GROW Australia

Submission to the Mental Health Select Committee

Submitted by: David Butt, National CEO, on behalf of Grow Australia

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National Standards for Mental Health Services

QUALITY ACCREDITED ORGANISATION

Submission: Inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Summary

On Queensland mental health expenditure:

The latest Report on Government Services 2022 from the Productivity Commission shows that Queensland Government expenditure on mental health community managed organisations (NGOs) has almost halved since 2017 – from $95.3 million to $50.7 million in 2020 or 47 percent.[1]

The report, released on 1 February and recognised as Australia's most definitive report on government expenditure, shows that Queensland state expenditure on mental health community managed organisations fell from 8.1 percent of total state mental health expenditure in 2017 to only 4.0 percent in 2020.

This is the second lowest proportion of expenditure on mental health community managed organisations of all states and territories (the state average is 5.9 percent).

Ironically, expenditure on acute mental health services has continued to rise over that period, yet the very services which could take pressure off the acute sector – community managed mental health services – are losing funding.

What this means:

- Returning funding to the community managed sector at the state/territory average of 5.9 percent would require an injection of funding of $24 million. Returning funding to 2017 levels would require $44.6 million
- The benefits to the mental health and wellbeing of Queenslanders would be enormous – more individuals, families and communities being supported in the community, rather than in acute settings
- Likewise the benefits to the mental health system would be enormous – pressure being taken off the acute sector so that the acute sector can care for those who really need acute care, with people who can be better supported in their homes and local community being able to remain at home and with their families, carers and other support people.

On GROW in Queensland

GROW seeks formal recognition (including dedicated funding) by the Queensland Government for the vital role of intentional peer to peer support in supporting and enabling people to recover from mental ill-health, and to lead contributing lives as vital members of thriving communities across Queensland.

[1] https://www.pc.gov.au/research/ongoing/report-on-government-services/2022/health/services-for-mental-health?_cldee=Y2VvQGdyb3cub3JnLmF1&recipientid=contact-ca6fddd12aeee911a812000d3a79983b-8f9504f5c0c24c6499e9ed6d302060f3&esid=147c185f-c283-ec11-8d21-002248182b49

What this means:

- Queensland Health has increasingly focused on mental health funding to support individuals – a transactional approach where someone is paid to provide an individual service to someone else (regardless of whether this is provided in the public, private or not for profit sectors)
- Yet this approach is not designed to solve the problems that often engender and escalate poor mental health problems – isolation, loneliness, uncertainty, relationship problems, distress, anxiety, depression, lack of control and powerlessness
- There is overwhelming evidence about the healing power of building social connectedness – humans are social creatures and need to connect with others: just as it takes a village to raise a child, it takes a community to enable people to fulfill their lives and opportunities, and in turn to support others so that they too can live fulfilling lives
- This involves social inclusion, self-help and mutual support, based on principles of equality, respect, mutual learning and growth, empathy, understanding, shared responsibility, building functional relationships and community, and obligation to yourself and each other – recognising that while each person's experience is individual there are shared experiences of emotion, distress and loss of power and place.
- This is what GROW has done in Queensland for more than half a century: building community, helping people to live at home, with family and loved ones, and to have meaningful careers, while keeping them out of hospital and less reliant on pharmacological therapy
- Yet in 2019 GROW and other organisations providing peer support had their funding significantly reduced by the Queensland Government, resulting in a reduction in essential services to Queenslanders
- Intentional peer to peer support organisations such as GROW need to have their funding increased so they can provide their vital services to support more people in their journeys of recovery
- Intentional peer to peer support is an essential ingredient in a cohesive, comprehensive and integrated approach to mental health and wellbeing recovery, and should have a long-term dedicated funding stream which is ring-fenced from acute and intensive care, or transactional funding streams
- All other states and territories already have these streams – commonly called mutual support and self help streams: why has Queensland moved away from this?
- The people of Queensland – and particularly those with mental illness challenges – need Queensland Health to introduce a properly funded Mutual Support and Self Help stream, with funding certainty over time
- The Select Committee now has the opportunity to recommend such a funding stream.

GROW would be delighted to appear before the Committee.

Overview:

This submission will address the following topics from the perspective of a consumer led intentional peer support organisation:

- the economic and societal impact of mental illness in Queensland
- opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health through state funded specialist mental health services
- the experiences and leadership of people with lived experience of mental illness.

About GROW Australia:

GROW was established in 1957 and is the original prototype of a program which was designed and led by people with lived experience. Decades before buzz words like co-design and co-production were being bandied around, the GROW program was designed by consumers and delivered by consumers, and that still remains the case today. The Grow Program has consistently operated in Queensland for more than 50 years.

Across Australia, GROW plays a special role:

- Many people with mental illness find themselves isolated and estranged from family, friends and the community, and without the resources to engage in the kind of critical thinking that can help them maximise their quality of life.
- Formal mental health services are not designed to provide the kind of social support, friendship, role models and community that is important to mental health recovery.
- Without opportunities to engage in critical thinking within a trusted social group, and to interact socially, it is difficult to sustain a pathway to recovery.

GROW works on a model of Peer Support, or Peer to Peer support (often called Intentional Peer Support) and continues to provide leadership in this area across Australia whether through the classic Adult Grow group programs, or newer programs such as Get Growing in schools, Growing Resilience, eGrow online forums, young adult programs, specific programs for carers and prison inmates, and residential recovery programs for people with a dual diagnosis of mental illness and substance misuse.

Grow has helped tens of thousands of people to recover from severe mental ill-health using an evidence-based approach to peer support. This involves Grow's distinctive services of fostering personal leadership, mutual help, peer support, self-activation leading to self-actualisation and ultimately recovery.

