1 Overview

Mental Health Services in Australia 2002–03 is the sixth of the Australian Institute of Health and Welfare's annual reports describing the characteristics and activity of Australian mental health services. This chapter presents summary data on key themes within the report.

1.1 Changes in mental health care over time

The three Plans of the National Mental Health Strategy have guided the reform of mental health services in Australia since 1993. The reform has resulted in significant changes in the level and type of activity of some mental health-related services.

General practice

In 2003–04, there were an estimated 10.4 million mental health-related general practice encounters. The contribution of general practice to mental health care has remained relatively stable in recent years. In 2003–04, the estimated number of mental health-related general practice encounters was 522 encounters per 1,000 population (Figure 1.1 and Table 3.1).

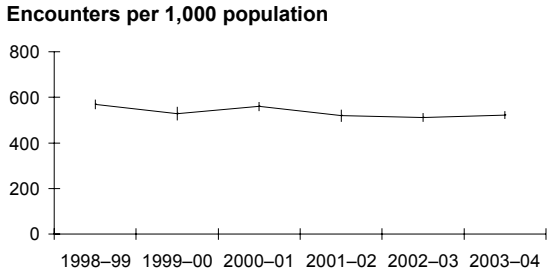

Figure 1.1: Mental health-related general practice encounters per 1,000 population, 1998–99 to 2003–04

Private psychiatrists

In 2003–04, there were over 2 million Medicare-funded psychiatrist attendances, provided at a rate of 100.6 attendances per 1,000 population. This rate has declined each year since 1998–99 (Figure 1.2 and Table 3.1).

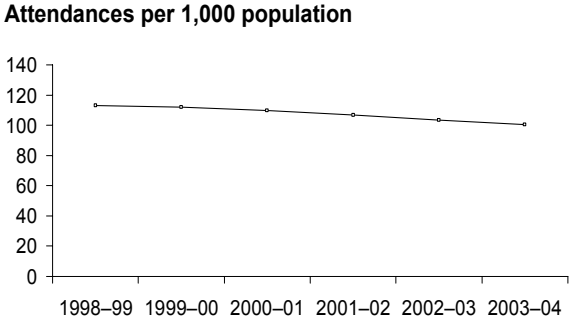

Figure 1.2: Medicare-funded psychiatrist attendances per 1,000 population, 1998–99 to 2003–04

The decline was accompanied by an 11.4% increase in the number of medical officers employed in public mental health services between 1998–99 and 1999–2000 (DHA 2002). The total number of psychiatrists employed in the public and private sectors increased 9.9% between 1998 and 2002 (Table 7.2).

Community mental health services

An objective of the National Mental Health Strategy has been to increase the provision of community-based mental health care. In 2002–03, there were nearly 4.7 million mental health service contacts in public hospital outpatient clinics and community-based mental health services. This equated to 236.5 service contacts per 1,000 population (Table 3.2). At this stage, there are no reliable national time series

data available on the activity of these services.

Some same-day care for a hospital-admitted patient can be considered to be ambulatory equivalent (see Appendix 2). The number of ambulatory-equivalent mental health-related separations increased from 82,326 in 1998–99 to 108,946 in 2002–03. The number per 1,000 population increased in the private sector by 50.0% and decreased in the public sector by 18.8% (Figure 1.3 and Table 3.1).

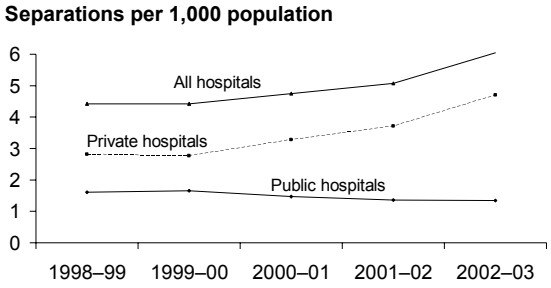

Figure 1.3: Ambulatory-equivalent mental health-related separations per 1,000 population, by hospital sector, Australia, 1998–99 to 2002–03

Disability support services

The Commonwealth State/Territory Disability Agreement (CSTDA) allocates responsibility and funding for disability support services between the Australian, state and territory governments. CSTDA-funded services include accommodation support, residential care, employment support and community access support. Data have been collected in all jurisdictions on clients of these services on a 'snapshot day' each year between 1997 and 2002. Some psychiatric disability services are not CSTDA-funded and are not included in this collection.

The number of CSTDA-funded services (residential and ambulatory) received by people with a psychiatric disability (i.e. primary or other significant disability) was between 55 and 60 services per 100,000 population between 1999 and 2002 (Figure 1.4). The rate for people with a psychiatric disability that was not their primary disability increased; this contrasted with an overall decrease, due to a drop in 2002, for those for whom it was their primary disability.

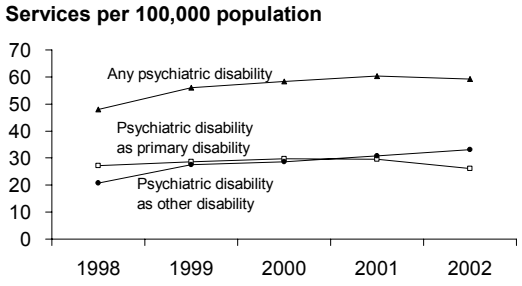

Figure 1.4: CSTDA-funded disability support services received by people with a psychiatric disability per 100,000 population, 1998 to 2002

For 2002–03, these data were collected on all services provided in the period 1 January to 30 June. These data are not comparable to the snapshot day data collected between 1997 and 2002 (see Figure 3.4 for 2003 data).

Hospital admitted patient care

Another objective of the National Mental Health Strategy has been to reduce the size and number of stand-alone psychiatric hospitals and increase the role of psychiatric units in general hospitals in providing mental health-related care to admitted patients. Admission to a specialist psychiatric unit or hospital is not always the most appropriate treatment for all mental and behavioural disorders. For some disorders, treatment without specialised psychiatric care may be appropriate to the needs of the patient.

This section presents information on the changes to admitted patient care in terms of the number of separations, patient-days and average length of stay. Information on the relative merits of these different measures of hospital activity is provided in Box 4.1.

Hospital admitted patient care is regarded as mental health-related in this report if it includes specialised psychiatric care and/or a mental health-related principal diagnosis is reported for it. It can also be regarded as comprising ambulatory-equivalent same-day care (see above), other same-day care, and care that lasts for at least one night. Information on non-ambulatory-equivalent separations is presented below.

