

Expenditure on mental health services

This section reviews the available information on [recurrent expenditure](#) (running costs) for mental health-related services. [Health expenditure](#) (what was spent) and [health funding](#) (funding provided and who provided the funds) are distinct but related concepts essential to understanding the financial resources used by the health system. Data on expenditure and funding, calculated in both [current](#) and [constant](#) prices, are derived from a variety of sources, as outlined in the [data source](#) section. Most data presented is for the 2014–15 period, therefore, constant prices are adjusted to 2014–15 levels, including more recent 2015–16 Australian Government Medicare expenditure and mental health-related medications subsidised under the PBS and RPBS expenditure data. Further information on health expenditure is available in *Health expenditure Australia 2014–15* (AIHW 2016).

Key points

- Around \$8.5 billion, or \$361 per person, was estimated to be spent on mental health-related services in Australia during 2014–15, an increase from \$343 per person (adjusted for inflation) in 2010–11 (2014–15 dollars).
- \$5.2 billion was spent on state and territory specialised mental health services, an average annual real increase of 2.3% between 2010–11 and 2014–15. Of this, most was spent on public hospital services for admitted patients (\$2.2 billion), followed by community mental health care services (\$1.9 billion).
- Expenditure on specialised mental health services in private hospitals was \$433 million during 2014–15.
- The Australian Government paid about \$1.1 billion in benefits for Medicare-subsidised mental health-related services in 2015–16, equating to 5.3% of all Medicare subsidies. Expenditure on psychologist services (clinical and other) (\$489 million) made up the largest component of mental health-related Medicare subsidies in 2015–16.
- The Australian Government spent \$564 million, or \$24 per person, on subsidised prescriptions under the PBS/RPBS during 2015–16, equating to 5.0% of all PBS/RPBS subsidies. Prescriptions for antipsychotics (49.6%) and antidepressants (36.5%) accounted for the majority of mental health-related PBS and RPBS expenditure during this time period.

Data in this section were last updated in June 2017.

Overview

The national recurrent expenditure on mental health-related services in 2014–15 was estimated to be around \$8.5 billion; an average annual real increase of 2.9% between 2010–11 and 2014–15. Overall, national expenditure on mental health-related services increased from \$343 per person in 2010–11 to \$361 per person during 2014–15, adjusted for inflation (Table EXP.32). Expenditure on mental health-related services in 2014–15 was estimated to be around 7.8% of total health expenditure, which was relatively stable compared to 7.7% in 2010–11 (Table EXP.33).

Of the \$8.5 billion spent nationally in 2014–15, 59.6% (\$5.1 billion) was funded by state and territory governments, 35.7% (\$3.0 billion) by the Australian Government and 4.8% (\$408 million) by private health insurance funds. This distribution has remained relatively stable over time, with 60.8% of national spending coming from state and territory governments, 35.4% from the Australian Government and 3.8% from private health insurance funds in 2010–11 (Table EXP.32).

Funding from the Australian Government for mental health-related services (adjusted for inflation) increased by an average annual rate of 3.6% over the period 2010–11 to 2014–15, while funding from state and territory governments increased by an average annual rate of 2.0% (Table EXP.32).

The National Mental Health Commission's 2014 Review of Mental Health Programmes and Services (NMHC 2014) used a broader methodology to estimate Australian Government expenditure on mental health. The methodology included broader mental health-related costs, such as the Disability Support Pension and Carer Payment and allowances. The Australian Government mental health-related expenditure in 2012–13 was estimated to be \$9.6 billion, compared to \$2.8 billion using the methodology employed in this publication, as outlined in the [data source](#) section.

References

[AIHW 2016](#). Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW

[National Mental Health Commission 2014](#). The national review of mental health programmes and services. Sydney: NMHC.

Expenditure on specialised mental health services

State and territory specialised mental health services

Recurrent expenditure

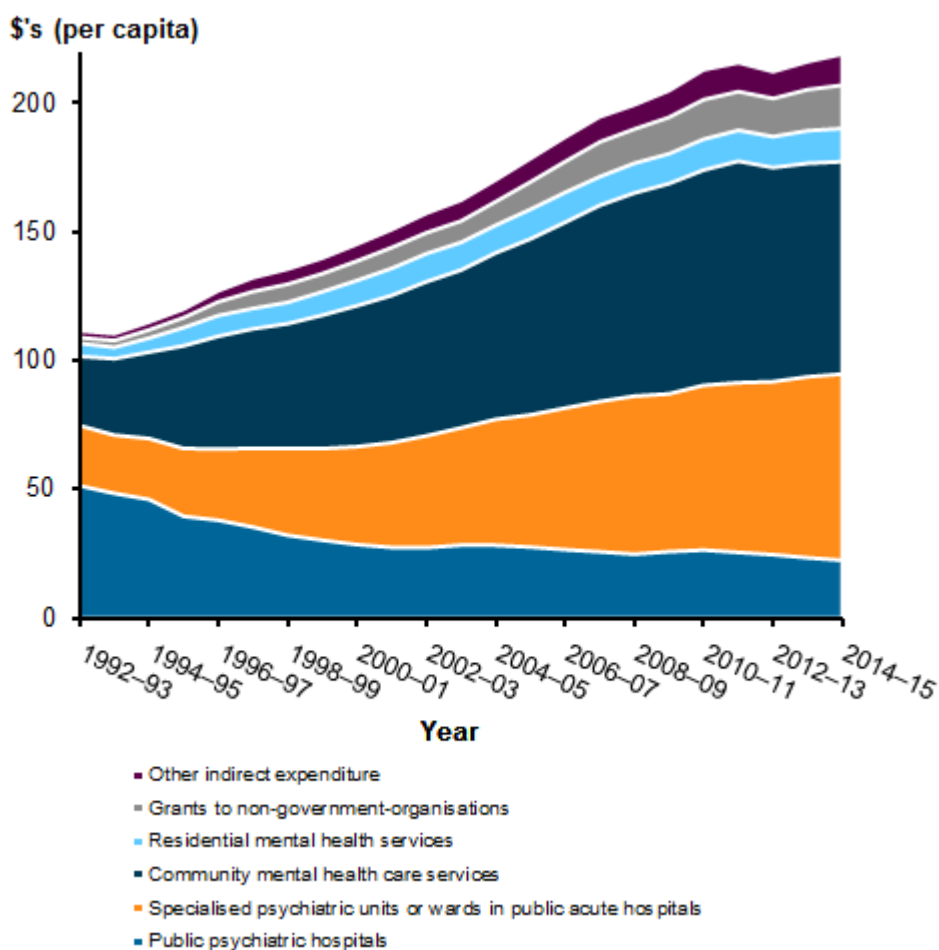
Around \$5.2 billion was spent on state and territory specialised mental health services in 2014–15. The largest proportion of this recurrent expenditure was spent on public hospital services for admitted patients (\$2.2 billion), comprising public acute hospitals with a specialist psychiatric unit or ward (\$1.7 billion) and public psychiatric hospitals (\$0.5 billion). This was closely followed by expenditure on community mental health care services totalling \$1.9 billion (Table EXP.1).

Per person expenditure on specialised mental health services ranged from \$197 per person in Victoria to \$281 per person in Western Australia, compared to the national average of \$219 per person during 2014–15 (Table EXP.1).

