

1 Introduction

Mental health services in Australia 2005–06 is the latest in the Australian Institute of Health and Welfare’s series of annual reports that describe the activity and characteristics of Australia’s mental health care services. As well as giving 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 latest year reported for most information in this report is 2005–06, 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 before 2005–06 are available in previous reports in this series.

1.1 Report structure

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 major features of the current policy framework and government initiatives in relation to mental health service provision.
- The main body of the report consists of three main sections, as shown in Figure 1.1. The first section (chapters 2–10) describes the activities and characteristics of the wide range of treatment and care services provided 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 service providers, but private hospitals, non-government organisations and private medical practitioners responsible for providing mental health care are also included in the range of service providers covered. Services that cater to the wider needs of clients with psychiatric illnesses or mental health issues, such as the Supported Accommodation Assistance Program (Chapter 9), and services that cater to a wider range of disabilities, but including psychiatric disabilities, such as those provided under the Commonwealth State/Territory Disability Agreement (Chapter 10), are also covered.
- The second section (Chapter 11) provides information on prescriptions dispensed for mental health-related conditions.
- The third section (chapters 12–14) looks at the resources used and/or involved in the provision of mental health services – namely, facilities, the specialist mental health workforce and expenditure.
- The summary tables provide state/territory and national profiles (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 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 comparison to the 2004–05 report, most of the elements have been retained but there have been some additions and deletions of content within chapters:

- The *Mental health-related care in general practice* chapter, in addition to presenting analysis of the Bettering the Evaluation and Care of Health (BEACH) survey data, now includes analysis of data on the use of mental health-specific items included in the Medicare Benefits Schedule (MBS) since 2002 to provide support to general practitioners coordinating the treatment needs of patients with mental health-related problems.
- The chapter on *Medicare-subsidised psychiatrist services* appearing in the previous report has been renamed *Medicare-subsidised psychiatrist and allied health services*. It has been expanded from the previous presentation of data on MBS-subsidised psychiatrist services to include analysis of data about items recently added to the MBS, which provide consumer access to a range of allied health services, including psychologists and other mental health workers.
- The *Mental health-related prescriptions* chapter includes analysis of data on patients obtaining mental health-related prescriptions, as well as on the number of prescriptions.
- Estimates of the psychologist workforce have been omitted from the *Mental health workforce* chapter, as there has been no update of these estimates since the previous report.

In addition to the information published in this report, detailed data on some mental health-related 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 this report aims 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, comparable national data. Consequently, there are some overlaps and gaps in the information on services provided in this report.

1.2 Definition of mental health-related services

Mental health-related services are provided in Australia in a variety of ways – from hospitalisation and other residential care, hospital-based outpatient services and community mental health services, through to consultations with both specialists and general practitioners. The Australian Government assists in this service provision by subsidising consultations, other medical and certain allied health services, and prescribed medications through the Medicare and Pharmaceutical Benefits Schemes. Government assistance is also provided for broader needs such as housing. This report presents data on this diverse range of services and support.

There is no standard way of defining mental health-related services. 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.

