12 Mental health management

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Attachment tables

Attachment tables are identified in references throughout this Indigenous Compendium by an '12A' prefix (for example, in this chapter, table 12A.1). As the data are directly sourced from the 2012 Report, the Compendium also notes where the original table, figure or text in the 2012 Report can be found. For example, where the Compendium refers to '2012 Report, p. 12.15' this is page 15 of chapter 12 of the 2012 Report, and '2012 Report, table 12A.1' is attachment table 1 of attachment 12A of the 2012 Report. A full list of attachment tables referred to in the Compendium is provided at the end of this chapter, and the attachment tables are available from the Review website at www.pc.gov.au/gsp.

The Mental health management chapter (chapter 12) in the *Report on Government Services 2012* (2012 Report) reports on the management of mental health in Australia. Data are reported for Indigenous people for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and

intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of mental health, which represents one activity of the Australian, State and Territory governments in health management.

Specialised mental health management services offered by a range of government and non-government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, general practitioners (GPs), Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Mental health is also the subject of programs designed to improve public health. Public health programs require the participation of public hospitals, primary and community health services, and other services. The performance of public hospitals is reported in chapter 10 and the performance of primary and community health services generally is reported in chapter 11.

Previously this chapter also reported on breast cancer screening and management. Some performance data on the management of breast cancer are now included in the 'Primary and community health' chapter. Future versions of this chapter might include performance reporting on other national health priority areas that need to be managed through a range of health services.

Indigenous data in the Mental health management chapter

The Mental health management chapter in the 2012 Report contains the following data for Indigenous people:

- Ratio of Indigenous to non-Indigenous specialised mental health service use
- Proportion of population using State and Territory specialised public mental health services
- Proportion of population using MBS-subsidised ambulatory mental health services

- Community mental health service contacts provided by public sector community mental health services
- Rate of ambulatory mental health services provided
- Suicide deaths.

Size and scope of sector

Prevalence and impact of mental illness

According to the National Health Survey (NHS), a significantly higher proportion of females reported high/very high levels of psychological distress than males in 2007-08 (14.4 ± 1.1 per cent compared with 9.6 ± 0.9 per cent) (2012 Report, table 12A.9). The proportion of high/very high levels of psychological distress was also higher for people aged 18–64 years, than for people aged 65 years or over (2012 Report, table 12A.9). In 2008, 32 per cent of Indigenous Australians aged 18 years or over reported high levels of psychological distress. After adjusting for age, this was 2.5 times the rate for non-Indigenous adults (AHMAC 2011).

Admitted patient care and community-based mental health services — service use

Estimating activity across the publicly funded specialised mental health services sector, which comprises admitted patient care and community-based mental health services, is problematic as the service types differ. Service activity is reported by separations for admitted patient care, episodes for community-based residential care and contacts for community-based ambulatory care. Service use data for the NGO sector are not available.

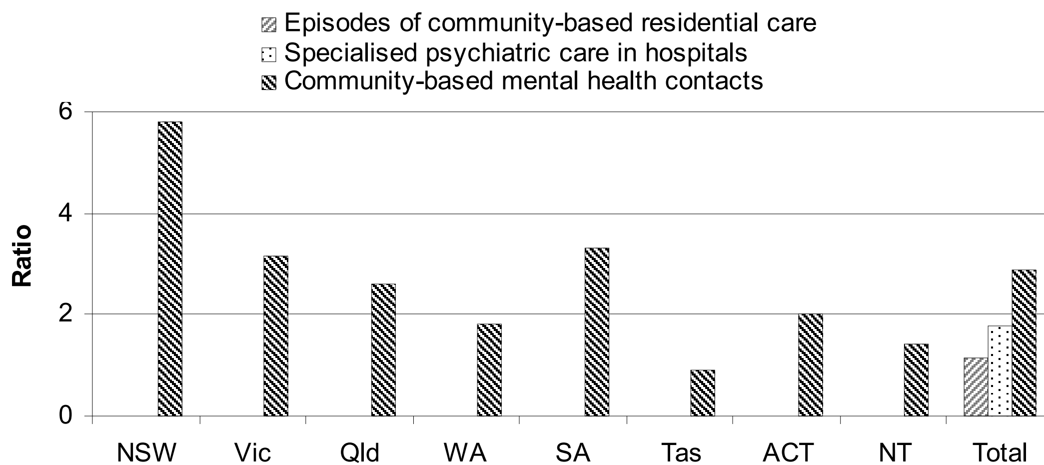
There were 3497 episodes of community-based residential care in 2008-09 (table 12A.14). Schizophrenia, schizotypal and other delusional disorders as a principal diagnosis accounted for the largest proportion of these episodes (61.1 per cent) (AIHW 2011b). There were 6.6 million community-based ambulatory care patient contacts, equivalent to 300.3 contacts per 1000 people, in 2009-10 (2012 Report, table 12A.24). Data on the rate of contacts by Indigenous status, Socio-Economic Indexes for Areas (SEIFA) and remoteness are in 2012 Report, table 12A.23. Data on the number and rate of contacts for 2008-09 by sex and age are in 2012 Report, table 12A.13. For those contacts in 2008-09 where a principal diagnosis was available, the largest proportion was for schizophrenia (31.0 per cent) (AIHW 2011b).

