Monitoring and reporting on Australia's mental health system

National Report Card 2025

Technical Report

Australian Government
National Mental Health Commission

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Acknowledgement

Acknowledgement of Country

The National Mental Health Commission (the Commission) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters on which we live, work and learn.

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.

The Commission's Report Card Technical Report presents a population level view of mental health in Australia, drawing on large-scale data and trends. We acknowledge that behind every statistic is a person and their lived experience.

We are privileged to report on high-quality data and evidence and thank everyone who has participated in surveys, shared their experiences through data collection, and contributed to advancing knowledge and practice in this field.

Contributors

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

A note on language

The Commission acknowledges that language relating to mental health and suicide is not neutral and evolves over time. It can influence how people experience, interpret and respond to these issues, carry different meanings for different people and communities, and may at times be contested. 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.

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.

Support

Support is available if you or someone you care for is in need of assistance. For information on support go to: www.mentalhealthcommission.gov.au/find-support

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Overview

Each year, the National Mental Health Commission (the Commission) publishes a report on the state of Australia's mental health system. In the National Report Card 2023, the Commission refreshed its reporting approach, drawing on a small number of meaningful core indicators to inform the Commission's assessment of how the system is performing.

The core indicators were selected as an initial set, based on objective criteria and informed by a review of existing and proposed mental health indicator frameworks. A respective primary data source was identified for each core indicator. These data sources were selected as they represent robust and reliable measures of mental health and social determinants. While the Commission intends to track these primary data sources over time, many of these data sources are not updated annually as they represent very large nationally representative surveys.

In 2025, the Commission has continued this empirically based approach to reporting. The Report Card 2025 provides:

- updates across the core indicators, where updated data is available from the *primary* data source
- an overview of new data from *supplementary* data sources collected up to, and throughout the 2025 calendar year to provide a more detailed and contemporary picture of how key outcomes are tracking over time.

For the first time, Report Card 2025 includes defined indicators in Domain 3 – the mental health system. The Commission developed this revised domain with stakeholders, building on previous Report Cards and emerging evidence. In this domain, guiding questions are applied across five key themes and draw on indicators to explore aspects of the mental health system performance. Gaps in data coverage which limit our understanding of the mental health system are also highlighted throughout this domain.

Accompanying the National Report Card 2025 is this document – the *National Report Card 2025 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. The Technical Report explores data from our *primary* data sources and supplementary data sources where necessary. For technical information on data sources, please see Appendix 1 of the National Report Card 2025.

For each core indicator (**CI**) in Domains 1 and 2, the Technical Report outlines what we are tracking and why, a summary of what the most recently available data tells us, technical information about the primary data source and additional information that is important to consider when interpreting the results. Where possible, for each Domain 1 and 2 indicator the Technical Report explores:

- data at both a whole of population level and for people with lived experience of mental health challenges
- comparisons between males and females, and different age groups
- comparisons between people living in different geographic areas (e.g., Major Cities, Inner Regional areas, Outer Regional and remote areas)
- comparisons between people with different levels of relative socio-economic advantage and disadvantage[1] (i.e., access to material and social resources, and their ability to participate in society).

[1] Australian Bureau of Statistics. *Socio-Economic Indexes for Areas (SEIFA), Australia* [Internet]. Canberra: ABS; 2021

For Domain 3, the Technical Report provides technical information about the data sources used for indicators in each theme. It also provides any additional information that is important to consider when interpreting results presented in Report Card 2025.

Scope, rationale, and additional findings are not presented for Domain 3 indicators, as these were published in *Report Card 2025*. Readers should refer to Domain 3 of Report Card 2025 when interpreting the technical information reported here.

For more information, including on the Commission's reporting framework and selection of core indicators, please see the full National Report Card 2025 available at www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports.

Domain 1 - Mental Health

CI 1: Prevalence of mental disorders

What we are tracking (and why)

This indicator tracks the prevalence of 12-month anxiety, affective and substance use disorders for people in Australia aged 16-85 years. Prevalence rates help us understand how common mental disorders are for people in Australia. While subject to a wide array of factors, low or reducing prevalence rates may indicate improvements in the mental health system, and/or improvements in external factors that impact mental health across society.

How are mental disorders defined?

National Study of Mental Health and Wellbeing (NSMHW)

In the NSMHW, 12-month mental disorders refer to the number of people who met the diagnostic criteria for having a mental disorder at some time in their life and had sufficient symptoms of that disorder in the 12 months prior to when they completed the survey. A person may have more than one 12-month mental disorder.

In the NSMHW, three groups of mental disorders were assessed – *Anxiety, Affective and Substance Use disorders*. These groups are based on definitions and criteria of the World Health Organisation International Classification of Diseases, Tenth Revision (ICD-10).

National Health Survey (NHS)

In the NHS, mental or behavioural conditions are described as 'Persons who have a current, self-reported mental and behavioural condition that has lasted, or is expected to last, for 6 months or more. Condition is not based on any diagnostic screening tool.'

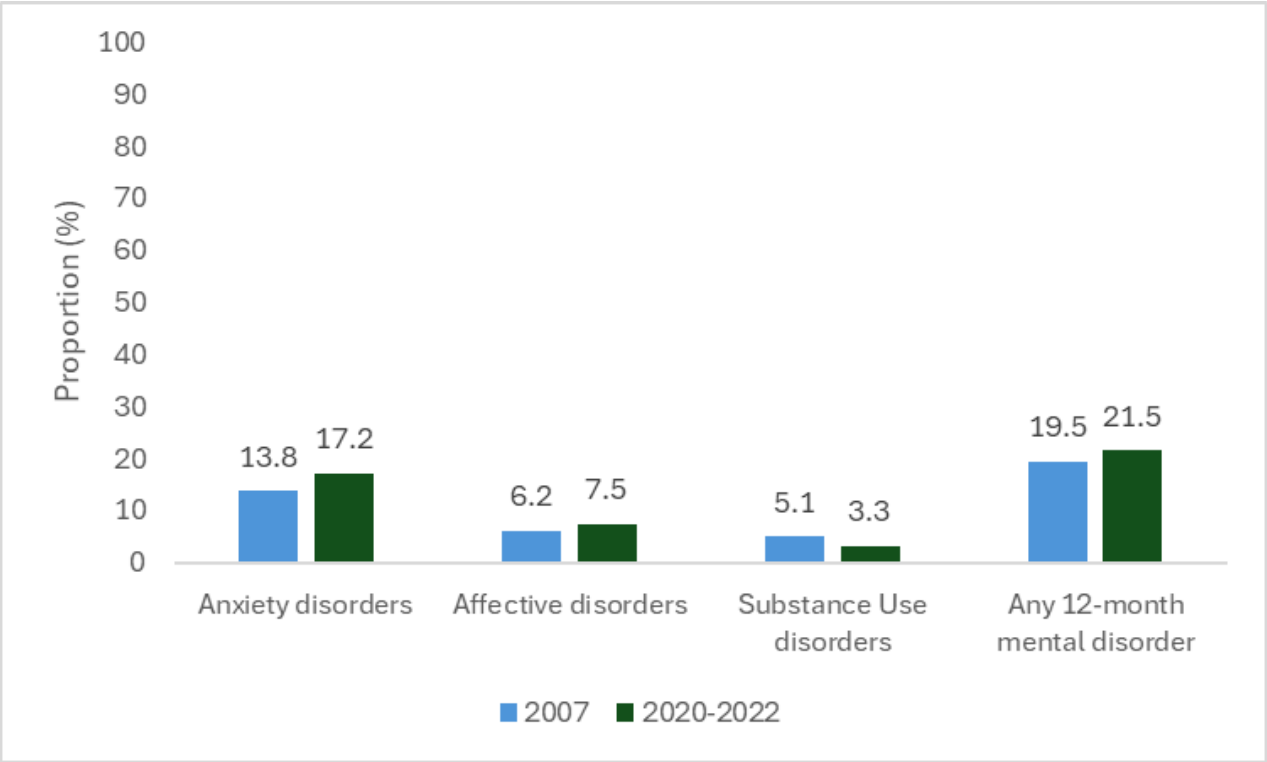
What the data tells us

Indicator findings

Between 2007 and 2020-2022:

- The estimated number of people with a 12-month mental disorder has increased, from 3.1 million (19.5%) in 2007 to 4.3 million (21.5%) in 2020-22.
- The proportion of people in Australia with a substance use disorder has decreased (from 5.1% to 3.3%)
- The proportion of people with an anxiety disorder has increased (from 13.8% to 17.2%)
- The proportion of people with an affective disorder has increased (from 6.2% to 7.5%).

Figure A1. Proportion of people aged 16-85 years in Australia with a 12-month mental disorder, by disorder type, 2007 to 2020-2022



How do these findings differ between groups?

Age and Sex

In 2020-2022:

- Females were more likely than males to have a 12-month mental disorder (24.6% compared with 18.3%)
- Females were more likely to experience anxiety (21.1%) and affective disorders (8.6%) compared with males (13.3% and 6.5%)
- Males were more likely to experience substance use disorders than females (4.4% compared with 2.1%)
- 12-month mental disorders were more common among people aged 16-34 years relative to older adults aged 65-85 years (31.7% compared with 9.6%).

Between 2007 and 2020-2022:

- The proportion of people who had a 12-month mental disorder increased (from 19.5% to 21.5%)
- The proportion of people aged 16-24 who had a 12-month mental disorder increased (from 25.8% to 38.8%)
- Around 1 in 3 males aged 16-24 years had a 12-month mental disorder in 2020-22 (32.4%), compared with 23.2% in 2007
- Almost half (45.5%) of females aged 16-24 years had a 12-month mental disorder in 2020-22, compared with 28.5% in 2007
- An increase over time, although less pronounced, was also observed for females aged 25-34 years, and for both sexes aged 55-64 years and 65-74 years.

- The only age group that showed a reduction in the prevalence of 12-month mental disorders over time was the 35–44-year age group, for this group between 2007 and 2020-2022:16.7% of males had a 12-month mental disorder in 2020-2022, compared with 20.5% in 2007.
- Almost 1 in 4 females had a 12-month mental disorder (23.8%), compared with 24.9% in 2007.

Remoteness and Socioeconomic indexes

According to the NSMHW, in 2020-2022, more than 1 in 5 people living in *Major cities* had a 12-month mental disorder (21.3%), similar to people living in *Inner regional* areas (22.3%), or *Outer regional* areas (21.5%). According to the NHS, 2022, people living in the most socioeconomically disadvantaged areas (Quintile 1) were more likely to have a mental or behavioural condition (29.9%), compared with people living in the least socioeconomically disadvantaged areas (Quintile 5; 20.1%).

Technical information

Source

Australian Bureau of Statistics (ABS) *National Study of Mental Health and Wellbeing, 2020-2022*; ABS *National Survey of Mental Health and Wellbeing, 2007*

ABS National Health Survey 2022

Frequency of data collection

Irregular. No future releases scheduled.

Limitations

- The study sample was designed to provide reliable national-level estimates, and thus there are limited state and territory breakdowns available.
- Estimates of the number of people with mental disorders may be lower than reality given the study assesses a selected number of mental disorders and certain groups are excluded from the scope of the NSMHW (e.g., people who are homeless or living in aged care facilities).
- The NSMHW uses objective diagnostic criteria, prevalence estimates are generally recorded only for disorders that affect more than 1% of the population, and less common disorders may not be captured. Therefore, results may not necessarily reflect people's lived experience of mental health.

Additional notes

- Data for this study was collected in two stages. The first cohort was conducted between December 2020 and July 2021. The second cohort was conducted between December 2021 and October 2022. Data presented in this report are derived from the combined sample of both cohorts. Data was collected through a face-to-face interview with an ABS interviewer for each respondent. Detailed information on the methodology is available on the ABS website.
- Mental disorders were classified according to the World Health Organization's International Classification of Diseases, Tenth Revision (ICD-10). Changes were made to diagnostic criteria for post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) between the 2007 and 2020-2022 surveys. Data for 2007 in this report is re-derived using diagnostic criteria used in the 2020-2022 survey.
- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- There are four SEIFA indexes, each summarising a different aspect of the socio-economic conditions in an area using different Census data.

    - For NSMHW analysis, the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) is used, which focuses on both advantage and disadvantage.
    - For NHS analysis, the Index of Relative Socio-economic Disadvantage (IRSD) is used, and focuses on relative socio-economic disadvantage.
- SEIFA analysis was updated for Report Card 2025 with NHS data to align with findings in Report Card 2025. Findings above supersede analysis from previous reporting.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2016.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.

CI 2: Psychological distress

What we are tracking (and why)

This indicator tracks the proportion of people in Australia aged 18 years and over experiencing high or very high levels of psychological distress.

Psychological distress, especially when experienced for prolonged periods of time, is associated with mental health conditions.[2] Monitoring levels of psychological distress helps assess the mental health and wellbeing of people in Australia outside of diagnostic criteria. People with or without mental or behavioural conditions may experience negative emotional states for any length of time, and this indicator may provide an estimate of the need for support and services across the population. As with mental disorder prevalence rates, low or reducing levels of psychological distress may signal a more effective mental health system and/or improvements in external factors that impact mental health and wellbeing across society.

How is psychological distress measured?

For the NHS, psychological distress is measured using the Kessler 10 Psychological Distress Scale (K10). The K10 scale includes questions regarding negative emotional states experienced in the past 30 days.

As the K10 scale provides a point-in-time assessment of distress levels amongst the population, it does not signify longer-term levels of psychological distress. For more detailed information on the methodology, please see the https://www.abs.gov.au/methodologies/national-health-survey-methodology/2022.

What the data tells us

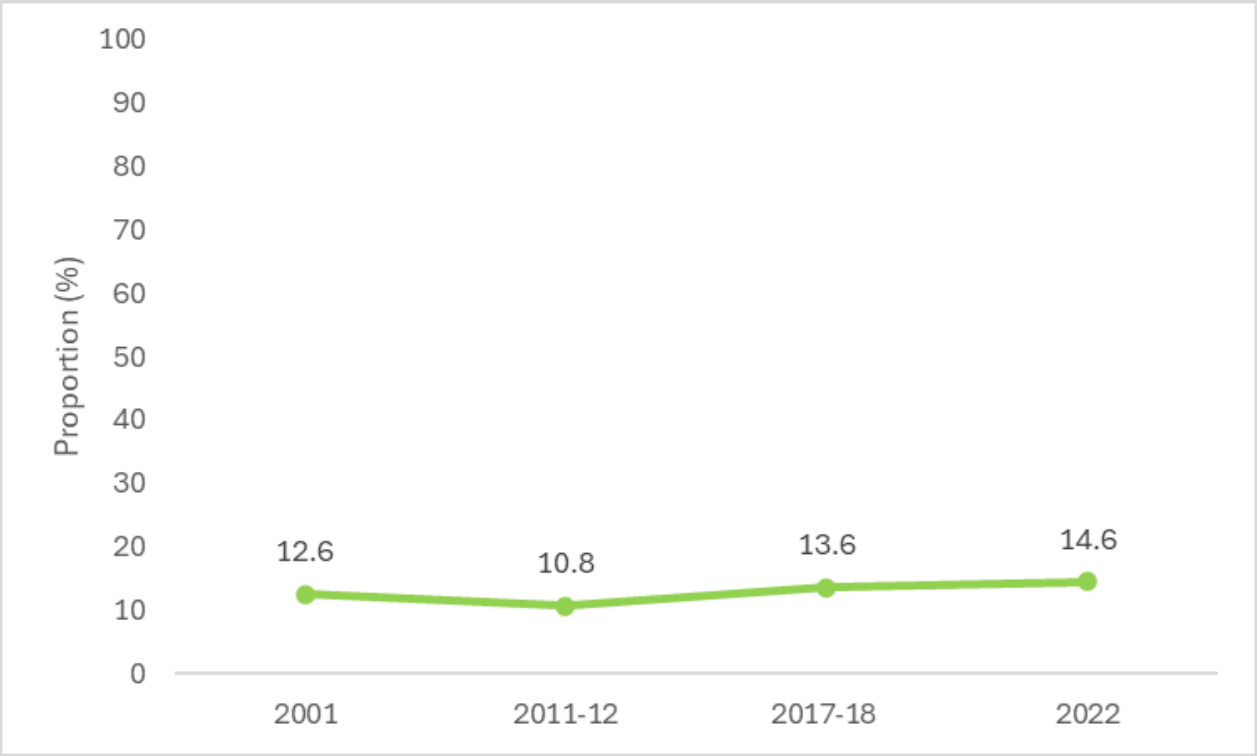
Indicator findings

Whole of population

[2] Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SL, Walters EE, Zaslavsky AM. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychol Med. 2002 Aug;32(6):959-76. doi:10.1017/s0033291702006074.

The proportion of people in Australia aged 18 years and over with high or very high levels of psychological distress has remained relatively stable over time (Figure A2). However, there has been a significant increase in psychological distress between the low point of 2011-12 and the most recently available data in 2022.

Figure A2. Age standardised proportion of people in Australia aged 18 and over who experienced high or very high levels of psychological distress, 2001-2022



Lived Experience

In 2022, almost 2 in 5 people with a mental or behavioural condition experienced high or very high levels of psychological distress (38.7%), compared with 4.7% of people without a mental or behavioural condition.

Among people who experienced psychological distress, in 2022:

- 88.1% of people who experienced **very high** psychological distress had a mental or behavioural condition.
- 71.9% of people who experienced **high** psychological distress had a mental or behavioural condition.
- 40.0% of people who experienced **moderate** psychological distress had a mental or behavioural condition.
- 13.0% of people who experienced **low** psychological distress had a mental or behavioural condition.

How do these findings differ between groups?

Whole of population

Age and Sex

Among people in Australia aged 18 years and over:

- Females were more likely to experience high or very high levels of psychological distress in 2022 (16.7%) compared with males (11.8%). This is consistent with findings from 2017-18 (Females: 14.5%, Males: 11.3%).

- The difference between males and females was largest among people aged 18-24 years (Females: 28.0%, Males:13.1%).

In 2022, people aged 18-24 years were most likely to experience high or very high levels of psychological distress (20.2%), while people aged 65 years and over were least likely (10.5%). A similar pattern was observed in 2017-18 (15.2% of people aged 18-24 experienced high or very high psychological distress, compared with 9.9% of people aged 65 years and over).

Remoteness and Socioeconomic indexes

In 2022, people who were living in areas of most disadvantage according to SEIFA scores, were most likely to experience high or very high levels of psychological distress (Quintile 1:21.9%) compared with people living in areas of least disadvantage (Quintile 5:10.0%).

In 2022, people living in *Major cities* were less likely to experience high or very high levels of psychological distress than people living in *Outer regional* and *remote* areas (13.8% compared with 17.4%).

