

6.4 Specialised mental health services

Australians use a variety of public and private health service providers for mental health care. They include GPs (see above) and specialised mental health services such as private psychiatrists, public community-based mental health services, public and private psychiatric hospitals, and specialised residential mental health care facilities. Public specialised mental health services operate in each state and territory, integrating services provided to patients in community settings, residential care facilities, specialised psychiatric hospitals and specialised psychiatric units within public acute hospitals.

Historically, stand-alone public psychiatric hospitals were the main focus of specialised mental health care. However, the availability of effective antipsychotic drugs, changes in clinical practice and the emergence of the human rights movement provided the setting for reform of mental health care. Since 1993, national action to reform mental health care has been driven by a series of national mental health plans under the National Mental Health Strategy.

Private psychiatry

In 2002–03, there were an estimated 1,030 full-time equivalent psychiatrists in private practice (AIHW 2004). There were 914 in metropolitan areas (6.9 per 100,000 population) and 116 (1.1 per 100,000 population) in rural and remote areas.

Medicare funded 2,065,009 services provided by private psychiatrists in 2002–03. They included 1,781,337 patient attendances in consulting rooms, 205,045 patient attendances in hospitals and 45,078 group psychotherapy services. Females received more services (1,257,236, or 126.1 per 1,000 population) than males (807,773, or 82.3 per 1,000 population), and highest rates were reported for the 45–54-year age group for both sexes (223.8 per 1,000 population for females and 145.3 per 1,000 population for males). Medicare expenditure on these services was \$197 million in total, including \$178 million for patient attendances in consulting rooms and \$14 million for patient attendances in hospitals. Private psychiatrists provided 1,785,825 prescriptions subsidised by the Pharmaceutical Benefits Scheme (PBS) in 2002–03. The most commonly prescribed drugs were antidepressants (968,777) and antipsychotics. PBS expenditure for these pharmaceuticals was \$101 million, including \$52 million for antipsychotics and \$37 million for antidepressants (AIHW 2004).

Community mental health services

Public community mental health services provide specialised mental health care services to patients in community settings. Included are specialised services for adults, for older adults, and for children and adolescents; mobile treatment teams; and hospital-based services such as psychiatric outpatient services, day programs and community outreach services.

In 2001–02, these services (with residential facilities included) had a recurrent expenditure of \$778 million and an average of 9,785 full time-equivalent staff (AIHW 2004). Staff numbers increased by 12.8% over the 3 years from 1998–99. However,

reflecting the longer term move of mental health services to community settings, between 1992–93 and 1999–00 the number of clinical full time-equivalent staff rose by 90%, and expenditure rose by 109% (DoHA 2002).

For 2001–02, 4,203,721 service contacts between clients and staff were reported by community mental health care services to the AIHW National Community Mental Health Establishments Database. More service contacts were reported for males (2,123,439) than for females (1,993,625) and highest numbers were recorded for persons aged 25–34 years (906,153) and 35–44 years (849,713) (AIHW 2004).

Schizophrenia, schizotypal and delusional disorders accounted for over 48% of service contacts for which a principal diagnosis was reported (Table 6.16). Principal diagnoses of mood (affective) disorders and neurotic, stress-related and somatoform disorders accounted for 25% and 10% of these service contacts, respectively.

Table 6.16: Public community mental health service contacts by principal diagnosis^(a), 2001–02

Principal diagnosis	Number	Proportion of service contacts with a principal diagnosis (%)^(b)
Organic, including symptomatic, mental disorders	99,793	3.6
Mental and behavioural disorders due to psychoactive substance use	75,443	2.7
Schizophrenia, schizotypal and delusional disorders	1,343,960	48.1
Mood (affective) disorders	690,546	24.7
Neurotic, stress-related and somatoform disorders	268,456	9.6
Behavioural syndromes associated with physiological disturbances and physical factors	20,502	0.7
Disorders of adult personality and behaviour	111,529	4.0
Mental retardation	10,324	0.4
Disorders of psychological development	19,345	0.7
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	99,733	3.6
Other	53,862	1.9
No principal diagnosis reported, including Mental disorder not otherwise specified	1,410,238	..
Total	4,203,731	100.0

.. Not applicable.

(a) These data should be used with caution. They are from the second year of the National Community Mental Health Care Database and the quality of the principal diagnosis information is likely to have been inconsistent. No principal diagnosis information was available for service contacts in Queensland.

(b) Excluding those with a principal diagnosis of Mental disorder not otherwise specified.