Expenditure on state and territory specialised mental health services, adjusted for inflation, increased by an average annual rate of 2.3% between 2010–11 and 2014–15. This equates to an increase of \$6 per person, from \$213 in 2010–11 to \$219 in 2014–15 (Table EXP.3 & 4).

Detailed expenditure data are available covering over 20 years to 2014–15. The data in Figure EXP.1 illustrates the change in spending patterns; a reflection of changes to the state and territory specialised mental health service profile mix over this time, for example, increased investment in community mental health care services (see the related Profile of mental health care facilities section).

Figure EXP.1: Recurrent expenditure (\$) per capita on state and territory specialised mental health services, constant prices, 1992–93 to 2014–15



Source: National Mental Health Establishments Database. Source data Expenditure on mental health services Table EXP.4 (1.73MB XLS).

Funding

The majority (94% or \$4.9 billion of the \$5.2 billion total cost) of funding for state and territory specialised mental health services was provided by state or territory governments in 2014–15, with a further 3.9% (\$202 million) provided by the Australian Government, and 2.2% (\$113 million) from patients and other revenues and recoveries (Table EXP.30). (See the [data source](#) section for technical information regarding Australian Government expenditure.)

Public sector specialised mental health hospital services

The \$2.2 billion of recurrent expenditure for public sector specialised mental health hospital services during 2014–15 equates to an [average cost per patient day](#) of \$1,029. The Northern Territory (\$1,899) had the highest average cost per patient day, while the average cost in Victoria (\$901) was the lowest (Table EXP.5 & 6).

Recurrent expenditure on public sector specialised mental health hospital services can be described using [target population](#) (General, Child and adolescent, Youth, Older person and Forensic target groups), [program type](#) (acute and non-acute), or a combination of these.

Target population program type

Services provided to the General target population (\$1.6 billion or 72.5%) accounted for the majority of recurrent expenditure for public sector specialised mental health hospital services during 2014–15. Child and adolescent services (\$1,956 per patient day) had the highest per patient costs, continuing a long term trend of these services costing more than General target population services (\$1,025 per patient day), Older person (\$841 per patient day) and Forensic services (\$1,073 per patient day). Expenditure per patient day for all target population categories increased by an average of between 0.6% and 2.6% each year since 2010–11, adjusted for inflation (Table EXP.5 & 6).

Average patient day costs for acute public sector specialised mental health hospital services were more expensive than those for non-acute services for each target population category in 2014–15 (Table EXP.6).

Community mental health care services

Community mental health care services accounted for \$1.9 billion of recurrent expenditure on mental health services during 2014–15, representing 37.7% of total state/territory expenditure in 2014–15 (Table EXP.1).

Residential mental health services

Of the \$304 million spent on residential mental health services during 2014–15, the majority was spent on 24-hour staffed services (\$263 million or 86.6%). General services (\$204 million) accounted for more than two-thirds (67.0%) of the total residential expenditure (Table EXP.8).

The average national cost per patient day for residential mental health services was \$400 per day in 2014–15. Average costs varied between states and territories, ranging from \$246 per patient day in New South Wales to \$614 per patient day in the Northern Territory (Table EXP.9).

Expenditure by target population

Recurrent expenditure for public sector specialised mental health hospital, community and residential services can be combined and reported by target population. Expenditure on General services (\$212 per person) was the highest of the 5 target populations during 2014–15, reflecting that many jurisdictions do not have the other specialised target population hospital services which contribute substantial costs to the overall expenditure profile. Adjusted for inflation, per capita expenditure on Child and adolescent services increased by an average of 0.6% per year between 2010–11 and 2014–15. Per capita expenditure on Older person services decreased by an average of 3.3% over the 5 years to 2014–15. This was the only target population to record an overall decrease in per capita expenditure during this time (Table EXP.12).

Private hospital specialised mental health services

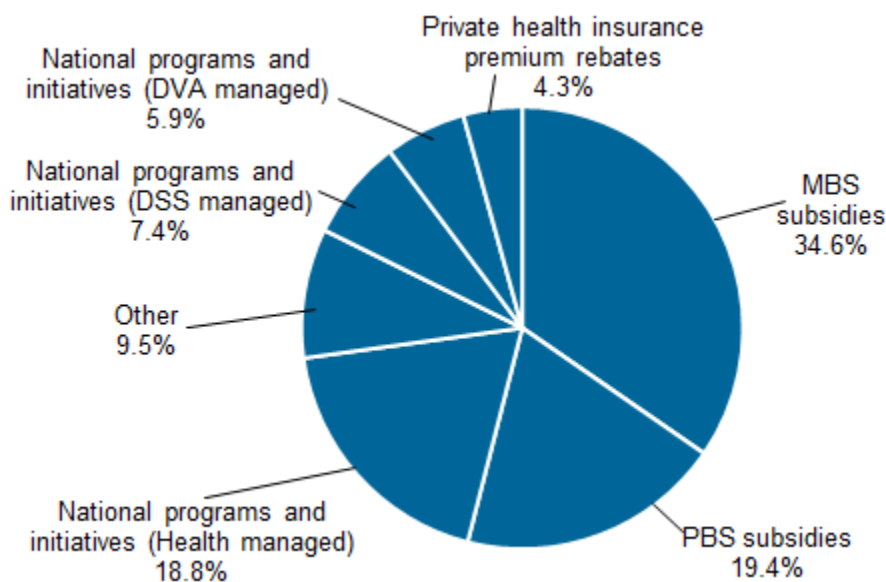
Adjusted for inflation, expenditure on specialised mental health services in private hospitals increased from \$340 million to \$433 million between 2010–11 and 2014–15. Per person expenditure increased from \$15 per person to \$18 per person during this time (Table EXP.14).

Australian Government expenditure

Australian Government expenditure on mental health-related services

Australian Government expenditure on mental health-related services was estimated as \$3.0 billion in 2014–15. However, as noted previously and detailed in the [data source](#) section of this report, there are other known Australian government outlays attributable to supporting mental health issues which are not included in this estimate e.g. disability support pension. Expenditure on MBS-subsidised mental health services and medications provided through the PBS accounted for 54.0% of the total (Figure EXP.2) (Table EXP.29). (See the [data source](#) section for technical information regarding the calculation of these figures.)

Figure EXP.2: Australian Government expenditure on mental health-related services, 2014–15



Key: 'Other' includes Research (3.0%), National Suicide Prevention Program (1.6%), Mental health specific payments to states and territories (2.0%), Indigenous social and emotional wellbeing programmes (1.3%) and National Mental Health Commission (0.2%).

Note: Percentages may not add to 100 due to rounding.

Source: Australian Government Department of Health (unpublished data). Source data Expenditure on mental health services Table EXP.29 (1.73MB XLS).

Australian Government expenditure on Department of Defence funded programs has increased an average of 14.9% per year for the period 2010–11 (\$24 million) to 2014–15 (\$41 million), adjusted for inflation. Expenditure covers a range of mental health programs and services delivered to Australian Defence Force (ADF) personnel. When the number of permanent ADF personnel is taken into consideration (57,718 people; Department of Defence, 2015) this equates to \$710 per permanent ADF member in 2014–15 (Table EXP.29).

