

## 3.4 Priority area 3: Service access, coordination and continuity of care

### Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to service access, coordination and continuity of care. Progress has been made on two of these (see Appendix 3). By way of example, substantial progress has been made on Action Area 16 which involves better targeting services and addressing service gaps through cooperative and innovative service models for the delivery of primary mental health care. The 2011-12 Federal Budget allocated resources to address service gaps in the delivery of primary mental health care, including doubling the funding for the Access to Allied Psychological Services (ATAPS) initiative and providing new funding for the Partners in Recovery program. ATAPS offers access to psychological services for people with common mental disorders like depression and anxiety, employing a service delivery model that is managed by Medicare Locals. Partners in Recovery aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by encouraging collaboration between the multiple services with which they come into contact.

### Indicator 13: Percentage of population receiving mental health care

#### KEY MESSAGES:

- The percentage of the population seen by state and territory community mental health services from 2006-07 to 2010-11 remained relatively stable at around 1.5%.
- The percentage of the population receiving mental health specific Medicare-funded services rose from 3.1% in 2006-07 to 6.9% in 2010-11. This increase was largely due to the introduction and uptake of services provided through the Better Access initiative.
- Targets for population coverage by mental health services are yet to be agreed but are expected to be advanced as part of the continuing development of the *Roadmap for Mental Health Reform*<sup>1</sup> agreed by the Council of Australian Governments (COAG) in December 2012.

Widespread concern about access to mental health care was a key factor that underpinned the COAG *National Action Plan on Mental Health* endorsed by governments in 2006, and was reinforced in the commitments made under the various *National Mental Health Plans*. The *Third* and *Fourth National Mental Health Plans* in particular have emphasised the need to improve access to primary mental health care, especially for people with common mental illnesses. For consumers, having access to the right services at the right time is of paramount importance.

First insights into the gap between need for mental health services and services actually delivered were provided by the National Surveys of Mental Health and Wellbeing undertaken in 1997 and 1998. The surveys revealed that only 38% of adults and one quarter of children and younger people with a mental illness received treatment from a health service. Of those who received services, the majority (77%) consulted their general practitioner, although about half also attended another health service. The implication is that, 15 years ago, about two

thirds of the one in five adult Australians who were experiencing a recent mental illness received no treatment for that illness from any part of the health system.

An updated picture on the extent of unmet need for mental health care in the adult population became available from the 2007 National Survey of Mental Health and Wellbeing. Conducted by the Australian Bureau of Statistics (ABS) in 2007, results released in October 2008 suggested that little change had occurred over the preceding decade in the overall rates of treatment for people with mental disorders, with approximately two thirds (65%) continuing to receive no treatment. Similar rates of treatment for mental illness have been reported in all population surveys conducted in other developed countries.

When the 2007 survey findings were scaled to the total population, they suggested that 2.1 million adult Australians experienced the symptoms of a mental illness but received no health care for their conditions. Treatment rates varied according to the severity of the person's condition and type of disorder. Approximately two thirds (64%) of those with disorders classified as severe according to the ABS methodology received some level of health care. About 39% of people with moderately severe disorders and only 17% of people with milder (but still clinically significant) disorders were found to receive mental health care. People with an affective disorder (mainly depression) were more likely to have received services for their mental health condition than those affected by one of the various anxiety disorders (59% and 38% respectively). These rates were similar to those observed in 1997.

Large scale population surveys like the National Surveys of Mental Health and Wellbeing provide snapshots of the level of mental illness in the community but cannot provide routine and regularly available information to monitor this indicator over time. To complement the periodic population surveys, for the purposes of this and related reports, health administrations within each jurisdiction agreed to pool data on the number

of people receiving services through government-funded clinical mental health care streams. The Private Mental Health Alliance, covering private hospitals and other providers of mental health care, also agreed to contribute data on people treated in private hospitals.

