14 Mental health

Christopher Harrison, Janice Charles

This chapter looks at the management of mental health problems in BEACH, and the changes that have occurred over the decade from 1998–99 to 2007–08. It summarises the top 10 psychological problems managed in 1998–99 and 2007–08, and looks at changes over time in depression, anxiety, and drug and alcohol problems. Characteristics of patients with these conditions, and changes in management, medications, other treatments—counselling, referrals, and length of consultations where these problems were managed are also discussed. An overview of the current management of schizophrenia and bipolar disorder is provided.

14.1 Background

Results from the *Burden of disease* report, the National Survey of Mental Health and Wellbeing (NSMHW) and several BEACH SAND substudies provide a picture of the current state of mental health in Australia. Mental disorders were responsible for 13.3% of the total burden of disease and injury in Australia in 2003, with anxiety and depression accounting for over half, and alcohol dependence making up 10% of this result.[1] The NSMHW found the prevalence of a diagnosed mental disorder over the previous 12 months to be 20%, generalised anxiety disorder 2.7%, depressive episode 4.1%, and alcohol or drug harmful use or dependence, to be 5.7%.[2] The prevalence of 20% for psychological problems found in the NSMHW is also supported by a SAND substudy done in 2005, in which the prevalence of diagnosed psychological problems currently under management was estimated at 19.4% in the Australian population.[3]

The NSMHW shows that of people with a psychological problem, 35% accessed health services for their problem and two-thirds (67.8%) of these consulted a GP at some point regarding their psychological problem.[2]

Policies and initiatives

Health policies specifically addressing mental health began to appear in the early 1990s. Some of those most relevant to general practice are described here:

- The first National Mental Health Plan was put in place in 1993 to strengthen the mental health system and improve general understanding of mental illness. This was followed by the 1998–2003 plan. Both plans relied on bilateral funding agreements between the Australian and state and territory governments.[4]
- In 1994, Australian state and territory governments endorsed the National Health Goals and Targets, which identified mental health as one of the four national priority areas together with cardiovascular health, cancer control and injury prevention.[5] In 1996 these were changed to National Health Priority Areas.[6]

- The year 2000 saw the establishment of beyondblue, an organisation focusing on prevention and treatment of depression. In 2006, it went into its second 5-year phase, with funding of $36 million from the Australian Government and a similar contribution from state and territory governments.[7]
- In 2001, Australian Government funding of $120 million in the form of Medicare payments and Practice Incentive Program points was provided over four years to Better Outcomes in Mental Health Care (BOIMHC) and to incentives through the Practice Incentives program. This initiative was introduced in recognition of the important role of GPs in managing mental health problems, and to enable team arrangements for referral of patients to allied health services.

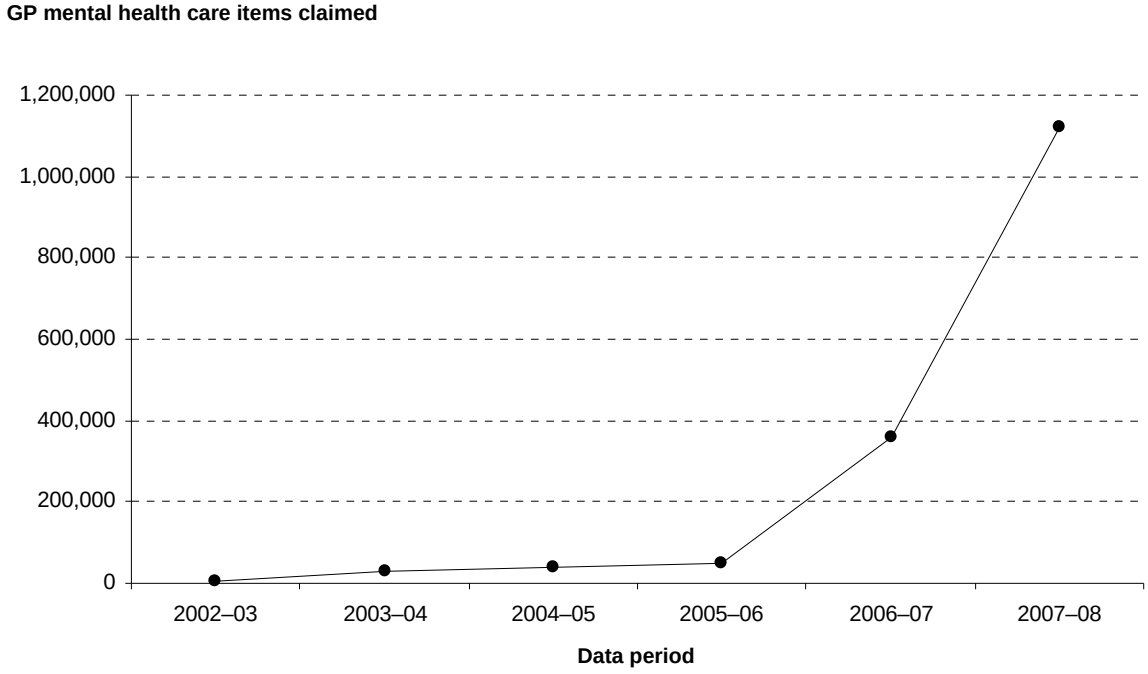
  This initiative had five components relevant to GPs:

  - Education and training: To access the MBS item numbers GPs had to undergo two levels of training in psycho-education, cognitive behavioural therapy and interpersonal therapy.
  - Access to MBS items for focused psychological strategies: Eligible GPs were able to provide patient care with the use of the above therapies. The therapies are time limited, normally deliverable in up to six planned sessions, each lasting a minimum of 30 minutes. In some instances, following review, another six planned sessions may be warranted.
  - MBS incentive items covering a three-step mental health process: The three steps were: assessment; provision of a care plan; and review of the plan; and required at least two planned follow-up consultations, and a review of the patient between four weeks and six months from the initial consultation.
  - Funding to divisions of general practice to operate a program of access to allied psychological services, which allowed GPs to refer patients to allied health professionals who delivered focused psychological strategies.
  - GP Psych Support: This provides GPs with patient management advice from psychiatrists within 24 hours.[8]
- The National Mental Health Plan 2003–2008 built on the earlier mental health plans, and focused on prevention, responsiveness, quality and research, embodying the United Nations' resolution on the protection of rights of people with mental illness.[9]
- In 2006, the GP Mental Health Care Plan replaced the three-step mental health process component, as part of the Better Access to Psychiatrists, Psychologists and General Practitioners through MBS initiative, worth $1.9 billion, to provide Medicare rebates encouraging team-based mental health care.[10] This was part of a Council of Australian Governments pledge of $4 billion over 5 years for a National Action Plan on Mental Health 2006–2011.[11] There are some major differences between Better Outcomes in Mental Health Care and Better Access. The most important change was that GPs no longer had to take additional training to conduct a GP Mental Health Care Plan. A GP Mental Health Care Plan involves both an assessment and preparation of the plan for care, but unlike the three-step process a review is not required to claim the incentive. The review is a separate item in itself. By preparing a GP Mental Health Care Plan, GPs are able to refer to psychologists for Medicare-subsidised care.

Uptake of GP mental health care items

Between 2002 and 2006, there was a modest uptake of the new GP mental health care items, with only 4,865 claimed in 2002–03 and 50,214 in 2005–06. This was probably due to the fact that GPs were required to undertake training to claim these items.

From November 2006, the Better Access initiative was introduced which allowed any GP to claim for preparing a mental health care plan. It seems this scheme is popular, with over 1.1 million claims in 2007–08 alone, thought by some to be far in excess of government (and budget) forecasts.[12]



Source: Medicare Australia.

Figure 14.1: Number of Medicare GP Mental Health Care items claimed, 2002–03 to 2007–08

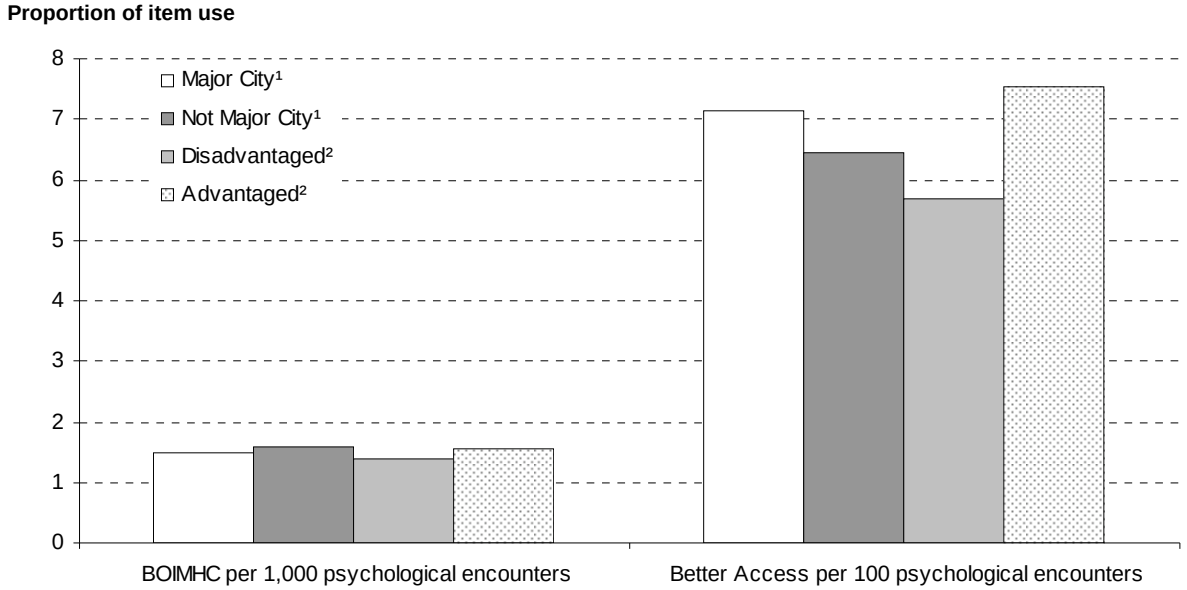
Which patients used the BOIMHC and Better Access initiative item numbers?

