

Government announced the 'Helping Australians with dementia, and their carers – making dementia a National Health Priority' initiative to support new care programs for people with dementia, dementia-specific training for care workers and additional research.

Further information about dementia in older Australians is presented in Chapter 4.

## 2.7 Mental health problems and illnesses

Mental health problems and illnesses include short-term anxiety and depression as well as longer term conditions such as anxiety disorders, chronic depression and schizophrenia.

Mental ill health is one of the leading causes of non-fatal burden of disease and injury in Australia. It is estimated to account for 13% of the disease burden in Australia in 2003, 2% of years of life lost due to premature mortality (YLL) and 22% of years of 'healthy' life lost due to poor health or disability (YLD) (AIHW: Begg et al. in press). (The DALY (including YLL and YLD) estimates were provisional at the time of writing.) Mental problems are also associated with increased exposure to health risk factors, poorer physical health, and higher rates of death from many causes, including suicide.

In view of its impact on the health of the Australian population and the possible reduction in disease burden with prevention and treatment, mental health has been declared a National Health Priority Area.

### Prevalence

The prevalence of mental illness in adults has been estimated using a variety of different measures. A computerised version of the Composite International Diagnostic Interview was used to identify mental illness in the adult component of the National Survey of Mental Health and Wellbeing (NSMHW), conducted in 1997 by the ABS. Estimates of the prevalence of mental and behavioural problems arising from the NHS were based on self-reports of illness, and on reports of the use of medications for mental wellbeing.

A person may reveal in other ways that they have psychological distress, without necessarily having been diagnosed or treated for a mental illness. In the 1997 NSMHW, the 2001 and 2004–05 NHS and the 2004 National Drug Strategy Household Survey, levels of distress were assessed using the Kessler 10 scale of psychological distress. The extent of mental illness in the population can also be estimated using measures of psychiatric disability (see below).

The 1997 NSMHW is the source of the most commonly quoted estimate of the prevalence of mental illness – that one in five Australian adults will experience a mental illness at some time in their life. Overall, an estimated 18% of Australian adults had experienced a mental illness in the preceding 12 months (ABS 1998). The prevalence decreased with age, with the highest prevalence being among those aged 18–24 years (27%), reflecting a relatively high rate of substance use disorders. The prevalence was lowest, at 6%, for those aged 65 years or over.

The 2004–05 NHS provides the latest estimates of the prevalence of mental health conditions in Australia (ABS 2006b). About 1 in 10 (equivalent to 2.1 million Australians) reported a long-term mental or behavioural problem. The prevalence was 6.7% (1 in 15) for children aged under 15 years, 9.4% for those aged 15–17 years, 12.3% for those aged

18–64 years and 9.5% for persons aged 65 years or over. Anxiety-related problems and mood (affective) problems were the most commonly reported conditions (each affecting approximately 5% of the population). More females (6%) than males (4%) reported each of these conditions. These prevalence estimates are considered to be less reliable than prevalence estimates for other conditions derived from the 2004–05 NHS, because responses could be based on self-diagnosis rather than diagnosis by a health professional. For other National Health Priority Area conditions, respondents were asked to report whether a diagnosis had been made by a health professional (ABS 2006b).

About 19% of respondents aged 18 years or over (equivalent to 2.9 million Australians) reported the use of medication for mental wellbeing in the 2004–05 NHS (ABS 2006b). Use was more common among females (23.9%) than males (14.3%), and was most common in respondents aged 65 years or over (24.1%). Use of antidepressants was reported by 5.2% of respondents and 4.5% reported use of sleeping tablets or capsules.

## Psychological distress

Table 2.30 shows trends in the proportion of adults with very high psychological distress scores. In 1997, an estimated 2.2% of Australians aged 18 years or over reported these levels of distress. The estimated proportion increased to 3.8% in 2004–05.

In 1997 and 2001, the highest rates of very high levels of psychological distress were reported in the age group 45–54 years by both sexes. In 2004–05, this applied to the age groups 55–64 years for males and 45–54 years for females. The distribution of very high psychological distress score in the 2004 NDSHS was, however, much different.