Lived Experience

Age and Sex

In 2022, among people with high or very high levels of psychological distress, aged 18 years and over:

- A similar proportion of males and females had a mental or behavioural condition (75.3% and 77.2%, respectively)
- The highest proportion of those who experienced high or very high psychological distress and had a mental or behavioural condition was among people aged 35-64 years (78.0%), whilst the lowest proportion was for those aged 65 years and over (71.4%).

Remoteness and Socioeconomic indexes

Among people with a mental or behavioural condition, people who were living in areas of most disadvantage were generally more likely to have experienced high or very high psychological distress when compared to people who were living in areas of least disadvantage.

In 2022, among people with a mental or behavioural condition those living in areas of most disadvantage (Quintile 1) were most likely to have experienced high or very high levels of psychological distress (50.4%) compared with people living in areas of least disadvantage (Quintile 5; 28.4%).

In 2022, among people with a mental or behavioural condition, the proportion of people experiencing high or very high levels of psychological distress did not significantly differ according to level of remoteness (*Major cities* 37.4%, *Inner regional* areas: 42.9% and *Outer regional and remote* areas: 43.3%).

Technical information

Source

Australian Bureau of Statistics (ABS) *National Health Survey, 2022*; ABS, *National Health Survey, 2017-18*; ABS *National Health Survey, 2014-15*; ABS *Australian Health Survey, 2011-12*; ABS *National Health Survey, 2007-08*; ABS *National Health Survey, 2004-05*; ABS *National Health Survey, 2001*.

Frequency of data collection

Approximately every three years. Note some differences in frequency of collection due to COVID-19.

Limitations

- Detailed information on the methodology is available on the ABS website.

Additional notes

- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- For this indicator, mental or behavioural conditions are described as 'Persons who have a current, self-reported mental and behavioural condition that has lasted, or is expected to last, for 6 months or more. Condition is not based on any diagnostic screening tool'.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- For age-standardised rates, proportions have been standardised to the 2001 Australian population to account for differences in the age structure of the population over time.
- The Index of Relative Socio-Economic Disadvantage (IRSD), one of the Socio-Economic Indexes for Areas (SEIFA), assigns collective socio-economic characteristics for people living within a designated geographic area. This measure broadly defines relative socio-economic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in society. Area levels indexes in this instance are used as a measure of socio-economic disadvantage, and as a result there may be misclassification at a person-level. SEIFA classifications are ranked according to quintiles for this analysis.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2021, 2016, and 2011.

CI 3: Overall life satisfaction

What we are tracking (and why)

This indicator tracks mean overall life satisfaction for people in Australia aged 15 years and over.

Life satisfaction is an element of overall wellbeing and can be described as a summary measure of subjective contentment or fulfilment with life. People with poorer mental health typically have lower life satisfaction than those with good mental health.[3] Improvements in life satisfaction cannot be easily attributed to any one factor but may signal improvements in the effectiveness of the mental health system and/or improvements across other systems that support the social determinants of mental health and wellbeing.

How is life satisfaction measured in the General Social Survey?

Overall life satisfaction is a summary measure of subjective wellbeing against a scale ranging from 0 to 10, where 0 means 'not at all satisfied' and 10 means 'completely satisfied.'

What the data tells us

Indicator findings

Whole of population

In 2025, mean overall life satisfaction for people in Australia aged 15 years and over was 7.1. This is similar to 2020 (7.2) but slightly lower than 2014 (7.6).

Lived Experience

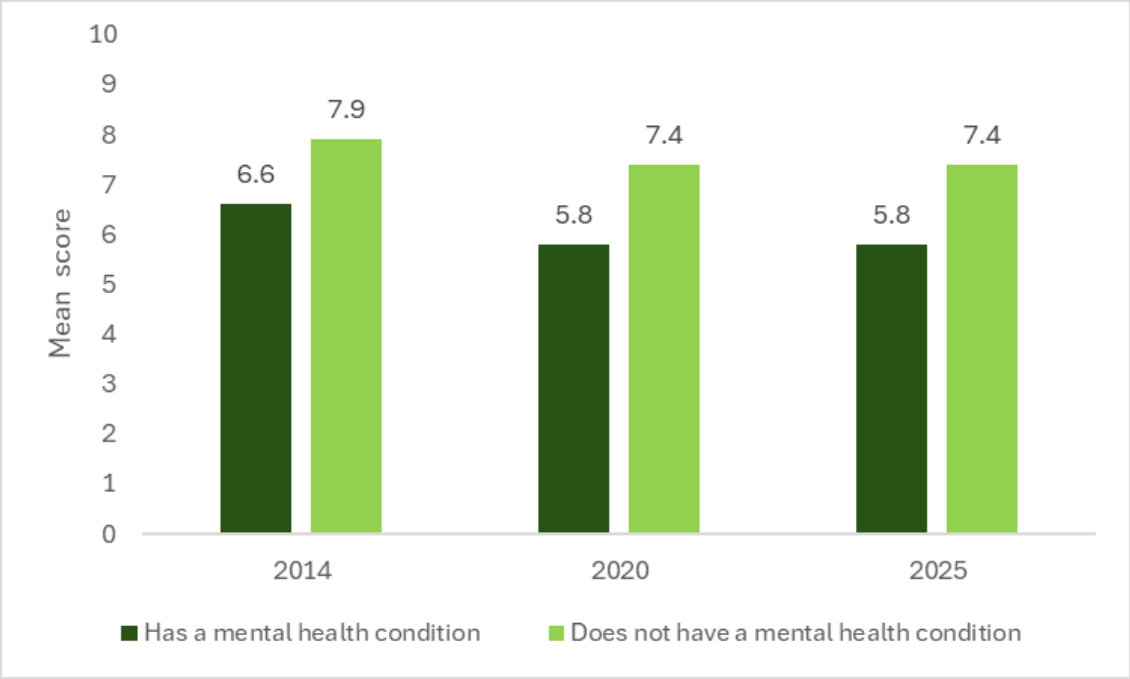
In 2025, mean life satisfaction for people in Australia aged 15 years and over who have a mental health condition was 5.8. This was significantly lower than mean life satisfaction among people who do not have a mental health condition (7.4).

Life satisfaction among people who have a mental health condition has remained consistent between 2020 and 2025 (5.8). This trend is also seen for people who do not have a mental health condition (7.4 in 2020 and 2025).

Between 2014 and 2025, mean life satisfaction for people who have a mental health condition has decreased slightly (6.6 to 5.8, respectively). This trend can also be seen for people who do not have a mental health condition (7.9 to 7.4, respectively).

[3] Lombardo P, Jones W, Wang L, Shen X, Goldner EM. The fundamental association between mental health and life satisfaction: results from successive waves of a Canadian national survey. BMC Public Health. 2018 Mar 12;18(1):342. doi:10.1186/s12889-018-5235-x

Figure A3. Mean overall life satisfaction for people with and without a mental health condition, 2014-2025



How do these findings differ between groups?

Whole of population

In 2025 mean life satisfaction for people in Australia was relatively consistent across age groups. The only notable exception was for people aged 65 years and over, who had higher mean life satisfaction (7.7) than all other age groups (range: 6.8–7.2).

Age and Sex

Over time, there has been a consistent and significant decrease in mean life satisfaction for almost all age groups, ranging from 0.4 to 0.7-point differences from 2014 to 2025.

In 2025, women had a slightly higher overall life satisfaction than men (7.3 compared with 7.1, respectively).

Remoteness and Socioeconomic indexes

Across the whole population in 2025, people living in the most disadvantaged area (Quintile 1) had the lowest overall life satisfaction (6.8). Whilst people living in areas of least disadvantage (Quintile 5) had the highest (7.5).

In 2025, people living in *Major cities*, *Inner regional* areas and *Outer regional and remote* areas all reported an overall life satisfaction of 7.1.

Lived Experience

Age and Sex

In 2025, across all age groups, people with a mental health condition reported lower life satisfaction compared to those without a mental health condition. The size of this gap was relatively consistent across age groups in 2025.

Over time, however, this gap has consistently widened for people aged 15-24 years. In 2014, among people aged 15-24 years, there was 1.1-point difference between people with a mental health condition and people without, which increased to 1.7 in 2020 and 1.9 in 2025.

In 2025, among people with a mental health condition, life satisfaction did not significantly differ between men (5.6) and women (6.1).

Remoteness and Socioeconomic indexes

In 2025, people living in areas of most disadvantage (Quintile 1) who have a mental health condition were more likely to report lower overall life satisfaction than people living in areas of least disadvantage (Quintile 5) who have a mental health condition (5.3 compared with 6.2, respectively). This difference was similar for people who do not have a mental health condition.

From 2014 to 2025, among people who have a mental health condition, life satisfaction has decreased significantly over time across all Quintiles of disadvantage, excluding Quintile 4. The largest decrease in life satisfaction scores was experienced for those living in Quintile 2, where life satisfaction scores dropped from 6.5 in 2014, to 5.3 in 2025. Quintiles 1, 3, and 5 experienced smaller but significant drops ranging from 0.8 to 1.0 points over the same period.

In 2025, for people who have a mental health condition, mean life satisfaction scores were similar across remoteness areas (*Major cities*: 5.8, *Inner regional* areas: 5.7, *Outer regional and remote* areas: 5.8).

Technical information

Source

Australian Bureau of Statistics (ABS) *General Social Survey, 2025*; ABS General Social Survey, 2020; ABS *General Social Survey, 2019*; ABS, *General Social Survey, 2014*.

Frequency of data collection

The GSS was previously collected irregularly. From 2025 onwards, the GSS will be collected annually.

Limitations

- The previous General Social Survey was conducted in 2020, during the emergency phase of the COVID-19 pandemic. Comparisons between 2020 and 2025 data should therefore be interpreted with this context in mind.
- Care should be taken when comparing 2020 data to earlier years due to changes in the survey methodology, higher rates of non-response and the impact of COVID-19 restrictions on the population.

Additional notes

- “Has a mental health condition” includes people who reported they had a ‘Mental health condition (including depression or anxiety)’ from the list of long-term health conditions.
- Overall life satisfaction measures a person's perceived level of life satisfaction in general and does not consider specific illnesses or problems a person may have.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- Data for 2025 and 2020 capture people with a ‘mental health condition (including depression and anxiety)’, while data from 2014 includes ‘depression or feeling depressed, behavioural or emotional disorders, dependence on drugs or alcohol, feeling anxious or nervous and problems learning or understanding things.’

- Detailed information on the methodology is available on the ABS website.
- The 2025 General Social Survey collected both the 'sex recorded at birth' and 'gender' of respondents using the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020. Because the social indicators collected in the GSS relate to social characteristics and experience, data in this report are presented using the gender variable.
- The Index of Relative Socio-Economic Disadvantage (IRSD), one of the Socio-Economic Indexes for Areas (SEIFA), assigns collective socio-economic characteristics for people living within a designated geographic area. This measure broadly defines relative socio-economic disadvantage in terms of people's access to material and social resources, and their ability to participate in society.
- Area levels indexes in this instance are used as a measure of socio-economic disadvantage, and as a result there may be misclassification at a person-level. SEIFA classifications for 2011 and 2021 are ranked according to quintiles for this analysis.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2021.

CI 4: Feeling in control

What we are tracking (and why)

This indicator tracks the proportion of people in Australia over the age of 15 who report feeling a 'high sense of control'.

Locus of control describes how an individual feels about the extent to which life events are caused by their own actions (people with an internal locus of control) rather than outside factors beyond their control (people with an external locus of control) (Rotter 1966).

How is locus of control measured?

In HILDA, locus of control is calculated through seven items from the Pearlin and Schooler's (1978) Mastery Scale, which measures the "extent to which one regards one's life chances as being under one's own control". There are 7 items:

1. I have little control over the things that happen to me.
2. There is really no way I can solve all the problems I have.
3. There is little I can do to change many of the important things in my life.
4. I often feel helpless in dealing with the problems of life.
5. Sometimes I feel that I'm being pushed around in life.
6. What happens to me in the future mostly depends on me.
7. I can do just about anything I really set my mind to do.

Individuals indicate how much they agree with the statements in the items on a scale from 1 ("strongly disagree") to 7 ("strongly agree"). The scale includes 2 items measuring personal mastery and 5 items measuring perceived constraints. The perceived constraint items are reverse-scored, and the mean of the items is computed for respondents who have valid items for all the items on the scale. A higher score indicates a more internal locus of control. For this analysis, locus of control will be referred to as 'sense of control'. Individuals who scored higher than 4.5 fall under the category of 'High sense of control', those who scored lower to or equal to 4.5 fall under the category 'Low sense of control'.

The AIHW's analysis of HILDA data presented in this indicator aligns with previous analysis of the HILDA data which found that a higher sense of control is 'generally associated with better mental health and greater wellbeing.[4]

[4] Botha F and Dahman SC (2022) Working Paper Series Locus of control, self-control and health outcomes, Applied Economic & Social Research, Melbourne Institute, accessed 30 April 2024.

What the data tells us

Indicator findings

Whole of population

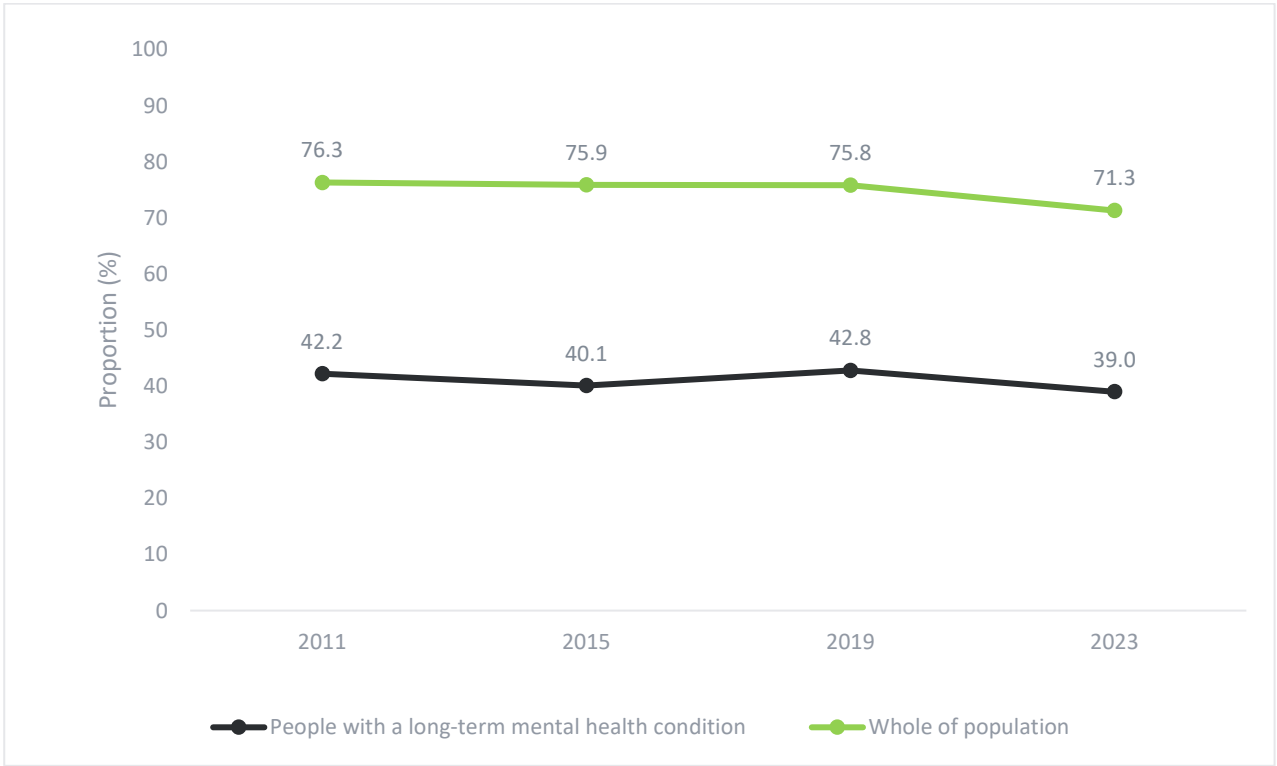
In 2023, for people aged 15 years and older, 71.3% reported feeling a high sense of control. Between 2011 and 2023, the proportion of people who reported feeling a high sense of control remained relatively steady, with a decrease shown between 2019 and 2023 (Figure A4).

Lived Experience

In 2023, the proportion of the total population feeling a high sense of control varied according to the presence of a long-term health condition. For people aged 15 years and over:

- Almost 2 in 5 people with **a long-term mental health condition** reported feeling a high sense of control (39%).
- More than 3 in 5 people with **a long-term health condition** reported feeling a high sense of control (62.6%).
- More than 3 in 4 people with **no long-term health condition** reported feeling a high sense of control (77.0%).

Figure A4. Proportion of people in Australia who reported a high sense of control, 2011-2023



How do these findings differ between groups?

Whole of population

Age and Sex

Of people in Australia aged 15 years and over:

- In 2023, a similar proportion of males and females reported feeling a high sense of control (72.3% and 70.3%, respectively)
    - These proportions are similar to previous proportions observed in 2011 (Males: 76.7%, Females: 76.0%), 2015 (Males: 76.4%, Females: 75.4%) and 2019 (Males: 76.8%, Females: 74.8%), and show no significant differences between the sexes.

- In 2023, the proportion of people reporting a high sense of control was similar across age groups. 71.6% of people aged 65 years and over reported feeling a high sense of control, followed by people aged 15-34 years (71.3%) and people aged 35-64 years (71.1%).
    - In earlier years, the proportion of older adults who reported a high sense of control was consistently lower than younger age groups. In 2011, for example, a clear age gradient was evident: 79.7% of people aged 15-34 years, 75.8% of those aged 35-64 years, and 70.2% of those aged 65 years and over reported high levels of control. This gap steadily narrowed over time, with proportions becoming more closely aligned in 2015 (77.7%, 76.1% and 71.7%, respectively) and 2019 (76.9%, 75.7% and 73.9%, respectively). Between 2019 and 2023, the proportion of people reporting a high sense of control fell for all age groups, with the greatest fall seen for people aged 15-34 years.

Socioeconomic indexes

When examining SEIFA scores, in 2023, the higher the SEIFA quintile (that is, the more advantaged an area) the higher the proportion of people who reported a high sense of control. This is consistent with findings from 2011, 2015 and 2019.

Remoteness Areas

In 2023, 71.5% of people living in *Major Cities* reported feeling a high sense of control, followed by people living in *Inner regional* areas (71.2%), and people living in *Outer regional and remote* areas (69.8%).

Lived Experience

Among people aged 15 years and over with a long-term mental health condition:

- In 2023, a similar proportion of males and females reported a high sense of control (39.2% compared with 38.9%, respectively)
    - This is slightly different to earlier findings from 2011, 2015, and 2019, where females were consistently more likely to report a high sense of control (47.3%, 43.8% and 45.1%, respectively) when compared to males (36.1%, 35.6% and 39.3%, respectively).