Source: AIHW 2004.

Non-government organisations also provide community-based mental health-related care. For example, disability support services funded under the Commonwealth-State Disability Agreement provided 4,929 non-residential services to clients with a

psychiatric primary disability on a snapshot day in the first half of 2002, and 4,183 services to clients for whom their psychiatric disability was not their primary disability (AIHW 2004).

Residential mental health care

Specialised residential mental health care facilities are services that provide residential care with specialised mental health care staff on duty either 24 hours a day, or part-time. Some are public sector facilities and others are operated by non-government organisations.

In 2001–02, public residential mental health care facilities that were staffed for 24 hours per day had a total of 1,249 available beds, a decrease of 4% since 1998–99 (1,301 beds). A total of 1,559 overnight stays were reported. The number of beds in these facilities increased by 68% between June 1993 and June 2000 (DoHA 2002).

Non-government organisations funded under the Commonwealth-State Disability Agreement provided 2,514 residential services to clients with a psychiatric disability on a snapshot day in the first half of 2002. For 201 of these services, the client's primary disability was psychiatric (AIHW 2004).

Admitted patients in hospitals

Specialised mental health care is provided to admitted patients in public psychiatric hospitals and in specialised psychiatric units in public acute and private hospitals. There were 100,388 mental health-related separations involving specialised psychiatric care in public hospitals in 2001–02 (Table 6.17), associated with 2,041,886 patient days. Public acute hospitals accounted for 84.4% of public hospital separations and 1,034,139 (50.6%) of the days spent in hospital. The majority of public psychiatric and public acute hospitalisations were for at least one night (overnight; 84.3% and 79.0%, respectively). For private hospitals, there were 87,770 mental health-related separations involving specialised psychiatric care in 2001–02, the majority of which were same-day (74.6%). There were 493,786 patient days associated with these hospitalisations.

Separation and patient day rates varied among the jurisdictions, possibly reflecting different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals (Table 6.17). Overall, highest rates were recorded for same-day separations in Queensland and for overnight separations in South Australia. Highest patient day rates were recorded in South Australia and Tasmania.

Involuntary hospitalisation was more frequent in public psychiatric hospitals, where 41.4% of the separations were involuntary, compared with 31.5% of separations in public acute hospitals and 0.6% in private hospitals (AIHW 2004).

Of the separations with specialised care, 77,189 same-day separations (14,620 in public hospitals and 62,569 in private hospitals) could be considered to be equivalent to ambulatory mental health care (AIHW 2004). These either had psychosocial interventions as the only reported interventions, or no reported interventions.

Table 6.17: Separations with specialised psychiatric care, by state and territory and hospital type^(a), 2001–02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number									
Public acute hospitals	26,024	18,451	21,899	7,184	5,752	3,155	1,429	788	84,682
Public psychiatric hospitals	9,663	393	459	2,170	2,833	188	15,706
Private hospitals	24,370	26,973	21,692	9,952	2,520	1,947	316	n.a.	87,770
Separations, same-day	28,152	23,727	22,044	7,928	1,319	2,419	81	55	85,725
Separations, overnight	31,905	22,090	22,006	11,378	9,786	2,871	1,664	733	102,433
<i>Total separations</i>	<i>60,057</i>	<i>45,817</i>	<i>44,050</i>	<i>19,306</i>	<i>11,105</i>	<i>5,290</i>	<i>1,745</i>	<i>788</i>	<i>188,158</i>
<i>Patient days</i>	<i>1,006,820</i>	<i>422,623</i>	<i>552,633</i>	<i>223,926</i>	<i>230,933</i>	<i>70,928</i>	<i>20,666</i>	<i>7,143</i>	<i>2,535,672</i>
Number per 1,000 population									
Public acute hospitals	4.0	3.8	6.1	3.8	3.8	6.9	4.4	4.0	4.4
Public psychiatric hospitals	1.5	0.1	0.1	1.1	1.9	0.4	0.8
Private hospitals	3.7	5.6	6.0	5.2	1.6	4.1	1.0	n.a.	4.6
Separations, same-day	4.3	4.9	6.1	4.2	0.9	5.1	0.3	0.3	4.4
Separations, overnight	4.8	4.6	6.1	6.0	6.4	6.2	5.2	3.9	5.3
<i>Total separations</i>	<i>9.1</i>	<i>9.5</i>	<i>12.2</i>	<i>10.2</i>	<i>7.3</i>	<i>11.3</i>	<i>5.5</i>	<i>4.2</i>	<i>9.7</i>
<i>Patient days</i>	<i>148.8</i>	<i>82.5</i>	<i>148.9</i>	<i>115.3</i>	<i>150.2</i>	<i>149.2</i>	<i>64.8</i>	<i>38.1</i>	<i>126.7</i>

(a) Interpretation of differences between jurisdictions needs to be undertaken with care, as they may reflect different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals. Victoria has only one public psychiatric hospital. It is a forensic facility and therefore not strictly comparable with public psychiatric hospitals in other jurisdictions.

