
13 Services for mental health interpretative material

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The Services for mental health interpretative material is supporting material and includes explanations of why indicators have been chosen, and wherever possible, a link to the stated objectives of the service. It includes indicator definitions, technical details defining how the indicator is measured and guidance on how the indicator is to be interpreted, including caveats and the indicator's completeness and comparability status.

Further information on the Report on Government Services including other reported service areas, the glossary and list of abbreviations is available at <https://www.pc.gov.au/research/ongoing/report-on-government-services>.

13.1 Indicators

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

The comparability of performance indicator results is shaded in indicator interpretation boxes, figures and section and data tables as follows:

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are either not comparable (subject to caveats) within jurisdictions over time or are not comparable across jurisdictions or both.

The completeness of performance indicator results is shaded in indicator interpretation boxes, figures and section and data tables as follows:

- Data are complete (subject to caveats) for the current reporting period. All required data are available for all jurisdictions.
- Data are incomplete for the current reporting period. At least some data were not available.

Outputs

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

Equity

Access — mental health service use by selected community groups

‘Mental health service use by selected community groups’ is an indicator of governments’ objective to provide services in an equitable manner (box 13.1).

Box 13.1 Mental health service use by selected community groups

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

- the proportion of the population in a selected community group using the service, compared to the proportion of the population outside the selected community group, for each of:
 - State and Territory governments’ specialised public mental health services
 - MBS/ DVA subsidised mental health services.

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

Results for this indicator should be interpreted with caution. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for the State and Territory governments’ specialised public mental health services’ measure are:

- comparable (subject to caveats) across jurisdictions and over time.
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions.

Data reported for the MBS/ DVA subsidised services for mental health measure are:

- comparable (subject to caveats) across jurisdictions and over time (from 2011-12 onwards by geographic location and SEIFA).
- incomplete (subject to caveats) for the current reporting period. 2018-19 MBS data by Indigenous status are not available for reporting.

Effectiveness

Access — timely access to mental health care

‘Timely access to mental health care’ is an indicator of governments’ objective to provide services in a timely manner (box 13.2).

Box 13.2 **Timely access to mental health care**

‘Timely access to mental health care’ is defined as the proportion of people who present to an emergency department with a mental health related care need (principal diagnosis of F00–F99) seen within clinically recommended waiting times.

The proportion of people seen within clinically recommended waiting times is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:

- triage category 1: need for resuscitation — patients seen immediately
- triage category 2: emergency — patients seen within 10 minutes
- triage category 3: urgent — patients seen within 30 minutes
- triage category 4: semi urgent — patients seen within 60 minutes
- triage category 5: non urgent — patients seen within 120 minutes.

High or increasing proportions of patients seen within the recommended waiting times is desirable. Contextual data for all presentations (not just those with a mental health related care need) are reported in section 12.

This is a partial measure for this indicator as emergency departments are only one of many services that provide access to mental health care. Future reporting will focus on timely access to State and Territory governments’ specialised public mental health services and MBS subsidised services for mental health.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
 - complete (subject to caveats) for the current reporting period. All required 2018-19 are available for all jurisdictions.
-

Access — affordability of mental health care

‘Affordability of mental health care’ is an indicator of governments’ objective to provide services that are affordable (box 13.3).

Box 13.3 Affordability of mental health care

‘Affordability of mental health care’ is defined by three measures:

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

A low or decreasing proportion for each measure is desirable.

Data are not yet available for reporting against this indicator.

Access — mental health service use estimates

‘Mental health service use estimates’ is an indicator of governments’ objective to provide services that are readily available to those who need them (box 13.4).

Box 13.4 Mental health service use estimates

‘Mental health service use estimates’ is defined as the estimated proportion of the population with a mental health condition receiving a mental health service.

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

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

Appropriateness — primary mental health care for children and young people

‘Primary mental health care for children and young people’ is an indicator of governments’ objective to facilitate early detection of mental health issues and mental illness, followed by appropriate intervention (box 13.5).

Box 13.5 Primary mental health care for children and young people

'Primary mental health care for children and young people' is defined as the proportion of young people aged under 25 years who received a mental health care service subsidised through the MBS from a GP, psychologist or other allied health professional.