Results at the national level over the period 2006-07 to 2010-11 are presented in Figure 59. Assuming minimal overlap between state and territory and Medicare-funded person counts, the data suggest that approximately 1.9 million people, or 8.5% of the population, received clinical mental health care in 2010-11, compared with 970,000 in the 2006-07.

Overall, the percentage of people seen by state and territory mental health services has remained relatively stable, fluctuating between 1.5% and 1.6%. Growth in the number of people seen by Medicare-funded mental health services, rising from 3.1% of the population in 2006-07 to 6.9% in 2010-11, is the sole driver of overall growth in treatment rates over the five year period.

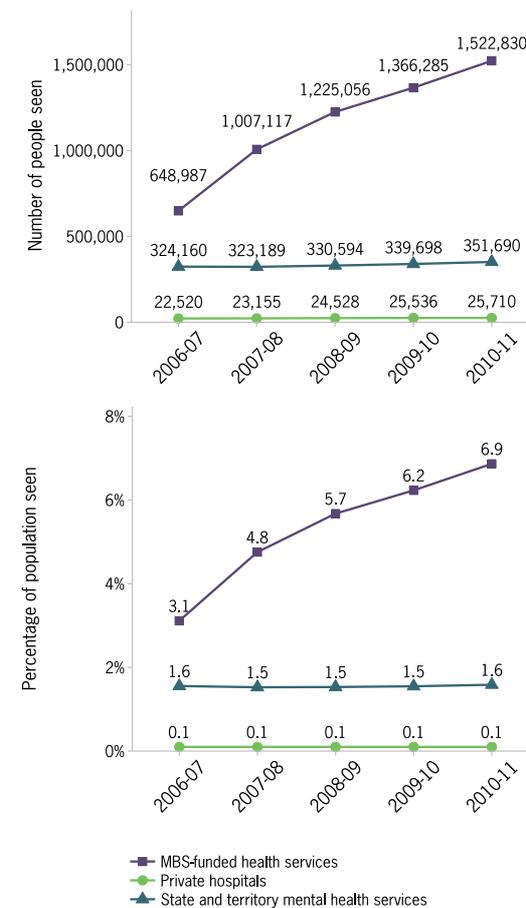
These figures highlight that the ABS estimates made in 2007 of access to mental health care are unlikely to reflect the population's current use of services. Analysis was undertaken by the Australian Government Department of Health and Ageing as part of the national evaluation of the Better Access program, and factored in the growth in the number of persons treated by Medicare-funded Better Access services and incorporated estimates from other service utilisation data.<sup>31</sup> The analysis suggested that the percentage of the population with a current mental illness who received care in 2009-10 was 46%, substantially higher than the 35% estimate found by the ABS in 2007. The growth occurring in 2010-11 evident in Figure 59 will have further increased treatment rates beyond those found in 2007.

Data on relative access figures across each of states and territories are provided in Part 4 of this report. Several caveats need to be considered when interpreting the data. First, assessing progress against this indicator is not as simple as adding together the percentages in Figure 59 for any given year due to the possibility that a sub-group of service users access both state and territory mental health services and Medicare-funded mental health services. Without a unique identifier that permits individuals to be 'tracked' across service sectors, all that can be said is that a minimum of 3.1% of the population received mental health care in 2006-07 and a minimum of 6.9% did so in 2010-11. The figures are likely to be higher than this, but the true percentages cannot be accurately ascertained. However, the trend is certainly in the right direction.<sup>E</sup>

Secondly, comparisons of relative coverage between state and territory mental health services and Medicare-funded services need to take account of differences in the type and intensity of services provided across these sectors, with states and territories having their main focus on treating people with severe mental disorders. Thirdly, the growth in Medicare-funded services is, in part, a function of the fact that the Better Access initiative commenced in the first year of the period examined in Figure 59. Fourthly, comparisons between state and territory services need to be made cautiously because jurisdictions differ in the way in which they count the number of people under care. Victoria in particular undercounts patients seen by clinical services when compared to other jurisdictions because it only reports people who are seen and accepted for case management.