Examination of Medicare claims data shows that the majority of patients who claimed a Better Access initiative item number were from advantaged and/or metropolitan areas.[12] This led to criticism and concern in popular media that the new plan and incentives favour patients from these areas over those from disadvantaged or rural areas. So, use of the Better Access initiative by geographical area was tested using the BEACH dataset.

Figure 14.2 shows the proportion of encounters in BEACH that involved the management of at least one eligible psychological problem, and claimed for using the two initiatives' (BOIMHC and Better Access) item numbers. Dementia, delirium, tobacco abuse and mental retardation are excluded, as they are not covered by these initiatives. The BOIMHC data are for 1 April 2002 to 31 March 2007 and the Better Access data are from 1 November 2006 to 31 March 2008. Since the BOIMHC items were rarely used, they are reported as a rate per 1,000 psychological encounters rather than as the rate per 100 encounters used for the Better Access items.

As shown in Figure 14.2, at encounters where an eligible psychological problem was managed, the proportion that were covered using a BOIMHC item number was similar for patients living in a Major City compared with patients living outside a Major City, and was similar for disadvantaged patients and advantaged patients.

The Better Access item numbers were claimed 40 times as often as BOIMHC item numbers for eligible psychological encounters in BEACH across the respective data periods. Figure 14.2 shows that there was no significant difference in the proportion of psychological encounters for which the Better Access item numbers were recorded between patients from Major Cities and those from outside Major Cities, and between disadvantaged and advantaged patients.



1 As defined by Australian Standard Geographical Classification.[13]

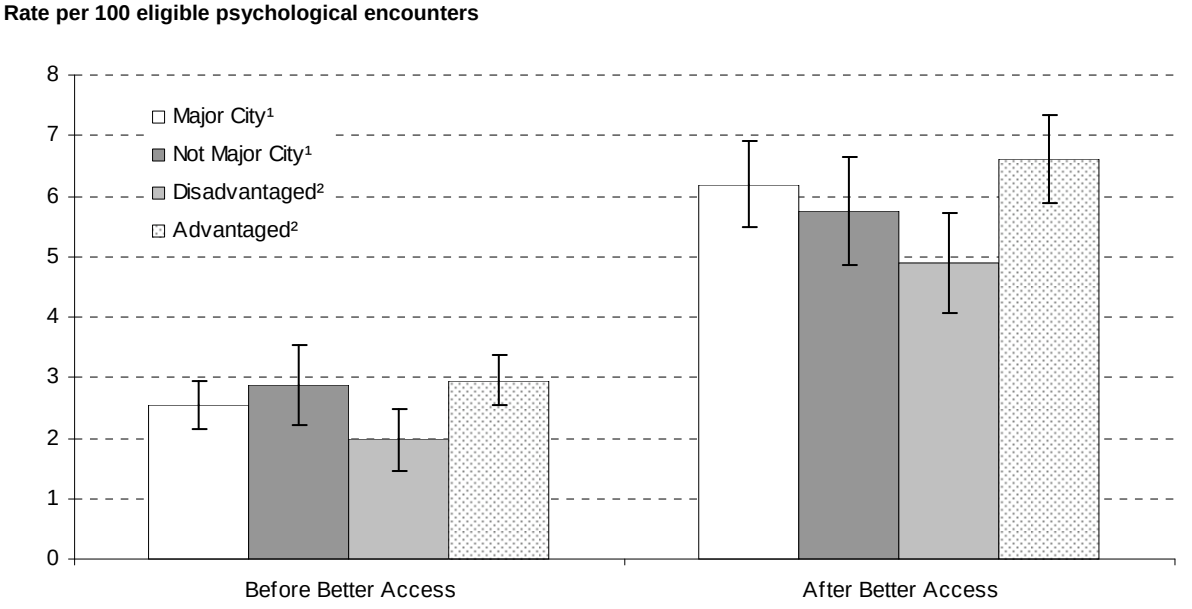
2 As defined by Socio-Economic Indexes for Areas (SEIFA).[14]

Note: BOIMHC data from 1 April 2002 to 30 March 2007; Better Access data from 1 November 2006 to 31 March 2008.

Figure 14.2: Variable-specific proportion using BOIMHC and Better Access item numbers for eligible psychological encounters

Figure 14.3 shows the likelihood of an eligible psychological problem being referred to a psychologist before and after the introduction of the Better Access initiative. Before the introduction of the Better Access initiative, the likelihood of referral to a psychologist was similar for patients from Major Cities and those from outside Major Cities. However, patients who were from relatively advantaged areas were 50% more likely to receive a referral to a psychologist than those who were from disadvantaged areas.

After the introduction of the Better Access initiative, the likelihood of referrals of an eligible psychological problem being referred to a psychologist increased significantly across all groups. There remained no significant difference between patients from Major Cities and patients from outside Major Cities in the proportion who received a psychologist referral. While patients from advantaged areas were still significantly more likely to receive a referral, they were only 35% more likely than patients from disadvantaged areas, compared with 50% previously. It therefore appears that the Better Access initiative has helped increase the referrals to psychologists for disadvantaged patients proportionally more than it has for advantaged patients. However, it is unknown from BEACH data how often these referrals were used by the patients. It is possible that patients from rural areas were less likely to see a psychologist due to lack of access.



1 As defined by Australian Standard Geographical Classification.[13]

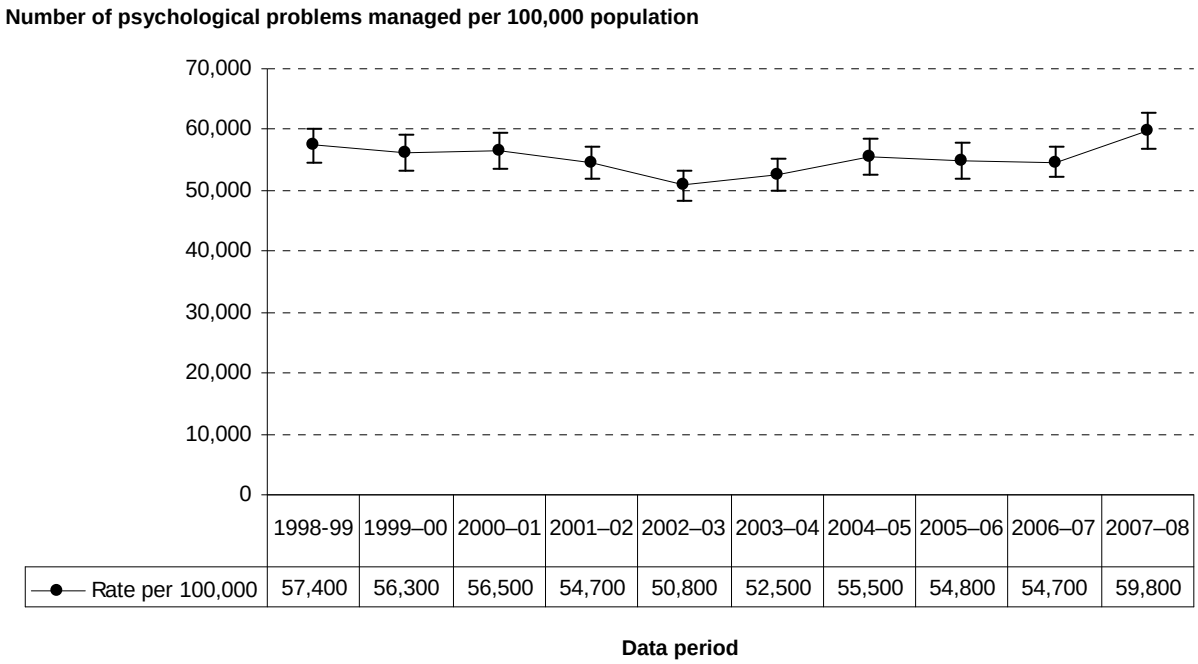
2 s defined by Socio-Economic Indexes for Areas (SEIFA).[14]

Note: Before data period is 1 April 2005 to 31 October 2006; After data period is 1 November 2006 to 31 March 2008.

Figure 14.3: Referral rates for eligible psychological encounters before and after the Better Access initiative

14.2 Management of psychological problems at BEACH encounters

Over the 10 years 1998–99 to 2007–08, psychological problems (ICPC-2 'P' codes, see Chapter 2) accounted for an average of 7.8% of all problems managed in BEACH. On average over that period, GPs managed 10.9 mental health problems per 100 encounters. In 1998–99, the rate was 10.5 per 100 encounters and in 2007–08 it was 11.5 per 100. The annual management rate ranged from 10.3 (95% CI: 9.8–10.8) in 2002–03 to the significantly higher rate of 11.5 per 100 encounters (95% CI: 10.9–12.0) in 2007–08. As Figure 14.4 shows the estimated number of psychological problems managed in general practice nationally per 100,000 population decreased from 57,400 in 1998–99 to 50,800 in 2002–03, and then increased significantly to 59,800 in 2007–08.



Sources: Number of GP encounters based on Medicare statistics found at http://www.health.gov.au/internet/main/publishing.nsf/Content/medstat-mar08-tables-b

Australian population based on ABS figures found at www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3426C038D443CB5ACA25748E0012451C/$File/41020_Population_Indicators_2008.xls

Figure 14.4: Number of psychological problems managed per 100,000 population 1998–2008

Most frequently managed psychological problems

The most frequently managed psychological problems in 1998–99 and 2007–08 are shown in Table 14.1. Comparison of the 2 years shows there was no significant change in the management rate of total psychological problems. The pattern of the most frequently managed problems did not change, with the exception of tobacco and alcohol abuse. The management of depression and tobacco abuse both significantly increased between 1998–99 and 2007–08. The management rate of schizophrenia and affective psychosis marginally increased over the same period.