Data on service use by the Indigenous status of patients are available, but comparisons not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous people, and differences in the complexity, incidence and prevalence of illnesses.

Combined data for the jurisdictions for which data are available, show that Indigenous people were 1.1 times more likely to have an episode of community-based residential care and 2.9 times more likely to have a community-based ambulatory mental health contact than were non-Indigenous people in 2008-09 (figure 12.1). For specialised psychiatric care in hospitals, Indigenous people were 1.8 times more likely to receive admitted (non-ambulatory) specialised psychiatric care in hospitals than were non-Indigenous people in 2008-09 (figure 12.1). However, this pattern of service use is not necessarily reflected for ambulatory-equivalent specialised psychiatric care in hospitals. Data for July 2006 to June 2008, show that Indigenous people were less likely than non-Indigenous people (rate ratio of 0.2) to receive this type of care (AIHW 2011a).

Table 12A.14 contains further information on use of these services by Indigenous status. Data for episodes of community-based residential care and specialised psychiatric care in hospitals are not available by Indigenous status across jurisdictions for 2008-09.

Figure 12.1 **Ratio of Indigenous to non-Indigenous specialised mental health service use, 2008-09[a, b, c, d, e]**



[a] Data for episodes of community-based residential care and specialised psychiatric care in hospitals are not available by Indigenous status across jurisdictions for 2008-09. National data should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. [b] Data for community-based mental heath contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data were reported by the following states and territories to be of acceptable quality: NSW, Queensland, WA Tasmania, the ACT and the NT. [c] The ratio is equal to the service use rate (episodes, contacts or separations) for Indigenous people divided by the service use rate for non-Indigenous people. [d] Specialised psychiatric care in hospital data for non-Indigenous people include those whose Indigenous status was 'not stated'. For the community-based data, people whose Indigenous status was 'not stated' are excluded. [e] Data for specialised psychiatric care in hospitals includes both public and private hospitals (except for the NT that are for public hospitals only).

Source: AIHW 2011, *Mental Health Services in Australia Online*, tables 4.14, 7.4 and 8.4, mhsa.aihw.gov.au/home/ (accessed 13 October 2011); table 12A.14; 2012 Report, figure 12.5, p. 12.14.

Framework of performance indicators for mental health management

Preventing the onset of mental illness is challenging, primarily because individual illnesses have many origins. Most efforts have been directed at treating mental illness when it occurs, determining the most appropriate setting for providing treatment and emphasising early intervention.

Data for Indigenous people are reported for a subset of the performance indicators and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

The framework of performance indicators for mental health services draws on governments' broad objectives for national mental health policy, as encompassed in

the NMHS and the COAG National Action Plan on Mental Health (box 12.1). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS-subsidised, admitted patient and community-based services) and includes outcome indicators of system-wide performance (figure 12.2).

Box 12.1 **Broad objectives of National Mental Health Policy**[a]

Key broad objectives include to:

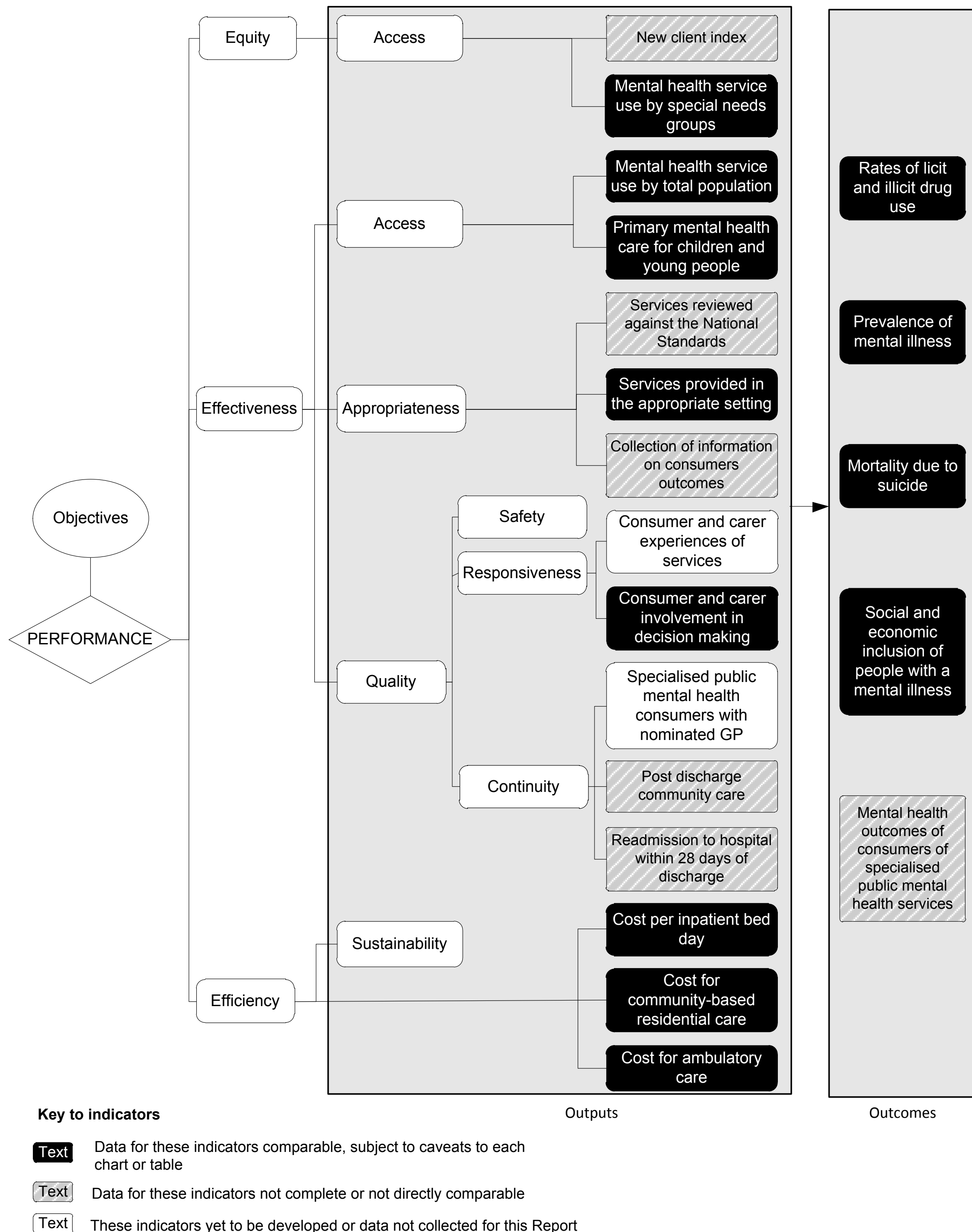
- improve the effectiveness and quality of service delivery and outcomes
- promote community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental illness
- undertake early intervention for mental health problems and mental illness
- promote recovery from mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- assure the rights of people with mental illness
- encourage partnerships among service providers and between service providers and the community
- provide services in an equitable (including improved access to mental health services, particularly in Indigenous and rural communities) and efficient manner
- improve mental health and facilitate recovery from illness through more stable accommodation and support and meaningful participation in recreational, social, employment and other activities in the community.

a These objectives represent a paraphrased interpretation of aspects of the National Mental Health Policy 2008.

The performance indicator framework shows which data are comparable in the 2012 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 of the 2012 Report discusses data comparability from a Report-wide perspective (see 2012 Report, section 1.6).

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 12.2 **Mental health management performance indicator framework**



Source: 2012 Report, figure 12.9, p. 12.21.

Equity — mental health service use by special needs groups

'Mental health service use by special needs groups' is an indicator of governments' objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.2).

Box 12.2 Mental health service use by special needs groups

'Mental health service use by special needs groups' is defined by two measures:

- proportion of the population in a special needs group using State and Territory specialised public mental health services, compared with the proportion of the population outside the special needs group using State and Territory specialised public mental health services
- proportion of the population in a special needs group using MBS-subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the special needs group using MBS-subsidised ambulatory mental health services.

The special needs groups reported are Indigenous people, people from outer regional, remote and very remote locations and people residing in low socio-economic areas.

This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across special needs groups. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

The proportions of the population using State and Territory specialised public mental health services in 2009-10, by special needs group are reported in figure 12.3. The results at the national level show that the proportion of the population using these services is higher:

- for Indigenous people, than for non-Indigenous people (figure 12.3a)
- in very remote locations, than in other locations (figure 12.3b)
- for people in the three most disadvantaged SEIFA quintiles (1, 2 and 3), than the more advantaged quintiles (figure 12.3c).

These results, which are derived using community-based ambulatory care data, should be interpreted with care, as:

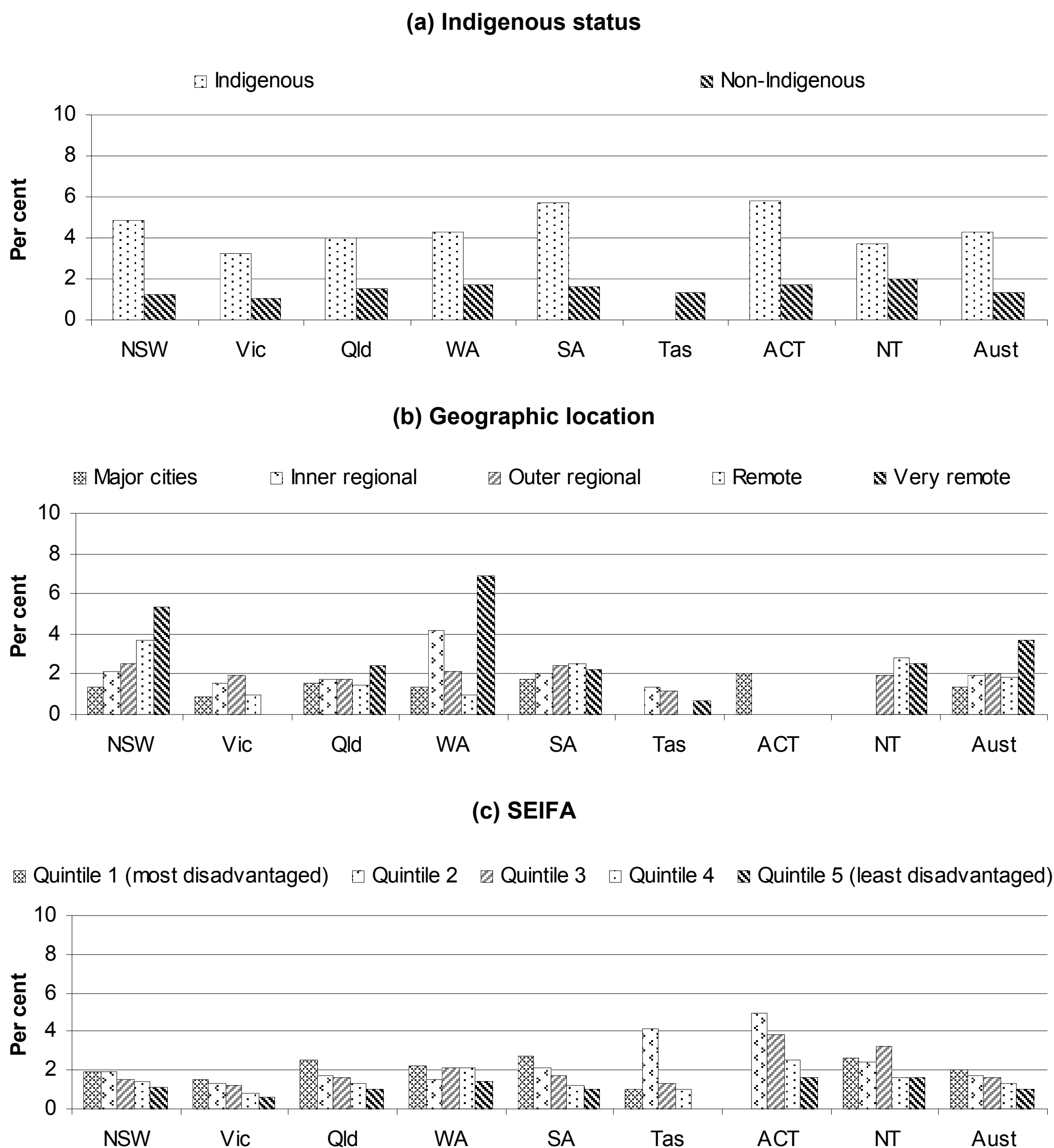
- people receiving only admitted and/or community-based residential services are not included in the proportion of people accessing services or in rates of service use
- there is no identifier to distinguish 'treatment' versus 'non-treatment' service contacts in the community mental health care data set
- jurisdictions differ in their collection and reporting of community-based ambulatory care data — there are variations in local business rules and in the interpretation of the national definitions.

The proportions of the population using MBS-subsidised ambulatory mental health services, by special needs group are reported in figure 12.4. The results at the national level show that the proportion of the population using MBS-subsidised ambulatory mental health services is lower:

- for Indigenous people, than for non-Indigenous people (figure 12.4a)
- in remote and very remote locations than in other locations (figure 12.4b)
- for those in the most disadvantaged SEIFA quintile 1, than for those in the more advantaged quintiles (figure 12.4c).

Further data on the use of State and Territory community-based specialised mental health services and MBS-subsidised ambulatory mental health services are in tables 12A.23 and 26. Data on the use of private hospital mental health services are also contained in 2012 Report, tables 12A.28 and 12A.19.

