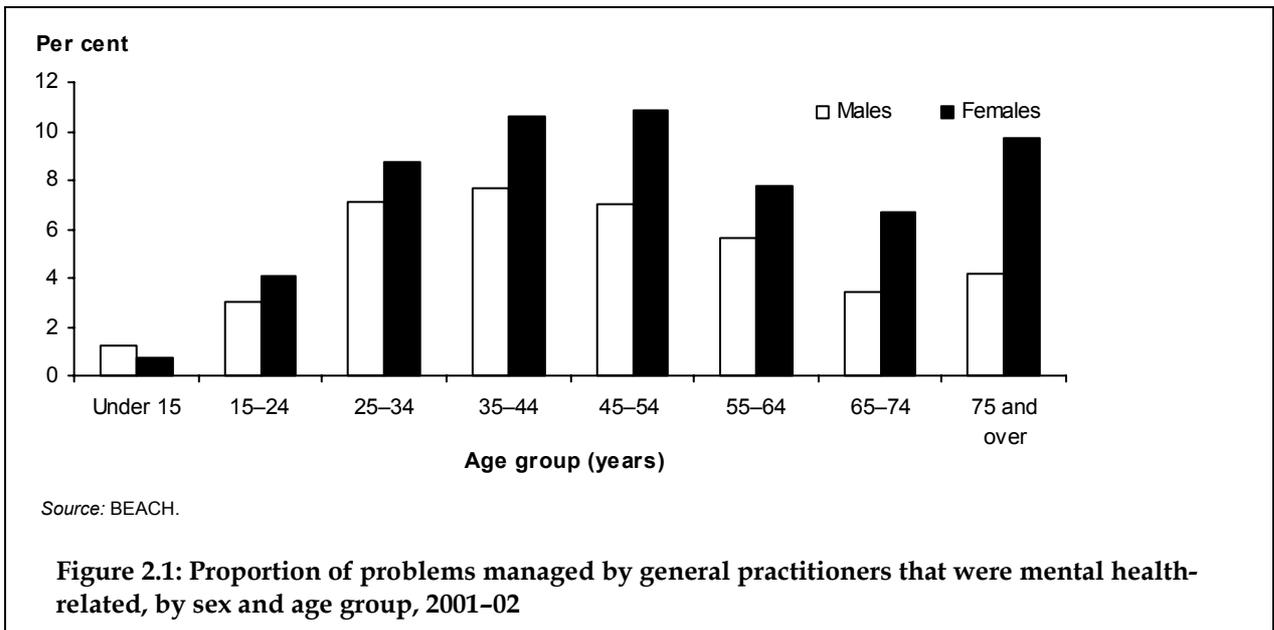


2 Overview

This chapter presents an overview of mental health-related service activity drawn from the more comprehensive data presented in Chapters 3, 4 and 5. The aim of this overview is to make key findings of this report accessible and to guide readers to the parts of the report relevant to their interests. Findings presented here do not represent performance indicators that relate to mental health services.

To obtain a more complete description of the data sources and their limitations, it is important to refer to relevant sections in later chapters, Appendix 1 and other documents as identified.

Mental health care in general practice



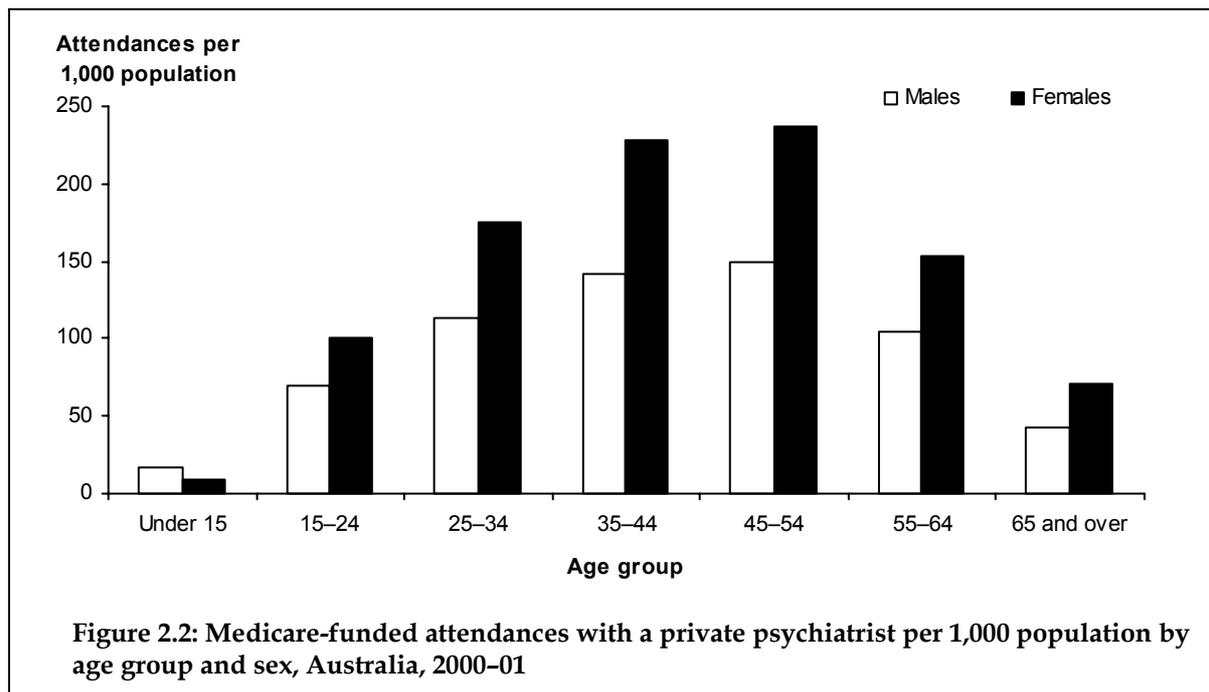
- The partnerships in service reform and service delivery theme of the Second Plan of the National Mental Health Strategy highlights the importance of building strategic alliances with services outside the specialised mental health care sector. General practitioners play an important role in the primary care and referral to specialist services of people with mental disorders.
- The Bettering the Evaluation and Care of Health (BEACH) program is an ongoing survey of general practitioners. Each year, 1,000 general practitioners report details on 100 consecutive encounters. More detail on the BEACH survey is presented in Appendix 1.
- During 2001-02, there were an estimated 10.2 million general practice encounters where mental health problems were managed. Mental health problems accounted for 7.4% of all problems managed by general practitioners.
- With the exception of the under 15 age group, a higher proportion of problems for female patients than for male patients (Figure 2.1) were mental health-related. The majority of patients with a mental health problem managed were aged 35-54 years.
- For both males and females, depression accounted for 32% of the mental health problems managed by general practitioners (Table 3.4).
- Between 1991 and 2000-01, the management rate for depression increased from 2.1 depression problems managed per 100 encounters to 3.4 (Britt et al. 1999, 2001).
- BEACH data from 1998-99 to 2000-01 indicate that prescriptions for Selective Serotonin Re-uptake Inhibitors (SSRIs) are gradually replacing prescriptions for older-style anti-depressants (Britt et al. 2001).

For more information, see:

Chapter 3 in this report (Tables 3.1-3.13).

Britt et al. 2002.