Separations

There were 192,169 mental health-related separations not considered to be ambulatory-equivalent in 2002–03.

The number of these separations was relatively stable between 1998–99 and 2002–03 (Figure 1.5). However, over this period, separations from public acute hospitals increased by 11.3%, but separations from private hospitals and public psychiatric hospitals decreased by 1.1% and 24.4% respectively (Table 4.1).

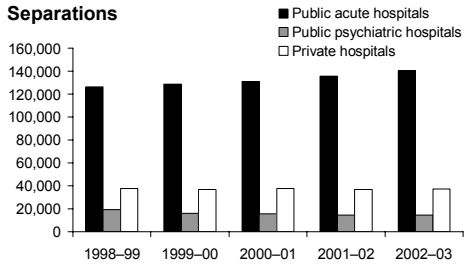

Figure 1.5: Non-ambulatory-equivalent mental health-related separations by hospital type, 1998–99 to 2002–03

The number of separations per 1,000 population by hospital type for the period 1998–99 to 2002–03 is available on the Internet at <www.aihw.gov.au>.

Patient-days

The patient-day data presented includes all days of patient care received during the hospitalisation. Some of these may have occurred in previous years, particularly for public psychiatric hospitals, for which numbers of very extended stays were reported, particularly in 1998–99 and 1999–00.

There were 2,926,670 patient-days attributed to non-ambulatory-equivalent mental health-related separations in 2002–03. The number of patient-days for public acute hospitals increased by 8.9% between 1998–99 and 2002–03, the number for private hospitals increased by 5.4% and the number for public psychiatric hospitals decreased by 28.7% (Table 4.1 and Figure 1.6).

The number of non-ambulatory-equivalent mental health-related patient - days per 1,000 population by hospital type for the period 1998–99 to 2002–03 is available on the Internet at <www.aihw.gov.au>.

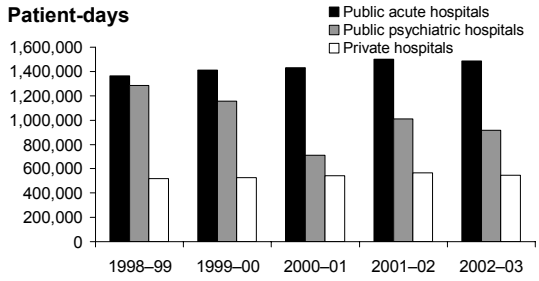

Figure 1.6: Patient-days attributed to overnight mental health-related separations by hospital type, 1998–99 to 2002–03

Average length of stay

In order to maximise the comparability over time, the average length of stay (ALOS) data in this chapter exclude separations for patients who transferred from one hospital to another, who changed type of episode of care during their hospital stay, who died in hospital, who left against medical advice or who were transferred to a residential aged care facility. These data also exclude any separations that began with a transfer from another hospital or a change of care type.

For public acute hospitals, the ALOS for these selected separations remained relatively stable between 1998–99 and 2002–03. In 1998–99, the ALOS was 9.8 days and had increased by 4.1% to 10.2 days in 2002–03 (Figure 1.7). Private hospital separations had longer average lengths than public acute hospital separations and increased to 16.3 days for 2002–03. In 2002–03, the median lengths of stay for public acute and private hospitals were 5 and 12 days, respectively.

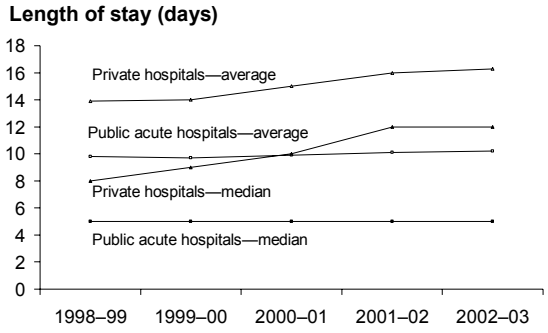

Figure 1.7: Average and median length of stay for selected mental health-related overnight separations by hospital type, 1998–99 to 2002–03

1.2 Patient demographics

Age and sex

The overall prevalence of mental disorders declines with age (ABS 1998). Females are more likely to experience affective and anxiety disorders whereas males are more likely to experience substance use and psychotic disorders (ABS 1998; Jablensky et al. 1999). Patterns of service use differ for males and females and by age group, often reflecting the particular disorders most often treated by the service provider.

General practice

In 2003–04, 59.5% of mental health-related general practice encounters were with female patients. The female proportion was higher than the male proportion in all age groups except for patients aged less than 15 years (Figures 1.8 and 3.2). This is consistent with the distribution pattern of male and female patients for all general practice encounters.

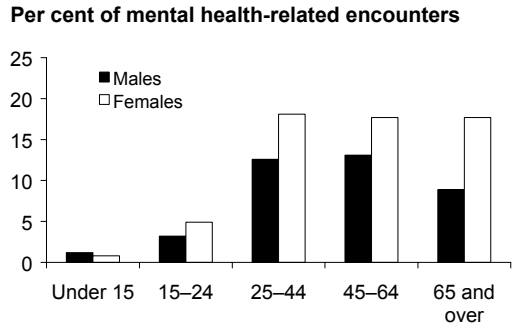

Figure 1.8: Mental health-related general practice encounters by age group and sex of patient, 2003–04

Private psychiatrists

The patient age and sex distribution for Medicare-funded attendances with private psychiatrists was similar to that for general practice. In 2003–04, 60.6% of these attendances were for female patients. There were 121.9 attendances per 1,000 population for females, compared with 80.4 for males. The rate was higher for females than males in all age groups except for patients under 15 years (Figure 1.9 and Table 3.19).

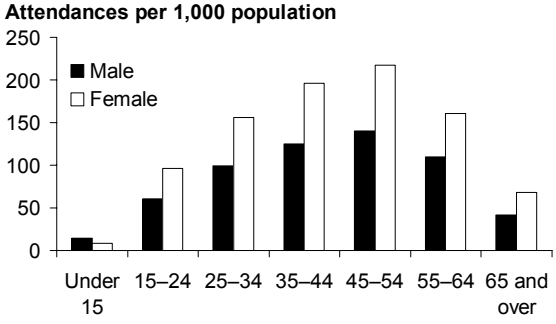

Figure 1.9: Medicare-funded psychiatrist attendances per 1,000 population by age group and sex of patient, 2003–04

Community mental health services

In 2002–03 there were more public community-based mental health service contacts for male (51.0%) than for female patients. There were 243.0 service contacts per 1,000 population for males, compared with 226.5 for females. Male patients dominated the age groups below 45 years and females dominated the older age groups (Figure 1.10 and Table 3.26).

