

1 Overview

Mental Health Services in Australia 2003–04 is the seventh 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 in 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 changes in the level and type of activity of some mental health-related services.

General practice

In 2004–05 there were an estimated 10 million mental health-related general practice encounters (Britt et al. 2005). The contribution of general practice to mental health care has remained relatively stable in recent years. In 2004–05 the estimated number of mental health-related general practice encounters was 505 encounters per 1,000 population (Figure 1.1 and Table 3.1).

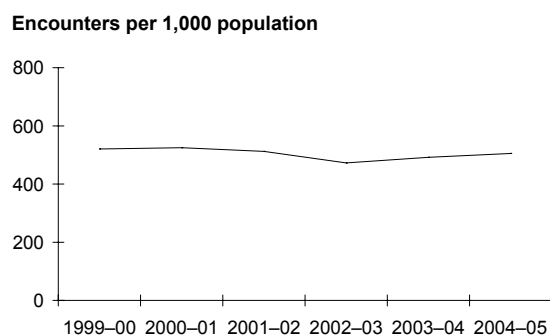


Figure 1.1: Mental health-related general practice encounters per 1,000 population, 1999–00 to 2004–05

Private psychiatrists

In 2004–05 there were over 2 million Medicare-funded psychiatrist attendances,

provided at a rate of 99.3 attendances per 1,000 population. This rate has declined each year since 1999–00 (Figure 1.2 and Table 3.1).

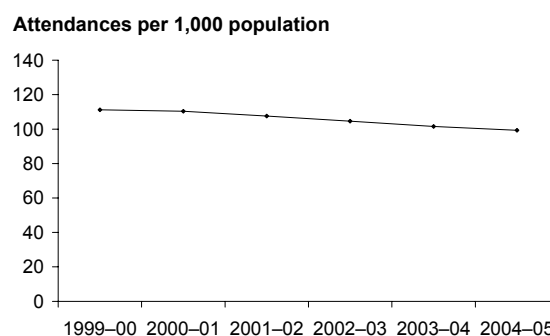


Figure 1.2: Medicare-funded psychiatrist attendances per 1,000 population, 1999–00 to 2004–05

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 2003–04 there were over 4.9 million mental health service contacts in public hospital outpatient clinics and community-based mental health services. This equated to 246.5 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.

Ambulatory-equivalent separations

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 83,442 in 1999–00 to 111,581 in 2003–04. The number per 1,000 population increased in the private sector by 50.0% and decreased in the public sector by 23.5% (Figure 1.3 and Table 3.1). For more information on these

ambulatory-equivalent separations, see Chapter 3 and Appendix 2.

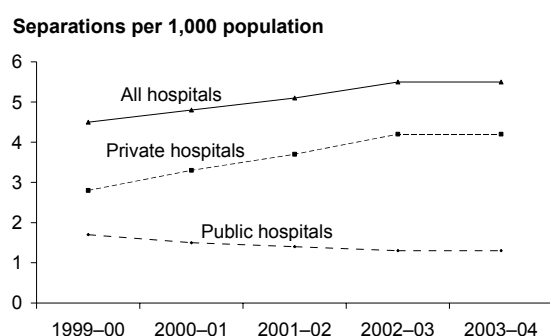


Figure 1.3: Ambulatory-equivalent mental health-related separations per 1,000 population, by hospital sector, Australia, 1999-00 to 2003-04

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 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 197,712 mental health-related separations not considered to be ambulatory-equivalent in 2003-04.

The number of these separations was relatively stable between 1999-00 and 2003-04, increasing at an average annual rate of 2.2% (Figure 1.4). Over this period, separations from public acute hospitals and private hospitals increased by 12.0% and 4.5% respectively, however separations from public psychiatric hospitals decreased by 5.3% (Table 4.1).