Medicare-funded attendances with a private psychiatrist



	Under 15	15-24	25-34	35-44	45-54	55-64	65 and over	Total
Sex	Attendances per 1,000 population							
Males	16.6	69.2	113	141.6	149.1	104.1	42.6	87.0
Females	9.5	100.9	175.3	227.6	236.7	153.2	70.8	132.3

Source: www.hic.gov.au.

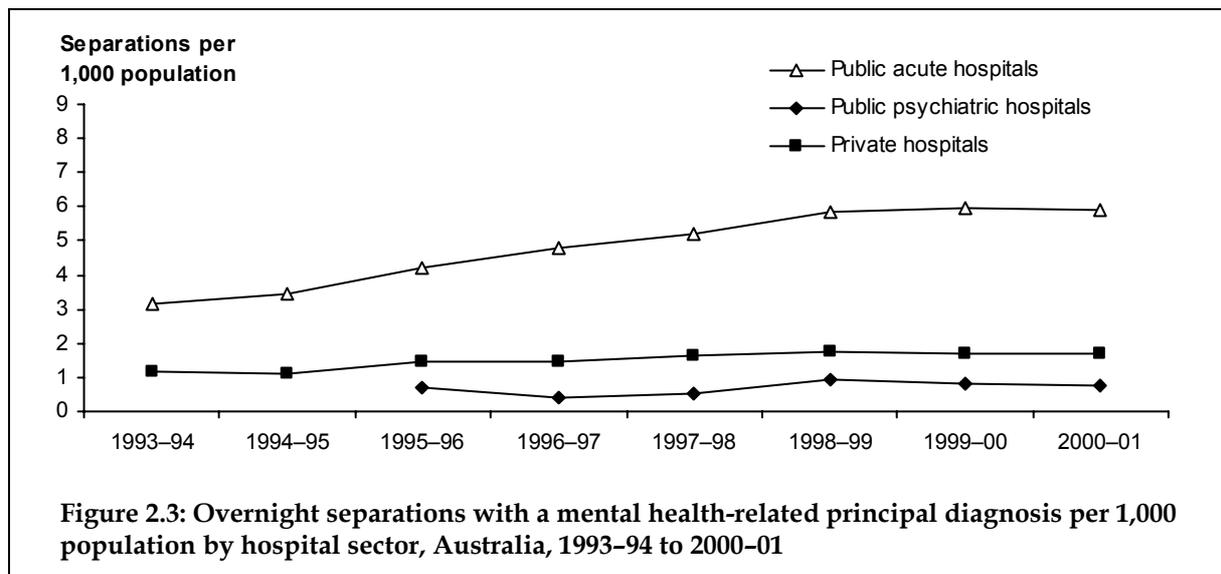
- The Health Insurance Commission (HIC) collects data on all psychiatrist services funded through Medicare. More detail on the Medicare data collection is presented in Appendix 1.
- During 2000-01, there were 2.1 million Medicare-funded attendances with private psychiatrists, 109.8 per 1,000 population. The number of these attendances per 1,000 population has been gradually falling since 1997-98 (Table 3.2).
- With the exception of the under 15 age group, there were more of these attendances reported for female patients than for male patients (Figure 2.2). The number of attendances per 1,000 population was largest for both male and female patients aged 35-54 years.
- According to the BEACH survey, most referrals for mental health-related problems from general practitioners were to a psychiatrist (2.2 referrals per 100 mental health-related problems) (Table 3.5).

For more information, see:

Chapter 3 in this report (Tables 3.2, 3.5, 3.14 and 3.15)

Chapter 5 in this report (Table 5.4).

Mental health-related hospital separations



Hospital type	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01
	Overnight separations per 1,000 population ^(a)							
Public acute hospitals	3.2	3.4	4.2	4.8	5.2	5.8	5.9	5.9
Public psychiatric hospitals	n.a.	n.a.	0.7 ^(b)	0.4	0.5	0.9	0.8	0.7
Private hospitals	1.2	1.1	1.4	1.5	1.7	1.7	1.7	1.7
Total^(b)	n.a.	n.a.	n.a.	6.7	7.3	8.5	8.4	8.3

(a) Rates are directly age-standardised to the Australian population at 30 June 1991.

(b) Totals for 1993-94 and 1994-95 do not include separations from public psychiatric hospitals and the total for 1995-96 does not include Queensland. They are therefore not comparable with total rates from 1996-97 onwards.

Source: AIHW National Hospital Morbidity Database.

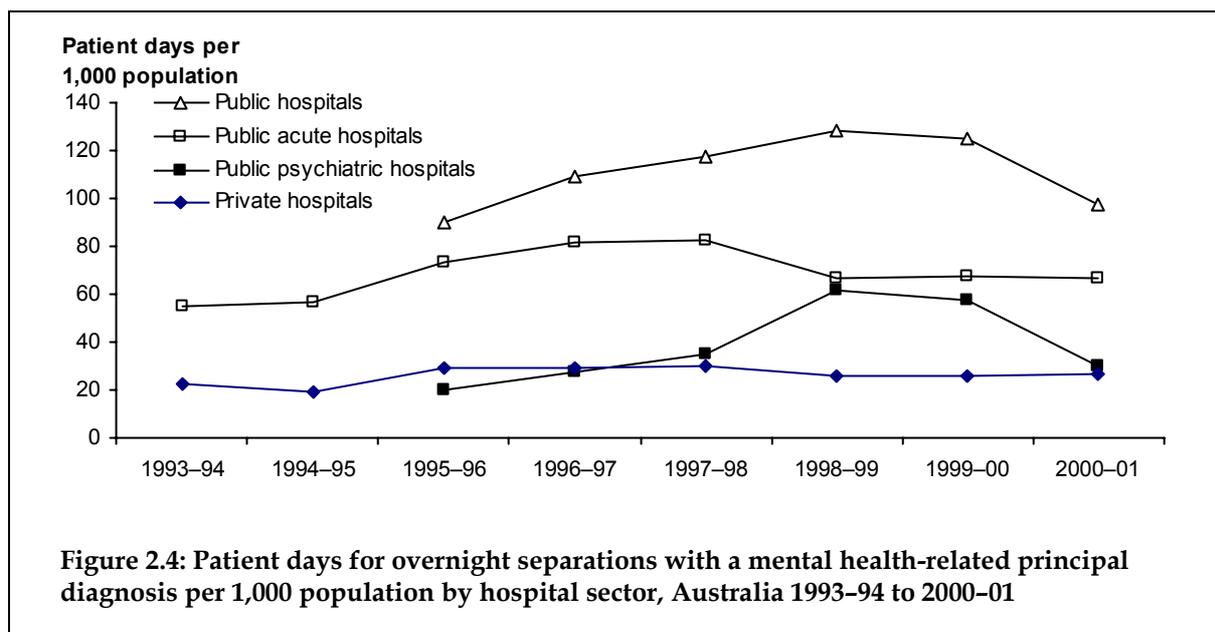
- An objective of the National Mental Health Strategy has been to reduce the size and number of stand-alone psychiatric hospitals and increase the activity of community-based services and general hospital psychiatric units.
- For mental health care, many same day separations can be regarded as being similar to ambulatory mental health care (e.g. group therapy). For this reason, only overnight separation data have been presented here.
- There were 166,279 overnight separations (i.e. a stay involving one or more nights) with a mental health-related principal diagnosis in 2000-01.
- The number of overnight separations with a mental health-related principal diagnosis per 1,000 population

increased between 1995-96 and 2000-01 for public acute hospitals (Figure 2.3). The number of these separations per 1,000 population remained comparatively stable for public psychiatric and private hospitals during this period.

