

Overview of mental health services in Australia

Mental health services in Australia is an online presentation of the Australian Institute of Health and Welfare's (AIHW) series of annual mental health reports that describe the activity and characteristics of Australia's health care and social care services accessed by people with a mental illness. This report provides the most recent data available on the national response of the health and welfare system to the mental health care needs of Australians.

The information in this report is constrained by the availability of comparable national data, which may result in some data overlaps and gaps in service information. As well as the data presented in the various webpages, readers can find detailed data for current and previous years in the Microsoft® Excel workbooks attached to each section. Data are progressively published as it becomes available throughout the year.

Australia's mental health system

There is a division of roles and responsibilities Australia's mental health system with services being delivered and/or funded by the Australian Government, state and territory governments and the private and non-government sectors.

State and territory governments fund and deliver public sector mental health services that provide specialist care for people with severe mental illness. These include specialised mental health care delivered in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services. In addition, states and territories provide other mental health-specific services in community settings such as supported accommodation and social housing programs.

The Australian Government funds a range of mental health-related services through the Medicare Benefits Schedule (MBS), and the Pharmaceutical Benefits Scheme (PBS)/Repatriation Pharmaceutical Benefits Scheme (RPBS). The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

Private sector services include admitted patient care in a private psychiatric hospital and private services provided by psychiatrists, psychologists and other allied health professionals. Private health insurance funds treatment costs in private hospitals, public hospitals and out of hospital services provided by health professionals.

Mental health non-government organisations are private organisations (both not-for-profit and for-profit) that receive government and/or private funding. Generally, these services focus on providing well-being, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically focused services.

Service access

The 2007 National Survey of Mental Health and Wellbeing collected data on mental health service access in the preceding 12 months. From this survey it was estimated that about a third (35%) of people with a 12-month mental disorder (about 1.3 million people based on the estimated 2016 population) made use of mental health services (Slade et al. 2009). Of these:

- 71% consulted a general practitioner
- 38% consulted a psychologist
- 23% consulted a psychiatrist.

Of those who did not receive mental health care, the majority (86%) reported that they perceived having no need for any mental health care. More recent estimates suggest that the treatment rates identified in 2007 have increased (to 46%), due primarily to the introduction of government subsidised mental health treatment items to Medicare (Whiteford et al. 2014).

Service providers

Mental health-related services are provided in Australia in a variety of ways, including:

- admitted patient care in hospital and other residential care
- hospital-based outpatient services
- community mental health care services
- consultations with both specialist medical practitioners and general practitioners (GPs).

Access to psychologists and other allied health providers may, dependent on eligibility, be subsidised through initiatives such as the Better Access initiative which gives patients Medicare-subsidised access to psychologists and other allied health providers after the preparation of a Mental Health Treatment Plan by a GP.

The Australian Government also subsidises mental health-related services through Primary Health Networks, headspace, the National Disability Insurance Scheme, the MBS and prescribed medications through the PBS and RPBS. State and territory governments fund and deliver services and assist with broader needs, such as accommodation support.

No standard definition exists for 'mental health-related service'. Information about how specific mental health-related services are defined is available in relevant sections of this report.

References

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Prevalence, impact and burden

Prevalence

On this website the terms ‘mental illness’ and ‘mental disorder’ are both used to describe a wide spectrum of mental health and behavioural disorders, which can vary in both severity and duration. The most prevalent mental illnesses in Australia are *Depression, Anxiety* and *Substance use disorders*.

A program of surveys, the **National Survey of Mental Health and Wellbeing (NSMHWB)**, began in Australia in the late 1990s. The role of these surveys is to provide evidence on the [prevalence](#) of mental illness in the Australian population, the amount of disability associated with mental disorders, and the use of health services by people with mental disorders.

These studies have 3 main components – a population-based survey of adults, a service-based survey of people with psychotic disorders, and a population-based survey of children.