<sup>E</sup> Work is underway by the Australian Institute of Health and Welfare to use data linkage to more accurately estimate the extent of duplication in consumer counts between state and territory services and MBS-subsidised mental health care. This work is progressing with the assistance of jurisdictions and in compliance with ethical requirements.

**Figure 59**  
Number of people and percentage of population seen by each of the major mental health service streams, 2006-07 to 2010-11



A final cautionary note is needed to guide interpretation of data on use of mental health services. Most people who meet diagnostic criteria for mental illness do not experience a need for professional assistance of any kind. The 2007 National Survey of Mental Health and Wellbeing reported that nine out of ten of those experiencing mental illness symptoms in the previous 12 months who were not receiving mental health care reported having no need for any of a range of services, including counselling, medication and information (see Table 11).<sup>9 14</sup> The implication is that the lack of health service use by people with mental illness may be more related to their perception of personal needs than to the actual availability of services. Further work is needed to tease out the extent to which this finding is a function of factors such as lack of recognition by the person that they have an illness, lack of awareness that effective treatments are available, negative experiences of previous service use, and continuing stigma associated with mental illness.

Deciding on an appropriate target for population coverage by mental health services remains a challenge for all governments. The recent *Roadmap for Mental Health Reform* agreed by COAG in December 2012 foreshadowed the developments of targets in this area. As a broad indication of the scope of a possible target, lifting treatment rates for people with mental illness from the 35% found in the 2007 survey to 66% would require 12% of the population receiving mental health care each year.

**Table 11**  
Percentage of people with a current mental illness who received no health services reporting no need for services, 2007

Type of service	% reporting no need
Information	94%
Medication	97%
Talking therapy	89%
Social intervention	94%
Skills training	96%
Any of the above	86%

## Indicator 14: Readmission to hospital within 28 days of discharge

### KEY MESSAGES:

- In 2010-11, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 15% nationally. This figure has been stable since 2005-06.
- Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%). South Australia's figures should be interpreted with caution because they may represent an undercount.
- There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

Internationally, readmission rates are often used as a litmus test of the performance of mental health systems. High rates may point to deficiencies in hospital treatment or community follow up care, or a combination of the two. Of course, other factors may also be implicated in rapid readmissions, with some reflecting the episodic nature of mental illness. Notwithstanding the complexity of the indicator, it is used by many countries to monitor health system performance. It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is

that, while multiple hospital admissions may be necessary over the course of a lifetime for some people with ongoing illness, a high proportion of unplanned readmissions occurring shortly after discharge largely reflects failures in the care system.

This indicator focuses on admissions to acute psychiatric inpatient units run by state and territory mental health services; comparable data for the private hospital sector are not available. Figure 60 presents the national average for each year from 2005-06 to 2010-11, and shows that with the exception of one year (2009-10) when it dropped to 14%, it has consistently sat at 15-16%.

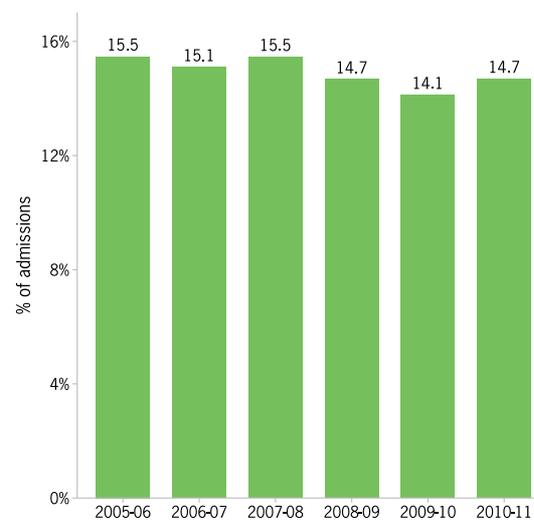
More detailed jurisdiction-level information is available in Part 4. Variation between jurisdictions is evident, with 28 day readmission rates in 2010-11 being below 10% for the Australian Capital Territory (5%) and South Australia (9%). Within jurisdictions, there has been little movement over time except in the Australian Capital Territory where the rate has more than halved since 2005-06.