- Separations from hospital are a commonly used measure of hospital activity. However, separation data can be a poor measure of hospital activity where patients stay for prolonged periods. For more detail on methods of measuring hospital activity refer to Box 4.2.

For more information, see:
Chapter 4 in this report (Tables 4.1 and 4.2).

Mental health-related patient days



Hospital type	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01
	Overnight patient days per 1,000 population ^(a)							
Public hospitals								
Public acute hospitals	55.0	56.7	73.4	81.9	82.7	66.7	67.9	67.0
Public psychiatric hospitals	n.a.	n.a.	20.2 ^(b)	27.1	34.7	61.6	57.4	30.3
<i>Total</i>	<i>n.a.</i>	<i>n.a.</i>	93.6	109.0	117.4	128.3	125.3	97.3
Private hospitals	22.6	19.0	28.9	28.9	29.7	25.6	25.4	26.3
Total^(b)	n.a.	n.a.	n.a.	137.7	146.9	153.7	150.5	123.4

(a) Rates are directly age-standardised to the Australian population at 30 June 1991.

(b) Totals for 1993-94 and 1994-95 do not include separations from public psychiatric hospitals and the total for 1995-96 does not include Queensland. They are therefore not comparable with total rates from 1996-97 onwards.

Source: AIHW National Hospital Morbidity Database.

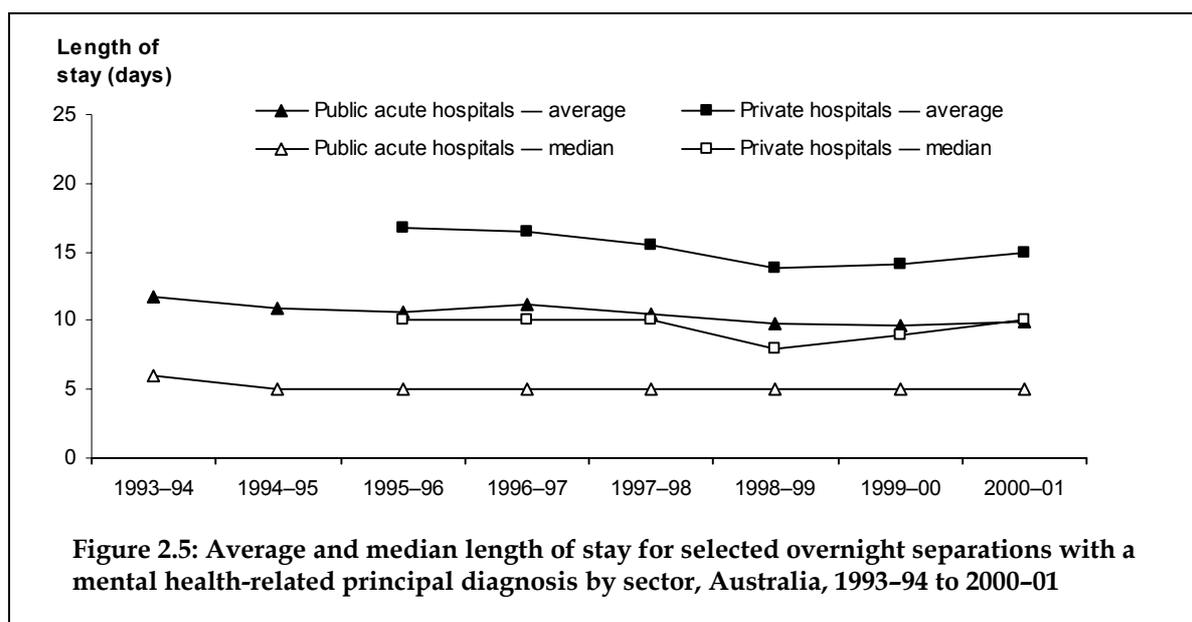
- Patient days are an alternative measure of hospital activity to separations. The patient day data presented includes all days of patient care received during the hospitalisation. Some of these may have occurred in previous years, particularly for public psychiatric hospitals, for which numbers of very extended stays were reported, particularly in 1998-99 and 1999-00.
- There were 2,482,811 patient days attributed to overnight separations with a mental health-related principal diagnosis in 2000-01. For public acute hospitals, the number of these patient days per 1,000 population increased from 55.0 in 1993-94 to 82.7 in 1997-98

(Figure 2.4). After that the rate decreased to 67.0 in 2000-01. These fluctuations were largely due to changes in the two largest States. In New South Wales before 1997-98 and Victoria before 1996-1997, beds were transferred from public psychiatric hospitals to public acute hospitals. The subsequent decrease was largely due to the transfer of beds for non-acute care from hospitals to community residential facilities.

- The rate for private hospitals remained stable throughout this period.

For more information, see:
Chapter 4 (Tables 4.1 and 4.3).

Average and median length of stay for hospital separations



	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01
Hospital type	Average length of stay (days)							
Public acute hospitals	11.8	10.9	10.6	11.2	10.5	9.8	9.7	9.9
Private hospitals ^(a)	n.a.	n.a.	16.8	16.5	15.5	13.9	14.0	15.0
Public acute and private hospitals^(a)	n.a.	n.a.	12.4	12.6	11.7	10.8	10.7	11.1
	Median length of stay (days)							
Public acute hospitals	6	5	5	5	5	5	5	5
Private hospitals ^(a)	n.a.	n.a.	10	10	10	8	9	10
Public acute and private hospitals^(a)	n.a.	n.a.	6	6	6	5	5	5

(a) Private hospital data for source of referral and referral to further care were unreliable for 1993-94 and 1994-95. Total figures for these years are therefore not available.

Source: AIHW National Hospital Morbidity Database.