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

Results for this indicator should be interpreted with caution. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. In addition, this indicator does not provide information on whether the services are appropriate for the needs of the young people receiving them, or correctly targeted to those young people most in need. Further, some primary mental health services for children and young people are excluded from these data; for example, community health centres, school and university counsellors and health nurses and some mental health care provided by State and Territory governments' specialised mental health services (NMHPSC 2011a).

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
 - complete (subject to caveats) for the current reporting period. All required 2019-20 data are available for all jurisdictions.
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Appropriateness — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective to provide universal access to services that are responsive to consumer and carer goals (box 13.6).

Box 13.6 Consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is defined by two measures, the number of paid FTE:

- consumer workers per 1000 FTE direct care staff
- carer workers per 1000 FTE direct care staff.

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

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and (from 2010-11) over time.
 - complete for the current reporting period. All required 2018-19 data are available for all jurisdictions.
-

Quality — safety — services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide universal access to services that are high quality (box 13.7).

Box 13.7 **Services reviewed against the National Standards**

Services reviewed against the National Standards’ is defined as the proportion of expenditure on State and Territory governments’ specialised public mental health services that had completed a review by an external accreditation agency against the National Standards for Mental Health Services (NSMHS) and met ‘all standards’ (level 1). The assessment levels are defined in sub-section 13.2.

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

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

Data reported for this indicator are:

- not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
 - complete (subject to caveats) for the current reporting period. All required 30 June 2019 data are available for all jurisdictions.
-

Quality — safety — restrictive practices

‘Restrictive practices’ is an indicator of governments’ objective to provide access to services that are safe (box 13.8).

Box 13.8 **Restrictive practices**

‘Restrictive practices’ is defined by two measures:

- ‘Seclusion rate’, defined as the number of seclusion events per 1000 bed days in State and Territory governments’ specialised mental health acute inpatient units
- ‘Restraint rate’, defined by two sub measures:
 - the number of mechanical restraint events per 1000 bed days in State and Territory governments’ specialised mental health acute inpatient units
 - the number of physical restraint events per 1000 bed days in State and Territory governments’ specialised mental health acute inpatient units.

Seclusion involves a patient being confined at any time of the day or night alone in a room or area from which he or she cannot leave (sub-section 13.2 provides further details on seclusion and ‘seclusion events’). Legislation or mandatory policy governs the use of seclusion in each State and Territory and may result in exceptions to the definition of a seclusion event and variations in the data collected across jurisdictions (NMHPSC 2011b).

Restraint is defined as the restriction of an individual’s freedom of movement by physical or mechanical means. Sub-section 13.2 provides further details on mechanical and physical restraint.

A low or decreasing number of seclusion and restraint events per 1000 bed days in specialised public mental health inpatient units is desirable.

Supporting data on the duration of seclusion events are provided in table 13A.25. These data, when considered with the rate of seclusion, provide information on the use and management of seclusion within each jurisdiction. A low rate of seclusion events combined with shorter average durations is desirable.

Data reported for the first measure are:

- comparable across jurisdictions (subject to caveats) and over time.
- complete (subject to caveats) for the current reporting period. All required data for 2019-20 are available for all jurisdictions.

Data reported for the second measure are:

- not comparable across jurisdictions or over time.
- complete (subject to caveats) for the current reporting period. All required data for 2019-20 are available for all jurisdictions.

Quality — responsiveness — consumer and carer experiences of mental health services

‘Consumer and carer experiences of mental health services’ is an indicator of governments’ objective to provide access to services that are responsive to consumer and carer goals (box 13.9).

Box 13.9 **Consumer and carer experiences of mental health services**

‘Consumer and carer experiences of mental health services’ is defined by two measures:

- the proportion of mental health service consumers reporting positive experiences of mental health services
- the proportion of carers of mental health service consumers reporting positive experiences of mental health services

A high or increasing proportion of mental health consumers and carers with positive experiences of service is desirable. Data are reported by service delivery setting (residential care, admitted care and ambulatory care — see sub-section 13.2 for definitions).

Data reported for the first measure are:

- not comparable across jurisdictions, but are comparable within jurisdictions over time.
- incomplete for the current reporting period. 2018-19 data are only available for NSW, Victoria and Queensland.

Data are not yet available for reporting on the second measure.

Quality — continuity — community follow-up after psychiatric admission/hospitalisation

‘Community follow-up after psychiatric admission/hospitalisation’ is an indicator of governments’ objective to provide services that are coordinated and provide continuity of care (box 13.10).

