

8 Mental health care for depression

This report presents information on the delivery of specialised and non-specialised mental health care relating to all mental disorders categorised by the type of care provided. An alternative presentation of these data is to present the information for each or selected mental disorders to illustrate disorder-specific patterns in service utilisation. As an example of this approach, this chapter presents an overview of the available data on mental health care for people with depressive disorders.

This chapter describes the prevalence and burden of depressive disorders in the Australian community, the characteristics of mental health care and medication provided for people with these disorders and the health system costs associated with them.

The National Action Plan for Depression published in 2001 as part of the Second Plan of the National Mental Health Strategy and the focus on depression in the National Health Priority Areas are examples of national activities relating to depressive disorders in Australia (DHAC 2000c, DHAC & AIHW 1999).

The National Action Plan for Depression forms a foundation for the work of the National Depression Initiative, which supports additional clinical work on understanding depression. The work of the National Depression Initiative is being progressed through the company 'beyondblue', which is undertaking projects across Australia to increase community awareness and promotion of mental health issues in the Australian community.

Definitions

The term depression can be used to refer to a wide range of conditions from a low mood that most people experience at some time to a severe psychiatric disorder (DHAC & AIHW 1999). It is part of a broader group of mental disorders called mood (affective) disorders. The following definitions cover a number of the terms used in this chapter that relate to depression.

Mood (affective) disorders

Mood (affective) disorders include all disorders that are characterised by mood disturbance such as depression, dysthymia, mania, hypomania and bipolar affective disorder. In the International Classification of Diseases, 10th Revision (Australian Modification) (ICD-10(-AM)) these disorders are described as having a change in affect or mood to depression (with or without associated anxiety) or to elation as the fundamental disturbance (NCCH 2000). The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

Depressed mood

Depressed moods are common and short term, lasting minutes to a few days. The individual feels hopeless, helpless, pessimistic, self-critical and has lowered self-esteem. These moods can be severe but are generally brief (DHAC & AIHW 1999).

Depression

Depression is a mood disorder characterized by feelings of sadness, loss of interest or pleasure in nearly all activities, feelings of hopelessness and suicidal thoughts or self-blame (DHAC & AIHW 1999).

In ICD-10(-AM) (NCCH 2000), depression is represented as two categories, depressive episodes (code F32) and recurrent depressive disorders (code F33).

Depressive episode

In ICD-10(-AM), a depressive episode is described as a suffering from lowering of mood, reduction of energy, and decrease in activity (NCCH 2000). Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called 'somatic' symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.

Recurrent depressive disorder

Recurrent depressive disorder is described in ICD-10(-AM) as being characterised by repeated episodes of depression as described for depressive episode (F32), without any history of independent episodes of mood elevation and increased energy (mania) (NCCH 2000). There may, however, be brief episodes of mild mood elevation and overactivity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The duration varies from a few weeks to many months.

Data sources and definitions for depression in this chapter

Box 8.1 provides information on the source of the data on depression used in this chapter, the type of data used and the classification system used to define depression.

The definition of depression for the mortality data, hospital separations data and community mental health service contact data are based on the ICD-10(-AM) categories of depressive episode (F32) and recurrent depressive disorder (F33). Definitions used for other data sources are similar, but not exactly equivalent.

Prevalence

In 1997, the Australia Bureau of Statistics conducted the National Survey of Mental Health and Wellbeing of 10,600 people aged 18 years or over (ABS 1998).

Box 8.1: Depression data sources, type of data and classification system used

<i>1997 ABS National Survey of Mental Health and Wellbeing (NSMHWB)</i>	<i>NSMHWB uses the category affective disorders which comprise depression, dysthymia, mania, hypomania and bipolar affective disorder. In this survey most males (83%) and females (92%) with affective disorder had depression. All mental disorders, including depression, were diagnosed using the Composite International Diagnostic Interview (CIDI).</i>
<i>Child and Adolescent component of the 1997 ABS NSMHWB</i>	<i>As above, however the depressive disorders category also includes dysthymia (ICD-10-AM code F34.1).</i>
<i>AIHW National Hospital Mortality Database</i>	<i>Data on the underlying cause of death. Depression was defined as ICD-10 categories depressive episode (F32) and recurrent depressive disorder (F33).</i>
<i>AIHW Burden of Disease and Injury in Australia study</i>	<i>Data are disability-adjusted life years data (DALY). Depressive disorders were defined as ICD-9-CM categories major depressive disorder, single episode (296.2) and recurrent episode (296.3), other and unspecified affective psychoses (296.9), neurotic depression (300.4), and depressive disorder, not elsewhere classified (311)</i>
<i>BEACH survey of general practitioners</i>	<i>Data on encounters from the 2002-03 BEACH survey of general practitioners. Depression was defined as codes P03 (feeling depressed) and P76 (depressive disorder) from the International Classification for Primary Care (ICPC-2).</i>
<i>AIHW National Community Mental Health Care Database</i>	<i>Data are for service contacts in specialised mental health outpatient and ambulatory community-based services. Depression was defined as ICD-10-AM categories depressive episode (F32) and recurrent depressive disorder (F33).</i>
<i>AIHW National Hospital Morbidity Database</i>	<i>Ambulatory-equivalent admitted patient care data and hospital admitted patient care data. Depression was defined as ICD-10-AM categories depressive episode (F32) and recurrent depressive disorder (F33).</i>
<i>Health service expenditure data</i>	<i>Health service expenditure data by disease and injury categories for depression. Depression was defined as ICD-10-AM categories depressive episode (F32) and recurrent depressive disorder (F33) for 2000-01 and as for depressive disorders in the Burden of Disease and Injury in Australia study in 1993-94.</i>