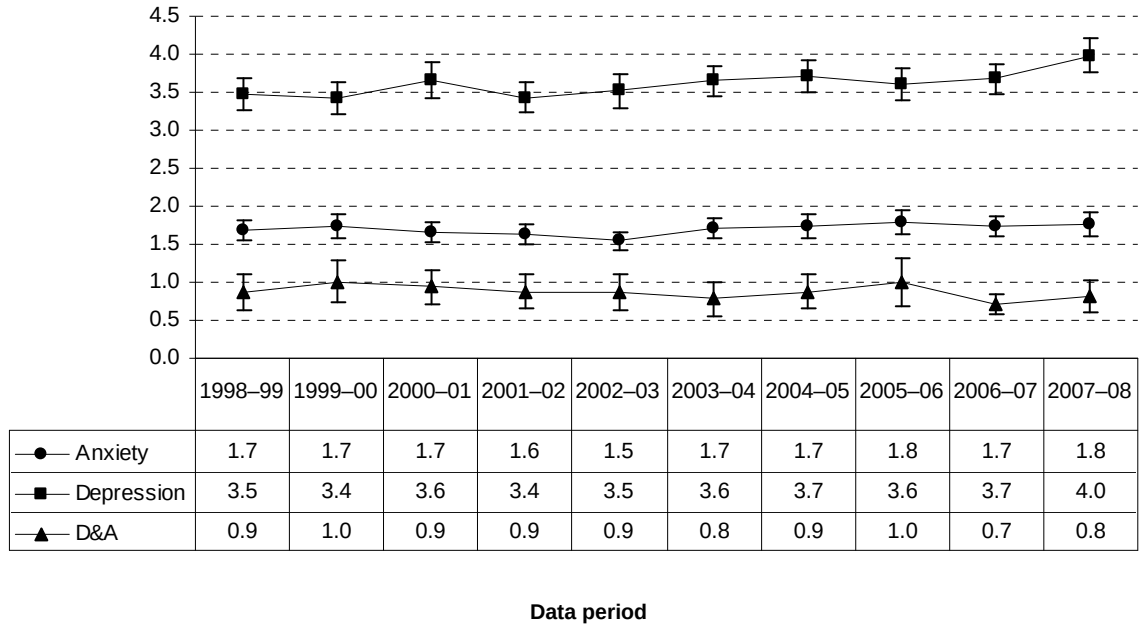
Table 14.1: Changes in management rates of common psychological problems, 1998–99 and 2007–08

	1998–99			2007–08			
Problem managed	**Number**	**Percentage of psych. problems**	**Rate per 100 encounters (*n* = 96,901) (95% CI)**	**Number**	**Percentage of psych. problems**	**Rate per 100 encounters (*n* = 95,898) (95% CI)**	**Change[(a)]**
Depression	3,367	33.2	3.5 (3.3–3.7)	3,822	34.7	4.0 (3.8–4.2)	↑
Anxiety	1,639	16.2	1.7 (1.6–1.8)	1,691	15.4	1.8 (1.6–1.9)	—
Sleep disturbance	1,579	15.6	1.6 (1.5–1.8)	1,547	14.1	1.6 (1.5–1.7)	—
Acute stress reaction	584	5.8	0.6 (0.5–0.7)	567	5.2	0.6 (0.5–0.7)	—
Drug abuse	552	5.4	0.6 (0.4–0.8)	473	4.3	0.5 (0.3–0.7)	—
Dementia (incl senile, Alzheimer's)	350	3.5	0.4 (0.3–0.4)	472	4.3	0.4 (0.3–0.6)	—
Schizophrenia	345	3.4	0.4 (0.3–0.4)	417	3.8	0.5 (0.4–0.6)	↑
Alcohol abuse	288	2.8	0.3 (0.2–0.4)	319	2.9	0.3 (0.3–0.4)	—
Tobacco abuse	275	2.7	0.3 (0.2–0.3)	400	3.6	0.4 (0.4–0.5)	↑
Affective psychosis	132	1.3	0.1 (0.1–0.2)	194	1.8	0.2 (0.2–0.2)	—
Subtotal (n, percentage of total)	*9,110*	*89.8*	*. .*	*9,902*	*90.0*	*. .*	*. .*
Total psychological problems	**10,142**	**100.0**	**10.5 (10.0–11.0)**	**11,009**	**100.0**	**11.5 (10.9–12.0)**	**—**

(a) The direction and type of change is indicated for each result: ↑/↓ indicates a statistically significant change, ↑/↓ indicates a marginal change, and — indicates there was no change.

Note: Psych—psychological; CI—confidence interval.

As shown in Figure 14.5, while the management rate of depression increased steadily from 2001–02 onwards, the management rate of anxiety and drug and alcohol problems remained relatively constant.

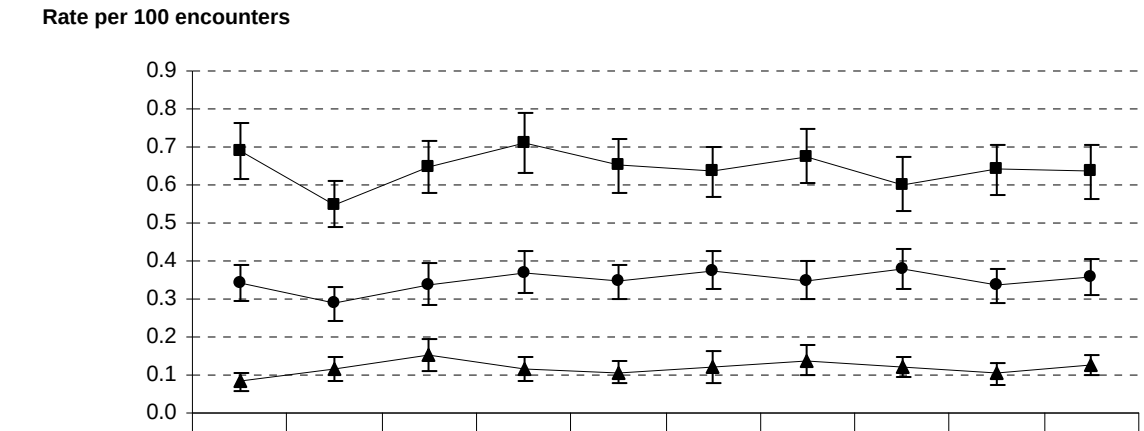


	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Anxiety	1.7	1.7	1.7	1.6	1.5	1.7	1.7	1.8	1.7	1.8
Depression	3.5	3.4	3.6	3.4	3.5	3.6	3.7	3.6	3.7	4.0
D&A	0.9	1.0	0.9	0.9	0.9	0.8	0.9	1.0	0.7	0.8

Note: D&A–drug and alcohol problem.

Figure 14.5: Rates of management for psychological problems, 1998–99 to 2007–08 (95% CI)

While there was a significant increase in the management rate of depression, Figure 14.6 shows that there was no corresponding increase in the management rate of new cases of depression. There was also no significant change in the management of new anxiety or new drug and alcohol problems over the decade. This suggests there was no change in the rate at which new cases were diagnosed, which is an interesting finding considering the recent efforts to improve diagnosis and treatment by GPs.



	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Anxiety	0.3	0.3	0.3	0.4	0.3	0.4	0.3	0.4	0.3	0.4
Depression	0.7	0.5	0.6	0.7	0.7	0.6	0.7	0.6	0.6	0.6
D&A	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1

Data period

Note: D&A–drug and alcohol problem.

Figure 14.6: Management rates of new psychological problems, 1998–99 to 2007–08 (95% CI)

14.3 Management of depression

Depression is the most common psychological problem experienced by Australians [3] and is also the most frequently managed in Australian general practice (Table 14.1). The NSMHW found that in 2007, 6.2% of Australians met the criteria for a diagnosis of an affective disorder in the previous 12 months, 4.1% meeting the criteria for a depressive episode.[2] In a BEACH SAND substudy in 2005, it was estimated that 11.3% of Australians currently had diagnosed depression requiring ongoing management.[3]

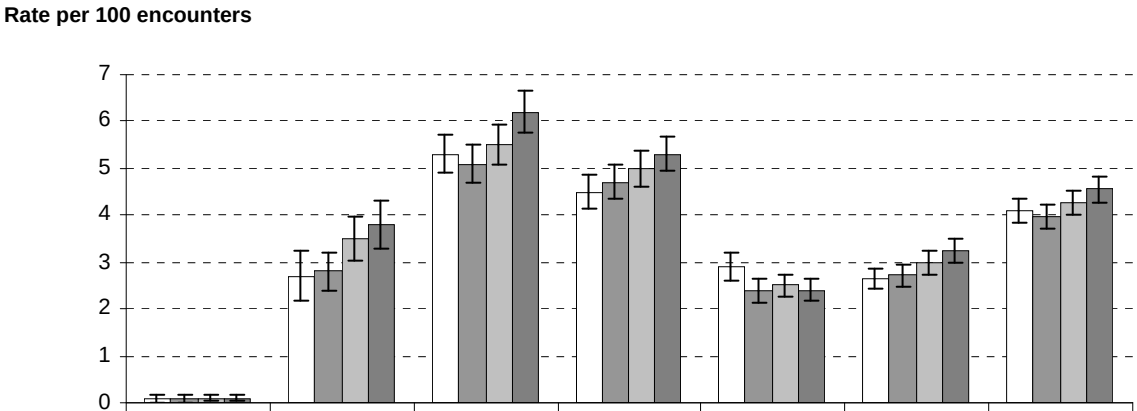
The following analysis includes diagnosed depression (Depressive disorder: ICPC code P76), which encompasses anxiety with depression, postnatal and reactive depression, affective disorder and depressive psychosis. It also includes problems labelled by the GP as symptoms of depression (Feeling depressed: ICPC code P03; for example, feeling hopeless, miserable, sad or unhappy; see Appendix 3).

There was a significant increase in the management rate of depression in Australian general practice between 1998–99 and 2007–08, from 3.5 per 100 encounters to 4.0 per 100 encounters. The current rate of management is significantly higher than the rate recorded during all of the earlier BEACH years except in 2000–01 when the rate of 3.6 per 100 was not significantly lower (Figure 14.5). The average management rate over the 10-year period was 3.6 per 100 encounters, and new diagnoses of depressions were made at an average rate of 0.6 per 100 encounters. Depression accounted for an average 2.5% of all problems managed in BEACH over the 10-year period.