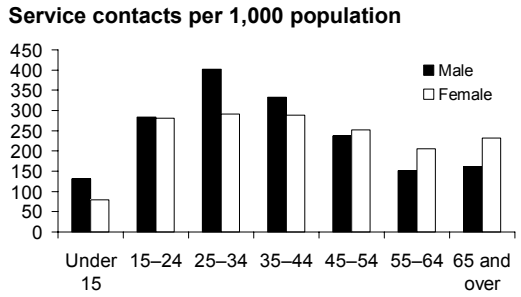

Figure 1.10: Community mental health service contacts per 1,000 population by age group and sex of patient, 2002–03

Ambulatory-equivalent separations

In 2002–03, there were 42,630 ambulatory-equivalent separations for male patients (39.1%) and 66,315 for female patients (60.9%). Separations for male patients who received ambulatory-equivalent care were most likely to be for the 45–54 years age group (20.7% of male separations) and for the 35–44 years age group for females (22.2% of female separations) (Figure 1.11 and Table 3.35).

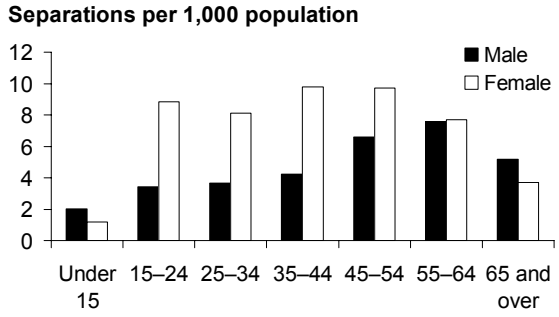

Figure 1.11: Ambulatory-equivalent mental health-related separations per 1,000 population by age group and sex of patient, 2002–03

Hospital admitted patient care

In 2002–03, there were 192,169 mental health-related separations, excluding separations that could be considered to be equivalent to ambulatory mental health care. For more information on these ambulatory-equivalent separations, refer to Chapter 3 and Appendix 2.

Of the 192,169 non-ambulatory-equivalent mental health-related separations, 52.5% were for female patients. There were 10.1 of these separations per 1,000 population for females, compared with 9.3 for males. The rate was higher for females in all age groups above 35 years and between 15 and 24 years (Figure 1.12).

In 2002–03, there were 1,510,706 patient-days for male patients compared with 1,434,269 for females. There were 153.9 days per 1,000 population for males, compared with 144.2 for females. The rates were higher for males than for females in all age groups except for the 55–64 age group where rates for females were higher (Tables 5.1 and 6.1).

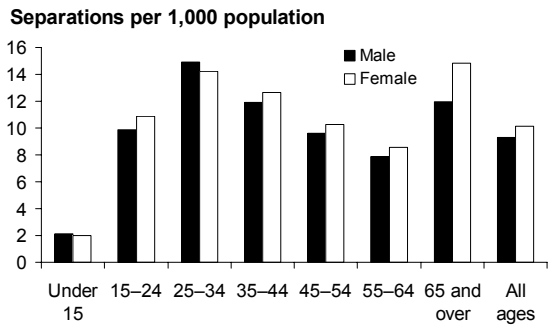

Figure 1.12: Non-ambulatory-equivalent mental health-related separations per 1,000 population by age group and sex of patient, 2002–03

Patient's area of usual residence

This section presents summary information on service use by the area of usual residence of the patient. Community mental health care is not included in this section due to substantial underreporting of patient's area of usual residence.

Hospital admitted patient care

The pattern of non-ambulatory-equivalent separations per 1,000 population by Remoteness Area differed for separations with and without specialised psychiatric care (Figure 1.13 and Tables 5.5 and 6.2). In the case of separations with specialised psychiatric care, the rate per 1,000 population was highest for patients living in major cities (5.8) and lowest for those living in very remote areas (2.7).

The opposite was true for separations without specialised psychiatric care. There the rate was highest for patients living in very remote areas (8.3) and lowest for those living in major cities (3.3).

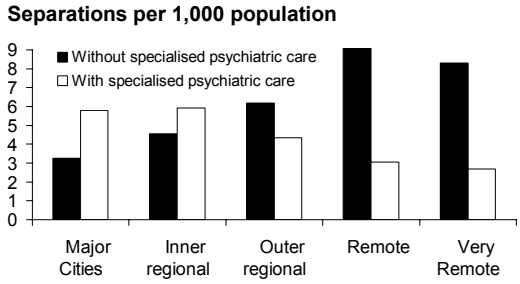

Figure 1.13: Non-ambulatory-equivalent mental health-related separations per 1,000 population by Remoteness Area of usual residence, 2002–03

Aboriginal and Torres Strait Islander peoples

Indigenous Australians view mental health basically as social and emotional wellbeing. Hence, data on their use of services may reflect a different range of conditions compared with other Australians. Aboriginal and Torres Strait Islander peoples are thought to be under-identified in health care data collections, including those for mental health care.

Ambulatory-equivalent separations

The number of ambulatory-equivalent mental health-related separations per 1,000 Aboriginal and Torres Strait Islander peoples was lower than that of other Australians (3.2 compared with 5.5) (Table 3.36).

This was particularly the case for ambulatory-equivalent separations with specialised psychiatric care. The rate of these separations per 1,000 Aboriginal and Torres Strait Islander peoples was less than one-third that of the rate for other Australians (1.3 compared with 4.5) (Figure 1.14 and Table 3.36).

In contrast, the number of ambulatory-equivalent separations with non-specialised psychiatric care per 1,000 Aboriginal and Torres Strait Islander peoples was almost double that of other Australians (1.8 compared with 1.0) Figure 1.14 and Table 3.36).

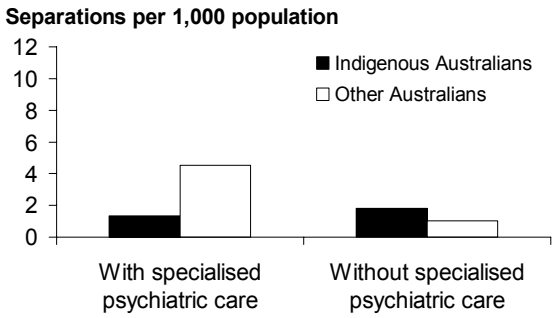

Figure 1.14: Ambulatory-equivalent mental health-related separations per 1,000 population by Indigenous status, 2002–03

Hospital admitted patient care

For non-ambulatory-equivalent mental health-related separations per 1,000 Aboriginal and Torres Strait Islander peoples the rate was more than double that of other Australians (22.6 compared with 9.4) (Figure 1.15 and Tables 5.6 and 6.3).

