

Monitoring the performance of
Australia's mental health system

National Report Card 2023



Australian Government
National Mental Health Commission

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Acknowledgements

Acknowledgement of Country

The National Mental Health Commission (the Commission) acknowledges the traditional custodians of the lands throughout Australia.

We pay our respects to their clans, and to the elders, past and present, and acknowledge their continuing connection to land, sea and community.

Recognition of Lived Experience

We recognise the individual and collective contributions of those with a lived and living experience of mental ill-health and suicide, and those who love, have loved and care for them. Each person's journey is unique and a valued contribution to Australia's commitment to mental health and suicide prevention systems reform.

Contributors

The Commission acknowledges the assistance and cooperation of the Australian Bureau of Statistics and Australian Institute of Health and Welfare.

A note on language

The Commission acknowledges that language surrounding mental health and suicide can be powerful, emotive and at times contested. People make sense of their experiences in different ways, and there is no consensus on preferred terminology. The Commission has been conscious to use terminology throughout this report that is respectful of those whose experiences we are describing and is well understood by the audience reading this report. This report covers a broad range of topics in relation to mental health and suicide prevention.

Data collection activities and reports use terms like 'mental or behavioural conditions' and '12-month mental disorder' to clearly define the scope of the mental health experience(s) under consideration. This publication uses the same terms as used in these original sources to not misrepresent the findings. The Commission endorses and follows the Mindframe guidelines *Our Words Matter* and *Images Matter*. The Commission also endorses the Mindframe Guidelines on Media Reporting of Severe Mental Illness in the Context of Violence and Crime and requests that media using this report do so in accordance with the Guidelines.

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Joint Foreword

We are pleased to present the National Mental Health Commission's National Report Card 2023 on mental health and wellbeing.

In this report, we present a refreshed approach to annual reporting on the state of Australia's mental health system. Through an empirically-based and simplified approach to reporting, our hope is to provide a more succinct, consistent and informative report to promote transparency and track whole-of-life outcomes for people living with mental health concerns. The report draws together relevant events and available core indicators to reflect on the 2023 calendar year and understand how the system is faring in supporting the mental health of people in Australia.

Overall, the data continues to paint a concerning picture of the state of mental health and wellbeing in Australia. The prevalence of people living with mental illness is at a record high and the determinants of mental health are either not improving or getting worse. We are also not seeing improvements in the system's effectiveness in meeting demand or preventing distress. The latest data in this report strongly reinforces the need to act with urgency in addressing the needs of people with mental health concerns and ensuring the right supports are in place, particularly for our younger generations.

It is also clear that we need a more complete picture of what is happening across the system and why. To that end, the Commission will continue to evolve its national reporting framework to ensure it captures meaningful data and facilitates new insights. We are committed to ensuring the Report Card is a useful product that draws on the right information to inform a national view of the effectiveness of the mental health system. This will be an iterative process as we continue to engage with the mental health sector and governments to refine our framework.

We would like to thank the Australian Bureau of Statistics and the Australian Institute of Health and Welfare for their valuable contributions and guidance to inform this report, along with all of our partners across the mental health sector and governments who provided input to develop this report.



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Executive Summary

The Commission's National Report Card for the 2023 calendar year applies a reporting framework to objectively monitor the performance of Australia's mental health system. Our analysis shows a substantial number of people in Australia are experiencing mental health concerns and many of the factors that impact mental health—such as financial stress, loneliness and discrimination—are not showing improvement. Available data also suggests the system is struggling to meet demand and improve experiences for people, however further data is needed to provide a more complete picture.

Our reporting framework

To provide consistent and objective monitoring and reporting on the performance of the Australian mental health system over time, the National Report Card 2023 (RC2023) applies a reporting framework. The framework organises information and data under three broad domains:

- **Domain 1: Mental health** – the status of key mental health and wellbeing outcomes for people with lived experience of mental health concerns.
- **Domain 2: Social determinants** – the broader social factors that have an impact on mental health of people in Australia, as well as the whole of life outcomes for people with lived experience.
- **Domain 3: System inputs and activities** – the performance of system activities that impact mental health outcomes for people in Australia.

Within each of these domains is a series of data indicators. For RC2023, a core set of initial indicators has been selected for Domains 1 and 2. They were chosen because they represent nationally available, robust and reliable data that align with other relevant frameworks that measure aspects of how the system is performing in meeting the needs of people with mental health concerns. They are a starting point and will be built on in future reports.

For Domain 3, we provide an overview of the type of data available and findings against some example measures commonly used to understand system performance. In future Report Cards, we will expand our understanding of the data landscape by working further with experts—including people with lived experience, carers, family and kin, governments and the sector—to ensure our Report Card focusses on the areas that matter and provides unique and objective insights to inform system improvement.

What the data tells us

Domain 1: Mental health

Rates of mental health concerns have not improved when looking at the whole population, and some cohorts are experiencing increased rates of mental health concerns. In the period between 2020 and 2022 when the latest *National Study of Mental Health and Wellbeing* was carried out, just over 1 in 5 people (21.5%) in Australia aged 16-85 years experienced a mental disorder in the previous 12 months. This represents a slight increase from the previous *National Survey of Mental Health and Wellbeing* in 2007 (19.5%).

The study paints an alarming picture of levels of mental health concerns among young people, and particularly young females. Young people have higher rates of mental disorders relative to older adults. The size of this gap was larger in 2020-2022 compared to 2007. The proportion of people aged 16-24 years with a mental disorder in the last 12 months has increased from 25.8% in 2007 to 38.8% in 2020-2022. When looking at young females specifically, this increase was even larger: from 28.5% in 2007 to 45.5% in 2020-2022. For young males, the increase was from 23.2% in 2007 to 32.4% in 2020-2022.

The latest *National Health Survey* shows that the proportion of adults with high or very high levels of psychological distress has significantly increased over the last decade from 10.8% in 2011 to 14.4% in 2022. And the latest *General Society Survey* shows that life satisfaction among people with a mental health condition has slightly reduced over time from 6.6 on a scale of 1 to 10 in 2014 to 5.8 in 2020.

Domain 2: Social determinants

Data from the Australian Bureau of Statistics and other authoritative sources—including the Melbourne Institute, the Australian Institute of Health and Welfare, and the Commonwealth Department of Education, Skills and Employment—indicate that the determinants of mental health are generally not showing improvement. In some cases, they are deteriorating. For example, there are small increases in loneliness. There are also small increases in the proportion of children considered developmentally vulnerable in Australia. Despite employment rates being consistently high, financial hardship has also risen between 2006 and 2020.

The data also shows people with a mental or behavioural condition are more likely than people without a mental or behavioural condition to report loneliness, experiences of discrimination, lower life satisfaction and being without a permanent place to live in their lifetime. People with a mental or behavioural condition are also less likely to be employed than those without a condition, however this gap appears to have narrowed between 2017-18 and 2022.

Without appropriate focus on improving the determinants of mental health, including financial security and loneliness, Australia's mental health has the potential to decline even further.

Domain 3: System inputs and activities

There are some promising signs that progress is being made on key safety and consumer rights. In 2022–23, the national rate of seclusion for people in public mental health hospital care was less than half the rate reported in 2009-10. Further, the national rate of physical restraint in public mental health hospital care is the lowest since data was first collected in 2015-16.

Some of the available evidence also suggests better coordination of hospital and community care services. For example, nationally, the rate of community follow-up for people within the first seven days of discharge from an acute inpatient psychiatric unit increased from 60.6% in 2012-13 to 75.2% in 2021-22.

However, the number of system performance measures that are not showing positive change is concerning. There are significant shortages of all professions in the mental health workforce. In addition, a substantial proportion of people in Australia delayed seeing or did not see any mental health professional in the last 12 months due to cost in 2022-23 (19.3%). This rate was higher than previous years (2021-22: 16.7%, 2020-21: 12.0%).

Critically, available data suggests the system's ability to provide effective care is not improving. Between 2017-18 and 2021-22, we have not seen significant change in the proportion of consumers experiencing a significant improvement in clinical mental health outcomes following care from public mental health services, or the proportion of consumers reporting positive experiences of public mental health care.

Key considerations and next steps

It is important to keep in mind the environmental context, including the continuing and emerging impacts of the still recent COVID-19 pandemic, compounding natural disasters, global conflicts, and cost of living pressures. These factors likely impacted mental health and service use in different ways, and therefore long-term monitoring is critical.

It must also be acknowledged that currently we have an incomplete national picture as there remains much we do not know. In particular:

- while we have a lot of information on state and territory specialised mental health services, far less is known about outcomes of nationally funded initiatives.

- little data is available on the impact and efficacy of the billions of dollars invested by governments across the system each year, or the experiences and outcomes of people who receive support through the system, and their families, carers and kin.
- we often don't have point-in-time or up-to-date data to understand how the system is currently performing. This delay also means it can take several years for the impact of new initiatives to be seen in the data we have available.

Some jurisdictions have well established frameworks for reporting on mental health or on broader wellbeing across their communities. For example, the Mental Health Commission of New South Wales monitors and reports on *Living Well* Indicators, which draw on some of the same national datasets that this national report uses. Further, the Commonwealth's *Measuring What Matters* framework, led by The Treasury, is seeking to track our progress towards a more healthy, secure, sustainable, cohesive and prosperous Australia. Again, this utilises some of the same national datasets referenced here.

However, there is a critical need for a whole-of-system view of mental health in Australia—across governments, across portfolios and across jurisdictions—that brings the key data together and describes the impact and efficacy of the mental health system holistically. The Commission believes this can be better achieved through consistent monitoring and reporting over the longer term, undertaken collaboratively across jurisdictions and the sector, informed by lived experience and supported by appropriate focus on system design and data collection. Current system understanding and data sets do not adequately support this holistic understanding.

Moving forward, we will be consulting further with governments and the sector to build on the National Mental Health Commission's reporting framework and ensure we are reporting back to all people in Australia on what matters. We will be engaging with a wide range of stakeholders—including data custodians, system analysis experts and lived experience representatives—to inform our selection and refinement of core indicators, along with our reporting framework more generally. We will also work with those stakeholders to support ongoing efforts to improve national data collections, analytical capability and data development activities.