- In 2023, more than 2 in 5 (43.6%) people aged 15-34 years reported a high sense of control, followed by people aged 35-64 years (37.4%) and people aged 65 years and over (33.8%).
    - This pattern is consistent with findings from 2011 and 2019. However, in 2015, a slightly different trend was observed, with a higher proportion of people aged 65 years and over (43.7%) reporting a high sense of control when compared to people aged 15-34 years (39.7%) and 35-64 years (39.2%).

Technical information

Source

Melbourne Institute of Applied Economic and Social Research. *The Household, Income and Labour Dynamics in Australia Survey (HILDA), Wave 11, 15, 19, and 23*

Frequency of data collection

Annually. Relevant items only collected every 4 years.

Limitations

- Data for this indicator relating to people with a long-term mental health condition have relative standard error sizes that in some cases makes it difficult to detect statistical differences between groups (e.g. some age groups).
- The HILDA methodology has a number of limitations around survey attrition, response rates, questionnaire design and data collection for 'Sex' (for further information, see the HILDA Survey User Manual). These do not, however, significantly impact the data and analyses presented for this indicator.

Additional notes

- In the HILDA survey, the term 'long-term health condition' is used to describe where a respondent records any long-term health condition, impairment or disability 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 those respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- HILDA uses SEIFA to measure and rank areas in Australia based on relative socio-economic conditions in an area using Census data. There are 4 SEIFA indexes, each summarising different aspects of the socio-economic conditions. The data presented here are classified according to the SEIFA Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). SEIFA data are presented using quintiles, dividing the areas into 5 groups based on their scores. Quintile 1 represents the lowest 20% of areas (i.e., the most disadvantaged) and Quintile 5 the highest 20% (i.e., the most advantaged). For further information, see Socio-Economic Indexes for Areas (SEIFA), Australia, 2021 | Australian Bureau of Statistics
- Remoteness areas (i.e., *Major cities*, *Inner regional*, *Outer regional*, and *remote areas*) are defined by the Australian Statistical Geography Standard (ASGS). In the data presented here, *Outer regional* and *remote* areas have been combined as one remoteness category. This is due to the high relative standard errors for *remote* area estimates which arise from small sample numbers for this category. For further information, see Remoteness Areas | Australian Bureau of Statistics

Domain 2 - Social Determinants

CI 5: Proportion of children who are developmentally vulnerable

What we are tracking (and why)

This indicator tracks the proportion of children considered developmentally vulnerable in the Australian Early Development Census (AEDC). Monitoring developmental vulnerability helps identify where children, families and communities may benefit from additional support, early intervention and equitable access to health, education, and social services.

What is the AEDC?

The AEDC is a national measure of children's development as they enter their first year of full-time school. Data has been collected every three years since 2009.

The AEDC captures data on five key domains of early childhood development: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge.

Children receive a score (0-10) for each of the five AEDC domains. These domain scores are then classified into one of three groups using benchmarks that were developed from the first AEDC collection in 2009. These categories are:

- **Developmentally on track – Children are developing well**
  - Scores above the 25th percentile or in the top 75 per cent of the 2009 scores
- **Developmentally at risk – Children are facing challenges in some aspects of their development.**
  - Scores between the 10th and 25th percentile
- **Developmentally vulnerable – Children are facing some significant challenges in their development**
  - Scores below the 10th percentile or in the lowest 10 per cent of the 2009 scores.

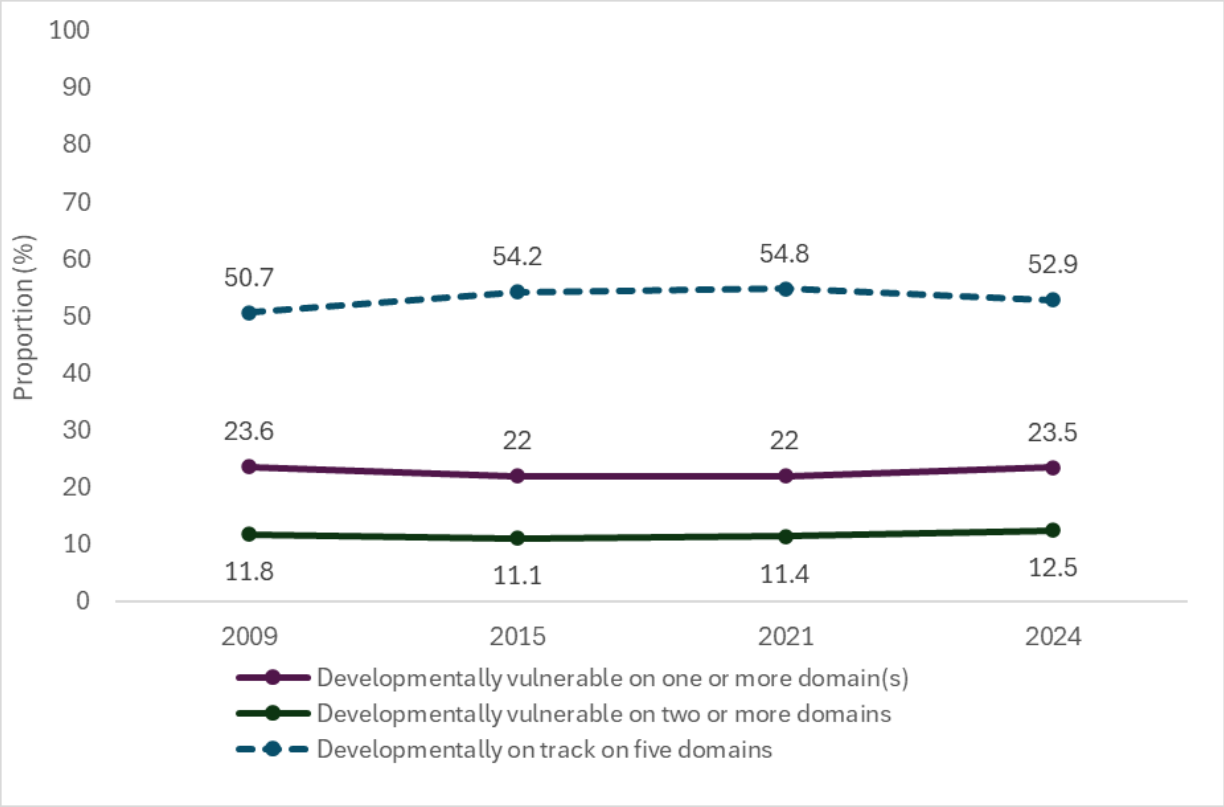
As the 2024 AEDC is the sixth collection since 2009, results can be compared to past collections to identify shifts in children's development over time.

What the data tells us

Indicator findings

The proportion of children in Australia who were developmentally vulnerable on one or more AEDC domain(s) has increased significantly since 2021 (Figure A5). The percentage of children who were developmentally vulnerable on two or more domains also significantly increased between 2021 and 2024 and is now significantly higher than figures from 2009.

Figure A5. Proportion of children considered developmentally vulnerable on one or more domains, developmentally vulnerable on two or more domains, and developmentally on track on five domains, 2009-2024



How do these findings differ between groups?

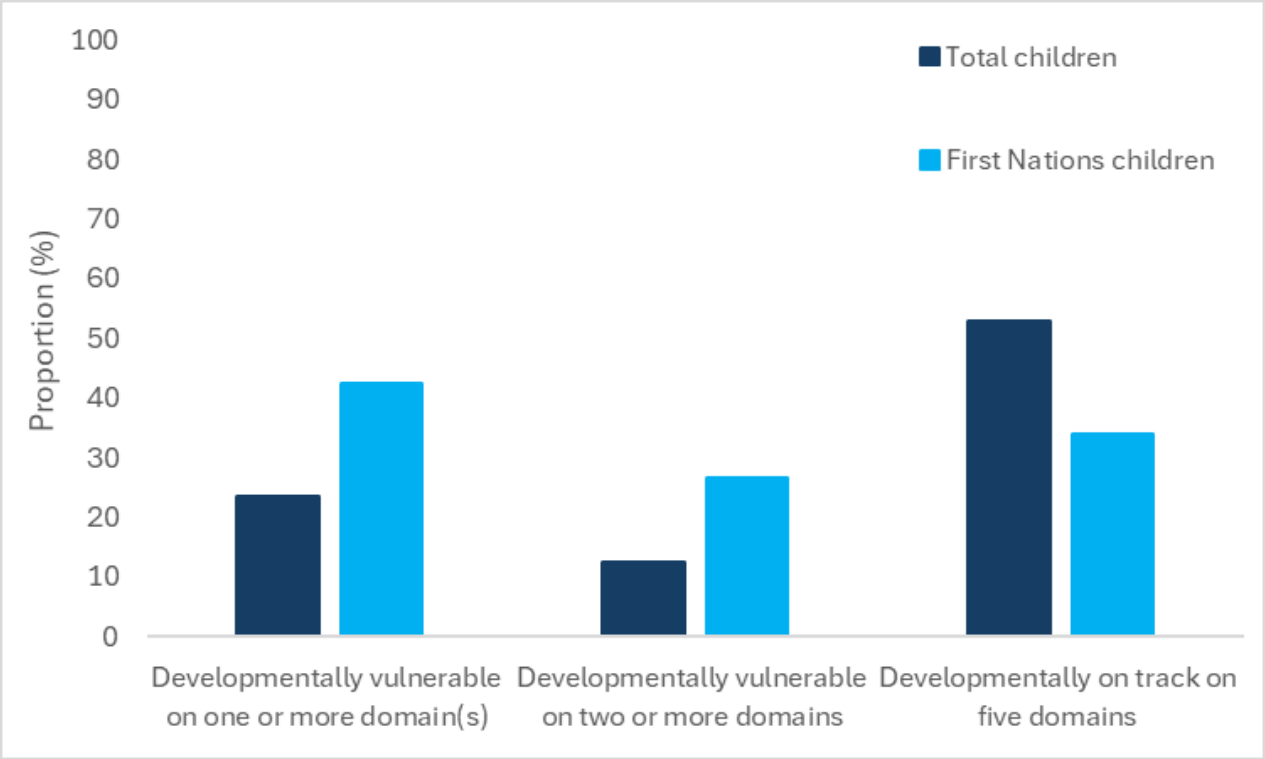
Detailed group analyses were not conducted for the purpose of this report. However, it should be noted that the 2021 AEDC report[5] found that the proportion of children who were considered vulnerable in one or more domains was higher for children living in socio-economically disadvantaged communities. This trend was also observed in 2024.

The 2024 AEDC report[6] noted several key differences between groups. While the proportion of Aboriginal and Torres Strait Islander children who were on track in all five AEDC domains (33.9%) was significantly lower than all children in Australia (52.9%) in 2024, it has stabilised since 2021 (34.3%) with a non-significant decline of 0.4 percentage points.

In 2024, children who were in *Inner/Outer regional* and *Remote/Very remote* areas were less likely to be developmentally on track on all five AEDC domains compared to *Major cities*. Despite this, there was a smaller decline in this proportion from 2021 to 2024 when compared to children in *Major cities*.

[5] Department of Education, Skills and Employment. Australian Early Development Census National Report 2021. Canberra: DESE; 2022.
[6] Department of Education. Australian Early Development Census National Report 2024. Canberra; 2025.

Figure A6. Proportion of children by developmental vulnerability and Indigenous status, 2024



Technical information

Source

Australian Government. Department of Education *Australian Early Development Census National Report 2024*

Frequency of data collection

Every three years.

Limitations

- Data on developmental vulnerability does not speak to the cause of the developmental vulnerability, whether it relates to the child's mental health, or whether the child has previously received or is currently receiving additional supports.

Additional notes

- Scores on the AEDC are teacher-rated.
- Children who are developmentally vulnerable in two or more domains are included in both developmentally vulnerable categories. As such the sum of the percentage of on track and developmentally vulnerable children does not add to 100%.
- AEDC results are not reported for children with special needs, as defined in AEDC 2024 report, at a national level.
- Detailed information on the methodology is available at https://www.aedc.gov.au/resources/detail/2021-aedc-data-collection-technical-report. Please note that at the time of publishing the 2024 AEDC Data Collection Technical Report is not available.

CI 6: Housing security (homelessness)

What we are tracking (and why)

This indicator tracks people in Australia aged 16-85 years who have ever been without a permanent place to live in their lifetime as measured by the National Study of Mental Health and Wellbeing (NSMHW).

People who are without a permanent place to live and experience homelessness have poorer health outcomes and significant disadvantage across a wide range of social determinants[7]. Health-related issues include chronic and acute physical conditions, as well as mental health conditions like anxiety, depression and substance use disorders[8]. By contrast, access to secure housing is associated with improved mental health and wellbeing. As such, a decrease in the rate of lifetime homelessness may forecast improvements in mental health and a range of other social determinants.

How is housing security (homelessness) measured?

The NSMHW asks whether a person has ever been without a permanent place to live. This includes:

- Sleeping rough
- Staying in a crisis or homeless shelter
- Staying in a refuge
- Staying with friends or relatives
- Staying in support/ transitional accommodation
- Staying in a boarding house
- Staying in other temporary accommodation

As the NSMHW assess whether a person has ever been without a permanent place to live, as opposed to current living arrangements, findings do not represent current rates of homelessness across the population, or among people living with a 12-month mental disorder. More current estimates of homelessness can be accessed at https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release

As people can have different experiences of homelessness, there is no single definition of homelessness. As a result, different datasets apply varying approaches to describe and measure homelessness.

[7] Stafford A, Wood L. Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants. Int J Environ Res Public Health. 2017 Dec 8;14(12):1535. doi:10.3390/ijerph14121535.
[8] Bensken WP, Krieger NI, Berg KA, Einstadter D, Dalton JE, Perzynski AT. Health Status and Chronic Disease Burden of the Homeless Population: An Analysis of Two Decades of Multi-Institutional Electronic Medical Records. J Health Care Poor Underserved. 2021;32(3):1619-1634. doi:10.1353/hpu.2021.0153.

What the data tells us

Indicator findings

Whole of population

In 2020-2022, 9.8% (1.9 million) of people in Australia aged 16-85 years had been without a permanent place to live in their lifetime.

Lived Experience

In 2020-2022, 17.7% (756,000) of people in Australia with a 12-month mental disorder had been without a permanent place to live in their lifetime. This was significantly higher than the proportion of people without a 12-month mental disorder (7.6% or an estimated 1.2 million people).

How do these findings differ between groups?

Whole of population

Age and Sex

In 2020-2022, across the whole population:

- A significantly larger proportion of males (10.5%) had ever been without a permanent place to live when compared with females (9.1%).
- A significantly lower proportion of people aged 65-85 years (7.2%) had ever been without a permanent place to live compared with people aged 16-34 (9.9%) and 35-64 (10.7%) years.
- Among people aged 65-85 years, males were significantly more likely to have been without a permanent place to live in their lifetime (9.8%) compared with females (5.1%).

Remoteness and socioeconomic indexes

- In 2020-2022, people who were living in areas of most disadvantage (15.6%; Quintile 1) were around 3 times more likely to have ever been without a permanent place to live compared to people living in areas of most advantage (5.5%; Quintile 5).
- In 2020-2022, people living in *Outer regional and remote* areas were more likely to have ever been without a permanent place to live compared with those living in *Major cities* (14.2% compared with 9.0%, respectively)

Lived Experience

In 2020-2022, a similar proportion of males and females with a 12-month mental disorder had ever been without a permanent place to live (17.3% and 17.9%, respectively).

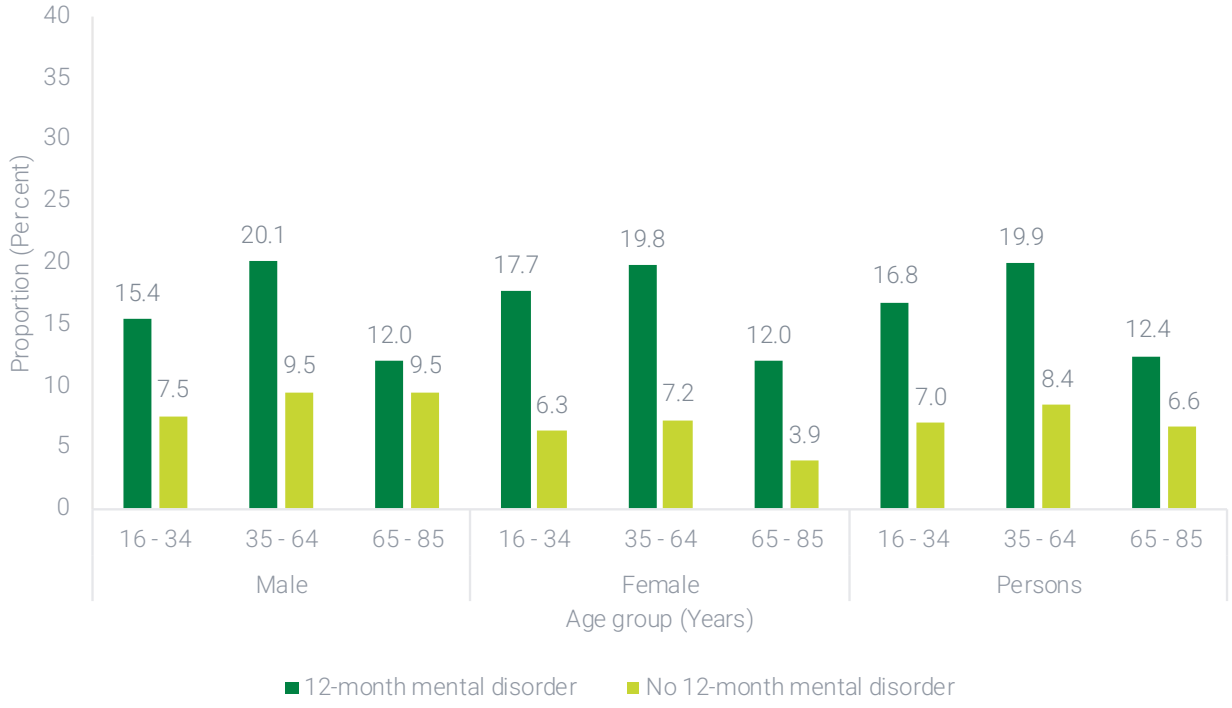
This is different to those without a 12-month mental health disorder; a higher proportion of males had ever been without a permanent place to live compared with females (8.9% and 6.2%, respectively).

Among people with a 12-month mental disorder, the proportion of people who had ever been without a permanent place to live differed slightly across age groups.

