Burden of Disease

due to mental illness & mental health problems 2007

VicHealth

MENTAL HEALTH & WELLBEING UNIT

VicHealth currently focuses on four factors influencing mental health and wellbeing: 1) increasing social participation; 2) reducing race-based discrimination, 3) preventing violence perpetrated against women and 4) increasing access to economic resources. This document presents some recent research related to mental health and mental illness with a focus on the:

1. Burden of disease and costs due to mental illness and mental health problems.
2. Links between physical and mental health.
3. Links between mental health problems and social and economic disadvantage.
4. The mental health status of sub-population groups.

Data has been drawn from evidence reviews and independent studies. This is one of a series of research summaries on mental health promotion. Others include focus on the links between: 1) mental health & social and economic participation, 2) mental health & race-based discrimination and 3) mental health & violence against women.

Key definitions and concepts

Mental health is the embodiment of social, emotional and spiritual wellbeing. It provides individuals with the vitality necessary for active living, to achieve goals, and to interact with one another in ways that are respectful and just (VicHealth 2005).

Mental illness and mental health problems

Mental illness[1] and mental health problems refer to a range of cognitive, emotional and behavioural disorder that interfere with the lives and productivity of individuals.

- Mental illness is a diagnosable disorder that significantly interferes with an individual's cognitive, emotional and or social abilities. There are different types of mental illnesses with different degrees of severity. Major mental illnesses that are public health issues include depression, anxiety, substance use disorders, and psychosis (CDHA 2004).
- Mental health problems also interfere with a person's cognitive, emotional and or social abilities but to a lesser extent than the impact of a mental illness. They are more common than mental disorders and include mental ill health temporarily experienced as a reaction to life stressors. The distinction between mental health problems and mental illness is not well defined and is made on the basis of severity and duration of symptoms (CDHA 2004).

The focus of VicHealth activity in this area is on the modifiable determinants of mental health problems such as stress, anxiety and depression.

Burden of disease due to mental illness and mental health problems

International data

In contrast to the overall health gains of world populations in recent decades, the burden of mental illness is growing. Mental and behavioural health disorders are common, affecting more than 25% of all people at some time during their lives and are present at any point in time in about 10% of the population (WHO, 2001).

Depression is an important global health problem due to both its relatively high lifetime prevalence and the significant disability that it causes. In 2002, depression accounted for 4.5% of the worldwide total burden of disease. It is also responsible for the greatest proportion of burden attributable to non-fatal health outcomes, accounting for almost 12% of total years lived with disability worldwide (WHO, 2005).

By 2030, depression will be one of the leading causes of disease along with HIV/AIDS and heart disease (Mathers & Loncar, 2006).

[1] The term mental illness is synonymous with mental disorder.

Australian data

Mental ill health is one of the top three leading causes of burden of disease and injury[2] in Australia. In 2003, mental disorders accounted for 13% of the total disease burden in Australia and 24% of non-fatal burden[3] (AIHW, 2007a).

Anxiety and depression, alcohol abuse, and personality disorders dominate the burden of mental disorders (AIHW, 2006).

In 2003, depression and anxiety was the leading specific cause of burden in women (10%) and the third for men (4.8%). It is the leading specific cause of non-fatal burden for both women and men (AIHW, 2007a).

Mental disorders account for the greatest burden in adults aged 15 to 44 years (36%) and children aged 0-14 years (23%) (AIHW, 2007a).

Self reported data in the 2004-05 National Health Survey (NHS)[4] shows:

- Around 1 in 10 (equivalent to 2.1 million Australians) had a long-term mental or behavioural problem. Age-related prevalence was:
  - 6.7% 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.
- The most commonly reported problems were anxiety related problems and mood (affective) problems (6% of females and 4% of males reported each of these conditions).
- The proportion of adult Australians reporting levels of psychological distress[5] increased from 2.2% in 1997 to 3.8% 2004-05. More women than men reported higher levels of psychological distress[5]. 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%).
- Of those using medications for mental wellbeing in 2004-05, 27% reported using anti depressants, 23% used sleeping tablets and 10% used medications for anxiety or nerves. Use of medications was higher among females than males overall (24% and 14% respectively) (ABS 2006a).