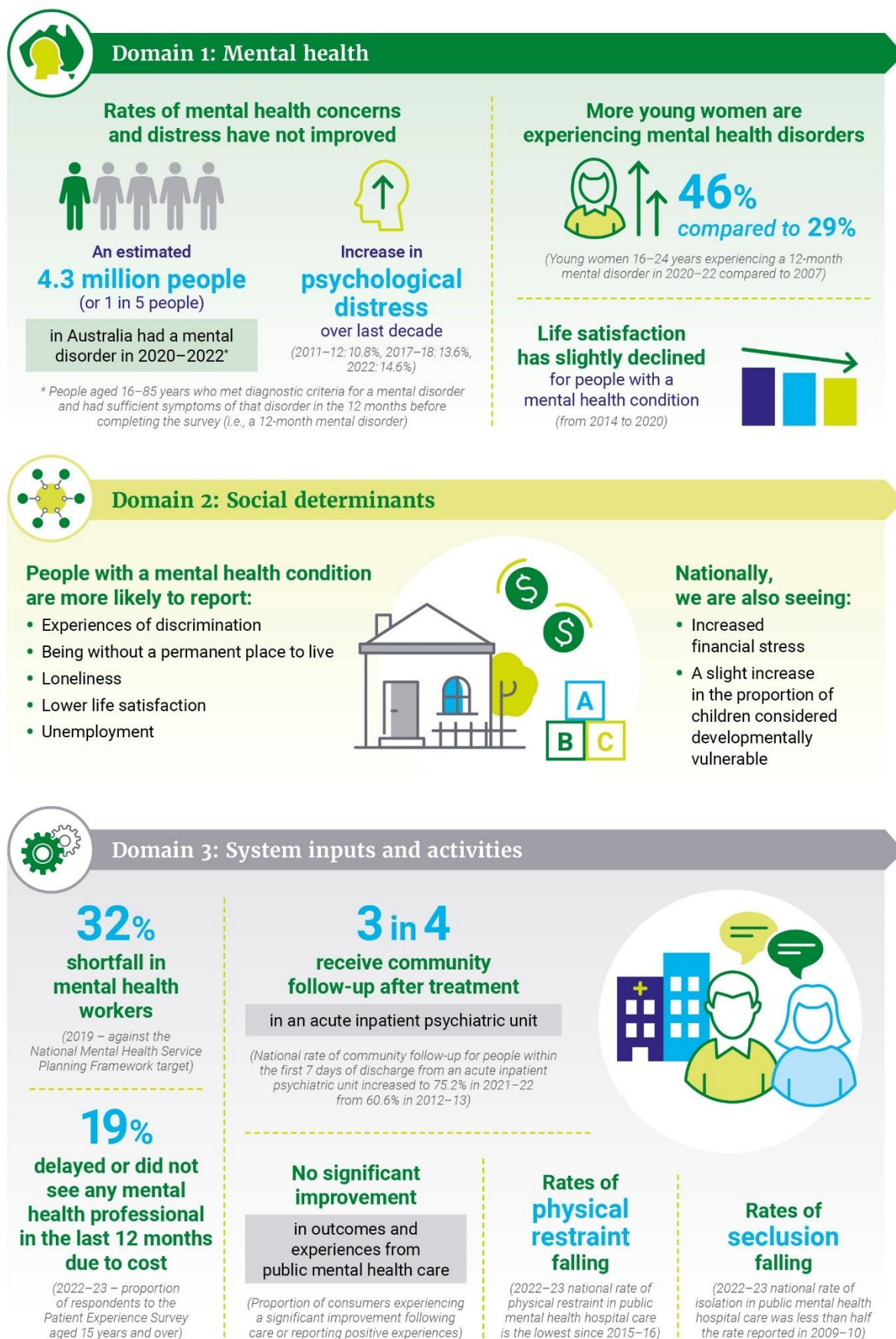
Future Report Cards will be able to include additional indicators, updated data and new analyses, to better understand and measure progress towards an improved mental health system. Our hope is to develop a solid foundation for understanding the effectiveness of the mental health system that is meaningful and that informs change for the better.

How to read this report

The analysis presented in this report is best interpreted in conjunction with the accompanying *National Report Card 2023 Technical Report* (Technical Report). The Technical Report provides a detailed description of the scope, rationale, findings and data source for each of the core indicators. Where this report refers to data and analyses presented in the Technical Report, we have flagged the relevant core indicator (CI) that should be referred to within the Technical Report for further information.

View the Technical Report here: www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports

Figure 1. Snapshot of RC2023



Further details and analysis is contained in the National Report Card 2023 at www.mentalhealthcommission.gov.au

Introduction

Australia's mental health system is a complex interplay of services and supports that are designed, funded and/or delivered by Commonwealth, state and territory governments as well as non-government organisations. Systematic monitoring and reporting of the mental health system provides critical insights into whether investments are addressing the needs of all people with mental health concerns, their carers, families and kin. Conducting monitoring and reporting at a national level enables us to 'zoom out' from individual services, policies and programs to provide a broad and systemic view of the state of mental health and wellbeing in Australia.

Because the National Mental Health Commission does not itself design, deliver or fund any form of service delivery, it is uniquely placed to report on system performance at a national level. The Commission has a level of independence from those entities that do design, deliver or fund parts of the system that allows for more objective analysis and review. As such, providing an annual report on the performance of the mental health system has been a core function of the National Mental Health Commission since its establishment in 2012. This is the Commission's Report Card for the 2023 calendar year.

Significant and cumulative challenges for people living in Australia, including the COVID-19 pandemic and natural disasters, have placed unprecedented demand on an already overstretched mental health system. In response, we have seen new reform activities and governments collectively committing to activities to transform the mental health system, including through the *National Mental Health and Suicide Prevention Agreement* (National Agreement). The National Agreement builds on the policy and reform directions outlined in the *Fifth National Mental Health and Suicide Prevention Plan (2017-2022)* (Fifth Plan) and sets out the shared intention of governments to work in partnership to improve the mental health of people in Australia and enhance the mental health and suicide prevention system. It represents a key step in the mental health and suicide prevention reform agenda and nominates areas requiring immediate reform, including reducing system fragmentation and prioritising investment in prevention and early intervention.

A number of recent reviews and evaluations have called for significant changes in how the system delivers care, including the *National Health Reform Agreement Mid-term Review* and the *Evaluation of the Better Access Initiative*. Similarly, the release of the *National Mental Health Workforce Strategy (2022-2032)* recommended a broad range of actions to ensure a sustainable and effective workforce. In addition, many findings of other recent landmark reports are in the process of implementation or remain relevant today, including those of the *Productivity Commission's Mental Health Inquiry Report*, the *Royal Commission into Victoria's Mental Health System*, the *National Suicide Prevention Adviser Final Advice* and the *Independent Review into the National Disability Insurance Scheme*.

In this context of policy change and new national directions, it is an opportune time to reset the framework guiding the Commission's monitoring and reporting. As such, this Report Card reflects a refreshed approach.

This National Report Card 2023 (RC2023) focuses on an initial set of core indicators that are based on reliable data that are collected nationally. These include indicators of the mental health and wellbeing of people in Australia, the broader social factors that impact on people's mental health, and the performance of the mental health system itself. Moving forward, the Commission intends to use this consistent set of core indicators for each future Report Card, adding additional indicators when and where warranted, to ensure data-driven monitoring and enable comparisons over time.

RC2023 also incorporates the recent results from the Australian Bureau of Statistics' latest *National Study of Mental Health and Wellbeing (2020-2022)*, which provides information on the prevalence of mental disorders among adults in Australia. It reviews this data in the context of a selection of broader trends across the population to provide unique and valuable insights to inform ongoing system improvement. It also looks at data published elsewhere to inform our assessment of the system. RC2023 draws on all these key pieces of information to provide an overarching analysis of opportunities for system improvement.

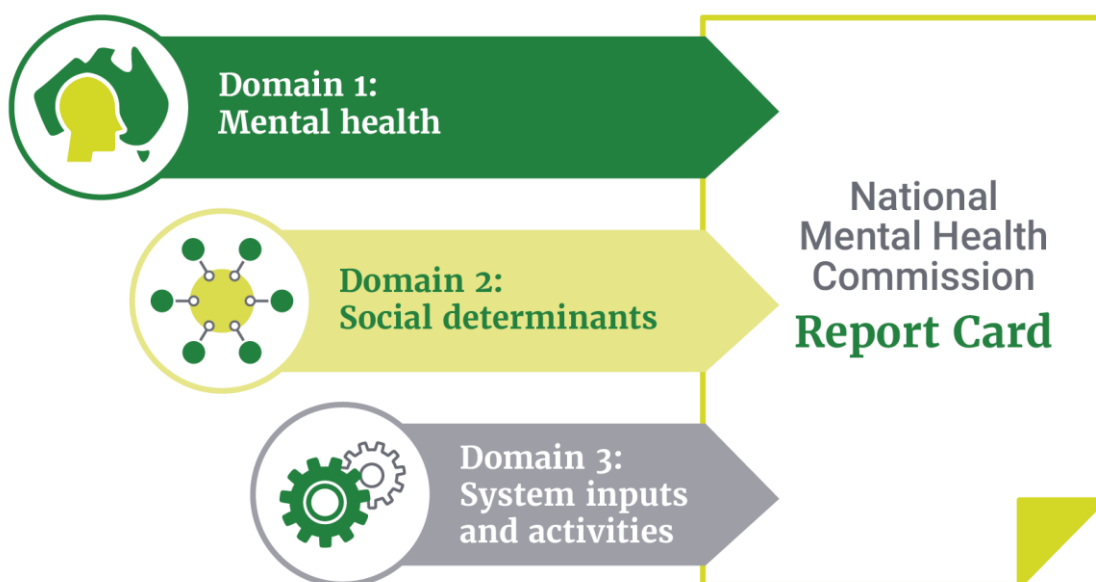
Our reporting framework

RC2023 applies a reporting framework that is designed to provide consistent and objective monitoring and reporting on the performance of the Australian mental health system over time.

Our approach combines data and information relevant to overall system performance to present a unique view of the system at a national level. The framework organises this information under three broad domains (see Figure 2):

- **Domain 1: Mental health** – the status of key mental health and wellbeing outcomes for people with lived experience of mental health concerns.
- **Domain 2: Social determinants** – the broader social factors that have an impact on mental health of people in Australia, as well as the whole of life outcomes for people with lived experience.
- **Domain 3: System inputs and activities** – the performance of system activities that impact the mental health outcomes of people in Australia.