In 1998, the University of Adelaide undertook the Child and Adolescent component of the National Survey of Mental Health and Wellbeing (Sawyer et al. 2000). The study examined the prevalence of clinically significant mental disorders, including depressive disorders, among Australians aged 6-17 years using the Diagnostic Interview Schedule for Children (Version IV). Depressive disorders were reported for 3.7% of children and adolescents (Table 8.2).

The National Health Survey conducted by the ABS in 2001 estimated that 4.7% of Australians had taken an antidepressant for their mental wellbeing within the prior two weeks (Table 1.2). Almost 6.0% of females had reported using an antidepressant compared with 3.4% of males.

Table 8.1: Prevalence of affective disorders^(a) in adulthood, Australia, 1997

Per cent of population	18–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years and over	Total
Males	2.9	4.9	6.0	5.4	3.2	^(b) 0.8	4.2
Females	10.7	8.4	8.5	7.3	6.9	2.4	7.4
Persons	6.7	6.6	7.2	6.4	5.0	1.7	5.8

(a) Affective disorders comprised depression, dysthymia, mania, hypomania and bipolar affective disorder. Depression comprised the majority of these affective disorders. There were 92% of females and 83% of males with depression as their affective disorder.

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

Source: ABS 1998.

Table 8.2: Prevalence of depressive disorders^(a) in children and adolescents, Australia, 1998

Per cent of population	6–12 years	13–17 years	Total
Males	3.7	4.8	4.2
Females	2.1	4.9	3.2
Persons	n.a.	n.a.	3.7

(a) Depressive disorders included depressive episodes, recurrent depressive disorders and dysthymia.

n.a. Not available.

Source: Sawyer et al. 2000.

Mortality

In 2002, there were 3,172 deaths where depressive disorder was the underlying cause of death. Between 1997 and 2002 the age-standardised mortality rate for depressive disorders (ICD-10 codes F32–F33) as the underlying cause of death decreased from 17 deaths per 100,000 population in 1997 to 15.6 deaths in 2002. The decrease was solely due to a decline in male deaths from these disorders, down from 19.1 deaths per 100,000 males in 1997 to 16.1 deaths in 2002. The rate for females remained comparatively stable (14.4 per 100,000 females in 1997 and 14.8 in 2002) (AIHW National Mortality Database).

Burden

In 1999, the *Burden of Disease and Injury in Australia* study attempted to measure and compare the burden for all diseases and injuries in Australia (AIHW: Mathers et al. 1999). The study utilised a health summary measure called a disability-adjusted life year, or DALY, developed by Murray & Lopez (1996). This measure was designed to combine the concept of years of life lost due to premature death with a concept of years of equivalent healthy life lost through disability. One DALY represents one lost year of healthy life.

The study found that depressive disorders were a major burden in Australia, accounting for 3.7% of the total DALYs in 1996. Depressive disorders were the fourth leading cause of burden after ischaemic heart disease (12.4%), stroke (5.4%) and chronic obstructive pulmonary disease (3.7%). Depressive disorders were not a leading cause of mortality (0.02% of years lost due to mortality), but were associated with 8% of the years lost due to disability.

Mental health care

This section summarises the available data on the utilisation of mental health-related services by people with depression. National data on the treatment, care and medication provided for those experiencing depression are largely limited to general practice, private psychiatrist services, community mental health care and admitted patient care.