.. Not applicable.

n.a. Not available.

Source: AIHW 2004.

Excluding those separations, the most frequently recorded principal diagnosis group for overnight separations in public hospitals was schizophrenia, schizotypal and delusional disorders (28,343 separations) (Table 6.18) followed by mood (affective) disorders (21,229). For same-day separations, the most common was mood (affective) disorders (3,496). In private hospitals, the most frequently recorded principal diagnosis for both overnight and same-day separations was mood (affective) disorders (2,289 and 10,916 separations, respectively).

Principal diagnoses commonly reported for the same-day separations that could be considered ambulatory equivalent were mood (affective) disorders (3,424 separations in public hospitals and 28,575 in private hospitals) and neurotic, stress-related and somatoform disorders (3,036 in public hospitals and 16,840 in private hospitals).

Table 6.18: Separations^(a) with specialised psychiatric care by principal diagnosis and hospital type, 2001–02

Principal diagnosis	Public hospitals ^(b)		Private hospitals	
	Same-day	Overnight	Same-day	Overnight
Organic, including symptomatic, mental disorders	24	1,812	2	297
Mental and behavioural disorders due to psychoactive substance use	160	6,174	264	3,264
Schizophrenia, schizotypal and delusional disorders	810	28,343	190	2,295
Mood (affective) disorders	3,496	21,229	2,289	10,916
Neurotic, stress-related and somatoform disorders	419	9,326	156	4,004
Behavioural syndromes associated with physiological disturbances and physical factors	176	777	5	611
Disorders of adult personality and behaviour	112	4,503	33	486
Mental retardation	5	185	0	4
Disorders of psychological development	11	155	0	12
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	38	675	1	29
Other or not reported	334	7,004	11	332
Total	5,585	80,183	2,951	22,250

(a) Excludes 77,189 same-day separations categorised as ambulatory-equivalent.

(b) Includes public psychiatric hospitals.

Source: AIHW 2004.

Psychiatric hospitals

The mental health care reforms of the last decade have seen a reduction in the proportion of resources devoted to public psychiatric hospitals and a corresponding increase in resources for psychiatric units in acute care hospitals.

Between 1995–96 and 2001–02, the number of public psychiatric hospitals fell from 34 to 22 (Table 6.4), and bed numbers fell 38%, from 3,992 to 2,457 (AIHW 2002). Matching this pattern, between 1992–93 and 1999–00 there was a decrease in spending per person on these hospitals, from \$33 to \$19 per year (DoHA 2002). In 2001–02, total recurrent expenditure for these hospitals (including non-admitted patient and community services managed by the hospital) was \$445 million, and they employed an average of 5,545 full-time equivalent staff (AIHW 2004).

The reduction in public psychiatric hospitals has been accompanied by an increase in the number of psychiatric unit beds in public acute care hospitals. They increased by 51% between 1992–93 and 1999–00, during which time there was an increase in spending on them from \$15 to \$23 per person per year (DoHA 2002). In 2001–02, there were 107 public acute hospitals with specialised psychiatric units, with a total of 2,199 beds (AIHW 2004).

In 2001–02, there were 24 private psychiatric hospitals (ABS 2003a). They had a total of 1,387 beds, within the range reported for 1998–99 to 2000–01 (1,344 to 1,471). These hospitals had an expenditure of \$144 million, and employed an average of 1,707 full-time equivalent staff, mainly nurses (919).

Vietnam Veterans Counselling Service

The prevalence of anxiety disorders, depression and post-traumatic stress disorder was found to be higher in male Vietnam veterans than expected in the community generally (DVA 1998). In a survey conducted in 1997, anxiety disorders were reported by 41% of responding veterans, higher than expected based on the prevalence of anxiety disorders in the general community (31%). Depression (45%) and post-traumatic stress disorder (31%) were also more common than expected (36% and 8% respectively).