Survey of Adult Population (aged 16–85)

The 2007 National Survey of Mental Health and Wellbeing of adults provides information on the 12-month and lifetime prevalence of mental disorders in the Australian population aged 16–85 years. The survey estimated that almost half (45%) of the population in this age range will experience a mental disorder at some time in their life (about 8.6 million people based on the estimated 2016 population). It also estimated that 1 in 5 (20%) of the population had experienced a common mental disorder in the previous 12 months (about 3.8 million people based on the estimated 2016 population). Of these, *Anxiety disorders* (such as social phobia) were the most prevalent, afflicting 1 in 7 (14.4%) of the population, followed by *Affective disorders* (such as depression) (6.2%), and *Substance use disorders* (such as alcohol dependence) (5.1%).

For further information see [the full NSMHWB report](#) (ABS 2008).

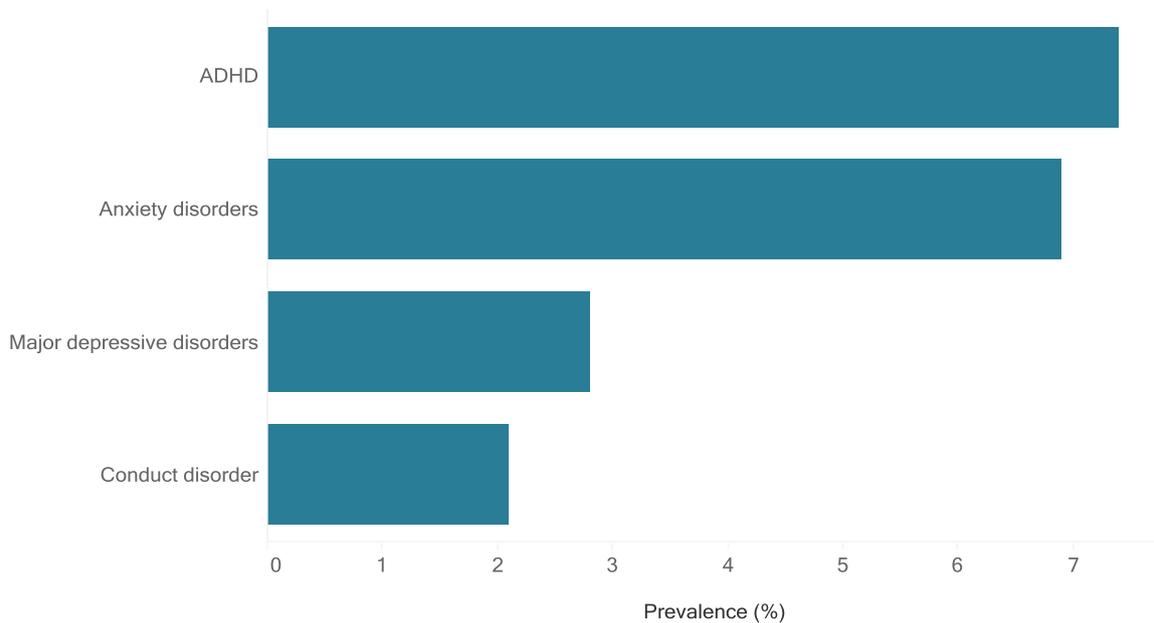
Survey of Children and Adolescents (aged 4–17)

A national household survey, the Australian Child and Adolescent Survey of Mental Health and Wellbeing, was conducted for the second time in 2013–14 (also referred to as the ‘*Young Minds Matter*’ survey).

Almost 1 in 7 (13.9%) of children and adolescents aged 4–17 years were assessed as having mental health disorders in the previous 12 months, which is equivalent to about 586,000 (based on the estimated 2016 population) children and adolescents. *Attention Deficit Hyperactivity Disorder* (ADHD) was the most common mental disorder (7.4% of all children and adolescents, or about 312,000 based on the estimated 2016 population), followed by *Anxiety disorders* (6.9% or about 291,000), major *Depressive disorder* (2.8% or about 118,000) and *Conduct disorder* (2.1% or about 89,000)— see Figure 1.

