

1 Overview of mental health

The health and living conditions of Australians have improved greatly this century. The average life expectancy has increased by more than 20 years, from around 55 years for males and 59 years for females at the turn of the century to more than 75 and 81 years, respectively, in 1994–96 (AIHW 1998a). The infant mortality rate has come down from one infant death for every 10 live births in the 1900s to less than one for every 175 live births in the 1990s. People's real income has also increased greatly during this period, leading to much more material wealth and services (Snooks 1994). There is, however, a marked diversity of population health outcomes in Australia and the continuing poor health and socioeconomic status of Aboriginal peoples and Torres Strait Islanders is but one example (Swan & Raphael 1995, ABS 1997c).

The remarkable progress in physical and material wellbeing for most Australians has not necessarily been matched by gains in mental and subjective wellbeing. There are diverse patterns of mental health among populations, resulting probably from an array of demographic and social factors, continuing gaps in socioeconomic conditions, changing social structures and significant restructuring of the economy. Mental disorders form a substantial part of the burden of disease in Australia.

It is estimated that close to one in five people in Australia will be affected by a mental health problem at some stage in their lives (AIHW & DHFS 1997). Based on the 1995 National Health Survey (NHS), conducted by the Australian Bureau of Statistics (ABS), more than one million Australians are estimated to suffer from a mental disorder with almost one-half of these affected long-term. Depression is the most common (35 per cent), both recent and long-term, mental disorder reported (ABS 1997a).

Although the number of deaths associated with mental problems is low compared with other National Health Priority Areas, mental disorders are responsible for a larger number of hospitalisations, in particular among those in the age group 25–44 years (AIHW 1998b). Mental health problems also account for much disability, incur high direct and indirect costs, and impose a heavy burden of human suffering, including stigmatisation of people with mental disorders and their families.

1.1 Defining mental health

Mental health is the capacity of individuals and groups to interact with one another and the environment, in ways that promote subjective wellbeing, optimal development, and use of cognitive, affective and relational abilities. It refers to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHHS 1989). The achievement of individual and collective goals consistent with justice is central to a positive state of mental health (DHFS 1997).

Defined in this way, mental health is much more than the absence of mental illness. It is the realisation of one's potential, shaped by factors such as biological make-up, gender roles, family life, human relationships, work opportunities, educational achievements, and a variety of structural and socioeconomic determinants. At an individual level, it is also a sense of wellbeing and functioning unique to each person.

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At a population level, mental health status highlights several crosscutting themes such as inter-group dynamics, culture and identity, and the overall feeling of positive wellbeing (Nutbeam et al 1993). For Aboriginal peoples and Torres Strait Islanders, mental health must be considered in the wider context of physical, emotional and social wellbeing. There must be the understanding that both social-emotional ill health and psychiatric disorders can result from oppression, racism, environmental circumstances, economic factors, stress, trauma, grief, loss, cultural genocide, psychological processes and poor physical health.

1.2 Measuring mental health

The measurement of mental health is complex; even the experts disagree about the best ways to define and measure mental health (AIHW 1998a). The term 'mental health' is often used when what is really being talked about is 'mental illness' and 'mental disorder'. Measured differences in mental health are more often based on the presence of illness than its absence, and generally do not take into account mental health as a positive attribute.

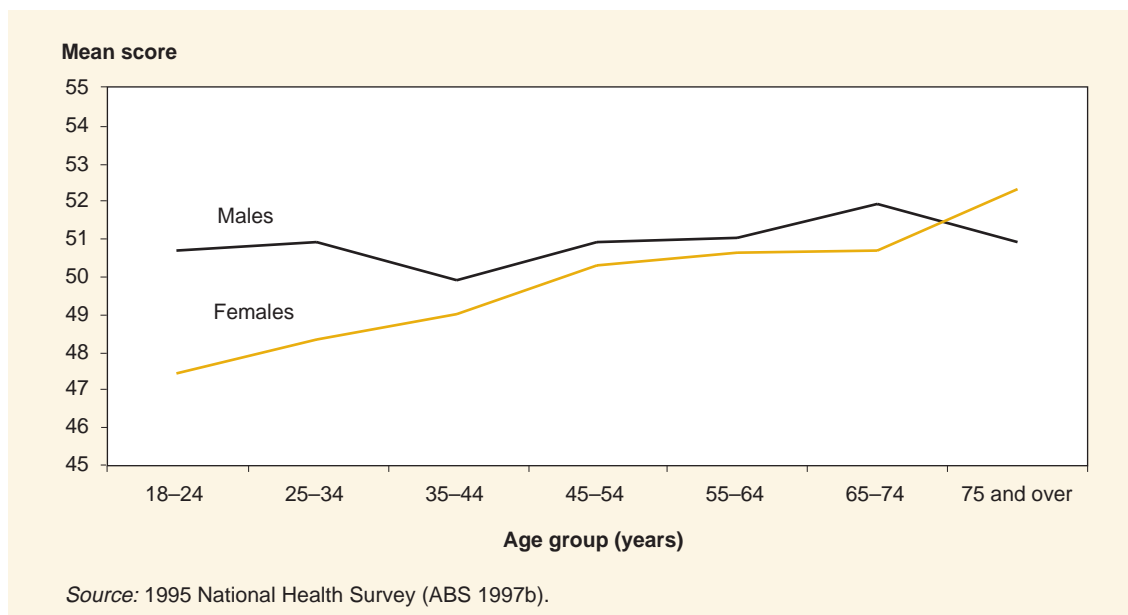
A variety of inventories and instruments have been developed to measure mental health or wellness. Prominent among these is the Short Form-36 (SF-36), developed by Ware et al (1993) to collect standardised information on eight dimensions of health, including general mental health. The mental health dimension is measured with a score, also called the Mental Component Summary (MCS) score, based on a set of five questions. The range of scores is zero to 100, with a higher score indicating a better state of wellbeing. A short form of the instrument, based on 12 questions (SF-12), is also used for generating information on aspects of mental health in the general population (ABS 1998).

The 1995 NHS has generated some information on the mental health of Australians using the SF-36 instrument. The MCS scores from the survey (Figure 1.1) reveal a marked gender difference in perceived psychological wellbeing for those in the age group 18–24 years, with young males reporting better wellbeing than young females. This difference narrows with age and among respondents aged 75 years and older there is a 'crossover' effect, whereby older females report a greater sense of wellbeing than older males. Overall, for women there is a steady increase in mental wellbeing with age, whereas for men there is a less consistent increase with declines in scores at ages 35–44 years and over 75 years (ABS 1997b). It should be noted, however, that the results of the survey, based on self-reports, are likely to be influenced by whether the respondent has a mental disorder.

Additional information on the general mental health status of Australians with and without a physical condition has become available through the 1997 National Survey of Mental Health and Wellbeing (SMHWB), a household survey also conducted by the ABS (1998). The MCS for this survey, based on SF-12, focuses mainly on role limitations due to emotional problems, social functioning, mental health and vitality. The survey found a small difference in MCS scores between males and females. The survey also found, as expected, lower average MCS scores among persons with a physical condition compared with those without.

Mental health problems and mental disorders

Figure 1.1: Mean scores on the SF-36 Mental Component Summary, by age and sex, 1995



1.3 Mental health problems and mental disorders

Mental health problems and mental disorders refer to the spectrum of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people at school, at work and at home, and impact upon their interpersonal relationships. The spectrum covers cognitive impairment and disabilities, phobias, panic attacks, drug-related harm, anxiety, post-traumatic stress disorder (PTSD), personality disorder, depressive disorders, schizophrenia and psychoses.

Mental health problems refer specifically to common mental complaints and symptoms. The term includes the mental ill health occasionally experienced by healthy people in relation to normal life stresses. It may also refer to signs and symptoms of mental disorders, irrespective of whether a clear diagnosis has been made or not.

A *mental disorder*, on the other hand, implies the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions (WHO 1992). Mental disorders may require treatment, including hospitalisation, to alleviate the symptoms and to provide rehabilitation (AIHW 1998a).

This distinction between a mental health problem and a mental disorder is not well defined and is made on the basis of severity and duration of the illness. However, there is some overlap between the two categories. A mental health problem may refer to signs and symptoms of a mental disorder regardless of whether or not criteria for clinical diagnosis are met.

Some of the major types of mental disorders that may be perceived as public health problems are schizophrenia, depression, anxiety disorders, dementia and substance use disorders.

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Schizophrenia is a group of severe psychiatric disorders that are characterised by major disturbances in thought, emotion and behaviour. The symptoms may include delusions, hallucinations, disorganised thoughts and behaviours (APA 1994). Schizophrenia usually starts in late adolescence or early adult life. These disorders place a heavy burden on the person's family and relatives, both in terms of the costs and stigma attached to the illness. Schizophrenia occurs in one per cent of the adult population aged 20 years and over on an annual basis. Worldwide, around 45 million people are estimated to suffer from schizophrenia (WHO 1996a).

Depression is a mood disorder characterised by feelings of sadness, loss of interest or pleasure in nearly all activities, feelings of hopelessness and suicidal thoughts or self-blame. It is one of the most common mental disorders in the community.

Major depression has a one-year adult prevalence rate of around five per cent in Australia (ABS 1998). The proportion of the adult population suffering from major depression over the lifetime is much larger. A proportion of people experiencing depressive episodes (lowered mood and decreased energy) also go through repeated episodes of mania (elation and overactivity). It is estimated that more than 300 million people suffer from depression worldwide and the number is set to rise significantly over the next two decades (Murray & Lopez 1996).

Anxiety disorders, characterised by symptoms of anxiety, fear and avoidance behaviour, include panic disorders, phobias, obsessive-compulsive disorder and post-traumatic stress disorder. These disorders are estimated to affect some 400 million people at any point in time worldwide (WHO 1996a).

Dementia is a brain syndrome, usually of a chronic or progressive nature, that is manifested by a decline of memory, comprehension, learning capacity, language and judgement as well as the ability to think and to calculate (WHO 1996b). The age of onset for dementia is usually late in life with people over 85 years having the highest prevalence (APA 1994). It is estimated that around 22 million people have dementia worldwide.

Substance use disorders result from harmful use or dependence on drugs and/or alcohol.

Two major classifications, WHO's *International Classification of Diseases*, tenth revision or ICD-10 (superseding ICD-9) (WHO 1993) and the American Psychiatric Association's (APA 1994, 1996) classification as given in its *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition or DSM-IV (APA 1994), are in common use for systematically grouping mental disorders (see Chapter 2, Section 2.1).

1.4 Measuring the prevalence of mental disorders

Measuring the prevalence of mental disorders in the community is complex, as they are usually clinical diagnoses (ABS 1998). The 1995 NHS provides some information on the prevalence of self-reported mental disorders in Australia (ABS 1997a). Specific information on mental disorders has, however, been obtained through the 1997 SMHWB. The survey used the Composite International

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Diagnostic Interview (CIDI) to diagnose selected mental disorders among Australian adults (ABS 1998).

Under the 1997 SMHWB, approximately 10,600 persons aged 18 years and over were interviewed, selected from a random sample of households. Information was recorded on more common mental disorders (depression, anxiety and substance use disorder) that occurred during the 12 months before the survey. The survey topics also covered the level of disability associated with these disorders, as well as the health services used (and perceived need for health services) as a consequence. Information on physical conditions and a range of demographic and socioeconomic characteristics was also collected (ABS 1998). Further details on the 1997 SMHWB survey are given in Appendix 2.

Information on mental disorders such as schizophrenia is being collected through a complementary survey of low prevalence psychotic disorders. Mental disorders that are more prevalent in older persons, such as dementia and Alzheimer's disease, were also not determined from the 1997 SMHWB because of the difficulty of identifying these conditions in an interview-based household survey. Furthermore, older people living in institutional settings, such as nursing homes and hostels, were not included in the survey. The 1997 SMHWB, therefore, may have underestimated the prevalence of mental health conditions for older people.