It should be noted that the estimates from some jurisdictions are more accurate than others. This is because accurate monitoring of 28 day readmission rates depends on a unique identifier information system that tracks the movement of people between hospitals. True readmission rates are likely to be underestimated in the absence of such a system, because a person who is discharged from one hospital and readmitted to another within 28 days will not be represented in the figures. In 2005-06, all jurisdictions except South Australia and Tasmania had such a system. Tasmania developed this capacity in 2007-08, but South Australia has not yet done so.

Considerable attention has been devoted to identifying ways of reducing readmission rates. For example, eight mental health services from around the country considered this issue when they participated in the National Mental Health Benchmarking Project, which began in 2005.

Representatives from these services used a combination of methods to identify positive practices in this area. They concluded that seamless provision of care across inpatient and ambulatory services is required to improve readmission rates, as are good discharge planning and proactive community follow up. They also emphasised good governance, and consumer and carer engagement across the continuum of care.<sup>61</sup>

**Figure 60**  
Percentage of admissions to state and territory acute inpatient units followed by a readmission within 28 days, 2005-06 to 2010-11



## Indicator 15: Rates of pre-admission community care

### KEY MESSAGES:

- In 2010-11, 47% of admissions to state and territory acute inpatient psychiatric units were preceded by community care in the seven days before the admission. This figure represents a small improvement over recent years.
- There is considerable cross-jurisdictional variability. The Australian Capital Territory is the only jurisdiction to have achieved rates above 70%, with 76% of its acute inpatient admissions in 2010-11 being preceded by community care in the seven days prior to admission.
- The 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

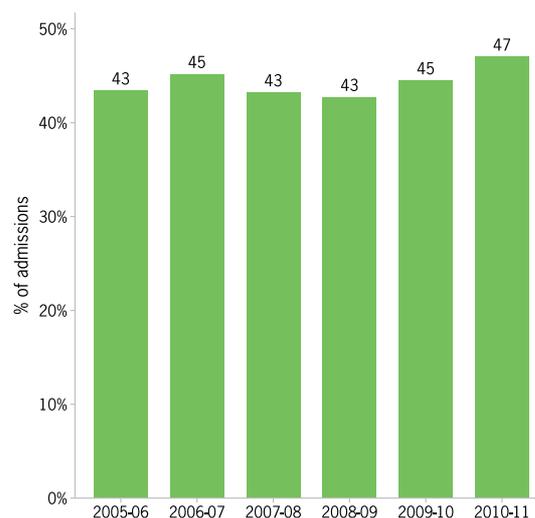
Much of the reform effort in the early years of the National Mental Health Strategy was aimed at creating integrated public sector mental health services, in which hospital and community-based services operate as a single service characterised by continuity of care, particularly when consumers move between treatment settings. Continuity of care has special relevance for the mental health sector because the enduring nature of many mental illnesses often means that care needs to be provided on an ongoing basis or intermittently over a considerable period of a person's life.

This indicator focuses on one aspect of continuity of care and looks at the extent to which consumers who require admission for inpatient care receive community care by clinical teams in the seven days leading up to the hospital admission. The indicator is complemented by Indicator 16 which looks at continuity of care following discharge from hospital.

Monitoring pre-admission community care rates is based on the fact that many consumers who are admitted to an acute inpatient unit are known to the local community mental health service, and the expectation that, where the person is a registered consumer of the service, community teams should be involved in their care in the period prior to admission. Contact by the community team is appropriate to assess the consumer's situation and ensure that admission is the most appropriate treatment option. Community mental health teams that have established a good relationship with the consumer are likely to be able to identify signs of deterioration in his or her condition, and, where required, smooth the way to an inpatient admission.

Figure 61 shows that in 2010-11, 47% of admissions were preceded by community care. Although this represents a small improvement over recent years, the contact rate remains relatively low.