Box 13.10 Community follow-up after psychiatric admission/hospitalisation

'Community follow-up after psychiatric admission/hospitalisation' is defined as the proportion of State and Territory governments' specialised public admitted patient overnight acute separations from psychiatric units for which a community-based ambulatory contact was recorded in the seven days following separation.

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

This indicator does not measure the frequency of contacts recorded in the seven days following separation. Neither does it distinguish between the mode of contact. Only follow-up contacts made by State and Territory governments' specialised public mental health services are included.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions

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

'Readmissions to hospital within 28 days of discharge' is an indicator of governments' objective to provide services that are coordinated and provide continuity of care (box 13.11).

Box 13.11 Readmissions to hospital within 28 days of discharge

'Readmissions to hospital within 28 days of discharge' is defined as the proportion of State and Territory governments' admitted patient overnight separations from psychiatric acute inpatient units that were followed by readmission to the same type of unit within 28 days of discharge.

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

While readmissions can indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate, they can also be affected by other factors such as the cyclic and episodic nature of some illnesses.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions.

Sustainability — workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable services (box 13.12).

Box 13.12 **Workforce sustainability**

‘Workforce sustainability’ reports age profiles for the mental health workforce. It shows the proportion of full time equivalent (FTE) medical practitioners (including psychiatrists), mental health nurses, registered psychologists and other allied mental health practitioners in ten year age brackets, by jurisdiction.

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

These measures are not a substitute for a full workforce analysis comprising assessment of migration patterns, trends in full time work, recruitment and retention, workforce efficiency, service quality and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for services for mental health.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
 - complete (subject to caveats) for the current reporting period. All required 2019 data are available for all jurisdictions.
-

Efficiency

The efficiency indicators reported here cover State and Territory governments' specialised mental health services.

Cost of care

'Cost of care' is an indicator of governments' objective that services are delivered in an efficient manner (box 13.13).

Box 13.13 Cost of care

'Cost of care' has three measures.

- 'Cost of inpatient care', defined by two sub measures:
 - 'Cost per inpatient bed day', defined as expenditure on inpatient services divided by the number of inpatient bed days — data are disaggregated by hospital type (psychiatric and general hospitals) and care type (acute and non-acute units) and by inpatient target population (acute units only).
 - 'Average length of stay', defined as the number of inpatient patient days divided by the number of separations in the reference period — data are disaggregated by inpatient target population (acute units only). Patient days for consumers who separated in the reference period (2018-19) that were admitted during the previous period (2017-18) are excluded. Patient days for consumers who remain in hospital (that is, are not included in the separations data) are included.

These sub measures are considered together for the inpatient acute units by target population to provide a 'proxy' measure to improve understanding of service efficiency. Average inpatient bed day costs can be reduced with longer lengths of stay because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care. Data for forensic services are included for costs per inpatient bed day only, as the length of stay is dependent on factors outside the control of these services.

- 'Cost of community-based residential care' is defined as the average cost per patient day. Data are reported for both the care of adults and older people.
- 'Cost of ambulatory care' is defined by two sub measures:
 - average cost per treatment day
 - average number of treatment days per episode – this measure is provided, along with average costs, as frequency of servicing is the main driver of variation in care costs.

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

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Box 13.13 (continued)

Mainstreaming has occurred at different rates across states and territories, with some jurisdictions treating a greater proportion of consumers with severe mental illnesses in community-based services than other jurisdictions (see sub-section 13.2 for a definition of mainstreaming). This can create differences across states and territories in the mix of consumers, and therefore the costs, within service types.

Data reported for all three measures are:

- comparable (subject to caveats) across jurisdictions and over time.
- complete (subject to caveats) for the current reporting period. All required 2018-19 data are available for all jurisdictions.

Outcomes

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

Prevalence of mental illness

‘Prevalence of mental illness’ is an indicator of governments’ objective to, where possible, prevent the development of mental health problems, mental illness and suicide (box 13.14).

Box 13.14 Prevalence of mental illness

‘Prevalence of mental illness’ is defined as the proportion of the total population who have a mental illness.

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

Many of the risk and protective factors that can affect the development of mental health problems and mental illness are outside the scope of the mental health system. These include environmental, sociocultural and economic factors, some of which can increase the risk of mental illness while others can support good mental health.