The 1997 SMHWB was designed to provide information on the prevalence of a range of mental disorders for Australian adults only. The Survey did not include children and adolescents. The results of the child and adolescent component of the SMHWB will be available in 1999.

There are several limitations to a household survey with a sample size of just over 10,000 in estimating the prevalence of mental disorders in specific population groups. For example, while mental disorders may be highly prevalent among Aboriginal peoples and Torres Strait Islanders, it is not possible to determine reliably the extent of disorder through a general population survey of this size. Similarly the numbers are too small to undertake a systematic comparison of prevalence rates between rural, remote and metropolitan areas.

1.5 Prevalence of mental disorders in Australia

Table 1.1 lists the distribution of common mental disorders in Australia based on the 1997 SMHWB. Over one in six Australian adults were determined by computer-based CIDI to have experienced anxiety, affective or substance use disorders at some time during the 12 months before the survey. While both males and females had similar overall prevalence rates, females were more likely to have experienced anxiety disorders and affective disorders. On the other hand, substance use disorders were more commonly prevalent among males.

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Table 1.1: Prevalence of common mental disorders in Australia, 1997

Mental disorders ^(a)	Males		Females		Persons	
	'000	Per cent	'000	Per cent	'000	Per cent
Anxiety disorders						
Panic disorder	36.7	0.6	133.8	2.0	170.6	1.3
Agoraphobia	49.2	0.7	101.9	1.5	151.1	1.1
Social phobia	161.4	2.4	207.3	3.0	368.7	2.7
Generalised anxiety disorder	156.8	2.4	256.0	3.7	412.8	3.1
Obsessive-compulsive disorder	19.3	0.3	29.2	0.4	48.6	0.4
Post-traumatic stress disorder	153.3	2.3	285.8	4.2	439.2	3.3
<i>Total anxiety disorders</i>	<i>470.4</i>	<i>7.1</i>	<i>829.6</i>	<i>12.1</i>	<i>1,299.9</i>	<i>9.7</i>
Affective disorders						
Depression	227.6	3.4	465.3	6.8	692.9	5.1
Dysthymia	63.4	1.0	88.3	1.3	151.7	1.1
<i>Total affective disorders ^(b)</i>	<i>275.3</i>	<i>4.2</i>	<i>503.3</i>	<i>7.4</i>	<i>778.6</i>	<i>5.8</i>
Substance use disorders						
Alcohol harmful use	285.4	4.3	123.8	1.8	409.2	3.0
Alcohol dependence	339.8	5.1	126.9	1.9	466.7	3.5
Drug use disorders ^(c)	206.9	3.1	89.2	1.3	296.0	2.2
<i>Total substance use disorders</i>	<i>734.3</i>	<i>11.1</i>	<i>307.5</i>	<i>4.5</i>	<i>1,041.8</i>	<i>7.7</i>
Total mental disorders ^(d)	1,151.6	17.4	1,231.5	18.0	2,383.1	17.7
Total persons	6,627.1	100.0	6,837.7	100.0	13,464.8	100.0

(a) During the last 12 months prior to interview.

(b) Includes other affective disorders such as mania, hypomania and bipolar affective disorder.

(c) Includes harmful use and dependence.

(d) A person may have more than one mental disorder. The components when added may therefore be larger than the subtotals or total.

Source: ABS (1998).

Figures 1.2a and 1.2b present the distribution of common mental disorders in Australia in various age groups by gender and type of disorder. Young males aged 18–24 years had the highest prevalence of these mental disorders (27 per cent). The prevalence declined to around six per cent among persons aged 65 years and over. The much lower prevalence rate for anxiety disorders among females aged 55 years and over in comparison to those in the younger age groups is noteworthy, as is the steady decline in substance use disorders with age for both males and females.

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Figure 1.2a: Age-specific prevalence of common mental disorders/problems among Australian males, 1997

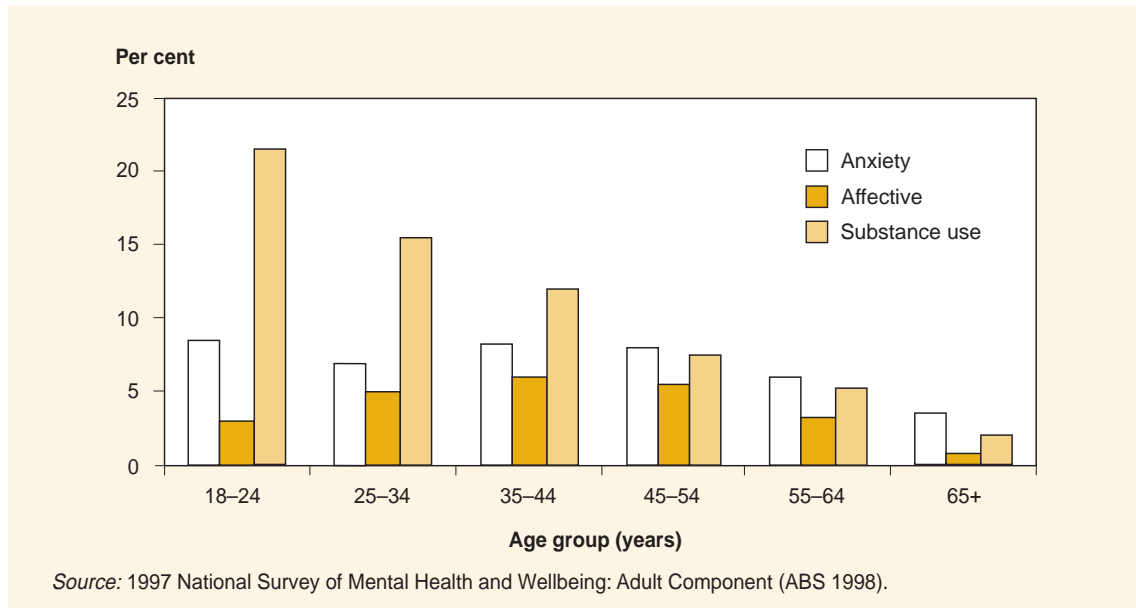
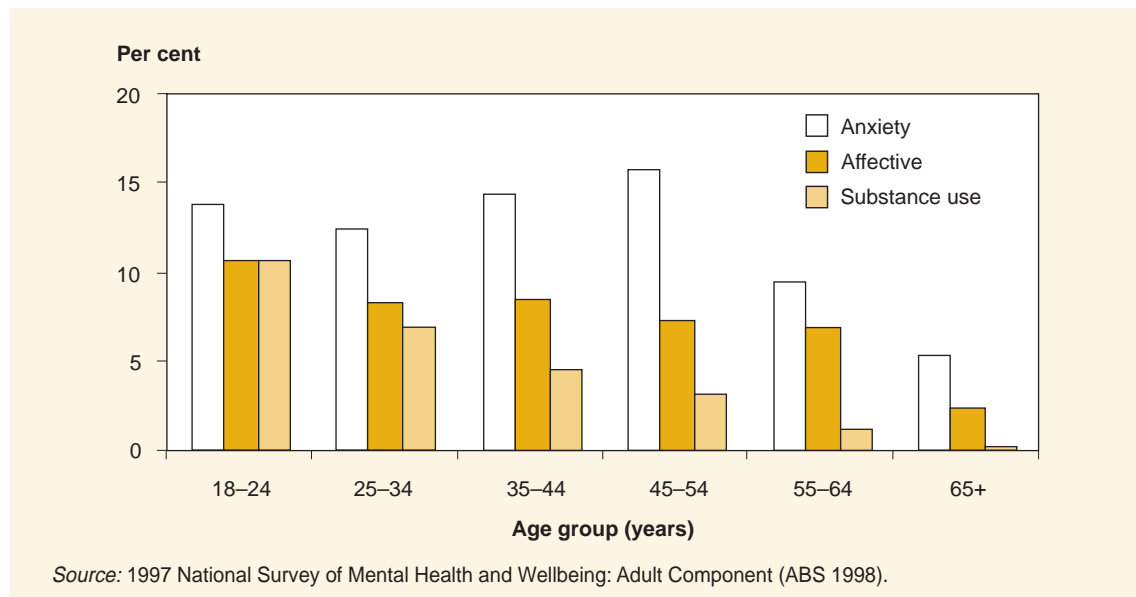


Figure 1.2b: Age-specific prevalence of common mental disorders/problems among Australian females, 1997

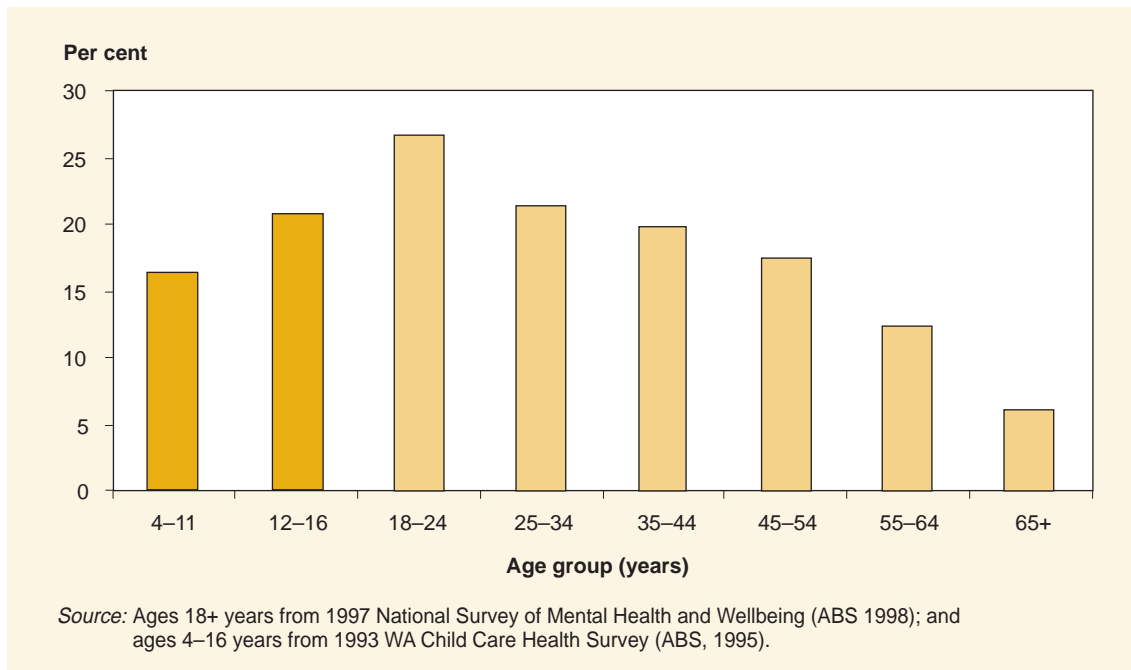


No national estimates of the prevalence of mental disorders among children and adolescents are available. The 1993 Western Australian Child Health Survey (Zubrick et al 1995) does, however, provide some information on the prevalence of mental health problems among children and adolescents aged 4–16 years. Figure 1.3 combines information from this survey and the 1997 SMHWB to provide a comparative picture of the prevalence of mental health problems between children and adults in Australia. The figure reveals considerable morbidity in childhood

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with a steady rise to early adulthood and a gradual decline thereafter. The limitations of combining information from two surveys with varying population bases and sampling frames should, however, be kept in mind while interpreting the results presented in Figure 1.3.