Almost 1 in 5 people aged 35-64 years had ever been without a permanent place to live (19.9%), followed by people aged 16-34 years (16.8%) and 65-85 years (12.4%). Similar age group trends were observed for people without a 12-month mental disorder, albeit at a smaller scale.

The disparity between people with a 12-month disorder and people without is seen across age groups and sexes. The largest gap was for females aged 35-64 years (12.1 percentage points), and the smallest gap was for males aged 65-85 years (2.5 percentage points) (Figure A7).

Figure A7. Proportion of people in Australia aged 16-85 years who have ever been without a permanent place to live by 12-month mental disorder status, age group, and sex, 2020-2022



Remoteness and Socioeconomic indexes

In 2020-2022, for people with a 12-month mental disorder who were living in areas of most disadvantage (Quintile 1) according to SEIFA scores, 28.5% had ever been without a permanent place to live. This was significantly higher than other Quintiles (Quintile 2: 20.5%, Quintile 3: 15.6%, Quintile 4: 16.1%, Quintile 5: 9.6%).

In 2020-2022, among people with a 12-month mental disorder, people living in *Major Cities* were less likely to have ever been without a permanent place to live than people living in *Outer regional and remote* areas (17.7% compared with 28.9%, respectively).

Among people without a 12-month mental disorder, the proportion of people who had ever been without a permanent place to live was similar across remoteness areas (*Major cities* (7.1%); *Inner regional* areas (8.7%); *Outer regional* and *remote* areas (9.4%). Across all areas, proportions were higher for people with a 12-month mental disorder compared to those without a 12-month mental disorder.

Technical information

Source

Australian Bureau of Statistics *National Study of Mental Health and Wellbeing, 2020-2022*.

Frequency of data collection

Irregular. No future releases scheduled.

Limitations

- Detailed information on the methodology is available at https://www.abs.gov.au/methodologies/national-study-mental-health-and-wellbeing-methodology/2020-2022

Additional notes

- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- A 12-month mental disorder refers to people who met the diagnostic criteria for having a mental disorder at some time in their life and had sufficient symptoms of that disorder in the 12 months prior to completing the survey. A person may have more than one 12-month mental disorder.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- The Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD), one of the Socio-Economic Indexes for Areas (SEIFA), assigns collective socio-economic characteristics for people living within a designated geographic area. This measure broadly defines relative socio-economic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in society. Area levels indexes in this instance are used as a proxy measure of individual socio-economic advantage and disadvantage, and as a result there may be misclassification at a person-level. SEIFA classifications for 2016 are ranked according to quintiles for this analysis.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional areas*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2016.

CI 7: Financial stress

What we are tracking (and why)

This indicator tracks the proportion of people aged 15 years and over in Australia living in households that are unable to raise $2,000 within a week for something important.

Experiences of financial stress may be influenced by age, sex, employment status, family type, housing status, income, education and geographic location[9]. Increases in financial stress may be associated with poorer mental health outcomes across the population and increased demand for mental health services.

What the data tells us

Indicator findings

How is financial stress measured?

The measure, proportion of people aged 15 years and over that are unable to raise $2,000 within a week for something important is used to update this indicator. This measure does not prescribe how those funds would be raised and so accounts for the diversity of resources that households might draw on, such as from savings, loans from family or friends, or selling belongings.

Data for the ability to raise $2,000 is nominal (not adjusted for inflation). The observed increase over time for this measure may therefore under-represent the actual rise in financial stress across the population.

Whole of population

In 2025, around 1 in 5 people in Australia were unable to raise $2,000 within a week for something important (21.2%). This is an increase from 2014 (13.1%) and 2020 (18.8%).

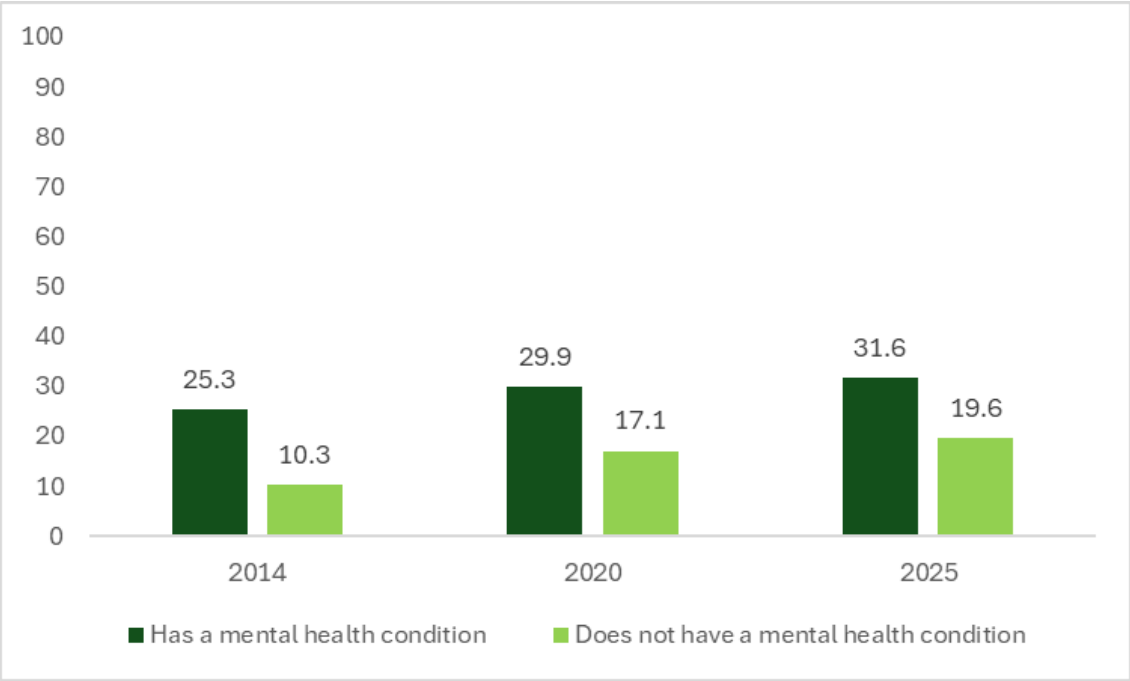
Lived Experience

In 2025, almost 1 in 3 people who have a mental health condition were unable to raise $2,000 within a week (31.6%), a significantly higher proportion compared with those who do not have a mental health condition (19.6%).

Among people who have a mental health condition, the proportion of those who were unable to raise $2,000 within a week has remained similar to 2020 (29.9%) and slightly higher than 2014 (25.3%). This trend can also be seen amongst those who do not have a mental health condition (17.1% in 2020; 10.3% in 2014).

[9] Australian Institute of Health and Welfare (AIHW), Financial stress and mental health. 2025.

Figure A8. Proportion of people who were unable to raise funds for something important over time[(a)], 2014 to 2025



[(a)] The General Social Survey asks respondents aged 15 years and over in Australia living in households if they are unable to raise $2,000 within a week for something important.

How do these findings differ between groups?

Lived Experience

Remoteness

In 2025, the proportion of people who have a mental health condition who reported being unable to raise $2,000 within a week was similar across all remoteness areas.

Over time between 2014 and 2025, among people who have a mental health condition:

- The proportion of people living in *Major cities* who could not raise $2,000 within a week has increased (22.8% to 29.5%, respectively)
- The proportion of people living in *Inner regional* areas who could not raise $2,000 within a week has remained steady (32.0% to 35.8%)
- The proportion of people living in *Outer regional and remote* areas who could not raise $2,000 within a week has increased (26.4% to 37.7%).

Technical information

Source

Australian Bureau of Statistics (ABS) *General Social Survey, 2025*; *ABS General Social Survey 2020*; ABS *General Social Survey, 2019*; ABS *General Social Survey, 2014*.

Frequency of data collection

The GSS was previously collected irregularly. From 2025 onwards, the GSS will be collected annually.

Limitations

- The previous General Social Survey was conducted in 2020, during the emergency phase of the COVID-19 pandemic. Comparisons between 2020 and 2025 data should therefore be interpreted with this context in mind.
- Care should be taken when comparing 2020 data to earlier years due to changes in the survey methodology, higher rates of non-response and the impact of COVID-19 restrictions on the population.
- There are several high standard error figures for SEIFA and Remoteness disaggregation analyses, which has limited the number of possible comparisons between groups.

Additional notes

- Has a mental health condition includes people who reported they had a 'Mental health condition (including depression or anxiety)' from the list of long-term health conditions.
- Data for 2025 and 2020 capture people with a 'mental health condition (including depression and anxiety)', while data from 2014 includes 'depression or feeling depressed, behavioural or emotional disorders, dependence on drugs or alcohol, feeling anxious or nervous and problems learning or understanding things'.
- Detailed information on the methodology is available on the ABS website.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- The 2025 General Social Survey collected both the 'sex recorded at birth' and 'gender' of respondents using the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020. Because the social indicators collected in the GSS relate to social characteristics and experience, data in this report are presented using the gender variable.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2011 and 2021.

CI 8: Employment rate

What we are tracking (and why)

This indicator tracks the employment rate of people with a mental or behavioural condition in Australia aged 16-64 years.

Employment can improve mental health, acting as a protective factor in the short-term and reducing the likelihood of long-term reliance on mental health services.[10] Employment can also help provide financial security, develop social and community relationships, and contribute to personal fulfilment. However, the relationship between employment and mental health is complex. People with mental health conditions may face significant barriers to securing meaningful work, such as discrimination, stigma, and lack of adequate support to engage in the workforce.[11] While the employment rate is impacted by a complex interplay of social and economic factors, high or increasing employment rates may be associated with improvements in mental health, social connectedness and financial security.

How is the employment rate captured?

The National Health Survey provides information on employment rates for people with a mental or behavioural condition and provides a comparison population of all people in Australia. However, items used within the National Health Survey are not primarily designed to capture and estimate employment rates across the whole population. Therefore, findings may slightly differ to employment data sources reported elsewhere. For whole of population employment rate figures, please refer to labour force findings on the ABS website

The employment rate is just one of many relevant measures of participation in the labour market (e.g., unemployment rate, job vacancies, underemployment rate and labour force participation rate). These measures are impacted by a complex interplay of social and economic factors. For more information on other key measures, please see Employment and unemployment - Australian Institute of Health and Welfare.

A related and commonly tracked measure is labour force participation. This is a broader measure of economic participation, encompassing both people who are employed and people who are unemployed but actively looking for work. Analyses of labour force data were conducted alongside employment figures to check for relevant differences, but findings were similar to employment figures. As a result, labour force findings have not been discussed for this indicator.

[10] Drake RE, Wallach MA. Employment is a critical mental health intervention. Epidemiology and Psychiatric Sciences. 2020;29:e178. doi:10.1017/S2045796020000906.
[11] Groot C, Rehm I, Andrews C, Hobern B, Morgan R, Green H, Sweeney L, Blanchard M. Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues. 2020, SANE Australia: Melbourne.

What the data tells us

Indicator findings

Whole of population

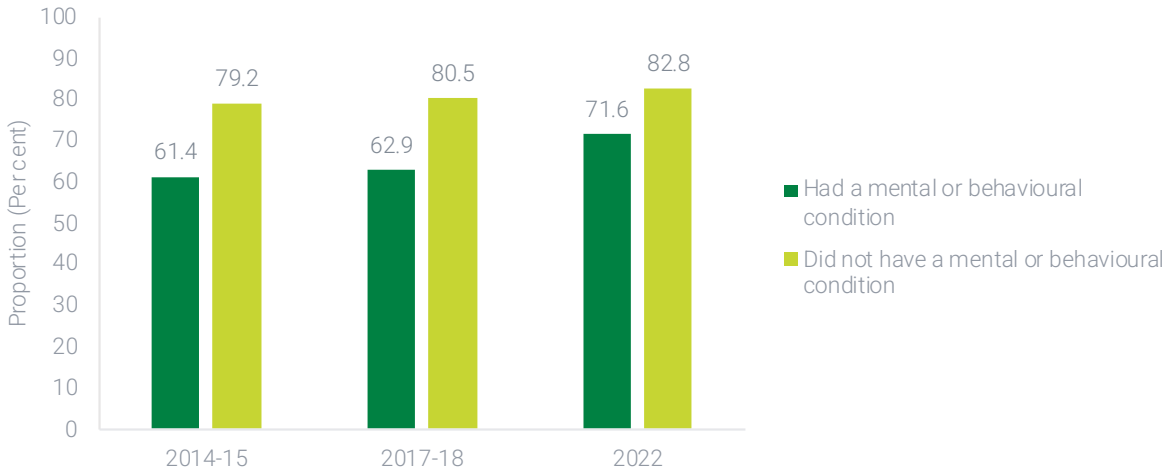
According to the 2022 *National Health Survey*, for all people in Australia aged 16-64 years, the employment rate was 79.5%. This is higher than in previous years (75.7% in 2014-15; 76.5% in 2017-18).

Lived Experience

In 2022, among people in Australia aged 16-64 years with a mental or behavioural condition, the employment rate was 71.6%.

Whilst the employment rate of people with a mental or behavioural condition has increased over time, it remains lower than the employment rate of people without a mental or behavioural condition (Figure A9).

Figure A9. Proportion of people in Australia who are employed by mental or behavioural condition status, 2014-15 to 2022



How do these findings differ between groups?

Whole of population

Age and Sex

In 2022, a significantly higher proportion of males were employed (83.2%) compared to females (76.0%). The employment gap between males and females has reduced over the last decade, from 11.5 percentage points in 2014-15, to 9.8 in 2017-18 and 7.2 in 2022.

In 2022, the employment rate was lowest for people aged 16-24 years (73.6%) and people aged 55-64 years (66.2%). Across all age groups, increases in the employment rate from 2014-15 to 2022 ranged from 2.3 to 3.8 percentage points, except for people aged 16-24 years. Among this group, there was a 7.3 percentage point increase, which is approximately double the increase observed for other age groups.

Remoteness

In 2022, people living in *Major cities* were more likely to be employed compared with those living in *Inner regional* areas (80.3% compared with 78.8%, respectively).

Between 2014-15 and 2022, people living in *Major cities* were the only group to show an increase in employment rates over time.

Lived Experience

Age and Sex

Analyses indicate there are complex interactions between employment, the presence of a mental or behavioural condition, sex and age.

For all age groups, the employment gap between people with and without a mental or behavioural condition reduced slightly between 2014-15 to 2022.

However, in 2022, among people with a mental or behavioural condition:

- More than 3 in 4 people aged 25-34 years were employed (77.4% compared with 88.6% of people without a mental or behavioural condition).
- Almost 4 in 5 people aged 35-44 years were employed (79.1% compared with 89.0% of people without a mental or behavioural condition)
- 71.7% of people aged 45-54 years were employed (compared with 87.5% of people without a mental or behavioural condition)
- About half (50.6%) of people aged 55-64 years were employed (compared with 71.8% of people without a mental or behavioural condition)

In 2022, among all people with a mental or behavioural condition, the employment rate for males and females did not significantly differ. This was consistent with findings from 2017-18, but not with those from 2014-15 where there was a significant difference between males (64.9%) and females (58.9%).

In 2022, for people without a condition, a greater proportion of males were employed (87.2%) compared to females (77.9%). This difference between males and females without a mental or behavioural condition was also observed in 2017-18 and 2014-15.

In 2022, for people aged 16-24 years with a mental or behavioural condition, a greater proportion of females (77.5%) were employed compared to males (67.7%). Conversely, a greater proportion of males were employed compared to females among the 35-44 years age group (82.5% compared with 76.5%, respectively) and 45-54 years age group (76.4% compared with 67.3%, respectively).

Remoteness

In 2022:

- Among people with a mental or behavioural condition those living in *Major cities* were most likely to be employed (74.0%) compared with 67.2% of people living in *Outer regiona*l and *remote* areas, and 64.7% of people living in *Inner regional* areas.
- For people without a mental or behavioural condition, the employment rate across all remoteness areas was similar.

Between 2014-15 and 2022, people with a mental or behavioural condition in *Major cities* showed larger improvements in employment rates compared to people in *Inner regional* areas and *Outer regional and remote* areas. People without a mental or behavioural condition have seen improvements in *Major cities* and *Outer regional* and r*emote* areas compared to *Inner regional* areas.

Technical information

Source

Australian Bureau of Statistics (ABS) *National Health Survey, 2022*; ABS *National Health Survey, 2017-18*; ABS *National Health Survey, 2014-15.*

Frequency of data collection

Every three years. Note some differences in frequency of collection due to COVID-19.

Additional notes

- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- People who are considered to meet the criteria for a mental or behavioural condition meet the following definition 'Persons who have a current, self-reported mental and behavioural condition which has lasted, or is expected to last, for 6 months or more. Condition is not based on any diagnostic screening tool'.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2021, 2016, and 2011. SEIFA analyses have been excluded from this core indicator analysis. SEIFA is determined using income, education, employment, occupation, housing, and miscellaneous variables. Given employment is used to determine SEIFA scores, it should not be used to compare or cross-tabulate by SEIFA scores. For more information, please see the ABS website.
- Detailed information on the methodology is available on the ABS website.

CI 9: Engagement in employment or study for young people

What we are tracking (and why)

Engagement in employment or study is particularly important for young adults. The transition from school to further education and/or work is a critical period of personal and educational development, providing a foundation for life-long vocational skills, social connectivity and financial security. Research shows a lack of engagement in employment or study following compulsory education can contribute to future unemployment, lower incomes and employment insecurity[12]. Among young adults, there is also a clear association between being engaged in employment and study and positive mental health and wellbeing outcomes[13]. Higher rates of engagement by young people in employment and study may be associated with improved mental health, social connectedness and financial security among young people in Australia.

How is engagement in employment or study measured?

This indicator tracks people in Australia aged 16-24 years who are engaged in employment and/or enrolled for study in a formal secondary or tertiary qualification (full or part-time).

Items used within the National Health Survey are not primarily designed to capture and estimate employment and/or studying rates across the relevant population. Therefore, findings may differ slightly to data sources available elsewhere.

For more information, please see detailed information on the methodology on the ABS website.

What the data tells us

Indicator findings

Whole of population

In 2022, 94.0% of people in Australia aged 16-24 years were employed and/or studying. This proportion is higher than reported in previous years (2014-15: 89.9%, 2017-18: 90.5%).

Lived Experience

In 2022, 89.2% of people in Australia aged 16-24 years with a mental or behavioural condition were employed and/or studying. This is significantly lower than the proportion of people without a mental or behavioural condition who were employed and/or studying (96.4%).

The gap between people with and without a mental or behavioural condition who are employed and/or studying has decreased since 2014-15 (Figure A10).

