

# 1 Introduction

*Mental health services in Australia 2004–05* is the eighth in the AIHW's series of annual reports that describe the activity and characteristics of Australia's mental health care services. As well as providing information on a wide range of mental health care services provided in Australia in a centralised and accessible form, these reports make publicly available the data collected as specified in the National Minimum Data Sets (NMDSs) for Mental Health Care. These NMDSs cover specialised community and residential mental health care, specialised mental health care for patients admitted to public and private hospitals, and data on the facilities providing these services (Chapters 4, 5, 7, 8, 12 and 14).

The focus of this report is on the provision of mental health-related services and the resources that underpin those services. The latest year reported for most information in this report is 2004–05, with more recent data provided when available. Where appropriate and possible, time series data are also provided. More detailed data on mental health services in the years prior to 2004–05 are available in previous reports in this series.

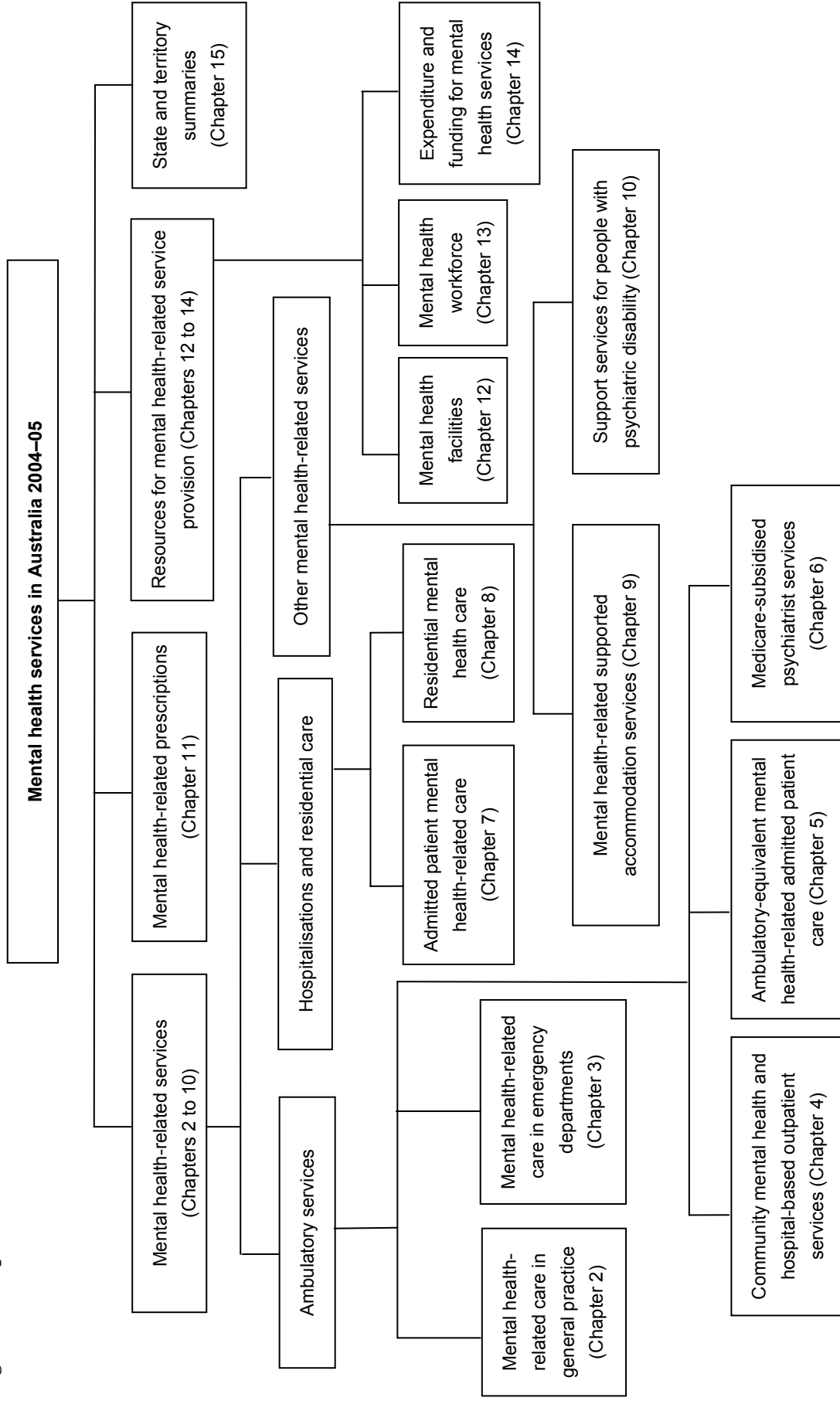
## 1.1 Report structure

Compared with previous reports in this series, this report has been restructured in order to increase the accessibility of the information presented, as well as its relevance to decision making and policy. Moreover, a more complete picture of mental health services and resources in Australia is provided. For example, mental health services provided by emergency departments and information on the psychologist workforce are included for the first time. Another new feature is the inclusion of summary tables that present, in one place, information on the topics covered in this report for each state and territory, as well as for Australia as a whole.

The report is structured into the following broad areas.

- This introductory chapter provides a brief discussion on the definition of mental health-related services, presents background information on the prevalence of mental illness in Australia, and outlines the current policy framework and government initiatives in relation to the provision of mental health services.
- The main body of the report consists of four main sections, as shown in Figure 1.1. The first, and main, section (which consists of Chapters 2 to 10) describes the activities and characteristics of the wide range of services involved in providing treatment and care for people with mental health problems in Australia. This includes mental health-related services provided by specialist mental health services and general health services in both residential and ambulatory settings. Many are government services, but private hospitals, non-government organisations and private medical practitioners responsible for providing mental health care are also included in the range of services covered.

Figure 1.1: Report outline



The second section (Chapter 11) provides information on prescriptions dispensed for mental health-related conditions. The third section (Chapters 12 to 14) looks at the resources utilised and/or involved in the provision of mental health services – namely facilities, the specialist mental health workforce and expenditure. The fourth section provides state and territory profiles, as well as a national profile, in tabular form (Chapter 15).