Figure 1.3: Prevalence of common mental health problems in children and of common mental disorders in adults



Prevalence of mental disorders in specific population groups

The prevalence and types of mental disorders are known to vary with age, gender, and across population groups. Importantly, the symptoms of a disorder, and the specific ways in which a person may experience it, also vary markedly from one culture to another. An association between socioeconomic factors and mental health also exists, such that people who are socioeconomically advantaged are at lesser risk of mental disorders than those who are disadvantaged (Kleinman & Cohen 1997).

The Burdekin report identified a range of population groups that may be at increased risk for mental health problems in Australia (Human Rights and Equal Opportunity Commission 1993). Population groups considered at high risk to develop mental health problems or with special mental health issues are children and adolescents, older Australians (particularly those in residential care), Aboriginal peoples and Torres Strait Islanders, rural and remote area populations, and people from culturally and linguistically diverse backgrounds. Homeless people, women, people with dual and multiple disabilities, and forensic patients and prisoners are also reported to be at increased risk for mental health problems.

Children and adolescents

Almost one out of five children and adolescents suffer from a mental health problem or disorder within any six-month period (Zubrick et al 1995). The onset of most mental disorders occurs in mid-to-late adolescence (Sawyer et al 1990, Kosky

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& Hardy 1992). It is also recognised that mental health problems and mental disorders developed during this period are more likely to become chronic and to impact upon future psychosocial development (Rutter & Smith 1995).

The mental health problems and disorders of most concern among children and adolescents include depression and anxiety disorders, disruptive behaviours, self-injury, first onset psychosis, and body image and eating disorders (particularly among girls). The factors predisposing to mental health problems early in life include coercive and affectionless parenting styles, divorce, bereavement, trauma, child abuse, disability, not having a key support person, poor peer relationships, adverse school environments and genetic determinants. Prominent markers of increased propensity to mental health problems are poor school attendance, aggressive behaviour and substance use disorders.

According to the 1993 Western Australian Child Health Survey, nearly one out of six 4–11 year olds have had a mental health problem compared with more than one out of five 12–16 year olds (see Figure 1.3). When asked if they had felt under strain, stress or pressure in the six months prior to the survey, eight per cent of 12–16 year olds reported feeling extreme levels of stress; more than one-third of these respondents were also found to suffer from mental health problems (Zubrick et al 1995).

The Royal Australian College of General Practitioners (RACGP) is currently conducting a national survey, 'Young People in Your Practice' of 15–24 year olds (Beckinsale 1999). To date, over 3,000 young people have been surveyed out of the planned 15,000. Preliminary results reveal that around 12 per cent of young people claim to be depressed most of the time and almost six per cent had recently considered (planned) suicide. Some young people who scored high on suicidal ideation reported being sexually abused, were confused about their sexuality, and frequently used drugs including alcohol. In comparison, young people actively looking for work, but who could not find the job they wanted, were more likely to be depressed than to have suicidal thoughts.

Older Australians

The distribution of types of mental disorders changes with increasing age. Although the prevalence of mental disorders such as anxiety and substance use decreases with age, other disorders such as dementia occur with greater frequency. Dementia is increasingly recognised as a significant contributor to the mental health problems of the elderly. The prevalence of dementia is increasing because of better awareness and earlier diagnosis and because more people are living long enough to reach the ages at which the risk of dementia is highest.

The 1997 SMHWB estimated the total prevalence of the common mental disorders (depressive, anxiety and substance use disorders) to be about six per cent among those aged 65 years and over. An additional six per cent of people aged 65 years and over are estimated to have dementia. The risk of dementia increases significantly with age and the prevalence of dementia among those aged 80 years or more is almost 20 per cent. Among the elderly in residential care, the prevalence of dementia is even higher. Rosewarne (1997) found that over 28 per cent of hostel residents and 60 per cent of nursing home residents have some form of dementia.

The prevalence of depressive disorders decreases with age among those who live in the community, but depressive symptoms and depressive disorders are common

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among those in residential aged care (Parmalee et al 1989). Underdiagnosis of depression often occurs in older people (Bowers et al 1990, Friedhoff 1994). It has been suggested that depression may be twice as common as dementia (Snowdon 1987).

Aboriginal peoples and Torres Strait Islanders

Mental health has been identified only recently as a priority by Aboriginal peoples and Torres Strait Islanders. This is because stigma, cultural misunderstanding, involuntary confinement, and a failure of past mental health policies and approaches have led many Aboriginal and Torres Strait Islander communities to be hesitant to discuss mental health issues in the public arena. The National Indigenous Mental Health Data Workshop, held in Brisbane 13–14 November 1996, attempted to identify Indigenous peoples' issues and concerns about data collected on mental health. The workshop was auspiced under the National Mental Health Strategy and the main concern was the need for community ownership of data, improvement of data systems, data collection processes and the collection of culturally appropriate meaningful data, incorporating traditional and spiritual Indigenous beliefs. While there are no current national statistics available, local investigations have shown that loss, separation and traumatic experiences for Aboriginal peoples contribute significantly to psychosocial morbidity. These factors correlate strongly with the presence of depressive symptoms and disorders (McKendrick & Thorpe 1994).

No understanding of mental health outcomes could take place without recognising the impact of trauma, grief and loss for Aboriginal peoples and Torres Strait Islanders. These factors have undoubtedly had an impact on physical as well as mental health, yet there are no data available to quantify their extent and role. Studies in one health service show that these risk factors are key variables contributing to the high levels of psychiatric disorder found in Aboriginal and Torres Strait Islander communities, in particular to a very high frequency of depression (Swan & Raphael 1995). The high rates of incarceration and entry into the criminal and juvenile justice system for Aboriginal peoples and Torres Strait Islanders are also risk factors. These are issues for mental health treatment and prevention services provided in correctional settings.

Rural and remote area populations

The health of populations living in rural and remote areas of Australia is worse than that of those living in capital cities and other metropolitan areas (Mathers 1994, Strong et al 1998a). However, limited national information on the prevalence of mental health problems and disorders among people living in rural and remote areas makes it difficult to quantify these differences.

Results from the Women's Health Australia project reveal lower levels of stress among females living in rural and remote areas compared with their counterparts in urban areas, although the number of stressful life events experienced by females from these three geographic areas are similar. Ratings of self-reported mental health using the SF-36 MCS scores are similar among females from various areas, with mean scores of around 48, 47 and 46 among those living in remote, rural and urban areas, respectively (Brown et al 1997).

Strong et al (1998a) have recently compared death rates for suicide and self-inflicted injury in Australia using the rural, remote and metropolitan area (RRMA)

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classification. They have found the rates to be significantly higher among males from 'large rural centres' and 'other remote areas' when compared with those living in 'capital cities'. In contrast with males, death rates for suicide and self-inflicted injury were the highest among females living in metropolitan areas and the lowest among those living in remote areas.

People from culturally and linguistically diverse backgrounds

The prevalence of mental health problems and disorders vary greatly amongst various communities around the world (Kleinmann & Cohen 1997). These differences do not completely disappear upon migration to Australia, although better living conditions may reduce the extent of the variation. In some cases, migration and resettlement may result in negative mental health outcomes for individuals belonging to these population groups.

According to the 1997 SMHWB, persons born in Australia had a higher prevalence of mental disorders (19 per cent) than those born in the main English-speaking countries (USA, Canada, UK, Ireland, South Africa, and New Zealand). The latter, in turn, had higher rates (16 per cent) than those born in countries where English is not the main language spoken (14 per cent). The relative differences were higher among males than females. These patterns correspond well with those observed for physical health (Strong et al 1998b).

The Longitudinal Survey of Immigrations to Australia (LSIA)¹, conducted by the Department of Immigration and Multicultural Affairs aimed to determine the self-reported mental health status of immigrants in Australia and their utilisation of health services, by country of birth, non-English-speaking background and English-speaking background. Kliewer and Jones (1997) report the percentage of female immigrants with a minor psychiatric illness was higher than their male counterparts (male 27.3, female 30.8), and similarly for utilisation of medical services (males 45.2, females 58.4). The National Heart Foundation's 1983 Risk Factor Prevalence Survey (RFPS) also reports that immigrant males tend to have a lower prevalence of mental disorders than immigrant females for the native-born aged 25–64 years (males 23.6, females 28.6). Although the RFPS rates are lower than the LSIA immigrants of the same age (males 28.6, females 32.20), the results for the total foreign-born (males 27.0, females 32.3) were similar to the LSIA immigrants.

Analysis by Kliewer and Jones (1997) shows that immigrants with a non-English-speaking background constitute a heterogeneous group in terms of their health status and medical service utilisation. Immigrant health status is more strongly associated with the ability to speak English well, rather than immigrant status alone. Inability to use English effectively may reduce the chances of gainful employment as well as hinder access to services. Other studies show little evidence of a relationship between length of residence and mental disorder in Australia (Jayasuriya et al 1992, Minas et al 1996).

Using samples from the National Heart Foundation's 1983 RFPS and LSIA Kliewer and Jones (1997) report that immigrant males tend to have a lower prevalence of mental disorders than immigrant females at all ages, except for those aged 55–64 years.

¹ The measurement of mental health in LSIA was based on the General Health Questionnaire-12 (GHQ-12).

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Experiences of torture, trauma, loss, unemployment, discrimination and being of refugee status all contribute to a vulnerability to mental disorders (Zubrick et al 1997). Several studies have confirmed the poorer health status of refugees compared with immigrants of other categories (Kliewer & Jones 1997).

Other risk factors

Measuring the effect of risk factors on mental disorder is important, but little information is available on a national level. A variety of health determinants and risk factors are likely to contribute to mental disorder. The MCS scores of the 1995 NHS, for example, reveal the effect of employment status, with adults aged 18–64 years scoring the highest for mental health and wellbeing when employed (ABS 1997b). In contrast, smokers report poorer mental health and wellbeing compared with both those who had never smoked and those who are ex-smokers.

1.6 Health care utilisation

People with a mental disorder, or those at risk of developing a mental disorder, receive health care from a variety of health professionals. The settings in which these services are provided range from primary health care to specialist treatment in psychiatric hospitals. Treatment received in community health centres from nursing and allied health professionals also contributes significantly to the management of mental health problems.

The impact of various mental disorders on health services is not uniform. For example, although low in prevalence, some of the mental disorders utilise or require resources disproportionate to their numbers. Disparities in resource use can be identified through a comparison of the utilisation of mental health services and the prevalence of mental disorders.

Mental disorders and health service use

Information on health services used by persons with and without a mental disorder was collected as part of the 1997 SMHWP. The survey found that approximately 56 per cent of persons with affective disorders, 28 per cent of persons with anxiety disorders, and 14 per cent of persons with substance use disorders had used health services in the 12 months before the survey (ABS 1998). For depression, this proportion rose to 64 per cent. In all age groups, depressed females tended to use health services more often than males. In both males and females, those in the age group 35–54 years were the highest users of mental health services.

Health care use by provider type

Information on health care utilisation and providers by type of mental health service is variable. While there is national information available about people who have been hospitalised with a mental problem or associated disability, limited data are available on other health services utilised by these persons.

A brief description of types of mental health care services, along with information on the utilisation of these services and the workforce, follows.

Primary health care

A range of professionals and health workers provide primary health care. In 1996, there were 20,516 primary care providers in Australia. More than six per cent of these were practising in the special interest field of counselling and psychotherapy. The primary health care practitioner is in a unique position to play a key role in the prevention and early management of mental disorders. In particular, general practitioners play a pivotal role in the provision of primary health care services, and in providing access to medication, specialist care, hospitals and other health care services.

The 1997 SMHWB reveals that of those who reported having a mental disorder, 29 per cent had consulted a general practitioner for depression in the 12 months prior to the interview. In their 1993 survey, Harris et al (1996) found that general practitioners had treated about one-fifth of their patients for anxiety or depression in the previous 12 months; 52 per cent were prescribed at least one medication for the problem.