Almost one third (30.0% or 4.2% of all 4–17 year olds) with a disorder had 2 or more mental disorders at some time in the previous 12 months.

Figure 1: Prevalence of mental disorders in the past 12 months among those aged 4-17



Source: Lawrence et al. 2015.

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Child and adolescent males (16.3%) were more likely than females (11.5%) to have experienced mental disorders in the previous 12 months. The prevalence of mental disorders was slightly higher for older females (12.8% for 12–17 year olds) than for younger females (10.6% for 4–11 year olds). However, the prevalence for males did not differ markedly between the younger and older age groups (16.5% and 15.9% respectively).

There were a number of significant methodological differences between the *Young Minds Matter* survey and the first child and adolescent survey conducted in 1998. However, it is possible to compare the prevalence data for 3 mental health disorders (*Major depressive disorder*, *ADHD* and *Conduct disorder*). Prevalence of *Depressive disorder* increased from 2.1% to 3.2%, *ADHD* decreased from 9.8% to 7.8%, and *Conduct disorder* decreased from 2.7% to 2.1%. Readers are directed to [the full report](#) for further information (Lawrence et al. 2015).

Survey of People Living with Psychotic Illness (aged 16–84)

Mental illness includes conditions with low prevalence and severe consequences, including psychotic illnesses and a range of other conditions such as eating disorders, and severe personality disorder (DoHA 2010). Psychotic illnesses are characterised by fundamental distortions of thinking, perception and emotional response and include *Schizophrenia*, *Schizoaffective disorder*, *Bipolar disorder* and *Delusional disorder* (Morgan et al. 2011).

Estimates from the 2010 National Psychosis Survey were that 64,000 people in Australia aged 18–64 had a psychotic illness and were in contact with public specialised mental health

services each year. This equates to 5 cases per 1,000 population or 0.5% of the population (Morgan et al. 2011). The survey found the most frequently recorded of these disorders was *Schizophrenia* which accounted for almost half of all diagnoses (47.0%). Readers are directed to [the full report](#) for further information.

Impact and burden

Mental disorders can vary in severity and be episodic or persistent in nature. A recent review estimated that 2–3% of Australians (about 730,000 people based on the estimated 2016 population) have a severe mental disorder, as judged by diagnosis, intensity and duration of symptoms, and degree of disability caused (DoHA 2013). This group is not confined to those with psychotic disorders and it also includes people with severe and disabling forms of depression and anxiety. Another 4–6% of the population (about 1.5 million people) are estimated to have a moderate disorder and a further 9–12% (about 2.9 million people) a mild disorder.

Mental and behavioural disorders, such as *Depression*, *Anxiety* and *Drug use*, are important drivers of disability and morbidity. The Australian Burden of Disease Study 2011 examined the health loss due to disease and injury that is not improved by current treatment, rehabilitative and preventative efforts of the health system and society (AIHW 2016). For Australia, *Mental and substance use disorders* were estimated to be responsible for 12.1% of the total [burden of disease](#) in 2011, placing it third as a broad disease group after *Cancer* (18.5%) and *Cardiovascular diseases* (14.6%) (AIHW 2016).

In terms of the non-fatal burden of disease, which is a measure of the number of years of 'healthy' life lost due to living with a disability, *Mental and behavioural disorders* were the largest contributor (23.6%) of the non-fatal burden of disease in Australia followed by *Musculoskeletal disorders* (22.7%) and *Respiratory disorders* (11.9%) (AIHW 2016).

For further information see [Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011](#).

In addition, in 2013, almost a third (31%) of people in receipt of the Disability Support Pension had a primary medical condition of 'psychological/psychiatric' (DSS 2014).

