

1 INTRODUCTION

1.1 Mental disorders in the Australian population - setting the scene

When the first National Survey of Mental Health and Wellbeing was conducted in 1997 there were no data that could be used to estimate the number of people in Australia with mental disorders. There was little idea of the disability associated with mental illness, the services that people accessed and how many people were untreated. Evidence from surveys in other countries (primarily from the United States and the United Kingdom) suggested that mental disorders were relatively common, were associated with significant disability and that less than half of people with mental disorders sought help for their problems. The 1997 survey answered these basic questions within an Australian context.

Many other countries have since invested in national surveys to answer these same questions and provide the evidence base for policy and program development targeted at improving mental health outcomes. Like Australia, at least 28 other countries have undertaken these surveys as part of the World Mental Health Survey Initiative, using the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI). These surveys have focussed on the adult population and on the more common or high prevalence mental disorders, which can be effectively identified through this survey method.

Since 1997 there have been substantial changes in the way that Australians perceive mental illness and in their knowledge and expectations of mental health services. There have also been significant changes in the way that services are provided. Funding has increased for public specialised mental health services. Prompted in part by the findings of the 1997 survey, there has been an increased focus on identification and treatment of mental disorders by primary care professionals, particularly general practitioners. An expanded range of services for the coordinated treatment of people with mental disorders by general practitioners and psychologists is now funded through Medicare, the Australian system providing universal access to medical, optometrical and hospital services. Access to mental health services, however, is still not considered adequate and significant additional investments, such as through the Council of Australian Government's *National Action Plan on Mental Health 2006-2011*, continue to provide additional funding for these.

1.2 The 2007 National Survey of Mental Health and Wellbeing

The 2007 National Survey of Mental Health and Wellbeing was designed to update the evidence on mental health in Australia, with a particular focus on service use information. Like the 1997 survey, the three main questions the survey aimed to address were:

1. How many Australians have which mental disorders?
2. What impact do mental disorders have on people, their families and society?
3. How many people have used services and what services have they used?

The survey instrument was based on the WMH-CIDI. Modules were selected from this instrument, adapted or written specifically for the Australian survey to align with the survey aims and to fit the Australian cultural context.

The survey was designed to estimate the prevalence of common mental disorders defined according to clinical diagnostic criteria, as directed by both the International Classification of Diseases 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Three broad classes of mental disorders were included in the survey, namely affective, anxiety and substance use disorders. These cover a wide range of common mental disorders as follows:

- Affective disorders - mild, moderate and severe depression, dysthymia, and bipolar affective disorder;
- Anxiety disorders - panic disorder, agoraphobia, social phobia, generalized anxiety disorder, obsessive-compulsive disorder and posttraumatic stress disorder; and

- Substance use disorders - abuse or harmful use and dependence on alcohol, cannabis, opioids, sedatives and stimulants.

The information collected through the diagnostic modules was processed through complex algorithms to determine whether the respondents met diagnostic thresholds for the mental disorders included in the survey. The diagnostic methods implemented by the WMH-CIDI instrument have been validated to ensure that individuals with a WMH-CIDI diagnosis are sufficiently unwell to be diagnosed with the given mental disorder if they were assessed by a clinician. This represents the latest innovation in diagnostic assessment for the common mental disorders within populations.

The assessment of service use was a key component of the 2007 survey. The content of the service use module was specifically developed for this survey. Information on general health care was collected, as well as more specific information on service use and medication taken for mental health problems. Collection of this information in a dedicated mental health survey enables examination of service use and medication in relation to specific mental disorders. Information on perceived needs for help with mental health problems was also collected, that is, firstly whether people's needs for services were being met and, secondly, whether they recognised that they might need services that they were not receiving.

Functioning and disability were assessed using a number of standardised measures. The World Health Organisation Disability Assessment Schedule (WHO-DAS) and the Australian Bureau of Statistics' Short Form Disability Module reflect the concept of disability as described in the International Classification of Functioning, Disability and Health and provide comparability with international and Australian national surveys. Sheehan Disability Scales were used to examine the interference with life in a number of domains (home, work or study, close relationships and social life) in relation to each mental disorder. Questions about days out of role, which assess the impact of mental disorders on day-to-day activities, were also asked in relation to specific disorders and, more generally, about all health problems.