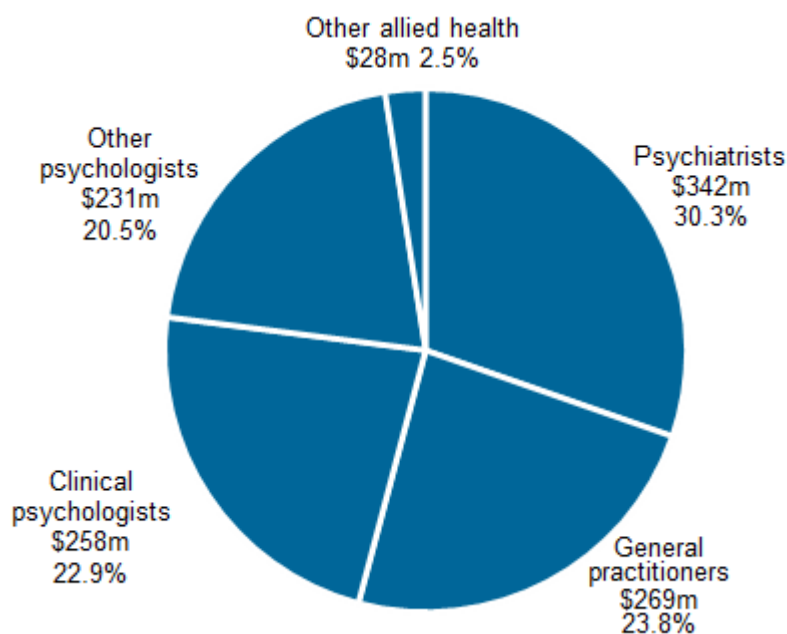
Australian Government expenditure on mental health-related services, adjusted for inflation, increased by an average annual rate of 3.6% between 2010–11 and 2014–15. This equates to an increase of \$10 per person, adjusted for inflation, from \$119 per person in 2010–11 to \$129 in 2014–15 (Table EXP.29).

Australian Government expenditure on Medicare-subsidised mental health-related services

More recent expenditure data for 2015–16 Medicare-subsidised mental health related services is presented in this section. These services include mental health-related services provided by psychiatrists, general practitioners (GPs), psychologists (both clinical and other), and other allied health professionals. These services are defined in the Medicare Benefits Schedule (MBS). Refer to the [data source](#) section for further information.

In 2015–16, \$1.1 billion was paid in benefits for Medicare-subsidised mental health-related services, equating to 5.3% of total Medicare expenditure (\$21.4 billion) (DHS 2016). Expenditure for services provided by psychologists (\$489 million or 43.3%) made up the largest proportion (Figure EXP.3), comprising mostly Psychological Therapy Services (clinical psychologists; \$258 million) and Focused Psychological Strategies (other psychologists; \$228million). Expenditure on services provided by psychiatrists was the next largest expenditure group (\$342 million or 30.3%). GP expenditure comprised \$269 million (23.8%) of total Medicare-subsidised mental health-related benefits (Table EXP. 16).

Figure EXP.3: Australian Government expenditure (\$ million) on Medicare-subsidised mental health-related services, 2015–16



Note: Totals may not add due to rounding to the nearest \$million.
Source: Medicare data (Department of Health).

Source data Expenditure on mental health services Table EXP.16 (1.73MB XLS).

Nationally, benefits paid for Medicare-subsidised mental health-related services averaged \$46 per person in 2015–16, adjusted for inflation to 2014–15 prices. The average benefits paid per person in Victoria (\$55 per person) was the highest, while those in the Northern Territory were the lowest (\$13 per person) (Table EXP.19).

There was an average annual increase of 5.5% in the total expenditure on Medicare-subsidised mental health-related services (adjusted for inflation) between 2011–12 and 2015–16. This change equates to an

average annual increase (per person) in spending of 3.9%, adjusted for inflation, from \$40 in 2011–12 to \$46 in 2015–16 (Table EXP.18 & 19).

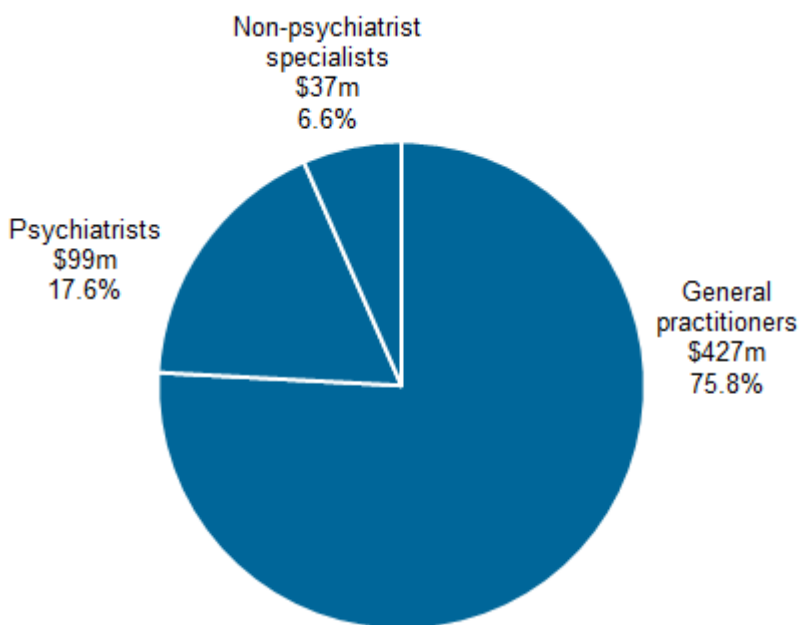
Australian Government expenditure on mental health-related subsidised prescriptions

More recent expenditure data for 2015–16 PBS/RPBS mental health-related subsidised prescriptions are presented in this section.

Australian Government expenditure on mental health-related subsidised prescriptions under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) was \$564 million, or \$24 per person, in 2015–16. This was equivalent to 5.0% of all PBS and RPBS subsidies (\$11.2 billion) (DHS 2016). For further information on data quality, coverage and other aspects of the PBS and RPBS refer to the [data source](#) section (Table EXP.25).

Over three quarters (75.8% or \$427 million) of the expenditure on mental health-related subsidised prescriptions was for prescriptions issued by general practitioners (GPs) (Figure EXP.4). This was followed by prescriptions written by psychiatrists (\$99 million or 17.6%), with non-psychiatrist specialists' prescriptions accounting for 6.6% (\$37 million). Around \$0.4 million of prescriptions were issued where the speciality of the prescriber was unknown (Table EXP.24).

Figure EXP.4: Australian Government expenditure (\$ million) on mental health-related subsidised prescriptions, by prescribing medical practitioner, 2015–16



Note: Expenditure where the prescriber is unknown is included in calculations (representing \$0.4 million or 0.1%); however, it is not illustrated above due to small numbers.

Sources: Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data (Australian Government Department of Health).

Source data Expenditure on mental health services Table EXP.24 (1.73MB XLS).

Prescriptions for antipsychotics (49.6%) and antidepressants (36.5%) accounted for the majority of mental health-related PBS and RPBS expenditure in 2015–16, followed by prescriptions for psychostimulants and nootropics (7.8%), anxiolytics (3.7%) and hypnotics and sedatives (2.3%) (Table EXP.24). See the Prescriptions section for further information about the PBS and RPBS systems.