There were 2,101 deaths from suicide registered in 2005, and nearly 80% of these were deaths of males (1657 suicide deaths for males compared with 444 deaths for females). The male suicide rate in Australia for the last three decades has been around 20 deaths per 100,000 males (ABS, 2006b).

The highest age-specific suicide death rate for males in 2005 was observed in the 30-34 years age group (27.5 per 100,000) and the lowest was in the 15-19 years age group (9.5 per 100,000). For females the highest age-specific suicide death rate in 2005 was observed in the 35-39 years age group (6.9 per 100,000) and the lowest in the 15-19 years age group (3.6 per 100,000) (ABS, 2005).

Victorian data

14% of men and 23% of women participating in the Victorian Population Health Survey had been told by their doctor that they had depression or anxiety (VGDHS, 2005).

The costs of mental illness and mental health problems

Individual and family cost

Serious mental disorders are associated with a substantial role disability for individuals and may be a significant burden on the family who are often the primary carers (WHO 2003).

Experiencing a mental disorder is associated with lower educational attainment, joblessness and poorer physical health (CDHA 2004).

The Australian *National Survey of Mental Health and Wellbeing* in 1997 found people with a mental disorder averaged three days out of role (i.e. not undertaking normal activity because of health problems including going to work) over a four-week period. This compared with one day out of role for people with no physical or mental condition (ABS 1998).

In a 2004 World Health Organization survey, respondents with serious mental disorders reported at least 30 days in the past year when they are totally unable to carry out usual daily activities (WHO 2004b).

Approximately 5% of Australians experience anxiety so disabling that it affects every aspect of their lives (Andrews et al, 1999).

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[2] The 'disability-adjusted life year' (DALY) was used to measure burden and it 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.

[3] Non-fatal burden is measured in years of 'healthy' life lost due to disability (YLD).

[4] The 2004–05 NHS provides the latest estimates of the prevalence of mental health conditions in Australia.

[5] Measured by the Kessler Psychological Distress Scale – 10 (K10) which assesses non-specific psychological distress. A very high level of psychological distress, as shown by the K10, may indicate a need for professional help.

Economic cost

The economic burden related to mental disorders incurs costs due to premature death and disability, provision of treatment and support services, reduced productivity and loss of income both from those with the mental illness and their carers.

A study supported by the Australian Productivity Commission found that better health and education can result in substantially greater labour force participation for those affected. Of the six health conditions identified (cancer, cardiovascular disease, injury, diabetes, arthritis, and mental conditions), mental health or nervous conditions, when averted, has the largest positive impact on labour force participation, increasing the likelihood of working by around 25% (Laplagne, P. et al 2007).

The dollar value of mental illness is high in Australia. It is estimated that the total annual cost of mental illness in Australia is approximately $20 billion, which includes the costs from loss of productivity and participation in the workforce (COAG, 2006).

Depression-associated disability alone costs $14.9 billion annually and results in more than six million working days lost each year (beyondblue, 2004a).

Economic analyses suggest the following real costs for:

- Schizophrenia and associated suicide – $1.85 billion per annum in real financial costs (Access Economics 2002).
- Bipolar disorder and associated suicides – $1.59 billion per annum in real financial costs (Access Economics 2003a).
- Depression and mental disorders in the workplace – $3.3 billion per annum in lost productivity plus compensation claims (beyondblue, 2004b).
- Dementia, of which Alzheimer's disease is the most common form, and other mental illnesses of ageing – currently $6.6 billion per annum and projected to double over the next decade increasing in line with the ageing population (Access Economics, 2003b).

A report on Australian mental health services in 2000-01, estimated the costs of mental health disorders as $3.74 billion, or 7.5% of total allocated health system expenditure in that year. On a per capita basis, expenditure on mental disorders rose by 27.6% over the period from 1993-94 to 2000-01. Expenditure on depression alone was $1,107 million, accounting for 29.6% of allocated expenditure on mental disorders and 2.2% of all allocated health expenditure in 2000-01 (AIHW 2007b).