While general practitioners tend to refer people to psychiatrists if they are depressed or a suicide risk, those with anxiety are not often referred (Harris et al 1996).

Private specialist care

In 1996, there were 1,943 specialists practicing psychiatry. In addition, there were 552 psychiatry specialists in training who worked on average almost 49 hours per week (AIHW 1997b).

One out of 65 Australians visits a private psychiatrist at least once a year (1.6 per cent in 1995–96, and 1.5 per cent in 1996–97). The 1997 SMHWB also reports that almost eight per cent of people with mental health problems consulted a psychiatrist in the 12 months before the survey.

The number of private psychiatry services funded by the Medicare Benefits Schedule (MBS) has continued to grow (DHFS 1998) although this trend has slowed down lately. The average number of psychiatric services per psychiatric patient has declined from more than eight in 1992–93 to less than eight in 1995–96. The number of patients treated, adjusted for variation in population numbers, also increased by less than two per cent in 1995–96 over the previous year, compared with an annual average of more than three per cent through the previous decade.

Community mental health services

Over the last few years, there has been a move away from segregated, institutionalised mental health care to a system that integrates hospital services with care provided in community settings (Australian Health Ministers 1992). While the role of large public psychiatric hospitals in providing mental health services has been significantly reduced, these services have been transferred to general public hospitals.

Most people with mental disorders are managed outside the hospital setting by community mental health services. People requiring short-stay hospital management are cared for more appropriately in specialised psychiatric units of acute care hospitals than in large psychiatric hospitals. In addition, residential units have been established within the community. The community mental health services are provided through a variety of government and non-government agencies.

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To date, there are limited national data available on community care for people with mental disorders. Some information on community care for mental disorders has been generated through the Mental Health Classification and Service Costs (MH-CASC) project, but the degree to which the data are transferable to the general Australian population is unknown, as comparable data are not yet routinely collected nationally. MH-CASC sampled only specialised mental health services, which do not treat all mental disorders.

The MH-CASC project has identified that approximately 38 per cent of people receiving mental health care in the community had the principal diagnosis of schizophrenia and related disorders (DHFS 1998). Mood disorders were the second most common cause, accounting for about 22 per cent of people receiving community mental health care.

Ten per cent of the people receiving community care, according to MH-CASC, were treated for disorders of childhood and adolescence (DHFS 1998). Mixed disorders of conduct and emotions accounted for most episodes of care.

1.7 Distribution of mental health providers

Since the role of public psychiatric hospitals in providing mental health services changed considerably, the mental health workforce employed in these hospitals has reduced significantly. A decline of almost 40 per cent in the number of persons employed in psychiatric hospitals was noted between the 1991 and the 1996 mental health censuses. By the 1996 census, there were 8,424 persons (total staff, including domestic and maintenance staff) employed in psychiatric hospitals (46 per 100,000 population). These declines in staff numbers notwithstanding, the workforce of the public and private psychiatric hospitals still makes a large contribution to the provision of mental health services in Australia.

The decline in hospital staff numbers involved in providing specialist mental health care has been partially offset by a strong growth in employment in ambulatory mental health care and in community residential care services. In the last three years, there has been a six per cent increase in medical staff and a 21 per cent increase in allied staff providing services in community settings. The overall number of nursing staff has remained stable during this period, although the balance has shifted from public hospital nursing to community health nursing.

This redistribution of public mental health services has altered the relative proportion of various types of workers. Whereas domestic and maintenance staff numbers declined by 20 per cent between 1991 and 1996, the proportion of staff providing care in community settings has increased from 27 per cent to 37 per cent between 1993 and 1996. These trends are in line with policy changes that encourage an increased proportion of mental health care to be provided in community settings.

Mental health workforce

Access to private psychiatric services is unevenly distributed in Australia since almost 87 per cent of psychiatrists practise in a capital city, 4.8 per cent in major urban centres, 4.7 per cent in large rural centres, and 3.7 per cent in other areas (AIHW 1997b). This distribution departs significantly from the population distribution in Australia (see, for example, Strong et al 1998a).

Consumers of mental health services

In 1995–96, specialist mental health services employed a total of 1,126 psychiatrists and psychiatry registrars, 339 medical officers who were not registered as psychiatrists or trainees, 9,779 nursing staff, and 2,720 allied health staff (social workers, psychologists, occupational therapists, and other allied health staff). Of these, 31 per cent provided ambulatory care, six per cent community residential care, and 62 per cent provided inpatient services.

Nurses are the largest group of mental health workers, comprising about 53 per cent of the mental health workforce. In 1996, a total of 9,428 registered nurses and 1,820 enrolled nurses were employed as clinicians in psychiatric/mental health facilities. However, only 6,039 of these were registered mental health nurses (33 per 100,000 population). Seventy-five per cent of these nurses worked in a capital city or other metropolitan centre, more than 14 per cent in a large rural centre, almost six per cent in a small rural centre, four per cent in other rural areas, and less than one per cent in remote areas. This distribution is less skewed than that evident for private psychiatrists.

1.8 Consumers of mental health services

A detailed profile of the consumers of mental health services by type of mental disorder has been recently obtained through the MH-CASC project. This project, one of the largest studies of mental health service utilisation ever conducted, collected information on approximately 18,000 mental health consumers. The study design involved a detailed three-month prospective data collection, covering one-quarter of specialised mental health services in both the public and private sectors.

Sociodemographic profile

The sociodemographic profile of mental health services clients differs significantly, particularly in its socioeconomic component, from that obtained for consumers of other types of health services. The main features are:

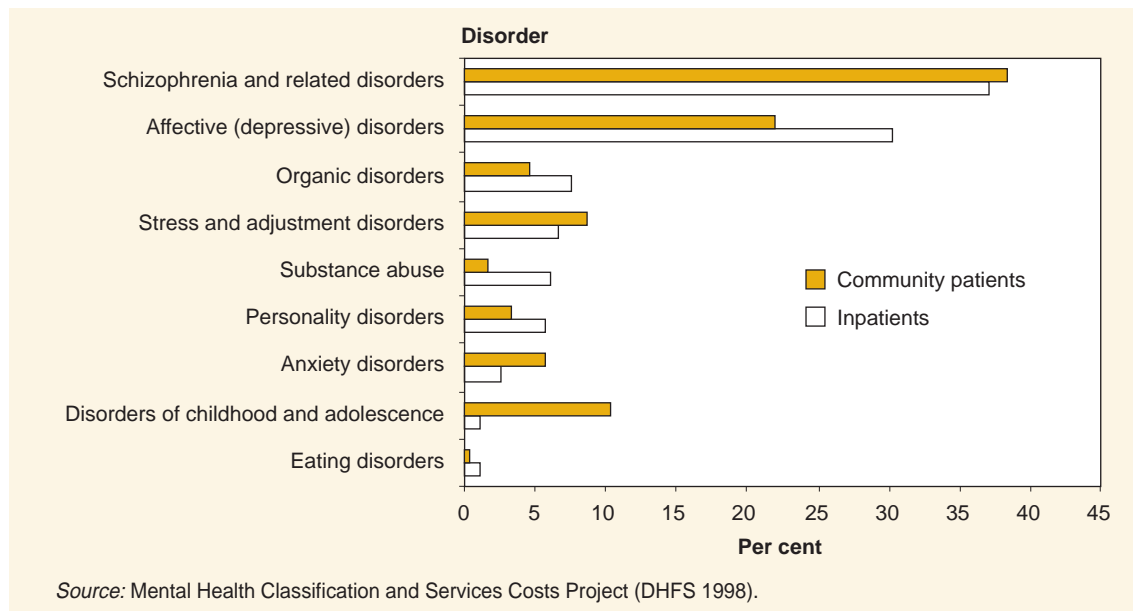
- There is no overall gender difference in mental health service utilisation (a male/female ratio of 53:47). Almost 54 per cent of the consumers are in the age group 20–50 years.
- Male children and adolescents (0–19 years) use mental health services more often than female children and adolescents, but the pattern is converse for people aged 65 years and over.
- A large majority of consumers of mental health services have never been married (almost 56 per cent), while more than one-fifth (almost 22 per cent) are divorced, widowed or separated. Less than a quarter (22 per cent) are married or in de facto relationships.
- Most consumers have no dependent children (71 per cent), depend on a government income (64 per cent), and live in private housing (82 per cent).
- A large majority of consumers are born in Australia (almost 80 per cent), followed by those born in Europe (13 per cent).
- Of those born in Australia, about two per cent are of Aboriginal or Torres Strait Islander descent.

Overview of mental health

Types of mental disorders and service utilisation

According to MH-CASC, the main types of disorders for which people receive treatment from mental health services are schizophrenia and related psychotic disorders, and mood disorders (Figure 1.4). These disorders account for more than 67 per cent of persons treated in inpatient settings and 60 per cent treated in community settings. Although schizophrenia has a much lower prevalence in the population in comparison to other mental disorders (Kessler et al 1994), people suffering from schizophrenia and related disorders utilise almost 40 per cent of all mental health services. Mood disorders account for more than 30 per cent of the services utilised (DHFS 1998)

Figure 1.4: Proportion of people with selected mental disorders (principal diagnosis) treated by mental health services, by patient status



A significant difference is also noted between the distributions of mental disorders treated by mental health services in inpatient and community care settings. While the proportions of services utilised for the treatment of schizophrenia and related disorders are roughly similar in the two settings, the proportion of those treated as inpatients is much higher for mood disorders.

The degree to which the MH-CASC estimates are extendable to the population as a whole is unknown, as comparable data are not yet collected routinely on a national basis. The 1997 SMHWP sample did not allow sufficient persons with schizophrenia to be identified to permit such a comparison a separate survey of low prevalence disorders is under way.

Types of mental disorders and hospitalisation

Another profile of the consumers of mental health care may be obtained from data on episode-based hospital separations as shown in Table 1.2. As a principal diagnosis, mental disorders (ICD-9 codes: 290–319)² were the reason for over

² The hospital admissions are currently coded using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Consumers of mental health services

200,000 hospital separations (both public and private hospitals combined) at a rate of 12.4 per 1,000 persons in 1996–97. Persons diagnosed with major depressive disorder or schizophrenic disorders accounted for the largest proportion of hospital separations for mental disorders (17.5 per cent and 14.5 per cent, respectively). Anxiety states and obsessive-compulsive disorders accounted for another 9.9 per cent of separations.

Table 1.2: Hospital separations for mental disorders and self-harm, 1996–97

ICD-9-CM codes and principal diagnosis		Number of separations	Per cent of all mental disorders	Separations per 1,000 population ^(a)
Mental disorders				
306–310, 312–316	Other non-psychotic mental disorders	36,177	17.7	2.0
296.2–296.3	Major depressive disorder	35,928	17.5	2.0
295	Schizophrenic disorders	29,695	14.5	1.6
300	Neurotic disorders	20,332	9.9	1.1
291–294	Other organic psychotic conditions ^(b)	14,799	7.2	0.8
296	Other affective psychoses ^(c)	14,602	7.1	0.8
303	Alcohol dependence syndrome	13,785	6.7	0.7
290, 294.1, 331.0	Dementia	7,681	3.8	0.4
301	Personality disorders	7,387	3.6	0.4
311	Depressive disorder, nec	6,884	3.4	0.4
304	Drug dependence	5,845	2.9	0.3
305	Non-dependent drug use disorder	5,721	2.8	0.3
298–299	Other psychoses	3,992	1.9	0.2
297	Paranoid states	1,715	0.8	0.1
302	Sexual deviations and disorders	225	0.1	< 0.1
Total mental disorders		204,768	100.00	11.2
Self-harm				
E950–E959	Suicide and self-inflicted injury	19,499	..	1.2
All stated conditions		224,267	..	12.4

Notes: (a) Mid-year population, December 1996.