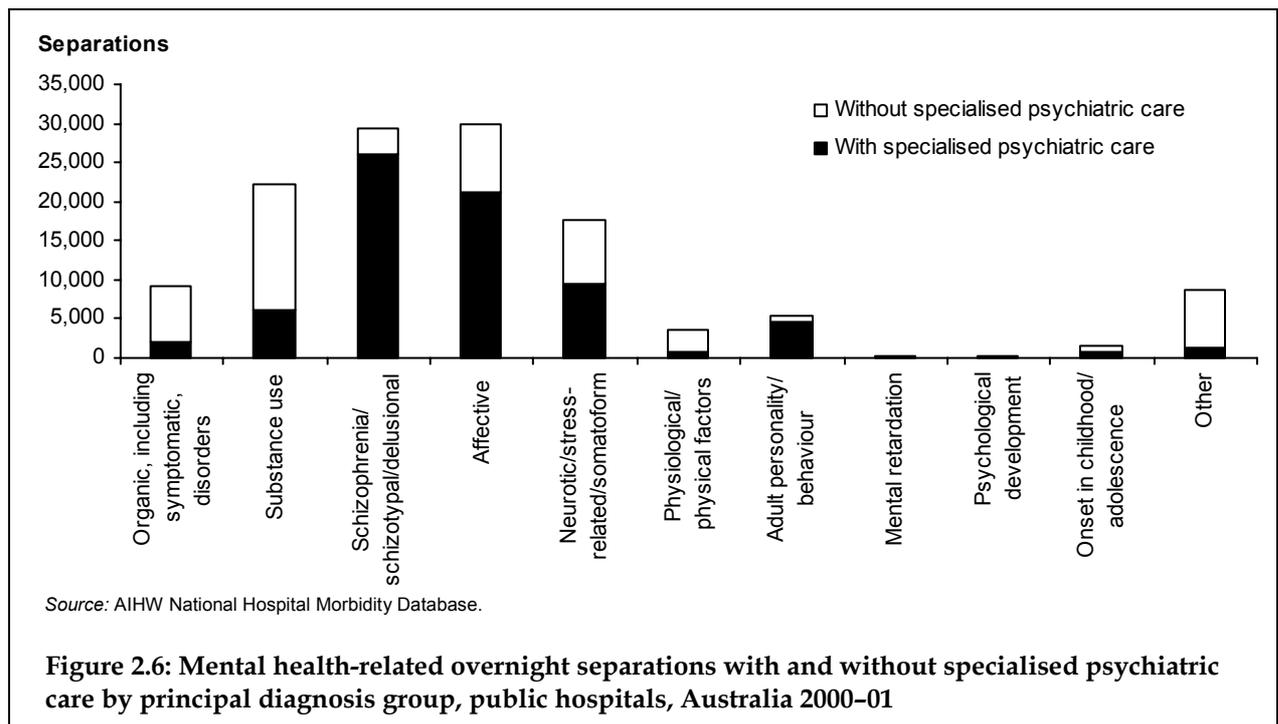
- Average length of stay (ALOS) data for this section excludes separations for patients who transferred from one hospital to another, who changed type of episode of care during their hospital stay, who died in hospital, who left against medical advice or who were transferred to a nursing home. It also excludes any separations admitted as a transfer from other hospitals or as the result of a change of care type. These exclusions were made because of changes in the reporting of modes of admission and separation between 1993-94 and 1999-00. These modes of admission and separation could have had the effect of artificially shortening

or lengthening the length of stay in hospital, and could reduce the comparability of ALOS data over time.

- For public acute hospitals, the ALOS for these selected separations decreased from 11.8 days in 1993-94 to 9.9 days in 2000-01 (Figure 2.5). Private hospital separations had longer average lengths than public acute hospital separations. In 2000-01, the median lengths of stay for public acute and private hospitals was 5 and 10 days, respectively.

For more information, see:
Chapter 4 in this report (Tables 4.35a, 4.35b, 4.36a and 4.36b).

Mental health-related hospital separations in public hospitals

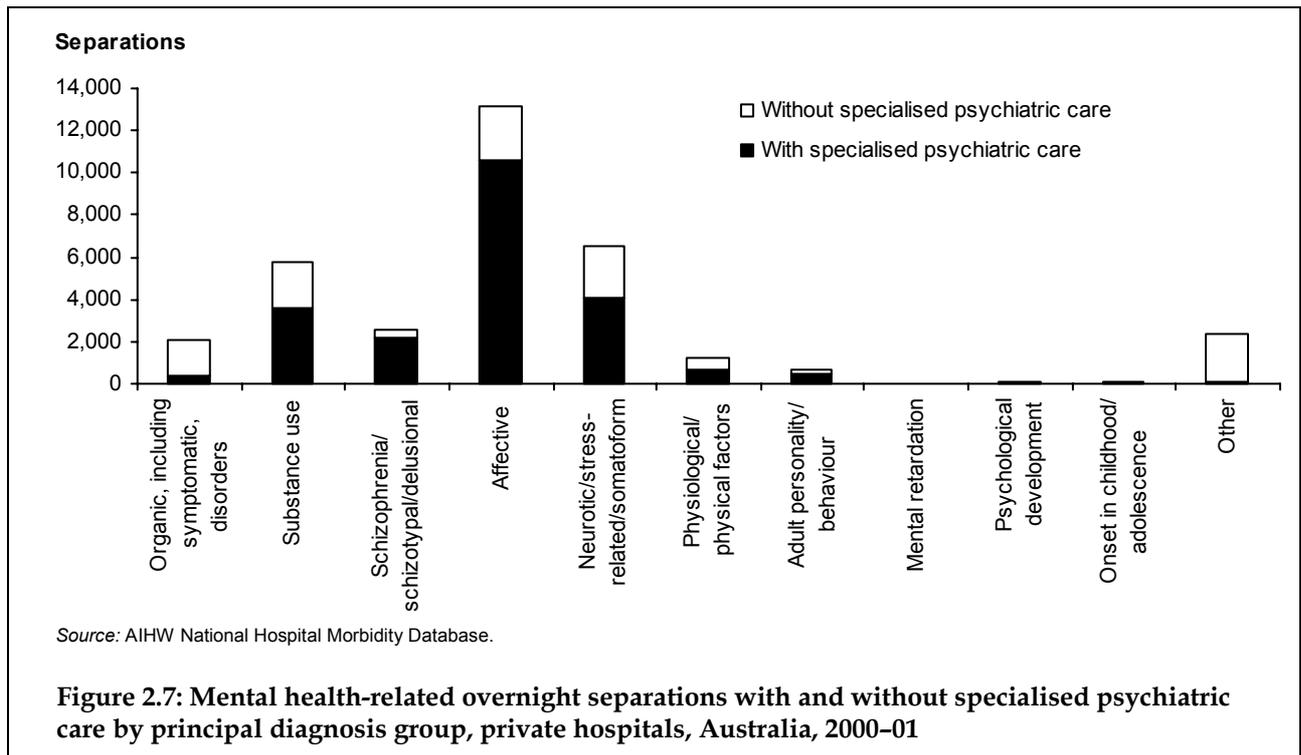


- Admitted patient care for patients with mental disorders can be either in a specialised psychiatric unit or hospital or in a unit or hospital not specialising in psychiatric care. Admission to a specialist psychiatric unit or hospital is not always the most appropriate treatment for all mental and behavioural disorders. For some disorders, treatment without specialised psychiatric care would be appropriate to the needs of the patient.
- There were 131,520 overnight mental health-related separations from public hospitals in 2000-01. Of these, 58.2% or 76,555 included a component of specialised psychiatric care, that is, care in a specialised psychiatric unit or hospital.
- Principal diagnoses of *Affective disorders* and *Schizophrenia, schizotypal and delusional disorders* were the most common for public hospital overnight separations (Figure 2.6).
- Overnight separations with specialised psychiatric care made up a small proportion of public hospital separations with principal diagnoses of *Organic mental disorders* and *Behavioural syndromes associated with physiological disturbances and physical factors*. A higher proportion of separations with principal diagnoses of *Affective disorders*, *Schizophrenia, schizotypal and delusional disorders* and *Disorders of adult personality and behaviour* had specialised psychiatric care.
- Overnight separations from hospital are a commonly used measure of hospital activity. For more detail on methods of measuring hospital activity refer to Box 4.2. The ICD-10-AM codes used to define these disorder groups are presented in Appendix 3.

For more information, see:

Chapter 4 in this report (Tables 4.10a, 4.10b and 4.11b).