**Table 2.30: Proportion of adults with very high psychological distress scores, 1997–2004 (per cent)**

Year	Age group						Total
	18–24	25–34	35–44	45–54	55–64	65 or over	
<b>Males</b>							
1997	<sup>(a)</sup> 0.6	<sup>(a)</sup> 1.3	2.2	3.0	2.7	<sup>(a)</sup> 1.9	1.9
2001	2.7	2.1	2.5	3.7	3.6	1.9	2.7
2004	2.5	2.9	1.5	2.0	1.9	1.0	2.0
2004–05	3.3	2.3	3.4	4.0	4.6	2.9	3.3
<b>Females</b>							
1997	<sup>(a)</sup> 2.1	2.8	2.4	3.8	<sup>(a)</sup> 1.5	<sup>(a)</sup> 1.3	2.4
2001	5.4	4.6	4.2	5.5	3.6	3.2	4.4
2004	4.5	3.2	2.9	2.0	1.7	1.4	2.6
2004–05	3.5	3.5	5.1	5.5	4.3	3.5	4.3
<b>Persons</b>							
1997	1.3	2.1	2.3	3.4	2.1	1.6	2.2
2001	4.0	3.4	3.4	4.6	3.6	2.6	3.6
2004	3.5	3.0	2.2	2.0	1.8	1.2	2.3
2004–05	3.4	2.9	4.3	4.8	4.4	3.2	3.8

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

Note: Persons with scores of 30 to 50 are rated as having very high level of psychological distress on the Kessler 10 scale of psychological distress.

Sources: ABS 1998, 2002, 2006b; AIHW 2005f.

According to the 2004–05 NHS, very high levels of psychological distress were more common in females (Table 2.31). Males (66.6%) were more likely to report low levels of psychological distress than females (59.1%). Adults reporting a long-term mental or behavioural problem were more likely to have high or very high levels of psychological distress than the total adult population (48% compared with 13%) (ABS 2006b).

## Psychiatric disability

The prevalence of psychiatric disabling conditions was estimated at 5.2% of the Australian population in 2003, around 1.0 million people, based on the ABS Survey of Disability, Ageing and Carers.

**Table 2.31: Prevalence of psychological distress, 2004–05 (per cent)**

Age group	Level of psychological distress (K10 scale <sup>(a)</sup> )			
	Low	Moderate	High	Very high
<b>Males</b>				
18–24	60.4	27.1	9.1	3.3
25–34	64.3	26.4	7.0	2.3
35–44	64.7	23.8	7.9	3.4
45–54	67.8	21.0	7.0	4.0
55–64	70.4	18.0	6.7	4.6
65 or over	72.4	17.2	7.3	2.9
<b>Total</b>	<b>66.6</b>	<b>22.4</b>	<b>7.5</b>	<b>3.3</b>
<b>Females</b>				
18–24	49.4	31.8	15.2	3.5
25–34	55.3	30.2	10.9	3.5
35–44	57.2	26.1	11.5	5.1
45–54	59.4	24.1	10.7	5.5
55–64	69.1	17.8	8.8	4.3
65 or over	65.4	22.8	8.1	3.5
<b>Total</b>	<b>59.1</b>	<b>25.7</b>	<b>10.8</b>	<b>4.3</b>

(a) Based on the Kessler 10 scale of psychological distress.

Source: ABS 2006b.

Almost half (48.4%) of the people with a psychiatric disability had severe or profound core activity limitation—that is, they sometimes or always needed help with self-care, mobility or communication (Table 2.32). The proportion of females with a psychiatric disability who had a severe or profound activity limitation was higher than for males (3.0% and 2.0% respectively).

Psychiatric disability is also associated with other disabling conditions. For those in whom psychiatric disability was reported as the main or another disabling condition, 36.7% also reported a sensory/speech disability and 36.2% reported physical and/or diverse disabilities. In those aged under 15 years, 83.9% also reported an intellectual disability.

As at June 2004, of the total number of recipients of the Australian Government's Disability Support Pension, 25.4% had a psychiatric/psychological condition

(Australian Government 2005). This was the second largest recipient group, following those with musculoskeletal and connective tissue conditions (34.0%).

**Table 2.32: Prevalence of psychiatric disability<sup>(a)</sup> by core activity limitation, 2003**

Core activity limitation	Males		Females		Persons	
	Number ('000)	Per cent	Number ('000)	Per cent	Number ('000)	Per cent
Profound core activity limitation	109.6	1.1	187.4	1.9	297.0	1.5
Severe core activity limitation	89.6	0.9	106.2	1.1	195.8	1.0
Moderate core activity limitation	65.6	0.7	91.1	0.9	156.6	0.8
Mild core activity limitation	87.9	0.9	96.9	1.0	184.8	0.9
<b>Total with a psychiatric disability<sup>(b)</sup></b>	<b>447.4</b>	<b>4.6</b>	<b>570.5</b>	<b>5.8</b>	<b>1,017.9</b>	<b>5.2</b>

(a) Persons with a psychiatric disability as the main or other disabling condition.

