

5 Mental health

Primary goal:

“ Reduce the loss of health, well-being and social functioning associated with mental health problems and mental disorders ”

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Overview

The designation of mental health as one of the five National Health Priority Areas is recognition of its enormous social and public health importance. In addition to the pain and disability suffered by individuals, mental illness also burdens their families enormously (Human Rights and Equal Opportunity Commission 1993). The economic, social and personal cost of these problems and disorders is large and has been extensively documented.

The prevalence of mental illness in Australia has not been established, although it is estimated that between one in four and one in five individuals will be affected by a mental health problem or mental disorder at some point in their lives. The 1989–90 National Health Survey estimated that some 3.5% of the population, or 599,000 people, suffer from one or more mental disorders (Australian Bureau of Statistics 1991). Almost one-half of these had the problem (excluding retardation and specific delays in development) as a long-term condition.

Depression and related disorders (post-partum depression, bipolar disorder, etc.) have a life-time prevalence of 6.3%, and a one-year prevalence of 3.7%, in Australia (Tippet et al. 1994). With a median age of onset at 25 years and an average duration of 6.4 years for depressive morbidity, it is a large contributor to the burden of mental ill-health. The mortality associated with depression, based on the estimate that some 60% of those who commit suicide have a significant psychiatric disorder, contributes to the years of life lost (Stoudemire et al. 1987). Depression is a debilitating illness often affecting work performance, leading to withdrawal from social and family activities, and sometimes causing the individuals to become isolated. The impact of depression and related disorders on the quality of life yet needs to be established.

Other mental disorders such as alcoholism, schizophrenia and drug abuse also have a strong negative impact. In 1992, alcoholism is estimated to have caused the loss of 3,660 lives and 55,450 person-years of life before age 70 (English et al. 1995). There were 71,539 episodes and 731,169 hospital bed-days caused by high level of alcohol consumption in that year. Some 28% of male and 12% of female current drinkers, aged 14 years and over, consume alcohol at levels defined as hazardous or harmful by the National Health and Medical Research Council (National Health and Medical Research Council 1992; Commonwealth Department of Health and Family Services 1996a).

There is no reliable source of information that specifically focuses on schizophrenia prevalence, but it is accepted that its rate of prevalence in Australia is similar to that seen in other Western nations (Tippet et al. 1994). With a lifetime prevalence of 1.5% and a median age of onset at 19 years (Rey 1992), schizophrenics have a higher risk of death (a standardised mortality ratio (SMR) of 2.53; cf. Tippet et al. 1994).

Illicit drugs caused 488 deaths in Australia in 1992, which resulted in the loss of 17,899 person-years of life lost before age 70. A total of 5,390 hospital episodes and 40,522 hospital bed-days in 1992 are also ascribed to illicit drug use (Australian Institute of Health and Welfare 1996a).

Suicide ranks highly among deaths attributed to mental ill-health. In addition to clinically significant depression, which contributes to a large proportion of suicides, a high toll is taken by other psychiatric disorders such as alcoholism, personality disorders, schizophrenia and drug abuse. Australia has a high rate of suicide within the industrialised world, particularly among young males (Abraham et al. 1996).

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Direct costs of mental health and related services have been estimated to be about \$2 billion in 1989–90 (Australian Institute of Health and Welfare 1996a). This includes \$1.14 billion on hospitalisation (including public psychiatric facilities), \$0.42 billion on nursing homes, \$0.23 billion on medical costs, \$0.17 billion on pharmaceuticals and \$0.08 billion on allied professionals.

Trends and differentials

Limited information is available to establish trends and differentials for mental health in Australia. Bennett et al. (1994) have recently reported on trends in mortality from 1980 to 1992 which reveals that mortality from all mental disorders is increasing annually at 4.0% in men and 4.6% in women. The highest rates of change in death rate are noticed for drug dependence in men (7.4%) and senile and presenile organic psychotic conditions in women (5.8%).

Suicide and deaths from self-inflicted injury declined in women between 1980 and 1992 with an annual rate of change of 0.8% (Bennett et al. 1994). However, the male suicide rate gradually increased from 17.9 deaths per 100,000 in 1981 to 20.9 deaths per 100,000 in 1992 (with an annual rate of change of 1.9%).

The mortality from mental disorders is much higher among Indigenous than non-Indigenous people, with an SMR of 5.5 in 1992–94 (Anderson et al. 1996). The age-standardised death rate for mental disorders declined significantly among Indigenous males between 1985 and 1994. Consequently, the gap between Indigenous and non-Indigenous males for mortality from mental disorders has declined significantly, with the SMR falling from 11.4 in 1989–91 to 5.5 in 1992–94 but it is still unacceptably high. No significant decline in death rate was noted among Indigenous females (Anderson et al. 1996).