In 2004-05, principal diagnoses of depressive disorders (36%), neurotic and stress-related disorders (17%), mental and behavioural disorders due to alcohol (12%) and schizophrenia (11%) accounted for the largest proportions of mental health related hospital separations (AIHW 2007b).

Links between physical and mental health and wellbeing

There are causal associations between our physical and mental health and wellbeing.

Mental illness and mental health problems are associated with increased exposure to health risk factors, poorer physical health and higher rates of death from many causes, including suicide (AIHW, 2006).

Psychosocial factors may affect physical health by triggering a fight or flight response to stress and diverting energy and resources away from physiological processes important to long-term health maintenance. Both the cardiovascular and immune systems are affected if people feel tense too often. If the tension goes on for too long they become more vulnerable to a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression (Wilkinson & Marmot 2003).

The National Heart Foundation (Australia) concluded that there is strong and consistent evidence of an independent causal association between depression, social isolation and lack of quality social support and the causes and prognosis of coronary heart disease (Bunker et al. 2003).

Positive mental health can influence onset, course, and outcomes of both physical and mental illness (WHO 2004a).

Depression increases the likelihood of developing a chronic physical illness, particularly cardiovascular (heart) disease or stroke (beyondblue 2005, Kuper, Marmot & Hemingway 2002, Hackett & Anderson, 2005).

Australians with mental and behavioural problems had higher prevalence rates of diseases of the musculoskeletal system and connective tissue (47.7% compared with 30.4%), diseases of the circulatory system (21.2% compared with 16.4%), asthma (17.0% compared with 11.0%) and injury event in the last month (16.8% compared with 11.7%) (ABS 2003).

Links between mental health & social & economic disadvantage

People experiencing social and economic disadvantage experience mental health problems at a higher rate.

International data

- Depression is 1.5 to 2 times more prevalent among low-income groups of a population (WHO 2003).
- Adverse mental health outcomes are 2 to 2.5 times higher among those experiencing greatest social disadvantage compared to those experiencing least disadvantage (Astbury 2001).
- A systematic review of large adult population studies in Canada, USA, Australia, UK and the Netherlands showed that there are consistent associations between prevalence of mental disorders and a range of indicators of less privileged social position (Petticrew et al. 2005).
- A UK review of mental health problems amongst children found a close association between mental disorder in children and economic disadvantage in their household. Among boys and girls the prevalence of mental disorder tends to rise as household income falls. Children in families on the lowest incomes had mental illness prevalence rates of between 13-18% compared with a prevalence rate of between 4 and 7% amongst children in the highest income earning households (UK Office for National Statistics 2007).

Australian data

The *National Health Survey: Mental Health*, Australia indicates that:

- After age standardisation, the rates of mental and behavioural problems were highest for males and females who were unemployed (11.3% of males and 19.5% of females) and those who were not in the labour force[6] (15.6% of males and 14.0% of females).
- Rates of very high level of psychological distress were highest among adults who were unemployed (9.8%) and those not in the labour force (6.4%). For people who were unemployed, the prevalence of a very high level of psychological distress was more than two times the average (3.6%). In contrast, the rate for employed people (1.9%) was substantially lower than the average rate.
- Those people from the most disadvantaged socio-economic areas (those in lowest SEIFA[7] quintiles) were more likely to have a higher prevalence of mental and behavioural problems (12.3%) compared with 8.1% of people from the least disadvantaged socioeconomic areas. Both men and women living in the most disadvantaged areas had higher rates of mental and behavioural problems.
- Prevalence of mental and behavioural problems was higher among people without any post-school qualifications (11.2%) than among those with these qualifications (9.3%) (ABS, 2003).