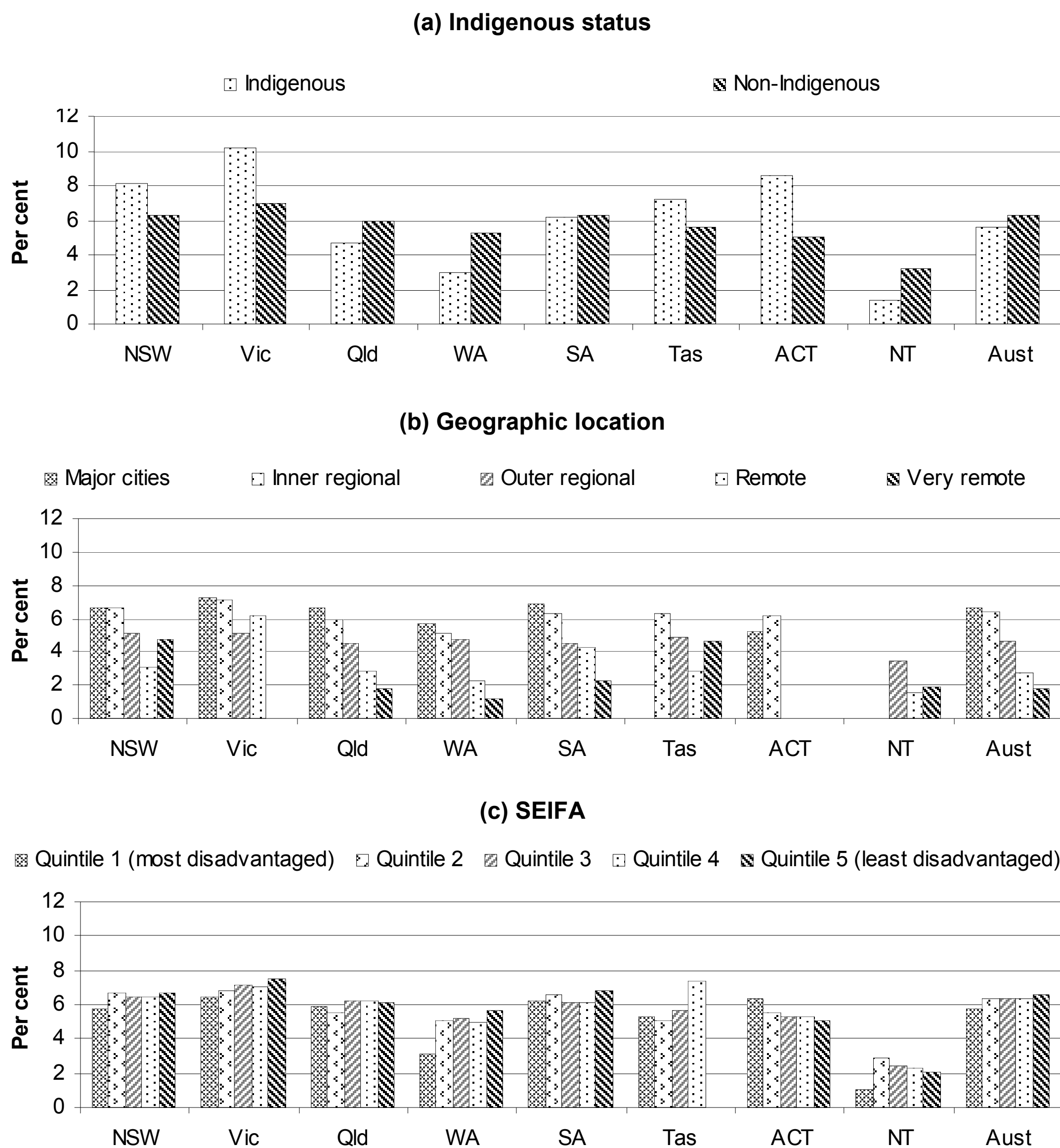
Figure 12.3 **Population using State and Territory specialised public mental health services, by special needs groups, 2009-10**[a, b, c, d, e, f, g]



SEIFA = Socio-Economic Indexes for Areas. [a] Proportions are age-standardised to the Australian population as at 30 June 2001. [b] Counts for State and Territory specialised public mental health services are counts of people receiving one or more service contacts provided by community-based ambulatory services. [c] SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. [d] Victoria does not have very remote locations. [e] Tasmanian data for Indigenous people are not published. Tasmania does not have major cities and the contact rate in remote areas is zero. SEIFA Quintile 5 is not applicable for Tasmania. [f] The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. [g] The NT does not have major cities or inner regional locations.

Source: State and Territory governments (unpublished) CMHC data; table 12A.19; 2012 Report, tables 12A.20-21; 2012 Report, figure 12.11, p. 12.26.

Figure 12.4 **Population using MBS-subsidised ambulatory mental health services, by special needs groups, 2009-10**[a, b, c, d]



SEIFA = Socio-Economic Indexes for Areas. **a** Proportions are age-standardised to the Australian population as at 30 June 2001. **b** MBS-subsidised services are those mental health-specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in table 12A.28. **c** Victoria does not have very remote areas. Tasmania does not have major cities. ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. **d** SEIFA Quintile 5 is not applicable for Tasmania.

Source: DoHA (unpublished) Medicare Statistics data; DVA (unpublished); table 12A.19; 2012 Report, tables 12A.20-21; 2012 Report, figure 12.12, p. 12.27.

Mortality due to suicide

'Mortality due to suicide' is an indicator of governments' objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.3).

Box 12.3 **Mortality due to suicide**

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for Indigenous and non-Indigenous people.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.

Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2012.

People with a mental illness are at higher risk of suicide than are the general population. They are also at higher risk of death from other causes, such as cardiovascular disease (Coghlan et al. 2001; Joukamaa et al. 2001; Sartorius 2007).

Australian Bureau of Statistics' causes of death data are the source of suicide statistics in this chapter (ABS 2011). Developments that have improved the quality of ABS' causes of death data for the three most recent years of data are processing improvements and a revisions process.