Real expenditure (constant prices) for mental health-related prescriptions consistently declined between 2011–12 and 2015–16, from \$852 million to \$564 million (Table EXP.26).

References

DHS 2016. Department of Human Services annual report 2015–16. Canberra: Department of Human Services.

Department of Defence 2015. Defence Annual Report 2014–15. Canberra: Department of Defence.

Data source

National Mental Health Establishments Database

Collection of data for the Mental Health Establishments (MHE) National Minimum Data Set (NMDS) began on 1 July 2005, replacing the Community Mental Health Establishments NMDS and the National Survey of Mental Health Services. The main aim of the development of the MHE NMDS was to expand on the Community Mental Health Establishments NMDS and replicate the data previously collected by the National Survey of Mental Health Services. The National Mental Health Establishments Database is compiled as specified by the MHE NMDS.

The scope of the MHE NMDS includes all specialised mental health services managed or funded, partially or fully, by state or territory health authorities. Specialised mental health services are those with the primary function of providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.

The MHE NMDS data are reported at a number of levels: state, regional, organisational and individual mental health service unit. The data elements at each level in the NMDS collect information appropriate to that level. The state, regional and organisational levels include data elements for revenue, grants to non-government-organisations and indirect expenditure. The organisational level also includes data elements for salary and non-salary expenditure, numbers of full-time-equivalent staff and mental health consumer and carer worker participation arrangements. The individual mental health service unit level comprises data elements that describe the function of the unit. Where applicable, these include target population, program type, number of beds, number of accrued patient days, number of separations, number of service contacts and episodes of residential care. In addition, the service unit level also includes salary and non-salary expenditure and depreciation.

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. See the [Mental health establishments NMDS 2014–15: National Mental Health Establishments Database, 2017; Quality Statement](#).

Data validation

Data presented in this publication are the most current data for all years presented. The validation process rigorously scrutinises the data for consistency in the current collection and across historical data. The validation process applies hundreds of rules to the data to test for potential issues. Jurisdictional representatives respond to each issue before the data are accepted as the most reliable current data collection. This process may highlight issues with historical data. In such cases, historical data may be adjusted to ensure data are more consistent. Therefore, comparisons made to previous versions of *Mental health services in Australia* publications should be approached with caution.

New South Wales CADE and T-BASIS services

All New South Wales Confused and Disturbed Elderly (CADE) 24-hour staffed residential mental health services were reclassified as specialised mental health non-acute admitted patient hospital services, termed Transitional Behavioural Assessment and Intervention Service (T-BASIS), from 1 July 2007. All data relating to these services have been reclassified from 2007–08 onwards, including number of services, number of beds, staffing and expenditure. Comparison of data over time should therefore be approached with caution.

New South Wales HASI Program

Since 2006, New South Wales has been developing the [NSW Housing Accommodation Support Initiative \(HASI\) Program](#). This model of care is a partnership program between NSW Ministry of Health, Housing NSW and the non-government-organisation (NGO) sector that provides housing linked to clinical and psychosocial rehabilitation services for people with a range of levels of psychiatric disability. These services are out-of-scope as residential services according to the MHE NMDS, however, are reported as Supported housing places. Expenditure on the HASI program is reported as Grants to non-government-organisations. See the above hyperlink for further information about the NSW HASI program.

Rate calculations

Calculations of rates for target populations are based on age-specific populations as defined by the MHE NMDS metadata and outlined below.

- General services: persons aged 18–64.
- Child and adolescent services: persons aged 0–17.
- Youth services: persons aged 16–24.
- Older persons: persons aged 65 and over.
- Forensic services: persons aged 18 and over.

Crude rates were calculated using the Australian Bureau of Statistics estimated resident population (ERP) at the midpoint of the data range (for example, rates for 2014–15 data were calculated using ERP at 31 December 2014). Historical rates have been recalculated using revised ERPs based on the 2011 Census of Population and Housing, as detailed in the online technical information. Previously, rates from 1992–93 to 1995–96 were calculated using ERP at 30 June of the earlier reference year (for example, rates for 1992–93 were calculated using ERP at 30 June 1992). December ERP data became available in 2012–13 and rates were recalculated using the December ERPs so comparisons with earlier versions of the data tables are not valid.

Reference

DHFS (Commonwealth Department of Health and Family Services) 1996. National Standards for Mental Health Services. Canberra: Commonwealth of Australia.

Private Health Establishments Collection

The ABS conducts a census of all private hospitals licensed by state and territory health authorities and all freestanding day hospitals facilities approved by the Commonwealth Department of Health. As part of that census, data on the staffing, finances and activity of these establishments are collected and compiled in the Private Health Establishments Collection. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication *Private hospitals, Australia* (ABS 2016).

The data definitions used in the Private Health Establishments Collection are largely based on definitions in the *National health data dictionary* (NHDD) published on the AIHW's Metadata online Registry (METeOR) website. The ABS defines private psychiatric hospitals as those licensed or approved by a state or territory health authority and which cater primarily for admitted patients with psychiatric, mental or behavioural disorders (ABS 2016). This is further defined as those hospitals providing 50% or more of the total patient days for psychiatric patients. This definition can be extended to include specialised units or wards in private hospitals, consistent with the approach in the public sector. For further technical information see the Private psychiatric hospital data section of the *National mental health report 2013* (DoH 2013).

The most recent data were collected for the 2014–15 period. Additional information on the Private Health Establishments Collection can be obtained from the ABS publication Private hospitals, Australia (ABS 2016).

References

ABS 2016. Private hospitals, Australia, 2014–15. ABS cat. no. 4390.0. Canberra: ABS.

AIHW 2012. National Health Data Dictionary 2012 version 16. Cat. no. HWI 119. Canberra: AIHW.

DoH (Department of Health) 2013. National mental health report: tracking progress of mental health reform in Australia, 1993–2011. Canberra: Commonwealth of Australia.

PMHA 2013. Private Hospital-based Psychiatric Services 1 July 2011 to 30 June 2012. PMHA-CDMS annual statistical report for the 2011–2012. Private Mental Health Alliance.

[National health data dictionary \(NHDD\) Version 16](#). Viewed November, 2016.

Australian Government expenditure on mental health-related services

The Australian Government Department of Health annually compiles the total Australian Government expenditure on mental health-related services for publication in the National Mental Health Report and related reports. Estimated Australian Government expenditure reported in table EXP.29 of this report covers only those areas of expenditure that have a clear and identifiable mental health purpose. A range of other expenditure, which may be either directly or indirectly related to the provision of support for people affected by mental illness, is not covered in this table. Broadly, this covers:

- programs and services principally targeted at providing assessment, treatment, support or other assistance to people affected by mental ill health;
- population-level programmes that have as their primary aim the prevention of mental illness or the improvement of mental health and well-being; and
- research with a mental health focus.