The DVA recognises these conditions as consequences of war-related service and established the Vietnam Veterans Counselling Service (VVCS) to help veterans cope with them. The VVCS offers free services to veterans of all conflicts, including those from peacekeeping missions. Partners of veterans are also eligible, as are the sons and daughters of Vietnam veterans. The service operates from 15 centres across Australia and provides services in rural, remote and outer metropolitan areas through more than 320 Outreach Program counsellors.

Services include counselling, therapeutic and educational group programs, community development and health promotion. There are specialist projects such as one aimed at promoting cardiovascular fitness, and another at sons and daughters to combat suicide. VVCS also provides an after-hours telephone crisis counselling service known as Veterans Line.

Outreach Program counselling session numbers numbered 33,385 in 2002–03 and there were 6,499 calls to the Veterans Line (Table 6.19).

Table 6.19: Vietnam Veterans Counselling Service activity, 2002–03

Service	Number
Outreach Program counselling sessions	33,385
Veterans Line calls	6,499
Centre-based counselling	
Hours	25,656
Clients	13,097
Services	30,048

Source: Department of Veterans' Affairs, unpublished data.

6.5 Use of medications

The use of medications is the most common health-related action taken by Australians (ABS 1997). Estimates from the National Health Survey in 1995 were that 59.1% of Australia's population had used some form of conventional medication (medications other than homeopathic, herbal, nutritional, and other complementary and alternative medicines) in the two weeks before the interview. About 25.8% had used vitamins or minerals and 1.7% had used herbal or natural medications.

Prescription medications are provided largely through community pharmacies and hospitals, whereas non-prescription medicines and complementary and alternative medicines are available from pharmacies and other retail outlets. At 30 June 2002, there were 4,926 approved community pharmacies in Australia (Pharmacy Guild of Australia 2004).

Prescribed medicines

Information on the supply of prescription medicines in the community is compiled by the Health Insurance Commission. This information is derived from prescriptions submitted for subsidy payment under the Pharmaceutical Benefits Scheme or the Repatriation Pharmaceutical Benefits Scheme (PBS and RPBS, see Box 6.5) and estimates of the use of non-subsidised prescription medicines, calculated from data collected for the Pharmacy Guild of Australia's ongoing survey of community-based pharmacies. Data are not available on the use of prescribed medicines in public hospitals and most private hospitals.

In 2002–03, there were 158.5 million community PBS prescriptions, 25.9 million for general patients and 132.7 million for concessional patients (DoHA 2004). This was an increase of 2.6% over the 154.5 million in 2001–02 and of 7.4% over the 147.6 million in 2000–01. Additionally, there were 15.4 million RPBS prescriptions in 2002–03 and 0.5 million PBS doctor's bag prescriptions.

In 2002–03 there were about 42.1 million prescriptions which did not attract a subsidy (26.0 million below the co-payment threshold and about 16.1 million private prescriptions, that is, prescriptions for drugs not covered by the PBS or RPBS) (DoHA unpublished data).

Apparent use of prescription medicine can be described using defined daily dose per 1,000 population per day (DDD/1,000/day) as the unit of measurement. The DDD is based on the assumed average dose per day of the drug, used for its main indication (reason for use) by adults. It provides an estimate of how many people per 1,000 population are taking the standard dose of the drug each day, on average, and allows for comparisons independent of differences in quantities of drugs per prescription. These measures assume, however, that the amount of medicines supplied is the same as the amount used, and that will not always be the case.

In 2002–03, atorvastatin (used for blood lipid (cholesterol) reduction) was the most commonly used drug using the DDD/1,000/day measurement (Table 6.20), followed by simvastatin (also used for blood lipid reduction) and diltiazem hydrochloride (a calcium channel blocker used for the treatment of chest pain and high blood pressure).

The top three generic medications by prescription volume in 2002–03 were atorvastatin and simvastatin (6.2 million and 5.5 million prescriptions respectively), followed by omeprazole (an anti-ulcer drug, 4.7 million prescriptions) and salbutamol (a bronchodilator mainly used for asthma, 4.4 million prescriptions). For most of these high-volume prescriptions, the vast majority were provided through the PBS or RPBS; however, salbutamol was provided as a non-PBS/RPBS prescription on 1.1 million occasions (24.4%) (Table 6.20).

