STATISTICAL DATABASE

MHCC has compiled a database of statistics relevant to mental illness and mental health services in NSW. This resource brings into one database the statistics found in a broad range of sources and documents. It is easily accessible and navigable by anyone with Microsoft Word.

It will be useful to people compiling:

- Submissions for funding
- Business plans
- Needs assessments
- Publications & reports
- A range of other documents.

It is regularly updated as new statistics become available.

Contents:

Mental Illness

Mental illness – prevalence (Australia)

- **18% of adults have a mental health problem in any given 12 month period**
- **Prevalence decreases with age: the highest percentage of mental illness is in those 18-24 years (27%), and the lowest percentage in those aged 65+ years (6%)**

The National Survey of Mental Health and Wellbeing (NSMHW) was undertaken in 1997 with a random sample of 10,600 people aged 18 years and over. It is being conducted again in 2007, and we expect to see the results next year. The most commonly reported problem was anxiety.

The NSMHW found that an estimated 17.7% of Australian adults had experienced a mental illness in the preceding 12 months. It also found that the prevalence of mental illness decreased with age. That is, the highest percentage of mental illness was reported for those aged 18 to 24 years (26.6%), reflecting a relatively high rate of substance use disorders in that age group. The prevalence was lowest for those aged 65 years and over (6.1%).

The child and adolescent component of the 1997 NSMHW found that the most frequently reported disorder for children aged 6 to 17 years was Attention deficit hyperactivity disorder (11%, or an estimated 355,000 children and adolescents). Less prevalent were depressive disorders (4%) and conduct disorders (3%).
Source: Mental Health and Wellbeing: Profile of Adults, Australia, 1997, ABS, 1998

- **11% of the population has a long term mental or behavioural problem (2 million Australians)**

ABS's 2004–05 National Health Survey (NHS) collected self-reported information on long-term medical conditions (that is, conditions that had lasted or were expected to last for 6 months or more) for adults and children. In 2004–05, an estimated 2.1 million Australians (10.7% of the population) had a long-term mental or behavioural problem.
Source: 2004-05 National Health Survey, ABS, 2006

Mental illness – prevalence (NSW)

- **3% of adults report very high levels of distress**
- **17% of high school students report high levels of distress**

Around 3% of adults in NSW report very high levels of psychological distress and overall adults cut down on their activities in almost 1 day per month on average due to psychological distress.

In 2005, one in 6 (16.6%) high school students reported high levels of psychological distress. Out of those who experienced high psychological distress one third talked to no-one about it and another one third talked to someone but found it not at all helpful
Source: Report of the New South Wales Chief Health Officer NSW Government 2007 (Report of the Chief Health Officer)

BACK TO TOP

Mental illness - burden of disease (Australia)

- **Mental illness is the leading cause of non-fatal burden of disease in Australia (24% of total non fatal burden of disease)**
- **Mental illness is the third highest cause of burden of disease (13% of total burden of disease)**
- **For men, anxiety and depression was the third highest cause of burden of disease (4.8%), and the highest cause of non-fatal burden of disease (10%)**
- **For women, anxiety and depression was the highest cause of both burden of disease (10%) and non-fatal burden of disease (18.1%)**
- **7% of the burden from mental disorders was due to mortality, most of which was accounted for by fatal outcomes associated with substance abuse.**

Burden of Disease is a measurement of the different between a population's health status and the ideal situation where all of the population lives their full life expectancy free of disease or injury.

Burden of disease analysis goes beyond the mortality impact of a disease, as it also looks at the impact of illness and disability. The non-fatal burden is the amount of healthy life years lost due to disability from disease and injury, and this made up 51% of the total burden of disease.

Cancer (19%) and cardiovascular disease (18%) were the two leading causes of the burden of disease in 2003.

Mental ill health is the leading cause of non-fatal burden of disease and injury in Australia. The five leading causes of non-fatal burden of disease were anxiety and depression (14% of the non-fatal burden), Type 2 diabetes (8%), dementia (5%), adult-onset hearing loss (5%) and asthma (4%).

The five leading specific causes of burden in women were anxiety & depression (10.0%), ischaemic heart disease (8.9%), stroke (5.1%), Type 2 diabetes (4.9%) and dementia (4.8%).

The five leading specific causes of non-fatal burden among women were anxiety & depression (18.1%), Type 2 diabetes (7.2%), dementia (6.4%), asthma (4.5%) and ischaemic heart disease (3.3%).

The five leading specific causes of burden in men were ischaemic heart disease (11.1%), Type 2 diabetes (5.2%), anxiety & depression (4.8%), lung cancer (4.0%) and stroke (3.9%).

The five leading specific causes of non-fatal burden among men were anxiety & depression (10.0%), Type 2 diabetes (8.5%), adult-onset hearing loss (6.5%), asthma (4.2%) and dementia (3.9%).

Mental disorder burden by specific cause is illustrated in this chart *(page 60)*:

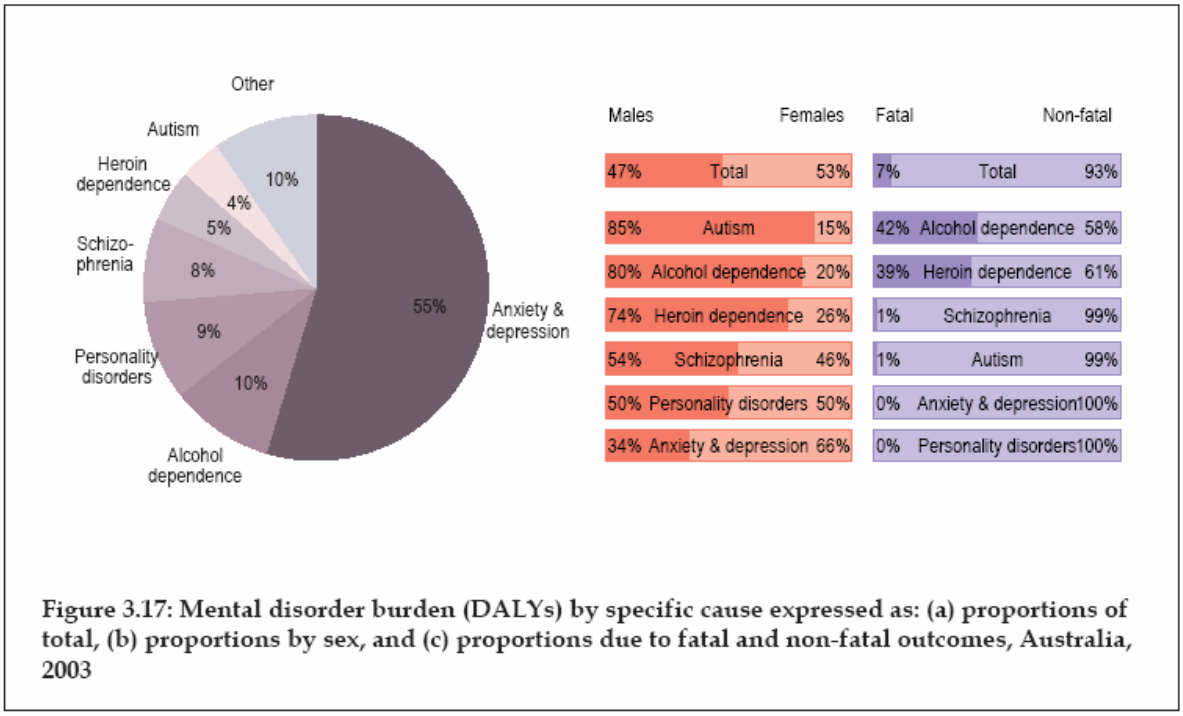


Figure 3.17: Mental disorder burden (DALYs) by specific cause expressed as: (a) proportions of total, (b) proportions by sex, and (c) proportions due to fatal and non-fatal outcomes, Australia, 2003

The key measure used to measure the total burden of disease and injury is the 'disability-adjusted life year' (DALY). This describes the amount of time lost due to both fatal and non-fatal events, that is, years of life lost due to premature death coupled with years of 'healthy' life lost due to disability.

Mental illness is estimated to account for 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)

Source: Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD (2007), The burden of disease and injury in Australia 2003. PHE 82. Canberra: Australian Institute of Health and Welfare (AIHW).

BACK TO TOP

Suicide

Suicide (Australia)

- **In 2005, there were 2,101 registered deaths from suicide (1.6% of all deaths in Australia)**
- **Males were almost 4 times more likely than females to die by suicide in 2005 (1,657 males compared with 444 females, respectively)**
- **Age standardised death rate in 2005 - 10.3 per 100,000 population**
- **Age standardised suicide death rate (2005) for males was 16.4 per 100,000 people and 4.3 per 100,000 for females**
- **The age standardised rate in 2005 was 1% lower than in 2004 and 30% lower than in 1997**

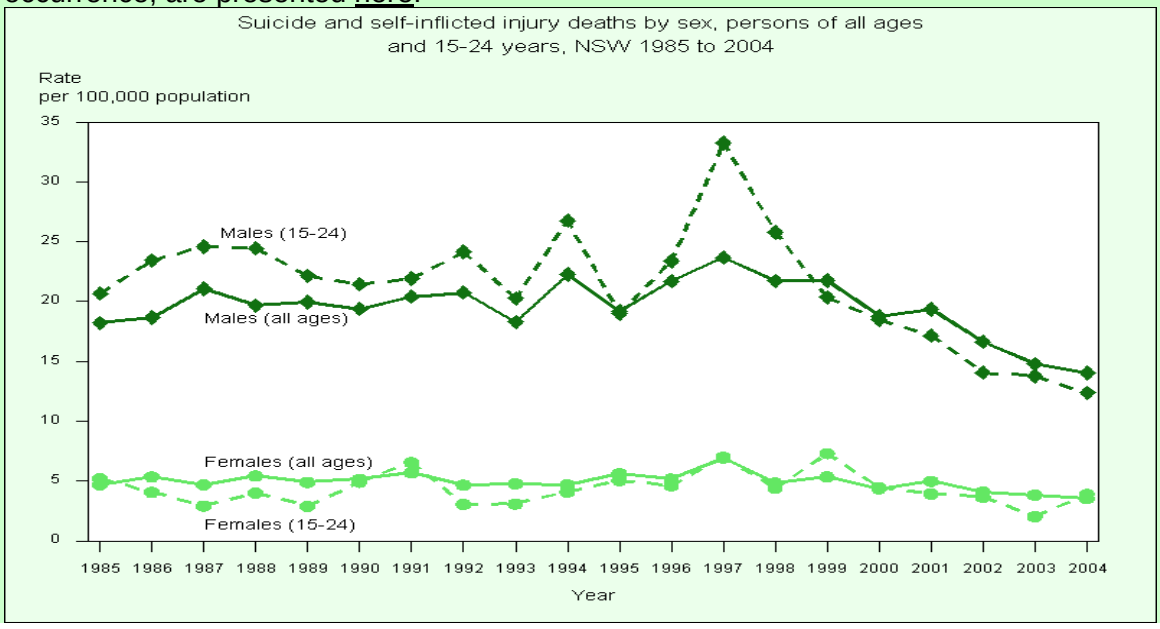
Source: Suicides Australia 2005. ABS 2007

Suicide (NSW)

- **In 2005, 549 people died by suicide (ABS 2007), compared with 587 in 2004**
- **80% were males (438 males; 111 females)**
- **Age standardised death rate in 2004- 8.7 per 100,000 population**
- **The lowest rate in 20 years**

Suicide rates have been dropping in NSW since 1997.
Sources: Report of the New South Wales Chief Health Officer (Key points >Report of the Chief Health Officer >Contents >Mental health >Key points)
Suicides Australia 2005. ABS 2007

The most recent available data (until 2004) on deaths by suicide in NSW, by year of occurrence, are presented here.



These figures differ from reports based on year of registration of death, such as the annual reports by the Australian Bureau of Statistics. The rate of suicide can fluctuate considerably from year to year, especially in small population groups.

The death rate from suicide has decreased gradually from the high rates recorded in 1997 of 15.1 per 100,000 population (23.7 deaths per 100,000 population in males and 6.9 in females). The suicide death rate in males aged 15-24 years dropped by more than half, from 33.2 deaths per 100,000 in 1997 to 12.4 in 2004. In general, death rates from suicide are about three to four times greater in males than in females. This difference is thought to be due mostly to males using more lethal methods than females, as there is less difference in suicide attempts between sexes (OECD, 2003).

The current suicide rates in Australia are among the lowest since collections began in 1907 (excluding the World War II period). It is possible, however, that the number of deaths coded as suicide in the current year will change in the future as the currently open coronial cases are closed (AIHW, 2006). The restrictions placed on gun ownership have been credited with a positive impact on the suicide rates in Australia.

