL TERRITORY

Mental Health ACT
ACT Health
GPO Box 825
CANBERRA ACT 2601
Phone: (02) 6207 1066