
2.4 Trends in state and territory mental health services

KEY MESSAGES:

- Between 1992-93 and 2010-11, annual state and territory government spending on services provided in general hospitals and the community grew by \$2.6 billion, or 283%. This was accompanied by a decrease in spending on stand-alone psychiatric hospitals of \$289 million, or 35%. About two thirds of the \$2.6 billion was invested in community-based services (ambulatory care services, services provided by non-government organisations or NGOs, and residential services). The remaining third was spent on increased investment in psychiatric units located in general hospitals.
- Funding to ambulatory care services increased between 1992-93 and 2010-11 by 291% (from \$421 million to \$1.6 billion). Over the same period, the full-time equivalent direct care workforce in these services also increased, but not by the same magnitude (215%).
- The non-government community support sector's share of the mental health budget increased from 2.1% to 9.3%, with \$372 million allocated to NGOs in 2010-11. Psychosocial support services account for about one third of this funding, and staffed residential mental health services accounted for about one fifth.
- Community residential support services expanded between 1992-93 and 2010-11. The number of 24 hour staffed general adult beds doubled (from 410 to 846). The number of 24 hour staffed older persons' beds was also higher in 2010-11 (682) than it was in 1992-93 (414) although it reached a peak in 1998-99 (805) and has been declining since then. The number of non-24 hour staffed beds in general adult residential services and the number of supported public housing places also increased with time.
- The number and mix of inpatient beds has changed during the course of the National Mental Health Strategy. There were significant decreases in beds in stand-alone psychiatric hospitals in the early years of the Strategy, particularly non-acute beds and general adult and older persons' beds. These decreases have been followed by more gradual declines in recent years. The decreases have been accompanied by commensurate increases in psychiatric beds in general hospitals, particularly acute beds. The average bed day costs in inpatient settings have increased (by 77% in stand-alone hospitals and by 51% in general hospitals).

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*. Each of the four *National Mental Health Plans* has 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 towards community-based care;
- stand-alone hospitals consumed half of the total mental health spending by states and territories;
- less than 2% of resources were allocated to non-government programs aimed at supporting people in the community.

Agreement on a national approach to mental health reform committed state and territory governments to 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 1992-93, the *First National Mental Health Plan* promoted the integration of inpatient and community services into cohesive mental health programs. The *Second, Third* and *Fourth National Mental Health Plans* continued this direction, but expanded the focus of reform to additional activities to complement development of the specialist mental health system.

Previous *National Mental Health Reports* have provided evidence of significant change in the direction advocated by the Strategy, although this change has been variable across 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 information published in previous *National Mental Health Reports* and presents a summary of progress to 2010-11.

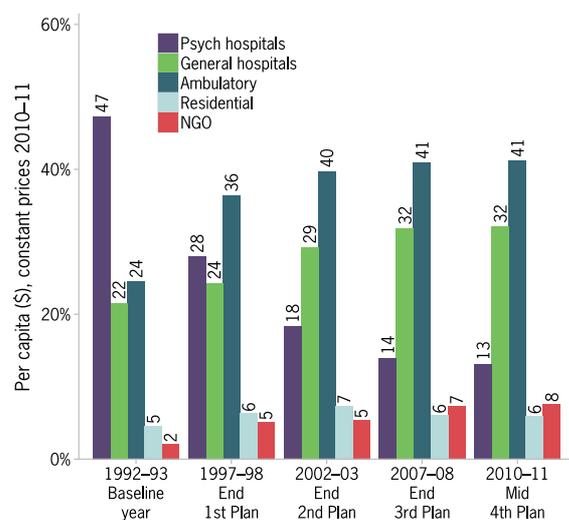
Investment in service mix reform

Information collected through the annual National Minimum Data Set – 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 17 shows the relative proportions of the total state and territory mental health budgets that were spent on various types of services between 1992-93 and 2010-11. Annual spending on stand-alone psychiatric hospitals decreased by 35% (\$289 million), taking their share of total spending on services from 47% to 13%. Annual spending on services provided in general hospitals and in the community grew by 283%, equivalent to \$2.6 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*.

Figure 17
Distribution of total state and territory expenditure on mental health services, 1992-93 to 2010-11^a



(a) NGO managed residential services are included in the 'Residential' category.

Expansion of community-based services

About two thirds of the \$2.6 billion growth in annual spending on services to replace stand-alone hospitals has been invested in expansion of community-based services – most notably ambulatory care services (48%), but also services provided by NGOs (11%) and residential services (6%). The remainder is accounted for by increased investment in psychiatric units located in general hospitals (36%). Each of these developments is described in more detail below.

Ambulatory care

Ambulatory care services comprise 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.

Figure 18 shows that there has been significant growth in the resources directed to ambulatory mental health care services during the course of the National Mental Health Strategy. Between 1992-93 and 2010-11, there was a 291% increase in expenditure on ambulatory services (from \$421 million to \$1.6 billion). Over the same period, the full-time equivalent direct care workforce employed in ambulatory settings increased by 215% (from 3,358 to 10,592). In per capita terms, this is an increase from 19.1 per 100,000 population to 47.1 per 100,000 population (see Figure 19).