Suicide by Indigenous people received much prominence in relation to the work of the Royal Commission into Aboriginal Deaths in Custody. Incarceration is strongly linked to suicides among both Indigenous and non-Indigenous people, but the high rate of detention and imprisonment among Indigenous males contributes heavily to their higher suicide rates overall. Suicide rates among Indigenous women are not significantly different from those noted among non-Indigenous women (Anderson et al. 1996).

At present, it is not possible to establish trends in the prevalence of various mental disorders in Australia at a national level. However, with the availability of results of the 1995 National Health Survey, it may be possible to discern some trends. The Australian Bureau of Statistics National Survey of Mental Health and Wellbeing, planned for 1997, will provide important population-based information on a range of mental health issues.

National mental health information needs

Information required to monitor progress towards targets is poor or lacking for various aspects of National Health Priority Areas. Baselines and targets have not been set for several indicators due to the poor quality of available information. In the priority area of mental health, the available information is often not sufficient to support the design and validation of suitable indicators. Currently, only the 1989–90 National Health Survey data on self-reported prevalence of mental health is available, albeit soon to be updated following the release of 1995 National Health Survey results, but a general survey cannot be expected to yield information on specific illnesses. There are no data

on the incidence of mental disorders, nor on the welfare of mentally ill people in the community. Data on the use of mental health services are also sparse (Australian Institute of Health and Welfare 1994).

In December 1995, the AHMAC National Working Group on Mental Health Policy endorsed a broad information strategy for data development in mental health (Commonwealth Department of Health and Family Services 1996b). Under this strategy, data from three surveys of mental health services have been released to monitor service-related indicators and set achievable targets. Minimum data sets for institutional and community mental health care are also under development by the Australian Institute of Health and Welfare.

The National Mental Health Strategy

The National Mental Health Strategy is a commitment by State, Territory and Commonwealth Governments to improve the lives of people with a mental illness. The aims of the strategy are:

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

The National Mental Health Strategy outlines objectives and strategies promoting a community-based system of treatment and support within a national framework of mental health reform. It addresses key issues such as: consumer rights; the provision of integrated mental health services; mainstreaming mental health services within general health service delivery arrangements; intersectoral links; legislation; workforce reforms; and monitoring and accountability procedures. It also addresses the requirements of special needs groups such as people from a non-English-speaking background and Indigenous people.

The reforms being pursued through the strategy will assist people with a mental illness to have access to improved services and support in years ahead. The strategy will also assist in meeting the goals for mental health envisioned in the report *Better Health Outcomes for Australians* (Commonwealth Department of Human Services and Health 1994), which are:

- reduce the loss of health, wellbeing and social functioning with mental health problems and mental disorders; and
- reduce the rate of suicide among people with mental disorders.

Highlights

- Between 1986 and 1994, suicide rates declined at an annual rate of 0.8%. In order to reach the target set for the total population for the year 2000, the suicide rate will need to decline by 2.5% annually.
- Suicide rates are higher for males aged 15 to 34 years, and for older men aged 65 years and over. No targets have been set for the year 2000 for these age groups.

Priority indicator

This section covers only one indicator for which adequate data are currently available and Target 2000 has been set.

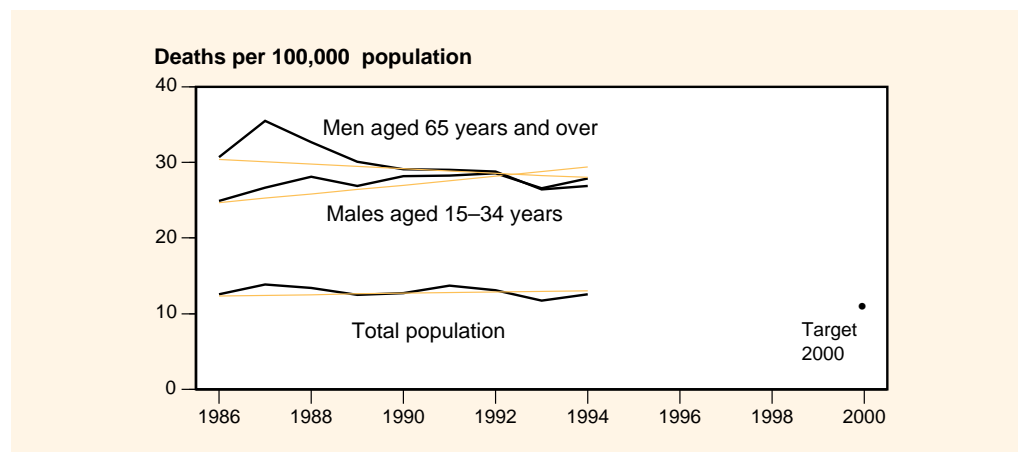
5.3.1 Death rate for suicide

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INDICATOR 5.3.1 Death rate for suicide