Other single studies show:

- In Australia those who are unemployed compared with those who were employed, the risk of depression was 2.6 times greater, the risk of poor physical health was 2.47 times greater, and they were 3.1 times more likely to rate their health as poor (Broom et al 2006).
- More than 30% of income support recipients (or one in three) have a diagnosable mental health disorder compared to 18.6% for non-recipients. Lone mothers are three to four times more likely to be suffering from clinical anxiety or depressive disorders than the rest of the population (Butterworth 2003).
- While suicide rates decreased for Australians of high and mid socioeconomic status, suicide rates continued to increase for young men and women (aged 20–34) with limited access to socioeconomic resources (Page et al 2006).
- In inner city areas of major Australian cities up to 75% of people who are homeless have a mental health issue (Hodder, Teesson & Buhrich, 1998; Herrman, et al, 1996). Mental health issues are both a trigger for and a consequence of people becoming homeless – individuals with no psychiatric impairment when they first become homeless are at risk of developing mental illness the longer they are homeless (Kamienieki, 2001, Council for Homeless Persons, 2005).

Victorian data

The Victorian Population Health Survey (2005) reported that adults more likely to be categorised as experiencing psychological distress[8] were:

- Those persons with lower education levels.
- Those unemployed or not in the labour force.
- Those in non-professional occupations.
- Smokers.
- Those with doctor-diagnosed high blood pressure.
- Those told by a doctor that they had depression or anxiety.
- Those self-reporting poor health status.
- Those not having private health insurance.
- Those in households having lower income levels (VGDHS, 2005).

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[6] Labour force status information was collected for persons aged 15 years and over. Respondents were classified as either employed, unemployed, or not in the labour force.

[7] The Socio-Economic Index for Area (SEIFA) compiled by the ABS includes attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. The index refers to the area (the census collectors district) in which a person lives, it does not describe the socioeconomic situation of the particular individual.

[8] Kesslle 10 scores greater than or equal to 22.

Aboriginal and Torres Strait Islander Peoples

In 2005, the Australian Bureau of Statistics reported on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. The report noted:

- Chronic life stress is detrimental to a person's health. Major life changes that alter a person's social roles and relationships, such as divorce, serious illness, or the death of a loved one, can increase susceptibility to stress, especially when several of these changes occur within a brief time period (Bryce 2001).
- In 2002, 82% of Indigenous people aged 15 years or over reported experiencing at least one life stressor in the last 12 months. The most common types of stressors reported were the death of a family member or close friend (46%), serious illness or disability (31%) and inability to get a job (27%). For those living in remote areas the most frequently reported stressors were death of a family member or close friend (55%), overcrowding at home (42%) and alcohol and drug-related problems (37%).
- When age differences between the Indigenous and non-indigenous populations were taken into account, Indigenous people aged 18 years or over were almost one and a half times as likely as non-indigenous people to report having experienced at least one stressor in 2002 (ABS, 2005).

The Australian Health Ministers' Advisory Council (2006) when reporting on the *Aboriginal and Torres Strait Islander Health Performance Framework* noted the following:

- Aboriginal and Torres Strait Islander peoples have higher levels of acute morbidity and mortality from mental illness, assault, self-harm and suicide than other Australians.
- In 2002-03 and 2003-04 Aboriginal and Torres Strait Islander peoples were hospitalised for mental and behavioural disorders at twice the rate of other Australians. The greatest excess of mental health-related hospitalisations was in the younger adult age groups while the greatest relative excess of mental health related deaths was in the 35-54 year age group.
- Mental health related problems were among the top five most common problems managed during visits to general practitioners. Depression was the most frequently reported mental health related problem managed by general practitioners for both Aboriginal and Torres Strait Islander peoples (25%) and other Australians (34%) during 2000-01 to 2004-05 (AHMAC, 2006).