The main sources of data on the activities of general practitioners and private psychiatrists in Australia are the Medicare and PBS data collections and the BEACH survey. However, the Medicare data collection does not include any data items that could be used to identify those attendances where depression was managed or treated. The PBS data collection includes information on the type of medication prescribed, classified according to the Anatomical Therapeutic Chemical (ATC) classification. In the ATC, antidepressant medications are classified as code N06A, which consists of four distinct sub-categories, as follows:

- Non-selective monoamine re-uptake inhibitors, also called tricyclics (ATC code N06AA)
- Selective Serotonin Re-uptake Inhibitors (SSRIs) (ATC code N06AB)
- Non-selective monoamine oxidase inhibitors (MAOIs) (ATC codes N06AG and N06AF)
- Other antidepressants (ATC code N06AX)

The BEACH survey includes information on the reason for the patient visit (encounter), the problem that was managed, the medication that was prescribed, supplied or recommended and whether a referral was made.

People with depression do not always utilise health care services for their condition. Only 56% of those with affective disorders (and no other mental disorders) sought any form of health care in the previous twelve months (ABS 1998). Forty per cent had seen a general practitioner in the previous twelve months, 8.4% had seen a psychiatrist and 6.2% had seen a psychologist (Andrews et al 1999).

Ambulatory mental health care

General practice

As noted above, the greatest proportion of people with depression who utilise health services see general practitioners. Figure 8.1 describes BEACH data on encounters where depression was managed and how this relates to other data collected for the encounter. In 2002–03, depression was managed at 3.5% of general practitioner encounters, a level that has been consistent since 1998–99 when the BEACH survey commenced. In this time depression has also consistently accounted for around 2.4% of all problems managed by general practitioners. Based on these data, it is estimated that there were 3.4 million visits to general practitioners that involved the management of depression in 2002–03, the same number of estimated visits as in 2001–02.

Patients aged between 25–44 years (37.5%) and 45–64 years (35.1%) accounted for the greatest proportion of depression problems managed. Patients were predominantly female (67.9%). Given that 73% of general practitioners were located in major cities or other metropolitan areas, it is not surprising that general practitioners who resided in these areas managed the majority of problems relating to depression (71.5%).

The most commonly described patient reason for these encounters was depression, reported at a rate of 46.7 per 100 encounters at which depression was managed. A prescription request was also a common reason, recorded at 18.7 per 100 of these encounters.

Clinical treatments were utilised at a much higher rate than in the total data set (53.8 per 100 depression problems managed, compared with 47.4 per 100 mental health-related problems overall) (Table 3.10). Psychological counselling was the most common clinical treatment, at 40.2 per 100 depression problems. The patient was referred to other health professionals at a rate of 8.6 per 100 depression problems managed, most commonly to a psychiatrist (3.7).

Antidepressant medication and general practice

During 2002–03, general practitioners prescribed a total of 9.3 million PBS-subsidised antidepressant medications (Table 3.13). This equated to 470 antidepressant prescriptions per 1,000 population and was a 148% increase on 1994–95 (compared with increases of 56.8% for private psychiatrists and 140.5% for other medical specialists). Antidepressant medication made up 6.5% of total medications prescribed by general practitioners (compared with 54.2% for private psychiatrists and 2.6% for non-psychiatrist specialists).

Based on BEACH data, medications were prescribed or supplied for depression at a rate of 79.2 per 100 depression problem contacts in 2002–03 (Table 3.12). Two SSRI medications (sertraline and citalopram) were the medications most frequently prescribed for depression, at rates of 16.6 and 12.9 per 100 depression problem contacts, respectively (Figure 8.1).

Male patients were more likely to be prescribed antidepressant medication by general practitioners (82.3 antidepressant medications prescribed per 100 depression problems managed) than were female patients (77.8 per 100). Persons aged between 45 and 64 years (37%) received the highest proportion of antidepressant medications prescribed by general practitioners.

The rate of antidepressant medication per 100 depression encounters increased from 62.2 medications per 100 depression encounters in 1998–99 to 67.4 medications per 100 depression encounters in 2002–03. A key change was an increase in the rate of prescribing of SSRIs, from 34.7 to 44.5 medications per 100 depression encounters. Other antidepressants increased from 6.5 to 12.3 medications per 100 depression encounters, largely due to the increase in the prescription of venlafaxine. These increases were accompanied by a decline in the prescription of tricyclic and MAOI medications. Tricyclics declined from 14.4 medications per 100 depression encounters in 1998–99 to 8.4 in 2002–03. Similarly MAOIs declined from 6.9 in 1998–99 to 2.1 in 2002–03 (Britt et al 2002 and unpublished BEACH data).