Mental health-related hospital separations in private hospitals

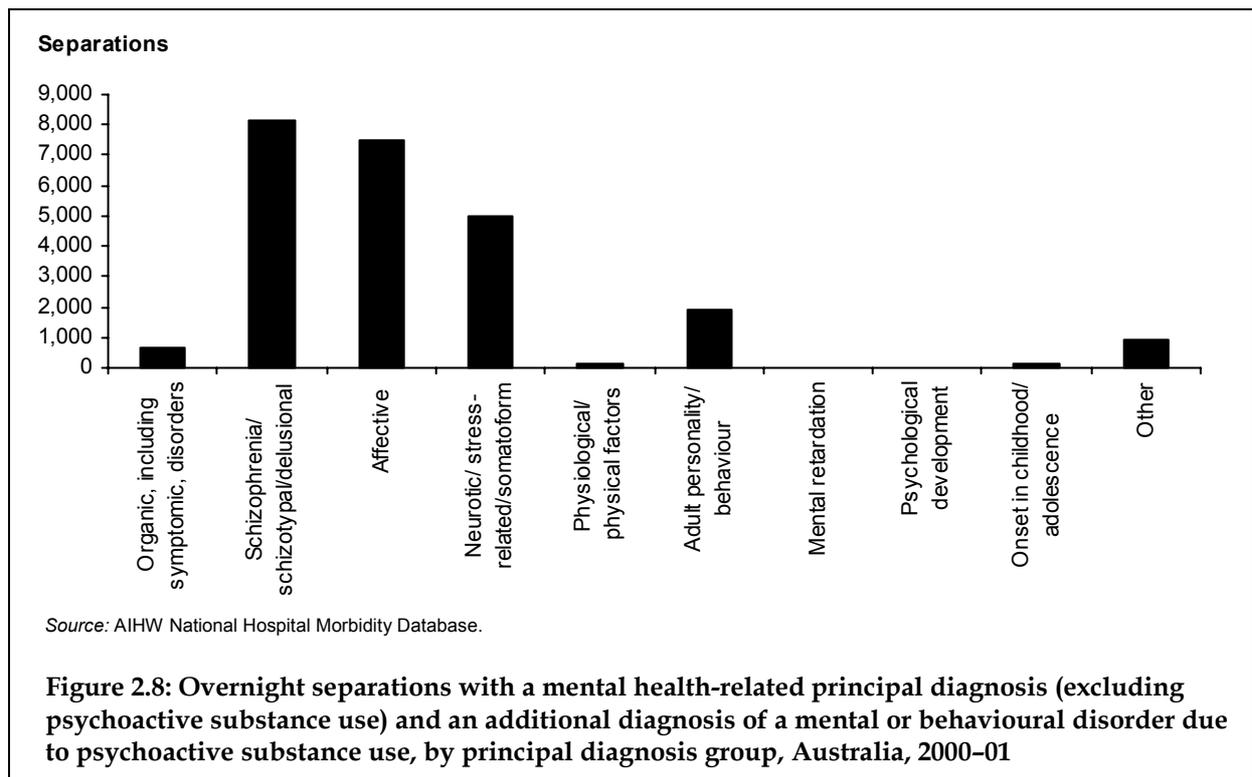


- Admitted patient care for patients with mental disorders can be either in a specialised psychiatric unit or hospital, or in a unit or hospital not specialising in psychiatric care.
- There were 34,759 overnight mental health-related separations from private hospitals in 2000-01. Of these, 64.6% or 22,461 included a component of specialised psychiatric care, that is care in a specialised psychiatric unit or hospital.
- Principal diagnoses of *Affective disorders* including depression, were the most common private hospital overnight separations, followed by *Neurotic, stress-related and somatoform disorders* (Figure 2.7).
- Private hospitals had a high proportion of separations for *Mental and behavioural disorders due to psychoactive substance use* that had specialised psychiatric care.
- Overnight separations with specialised psychiatric care made up a comparatively small proportion of private hospital separations with principal diagnoses of *Organic mental disorders* and *Disorders of psychological development*. A higher proportion of separations with principal diagnoses of *Affective disorders*, *Schizophrenia, schizotypal and delusional disorders* and *Disorders of adult personality and behaviour* had specialised psychiatric care.
- Overnight separations from hospital are a commonly used measure of hospital activity. For more detail on methods of measuring hospital activity refer to Box 4.2. The ICD-10-AM codes used to define these disorder groups are presented in Appendix 3.

For more information, see:

Chapter 4 in this report (Tables 4.10a, 4.10b, 4.11a and 4.11b).

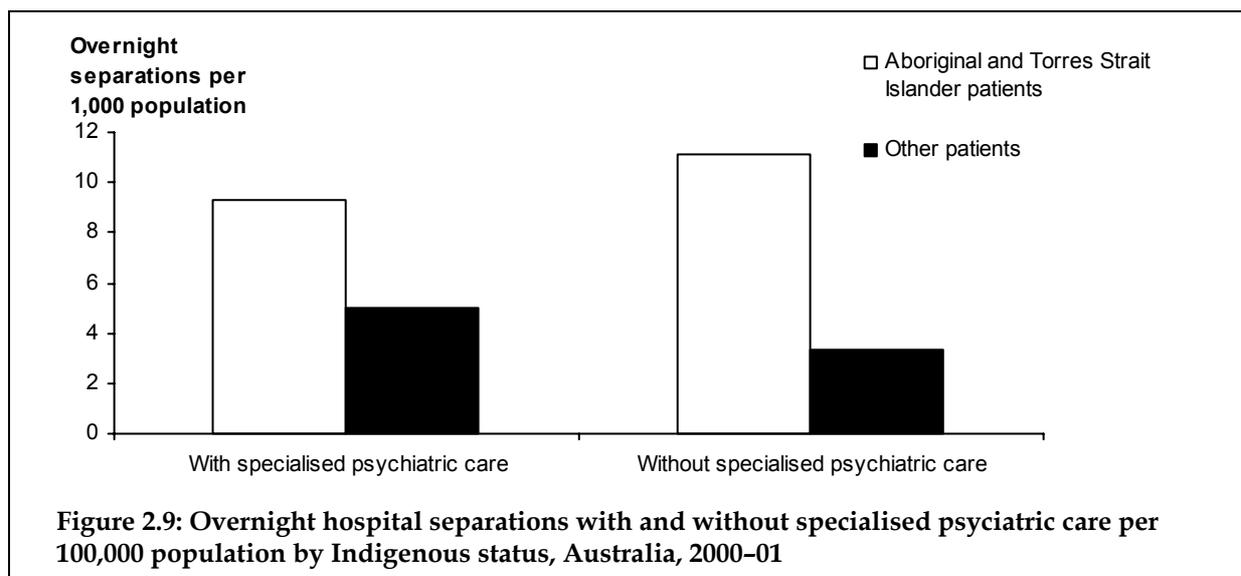
Hospital separations for mental and substance use disorders



- There is evidence that some people with mental disorders who also have a substance use disorder. The National Survey of Mental Health and Wellbeing of Adults found that about 30% of males and 19% of females with an anxiety and/or affective disorder also had a substance use disorder.
- Figure 2.8 presents data on the 24,424 overnight mental health-related hospital separations in 2000-01 where the principal diagnosis was a mental health disorder (excluding substance use disorders) and there was also an additional diagnosis of a substance use disorder. *Affective disorders* and *Schizophrenia, schizotypal and delusional disorders* were the most commonly reported principal diagnoses for these separations.
- There were also 6,788 overnight separations with principal diagnoses of substance use disorders and additional diagnoses of other mental health disorders (Table 4.21).
- Of general practitioner encounters involving the management of one or more mental health-related problems, 1.7% involved both a substance use problem and a mental health problem not involving substance use (0.1% of total problems managed).

