

# Paper 2: Mental health need and Australia's response

After looking to the past, the next phase of analysis involved looking out across the nation to gain a high-level overview of current mental health need in the Australian population, and how we are currently responding. This overview is provided below, showing what we found in terms of demand for and supply of mental health supports, evidence of unmet need, and how governance of mental health support is currently organised.

## Australia's mental health needs

### Prevalence and burden of disease

It is estimated that 45 per cent of Australians aged 16–85—that is, 7.3 million people—will experience some form of mental disorder in their lifetime. In the past year alone, one in five Australians have experienced symptoms of a mental health problem.<sup>1</sup>

The most common mental illnesses experienced in Australia among those aged 16–85 are anxiety disorders (experienced by 14.4 per cent during the past 12 months), mood disorders (6.2 per cent), and substance use disorders (5.1 per cent).<sup>1</sup> Less common illnesses involving psychosis tend to have greater impact on many aspects of a person's life and an estimated 64,000 people are in contact with specialised mental health services for psychotic illness nationally each year.<sup>2</sup>

The most recent available estimates show that in 2010 mental illness accounted for about 12.9 per cent of Australia's total burden of disease, which is a combination of premature mortality and years lived with disability.<sup>3</sup> Mental and behavioural health problems are the second-highest cause of healthy years of life lost globally as well as in Australia, accounting for almost one quarter (22.3 per cent) of this total burden.<sup>3</sup> It is estimated that about 327,000 years of healthy life are lost each year in Australia due to mental illness.<sup>4</sup>

The pattern of mental illness for people across their life course is highly variable when compared to many other types of health conditions. While many people recover from a single episode of illness (especially if it was connected to the stress of a particular life event), sometimes mental health problems follow a chronic or episodic course. This means that an individual will have different levels of need for formal and informal support during their lifetime. This also makes early intervention relevant and vital at any age or stage of life.

The statistics represent massive human suffering and a loss of opportunity for those who are unwell and for their families and supporters. The following sections look in more depth at how Australia's response to its population's mental health needs is organised and delivered, and at the evidence of unmet mental health need in the Australian population.

For Aboriginal and Torres Strait Islander peoples, the data suggests an entrenched, perhaps worsening mental health crisis and significantly greater mental health needs than other Australians. In 2012–13, 30 per cent of respondents to the *Australian Aboriginal and Torres Strait Islander Health Survey* over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.<sup>5</sup> That is nearly three times the non-Indigenous rate.<sup>5</sup> In 2004–05, high and very high psychological distress levels were reported by 27 per cent of respondents, suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.<sup>5</sup>

## Current responses to Australia's mental health needs

### Roles, responsibilities and governance

Although Australian articulation of national mental health policy has been world-leading, the reality of high-quality implementation has not followed.<sup>6</sup> This difficulty with implementation is partly attributed to the divided responsibilities for funding and provision between Commonwealth and state/territory governments as well as between public, private and not-for-profit entities.

States and territories are principally responsible for the provision of specialist mental health services, including inpatient hospital care, community mental health services, and community-based residential care to those with 'low prevalence, high severity' difficulties. Commonwealth funds are mainly dedicated to public mental health initiatives including prevention and promotion, welfare support such as the Disability Support Pension, and universally accessible benefits paid under the Pharmaceutical Benefits Scheme and Medicare Benefits Schedule.

The Commonwealth Government has historically been responsible for setting direction through policy, influencing workforce development and influencing system behaviour via pricing and incentives. In recent years the Commonwealth's role has expanded into service provision to target perceived gaps in services, including for primary care level services (via the Mental Health Nurse Incentive Programme), young people's mental health (via headspace), and for disadvantaged groups (via ATAPS Tier 2).