The difference in rates between the two groups was less pronounced for non-ambulatory-equivalent separations with specialised psychiatric care. The rate of these separations per 1,000 Aboriginal and Torres Strait Islander peoples was almost double the rate for other Australians (10.0 compared with 5.6) (Figure 1.15 and Table 5.6).

In contrast, the number of non-ambulatory-equivalent separations with out specialised psychiatric care per 1,000 Aboriginal and Torres Strait Islander peoples was more than three times that of other Australians (12.6 compared with 3.8) (Figure 1.15 and Table 6.3).

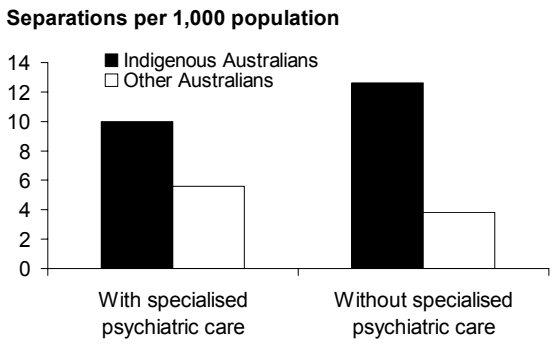

Figure 1.15: Non-ambulatory-equivalent mental health-related separations per 1,000 population by Indigenous status, 2002–03

The relatively greater reliance of Aboriginal and Torres Strait Islander peoples on non-specialised care compared to specialised care may be partially explained by geographical differences. A higher proportion of this group live in remote or very remote areas (25%) compared to other Australians (2%) (AIHW & ABS 2003), and there are fewer specialised care facilities in these areas. In 2002–03, there were no public psychiatric hospitals and only one public acute care hospital with a psychiatric unit or ward with 1.19 available beds per 100,000 population in remote and very remote areas (Tables 7.14 and 7.19). Conversely, the proportion of other Australians living in major cities (67%) was much higher than the proportion of Aboriginal and Torres Strait Islander peoples (30%) (AIHW & ABS 2003). In 2002–03 in major cities, there were 10 public psychiatric hospitals with 12.7 available beds per 100,000 population, and 87 public acute care hospital with a psychiatric unit or ward with 19.51 available beds per 100,000 population (Tables 7.14 and 7.19).

Along with reduced access to hospital services, Aboriginal and Torres Strait Islander peoples had a shorter average length of stay for overnight separations without specialised psychiatric care (4.6 days compared with 8.5 for other Australians). Difference in length of stay may reflect differences in casemix between

Indigenous Australians and other Australians.

The accuracy of Indigenous identification in hospital separations data needs improvement and these data need to be used with caution (further detail about the quality of these data can be found in *Australian Hospital Statistics 2002–03* (AIHW 2004d)).

1.3 Mental health problems and disorders

This section presents information on the problems and disorders treated by the different types of mental health service providers. Mood (affective) and anxiety disorders are the most prevalent forms of mental disorder in the Australian population (ABS 1998; Sawyer et al. 2000).

General practice

Of the mental health problems managed by general practitioners in 2003–04, problems related to mood (affective) were the most frequently managed, followed by anxiety-related and physical disturbances (mainly sleep disturbance) (Figure 1.16 and Table 3.6).

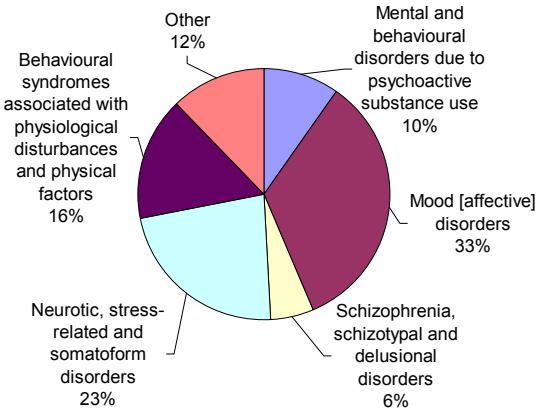

Figure 1.16: Mental health-related problems managed by general practitioners, 2003–04

Community mental health care services

The mental disorders treated in public community-based ambulatory mental health services and hospital outpatient services in 2002–03 included low-prevalence disorders such as *Schizophrenia, schizotypal and delusional disorders* (Figure 1.17 and Table 3.32).

These data should be interpreted with caution because no principal diagnosis information was available for a large proportion of service contacts.

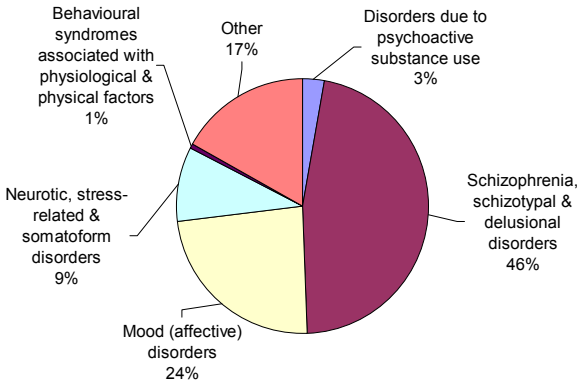

Figure 1.17: Principal diagnoses for service contacts, public community mental health care, 2002–03

Ambulatory-equivalent separations

The most common principal diagnoses, for ambulatory-equivalent mental health-related separations with specialised psychiatric care, were *Mood (affective) disorders* (45%) and *Neurotic, stress-related and somatoform disorders (24%)* (Figure 1.18).