Private psychiatry

Private psychiatrists prescribed 968,777 antidepressant medications during 2002–03 (50.0 antidepressant prescriptions per 1,000 population) (Table 3.16). This was a 56.8% increase on the 617,871 (34.4 per 1,000 population) prescribed in 1994–95. The private psychiatrist prescribed antidepressant medications made up 54.2% of the total medications prescribed by private psychiatrists and 9.1% of all antidepressants prescribed under the PBS.

Consistent with prescribing patterns by general practitioners, females were more likely to be prescribed antidepressant medications by private psychiatrists (58% of these prescriptions) than males (42%). Persons aged between 35 and 54 years (43%) received the highest proportion of antidepressant medications prescribed by private psychiatrists.

Outpatient services and community-based ambulatory mental health care

Data on these services presented in this report are drawn from the National Community Mental Health Care Database (NCMHCD). The data quality concerns pertaining to this data collection are detailed in Chapter 3 (e.g. the proportion of service contacts with no principal diagnosis reported).

In 2001–02, of service contacts provided by those ambulatory mental health services for which a principal diagnosis was reported, depression (ICD-10-AM codes F32–F33) was reported for 14.2% (396,448 service contacts) (Table 3.20).

Depression was more frequently reported for females (64.0% of service contacts with a depression diagnosis or a rate of 25.9 of these service contacts per 1,000 females) (Table 8.3). The rate for males was 14 per 1,000. Patients in the 35–44 year age group had the highest rate of service contacts with a depression diagnosis (23.8 per 1,000 in this age group) followed by patients aged between 25 and 34 years (22.5 per 1,000).

There were 2.2% of patients with depression-related service contacts who identified as Aboriginal and/or Torres Strait Islander.

A small proportion of depression-related service contacts were involuntary (1.0%).

Ambulatory-equivalent admitted patient care

Figure 8.2 describes hospital separations that were considered equivalent to ambulatory mental health care (see Appendix 3) and where the patient's principal diagnosis was depression (ICD-10-AM codes F32–33). In 2001–02, there were 29,423 separations with a principal diagnosis of depression with 26,672 psychiatric care days. The majority of patients (93.8%) had acute care. A small proportion of these separations were involuntary (0.3%).

Almost 87% of separations with this principal diagnosis were in private hospitals. Since 1998–99 the number of these separations that were in private hospitals increased 35% (from 18,953 separations to 25,591 in 2001–02). During the same period the number of these separations that were in public hospitals decreased by 18% (from 4,684 separations to 3,832) (Table 8.4).

The most common diagnosis in addition to a principal diagnosis of depression was *Persons encountering health services for other counselling and medical advice (Z71)*, while the most common procedures performed were *Psychological therapies (Block 1873)* and *Generalised allied health interventions (Block 1916)*. The most commonly reported AR-DRG was *Mental health treatment, same day, without electroconvulsive therapy (AR-DRG U60Z)*.

Hospital admitted patient care

Figure 8.3 describes available data for mental health-related separations that were considered as not equivalent to ambulatory mental health care and where the patient's principal diagnosis was depression (ICD-10-AM codes F32–F33). There were 39,027 separations with a principal diagnosis of depression with 333,818 psychiatric care days and 422,801 patient days. The average length of stay was 10.8 days and the median length of stay was 8 days. Over two thirds (66.9%) of separations with this principal diagnosis were in public hospitals. The majority of patients (93.9%) had acute care. A small proportion of these separations were involuntary (7.5%).

Separations with a principal diagnosis of depression accounted for 24,895 (22.4%) of mental health-related separations with specialised psychiatric care and 14,132 (18.6%) of mental health-related separations without specialised psychiatric care (Tables 5.6 and 6.4).

The most common diagnosis in addition to a principal diagnosis of depression was *Personal history of risk-factors* (Z91), while the most common procedures performed were *Electroconvulsive therapy* (Block 1907) and *General anaesthesia* (Block 1910). The most commonly reported AR-DRG was *Major affective disorder age less than 70 without catastrophic or severe complications or comorbidities* (AR-DRG U63B).

The total number of mental health-related separations, including ambulatory equivalent separations, with a principal diagnosis of depression increased from 58,682 in 1998–99 to 68,450 in 2001–02 (Table 8.4), with 86% of the increase in private hospitals. However the number of patient days decreased (460,690 in 1998–99 to 452,224 in 2001–02). The number of same day separations in public acute hospitals rose 49% during this period (from 4,886 to 7,294) and 69% in private hospitals (from 1,353 to 2,284).