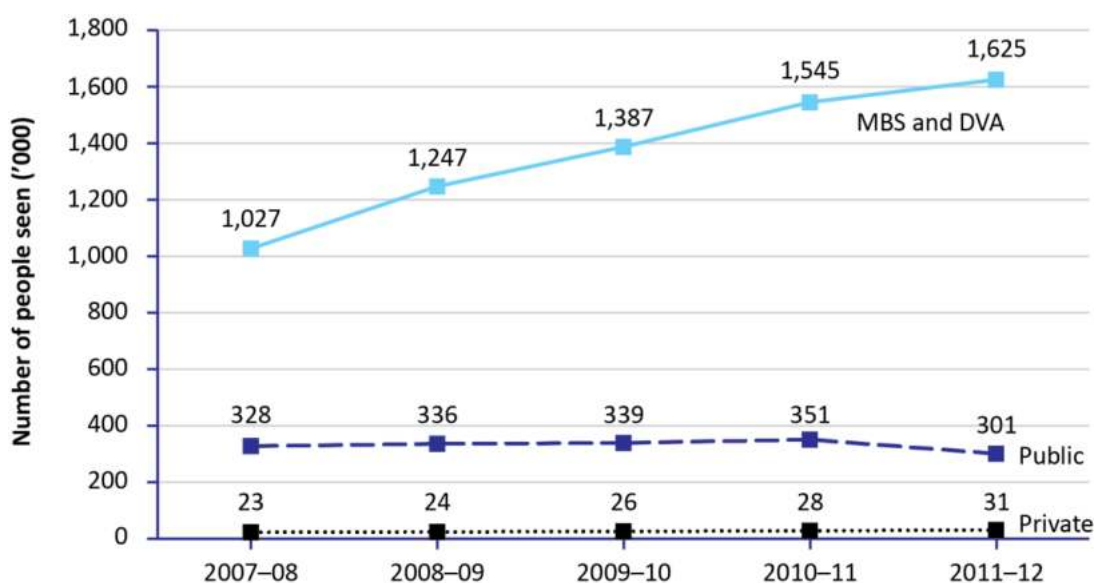
The result of these developments is a fragmented system of governance, complex funding streams and reporting requirements, and siloed provision which is difficult to navigate for those needing help.<sup>7</sup>

### Service provision

People with mental health issues have access to a variety of support services provided by a range of healthcare professionals in a number of settings. Someone with a mental health issue might receive care, for example, from a specialised public or private hospital service, residential mental health service, community mental health care service, private clinical practice and/or a non-government organisation.

Approximately 1.95 million people or 9.3 per cent of the population received clinical mental health services in 2011–12, compared with 1.38 million people or 6.6 per cent in 2007–08.<sup>8</sup> Approximately 300,000 of the 1.95 million people received mental health treatment from a public provider in 2011–12 (Figure 1).

**Figure 1 Number of people receiving mental health treatment by service type, 2007–08 to 2011–12**



Source: National Health Agreement, Performance Indicator 17

Note: Data for treatment received in public mental health services in 2011–12 does not include Victoria.

There is inherent variability between jurisdictions in the type of mental health services offered, mental health spending and activity. Although the services implemented by states and territories reflect national goals and approaches, their processes have been tailored to meet local requirements and differing models of care adopted by each jurisdiction. Similarly, methods used to count and identify activity also differ between jurisdictions.

The Commission estimates that the Commonwealth Government and the state and territory governments spent a combined total of \$13.52 billion on specialised mental health services in 2011–12. While this is an underestimate of the total spending by governments on mental health-related services (it does not include services such as ambulance, police, justice and some housing support), it also includes an estimated \$1 billion double count of National Healthcare Agreement/National Health Reform Agreement funds paid by the Commonwealth Government to the states and territories. Of the estimated \$13.52 billion, the Australian Government spent \$9.02 billion on mental health programmes and services in 2011–12; the remaining \$4.5 billion was spent on state and territory specialised mental health services.

#### Commonwealth funding and provision

- The Commonwealth Government spent \$9.02 billion on mental health programmes in 2011–12. Of this, spending was largest for the Disability Support Pension (\$4.410 billion), National Healthcare Agreements (\$989.6 million), Carer Payment and Allowance (\$862.3 million), Medicare Benefits Schedule (\$850.6 million), and the Pharmaceutical Benefits Scheme (\$830.4 million).
- According to our analysis of direct and indirect mental health spending, Commonwealth funding of mental health services increased by about 29.2 per cent over the past five years.
- This increase was due in large part to investment in, and uptake of, brief psychological interventions through the Better Access initiative which resulted in an average annual increase in all Medicare subsidised mental health consultations of 8.2 per cent.<sup>9</sup>

- GP visits for mental health problems number roughly 15.8 million per year in Australia, which is about 12 per cent of visits.<sup>10</sup> However, this is likely to be an underestimate because GPs may not code a mental health visit with a mental health-related MBS item.
- Psychiatric medications are responsible for direct Commonwealth health spending on mental illness, and absolute spending rose by 0.5 per cent annually in the five years to 2012–13. However, this represents a decreasing proportion of Commonwealth spending over that period. Approximately 24 million PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) subsidised prescriptions for mental health related medications were issued during that year, and about 31 million mental health-related medications in total (both subsidised and under co-payment), of which more than 60 per cent were antidepressants.<sup>11</sup>