Each week about 1500 people with mental illness – many with quite severe illness – meet in small groups across Australia, or via online eGrow services, and go through a structured program which aims to give them a community in which they belong, a structure where their lives often otherwise have none, a way forward to grow and recover, to keep them out of hospital, at home participating in the community and as far as possible productive at work.

You don't need to have a diagnosis – even though most people do have one – you don't need a medical referral, although we are engaged in integrated care pathways, for example, in acute mental health units where our field workers with our consumers meet with inpatients and provide them

with information on what we do, and the opportunity to join a group – a way forward after their hospitalisation.

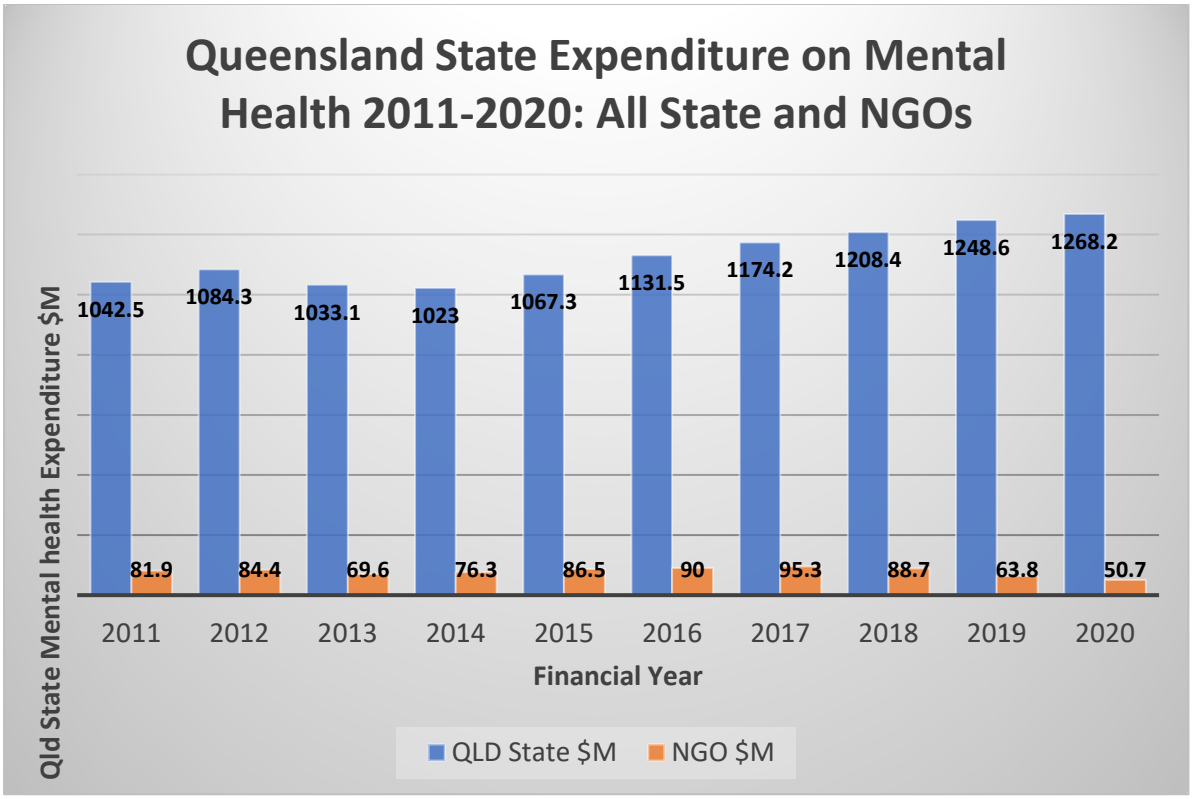
The economic and societal impact of mental illness in Queensland:

As advised above, the latest Productivity Commission Report on Government Services 2022 shows that funding for the community mental health sector from the Queensland Government has fallen considerable – from $95.3 million in 2017 to $50.7 million in 2020.

The following charts illustrate the funding reductions which have occurred over time.

Table 1: Queensland State Expenditure on Mental Health 2011-2020: All State and NGOs

Financial Year	QLD State $M	NGO $M
2011	1042.5	81.9
2012	1084.3	84.4
2013	1033.1	69.6
2014	1023	76.3
2015	1067.3	86.5
2016	1131.5	90
2017	1174.2	95.3
2018	1208.4	88.7
2019	1248.6	63.8
2020	1268.2	50.7
Total	11281.1	787.2