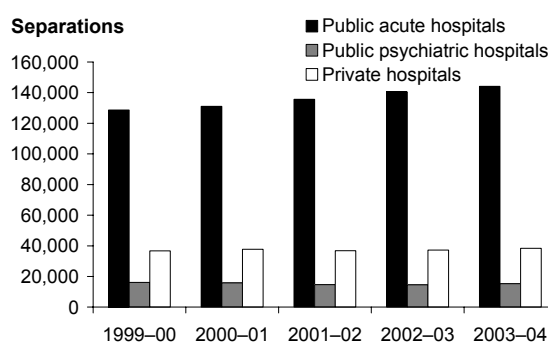


Figure 1.4: Non-ambulatory-equivalent mental health-related separations by hospital type, 1999-00 to 2003-04

The number of separations per 1,000 population by hospital type for the period 1999-00 to 2003-04 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, especially for public psychiatric hospitals, for which numbers of very extended stays were reported, particularly in 1999-00.

There were 2,737,443 patient days attributed to non-ambulatory-equivalent mental health-related separations in 2003-04. The number of patient days for public acute hospitals and private hospitals increased by 7.7% between 1999-00 and 2003-04, the number for private hospitals increased by 3.5%, and the number for public psychiatric

hospitals decreased by 41.6% (Table 4.1 and Figure 1.5).

The number of non-ambulatory-equivalent mental health-related patient - days per 1,000 population by hospital type for the period 1999-00 to 2003-04 is available on the Internet at <www.aihw.gov.au>.

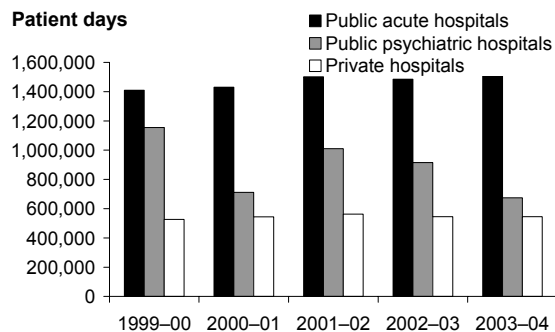


Figure 1.5: Patient days for mental health-related separations, by hospital type, 1999-00 to 2003-04

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 was relatively stable between 1999-00 and 2003-04. In 1999-00, the ALOS was 11.0 days and had decreased to 10.5 days in 2003-04 (Table 4.1 and Figure 1.6). Private hospital separations had longer average lengths than public acute hospital separations, at 14.2 days for 2003-04. In 2003-04, the median lengths of stay for public acute and private hospitals were 4 and 9 days, respectively.

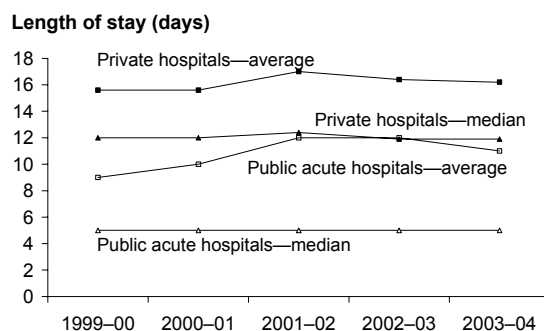


Figure 1.6: Average and median length of stay for selected mental health-related overnight separations, by hospital type, 1999-00 to 2003-04

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 types of disorders treated by the service providers.

General practice

In 2003-04, 60.0% of mental health-related general practice encounters were with female patients, consistent with all general practice encounters. There were more mental health-related general practice encounters with females than with males (Figure 1.7 and 3.2). Most encounters were with persons in the 25-64 years age range.

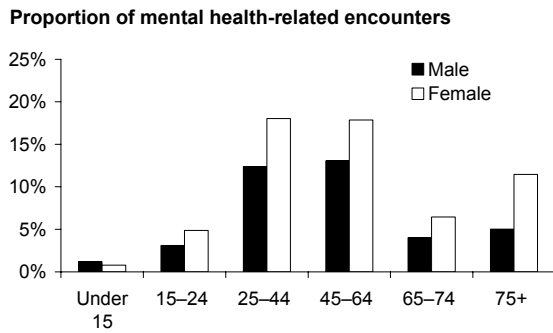


Figure 1.7: Mental health-related general practice encounters, by age group and sex of patient, 2003-04