A range of other expenditure, which may be either directly or indirectly related to the provision of support for people affected by mental illness, is not covered in this table. Expenditure that can be directly linked to mental health service provision but not counted in the table includes:

- An estimated mental health share of Commonwealth payments made to states for the running of public hospitals provided through the non-specific 'base grants' provided to states and territories under the former:
 - Medicare Agreements (1993–98),
 - Australian Health Care Agreements (1998–03, 2003–09),
 - National Healthcare Agreements (2009–2012) and
 - grants and activity-based payments made under the current National Health Reform Agreement.

Because most state and territory mental health services are delivered through public hospitals, and make up about 10% of state-run health services, it is reasonable to assume they benefit from Commonwealth funding contributions. However, estimates are not included in conventional reporting because they fall outside the scope of 'mental health specific' services given that payments are not specifically tagged for mental health purposes.

- From 2006–07, the costs of GP-provided mental health care delivered using MBS general consultation items rather than the mental health specific items introduced to the MBS in November 2006. See section 'Medicare Benefits Schedule—general practitioners' below for further details.
- An estimated mental health share of Commonwealth payments to states for sub-acute mental health services made under the National Partnership Agreement – Improving Public Hospital Services (2009–2014). Although mental health sub-acute beds represented 16% of the growth funded under the Agreement, programme specific expenditure was not tracked under the NPA reporting arrangements preventing mental health estimates being distinguished from payments for other categories of subacute beds. As a broad estimate however, the mental health component of the Agreement represented approximately \$175 million over the period 2010–11 to 2014–15.
- Commonwealth subsidies paid to nursing homes and hostels provided for mental health-related care in nursing homes
- All administrative overheads associated with administration of the mental health items within the PBS and MBS (Note: administrative costs associated with the Department of Health's mental health policy and program management areas are included).

Accurate estimates of the costs of the mental health related components of each of the above items is not possible.

In addition, the Australian Government provides significant support to people affected by mental illness through income security provisions and other social and welfare programs. Consistent with the focus on mental health specific expenditure, these costs have been excluded from the analysis.

The following detailed notes on how estimates specific to Australian Government mental health specific expenditure have been revised in consultation with the Department of Health, building on those described in Appendix 11 of the National Mental Health Report 2010 (DoHA 2010).

Mental health-specific payments to states and territories

For years up to 2008–09, this category covers specific payments made to states and territories by the Australian Government for mental health reform under the Medicare Agreements 1993–98, and Australian Health Care Agreements 1998–2003 and 2008–09. From July 2009 the Australian Government provided Specific Purpose Payments (SPP) to State and Territory governments under the National Healthcare Agreement (NHA) that do not specify the amount to be spent on mental health or any other health area. As a consequence, specific mental health funding cannot be identified under the NHA.

From 2008–09 onwards, the amounts include:

- National Partnership Agreement—National Perinatal Depression Plan—Payments to States;
- National Partnership Agreement—Supporting Mental Health Reform, commencing 2011–12; and
- National Partnership Agreement—Improving Health Services in Tasmania (Innovative flexible funding for mental health), commencing 2012–13

As noted earlier, expenditure reported here excludes payments to states and territories for the development of subacute mental health beds made under Schedule E of the National Partnership Agreement—Improving Public Hospital Services.

The data under this item do not include Department of Veterans' Affairs payments to states and territories for public hospital mental health services delivered to veterans and other eligible recipients. These costs are included under the item 'National programs and initiatives (DVA managed)'.

National program and initiatives (Department of Health managed)

This category of expenditure includes the following programs and activities:

- Initiatives funded through national mental health reform funding provided under special appropriations linked to the Australian Health Care Agreements (excluding amounts reported against Mental health specific payments to states and territories above).
- For years up to 2005–06, this covers the following categories of Commonwealth spending:
 - National Mental Health Program
 - National Depression Initiative (beyondblue)
 - More Options Better Outcomes (ATAPS)
 - Kids Helpline — one off grant 2003–04
 - Youth mental health (headspace)
 - Program of Assistance for Survivors of Torture and Trauma
 - OATSIH Social & Emotional Wellbeing Action Plan
 - Departmental costs
- For the period 2006–07 onwards, programs include the above plus new Department of Health-administered measures funded by the Australian Government under the COAG Action Plan on Mental Health 2006 (excluding MBS expenditure through Better Access) and additional measures introduced in subsequent Federal budgets. Programs added to the category are:
 - Alerting the Community to Links between Illicit Drugs and Mental Illness
 - New Early Intervention Services for Parents, Children and Young People
 - Better Access to Psychiatrists, Psychologists, GPs - Education and Training component
 - New Funding For Mental Health Nurses (Mental Health Nurse incentive program)
 - Support for Day to Day Living program
 - Mental Health Services in Rural and Remote Areas
 - Improved Services for People with Drug and Alcohol Problems and Mental Illness
 - Funding for Telephone Counselling, Self-help and Web based Support Programmes
 - Mental Health Support for Drought Affected Communities Initiative
 - Additional Education Places, Scholarships and Clinical Training in Mental Health - Scholarships and Clinical Training components only
 - Mental Health in Tertiary Curricula
 - National Perinatal Depression initiative (excluding mental health specific payments to states and territories include above)
 - Expansion of Early Psychosis Prevention and Intervention Centres
 - Partners In Recovery Program
 - Leadership in Mental Health Reform

Some of these programs were time limited and do not apply to all data presented in this section. Previous years' reporting also included the programmes 'OATSIH Social & Emotional Wellbeing Action Plan' and 'Improving the Capacity of Health Workers in Indigenous Communities'. Following transfer of responsibility for indigenous programmes to the Department of Prime Minister and Cabinet from 2013–14, expenditure is now reported separately.

Note also that the category excludes expenditure on the National Suicide Prevention Program. While managed by the Department of Health this is reported separately.

National program and initiatives (DSS managed)

This refers to funding outlays on 3 initiatives funded by the Australian Government under the COAG Action Plan on Mental Health (Personal Helpers and Mentors, More Respite Care Places to Help Families and Carers, Community based programmes to help families coping with mental illness) managed by the former Department of Families, Housing, Community Services and Indigenous Affairs (now the Department of Social Services). Collectively, the three programmes are titled 'Targeted Community Care (Mental Health) Program'.

National programs and initiatives (DVA managed)

Reported expenditure includes Repatriation Pharmaceutical Benefits Scheme expenditure, Repatriation Medical Benefits expenditure on general practitioners, psychiatrists and allied health providing mental health care, payment for mental health care provided in public and private hospitals for veterans, grants to the Australian Centre for Posttraumatic Mental Health and expenditure on the Vietnam Veterans Counselling Service and related mental health programs. Note that estimated expenditure on mental health-related Pharmaceuticals includes the costs of anti-dementia drugs for years up to and including to 2009–10 but these have been removed for subsequent years.

DVA provided the following information in respect of its mental health related expenditure in 2014–15.