The survey also collected information on the following:

- levels of psychological distress using the Kessler 10 scale (K10), a standardised questionnaire commonly used in Australia, including in the National Health Surveys, and internationally;
- the Assessment of Quality of Life (AQoL) to measure the burden of disease through questions on illness, independence, social relationships, physical senses and psychological wellbeing¹;
- chronic physical conditions and risk factors for poor physical health;
- social networks; and
- provision of care to family for physical and mental health problems.

1.3 The sample

The sample was representative of people aged 16-85 years who were usual residents of private dwellings across Australia. People living in very remote areas and in non-private dwellings, such as hotels, motels, hostels, hospitals and nursing homes, were excluded.

Dwellings were selected at random using a stratified, multistage area sampling technique.

To improve the reliability of estimates for the younger (16-24 years) and older (65-85 years) age groups, these groups were given a higher chance of selection in the household person selection process.

Interviews were conducted between August and December 2007. Proxy and foreign language interviews were not conducted. Interviews took an average of 90 minutes to complete.

The projected Australian adult population represented by the sample was 16,015,033. Of the eligible dwellings selected, there were 8,841 fully-responding households, representing a 60% response rate.

¹ Data from the AQoL was not available at the time of publication.

1.4 Strengths and limitations of the survey

The 2007 National Survey of Mental Health and Wellbeing provides estimates of the prevalence of common mental disorders in the Australian general population. It also provides detailed information on the impact of these disorders and use of health services for mental health problems.

Use of the WMH-CIDI as the base instrument for the survey capitalised on the extensive methodological testing and development invested in this instrument and also facilitates international comparability. Adaptations to the instrument were made to improve its fit within the Australian context. Standardised measures were included to allow comparisons with other Australian national surveys and service use questions were written to be relevant to the Australian health system.

The WMH-CIDI instrument assesses mental disorders across the lifetime. Data on the age of onset of mental disorders, when treatment was first sought and when symptoms were last experienced were all collected. These provide important information on the timing of these events in relation to each other, but are unable to be used to determine the causes of disorders.

The survey does not attempt to detect less common or low prevalence mental disorders, such as schizophrenia and other psychotic disorders, somatoform disorders, eating disorders, impulse-control disorders and personality disorders. It also did not cover dementia. Surveys with tailored sampling strategies and, in some cases, clinician or other specifically skilled interviewers are required to obtain useful information on these mental disorders. Good estimates for these disorders would also usually require sampling of non-private dwellings. Interview length and consequent factors, in particular the response burden, also restricted the number of mental disorders that could be included.

The survey sampling strategy and response rate have important implications for the reliability of estimates for sub-groups in the population. As a household survey, homeless people, people resident in nursing homes, hostels, and hospices and those in prison or other corrective service facilities were not surveyed. Although these groups comprise a relatively small proportion of the total Australian adult population, it is known that the prevalence of mental disorders is higher in these groups.

The 60% response rate of the 2007 survey was lower than expected, given the 78% response rate in 1997. A follow-up study of non-respondents was conducted by the Australian Bureau of Statistics to determine the effects of the non-response bias. This revealed that there is possible underestimation in the prevalence of mental disorders for men and for young people. However, this underestimation is likely to be small and the results presented in this report are considered to be representative of the Australian population.

1.5 Scope of the report

In summary, the data contained in this report present a broad overview of the important interactions between mental disorder status (defined according to ICD-10 diagnostic criteria), associated demographic characteristics and other factors, such as suicidality, comorbid physical conditions, social networks and use of health services. Further detailed analyses of the data will be required to gain a better understanding of these complex relationships and the potential moderating role of perceived need for care. The results of these analyses have the potential for providing vital information on the service use patterns of people with mental disorders and the implications of this for the delivery of mental health services.

4 The Mental Health of Australians 2