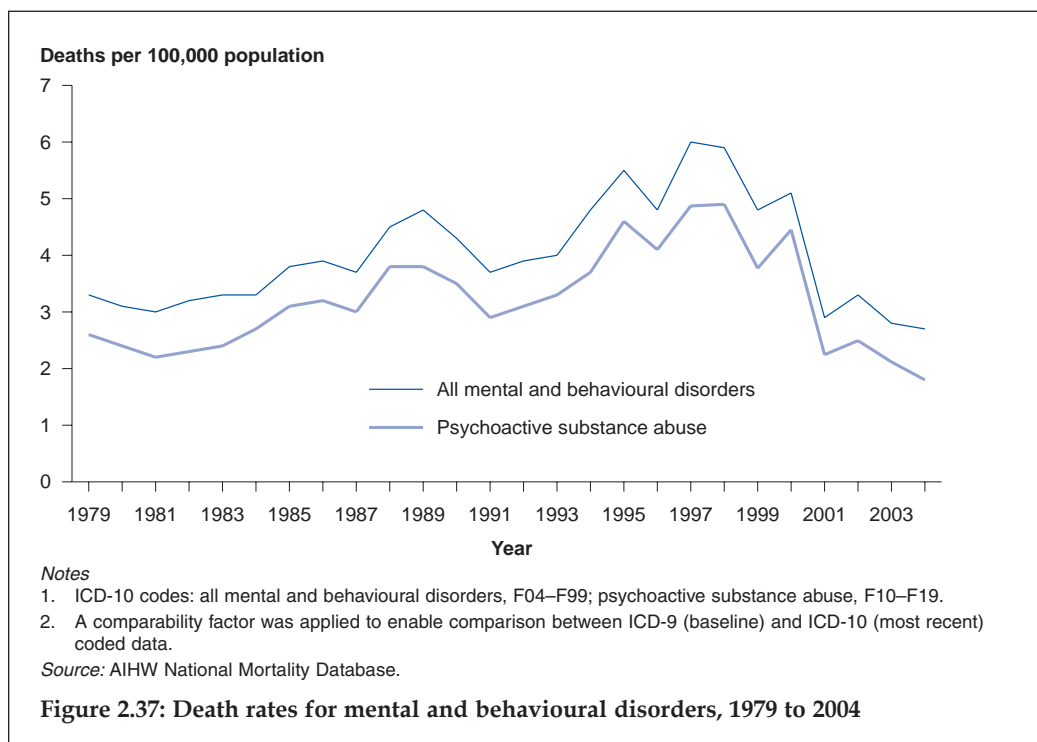
(b) Includes persons with no core activity limitation but who are restricted in schooling or employment only, and persons without specific limitations or restrictions.

Note: Equals the percentage of the respective Australian population.