Figure 2. Report Card reporting framework



Within each of these domains is a series of data indicators. For RC2023, a core set of initial indicators has been selected for Domains 1 and 2, based on objective criteria (see Box 1) and informed by a review of existing and proposed mental health indicator frameworks, including:

- the National Mental Health Commission's Contributing Life framework
- [the Fifth National Mental Health and Suicide Prevention Plan indicators](#)
- indicators suggested by the [Productivity Commission's 2020 Mental Health Inquiry](#)
- the [National Mental Health Performance Framework 2020](#)
- the Australian Government's [Measuring What Matters Framework](#)
- indicator and outcomes frameworks developed by states and territories
- priority data items identified under Annex B of the [National Agreement](#) and proposed indicators for initial reporting
- historical advice to the Council of Australian Governments (COAG) on mental health targets and indicators.

Box 1. Criteria for selection of core indicators

- **Nationally available** – derived from robust nationally available data sources with relevant disaggregation to allow analysis of selected population groups
- **Regularly collected** – ideally with an existing time-series
- **Reliable** – sourced from well-supported data collections with robust methodologies
- **Sustainable** – readily accessible and replicable in subsequent years
- **Relevant** – to the Commission’s purpose and unique value-add in monitoring and reporting
- **Foundational** – provides a solid platform for stakeholder feedback and further development in future Report Cards

While each indicator will not necessarily meet every criterion, the criteria help guide the development and continual improvement of the indicator set.

The core indicator sets for Domains 1 and 2 of the framework are outlined in Table 1. The accompanying [Technical Report](#) provides further information about the scope, rationale and findings for these indicators. Due to differences in the collection schedules of the sources for these indicators, the data used in this report vary in the number of years of data available and the time periods they cover. For example, some data sources are annually collected with many years of data available, while others are national surveys that are collected relatively infrequently and have few years of data available to assess trends over time. Where possible, we have used the most recent data available to assess the indicators.

For Domain 3, this report draws on data published elsewhere, including the AIHW’s [Mental Health website](#) and the [Report on Government Services 2024](#) (RoGS). Future reports will consider a broader range of insights from across the data landscape, working further with experts—including people with lived experience, governments and the mental health sector—to ensure our framework focuses on the most important areas to understand system effectiveness.

Table 1. Core indicators for RC2023

Domain	Core indicator (CI)
Domain 1: Mental health	CI 1: Prevalence of mental disorders CI 2: Psychological distress CI 3: Overall life satisfaction CI 4: Feeling in control
Domain 2: Social determinants	CI 5: Proportion of children developmentally vulnerable CI 6: Housing security (homelessness) CI 7: Financial stress CI 8: Employment rate CI 9: Engagement in employment or study for young people CI 10: Prevalence of physical health conditions CI 11: Alcohol consumption CI 12: Feeling lonely CI 13: Experiences of discrimination
Domain 3: System inputs and activities*	*Note: core indicators are not identified for Domain 3 in this report. The report draws on performance data published elsewhere (e.g., on the AIHW’s Mental Health website and the Report on Government Services 2024) and presents on overview of available data on several measures of system inputs and activities, including expenditure, workforce, consumer experience and outcomes, safety, cost, wait time and treatment rates.

It is important to acknowledge that the current indicator list does not reflect every measure that impacts the mental health of people in Australia because data on some factors that are clearly important to mental health are not currently collected in a robust or consistent way.

While these are the core indicators used in RC2023, we intend to continually develop and improve the indicator set in response to feedback and emerging data opportunities. As more data becomes available and new priorities emerge, this reporting framework is expected to evolve over time. However, efforts will also be made to ensure the framework remains high-level and focused on the most important metrics to ensure it provides a clear picture of the state of the system from a national perspective.

We recognise that the three domains are not inherently distinct—changes in one domain will often impact other domains. For example, a lack of housing security can impact psychological distress and life satisfaction. Given these interconnections, analysing indicators across the three domains, along with key contextual information and other data sources, is a key part of this reporting framework in supporting a holistic assessment of system performance.

Box 2. Relationship with other frameworks

Currently, there are a range of national and state level frameworks in Australia that similarly track components of mental health and wellbeing. However, these frameworks vary in their objectives and remit.

For example, in 2023, Australia's first national wellbeing framework—[Measuring What Matters](#)—was introduced to track Australia's progress across five wellbeing themes: healthy, secure, sustainable, cohesive and prosperous. The Framework consists of 50 key indicators that are available to view on an online [dashboard](#) updated annually. Our framework draws on some of the same measures, including psychological distress ([CI 2](#)), life satisfaction ([CI 3](#)), financial stress ([CI 7](#)) and experiences of discrimination ([CI 13](#)). However, our framework is also distinct, presenting a more specific and detailed view of how people with mental health concerns are faring compared to the rest of the community, and to what extent the mental health system specifically is adequately supporting these needs.

In addition to national level frameworks, some states and territories have also developed frameworks to track mental health and wellbeing outcomes among their citizens. These include, for example, the [Living Well indicators](#) reported by the Mental Health Commission of New South Wales, elements of the [ACT Wellbeing Framework](#) and the Victorian *Mental Health and Wellbeing Outcomes and Performance Framework* being developed in response to the *Royal Commission into Victoria's Mental Health System*. Our framework is intended to complement and align with these frameworks. While it draws on some of the same data sources, our framework serves the unique purpose of providing an overarching national view of how well the mental health system is supporting people's needs.



Domain 1: Mental Health

This snapshot shows mental health concerns remain common and continue to be associated with inequitable whole of life outcomes.

How mentally healthy are people in Australia?

Results from the *National Study of Mental Health and Wellbeing* (see Box 3) show that in 2020-2022, just over 1 in 5 people (21.5%) in Australia aged 16-85 years experienced a mental disorder in the previous 12 months (CI 1¹) – equating to an estimated 4.3 million people. This is an increase from 19.5% (or an estimated 3.2 million people) in 2007. This increase represents over 1 million more people experiencing mental health concerns, which is likely placing additional demand on the system.

The Australian prevalence rate is roughly similar to rates observed in comparable countries such as New Zealand, Canada and the United States.² When looking at types of mental disorders, there was a slight rise in the proportion of people in Australia with anxiety and affective disorders. For all types of anxiety disorders other than post-traumatic stress disorder (PTSD) there was an increase in prevalence between 2007 and 2020-2022. However, the largest increase was for the proportion of people with social phobia (2007: 4.7%, 2020-2022: 7.3%) and agoraphobia (2007: 2.8%, 2020-2022: 4.5%). For affective disorders, the largest increase was observed for people who experienced a depressive episode (2007: 4.1%, 2020-2022: 4.9%). In contrast to anxiety and affective disorders, the proportion of people in Australia with substance use disorders has decreased.

Box 3. National Study of Mental Health and Wellbeing, 2020-2022

The *National Study of Mental Health and Wellbeing* (NSMHW) surveyed a total sample of 15,893 people aged 16-85 years over 2020 to 2022 to estimate the prevalence of mental disorders in Australia. Unlike other data sources that rely on people identifying whether they have a particular condition, the NSMHW assesses mental disorders against diagnostic criteria. However, it should be acknowledged that clinical and diagnostic definitions may not necessarily accord with people's lived experience of mental health.

'Mental disorders' included in the survey are defined by the diagnostic criteria of the World Health Organization International Classification of Diseases, Tenth Revision (ICD-10). When interpreting prevalence rates, it should be noted that the NSMHW assessed selected mental disorders (anxiety disorders, affective disorders and substance use disorders) and therefore prevalence rates do not include a range of other mental disorders such as eating disorders, schizophrenia and neurodevelopmental disorders. Certain groups are excluded from the scope of the NSMHW (e.g., people who are homeless or living in aged care facilities).

The NSMHW does not report data on mental health among Aboriginal and Torres Strait Islander people, or people aged under 16 years old. Two studies have recently been funded by the Australian Government to measure mental health prevalence among First Nations peoples, and children and adolescents in Australia. The First Nations Mental Health and Wellbeing Study is currently in its planning phases with data collection expected to commence in 2026, while study design for the Child and Adolescent Mental Health and Wellbeing study is expected to begin in 2024.

The NSMHW is a recent and robust source of information on the prevalence of mental disorders among adults in Australia and several core indicators are drawn from this study (CI 1, CI 6 and CI 10). However, as the NSMHW is conducted relatively infrequently, the RC2023 uses additional data from other sources (CI 2, CI 3 and CI 4) to assess the mental health of people in Australia (Domain 1). These and other additional sources will be explored in future Report Cards to ensure we provide a holistic and up-to-date picture of the mental health and wellbeing of people in Australia.

It is important to note that some population surveys may underestimate the actual number of people with mental disorders given:

- certain groups are sometimes not included in data collections (e.g., people who are homeless or in aged care facilities)
- some survey participants may be reluctant to disclose their experiences and symptoms
- surveys generally assess a selected number of mental disorders.

Similar trends are seen in other data that is more focused on general psychological distress. The proportion of adults in Australia with high or very high levels of psychological distress (CI 2³) has significantly increased over the last decade, and was higher in 2022 (14.6%) compared to both 2017-18 (13.6%) and 2011-12 (10.8%). The increase between 2011-12 and 2022 was statistically significant. Among people with high and very high levels of psychological distress in 2022, close to a quarter (23.8%) reported they did not have a mental or behavioural condition. This is not necessarily unexpected as people can experience negative emotion in the short-term but not experience a mental health condition.

It is also important to keep in mind the period in which data was collected. A number of the data indicators used in this Report Card were collected at a time when there were several measures in place to stop the spread of COVID-19 (e.g., border closures, remote learning and stay at home orders), as well as new supports (e.g., JobSeeker and Crisis payments, and the expansion of Medicare funded telehealth consultations). These factors may have impacted mental health and use of services or supports in different ways. This further emphasises the importance of consistent, long-term monitoring based on nationally consistent and regularly updated data to understand the impact of these factors and accurately interpret trends.

The Commission recognises the broader concept of 'mental health' and therefore includes measures of positive mental health and wellbeing in this Report Card. In 2020, the overall life satisfaction rating for people in Australia—as measured from 0 ('not at all satisfied') to 10 ('completely satisfied')—was 7.2 (CI 3⁴). Importantly, life satisfaction was significantly lower (5.8) among those with a mental health condition compared to those without (7.4). Overall, life satisfaction among people with a mental health condition has slightly reduced over time, from 6.6 in 2014 to 5.8 in 2020. This decline was also present for people without a mental health condition (2014: 7.9, 2020: 7.4).