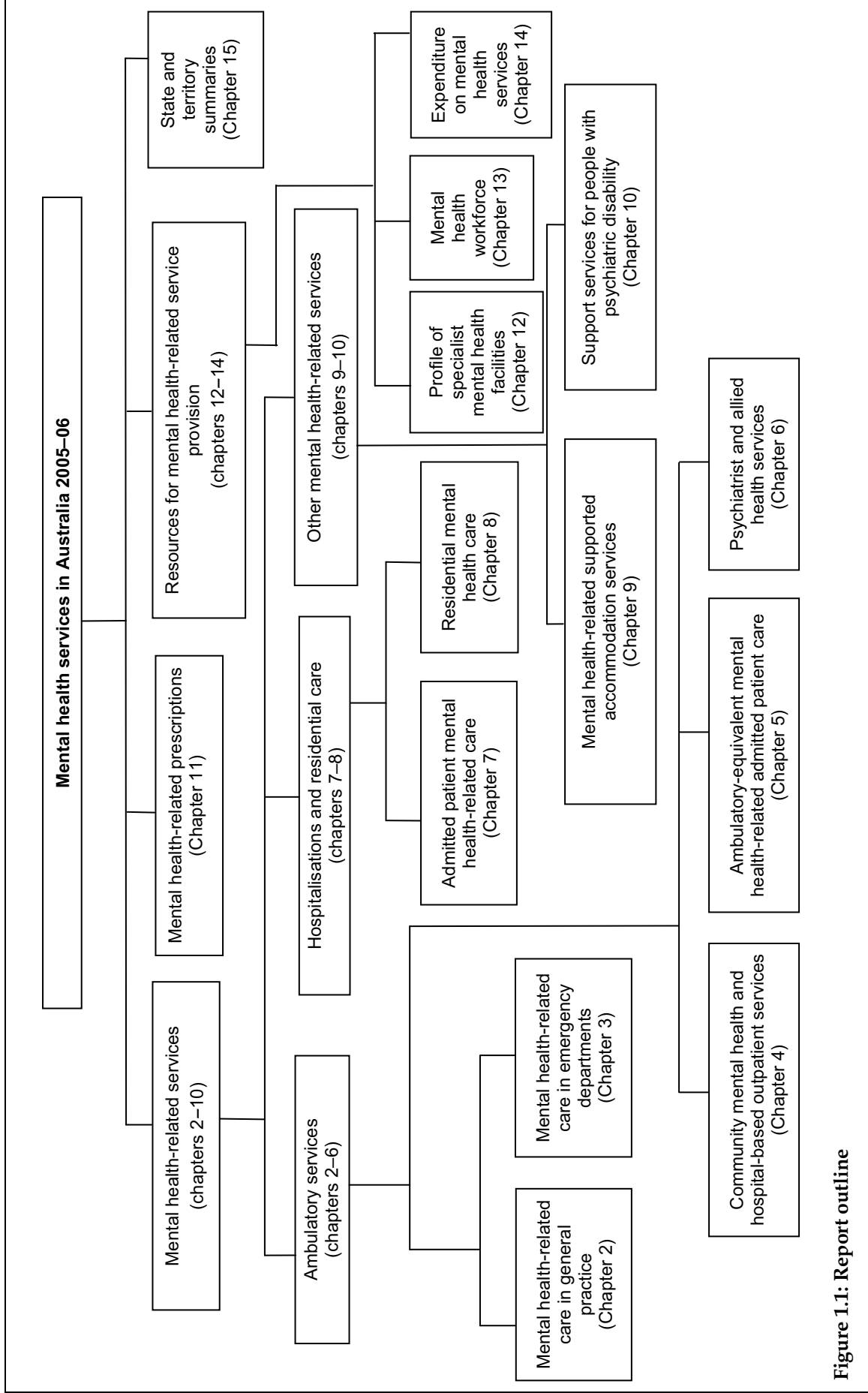


Figure 1.1: Report outline

1.3 Background

Mental health is one of Australia's National Health Priority Areas. Mental illness is one of the more prevalent conditions affecting the Australian population. According to the National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics (ABS) in 1997, almost one in five Australian adults will experience a mental illness at some time in their life. Overall, an estimated 18% of Australian adults had experienced a mental illness in the 12 months preceding the survey (ABS 1998). Another National Survey of Mental Health and Wellbeing was conducted in 2007, with results not available at the time of preparation of this publication.

Data from the AIHW National Mortality Database show that a mental or behavioural disorder was recorded as the underlying cause for 579 deaths in Australia in calendar year 2005, at a rate of 2.7 deaths per 100,000 population. Most of the deaths with a mental or behavioural disorder as the underlying cause were due to abuse of psychoactive substances such as alcohol and heroin. Suicides are not included in these figures.

More detail on the prevalence of mental illness in Australia was provided in the 2004–05 edition of this publication.