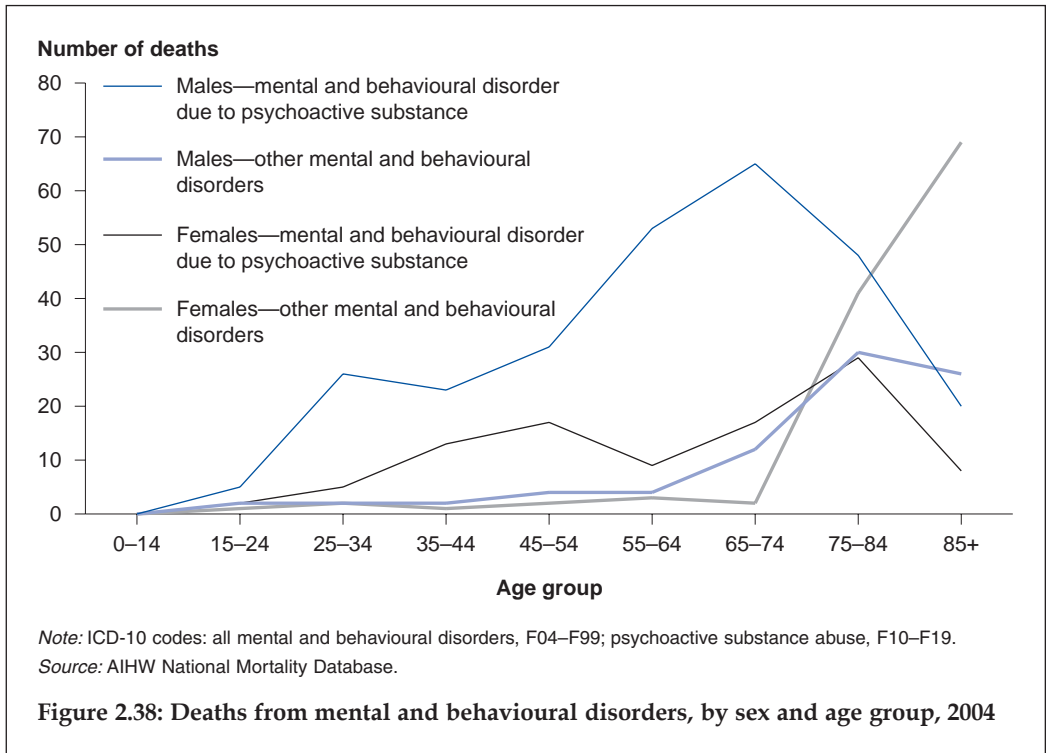
Source: AIHW 2005g.

## Mortality

A mental or behavioural disorder was recorded as the underlying cause for 574 deaths in 2004. The age-standardised rate was 2.7 per 100,000 persons, down from the peak years of 1994–1996 (Figure 2.37). Most of the deaths with a mental or behavioural disorder as the underlying cause of death were due to abuse of psychoactive substances such as alcohol and heroin. These 574 deaths do not include suicides, reported separately in Section 2.9.



Deaths attributed to mental and behavioural disorders due to psychoactive substance abuse were more common among males than females (Figure 2.38). Deaths with another mental or behavioural disorder as the underlying cause (that is, not psychoactive substance abuse) were mainly recorded for persons over the age of 65 years.



## Comorbidity

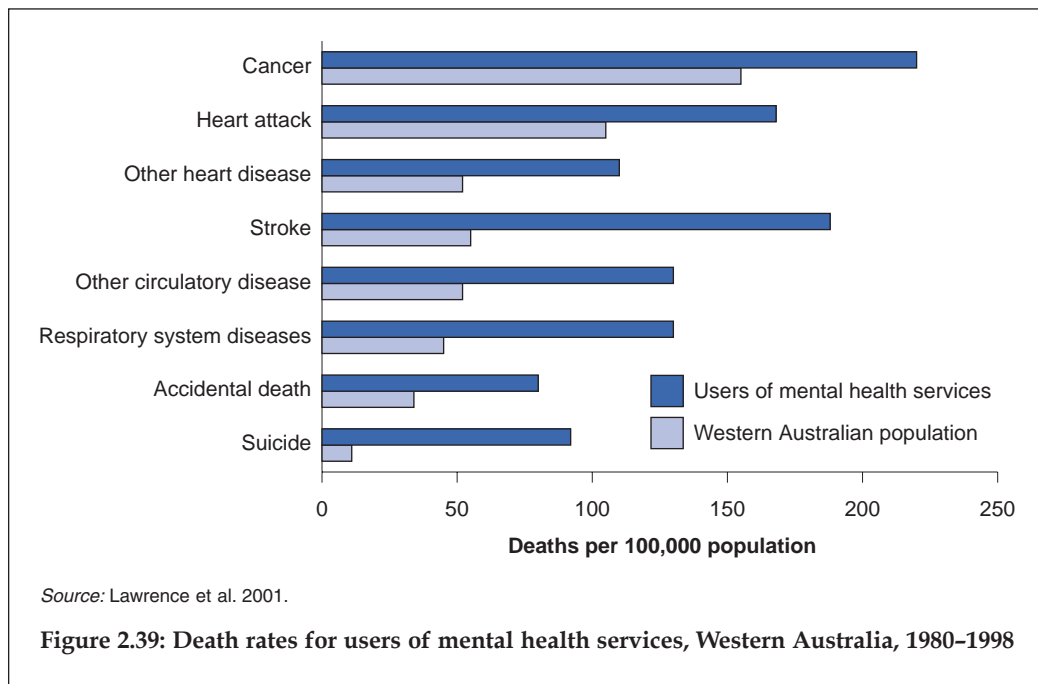
Comorbidity, involving more than one mental illness, or at least one mental illness and one or more physical illnesses, is common among persons with mental illness. In the NSMHW, about one in four persons with an anxiety, affective or substance use disorder also had at least one other mental illness (Hall et al. 2001). Among those with psychotic disorders, 30% had a medical history of alcohol abuse or dependence, 25.1% of cannabis abuse and 13.2% of other substance abuse or dependence (Jablensky et al. 1999).