People vary in the extent to which they believe life events are caused by their own actions, as opposed to outside factors beyond their control. A belief that events in life are within one's own control—i.e., a high sense of control—is generally associated with better mental health and wellbeing outcomes.⁵ In 2019, an estimated 93.1% of people in Australia aged 15 years and over reported feeling a high sense of control (CI 4⁶). However, this proportion was much lower for those reporting a long-term mental health conditionⁱ (74.3%). The proportion of people feeling a high sense of control was relatively steady between 2007 (93.2%) and 2019 (93.1%).

ⁱ In the HILDA survey, the term 'long-term health condition' is used to describe any long-term health condition, impairment or disability which a respondent reports that restricts them in their everyday activities, and which has lasted or is likely to last for six months or more. People with a long-term mental health condition refers to respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.

Box 4. Suicide and self-harm

Rates of suicide in Australia continue to be a significant national concern. Nationally, over the previous 10 years, the age standardised rate of suicide (deaths per 100,000) has increased from 11.2 in 2013 to 12.3 in 2022. In 2022, 3,249 people died by suicide in Australia, making it the 15th leading cause of death in Australia overall and the leading cause of death among people aged 15-44 years. In 2020–2022, 1 in 6 people (16.7% or 3.3 million people) aged 16-85 years in Australia had experienced suicidal thoughts or behaviours at some point in their lives and 8.7% (1.7 million people) had self-harmed in their lifetime⁷.

Historically, suicidal distress has been viewed as a predominantly clinical problem associated with mental illness. As such, mental health and suicide prevention have frequently been coupled together in strategic frameworks and suicide-related indicators have often been included within associated monitoring and reporting.

However, suicidal distress is complex and typically the result of many factors rather than a single isolated cause⁸. In recognition of this, there has been a shift from viewing suicide as a largely clinical problem related to mental illness towards a view that it is a much broader issue arising from a complex interplay of social determinants and risk factors.

This improved understanding does not seek to diminish that mental illness is a contributing factor to suicide, but it does mean monitoring suicides should not be considered a reliable indicator of the effectiveness of the mental health system.

Consistent with this contemporary conceptualisation of suicide prevention, and recognising that other entities (including the National Suicide Prevention Office and Australian Institute of Health and Welfare (AIHW)) consider, monitor and report on the performance of the suicide prevention system specifically, we do not include suicide-related measures as core indicators in this Report Card.

The AIHW's National Suicide and Self-harm Monitoring System collates data on deaths by suicide, intentional self-harm and suicidal behaviour among Australians. It includes a public website to provide information and a restricted portal for vetted users to share content between governments and agencies. For further information, refer to www.aihw.gov.au/suicide-self-harm-monitoring

The National Suicide Prevention Office is developing a National Suicide Prevention Strategy that sets a clear direction for improved suicide prevention efforts across the country, as well as a National Suicide Prevention Outcomes Framework to monitor progress. The Outcomes Framework will identify an agreed set of suicide prevention outcomes and indicators, extending beyond health measures, to meaningfully and comprehensively track progress in suicide prevention. Moving forward, the Commission will be working with the NSPO to ensure our respective frameworks complement each other to collectively provide a fuller picture and add unique value to system improvement.

Is it the same for everyone?

No. Mental health is not experienced evenly across the Australian population and certain groups are at greater risk of experiencing mental disorders.

Females have higher rates of mental disorders. In 2020-2022, close to a quarter of females (24.6%) experienced a mental disorder in the previous 12 months compared with less than one fifth (18.3%) of males.ⁱⁱ Over the period 2007 to 2019 females also consistently reported a lower sense of control compared to males.

Young people have higher rates of mental disorders relative to older adults. The size of this gap was larger in 2020-2022 compared to 2007. The proportion of people aged 16-24 years with a 12-month mental disorder increased from 25.8% in 2007 to 38.8% in 2020-2022 (compared to 18.3% to 18.7% for the rest of the population). This increase was even more pronounced for young females than young males. Almost half (45.5%) of females aged 16-24 experiencing a 12-month mental disorder in 2020-2022, compared to 28.5% in 2007. A third of males (32.4%) aged 16-24 years had a 12-month mental disorder in 2020-2022, compared to 23.2% in 2007.

The increasing rate of mental disorders among young people may be influenced by a complex interplay of factors, such as increased cost-of-living, concerns about climate change, changes in social connection, and the disproportionate impact of COVID-19 on the lives of young people.⁹ While it is well-established that mental health concerns often begin during adolescence,¹⁰ further research is needed to understand the drivers behind this increased distress among young people.

When considering mental health data across population groups, it is important to keep in mind that findings may be influenced by a range of factors, such as experiences of stigma or cultural conceptualisations of wellbeing. Additionally, a person's understanding or familiarity with the concepts being asked about may also influence their responses.

It is important to acknowledge that the initial indicators identified in this Report Card have been disaggregated by age and sex only. There are many other differences in the experience of mental health concerns across groups in our community, including Aboriginal and Torres Strait Islander communities, people living in regional, rural and remote areas of Australia, people from culturally and linguistically diverse communities, LGBTIQ+ people and people with disabilities. We need to understand how attributes like race, gender, sexuality, disability status, neurodiversity, culture and class intersect and impact mental health in groups and communities. A key focus for the development of future Report Cards will be working with stakeholders including data custodians to evolve our reporting framework to better reflect the experience of different groups and explore existing data in new ways to provide a nuanced picture of mental health across Australia.

ⁱⁱ Note comparisons between groups are based on sex assigned at birth, as opposed to gender (man, woman, non-binary) or gender experience (cis experience or trans experience). A disproportionate number of non-binary people (80.4%) and trans and gender diverse people (33.1%) experienced a 12-month mental health disorder. Similarly, people who describe their sexual orientation as Gay or Lesbian, Bisexual or who used a different term (including Asexual, Pansexual and Queer) had higher rates (58.7%) compared to people who described their sexual orientation as heterosexual (19.9%). These elevated rates may reflect a range of different life factors experienced by these population groups, including social, economic and other health-related circumstances, as well as experiences of stigma, discrimination, bullying, violence and exclusion. For further information, refer to www.abs.gov.au/articles/mental-health-findings-lgbtq-australians

Box 5. First Nations people's mental health and wellbeing

Social and emotional wellbeing (SEWB) is an Aboriginal and Torres Strait Islander paradigm – grounded in Aboriginal and Torres Strait Islander understandings of wellbeing and incorporating eight interconnected domains that contribute to an individual's holistic health, including mental health.

Consistent with the principles of Indigenous Data Sovereignty and Indigenous Data Governance, the collection, management and dissemination of data about First Nations people should always include Aboriginal and Torres Strait Islander communities and organisations as equal partners. In recognition of this, use and interpretation of Aboriginal and Torres Strait Islander people's data and information will be made in partnership with First Nations people to ensure reporting of data accurately reflects stories, knowledges and experiences, and captures intrinsic cultural differences, values and priorities.

Created under the [National Agreement on Closing the Gap](#), the SEWB Policy Partnership aims to improve social and emotional wellbeing and mental health for Aboriginal and Torres Strait Islander peoples. As an initiative of the SEWB Policy Partnership, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (2017–2023) is currently under review and being refreshed to reflect contemporary views of SEWB and mental health.

There are several existing data collections and studies underway focused on measuring the SEWB and mental health of Aboriginal and Torres Strait Islander people. These include:

- The [Mayi Kuwayu Study](#): a national longitudinal study focusing on Aboriginal and Torres Strait Islander SEWB which launched in 2018. It aims to understand the cultural determinants of health and their impacts on mental and physical health.
- [Footprints in Time: The Longitudinal Study of Indigenous Children](#) (LSIC): an initiative of the Australian Government that commenced in 2008 and aims to provide quality quantitative and qualitative data on how a child's early years affect their development over the life course. LSIC is guided by a majority Indigenous Steering Committee and involves annual waves of data collection.
- The [National Aboriginal and Torres Strait Islander Health Survey](#): a national survey that collects data on a broad range of health-related topics, including social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. The next data release for the 2022-23 financial year is due to be released on 26 November 2024.

Further information on up-to-date data, emerging research and evaluation projects about Aboriginal and Torres Strait Islander people's wellbeing, mental health and suicide prevention is available within the [Indigenous Mental Health and Suicide Prevention Clearinghouse](#).

Moving forward, we will evolve and improve our reporting framework to ensure it adds value to this existing work, along with other strategic policy work currently under development, including: the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, the *Gayaa Dhuwi Declaration Implementation Framework and Implementation Plan*, and the refresh of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*.



Domain 2: Social determinants

This section presents results from our environmental scan analysis and summarises data related to the social determinants of mental health. Overall, the broad factors that impact mental health are not showing improvement, and in some cases, are deteriorating.