A whole of government suicide prevention strategy has been implemented in NSW, along with a range of other early intervention and prevention in mental health strategies which contribute to a reduction in mental health problems. For example, the School-Link program (NSW Department of Health, 2003) supports young people with depression and related disorders.
Source: Report of the New South Wales Chief Health Officer>Report of the Chief Health Officer

Attempted suicide (NSW)

- **3.5% of adults attempt suicide each year**
- **Approx 18,000 attempts in NSW annually**

In the 1997 National Survey of Mental Health and Wellbeing, 3.5% of respondents aged 18 and over reported suicidal thoughts in the previous 12 months, and about 12% of that group also reported having made a suicide attempt (Pirkis et al., 2000). This corresponds to about 18,000 attempts in NSW in a year by people aged 18 and over.
Source: Australian Bureau of Statistics (ABS), Suicides: 1994 – 2004 (March 2006)

Hospitalisation for suicide attempts

- **In 2004-05, more than 10,000 people were hospitalised for attempting suicide**
- **60% were females**

In 2004-05, there were more than 10,000 hospitalisations of NSW residents for attempted suicide. Females accounted for 60% of these hospitalisations.

Most people who contact health services after a suicide attempt are seen by emergency departments. They may or may not be admitted as hospital inpatients, and the injury may or may not be recorded as intentional. In recent years, there have been more than 10,000 hospital separations per year following suicide attempts.
Hospitalisation rates for suicide attempts (here) are consistently higher in females than in males, while the death rates from suicide are about 3 - 4 times greater in males than in females. This is mostly due to males using more lethal methods than females.

Report of the New South Wales Chief Health Officer>Report of the Chief Health Officer

Suspected suicides of Mental Health Service clients (NSW)

- **Area Mental Health Services reported 95 suspected suicides of mental health clients between 1 Jan - 30 June 2006**

Mental Health Services are required to report all deaths of current or recent clients which appear to have been by suicide. This indicator measures the number of those reports. There is no acceptable level or target for this indicator. The timeframe of 7 days is now used instead of the previous indicator of 28 days.

Area Mental Health Services reported 95 suspected suicides of mental health clients between 1 Jan and 30 June 2006. The largest group group of these (54 reports) were of community mental health clients who had been in contact with services in the preceding 7 days. There were 6 reports of suspected suicide of inpatients on leave (either authorised or unauthorised) from hospital mental health units, and 4 suspected suicide deaths occurring in hospital.
Source: NSW Mental Health Performance Report, Jan – June 2006 INFORMH

Suicides within 7 days of contact with mental health service (NSW)

- **NSW Health registered 99 suspected suicide deaths of clients within 7 days of contact with the Mental Health Service between 1 Jan - 30 June 2006**

NSW Health policy requires that mental health services complete a Root Cause Analysis (RCA) following the death of mental health service client by apparent suicide
Source: NSW Mental Health Performance Report, Jan – June 2006 INFORMH

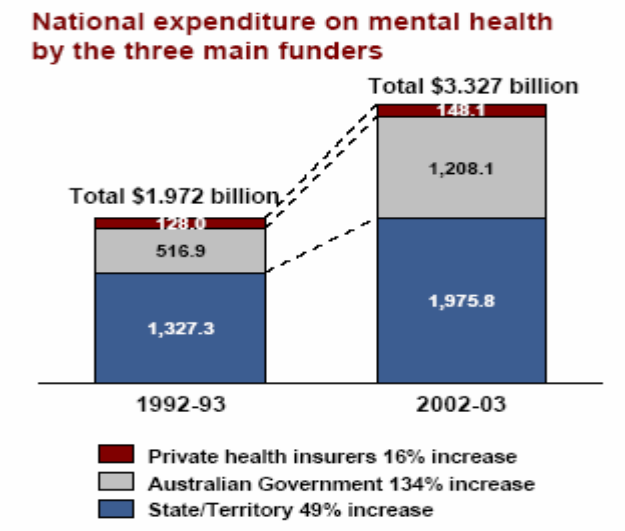
BACK TO TOP

Spending on mental health

Spending on mental health (Australia)

- **Mental health made up 7% of total government health spending in 2003**
- **Australian government spent $1.2bn in 2002-03**
- **Total government spending (Fed + all states and territories) was $3.2bn in 2003**
- **73% increase in government spending since 1993**
- **29% of Australian govt mental health spending was on hospitals**
- **3.1% of Australian govt mental health spending was on NGOs**

Spending on mental health (by the three main funders – State/Territory governments, Australian government, and private health insurers) in 2003 was $3.3 billion, a 69% increase in real terms since 1993. Australian Government spending was $1.21 billion, states and territories $1.98 billion and private health insurers $148 million. Government spending increased by 73% during this time.



Mental health accounted for 6.6% of total expenditure on health care and 7% of government health spending. These proportions have remained relatively stable over the course of the National Mental Health Strategy.

Spending on mental health (NSW)

- **The table on the next page compares key indicators in NSW compared with Australia, as well as the trend over the last 10 years in NSW.**
- **The charts on the following page graphically compare some of the indicators for NSW and Australia.**
- **NSW Govt spent $646 million on mental health in 2002-03**
- **Per capita expenditure on mental health is less than Australia as a whole ($97 compared with $100); NSW is 5th highest of all states and territories.**
- **Proportion spent on NGOs was less than half Australian proportion in 2002-03 (NSW 2.4% of mental health funding spent on NGOs, compared with 6.2% for Australia).**

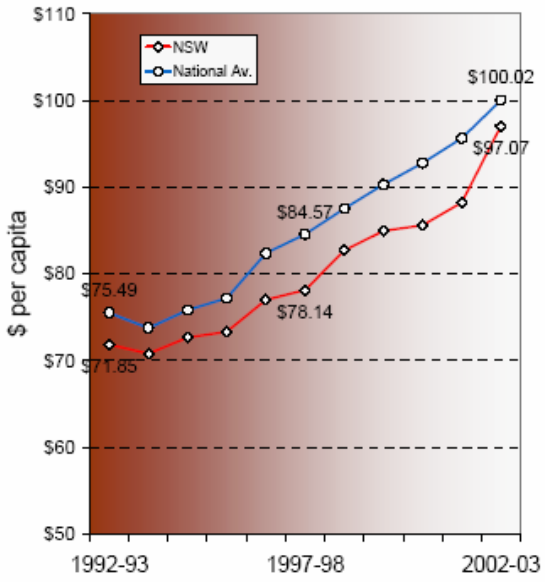
Table 13: Indicators of mental health service provision in New South Wales