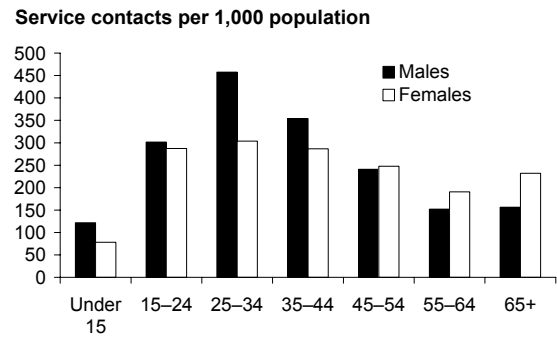


Figure 1.9: Community mental health service contacts per 1,000 population, by age group and sex of patient, 2003-04

Private psychiatrists

The patient age and sex distribution for Medicare-funded attendances with private psychiatrists was similar to that for general practice. In 2004-05, 60.7% of these attendances were for female patients. There were 119.8 attendances per 1,000 population for females, compared with 78.6 for males. The rate was higher for females than for males in all age groups except for patients under 15 years (Figure 1.8 and Table 3.19).

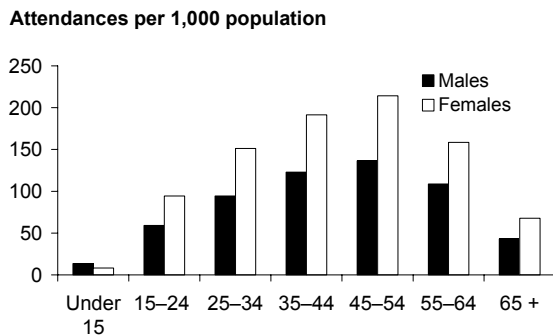


Figure 1.8: Medicare-funded psychiatrist attendances per 1,000 population, by age group and sex of patient, 2004-05

Community mental health services

In 2003-04 there were more government-operated community-based mental health service contacts for male (51.7%) than for female patients. There were 256.4 service contacts per 1,000 population for males, compared with 226.0 for females. Male patients dominated the age groups below 45 years and females dominated the older age groups (Figure 1.9 and Table 3.26).

Ambulatory-equivalent separations

In 2003-04 there were 44,346 ambulatory-equivalent separations for male patients (39.7%) and 67,235 for female patients (60.3%). The numbers of service contacts per 1,000 population for male patients who received ambulatory-equivalent care was highest for the 55-64 years age group (8.1 attendances per 1,000 population) and for the 45-54 years age group for females (10.4 attendances per 1,000 population) (Figure 1.10 and Tables 3.36 and 3.37). For more information on these ambulatory-equivalent separations, see Chapter 3 and Appendix 2.

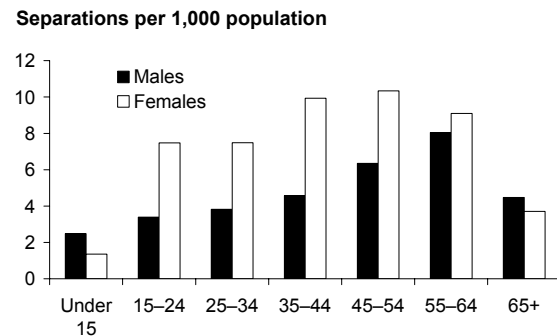


Figure 1.10: Ambulatory-equivalent mental health-related separations per 1,000 population, by age group and sex of patient, 2003-04

Hospital admitted patient care

In 2003-04 there were 197,728 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, see Chapter 3 and Appendix 2.

Of the 197,728 non-ambulatory-equivalent mental health-related separations, 52.5% were for female patients. There were 10.3 of these separations per 1,000 population for females, compared with 9.5 for males. The rate was higher for females in all age groups above 35 years and between 15 and 24 years (Figure 1.11).

In 2003-04, there were 1,397,372 patient days for male patients compared with 1,340,302 for females. There were 140.7 days per 1,000 population for males, compared with 133.4 for females. The rates were higher for males than for females in all age groups except for the under 15 years and 55-64 years age groups, where rates for females were higher (Tables 5.1 and 6.1).