All jurisdictions have more than doubled their ambulatory care workforce over the course of the Strategy. Two (Western Australia and Queensland) stand out with increases of 307% and 440%, respectively. More detail on jurisdictions' performance can be found in Part 4.

Figure 18 also shows that growth in expenditure has outstripped growth in the direct care workforce, even when inflation is taken into account. The implication is that more dollars have not proportionally translated into increased staffing levels in state and territory ambulatory services. Nationally, the purchasing power of the

mental health dollar in 2010-11 was 24% less than in 1992-93 when measured by the number of staff employed in ambulatory care. 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. As noted later in this report, similar cost increases have occurred in inpatient services.

Figure 18
Changes in resourcing of ambulatory care services, 1992-93 to 2010-11

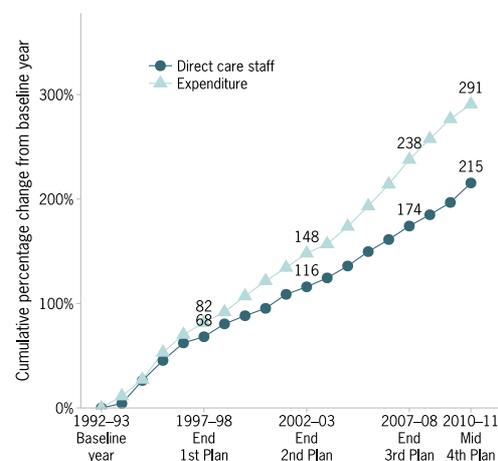
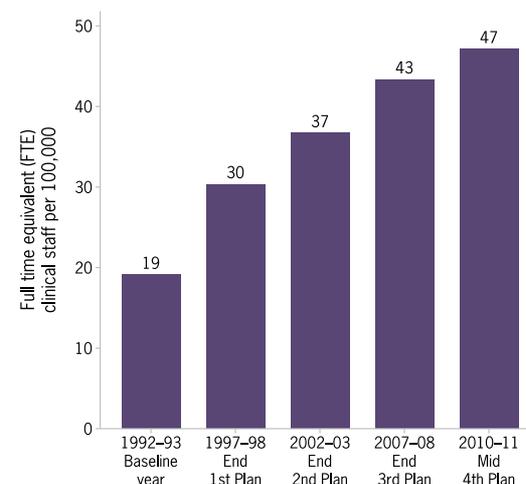


Figure 19
Full-time equivalent (FTE) direct care staff per 100,000 population employed in ambulatory mental health care services, 1992-93 to 2010-11



These indicators provide a simplified view of the collective progress of the states and territories. However, they do not tell us about the workforce levels required to meet priority community needs, nor about the amount of care actually provided. The National Mental Health Service Planning Framework, mentioned above, will establish targets for the optimal mix and level of the full range of mental health services, including ambulatory services.

The non-government community support sector

The non-government community support sector includes services provided by not-for-profit NGOs, funded by governments to provide support for 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.

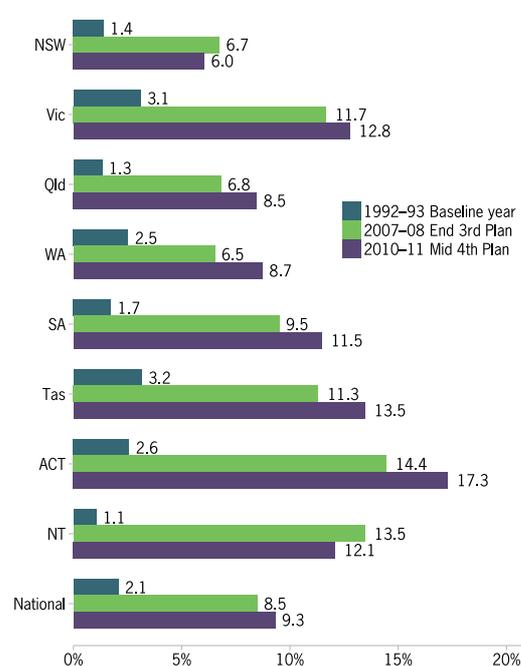
From the outset, the National Mental Health Strategy advocated the expansion of the role of NGOs in providing support services to consumers and carers whose lives are affected by mental illness. Expansion of the sector was promoted as a means to strengthen community support and develop service approaches that complement the clinical services provided by inpatient services and community teams. More recently, the COAG *National Action Plan on Mental Health* renewed the call to elevate the priority of the NGO sector, and stimulated a major expansion of funding by most jurisdictions.

Figure 20 shows that the overall proportion of mental health budgets allocated to NGOs before the National Mental Health Strategy began was only 2.1%. This share grew during the course of the *First* and *Second National Mental Health Plans*, such that by the end of the *Third Plan* (2007-08), 8.5% of state and territory mental health budgets was directed to the sector. Mid-way through the *Fourth Plan*, the figure now sits at 9.3%. Total state and territory funding allocated to NGOs in 2010-11 amounted to \$372 million, distributed to a broad range of

organisations from some very small entities employing only a few workers to complex, multi-million dollar organisations.^c

Figure 20 also shows that despite the significant growth in recent years, differences between jurisdictions remain prominent. By 2010-11, the 'NGO share' was strongest in the Australian Capital Territory (17.3%) and lowest in New South Wales (6.0%).