2023 in review

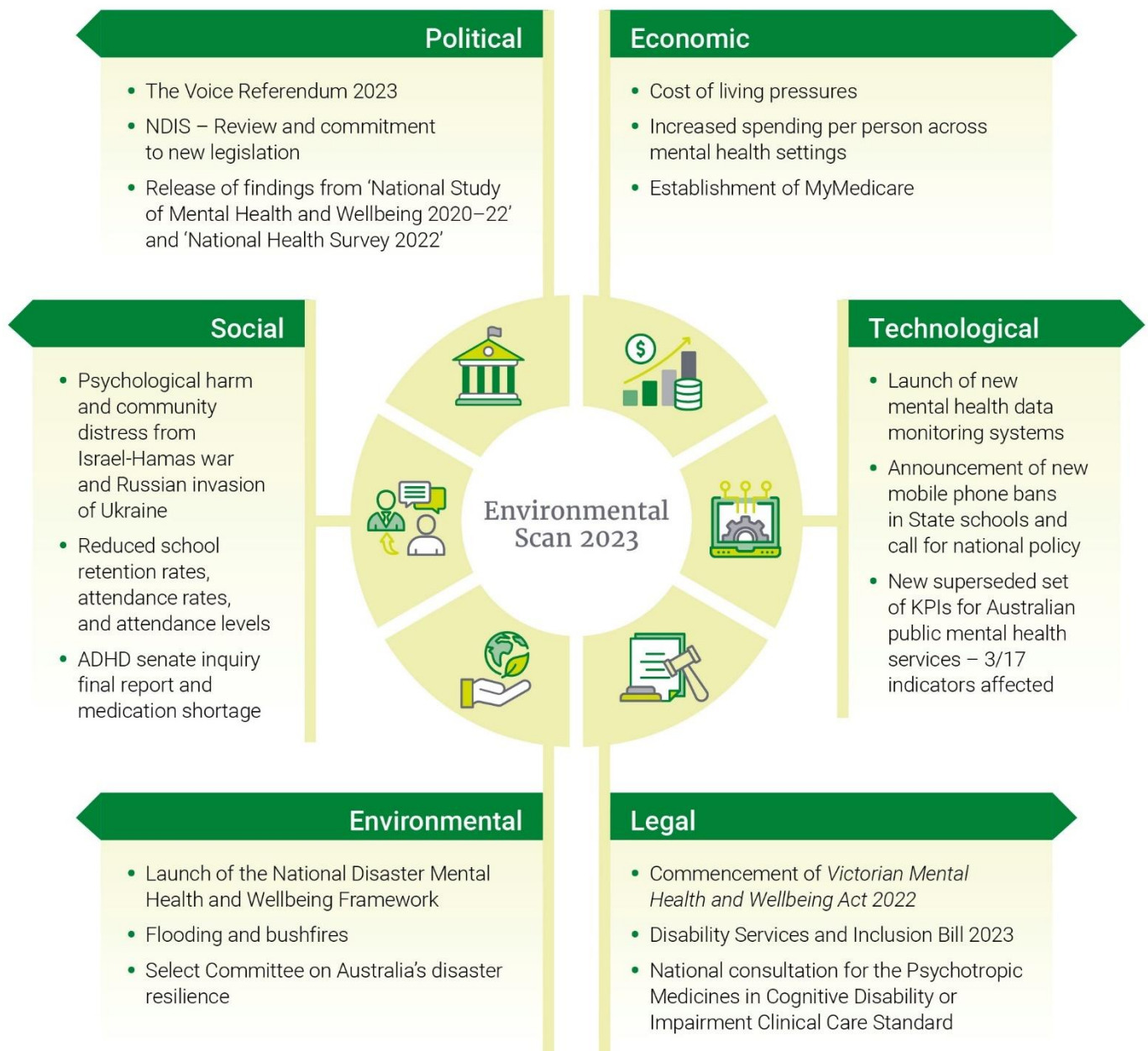
We undertook an environmental scan of major events or trends that may have influenced the mental health of people in Australia between 1 January 2023 and 31 December 2023. As shown in Figure 3, we used a PESTEL methodology (i.e., political, economic, social, technological, environmental, and legal) to identify key events and trends. Environmental shifts were selected according to the relative reach and size of the expected impact on the mental health of people in Australia, the strength of the available evidence supporting the shift and its association with mental health, and its general relevance to the mental health of people in Australia. This environmental scan helps to contextualise data presented within this Report Card.

The year 2023 was characterised by polarising political and social affairs, economic pressures, and continued extreme weather events. The Russian invasion of Ukraine escalated through 2023, alongside the beginning of the Hamas-Israel conflict in October. Together, these geopolitical conflicts resulted in exposure to potentially harmful content and discourse. Intense debate across Australia was also seen in the lead up to and following the Indigenous Voice to Parliament referendum. Compounding natural disasters, including flooding and bushfires in Western Australia, Queensland, Victoria and New South Wales, posed complex recovery challenges. Cost-of-living pressures also took a toll on the financial security of many Australians, putting further pressure on households. We also saw engagement in education and training go backwards, with data revealing reduced school retention and increased school refusal in 2023.

The year was also filled with significant policy activity relating to the mental health system. As a result of the National Disability Insurance Scheme (NDIS) review that was delivered in 2023, National Cabinet committed to implement legislative and other changes to improve the experience of NDIS participants and restore the original intent of the NDIS to support people with permanent and significant disability, within a broader system of support. The Government also introduced a range of reform measures for the Medicare Benefits Schedule and established MyMedicare – a new voluntary patient registration model aimed at formalising the relationship between patients, general practitioners, and other primary care providers.

The environmental scan only captures a small sample of things that happened in 2023. But the events and trends it does capture help contextualise the findings explored elsewhere in this Report Card. The Commission will continue to track events and trends over time through the PESTEL methodology to identify potential impacts on the mental health of people in Australia.

Figure 3. Environmental shifts from 1 January 2023 to 31 December 2023



Are the factors that influence mental health improving?

Our relationships and the environments around us across all aspects of life are critical influences on our mental health and wellbeing. They can promote positive outcomes for people, but they can also drive or exacerbate inequities between population groups. Tracking changes in these conditions is therefore a key piece of the puzzle in understanding the mental health of people in Australia and the broader need for programs, services and supports from the system.

Connecting with others and having stable, supportive relationships has been shown to have a substantial influence on positive mental health and wellbeing. Conversely, loneliness has been linked with greater psychological distress and dissatisfaction with life, along with poor physical and mental health.¹¹ In 2022, approximately 1 in 6 (16.4%) people aged 15 years and over reported lonelinessⁱⁱⁱ (CI 12¹²). This was slightly higher than the estimated proportion in 2019 (15.6%) and 2020 (14.9%). The number of people aged 15-24 experiencing loneliness has increased between 2012 and 2022, while the number of people aged 65 and over experiencing loneliness has been steadily declining since 2001.¹³

Although employment rates are at record highs at the whole-of-population level (CI 8¹⁴), wage growth has been relatively low and we are seeing a continued rise in financial hardship across Australia, which is most acutely impacting single parents with dependent children. The proportion of households experiencing financial stress (CI 7¹⁵) has increased, with 18.7% of people unable to raise \$2,000 within a week^{iv} if needed in 2020, compared to 14.5% in 2006. It is likely that the number of Australians experiencing financial hardship was even higher by the end of 2023, due the general slowing of the economy following COVID-19, inflation and rising interest rates.¹⁶ In the absence of appropriate supports or intervention, this increase in financial stress will likely have flow-on effects for living conditions, psychological distress and life satisfaction more generally.

In terms of physical health, the proportion of people in Australia who have one or more chronic health conditions (CI 10¹⁷) has been relatively stable over time (37.3% in 2007-08 and 37.4% in 2022). However, there has been an overall downwards trend in the proportion of people aged 18 years and over in Australia drinking at risky levels^v (CI 11¹⁸) between 2010 (38.8%) and 2022-2023 (32.3%).

Looking earlier in the life span, we have also seen a small increase in the percentage of children in Australia who were 'developmentally vulnerable' (CI 5¹⁹). The proportion of children who were developmentally vulnerable on one or more domains of the Australian Early Development Census (AEDC) was higher in 2021 (22.0%) than in 2018 (21.7%). This was more pronounced for children living in socio-economically disadvantaged communities and may have been exacerbated by the interruptions COVID-19 caused to early learning, as well as its impact on household stress.

How are people with mental health concerns faring compared to the rest of the community?

Without an adequate system of support, a person's mental health can have a significant detrimental impact on their outcomes across a broad range of determinants that impact one's ability to lead a healthy and fulfilling life, including physical health, employment and housing security. Conversely, we know that these determinants can also have a substantial impact on one's mental health and wellbeing. Understanding the extent to which outcomes across these determinants differ between people with mental health concerns and the rest of the community can therefore provide important insights into the state of the mental health system.

ⁱⁱⁱ The loneliness measure is based on a 3-item scale ('People don't come to visit me as often as I would like', 'I often need help from other people but can't get it', 'I often feel very lonely').

^{iv} Data for the ability to raise \$2,000 is nominal (not adjusted for inflation). The purchasing power of \$2,000 was less in 2020 compared to 2006, yet a higher proportion of people were unable to raise \$2,000 in 2020. The observed increase over time for this measure may therefore under-represent the actual rise in financial stress across the population.

^v i.e., exceeding the Australian Alcohol Guideline released in 2020 (on average consuming more than 10 standard drinks a week, and/or consuming more than 4 standard drinks on any day at least monthly in the last 12 months).

When the system is performing well, we would expect to see an improvement in whole-of-life outcomes among people with mental ill-health, such as in their physical health, their participation in the labour force and their general wellbeing. We would also expect to see a narrowing of the gap between people with mental ill-health and the wider community on these measures.

It should be acknowledged that data collection activities and associated reports commonly assess outcomes for people with a mental health condition overall, as opposed to considering outcomes separately for people with mild, moderate or severe mental illness. However, experiences and outcomes tend to be worse for people with severe mental illness and complex mental health needs.²⁰ The comparisons presented in the following section therefore likely underestimate the actual gap in outcomes between those with severe mental health conditions and the wider community.

Physical health

Equity in health is a fundamental human right. However, people with mental health concerns are more likely to have poorer physical health than those without mental health concerns.²¹ Research shows that people with co-existing mental and physical illnesses tend to die earlier than the general population, with the cause of early death commonly related to physical illness.²² A recently published data linkage project revealed a significant life expectancy gap of 11 years for people in Australia who accessed mental-health related treatments compared to the rest of the population.²³

An estimated 1.7 million people in Australia with a 12-month mental disorder also had a long-term physical condition in 2020-2022 (CI 10). This represents 2 in 5 (39%) people with a 12-month mental disorder. Females were more likely to experience co-occurring mental disorders and physical conditions, when compared to males. There are not enough years of data available to comment on trends over time.

Consuming alcohol is shown to increase the risk of physical conditions and may make existing mental health concerns worse and can affect different age groups in distinct ways. The proportion of people in Australia aged 18 years and over diagnosed or treated for a mental health condition who exceeded the Australian Alcohol Guideline in 2022-2023^{vi} was 36.9% (CI 11). This was higher than the proportion of people without a mental illness (31.6%). The size of this gap has not reduced over time and the proportion of people drinking at risky levels has remained relatively stable among people with a mental health condition since 2013.

Employment and housing security

A host of mental health benefits are associated with employment. We know that participation in personally rewarding work can help provide financial security, develop social and community relationships, and contribute to a sense of purpose and personal fulfilment. In 2022, 71.6% of people with a mental or behavioural condition were employed (CI 8), compared to 82.8% in the rest of the community. We also see a similar but smaller difference when looking at engagement in work or study among young adults (CI 9²⁴). In 2022, among people aged 16-24 years, 89.2% of people with a mental or behavioural condition were employed or studying, compared to 96.4% of people without a mental or behavioural condition.

Interestingly, these gaps are narrower than what we have seen previously. This narrowing could be due to a range of reasons, such as the impacts of COVID-19 on the Australian labour market, including the residual effect of restrictions on migration and changes in demand for different skill sets. They could also be due to more people in Australia identifying as having a mental or behavioural condition, including those with less severe symptoms. It is important that we keep monitoring these differences over time to understand whether recent changes are transient or long term.