**Figure 61**  
Percentage of admissions to state and territory acute inpatient units where contact was provided by a community mental health team in the 7 days prior to admission, 2005-06 to 2010-11



Equivalent figures are provided for each state and territory in Part 4. The Australian Capital Territory had the highest pre-admission contact rates, with 76% of all its acute inpatient admissions in 2010-11 being preceded by community care, compared with 60% in 2005-06. The Australian Capital Territory is the only jurisdiction with rates above 70%; the 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

Estimates from some jurisdictions are more likely to reflect the true picture than those from others. This is because some states and territories (notably Tasmania and South Australia) only have the capacity to determine whether an individual received pre-admission community care from the community team within the inpatient unit's catchment. Some people may receive community care from elsewhere and be referred from there to the inpatient unit, which means the rates in these jurisdictions may represent an undercount.

As a measure of performance this indicator cannot be looked at in isolation from other services (including non-government services or general practitioners). If people receive care from these services or providers prior to an admission, this will not be reflected in the above figures.

As with other related indicators, deciding on an appropriate target for pre-admission community contact rates remains a challenge for all governments. While 100% is not feasible, given that a proportion of admissions to hospital will continue to be unexpected and accounted for by people not known to the local community mental

health team, the current national rate of 47% falls short of reasonable expectations. The *Roadmap for Mental Health Reform*,<sup>1</sup> agreed by the Council of Australian Governments in December 2012, foreshadows the development of targets in this area.

## Indicator 16: Rates of post-discharge community care

### KEY MESSAGES:

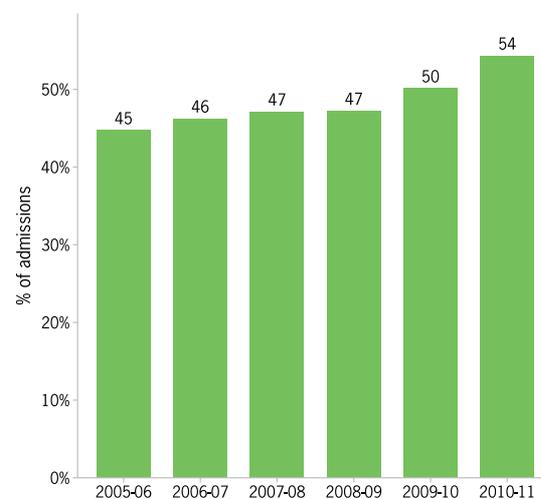
- In 2010-11, 54% of Australian admissions to state and territory acute psychiatric inpatient units were followed by community care (in the seven days after discharge). This percentage has been improving incrementally since 2005-06.
- There is substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory).

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. The post-discharge period is also a period of great stress and uncertainty for families and carers.

Evidence gathered in recent years from a number of consultations around Australia suggests that the transition from hospital to home is often not well managed. The inclusion of this indicator as a measure of progress of the *Fourth National Mental Health Plan* targeted the performance of the overall health system in providing continuity of care, recognising the need for substantial improvement in this area. The standard underlying the measure is that continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital.

Figure 62 shows that in 2010-11, 54% of hospital episodes were followed by community care in the week after discharge. This percentage has been improving incrementally since 2005-06, when it was 45%.

**Figure 62**  
Percentage of discharges from state and territory acute inpatient units in which contact was provided by a community mental health team in the 7 days after discharge, 2005-06 to 2010-11



Equivalent figures are provided for each state and territory in Part 4. They reveal substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory). For most jurisdictions, follow up rates show gradual but small improvement over the six years for

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which data are available, although greater improvement is evident in two jurisdictions with relatively low baseline rates (Tasmania and South Australia).