The patients

2007–08

As shown in Figure 14.7, the management rate of depression was significantly higher among female patients in 2007–08 than among male patients. Patients aged 25–44 years had depression managed at 6.2 times per 100 encounters, which was significantly higher than any other age group. Patients aged 45–64 years had the second highest management rate, at 5.3 per 100 encounters. Depression was rarely managed in children under the age of 15. The rate of depression management in patients aged 65 years and older was about half that of those aged 45–64 years. This lower management rate may be due to the well-documented under-recognition of depression in the elderly by both the GPs and the patients.[15,16]



	0–14	15–24	25–44	45–64	65+	Male	Female
1998–99	0.1	2.7	5.3	4.5	2.9	2.6	4.1
2001–02	0.1	2.8	5.1	4.7	2.4	2.7	4.0
2004–05	0.1	3.5	5.5	5.0	2.5	3.0	4.3
2007–08	0.1	3.8	6.2	5.3	2.4	3.2	4.6

Age group (years) or sex

Figure 14.7: Age and sex-specific management rates of depression, 1998–99 to 2007–08 (95% CI)

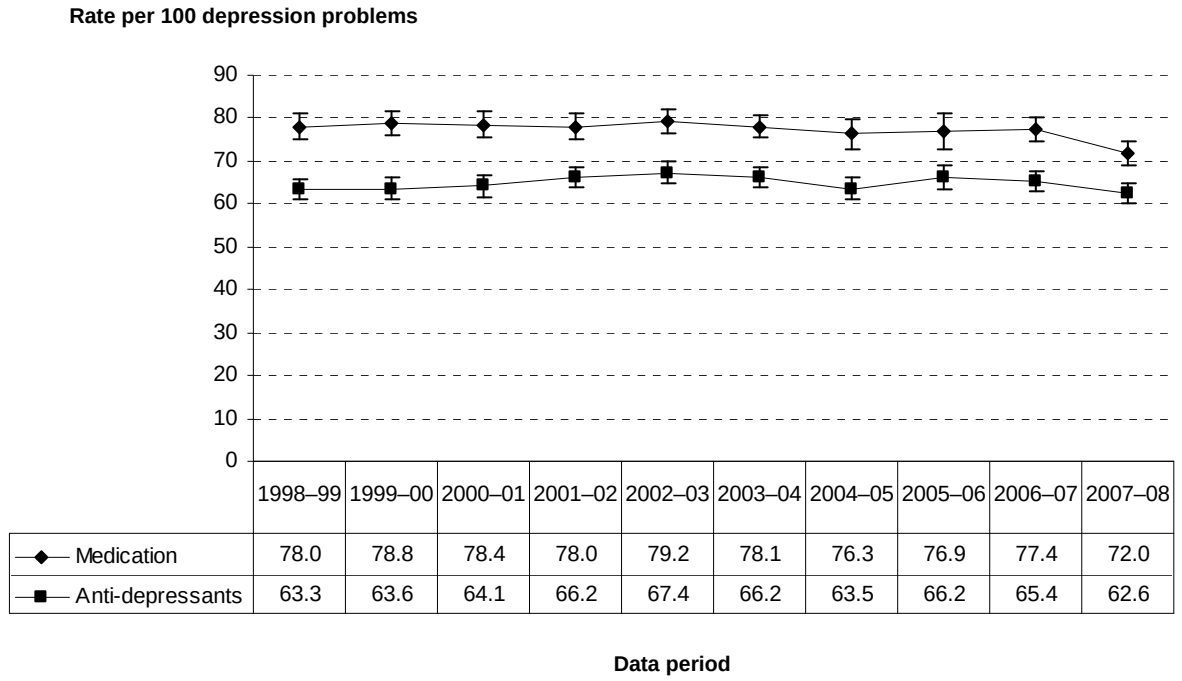
1998–99 to 2007–08

The increase over the decade in the management of depression was apparent for all patient age groups in the 15–64 years range (which all increased significantly). There was a marginal decrease across the decade in the rate of depression management in patients aged 65 years and older.

- Female patients were managed for depression more often than were male patients across all years.
- Management of depression for male patients increased from 2.6 per 100 encounters in 1998–99 to 3.2 in 2007–08. However this difference was not found in female patients.

Medications for depression

In 2007–08, GPs prescribed medications at a rate of 72.0 per 100 depression problems managed, significantly less than between 1998–99 and 2003–04 (Figure 14.8). However, the rate at which anti-depressants were prescribed did not change significantly across this period. It is interesting to note that the decrease between 2006–07 and 2007–08 coincided with an increase in the rate at which patients with depression were referred to psychologists (Figure 14.10).



	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Medication	78.0	78.8	78.4	78.0	79.2	78.1	76.3	76.9	77.4	72.0
Anti-depressants	63.3	63.6	64.1	66.2	67.4	66.2	63.5	66.2	65.4	62.6

Figure 14.8: Medication rates for depression, 1998–99 to 2007–08 (95% CI)

Other treatments for depression

Figure 14.9 shows the rates at which clinical treatments (mostly counselling, advice and education) were used by GPs in the management of depression. Among these clinical treatments:

- between 1998–99 and 2001–02, there was a significant increase in the rate of psychological counselling in the management of depression. Interestingly this was before the introduction of the BOIMHC initiative
- from 2001–02 to 2004–05 the rate of clinical treatments and psychological counselling for depression remained relatively stable
- between 2004–05 and 2006–07 there was a significant decrease in the use of clinical treatments overall; however, the rate at which psychological counselling is used did not change. The change in clinical treatment has come from a decrease in the rate at which other clinical treatments are used (such as non-psychological counselling, advice, education and administrative work). This decrease has been seen in the BEACH data set overall, and is thought to be related to the greater role that practice nurses have played in general practice since 2004–05.

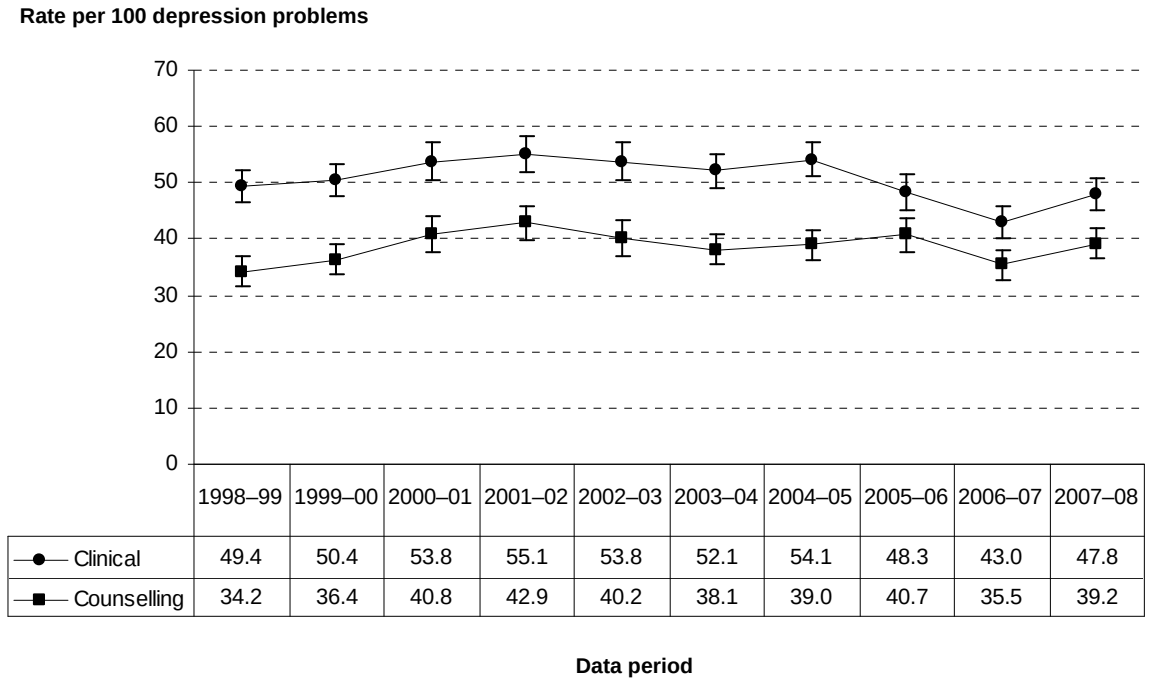


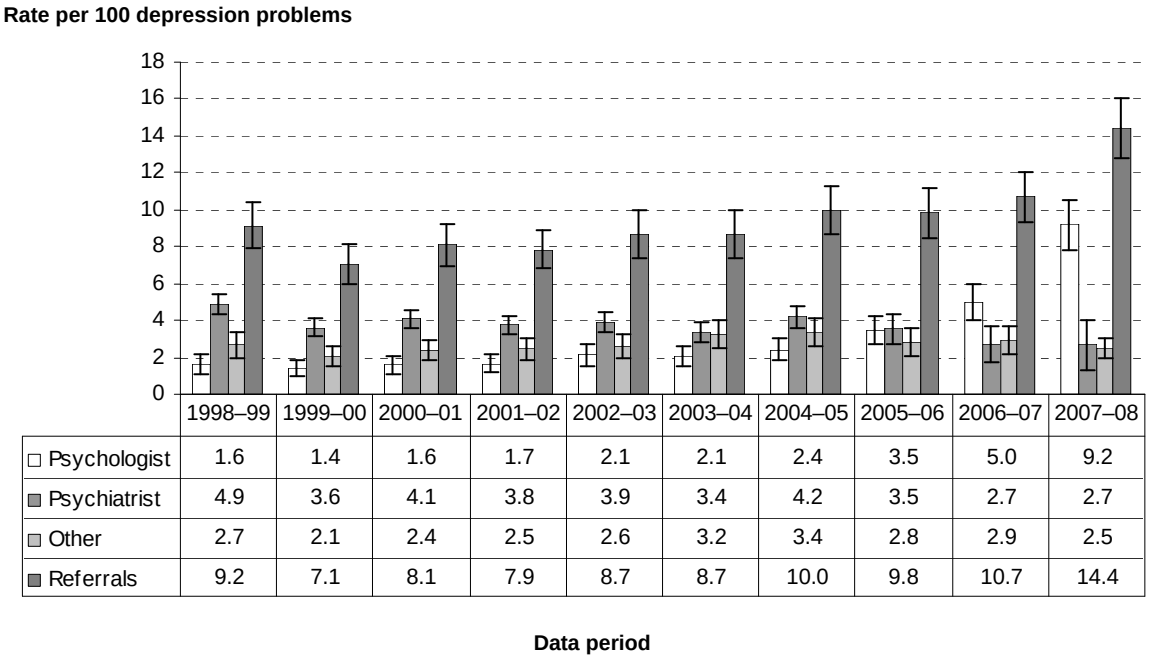
Figure 14.9: Rates of clinical treatment (and psychological counselling in particular) for depression, 1998–99 to 2007–08

Referrals for depression

The rate at which patients were referred for depression increased by about 50% from 7.1 per 100 depression problems in 1999–00 to 10.7 per 100 in 2006–07. From 2006–07 to 2007–08, the rate of referral increased by one-third to 14.4. The pattern of referrals changed markedly over the decade (Figure 14.10).