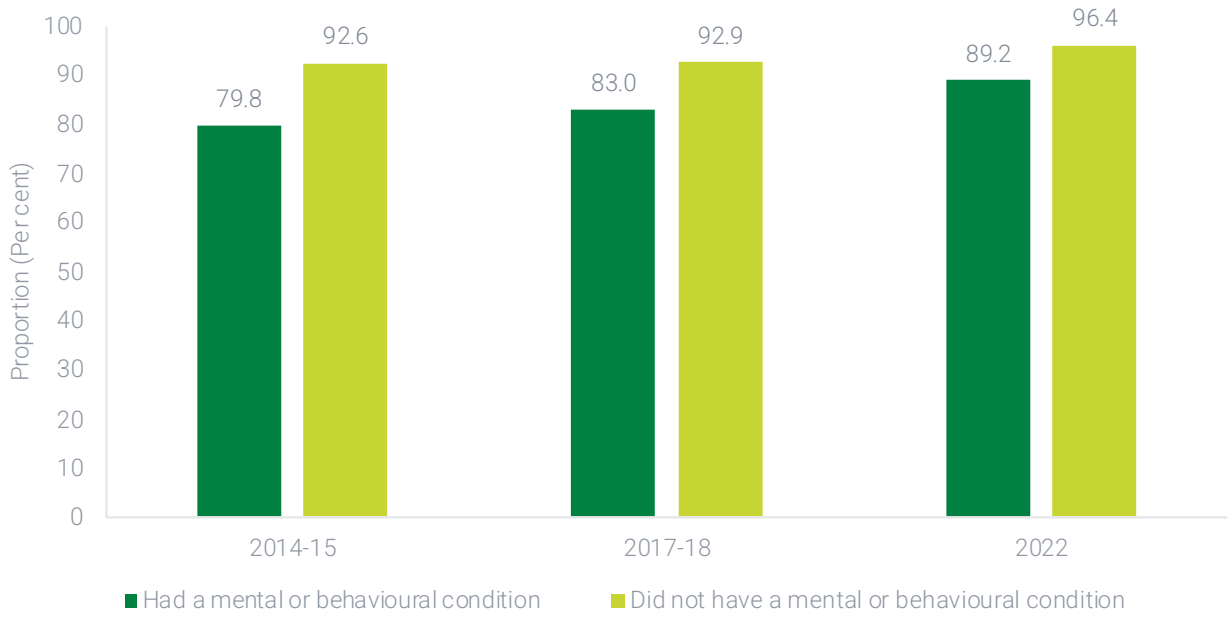
When considering these findings, it should be noted that from 2014-15 to 2022, the overall number of people reporting a mental or behavioural condition has increased. The reduction in the gap may in part be driven by

[12] Australian Institute of Health and Welfare. Australia's youth: Engagement in education or employment [Internet]. Canberra: Australian Institute of Health and Welfare, 2021 [cited 2024 Jun. 4]. Available from: https://www.aihw.gov.au/reports/children-youth/engagement-in-education-or-employment

[13] Gariépy G, Danna SM, Hawke L, Henderson J, Iyer SN. The mental health of young people who are not in education, employment, or training: a systematic review and meta-analysis. Soc Psychiatry Psychiatr Epidemiol. 2022 Jun;57(6):1107-1121. doi:10.1007/s00127-021-02212-8. Epub 2021 Dec 21.

more people identifying as having a mental health or behavioural condition, including people with less severe symptoms.

Figure A10. Proportion of people with and without a mental or behavioural condition aged 16-24 years who are employed and/or studying, 2014-15 to 2022



How do these findings differ between groups?

Whole of population

Age and Sex

In 2022, rates of engagement in employment and study did not significantly differ between males (94.3%) and females (93.3%). This is consistent with findings from 2014-15 and 2017-18 where there were also no significant differences.

Remoteness

In 2022, among people aged 16-24 years who lived in *Major cities*, 96.8% were employed and/or studying, which was significantly higher than those in *Inner regional* areas (85.1%), and *Outer regional* and *remote* areas (85.5%).

Between 2014-15 and 2022, only *Major cities* showed improvement in the proportion of people engaged in employment and/or study (2014-15: 90.4%, 2022: 96.8%).

Lived Experience

Age and Sex

In 2022, for both males and females, people aged 16-24 years with a mental or behavioural condition were less likely to be employed and/or studying than people without a condition. This gap was larger for females (86.2% compared with 95.5%, respectively) compared to males (91.4% compared with 96.8%, respectively).

Over time, the proportion of females aged 16-24 years with a mental or behavioural condition who were employed and/or studying has remained stable. In 2017-18, 87.1% of females within this group were

employed and/or studying, compared to 86.2% in 2022. In contrast, an increase over time was observed for males in the same group: 79.2% were employed and/or studying in 2017-18, compared to 91.4% in 2022.

This difference may in part be due to a larger proportional increase in the number of males reporting a mental or behavioural condition over time compared to females. The increase over time for males with a mental health or behavioural condition was not mirrored among males without a mental or behavioural condition (2017-18: 95.1%, 2022: 96.8%).

Remoteness

In 2022, people with a mental or behavioural condition living in *Major cities* were more likely to be employed and/or studying, compared to those living in *Outer regional and remote* areas (92.7% compared with 79.6%, respectively)

Over time, the proportion of people with a mental or behavioural condition who were employed and/or studying has improved for those in *Major cities*: in 2014-15, 81.4% were employed and/or studying, which increased significantly to 92.7% in 2022. The proportion did not significantly differ over time for people with a mental or behavioural condition in *Outer regional and remote* areas.

Technical information

Source

Australian Bureau of Statistics (ABS) *National Health Survey, 2022*; ABS *National Health Survey, 2017-18*; ABS *National Health Survey, 2014-15.*

Frequency of data collection

Every three years. Note some differences in frequency of collection due to COVID-19.

Limitations

- There are several high standard error figures for Remoteness analyses, which has limited the number of possible comparisons between groups.

Additional notes

- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- People who are considered to meet the criteria for a mental or behavioural condition meet the following definition 'Persons who have a current, self-reported mental and behavioural condition which has lasted, or is expected to last, for 6 months or more. Condition is not based on any diagnostic screening tool'.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2021, 2016, and 2011. SEIFA analyses have been excluded from this core indicator analysis. SEIFA is determined using income, education, employment, occupation, housing, and miscellaneous variables. Given employment is used to determine SEIFA scores, it should not be used to compare or cross-tabulate by SEIFA scores. For more information, please see the ABS website.

CI 10: Prevalence of physical health conditions

What we are tracking (and why)

This indicator tracks the prevalence of long-term physical conditions and their co-occurrence with 12-month mental disorders for people in Australia aged 16-85 years. People with mental illness typically experience worse physical health outcomes than people without mental illness. Higher rates of co-occurring physical and mental conditions can result in reduced life expectancy, increased levels of ongoing disability, and reduced workforce participation. Reduction in the co-occurrence of physical and mental health conditions may signal an improvement in the system's performance in improving the physical health of people with mental illness. It may also have flow-on effects for broader factors that influence mental health outcomes, such as improved employment rates or decreased financial stress.

How are long-term physical health conditions measured?

For this indicator, long-term physical conditions are those where a person had been told by a doctor or nurse that they had a long-term physical health condition, which had lasted, or was expected to last, for 6 months or more. When interpreting findings presented for this indicator, it is important to consider that the effects physical conditions have on someone's life can vary greatly. For instance, an individual living with asthma may have a very different experience with their mental health when compared to someone living with diabetes.

For this indicator, we draw on National Health Survey (NHS) 2022, and National Study of Mental Health and Wellbeing (NSMHW) 2020-22 to analyse the relationship between long-term physical health conditions and mental health conditions.

Long-term physical health conditions in the NHS and NSMHW

National Health Survey	National Study of Mental Health and Wellbeing
• Arthritis • Asthma • Back problems (dorsopathies) • Cancer (malignant neoplasms) • Chronic obstructive pulmonary disease (COPD) *(includes chronic bronchitis, emphysema and chronic airflow limitation) • Diabetes mellitus • Hay fever and allergic rhinitis • Heart, stroke and vascular disease (includes angina, heart attack, other ischaemic heart diseases, stroke and other cerebrovascular diseases, oedema or heart failure, diseases of the arteries, arterioles and capillaries) • Hypertension • Kidney disease • Mental and behavioural conditions (includes self-reported harmful use on alcohol and/or drugs, mood (affective) disorders, anxiety related disorders, problems of psychological development, organic mental disorders and other mental and behavioural conditions) • Osteoporosis	• Arthritis • Osteoporosis • Asthma • Cancer (including remission) • Dementia • Diabetes (excluding during pregnancy) • Heart diseases (including angina or past heart attack) • Effects of a stroke • Chronic kidney disease • Mental health condition (including depression or anxiety) • Bronchitis or emphysema • Any other current, long-term health conditions

What the data tells us

Indicator findings

Whole of population

In the National Study of Mental Health and Wellbeing (NSMHW) 2020-2022, of people in Australia aged 16-85 years:

- 7.5 million (37.9%) had a long-term physical condition
- 5.8 million (29.5%) had a physical condition only
- 1.7 million (8.4%) had both a mental and physical condition

Time series data on long-term physical conditions are not available for the NSMHW. However, the National Health Survey (NHS) shows no change over time in the proportion of people in Australia who have a chronic physical health condition (from 37.3% in 2007-08, to 38.7% in 2014-15 and 37.4% in 2022)[14].

Lived Experience

In 2020-2022, among people in Australia aged 16-85 years:

- 4.3 million (21.5%) had a 12-month mental disorder.
- A similar proportion of people with and without a 12-month mental disorder experienced a long-term physical condition (39.3% compared with 37.5%, respectively)

How do these findings differ between groups?

Whole of population

Age and Sex

Among people in Australia aged 16-85 years, the proportion of people with a physical condition increased consistently with age, in 2020-2022:

- For people aged 16-24 years, 15.4% had a physical condition.
- More than 1 in 3 people aged 45-54 years had a physical condition (34.7%).
- More than 4 in 5 people aged 75-85 years had a physical condition (83.1%).
- 2 in 5 (40.1%) females had a physical condition compared with 35.6% of males.

Across most age groups a higher proportion of people with a mental disorder had a physical condition compared to people without a mental disorder. This difference was most pronounced for people aged 55-64 years (Figure A11).

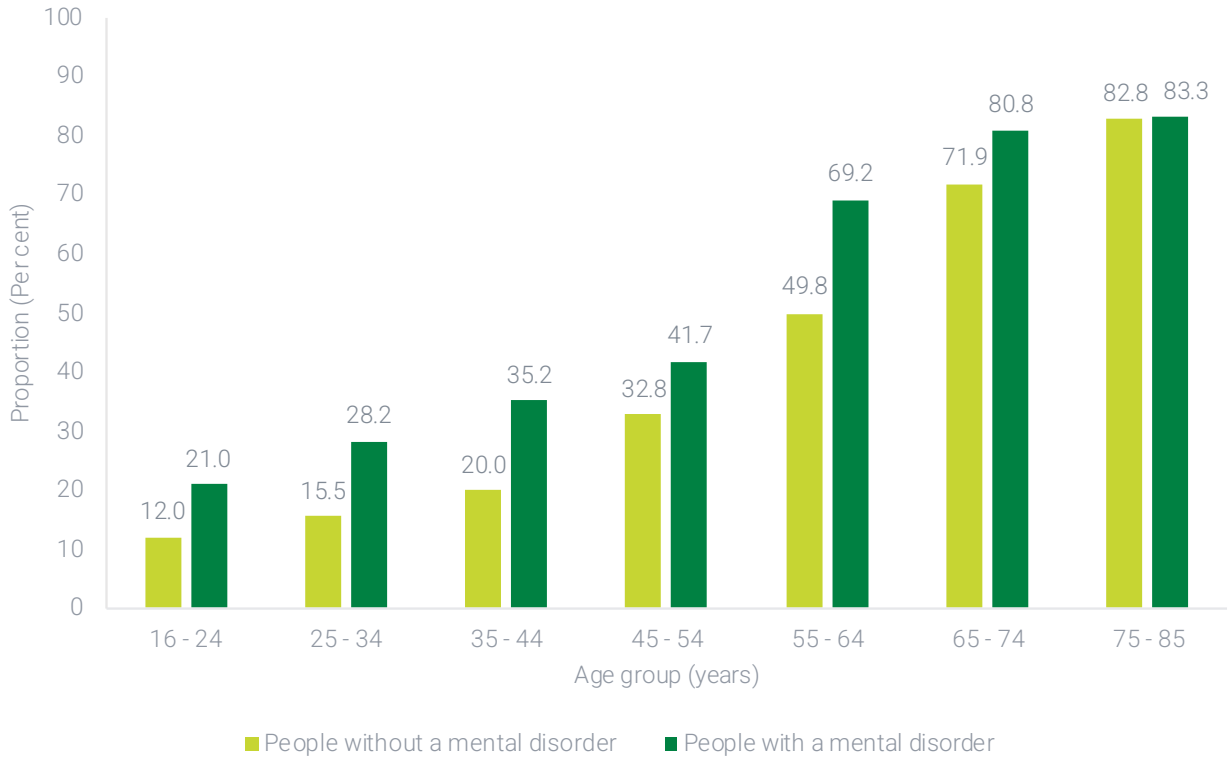
Remoteness and Socioeconomic indexes

In 2020-2022, people living in the most disadvantaged areas (Quintile 1) according to SEIFA scores, were most likely to have a physical health condition (46.0%) compared with people in Quintile 2 (42.0%), Quintile 3 (36.6%), Quintile 4 (33.3%), and Quintile 5 (34.6%).

[14] Time series data drawn from National Health Surveys 2007-08 to 2022. Proportions differ from those reported above due to differences in questions asked about physical conditions between data sources.

In 2020-2022, people living in *Inner regional* and *Outer regional and remote* areas were more likely to have a physical health condition than people living *in Major cities* (both 44.6% compared with 35.6%)

Figure A11. Proportion of people in Australia aged 16-85 years with a physical condition, by age group and mental disorder status, 2020-2022



Lived Experience

Age and Sex

In 2020-2022 across the whole population, there was a higher proportion of females with a 12-month mental disorder and co-occurring physical condition (10.5%) compared to males (6.3%).

Furthermore, among people with a 12-month mental disorder:

- a higher proportion of males had no accompanying physical condition (65.2%) compared to females (57.3%),
- the proportion of people with a 12-month mental disorder that co-occurs with a physical condition remains relatively stable across age groups (refer to Figure A11).

Remoteness and Socioeconomic indexes

In 2020-2022, among people with a 12-month mental disorder:

- Almost half (48.5%) of people living in the most disadvantaged areas (Quintile 1) had a co-occurring physical condition, compared with people living in areas of most disadvantage who had a co-occurring physical health condition (Quintile 4: 33% and Quintile 5: 32.3%).
- Around half (50.4%) of people living in *Outer regional* and *Remote areas* had a co-occurring physical condition, compared with people living in *Major cities* (36.9%).

For people without a 12-month mental disorder, those living in *Major cities* were less likely to have a physical condition (35.3%) compared with those living in *Inner regional* areas (45.0%) and *Outer regional* and *remote* areas (42.8%).

Technical information

Source

Australian Bureau of Statistics (ABS) *National Study of Mental Health and Wellbeing* (NSMHW), *2020-2022*; ABS *National Health Survey* (NHS), *2022*; ABS *National Health Survey, 2017-18*; ABS *National Health Survey, 2014-15*; ABS *Australian Health Survey, 2011-12*; ABS *National Health Survey, 2007-08*.

Frequency of data collection

NSMHW – Irregular. No future releases scheduled.
NHS – Approximately every three years. Note some differences in frequency of collection due to COVID-19.

Limitations

- Due to the differences in questions used to assess physical health conditions, comparisons between the 2007 *National Survey of Mental Health and Wellbeing* and 2020-2022 *National Study of Mental Health and Wellbeing* for co-occurring mental and physical conditions are not possible.
- NSHMW – Detailed information on the methodology is available at: https://www.abs.gov.au/methodologies/national-study-mental-health-and-wellbeing-methodology/2020-2022.
- NHS – Detailed information on the methodology is available at: https://www.abs.gov.au/methodologies/national-health-survey-methodology/2022

Additional notes

- Cross sectional analyses presented for the 2020-2022 reference period are sourced from the NSMHW, whereas time series analyses are sourced from the NHS. While descriptive statistics differ between these data sources due to methodological differences, the general pattern of findings is consistent.
- Comparisons between males and females are based on sex recorded at birth (i.e., what was determined by sex characteristics observed at birth or infancy).
- The NHS includes persons who have a current health condition which has lasted, or is expected to last, for 6 months or more; except for persons reporting diabetes mellitus and/or heart, stroke and vascular disease which are included irrespective of whether the condition is current and/or long-term.
- In the NSMHW, a 12-month mental disorder refers to people who met the diagnostic criteria for having a mental disorder at some time in their life and had sufficient symptoms of that disorder in the 12 months prior to completing the survey. A person may have more than one 12-month mental disorder. Mental disorders are classified according to the World Health Organization's International Classification of Diseases, Tenth Revision (ICD-10).
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- Socio-Economic Indexes for Areas (SEIFA) assigns collective socio-economic characteristics for people living within a designated geographic area. SEIFA broadly defines relative socio-economic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in

society. Area-level indexes in this instance are used as a proxy measure of individual socio-economic advantage and disadvantage, and as a result there may be misclassification at a person-level. SEIFA classifications for 2016 are ranked according to quintiles for this analysis.

- There are four SEIFA indexes, each summarising a different aspect of the socio-economic conditions in an area using different Census data.
    - For NSMHW analysis, the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) is used, which focuses on both advantage and disadvantage.
    - For NHS analysis, the Index of Relative Socio-economic Disadvantage (IRSD) is used, and focuses on relative socio-economic disadvantage.
- Remoteness has been defined using the Australian Statistical Geography Standard (ASGS) and characterises relative geographic access to services. This has been grouped into three groups including '*Major cities*', '*Inner regional*', and '*Outer regional and remote*'. This analysis used ASGS classifications from 2016.

CI 11: Alcohol consumption

What we are tracking (and why)

This indicator tracks the proportion of people in Australia aged 14 years and over who exceeded the Australian *Guidelines To Reduce Health Risks From Drinking Alcohol*[15] (the Australian Alcohol Guidelines) released in 2020.

Consuming alcohol at harmful levels is shown to increase the risk of experiencing some physical conditions and may contribute to existing mental illness. It can also contribute to violence and assaults, avoidable injury, motor accidents and birth defects.[16] A low or decreasing proportion of people who consume alcohol at harmful levels may signal improvements in the general health and wellbeing of people in Australia and reduced demand on the health and mental health system.

How is alcohol consumption measured?

In 2020, the National Health and Medical Research Council (NHMRC) released the revised Australian guidelines to reduce risks from drinking alcohol. These guidelines define drinking behaviours that Australians can follow to reduce their risk of alcohol-related disease or injury.