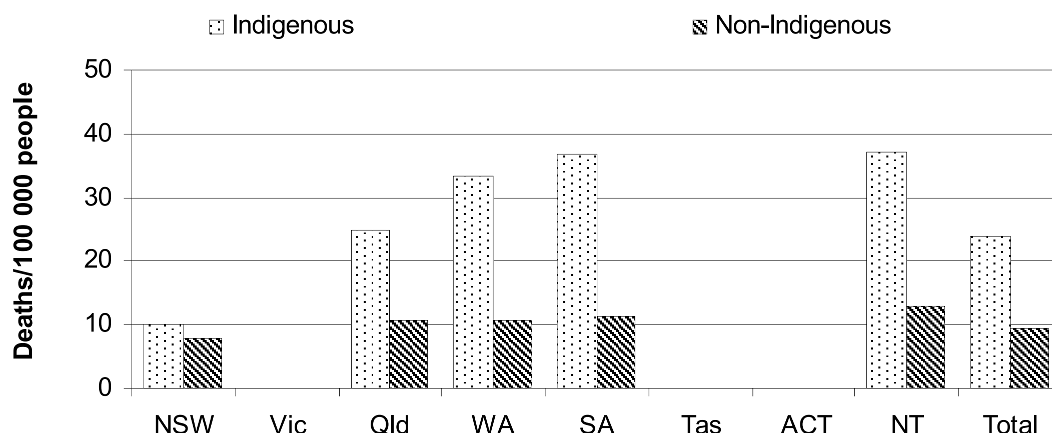
Two processing improvements, relating to the way the ABS codes Coroner certified deaths, have been introduced to the causes of death collection for the release of the preliminary data. 'Cause of death' codes are now better assigned to Coroner certified cases and all causes of death data have been positively impacted by these improvements (ABS 2010).

All Coroner certified deaths registered after 1 January 2007 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD-10 codes over time (ABS 2010). Each year of data will be released as preliminary, revised and final, respectively.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.5). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous people during the period 2005–2009, for the reported jurisdictions, was higher than the corresponding rate for non-Indigenous people.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

Figure 12.5 **Suicide rates, by Indigenous status, 2005–2009**[a, b, c, d, e, f, g]



[a] Deaths from suicides are deaths with ICD-10 codes X60–X84 and Y87.0. [b] Suicide rate is indirectly age-standardised. [c] Denominators used in the calculation of rates for the Indigenous population are from ABS *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians*, Cat. no. 3238.0 (series B, 2006 base). Non-Indigenous estimates are available for Census years only. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the Indigenous projection series increases. [d] Data on deaths of Indigenous people are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non-Indigenous data. [e] Deaths with a 'not stated' Indigenous status are excluded. [f] Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process. [g] Total data are for NSW, Queensland, WA, SA, and the NT combined, based on State or Territory of usual residence. Victoria, Tasmania and the ACT are excluded due to small numbers of registered Indigenous deaths.

Source: SCRGSP (2011) *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra; table 12A.56; 2012 Report, figure 12.12, p. 12.27.

Future directions for reporting on mental health management

Key challenges for improving the reporting on mental health include improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups.

Definitions of key terms and indicators

General practice	The organisational structure in which one or more GPs provide and supervise health care for a 'population' of patients. This definition includes medical practitioners who work solely with one specific population, such as women's health or Indigenous health.
Health management	The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies.
Separation	An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care.

Mental health

Community-based residential services	Staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. To be defined as community-based residences, the services must: provide residential care to people with mental illnesses or psychiatric disability; be located in a community setting external to the campus of a general hospital or psychiatric institution; employ onsite staff for at least some part of the day; and be government funded.
Mental illness	A diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities.
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice.
Mental health problems	Diminished cognitive, emotional or social abilities, but not to the extent of meeting the criteria for a mental illness.
Mortality rate from suicide	The proportion of the population who die as a result of suicide.
Non-government organisations	Private not-for-profit community managed organisations that receive State and Territory government funding specifically for the purpose of providing community support services for people affected by a mental illness or psychiatric disability. Programs provided by the non-government organisation sector can include supported accommodation services (including community-based crisis and respite beds), vocational rehabilitation programs, advocacy programs (including system advocacy), consumer self-help services, and support services for families and primary carers.
Prevalence	The number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence).
Preventive interventions	Programs designed to decrease the incidence, prevalence and negative outcomes of illnesses.
Psychiatrist	A medical practitioner with specialist training in psychiatry.

Public health	The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at-risk groups) and complements clinical provision of health care services.
Schizophrenia	A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour.
Stand-alone psychiatric hospitals	Health establishments that are primarily devoted to the treatment and care of inpatients with psychiatric, mental or behavioural disorders, and that are situated at physically separate locations from a general hospital. Stand-alone hospitals may or may not be managed by the mainstream health system. Psychiatric hospitals situated at physically separate locations from a general hospital are included within the 'stand-alone' category regardless of whether they are under the management control of a general hospital. A health establishment that operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus can also be a stand-alone hospitals if the following criteria are not met: • a single organisational or management structure covers the acute care hospital and the psychiatric hospital • a single employer covers the staff of the acute care hospital and the psychiatric hospital • the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus • the patients of the psychiatric hospital are regarded as patients of the single integrated health service.
Substance use disorders	Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence).

List of attachment tables

Attachment tables for data within this chapter are contained in the attachment to the Compendium. These tables are identified in references throughout this chapter by a '12A' prefix (for example, table 12A.1 is table 1 in the Mental health management attachment). Attachment tables are on the Review website (www.pc.gov.au/gsp).