In the 2004–05 NHS, the prevalence of other National Health Priority Area diseases and conditions was higher among persons reporting a long-term mental or behavioural problem than among the population in total (ABS 2006b). Arthritis was reported by 23.4% of persons reporting a long-term mental or behavioural problem, compared with 14.9% of the total population. For asthma, the rates were 16.0% and 10.2%, respectively; for heart, stroke and vascular diseases (as defined by ABS) they were 6.3% and 3.8%. Among persons with long-term mental and behavioural problems, arthritis was most common in the 45–64 years age group (38%) while asthma was most common in the 25–44 years age group (15.4%).

A study reviewing the health experience of over 240,000 persons who used mental health services in Western Australia from 1966–1998 (equivalent to 8% of the Western Australian population) found that during 1980–1998 their death rate was 2.5 times the rate of the general population (Lawrence et al. 2001). Almost half the suicides in Western Australia were by people who had used mental health services, with rates seven times those of the general population. The greatest number of excess deaths for people who had used mental health services were from cardiovascular disease (Figure 2.39).

Further, 44% of hepatitis C cases and 19% of HIV cases in Western Australia over this period occurred in users of mental health services. Persons with psychoses and alcohol and drug disorders were most at risk of infectious diseases. Those with mental illness had higher rates of digestive system disorders linked to alcohol abuse, and higher rates of respiratory disorders linked to smoking. They had a higher risk of all types of injuries, especially drug-related poisonings and injuries inflicted by other people.

The Western Australian study also noted that people with mental illness have high rates of physical illness related to behavioural and lifestyle risk factors, including smoking, alcohol and drug abuse, obesity and poor diet. These physical illnesses often go undiagnosed, leading to lower hospital admission rates but higher unnecessary deaths.



## Use of health services

### Hospital separations

People with mental and behavioural problems are more likely to be hospitalised than those without these problems. According to the 2001 NHS, the proportion of people with mental or behavioural problems admitted to hospital in the two weeks before the

survey was nearly twice that of people without such problems (19.1% compared with 11.5%). Those with very high levels of psychological distress (28.9%) were also more than twice as likely to be admitted to hospital than those with low levels (11.7%).

There were 309,293 hospital separations with either a mental health-related principal diagnosis or a record of specialised psychiatric care in 2003–04, or 1,540 separations per 100,000 persons. These separations accounted for 2,849,024 patient days, which equates to an average stay of 9.2 days per episode of separation (Table 2.33). Although comprising 4.5% of all hospital separations, mental health-related separations accounted for 12.1% of total patient days.

**Table 2.33: Mental health-related hospital separations<sup>(a)</sup>, 2003–04 (number)**

<b>Principal diagnosis</b>	<b>Separations</b>	<b>Patient days</b>
Dementia	6,618	177,528
Other organic mental disorders	5,083	83,755
Mental and behavioural disorders due to use of alcohol	33,427	142,710
Mental and behavioural disorders due to other psychoactive substances use	14,471	84,253
Schizophrenia	30,217	643,994
Other schizophrenic, schizotypal, delusional disorders	19,991	249,303
Manic episode	1,232	12,599
Bipolar affective disorders	17,904	211,663
Depressive disorders	80,112	481,912
Other mood (affective) disorders	4,092	21,038
Neurotic, stress-related and somatoform disorders	49,975	209,919
Eating disorders	5,652	49,189
Other behavioural syndromes associated with physiological disturbances and physical factors	1,559	9,780
Disorders of adult personality and behaviour	9,655	51,673
Mental retardation	421	32,325
Disorders of psychological development	1,169	5,439
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	5,015	16,140
Mental disorder not otherwise specified	440	7,253
Other mental health-related diagnosis <sup>(b)</sup>	15,767	128,182
Other <sup>(c)</sup>	6,493	221,025
<b>Total</b>	<b>309,293</b>	<b>2,849,024</b>

(a) Includes separations which reported either specialised psychiatric care days and/or a mental health-related principal diagnosis.