Figure 20
Percentage of total mental health services expenditure allocated to non-government organisations, 1992-93 to 2010-11



^c 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 purposes of the analysis in this section, funding to NGO-managed staffed residential services (approximately \$66 million in 2010-11) has been combined with non-residential NGO programs to ensure better consistency in monitoring the 18 year spending trends. The 2010-11 estimate of 9.3% of expenditure allocated to NGOs described in this section differs from the 7.6% shown in Figure 17 because, in the latter, NGO-managed residential programs are grouped with other residential services.

Previous *National Mental Health Reports* have observed that the role played by NGOs varies across the jurisdictions, reflecting differences in the extent to which states and territories fund the organisations that take on the functions that substitute 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 21 shows the national profile of NGO services funded by states and territories in 2010-11. Psychosocial support services account for about one third of the funding, and staffed residential mental health services account for about one fifth.

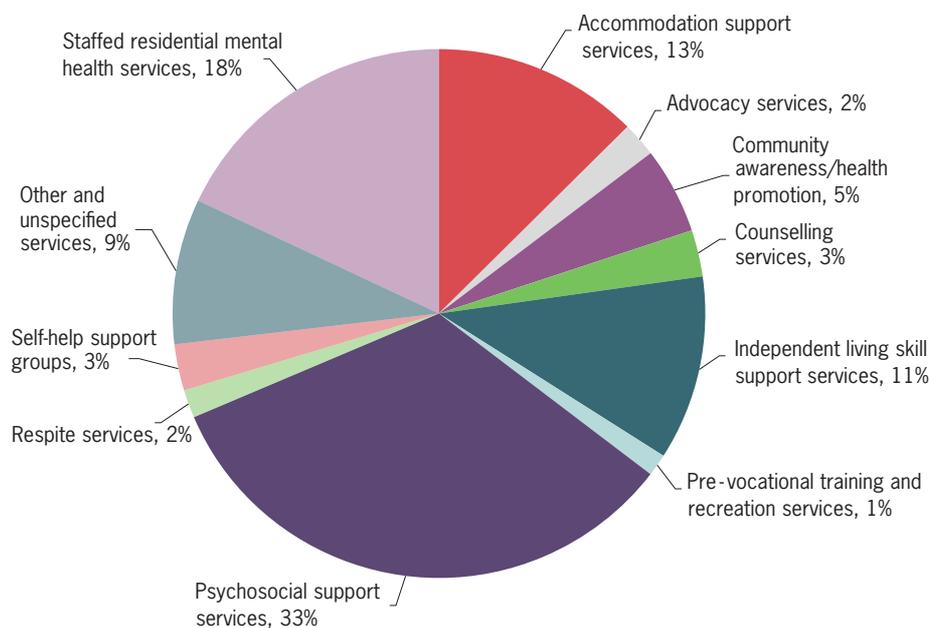
Community residential services

From its inception, the National Mental Health Strategy recognised the central place of accommodation in promoting quality of life and recovery 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 Opportunities Commission in the period immediately preceding the Strategy. Similar opinions have been voiced by consumer advocacy groups over the course of the Strategy.

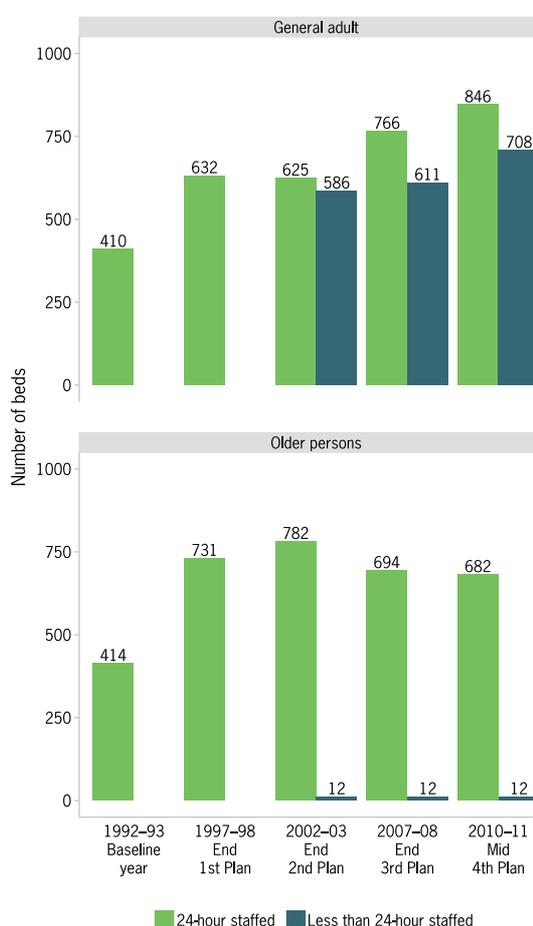
The approach taken by previous *National Mental Health Reports* to monitoring community accommodation under the Strategy has focused mainly on the extent to which each state and territory has developed specialised community residential services, staffed by trained mental health workers, that provide alternative care to that previously available in longer term psychiatric institutions. This report also presents information on 24 hour staffed beds in these specialised services, but augments it with data on services with beds staffed on a less than 24 hour basis. Figure 22 shows that in 2010-11, the number of 24 hour staffed general adult beds was more than double that in 1992-93 (846 compared with 410). The number of 24 hour staffed older persons' beds was also

Figure 21
Types of services funded by state and territory grants to non-government organisations, 2010-11



higher in 2010-11 (682) than it was in 1992-93 (414), although it reached a peak in 1998-99 (805) and has been declining since then. Data on non-24 hour staffed beds have not been available for the full period, but have increased since 2002-03 (from 586 to 708) in general adult residential services and remained the same (12) in older persons' residential services.