### State and territory funding and provision

- The largest proportion of state and territory funds for specialised mental health services is spent on inpatient care (\$1.9 billion in 2011–12) followed by community mental health care (\$1.8 billion).<sup>12</sup>
- The majority of publicly funded mental health beds are now located in psychiatric units or wards as part of public acute hospitals, rather than in standalone psychiatric hospitals. The number of hospital beds dedicated to mental health use has reduced from 45.5 per 100,000 people in 1992–93 to 29.8 per 100,000 in 2011–12. In 2011–12 there was a total of 8,781 mental health beds, of which 24 per cent were in the private sector.<sup>12</sup>

### NGO sector provision

- The contribution made by mental health non-government organisations (NGOs) in providing mental health-related services to people living with a mental illness, their families and carers has grown significantly over the past decade.
- NGOs are funded by both the Commonwealth and state and territory governments, with each state and territory commissioning a unique set of programmes and initiatives from NGOs to meet local requirements and service delivery models. This diversity in NGO service delivery, coupled with the absence of a systematic mental health NGO data collection, has resulted in a lack of definitive information regarding the number of NGOs receiving government funding, the amount of funding received and the activities funded.
- In 2009–10 it was estimated that there were 798 ‘mental health’ NGO service providers offering a range of services from face-to-face counselling through to telephone services operating in Australia.<sup>13</sup> However, this investigation did not differentiate between those funded by state and territory and Australian Government funding.
- Analysis undertaken by the Commission found that in 2012–13 the Commonwealth Government Departments of Health, Social Services and The Prime Minister and Cabinet funded 542 NGOs, with a total expenditure of \$606 million.
- In 2011–12, the latest data available, mental health NGO funding from state and territory health portfolios was \$380 million.<sup>14</sup> This figure is inclusive of all jurisdictional NGO grants for services provided to those with a mental illness dispersed across all areas of social and community care, health promotion, accommodation, vocational, policy and advocacy (not only mental health).

## Private sector provision

- The private sector, funded by either insurance funds, personal funds or through MBS-subsidised items such as psychiatrist and psychologist consultations, plays a significant role in Australia's mental health provision. Eight out of ten people who received mental health-specific health services received these from the private sector.<sup>15</sup>
- Data on private hospital-based psychiatric services are collected and reported from the Private Mental Health Alliance's Centralised Data Management Service (PMHA-CDMS).
- Nationally, 31,846 patients received specialised psychiatric care from private hospitals which contributed data to the PMHA-CDMS in 2012–13. However, as data is only available for four states and the private hospital model differs between jurisdictions, adequate comparisons between state and territory private mental health services cannot be made.<sup>16</sup>
- The PMHA-CDMS also captures the outcomes of people discharged from private hospital psychiatric units using the Health of the Nation Outcome Scales (HoNOS). Of all private hospital specialised psychiatric care separations, 79.5 per cent had completed HoNOS ratings at both admission and discharge. From these, 72.4 per cent reported a significant improvement following care.<sup>16</sup>
- It is estimated recurrent expenditure by private psychiatric units in 2010–11 was \$307 million, an increase of 142 per cent since 1992–93. This increase in expenditure outweighs the increases in beds, patient days and staffing.<sup>15</sup>

**More detail about mental health service investment and provision is given in Volume 1: Attachment A (Commonwealth) and Volume 4: Paper 3 (state and territory).**

## Evidence of unmet need

There are three principal pieces of evidence of unmet mental health need in Australia.

1. Low rates of access to timely and appropriate support.
2. High indirect costs of reduced productivity due to mental illness.
3. Compounding cycles of disadvantage for people experiencing mental illness.

### Low rates of access to timely and appropriate support

There is evidence of low levels of access in the Australian population to timely, appropriate, evidence-based clinical services for mental health problems.

- It is estimated that fewer than half of people experiencing a common mental health problem access treatment for that problem.<sup>17</sup>
- Emergency department (ED) attendances for mental illness have not declined over the past five years, with almost 250,000 attendances during 2011–12.<sup>18</sup> Compared to non-mental health attendances, these were much more likely to be among young and middle-aged people (15–54 years).<sup>18</sup> Such high levels of ED attendances are evidence of failure to provide timely community-based mental health support.
- There is inequitable opportunity to access appropriate clinical support in rural areas and in Indigenous communities. Help-seeking is low among certain populations including those who are homeless, and young men.