- Referrals to psychiatrists almost halved over the decade, from 4.9 per 100 depression problems in 1998–99 to 2.7 per 100 in 2007–08.
- In contrast, the referral rate to psychologists doubled between 2004–05 (2.4 per 100 depression problems) and 2006–07 (5.0 per 100) and nearly doubled again in 2007–08 (9.2 per 100).
- Referrals to other health professionals did not significantly change across the decade.

These results suggest that the early increase in the rate of referrals to psychologists may have been due to the introduction of the access to allied psychological services initiative as part of BOIMHC in 2002. The later increase in referrals to psychologists is probably due to the Better Access initiative of November 2006, which allowed all GPs to refer to a psychologist for subsidised care after the preparation of a GP mental health care plan. The increase in referrals to psychologists seems initially to be a move away from psychiatrists. By 2005–06 referrals were equally distributed between the two professions. However, between 2006–07 and 2007–08 the rate of referrals to psychiatrists remained stable while referrals to psychologists continued to rise significantly.



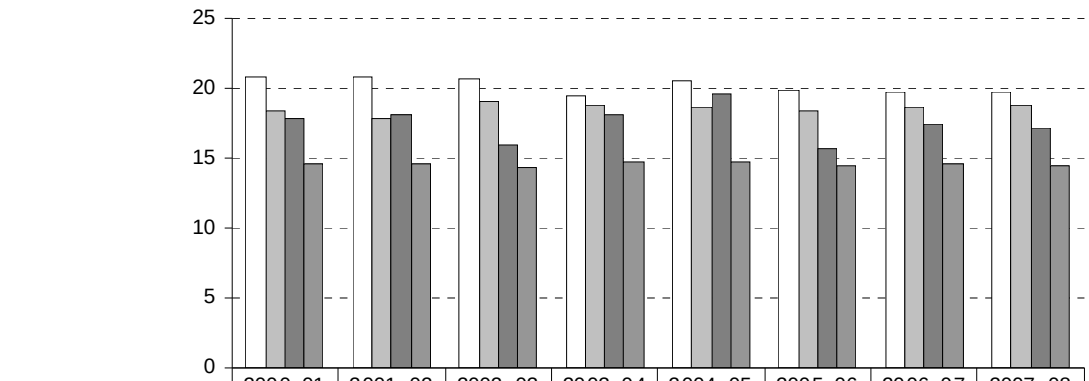
	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Psychologist	1.6	1.4	1.6	1.7	2.1	2.1	2.4	3.5	5.0	9.2
Psychiatrist	4.9	3.6	4.1	3.8	3.9	3.4	4.2	3.5	2.7	2.7
Other	2.7	2.1	2.4	2.5	2.6	3.2	3.4	2.8	2.9	2.5
Referrals	9.2	7.1	8.1	7.9	8.7	8.7	10.0	9.8	10.7	14.4

Figure 14.10: Rates of referral of depression, 1998–99 to 2007–08 (95% CI)

Length of consultation

Since 2000–01, in a subsample of the BEACH program, 40 of the 100 encounters recorded by each GP also had the start and finish time recorded. This allows calculation of the consultation length (see Chapter 2). Figure 14.11 presents the annual average length of consultations where a depression, anxiety, drug or alcohol problem was managed, and the length of all other consultations where none of these problems were managed.

Across all the years studied, consultations where depression was managed were longer, by 5–6 minutes on average, than those consultations where a depression, anxiety, drug or alcohol problem was not managed. Between 2000–01 and 2007–08, there was no significant change in the lengths of consultation where depression was managed, nor where depression, anxiety, drug or alcohol were not managed (Figure 14.11).



	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
With depression	20.9	20.9	20.7	19.5	20.6	19.9	19.7	19.7
With anxiety	18.4	17.8	19.1	18.8	18.7	18.4	18.7	18.8
With drug or alcohol	17.9	18.2	16.0	18.1	19.6	15.7	17.5	17.2
Other consultations	14.6	14.6	14.4	14.7	14.7	14.5	14.6	14.5

Data period

Note: Only includes direct (patient seen) BEACH encounters. Other consultations—all encounters (patient seen) where a depression, anxiety, drug or alcohol problem were not managed.

Figure 14.11: Length (minutes) of consultations with and without depression, anxiety, drug or alcohol problem management, 2000–01 to 2007–08

14.4 Management of anxiety

The 2007 NSMHW estimated the prevalence of anxiety disorders in the Australian population to be 14.4%.[2] This was made up of a combination of panic disorders (2.6%), agoraphobia (2.8%), social phobia (4.7%), generalised anxiety disorder (2.7%), obsessive-compulsive disorder (1.9%) and post-traumatic stress disorder (6.4%). According to a BEACH substudy of more than 9,000 patients, the population prevalence of anxiety currently requiring management was 8.4%.[3]

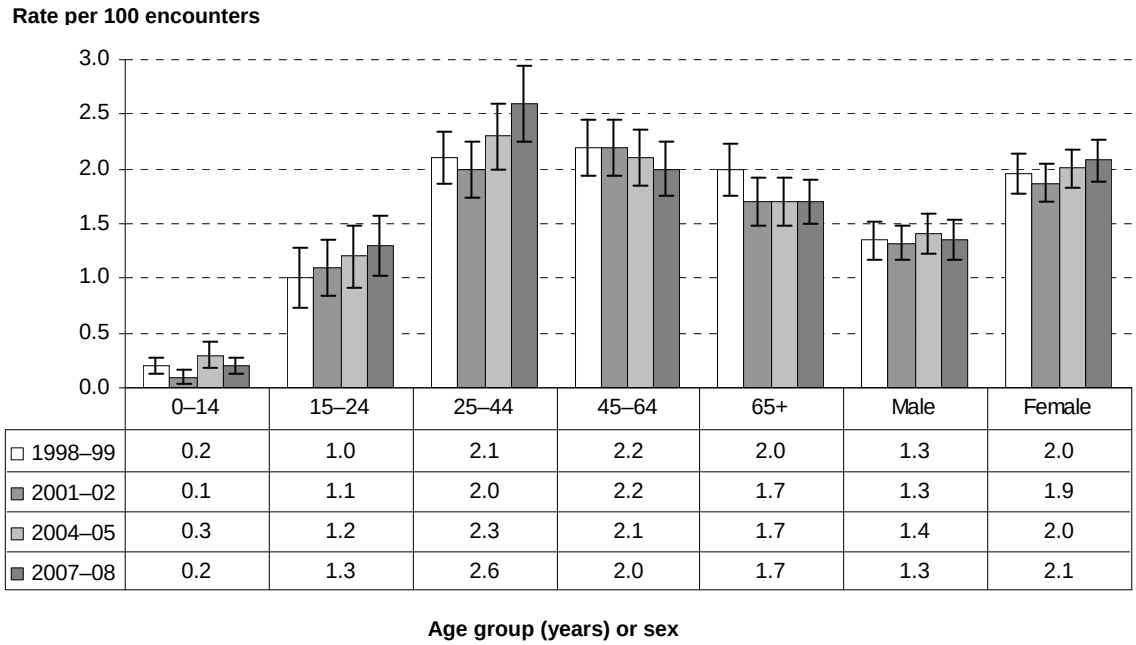
For the following analysis, anxiety was defined as diagnosed anxiety (Anxiety disorder/anxiety state: ICPC code P74), which encompasses anxiety neurosis and panic disorder. It also includes problems labelled by the GP as symptoms of anxiety (Feeling anxious/nervous/tense: ICPC code P01); for example, bad nerves, emotional, feeling frightened or unsettled. Symptoms are included because when a GP writes 'anxiety' as the problem managed, according to international coding rules it is classified as P01 in the ICPC-2.

From 1998–99 to 2007–08, the management rate of anxiety per 100 encounters remained steady. The mean rate of management was 1.7 per 100 encounters over the decade (Figure 14.5). The average rate at which new cases of anxiety were diagnosed was 0.3 per 100 encounters (Figure 14.6). Anxiety accounted for an average 1.2% of all problems managed in BEACH over the 10-year period.

The patients

2007–08

In 2007–08, patients aged 25–44 years had the highest management rate of anxiety, at 2.6 cases per 100 encounters. Children under the age of 15 years had the lowest rate, at 0.2 anxiety problems managed per 100 encounters. Females were managed more often for anxiety (2.1 per 100 encounters) than male patients (1.3 per 100 encounters) (Figure 14.12).



	0–14	15–24	25–44	45–64	65+	Male	Female
1998–99	0.2	1.0	2.1	2.2	2.0	1.3	2.0
2001–02	0.1	1.1	2.0	2.2	1.7	1.3	1.9
2004–05	0.3	1.2	2.3	2.1	1.7	1.4	2.0
2007–08	0.2	1.3	2.6	2.0	1.7	1.3	2.1

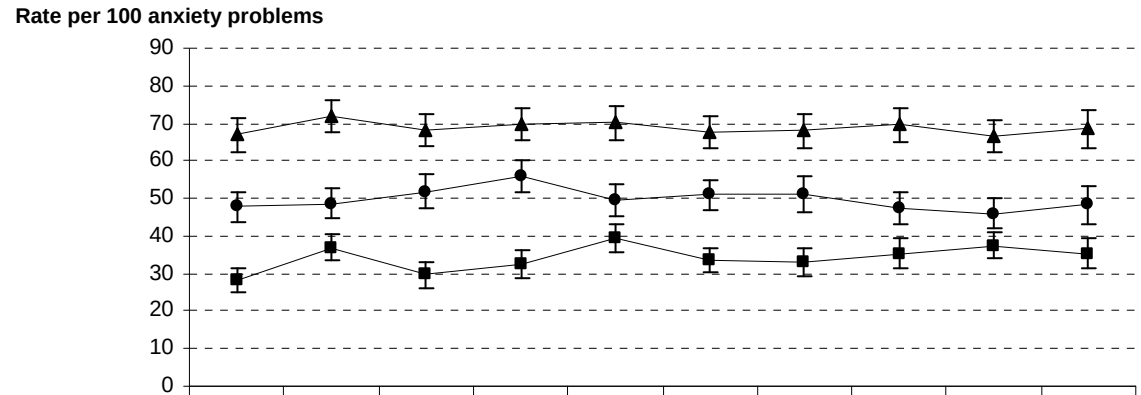
Figure 14.12: Age and sex-specific management rates of anxiety, 1998–99 to 2007–08 (95% CI)

1998–99 to 2007–08

In contrast, 10 years earlier the management rate of anxiety in those aged 25–44 years was similar to that of the 45–64 and 65 years and older age groups. Between 1998–99 and 2007–08, there was no significant change in the management rate of anxiety for any age or sex group. The higher management rate among female patients was consistent across all years (Figure 14.12).