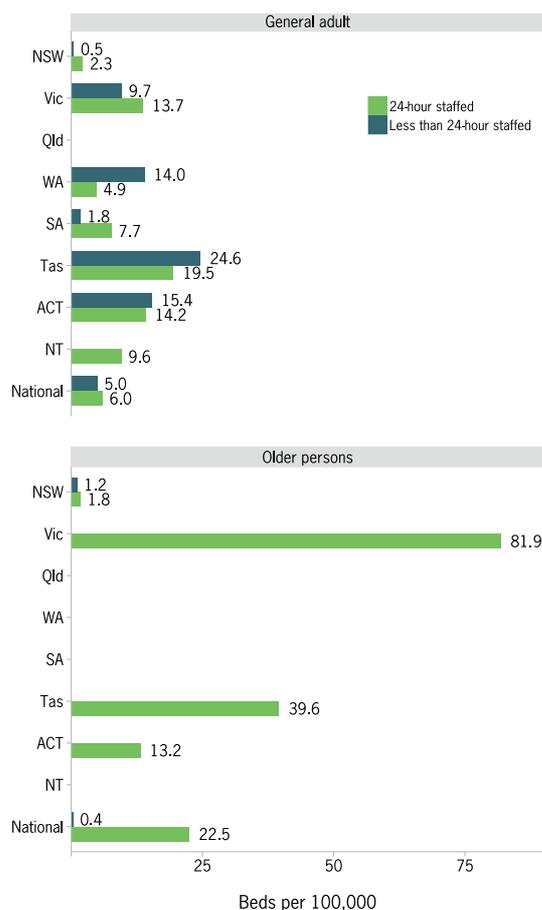
Figure 22
Total beds in general adult and older persons' residential services, 1992-93 to 2010-11^a



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Development of staffed community residential services has been patchy, with much variation between jurisdictions. Until well into the mid-2000s, Victoria led the way. More recently, however, jurisdictions with very limited early development have begun investing in staffed residential services for adult consumers to fill a widely acknowledged service gap.

Figure 23
Number of beds per 100,000 in general adult and older persons' residential services by jurisdiction, 2010-11^a



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Figure 23 compares the jurisdictions on adult and older persons' residential services available in 2010-11. For general services, three jurisdictions – Tasmania, the Australian Capital Territory and Victoria – were the leading providers, standing well above their peers. For older persons' residential services there was greater variability but the same three jurisdictions were marked by their service provision levels relative to other jurisdictions. Victoria in particular is unusual when compared to other jurisdictions in terms of its investment in specific residential services for older consumers. Nine out of ten residential beds for older persons available in Australia in 2010-11 were provided by Victoria.^D

^D Caution is required when interpreting residential services data for Queensland. A substantial number of general adult beds in Queensland that meet the definition of beds in staffed residential services were reported by Queensland as non-acute inpatient beds. Queensland has foreshadowed that it will review reporting of these beds in future years.

At a national level, the growth since 1992-93 in 24 hour staffed residential services (717 beds) is equivalent to only about one quarter of the reduction in longer stay (non-acute) beds in psychiatric hospitals (2,719 beds). The additional 730 beds staffed on less than a 24 hour basis became available during the period and provide partial compensation, but it is not possible to chart how these have developed over the full 18 year period. They have almost exclusively been developed for adults rather than older persons, and provide varying levels of on site supervision, ranging from six to 18 hours per day.

The number of supported public housing places is also relevant here. These places are 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. These are seen by consumer advocates as essential components of a recovery oriented system, and provide independent living support to some people who, in 1992-93, might have been in receipt of long stay institutional care. Several jurisdictions are developing individual care and support packages tied to public housing in preference to investing in staffed residential units, arguing that this sort of care is preferred by many consumers. The New South Wales Housing and Support initiative, for example, provides for support packages ranging from low to intensive support, the latter of which have similar costs to individual care provided in staffed residential services.

Figure 24 summarises the data on the availability of supported public housing places over time. It shows that 4,997 such places were available in 2010-11, 87% more than in 2002-03. This equates to 22.2 places per 100,000 in the latter period, an increase of 64% over the 13.5 places per 100,000 that were available in 2002-03.

Figure 25 shows that although all states and territories provided supported public housing places in 2010-11 and contribute to the above national averages, there was considerable cross-jurisdiction variation. Western Australia was the clear leader, with 62.1 places per 100,000. Queensland and Tasmania provided far fewer than the national average, at 6.1 and 4.5 per 100,000, respectively.