Not all mental illnesses are preventable and a reduction in the effect of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions.
- complete (subject to caveats) for the most recent reporting period of 2007. A new ABS survey of mental health and wellbeing is scheduled for 2020-2021 with data anticipated to be available in 2021-2022.

Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective to, where possible, prevent the development of mental health problems, mental illness and suicide (box 13.15).

Box 13.15 **Mortality due to suicide**

‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. Deaths from suicide are defined as causes of death with the International Classification of Diseases (ICD) 10 codes X60–X84 and Y87.0.

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

While services for mental health contribute to reducing suicides, other services also have a significant role including public mental health programs and suicide prevention programs (addressed through the initiatives of other government agencies, NGOs and other special interest groups).

Many factors outside the control of services for mental health can influence a person’s decision to die by suicide. These include environmental, sociocultural and economic risk factors. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time for some years and disaggregations but not comparable for other years and disaggregations.
 - complete (subject to caveats) for the current reporting period. All required 2019 data are available for all jurisdictions.
-

Physical health outcomes for people with a mental illness

‘Physical health outcomes for people with a mental illness’ is an indicator of governments’ objective to promote recovery and physical health and encourage meaningful participation in society (box 13.16).

Box 13.16 **Physical health outcomes for people with a mental illness**

‘Physical health outcomes for people with a mental illness’ is defined as the proportion of adults with a mental illness (compared to those without a mental illness) who experienced a long-term physical health condition: cancer, diabetes, arthritis, cardiovascular disease and asthma.

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

People with a mental illness have poorer physical health outcomes than people without mental illness (Happell et al. 2015; Lawrence, Hancock and Kisely 2013), but the relationship between the two is complex. Poor physical health can exacerbate mental health problems and poor mental health can lead to poor physical health. In addition, some psychiatric medications prescribed to treat mental health conditions may lead to poorer physical health.

Greater exposure to particular health risk factors can also contribute to poorer physical health. Information on selected risk factors by mental illness status can be found in table 13A.56.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
 - complete (subject to caveats) for the current reporting period. All required 2017-18 data are available for all jurisdictions
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Social and economic inclusion of people with a mental illness

‘Social and economic inclusion of people with a mental illness’ is an indicator of governments’ objective to promote recovery and physical health and encourage meaningful participation in society (box 13.17).

Box 13.17 **Social and economic inclusion of people with a mental illness**

‘Social and economic inclusion of people with a mental illness’ is defined by two measures, with the proportion of people:

- aged 16–64 years with a mental illness who are employed
- aged 15 years or over with a mental illness who had face-to-face contact with family or friends living outside the household in the past week

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

This indicator does not provide information on whether the employment, education or social activities participated in were appropriate or meaningful. It also does not provide information on why people who were not employed were not looking for work (for example, those outside the labour force).

Data reported for both measures are:

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

Data reported for the first measure are:

■ complete (subject to caveats) for the current reporting period. All required 2017-18 data are available for all jurisdictions.

Data reported for the second measure are:

■ complete for the current reporting period. 2019 data are only available at the national level due to the introduction of an annual collection of data (previously every 4 years) with a smaller sample size resulting in high sampling error.

Mental health outcomes of consumers of specialised public mental health services

‘Mental health outcomes of consumers of specialised public mental health services’ is an indicator of governments’ objective to promote recovery and physical health and encourage meaningful participation in society (box 13.18).

Box 13.18 Mental health outcomes of consumers of specialised public mental health services

'Mental health outcomes of consumers of specialised public mental health services' is defined as the proportion of people receiving care who had a significant improvement in their clinical mental health outcomes, by service type. Sub-section 13.2 provides information on how the consumer outcomes average score is derived.

Outcomes are calculated for the following consumer groups:

- Group A: Consumers separated from hospital. People who received a discrete episode of inpatient care within a State/Territory designated psychiatric inpatient unit during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.
- Group B: Consumers discharged from community-based ambulatory care. People who received relatively short-term community care from a State/Territory mental health service during the reference year. The defining characteristic of the group is that the episode of care commenced, and was completed, within the year.
- Group C: Consumers in ongoing community-based ambulatory care. People receiving relatively long-term community care from a State/Territory mental health service. It includes people who were receiving care for the whole of the reference year, and those who commenced community care sometime after 1 July who continued under care for the rest of the year. The defining characteristic of the group is that all remained in ongoing care when the year ended (30 June).