- The appendixes provide: information on the data sources used in this report (Appendix 1); technical notes on data presentation and the calculation of population rates (Appendix 2); information on the classifications used in this report (Appendix 3); and the specific codes used to define ‘mental health-related’ encounters and separations in particular chapters of this report (Appendix 4).

In addition to the information published in this report, detailed data on some mental health services are provided by the AIHW in the form of internet tables and data cubes. These can be found on the AIHW website (see Section 1.5 for further details).

Note that while the aim of this report is to provide a view of the broad range of mental health-related services provided in Australia, the ability to achieve this aim is driven to a large extent by the availability of quality and comparable national data. For this reason, there are some overlaps and gaps in the information on services covered in this report.

## 1.2 Definition of mental health-related services

There is no standard definitive means of identifying the broad range and type of services provided to people who have poor mental health. In order to compile information on mental health services for this report, it was necessary to develop definitions of ‘mental health-related services’ that were applicable to each individual data source. The specifics of how ‘mental health-related services’ are defined in relation to each data source are detailed in the relevant chapters and in the appendixes.

This report focuses on mental health services and, as result, most of the information presented relates to episodes of service, hospital separations, service contacts, encounters, support periods or prescriptions. However, information on the number and characteristics of people receiving these services is also provided where possible. In addition, some information on the prevalence of mental health problems is provided as contextual information in the next section.

## 1.3 Background

Mental health is described by the World Health Organization (WHO) as:

“... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”  
(WHO 2001:1).

Mental health is included as one of Australia’s National Health Priority Areas. As outlined below, mental health-related problems have a considerable impact on the health of the Australian population.

## **Prevalence**

Prevalence is a measure of how commonly a condition or illness occurs within a population. There is a range of measures of its prevalence in the Australian population. The following section looks at a number of measures of the prevalence of mental health conditions or illnesses and presents available data. The estimates of prevalence vary due to several reasons, including differences in survey methodologies, and the definition of mental illness, condition, disability or wellbeing used.

### **Prevalence estimates from the National Survey of Mental Health and Wellbeing of Adults 1997**

The most frequently quoted figure for mental illness in Australia is that one in five adults will experience a mental illness at some stage in their lives. This figure was derived from the National Survey of Mental Health and Wellbeing of Adults (NSMHW) conducted in 1997 by the Australian Bureau of Statistics (ABS 1998). This survey used a computerised version of the Composite International Diagnostic Interview to identify a range of mental disorders in people aged 18 years and over. Note that some of the people who were identified as having a mental illness would not have had a mental illness diagnosed or treated by a professional.