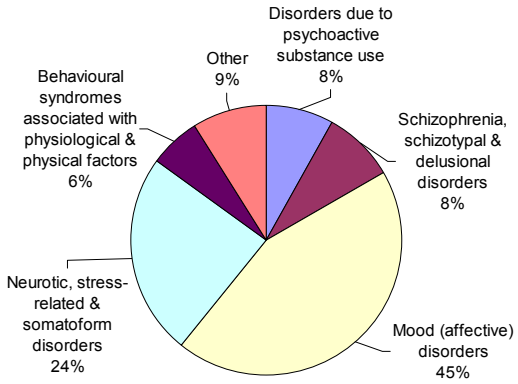

Figure 1.18: Principal diagnoses for ambulatory-equivalent mental health-related separations, with specialised psychiatric care, 2002–03

The most common principal diagnoses, for ambulatory-equivalent mental health-related separations without specialised psychiatric care, were *Disorders due to Psychoactive substance use* (40%) and *Neurotic, stress-related and somatoform disorders* (21%) (Figure 1.19).

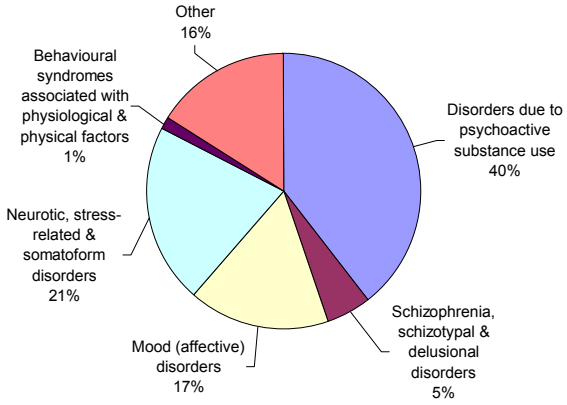

Figure 1.19: Principal diagnoses for ambulatory-equivalent mental health-related separations, without specialised psychiatric care, 2002–03

Hospital admitted patient care

This section presents information on the mental health-related diagnoses reported for non-ambulatory-equivalent mental health-related separations in public and private hospitals, and related patterns of the provision of specialised psychiatric care.

Of the non-ambulatory-equivalent mental health-related separations in public and private hospitals, 56.3% or 87,343 public hospital separations included a component of specialised psychiatric care, that is, care in a specialised psychiatric unit or hospital. This compares with 69.2% or 25,702 separations with a component of specialised psychiatric care in private hospitals (Tables 5.2 and 6.2).

Public hospitals

In 2002–03, *Mood (affective) disorders* and *Schizophrenia, schizotypal and delusional disorders* were the most common principal diagnoses for public hospital non-ambulatory-equivalent mental health-related separations (Figure 1.20 and Tables 5.9 and 6.6).

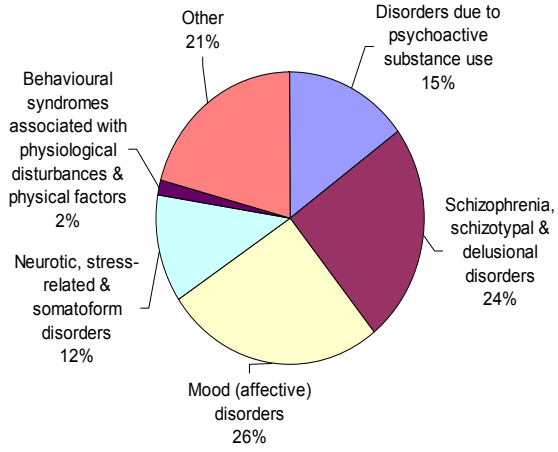

Figure 1.20: Principal diagnoses for non-ambulatory-equivalent mental health-related separations, public hospitals, 2002-03

A high proportion of separations with principal diagnoses of *Mood (affective) disorders*, *Schizophrenia, schizotypal and delusional disorders* and *Disorders of adult personality and behaviour* had specialised psychiatric care (Figure 1.21 and Tables 5.9 and 6.6).

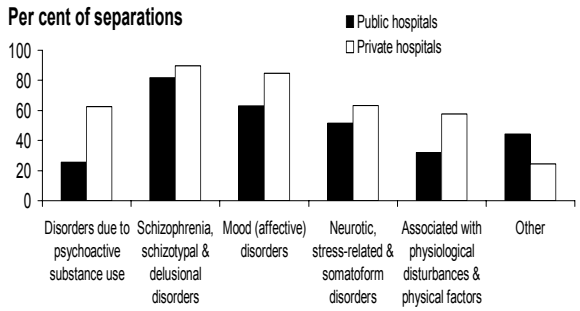

Figure 1.21: Non-ambulatory-equivalent mental health-related separations with specialised psychiatric care, 2002-03

Private hospitals

Principal diagnoses of *Mood (affective) disorders* and *Neurotic, stress-related and somatoform disorders* were the most common for private hospital non-ambulatory-equivalent mental health-related separations (Figure 1.22 and Tables 5.9 and 6.6).

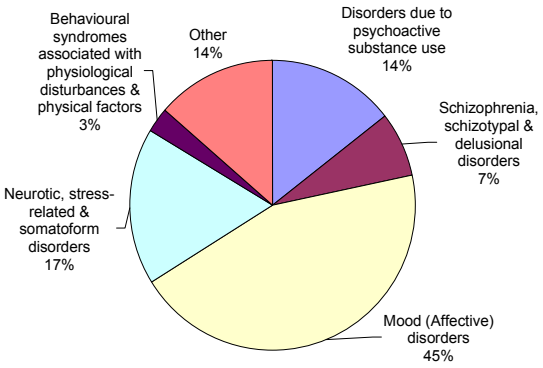

Figure 1.22: Principal diagnoses for non-ambulatory-equivalent mental health-related separations, private hospitals, 2002–03

1.4 Medication

This report presents data on mental health-related medication subsidised through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) and prescribed by private psychiatrists and other medical practitioners.

For non-psychiatrists, only mental health-related medications are included (see Appendix 2 for more details). For psychiatrists, all medications prescribed are included.

In 2003–04, mental health-related medications accounted for 10.9% (17.8 million) of all the medications prescribed by general practitioners (Table 3.15 and unpublished PBS and RPBS data). Private psychiatrists prescribed a total of 1.96 million medications (Table 3.23).

In 2003–04, antidepressants were the most frequently prescribed mental health-related medication, accounting for 59.4% of mental health-related medications, 54.6% of mental health-related medication prescribed by psychiatrists and 59.9% of mental health-related medication prescribed by general practitioners (Tables 3.15 and 3.23).

Between 1998–99 and 2003–04, there was an increase in the number of antidepressant and antipsychotic PBS-subsidised medications and a decrease in the numbers for hypnotics and sedatives and anxiolytics (Figure 1.23 and Tables 3.14 and 3.22).