Table 12A.14 Specialised mental health care reported, by Indigenous status, 2008-09

Table 12A.19 Proportion of people receiving clinical mental health services by service type and Indigenous status

Table 12A.23 Community mental health service contacts provided by public sector community mental health services

Table 12A.26 Rate of ambulatory mental health services provided, by sex, Indigenous status, remoteness and SEIFA

Table 12A.56 Suicide deaths, by Indigenous status, 2005–2009

References

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—— 2011, *Causes of Deaths, Australia 2009*, Cat. no. 3303.0, Canberra.

AHMAC (Australian Health Ministers' Advisory Council) 2011, *The Aboriginal and Torres Strait Islander Health Performance Framework 2010 Report*, AHMAC, Canberra.

AIHW (Australian Institute of Health and Welfare) 2011a, *Aboriginal and Torres Strait Islander Health Performance Framework 2010: Detailed Analyses*, Cat. no. IHW 53, www.aihw.gov.au/publication-detail/?id=10737420099 (accessed 18 November 2011).

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Joukamaa, M., Heliovaara, M., Knekt, P., Aromaa, A., Raitasalo, R. and Lehtinen, V. 2001, 'Mental disorders and cause-specific mortality', *The British Journal of Psychiatry*, vol. 179, no. 6, pp. 498–502

Sartorius, N. 2007, 'Physical illness in people with mental disorders', *World Psychiatry*, vol. 6, no. 1, pp. 3-4.

12A Mental health management — attachment

Tables in this attachment are sourced from the Mental health management attachment of the 2012 Report. Table numbers refer to the 2012 Report, for example, a reference to ‘2012 Report, table 12A.15’ refers to attachment table 15 of attachment 12A of the 2012 Report.

Definitions for indicators and descriptors in this attachment are in the Mental health management chapter of the Compendium.

Data in this Compendium are examined by the Health Working Group, but have not been formally audited by the Secretariat.

Data reported in the attachment tables are the most accurate available at the time of data collection. Historical data may have been updated since the last edition of RoGS.

This file is available in Adobe PDF format on the Review web page (www.pc.gov.au/gsp).

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Table 12A.23	Community mental health service contacts provided by public sector community mental health services
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Table 12A.56	Suicide deaths, by Indigenous status, 2005–2009

Table 12A.14 Specialised mental health care reported, by Indigenous status, 2008-09

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Episodes of residential mental health care (a), (b)										
Number										
Indigenous	no.	13	34	..	5	11	9	–	9	81
Non-Indigenous	no.	200	1 685	..	249	219	822	45	40	3 260
Total	no.	213	1 730	..	254	237	968	46	49	3 497
Rate per 10 000 people (c)										
Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.7
Non-Indigenous	per 10 000 people	np	np	..	np	np	np	np	np	1.5
Rate ratio (d)		np	np	..	np	np	np	np	np	1.1
Total	per 10 000 people	0.3	3.2	..	1.1	1.6	18.4	1.3	2.2	1.6
Community mental health service contacts (e)										
Number										
Aboriginal	no.	155 180	26 648	67 758	32 355	26 639	3 645	5 332	12 100	329 657
Torres Strait Islander	no.	3 647	1 755	7 181	81	417	48	33	70	13 232
Both Aboriginal and Torres Strait Islander	no.	12 899	2 570	4 419	1 469	890	641	–	348	23 236
Indigenous (b)	no.	171 726	30 973	79 358	33 905	27 946	4 334	5 365	12 518	366 125
Neither Aboriginal nor Torres Strait Islander	no.	1 441 593	1 643 674	872 221	557 448	434 958	142 697	191 895	21 500	5 305 986
Not reported	no.	438 260	14 681	7 342	17 923	62 313	26 757	26 068	5 310	598 654
Total		**2 051 579**	**1 689 328**	**958 921**	**609 276**	**525 217**	**173 788**	**223 328**	**39 328**	**6 270 765**
Rate per 1000 people (c)										
Indigenous	per 1 000 people	1 224	975.0	556.7	482.7	943.6	269.5	1108.3	188.1	731.2
Non-Indigenous (f)	per 1 000 people	211.5	308.8	212.1	264.5	283.8	300.5	549.2	131.3	254.0
Rate ratio (d)		5.8	3.2	2.6	1.8	3.3	0.9	2.0	1.4	2.9

Table 12A.14 **Specialised mental health care reported, by Indigenous status, 2008-09**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*
Total	**per 1 000 people**	**294.8**	**313.6**	**223.5**	**277.1**	**335.5**	**351.5**	**632.5**	**167.4**	**291.9**
Admitted patient mental health-related separations with specialised psychiatric care (g), (h), (i), (j)										
Indigenous										
Separations	no.	np	np	np	np	np	np	np	np	4 951
Separation rate (c)	per 1 000 people	np	np	np	np	np	np	np	np	10.6
Non-Indigenous (e)										
Separations	no.	np	np	np	np	np	np	np	np	122 255
Separation rate (c)	per 1 000 people	np	np	np	np	np	np	np	np	6.0
Rate ratio (d)		np	np	np	np	np	np	np	np	1.8

(a) National data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions.

(b) Queensland does not have any government-operated residential mental health services. Tasmanian information contains data for government-funded residential units operated by the non-government sector in that state, being the only jurisdiction providing this level of reporting.