For this indicator, exceeding the Australian Alcohol Guidelines is interpreted as consuming more than 10 standard drinks per week, and/or more than 4 standard drinks in a single day at least monthly, or exceeding both components on average in the previous 12 months.

What the data tells us

Indicator findings

Whole of population

In 2022-2023, 6.6 million (30.7%) of people in Australia aged 14 years and over exceeded the Australian Alcohol Guidelines. There has been a steady downwards trend in the proportion of people in Australia who exceeded the Australian Alcohol Guidelines since 2010 (37.7%), which has been slightly less pronounced in recent years (from 33.2% in 2016 to 32.0% in 2019 and 30.7% in 2022-23).

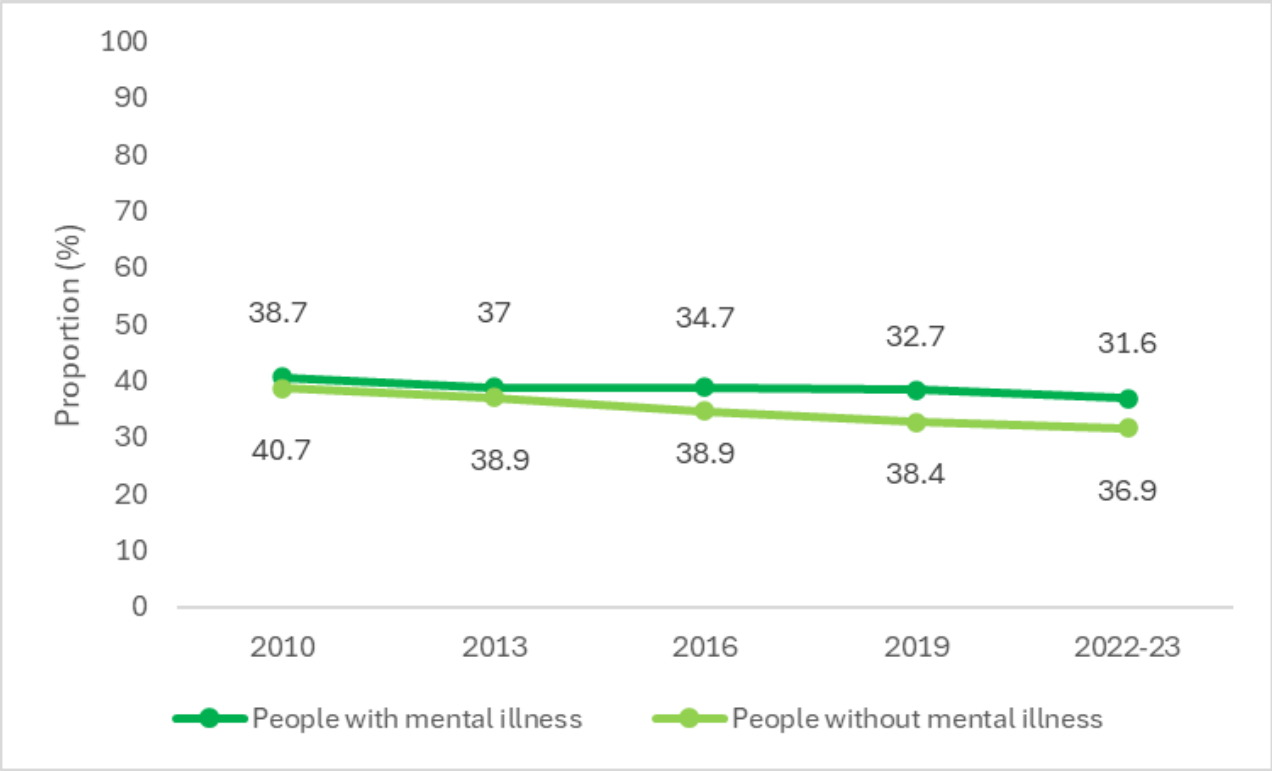
Lived Experience

In 2022-2023, a higher proportion of people with a mental illness aged 18 years and over exceeded the Australian Alcohol Guidelines (36.9%) than people without a mental illness (31.6%). This gap has increased over time (Figure A12).

[15] National Health and Medical Research Council. Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Canberra: Commonwealth of Australia; 2020.

[16] Department of Health and Aged Care. National alcohol strategy 2019–2028. Canberra: Commonwealth of Australia; 2019.

Figure A12. Proportion of people aged 18 years and over who exceeded the Australian Alcohol Guidelines by mental health status, 2010 to 2022-2023



When looking at specific drinking behaviour:

- Close to one-third (30.4%) of people with a mental illness consumed on average more than 10 standard drinks per week in the previous 12-months, compared with one-quarter (25.3%) of people without a mental illness.

- 29.0% of people with a mental illness consumed more than 4 standard drinks in a single day at least monthly on average in the previous 12-months, compared with 24.6% of people without a mental illness.

How do these findings differ between groups?

In 2022-2023, the proportion of people in Australia who exceeded the Australian Alcohol Guidelines varied according to both gender and age.

Among people aged 14 years and over:

- Almost 1 in 3 males consumed more than 10 standard drinks per week on average in the previous 12-months (31.8% compared with 17.8% of females).
- A similar difference was observed when comparing rates for people who consumed on average more than 4 standard drinks in a single day at least monthly in the previous 12-months, but not as often as weekly (Males: 12.7%, Females: 8.7%).

In general, in 2022-2023 younger people were more likely to have exceeded the Australian Alcohol Guidelines by drinking more than 4 standard drinks in a single day at least monthly, while older people were more likely to do so by consuming more than 10 standard drinks per week in the previous 12-months.

The proportion of people who exceeded the Australian Alcohol Guidelines has been relatively consistent since 2016 across different age groups. However, among people aged 14-17 years there was a reduction in the proportion of people exceeding the Australian Alcohol Guidelines[17] between 2019 (9.5%) and 2022-2023 (5.5%).

Data disaggregated by age, sex, SEIFA Quintiles, and Remoteness for people with a mental illness is currently unavailable.

Technical information

Source

Australian Institute of Health and Welfare (AIHW) *National Drug Strategy Household Survey, 2022-2023*; AIHW *National Drug Strategy Household Survey, 2019*; AIHW *National Drug Strategy Household Survey, 2016*; AIHW *National Drug Strategy Household Survey, 2013*; AIHW *National Drug Strategy Household Survey, 2010*.

Frequency of data collection

Approximately every three years.

Limitations

- Data are self-reported, and people may not accurately report information relating to alcohol consumption. Detailed information on the methodology, including limitations, is available on the AIHW website.

Additional notes

- It is important to note that adherence to the Australian Alcohol Guidelines minimises the risks associated with consuming alcohol, but they do not eliminate the risk entirely.
- People with a mental illness include those who self-reported that they had been diagnosed or received treatment for depression, an anxiety disorder, schizophrenia, bipolar disorder, other form of psychosis or an eating disorder in the previous 12 months.
- For analyses presented for people with a mental illness, the age range of the sample population is 18 years and over. For other analyses presented, the age range of the sample population is 14 years and over where noted.

[17] The Australian alcohol guidelines have different advice for people under the age of 18 years, recommending that people under the age of 18 years do not consume alcohol, as any level of consumption can put their health a risk. The proportion of people aged 14-17 years who had consumed any alcohol in the previous year was 30.2% in 2019 and 31.0% in 2022-2023.

CI 12: Feeling lonely

What we are tracking (and why)

This indicator tracks the proportion of people in Australia aged 15 years and over who reported feeling lonely.

Loneliness can be described as a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more or more satisfying, social relationships.[18] People who feel lonely are more likely to experience depression,[19] social anxiety,[20] poorer wellbeing, and premature death.[21] Decreases in the rates of loneliness across the population may signify improvements in external factors that impact mental health and wellbeing across society.

How is loneliness measured?

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'). It provides a more robust measure of loneliness than the single item 'I often feel very lonely', which can be affected by stigma associated with loneliness.[22]

What the data tells us

Indicator findings

Whole of population

Overall, 15.4% of people in Australia aged 15 years and over reported feeling lonely in 2024. Between 2011 and 2024, the proportion of people in Australia who reported feeling lonely has remained relatively steady (2011: 15.3%, 2015: 15.0%, 2019: 15.6%, 2022: 16.3%) (Figure A13).

[18] Badcock JC, Holt-Lunstad J, Garcia E, Bombaci P, Lim MH. Position statement: Addressing social isolation and loneliness and the power of human connection. Global Initiative on Loneliness and Connection (GILC). 2022 [accessed 9 February 2024]. Our Position Statements | GILC].

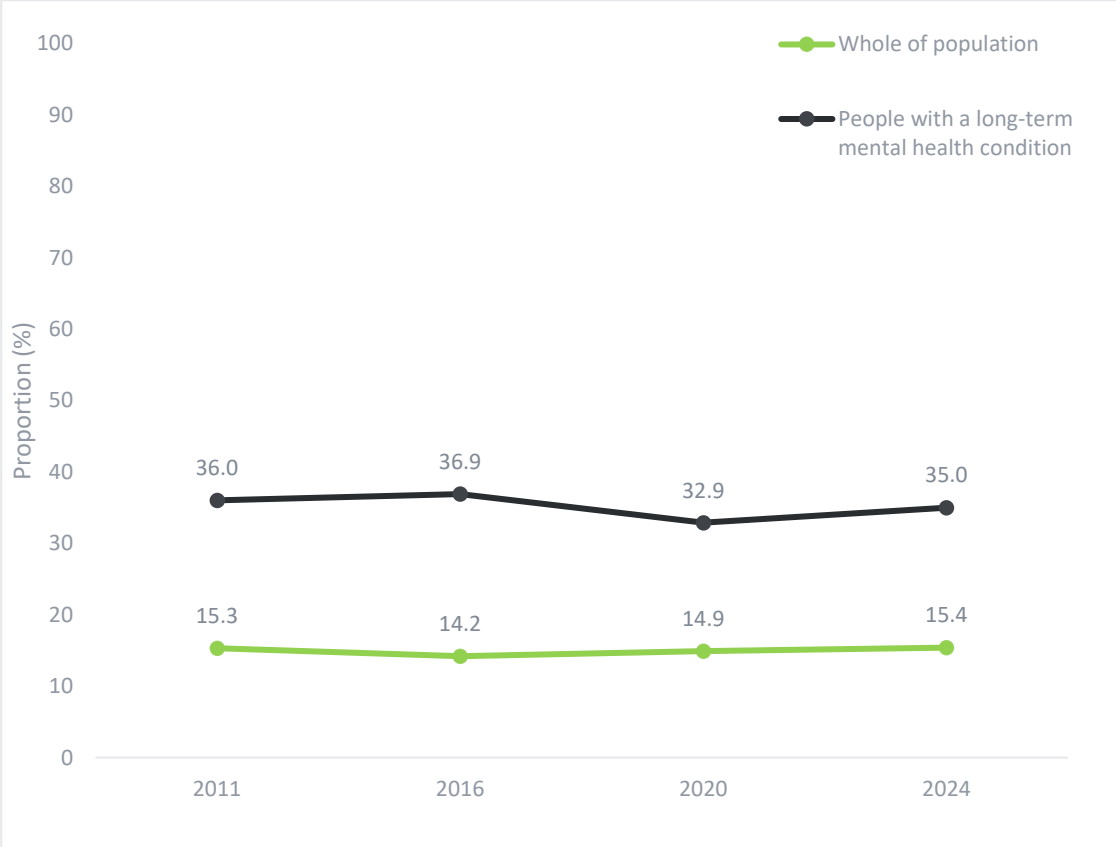
[19] Cacioppo JT, Hawkley LC, Thisted RA. Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study. Psychol Aging. 2010 Jun;25(2):453-63. doi:10.1037/a0017216. [accessed 19 June 2024].

[20] Lim MH, Rodebaugh TL, Zyphur MJ, Gleeson JFM. Loneliness over time: The crucial role of social anxiety. Journal of Abnormal Psychology. 2016;125(5):620–630. doi.org/10.1037/abn0000162 [accessed 19 June 2024].

[21] Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. Perspectives on Psychological Science. 2015;10(2):227-237. doi.org/10.1177/1745691614568352 [accessed 19 June 2024].

[22] Manera KE, Smith BJ, Owen, KB, Phongsavan P and Lim MH (2022) Psychometric assessment of scales for measuring loneliness and social isolation: an analysis of the household, income and labour dynamics in Australia (HILDA) survey, Health and Quality of Life Outcomes, 20(40), doi: 10.1186/s12955-022-01946-6.

Figure A13. Proportion of people in Australia aged 15 years and over who reported feeling lonely, 2011-2024



Please note for readability, Figure A13 only presents data with 5-year interval points.

Lived Experience

Among people in Australia aged 15 and over with a long-term mental health condition, 35.0% reported feeling lonely in 2024. Between 2011 and 2024, the proportion ranged between 32.0% to 40.8%, peaking in 2015 (40.4%) and again in 2021 (40.8%).

In 2024, similar to previous years, people who reported being diagnosed with a long-term health condition, disability or impairment were more likely to report feeling lonely (19.0%) compared to people who did not (12.3%). However, rates were not as high as those observed for people with a long-term mental health condition.

How do these findings differ between groups?

Whole of population

Age and Sex

In 2024, across the whole population, a similar proportion of males (15.1%) and females (15.6%) reported feeling lonely.

When comparing proportions across age groups, there was also limited variation. The lowest rate of people feeling lonely was observed for people aged 15-34 years (14.6%) and the highest was for people aged 35-64 years (16.0%).

Socioeconomic indexes

When examining SEIFA scores, in 2024, people who were living in the most disadvantaged areas (Quintile 1) were more than twice as likely to report feeling lonely, compared with those living in the most advantaged areas (Quintile 5) (23.2% compared with 10.6%, respectively)

Remoteness Areas

In 2024, 17.4% of people living in *Outer regional and remote* areas reported feeling lonely, followed by 16.9% of people living in *Inner regional* areas, and 14.8% of people living in *Major cities*.

Lived Experience

Age and Sex

In 2024, among people with a long-term mental health condition:

- A similar proportion of males and females reported feeling lonely (36.3% and 34.1%, respectively)
- Nearly 2 in 5 people aged 35-64 years reported feeling lonely (37.5%), followed by those aged 15-34 years and 65 years and over (both 32.3%).

Over time, the proportion of people with a long-term mental health condition who reported feeling lonely fluctuated (36.0% in 2011; 32.9% in 2020; 35.0% in 2024), with similar patterns observed across demographic groups:

- Females: 38.0% reported feeling lonely in 2011, compared with 34.5% in 2020 and 34.1% in 2024.
- Males: 33.7% reported feeling lonely in 2011, compared with 30.7% in 2020 and 36.3% in 2024.
- While the differences between age groups remained relatively small in 2024, notable fluctuations were observed within each age group over time: For people aged 65 years and over, the proportion was highest in 2011 (41.2%), decreased to 23.5% in 2020, then increased to 31.3% in 2021 and remained relatively stable through to 2024 (32.3%).
- For people aged 15–34 years, the proportion was highest in 2018 (47.4%) yet dropped substantially in 2019 (31.7%), followed by a rapid increase in 2021 (42.2%), then decreased between 2022 and 2024 (32.3%).
- For people aged 35–64 years, the proportion fluctuated considerably, increasing from 41.6% in 2019, decreasing to 31.3% in 2020, increasing again to 42.8% in 2021, and then declining to 37.5% in 2024.

Technical information

Source

Melbourne Institute of Applied Economic and Social Research. *The Household, Income and Labour Dynamics in Australia Survey (HILDA), Waves 11-24*.

Frequency of data collection

Annually.

Limitations

- The smaller sample size for people with a long-term mental health condition reduces the chance of detecting statistically significant findings.

Additional notes

- In the HILDA survey, the term 'long-term health condition' is used to describe where a respondent records any long-term health condition, impairment or disability 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 those respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.

- HILDA uses SEIFA to measure and rank areas in Australia based on relative socio-economic conditions in an area using Census data. There are 4 SEIFA indexes, each summarising different aspects of the socio-economic conditions. The data presented here are classified according to the SEIFA Index of Relative Socio-economic Advantage and Disadvantage (IRSAD). SEIFA data are presented using quintiles, dividing the areas into 5 groups based on their scores. Quintile 1 represents the lowest 20% of areas (i.e., the most disadvantaged) and Quintile 5 the highest 20% (i.e., the most advantaged). For further information, see Socio-Economic Indexes for Areas (SEIFA), Australia, 2021 | Australian Bureau of Statistics

- Remoteness areas (i.e., *Major cities*, *Inner regional*, *Outer regional*, and *Remote* areas) are defined by the Australian Statistical Geography Standard (ASGS). In the data presented here, *Outer regional* and *remote* areas have been combined as one remoteness category. This is due to the high relative standard errors for *Remote* area estimates which arise from small sample numbers for this category. For further information, see Remoteness Areas | Australian Bureau of Statistics

Detailed information on the methodology is available in the HILDA Survey User Manual.

CI 13: Experiences of discrimination

What we are tracking (and why)

This indicator tracks the proportion of people in Australia aged 15 years and over who experienced discrimination or had been treated unfairly in the previous 12 months.

Discrimination may happen when people are treated unfairly because they are seen as being different from others. Negatively stereotyped attitudes and behaviours can harm a person's day-to-day health and wellbeing by excluding, devaluing or shaming them, and can cause and exacerbate distress[23,24]. Discrimination can cause a person to believe negative stereotypes about themselves, increase feelings of isolation, reduce help-seeking and create barriers to social, economic and cultural participation[25].

Higher proportions of people who experience discrimination suggest lower levels of wellbeing. A reduction in experiences of discrimination and unfair treatment may indicate more inclusive attitudes and behaviours across the community and in service provision, including mental health services.

How are experiences of discrimination measured in the General Social Survey?

People who had experienced discrimination were asked how often they had experienced discrimination, the reason for their most recent incident of discrimination, and where the experience of discrimination occurred.

For this indicator, it is important to note that the General Social Survey does not ask respondents if they had experienced discrimination on the basis of experiencing mental health challenges.

The sample size in the 2025 General Social Survey does not allow for detailed disaggregation, including comparisons across age groups, SEIFA Quintiles, and Remoteness areas for people with a mental health condition who experienced discrimination.

What the data tells us

Indicator findings

In 2025, among people who have a mental health condition:

- Around 1 in 3 (31.2%) had experienced discrimination or had been treated unfairly in the past 12 months.
- Almost 1 in 4 (#23.3%) who had experienced discrimination or had been treated unfairly, had experienced this all or most of the time.

Looking over time, similar differences were observed in previous years. In 2014 and 2020, for people with a mental health condition who had experienced discrimination, 18.0% and 14.5% respectively reported being

Proportion has a high Margin of Error and should be used with caution.