Medications for anxiety

There was no significant change in medication rates for anxiety between 1998–99 and 2007–08, the mean across the years being 68.8 medications prescribed, supplied or advised per 100 anxiety problems managed (Figure 14.13).



	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Clinical Tx	47.7	48.7	51.8	55.9	49.5	51.0	51.2	47.4	46.0	48.2
Counselling	28.2	36.9	29.7	32.3	39.4	33.4	33.0	35.3	37.5	35.2
Medication	67.0	72.1	67.9	69.7	70.2	67.7	68.1	69.6	66.6	68.5

Data period

Note: Tx–treatment.

Figure 14.13: Pharmacological and clinical management of anxiety, 1998–99 to 2007–08 (95% CI)

Other treatments for anxiety

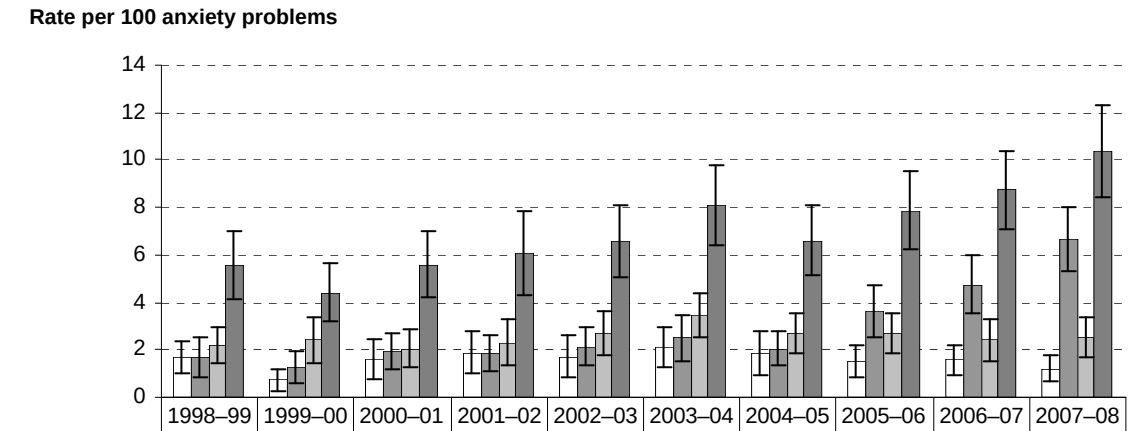
Between 2001–02 and 2006–07, the overall rate of clinical treatments (mostly counselling, advice and education) decreased significantly. In contrast, the rate at which psychological counselling was used in management of anxiety increased significantly between 1998–99 and 2002–03 and remained steady to 2007–08. (Figure 14.13).

It is interesting to note that while over the decade psychological counselling was more frequent for depression (38.7 per 100, 95% CI: 37.8–39.6) than for anxiety (34.1 per 100, 95% CI: 32.9–35.2), advice/education was used more frequently for anxiety (17.7 per 100, 95% CI: 16.8–18.6) than it was for depression (12.9, 95% CI: 12.3–13.5) (results not tabled).

Referrals for anxiety

The referral of patients with anxiety doubled between 1998–99 to 2007–08 (Figure 14.14).

- In contrast to depression, referrals for anxiety to psychiatrists did not significantly change across the decade. Also unlike depression, the use of other referrals, mainly to social workers, counsellors, mental health teams and physiotherapists, was relatively high and constant across the decade.
- Referrals of anxiety to psychologists remained stable between 1998–99 (1.7 per 100 anxiety problems) and 2004–05 (2.1 per 100). However it then tripled across the next 3 years to 6.6 per 100 anxiety problems managed in 2007–08.



	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Psychiatrist	1.7	0.7	1.6	1.9	1.7	2.1	1.8	1.5	1.6	1.2
Psychologist	1.7	1.3	1.9	1.9	2.1	2.5	2.1	3.6	4.8	6.6
Other	2.2	2.4	2.1	2.3	2.7	3.5	2.7	2.7	2.4	2.5
Total	5.6	4.4	5.6	6.1	6.6	8.1	6.6	7.9	8.7	10.4

Data period

Figure 14.14: Referral rates for anxiety, 1998–99 to 2007–08 (95% CI)

The introduction of the BOIMHC in 2002 did not appear to have any significant impact on referrals to psychologists for anxiety. However, like depression, there has been a large increase in the rate of referrals to psychologists since 2004–05. While the Better Access initiative of November 2006 can't explain the rise between 2004–05 and 2005–06 it would have probably had an impact on referrals since then.

Length of consultation

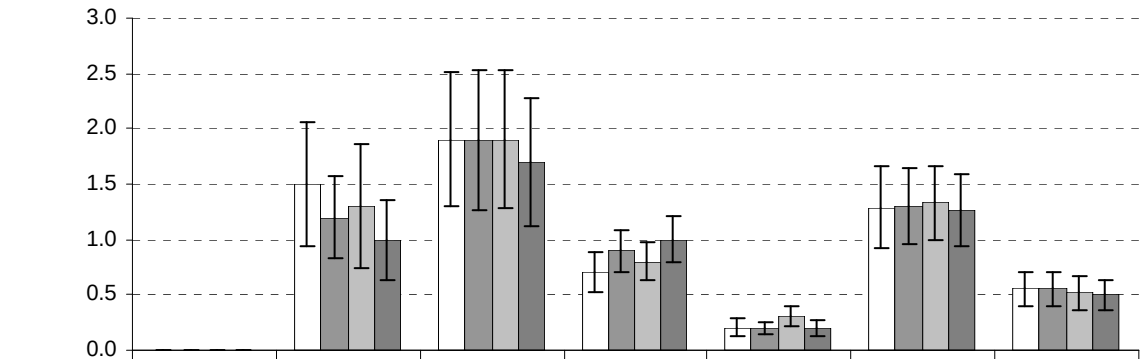
For all the years for which length of consultation was measured (2000–01 to 2007–08), encounters where anxiety was managed were significantly longer, by 3–4 minutes on average, than those where anxiety, depression, drug or alcohol problems were not managed. Between 2000–01 and 2007–08, there was no significant change in average length of consultations where anxiety was managed (Figure 14.11).

14.5 Management of drug and alcohol problems

The 2007 NSMHW estimated the prevalence of substance abuse disorders in the Australian population to be 5.1% and higher in men than in women.[2] This analysis of drug and alcohol problems investigated chronic and acute alcohol abuse, medication and drug abuse. It did not include nicotine addiction. From 1998–99 to 2007–08, the management rate of drug and alcohol problems remained steady at an average rate of 0.9 per 100 encounters over the 10-year period (Figure 14.5). The rate at which new cases of drug and alcohol problems were diagnosed also remained stable, averaging 0.1 per 100 encounters (Figure 14.6).

The patients

Across the decade, management rate of drug and alcohol problems among patients aged 25–44 years were consistently higher than for the other age groups, although differences did not always reach statistical significance. Drug and alcohol problems were almost never recorded for patients aged less than 15 years, and rates were low for those aged 65 years and over. In contrast to depression and anxiety, male patients were managed for drug and alcohol problems more often than were female patients in all years (Figure 14.15).



	0–14	15–24	25–44	45–64	65+	Male	Female
1998–99	0.0	1.5	1.9	0.7	0.2	1.3	0.6
2000–01	0.0	1.2	1.9	0.9	0.2	1.3	0.6
2004–05	0.0	1.3	1.9	0.8	0.3	1.3	0.5
2007–08	0.0	1.0	1.7	1.0	0.2	1.3	0.5

Age group (years) or sex

Figure 14.15: Age and sex-specific management rate of drug and alcohol problems, 1998–99 to 2007–08 (95% CI)

Medications for drug and alcohol problems

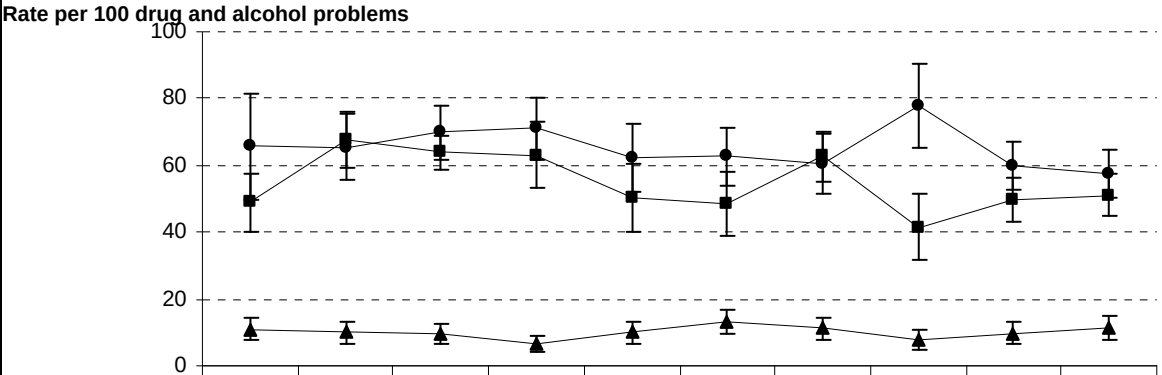
Across the decade the average rate of medications prescribed, supplied or advised was 65.9 per 100 drug and alcohol problems managed. Rates were consistent between 1998–99 and 2004–05 before a sudden and short-lived increase in medication rates (78.0 per 100) in 2005–06 (Figure 14.16).