Figure 24
Growth in supported public housing places (absolute and per 100,000), 2002-03 to 2010-11

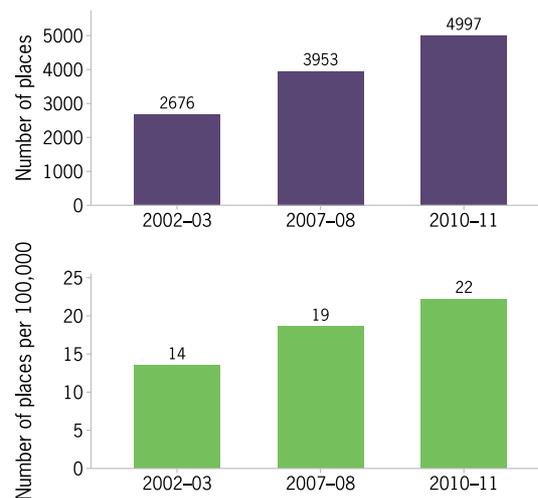
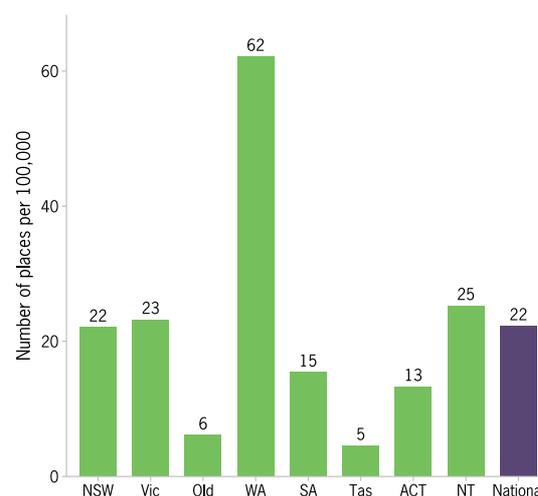


Figure 25
Number of supported public housing places per 100,000 by state and territory, 2010-11



There is no national consensus on planning benchmarks for the provision of community residential services or supported housing places. However, there is agreement that such services are an integral part of the full range of community services required to replace the historical functions of the stand-alone psychiatric hospitals. Developments during the *Third* and *Fourth National*

Mental Health Plans indicate that jurisdictions are undertaking the service development needed to fill gaps that existed when the National Mental Health Strategy began. As noted earlier, the National Mental Health Service Planning Framework will establish targets for residential and supported housing places that will guide future service development.

Changes in inpatient services

The profile of inpatient services has changed significantly during the course of the National Mental Health Strategy. As noted in Part 1, 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. Progress against these indicators has been extensively discussed in previous *National Mental Health Reports* and is presented in a more abbreviated fashion here because the majority of the change occurred during the early part of the Strategy.

In the year before the *First National Mental Health Plan* was launched (1992-93), the number of psychiatric beds available in Australia was 7,991 (46 per 100,000). By the end of the *First Plan* (1997-98) this had dropped to 6,265 (34 per 100,000), and by the end of the *Second Plan* (2002-03) it had reduced further to 6,073 (31 per 100,000). After this, the bed numbers increased slightly in absolute terms but plateaued on a per capita basis. In 2010-11, mid-way through the *Fourth Plan*, there were 6,755 psychiatric beds (30 per 100,000).

Reduction in stand-alone psychiatric hospitals

To put these reductions in context, Australia, like many other countries around the world, had already instituted a significant process of deinstitutionalisation in the decades before the National Mental Health Strategy began. In the mid-1960s, when the isolation and detention of people with mental illness in long stay

institutions dominated the treatment culture, bed numbers had peaked at around 30,000.

A significant proportion of the reduction in beds is accounted for by ongoing closures of stand-alone psychiatric hospitals. Between 1992-93 and 2002-03, the number of beds in stand-alone hospitals decreased by 59%, from 5,802 (33 per 100,000) to 2,360 (12 per 100,000). By 2010-11, there had been a further 5% decrease (to 2,083, or nine per 100,000).

During this period there was a commensurate increase in psychiatric beds located in general hospitals. In 1992-93, Australia had 2,189 such beds (13 per 100,000). By 2002-03, this had increased by 70% to 3,713 (19 per 100,000), and by 2010-11 it had increased by an additional 44% to 4,672 (21 per 100,000).

Changes in the inpatient program mix

The decrease in hospital bed numbers has been accompanied by changes in the mix of inpatient services. Reductions during the National Mental Health Strategy have been selectively targeted at the service type mostly delivered by psychiatric hospitals – that is, hospital wards that provide medium to longer term care. Figure 26 charts the changes in the provision of acute and non-acute beds from 1992-93 to 2010-11. On a per capita basis, the availability of acute beds has remained level (at around 20 per 100,000), whereas the availability of non-acute beds has dropped (from 25 per 100,000 to 10 per 100,000). There is general consensus that 20 acute beds per 100,000 constitutes a reasonable level of service delivery,

whereas there is less agreement about the provision of non-acute beds and much greater variability across jurisdictions. In part this relates to the varying levels of community residential services that provide longer term care in different states and territories (see above).