The NSMHW found that an estimated 17.7% of Australian adults had experienced a mental illness in the preceding 12 months (ABS 1998). It also found that the prevalence of mental illness decreased with age. That is, the highest percentage of mental illness was reported for those aged 18 to 24 years (26.6%), reflecting a relatively high rate of substance use disorders in that age group. The prevalence was lowest for those aged 65 years and over (6.1%).

The child and adolescent component of the 1997 NSMHW found that the most frequently reported disorder for children aged 6 to 17 years was Attention deficit hyperactivity disorder (11%, or an estimated 355,000 children and adolescents). Less prevalent were depressive disorders (4%) and conduct disorders (3%) (AIHW 2005d).

As part of the NSMHW, a study coordinated by the University of Western Australia examined the prevalence of psychotic disorders among Australian adults aged 18 to 64 years (Jablensky et al. 1999). The survey was based on a census of 3,800 people with psychotic illness who attended a public or private mental health service within defined areas of Brisbane and surrounds, Melbourne, Perth and the Australian Capital Territory. This study found that between 39 and 69 persons per every 10,000 adults residing in urban areas (a weighted mean of 47) were in contact with mental health services each month due to symptoms of a psychotic disorder. Schizophrenia and schizoaffective disorder accounted for over 60% of the prevalence of psychotic disorders.

### **Self-reported mental or behavioural problems**

More recent measures of the prevalence of mental or behavioural problems in the Australian population are available from the ABS's 2004–05 National Health Survey (NHS) (ABS 2006c). A brief description of the scope and methodology of this survey is provided in Appendix 1.

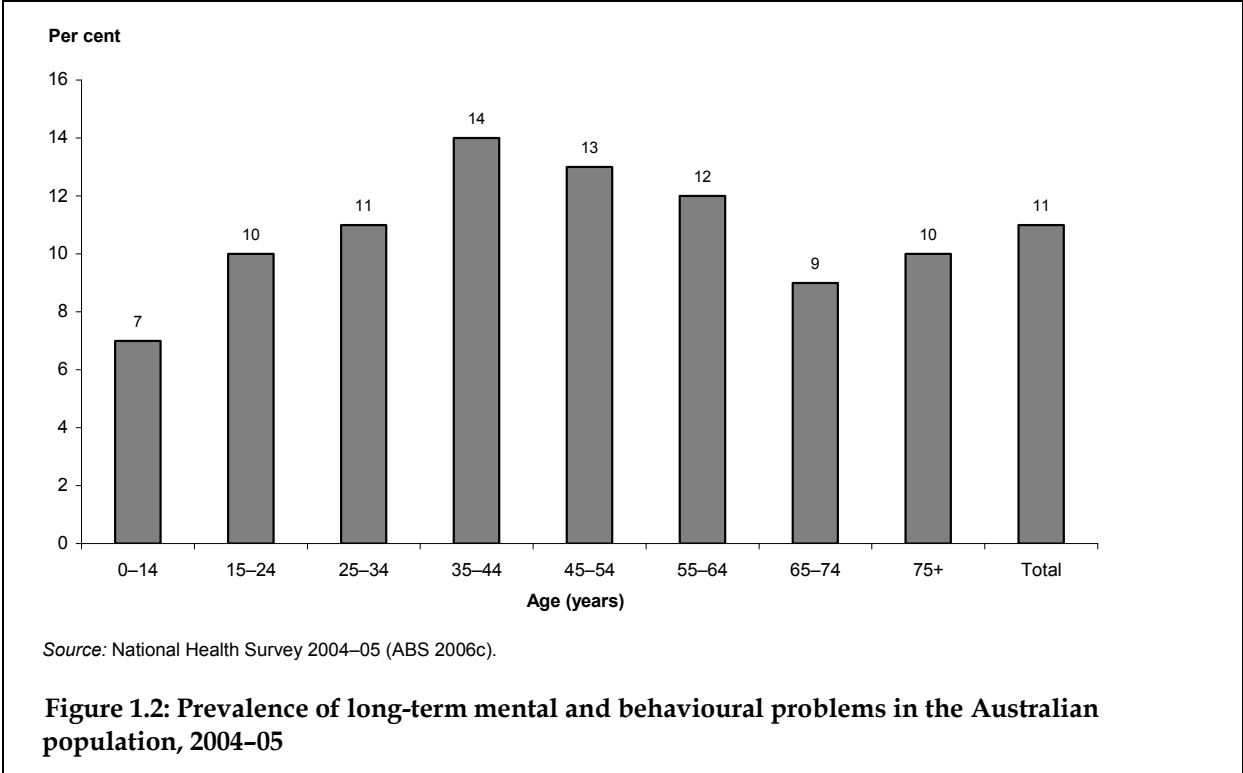
The NHS collected self-reported information on long-term medical conditions (that is, conditions current at the time of the survey that had lasted or were expected to last for 6 months or more) for adults and children. In 2004–05, an estimated 2.1 million Australians (10.7% of the population) had a long-term mental or behavioural problem. In comparison, 14.9% reported long-term arthritis and 10.2% indicated having long-term asthma. It should be noted, however, that the prevalence estimates for mental and behavioural problems are