INDICATOR			NEW SOUTH WALES			AUSTRALIA
			1992-93	1997-98	2002-03	2002-03
STATE GOVERNMENT EXPENDITURE						
• State spending on mental health services ($Millions)			430	493	646	1,976
• State spending per capita ($)			71.85	78.14	97.07	100.02
• Per capita spending rank			5	6	5	
• Average annual per capita spending growth 1993-2003 (%)			n.a	n.a	3.1	2.9
• % spending on	– General adult services		n.a	77.1	74.5	69.9
	– Child and adolescent services		n.a	6.1	9.0	9.9
	– Older persons services		n.a	13.5	11.2	14.4
	– Forensic services		n.a	3.3	5.3	5.8
SERVICE MIX						
• % total service expenditure	– Community services		30.0	41.4	46.9	51.2
	– Stand alone psychiatric hospitals		43.6	32.4	25.1	18.7
	– Colocated hospitals		26.5	26.3	28.0	30.1
INPATIENT SERVICES						
• Total hospital beds			2,652	2,121	2,086	6,073
• Per capita expenditure on inpatient care ($)			51.91	47.58	50.68	48.79
• Inpatient beds per 100,000			44.3	33.6	31.3	30.7
• Acute inpatient beds per 100,000			18.1	18.1	18.7	19.9
• Non acute inpatient beds per 100,000			26.2	15.5	12.7	10.9
• % acute inpatient beds located in general hospitals			62.7	69.5	71.6	83.4
• Stand alone hospitals as % of total beds			69.3	56.8	52.6	38.9
• Average cost per patient day ($)			395	463	521	519
COMMUNITY SERVICES						
• Ambulatory care	– % total service expenditure		24.0	35.6	40.7	38.6
	– Per capita expenditure ($)		17.81	28.92	38.81	38.63
• NGOs	– % total service expenditure		1.3	1.7	2.4	6.2
	– Per capita expenditure ($)		0.96	1.37	2.26	6.18
• Residential services	– % total service expenditure		4.6	4.0	4.3	7.3
	– Per capita expenditure ($)		3.45	3.25	4.14	7.30
	– Adult beds per 100,000:	24 hour staffed	4.6	3.7	2.7	5.0
		Non 24 hour staffed	n.a	n.a	6.9	5.5
	– Older persons beds per 100,000:	24 hour staffed	15.3	18.0	14.6	30.7
		Non 24 hour staffed	n.a	n.a	1.3	0.5
• Supported public housing places per 100,000			n.a	n.a	14.8	13.2
CLINICAL WORKFORCE						
• Number Full Time Equivalent (FTE) staff			4,108	4,704	5,560	17,951
• FTE per 100,000			68.6	74.6	83.5	90.9
• % FTE in community based services			33.6	45.5	48.9	49.7
• FTE per 100,000 – ambulatory services			18.8	29.8	36.0	36.7
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
• % services Level 1 implementation of Standards			n.a	n.a	50	41
• % service expenditure covered by Level 1 services			n.a	n.a	56	43
CONSUMER AND CARER PARTICIPATION						
• % services with Level 1 consumer participation arrangements			19	70	48	53
• Consumer consultants employed per 1000 clinical FTE			n.a	n.a	4.2	3.0
• Carer consultants employed per 1000 clinical FTE			n.a	n.a	0.6	0.5
MBS-FUNDED CONSULTANT PSYCHIATRIST SERVICES						
• Attendances per 100 population			11.1	11.1	9.9	10.4
• % population seen			1.4	1.6	1.4	1.4
• Benefits paid per capita			11.59	11.08	9.67	9.92
PBS-FUNDED PHARMACEUTICALS						
• Benefits paid per capita			4.82	14.40	26.32	28.39

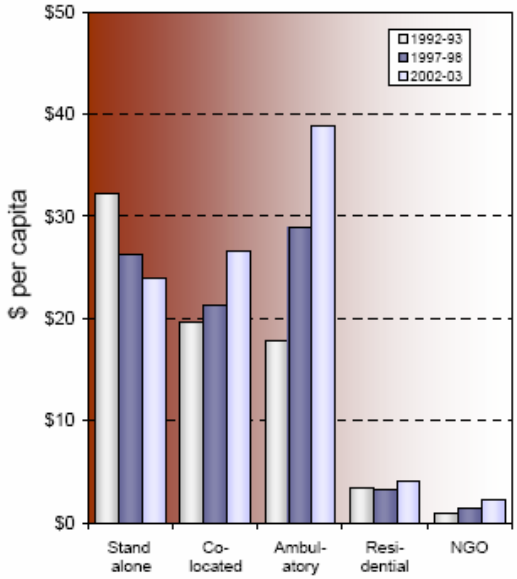
Legend: n.a. Signifies that the indicator is not available because relevant national data not collected.
– Indicates zero.