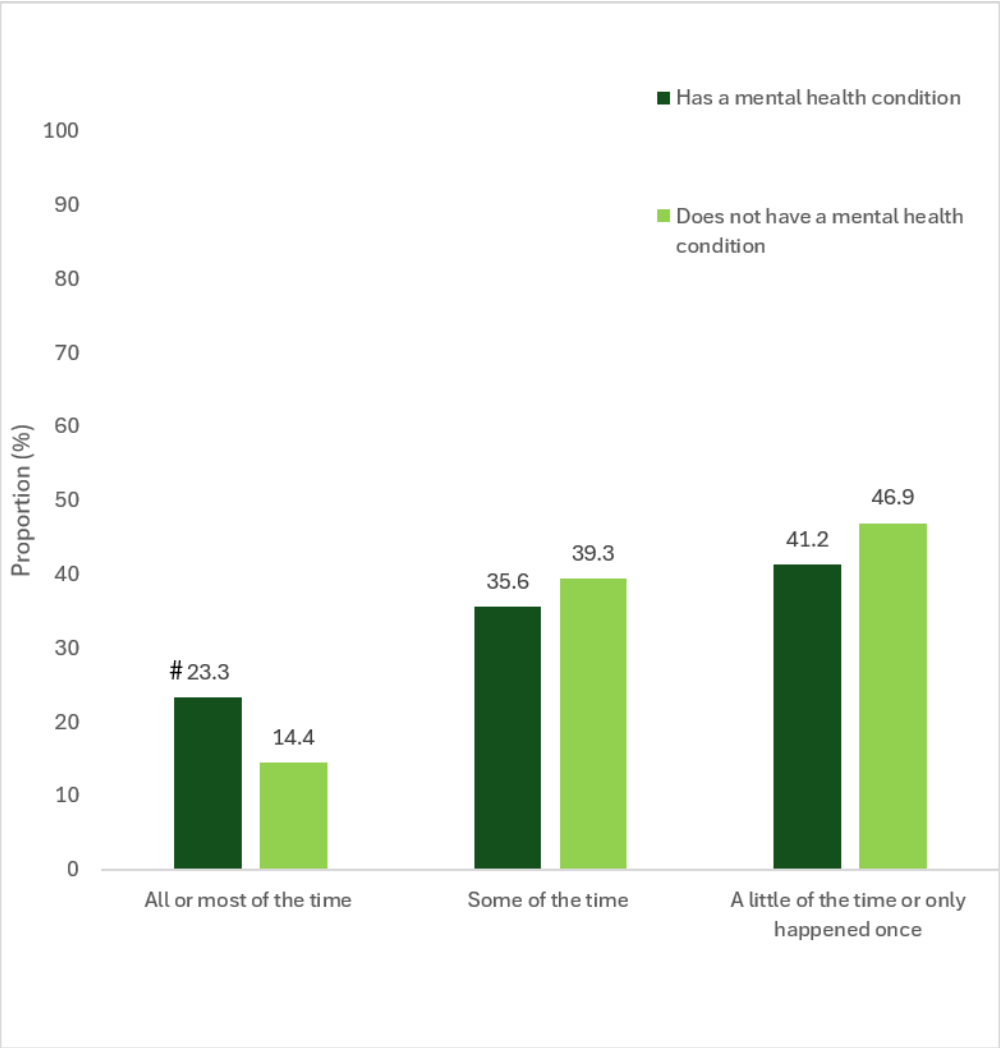
[23] Link B, Phelan J. Conceptualizing Stigma. Annual Review of Sociology. 2001;27:363-85. http://www.jstor.org/stable/2678626

[24] Corrigan PW, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can J Psychiatry. 2012 Aug;57(8):464-9. doi:10.1177/070674371205700804.

[25] Groot C, Rehm I, Andrews C, Hobern B, Morgan R, Green H, et al. Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues. Melbourne; 2020.

treated unfairly all or most of the time. For people without a mental health condition who had experienced discrimination, these proportions were 12.0% (2014) and 7.3% (2020).

Figure A14. Proportion of persons aged 15 years and over who experienced discrimination, by presence of mental health condition and how often experienced discrimination or been treated unfairly, 2025

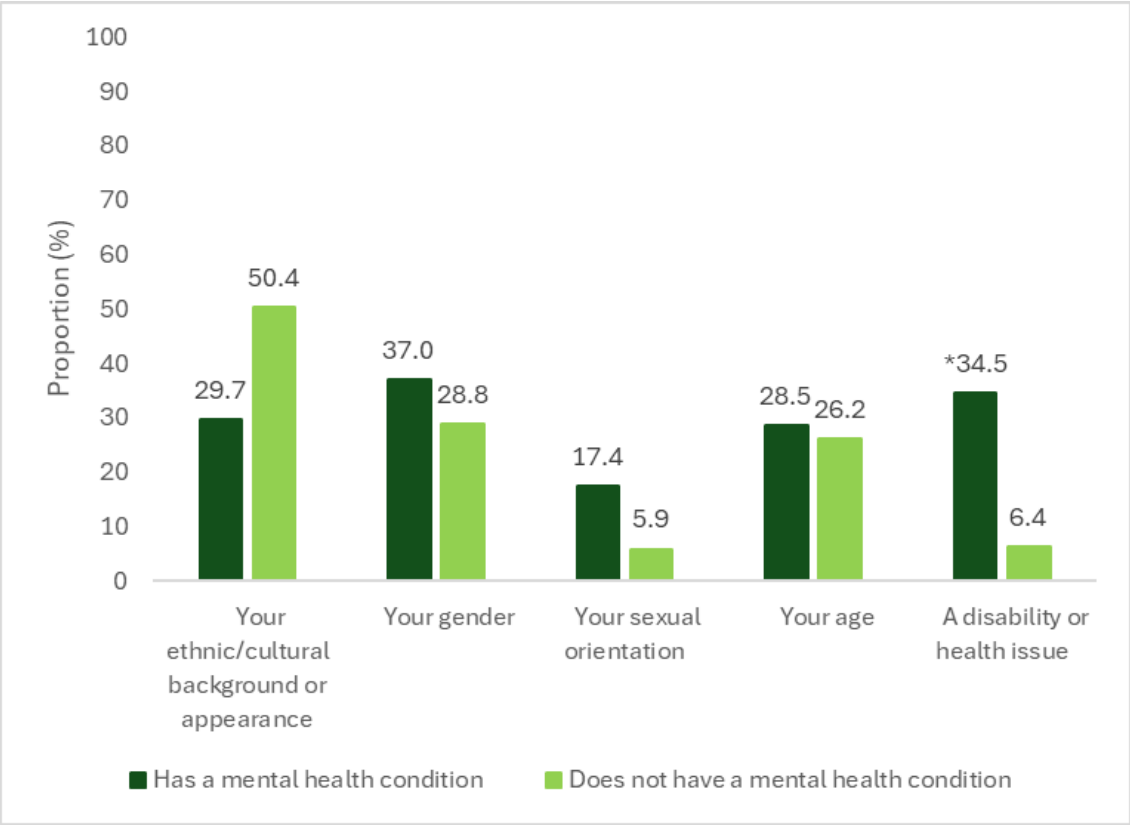


Proportion has a high Margin of Error and should be interpreted with caution.

In 2025, people experienced discrimination across a range of different settings and for various reasons:

- More than 1 in 3 people with a mental health condition who had experienced discrimination had experienced this based on a disability or health issue (34.5% compared with 6.4% of people who do not have a mental health condition).
- 2 in 5 people with a mental health condition who reported discrimination, had experienced this when dealing with the justice system, government officials or people involved in health care (40.7% compared with 25.2% of people who do not have a mental health condition).

Figure A15. Proportion of people in Australia aged 15 years and over reporting discrimination, by reason for discrimination, and presence of a mental health condition, 2025



(a) Proportion has a high margin of error and should be used with caution.

How do these findings differ between groups?

In 2025, among people aged 15 years and over:

- 28.8% of men who have a mental health condition experienced discrimination or had been treated unfairly (compared with 15.8% of men who do not have a mental health condition).
- Almost 1 in 3 women with a mental health condition experienced discrimination or had been treated unfairly (31.7% compared with 17.1% of women who do not have a mental health condition).

Technical information

Source

Australian Bureau of Statistics (ABS) General Social Survey, 2025; ABS *General Social Survey, 2020*; ABS *General Social Survey, 2019*; ABS *General Social Survey, 2014*.

Frequency of data collection

The GSS was previously collected irregularly. From 2025 onwards, the GSS will be collected annually.

Limitations

- The previous General Social Survey was conducted in 2020, during the emergency phase of the COVID-19 pandemic. Comparisons between 2020 and 2025 data should therefore be interpreted with this context in mind.
- Care should be taken when comparing 2020 data to earlier years due to changes in the survey methodology, higher rates of non-response and the impact of COVID-19 restrictions on the population.
- High standard errors and margins of error make it difficult to detect statistical differences between people with a mental health condition and people without a mental health condition.

Additional notes

- Data from 2014 includes people who are aged 18 years and over, whereas the GSS from 2019 onwards, includes people who are aged 15 years and over.
- "Has a mental health condition" includes people who reported they had a 'Mental health condition (including depression or anxiety)' from the list of long-term mental health conditions.
- Data for 2025 and 2020 capture people with a 'mental health condition (including depression and anxiety)', while data from 2014 includes 'depression or feeling depressed, behavioural or emotional disorders, dependence on drugs or alcohol, feeling anxious or nervous and problems learning or understanding things'.
- Some proportions may not add up to 100% due to perturbation of the data implemented by the data source owner.
- The 2025 General Social Survey collected both the 'sex recorded at birth' and 'gender' of respondents using the Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables (2020), available at https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/2020.
- Because the social indicators collected in the GSS relate to social characteristics and experience, data in this report are presented using the gender variable.
- Detailed information on the methodology is available at https://www.abs.gov.au/methodologies/general-social-survey-summary-results-australia-methodology/2025#overview

Domain 3 - the Mental Health System

Since releasing Report Card 2024, the Commission has been collaborating with stakeholders, including lived experience organisations, with a primary focus on developing Domain 3- the Mental Health System, as part of the Commission's reporting framework.

To move towards the establishment of a revised domain 3, the Commission established a small working group with a cross-section of organisations with relevant expertise, including lived experience, policy, data and measurement.

Informed by a range of comparable frameworks, reports, reviews, strategies, and the considered input from the working group, the Commission has included an initial version of Domain 3 - the Mental Health System in Report Card 2025. The Commission intends to continue to build on Domain 3 in future Report Card editions over time, as further data and evidence becomes available and informed by people with lived experience and consumers and carers, as well as feedback from the sector. Refer to Developing the National Report Card section of the Report Card 2025 for detailed information about the role of the Report Card Working Group.

This section outlines the initial data sources used to inform our understanding of the revised domain 3 indicators. This section also highlights identified data gaps that currently limits understanding of some indicators. Recognising that not all indicators are well measured by the data available, this approach allows the reporting framework to evolve as data availability and quality improve over time. For more information on why these data gaps matter, please refer to Report Card 2025.

This section differs from Domains 1 and 2 for several reasons. Domain 3 of Report Card 2025, and this Technical Report includes themes due to the complexity and breadth of the mental health system. Additionally, whilst findings from Domains 1 and 2 are based on survey data, which allows for opportunity to include more in-depth analysis of findings in the Technical Report, Domain 3 is largely based on administrative data, and all findings are present in Report Card 2025. Therefore, Domain 3 of the Technical Report focuses only on the technical detail of the data sources used in Domain 3 of Report Card 2025. It is suggested to cross-reference this section with the insights presented in Domain 3 of Report Card 2025.

Data gaps and opportunities

The Commission draws on high quality, nationally available, and reliable datasets to monitor system performance over time. In the context of the Commission's monitoring and reporting work, data gaps are areas where there is not enough national data to understand and track how aspects of the mental health system are performing.

In Domain 3 of Report Card 2025, indicators with data gaps for each theme are explored. For more information, please see Report Card 2025.

Theme: Accessibility

Guiding question - Are consumers, carers, family and kin getting the right care and support when they need it?

Guiding question – to what extent are consumers, carers, family and kin unable to access the mental health supports they need, trust and prefer?

Guiding question - To what extent do consumers, carers, family and kin have awareness, understanding, and trust towards available mental health supports?

Indicator: Mental health care is timely, affordable and geographically accessible for all communities

This indicator draws on a range of data sources which cover the breadth of available data regarding service usage. Please note, whilst this provides a comprehensive picture of the accessibility of mental health care, not all services, experiences and outcomes are captured.

Technical information

Admitted hospital care service use

Source

National Hospital Morbidity Database 2023-24

Frequency of data collection

Annually

Limitations

- This data source describes patterns of service use across population groups and areas. It does not directly measure need, service availability, affordability or whether people received the care they preferred
- Between 2016-17 and 2021-22, private hospital same day admitted mental health care data was sourced from the Australian Private Hospitals Association Private Psychiatric Hospitals Data Reporting and Analysis Service (PPHDRAS) and was not comparable with data from the NHMD. From 2024 (2022-23 collection year), the data source for same day private hospitalisations has changed from the PPHDRAS to the NHMD. This change has been reflected in the current reporting period.

Additional notes

- The National Hospital Morbidity Database (NHMD) collects information about care provided to admitted patients in Australian hospitals and includes information from the Admitted Patient Care NMDS and the Admitted Subacute and Non-acute Hospital Care NBEDS.
- Patients can receive specialised psychiatric care in a psychiatric hospital or in a psychiatric unit in a general hospital (classified as 'with specialised care'). Patients with mental illness may also be admitted to other areas of the hospital for medical and/or surgical care, or a general ward in a hospital without a specialised psychiatric unit, where health care workers may or may not be specifically trained to care for the mentally ill (classified as 'without specialised care').
- Separations (hospitalisations where there has been admission, followed by discharge) with a care type of Newborn (without qualified days), and records for Hospital boarders and Posthumous organ procurement have been excluded from all tables.
- Remoteness Area and Index of Relative Socio-Economic Disadvantage (IRSD) SEIFA quintiles are reported by the area of usual residence of the admitted patient.
- Rates for remoteness areas and IRSD SEIFA quintiles are crude rates based on estimated resident populations as at 30 June, the day prior to the beginning of the reference financial year.
- Details about the data sources and key concepts, including how a separation (hospitalisation) is classified as mental health-related, can be found in the data source section of the online report. Information about classifications used across AIHW mental health reporting (including but not limited to, remoteness, socio-economic status, the International Classification of Diseases), can be found in the Classifications and Technical Notes sections of the Mental Health Online Report Resources page.

Residential mental health service use

Source

National Residential Mental Health Care Database 2023-24

Frequency of data collection

Annually

Limitations

- This data source describes patterns of service use across population groups and areas. It does not directly measure need, service availability, affordability or whether people received the care they preferred.
- The scope for this collection is all episodes of care in all government-funded residential mental health care (RMHC) services in Australia, except those RMHC services that are in receipt of funding under the *Aged Care Act 1997* and subject to other Commonwealth reporting requirements.

Additional notes

- Residential mental health care services provide specialised care on an overnight basis in a domestic-like environment and may include a range of services such as rehabilitation, treatment and extended care.
- Percentages do not include records for which the information was missing or not reported.

- Rates are based on unrounded numbers, so may differ slightly from values obtained by rederiving from the published numbers.
- Rates for remoteness areas, SEIFA quintiles and country of birth are crude rates based on the 2021 Census population estimated resident populations as at 30 June, the day before the referenced financial year.
- SEIFA quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. SEIFA quintiles represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory. Disaggregation by SEIFA is based on a person's usual residence. Excludes episodes for which SEIFA was missing or not reported.
- Remoteness area and SEIFA quintile data are calculated based on the area of usual residence of the consumer.

Emergency Department presentations

Source

National Non-admitted Patient Emergency Department Care Database 2024-25

Frequency of data collection

Annually

Limitations

- Mental health-related emergency department presentations included in Report Card 2025 are those that had a principal diagnosis that fell within the Mental and behavioural disorders chapter (Chapter 5) of ICD-10-AM (codes F00–F99) or the equivalent ICD-9-CM or SNOMED codes. This may not capture all presentations involving mental health concerns, including presentations coded primarily as self-harm or poisoning.

Additional notes

- Rates for Remoteness areas and Socio-Economic Index for Areas (SEIFA) quintile are crude rates based on the ABS Census estimated resident population by remoteness area as at the beginning of the reference period. Remoteness areas were classified according to the Accessibility and Remoteness Index of Australia Australian Statistical Geography Standard (ASGS). SEIFA quintiles were determined by a ranking of areas in Australia according to the SEIFA Index of Relative Socio-Economic Disadvantage (IRSD).
- Rates may differ slightly from previously published data due to rebasing of the ABS populations for previous years after each census. Rates by SEIFA quintile published from 2024 onwards may differ from previously published data, due to the change in methodology from determining SEIFA quintile populations based on people as the unit, to using Statistical Area Level 2 as the unit.

Community mental health services

Source

National Community Mental Health Care Database 2023-24

Frequency of data collection

Annually

Limitations

- PHN funded state managed mental health services are reported in the CMHC and Mental Health Expenditure National Minimum Data Sets (NMDS) by Victoria. Western Australia reports these services in CMHC only. Other states/territories do not currently report on these services to either NMDS.
- Patient counts include uniquely identifiable consumers only. Consumers who receive services in more than one jurisdiction may be counted more than once nationally. Contact counts are based on each service contact, so one consumer can contribute multiple contacts.

Additional notes

- Historical results may not match previously published data. Largest influencers for this include the following:
    - In the 2022–23 publication period, a change to South Australia unique patient count methodology was applied from 2013–14 to 2021–22. This resulted in small increases in unique patient counts, and subsequently the number of treatment days, for South Australia and National.
    - Per 1,000 population could change due to revised ABS Population statistics.
- Population remoteness denominators used to calculate rates were modelled by the AIHW using available ABS population estimates and projections (series B).
- Contact count is based on each contact. For example, a 24-year-old patient received two services before their 25th birthday and one service after their birthday. The Contacts count will allocate Age group 18–24 = 2 and Age group 25–34 = 1.
- Rates for Remoteness areas and Socio-Economic Index for Areas (SEIFA) quintiles are crude rates based on the ABS Census estimated resident populations as at 30 June, the day before the referenced financial year. Remoteness areas were classified according to the Accessibility and Remoteness Index of Australia Australian Statistical Geography Standard (ASGS). SEIFA quintiles were determined by a ranking of areas in Australia according to the SEIFA Index of Relative Socio-Economic Disadvantage (IRSD).