Other treatments for drug and alcohol problems

The average rate of clinical treatments (mostly drug and alcohol counselling) used in the management of drug and alcohol problems over the 10 years was 55.0 per 100 of these problems. However, rates fluctuated significantly from the highest rate of 67.5 per 100 in 1999–00 to the lowest rate of 41.5 per 100 in 2005–06. While this decrease is not surprising due to the previously mentioned practice nurse effect, it is interesting that this lowest rate of clinical treatments coincided with the highest rate of medications for drug and alcohol problems (Figure 14.16).

Referrals for drug and alcohol problems

The rate at which patients were referred for drug and alcohol problems was fairly constant with about one in 10 being referred (Figure 14.16). Most referrals were to drug and alcohol counsellors, psychologists and psychiatrists.



	1998–99	1999–00	2000–01	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
Medication	65.8	65.3	69.8	71.2	62.3	62.9	60.7	78.0	60.1	57.5
Clinical Tx	48.9	67.5	63.8	63.0	50.2	48.5	62.6	41.5	49.6	51.2
Referral	10.9	10.0	9.7	6.6	9.9	13.3	11.3	7.8	9.8	11.6

Data period

Note: Tx–Treatment

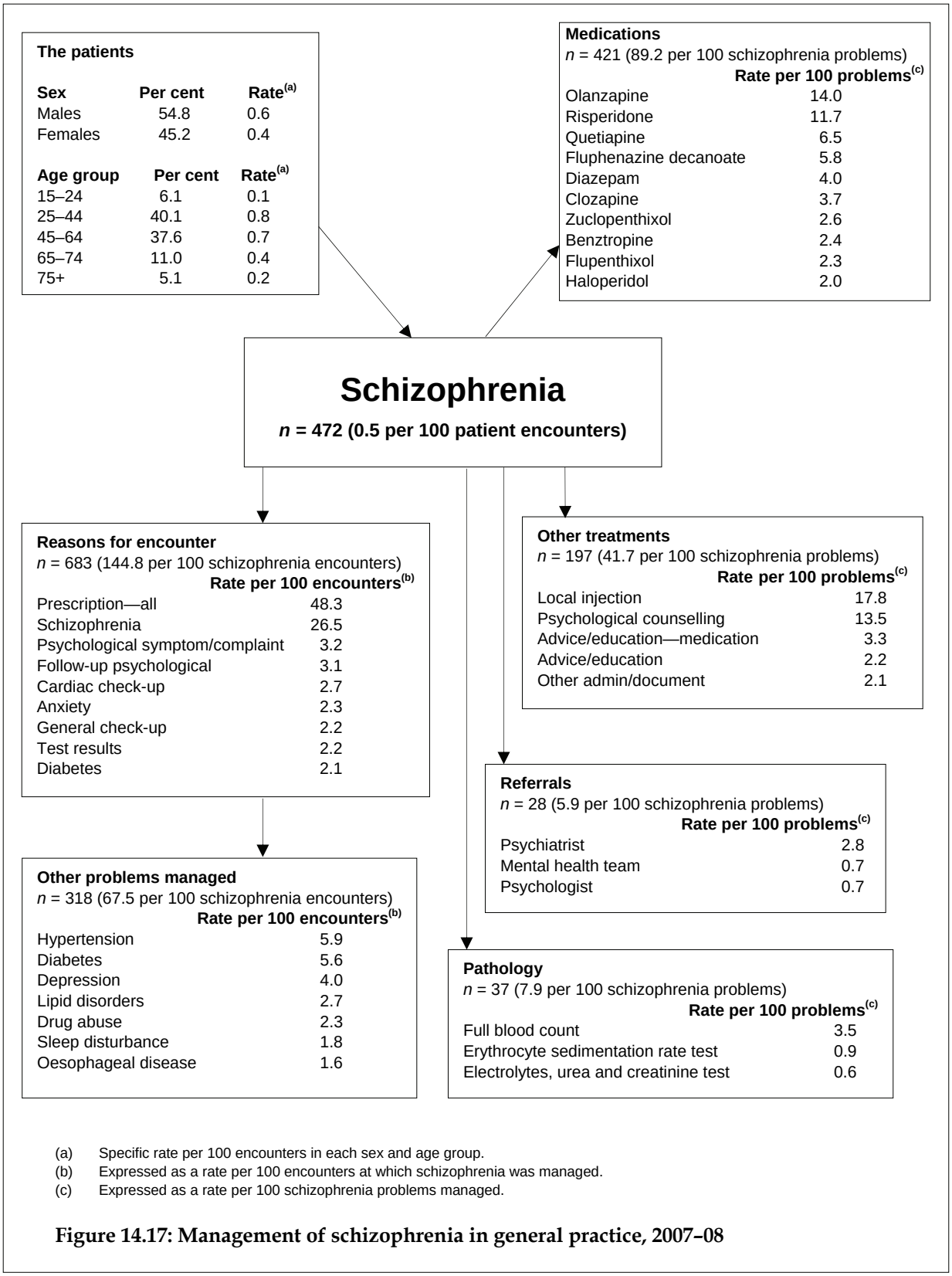
Figure 14.16: Pharmacological and clinical management of drug and alcohol problems, 1998–99 to 2007–08 (95% CI)

Length of consultation

Since 2001–02, in all but 2 years (2002–03 and 2004–05), consultations where a drug or alcohol problem was managed were significantly longer (by about 3 minutes on average) than all other encounters where a drug or alcohol problem, depression or anxiety were not managed. Between 2000–01 and 2007–08, there was no significant change in the lengths of consultation where a drug and alcohol problem was managed (Figure 14.11).

14.6 Management of schizophrenia in 2007–08

- According to the 2007 *Burden of disease* report, in 2003 an estimated 87,538 people or about 4 people per 1,000 had schizophrenia. Even though schizophrenia is not highly prevalent, for those it does affect, it is quite disabling, with 1% of the total disease burden being attributable to schizophrenia alone.[1] However, little is known about how schizophrenia is managed in general practice. Figure 14.17 summarises the management of schizophrenia in Australian general practice from April 2007 to March 2008.



(a) Specific rate per 100 encounters in each sex and age group.
(b) Expressed as a rate per 100 encounters at which schizophrenia was managed.
(c) Expressed as a rate per 100 schizophrenia problems managed.

Figure 14.17: Management of schizophrenia in general practice, 2007–08

In 2007–08, schizophrenia was managed at a rate of 5 per 1,000 encounters. Male patients had a 50% higher management rate (6 per 1,000 encounters) than females (4 per 1,000). Patients aged 25–44 years and 45–64 years had the highest management rate (8 and 7 per 1,000)

- The reason most often expressed by the patient for the encounter was a need for their medication—either a renewal of their script or their regular injection (48.3 per 100 schizophrenia encounters).

The most frequent comorbidities managed with schizophrenia largely reflected common chronic conditions, including hypertension, diabetes, depression and lipid disorders. It is notable that drug abuse was managed at a significantly higher rate than average (2.3 per 100 schizophrenia encounters compared with 0.8 per 100 encounters overall).

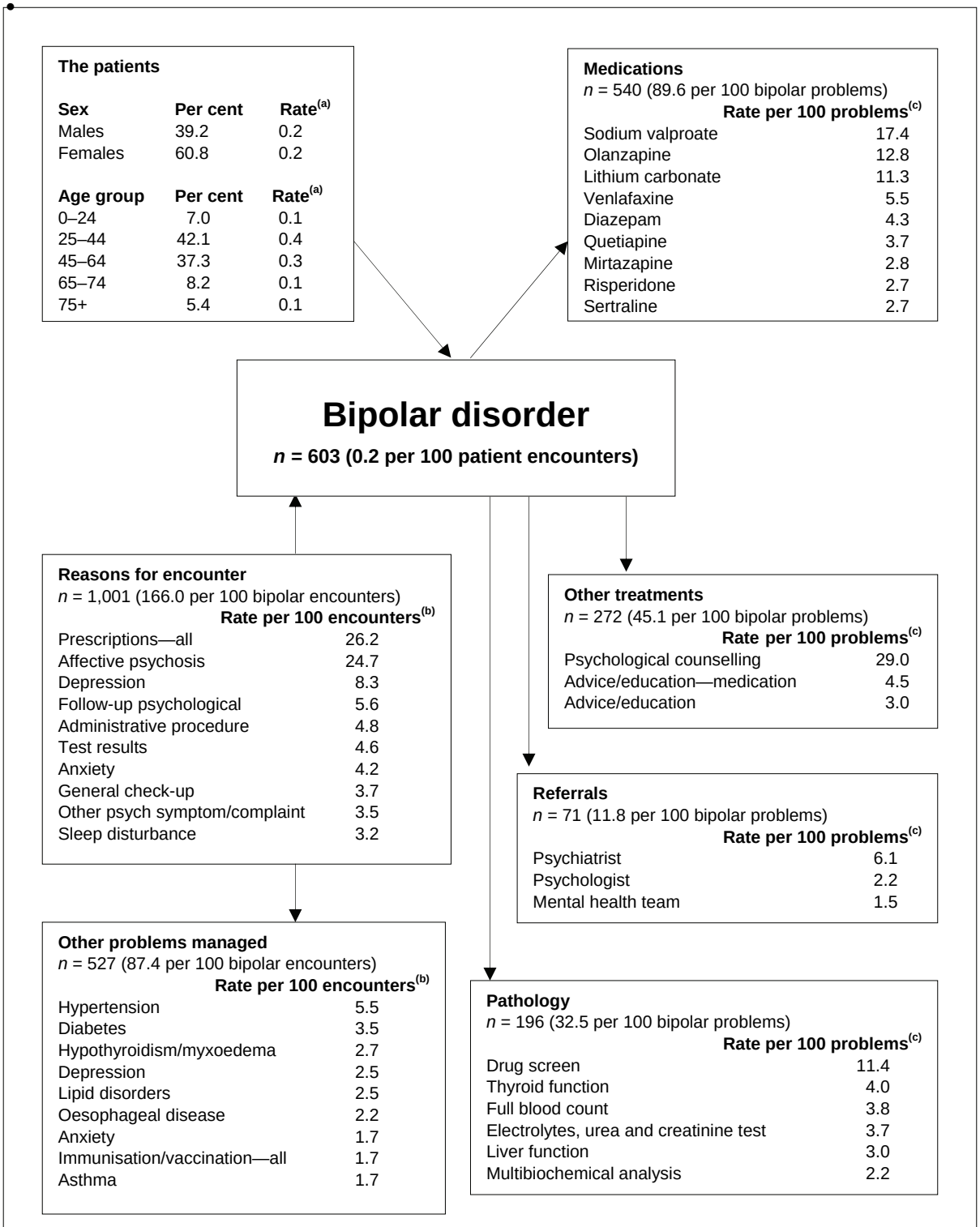
- Schizophrenia was primarily managed with medications, which were recorded at a rate of 89.2 per 100 schizophrenia problems. The majority of medications were antipsychotics, led by olanzapine (14 per 100 schizophrenia encounters) and risperidone (11.7 per 100).
- Other treatments were provided at a rate of 41.7 per 100 schizophrenia problems, the most frequent being the injection of their antipsychotic medication.
- Unlike the other psychological problems such as depression or anxiety, GPs provided psychological counselling at a low rate of 13.5 per 100 schizophrenia problems.
- Referrals were rarely made (5.9 per 100 schizophrenia problems managed), the majority being to psychiatrists and pathology tests orders were for schizophrenia were low (7.9 per 100 problems) and the majority were for a full blood count.