As well as employment, a safe and suitable home is important to many aspects of health and wellbeing. In 2022, 17.7% of Australians with a mental or behavioural condition had experienced not having a permanent place to live in their lifetime (CI 6²⁵), compared to 7.6% of the rest of the community. This difference is relatively consistent across age

^{vi} This includes those who consumed more than 10 standard drinks a week and/or more than 4 standard drinks on any day at least monthly in the last 12 months (on average).

groups. These findings align with other data showing a significant proportion of people accessing specialist homeless services in 2022-23 have a current mental health issue (31%).²⁶ Overall, these data show the clear intersection between homelessness and mental health concerns and highlight the need to maintain a focus on monitoring and reporting in this area. While we don't have enough years of data available to see how these figures are changing over time, this will be a focus of future Report Cards as more data becomes available. The connection between family and domestic violence and homelessness, and its impact particularly for women and children will be considered as our reporting framework evolves in response to feedback. For information on the relationships between homelessness and family and domestic violence, refer to [Family, domestic and sexual violence—responses and outcomes](#).

Connection and belonging

Reducing discrimination and promoting social inclusion is critical to improving the wellbeing of people living with mental illness and promoting better mental health across society. Poor social connections and discrimination are among the biggest barriers to living a productive, fulfilling and healthy life. Data suggests we still have a long way to go in addressing these barriers.

In 2020, the proportion of people with a mental health condition who experienced discrimination in the previous 12 months (CI 13²⁷) was significantly higher (20.8%) than that of the rest of the Australian community (12.3%). Of people who experienced discrimination, people with a mental health condition were also more likely to report experiencing discrimination or being treated unfairly “all or most of the time” (14.5%) relative to people without a mental health condition (7.3%). Among people with a mental health condition who experienced discrimination, the most common reasons for the most recent incident of discrimination were the respondent's gender (40.6%), a disability or health issue (31.0%) and age (27.8%).

In 2022, over one-third (34.0%) of people with a long-term mental health condition^{vii} reported loneliness (CI 12). This proportion was higher than the percentage reported for people with no long-term health condition (13.1%) and those with another long-term health condition that was not mental-health related (20.4%).

^{vii} In the HILDA survey, the term 'long-term health condition' is used to describe any long-term health condition, impairment or disability which a respondent reports that restricts them in their everyday activities, and which has lasted or is likely to last for six months or more. People with a 'long-term mental health condition' refers to respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.



Domain 3: System inputs and activities

In this section we explore how the system is functioning in delivering care to people with mental health concerns and highlight where further data is needed to provide a fuller picture.

This section draws on data published elsewhere, including the AIHW's [Mental Health website](#) and the [Report on Government Services 2024](#), which provides annual information on the equity, efficiency and effectiveness of key government services in Australia.

Box 6. Domain 3 indicators

While there is a wide array of potential system indicators, much of the available data is at a detailed service-level, focused on processes or activity, not collected nationally, or already reported through other performance frameworks. We want to ensure that the Report Card draws on the right information and data to enable a whole-of-system view – across governments, across portfolios and across jurisdictions. We also want to make sure that our Report Card provides unique and valuable insights to inform system improvement.

In this Report Card we have provided an overview of the type of data available and findings against some example measures commonly used to understand system performance. In future Report Cards we will expand our understanding of the data landscape by working further with experts—including people with lived experience, carers, family and kin, governments and the sector—to ensure our Report Card focusses on the areas that matter and provides unique insights to inform system improvement.

What resources are being invested in the system?

Expenditure

A key measure of the mental health system's performance is the extent to which the system is adequately funded and resourced to meet the needs of people in Australia now and into the future.

In 2021-22, around \$12.2 billion was spent on mental health related services in Australia. This is equivalent to \$472 per person in the population, and represents an annual average increase of 2% since 2017-18 in real terms (i.e., adjusted for inflation). Approximately \$11.6 billion of overall expenditure was government mental health expenditure (across the Commonwealth and jurisdictions), equivalent to \$449 per person, with the remainder being expended through private health insurance funds and other third-party insurers. Between 2017-18 and 2021-22, Australian Government expenditure increased by an average annual rate of 4% (an increase from \$149 to \$166 per person), while state and territory government expenditure increased by an average annual rate of 3% (an increase from \$268 to \$286 per person). For more information, refer to [Expenditure on mental health-related services](#).

While it is assumed expenditure is connected to increased supports and improved mental health outcomes for people, in isolation, this measure is unable to tell us much about how the system is actually performing. For example, data is unable to tell us whether funding is being directed towards the areas of highest need and/or enhancing access to or improving the quality of services or outcomes. Broad measures of expenditure also don't tell us what factors are driving changes in expenditure over time. Interpreting changes requires a nuanced understanding of the system at the Commonwealth and state and territory levels, and the factors that influence expenditure. For example, changes in spending patterns are influenced by variations in service profile mix over time, such as investment in community mental health services, and PBS expenditure is influenced by various factors including price reduction on medications no longer under patent.

Workforce

In addition to expenditure, the mental health workforce is a critical resource with significant influence on the quality, accessibility, effectiveness and sustainability of the mental health system.

In 2021, for every 100,000 people in Australia, there were 15 psychiatrists, 122 psychologists, 97 mental health nurses, 10 mental health occupational therapists and 10 accredited mental health social workers. Currently, there is minimal reliable data on the total number of lived experience workers in Australia due to the broad scope of lived experience workers' engagement with the mental health sector. However, data is available for specialised mental health facilities: in 2021, there were 329 full time equivalent (FTE) paid consumer workers and 103 FTE paid carer workers employed in such facilities. For more information, refer to [Mental health workforce](#).

The age distribution of the mental health workforce indicates governments' ability to provide sustainable services in Australia. A sustainable workforce is reflected by a high or increasing percentage of workers that are new entrants and/or a low or decreasing percentage of workers who are nearing retirement. In 2022, among medical practitioners (including psychiatrists), nurses and psychologists, the proportion of FTE workers younger than 30 years old ranged between 2.9% and 14.7%, while the proportion of FTE workers aged 60 years or over varied between 16.7% and 24.2%. In contrast, among other allied mental health practitioners, around one quarter (25.1%) of FTE workers were under 30 years old, while 5.9% were 60 years or older. The profession with the highest proportion of mental health workers aged 60 years or over were medical practitioners (24.2%) and this proportion has remained relatively stable over the past 5 years. For more information, refer to the [Report on Government Services 2024](#).

While these findings can be useful in understanding areas for further attention, they are not a substitute for a full workforce analysis that considers factors such as duration of professional training, estimated demand increase, trends in full-time work and skilled migration. Recent national workforce research and analysis suggests critical shortages across all professions in the mental health workforce. In 2019, there was a 32% shortfall in mental health workers when compared to the National Mental Health Service Planning Framework^{viii} (NMHSPF) target²⁸. If this shortage is not appropriately addressed, it is expected to increase to 42% by 2030.

To what extent does the system deliver effective, high quality, safe and responsive care to people with mental health concerns?

Consumer experience

Measuring experiences of consumers and carers is a key component of understanding the effectiveness of the mental health system in meeting the needs of people living with mental illness.

The Your Experience of Service (YES) survey is a national measure of experiences of care among people receiving public mental health care in Australia. The survey was developed in partnership with mental health consumers across Australia and measures feedback across six domains (i.e., Making a Difference, Information and Support, Individuality, Participation, Respect, and Safety and Fairness). In 2021-22, across the jurisdictions where data is currently collected, between 47% and 69% of consumers reported positive experiences of service^{ix} in admitted care, and between 70% and 80% of consumers reported a positive experience in ambulatory care. These proportions have been relatively stable over time. In 2021-22, across the jurisdictions where data is currently collected, between 5% and 13% of consumers rated their overall experience of care as poor^x in admitted care and between 3% and 8% of consumers rated their overall experience of care as poor in ambulatory care.

^{viii} The NMHSPF is a needs-based planning model for mental health services in Australia that quantifies the total mental health need in the community and estimates the resources required to deliver effective care to the population.

^{ix} The positive experience of service score is calculated based on respondent's answers to 22 survey questions. A threshold score of 80 and above (out of 100) is used to indicate a positive experience of service. For further information on interpreting consumer ratings refer to [Consumer perspectives of mental health care](#).

^x Ratings are in response to the survey question "Overall, how would you rate your experience of care with this service in the last 3 months?". Response options include: poor, fair, good, very good and excellent.

It should be noted that there are several features of how the YES survey is administered that limit the conclusions we can draw about how mental health services are experienced across Australia. In particular, the YES survey is currently administered across only three jurisdictions in Australia and there are differences across these jurisdictions in how the survey is administered. In addition, completion of the survey is voluntary and many people accessing services may opt to not complete the survey. Data on the completion rate of the YES survey is not currently collected.

Consumer outcomes

If the system is delivering effective care, we should expect to see a high proportion of consumers experiencing a significant improvement in mental health outcomes following care, and few or no consumers experiencing a significant deterioration or no change in outcomes.

In 2021-22, 71.0% of people discharged from a hospital psychiatric unit showed a significant improvement^{xi} in their clinical mental health outcomes, while close to a quarter (23.7%) showed no change and 5.3% showed significant deterioration. These proportions have remained relatively consistent over the past five years. Among those who completed ambulatory care,^{xii} in 2021-22 just under half (49.7%) showed a significant improvement between baseline and follow-up, while 44.0% showed no change and 6.3% showed significant deterioration. Again, these findings are similar to what has been reported in previous years.

There are several limitations of this metric that must be considered when interpreting these findings. In particular, mental health outcomes are assessed by the service provider (as opposed to the consumer), and the approach considers care and outcomes from a clinical perspective and within discrete segments (hospital and community), rather than measuring overall outcomes across care settings or broader whole-of-life outcomes.

Safety

Ensuring the safety of people accessing mental health services is fundamental to protecting them from harm and improving the quality of services provided.

To help achieve this, mental health services are required to meet a range of safety and quality standards. The majority of expenditure on publicly funded specialised mental health services is through organisations that comprehensively meet the required standards. As at 30 June 2022, 93.7% of expenditure on these services was through organisations that met the required standards.^{xiii} This rate is higher than what has been reported in previous years.

While this trend indicates progress in meeting the standards, it does not tell us about the quality and safety of those services that have not been assessed. It also does not tell us about the quality and safety of many other types of mental health services accessed outside of the public health system, including services in non-government sectors, services in the private sector and those in primary care including general practice. Currently, there is limited national data available to understand the extent to which these services uphold the rights of consumers. Safety incidents and complaints are captured differently through local systems. This is a significant gap requiring attention.