NSW

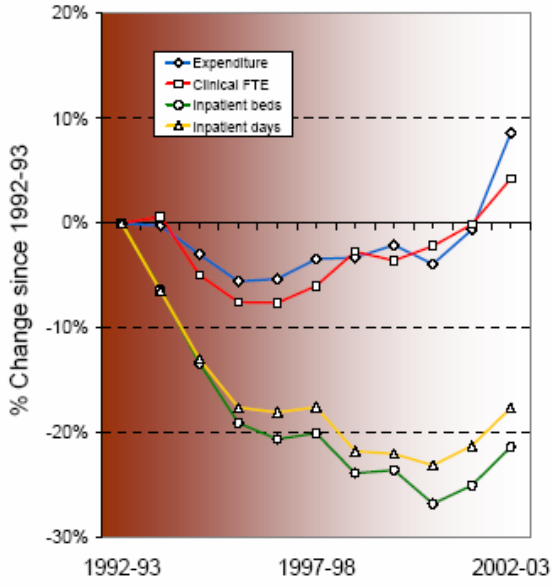
Overall spending on mental health



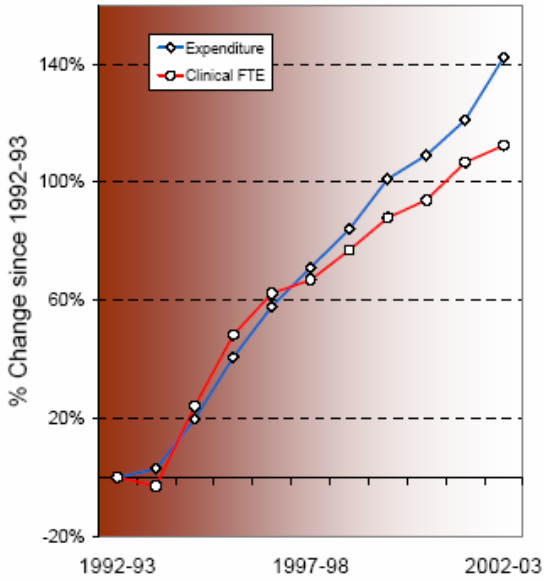
Changes in spending mix



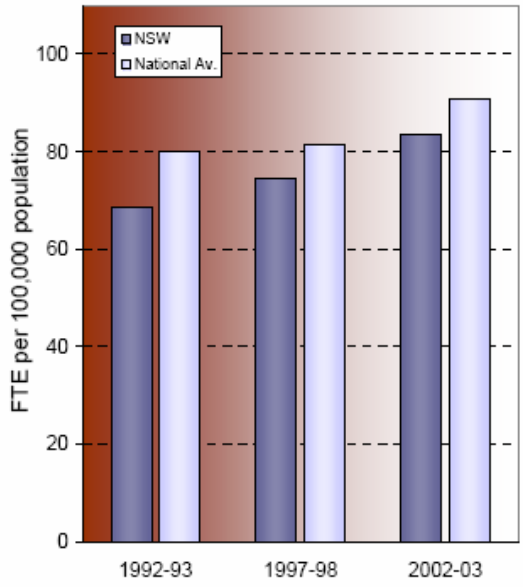
Changes in inpatient services



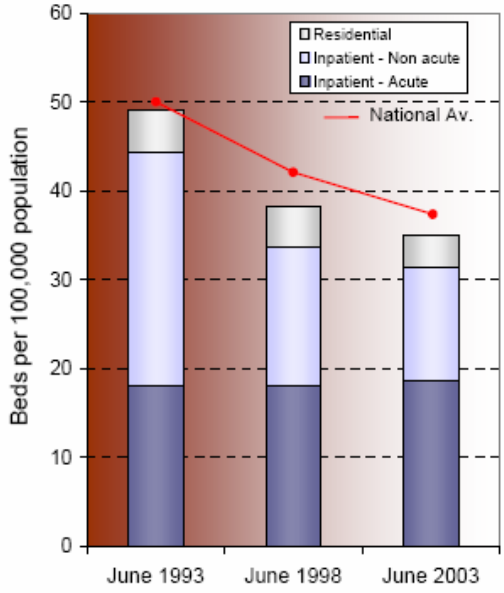
Changes in ambulatory care services



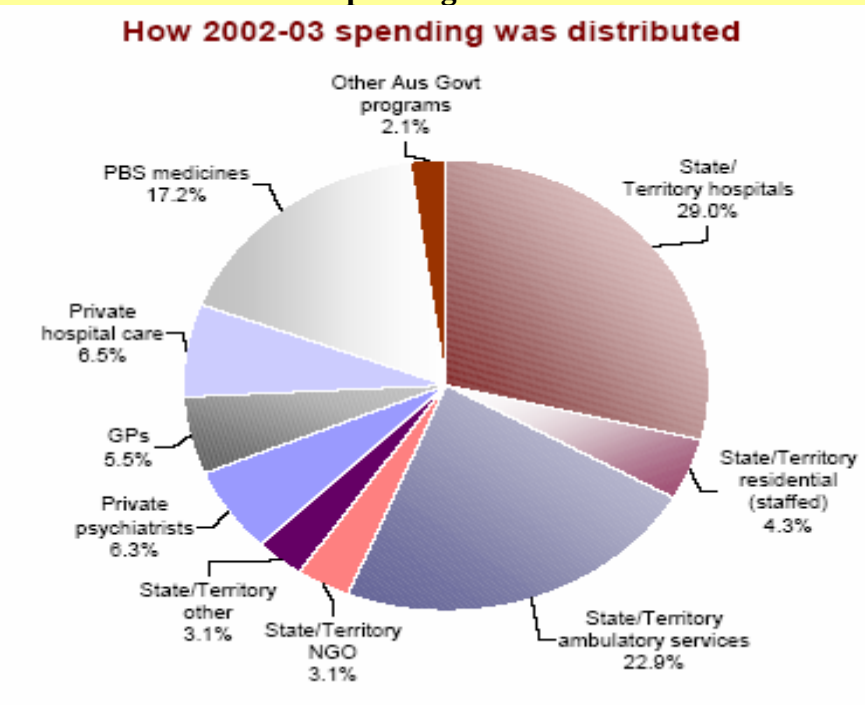
Clinical workforce



Inpatient and 24 hour residential beds



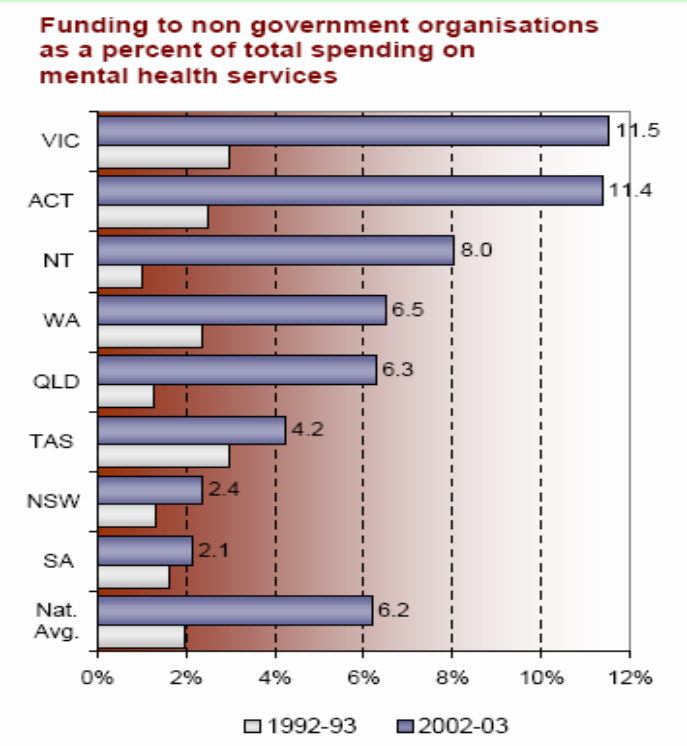
Australian Government spending:



Source: Department of Health and Ageing, National Mental Health Report 2005: Summary of ten years of reform in Australia's mental health services under the National Mental Health Strategy, 1993 – 2003, Commonwealth of Australia, 2005

Spending on NGOs (NSW and Australia)

- **2.4% of NSW mental health expenditure in 2002-03 was on NGOs**
- **Well below national average of 6.2%; the second lowest of all states / territories**



Source: Department of Health and Ageing, National Mental Health Report 2005: Summary of ten years of reform in Australia's mental health services under the National Mental Health Strategy, 1993 – 2003, Commonwealth of Australia, 2005, p. 5

Psychiatric beds (Australia)

- **In public psychiatric hospitals, the available beds for 2004–05 was 2487**
- **In public acute hospitals with a specialised psychiatric ward, the available beds was 3450.**
- **In private hospitals, there were 1512 available beds.**

In public psychiatric hospitals, the available beds for 2004–05 was 2487, compared with 2560 in 2003–04 and 2523 in 2002–03. For the first time since 2001–02, a decline in the number of beds was observed compared with the previous year. This observed decrease was mainly due to a decrease of 76 available beds in New South Wales between 2003-04 and 2004–05.