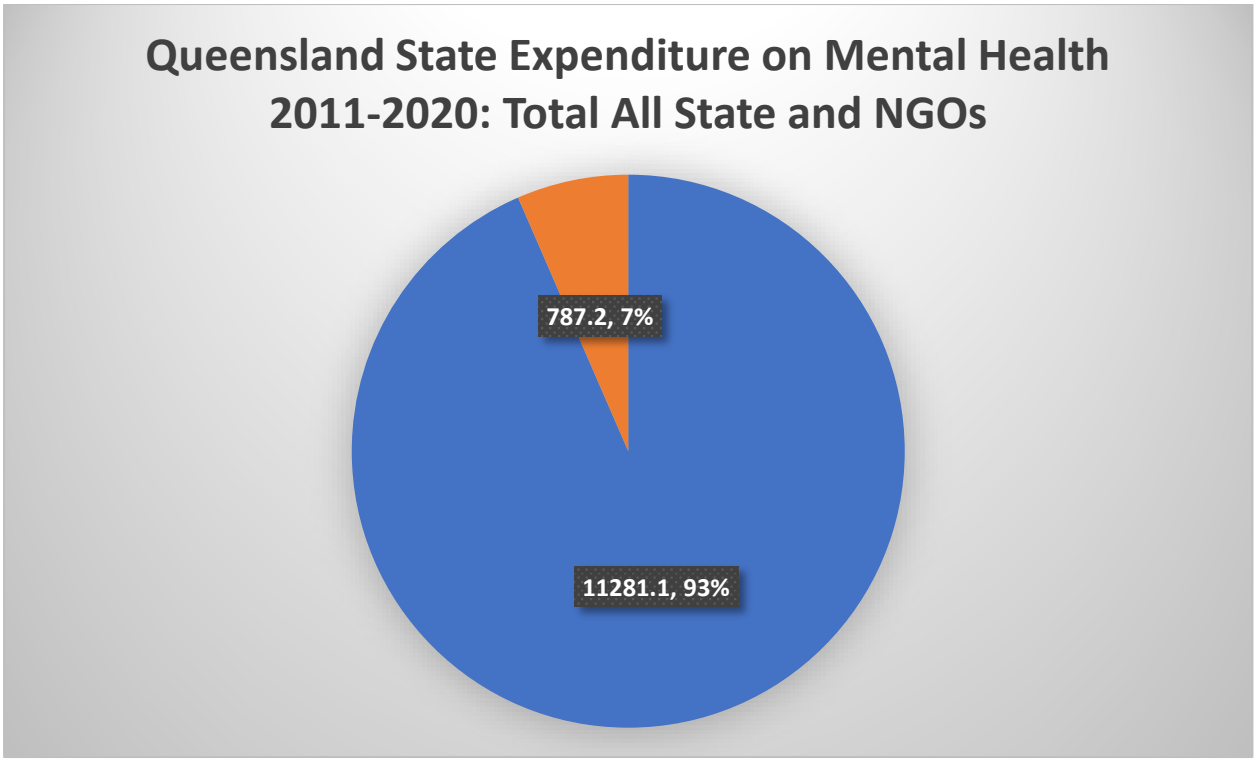
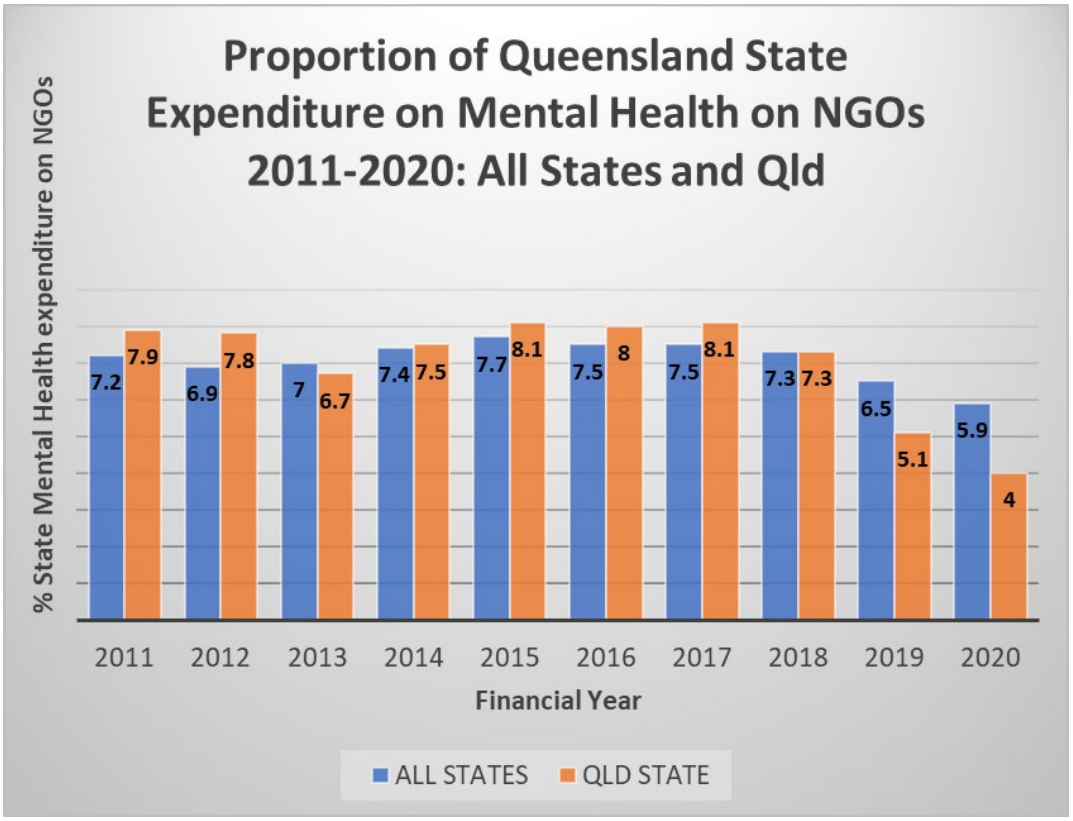
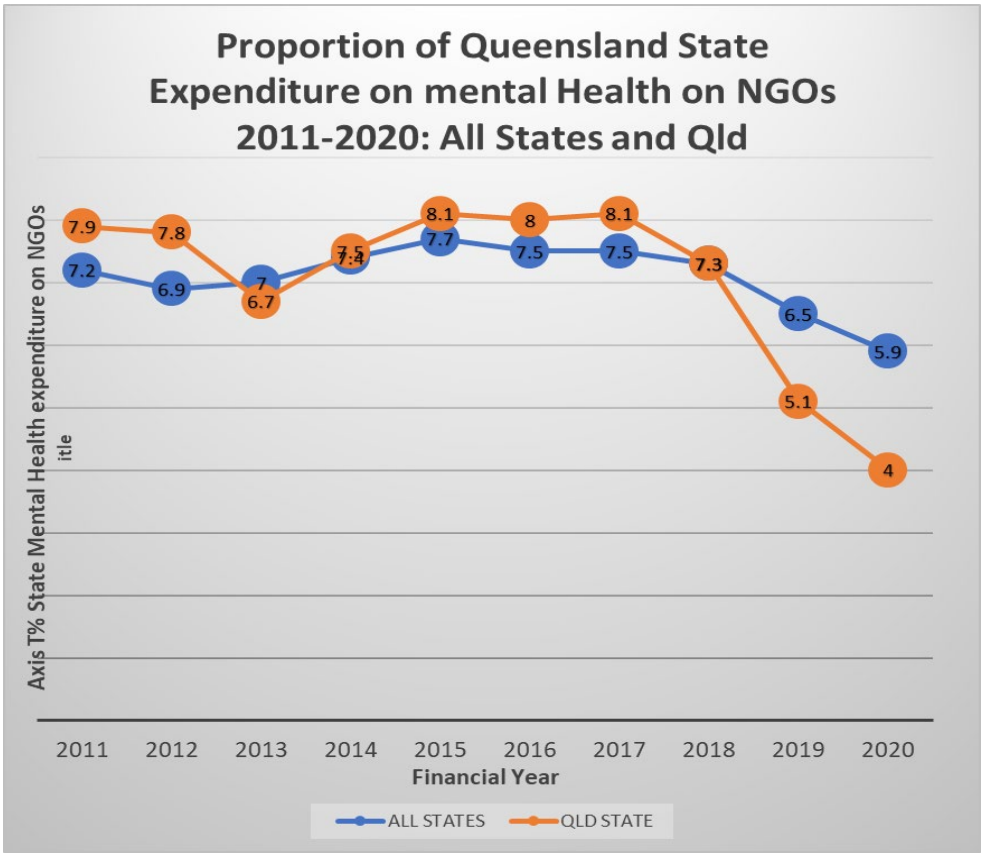