Frequent use of seclusion and restraint may point to inadequacies in the functioning of the overall system, and risks to the safety of people receiving mental health care. Seclusion refers to the confinement of a person at any time alone in a room or area where free exit is prevented. Restraint^{xiv} for the purpose of this report refers to the process of holding down

^{xi} Classifications (i.e., 'significant improvement', 'no change' and 'significant deterioration') are based on the extent of change between the clinical ratings at the 'Start' and 'End' of an episode of mental health care. Classification is based on statistical testing using an effect size metric. For further information, refer to [Consumer outcomes in mental health care](#).

^{xii} Ambulatory care refers to non-admitted, non-residential services provided by health professionals with specialist mental health qualifications or training.

^{xiii} ACT data for 2021-22 were not available at the time of publication.

^{xiv} Although chemical/pharmacological restraint is defined in some jurisdictional Mental Health Acts, national data on this type of restraint is not currently unavailable.

or stopping a person from moving freely, either through use of an item (i.e., mechanical restraint) or one's hands or body (i.e., physical restraint).

In 2022–23, the national rate of seclusion for people in public acute mental health hospital care (excluding the ACT^{xv}) was 5.9 events per 1,000 bed days. This is a decrease from a rate of 6.6 the previous year and is less than half the rate that was reported in 2009–10 (13.9). In 2022–23, the national rate of physical restraint was 9.7 events per 1,000 bed days, while the rate of mechanical restraint was 0.7 events per 1,000 bed days (excluding the ACT). The national rate of physical restraint is the lowest that has been reported since data was first collected in 2015–16, while the national rate of mechanical restraint has remained consistently low over this period.

Currently, we do not have full visibility of use of seclusion and restraint in all mental health care settings, as data collection is limited to acute admitted units in public hospitals. However, national data and reporting—and comparison across services—is shown to drive reductions in the use of these practices and improvements in safety.²⁹ As such, continued and expanded collection and monitoring of this data across the entire mental health system should be a key priority area.

To what extent does the system provide continuity of care and deliver coordinated services?

Continuity of care refers to the ability to provide uninterrupted and integrated care or services across different treatment settings, healthcare practitioners and levels of care or support over time. Research suggests continuity of care is associated with positive consumer experiences, higher satisfaction and improved outcomes^{30,31}. Measures of continuity of care are therefore important in understanding overall system effectiveness.

High or increasing rates of community follow-up after hospitalisation for mental health can indicate the system is performing well in providing continuity of care. Nationally, the rate of community follow-up^{xvi} for people within the first seven days of discharge from an acute inpatient psychiatric unit increased from 60.6% in 2012–13 to 75.2% in 2021–22. However, this data cannot tell us why there was no contact with a community mental health service post-discharge, or if other forms of support were accessed post-discharge. This measure also does not consider the frequency of service contacts following discharge.

Readmission to hospital within 28 days of discharge from inpatient treatment may indicate that treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. As such, a low or decreasing rate of readmissions may suggest that the system is performing well in providing coordinated services and enabling continuity of care. Nationally, the rate of readmission to hospital acute psychiatric units within 28 days of discharge has been relatively consistent from 2018–19 (14.6%) to 2021–22 (14.7%). When interpreting this data, it is important to note that this measure does not distinguish between planned or unplanned readmissions, so an unknown proportion of readmissions are likely to be planned readmissions. Further, in some instances readmissions may reflect the episodic nature of certain mental disorders, as opposed to initial treatment being ineffective. Finally, a reduction in the rate of readmissions could also be driven by poor initial experiences of services, as opposed to improvements in the system's ability to enable continuity of care.

It is important to note that the data we currently have available to measure continuity of care is focused on people who receive care from public hospitals. However, we know people access mental health care in a range of settings outside of

^{xv} ACT data for 2022–23 were not available at the time of publication because the ACT was undergoing data quality assurance work following implementation of the Digital Health Record in November 2022. Data are expected to be available for publication in the 2025 RoGS report.

^{xvi} The provision of a clinically significant service by a specialised mental health service provider(s) for consumers, and/or their carer/support person, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.

public hospitals, including GPs and private practices. As such, overall, we know relatively little about the extent to which the system as a whole provides uninterrupted care across programs and providers.

How timely, affordable and accessible are services to those who need them?

Cost and wait times

There is evidence that the severity, duration and recurrence of mental illness can be modified by early identification of mental health concerns, followed by timely treatment and support.³² As such, an effective mental health system is one where people can readily access support when and where they need it.

While many factors determine the accessibility of mental health care, both cost and wait times can provide an insight into how well the mental health system is operating in responding to people's needs in a timely way. In 2022-23, almost one in five (19.3%) respondents to the ABS' *Patient Experience Survey* indicated they delayed seeing or did not see any mental health professional in the last 12 months due to cost.³³ This rate was higher than what has been reported in previous years (2021-22: 16.7%, 2020-21: 12.0%). A higher proportion of respondents reported delaying or not receiving mental health care due to cost for psychiatrists, psychologists and other mental health professionals (23.4%) compared to GPs (10.4%).

In 2022-23, 59% of people who presented to a hospital emergency department (ED) with a mental health related care need were seen within clinically recommended waiting times according to their triage category, compared to 65% of all ED presentations.³⁴ Approximately 10% of mental-health related presentations had a waiting time longer than 2 hours and 26 minutes, while the median waiting time was 22 minutes. By comparison, 10% of all ED presentations had a waiting time longer than 2 hours and 4 minutes, while the median waiting time was 20 minutes. Data on waiting times for other mental health services, including specialised public mental health services and MBS subsidised services for mental health, is not currently available.

Importantly, other barriers aside from cost and wait time can inhibit access to appropriate care. These include factors such as the availability and cultural appropriateness of services, time pressures and distance to care, as well as past or anticipated experiences of stigma or discrimination. National data on these barriers is currently lacking.

Treatment rates

The delivery of treatment from a mental health professional is a fundamental component of the mental health system. Treatment can play a vital role in easing symptoms, connecting people to other supports and helping people feel supported in their recovery journey. Monitoring the rate at which people in Australia access such treatment is therefore a central focus in assessing system performance.

Nationally, in 2021-22, 9.0% of people in Australia accessed MBS/DVA subsidised mental health services from a *General Practitioner*,^{xvii} 3.5% received services from *Other allied health professionals*; 2.2% received services from *Clinical psychologists* and 2.0% received services from *Psychiatrists*. These rates were higher than the proportion of the population accessing state and territory governments' specialised public mental health services (1.9%) and Private services (0.1%). Overall, these proportions have remained relatively consistent since 2017-18.

Use of state and territory governments' specialised public mental health services was greater among people residing in lower socioeconomic areas, people in outer regional, remote and very remote areas, and Aboriginal and Torres Strait Islander people. For more information, refer to the [Report on Government Services 2024](#).

Monitoring population treatment rates against what is known about the prevalence of mental illness should help provide a broad estimate of unmet need. An increase in treatment rates, combined with a stable or reducing prevalence rate, may

^{xvii} These proportions relate only to services claimed under specified mental health care MBS item numbers. However, an unknown number of people receive GP mental health-related care that is billed as a general MBS item number. As such, the reported percentage likely under-estimates the actual proportion of people who receive mental health care.

point to improvement in the accessibility of services to those who need them. However, due to differences in the collection schedules of the data sources, it is currently not possible for this iteration of the Report Card to make these comparisons between sources and estimate unmet need. Further, service access data cannot indicate whether people are accessing the right services to meet their needs or whether people can readily access care without barriers. Service access data alone also cannot indicate the proportion of people who might benefit from accessing care who do not access care, or their reasons for not accessing care. It also does not tell us what proportion of people choose to self-manage their symptoms or use alternative services or supports.

The recent Better Access Initiative Evaluation³⁵ revealed some interesting insights about the uptake and accessibility of MBS-subsidised mental health services. The evaluation found less than half of those with very high levels of distress used some form of the Better Access service, and 25% accessed psychological treatment,^{xviii} suggesting a large degree of unmet need across the population. It also identified costs of accessing care have increased for consumers, and barriers to accessing the Better Access program were mostly financial for both those who used the service and those who did not.

^{xviii} i.e., services claimed under the dedicated MBS items for psychological therapy services delivered by clinical psychologists and focussed psychological therapy services delivered by psychologists, social workers, occupational therapists and GPs or other medical practitioners.

Next steps

Adopting a refreshed approach to reporting, RC2023 provides a foundation that we can build on over time. Subsequent Report Cards will be able to include additional indicators, updated data and new analyses, to better understand and measure progress towards an improved mental health system. The measures discussed in this iteration of the Report Card are intended as a starting point only.

There has been considerable expansion of mental health data over the last few decades. Examples include the roll-out of a national suite of clinical, functional and self-report outcomes measures for use in mental health services (i.e., the Mental Health National Outcomes and Casemix Collection), the development of the YES survey and the commencement of national data collection on seclusion. However, there are several constraints that limit what we can say about system performance. For example, national data on outcomes for consumers is relatively limited outside of the public health system and delays between collection and release of data often make it difficult to provide a comprehensive and up to date picture of how the system is performing.




































































































One key constraint is that there are a number of areas where data is lacking and adequate indicators are not currently available. Figure 4 shows the available information across the mental health system and illustrates some of the disparities that exist across different service settings. Key information gaps include:






- experiences of mental health workers (including workers with lived experience)
- care people in Australia receive from office-based specialists outside of hospitals, including psychiatrists and psychologists
- needs, experiences and outcomes of people in Australia who see a GP for their mental health
- services provided outside of government to people with mental health concerns
- experiences and outcomes of:
 - families, carers and kin
 - people with severe or complex mental health needs
 - populations who are at higher risk of mental health concerns due to experiencing vulnerability caused by social, economic and/or environmental circumstances.

Addressing data gaps takes significant time, investment and coordination. The information development work occurring through the *National Mental Health and Suicide Prevention Agreement*—including supporting national data linkage and developing priority indicators—will play an important role in addressing these gaps and establishing relationships between inputs, outputs and outcomes to provide a more complete picture of how the system is performing.

In addition to these data gaps, there are challenges in measuring outcomes and attributing them to system performance, given the wide array of variables that can impact a person's mental health. While outcomes may be the result of a particular intervention or treatment, they can also be driven by various social, cultural, environmental and economic determinants. A further complexity is that the policy landscape is constantly evolving, including governments announcing and implementing new and expanded services, programs and other initiatives (see Box 7). Making a true assessment of the effectiveness of the system requires an understanding not only of the specific drivers behind observed outcomes, but of how the various components of the mental health and adjacent systems interact and fit with one another to deliver a cohesive system.