Work undertaken as part of the Australian Government-funded National Mental Health Benchmarking Project provided insights about the reasons organisations and jurisdictions may vary on seven day post-discharge follow up rates.<sup>62</sup> Accuracy of information systems in tracking the movement of people between hospital and community care, particularly across organisations, is critical. For example, two jurisdictions (Tasmania and South Australia) can only confidently determine whether community care was provided in the same area as the hospital from which the consumer was discharged. This is likely to lead to an undercount, because some people may receive community care from elsewhere once they are discharged. Lower follow up rates may also be the result of some consumers being managed outside the state and territory public system (for example, by general practitioners, private psychiatrists or,

in the Northern Territory, by Aboriginal/remote health services). These activities are not captured by existing mental health information systems.

Overall, the variation in post-discharge follow up rates suggests important differences between mental health systems in terms of their practices. An observation made by organisations engaged in the benchmarking work was that, although there may be legitimate reasons for non-follow up of some consumers in the week after discharge (for example, perhaps in circumstances where there is follow up by general practitioners, private psychiatrists, non-government organisations etc.), this group is small and routine follow up should be the norm. The implication is that the current national rate of 54% is well below what would be expected from best practice services.

Setting a national target for this indicator is expected to be explored as part of the work to be progressed under the *Roadmap for Mental Health Reform*,<sup>1</sup> agreed by the Council of Australian Governments in December 2012.

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## Indicator 19: Prevalence of mental illness among homeless populations

### KEY MESSAGES:

- Routinely collected data from the former Supported Accommodation Assistance Program (SAAP) suggests that, in 2010-11, 11% of SAAP clients sought accommodation because of mental health problems, 9% did so because of substance use problems, and 7% did so because of comorbid mental health and substance use problems.
- These figures are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral.
- From July 2011, the Special Homelessness Services (SHS) collection will enable more accurate estimates of mental illness among homeless populations to be calculated.

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

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

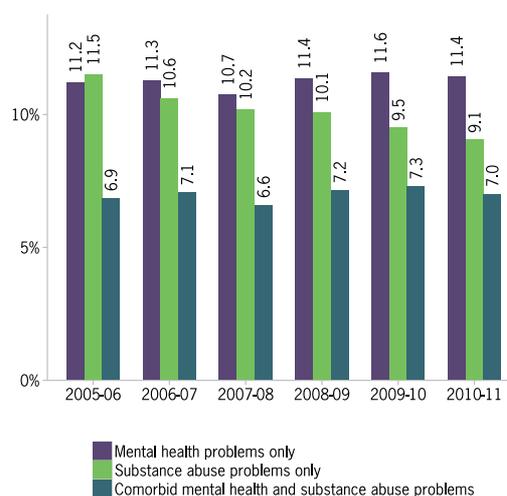
For the purposes of this indicator, estimates are taken from data collected on clients of the former Supported Accommodation Assistance Program (SAAP), a cost-shared program funded by the Australian Government and state and territory governments and providing crisis accommodation and related support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

Figure 63 shows the percentage of SAAP clients in each group from 2005-06 to 2010-11. In 2010-11, 11% of SAAP's 142,500 clients were deemed to have sought assistance due to mental health issues. These included clients who were referred from a psychiatric unit, reported psychiatric illness and/or mental health issues as a reason for seeking assistance, were in a psychiatric institution before or after receiving assistance, and/or needed, were provided with or were referred on for

support in the form of psychological or psychiatric services. An additional 9% were identified with problematic drug, alcohol and/or substance use as reasons for seeking assistance. A further 7% of clients were considered to have both mental health and substance use problems (comorbidity). The figures for mental health problems and comorbid mental health and substance use problems have remained fairly consistent over time, but those for substance use problems have dropped from 12% in 2005-06.

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

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



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Further evidence that the routinely collected SAAP data underestimates the true prevalence of mental illness among homeless populations comes from the National Survey of Mental Health and Wellbeing. This survey, conducted in 2007, found that over half (54%) of the people who had ever been homeless had a current mental illness, defined by their having a mood disorder, an anxiety disorder or a substance use disorder in the previous 12 months. This was almost three times the rate for those who had never been homeless.<sup>965</sup>

On July 2011, the SAAP data collection was replaced by the Special Homelessness Services (SHS) collection. SHS will provide better information about clients of homelessness

assistance services, and is likely to enable more accurate estimates of mental illness among homeless populations to be calculated.