14.7 Management of bipolar disorder in 2005–08

According to the NSMHW, in 2007, 285,600 people had bipolar disorder, about 1.8% of the population.[2] Figure 14.18 shows the management of bipolar disorder in Australian general practice from April 2005 to March 2008. Three years of data were analysed to increase the sample size for the analysis.

- Bipolar disorder was managed at a rate of 2 per 1,000 encounters, and at the same rate in males and females. Patients aged 25–44 years and 45–64 years had the highest management rate of bipolar disorder (4 and 3 per 1,000 encounters, respectively).
- The most frequent reasons given by patients for seeing the GP was to renew their prescription (26.2 per 100 bipolar disorder encounters).
- The most frequent comorbidities managed largely reflected common chronic conditions, including hypertension, diabetes, depression and lipid disorder. Interestingly, the co-management rate of hypothyroidism was unusually high, probably due to the known association of bipolar disorder and hypothyroidism.
- Bipolar disorder was primarily managed using medications, which were recorded at a rate of 89.6 per 100 bipolar disorder problems managed. The most frequent were sodium valproate (an anticonvulsant) (17.4 per 100 problems) and the antipsychotic drugs olanzapine (12.8 per 100) and lithium carbonate (11.3 per 100).
- Psychological counselling was undertaken at 29 per 100 bipolar disorders problems.
- There were 11.8 referrals for every 100 bipolar disorder problems managed, half of which were to psychiatrists, with fewer to psychologists and mental health workers.

Pathology tests were ordered at a rate of 32.5 per 100 bipolar disorder problems, with drug screens being the most frequent, at 11.4 per 100 bipolar disorder problems.



(a) Specific rate per 100 encounters in each sex and age group.
(b) Expressed as a rate per 100 encounters at which bipolar disorder was managed.
(c) Expressed as a rate per 100 bipolar disorder problems managed.

Figure 14.18: Management of bipolar disorder in general practice, 2005–08

14.8 Discussion

Mental health problems were responsible for 13.3% of the total burden of disease and injury in Australia in 2003.[1] When people seek professional help for a psychological problem, general practice is the service most often used, with two-thirds (67.8%) of people consulting a GP at some point about their psychological problem.[2]

This chapter looked at the major changes found in the management of psychological problems in Australian general practice between 1997–98 and 2007–08 and related them to policy introduced over that decade. The major changes are summarised below.

- There was a significant increase in the management of all psychological problems between 2002–03 and 2007–08, after the introduction of the 2002 BOIMHC initiative and the subsequent 2006 Better Access initiative.
- There was a significant increase in the management rate of depression from 1998–99 to 2007–08.
- There was a significant increase in the rate of psychological counselling for depression management between 1998–99 and 2001–02 and for anxiety management between 1998–99 and 2002–03. It is interesting to note that the majority of this increase in psychological counselling happened before the introduction of the 2002 BOIMHC initiative. During the course of the BOIMHC and the Better Access initiatives the use of psychological counselling remained relatively constant.
- There was a significant decrease in the use of clinical treatments (apart from psychological counselling) after 2004–05. This decrease was likely due to the increasing role of the practice nurse in helping the patients with advice and education.
- There was a significant increase in the rate at which patients with depression and anxiety problems were referred, with a significant shift in referral patterns for patients with depression from psychiatrists to psychologists associated with the introduction of the MBS items for psychologist services. This result suggests that patients are getting better access to psychologists, a focus of the BOIMHC initiative and the continuing focus of the Better Access initiative.
- The results in this report demonstrate that encounters involving the management of depression, anxiety and drug and alcohol problems are, on average, longer than those where they are not managed. The increased referral rate to psychologists may therefore also reflect GP acknowledgement that counselling and therapy are important in the management of depression, anxiety and drug and alcohol problems but are too time-consuming in the current general practice setting.
- No difference was found between patients from Major Cities and those from outside Major Cities in the proportion of psychological encounters covered by either the BOIMHC or Better Access item numbers, nor was there a difference between them in the proportion referred to a psychologist before or after the Better Access initiative was introduced. This finding runs contrary to the often heard criticism that the Better Access initiative favours patients from Major Cities.

- No difference was found between patients from disadvantaged areas and advantaged areas in the proportion of psychological encounters that were covered by BOIMHC or Better Access initiative item numbers. While patients from advantaged areas were referred more often to psychologists than patients from disadvantaged areas after the Better Access initiative, the difference was proportionally less than it was before the introduction of the Better Access initiative. This suggests that this initiative has had a greater positive impact on those from disadvantaged areas than on those from advantaged areas.

The Australian and state and territory governments have acknowledged the importance of mental health in Australia, and have spent billions in initiatives between 1998 and 2008 to improve it. GPs play a central role in this with many of the initiatives focussed on their management of mental health.

Suggested chapter citation

Harrison C & Charles J 2009. Mental health. In: Britt H & Miller GC (eds). General practice in Australia, health priorities and policies 1998 to 2008. General practice series no. 24. Cat. no. GEP 24. Canberra: Australian Institute of Health and Welfare.

References

1. Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD 2007. The burden of disease and injury in Australia 2003. Cat. no. PHE 82. Canberra: Australian Institute of Health and Welfare.
2. Australian Bureau of Statistics 2008. National survey of mental health and wellbeing: summary of results, 2007. Cat. no. 4326.0. Canberra: ABS.
3. Knox SA, Harrison CM, Britt HC, Henderson JV 2008. Estimating prevalence of common chronic morbidities in Australia. Med J Aust 189(2):66–70.
4. Department of Health and Family Services 1998. Ministers endorse second National Mental Health Plan. Canberra: DHFS. Viewed 19 October 2007, <http://www.health.gov.au/internet/ wcms/publishing.nsf/content/health-archive-mediarel-1998-mw16898.htm>.
5. Department of Human Services and Health 1994. Better health outcomes for Australians. National Goals, Targets and Strategies for better health outcomes into the next century. Canberra: DHSH.
6. Australian Institute of Health and Welfare and Commonwealth Department of Health and Family Services 1997. First report on National Health Priority Areas 1996. Cat. no. PHE 1. Canberra: AIHW and DHFS.
7. Beyondblue 2006. Beyondblue: the national depression initiative. Melbourne: beyondblue. Viewed 10 December 2008, <http://www.beyondblue.org.au/ index.aspx?>.
8. Australian Government Department of Health and Ageing 2006. Better outcomes in mental health care. Canberra: DoHA. Viewed 19 October 2007, <http://www.health.gov.au/internet/ wcms/publishing.nsf/Content/mental-boimhc>.

9. Australian Government Department of Health and Ageing 2005. Implementation plan for the National Mental Health Plan 2003–2008. Canberra: DoHA. Viewed 19 October 2007, <http://www.healthconnect.gov.au/ internet/wcms/publishing.nsf/Content/health-mediarel-yr2005-jointcom-jc014.htm>.
10. Australian Government Department of Health and Ageing 2007. Better access to psychiatrists, psychologists and general practitioners through the MBS, GP mental health care Medicare items. Canberra: DoHA. Viewed 19 October 2007, <http://www.health.gov.au/ internet/wcms/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare>.
11. Council of Australian Governments 2006. Council of Australian Governments meeting, 14 July 2006, Communique. Canberra: COAG. Viewed 19 October 2007, <http://www.coag.gov.au/meetings/140706/docs/coag140706.rtf>.
12. Crosbie D & Rosenberg S 2008. COAG Mental Health Reform - Mental health and the new Medicare services–2nd Report November 2006–August 2008. Mental Health Council of Australia.
13. Australian Bureau of Statistics 2006. Australian Standard Geographical Classification. Cat. no. 1216.0. Canberra: ABS. Viewed 16 December 2008, < Canberra: COAG. http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/1216.0Contents12005?opendocument&tabname=Summary&prodno=1216.0&issue=2005&num=&view=>.
14. Australian Bureau of Statistics 2006. An Introduction to Socio-Economic Indexes for Areas (SEIFA). Cat. no. 2039.0. Canberra: ABS. Viewed 19 February 2009, <http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/D729075E079F9FDECA2574170011B088/$File/20390_2006.pdf>.
15. VanItallie T 2005. Subsyndromal depression in the elderly: underdiagnosed and undertreated. Metabolism Clinical and Experimental 54 (Suppl 1):39–44.
16. Assem-Hilger E, Jungwirth S, Weissgram S, Kirchmeyr WFP, Barnas C 2009. Benzodiazepine use in the elderly: an indicator for inappropriately treated geriatric depression? Int J Geriatr Psychiatry 24(6): 563–569.