(b) Excludes dementia in conditions classified elsewhere (294.1).

(c) Excludes major depressive disorder (296.2–296.3).

Source: AIHW, National Hospital Morbidity Database.

These hospital separations accounted for more than three million patient days in 1996–97 (AIHW 1998a). Patients with mental disorders were responsible for a high use of beds (134 patient days per 1,000 population) and a long average length of stay (21 days, excluding same day separations) in 1996–97.

The average length of hospital stay for patients with schizophrenic disorders in large psychiatric hospitals (120 patient days) is markedly higher than that in acute psychiatric inpatient units or beds in general hospitals (36 days). Similarly, the average length of stay for patients with dementia (182 days) is longer in large psychiatric hospitals than in hospitals overall (46 days) (AIHW 1998b).

Overview of mental health

The total number of patient days for mental disorders declined by about 20 per cent between 1992–93 and 1995–96. Most of this decline was noted for the large, stand-alone psychiatric hospitals. In comparison, the number of patient days reported for co-located psychiatric units in general hospitals has increased during that period.

In addition to separations for mental disorders, almost 20,000 hospital separations occurred due to suicide and self-harm attempts (ICD-9 codes: E950–E959), accounting for over 53,000 patient days. These include people who died in hospital following the suicide attempt. These separations do not reflect the prevalence of suicide or attempted suicide and self-inflicted injury in the community (AIHW 1998a).

An analysis of 1992–93 hospitalisation statistics reveals that there are about three times more public hospital separations than expected for mental disorders among Aboriginal peoples and Torres Strait Islanders. Mental disorders accounted for almost three per cent of all hospitalisations for Aboriginal and Torres Strait Islander females and five per cent for Aboriginal and Torres Strait Islander males (ABS 1997c). These statistics are based on data only for public hospitals in Western Australia, the Northern Territory, South Australia and Queensland. The psychiatric hospitals are not included. These figures should be interpreted with caution, as Aboriginal peoples and Torres Strait Islanders are not always reliably identified in administrative data collections.

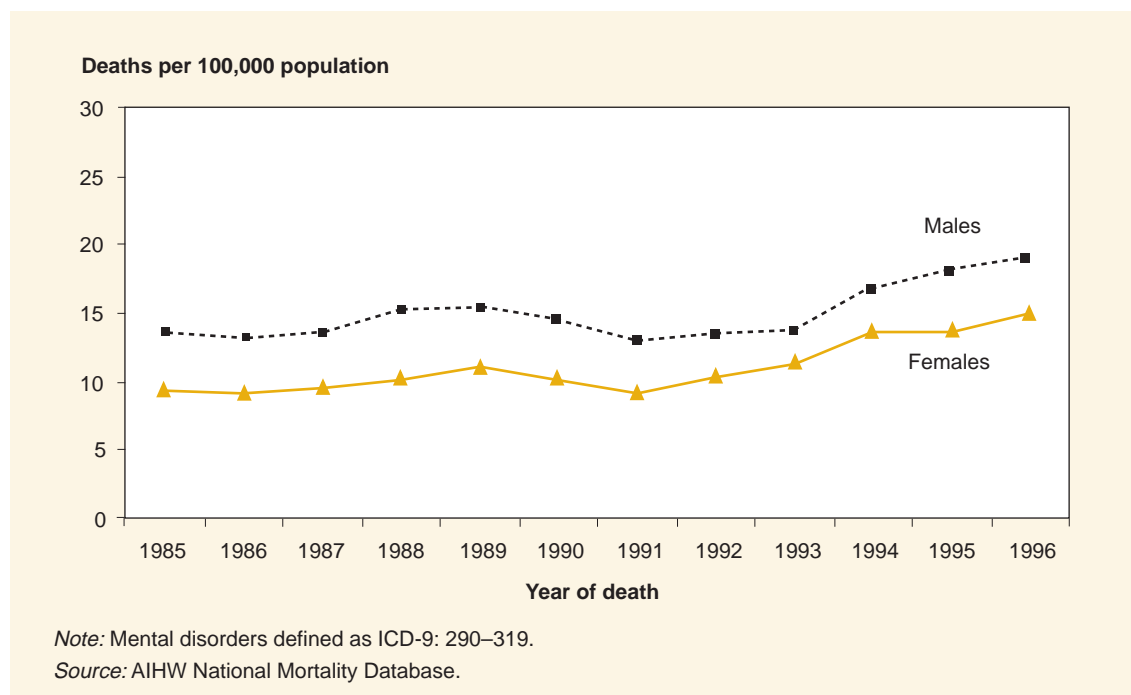
The above statistics are based on separations where a mental health problem is listed as the principal diagnosis. Information on separations where a mental disorder is a co-diagnosis rather than a principal diagnosis is not included. It is also important to mention here a major limitation of the hospital separations data in that they are episode-based rather than person-based, and therefore do not provide a direct estimate of morbidity prevalence.

1.9 Mortality

Mental disorders were cited as the primary cause of 3,560 deaths (1,495 males and 2,065 females) in Australia in 1996, representing 2.8 per cent of all deaths registered in that year. These figures do not include suicides, which are described separately in this report. The numbers are small in comparison to the high impact that mental disorders have in terms of morbidity. Nonetheless, 47,000 years of life were lost in 1996 alone due to premature mortality resulting from these disorders (Mathers 1998).

Death rates for mental disorders increased greatly between 1985 and 1996, with an average annual increase of 2.8 per cent. For males, the age-standardised rate increased from 13 deaths per 100,000 population in 1985 to 15 deaths in 1989, rising to 19 deaths in 1996 (Figure 1.5). A similar pattern is observed for females, with a corresponding gradual increase in the death rate from 9 deaths per 100,000 population in 1985 to 15 deaths per 100,000 in 1996.

Figure 1.5: Trends in death rates for mental disorders, by sex, 1985–96



This increase in death rates is largely due to a rise in mortality from senile and pre-senile psychoses (Alzheimer's disease is not included in this category). The rates for these psychoses have increased by an average of three per cent annually among males and 5.5 per cent among females. The increases were noted mostly in ages over 75 years, reflecting the age-specific nature of the disorders. No explanation can be offered at this stage for the recent increase in death rates, but varying practices in death certification and more reliable diagnoses may have contributed to this apparent increase.

Another major contributor to the increase in death rates for mental problems is use of illegal drugs. The age-standardised rate for deaths related to drug misuse increased annually by six per cent among males between 1985 and 1996. In comparison, deaths related to drug misuse in females are on the decline, by an average of 0.9 per cent per year, and are currently about one-quarter of the rate among males. Alcoholism is another large contributor to deaths categorised as being due to mental disorders.

It is estimated, based on 1992–94 mortality data for South Australia, Western Australia and the Northern Territory, that mental disorders are responsible for almost six times more deaths than expected among Aboriginal peoples and Torres Strait Islanders. A large part of this difference is accounted for by much higher death rates among Aboriginal and Torres Strait Islander males (Anderson et al 1996).

Suicide

Suicide is a leading cause of death in Australia, resulting in a total of 2,393 deaths (1,931 males, 462 females) in 1996. Since 1990, suicides have exceeded road injury deaths and have been the leading cause of death due to injury in Australia (DHFS & AIHW 1998a).

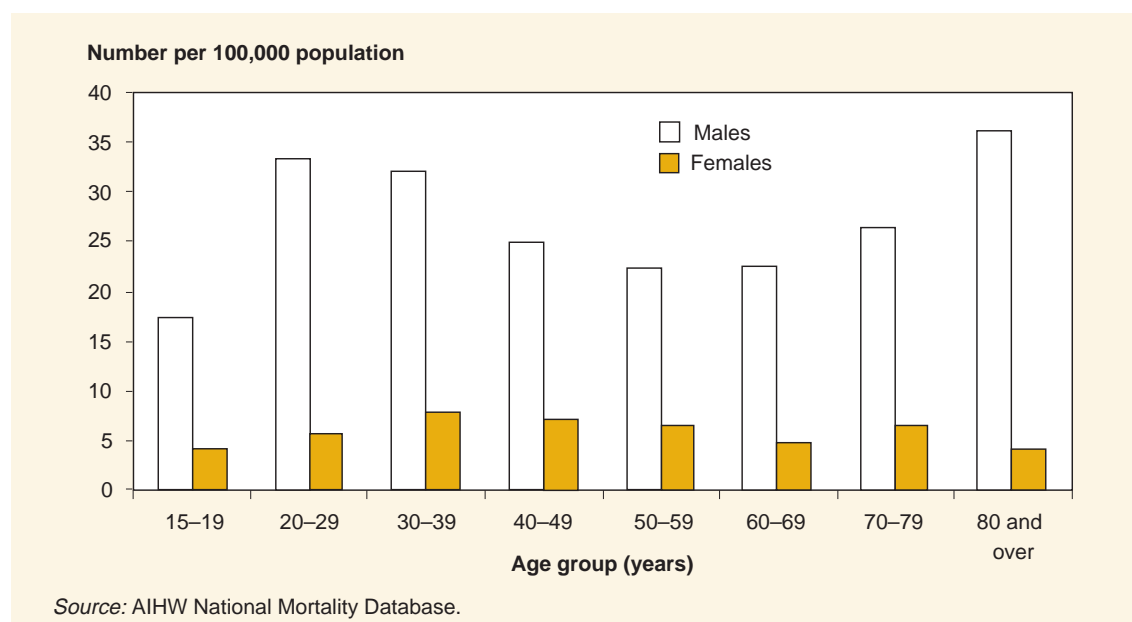
Overview of mental health

Several known factors can, under certain circumstances, contribute to a person attempting suicide. Mental disorder, and specifically depression, consistently emerges as the largest single risk factor for suicide and suicidal behaviour (Patton et al 1997). It is estimated that about 88 per cent of people who died from suicide suffered from a diagnosable mental disorder at the time of their death (Henriksson et al 1993). People with a history of mental disorder are 10 times more at risk of dying from suicide compared to the general population (Gunnel & Frankel 1994).

The lifetime risk for suicide in alcoholism has been estimated to be about 3.4 per cent (Murphy & Wetzel 1990). Similarly, the lifetime risk for suicide among those diagnosed with major depressive disorder has been estimated to be about 3.5 per cent (Blair-West & Mellsoop 1997). The figure for schizophrenia has also been suggested to vary between three and five per cent (Professor Robert Goldney, personal communication).

Males and females are equally at risk of attempting suicide, but there is a marked gender difference for suicide deaths, with the male suicide rate almost five times higher than the rate among females. In Australia and other western countries, the male rates are consistently higher across all age groups. Also, suicide rates for females are relatively stable across all age groups, but male suicide rates show two peaks, one in younger males and the other in the older age groups (Figure 1.6). While the rates are highest for males aged 80 years and over, the number of males in this age group is small and suicide deaths in this age group account for only a small proportion of all suicide deaths. In 1996, just over one per cent of all male suicide deaths occurred in men aged 80 years and over.

Figure 1.6: Age-specific suicide rates, by sex, 1996



During the period 1985 to 1996, the age-standardised suicide rate increased annually by 1.2 per cent for males (Figure 1.7a), but decreased by an annual average of 0.3 per cent for females (Figure 1.7b). The greatest increases were among males aged 30-34 years (3.1 per cent), 35-39 years (4.7 per cent), and 80-84 years (3.6 per cent).