Medicare service use

Source

AIHW analysis of MBS data maintained by the Australian Government Department of Health, Disability and Ageing 2024-25

Frequency of data collection

Annually

Additional notes

- Medicare mental health services are delivered by Psychiatrists, General Practitioners (GPs), Psychologists and Other allied health professionals. They are delivered across a range of settings – including hospitals, consulting rooms, home visits and telehealth – as defined in the Medicare Benefits Schedule (MBS).
- The MBS data presented relate to services delivered on a fee-for-service basis for which MBS benefits were paid. The year and month is determined from the date the service was processed rather than the date the service was provided.
- The percentages do not include services or patients for which demographic information was missing or not reported.
- Historical data may differ from previously published data due to data maturation or changes to methodology such as how patients are categorised into geospatial areas, changes to statistical geography standards, or changes to estimated resident populations.
- Remoteness area and Socio-Economic Index for Areas (SEIFA) quintile are based on the postcode of the residential mailing address of the patient as recorded by Services Australia at the last service processed during the reference period. Australian Bureau of Statistics (ABS) correspondences based on the 2021 census were used to proportionally allocate street delivery postal areas to Remoteness area and SEIFA quintile. Postcodes for post office boxes, mail back competitions, large volume receivers and specialist delivery postcodes are not included in the ABS correspondences. Therefore, data for these postcodes were allocated to “Unknown” and are not reported by Remoteness or SEIFA but are included in the National totals.
- Remoteness areas were classified according to the Accessibility and Remoteness Index of Australia Australian Statistical Geography Standard (ASGS) Edition 3. SEIFA quintiles were determined by a ranking of areas in Australia according to the SEIFA 2021 Index of Relative Socio-Economic Disadvantage (IRSD). Refer to the Australian Bureau of Statistics for further information on remoteness structure and SEIFA.
- Rates for Remoteness area or SEIFA quintiles are crude rates based on the 2021 Census estimated resident populations as at 30 June, the day prior to the beginning of the reference financial year.
- Rates, percentages and average annual percentage changes are calculated on unrounded numbers, so may differ slightly from values obtained by rederiving from the published numbers.

PBS medications dispensed

Source

AIHW analysis of PBS data maintained by the Australian Government Department of Health, Disability and Ageing 2024-25

Frequency of data collection

Annually

Additional notes

- All data is sourced from the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data maintained by the Department of Health, Disability and Ageing and sourced from Services Australia. Data was extracted by the AIHW. All data is presented by the date of supply, that is, when the prescription was dispensed to the patient.

- For more information on PBS data please see https://www.aihw.gov.au/mental-health/topic-areas/community-based-services/mental-health-prescriptions#data-sources
- PBS and RPBS prescriptions for mental health-related medications include Antipsychotics, Anxiolytics, Hypnotics and sedatives, Antidepressants, Psychostimulants, agents used for attention deficit hyperactivity disorder (ADHD) and nootropics.
- Number of patients by Remoteness area and Socio-Economic Index for Areas (SEIFA) quintile are based on the postcode of the address of the patient as recorded by Services Australia. If the patient's address postcode is unknown, the supplying pharmacy's postcode is used. Australian Bureau of Statistics (ABS) correspondences based on the 2021 census were used to proportionally allocate street delivery postal areas to Remoteness area, SEIFA quintile, SA4, and PHN. Postcodes for post office boxes, mail back competitions, large volume receivers and specialist delivery postcodes are not included in the ABS correspondences. Therefore, data for these postcodes were allocated to "Unknown" and are not reported by Remoteness or SEIFA but are included in the national totals.
- Remoteness areas were classified according to the Accessibility and Remoteness Index of Australian Statistical Geography Standard (ASGS) Edition 3. SEIFA quintiles were determined by a ranking of areas in Australia according to the SEIFA 2021 Index of Relative Socio-Economic Disadvantage (IRSD). Refer to the Australian Bureau of Statistics for further information on remoteness structure and SEIFA.
- Rates for geospatial areas by Remoteness or SEIFA quintile are crude rates based on the 2021 Census estimated resident populations as at 30 June, the day prior to the beginning of the reference financial year.

Indicator: Treatment rates

Technical information

Source

State and territory governments (unpublished); Private Mental Health Alliance Centralised Data Management Service data (unpublished) 2007–08 to 2014–15; Private Psychiatric Hospitals Data Reporting and Analysis Service (unpublished) 2015–16 onwards; Department of Health, Disability and Ageing MBS Statistics (unpublished); Department of Veterans' Affairs Treatment Account System data (unpublished).

Frequency of data collection

Annually

Limitations

- Data exclude non-uniquely identifiable consumers, assessment-only cases and services delivered on behalf of consumers where the consumer did not directly participate.

Additional notes

- Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider, except public data the Northern Territory, for which the majority of the data was based on the location of the service. Not all remoteness areas are represented in each state or

territory. State/territory is the state/territory of the service provider. Excludes people for whom remoteness area was missing or not reported.

Indicator: Cost related delays to accessing care

Technical information

Source

Australian Bureau of Statistics (ABS) Patient Experience Survey 2024-25

Frequency of data collection

Annually

Limitations

- Excludes Australian permanent defence force members and their dependants, non-Australian defence forces, residents in very remote Australia and the Indigenous Community Strata.

Additional notes

- Proportions reported are proportions of persons 15 years and over who needed to see a mental health professional in the last 12 months, however at least once delayed or did not see a mental health professional with cost as a reason.
- Mental health professionals include GPs, Psychiatrists, Psychologists, mental health nurses, social workers, counsellors and occupational therapists.
- This survey is conducted annually through the ABS' Multipurpose Household Survey (MPHS) and collects information on healthcare access, waiting times, barriers to care, and experiences with health professionals during the previous 12 months.
- Remoteness areas were classified according to the Australian Statistical Geography Standard (ASGS) Remoteness Structure. SEIFA quintiles were based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with Quintile 1 representing the most disadvantaged areas and Quintile 5 representing the least disadvantaged areas.
- For more information on the survey methodology please see Patient Experiences methodology, 2024-25 financial year | Australian Bureau of Statistics.

Data gaps for accessibility

Indicators	
Unmet need for mental health care	**Identified data gap**
Access to non-government mental health services	**Identified data gap**
Services received that did not meet needs	**Identified data gap**
Wait times following referral	**Identified data gap**

Capability and capacity of families, carers and kin to effectively support people experiencing mental health challenges	**Identified data gap**
Knowledge and awareness of how to navigate to relevant mental health care	**Identified data gap**
Mental health literacy	**Identified data gap**
Proportion of people who report receiving effective support to navigate between multiple mental health providers	**Identified data gap**
Experiences of stigma in mental health services	**Identified data gap**

Theme: Continuity and integration of care

Guiding question - To what extent do consumers, carers, family and kin experience supported, connected navigation across all parts of their care journey?

Indicator: Community follow-up after hospitalisation for mental health

Technical information

Source

Unpublished State and Territory data 2023-24

Frequency of data collection

Annually

Limitations

- Australian Capital Territory data for 2021-22 to 2023-24 were not available at the time of publication. National total calculations for 2021-22 to 2023-24 do not include ACT data. Caution should be exercised when conducting time series analyses. The following separations and service contact types were excluded:
    - Same day separations,
    - Statistical and change of care type separations,
    - Separations that end by transfer to another acute or psychiatric inpatient hospital, or residential mental health service,
    - Separations that end in death,
    - Separations where the length of stay is one night only and a procedure code for ECT or TMS is recorded,
    - Service contact on day of separation
    - Service contact where a consumer and/or their carer does not participate, and
    - Service contact with non-state/territory community-based providers, such as GPs and private psychiatrists.

Additional notes

- The percentage of separations from public acute psychiatric inpatient unit(s) for which a community mental health service contact, in which the consumer or their carer/support person participated, was recorded in the seven days following that separation.
- The following mental health contacts are included:
  - Face-to-face contact, and
  - Indirect contact, which can be by the telephone or otherwise.
  - Community mental health contacts are defined as contacts with any public community mental health team within the given state or territory. Except in the Northern Territory, these contacts are restricted to those in which the consumer participates directly.
  - Same day separations are defined as inpatient episodes where the admission and separation dates are the same.
  - Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider, except public data from the Northern Territory, for which the majority of the data was based on the location of the service. Excludes people for whom remoteness area was missing or not reported.
  - Remoteness areas were classified according to the Australian Statistical Geography Standard (ASGS) Remoteness Structure. SEIFA quintiles were based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with Quintile 1 representing the most disadvantaged areas and Quintile 5 representing the least disadvantaged areas.

Data gaps for continuity and integration of care

Indicators	
Mental health workforce satisfaction rates	**Identified data gap**
Proportion of consumers reporting supported navigation across their care journey	**Identified data gap**
Rates of discontinuing treatment services after referral	**Identified data gap**
Rates of standardised assessment and referrals	**Identified data gap**
Consumer and family rated measures of referral “warmth”	**Identified data gap**

Theme: Safety and quality

Guiding question - To what extent do consumers, carers, family and kin receive care that feels safe, rights-respecting and aligned with their preferences, culture and identity?

Guiding question - To what extent are consumers, carers, family and kin feeling safe in interactions with the mental health system?

Indicator: Use of restrictive and involuntary practices in mental health care

Technical Information

Seclusion and Restraint

Source

National Seclusion and Restraint Database 2024-25

Frequency of data collection

Annually

Limitations

- Seclusion and Restraint event data are limited to events occurring in public sector acute admitted specialised mental health units.
- The following exclusions apply to this indicator:
    - Some public sector acute forensic mental health hospital services operated in correctional facilities, and
    - leave days from the denominator.

Additional notes

- Rate is calculated as the number of seclusion or restraint events per 1,000 bed days for public sector acute admitted specialised mental health hospital services.
- Seclusion and restraint rates by remoteness are based on the location of service provider, not the patient's usual residence.

Involuntary treatment

Source

State and Territory Governments, unpublished 2023-24.

Frequency of data collection

Annually

Limitations

- Service setting is limited to public sector specialised psychiatric services.

Additional notes

- Information on legal status data is collected by state and territory governments and supplied to the AIHW for national reporting across a range of data sets. Differences in state and territory mental health legislation and reporting practices may affect comparability.
- Mental health legal status is defined for this indicator as: 'Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation'.
- Mental health legal status is recorded for service contacts, episodes, hospital separations, or hospital patient days.

Data gaps for safety and quality

Indicators	
Consumers feel safe in interactions with the mental health system	**Identified data gap**
Consumers and carers are involved and supported in decision-making about care	**Identified data gap**
Cultural and gender responsiveness of care	**Identified data gap**
Experiences of stigma, discrimination, and coercion in mental health care	**Identified data gap**
Awareness and confidence in complaints mechanisms and safeguards	**Identified data gap**

Theme: Sustainability and efficiency

Guiding question - To what extent are consumers, carers, family and kin supported by a well-resourced and efficient mental health system now and into the future?

Indicator: Proportion of public and private expenditure on mental health related services

Technical information

Source

Australian Government Department of Health, Disability and Ageing (unpublished) 2023-24

National Mental Health Establishments Database 2023-24

Frequency of data collection

Annually

Limitations

- Some mental health services (for example, mental health services in aged care facilities) are not included.
- Some mental health services and funding sources are outside scope, including private out-of-pocket expenses. The indicator should not be interpreted as a complete measure of all public and private spending on mental health-related services.

Additional notes

- State and territory governments includes funded by state/territory, funded by other revenue and other Australian Government funds, and funded by state/territory may include Australian Government funds provided under the NHRA.

- Health expenditure, or spending, (unless otherwise specified) is reported using constant price, also referred to as 'in real terms'. Constant price estimates are derived by adjusting the current price to remove the effects of inflation over time and allow for spending in different years to be compared and for changes in spending to reflect changes in the volume of health goods and services.
- The Australian Capital Territory (ACT) data for 2021–22 to 2023–24 were not available at the time of publication. National total calculations for state and territory expenditure from 2021–22 onwards do not include ACT data. Caution should be exercised when conducting time series analyses.

Indicator: Workforce distribution (FTE) of psychiatry, psychology, allied health professionals and peer workforce

Technical information

Source

National Health Workforce Dataset (NHWDS) 2024

Australian Association of Social Workers (AASW) (unpublished) 2024

Frequency of data collection

Annually

Additional notes

- Historical data may differ from previously published data due to resupplied information. Data were extracted from the NHWDS through the Health Workforce Data Tool (HWDT) on 22 January 2026.
- Differences may occur between these data and data published elsewhere due to the different calculation of estimate methods or extraction dates.
- Due to the sensitive nature of the data, the Health Workforce Data Tool applies perturbation to all figures between 0 and 3. This means that any figures you see with a value of 0 or 3 may have a true value of anywhere between 0 and 3.
- Data on accredited mental health social workers are not sourced from the HWDT. These data were supplied by the Australian Association of Social Workers (AASW) on 27 January 2026. Disaggregation by remoteness for accredited mental health social workers was only provided for 2024 data.
- Mental health profession definitions are as follows:
    - Mental health occupational therapists are occupational therapists who indicated on the annual workforce survey that their scope of practice is mental health
    - Mental health nurses are nurses who indicated on the annual workforce survey that their primary job area is mental health.
    - Psychologists refer to professionals registered as psychologists.
    - Psychiatrists are medical practitioners with primary specialty in psychiatry.
    - Accredited mental health social workers are social workers accredited by the AASW as having mental health expertise.
- Crude rates are based on Australian Bureau of Statistics (ABS) 2021 Census estimated resident population projections, as at 30 June of the reference year.
- Remoteness area rates are based on ABS 2021 Census estimated resident population and remoteness area population estimates and projections as at 30 June of the reference year.

Indicator: Participation of peer workers in the mental health workforce

Please note that Report Card 2025 references data related to the participation of peer workers employed by specialised mental health organisations. However, from a national view, we are largely limited to data about public sector services who employ consumer and carer workers. Future reporting of this indicator will look to draw on broader sources of evidence about the participation of this workforce.

Technical detail related to the data source used in Report Card 2025 is below.

Technical information

Source

Specialised mental health care facilities dataset 2023-2024, derived from the National Mental Health Establishments Database (NMHED) 2023-2024

Frequency of data collection

Annually

Limitations

- Limited to public sector services who employ consumer and carer workers.
- Caution is required when interpreting these data as consumer worker and carer worker FTE is relatively small, and therefore small changes in these FTE numbers may have a relatively large percentage impact on the rates of changes.

Additional notes

- States and territories are required to supply data annually in accordance with specifications. The reference period for the most recent year of data is 2023–24, that is, services that were operational between 1 July 2023 and 30 June 2024, or part thereof.
- Crude rate based on the total number of mental health care provider FTE staff for the reference year. Health care providers include salaried medical officers, nurses, diagnostic and allied health professionals, other health care providers and other personal care staffing categories.
- Australian Capital Territory data for 2021–22 to 2023–24 were not available at the time of publication. National total calculations from 2021–22 onwards do not include ACT data. Updated data for ACT will be published when available. Caution should be exercised when conducting time series analyses.
- Rates and average annual percentage changes are based on unrounded numbers, so may differ slightly from values obtained by rederiving from the published numbers.

Data gaps for sustainability and efficiency

Indicators	
Participation of peer workers in the mental health workforce	**Identified data gap**
Involvement of consumers and people with lived experience in national mental health research activities	**Identified data gap**

Consumers have meaningful, decision-making power in the governance, design delivery and evaluation of the mental health system	**Identified data gap**

Theme: Effectiveness

Guiding question - To what extent do consumers, carers, family and kin experience improved outcomes after interacting with the mental health system?

Guiding question - To what extent is mental health care for consumers, carers, family and kin informed by best available and emerging evidence?

Indicator: Consumer, carer, family and kin experiences of mental health services

Technical information

Source

Your Experience of Service (YES) Survey Database 2023-24

Frequency of data collection

Annually

Limitations

- Survey administration differs across jurisdictions. In New South Wales, consumers are offered the YES survey during every hospital stay or community episode of care, while in Victoria and Queensland, consumers are offered the YES survey over a particular time of year. Comparisons between jurisdictions should be made with caution.

Additional notes

- Three states (New South Wales, Queensland and Victoria) supplied data to the AIHW from the YES survey for national reporting purposes.
- An experience of care score is calculated by determining the average response of questions 1-22 in the YES survey multiplied by 20. The resulting overall score converts the individual question responses into a score out of 100. A threshold score of 80 and above is used to indicate a positive experience of service.
- An individual consumer may complete the survey more than once in the reporting period.

Indicator: Clinical measures of mental health outcomes

Technical information

Source

National Outcomes and Casemix Collection 2023-24

Frequency of data collection

Annually

Limitations

The following exclusions apply to this indicator:

- Brief ambulatory episodes of mental health care,
- Brief inpatient episodes of mental health care, and
- Ambulatory episodes of mental health care that end because of admission to hospital or residential mental health care.

Additional notes

- Clinician-rated outcomes are recorded in public specialised mental health services using the HoNOS instrument which is reported as part of the National Outcomes and Casemix Collection by the AIHW.
- The proportion of mental health-related episodes of care where significant improvement, significant deterioration or no significant change was identified between baseline and follow-up of completed outcome measures.
- Change in consumers' clinical outcomes is not presented for states and territories with less than 200 unique consumer outcomes (total episodes) identifiable within the reference period. Total episodes is not presented for states and territories with less than 6 total episodes. States and territories excluded from individual publication are used to calculate the change in consumers' clinical outcomes for Australia.

Consumers in ongoing ambulatory care are defined as consumers who have an 'open' ambulatory episode of care at the end of the reference period.

Indicator: Proportion of people who present to a hospital emergency department (ED) with a mental health related care need who are seen within clinically recommended waiting times

Technical information

Source

National non-admitted Patient Emergency Department Care Database 2023-24

Frequency of data collection

Annually

Limitations

Additional notes

- An Emergency Department (ED) presentation is classified as ‘seen on time’ when commencement of clinical care is within the time specified in the definition of the triage category:

- Category 1 (Resuscitation): Immediate (within seconds),
- Category 2 (Emergency): Within 10 minutes,
- Category 3 (Urgent): Within 30 minutes,
- Category 4 (Semi-urgent): Within 1 hour, and
- Category 5 (Non-urgent): Within 2 hours.

Data gaps for Effectiveness

Indicators	
Person-centred outcomes that matter to consumers	**Identified data gap**
Research and evaluation of service effectiveness and improvement	**Identified data gap**

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ASGS	Australian Statistical Geography Standard
CI	Core Indicator
ED	Emergency department
HILDA	Household, Income and Labour Dynamics in Australia
ICD-10	World Health Organization International Classification of Diseases, Tenth Revision
K10	Kessler Psychological Distress Scale
NHS	National Health Survey
NMHC	National Mental Health Commission
NSMHW	National Study of Mental Health and Wellbeing
SEIFA	Socio-Economic Indexes for Areas
YES	Your Experience of Service Survey