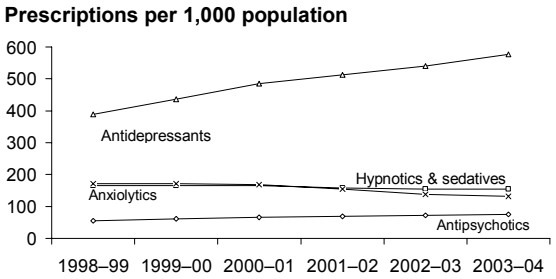

Figure 1.23: Selected PBS-funded mental health-related prescriptions per 1,000 population, 1998–99 to 2003–04

1.5 Labour force

This report presents data on three mental health-related professions for which there are recent national data available:

psychiatry, mental health nursing and clinical psychology. For psychiatrists and mental health nurses, labour force data were collected in conjunction with the annual registration renewal of these practitioners. Data for clinical psychologists were from the Australian Bureau of Statistics (ABS) Census of Population and Housing.

Psychiatrists

Psychiatrists presented here are those that identified themselves as being a specialist (i.e., a person who holds a qualification awarded by a specialist college, for example, the Royal Australian and New Zealand College of Psychiatrists (RANZCP)) and whose main specialty of practice is psychiatry. Both public and private sector psychiatrists are included.

In 2002, Australia had 12.1 psychiatrists per 100,000 population (including 1.0 non-clinician) and 3.0 psychiatrists-in-training per 100,000 population (Table 7.1).

Major cities had a relatively high number of psychiatrists per 100,000 population (Figure 1.24 and Table 7.1). Remote and very remote areas had fewer psychiatrists per 100,000 population.

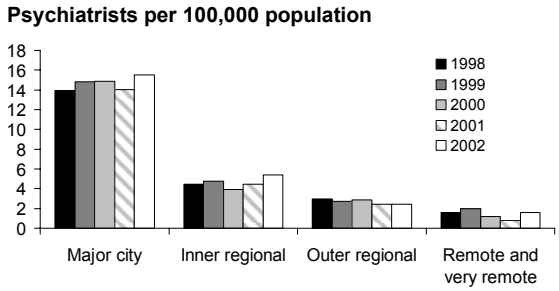

Figure 1.24: Psychiatrists per 100,000 population by Remoteness Area, 1998 to 2002

Mental health nurses

Mental health nurses were defined as nurses who reported that their main area of nursing was mental health. Both public and private sector nurses are included.

In 2001, 12,094 nurses identified psychiatric and mental health nursing as their main area of nursing (Table 7.6). They accounted for 6.0% of all employed clinical nurses.

There were 62.2 mental health nurses per 100,000 population in 2001, a level consistent with previous years.

Major cities and inner regional areas had a relatively high number of mental health nurses per 100,000 population (Figure 1.25). Remote and very remote areas had fewer of these nurses per 100,000 population, but rates increased between 1997 and 2001.

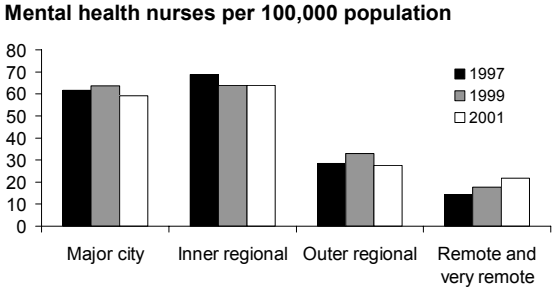

Figure 1.25: Mental health nurses per 100,000 population by Remoteness Area, 1997 to 2001

In 2001, just over two-thirds of mental health nurses were female. The majority of mental health nurses were in the 45–54 and 34–44 year age groups (35.9% and 32.9%, respectively) (Figure 1.26 and Table 7.6).

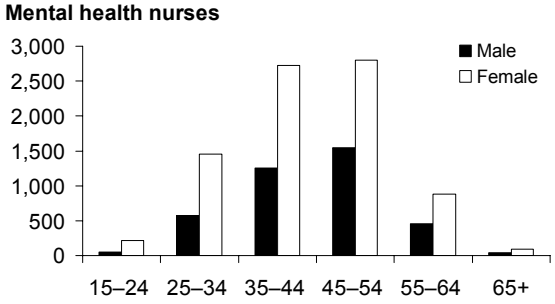

Figure 1.26: Mental health nurses by age and sex, Australia, 2001

2 Introduction

Mental Health Services in Australia 2002–03 is the sixth in the Australian Institute of Health and Welfare's (AIHW) series of annual reports describing the activity and characteristics of Australia's mental health care services. A key role of these reports is to make publicly available the data collected as specified in the National Minimum Data Sets (NMDSs) for Mental Health Care, which cover public community mental health services and specialised psychiatric care for patients admitted to public and private hospitals (see Appendix 1 for descriptions). Alongside the NMDS data, these reports also include a range of other data to describe mental health-related service delivery in Australia.

A wide range of service types is involved in providing treatment and care for people with mental health disorders. These include specialist mental health services, general health services and services outside the health sector, provided in both residential and ambulatory care settings. Many are government services, but private hospitals, non-government organisations and private medical practitioners are also responsible for providing mental health care. This report gives an overview of this range of services.

This report and accompanying additional tables are available on the Internet at <www.aihw.gov.au/publications/hse/mhsa02-03/>. Some of the national data on admitted-patient care are also available in an interactive data cube format on the Internet at <www.aihw.gov.au/hospitaldata/datacubes/index.html>. Users can access these data cubes to create customised tables based on the age group, sex, principal diagnosis and mental health legal status of admitted patients who received specialised psychiatric care between 1998–99 and 2002–03.

2.1 Report structure

Chapter 1 presents overview information on mental health-related service activity over recent years and mental health-related service use by selected population groups.

Chapter 2 presents information on this report's structure and background information on the prevalence of mental disorders and on the objectives of the National Mental Health Strategy.

Chapter 3 summarises the available data on ambulatory care provided by specialised mental health care services and other non-specialised service providers that play a role in providing services for people with mental disorders. Reported specialised mental health care services include those provided by private psychiatrists and specialist mental health outpatient and community mental health care services. The non-specialised services reported include general practitioners, and ambulatory disability support services that were funded under the Commonwealth State/Territory Disability Agreement (CSTDA). The CSTDA-funded services include some specialised mental health care services provided by non-government organisations. This chapter also presents Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) data on mental health-related medications.