Figure 27 provides data on beds available for each of the four target populations served by public sector inpatient units. The denominator has been calculated separately for each group from 2010-11 back to 1993-94 (the first year of the National Mental Health Strategy), rather than 1992-93 (the baseline year used elsewhere). Figure 27 shows that most of the reductions in bed numbers have taken place within adult and older persons' mental health services, with the former reducing by 29% and the latter by 57%. Beds provided in child and adolescent and forensic mental health services increased in per capita terms by 15% and 25%, respectively, both from a low baseline.

Changes in the resourcing of inpatient units

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 data collected over the period from 1992-93 to 2010-11 confirms that the reconfiguration of inpatient services has been associated with significant movement in unit costs. Figure 28 shows the average bed day costs for stand-alone psychiatric hospitals and for psychiatric beds in general hospitals. Over the 18 year period, the average bed day costs in the former increased by 77% in constant price terms, and in the latter by 51%. The average cost per patient day in stand-alone hospitals was 23% below that in general hospitals in the baseline year, but by the beginning of the *Second National Mental Health Plan* was almost equal to it. These costs tracked alongside each other until towards the end of the *Third National Mental Health Plan* and then diverged again. In 2010-11, the average bed day cost in stand-alone hospitals was 9% lower than that in general hospitals.

Figure 26
Acute and non-acute psychiatric inpatient beds per 100,000, 1992-93 to 2010-11

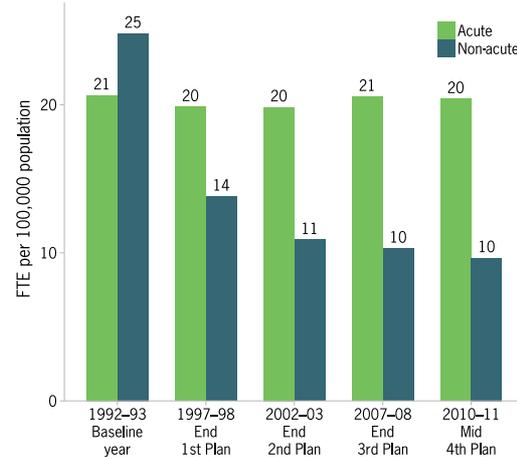


Figure 27
Total psychiatric inpatient beds per 100,000 by target population, 1993-94 to 2010-11

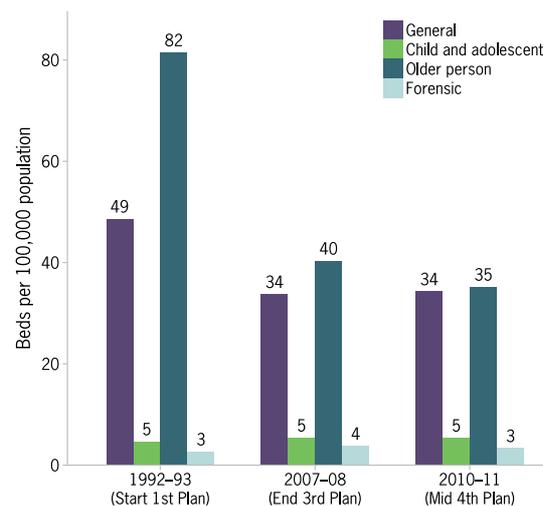
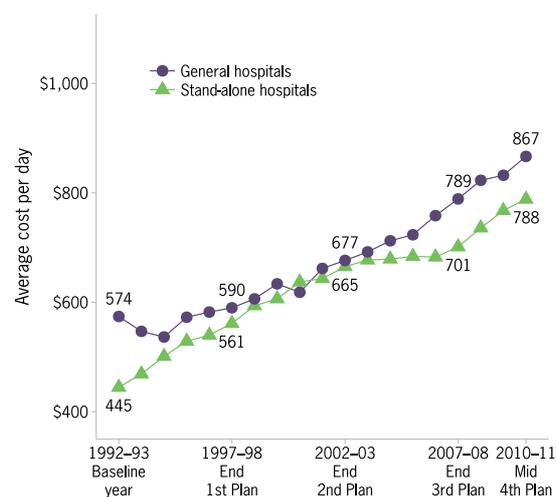


Figure 28
Average costs per day in psychiatric inpatient units, 1992-93 to 2010-11



Economic and clinical factors are responsible for the increase in the costs of hospital care, although the relative contribution of each is not known. Economic factors are implicated in the data shown in Figure 29 which charts resource shifts within Australia's psychiatric inpatient services over the period from 1992-93 to 2010-11. It shows that, at the national level, reduced bed numbers have not translated into reduced overall spending. While the number of beds and the number of bed days have reduced by 15% and 13%, respectively, spending on hospital services has increased by 52%. Direct care staffing levels in inpatient units have increased by 19%, about one third of the rate of growth in overall expenditure on inpatient services. The implication is that inpatient services are substantially more costly than they were at the beginning of the National Mental Health Strategy. When measured in terms of days in hospital, 2010-11 funding would buy 47% less by way of services than the same level of funding 18 years earlier.

Clinical factors contributing to increased costs include the changing role of stand-alone psychiatric hospitals. These services have developed specialised roles as they have reduced in size, treating consumers with more complex conditions that require increased staff:consumer 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. Data reported by states and territories over the course of the Strategy provide some support for this view, and suggest that average direct care staffing levels within psychiatric inpatient units have increased by 38% (see Figure 30).