For more information, see:
 Chapter 3 in this report (Tables 3.3 to 3.11)
 Chapter 4 in this report (Tables 4.21 to 4.22).

Hospital separations for Aboriginal and Torres Strait Islander people



Overnight separations per 1,000 population ^(a)	With specialised psychiatric care	Without specialised psychiatric care	Total
Aboriginal and Torres Strait Islander patients	9.3	11.1	20.3
Other patients	5.0	3.3	8.3
Total^(b)	5.1	3.5	8.7

(a) Separations per 1,000 population are indirectly age-standardised rates based on projected Aboriginal and Torres Strait Islander population for 30 June 1999 and the estimated resident population for 30 June 1999.

(b) Totals include separations of patients for whom Indigenous status was unknown or not reported.

Source: AIHW National Hospital Morbidity Database.

- Figure 2.9 shows that the number of overnight separations with specialised psychiatric care per 1,000 Aboriginal and Torres Strait Islander people was higher than that for other Australians (9.3 compared with 5.0).
- However, the proportion of care that was specialised was lower for Indigenous persons (46.7%) compared with other patients (60.2%). This reflects the much higher usage of non-specialised care by Indigenous people compared with other patients (Table 4.8).
- The comparatively high hospitalisation rate could be explained by a greater prevalence of mental disorders for Aboriginal and Torres Strait Islander people or different patterns of access of different types of services (e.g. ambulatory and admitted patient services).
- The higher rate of non-specialised care of Indigenous people can be partially explained by the differing pattern of disorders between Indigenous and other Australians. However, after directly standardising by diagnosis groups (as presented in Figure 2.6) the proportion of overnight separations that included specialised psychiatric care remained lower for Indigenous persons (46.9%) than other Australians (59.2%).
- The accuracy of Indigenous identification in hospital separations data needs improvement and these data need to be used with caution (refer to Chapter 4 for further details).

For more information, see:

Chapter 4 in this report (Table 4.8).
ABS and AIHW 2002.

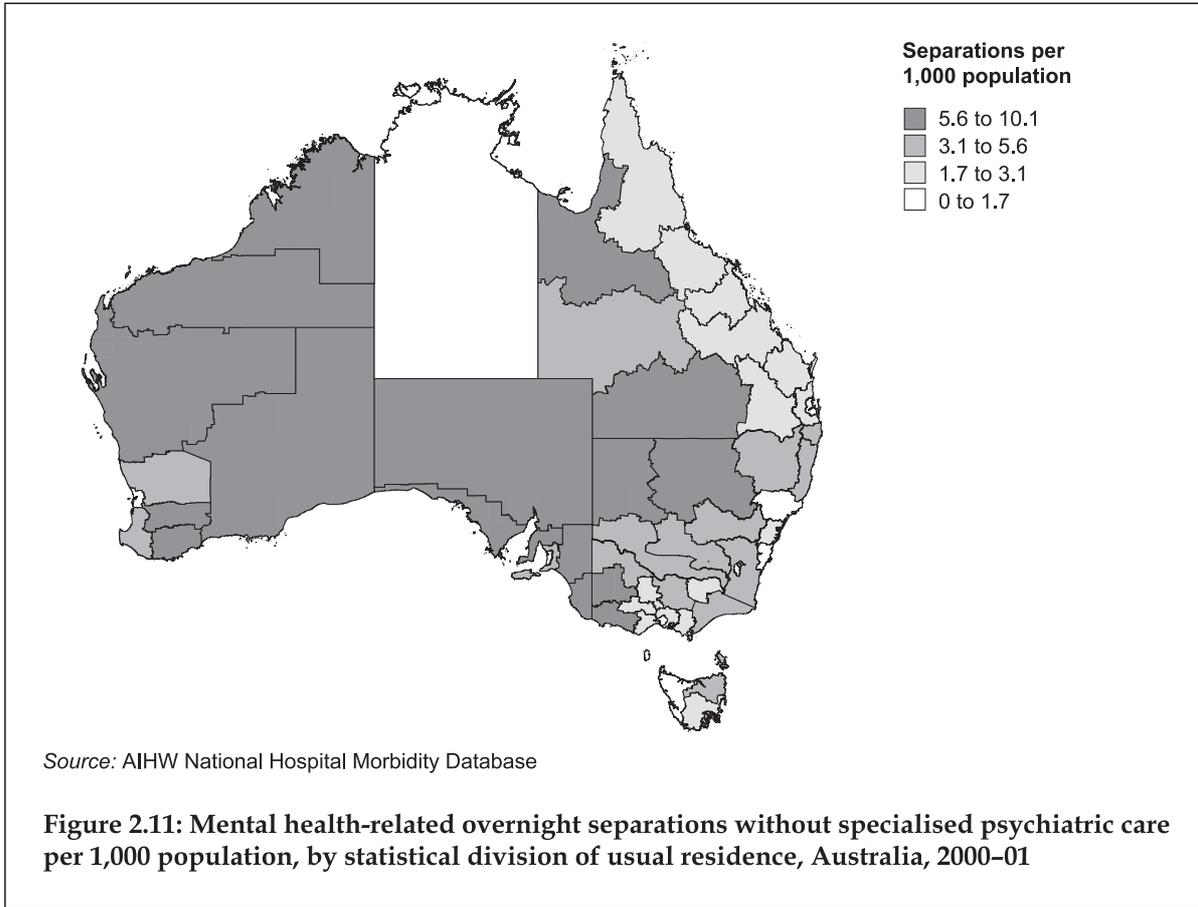
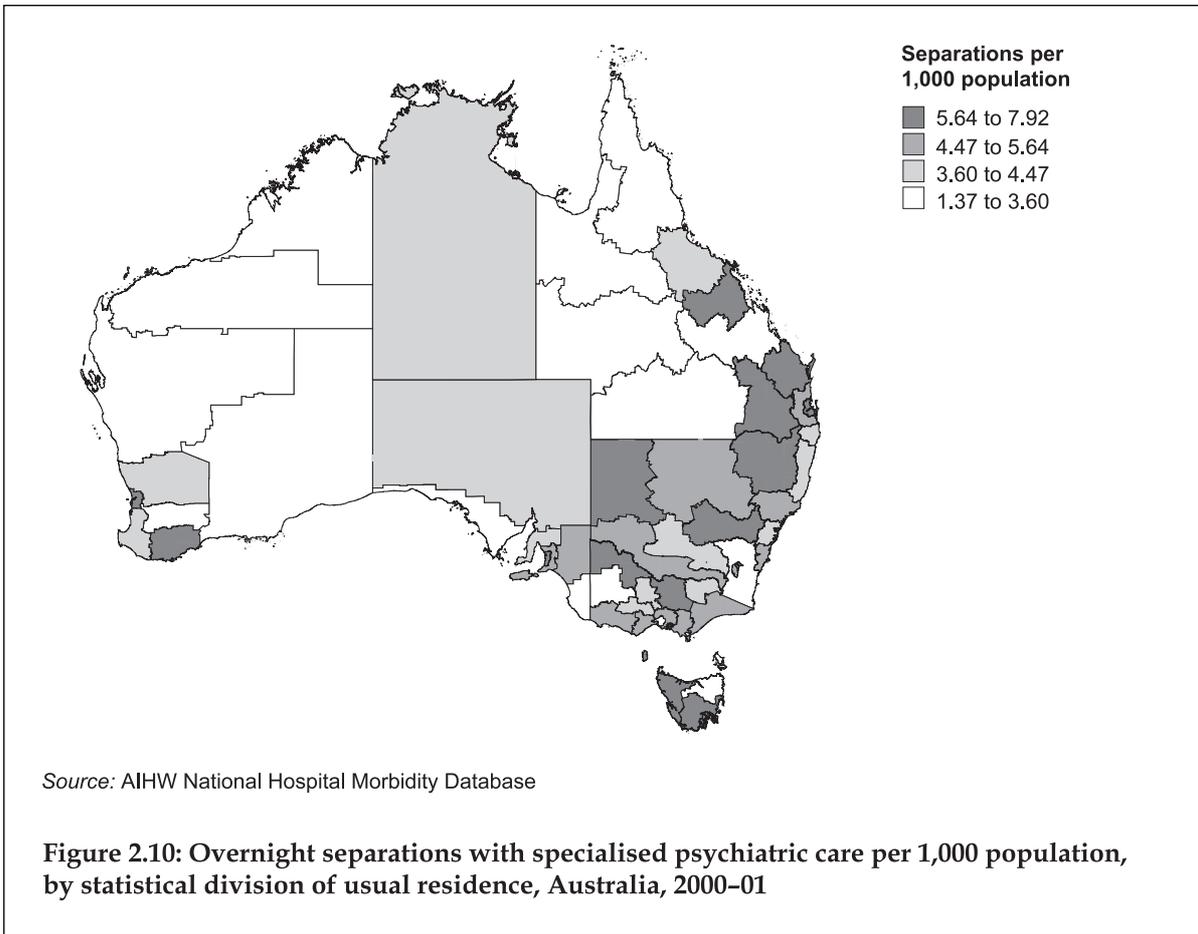
Mental health-related hospital separations in rural and remote areas