## Economic costs of lost productivity

The impact of mental illness is not limited to individuals and families but also to communities and ultimately to Australia's social fabric and economic productivity. Internationally, it has been found that the costs of lost productivity to the economy consistently dwarf the cost of direct service provision by a factor of two to one.<sup>19</sup>

Those with mental health problems experience high levels of unemployment and underemployment; for those with psychotic illness, the unemployment rate is more than five times that of the general population at 27.4 per cent.<sup>2</sup> Australia has one of the lowest employment participation rates for people with a disability anywhere in the developed world.<sup>20</sup>

The costs of human suffering and lost quality of life have not been calculated in Australia but have been estimated in the UK as being roughly equivalent to lost productivity and direct health and social care costs added together.<sup>21</sup>

Psychological illness and stress are now the leading causes of being absent from work – among Australian Public Service employees, for example, there was a 54 per cent increase in mental health-related claims accepted by Comcare between 2006–07 and 2010–11.<sup>22</sup> An upward trend is also evident in the numbers of people claiming the Disability Support Pension (DSP) for a psychological or psychiatric condition, which currently account for 31.2 per cent of DSP grants and which have grown by 20 per cent in the five years to 2012–13 against an overall increase of eight per cent.<sup>23</sup>

## Compounding cycles of disadvantage

Mental illness is not just an economic problem; it also compounds existing social disadvantage and damages chances for social and community participation. Although it can affect any person at any time, at a population level mental illness disproportionately affects those who already experience some level of disadvantage and who are often those with the least access to mental health support.

Those living in rural, regional and remote communities have lower access to support for health problems compared with metropolitan areas. Aboriginal and Torres Strait Islander peoples and those living in socio-economically disadvantaged areas experience high levels of psychological distress. For Aboriginal and Torres Strait Islander peoples, the well-documented poverty and disadvantage in many communities are associated with an underlying burden of mental health problems. Studies indicate that mental health problems and suicide already make significant contributions to the overall health gap.<sup>24</sup> Mental health issues also contribute to unemployment and lower community safety,<sup>25</sup> as well as the high levels of imprisonment of Aboriginal and Torres Strait Islander peoples.

Young people (aged 16–24) and elderly people living in residential care also experience a greater burden of mental illness than working-age adults.<sup>26, 27</sup>

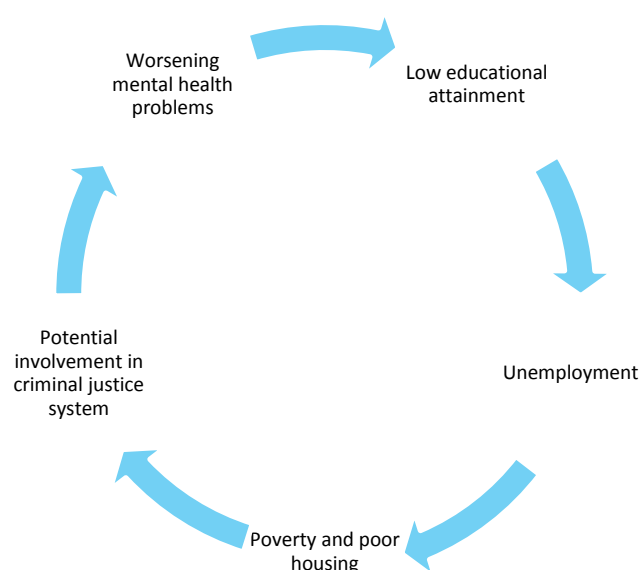
Social disadvantage and mental illness compound and exacerbate each other, creating and accelerating a cycle of disadvantage (see Figure 2).

- Young people experiencing mental health problems are less likely to complete high school and are more likely to fall into NEET (not in employment, education or training) status than their peers.<sup>28, 29</sup>



- In turn this makes unemployment more likely later in life. Unemployment is a psychological stressor which can exacerbate mental health difficulties,<sup>30</sup> but also increases risk of poverty and poor housing, and the cycle of disadvantage accelerates.
- Homelessness, substance abuse and involvement in the criminal justice system are all more likely to happen to those who have mental health problems, while at the same time worsening existing conditions.
- Those with a mental disorder are about 4.5 times as likely as their peers to have ever experienced homelessness,<sup>28</sup> and 23.8 per cent of those accessing Supported Homelessness Services report a current mental health problem.<sup>31</sup>
- Up to 70 per cent of those presenting to specialist mental health services also experience a substance use problem.<sup>32</sup>
- Nearly 40 per cent of people entering prison in 2012 had been previously told by a health professional that they had a mental illness.<sup>33</sup>

**Figure 2 Compounding cycle of disadvantage and mental illness**





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