Box 6.5: The Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) subsidises the cost of a wide range of prescription medications, providing Australians with access to necessary and cost-effective medicines at an affordable price. As at 1 February 2004, the scheme covered

- *602 generic drugs in 1,502 forms and strengths (items) marketed as 2,617 different drug products (brands) as general listings*
- *10 generic drugs in 42 forms and strengths marketed as 48 products as palliative care listings*
- *78 generic drugs in 209 forms and strengths marketed as 475 products as dental listings*
- *27 generic drugs in 34 forms and strengths marketed as 51 products as Doctor's bag listings*
- *75 generic drugs in 257 forms and strengths marketed as 273 products as Section 100 listings.*

Section 100 medicines are distributed through arrangements other than community pharmacies as appropriate, for example through hospitals with access to appropriate specialist facilities. They include medications for chronic conditions provided under the Highly Specialised Drugs Program.

Before a medicine can be subsidised by the PBS, it is assessed by the Pharmaceutical Benefits Advisory Committee, which includes medical practitioners, other health professionals and a consumer representative. The committee takes into account the medical conditions for which the medicine has been approved for use in Australia by the Therapeutic Goods Administration, its clinical effectiveness, safety and cost-effectiveness compared with other treatments. Once a medicine has been recommended by the committee, it is considered by the Pharmaceutical Benefits Pricing Authority, the price is negotiated between the manufacturer and the Department of Health and Ageing, and the listing is then considered by the Australian Government.

Australian residents and visitors from those countries with which Australia has a Reciprocal Health Care Agreement are eligible for PBS benefits. Patients are grouped into two classes. General patients pay the first \$23.70 for each prescription item. Concessional patients (people with low incomes and sickness beneficiaries who hold a health care card) make a copayment of \$3.80 per prescription item.

Individuals and families are protected from large overall expenses for PBS-listed medicines by safety nets. Once a general patient and/or immediate family has spent \$726.80 in a calendar year, the patient co-payment per item decreases to the concessional rate of \$3.80 per item. For concessional patients, the \$3.80 co-payment is not required once their expenditure on PBS items exceeds \$197.60 in a calendar year. These co-payments and safety net thresholds are indexed according to movements in the Consumer Price Index from 1 January each year.

(continued)

Box 6.5 (continued): The Pharmaceutical Benefits Scheme

Patients may pay more than the standard co-payment where a PBS item is priced above the benchmark price for different brands of the same drug or the benchmark price for a particular therapeutic group of drugs. These additional payments do not count towards safety nets.

The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides assistance to eligible war veterans and dependants. It is generally similar to the PBS for concessional beneficiaries and covers 172 additional generic drugs available in 368 forms and strengths marketed as 422 products.

Table 6.20: Top 15 generic medications by defined daily dose per 1,000 population per day, 2002-03

Generic name	Action	Defined daily dose per 1,000 population			Prescriptions		
		PBS/RPBS	Other ^(a)	Total	PBS/RPBS	Other ^(a)	Total
Atorvastatin	Blood lipid-reducing	66.05	0.10	66.15	6,202,867	11,720	6,214,587
Simvastatin	Blood lipid-reducing	43.48	0.04	43.52	5,460,842	4,763	5,465,605
Diltiazem hydrochloride	Anti-angina and anti-hypertensive	41.09	0.19	41.28	1,529,054	1,509	1,530,563
Salbutamol	Bronchodilator	20.44	7.49	27.93	3,317,652	1,071,413	4,389,065
Ramipril	Anti-hypertensive	26.30	0.56	26.86	2,501,351	135,253	2,636,604
Omeprazole	Anti-ulcer	22.61	0.05	22.66	4,664,881	10,124	4,675,005
Rofecoxib	Anti-inflammatory	20.62	0.14	20.77	2,929,013	19,238	2,948,251
Fruzemide	Diuretic	19.46	1.25	20.70	1,376,031	92,914	1,468,945
Irbesartan	Anti-hypertensive	18.07	0.10	18.18	3,073,831	39,993	3,113,824
Irbesartan with hydrochlorothiazide	Anti-hypertensive	17.63	0.04	17.67	2,380,637	5,784	2,386,421
Aspirin	Analgesic, anti-coagulant	15.62	1.07	16.68	1,352,338	103,574	1,455,912
Amlodipine besylate	Anti-hypertensive	15.16	1.07	16.23	2,326,904	24,1086	2,567,990
Celecoxib	Anti-inflammatory	15.76	0.14	15.90	3,534,851	32,018	3,566,869
Sertraline	Antidepressant	15.72	0.09	15.82	2,440,835	12,784	2,453,619
Thyroxine sodium	Thyroid hormone replacement	9.60	4.90	14.50	623,686	298,135	921,821

Note: PBS—Pharmaceutical Benefits Scheme; RPBS—Repatriation Pharmaceutical Benefit Scheme.