Figure 4. National Mental Health Information Landscape*

		National mental health data							
		Who receives	what services	from whom	why	at what cost	to what effect		
		 Consumer demographics	 Interventions	 Workforce	 Diagnosis	 Government expenditure	 Consumer outcomes	 Experience	 Consumer safety
Population health	Population surveys								
	Australian Government-funded online resources (e.g. Head to Health)		NA	NA	NA	NA			NA
Primary care	General practitioners								
	Primary Health Networks								
	Non-government organisations								
Specialised community care	Office-based specialists								
	Public community mental health services								
	Public residential mental health services								
	Ambulance services								
Hospital care	Emergency departments								
	Public admitted mental health services								
	Private admitted mental health services								

Key:  No information available  Initial information development  Partial information available nationally
 National information available, improvements in data quality required  National information of high quality available NA Not applicable

*This figure was developed by the Mental Health Information Strategy Standing Committee (MHISC) in 2019. Note since the onset of the COVID-19 pandemic in 2020, new data on use of crisis and support organisations (Lifeline, Beyond Blue, Kids Helpline) has been compiled and reported by the AIHW. The most current data are available at [Mental health services in Australia](#).
Source: Mental Health Information Strategy Standing Committee 2019. National Mental Health and Suicide Prevention Information Development Priorities, Third Edition. Commonwealth of Australia, Canberra

A wide variety of data, research, information and perspectives, including across sectors, is required to inform a systemic understanding of progress and gaps in the system. The nuances in interpreting the data outlined in Domain 3 demonstrates the need for a robust approach to system analysis that is informed by extensive engagement with relevant government bodies, the sector, people with lived experience and relevant data custodians.

Developing a national reporting framework that adds value and answers the right questions requires a coordinated, sustained and consistent approach with support from the sector and agreement by governments. Embedding a new approach to monitoring and reporting on the effectiveness of Australia's mental health system will require:

- engagement with other reporting bodies to align efforts and minimise duplication
- technical work and collaboration from governments and other data custodians, including across sectors
- support to consistently capture service level data across both government and non-government providers
- the establishment of governance structures with broad representation that includes lived experience, to provide independent and expert oversight and advice.

Box 7. Key policy developments

Australia's mental health system has undergone significant change—and continues to change—in response to significant reviews and evaluations. Over recent years, a range of reviews and inquiries have concluded and new policy initiatives and reforms have been introduced. In addition to initiatives within each state and territory, at local levels, key activities of national relevance include:

- ongoing implementation of the [*National Mental Health and Suicide Prevention Agreement*](#)
- ongoing implementation of the [*National Mental Health Workforce Strategy \(2022-2032\)*](#) and the [*National Medical Workforce Strategy \(2021-2031\)*](#)
- release of the [*Strengthening Medicare Taskforce Report*](#) and new investments to reform the primary care system
- release of the [*Independent Evaluation of the Better Access Initiative*](#) and subsequent changes to this initiative
- release of the [*Interim Report for the Royal Commission into Defence and Veteran Suicide*](#)
- release of the final report of the [*Independent Review into the National Disability Insurance Scheme*](#) and the announcement of new reforms to improve the experience of NDIS participants
- the [*Mid-term Review of the National Health Reform Agreement Addendum 2020-25*](#)
- the ongoing response to the *Royal Commission into Victoria's Mental Health System*
- establishment of the [*Closing the Gap Social and Emotional Wellbeing Policy Partnership*](#)
- release of the [*National Plan to End Violence against Women and Children 2022-2032*](#)
- new investments through Commonwealth and jurisdictional Budgets to address gaps in the system, minimise barriers to appropriate care, grow the workforce and support effective early intervention and prevention.

To build on the Commission's reporting framework, we will be consulting further with the sector to ensure we are reporting back on what matters. We will be engaging with a wide range of stakeholders—including data custodians, system analysis experts and lived experience representatives—to inform our selection and refinement of core indicators, along with our reporting framework more generally. Noting similar work currently underway to develop a performance reporting approach for the National Agreement, we will be working closely with relevant governance groups to align efforts and ensure the scope of our Report Card presents a unique value add. We will also be exploring different options to enhance accessibility of our reporting, such as interactive online dashboards.

Our framework will continue to evolve to reflect feedback from the sector and community, along with improved data availability. We will be working to further develop the Report Card and other reporting activities to build a transparent and

comprehensive picture that provides unique insights to inform system improvement. Our aim is to develop a solid foundation for understanding the effectiveness of the mental health system that is meaningful and informs change.

So, how are things tracking overall?

Overall, we are not seeing an improvement in mental health and wellbeing for people in Australia over the past decade or more, and some are experiencing a decline in whole of life outcomes.

When considering the broader environmental context of recent years—the continuing and emerging impacts of the COVID-19 pandemic, compounding natural disasters, international conflict and economic challenges—some of these trends are not surprising. However, the findings are certainly concerning. The data clearly shows that the rate of mental health concerns across our population, particularly for our younger generations, is a serious national problem requiring urgent attention. Without appropriate focus on improving the determinants of mental health, including financial security, housing, and loneliness, Australia’s mental health has the potential to decline even further.

The continued disparities for people living with mental illness highlight the clear need to provide a complete picture of what is happening and why. People with a mental or behavioural condition are more likely to report loneliness, lower life satisfaction, feeling a low sense of control, experiences of discrimination, or being without a permanent place to live in their lifetime. They are also less likely to be employed than those without a condition, however this gap appears to have narrowed recently.

In terms of system performance, there are some promising signs that progress is being made on key safety considerations, as shown by a reduction in seclusion and restraint rates. Although these system-level improvements are encouraging, a number of people are still being subjected to adverse events when receiving care. While these people represent a minority of Australians, we must not lose sight of the fact that the impacts of these events can be substantial and long-lasting.

The number of measures that are not showing positive change is concerning. Overall, we are not seeing improvements in the system’s ability to meet demand or to prevent distress. There are significant shortages of all professions in the mental health workforce and a significant number of people in Australia are delaying care due to cost.

Currently, we have an incomplete national picture. There are gaps in available data for certain measures that are important in understanding the whole story. In some cases, these measures simply aren’t collected, while in other cases they were collected a long time ago.

There are also challenges in understanding how well the system is working in preventing the onset of mental health concerns and the need for treatment and support in the first place. Many of the social determinants of mental health sit outside of the health portfolio, such as education, justice and social services. Mental health outcomes are therefore dependent on the availability of services across these areas, how well people are transitioned between them and the extent to which they are resourced to enable early identification of mental health concerns. Early intervention and support delivered in an accessible and responsive manner when mental distress does arise is equally critical. However, sufficient data is currently not available to understand the impact and effectiveness of all these parts of the system.

Meaningful system metrics are crucial in telling the whole story of how we are progressing in improving the mental health and wellbeing of people in Australia and what needs to change. These measures need to be carefully selected in partnership with experts to ensure we are drawing on the right information to add value to existing monitoring and reporting efforts. It is imperative that these gaps are addressed to enable us to closely monitor progress towards improving outcomes for people with mental health concerns.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AEDC	Australian Early Development Census
CALD	Culturally and Linguistically Diverse
CI	Core Indicator
COAG	Council of Australian Governments
ED	Emergency Department
AIHW	Australian Institute of Health and Welfare
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
FTE	Full Time Equivalent
HILDA	Household, Income and Labour Dynamics in Australia
ICD-10	World Health Organization International Classification of Diseases, Tenth Revision
LGBTIQA+	Lesbian, Gay, Bisexual, Trans, Intersex, Queer/Questioning, Asexual
LSIC	Longitudinal Study of Indigenous Children
MBS	Medical Benefits Schedule

MHISSC	Mental Health Information Strategy Standing Committee
National Agreement	National Mental Health and Suicide Prevention Agreement
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NSMHW	National Study of Mental Health and Wellbeing
PBS	Pharmaceutical Benefits Schedule
PESTEL	Political, Economic, Social, Technological, Environmental and Legal
PHN	Primary Health Networks
PTSD	Post-traumatic stress disorder
RC2023	National Report Card 2023
RoGS	Report on Government Services
SEWB	Social and emotional wellbeing
YES survey	Your Experience of Service Survey

Glossary

Affective Disorder

Affective disorders involve mood disturbance or change in affect. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

Agoraphobia

Characterised by marked and consistently manifested fear in, or avoidance of, at least two of the following situations: crowds, public places, travelling alone and travelling away from home.

Ambulatory mental health care

Mental health care provided to hospital patients who are not admitted to hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Anxiety Disorder

Anxiety disorders generally involve feelings of tension, distress, or nervousness. A person may avoid, or endure with dread, situations which cause these types of feelings.

Community mental health care

Government-funded and government-operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

Consumer

A person living with mental illness who uses, has used or may use a mental health service.

Loneliness

The loneliness measure is based on a 3-item scale ('People don't come to visit me as often as I would like', 'I often need help from other people but can't get it', 'I often feel very lonely').

Long-term health condition

In the HILDA survey, the term 'long-term health condition' is used to describe any long-term health condition, impairment or disability which a respondent reports that restricts them in their everyday activities, and which has lasted or is likely to last for six months or more. People with a long-term mental health condition are respondents who indicated they had a nervous or

emotional condition which requires treatment or/and any mental illness which requires help or supervision.

Mental disorder

A mental disorder is characterised by a 'clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour³⁶'. The term itself covers a range of disorders including anxiety, affective and substance use disorders.

Psychological distress

Measured using the Kessler Psychological Distress Scale. The scale measures the level of current anxiety and depressive symptoms a person may have experienced in the 4 weeks before the interview.

Restraint

The process of holding down or stopping a person from moving freely, either through use of an item (i.e., mechanical restraint) or one's hands or body (i.e., physical restraint).

Seclusion

The confinement of a consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

Specialised mental health services

Services with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. This includes admitted patient mental health care services, ambulatory mental health care services and residential mental health care services.

Substance use disorder

Substance use disorders involve the harmful use and/or dependence on alcohol and/or drugs. The misuse of drugs, defined as the use of illicit substances and the misuse of prescribed medicines, included opioids, cannabinoids, sedatives and stimulants.

Social phobia

Characterised by fear and/or avoidance of one or more social or performance situations, such as meeting new people, going to social gatherings, speaking up in a meeting or class and performing in front of an audience.

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