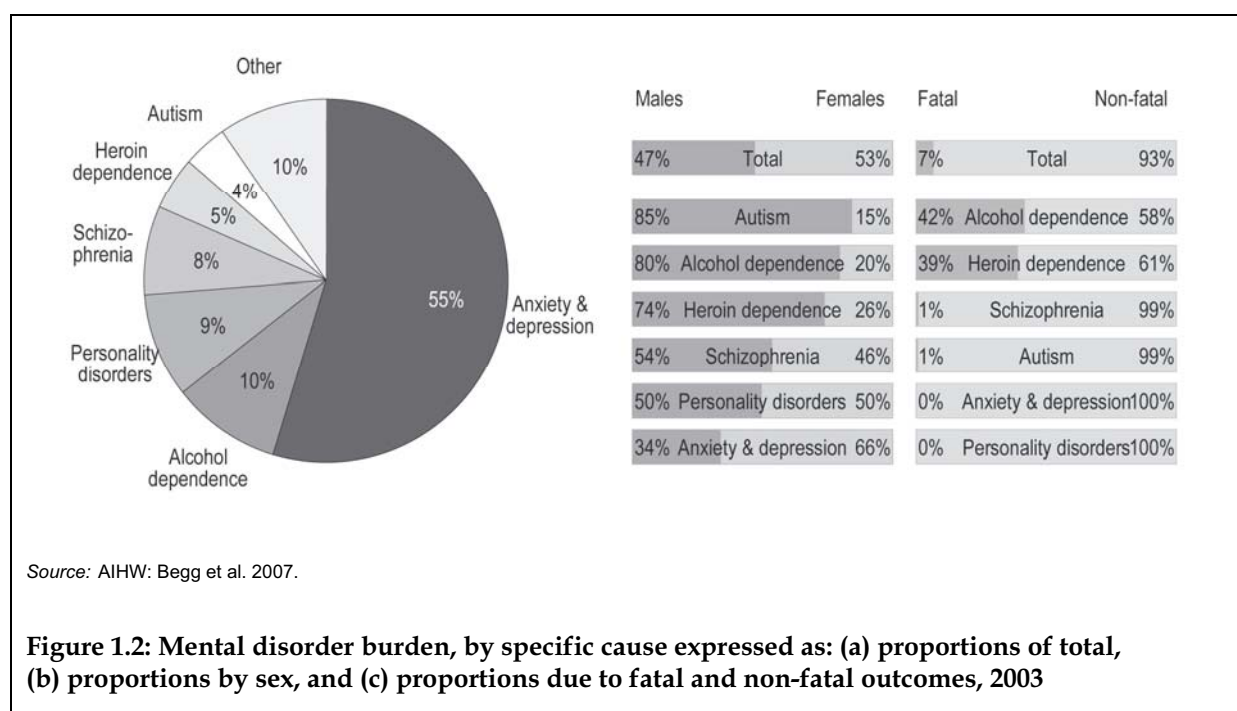


Figure 1.2: Mental disorder burden, by specific cause expressed as: (a) proportions of total, (b) proportions by sex, and (c) proportions due to fatal and non-fatal outcomes, 2003

The burden of mental illnesses

According to *The burden of disease and injury in Australia 2003*, mental illnesses were estimated to be responsible for 13.3% of the total burden of disease in Australia in 2003. The total burden of disease and injury is derived from adding fatal burden (years of life lost due to premature mortality) to non-fatal burden (years of healthy life lost due to non-fatal health conditions, which is estimated by combining the average duration of new cases of a condition with a severity weight quantifying the impact of the condition). Non-fatal burden

accounted for 51% of the total burden, and mental illnesses were the leading cause (24%) (AIHW: Begg et al. 2007).

The distribution of the mental disorders burden was 93% non-fatal and 7% fatal, most of the latter caused by substance abuse. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of the total burden attributable to mental illnesses (Figure 1.2).

Mental illnesses affect both sexes and all ages. Females accounted for 53% of the burden attributed to mental illness and males 47% in 2003. In females, anxiety and depression were the foremost causes, accounting for 10% of the overall female burden of disease, and ranked third (at 4.8%) in the overall male burden.

There were marked sex differences in the mental illness burden for particular disorders. The burden from anxiety and depression combined was twice as high for females as for males. Conversely, the burden from substance abuse was more than three times as high in males as in females and autism spectrum disorders were much more common in males. On the other hand, eating disorders occurred mainly in females.

The analysis surrounding Figure 1.2 relates to an incidence-based measure of the burden of disease where healthy years lost due to disability are estimated by multiplying the number of new cases of a disorder by the average duration of that disorder as well as by a severity weight. It is also possible to calculate a prevalence-based measure of the burden of disease, the prevalent years lost due to disability, by multiplying the number of cases prevailing in the population at a point of time by the severity weight. Incident burden is most useful in the planning of health services while prevalent burden is most useful in estimating service use or expenditure on health services. The two methods produce different but complementary pictures as shown in Figure 1.3.

Incident burden peaks in the late teenage years, with the anxiety and depression burden, the largest identified category, being greatest in this age group. Incident burden is also very high in the 20–24 year age group, with schizophrenia being at a maximum in terms of burden for this group. The overall incident burden then tapers off with increasing age, apart from a small peak in the 40–44 year age group due mainly to anxiety and depression, as well as personality disorders. This second peak at the 40–44 year age group is more evident in the prevalent burden chart where the burden attributable to new cases is added to the burden cumulated in that age group from previous years. The peak in the incident anxiety and depression burden in younger age groups is not nearly as evident for anxiety and depression in the prevalent burden chart as there the burden is spread across the life span rather than being attributed to the point of incidence.