Chapters 4, 5 and 6 summarise the available data on residential and admitted patient mental health care and CSTDA-funded residential disability support services. The information

presented on patients admitted to hospitals includes data on those who received specialised psychiatric care (chapter 5) and those who had a mental health-related principal diagnosis but were not reported as receiving specialised psychiatric care (chapter 6).

Chapter 7 presents information on the public and private psychiatrist, mental health nurse and clinical psychologist labour force. This chapter also presents data on the staffing and expenditure of public community mental health care establishments and public and private hospitals that provide specialised psychiatric care.

Chapter 8 presents information on mental health care for schizophrenia, accompanied by information on the estimated prevalence of this condition, and the burden and health system expenditure related to this condition.

The appendixes provide more detailed technical notes on the data and analyses that are included in the chapters. Appendix 1 outlines the data sources used for this report and their respective strengths and weaknesses, and details the data elements specified in the NMDSs for Mental Health Care. Appendix 2 provides information on the codes used to define mental health-related care and medications and on the definition of hospital separations that could be considered equivalent to ambulatory mental health care. Appendix 3 provides state- and territory-specific data on admitted patient care, including ambulatory-equivalent mental health care, and community mental health care. Appendix 4 presents information on the National Survey of Mental Health Services and how it compares with the establishment-level data collections used in this report.

The data in this report are mainly for 2002–03 or, in the case of the CSTDA MDS data, for the first six months of 2003. In the interest of presenting the most up-to-date data, data for 2003–04 are presented from the Medicare, PBS and Bettering the Evaluation and Care of Health (BEACH) data collections. Readers requiring 2002–03 data from the Medicare or PBS collections can refer to the Internet tables accompanying this report on the Institute's web site (<www.aihw.gov.au>). Those requiring 2002–03 data from the BEACH data collection can refer to the *Mental Health Services in Australia 2001–02* report (AIHW 2004a).

2.2 Background

This publication focuses on mental health services. However, this section provides some background information on the prevalence of mental disorders and psychiatric disability from the 1997 National Survey of Mental Health and Wellbeing of Adults, the 2003 Survey of Disability, Ageing and Carers, and the 1999 National Survey of Mental Health and Wellbeing of Children and Adolescents. This section also includes background information on the National Mental Health Strategy and its objectives (Box 2.1).

Prevalence of mental disorders in adults

The most commonly quoted figure of mental disorders in Australia is that approximately one in five adults will experience a mental illness at some time in their life. This figure is from the adult component of the National Survey of Mental Health and Wellbeing (NSMHWB) conducted in 1997 by the Australia Bureau of Statistics (ABS 1998). Approximately 10,600 people aged 18 years and over participated in the survey; a range of mental disorders was diagnosed using a computerised version of the Composite International Diagnostic Interview. These disorders included anxiety or affective disorders and substance use disorders.

The survey found that an estimated 18% of Australian adults had experienced a mental disorder in the 12 months before the interview (ABS 1998). The prevalence of mental disorders decreased with age, with the highest prevalence reported for adults aged 18–24 years (27%), reflecting a relatively high rate of substance use disorders in that age group. The prevalence was lowest, at 6%, for those aged 65 and over.

Women were more likely than men to have had an anxiety or affective disorder and men were more than twice as likely as women to have had a substance use disorder. Anxiety disorders were most common for women aged 45–54 years (16%). Affective disorders, which include depression, were most common for women aged 18–24 years (11%). Substance use disorders were most common for men aged 18–24 years (22%). More information on the results of this study can be found in *Mental Health Services in Australia 2000–01* (AIHW 2003a).

The child and adolescent component of the 1998 National Survey of Mental Health and Wellbeing found the most frequently reported disorder for children aged 6–17 years was attention-deficit hyperactivity disorders (ADHD) (11% or an estimated 355,000 children and adolescents). Less prevalent were depressive disorders (4% or 117,000) and conduct disorders (3% or 95,000) (Sawyer et al. 2000).

Box 2.1: National Mental Health Strategy

In 1992, the Commonwealth, state and territory governments in Australia endorsed the National Mental Health Strategy as a framework to guide the reform agenda for mental health. A brief outline of the Strategy is given below. For more information on the National Mental Health Strategy, refer to the National Mental Health Report 2002 *(DHA 2002). The aims of the Strategy are to:*

- *promote the mental health of the Australian community and, where possible, prevent the development of mental disorder;*
- *reduce the impact of mental disorders on individuals, families and the community*
- *assure the rights of people with mental disorders.*

The broad aims and objectives of the Strategy are described in the National Mental Health Policy. The Policy has 38 objectives including objectives relating to the shift from institutional to community care and the delivery of services in mainstream settings. The approach to be taken by the Australian, state and territory governments in implementing the aims and objectives of the Policy were described by the First National Mental Health Plan, which ran from 1992–93 to 1997–98. Near the end of the First Plan, an independent evaluation concluded that significant progress had been achieved but that the reform agenda had yet to be completed (AHMAC 1997).

In order to continue these reforms, the Second National Mental Health Plan (1998–99 to 2002–03) was endorsed by all governments in 1998. The aim of the Second Plan was to consolidate reforms of the First Plan and to extend into additional areas with a particular focus on promotion and prevention, partnerships in service reform and delivery, and service quality and effectiveness.

The National Mental Health Plan 2003–08 consolidates reforms begun under the first two plans and has four priority themes: promoting mental health and preventing mental health problems, increasing service responsiveness, strengthening quality and fostering research, and innovation and sustainability.

Prevalence of psychiatric disability

Having a mental health condition such as depression or anxiety can be disabling in its impact on day-to-day life and/or long-term functioning at home and in the community. In 2003, the Australian Bureau of Statistics conducted the Survey of Disability, Ageing and Carers

(SDAC). Data from this survey estimated the prevalence of psychiatric disability at 4.7% of the Australian population of all ages, representing around 926,000 people.

Data from the NSMHWB estimated the prevalence of mental disorders for persons aged 18 years and over at 18% (see previous page). The prevalence of disability, as defined in the NMHWB survey, was estimated at 7.8% of persons aged 18 years and over.

There are a number of differences between the two surveys which may account for these disparities in the prevalence rates and which show that the data from these surveys are not able to be compared. For example, the NSMHWB was specifically designed to measure, through a structured questionnaire, the prevalence of mental disorder, whereas the SDAC was designed, among other things, to measure levels of disability. The population surveyed for the NSMHWB was persons aged 18 years and over, whereas the SDAC surveyed the Australian population of all ages. In addition, the definitions used in each survey for mental disorder differ.