considered to be less reliable than prevalence estimates for other conditions derived from the 2004–05 NHS since respondents were not asked to report whether a diagnosis of mental or behavioural problems had been made by a health professional.

Results from the NHS conducted in previous years indicate that the prevalence of long-term mental or behavioural problems in the population was 5.9% in 1995 and 9.6% in 2001 (ABS 2006c).

The prevalence of long-term mental or behavioural problems in 2004–05 varied with age. It was highest in the 35 to 44 year age group (13.6% of the population) and the 45 to 54 year age group (13.1%), while it was lowest for children aged under 15 years (6.7%) (Figure 1.2).

The most commonly reported mental health problems were anxiety related problems (5.3% of the population) and mood (affective) problems (4.9%).



**Use of medication for mental wellbeing**

As well as collecting information about long-term medical conditions, the 2004–05 NHS also collected data on the use of medication for mental wellbeing. The results indicated that approximately 2.9 million people aged 18 years and over (19.2% of the population) reported the use of medication for mental wellbeing in the 2 weeks before being surveyed (ABS 2006c). Use of antidepressants was reported by 5.2% of respondents, while 4.5% reported the use of sleeping tablets or capsules. Use of medication for mental wellbeing was more common among females (23.9% of the population) than males (14.3%). Use also varied with age, with use of medication most frequent among respondents aged 65 years and over (24.1%), and least frequent among those aged 18 to 34 years (15.0%).

## Prevalence of psychological distress

The prevalence of reported psychological distress is another indicator of the mental health of Australians. The following surveys have collected information on the psychological distress of respondents aged 18 years and over using the Kessler 10 Scale of Psychological Distress (K10): the NSMHW conducted in 1997 by the ABS; the NHS conducted by the ABS in 2001 and 2004–05; the 2004 National Drug Strategy Household Survey (NDSHS) (ABS 1998, 2002b, 2003a, 2003b, 2006c; AIHW 2005e). The K10 scale consists of ten questions about non-specific psychological distress and seeks to measure the level of anxiety and depressive symptoms a person experienced in the 4 weeks before the interview. The scale contains low through to high threshold items and, for each item, there is a five-level response scale based on the amount of time the respondent experienced the particular problem (with the options ranging from 'All of the time' to 'None of the time'). Various cut-off scores can be used to define low, moderate, high and very high levels of psychological distress. K10 scores at the very high level (that is, a score between 30 and 50) may indicate a need for professional help (ABS 2003a).

While the same K10 module and method of scoring was used in the four surveys listed above, there are differences between aspects of each survey that relate to, for example, the sample design and coverage, survey methodology and content. Care should therefore be taken when comparing the prevalence of psychological distress in Australia across time, using results from these four surveys (Table 1.1).

Estimates from the 2004–05 NHS indicate that 3.8% of the population aged 18 years and over had a very high level of psychological distress (Table 1.1). People aged 45 to 54 years had the highest level of very high psychological distress (4.8%). Females had a higher prevalence of very high psychological distress than males within most age groups in 2004–05.