Health service expenditure for depression

A detailed analysis of health service expenditure by disease and injury categories, including mental health, has been undertaken for 1993–94 and 2000–01 (AIHW 2004a). For 2000–01 it was estimated that health care expenditure for depression (ICD-10-AM codes F32–F33), was \$1.0 billion (1.8% of recurrent health expenditure) (Table 8.5). (This expenditure excludes community mental health expenditure, as this expenditure was not able to be allocated to the different mental health disorders.) The majority of this \$1.0 billion expenditure was for out-of-hospital medical services (33% or \$330 million) such as unreferral attendances, imaging and pathology, and for pharmaceutical services (30% or \$302 million).

In comparison, the health care expenditure for depression in 1993–94 (2000–01 prices) was estimated at \$601 million or 1.5% of recurrent health care expenditure. This was mostly for hospital services (38% or \$226 million), out-of-hospital medical services (28% or \$168 million) and services in aged care homes (17% or \$104 million). The proportion of expenditure on pharmaceutical services in 1993–94 was lower (13% or \$79 million) than in 2000–01.

Table 8.3: Community mental health care service contacts and per 1,000 population^(a) by sex and age group, with a principal diagnosis of depression (F32–F33), 2001–02^(b)

	Less than 15 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years and over	Total ^(c)
Sex	Number							
Males	5,421	18,813	21,441	23,939	18,596	14,755	31,722	134,749
Females	6,684	37,911	41,717	44,965	32,674	19,665	69,790	253,584
Total^(c)	13,031	58,024	64,751	70,673	52,306	35,249	102,145	396,448
	Per 1,000 population							
Males	3.4	29.1	28.9	30.1	24.5	21.8	51.4	14.0 ^(d)
Females	2.7	13.9	15.0	16.2	14.0	15.9	29.5	25.9 ^(d)
Total^(c)	3.3	21.9	22.5	23.8	19.7	19.3	41.9	20.4^(d)

(a) The rate per 1,000 population is a crude rate based on the Estimated Resident Population at 31 December 2001.

(b) These data should be interpreted with caution due to incomplete coverage and inconsistencies in the definition of a service contact used between jurisdictions. For more information refer to Appendix 4.

(c) Includes service contacts for which sex and/or age group was not reported.

(d) Total rates were indirectly age-standardised to the Estimated Resident Population at 31 December 2001.

Table 8.4: Separations and patient days for mental health-related separations with a principal diagnosis of depression (F32–F33) by separation and hospital type, Australia, 2001–02

Hospital and separation type	1998–99		1999–00		2000–01		2001–02	
	Separations	Patient days	Separations	Patient days	Separations	Patient days	Separations	Patient days
Public acute hospitals								
Ambulatory-equivalent mental health care ^(a)	4,550	4,550	4,810	4,810	4,906	4,906	3,570	3,570
Other								
Same day	4,886	4,886	4,943	4,943	5,904	5,904	7,294	7,294
Overnight	17,209	205,319	17,808	207,345	17,847	206,221	17,508	191,147
<i>Total</i>	<i>22,075</i>	<i>210,205</i>	<i>22,751</i>	<i>212,288</i>	<i>23,751</i>	<i>212,125</i>	<i>24,802</i>	<i>201,441</i>
Public psychiatric hospitals								
Ambulatory-equivalent mental health care ^(a)	134	134	608	608	205	205	262	262
Other								
Same day	142	142	137	137	387	387	68	68
Overnight	1,643	49,570	1,532	43,331	1,317	28,373	1,250	25,849
<i>Total</i>	<i>1,785</i>	<i>49,712</i>	<i>1,669</i>	<i>43,468</i>	<i>1,704</i>	<i>28,760</i>	<i>1,318</i>	<i>25,917</i>
Private hospitals								
Ambulatory-equivalent mental health care ^(a)	18,953	18,953	19,320	19,320	21,629	21,629	25,591	25,591
Other								
Same day	1,353	1,353	1,408	1,408	1,911	1,911	2,284	2,284
Overnight	9,832	175,803	9,748	171,198	10,445	189,469	10,623	193,159
<i>Total</i>	<i>11,185</i>	<i>177,156</i>	<i>11,156</i>	<i>172,606</i>	<i>12,356</i>	<i>191,380</i>	<i>12,907</i>	<i>195,443</i>
Total	58,682	460,690	60,314	453,100	64,551	459,005	68,450	452,224

(a) See Appendix 3 for the definition of ambulatory-equivalent mental health-related separations.