Figure 1.7a: Trends in male suicide rates, selected age groups, 1996

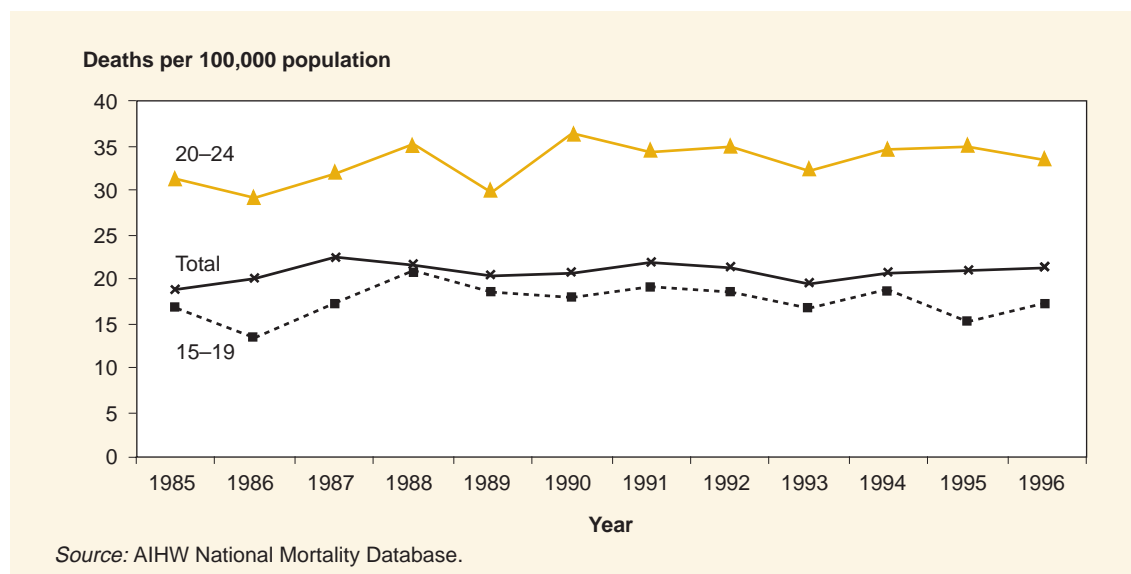
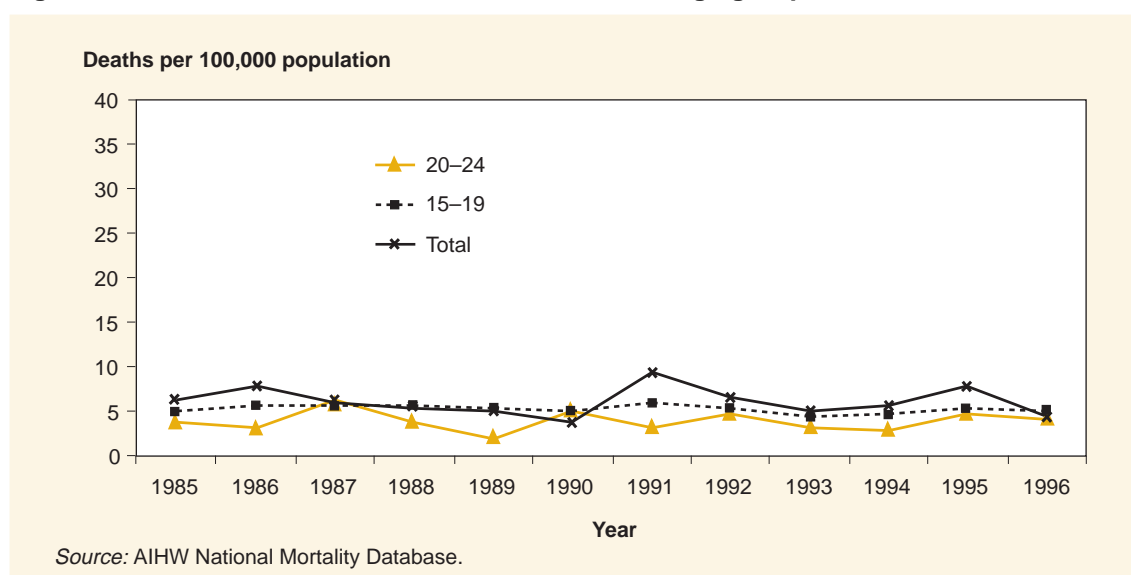


Figure 1.7b: Trends in female suicide rates, selected age groups, 1996



Youth suicide is a serious problem in Australia. In 1990, the suicide rate among males aged 15–24 years was about three times higher than the rate in 1960. However, the upward trend appears to have levelled off, and no further increase has been recorded since about 1990. There has been no parallel recent rise in the rate of suicide among young females (Harrison et al 1997).

Suicide rates are particularly high for males living in rural and remote communities. Using the RRMA classification (Appendix 2), Figure 1.8 shows that male suicide rates in remote area centres (with populations less than 5,000) tend to be higher than those among males living in other areas. In contrast, suicide rates for females are the highest among those living in metropolitan areas and the lowest among those living in remote areas (Strong et al 1998a).

Overview of mental health

Young males aged 15–24 years living in rural and remote areas are at an even greater risk of suicide. Dudley et al (1997) report that from 1964 to 1993, suicide rates for 15–24 year old males rose by a factor of 2.2 in metropolitan areas, four-fold in towns with populations between 4,000 and 25,000 and twelve-fold in towns with populations less than 4,000 people. While the suicide rate among young females did not change overall, the rate increased more than four-fold in towns with less than 4,000 people.

The suicide rates are also high among Aboriginal and Torres Strait Islander males. According to Anderson et al (1996), based on 1992–94 deaths data from Western Australia, South Australia and the Northern Territory, the standardised mortality ratio (SMR) for suicide between Indigenous and non-Indigenous males was 1.8. In contrast, no significant difference in suicide rates was noted between Indigenous and non-Indigenous females. The rate was particularly high among young Indigenous males, 51 per 100,000 among those aged 15–24 years, and still higher among those aged 25–34 years (66 per 100,000 persons). The suicide rate was much lower at six per 100,000 Indigenous females in the age group 15–24 years. No suicides were recorded among Indigenous females in the age group 25–34 years during 1992–94 in Western Australia, South Australia and the Northern Territory.

Figure 1.7c: Age-specific suicide rates among Aboriginal peoples and Torres Strait Islanders, 1991–96

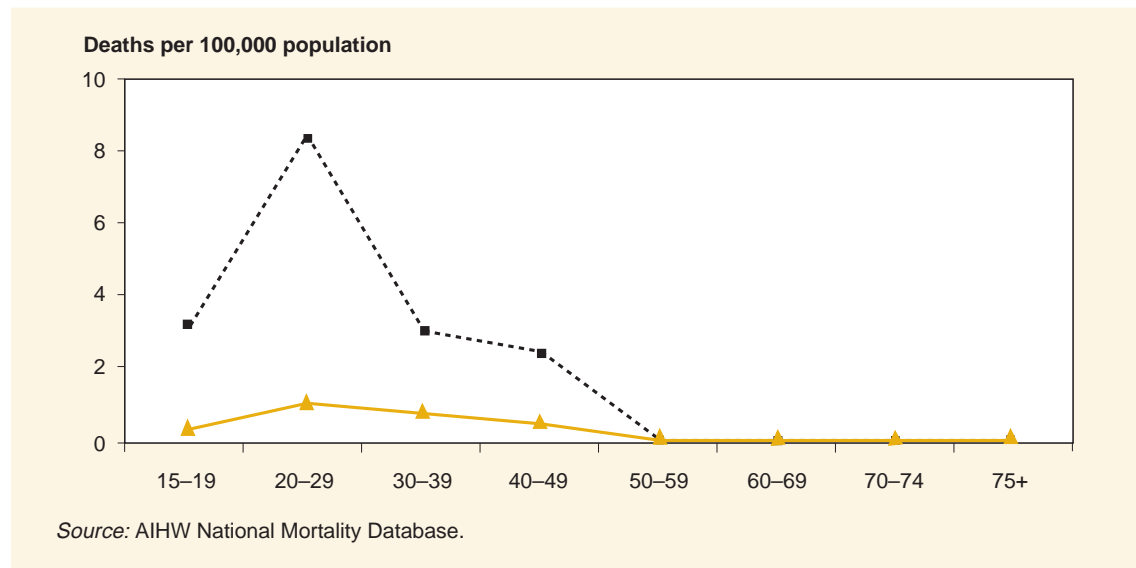
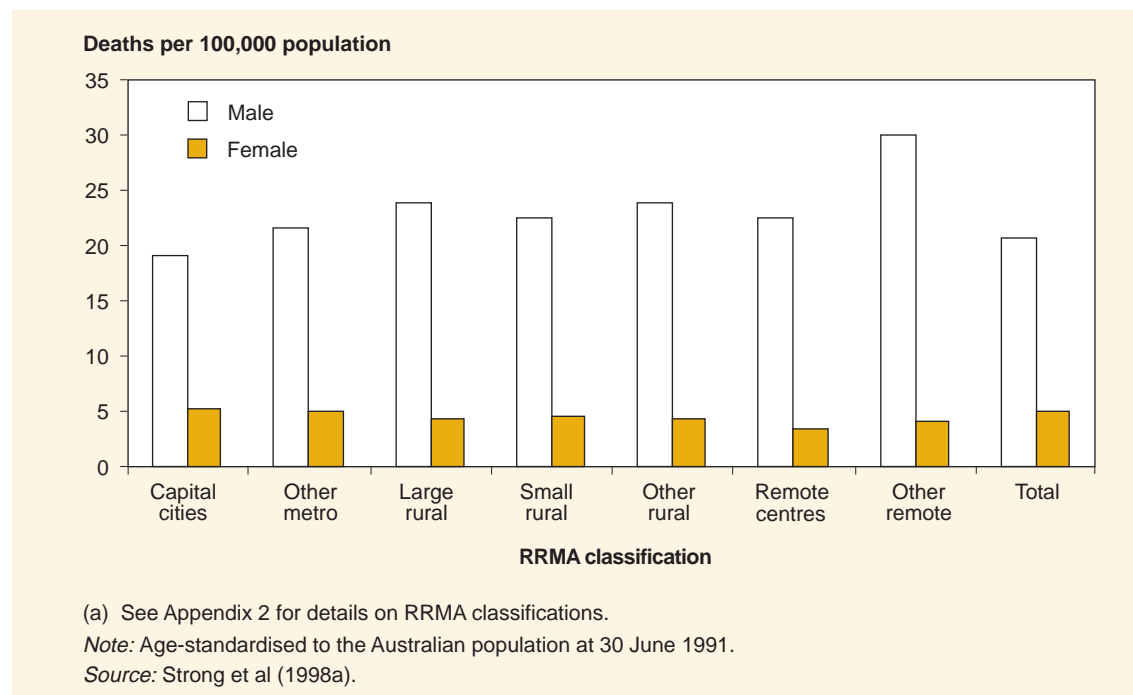


Figure 1.8: Suicide rates in rural, remote and metropolitan areas^(a) of Australia 1992–1996



Australia ranks in the middle of the main industrialised countries for which data were available in terms of deaths due to suicide (see Figure 1.9). In 1992, Australia ranked tenth lowest among a total of 19 developed countries (de Looper & Bhatia 1998). For suicide rates among young males aged 15–24 years, Australia ranked in the upper one-third of 45 countries compared by Harrison et al (1997).

Overseas-born suicide

There is significant diversity in the risk of suicide to immigrants. This diversity not only emanates from varying adjustments associated with settling in a new country, but is also often associated with lack of cultural support and linguistic disadvantages. Consequently, age and sex, two of the major predictors of suicide risks, reveal a range of suicide patterns among those from culturally and linguistically diverse backgrounds. Table 1.3 compares the suicide rates of the overseas-born with the Australian-born for the period 1994–96, using SMRs, for four different categories of overseas-born persons, i.e. those born in UK and Ireland; other Europe; Asia; and other Countries.