- People living in rural and remote areas have lower access to health care services than their metropolitan counterparts (AIHW 1998). Access can be restricted through the lack of health care facilities and professionals, distance, travelling time and transport accessibility.
- In 2000-01, the number of overnight mental health-related separations per 1,000 population with specialised psychiatric care was higher for people resident in metropolitan areas than for people resident in rural and remote areas (Figure 2.10). The opposite was true for separations without specialised psychiatric care (Figure 2.11).
- This reflects the concentration of psychiatric beds and psychiatrists in metropolitan areas (Tables 5.3 and 5.4).

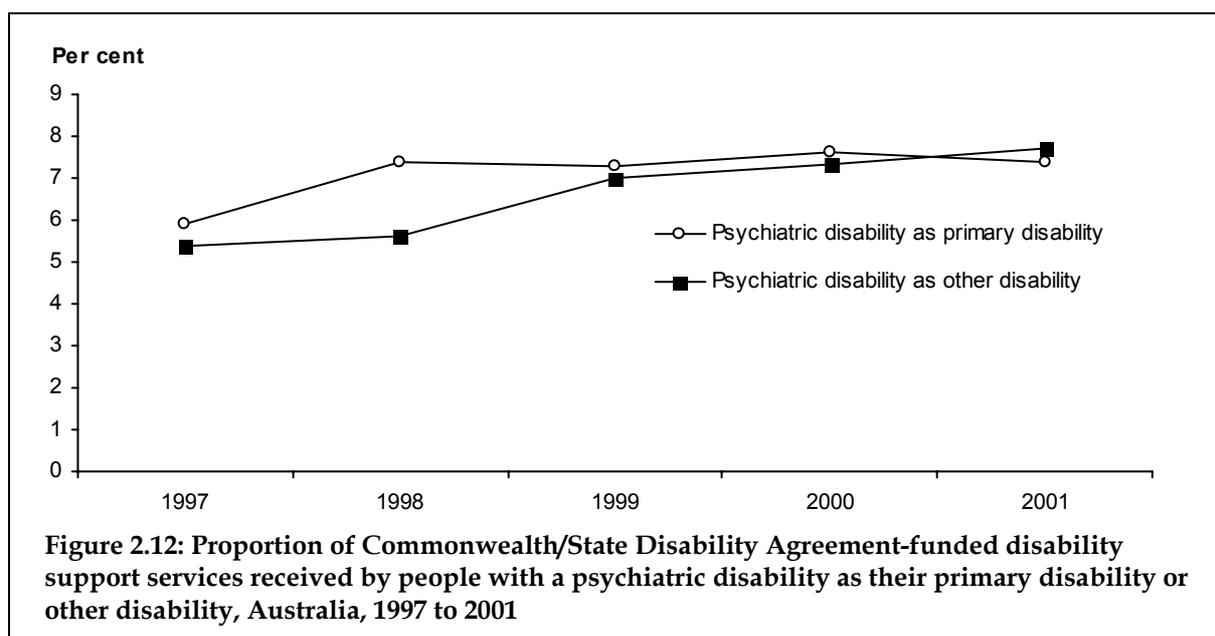
For more information, see:

Chapter 4 in this report (Tables 4.7a to 4.7b).

AIHW 1998.



Disability support services



Type of disability	1997	1998	1999	2000	2001
	Number of services received on snapshot day				
Psychiatric disability as primary disability	3,796	5,096	5,412	5,700	5,729
Psychiatric disability as other significant disability	3,465	3,877	5,207	5,489	5,973
Any psychiatric disability	7,261	8,973	10,619	11,189	11,702
	Proportion of all services received on snapshot day				
Psychiatric disability as primary disability	5.9%	7.4%	7.3%	7.6%	7.4%
Psychiatric disability as other significant disability	5.4%	5.6%	7.0%	7.3%	7.7%
Any psychiatric disability	11.3%	13.0%	14.3%	14.9%	15.1%