(a) Prescriptions not subsidised by the PBS or RPBS, because they were private prescriptions or the cost to the patient was not more than the patient co-payment.

Source: Drug Utilisation Sub-Committee Database (DoHA, unpublished) as at 12 January 2004.

The use of some prescription medicines has changed markedly over the last few years. For example, between 2001–02 and 2002–03 there was a nearly four-fold increase in the DDD/1,000 population/day for rofecoxib (an anti-inflammatory). Conversely there was a 46% decrease in the DDD/1,000 population/day for celecoxib (also an anti-inflammatory) over this period (Table S40). The DDD/1,000 population/day for the blood pressure lowering ramipril increased by 109% between 2000–01 and 2002–03, but the increase in prescription volume for this drug was less marked (66%).

Atorvastatin, simvastatin and omeprazole were the highest cost drugs for the PBS in 2002–03, with PBS expenditure on them totalling \$364.7 million, \$328.8 million and \$220.1 million respectively. The next most costly were salmeterol and fluticasone (a bronchodilator and anti-inflammatory combined, \$167.5 million) and olanzapine (an antipsychotic agent, \$144.0 million) (DoHA 2004). Between 2000–01 and 2002–03, expenditure on atorvastatin, simvastatin and omeprazole increased by 16%, 11% and 9% respectively. For salmeterol and fluticasone, expenditure increased by 32% and expenditure on olanzapine increased by 9% (DoHA 2003b).

The BEACH survey of general practice activity collects information on drugs prescribed by GPs (AIHW: Britt et al. 2003). In 2002–03, medications were prescribed at a rate of 84.3 per 100 encounters. Antibiotics were the most commonly prescribed group, accounting for 16.4% of all prescriptions. The next most common were cardiovascular medications (15.5%), central nervous system medications (12.5%), psychological medications (8.3%), musculoskeletal medications (6.8%) and respiratory medications (6.3%).

The most frequently prescribed individual generic medications are listed in Table 6.21. Four of the top ten drugs are from the antibiotic group. Simple analgesics were also frequently prescribed, reflecting their prescription for health care card holders for whom they are a cheaper option than over-the-counter purchase.

Table 6.21: Medications most frequently prescribed by GPs, 2002–03

Generic name	Action	Proportion of prescriptions (per cent)	Prescriptions per 100 encounters
Paracetamol	Analgesic	3.7	3.1
Amoxycillin	Antibiotic	3.7	3.1
Paracetamol+codeine	Analgesic	2.4	2.0
Cephalexin	Antibiotic	2.3	1.9
Salbutamol	Bronchodilator	2.0	1.7
Amoxycillin+potassium clavulanate	Antibiotic	1.9	1.6
Influenza virus vaccine	Vaccine	1.7	1.4
Roxithromycin	Antibiotic	1.6	1.3
Temazepam	Sedative	1.4	1.2
Rofecoxib	Anti-inflammatory	1.4	1.2

Source: AIHW: Britt et al. 2003.

Non-prescribed medicines

The BEACH survey collects and reports information on drugs that GPs advise patients to purchase over the counter, and those that the GPs supply directly (AIHW: Britt et al. 2003).

In 2002–03, 9.8% of medications prescribed, advised or provided by GPs were advised for over-the-counter purchase, and 9.0% were supplied by the GP. Australia-wide, this would represent nearly 10 million recommendations for the purchase of drugs, and over 9.3 million supplies of drugs by GPs. Over a quarter of drugs (25.1%) advised for over-the-counter purchase were for paracetamol and 6.5% for ibuprofen (an anti-inflammatory drug). The most common medications supplied by GPs were vaccines (influenza virus vaccine and oral polio vaccine) and rofecoxib (an anti-inflammatory).

Complementary and alternative medicines

In addition to the prescribed pharmaceuticals and other conventional medications, some Australians use a range of complementary and alternative medicines, including homoeopathic, herbal and nutritional medications.