Separations per 1,000 population

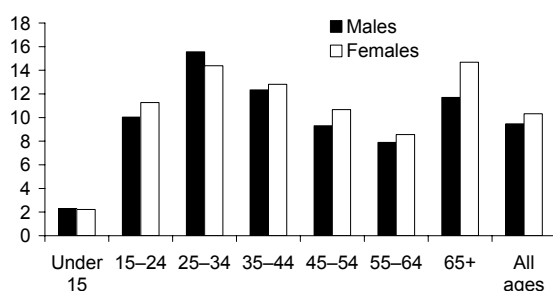


Figure 1.11: Non-ambulatory-equivalent mental health-related separations per 1,000 population, by age group and sex of patient, 2003-04

Patient's area of usual residence

This section presents summary information on service use by the area of usual residence of the patient.

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 1.12 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 (5.9) and lowest for those living in remote areas (2.7).

The opposite was true for separations without specialised psychiatric care. There the rate was highest for patients living in remote areas (8.0) and lowest for those living in major cities (3.4).

Separations per 1,000 population

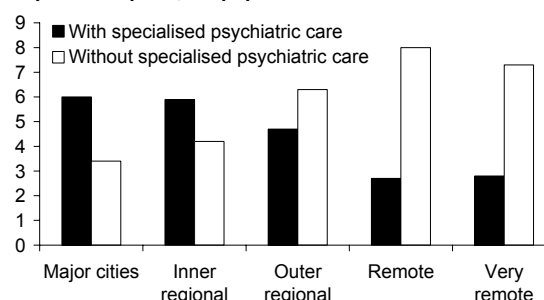


Figure 1.12: Non-ambulatory-equivalent mental health-related separations per 1,000 population, by Remoteness Area of usual residence, 2003-04

Aboriginal and Torres Strait Islander peoples

Discussions of mental health among Aboriginal and Torres Strait Islander leaders in health care and information have centred around 'social and emotional wellbeing', a holistic concept reflecting individual, family and community experience. Indigenous people's 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

In South Australia, Western Australia, Queensland and the Northern Territory, the number of ambulatory-equivalent mental health-related separations per 1,000 Aboriginal and Torres Strait Islander peoples was lower than that for other Australians (2.6 compared with 4.3) (Table 3.38).

This was particularly the case for ambulatory-equivalent separations with specialised psychiatric care. The number of these separations per 1,000 Aboriginal and Torres Strait Islander peoples was less than one-quarter the rate for other Australians (0.9 compared with 4.2) (Figure 1.13 and Table 3.38).

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 for other Australians (1.9 compared with 1.2) (Figure 1.13 and Table 3.38).

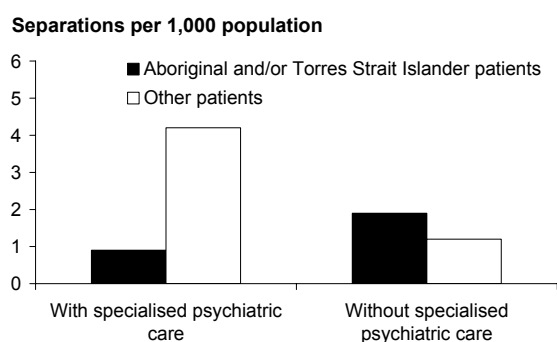


Figure 1.13: Ambulatory-equivalent mental health-related separations per 1,000 population, by Indigenous status, 2003-04

Hospital admitted patient care

In South Australia, Western Australia, Queensland, and public hospitals in the Northern Territory and, the number of non-ambulatory-equivalent mental health-related separations per 1,000 Aboriginal and Torres Strait Islander peoples was more than double that for other Australians (20.8 compared with 9.2) (Figure 1.14 and Tables 5.6 and 6.3).

The difference in rates between the two groups was not as pronounced for non-ambulatory-equivalent separations with specialised psychiatric care. The rate of these separations per 1,000 Aboriginal and Torres Strait Islander persons was lower than the rate for other Australians (8.8 compared with 6.2) (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 persons was four times that of other Australians (12.0 compared with 3.0) (Figure 1.15 and Table 6.3).

