

The disparity between changes in the prevalence of mental illness and disability support rates in Australia

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Clarifying the type of support needed by people with a psychiatric disability must be a priority



One major focus of Australia's national mental health strategy has been to increase access to treatment for those with common mental disorders, particularly anxiety and depressive disorders. Despite indications that treatment rates have increased in Australia,¹ there is little evidence that the population prevalence of these disorders has declined, a phenomenon also reported in other high income countries where increased treatment has been made available.²

Harvey and colleagues also conclude, as reported in this issue of the *MJA*, that the prevalence of probable common mental disorders among working age Australians has remained stable or even decreased slightly between 2001 and 2014.³ Prevalence was estimated by measuring the levels of psychological distress in respondents to Australian national health surveys, using scores on the Kessler Psychological Distress Scale (K10) as an indicator of the likelihood of a mental disorder diagnosis. Their finding that the prevalence of probable common mental disorders has not changed is consistent with conclusions drawn from Australian surveys in which the presence of a mental disorder was assessed by interview⁴ and from the Global Burden of Disease studies,⁵ each of which required that prevalence be established according to diagnostic criteria. But Harvey and his co-authors also found a 51% increase over the same period in the number of people receiving disability support pensions (DSPs) for mental disorders, and ask why this is so, given the prevalence of probable common mental disorders had not changed.

With respect to the epidemiology of mental disorders, two observations can be made regarding these findings. The first is to consider whether the proportion of people receiving DSPs for psychological and psychiatric reasons who have more disabling mental disorders, such as psychoses, is increasing. However, there is no evidence for such an increase in Australia.⁶ Further, the disability component of the burden of disease metric (disability-adjusted life years) is years lived with disability (YLD), and this measure is more aligned with the need for a DSP than the prevalence of psychological distress. However, there was no change in age-standardised YLD rates for anxiety or depressive disorders in Australia between 1990 and 2015 (Global Burden of Disease Study 2015 data, accessed via <https://vizhub.healthdata.org/gbd-compare/>).



Second, the number of individuals with a disorder can increase even if its prevalence does not change. The Global Burden of Disease analysis found no change in the prevalence of anxiety and depressive disorders, but nevertheless reported that the number of people with these disorders increased by 36% between 1990 and 2010 as a result of population growth and changing population age structures.⁵ The same modelling of the impact of population growth and changing age structure in Australia indicated that the number of people aged 15–69 years with a major depressive disorder increased between 2000 and 2015 from 649 000 to 853 000 (31% increase), and that the number of those with an anxiety disorder increased from 1 041 000 to 1 356 000 (30% increase; Global Burden of Disease Study 2015 data). The extent to which this increase in the absolute number of individuals with a disorder has contributed to the increase in the number of individuals receiving DSPs in Australia is unclear.

Harvey and his co-authors offer four other reasons that might explain the change in the number of DSPs granted to people with mental disorders. The first and second possibilities, an increasing tendency to apply a psychiatric disability label and a change in disability policy settings for welfare support payments, seem most plausible, and should be further explored. Empirical evidence about how providers select the disability type is scarce, as is information on how changes in disability policy have affected the awarding of pensions to people with mental health problems. The third explanation offered by the authors is that more people with psychiatric disability are seeking DSP benefits because of the reduced availability of appropriate employment opportunities. This is possible, but a more common outcome for previously employed individuals would be unemployment rather than disability benefits. The fourth explanation, an increased incidence of common mental disorders masked by treatments that reduce

symptom but not disability levels, seems implausible. Had incidence increased, there would also have been an increase in prevalence, unless their remission rates had also increased; this, however, would be unlikely if the disability persisted long enough for a DSP to be awarded.

The challenges posed by the introduction of the National Disability Insurance Scheme (NDIS) for people with psychiatric disability are significant, and are currently being examined by the Joint Parliamentary Standing Committee on the NDIS.⁷ As part of this examination, clarifying the threshold for the allocation of DSPs and the type of support needed by those with psychiatric disability must be a priority.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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