Goal: Reduce the rate of suicide among people with mental disorders

National trends



Population group	1986	1987	1988	1989	Baseline 1990	1991	1992	1993	1994	Target 2000
Total population	12.6	13.9	13.4	12.5	12.7	13.7	13.1	11.7	12.6	10.8
Males aged 15-34 years	24.9	26.7	28.1	26.9	28.2	28.3	28.6	26.6	27.9	Not set
Men aged 65 years and over	30.7	35.5	32.7	30.1	29.1	29.0	28.8	26.4	26.9	Not set

Source: AIHW mortality database.

- Suicide rate is one of the few currently measurable national indicators of mental health. Suicides are often expressions of breakdown in social integration and cohesion. However, as more people attempt than complete suicide, deaths data reveal only the tip of the problem.
- Suicide rates are greater for males than females across all age groups (Bordeaux & Harrison 1996). High risk groups include young men aged 15-34 years (Krupinski et al. 1994; Tulloch et al. 1994) and older men aged 65 years and over (NSW Health 1993). While both male and female rates are high for persons aged 80 or more, these account for only a small proportion of all suicide deaths.
- Between 1986 and 1994, the suicide rates declined slightly at an annual rate of 0.8%. However, no difference was noted between the 1990 baseline and the 1994 suicide rate. The rate of change will need to decline to 2.5% annually if the year 2000 target is to be met.
- Suicide rates continue to rise for young males aged 15-34 years, increasing at a rate of 0.9% annually since 1986. However, a downward trend was noted (2.8% annually) in the suicide rate for men aged 65 years and over between 1986 and 1994.

Suicide (ICD E950–959)

State comparisons

- Small numbers in some jurisdictions preclude the conclusion that there are significant differences in suicide rates between States and Territories, but nevertheless there are distinct variations in the data.
- Tasmania had the highest suicide rate for the total population both in 1986–88 and 1992–94. These high rates were also observed in Tasmanian males aged 15–34 years.
- Increases in suicide rates were observed between 1986–88 and 1992–94 in Tasmania, New South Wales and the Northern Territory. These increases are contrary to the overall national trend. The highest rate of increase between the two periods was noted in Tasmania.
- Trends in suicide among younger males did not reflect the trend in the total population. Increases of around 24% between 1986–88 and 1992–94 were noted for Tasmania and Western Australia.
- In contrast to the trend for younger males, declines in suicide rates were noted in all States and Territories, except in the Australian Capital Territory, among older men. The recent increase notwithstanding, the 1992–94 suicide rate in the Australian Capital Territory was below the national

Deaths per 100,000 population

State/Territory	Total population			Males aged 15–34 years			Men aged 65 years and over		
	Average 1986–88	Average 1992–94	Per cent change	Average 1986–88	Average 1992–94	Per cent change	Average 1986–88	Average 1992–94	Per cent change
NSW	11.9	12.3	3.8	24.0	26.8	11.6	30.3	28.9	–4.5
VIC	13.5	11.5	–15.1	26.0	24.5	–5.5	34.8	24.2	–30.7
QLD	15.9	13.4	–15.7	31.3	28.8	–7.9	34.7	33.3	–3.9
WA	13.2	12.9	–1.9	25.8	32.2	24.6	30.5	21.4	–29.8
SA	13.2	12.4	–5.6	26.6	27.9	4.9	34.4	21.1	–38.5
TAS	16.1	17.7	9.8	35.3	43.7	23.9	49.4	37.2	–24.7
ACT	12.8	9.7	–24.3	27.8	26.4	–5.2	18.1	25.7	42.1
NT	14.2	15.6	10.1	33.3	30.8	–7.6	47.4	45.1	–4.8
Australia	13.3	12.5	–6.5	26.6	27.7	4.1	33.0	27.4	–17.0

Source: AIHW mortality database.