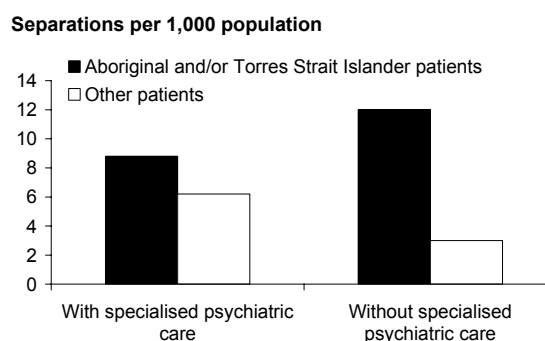


Figure 1.14: Non-ambulatory-equivalent mental health-related separations per 1,000 population, by Indigenous status, 2003-04

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 Indigenous people live in remote areas (27%) compared to other Australians (2%) (AIHW & ABS 2005), and there are fewer specialised care facilities in these areas. In 2003-04, there were no public psychiatric hospitals and only one public acute care hospital with a psychiatric unit or ward with 1.2 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 2005). In 2003-04 in major cities, there were 11 public psychiatric hospitals with 12.9 available beds per 100,000 population, and 85 public acute care hospitals with psychiatric units or wards with 19.9 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 for overnight separations without specialised psychiatric care stay in

the Northern Territory, South Australia, Queensland and Western Australia, (3.3 days compared with 7.2 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 therefore these data need to be used with caution. Only data for Queensland, Western Australia, South Australia and public hospitals in the Northern Territory were used in these analyses, because the quality of the data from other jurisdictions was not sufficient. The data from these four jurisdictions does not necessarily reflect the other four jurisdictions.

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 problems and physical disturbances (mainly sleep disturbance) (Figure 1.15 and Table 3.6).

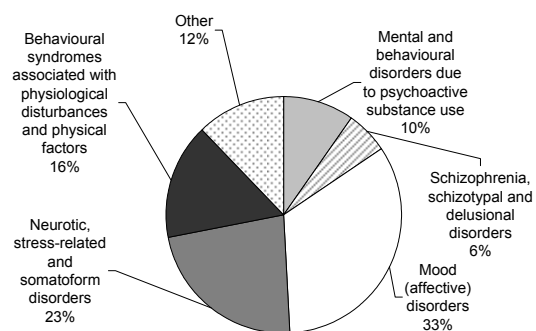


Figure 1.15: Mental health-related problems managed by general practitioners, 2003–04

Community mental health services

The mental disorders treated in government-operated community-based ambulatory mental health services and hospital outpatient services in 2003–04 included low-prevalence disorders such as *Schizophrenia, schizotypal and delusional disorders* (Figure 1.16 and Table 3.33).

These data should be interpreted with caution because no principal diagnosis information was available for 32.7% of service contacts.

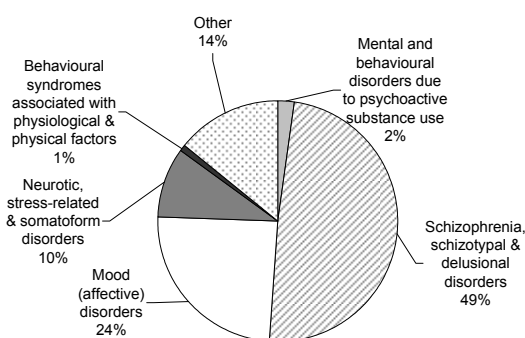


Figure 1.16: Principal diagnoses for community mental health service contacts, 2003–04

Ambulatory-equivalent separations

The most common principal diagnoses for ambulatory-equivalent mental health-related separations with specialised psychiatric care were *Mood (affective) disorders* (46%) and *Neurotic, stress-related and somatoform disorders* (22%) (Figure 1.17).