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

Supplementary data are reported on the proportion of people receiving care who experienced no significant change or a significant deterioration in their mental health outcomes. Information on the proportion of episodes for which completed outcomes data are available is in table 13A.61.

This indicator has a number of issues:

- The outcome measurement tool is imprecise as a single 'average score' does not reflect the complex service system in which services are delivered across multiple settings and provided as both discrete, short-term episodes of care and prolonged care over indefinite periods (AHMC 2012).
- The approach separates a consumer's care into segments (hospital versus the community) rather than tracking his or her overall outcome across treatment settings.
- Consumers' outcomes are measured from the clinician's perspective rather than the consumer's.

Data reported for this indicator are:

- comparable (subject to caveats) across jurisdictions and over time.
- complete (subject to caveats) for the current reporting period. All required data for 2018-19 are available for all jurisdictions.

Stigma and discrimination experienced by people living with mental health problems or mental illness

‘Stigma and discrimination experienced by people living with mental health problems or mental illness’ is an indicator of governments’ objective to reduce the impact of mental illness (including the effects of stigma and discrimination) (box 13.19).

Box 13.19 Stigma and discrimination experienced by people living with mental health problems or mental illness

‘Stigma and discrimination experienced by people with a mental health condition’ is defined by two measures:

- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly
- the proportion of people with a mental health condition who have experienced discrimination or been treated unfairly because of their mental health condition.

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

Data reported for the first measure are:

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

■ complete for the current reporting period. 2019 data are only available at the national level due to the introduction of an annual collection of data (previously every 4 years) with a smaller sample size resulting in high sampling error.

Data are not yet available for reporting against the second measure.

13.2 Definitions of key terms

Accrued mental health patient days Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services.

Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services. The days to be counted are only those days occurring within the reference period, which is from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

In short, the number of accrued mental health care days are calculated as follows:

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

Admitted care A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by

	health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.
Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment. Acute services can: <ul style="list-style-type: none"> • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, youth and forensic mental health services.
Ambulatory care	A specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training. Ambulatory mental health services include: <ul style="list-style-type: none"> • community-based crisis assessment and treatment teams; • day programs; • mental health outpatient clinics provided by either hospital or community-based services; • child and adolescent outpatient and community teams; • social and living skills programs; • psychogeriatric assessment services; • hospital-based consultation-liaison and in-reach services to admitted patients in non-psychiatric and hospital emergency settings; • ambulatory-equivalent same day separations; • home based treatment services; and • hospital based outreach services
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder.
Carer staff	A person specifically employed for the expertise developed from their experience as a mental health carer.
Child and adolescent services	These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.
Community-based residential care	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care on an overnight basis in a domestic-like environment for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Comparability	Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data.
Completeness	Data are considered complete if all required data are available for all jurisdictions that provide the service.
Consumer staff	A person specifically employed for the expertise developed from their lived experience of mental illness.
Forensic mental health	Services principally providing assessment, treatment and care of mentally ill

services	people whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18-65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, services that cannot be described as specialised child and adolescent services, youth services, services for older people or forensic services. General mental health services include hospital units with a principal function to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, postnatal depression, anxiety disorders).
General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients.
Health management	The ongoing process beginning with initial consumer contact and including all actions relating to the consumer. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Mainstreaming	The First National Mental Health Plan emphasised decreasing the number of psychiatric beds in favour of community-based options, reducing the reliance on stand-alone psychiatric hospitals, and 'mainstreaming' the delivery of acute inpatient care into general hospitals.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
National Standards for Mental Health Services (NSMHS)	Services at level 1 — services reviewed by an external accreditation agency and judged to have met all National Standards. Services at level 2 — services reviewed by an external accreditation agency and judged to have met some but not all National Standards. Services at level 3 — services (i) in the process of being reviewed by an external accreditation agency but the outcomes are not known, or (ii) booked for review by an external accreditation agency. Services at level 4 — services that do not meet criteria detailed under levels 1 to 3 (AHMC 2010).
Non-acute services	Non-acute services are defined by two categories: <ul style="list-style-type: none"> • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to midterm. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unrelenting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
Non-government organisations (NGOs)	Private not-for-profit community managed organisations that receive government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the NGO sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.