Data issues

Definitions

- Mortality data are based on year of registration rather than year of death.
- Age-standardised number of suicides per 100,000 population

Data availability

- State mortality data are obtained from the Registrars of Births, Deaths and Marriages

in each State and Territory, and are usually based on the records of coroners.

Data reliability

- Some deaths attributed to suicide may be registered as being of ‘undetermined intent’; the estimates for suicide rates given above therefore may have been underestimated.

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Priority indicators not reported due to incomplete information

Priority indicators for which the availability of data and/or the target status are presently incomplete, but which will be reported in future reports, are listed below.

Indicator	Data availability	Target status
5.1.1 Prevalence of depression and related disorders in the general population	1997–98	Requires revision
5.1.2 Prevalence of treated depression and related disorders	1997–98	Not set
5.2.1 Quality of life of those affected by schizophrenia and other psychoses	Not available by 1997–98	Not set
5.2.5 Access to and utilisation of treatment, rehabilitation and support programs for schizophrenia and other psychoses	Not available by 1997–98	Not set
5.3.2 Death rate for suicide among people suffering from schizophrenia and other psychoses	Not available by 1997–98	Not set

Notes

1. Data availability: '1997–98'—monitoring data are expected to become available by 1997–98; 'Not available by 1997–98'—monitoring data will not become available by 1997–98, but the indicator is considered to be of a sufficiently high priority for future reporting.
2. Target status: 'Not set'—no target has been set due to lack of baselines or trends data; 'Requires revision'—target has been set but is based on poor quality, insufficient or nonexistent monitoring data.

Strategies, initiatives and interventions

The following section deals with a selection of the activities that are occurring at the Commonwealth, State and Territory levels, with the broad aim of reducing the impact of mental illness and associated disability on the community. The information below is far from comprehensive; rather, it gives a few examples of the activities that are considered to have contributed to, or to have the potential to contribute to, changed health status. It is provided to facilitate the exchange of information about activity which is deemed to be particularly useful, and which may have potential to be adapted for use by other States/Territories.

Prevention	Management	Maintenance	Research/Information
Victorian statewide youth suicide prevention initiatives	Commonwealth early intervention projects		Institute for Suicide Research and Prevention at Griffith University
NSW initiatives in child and adolescent mental health	Rockingham Kwinana Health Service	General practitioners in youth suicide prevention project	
		The Aboriginal Mental Health Policy and Aboriginal Mental Health Workers	
		Tasmanian Consumer Task Force and consultant training	

Prevention

Victorian statewide youth suicide prevention initiatives

A statewide, interdepartmental Youth Suicide Prevention Committee has overseen the development of a package of initiatives. As part of an \$8 million upgrading of child and adolescent mental health services, each region will appoint a Mental Health Promotion Officer to support and coordinate workers in local communities working with young people. Benefits will include information and education for workers on depression, enhanced identification of young people at risk and improved protocols for service access.

This initiative is being complemented by establishing a youth suicide prevention clearing house, developing guidelines for management of suicidal young people by emergency departments, and a series of grants designed to help local agencies develop innovative approaches to assisting traumatised, depressed and suicidal young people across the State.

Management

Commonwealth early intervention projects

Under the National Mental Health Strategy, the Commonwealth is funding three projects for early intervention in the treatment of mental health disorders, specifically for children and young people. Early intervention reduces the long-term effects of disability, because the disorder is treated before it becomes entrenched, and social networks, employment, education etc. are maintained.

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Two programs that have had documented success with specific disorder groups (psychosis, and anxiety and depression) are being enhanced and promoted nationally. The third project is a national network to be funded until 30 June, 1999. Its goals include training, promoting and disseminating effective early intervention strategies, further developmental work with specific disorder groups, and re-orientating national mental health service delivery to an early intervention focus.

Rockingham Kwinana Health Service

The Rockingham Kwinana Health Service is an innovative project underway in Western Australia. It provides early intervention services, and is targeted at individuals in the first two years after initial presentation with a psychosis. Early intervention is linked with reduction in the seriousness of subsequent psychotic episodes, in the level of disability and secondary morbidity (e.g. depression and suicide), and in the length and frequency of inpatient treatment. The service is community-based and provides a multi-disciplinary approach. It is based on a partnership between a range of providers, including general practitioners, psychiatrists (working in private and public practice), a community mental health team and a non-government organisation. The partnership enables choice for consumers and ensures that services are provided in a holistic way. The range of interventions provided includes medical treatment and follow-up, psychosocial support, patient education, and family and individual therapy.