Figure 29
Changes in the number of psychiatric inpatient beds, patient days, expenditure and direct care full-time equivalent staff relative to 1992-93

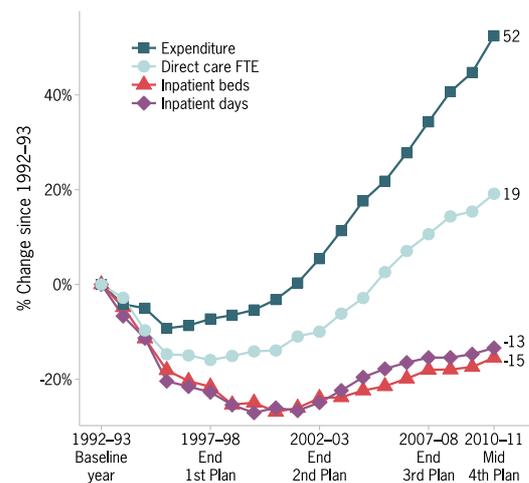
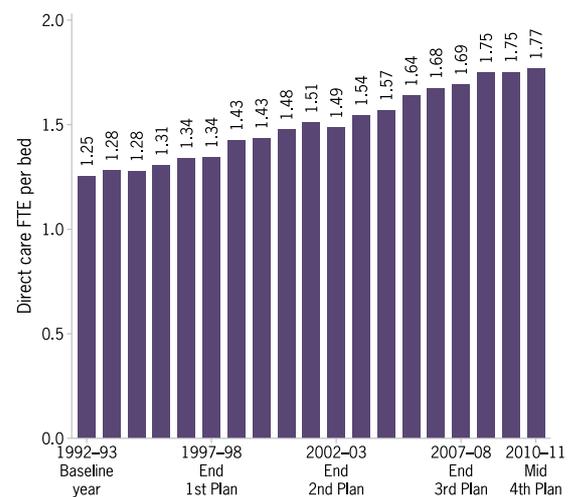


Figure 30
Average number of direct care staff (FTE) per bed, psychiatric inpatient units, 1992-93 to 2010-11



Comparative service levels in 24 hour staffed residential community services and in inpatient services

It is important to consider inpatient and community residential services data in tandem in order to gain a fuller understanding of how Australia has progressed in terms of levels of service availability. Table 5 provides a detailed view of the inpatient and residential service mix available for specific target populations in each jurisdiction in 2010-11. When inpatient and community residential beds are combined, the average number of beds is 40 per 100,000. Two jurisdictions provide well above this per capita average – Tasmania at 58 per 100,000 and Victoria at 49 per 100,000. These states are among the lower providing states when public sector inpatient beds are considered in isolation, but their relatively high provision of beds in

community residential settings – particularly those with 24 hour staffing – increases their overall per capita provision to above the other jurisdictions.

Another way of thinking about this is the relative proportions of all psychiatric beds that are located in the different settings. Nationally, 75% of all public sector beds are available in inpatient units, and 17% and 8% in 24 hour staffed and non-24 hour staffed community residential units, respectively. There is considerable variation across jurisdictions, however, with Queensland and New South Wales being particularly heavily reliant on their inpatient units, and Tasmania, the Australian Capital Territory and Victoria providing less than 50% of their beds in these settings.

Table 5
Inpatient and community residential beds per 100,000 population, 2010-11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Nat. Avg.
GENERAL ADULT									
Acute inpatient	28.9	20.6	21.6	24.5	24.5	25.9	20.3	21.3	24.3
Non-acute inpatient	13.3	3.0	17.4	8.9	5.9	8.6	0.0	0.0	10.0
24 hour staffed residential	2.3	13.7	0.0	4.9	7.7	19.5	14.2	9.6	6.0
Non-24 hour staffed residential	0.5	9.7	0.0	14.0	1.8	24.6	15.4	0.0	5.0
Total general adult	45.0	46.9	39.0	52.2	39.9	78.7	49.9	31.0	45.3
CHILD AND ADOLESCENT									
Acute inpatient	4.5	5.4	4.9	3.7	3.4	0.0	0.0	0.0	4.4
Non-acute inpatient	1.9	0.0	1.4	1.1	0.0	0.0	0.0	0.0	1.0
24 hour staffed residential	0.5	0.0	0.0	0.0	0.0	0.0	6.3	0.0	0.3
Non-24 hour staffed residential	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total child and adolescent	7.5	5.4	6.3	4.8	3.4	0.0	6.3	0.0	5.9
OLDER PERSONS									
Acute inpatient	17.6	28.1	9.0	40.7	26.8	0.0	39.6	0.0	21.3
Non-acute inpatient	18.6	0.0	25.2	7.1	26.4	0.0	0.0	0.0	13.9
24 hour staffed residential	1.8	81.9	0.0	0.0	0.0	39.6	13.2	0.0	22.5
Non-24 hour staffed residential	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Total older persons	39.2	110.0	34.2	47.8	53.2	39.6	52.8	0.0	58.1
FORENSIC									
Acute inpatient	2.5	2.2	0.0	1.7	0.6	4.9	0.0	0.0	1.7
Non-acute inpatient	2.3	1.3	1.8	0.4	2.4	0.0	0.0	0.0	1.6
Total forensic	4.8	3.5	1.8	2.1	3.0	4.9	0.0	0.0	3.4
ALL BEDS									
All inpatient	36.4	22.6	31.2	30.2	30.2	25.0	18.0	14.5	30.1
All 24 hour staffed residential	1.8	19.8	0.0	3.2	4.8	18.3	12.4	6.5	6.9
All non-24 hour staffed residential	0.6	6.1	0.0	9.1	1.1	15.1	10.5	0.0	3.2
TOTAL	38.8	48.5	31.2	42.4	36.1	58.3	40.9	21.0	40.2