There is an association between diagnosis of mental health disorders and a physical disorder, often referred to as a 'comorbid' disorder. From the 2007 NSMHWB of adults, 1 in 8 (12.0%) of people with a 12-month mental disorder also reported a physical condition, with 1 in 20 (5.0%) reporting 2 or more physical conditions.

According to the 2010 National Psychosis Survey, people with psychotic illness also frequently experience poor physical health outcomes and comorbidities (Morgan et al. 2011). For example, over one-quarter (27%) of survey participants had heart or circulatory conditions and over one-fifth (21%) had diabetes (compared with 16% and 6% respectively in the general population). The prevalence of *Diabetes* found in the National Survey of People Living with Psychotic Illness is more than 3 times the rate seen in the general population. Other comorbidities included *Epilepsy* (7% compared with 0.8% in the general population) and *Severe headaches/migraines* (25% compared with 9% in the general population).

National mental health policies and strategies

The Australian Government and all state and territory governments share responsibility for mental health policy and the provision of support services for Australians living with a mental disorder. State and territory governments are responsible for the funding and provision of state and territory public specialised mental health services and associated psychosocial support services. The Australian Government leads in national mental health reform initiatives and also funds a range of services for people living with mental health difficulties.

These provisions are coordinated and monitored through a range of initiatives, including nationally agreed strategies and plans.

Overview

The importance of good mental health, and its impact on Australians, have long been recognised by the Australian Government and all state and territory governments. Over the last 3 decades these governments have worked together, via the National Mental Health Strategy, to develop mental health programs and services to better address the mental health needs of Australians. The National Mental Health Strategy has included five 5-year *National Mental Health Plans* which cover the period 1993 to 2022, with the Council of Australian Governments (COAG) National Action Plan on Mental Health overlapping between 2006 and 2011.

Recent national developments

In 2014, the Australian Government requested the National Mental Health Commission (the Commission) to undertake a wide ranging review of existing mental health programs and services across the government, non-government and private sectors. The review's report was released in June 2015 and was considered by a Mental Health Expert Reference Group established by the Australian government's Department of Health to provide advice to inform the Australian government's response to the review.

Subsequently, a further series of mental health reform activities have been initiated, including the transfer of responsibility for a range of Australian Government mental health and suicide prevention activities to the newly created Australian government's Primary Health Networks (PHNs) from 1 July 2016. The role of PHNs is to lead mental health planning and integration with states and territory, non-government organisation, NDIS providers, private sector, Indigenous, drug and alcohol and other related services and organisations. In addition, 12 PHNs will be established as suicide prevention trial sites which will operate for 3 years.

The Fifth National Mental Health and Suicide Prevention Plan was agreed by Health Ministers in August 2017. The Commission has responsibility for reporting on the implementation progress of the fifth plan.

The Independent Hospital Pricing Authority, an independent government agency established by the Australian Government as part of the National Health Reform Act 2011,

has developed the Australian Mental Health Care Classification (AMHCC) Version 1.0. The development of the AMHCC is intended to improve the clinical meaningfulness of the way that mental health care services can be classified, leading to improvements in the cost-predictiveness of care and support the implementation of new models of care.

A staged implementation of the National Disability Insurance Scheme (NDIS) began in July 2013. People with a psychosocial disability who have significant and permanent functional impairment will be eligible to access funding through the NDIS. In addition, for people with a disability other than a psychosocial disability, funding may also be provided for mental health-related services and support if required.

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Key concepts

Prevalence, impact and burden

Key Concept	Description
Burden of disease	Burden of disease is measured in disability-adjusted life years (DALYs)—years of life lost due to premature mortality (fatal burden) and years of healthy life lost due to disability (non-fatal burden).
Comorbidity	Comorbidity refers to occurrence of more than 1 condition/disorder at the same time.
Prevalence	Prevalence measures the proportion of a population with a particular condition during a specified period of time (period/point prevalence), usually measured over a 12-month period or over the lifetime of an individual (lifetime prevalence).