Table 2: Queensland State Expenditure on Mental Health

% YEAR	ALL STATES	QLD STATE
2011	7.2	7.9
2012	6.9	7.8
2013	7	6.7
2014	7.4	7.5
2015	7.7	8.1
2016	7.5	8
2017	7.5	8.1
2018	7.3	7.3
2019	6.5	5.1
2020	5.9	4

Report on Government Services 2022 - Productivity Commission 1 February 2022





This very clearly illustrates the significant impact on the community managed mental health sector.

The societal impacts are harder to quantify as families, communities, and workplaces struggle with the burden of mental illness and suicide. Our program only makes up 0.03% of the mental health budget for the state and we play a vital role in improving economic and societal participation through our multifaceted program.

Our annual survey is statistically significant and shows us that attending Grow Groups and using the Grow Program has:

- helped 59% of respondents overcome suicidal thoughts
- 32% said GROW has stopped them from a suicide attempt
- 83% say that the Grow Program has reduced their need for hospital admissions
- 79% report that the Grow Program has prevented the need for further hospitalisation
- 55% of our members have been hospitalised for their mental illness.

In terms of economic participation, 51% of members report that the Grow Program helped them gain employment and 74% report that the Grow Program helped them deal with their employer. Indeed many of our own staff started out in the program and began working for us after being told their mental illness would prevent them from ever working again.

Opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health through state funded specialist mental health services:

The Grow Program is funded by the state as a specialist mental health service. Our speciality is intentional peer to peer support. Although Queensland Health and many non-government organisations employ peer workers, it is not the same as intentional peer support.

This needs to be made very clear: peer to peer support is very different to what peer workers do.

GROW is extremely concerned the Connecting Care to Recovery Plan 2017-2021 made no mention of mutual support and self help or intentional peer support. It was not identified as a priority specialised service area or as part of the Group Based Peer Recovery Support Program.

The Queensland Peer Workforce Support Framework confuses or misses the difference between Peer Support and Peer Workers. The framework falsely states:

> *Peer workers provide peer support to consumer and carers. Peer workers connect respectfully with consumers and carers and provide a positive example of recovery. There is no universally accepted definition of peer support, however Sherry (sic) Mead in 2001 gave the following definition: "Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on*

mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships."

In some ways, this is not surprising: terms such as “Peer Support”, “Self Help”, “Peer Workers” and “Consumer-led services” often are used interchangeably in the sector. However, they are very different types of intervention and it is important for the Mental Health Select Committee to recognise this in its final report.

- Peer Support is a mutual, bi-directional relationship-based approach with a philosophical basis in the potential for mutual growth and healing, and with clear principles and practices reflecting equality and respect [2]
- Peer Work as increasingly practiced in traditional and new mental health programs is not a peer-to-peer relationship given that in common usage a “peer” is an equal: “Relationships between peer staff and service users are usually hierarchical, similar to staff-service user relationships generally within the mental health system, in contrast to the horizontal relationships that characterize peer-developed peer support”[3].

This is particularly relevant given the Commission’s Draft Finding 20.1 — that social exclusion is associated with poor mental health. GROW’s programs were specifically designed by people with lived experience to overcome the problems of social exclusion and to build community among people in need.

Those who access the Grow Program, affectionately known as ‘Growers’, have social inclusion written into the program. Each Grower may receive a weekly phone call from a group member, a regular group social, regular branch socials, training and community weekends on top of the weekly social interaction in their group.

When people are going through a tough time and they hear that someone else has struggled but endured, they receive the priceless gift of hope. This gift of hope is unique to intentional peer support. Regardless of the situation, hope and the knowledge that others have endured means that people come to understand: “If there is hope for anyone, there is hope for me, if there is hope for me, there is hope for anyone”. It is this sharing of resilience that enables a community of intentional peers to assist each other in building their resilience to cope with crisis.