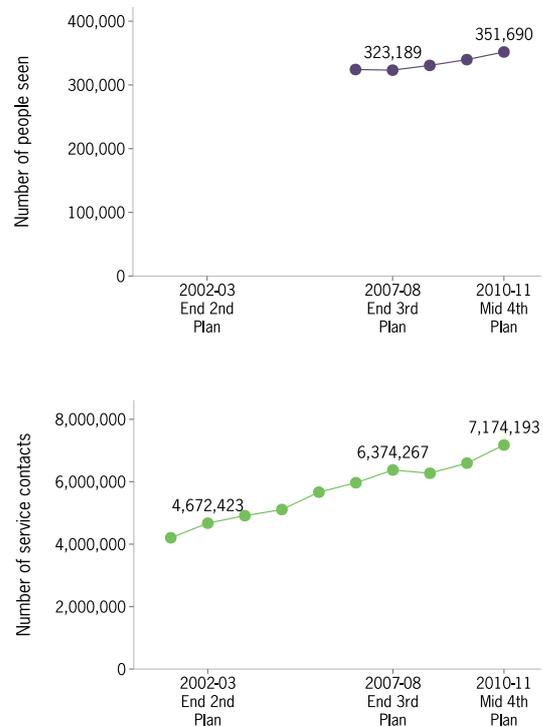
Trends in service delivery

Reliable national data on the number of people seen by state and territory community mental health care are available from 2006-07 to 2010-11. These raw numbers are provided in Figure 31 and show that the number of people seen increased from 324,160 in 2006-07 to 351,690 in 2010-11. In the latter year, about 40% of persons seen were new clients (i.e., clients who had not been seen by the service in the preceding five years).²⁸

Figure 31 also provides data on the number of service contacts provided and the number of people seen in community mental health care from 2001-02 to 2010-11. The number of service contacts rose from 4.2 million in 2001-02 to 7.2 million in 2010-11.

The frequency of services provided to people seen by state and territory community mental health services has remained fairly stable when measured by the number of days on which a service is provided (referred to as a 'treatment day'). Figure 32 shows that on average, consumers of state and territory mental health services are seen on 6.0 to 6.5 days each three month period while under care, equating roughly to once per fortnight. On average, registered consumers are seen on 14 days over a 12 month period, although there is substantial variation and many consumers receive community mental health care over substantially briefer periods than a full year. Ten per cent of consumers are seen by state and territory mental health services on more than 30 days over the year.

Figure 31
Number of service contacts^a provided, 2001-02 to 2010-11, and number of people seen by state and territory community mental health services, 2006-07 to 2010-11



(a) Includes unregistered contacts. Not all jurisdictions report unregistered contacts and reporting practices may have changed over time.

In the inpatient setting, the total number of patient days decreased on an annual basis from 2.5 million in the year before the National Mental Health Strategy began (1992-93) to a low of just over 1.8 million in 1999-00. Since then, the number has risen again and in 2010-11 it was 2.1 million. Figure 33 provides a detailed picture of the change in patient days over time.

Taken together, it can be seen that these trends in service delivery are consistent with the changes in investment in service mix, particularly in terms of the expansion of community-based services described above. The increased numbers of people seen and services provided in community mental health care settings reflect the significant growth in resources directed to these services during the life of the National Mental Health Strategy.

Figure 32
Average number of treatment days per three month period of community mental health care, 2005-06 to 2010-11

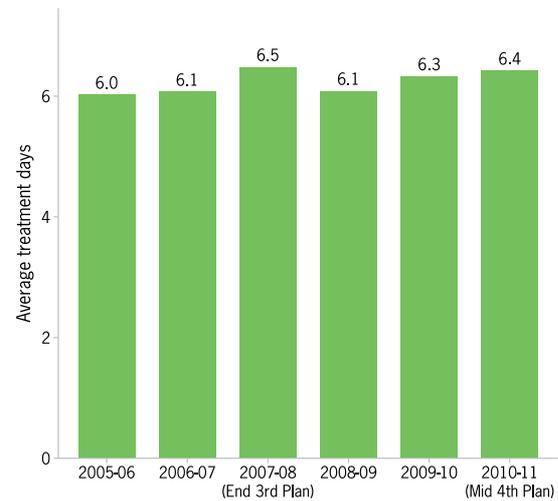


Figure 33
Total number of patient days in psychiatric inpatient settings, 1992-93 to 2010-11