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

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

### KEY MESSAGES:

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

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

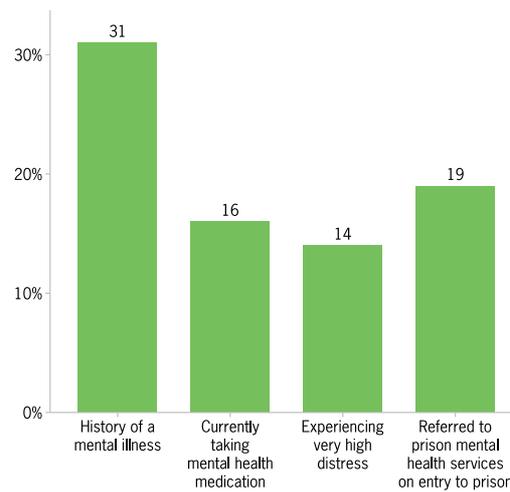
Data from the 2010 National Prisoner Health Census sheds some light on the prevalence of mental illness among those remanded or newly sentenced to adult prisons (no equivalent

information is available for their counterparts from juvenile correctional facilities).<sup>67 68</sup> Figure 64 shows that almost one third (31%) of new prison entrants reported having been told by a health professional that they had a mental illness (including depression, anxiety and drug and alcohol abuse). Sixteen per cent reported that they were currently taking mental health related medication. Fourteen per cent reported that they were experiencing very high levels of psychological distress according to the Kessler-10 (K-10).<sup>69</sup> On entry to prison, almost one fifth (19%) of prison entrants were referred to prison mental health services for observation and further assessment following the reception assessment.

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

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

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



## 3.5 Priority area 4: Quality improvement and innovation

### Progress of actions under this priority area

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

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

### KEY MESSAGES:

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

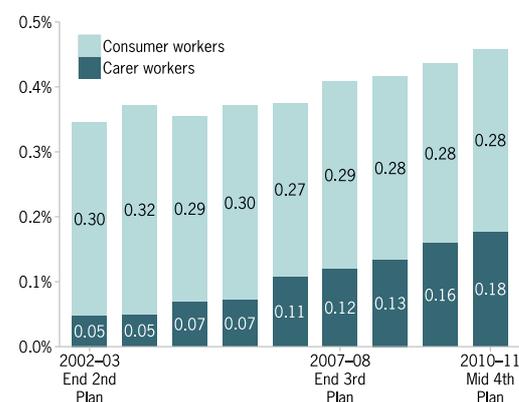
Since its inception, the National Mental Health Strategy has promoted the participation of consumers and carers in the planning, delivery and evaluation of mental health services. The availability of paid consumer and carer worker positions is an index of the opportunities available for, and an organisation's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

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

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

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

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



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care staff) and Victoria (0.61%); jurisdictions with the lowest proportions were the Australian Capital Territory and the Northern Territory. Only limited comparisons across jurisdictions can be made regarding change over time, because not all have had consumer and/or carer workers in all years since 2002-03. Of the four jurisdictions with complete time series data, the overall proportion of consumer and carer workers has increased since 2002-03 in South Australia, Queensland

and Victoria, but has decreased marginally in New South Wales. As with the national data, the available state and territory data indicated that although consumer workers still outnumber carer workers, the proportion of carer workers is moving in a positive direction and the change in this proportion is of a greater magnitude than that for consumer workers. More detailed jurisdiction-level data is available in Part 4.

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

### KEY MESSAGES:

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

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

11, service delivery processes and types of treatment and support.