Peer work is a paid dynamic. The mutual support and friendship found in intentional peer support is unique and different. The evidence of the benefits of peer to peer support and mutual help is widely established, both within mental health and suicide prevention and more broadly, for example with cancer support groups, heart disease, diabetes, domestic violence etc.

The experiences and leadership of people with lived experience of mental illness:

Unfortunately, stigmatizing attitudes are rife in the mental health sector. The SANE anti stigma report card found more than **83%** of respondents reported experiencing some level of stigma or discrimination in accessing or receiving healthcare during the previous 12 months. To truly address stigma and build trust, services must move beyond tokenistic consultation of those with a lived experience and practice integrated governance.

[2] Penney, D. Defining “Peer Support”: Implications for Policy, Practice, and Research, Advocates for Human Potential 2018
[3] Ibid

The Grow Program has done this for 65 years as the program is developed, led, and governed by consumers. At every level of our governance structure 'Growers' are present and active in decision making. The paid staff required to manage the legal and financial aspects of the organisation do so in collaboration with the Growers. At all times the Growers retain control of the program content and structure. This completely unique model ensures there is no expert and recipient, but rather a meeting of mature minds to work towards best outcomes. Many Growers started by attending a group and then developed their leadership by taking on various leadership roles in the program. Grow employed those with a lived experience before 'peer workers' were part of the lexicon.

To address the stigma and disempowerment experienced by those with a lived experience of mental illness we must recognize the important role of non clinical mental health services. Organisations such as GROW provide an opportunity for people with a lived experience to practice their leadership, experience self-determination, and gain new skills which can support them for life.

Conclusion:

GROW urges the inquiry to acknowledge the important role that non clinical services play in combating stigma, facilitating societal participation, and supporting those in their recovery journey to live fulfilling lives.

The state needs to consider specific funding for Mutual Support and Self Help as an ongoing funding category in recognition of the difference between peer support and peer work. As is the case in every other state and territory in Australia.

Non-government organisations require more certainty around funding so that they can reduce the burden of mental illness on the acute mental health system and build more robust systems of support. This should include a rolling funding schedule whereby organisations have certainty about employment of staff, rather than being notified of funding decisions in a relatively short period prior to contracts expiring.

This is a link to a testimonial on GROW from grower Paul:
https://www.youtube.com/watch?v=tZIgv3uxQ6c

Report on Government Services 2022 - Productivity Commission 1 February 2022 Table 13a.3 is included below.

Report on Government Services 2022 - Productivity Commission 1 February 2022

Table 13A.3 Total State and Territory recurrent expenditure on specialised mental health services, 2019-20 dollars (a), (b), (c), (d), (e)

	Unit	NSW (f)	Vic	Qld (g)	WA	SA (h)	Tas	ACT	NT	Total
2019-20										
Real recurrent expenditure										
Public psychiatric hospital	$m	279.0	77.6	83.5	88.7	71.6	–	–	–	600.4
Public acute hospital	$m	776.6	512.2	394.1	314.8	170.3	43.3	61.5	30.3	2 303.1
Total admitted patient (i)	$m	1 055.6	589.8	477.5	403.5	241.9	43.3	61.5	30.3	2 903.5
Community residential	$m	6.5	232.0	70.9	34.3	34.8	31.3	4.0	6.6	420.4
Ambulatory	$m	674.0	652.0	592.4	329.5	194.4	42.1	49.7	34.2	2 568.3
Non-government organisations	$m	164.4	60.2	50.7	49.0	31.9	15.5	11.9	6.8	390.4
Indirect	$m	110.0	119.6	76.6	44.2	12.7	4.7	4.9	2.4	375.1
Total	$m	2 010.6	1 653.4	1 268.2	860.5	515.7	136.9	132.1	80.4	6 657.7
Proportion of expenditure										
Public psychiatric hospital	%	13.9	4.7	6.6	10.3	13.9	–	–	–	9.0
Public acute hospital	%	38.6	31.0	31.1	36.6	33.0	31.6	46.5	37.8	34.6
Total admitted patient (i)	%	52.5	35.7	37.7	46.9	46.9	31.6	46.5	37.8	43.6
Community residential	%	0.3	14.0	5.6	4.0	6.7	22.8	3.0	8.2	6.3
Ambulatory	%	33.5	39.4	46.7	38.3	37.7	30.8	37.6	42.6	38.6
Non-government organisations	%	8.2	3.6	4.0	5.7	6.2	11.3	9.0	8.5	5.9
Indirect	%	5.5	7.2	6.0	5.1	2.5	3.5	3.7	3.0	5.6
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2018-19										
Real recurrent expenditure										
Public psychiatric hospital	$m	278.3	68.9	85.0	88.8	73.2	–	–	–	595.2
Public acute hospital	$m	802.9	511.1	386.9	309.8	168.8	40.7	56.8	29.4	2 307.4
Total admitted patient (i)	$m	1 081.2	580.0	472.0	398.7	242.1	40.7	56.8	29.4	2 902.6
Community residential	$m	9.2	236.4	57.6	33.5	35.2	32.8	4.0	7.2	414.7
Ambulatory	$m	665.7	616.8	576.3	330.0	195.8	42.1	49.5	32.9	2 509.5
Non-government organisations	$m	138.3	112.6	63.8	48.8	33.3	14.9	10.2	5.8	427.7
Indirect	$m	110.6	102.3	78.9	51.7	14.6	5.3	3.9	2.5	369.8
Total	$m	2 005.1	1 648.1	1 248.6	862.7	521.0	135.8	124.4	77.7	6 624.3