Table 8.5: Health system costs of depression^(a) in Australia, 2000–01 and 1993–94 (\$ millions)

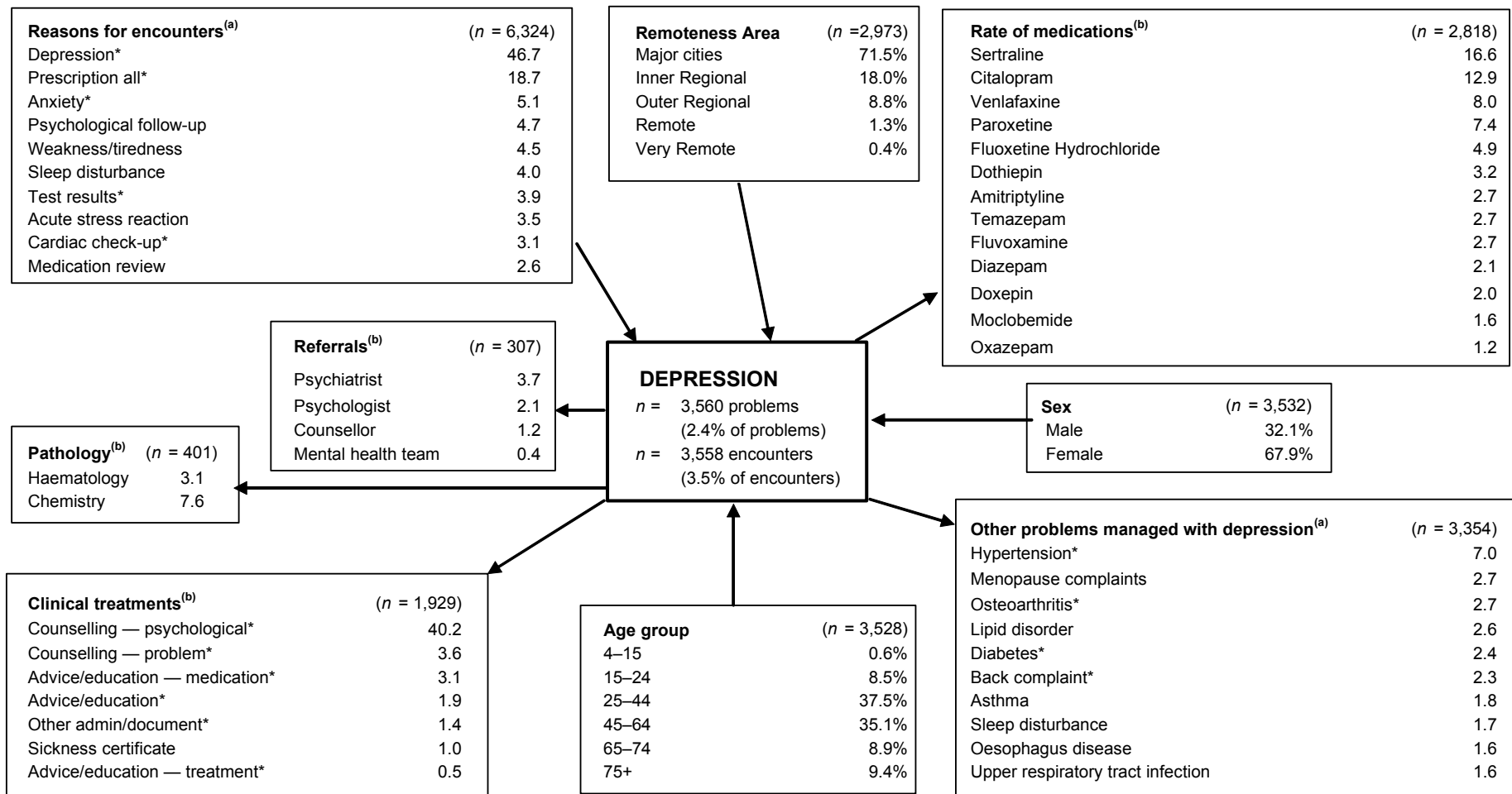
Year	Hospitals ^(b)	Aged care homes	Out-of-hospital medical ^(c)	Pharmaceuticals	Other professional services	Research	Total expenditure
2000–01	252	64	330	302	22	39	1,010
1993–94^(d)	226	104	168	79	14	10	601

(a) Includes ICD-10-AM codes F32–F33.

(b) Hospital costs include the costs of admitted and non-admitted patients and in-hospital private medical services.

(c) Out-of-hospital medical includes unreferral attendances, imaging, pathology and other medical.

(d) Expenditures for 1993–94 have been converted to 2000–01 prices by adjusting for health price inflation between 1993–94 and 2000–01.