Older persons mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outcomes measurement — calculating the consumers 'score'.	The assessment of a consumer's clinical mental health outcomes is based on the changes reported in a consumer's 'score' on a rating scale known as the Health of the Nation Outcomes Scale (HoNOS), or for children and adolescents, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Outcome scores are classified based on effect size — a statistic used to assess the magnitude of a treatment effect (AHMC 2012). The effect size is based on the ratio of the difference between the pre and post scores to the standard deviation of the pre score. Individual episodes are classified as 'significant improvement' if the effect size index is greater than or equal to positive 0.5; 'no change' if the index is between 0.5 and -0.5; and 'significant deterioration' if the effect size index is less than or equal to -0.5 (AHMC 2012).
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services — hospital based	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals. They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met:
	<ul style="list-style-type: none"> • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Psychiatrist	A medical practitioner with specialist training in psychiatry.
Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around the clock, comprehensive, qualified nursing services, as well as other necessary professional services.
Restraint	Mechanical restraint: The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that

restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Physical restraint:

The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.

Schizophrenia

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

Seclusion

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

The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition (AIHW 2015).

Seclusion event

An event is when a consumer enters seclusion and when there is a clinical decision to cease seclusion. Following the clinical decision to cease seclusion, if a consumer re-enters seclusion within a short period of time this would be considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episode' used across jurisdictions (NMHPSC 2011b).

Separation

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

Specialised mental health inpatient services

Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.

Specialised mental health services

Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.

Specialised residential services

Services provided in the community that are staffed by mental health professionals on a non 24 or 24 hour basis.

Staffing categories (mental health)	<p>Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee for service basis.</p> <p>Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.</p> <p>Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.</p> <p>Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.</p> <p>Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.</p> <p>Registered nurses: people with at least a three-year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.</p> <p>Enrolled nurses: refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the State registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).</p> <p>Diagnostic and health professionals (allied health professionals): qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.</p> <p>Social workers: people who have completed recognised training and are eligible for membership of the Australian Association of Social Workers.</p> <p>Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.</p> <p>Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.</p> <p>Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.</p> <p>Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.</p> <p>Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.</p>
Substance use disorders	<p>Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).</p>
Youth mental health services	<p>Services principally targeting children and young people generally aged 16-24 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.</p>

13.3 References

- AHMC (Australian Health Ministers' Conference) 2010, *National Standards for Mental Health Services 2010*, Canberra.
- 2012, *Council of Australian Governments National Action Plan for Mental Health 2006–2011: Progress Report 2009 10*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council).
- AIHW (Australian Institute of Health and Welfare) 2015, *Seclusion*, Meteor Metadata Online Registry, <http://meteor.aihw.gov.au/content/index.phtml/itemId/557975> (accessed 18 December 2017).
- Happell, B., Platania Phung, C., Webster, S., McKenna, B., Millar, F., Stanton, R., Galletly, C., Castle, D., Furness, T., Liu, D. and Scott, D 2015, 'Applying the World Health Organization Mental Health Action Plan to evaluate policy on addressing co-occurrence of physical and mental illnesses in Australia', *Australian Health Review*, Vol. 39, pp. 370–378, CSIRO Publishing (available at <http://dx.doi.org/10.1071/AH14098>).
- Lawrence, D., Hancock, K. and Kisely S. 2013, 'The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers', *British Medical Journal*, Vol. 346.
- NMHPSC (National Mental Health Performance Subcommittee) 2011a, The Fourth National Mental Health Plan Measurement Strategy 2011, Report produced for the Australian Health Ministers Advisory Council Mental Health Standing Committee, <https://www.aihw.gov.au/getmedia/d8e52c84-a53f-4eef-a7e6-f81a5af94764/Fourth-national-mental-health-plan-measurement-strategy-2011.pdf.aspx> (accessed 17 December 2019).
- 2011b, Key performance indicators for Australian public mental health services: second edition 2011, Report produced for the Australian Health Ministers Advisory Council Mental Health Standing Committee, <https://www.aihw.gov.au/getmedia/3c6614bb-87fd-4328-b276-f69542082a7c/Key-performance-indicators-for-Australian-public-mental-health-services-second-edition-2011.pdf.aspx> (accessed 17 December 2019).