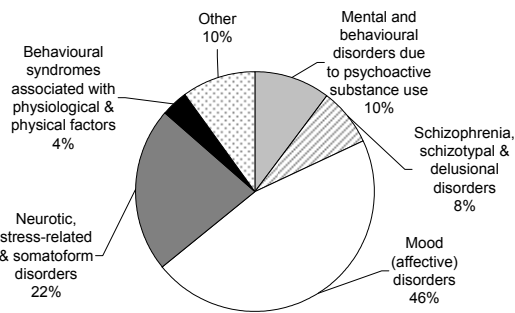


Figure 1.17: Principal diagnoses for ambulatory-equivalent mental health-related separations with specialised psychiatric care, 2003-04

The most common principal diagnoses for ambulatory-equivalent mental health-related separations without specialised psychiatric care, were *Mental and behavioural disorders due to psychoactive substance use* (37%) and *Neurotic, stress-related and somatoform disorders* (20%) (Figure 1.18).

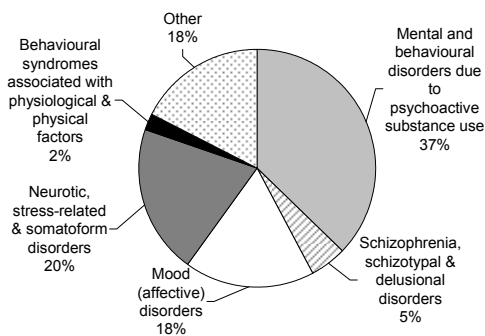


Figure 1.18: Principal diagnoses for ambulatory-equivalent mental health-related separations without specialised psychiatric care, 2003-04

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, 56.6% or 90,230 public hospital separations included a

component of specialised psychiatric care, that is, care in a specialised psychiatric unit or hospital. This compares with 69.1% or 26,495 separations with a component of specialised psychiatric care in private hospitals (Tables 5.2 and 6.2).

Public hospitals

In 2003-04, *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 1.19 and Tables 5.9 and 6.6).

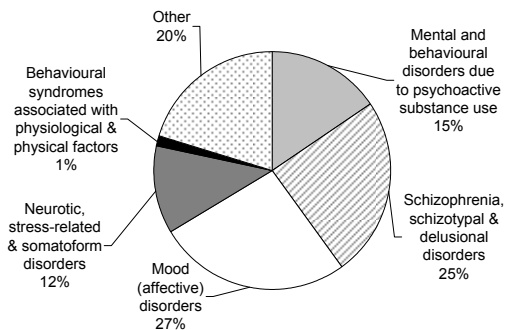


Figure 1.19: Principal diagnoses for non-ambulatory-equivalent mental health-related separations, public hospitals, 2003-04

A high proportion of separations with principal diagnoses of *Schizophrenia, schizotypal and delusional disorders* and *Mood (affective) disorders* had specialised psychiatric care (Figure 1.20 and Tables 5.9 and 6.6).

Proportion of separations

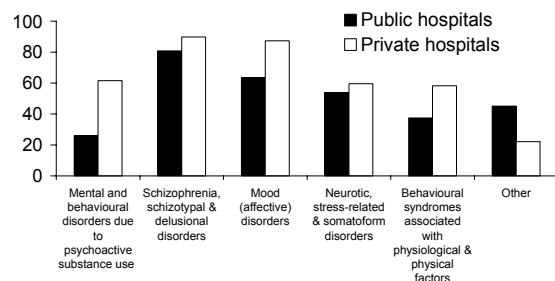


Figure 1.20: Non-ambulatory-equivalent mental health-related separations with specialised psychiatric care, 2003-04

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 1.21 and Tables 5.9 and 6.6).

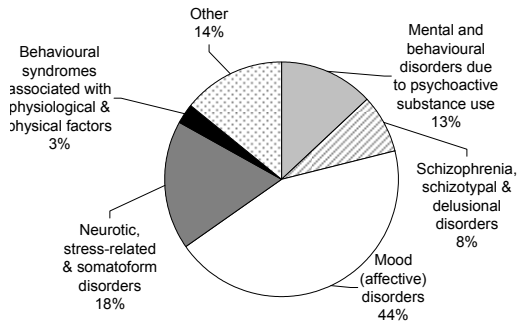


Figure 1.21: Principal diagnoses for non-ambulatory-equivalent mental health-related separations, private hospitals, 2003-04

1.4 Medication

This report presents data on mental health-related medication subsidised through the Pharmaceutical Benefits Scheme (PBS) and the 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 details). For psychiatrists, all medications prescribed are included.