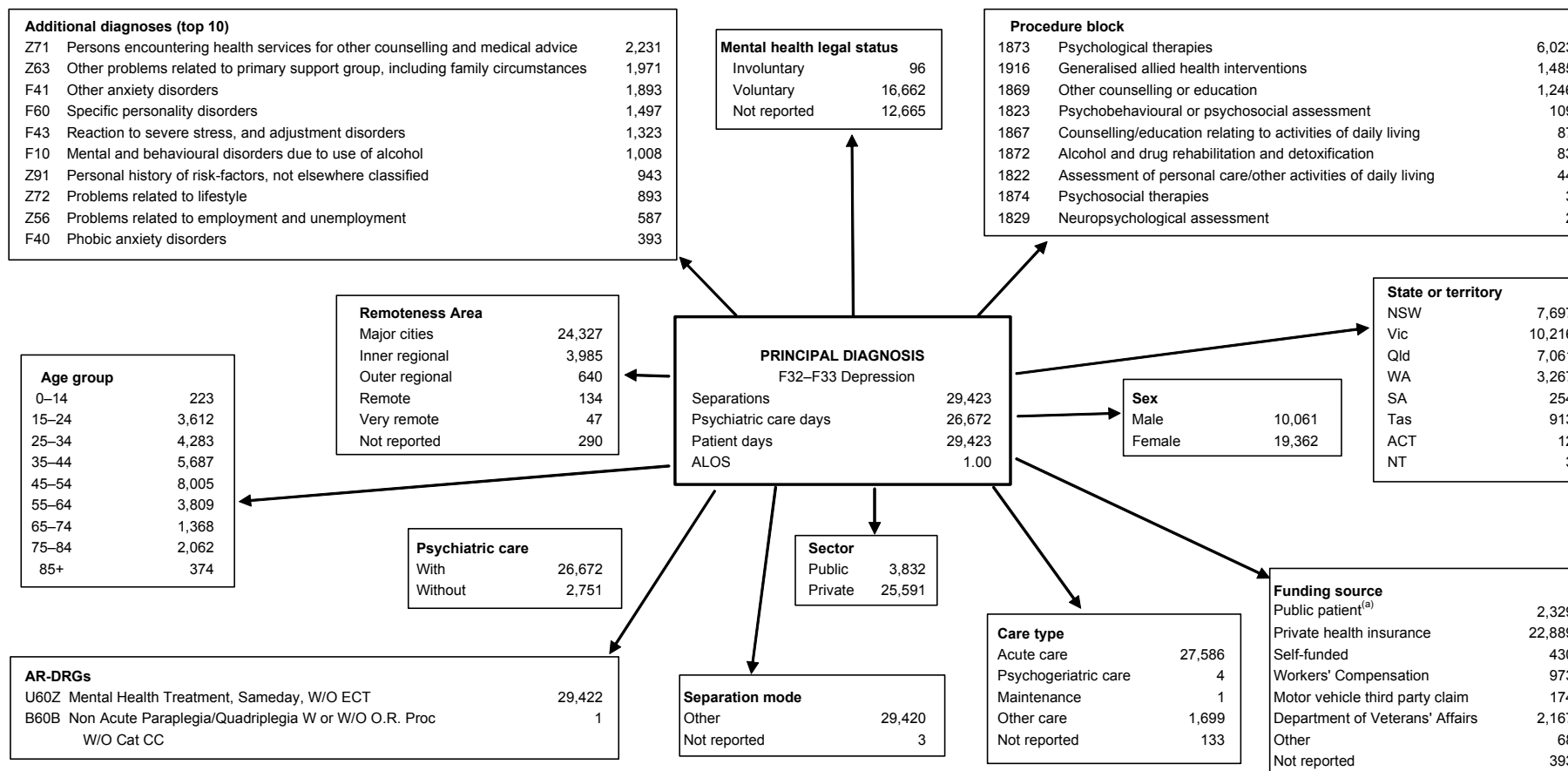
(a) Expressed as rates per 100 encounters at which depression was managed (n = 3,329).

(b) Expressed as rates per 100 depression problems managed (n = 3,329).

* Includes multiple ICPC-2 or ICPC-2 PLUS codes.