In the 2003 SDAC, prevalence levels were higher for those aged 65 years and older (11.8% compared with 3.7% for those aged less than 65 years), and higher among older females (14.0%) than older males (9.0%).

There was a proportion of the Australian population who had a psychiatric disability and also had a severe or profound core activity limitation (2.4%) (i.e. they sometimes or always needed help with self care, mobility or communication activities). These higher levels of restriction were more common in older people (8.6% of those 65 years and older compared with 1.5% of those aged less than 65), especially older females (10.6% compared to 6.0% of older males).

Table 2.1: Persons with a psychiatric disability ('000) by age group, sex and profound/severe core activity limitation, Australia, 2003

	Males		Females		Total	
	With a psychiatric disability	All males	With a psychiatric disability	All females	With a psychiatric disability[(a)]	Total
	0–64 years					
Profound/severe core-activity limitation	118.4	347.8	134.7	335.0	253.1	682.9
Total with a disability	292.5	1,346.5	339.9	1,220.3	632.4	2,566.8
All persons	*351.4*	*8,752.4*	*479.5*	*8,560.1*	*830.9*	*17,312.4*
	65 years and over					
Profound/severe core-activity limitation	66.5	190.5	147.4	371.2	213.9	561.7
Total with a disability	99.4	611.2	194.2	780.3	293.6	1,391.5
All persons	*111.8*	*1,110.0*	*212.4*	*1,388.7*	*324.2*	*2,498.7*
	Total					
Profound/severe core-activity limitation	184.9	538.3	282.1	706.2	466.9	1,244.5
Total with a disability	391.9	1,957.6	534.1	2,000.7	926.0	3,958.3
All persons	**463.2**	**9,862.3**	**691.9**	**9,948.8**	**1,155.1**	**19,811.1**

(a) Includes 229,100 persons with a psychiatric condition that was not a disability. That is, they were not restricted in their everyday life by their psychiatric condition.

Source: Unpublished data from the 2003 Survey of Disability, Ageing and Carers, Australian Bureau of Statistics.

2.3 Health service expenditure for mental health disorders

A detailed analysis of health service expenditure by disease and injury categories, including mental health, has been undertaken for 1993–94 and 2000–01 (AIHW 2004b). This analysis distributed total health expenditure in Australia by disease category, estimated using information such as diagnoses reported for patients admitted to hospital, and problems managed for patients attending general practitioners.

In this report, expenditure costs of dementias have been included as well as mental disorders because dementias are included in the definition of mental health-related separations used in this report. This reflects mental health-related care provided to patients with dementias who have been admitted to hospital. The expenditure on dementias in other settings (e.g. aged care homes) may not necessarily be regarded as mental health-related care to the same extent. Data for hospital services expenditure have been adjusted to take into account the impact of long-stay patients on annual expenditure figures.

For 2000–01 it was estimated that health care expenditure for mental health disorders, including expenditure on community mental health, was $3,861 million (Table 2.2), or 6.7% of recurrent health care expenditure. The majority of this expenditure was for hospital services (31.0% of mental health care expenditure or $1,196 million), community mental health services (21.8% or $842 million) and pharmaceuticals (15.9% or $615 million). In 2000–01, expenditure on Alzheimer's disease and other dementias totalled $2,679 million and the majority of this expenditure occurred in aged care homes (87.3% or $2,339 million).

In comparison, the health care expenditure for mental health disorders (including community health expenditure of $408 million) for 1993–94 (converted to 2000–01 prices) was estimated at $2,697 million or 6.6% of recurrent health care expenditure. The expenditure was mostly for hospital services (40.5% or $1,091 million) and out-of-hospital medical services (19.0% or $512 million). Expenditure on Alzheimer's disease and other dementias totalled $814 million in 1993–94 (2.0% of recurrent health care expenditure) which was lower than the expenditure in 2000–01 (4.7% or $2,679 million).

Table 2.2: Health system costs of mental disorders and Alzheimer's disease and other dementias in Australia, 1993–94[a] and 2000–01 ($ millions)

Year	Hospitals[b]	Aged care homes	Out-of-hospital medical[c]	Pharma-ceuticals	Other health professional services[d]	Research	Community mental health	Total
	Mental disorders excluding dementias[e]							
2000–01	1,196	366	589	615	144	109	842	3,861
1993–94 [a]	1,091	316	512	237	99	34	408	2,697
	Alzheimer's disease and other dementias[f]							
2000–01	175	2,339	20	33	9	102	n.a	2,679
1993–94 [a]	132	647	13	2	5	14	n.a	814

(a) Expenditures for 1993–94 have been converted to 2000–01 prices by adjusting for health price inflation between 1993–94 and 2000–01.

(b) Hospitals include admitted and non-admitted patients and in-hospital private medical services.

(c) Out-of-hospital medical includes unreferred attendances, imaging, pathology and other medical.

(d) Other health professional services include services delivered by physiotherapists, chiropractors, occupational therapists, audiologists, speech therapists, hydropaths, podiatrists, therapeutic and clinical massage therapists, clinical psychologists, dieticians and osteopaths.

(e) Mental disorders include ICD-10-AM codes F04–F99 (all mental and behavioural disorders excluding dementia in Alzheimer's disease, vascular dementia, dementia in other diseases classified elsewhere and unspecified dementia), and G31.2 (degeneration of nervous system due to alcohol) for 2000–01; ICD-9 chapter V (mental disorders), excluding 290 (senile and presenile organic psychotic conditions) and 330–331 (cerebral degenerations usually manifest in childhood and other cerebral degenerations) for 1993–94.

(f) Alzheimer's disease and other dementias include ICD-10-AM codes F01–F03 (vascular dementia, dementia in other diseases classified elsewhere and unspecified dementia), and G30–G31 (Alzheimer's disease and other degenerative disease of the nervous system not elsewhere classified) excluding G31.2 (degeneration of nervous system due to alcohol) for 2000–01; ICD-9 CM codes 290 (senile and presenile organic psychotic conditions) and 330–331 (cerebral degenerations usually manifest in childhood and other cerebral degenerations) for 1993–04.

n.a. Not available.

Further information

For information on recent estimates of the prevalence of self-reported long-term mental health conditions, psychological distress, use of medication for mental wellbeing, and consultations with health professionals, see *Mental Health Services in Australia 2001–02* (AIHW 2004a).