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

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

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

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

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

Table 12  
National Standards for Mental Health Services (2010)

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

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

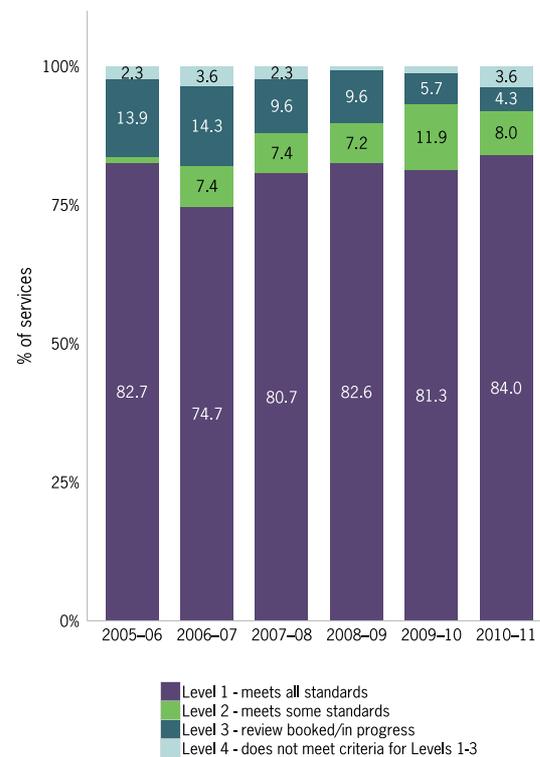


Figure 66 shows that nationally, in 2010-11, 84% of services met all standards (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4). Several jurisdictions reported at 100% or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

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

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

### KEY MESSAGES:

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

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

One of the specific objectives of the original *National Mental Health Policy*, released in the first year of the Strategy, was 'to institute regular review of ... outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery.' Since that time, Australia has invested heavily in establishing a standardised system for the routine monitoring of consumer outcomes that has been the focus of extensive activity in state and territory mental health services and the private hospital sector, with support from the Australian Government. The goal has been to develop standard measures of consumers' clinical status and functioning and apply these at entry to and exit from care to enable change to be measured. For consumers who require longer

term care, the measures are applied at review points every three months. A number of different measures are used, some of which are completed by clinicians and some of which are completed by consumers themselves. These repeated assessments allow changes in consumers' clinical status to be monitored over time from different perspectives. The approach taken by Australia to developing a comprehensive system of outcome measurement is well regarded internationally.

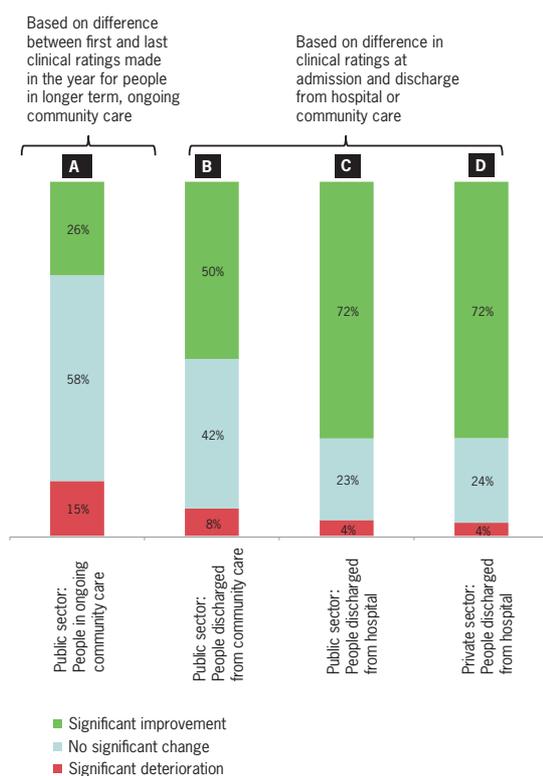
Today, 85% of state and territory public sector inpatient and community mental health services collect data that can be used to assess outcomes, as do 98% of private hospitals. Over 12,000 clinicians have received training in the use of outcome measures. Systems have also been established to enable pooling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

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

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

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

**Figure 67**  
Clinical outcomes for people receiving various types of mental health care, 2010-11<sup>a</sup>



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

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

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

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

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

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