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)* page 107

Table 12.1: Summary of public and private psychiatric hospitals and government-operated community and residential mental health services, 2000–01 to 2004–05

	2000–01	2001–02	2002–03	2003–04	2004–05	Average annual change (%)
Public psychiatric hospitals						
Number of hospitals[a]	22	21	19	20	20	–2.4
Available beds[b]	2,430	2,409	2,523	2,560	2,487	0.6
Full-time-equivalent staff	5,601	5,545	5,458	5,600	5,748	0.6
Public acute hospitals						
Number of hospitals with a specialised psychiatric unit or ward[a]	109	110	128	124	122	2.9
Available beds in psychiatric units or wards	n.a.	n.a.	3,281	3,458	3,450	2.5
Private psychiatric hospitals						
Number of hospitals	24	24	25	25	26	2.0
Available beds[b]	1,369	1,387	1,463	1,441	1,512	2.5
Full-time-equivalent staff	1,566	1,707	1,704	1,672	1,680	1.8
Government-operated community and residential mental health services						
Number of services[c]	233	246	242	246	234	0.1
Services providing residential care[c][d]	49	53	50	52	46	–1.6
Available beds[b]	1,306	1,249	1,241	1,246	1,226	–1.6
Full-time-equivalent staff	8,933	9,759	10,420	10,783	10,879	5.1

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses. Some data for 2000–01 to 2003–04 have been updated since previously published.

(b) Average available beds.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

(d) The number of establishments providing residential care services reported to the National Community Mental Health Establishments Database (NCMHED) is larger than the number of establishments reporting to the National Residential Mental Health Care Database (NRMHCD) because Victoria reported specialised aged care residential services in the NCMHED that are not in-scope for the NRMHCD.

n.a. Not available.

Sources: National Public Hospital Establishments Database, Private Health Establishments Collection, and National Community Mental Health Establishments Database.

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)* page 108

Psychiatric beds (NSW)

- **Total public beds in 2004-05 was 2056**
- **In public psychiatric hospitals, the available beds for 2004–05 was 1161**
- **In public acute hospitals with a specialised psychiatric ward, the available beds was 895.**
- **In private hospitals, there were 494 available beds.**

There was a decrease of 76 available beds in NSW between 2003-04 and 2004–05.

Table 15.3: Mental health facilities, New South Wales, 2000–01 to 2004–05

Mental health facilities	2000–01	2001–02	2002–03	2003–04	2004–05
Public psychiatric hospitals[(a)(x)]					
Number of hospitals	9	9	9	10	10
Average available beds	1,046	1,075	1,166	1,237	1,161
Full-time-equivalent staff	2,468	2,462	2,534	2,693	2,703
Public acute hospitals with a specialised psychiatric unit or ward[(a)(x)]					
Number of hospitals	35	34	42	44	42
Average available beds in specialised psychiatric units	n.a.	n.a.	810	911	895
Private psychiatric hospitals[(b)(xi)]					
Number of hospitals	9	8	9	9	9
Average available beds	471	444	531	316	494
Full-time-equivalent staff	555	607	571	592	572
Government-operated community and residential mental health services[(xii)]					
Number of services[(c)]	19	19	19	19	10
Services providing residential care	7	9	6	7	5
Average available beds	206	161	138	137	138
Full-time-equivalent staff	2,593	2,937	3,305	3,304	3,157

(a) The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospitals buildings or campuses.

(b) The ABS defines private psychiatric hospitals as those that are licensed or approved by a state or territory health authority and for which 50% or more of the total patient days were for psychiatric patients.

(c) The count of government-operated community and residential mental health services can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of service outlets.

n.a. Not available.

(x–xii) See page 144 for data sources.

Source*: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9) page 146

Some history about psychiatric beds:
Extensive reductions in the size of stand alone psychiatric hospitals occurred in the 30 years preceding the National Mental Health Strategy, decreasing the number of beds by about 22,000. Few alternative services were developed to replace the historical role of the hospitals during this period.

Reductions in the size of stand alone hospitals continued under the Strategy, with the number of beds decreasing by 59% between 1993 and 2003. By June 2003, beds located in

these hospitals accounted for only 39% of Australia's total psychiatric inpatient capacity, compared with 73% in June 1993.

The impact of the reductions has been the loss of about half of the non acute beds (2,211 beds) that were available in stand alone psychiatric hospitals in 1993. The role of these beds was to provide longer term care to people with serious and ongoing mental illness.

In contrast, the overall number of acute beds has increased slightly (293 beds), but their availability has remained relatively stable when population growth is taken into account.

The main change in the delivery of acute inpatient care has been the transfer of this function from stand alone psychiatric hospitals to general hospitals. The number of psychiatric beds located in general hospitals has grown by 65% since 1993. By June 2003, 83% of acute psychiatric beds were based in general hospitals compared with 55% in June 1993.

Source: Department of Health and Ageing, National Mental Health Report 2005: Summary of ten years of reform in Australia's mental health services under the National Mental Health Strategy, 1993 – 2003, Commonwealth of Australia, 2005, p. 6

Mental Health-Related Interventions

Presentations to Hospital Emergency Departments (Australia)

- **Approximately 190,000 mental health-related occasions of service in 2004-05**
- **3% of total occasions of service in EDs.**

All state and territory health authorities collect a core set of nationally comparable information on most emergency department occasions of service in public hospitals within their jurisdiction. This episode-level data are compiled annually by the AIHW into the National Non-admitted Patient Emergency Department Care Database (NAPEDCD). In addition, although not compiled as part of the NAPEDCD, all jurisdictions collect information (in some form) on the principal diagnosis for many of those emergency department occasions of service that they report to the NAPEDCD. This diagnosis information can be used to identify those emergency department occasions of service that were mental health-related.

In 2004–05, emergency departments in public hospitals in Australia reported 133,403 mental health-related occasions of service. There are several issues that strongly indicate this is an under-estimate (see source page 20-21), so a revised estimate of the number of total mental health-related occasions of service is approximately 190,000 (3.2% of the total number of occasions of service in emergency departments in public hospitals in 2004–05 - which is reported to be almost 6 million)

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)*, page 21

BACK TO TOP

Presentations to Hospital Emergency Departments (NSW)

- **Approximately 48,223 mental health-related occasions of service in 2004-05**

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)*, page 145

Hospitalisation for mental health problems (Australia)

- **There were 199,353 mental health related separations for admitted patients in hospitals, of which 80% were in public hospitals, and 59% involved specialised psychiatric care.**
- **There were 116,787 day-only non-procedural hospitalisations (non-admitted), of which 23% were in public hospitals, and 79% involved specialised psychiatric care**
- **5% of mental health related hospital separations were in public psychiatric hospitals.**
- **There are 20 public psychiatric hospitals and 26 private psychiatric hospitals in Australia (2004-05)**
- **There are 122 public acute hospitals with a specialised psychiatric unit or ward (2004-05)**

Go to Definitions for how these facilities are defined for the purposes of the stats.