The suicide rates among males born overseas are either significantly lower than or similar to the rate noted among Australian-born males. The rate is almost one-third among males born in Asia in comparison to the rate among Australian-born. In contrast, the female suicide rates among those born overseas are either significantly higher than or similar to the rate noted among Australian-born females.

Region-wise, those born in UK, Ireland and other parts of Europe have either similar or higher suicide rates than those born in Australia. In particular, the SMRs are significantly higher among females from these regions. In contrast, those born in Asia and other countries exhibit similar or lower suicide rates in comparison to those born in Australia. In particular, the SMRs are significantly lower for males from these regions.

Overview of mental health

Table 1.3: Mortality differentials for suicide by birthplace and sex, aged 15 years and over, 1994–96

Sex	Standardised mortality ratio (SMR) by region				Total number of deaths
	UK and Ireland	Other Europe	Asia	Other	
Males	0.99	1.00	0.37*	0.81*	5,568
Females	1.21*	1.31*	0.91	1.03	1,366

* Significantly different from the expected value of 1.0 at the 5% level of probability.

Notes:

1. The standardised mortality ratio is a comparative measure of death rates among the overseas-born population relative to the Australian-born population.
2. Standardised to the Australian population at 30 June 1991.

Source: Strong et al (1998b)

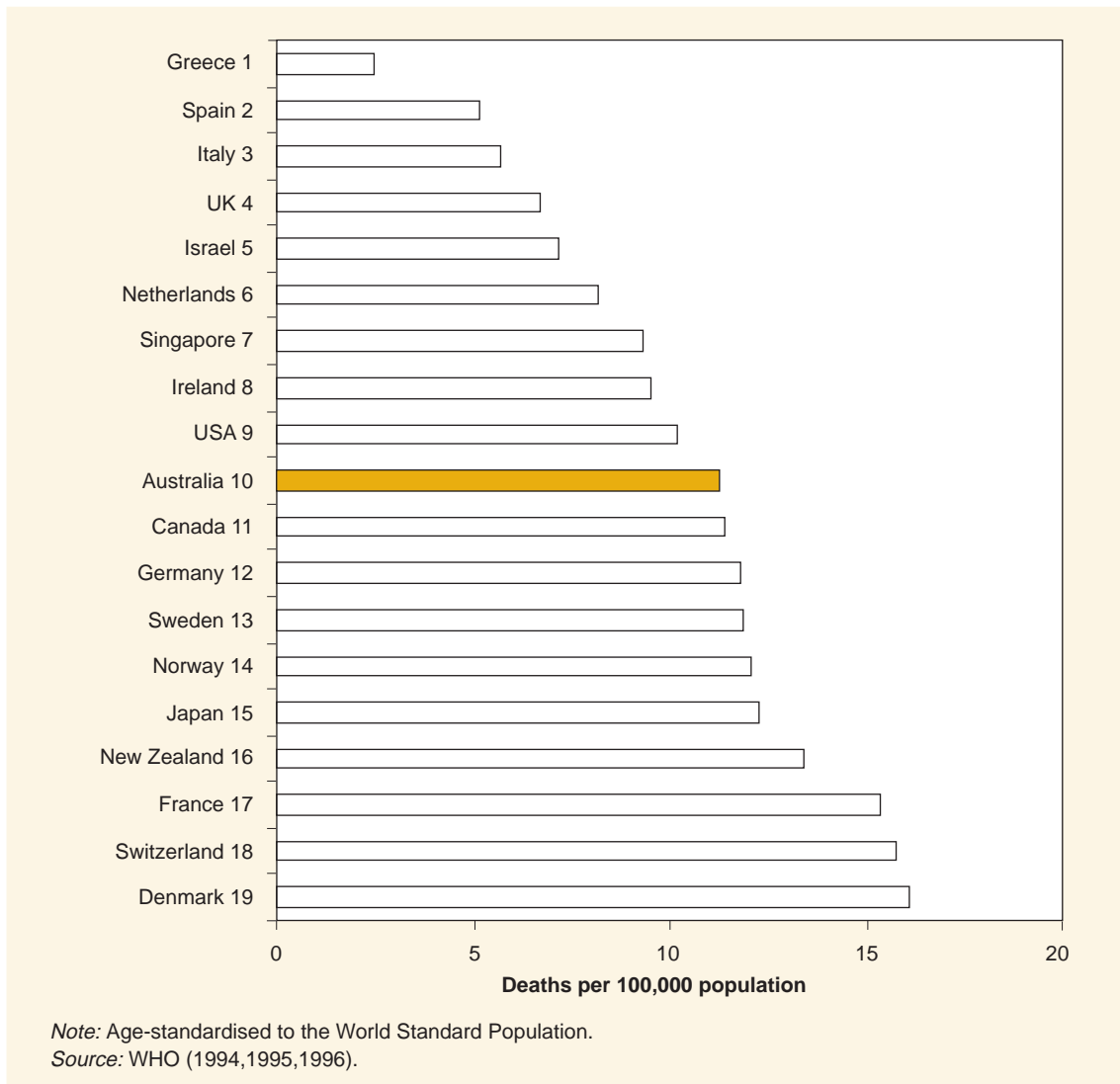
Age-specific differences in suicide rates have also been reported. Although younger immigrants of non-English speaking backgrounds experience suicide rates that are lower or similar to those for the Australian population as a whole, immigrants aged 65 years and over from these backgrounds have significantly higher suicide rates (McDonald & Steel 1997).

1.10 Comorbidity

Comorbidity, which refers to the occurrence of more than one disorder at the same time, is commonly found among people with mental disorders. Mental disorders may also contribute to the development and maintenance of several physical conditions and disabilities. Psychosocial problems constitute one of the most troublesome patient management problems for physicians caring for the medically ill. Co-existence of more than one mental health problem in the same individual is also common.

In the 1997 SMHWP, 17.7 per cent of the respondents reported having a mental disorder. Almost 43 per cent of these persons had a physical condition as well, which included heart problems, diabetes, cancer and many other conditions. In comparison, 38.8 per cent of the respondents reported the existence of a physical condition, a quarter of whom also reported a mental disorder. The probability of a person reporting both a physical condition and a mental disorder is estimated to be 6.9 per cent, significantly lower than the observed comorbidity of 7.6 per cent. Co-existence of a physical condition and a mental disorder was reported much more commonly among females than expected by chance alone. The presence of physical conditions does not seem to lead to an increase in substance use disorders.

Figure 1.9: A comparison of suicide rates in OECD countries, 1992



More than one in three of those with an anxiety disorder also had an affective disorder (defined as depression or dysthymia in this survey), while one in five also had a substance use disorder (ABS 1998). Similarly, a large proportion of those with an affective disorder also had an anxiety disorder (78.6 per cent). Although both anxiety and affective disorders are twice as common among females than males, no gender-specific increase was reported in the comorbidity of the two types of disorders.

1.11 Mental health and disability

The burden of mental disorders is more evident in associated disability than in mortality. The effects of this psychiatric disability are multidimensional. Not only is a person's full functioning compromised but their participation in day-to-day life may also be affected.

Overview of mental health

An important source of information on psychiatric disability in Australia is the ABS disability survey. Based on the 1993 Survey of Disability, Ageing and Carers conducted by the ABS, the prevalence rate for psychiatric disability has been estimated as 2.8 per cent (AIHW 1997a). For this survey, the ABS adhered to the definitions and the three dimensions of the 1980 International Classification of Impairments, Disabilities and Handicaps (ICIDH). However, the estimate from this survey may be lower than the true prevalence rate in the population. According to Madden et al (1995), the ABS disability survey screening questions may be a source of underestimation of psychiatric disability.

To cover developments since 1980, a new version of the ICIDH is being drafted. In this version, the ICIDH-2, the three re-named and re-structured dimensions are *impairment*, *activity* and *participation* to give more recognition to consequences of interaction between a person and their environment. The final version of the ICIDH-2 is planned for publication in 1999.

Additional data on disability associated with mental disorders have been generated recently through the 1997 SMHWP. The survey used the Brief Disability Questionnaire (BDQ) to investigate whether respondents were restricted in their movement because of health problems, and to what extent their capacity was limited (ABS 1998). The BDQ measures aspects of disability that are different from the ICIDH-based measures used in the Survey of Disability, Ageing and Carers. For more details on the questionnaire, see Appendix 2.

According to the 1997 SMHWP, 65.9 per cent of Australians aged 18 years and over were disability-free from mental disorders or physical conditions, as measured by the BDQ. Among those who reported a mental disorder and/or a physical condition, 12.9 per cent reported mild disability, 14.7 per cent moderate disability, and 6.5 per cent severe disability (ABS 1998). Females were more likely to report disability than males. The prevalence and severity of disability increased with age.

Among the 1997 SMHWP respondents who reported physical conditions only, 54.6 per cent were considered to have mild, moderate or severe disability, compared with 29.6 per cent among those with mental disorders only (ABS 1998). The proportion of disability was much higher among people with both a physical condition and a mental disorder (62.9 per cent).

Comorbidity has a cumulative effect on the severity of disability. Severe disability is much more common among those with a combination of both a physical condition and a mental disorder. Persons with mental disorders only reported an average of 2.2 days during which they were unable to fully carry out usual activities in the four weeks prior to the interview, compared with 4.1 days for persons with a mental disorder and a physical condition (ABS 1998).

If present in combination with a physical condition, anxiety and affective disorders have a more disabling impact than substance use disorders. More than 70 per cent of persons with anxiety disorders reported disability in 1997 SMHWP (ABS 1998). The proportion is slightly lower among those with affective disorders and physical condition(s) at 65 per cent. However, the severe end of the disability spectrum is much more evident among persons with affective disorders.

Disability support

A variety of services and assistance is available to people with a disability. These include disability-specific income support, disability support services and other generic services, some of which contain components targeted specifically at people with a disability. The MH-CASC study has estimated that about 31 per cent of those treated by mental health services received the disability support pension in 1995–96; a further 33 per cent of patients received some other form of pension such as repatriation, unemployment, aged, sickness benefit or other (DHFS 1998).

According to the Commonwealth Department of Social Security (DSS) estimates, 546,485 pensions were paid in the first quarter of 1998 under the Disability Support Pension Scheme. Of these pensions provided to people with an inability to work, nine per cent were paid for intellectual/learning conditions and 18 per cent for psychological/psychiatric conditions, as defined by the DSS. It should be noted that these estimates exclude other disability-related pensions such as age pensions and the veterans' disability pensions (DSS 1998).

People with psychiatric disability, however, have more specific needs than those with non-psychiatric disability. In 1997, psychiatric disability was the primary disability for almost six per cent of clients receiving services under the Commonwealth/State Disability Agreement (CSDA). Under the CSDA, the prime target group is the age group 0–64 years; however, a significant number of people over the age of 64 remain, due to their ongoing needs, service recipients as they age within the service (AIHW 1997). A large proportion of CSDA clients had an intellectual disability as their primary disability (67.3 per cent). This proportion was consistent for both sexes (Black & Maples 1999).