Data Source EXP.1: Department of Veterans Affairs mental health expenditure, 2014–15

	2014–15 (\$M) ^(a)
Private hospitals ^{(b)(c)(d)}	40.5
Public hospitals ^{(b)(e)}	38.0
Consultant psychiatrists	21.7
Veterans and Veterans' Families Counselling Service (salaries, contracted providers and pro	32.6
Pharmaceuticals	14.7
Private psychologists and allied health	5.4
General practitioners	23.1
Australian Centre for Posttraumatic Mental Health	1.4
Veterans' mental health care—improving access for younger veterans	2.2
Other programs	0.9
Total	180.6

- (a) Expenditure is indicative as not all data sets are fully complete. Small variations may be expected over time.
- (b) Based only on payments made for patients classified to Major Diagnostic Category (MDC) 19 (Mental Diseases and Disorders) under the Australian Refined Diagnosis Related Groups (AR-DRG) classification system. Excludes payments made for patients classified to MDC 20 (Alcohol/drug use and alcohol/drug induced organic mental disorders).
- (c) Private hospital figure includes payments to the hospital only (i.e. any other payments during these episodes such as payments to doctors have been excluded).
- (d) DVA depends on submitted Hospital Casemix Protocol data from private hospitals and Diagnostic Procedure Combinations to obtain correct MDC and diagnosis information. When this information is not available (e.g. provided by hospitals on a quarterly basis and most recent quarter's data not yet received) then an understatement can occur in reporting. For this report, and only in relation to private psychiatric facilities, billing item codes have been used to identify and include mental health data in this category.
- (e) For 2014–15, non admitted costs are included for all jurisdictions except ACT, Tasmania and Northern Territory.

National Mental Health Commission

The Commission commenced operation in January 2012.

Department of Defence-funded programs

The Department of Defence reported mental health-specific expenditure for the first time in 2012–13, with information backdated to 2009–10. Expenditure covers a range of mental health programs and services

delivered to ADF personnel. Increased expenditure over the period reflects, in part, increased accuracy of data capture. Details of the ADF Mental Health Strategy are available at <http://www.defence.gov.au/health/dmh/docs/2011ADFMentalHealthandWellbeingStrategy.pdf> .

National Suicide Prevention Program

This program commenced in 1995–96 as the National Youth Suicide Prevention Strategy but was broadened in later years. Reported expenditure includes all Australian Government allocations made under the national program, including additional funding made available under the COAG Action Plan and subsequent Federal Government Budgets.

Indigenous social and emotional wellbeing programs

This expenditure refers to two programs:

- The OATSIH Social & Emotional Wellbeing Action Plan program that commenced in 1996–97 following the Bringing Them Home report on the 'stolen' generation of Indigenous children. Up to 2012–13 this program was managed by the Department of Health and rolled into the reporting category 'National program and initiatives (Department of Health managed)'. As part of a realignment of responsibility for indigenous affairs, the program was transferred to the Department of Prime Minister and Cabinet in 2013–14.
- The measure titled 'Improving the Capacity of Health Workers in Indigenous Communities' funded under the COAG Action Plan in 2006–07. This measure ceased in 2010–11.

In previous years' reporting, expenditure on these programmes was included under 'National program and initiatives (Department of Health managed)'. From 2013–14, relevant expenditure is now reported separately, with appropriate adjustments to previous years.

Medicare Benefits Schedule—psychiatrists

Reported expenditure refers to benefits paid for all services by consultant psychiatrists processed in each of the index years. Data exclude payments made by the Department of Veterans' Affairs under the Repatriation Medical Benefits Schedule which are included in the item *National programs and initiatives (DVA managed)*.

Medicare Benefits Schedule—general practitioners

Reported expenditure includes data for the Medicare-subsidised Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative described above and in both the *Services provided by general practitioners* section and the *Medicare-subsidised specialised mental health services* section. However, as these new Medicare items were introduced in November 2006, the 2006–07 data do not represent a full financial year for these specific items. The data for this item before November 2006 were estimated to be 6.1% of total MBS benefits paid for GP attendances, based on data and assumptions as detailed in the *National mental health report 2010* (DoHA 2010). To incorporate these changes, GP expenditure reported for 2006–07 was based on total MBS benefits paid against these new items specific to mental health, plus 6.1% of total GP benefits paid in the period preceding the introduction of the new items (July to November 2006). For future years, all expenditure on GP mental health care is based solely on benefits paid against MBS Better Access mental health items, plus a small number of other items that were created in the years preceding the introduction of the Better Access initiative. The latter group includes items that may be claimed by other medical practitioners. This provides a significantly lower expenditure figure than obtained using the 6.1% estimate of previous year because it does not attempt to assign a cost to the range of GP mental health work that is not billed as a specific Better Access item. Comparisons of GP mental health-related expenditure reported in Table EXP. 19 prior to 2007–08 with subsequent years are therefore not valid as the apparent decrease reflects the different approach to counting GP mental health services. Data exclude Repatriation Medical Benefits expenditure on general practitioner mental health care which is included in the item *National programs and initiatives (DVA managed)*.

Medicare Benefits Schedule—psychologists/allied health

Expenditure refers to MBS benefits paid for services provided by clinical psychologists, psychologists, social workers and occupational therapists approved by Medicare, for items introduced through the Better Access to Mental Health Care initiative on 1 November 2006. Note that these items commenced 1 November 2006 and were not available for the full 2006–07 period. MBS benefits paid in relation to a small number of allied health items introduced in 2004 under the Enhanced Primary Care program are also included, but these represent less than 1% of the overall expenditure reported.

Pharmaceutical Benefits Scheme

Refers to all Australian Government benefits for psychiatric medication in each of the index years, defined as drugs included in the following classes of the Anatomical Therapeutic Chemical Drug Classification System: antipsychotics; anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, payments for off line Clozapine ceased on 31 December 2013; however, expenditure was included for all prior years. The amounts reported exclude payments made by the Department of Veterans' Affairs under the Repatriation Pharmaceutical Benefits Schedule which are included in the item *National programs and initiatives (DVA managed)*.

Private Health Insurance Premium Rebates

Estimates of the 'mental health share' of Australian Government Private Health Insurance Rebates are derived from a combination of sources and based on the assumption that a proportion of Australian Government outlays designed to increase public take up of private health insurance have subsidised private psychiatric care in hospitals. For illustrative purposes, the methodology underpinning these estimates is described below, sourced from Appendix 11 of the National Mental Health Report 2010 (DoHA 2010).

In 1997, the Australian Government passed the *Private Health Insurance Incentives Act 1997*. This introduced the Private Health Insurance Incentives Scheme (PHIIS) effective from 1 July 1997. Under the PHIIS, fixed-rate rebates were provided to low and middle-income earners with hospital and/or ancillary cover with a private health insurance fund. Those rebates could be taken in the form of reduced premiums (with the health funds being reimbursed by the Australian Government out of appropriations) or as income tax rebates, claimable after the end of the income year. On 1 January 1999, the means-tested PHIIS was replaced with a 30% rebate on premiums, which is available to all persons with private health insurance cover. As with the PHISS, the 30% rebate could be taken either as a reduced premium (with the health funds being reimbursed by the Australian Government) or as an income tax rebate.

The combined Australian Government outlays under the two schemes, and the estimated amounts spent on private hospital care for 2014–15 are as follows (current prices):

DataSource EXP.2: Estimated amounts spent on private hospital care, 2014–15

2014–15 (\$M)

(A) Total Australian Government outlays on private health insurance subsidies	5,698
(B) Estimated component of Australian Government private health insurance subsidies spent on hospital care	3,239

Source: [AIHW 2016](#). Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW.