The *Western Australia Aboriginal Child Health Survey* (WAACHS) 2001 and 2002, found that:

- A variety of health conditions, social circumstances and behaviours experienced by individuals, their carers and families can have an impact on the social and emotional well-being of Indigenous children.
- 24% of Aboriginal children aged 4 to 17 years were assessed as being at high risk of clinically significant emotional or behavioural difficulties compared with 15% of all children.
- Male Aboriginal children were twice as likely as female Aboriginal children to be at high risk of clinically significant emotional or behavioural difficulties. Those children living in areas of extreme isolation were less at risk than those living in urban areas.
- Those who had been subject to racism in the past six months were more than twice as likely to be at high risk of emotional and behavioural difficulties than those who had not experienced racism (Zubrick et al. 2005, AHMAC, 2006).

Women

Women's increased risks of adverse mental health outcomes are attributed to a wide range of significant adverse consequences disproportionately experienced by women, such as poverty; discrimination; violence; socio-economic disadvantage; low social status; and traditional female gender roles (Astbury, 2001; Patel et al, 1999).

The 2005 Victorian Population Health Survey collected information on whether a person had ever been told by a doctor that they had depression or an anxiety disorder. Overall, 23.3% of females compared with 13.1% of males had been told by a doctor that they had depression or anxiety (VGDHS, 2005).

In 1997, the *National Survey of Mental Health and Wellbeing of Adults*, reported that women are more likely than men to report anxiety disorders (12% compared with 7%) and mood disorders (7.4% compared with 4%) (ABS, 2003).

The Australian Longitudinal Study on Women's Health (ALSWH) is a longitudinal population-based survey, which examines the health of over 40,000 Australian women. Analyses of the surveys show that:

- Around 12% of women have been diagnosed with mental health conditions, but over 20% report symptoms of poor mental health (Lee & ALSWH 2003).
- Among the younger women, sole mothers were more likely than other women to have experienced suicidal thoughts and self-harm. Among the younger and mid-age women, sole mothers were more than twice as likely to have experienced depression, and had significantly poorer psychological health and used medication for depression (Loxton et al 2006).

Youth

Depression is highly prevalent amongst young people, where 50% or more of those who develop depression have their first onset before age 25 (beyondblue 2004a).

Seventy-five percent (75%) of mental illnesses begin between the ages of 15 and 25 years (Hickie et al, 2004).

Mental disorders were the leading contributor to the burden of disease and injury (49%) among young Australians aged 15-24 years in 2003, with anxiety and depression being the leading specific cause for both males and females (AIHW, 2007a).

A high proportion of young people who experience a major depressive disorder also have another mental disorder – commonly an anxiety disorder, substance-use disorder, or behavioural disorder (Bhatia & Bhatia 2007 cited in AIHW 2007c).

The *Longitudinal Study of Australian Youth* found young people who become unemployed have a 50% increase in the risk of psychological disturbance. Psychologically well young men who became unemployed reported feeling depressed, whereas young women reported loss of confidence (AIHW 2007c).

Studies have found young same-sex attracted youth were on average three times more likely to attempt suicide than heterosexual youth (Howard et al 2002).

Newly arrived migrants and refugees

People who resettle in Australia as refugees have poorer mental health than the Australian born and migrants (VandenHeuvel and Wooden 1999, Thomas and Lau 2002). This is due to deprivation and exposure to social exclusion and violence in the course of their refugee experiences as well as to the greater settlement difficulties faced by this group (Chung at al 1998; Dyregrov et al 2002; Gorst Unsworth and Goldenberg 1998). These adverse experiences are of particular concern for asylum seekers (Silove and Sinnerbrink 1997).

The 2004 Victorian Population Health Survey found that overseas born Victorians had a higher proportion who were more likely to report their health as fair or poor than Victorians born in Australia. In addition, they were more likely to experience psychological distress (DVC 2006).

Generally speaking, migrant and refugees' access to the resources required for health improves with increasing years of settlement (VandenHeuval and Wooden 1999).

Conclusion

International, Australian and Victorian data indicates the prevalence, human impacts and financial costs of mental illness and mental health problems. We also have a significant body of research indicating evidence-based approaches to the promotion of mental health and the prevention of mental health problems.

Through utilisation of this evidence it is possible to see substantial improvements in the mental health and wellbeing of the population, resulting in a very different picture than that presented in this synopsis.

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