Source: BEACH

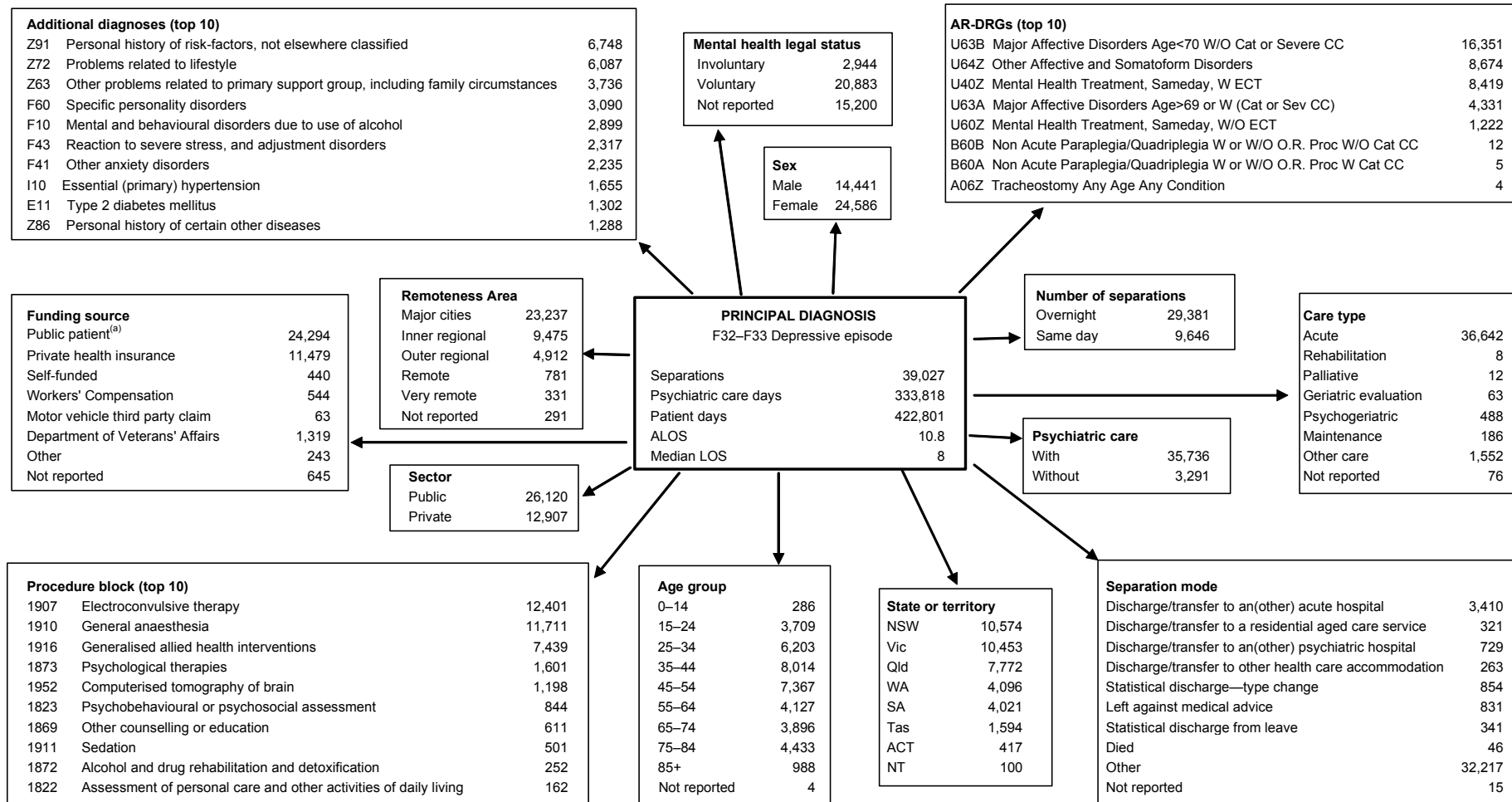
Figure 8.1: Data reported for encounters at which depression was managed, BEACH, 2001-02



(a) Public patients includes separations whose funding source was reported as *Australian Health Care Agreements* or *Reciprocal health care agreements*.

Note: Main abbreviations: ALOS—average length of stay, W—with, W/O—without, Cat—catastrophic, CC—complication or comorbidity, O.R.—Operating room, ECT—electroconvulsive therapy, Proc—procedures

Figure 8.2: Data reported for ambulatory-equivalent mental health-related separations with a principal diagnosis of depression (F32-F33), all hospitals, Australia, 2001-02



(a) Public patient includes separations whose funding source was reported as *Australian Health Care Agreements* or *Reciprocal health care agreements*.

Note: Abbreviations: ALOS—average length of stay, W—with, W/O—without, Cat—catastrophic, Sev—severe, CC—complication or comorbidity, O.R.—Operating room, ECT—electroconvulsive therapy, Proc—procedures

Figure 8.3: Data reported for non-ambulatory-equivalent mental health-related separations with a principal diagnosis of depression (F32-F33), all hospitals, Australia, 2001-02