1.12 Costs of mental disorders

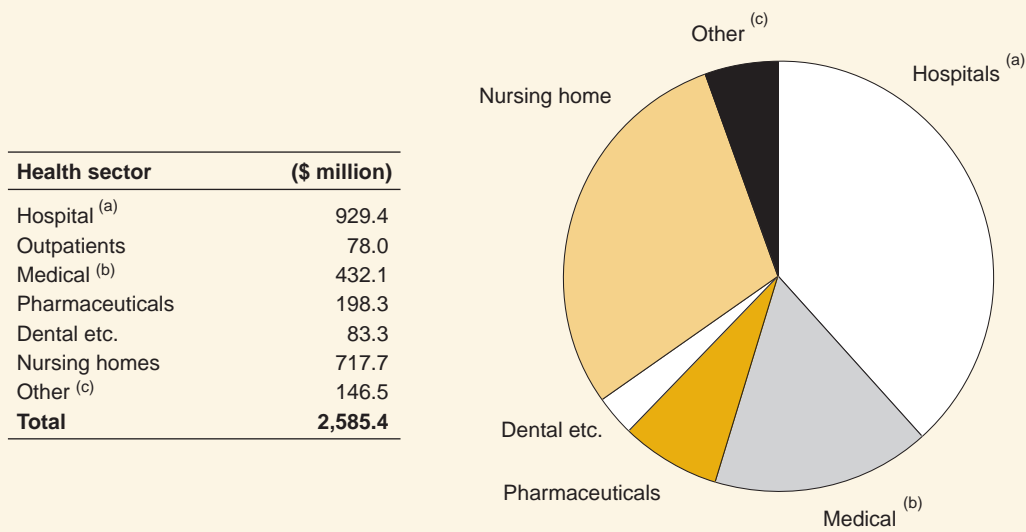
Mental disorders are estimated to be the fourth most expensive disease group, after digestive system diseases, circulatory disorders and musculoskeletal problems. High cost is partly a consequence of long-term chronic conditions with relatively low fatality rates.

The institutional and non-institutional costs of mental disorders in Australia have been estimated at \$2.58 billion in 1993–94 alone, if calculated at the broad ICD-9 disease group level. This constitutes 8.3 per cent of the total health system costs that year. Intentional self-inflicted injuries cost a further \$69 million (Mathers & Penm 1999).

Hospitals and nursing homes account for almost 64 per cent of all mental disorder treatment costs (Figure 1.10). It should be noted that the burden of mental disorders to the Australian community is much more than these costs, as costs relating to absenteeism, lost productivity, the burden on carers and family, legal costs, and lost quality and years of life are not included.

Overview of mental health

Figure 1.10: Health system costs for mental disorders, 1993–94



(a) Public and private acute hospitals, repatriation hospitals and psychiatric hospitals.

(b) Medical services for private patients in hospitals is included under 'hospitals'.

(c) Includes research and other institutional, non-institutional and administrative expenditure. Does not include other public health services, community health services, ambulances, or medical aids and appliances.

Source: Mathers & Penm et al (1998).

The costs are much higher for dementia, depression and schizophrenia than for other mental health problems. Table 1.4 also illustrates that the proportional contribution to the total costs from different types of services, such as general practitioners, specialists or pharmaceuticals, varies considerably for different mental health problems (Mathers & Penm 1999).

Table 1.4: Health system costs for specific mental health problems by health sector and ICD-9 chapter, 1993–94

ICD-9 Chapter	Hospital inpatients				Medical services				Pharmaceutical			Allied professionals		Total direct
	Public	Private	Non-inpatients	Total hospital	Nursing homes	Specialists		Total	Pre-scribed	Over counter	Research	Other	Total	
						GPs	Specialists							
Dementia	87.2	11.3	0.0	98.5	454.7	3.2	2.4	5.5	0.9	0.1	0.8	8.4	25.3	594.1
Non-drug psychoses	382.4	21.4	6.1	409.9	81.7	9.6	25.1	34.7	10.9	0.6	2.4	8.1	24.4	572.7
Schizophrenia	265.8	8.9	4.9	279.6	19.6	7.7	18.8	26.5	7.6	0.5	1.2	5.0	15.1	355.1
Bipolar disorder	24.9	6.3	0.4	31.6	12.6	0.5	1.8	2.3	1.5	0.1	0.4	0.7	2.2	51.4
Other	91.7	6.3	0.7	98.7	49.6	1.4	4.5	5.9	1.8	0.1	0.8	2.4	7.1	166.2
Depression	113.7	36.8	12.1	162.6	87.1	36.6	103.2	139.9	60.6	4.8	12.4	7.0	21.1	495.4
Major depression	83.1	21.6	1.1	105.8	40.9	1.5	4.7	6.1	4.1	0.2	1.1	2.4	7.1	167.7
Reactive depression	30.6	15.2	10.9	56.7	46.3	35.2	98.6	133.7	56.5	4.6	11.3	4.6	13.9	327.7
Reaction to stress/adjustment	14.4	7.6	17.4	39.4	5.7	12.7	14.9	27.6	4.5	22.0	7.3	1.7	5.1	113.2
Neurotic disorders	16.3	8.0	13.0	37.4	11.3	44.6	59.6	104.2	40.0	0.8	13.5	3.1	9.3	219.7
Personality disorders	21.6	2.1	1.7	25.4	5.3	1.4	6.1	7.5	0.5	0.0	1.7	0.6	1.8	43.0
Alcohol problems	95.4	13.4	4.1	112.9	27.4	6.0	13.5	19.4	2.1	0.2	4.9	2.5	7.5	177.1
Alcoholic psychosis	44.0	0.6	0.5	45.1	17.2	1.0	2.0	3.0	0.4	0.0	0.8	1.0	3.0	70.4
Alcohol dependence/abuse	51.4	12.8	3.6	67.8	10.2	5.0	11.4	16.5	1.8	0.2	4.1	1.5	4.5	106.7
Tobacco abuse	0.1	0.0	1.0	1.1	–	3.6	3.0	6.6	0.2	0.1	0.8	0.1	0.4	9.3
Drug problems	22.3	4.9	5.2	32.4	8.0	8.3	4.1	12.3	6.8	0.3	8.3	1.0	3.1	72.3
Drug psychoses	7.6	0.3	2.2	10.1	6.9	3.4	1.7	5.1	2.8	0.1	3.6	0.4	1.3	30.4
Drug dependence/abuse	14.7	4.6	3.0	22.2	1.2	4.9	2.3	7.2	4.0	0.2	4.7	0.6	1.8	41.9
Mental retardation	16.2	0.2	–	16.4	3.1	0.9	0.5	1.3	0.4	0.1	–	0.3	1.0	22.6
Other mental disorders	38.8	9.1	8.9	56.8	33.2	34.6	36.8	71.3	40.7	0.8	31.1	3.5	10.6	248.0
Prevention & screening	0.0	0.0	8.5	8.5	–	0.1	1.5	1.6	–	0.8	–	0.2	0.5	11.6
Total	814.5	114.9	78.0	1,007.5	717.7	161.5	270.6	432.1	167.6	30.7	83.3	36.6	110.0	2,585.4

Note: The above numbers are given as \$ million.
Source: Mathers & Penm (1999).

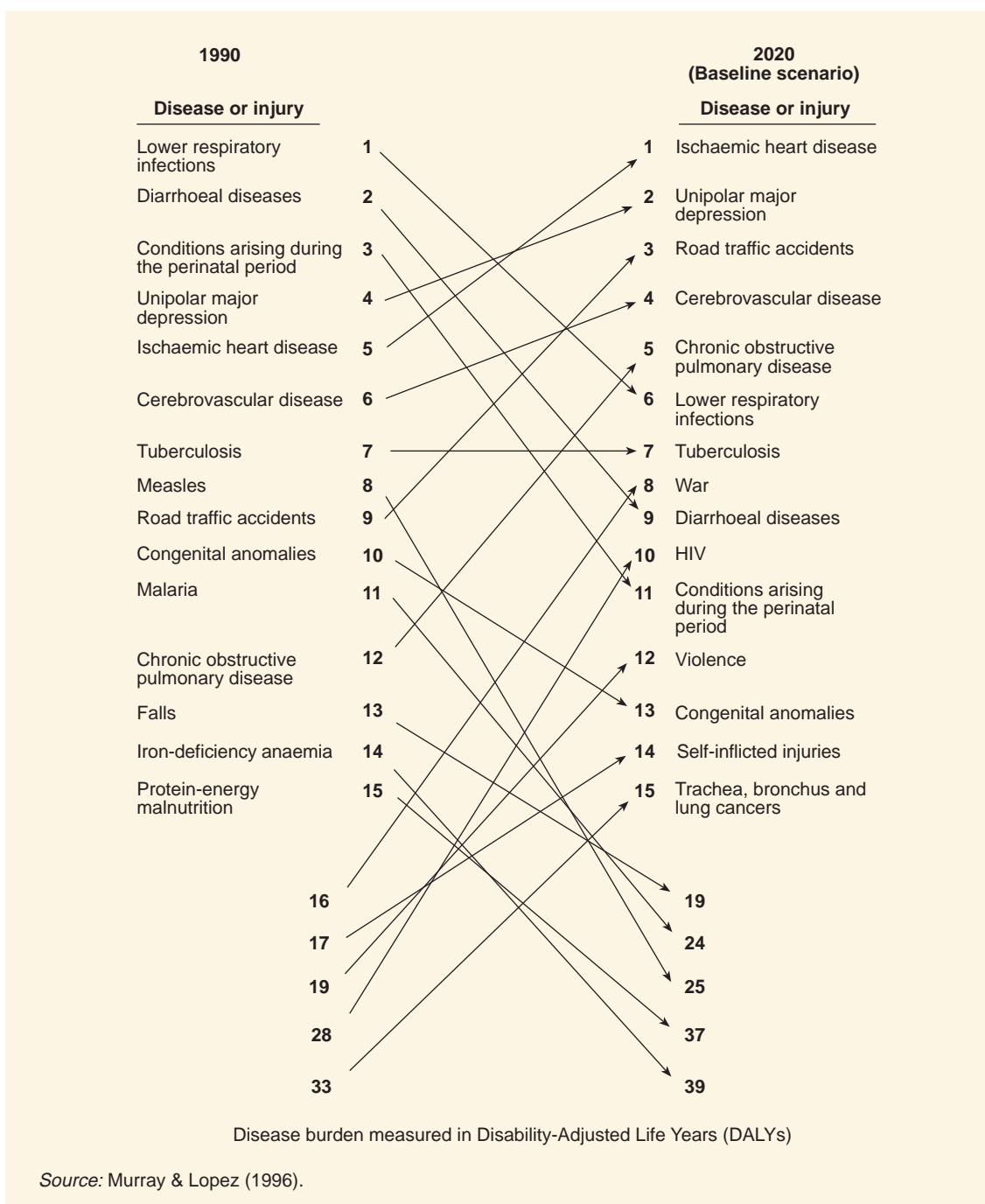
1.13 Depression as a focus area

The World Bank and the WHO have predicted that by the year 2020, the health burden attributable to neuropsychiatric disorders could increase by about 50 per cent, from 10.5 per cent of the total burden in 1990 to almost 15 per cent in 2020. Projections to the year 2020 indicate that depression will contribute the largest share to the burden of disease in the developing world and the second largest worldwide. The economic costs of this increase are likely to be high (Murray & Lopez 1996).

Figure 1.11 reveals the substantial health burden of depression in comparison to other diseases and its upward trend. The sum of the burden of unipolar major depression and suicide has been estimated at 5.1 per cent of total disease burden, making it the fourth most important cause of global burden in 1990.

Depression as a focus area

Figure 1.11 Change in the rank order of disease burden for 15 leading causes, world, 1990–2020



Overview of mental health

In view of these projections, the NHPC selected depression for focused attention under its initiatives in relation to the priority area of mental health in this round of reporting. Depression is also a major focus of the Second National Mental Health Plan, which includes the development of a proposed three-year National Depression Action Plan.

Efforts to improve mental health and reduce the impact of mental disorders are undergoing a process of significant reform in Australia. Under the National Mental Health Strategy, launched in 1992, there have been major changes to the public mental health services that are now extending into the private sector. The strategy has been recently renewed for a further five years.

The Second National Mental Health Plan will advance the new strategy. The plan identifies three broad areas for action including a stronger focus on:

- mental health promotion, prevention and early intervention;
- ensuring better partnerships within mental health services, and between mental health services and other health services, consumers, families and other sectors; and
- improving the quality and effectiveness of mental health services.