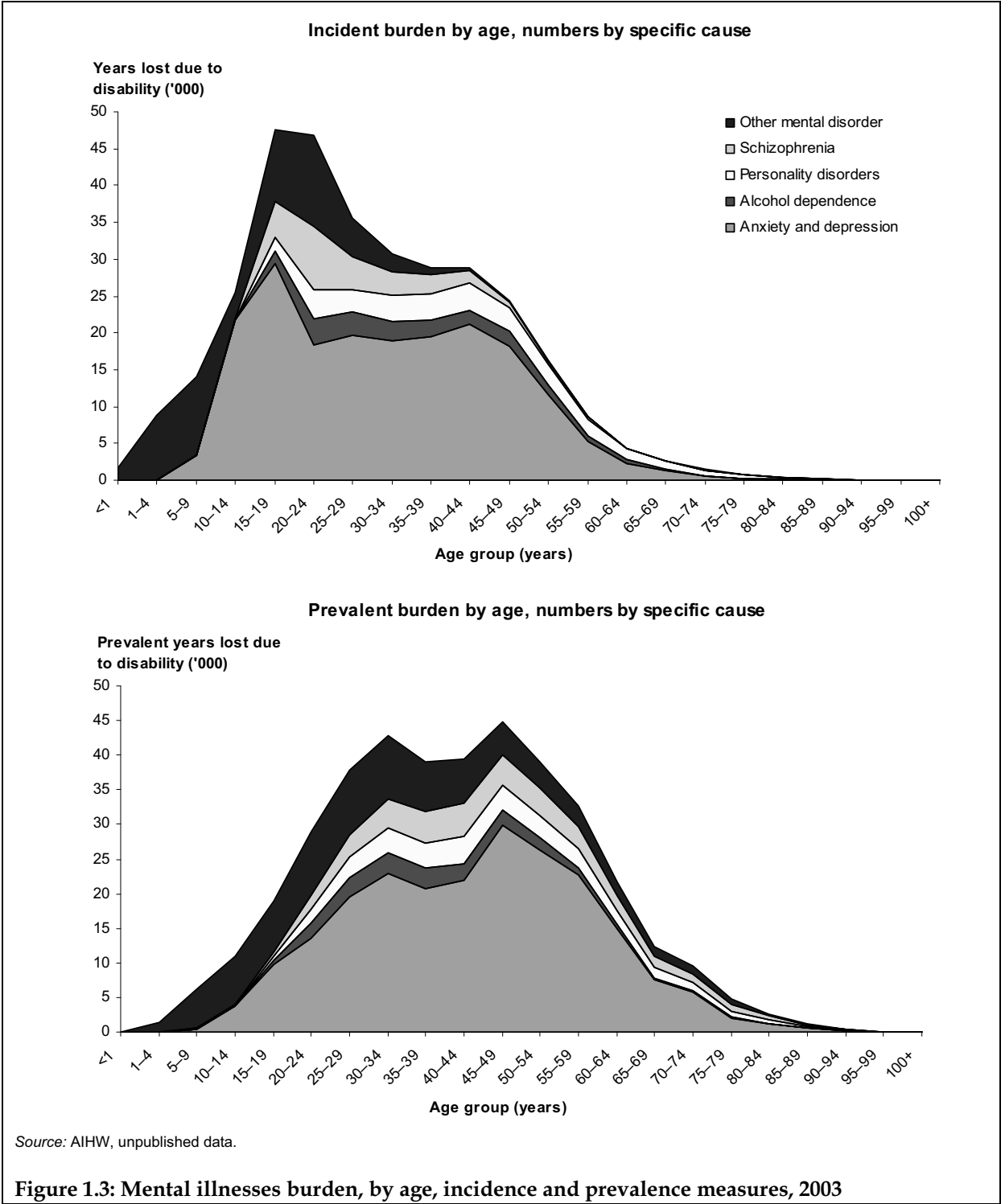


Figure 1.3: Mental illnesses burden, by age, incidence and prevalence measures, 2003

1.4 National policies for mental health

State and territory governments and the Australian Government have committed to improve the mental health of the Australian population through the ongoing National Mental Health Strategy and the Council of Australian Governments (COAG) National Action Plan on Mental Health. 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 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 2006).

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 applying 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. This plan 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, innovation and sustainability.

COAG National Action Plan on Mental Health

In early 2006, COAG agreed to the National Action Plan on Mental Health 2006–2011 (COAG 2006b). This plan involves a joint package of measures and new investment by all governments over a five-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 aims to achieve 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 Government and 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.

State and territory-based COAG Mental Health Groups have been established to carry out this plan. These groups involve the Australian Government and the states and territories working together to coordinate the implementation of their commitments. Progress on the plan is being monitored against nationally-agreed progress measures over the five-year period and will be subject to an independent review at the end of the period.

1.5 Additional information

An electronic version of this report is available on the AIHW website at <www.aihw.gov.au/mentalhealth/> (follow the link to Mental health services in Australia 2005–06). 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>. These data cubes allow users to choose and manipulate variables to create tables of data to suit their needs.

The *National Mental Health Report* (DoHA 2008b) provides a statistical report on progress made under the National Mental Health Strategy to 2004–05. Statistical indicators to provide comparisons of the performance of government mental health services by jurisdiction are provided in the *Report on Government Services* (SCRGSP 2008).