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW. Canberra: AIHW (Mental Health Series no. 9), p. 107 for psych hospitals*

Hospitalisation for mental health problems (NSW)

- **There were 63,664 mental health related separations for admitted patients in hospitals, of which 85% were in public hospitals, and 57% involved specialised psychiatric care.**
- **There were 32,950 day-only non-procedural hospitalisations (non-admitted), of which 36% were in public hospitals, and 85% involved specialised psychiatric care**
- **There are 10 public psychiatric hospitals and 9 private psychiatric hospitals in NSW (2004-05)**
- **There are 42 public acute hospitals with a specialised psychiatric unit or ward (2004-05)**

Go to Definitions for how these facilities are defined for the purposes of the stats.

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW, Canberra: AIHW (Mental Health Series no. 9), p. 107 for psych hospitals, 145 for overview.*

Re-admission within 28 days (NSW)

- **Between 1 Jan and 30 June 2006, 11% of people discharged from mental health inpatient care were re-admitted within 28 days.**

This indicator measures the rate of readmission within 28 days following discharge from an adult acute mental health inpatient unit. On average, 11% of persons discharged from mental health inpatient care are readmitted within 28 days. This includes planned and unplanned admissions, and only measures re-admission to the same hospital. There was no change from the previous period.
Source: NSW Mental Health Performance Report, Jan – June 2006 INFORMH

Contact with Govt community-based MH services (Australia)

- **In 2004–05, there were 5,108,524 community mental health care service contacts nationally.**
- **There were an estimated 522,894 clients, with an estimated contacts per client of 9.8**

Community mental health care refers to specialised mental health care provided by community mental health services and hospital-based ambulatory care services, such as outpatient clinics and day clinics, which are government-operated.

Some states and territories did not collect information on the actual number of patients who had had service contacts, so 522,894 people is an estimation based on the calculation of the number of unique person identifiers for each establishment. The number of patients may be over-estimated as patients registered with more than one establishment are counted separately each time.

The information has been derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on specialised mental health services provided to non-admitted patients in both community and hospital-based ambulatory care services that are government-operated.

***Source*:** *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)* page 26 - 28

Contact with Govt community-based MH services (NSW)

- **In 2004–05, there were 1,363,770 community mental health care service contacts in NSW.**
- **There were an estimated 236,458 clients, with an average contacts per client of 5.8**

Community mental health care refers to specialised mental health care provided by community mental health services and hospital-based ambulatory care services, such as outpatient clinics and day clinics, which are government-operated.

NSW has not collected information on the actual number of patients who had had service contacts, so 236,458 people is an estimation based on the calculation of the number of unique person identifiers for each establishment. The number of patients may be over-estimated as patients registered with more than one establishment are counted separately each time.

The information has been derived from the National Community Mental Health Care Database (NCMHCD), which is a collation of data on specialised mental health services provided to non-admitted patients in both community and hospital-based ambulatory care services that are government-operated.

***Source*:** *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)* page 26 - 28

BACK TO TOP

Residential care (Australia)

- **In 2004–05, there were 2,194 episodes of residential care provided to 1,431 residents. This corresponds to an average of 1.5 episodes of care per resident.**
- **The most common diagnosis for residents was schizophrenia (60%)**
- **The average length of residential stay was 271 days. The most common length of stay was 3 days and the median length of stay was 21 days.**

For the purposes of the report, residential mental health care refers to residential care provided by residential mental health services. A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on-site;
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of each day.

***Source*:** *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)*

General Practice visits (Australia)

- **11% of visits to GPs are for mental health related matters (2004-05)**
- **This is an estimated 10.2 million encounters**
- **An average-increase of 1.7% per annum between 2000–01 and 2004–05**

Note that "encounters" does not mean individuals. So individuals may be counted more than once if they had more than one mental health related visit.

***Source*:** *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9) page 12. Uses data from BEACH survey (Bettering the Evaluation and Care of Health (BEACH) survey of general practice activity).*

Psychiatrist visits (Australia)

- **There were just over 2 million psychiatrist services funded under Medicare in 2005-06 ($221 million in Medicare benefits)**

***Source*:** *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9) page xi.*

Prescription medication (Australia)

- **In 2005-06, 11% of Australian Govt expenditure on PBS medications was spent on mental health-related medications ($639m out of the total of $6053m).**

- **60% of these prescriptions were for antidepressants, 16% were for anxiolytics, and 14% for anti-psychotics**

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9) page 101*

BACK TO TOP

Mental illness and the prisoner population (NSW)

- **The twelve-month prevalence of 'any psychiatric disorder' (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neurasthenia) identified in the NSW inmate population is substantially higher than in the general community (74%)**

- **Almost half of reception (46%) and over one-third (38%) of sentenced inmates had suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.**

- **Female prisoners have a higher prevalence of psychiatric disorder than male prisoners.**

- **Almost one in ten inmates reported experiencing symptoms of psychosis in the twelve months prior to interview.**

- **The twelve-month prevalence of psychosis in NSW inmates was thirty times higher than in the Australian community.**

- **One in twenty prisoners had attempted suicide in the twelve months prior to interview.**

Corrections Health conduct two studies to examine this issue in 2001. Study 1 was a sample of male and female inmates screened on reception to the NSW correctional system over a three-month period. Study 2 screened a sample of sentenced inmates from across the state as part of the 2001 Inmate Health Survey.

The same instrument used in the National Survey of Mental Health and Wellbeing was adopted to enable comparisons with the wider community. This instrument is essentially a modified version of the Composite International Diagnostic Interview (CIDI), which yields twelve-month and one-month ICD-10 and DSM-IV diagnoses.

The prevalence of mental illness in the NSW correctional system is substantial and consistent with international findings.

Source: Butler T, Allnutt S. Mental Illness Among New South Wales' Prisoners. NSW Corrections Health Service, 2003.

Mental Illness and the Indigenous population –(Australia)

- **Indigenous people make up 2.3% of total Australian population (ABS, 2006 Census)**
- **Indigenous people suffer more ill health than other Australians. They die at much younger ages and are more likely to experience disability and reduced quality of life due to ill health. Median age is 21 years (cf 36 for general population) (ABS)**

Social and Emotional Wellbeing

- **78% of Indigenous people reported their health as either 'good', 'very good' or 'excellent', while 22% reported their health as 'fair' or 'poor'. After accounting for age differences, Indigenous people were almost twice as likely as non-Indigenous people to report their health as only fair or poor**

Aboriginal and Torres Strait Islander people perceive their health not only in terms of the physical health of the individual, but rather in regard to the social, emotional and cultural wellbeing of the whole community.