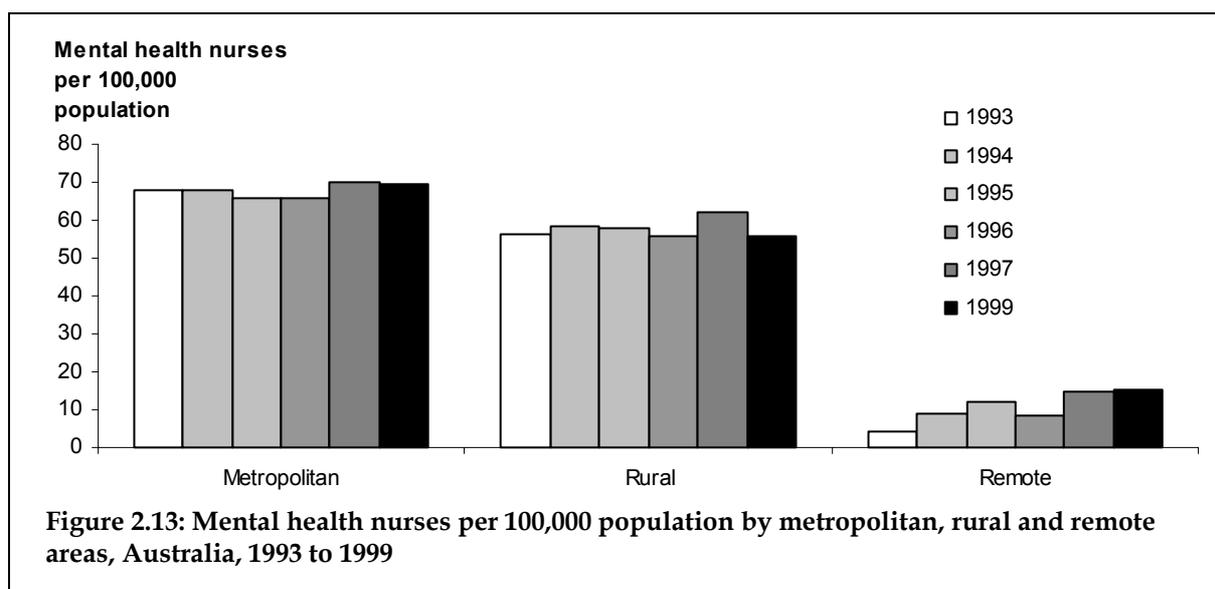
Source: CSDA MDS data collection.

- The Commonwealth/State Disability Agreement allocates responsibility and funding for disability support services between Commonwealth, State and Territory governments. CSDA-funded service types include accommodation support, residential care, employment support and community access support. Data have been collected on clients of these services on a 'snapshot day' each year since 1997. Many psychiatric disability services are not CSDA-funded and are not included in this collection.
- The proportion of CSDA-funded services (residential and ambulatory) received by people with a psychiatric

condition as their primary disability remained at about 7.5% between 1998 and 2001 (Figure 2.12). The proportion of services received by clients with a psychiatric disability that was not their primary disability increased from 5.4% to 7.7%.

For more information, see:
 Chapters 3 and 4 in this report
 (Figure 3.4 and 4.1).
 AIHW 2002a.

Mental health nurse workforce



	1993	1994	1995	1996	1997	1999
Mental health nurses per 100,000 population						
Metropolitan	68.0	67.8	66.0	65.9	70.2	69.3
Rural	56.4	58.6	57.9	55.6	62.0	55.9
Remote	4.3	8.7	12.3	8.5	14.9	15.1
Total	63.0	63.6	62.3	61.5	66.4	63.7

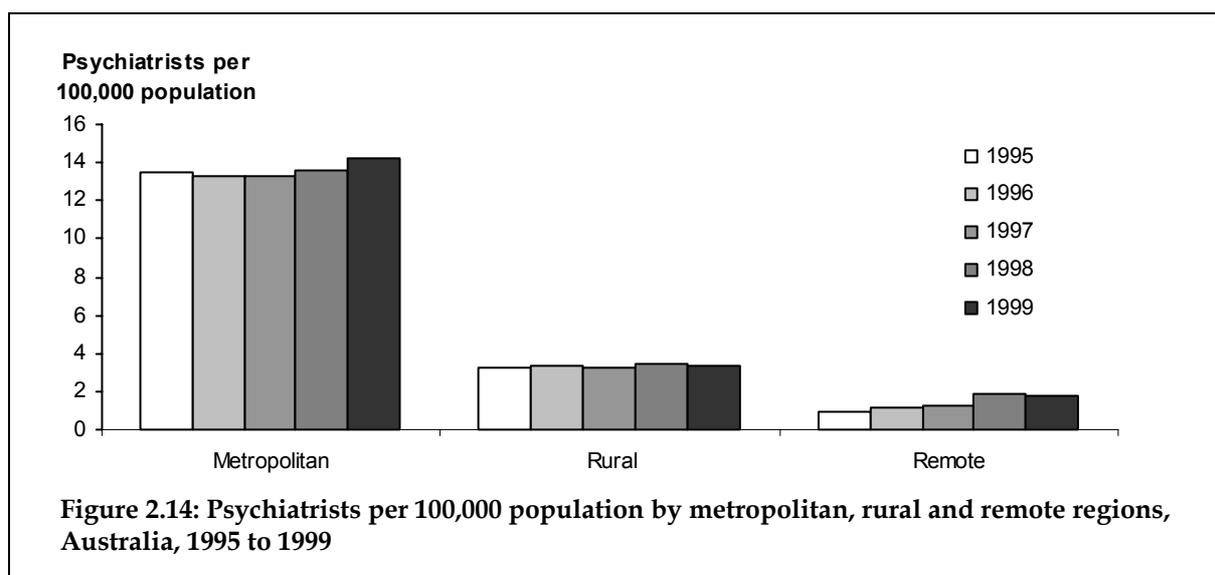
Source: AIHW 2001a.

- Nursing labour force data are collected in conjunction with the annual registration renewal of these practitioners with the relevant registration boards in each State and Territory. In this collection, mental health nurses are defined as nurses who reported that their main area of nursing is mental health.
- In 1999, there were 12,294 nurses with psychiatric and mental health nursing as their main area of nursing. They accounted for 6.2% of the total nurse workforce. There were 63.7 mental health nurses per 100,000 population in 1999, a slight increase over the level seen in previous years (Table 5.7).
- Figure 2.13 shows that metropolitan and rural areas had a relatively high number of mental health nurses per 100,000 population. Remote areas had fewer of these nurses per 100,000 population, but rates increased between 1993 and 1997.
- Comprehensive mental health nursing data for 1999 were not available at the time of this report. When these data are available (scheduled for release in 2003) they will be included in the Internet version of this publication at www.aihw.gov.au.

For more information, see:

Chapter 5 in this report (Table 5.7).
AIHW 2001a.

Psychiatrist workforce



	1995	1996	1997	1998	1999
Psychiatrists per 100,000 population					
Metropolitan	13.5	13.3	13.3	13.6	14.2
Rural	3.2	3.3	3.2	3.4	3.3
Remote	0.9	1.2	1.3	1.9	1.8
Total	10.5	10.4	10.4	10.6	11.1

Source: AIHW 2003.

- Psychiatrist labour force data are collected in conjunction with the annual registration renewal of these practitioners with the relevant registration boards in each State and Territory. A psychiatrist was defined as a medical practitioner who had been accepted as a member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Psychiatrists working in both the public and private sectors are included.
- In 1999, Australia had 11.1 specialists practising psychiatry per 100,000 population. This rate is above the average for high-income countries of 9 psychiatrists per 100,000 population (WHO 2001).
- Figure 2.14 shows that the number of psychiatrists per 100,000 population is

higher in metropolitan areas than other areas and that this situation has existed over the last 5 years.

- There seems to have been some growth in the number of psychiatrists per 100,000 population in remote regions between 1995 and 1999.
- These data do not take into account arrangements where psychiatrists make regular visits to remote sites or use telepsychiatry consultations.

For more information, see:

Chapter 5 in this report (Tables 5.1 and 5.4).

AIHW 2003.