In 2004-05, mental health-related medications accounted for 11.0% (18.4 million) of all the medications prescribed by general practitioners (Table 3.15 and unpublished PBS and RPBS data). Private psychiatrists prescribed a total of 1.99 million medications (Table 3.23).

In 2004-05, antidepressants were the most frequently prescribed mental health-related medication, accounting for 60.9% of mental health-related medications, 54.2% of medication prescribed by psychiatrists and 61.0% of mental health-

related medication prescribed by general practitioners (Tables 3.15 and 3.23).

Prescriptions per 1,000 population

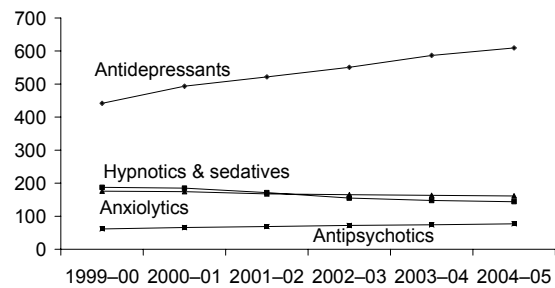


Figure 1.22: Selected PBS and RPBS-funded mental health-related prescriptions per 1,000 population, 1999-00 to 2004-05

Between 1999-00 and 2004-05, there was an increase in the number of antidepressant and antipsychotic PBS and RPBS-subsidised medications and a decrease in the numbers for hypnotics and sedatives and anxiolytics (Figure 1.22 and Tables 3.14 and 3.22).

1.5 Labour force

This report presents data on two mental health-related professions for which there are recent national data available: psychiatry and mental health nursing. Labour force data were collected in conjunction with the annual registration renewal of these practitioners.

Psychiatrists

Psychiatrists included in the data 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 2003, Australia had 14.1 full-time equivalent (FTE) psychiatrists per 100,000 population (including 1.0 FTE non-clinicians) and 3.2 FTE psychiatrists-in-training per 100,000 population (Table 7.1).

FTE data are based on a working week for specialists of 45 hours.

Major cities had a relatively high number of FTE psychiatrists per 100,000 population (Figure 1.23 and Table 7.1). Remote and very remote areas had the fewest FTE psychiatrists per 100,000 population, as had been the case since 1999.

FTE psychiatrists per 100,000 population

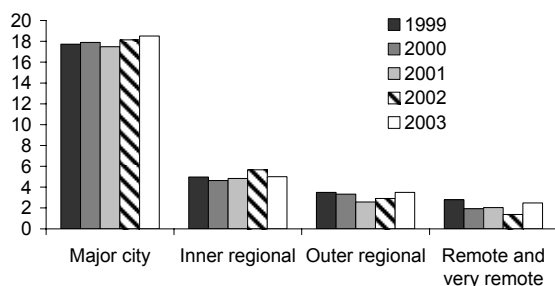


Figure 1.23: Full-time equivalent psychiatrists per 100,000 population, by Remoteness Area, 1999 to 2003

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 2003, 12,354 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 64.8 FTE mental health nurses per 100,000 population in 2003, a level consistent with previous years. FTE data are based on a working week of 35 hours. Major cities and inner regional areas had a relatively high number of FTE mental health nurses per 100,000 population (Figure 1.24). Remote and very remote areas had fewer of these nurses per 100,000 population, with rates decreasing between 1999 and 2003.