Overall, the 2004 NDSHS found that 2.3% of the population aged 18 years and over had very high levels of psychological distress and a further 7.6% had high levels of psychological distress. Data from this survey can also be used to examine levels of psychological distress according to reported drug use. These data show that, compared with those who had not used drugs in the previous month, a greater proportion of people aged 18 years and over who had used drugs reported high and very high levels of psychological distress (AIHW 2005e). Specifically, 14.0% of those who used any illicit drug in the previous month reported a high level of psychological distress, compared with 6.9% of those who had not. Similarly, 5.6% of those who had used and 1.9% of those who had not used illicit drugs reported a very high level of psychological stress. Almost a third (32.7%) of heroin users reported very high levels of psychological distress.

In addition to the surveys mentioned above, the 2004–05 National Aboriginal and Torres Strait Islander Health Survey collected data on the social and emotional wellbeing of Indigenous Australians (aged 18 years and over) using five questions from the K10 scale. Responses to these selected questions provided the following estimates: 9% of Indigenous adults reported feeling nervous all or most of the time; 7% reported feeling without hope all or most of the time; 12% reported feeling restless or jumpy all or most of the time; 17% reported feeling that everything was an effort all or most of the time; and 7% reported feeling so sad that nothing could cheer them up (ABS 2006b).

**Table 1.1: Estimated proportion of the Australian population aged 18 years and over with very high psychological distress scores, by age, 1997, 2001, 2004 and 2004–05 (per cent)**

Year <sup>(a)</sup>	Age group (years)						Total
	18–24	25–34	35–44	45–54	55–64	≥ 65	
<b>Males</b>							
1997	<sup>(b)</sup> 0.6	<sup>(b)</sup> 1.3	2.2	3.0	2.7	<sup>(b)</sup> 1.9	1.9
2001	2.7	2.1	2.5	3.7	3.6	1.9	2.7
2004	2.5	2.9	1.5	2.0	1.9	1.0	2.0
2004–05	3.3	2.3	3.4	4.0	4.6	2.9	3.3
<b>Females</b>							
1997	<sup>(b)</sup> 2.1	2.8	2.4	3.8	<sup>(b)</sup> 1.5	<sup>(b)</sup> 1.3	2.4
2001	5.4	4.6	4.2	5.5	3.6	3.2	4.4
2004	4.5	3.2	2.9	2.0	1.7	1.4	2.6
2004–05	3.5	3.5	5.1	5.5	4.3	3.5	4.3
<b>Total</b>							
1997	1.3	2.1	2.3	3.4	2.1	1.6	2.2
2001	4.0	3.4	3.4	4.6	3.6	2.6	3.6
2004	3.5	3.0	2.2	2.0	1.8	1.2	2.3
2004–05	3.4	2.9	4.3	4.8	4.4	3.2	3.8

(a) Care should be taken in interpreting change over time as results are based on different surveys and therefore are not strictly comparable.

(b) Estimate has a standard error of between 25% and 50% and should be used with caution.

Sources: National Survey of Mental Health and Wellbeing of Adults 1997 (ABS 1998); National Health Survey 2001 and 2004–05 (ABS 2002b, 2006c); 2004 National Drug Strategy Household Survey (AIHW 2005e).

## Psychiatric disability

Based on data collected in the 2003 Survey of Disability, Ageing and Carers, the prevalence of psychiatric disabling conditions in the Australian population is estimated to be 5.2% (Table 1.2), which represents just over 1.0 million people. The presence of a disabling condition (defined as a limitation, restriction or impairment which has lasted, or is likely to last, for at least 6 months and restricts everyday activities) was self-reported by respondents in this survey.

Over half (56.0%) of the people who reported a psychiatric disability in 2003 were women; in turn, a higher prevalence of a psychiatric disability for females than for males was observed (5.8% of the female population and 4.6% of the male population in Australia).

Almost half (48.4%) of the people reporting a psychiatric disability had severe or profound core activity limitations (that is, they sometimes or always needed help with self-care, mobility and/or communication). This is equivalent to 2.5% of the Australian population (or 493,000 people) in 2003. The prevalence of a psychiatric disability with severe or profound core activity limitations was higher for females than for males (3.0% and 2.0% for the population, respectively).