A study in 2000 estimated that 60% of women and 44% of men in South Australia had used alternative medicines in the previous year. Most commonly used were non-prescribed vitamins (32% of males and 41% of females), aromatherapy oils (8% of males and 22% of females), herbal medicines (10% of males and 17% of females) and mineral supplements (10% of males and 12% of females). There had been a significant increase in use of alternative medicines by females compared with 1993 (55%), with greatest increases in the use of herbal medicines, aromatherapy oils and ginseng. It was estimated that average expenditure per person per year on alternative medicines was \$315, or the equivalent of \$1.67 billion for Australia for 2000. This represented an increase of 120% (after adjusting for inflation) over the expenditure estimated for 1993 (\$0.62 billion) (MacLennan et al. 2002).

6.6 Alcohol and other drug treatment services

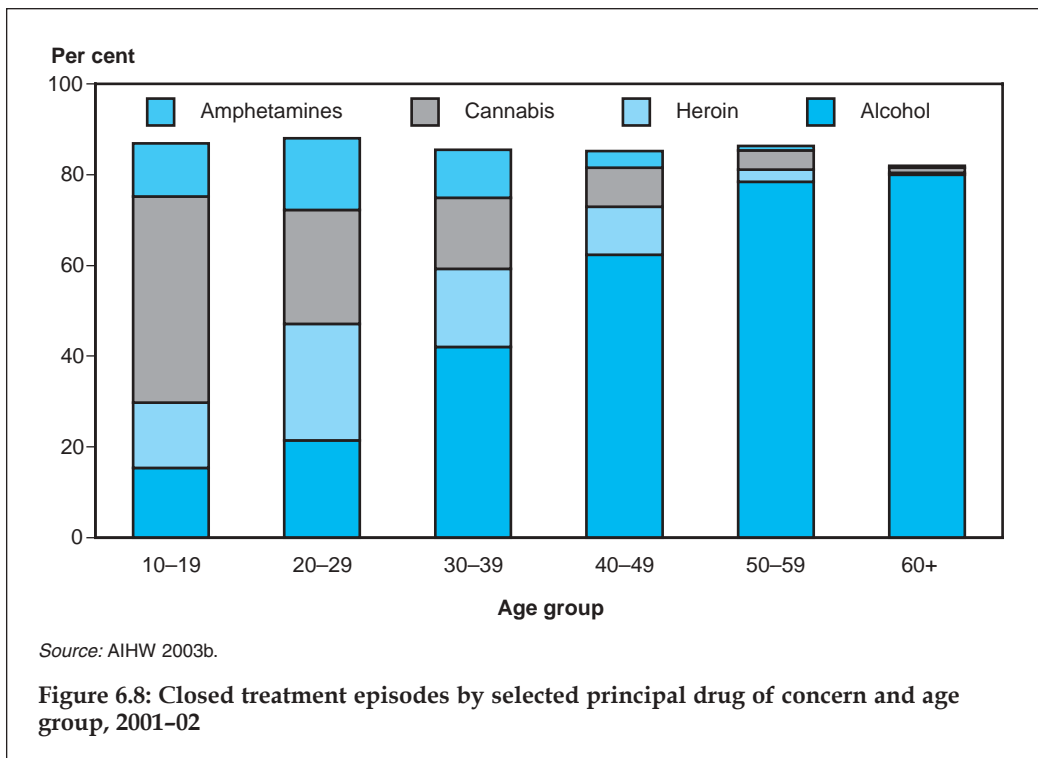
Alcohol and other drug treatment services cover a wide variety of treatment interventions and include detoxification and rehabilitation programs, information and education courses, and pharmacotherapy and counselling treatments, provided in both residential and non-residential settings. In 2001–02, 505 treatment agencies reported data for the Alcohol and Other Drug Treatment Services National Minimum Data Set, with 51% identified as non-government agencies (AIHW 2003a). This data set covers almost all government-funded treatment agencies. Major exceptions are services that are specific for Aboriginal and Torres Strait Islander peoples (as described in Section 6.7) and those for which the sole treatment provided is methadone treatment (opioid pharmacotherapy maintenance).

In 2001–02, 'closed treatment episode' data were collected for the AODTS-NMDS. A closed treatment episode refers to a period of contact between a client and a treatment

agency with defined dates of commencement and cessation. A closed treatment episode could be for a single treatment (such as education and information only) that may be part of a larger treatment plan. During 2001–02, there were 120,869 closed treatment episodes in these 505 alcohol and other drug treatment services (AIHW 2003a). Male clients accounted for close to two-thirds (65%) of these episodes. The majority of episodes were for clients aged between 20 and 49 years (77%), with just over one-third of all episodes (34%) provided for clients in the 20–29-year age group.