Proportion of expenditure										
Public psychiatric hospital	%	13.9	4.2	6.8	10.3	14.1	–	–	–	9.0
Public acute hospital	%	40.0	31.0	31.0	35.9	32.4	30.0	45.7	37.8	34.8
Total admitted patient (i)	%	53.9	35.2	37.8	46.2	46.5	30.0	45.7	37.8	43.8
Community residential	%	0.5	14.3	4.6	3.9	6.8	24.1	3.2	9.2	6.3
Ambulatory	%	33.2	37.4	46.2	38.3	37.6	31.0	39.8	42.3	37.9
Non-government organisations	%	6.9	6.8	5.1	5.7	6.4	11.0	8.2	7.5	6.5
Indirect	%	5.5	6.2	6.3	6.0	2.8	3.9	3.1	3.2	5.6
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2017-18										
Real recurrent expenditure										
Public psychiatric hospital	$m	285.4	62.5	82.9	91.8	73.6	–	–	–	597.8
Public acute hospital	$m	778.4	474.8	380.3	297.5	149.8	37.8	42.0	28.1	2 192.2
Total admitted patient (i)	$m	1 063.8	537.3	463.2	389.3	223.4	37.8	42.0	28.1	2 789.9
Community residential	$m	9.3	219.2	48.2	31.2	35.9	33.3	11.8	7.6	395.3
Ambulatory	$m	635.9	576.2	540.1	326.0	184.1	40.3	46.5	31.5	2 384.2
Non-government organisations	$m	137.9	124.8	88.7	49.2	33.3	14.4	8.9	5.7	463.1
Indirect	$m	114.5	98.2	68.1	46.4	13.1	4.9	3.3	2.9	351.6
Total	$m	1 961.2	1 555.7	1 208.4	842.0	489.9	130.6	112.5	75.8	6 384.1
Proportion of expenditure										
Public psychiatric hospital	%	14.6	4.0	6.9	10.9	15.0	–	–	–	9.4
Public acute hospital	%	39.7	30.5	31.5	35.3	30.6	28.9	37.3	37.1	34.3
Total admitted patient (i)	%	54.2	34.5	38.3	46.2	45.6	28.9	37.3	37.1	43.7
Community residential	%	0.5	14.1	4.0	3.7	7.3	25.5	10.5	10.0	6.2
Ambulatory	%	32.4	37.0	44.7	38.7	37.6	30.8	41.4	41.6	37.3
Non-government organisations	%	7.0	8.0	7.3	5.8	6.8	11.0	7.9	7.5	7.3
Indirect	%	5.8	6.3	5.6	5.5	2.7	3.8	2.9	3.9	5.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2016-17										
Real recurrent expenditure										
Public psychiatric hospital	$m	281.7	53.5	82.7	92.9	89.3	–	–	–	601.8
Public acute hospital	$m	798.1	424.6	412.2	288.7	132.7	38.2	37.8	28.4	2 164.8
Total admitted patient (i)	$m	1 079.8	478.1	494.9	381.5	222.0	38.2	37.8	28.4	2 766.6
Community residential	$m	12.4	212.3	–	30.5	25.1	30.1	12.0	7.5	327.9
Ambulatory	$m	607.5	519.2	522.5	316.2	184.5	39.6	43.8	30.4	2 267.8
Non-government organisations	$m	127.6	125.4	95.3	50.5	33.0	12.4	10.1	4.6	459.0

Indirect	$m	114.2	82.6	61.5	43.3	13.5	4.5	4.3	3.0	327.2
Total	$m	1 941.6	1 417.7	1 174.2	822.0	478.1	124.9	108.0	74.0	6 148.5
Proportion of expenditure										
Public psychiatric hospital	%	14.5	3.8	7.0	11.3	18.7	–	–	–	9.8
Public acute hospital	%	41.1	29.9	35.1	35.1	27.7	30.6	35.0	38.4	35.2
Total admitted patient (i)	%	55.6	33.7	42.1	46.4	46.4	30.6	35.0	38.4	45.0
Community residential	%	0.6	15.0	–	3.7	5.2	24.1	11.2	10.2	5.3
Ambulatory	%	31.3	36.6	44.5	38.5	38.6	31.8	40.6	41.1	36.9
Non-government organisations	%	6.6	8.8	8.1	6.1	6.9	10.0	9.4	6.2	7.5
Indirect	%	5.9	5.8	5.2	5.3	2.8	3.6	3.9	4.0	5.3
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2015-16										
Real recurrent expenditure										
Public psychiatric hospital	$m	299.2	53.4	91.1	90.4	78.7	–	–	–	615.2
Public acute hospital	$m	755.1	385.3	394.3	273.7	121.9	38.1	29.7	23.6	2 026.1
Total admitted patient (i)	$m	1 054.3	438.7	485.4	364.1	200.6	38.1	29.7	23.6	2 641.3
Community residential	$m	12.8	211.0	–	29.0	32.0	31.2	13.7	7.5	334.6
Ambulatory	$m	620.3	499.0	507.8	314.5	197.2	39.3	43.9	31.2	2 257.4
Non-government organisations	$m	108.8	124.7	90.0	58.7	34.5	12.4	12.7	4.9	447.1
Indirect	$m	104.7	79.9	48.3	46.2	10.6	5.1	2.4	2.6	300.2
Total	$m	1 900.7	1 353.3	1 131.5	812.5	474.9	126.2	102.5	69.9	5 980.6
Proportion of expenditure										
Public psychiatric hospital	%	15.7	3.9	8.1	11.1	16.6	–	–	–	10.3
Public acute hospital	%	39.7	28.5	34.8	33.7	25.7	30.2	29.0	33.8	33.9
Total admitted patient (i)	%	55.5	32.4	42.9	44.8	42.2	30.2	29.0	33.8	44.2
Community residential	%	0.7	15.6	–	3.6	6.7	24.7	13.3	10.8	5.6
Ambulatory	%	32.6	36.9	44.9	38.7	41.5	31.2	42.9	44.7	37.7
Non-government organisations	%	5.7	9.2	8.0	7.2	7.3	9.8	12.3	7.0	7.5
Indirect	%	5.5	5.9	4.3	5.7	2.2	4.0	2.4	3.7	5.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2014-15										
Real recurrent expenditure										
Public psychiatric hospital	$m	284.5	57.2	92.5	91.8	67.0	–	–	–	595.5
Public acute hospital	$m	731.0	366.1	365.0	244.7	122.8	39.3	26.4	21.9	1 921.7
Total admitted patient (i)	$m	1 015.5	423.2	457.5	336.5	189.9	39.3	26.4	21.9	2 517.2
Community residential	$m	11.5	217.0	–	29.2	32.7	32.6	14.4	7.1	342.3