Psychiatric disability was also found to be associated with other disabling conditions. For those for whom psychiatric disability was reported as the main or other disabling condition, 36.7% also reported a sensory/speech disability and 36.2% also indicated physical or other disability (AIHW 2005d).

**Table 1.2: Prevalence of a psychiatric disability<sup>(a)</sup>, by core activity limitation, 2003**

Core activity limitation	Males		Females		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
Profound	109.6	1.1	187.4	1.9	297.0	1.5
Severe	89.6	0.9	106.2	1.1	195.8	1.0
Moderate	65.6	0.7	91.1	0.9	156.6	0.8
Mild	87.9	0.9	96.9	1.0	184.8	0.9
<b>Total<sup>(b)</sup></b>	<b>447.4</b>	<b>4.6</b>	<b>570.5</b>	<b>5.8</b>	<b>1,017.9</b>	<b>5.2</b>

(a) Includes persons with a psychiatric disability as the main or other disabling condition.

(b) Includes persons with no core activity limitation but who are restricted in schooling or employment only, and persons without specific limitations or restrictions.

Source: AIHW analysis of ABS 2003 Survey of Disability, Ageing and Carers confidentialised unit record file.

## Mortality

A mental or behavioural disorder was recorded as the underlying cause of death for 574 people who died in 2004. This equates to an age standardised rate of 2.7 per 100,000 people in Australia. Most of these deaths were due to abuse of psychoactive substances such as alcohol and heroin. An additional 2,098 deaths in 2004 were attributed to suicide (AIHW 2006a).

## 1.4 National policies for mental health

State and territory governments and the Australian government have committed to improving the mental health of the Australian population through the National Mental Health Strategy and the recent Council of Australian Governments (COAG) initiatives on mental health care. These two major government initiatives set the broad agenda for mental health service provision in Australia. A brief outline of the main aims and objectives of these two initiatives is given below.

### National Mental Health Strategy

The National Mental Health Strategy was established to provide a framework to guide the reform agenda for mental health in Australia in a coordinated manner across the whole of government. It was endorsed by the Australian and state and territory governments in 1992 (DoHA 2006c).

This strategy consists of the National Mental Health Policy and the National Mental Health Plan, and is underpinned by the Mental Health Statement of Rights and Responsibilities.

The broad aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- 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 that relate to the shift from institutional to community-based care, and the delivery of services in mainstream settings.

The approach to be taken in implementing the aims and objectives of the Policy is described in the National Mental Health Plan. The current plan (2003–2008) was endorsed by all Australian Health Ministers in July 2003 (Australian Health Ministers 2003). This plan is the third National Mental Health Plan, and it consolidates reforms begun under the first two plans. It has four priority themes: promoting mental health and preventing mental health problems; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

## **COAG initiatives**

In early 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006). This plan involves a joint package of measures and new investments by all governments over a 5-year period that is aimed at promoting better mental health and providing additional support to people with mental illness, their families and their carers. In particular, the plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia;
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Through the National Action Plan, the Australian, state and territory governments have committed to undertaking actions that emphasise coordination and collaboration between government, private and non-government providers to achieve the stated outcomes.

COAG has agreed to establish a COAG Mental Health Group in each state and territory to implement this plan. These groups will involve the Commonwealth and the states and territories working together to coordinate the implementation of their commitments.

Progress on the plan will be monitored against nationally agreed progress measures over a 5-year period and will be subject to an independent review after 5 years.

## **1.5 Additional information**

An electronic version of this report is available from the AIHW's website at <[www.aihw.gov.au/mentalhealth/](http://www.aihw.gov.au/mentalhealth/)> (follow the link to *Mental health services in Australia 2004–05*). Additional tables, containing more detailed data from the National Hospital Morbidity Database, the National Community Mental Health Care Database and the National Residential Mental Health Care Database, are also available on the website. As well, data from the National Hospital Morbidity Database are available in interactive data cubes on the AIHW website <[www.aihw.gov.au/mentalhealth/datacubes/index.cfm](http://www.aihw.gov.au/mentalhealth/datacubes/index.cfm)>. These data cubes allow users to choose and manipulate variables in order to create tables of data to suit their needs.