Estimation of the 'mental health share' of the amounts shown at (B) is based on the proportion of total private hospital revenue accounted for by psychiatric care. This assumes that if psychiatric care provided by the private hospital sector accounts for x% of revenue, then x% of the component of the Australian Government private health insurance subsidies spent by health insurance funds in paying for private hospital care is directed to psychiatric care. The estimates provided by this approach are shown below (current prices):

DataSource EXP.3: Estimated mental health share of amounts spent on private hospital care, 2014–15

	2014–15 (\$M)
Estimated component of Australian Government private health insurance subsidies spent on hospital care	3,239
Per cent of total private hospital revenue earned through the provision of psychiatric care	4.04%
Estimated 'mental health share' of Australian Government private health insurance subsidies spent on hospital care	131.0

Details of the estimation of private hospital revenue earned from psychiatric care are provided in Appendix 10 of the National Mental Health Report 2010 (DoHA 2010). Total private hospital revenue was sourced from *Private Hospitals Australia 2014–15*, Australian Bureau of Statistics.

Research

Reported expenditure includes mental health-related grants administered by the National Health and Medical Research Council. Data were sourced from the [NHMRC website](#).

Reference

DoHA 2010. National mental health report 2010: summary of 15 years of reform in Australia's mental health services under the National Mental Health Strategy 1993–2008. Canberra: Commonwealth of Australia.

Medicare Benefits Schedule data

The Department of Human Services collects data on the activity of all persons making claims through the Medicare Benefits Scheme and provides this information to the Department of Health. Information collected includes the type of service provided (MBS item number) and the benefit paid by Medicare for the service. The item numbers and benefits paid by Medicare are based on the *Medicare benefits schedule book* (DoH 2014). Services that are not included in the MBS are not included in the data. The table below lists all MBS items that have been defined as mental health-related.

DataSource EXP.4: Medicare-subsidised mental health-related items

Provider	Item group	MBS Group & Subgroup	MBS item numbers
Psychiatrists	Initial consultation new patient ^(a)	Group A8	296, 297, 299
	Patient attendances—consulting room	Group A8	291 ^(a) , 293 ^(a) , 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319
	Patient attendances—hospital	Group A8	320, 322, 324, 326, 328
	Patient attendances—other locations	Group A8	330, 332, 334, 336, 338
	Group psychotherapy	Group A8	342, 344, 346
	Interview with non-patient	Group A8	348, 350, 352

	Telepsychiatry	Group A8	288, 353, 355, 356, 357, 358, 359 ^(b) , 361 ^(b) , 364, 366, 367, 369, 370
	Case conferencing		855, 857, 858, 861, 864, 866
	Electroconvulsive therapy ^(d)	Group T1 Subgroup 13	14224
	Referred consultation for assessment, diagnosis and development of a treatment and management plan for autism or any other pervasive developmental disorder (PDD) ^(d)	Group A8	289
General practitioners	GP Mental Health Treatment Plan—accredited	Group A20 Subgroup 1	2710 ^{(a)(f)} , 2715 ^(g) , 2717 ^(g)
	GP Mental Health Treatment Plan—non-accredited	Group A20 Subgroup 1	2700 ^(g) , 2701 ^(g) , 2702 ^{(e)(f)}
	GP Mental Health Treatment—other	Group A20 Subgroup 1	2712 ^(a) , 2713 ^(a) , 2719 ^{(g)(h)}
	Focussed Psychological Strategies	Group A20 Subgroup 2	2721, 2723, 2725, 2727
	Family Group Therapy	Group A6	170, 171, 172
	Electroconvulsive therapy ⁽ⁱ⁾	Group T10	20104
	3 Step Mental Health Process—general practitioner ^(j)	Group A18 Subgroup 4	2574, 2575, 2577, 2578
	3 Step Mental Health Process—other medical practitioner ^(j)	Group A19 Subgroup 4	2704, 2705, 2707, 2708
Clinical psychologists	Psychological Therapy Services ^(a)	Group M6	80000, 80005, 80010, 80015, 80020
Other psychologists	Enhanced Primary Care	Group M3	10968
	Focussed Psychological Strategies (Allied Mental Health) ^(a)	Group M7	80100, 80105, 80110, 80115, 80120
	Assessment and treatment of PDD ^(c)	Group A10	82000, 82015
	Follow-up allied health service for Indigenous Australians ^(k)	Group M11	81355
Other allied health providers	Enhanced Primary Care—mental health worker	Group M3	10956

Focussed Psychological Strategies (Allied Mental Health)—occupational therapist ^(a)	Group M7	80125, 80130, 80135, 80140, 80145
Focussed Psychological Strategies (Allied Mental Health)—social worker ^(a)	Group M	80150, 80155, 80160, 80165, 80170
Follow-up allied health services for Indigenous Australians—mental health worker ^(l)	Group M11	81325

- (a) Item introduced 1 November 2006.
(b) Item introduced 1 November 2007.
(c) Item may include services provided by medical practitioners other than psychiatrists.
(d) Item introduced 1 July 2008.
(e) Item introduced 1 January 2010.
(f) Item discontinued after 31 October 2011.
(g) Item introduced 1 November 2011.
(h) Item discontinued after 30 April 2012.
(i) Item is for the initiation of anaesthesia for electroconvulsive therapy and includes services provided by medical practitioners other than GPs.
(j) Item discontinued after 30 April 2007.
(k) Item introduced 1 November 2008.

The MBS data presented relate to services provided on a fee-for-service basis for which MBS benefits were paid. The year is determined from the date the service was processed by Medicare, rather than the date the service was provided. The state or territory is determined according to the postcode of the patient's mailing address at the time of making the claim. In some cases, this will not be the same as the postcode of the patient's residential address.

Reference

DoH 2015. Medicare Benefits Schedule Book, effective 01 July 2016. Canberra: Commonwealth of Australia.

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data

The Department of Human Services provides data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) to the Department of Health. Information collected includes the characteristics of the person who is provided with the prescription, the medication prescribed (for example, type and cost), the prescribing practitioner and the supplying pharmacy (for example, location). The figures reported relate to the number of mental health-related prescriptions processed by Medicare in the reporting period, the number of people provided with the prescriptions and their characteristics, as well as the prescription costs funded by the PBS and RPBS.

Although the PBS and RPBS data capture most of the prescribed medicines dispensed in Australia, these data have the following limitations:

- They refer only to prescriptions scripted by registered medical practitioners who are approved to work within the PBS and RPBS and to paid services processed from claims presented by approved pharmacists who comply with certain conditions. They exclude adjustments made against pharmacists' claims, any

manually paid claims or any benefits paid as a result of retrospective entitlement or refund of patient contributions.

- Until 1 April 2012 the PBS and RPBS excluded non-subsidised medications, such as private and under co-payment prescriptions (where the patient co-payment covers the total costs of the prescribed medication) and over-the-counter medications. As of 1 April 2012, under co-payment prescription data are supplied directly to the Department of Human Services (DHS 2013). This permits a more accurate count of this data, similar in quality to that of PBS and RPBS data, so they can be incorporated in the same tables. However, a time series presentation of these data is not possible at this time and comparison with the data from the previously used Drug Utilisation Sub-Committee (DUSC) database should be interpreted with caution as the DUSC survey methodology may have been an underestimate of under co-payment prescriptions volumes.
- The level of the co-payment increases annually and drug prices can reduce for a variety of factors (for example, patent changes), which means that some medicines that were captured in previous years might fall below the co-payment level and thus be excluded in following years.
- Programs funded by the PBS that do not use the Medicare PBS processing system include
 - most Section 100 drugs funded through public hospitals (although the pharmaceutical reform measures for public hospitals under the National Healthcare Agreement and the Chemotherapy Pharmaceutical Access Program are paid through Medicare)
 - Aboriginal health services program
 - Opiate Dependence Treatment Program
 - Special Authority Program
 - Botox (including Dysport)
 - in vitro fertilisation
 - human growth hormones.