Principal drug of concern

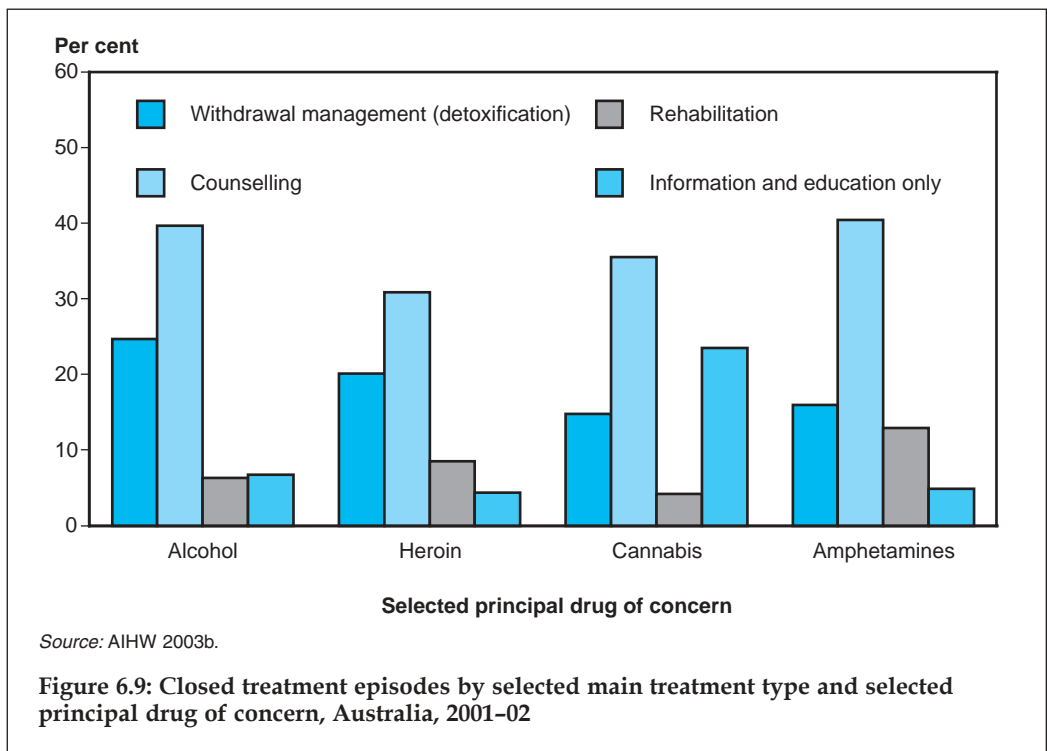
The principal drug of concern refers to the main substance that clients state led them to seek treatment from the alcohol and other drug treatment agency. In 2001–02, there were 113,231 episodes where clients were seeking treatment for their own substance use and nominated a principal drug of concern. Nationally, alcohol (37%) and cannabis (21%) were the most common principal drugs of concern to clients in closed treatment episodes, followed by heroin (18%) and amphetamines (11%) (AIHW 2003a). Cannabis was the drug most commonly recorded for clients in the 10–19-year age group (46%), whereas for clients in the 20–29-year age group heroin was the most common drug (26%) (Figure 6.8). Alcohol was nationally the most commonly reported principal drug of concern (37% of episodes) and was reported for higher proportions of clients aged over 30 years, with highest proportions for clients aged 60 years and over (80%) and clients aged 50–59 years (79%).



Treatment programs

In 2001–02, counselling was the most common form of main treatment provided (39% of closed treatment episodes), followed by withdrawal management (detoxification) (19%), assessment only (without treatment) (15%), and information and education only (without treatment) (10%) (AIHW 2003a). Rehabilitation was the main treatment in 6% of episodes.

The type of main treatment provided varied depending on the principal drug for which the client sought treatment. Closed treatment episodes where the principal drug was alcohol were more likely to involve withdrawal management (detoxification) (25%) than treatment episodes where the principal drug was cannabis (15%) (Figure 6.9). Treatment episodes for amphetamine use were more likely to include counselling (40%) than treatment episodes for heroin use (31%).



6.7 Primary health care services for Aboriginal and Torres Strait Islander peoples

Section 4.6 of this report provides data on the health status of, hospitalisation rates for and use of GPs by Aboriginal and Torres Strait Islander people, demonstrating that the pattern of use of these mainstream services is different for Indigenous peoples compared with the rest of the Australian population. Health expenditure data (Section 5.2) reinforce this point.