FTE mental health nurses per 100,000 population

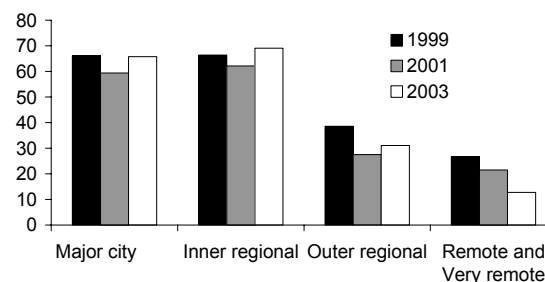


Figure 1.24: Full-time equivalent mental health nurses per 100,000 population, by Remoteness Area, 1999 to 2003

In 2003, just under two-thirds of FTE mental health nurses were female. The majority of FTE mental health nurses were in the 45–54 and 34–44 year age groups (38.8% and 28.1%, respectively) (Figure 1.25 and Table 7.7).

FTE mental health nurses

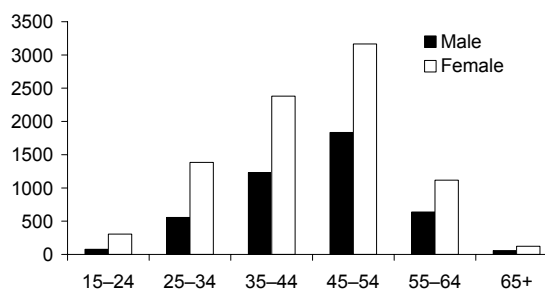


Figure 1.25: Full-time equivalent mental health nurses, by age and sex, Australia, 2003

1.6 Psychiatric hospitals and community and residential mental health services

This section summarises data on the characteristics of public and private psychiatric hospitals and government-operated community and residential mental health services.

Available beds

In 2003–04 there were 20 public psychiatric hospitals, 25 private

psychiatric hospitals, and government-operated community and residential mental health facilities reported for each state and territory. In addition, there were 124 public acute hospitals with a specialised psychiatric unit or ward.

The number of available beds increased between 1999-00 and 2003-04 for private psychiatric hospitals and government-operated residential mental health facilities but decreased for public psychiatric hospitals (Figure 1.26 and Table 7.9). Data for public acute hospitals for 1999-00 and 2000-01 are not available but there was an increase in the number of beds for specialised psychiatric units or wards in these hospitals from 2001-02 to 2003-04.

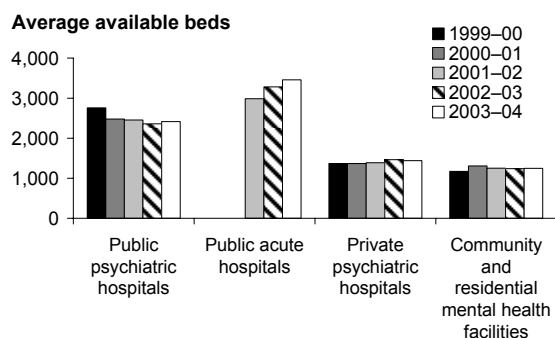


Figure 1.26: Average available beds for psychiatric hospitals and government-operated residential mental health facilities, 1999-00 to 2003-04

Recurrent expenditure

Recurrent expenditure includes salaries and wages expenditure, non-salary expenditure and depreciation.

Recurrent expenditure increased steadily between 1999-00 and 2003-04 for public psychiatric hospitals, private psychiatric hospitals and government-operated community and residential mental health facilities (Figure 1.27 and Table 7.9).

Government-operated community and residential mental health facilities had the greatest average annual change in total recurrent expenditure (constant prices) over the four year period (14.0%), while

public psychiatric hospitals had the smallest (6.9%).

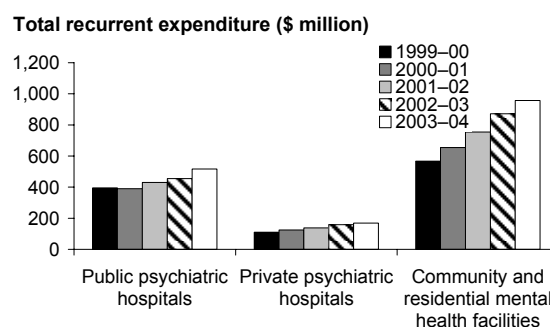


Figure 1.27: Total recurrent expenditure (\$ million) for psychiatric hospitals and government-operated community and residential mental health facilities, 1999-00 to 2003-04