The 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) included a module to assess aspects of social and emotional wellbeing of Aboriginal and Torres Strait Islander people, for the first time (NATSIHS)

Source: NATSIHS / ABS 2007

Incidence and Prevalence of Mental Illness

- **In 2003-04, Indigenous people were up to twice as likely to be hospitalised for mental and behavioural disorders as other Australians.**
- **In 2003-04, 5% of all hospitalisations of Indigenous males, and 4% of all hospitalisations of Indigenous females, were for mental and behavioural disorders.**
- **There were 7 times as many hospital separations for assault among Indigenous males, and nearly 31 times as many for Indigenous females, compared with non-Indigenous Australians.**
- **There were twice as many hospital separations for self-harm, for both Indigenous males and females, as non-Indigenous Australians.**
- **After adjusting for age, the rate at which Indigenous people accessed community mental health services was 1.4 times that of other Australians (342 and 236 service contacts per 1,000 population respectively). (this is likely to be under-estimated due to inconsistency in data collection about Indigenous status)**

The best proxy measure for the incidence and prevalence of mental illness seems to be rate of access to mental health interventions.
Source: ABS / AIHW 2005 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

Suicide

- **In 2005, suicide accounted for 4.3% of all Indigenous deaths compared with 1.6% of deaths for non-Indigenous Australians. (Auseinet 2007)**
- **In 1999-2003, for Indigenous males aged 0-24 and 25-34 years, suicide rates were 3 times those for non-Indigenous males.**
- **In 1999-2003, for Indigenous females aged 0-24 years, suicide rates were 5 times those for non-Indigenous females.**

Source: ABS / AIHW 2005 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

Imprisonment

- **In 2004, 21% of the total prisoner population was Indigenous.**
- **Indigenous people aged over 17 years were incarcerated at 11 times the rate of non-Indigenous Australians (1,417 / 100,000 compared to 129 / 100,000).)**
- **At 30 June 2004, 32% of young people in juvenile detention (10-17 years) were identified as Aboriginal and/or Torres Strait Islander**
- **Of the 68 deaths in custody in 2003, 17 (25%) were Indigenous people (McCall 2004)**

Source: ABS / AIHW 2005 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

Disability – general

- **37% of Indigenous persons aged 15 years or over had a disability or a long-term health condition.**

Source: NATSIHS / ABS 2007

Mortality

- **Overall age-standardised death rates were almost 3 times higher for Indigenous people as non-Indigenous population (Australia's Health 2006)**
- **Standardised mortality rates from mental and behavioural disorders were 6 times higher for Indigenous males than non-Indigenous males, and 2.5 times higher for Indigenous females than non-Indigenous females. (Australia's Health 2006)**

Source: AIHW, Australia's Health 2006, 2007

Substance use

- **Hospitalisations for 'mental and behavioural disorders due to psychoactive substance use' were 4 times higher for Indigenous males, and 3 times higher for Indigenous females, than non-Indigenous Australians**

Source: ABS / AIHW 2005 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

Intentional self harm

- **Indigenous Australians had double the rate of hospitalisation for intentional self-harm than non-Indigenous Australians**

Source: ABS / AIHW 2005 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

BACK TO TOP

Mental health and illness – broader interesting statistical information

Spending on mental health – New Zealand

- **In New Zealand in 2004/05, the proportion of mental health funding spent on services provided by NGOs was 30%.**
- **The proportion of mental health service funding for community services was almost 72%.**
- **Total public funding for mental health services was NZ$866 million in 2004-05**
- **New Zealand's population in 2005 was 4,098,300 (*Statistics NZ),* meaning the mental health funding per capita was $211.**

Source: Mental Health Commission (NZ) Report on progress 2004/05: Towards implementing the Blueprint for Mental Health Services in New Zealand, 2006, p. 10

Mental ill-health is associated with physical health problems and social problems

- **Almost half of all people with a mental health disorder also have a physical health problem**

Many mental health disorders can also co-exist with chronic, physical ill health conditions.

The National Survey of Mental Health and Wellbeing Report indicated that just under half of those with any mental health disorder also had a physical health problem (DHAC & AIHW 1999). These included asthma, chronic bronchitis, anaemia, high blood pressure, heart disease and kidney disease.

Mental health problems may also be associated with a wide range of other health and social problems such as substance misuse, homelessness, unemployment, and gambling. In Australia, depression is the fourth leading cause of disease burden, with high associated costs including reduced work productivity, days of lost work, educational failure, poor family functioning, poor social functioning, a diminished sense of wellbeing, and increased use of health services (AIHW 2002).

It is also a major risk factor for suicide and self-inflicted injury (DHAC & AIHW 1999). Socioeconomic inequalities are also apparent in the prevalence of mental health problems in Australia (Glover et al. 2004). Research undertaken with self-reported data from the 2001 NHS showed that there was a statistically significant differential of 67% at ages 25 to 64 years, with a strong, continuous gradient, in the prevalence of self-reported mental and behavioural problems across the socioeconomic gradient; differentials (also statistically significant) in the 0 to 14 year and 65 years and over age groups were 52% and 56%, respectively (Glover et al. 2004).

BACK TO TOP

Definitions

Mental Health Facilities -

A **public psychiatric hospital** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders that is controlled by a state or territory health authority and offers free diagnostic services, treatment, care and accommodation to all eligible patients.

A **private psychiatric hospital** is an establishment devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. In this report, they have been defined as those that are licensed/approved by a state or territory health authority and for which 50% of more of the total patient days were for psychiatric patients.

A **public acute hospital** is an establishment that provides at least minimal medical, surgical or obstetric services for admitted patient treatment and/or care and provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state or territory health department or be controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Psychiatric units or wards are specialised units/wards, within a hospital, that are dedicated to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders.

Government-operated community mental health services are facilities that provide specialised mental health services to non-admitted patients. They can be both community and hospital-based ambulatory care services that are government-operated. They do not include psychiatric hospitals or designated psychiatric units in acute care hospitals, and 24-hour staffed specialised residential mental health services.

Community mental health service outlets are the individual units providing services within a community mental health service. The number of outlets, for the purpose of this report, are derived from the number of individual service units reporting to the National Community Mental Health Care Database.

Government-operated residential mental health services are specialised mental health services which:

- are operated by Commonwealth or state or territory government;
- employ mental health-trained staff on-site for 24 hours per day;
- provide rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment; and
- encourage the resident to take responsibility for their daily living activities

A specialised mental health service organisation is a separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised

mental health care. A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres.

Source: *Australian Institute of Health and Welfare (AIHW) 2007. Mental health services in Australia 2004–05. AIHW cat no. HSE 47. Canberra: AIHW (Mental Health Series no. 9)* page 107

BACK TO TOP