Only one of these has a significant bearing on the mental health-related prescriptions data published in the Prescriptions and Expenditure sections: the Aboriginal health services program. Most affected are the data for *Remote* and *Very remote* areas and the data for the Northern Territory. Consequently, the mental health-related prescriptions data in these sections will not fully reflect Australian Government expenditure on mental health-related medications.

The Anatomical Therapeutic Chemical (ATC) classification version used is the primary classification as it appears in the PBS Schedule of Pharmaceutical Benefits. This can differ slightly from the WHO version (WHO 2011). There are two differences between the WHO ATC classification and the PBS Schedule classification that have a bearing on mental health data. Prochlorperazine is regarded as another antiemetic (A04AD) in the PBS Schedule while it is an antipsychotic according to the WHO classification. This means that information on prochlorperazine will not appear in the data provided as it is not classed as an N code in the PBS Schedule. Lithium carbonate on the other hand is classified as an antidepressant in the PBS Schedule while it is an antipsychotic according to the WHO classification. This means that lithium carbonate will appear in the data as an antidepressant rather than an antipsychotic (see the following table).

DataSource EXP.5: Differences between the WHO ATC classification and the PBS Schedule of Pharmaceutical Benefits classification

Drug name	WHO ATC Code	PBS Schedule Code	Scripts dispensed in 2015–16 ^(a)
Prochlorperazine	N05AB04	A04AD	586,284
Lithium carbonate	N05AN01	N06AX	108,034

(a) Prescriptions data using date of service basis.

Source: DHS (Department of Human Services) 2016. Pharmaceutical Benefits Schedule Item Reports website, Canberra: Commonwealth of Australia. Viewed 23 November 2016, < http://medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp >

To avoid double counting in the demographic tabulations, patients are allocated to the last category in which they appear. The category most affected by this will be age group as age is calculated at the time of supply, and patients' ages will be one year greater for prescriptions supplied after their birthday than before it.

State and territory are determined by the Department of Health according to the patient's residential address. If the patient's state or territory is unknown, then the state or territory of the pharmacy supplying the item is reported.

Unless otherwise indicated, the year was determined from the date the service was processed by Medicare, rather than the date of prescribing or the date of supply by the pharmacy.

Drug Utilisation Sub-Committee (DUSC) database

From 1 April 2012, under co-payment prescription data are supplied directly to the Department of Human Services (DoH 2014). That is, the DUSC-sponsored Pharmacy Guild survey ceased to be the source of under co-payment prescription data. This permits a more accurate count of these data, similar in quality to that of PBS and RPBS data. Therefore, time series data should be interpreted with caution as the previous survey methodology may be an underestimate of the volumes of under co-payment prescriptions.

References

WHO (World Health Organization) 2011. ATC: Structure and principles. Oslo: WHO Collaborating Centre for Drug Statistics Methodology. Viewed November 2016, http://www.whocc.no/atc/structure_and_principles/

DoH (Department of Health) 2014. Pharmaceutical Benefits Scheme Collection of Under Co-payment Data, Canberra: Commonwealth of Australia. Viewed November 2016, <http://www.pbs.gov.au/info/statistics/under-co-payment/under-co-payment-data>

Key concepts

Expenditure on mental health services

Key Concept	Description
Average cost per patient day	Average cost per patient day is determined by dividing the total recurrent expenditure of the specialised mental health service by the total number of patient days as presented in the Specialised mental health care facilities section.
Constant price	Constant price estimates are derived by adjusting the current prices to remove the effects of inflation. This allows for expenditures in different years to be compared and for changes in expenditure to reflect changes in the volume of health goods and services. Generally, the constant price estimates have been derived using annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS). In some cases, such indexes are not available, and ABS implicit price deflators have been used instead (AIHW 2015).
Current price	Current price refers to expenditures reported for a particular year, unadjusted for inflation. Changes in current price expenditure reflect changes in both price and volume (AIHW 2014).
Health expenditure	Health expenditure is reported in terms of who incurs the expenditure rather than who ultimately provides the funding. In the case of public hospital care, for example, all expenditures (that is, expenditure on medical and surgical supplies, drugs, salaries of doctors and nurses, and so forth) are incurred by the states and territories, but a proportion of those expenditures are funded by transfers from the Australian Government (AIHW 2014).
Health funding	Health funding is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospital care, for example, the Australian Government and the states and territories together provide over 90% of the funding; these funds are derived ultimately from taxation and other sources of government revenue. Some other funding comes from private health insurers and from individuals who choose to be treated as private patients and pay hospital fees out of their own pockets (AIHW 2014). The national recurrent expenditure on all mental health-related services can be estimated by combining funding from three sources: <ul style="list-style-type: none">• state and territory contributions to specialised mental health services• Australian government expenditure on mental health-related services and contributions to specialised mental health services• private health insurance fund component estimated by the Department of Health.

Patient days	Patient days are days of admitted patient care provided to admitted patients in public psychiatric hospitals or specialised psychiatric units or wards in public acute hospitals and in residential mental health services. The total number of patient days is reported by specialised mental health service units. For consistency in data reporting, the following patient day data collection guidelines apply: admission and discharge on the same day equals 1 day; all days are counted during a period of admission except for the day of discharge; and leave days are excluded from the total. Note that the number of patient days reported to the National Mental Health Establishments Database is not directly comparable with the number of patient days reported either to the National Hospital Morbidity Database (Admitted patient mental health-related care section) or the number of residential care days reported to the National Residential Mental Health Care Database (Residential mental health services section)
Recurrent expenditure	Recurrent expenditure refers to expenditure that does not result in the acquisition or enhancement of an asset—for example, salaries and wages expenditure and non-salary expenditure such as payments to visiting medical officers (AIHW 2014).
Program type	Public sector specialised mental health hospital services can be categorised based on program type , which describes the principal purpose(s) of the program rather than the classification of the individual patients. <i>Acute</i> care admitted patient programs involve short-term treatment for individuals with acute episodes of a mental disorder, characterised by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self and/or others. <i>Non-acute</i> care refers to all other admitted patient programs, including rehabilitation and extended care services (see METeOR identifier 288889).
Target population	Some specialised mental health services data are categorised using five target population groups (see METeOR identifier 445778): <ul style="list-style-type: none"> • Child and adolescent services focus on those aged under 18 years. • Youth services focus on those aged 16–24 years. • Older person programs focus on those aged 65 years and over. • Forensic health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. • General programs provides services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people. <p>Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database.</p>

Reference

[AIHW 2016](#). Health expenditure Australia 2014–15. Health and welfare expenditure series no. 57. Cat. no. HWE 67. Canberra: AIHW