(b) Includes mental health-related diagnoses other than those in the Mental and Behavioural Disorders chapter of ICD-10-AM, as detailed in AIHW 2003b.

(c) Includes separations for which specialised psychiatric care was provided without a mental health-related principal diagnosis being recorded.

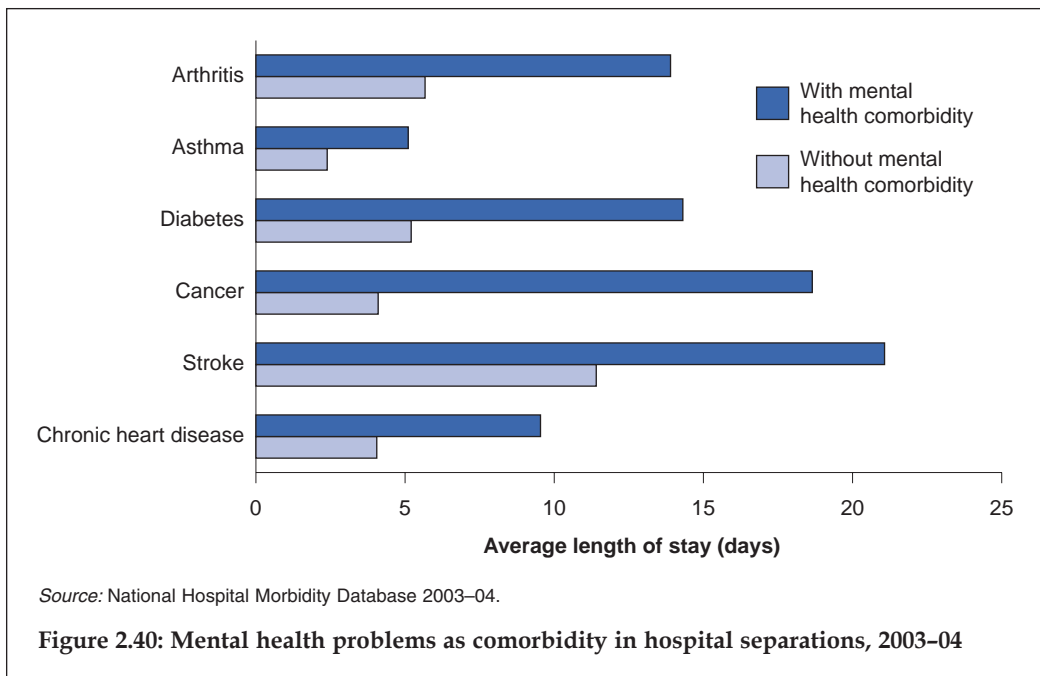
Source: AIHW National Hospital Morbidity Database.

Principal diagnoses of depressive disorders (25.9%), neurotic and stress-related disorders (16.2%), mental and behavioural disorders due to alcohol (10.8%), and

schizophrenia (9.8%) accounted for large proportions of mental health-related separations. Schizophrenia accounted for the largest proportion of patient days (23.4%).

In 2003–04, there were a further 273,833 hospital separations for which a mental health-related diagnosis was reported as an additional diagnosis with a non-mental health principal diagnosis. These separations accounted for 2,862,167 patient days.

The average length of stay in hospital for patients with a National Health Priority Area principal diagnosis was higher when the patient also had a mental health diagnosis reported (Figure 2.40).



## GP visits

The proportion of 2001 NHS (ABS 2004c) respondents with mental and behavioural problems who reported consulting a GP in the two weeks before the survey was higher (33.3%) than those without such problems (20.5%). The proportion was also much higher among those with very high levels of psychological distress (48.0%) than those with low levels of distress (20.1%).

According to estimates from the 2004–05 BEACH survey of general practice activity, 10.8% of GP attendances (about 10.4 million) involved the management of at least one mental health-related problem (AIHW: Britt et al. 2005). Depression was the fourth most commonly managed problem in general practice (3.7 per 100 encounters). Medications relating to the nervous system were the most commonly prescribed drug type. These included antidepressants, anxiolytics and antipsychotics.