Maintenance

NSW initiatives in child and adolescent mental health

In October 1996, the NSW Premier announced that \$5.8 million would be made available to promote the mental health of young people, as a further State commitment to youth suicide prevention. Three million dollars will be allocated for service provision for specialised mental health services for young people. One million dollars will be allocated for adolescent depression intervention programs, \$1 million to establish early psychosis programs for young people, and \$500,000 will be allocated to other suicide prevention initiatives including the policy development of the State strategy.

The Children and Young People Mental Health Task Force has been established to progress the development of children and young people's mental health service delivery in New South Wales. The Task Force is currently working to develop mental health service delivery models for children and young people that promote mental health, prevent mental health problems and disorders, intervene early where mental health problems and disorders exist, and provide treatment and continuing care for young people with significant mental health problems and disorders. Improved training programs will increase understanding of the particular needs of young people who experience mental health problems, and promote attitudinal change in the workforce. These issues are also being addressed through a Working Group and the Child and Adolescent Mental Health Task Force. The Child and Adolescent Mental Health Task Force is due to report in 1997.

Developing early psychosis services in New South Wales is a priority. As part of the National Early Psychosis Project, a NSW State Coordinator for the project has been appointed for 18 months, from August 1996, to the Centre for Mental Health. This is a jointly funded Victorian Early Psychosis Prevention and Intervention Centre (EPPIC)

and NSW Health initiative. The project aims to identify best practice in early psychosis service delivery, progress policy regarding early psychosis, assist and encourage the development of best practice early psychosis services in New South Wales, and foster a network for early psychosis initiatives throughout the State.

Depression has been recognised as a major public health issue. The National Health and Medical Research Council (NHMRC) is finalising guidelines on the clinical management of depression in adolescents. Four guides are being developed to assist with implementation—a guide for general practitioners, a guide for mental health professionals, a comic book and a booklet for adolescents. A New South Wales project for the implementation of the NHMRC guidelines has been initiated by the Centre for Mental Health and NSW Health, and a project officer has been appointed to identify mechanisms for the implementation of these guidelines in New South Wales. The aim is to ensure that the early recognition and treatment of depression in young people, in accordance with the guidelines, is implemented across the State.

General practitioners in youth suicide prevention project

The Southern Child and Adolescent Mental Health Service in South Australia conducts a national education project for general practitioners on youth suicide prevention, funded by a Commonwealth grant under the Here for Life program. The broad purpose of the project is to educate and develop general practitioners' clinical skills in the recognition, assessment and management of youth suicidal behaviours in five States and Territories (South Australia, New South Wales, Queensland, the Australian Capital Territory and the Northern Territory). The project makes use of audiotapes, videotapes and printed material, with follow-up workshops for general practitioners and other health professionals. It is expected that approximately 3,600 GPs and other professionals will receive training directly through this project.

The Aboriginal Mental Health Policy and Aboriginal Mental Health Workers

A comprehensive and innovative Aboriginal Mental Health Policy has been under development for some time, with extensive consultation with Aboriginal people and others, including mental health professionals and consumer representatives. The policy is expected to be finalised in early 1997. Early initiatives have been the creation of specialist Aboriginal Mental Health Workers, and the introduction of a tertiary professional education program in Aboriginal mental health at Batchelor College of Aboriginal Education in the Northern Territory.

Tasmanian Consumer Task Force and consultant training

The project involves an innovative application of consumer consultants in acute psychiatric care. Nationally funded, the program has provided training for self-selected consumers and a work program within an acute psychiatric ward. Participants have dramatically improved their own self-esteem, and are contributing in a measurable way to the operation of the ward. Of particular interest is the fact that the training program itself was developed and run by two consumers, who are the project manager and leader of the support body, the Consumer Task Force, in Southern Tasmania.

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Research/Information

Institute for Suicide Research and Prevention at Griffith University

This project is funded to undertake research and activities to contribute to the mental health policies and programs of Queensland Health. Queensland Health has committed funding of \$100,000 per annum for five years commencing in 1995–96. The main functions of the Institute are to:

- develop appropriate methodologies, strategies and priorities in suicide research and prevention;
- establish and maintain a suicide mortality database and develop a framework for access to data;
- develop frameworks for the establishment of surveillance mechanisms of suicidal behaviour;
- identify groups at risk of suicidal behaviour in Queensland;
- advise and, where appropriate, participate in training and evaluation of suicide intervention strategy supporters; and
- develop ethical guidelines for the collection of data and conduct of research in suicidology.

The program also provides for the education of both health workers and non-health human service workers.