Ambulatory	$m	592.1	484.6	476.9	311.4	206.5	40.1	43.8	30.5	2 191.0
Non-government organisations	$m	102.7	122.0	86.5	54.5	44.9	11.9	19.3	4.6	447.0
Indirect	$m	116.5	77.7	46.5	55.6	11.8	6.2	3.1	3.0	321.3
Total	$m	1 838.4	1 324.6	1 067.3	787.3	485.7	130.1	106.9	67.0	5 818.8
Proportion of expenditure										
Public psychiatric hospital	%	15.5	4.3	8.7	11.7	13.8	–	–	–	10.2
Public acute hospital	%	39.8	27.6	34.2	31.1	25.3	30.2	24.7	32.7	33.0
Total admitted patient (i)	%	55.2	32.0	42.9	42.7	39.1	30.2	24.7	32.7	43.3
Community residential	%	0.6	16.4	–	3.7	6.7	25.1	13.4	10.6	5.9
Ambulatory	%	32.2	36.6	44.7	39.6	42.5	30.8	40.9	45.5	37.7
Non-government organisations	%	5.6	9.2	8.1	6.9	9.2	9.1	18.1	6.8	7.7
Indirect	%	6.3	5.9	4.4	7.1	2.4	4.8	2.9	4.4	5.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2013-14										
Real recurrent expenditure										
Public psychiatric hospital	$m	293.1	51.9	100.0	96.7	68.2	–	–	–	611.9
Public acute hospital	$m	707.6	354.5	337.6	230.4	114.1	45.8	26.6	21.2	1 840.3
Total admitted patient (i)	$m	1 000.8	406.4	437.6	327.0	182.3	45.8	26.6	21.2	2 452.2
Community residential	$m	11.8	222.9	–	29.9	26.7	25.1	13.8	3.6	331.4
Ambulatory	$m	596.4	497.8	462.1	290.9	199.4	43.2	40.8	29.0	2 161.5
Non-government organisations	$m	96.9	118.3	76.3	49.7	42.7	9.6	17.6	4.8	415.9
Indirect	$m	95.3	68.7	47.0	48.8	11.9	5.3	3.3	3.4	284.2
Total	$m	1 801.3	1 314.1	1 023.0	746.4	462.9	128.9	102.2	62.0	5 645.3
Proportion of expenditure										
Public psychiatric hospital	%	16.3	4.0	9.8	13.0	14.7	–	–	–	10.8
Public acute hospital	%	39.3	27.0	33.0	30.9	24.6	35.5	26.1	34.3	32.6
Total admitted patient (i)	%	55.6	30.9	42.8	43.8	39.4	35.5	26.1	34.3	43.4
Community residential	%	0.7	17.0	–	4.0	5.8	19.5	13.5	5.8	5.9
Ambulatory	%	33.1	37.9	45.2	39.0	43.1	33.5	39.9	46.8	38.3
Non-government organisations	%	5.4	9.0	7.5	6.7	9.2	7.4	17.2	7.8	7.4
Indirect	%	5.3	5.2	4.6	6.5	2.6	4.1	3.2	5.4	5.0
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2012-13										
Real recurrent expenditure										
Public psychiatric hospital	$m	295.6	48.5	111.5	106.0	69.3	–	–	–	633.3
Public acute hospital	$m	661.6	343.3	327.9	216.6	86.5	47.1	25.3	21.0	1 732.9

Total admitted patient (i)	$m	957.3	391.8	439.4	322.6	155.8	47.1	25.3	21.0	2 366.2
Community residential	$m	12.9	206.3	–	26.9	22.9	26.3	13.5	2.5	309.4
Ambulatory	$m	587.5	481.5	474.6	287.7	188.0	42.7	40.9	27.7	2 133.3
Non-government organisations	$m	89.6	107.2	69.6	48.3	38.0	7.7	15.2	4.2	380.1
Indirect	$m	85.1	67.6	49.5	38.0	13.4	8.0	3.5	3.8	269.3
Total	$m	1 732.4	1 254.5	1 033.1	723.5	418.2	131.8	98.3	59.2	5 458.2
Proportion of expenditure										
Public psychiatric hospital	%	17.1	3.9	10.8	14.7	16.6	–	–	–	11.6
Public acute hospital	%	38.2	27.4	31.7	29.9	20.7	35.7	25.7	35.4	31.7
Total admitted patient (i)	%	55.3	31.2	42.5	44.6	37.3	35.7	25.7	35.4	43.4
Community residential	%	0.7	16.4	–	3.7	5.5	20.0	13.7	4.2	5.7
Ambulatory	%	33.9	38.4	45.9	39.8	45.0	32.4	41.6	46.7	39.1
Non-government organisations	%	5.2	8.5	6.7	6.7	9.1	5.8	15.5	7.1	7.0
Indirect	%	4.9	5.4	4.8	5.2	3.2	6.1	3.5	6.5	4.9
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2011-12										
Real recurrent expenditure										
Public psychiatric hospital	$m	288.7	50.1	118.5	106.9	78.6	..	..	..	644.3
Public acute hospital	$m	618.2	336.9	325.4	201.5	90.7	49.3	23.1	19.4	1 667.4
Total admitted patient (i)	$m	906.9	387.0	443.9	308.4	169.3	49.3	23.1	19.4	2 311.7
Community residential	$m	15.4	201.4	..	26.0	22.7	24.1	13.1	1.8	303.5
Ambulatory	$m	605.4	483.9	488.4	289.5	178.0	41.7	42.1	28.2	2 159.7
Non-government organisations	$m	85.3	102.6	84.4	38.3	41.2	7.9	12.5	4.3	376.7
Indirect	$m	83.0	68.8	67.6	38.4	10.6	7.7	3.3	5.2	284.9
Total	$m	1 696.0	1 243.7	1 084.3	700.6	421.8	130.8	94.2	58.8	5 436.5
Proportion of expenditure										
Public psychiatric hospital	%	17.0	4.0	10.9	15.3	18.6	..	..	..	11.9
Public acute hospital	%	36.5	27.1	30.0	28.8	21.5	37.7	24.5	32.9	30.7
Total admitted patient (i)	%	53.5	31.1	40.9	44.0	40.1	37.7	24.5	32.9	42.5
Community residential	%	0.9	16.2	..	3.7	5.4	18.5	13.9	3.1	5.6
Ambulatory	%	35.7	38.9	45.0	41.3	42.2	31.9	44.7	47.9	39.7
Non-government organisations	%	5.0	8.3	7.8	5.5	9.8	6.1	13.3	7.3	6.9
Indirect	%	4.9	5.5	6.2	5.5	2.5	5.9	3.5	8.8	5.2
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
2010-11										
Real recurrent expenditure										

Public psychiatric hospital	$m	302.7	52.8	112.9	102.5	84.5	..	..	..	655.3
Public acute hospital	$m	558.0	339.1	317.1	188.7	94.8	55.4	22.7	17.8	1 594.1
Total admitted patient (i)	$m	860.7	391.9	430.0	291.2	179.2	55.4	22.7	17.8	2 249.4
Community residential	$m	15.3	205.5	..	22.2	14.9	26.2	12.2	1.8	297.6
Ambulatory	$m	579.9	461.0	454.9	276.5	171.5	45.1	39.5	26.0	2 053.8
Non-government organisations	$m	90.1	100.5	81.9	35.5	46.1	9.6	10.5	4.2	378.1
Indirect	$m	85.8	72.9	75.7	30.7	7.9	8.7	3.6	4.1	289.6
Total	$m	1 631.8	1 231.7	1 042.5	656.1	419.6	145.0	88.5	53.8	5 268.6
Proportion of expenditure										
Public psychiatric hospital	%	18.6	4.3	10.8	15.6	20.1	..	..	..	12.4
Public acute hospital	%	34.2	27.5	30.4	28.8	22.6	38.2	25.6	33.0	30.3
Total admitted patient (i)	%	52.7	31.8	41.2	44.4	42.7	38.2	25.6	33.0	42.7
Community residential	%	0.9	16.7	..	3.4	3.5	18.1	13.8	3.4	5.6
Ambulatory	%	35.5	37.4	43.6	42.1	40.9	31.1	44.6	48.3	39.0
Non-government organisations	%	5.5	8.2	7.9	5.4	11.0	6.6	11.9	7.8	7.2
Indirect	%	5.3	5.9	7.3	4.7	1.9	6.0	4.1	7.5	5.5
Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

$m = Millions of dollars. .. Not applicable. – Nil or rounded to zero.

(a) For more information on data quality, including collection methodologies and data limitations, see METeOR on the AIHW website.

(b) Totals may not equal the sum of individual cells due to rounding and/or unpublished data.

(c) Time series financial data are adjusted to 2019-20 dollars (i.e. 2019-20=100) using the Implicit price deflators for Government Final Consumption Expenditure (GFCE) on Hospital and Nursing Homes (table 13A.66).

(d) Depreciation is excluded for all years.

(e) Due to the ongoing validation of the NMDS, data could differ from previous reports.

(f) The quality of the NSW 2010-11 MHE NMDS data used for this Report has been affected by the reconfiguration of the service system during the year. For further details see the Mental health establishments NMDS 2013–14: Data Quality Statement https://meteor.aihw.gov.au/content/index.phtml/itemId/661582.

(g) Prior to 2017-18, Queensland did not classify any services as community residential, however funded a number of extended treatment services that were classified and reported as non-acute inpatient care. Caution should be exercised when conducting time series analysis for residential and admitted non-acute services.

Funding to non-government services for psychiatric disability support services is administered by either Queensland Health or Department of Communities, Child Safety and Disability Services.

(h) For SA, the increases in admitted patient and ambulatory care expenditure in 2013-14 partly relate to genuine increases in mental health services. However, a significant proportion of the increases relate to improved identification and allocation of direct care and general overhead expenditure to mental health services.

(i) Includes expenditure on public hospital services managed and operated by private and non-government entities.

Source: AIHW (unpublished) *Mental Health Establishments National Minimum Data Set;* ABS (unpublished) *Australian National Accounts: National Income, Expenditure and Product,* Government final consumption expenditure, Hospital and nursing homes.