(c) The rates were directly aged standardised against the Australian Estimated Resident Population as at 30 June 2001.

(d) The rate ratio is equal to the service use (episodes, contacts or separations) rate for Indigenous Australians divided by the service use rate for non-Indigenous Australians.

(e) Data for community mental heath contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data were reported by the following states and territories to be of acceptable quality: Queensland, WA, Tasmania, the ACT and the NT.

(f) Includes data for people where Indigenous status was missing or not reported.

(g) Separations for which care type was reported as Newborn with no qualified days and records for Hospital boarders and Posthumous organ procurement have been excluded. Comprises separations with and without mental health-related principal diagnoses but with specialised psychiatric care.

(h) Interpretation of differences between jurisdictions needs to be undertaken with care as they may reflect different service delivery and admission practices and/or differences in the types of establishments categorised as hospitals.

(i) Includes only public hospital separations for the NT.

Table 12A.14 **Specialised mental health care reported, by Indigenous status, 2008-09**

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*

(j) Indigenous status data for NSW, Victoria, Queensland, WA, SA and the NT public hospitals are considered to be of acceptable quality for analytical purposes. Indigenous identification is likely to be incomplete and to vary among jurisdictions. Total includes data for these jurisdictions only.

– Nil or rounded to zero. **np** Not published. .. Not applicable.

Source: AIHW 2011, *Mental Health Services in Australia Online*, tables 4.14, 7.4, 8.4 and 8.11, http://mhsa.aihw.gov.au/home/.

Table 12A.19 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
	Age standardised proportion (%) (a)									no.
2007-08										
Public (b), (c)										
Indigenous	4.5	3.1	3.9	3.5	5.0	1.5	5.1	2.9	3.8	19 187
Non-Indigenous (d)	1.2	1.1	1.7	1.6	1.5	2.0	1.6	1.9	1.3	276 005
Private (e)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous (d)	na	na	na	na	na	na	na	..	na	na
MBS and DVA										
Indigenous	np	np	np	np	np	np	np	np	np	np
Non-Indigenous	np	np	np	np	np	np	np	np	np	np
2008-09										
Public (b), (c)										
Indigenous	4.7	3.2	3.8	3.8	5.7	1.3	5.6	3.1	4.0	20 616
Non-Indigenous (d)	1.2	1.1	1.6	1.6	1.6	1.3	1.7	1.9	1.3	277 321
Private (e)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous (d)	na	na	na	na	na	na	na	..	na	na
MBS and DVA (f)										
Indigenous	7.2	9.2	4.5	2.7	5.5	6.5	7.8	1.0	5.1	24 603
Non-Indigenous	5.9	6.4	5.3	4.9	5.6	5.0	4.6	2.7	5.7	1 200 337
2009-10										
Public (b), (c)										
Indigenous	4.9	3.2	4.0	4.2	5.7	np	5.8	3.7	4.3	22 930
Non-Indigenous (d)	1.2	1.0	1.6	1.7	1.6	1.3	1.8	2.0	1.3	282 620

Table 12A.19 **Proportion of people receiving clinical mental health services by service type and Indigenous status**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*	
Private (e)										
Indigenous	na	na	na	na	na	na	na	..	na	na
Non-Indigenous (d)	na	na	na	na	na	na	na	..	na	na
MBS and DVA (f)										
Indigenous	8.1	10.2	4.7	3.0	6.1	7.2	8.6	1.3	5.6	28 303
Non-Indigenous	6.3	7.0	5.9	5.3	6.3	5.6	5.1	3.2	6.2	1 337 882

(a) Rates are age-standardised to the Australian population as at 30 June 2001.

(b) The Indigenous status rates should be interpreted with caution due to the varying and, in some instances, unknown quality of Indigenous identification across jurisdictions.

(c) SA submitted data that was not based on unique patient identifier or data matching approaches. This was also the case for 2007-08 and 2008-09 data submitted by Tasmania. Therefore caution needs to be taken when making interjurisdictional comparisons.

(d) Includes non-Indigenous people and those for whom Indigenous status was not stated.

(e) Indigenous information is not collected for private psychiatric hospitals.

(f) DVA are data not available by Indigenous status. Medicare data presented by Indigenous status have been adjusted for under-identification in the Medicare Australia Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution. These statistics are not derived from the total Australian Indigenous population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to Medicare Australia. The statistics have been adjusted to reflect demographic characteristics of the overall Indigenous population, but this adjustment may not address all the differences in the service use patterns of the enrolled population relative to the total Indigenous population. The level of VII enrolment (50 per cent nationally as at August 2010) varies across age-sex-remoteness-State/Territory sub-groups and over time which means that the extent of adjustment required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.

na Not available. .. Not applicable. **np** Not published.

Source: State and territory unpublished, community mental health care data; Private Mental Health Alliance unpublished, Centralised Data Management System data; Department of Health and Ageing (DoHA) unpublished, Medicare data; Department of Veterans' Affairs (DVA) unpublished data; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, 30 June (prior to relevant period)*, Series B, Cat. no. 3238.0.

Table 12A.23 Community mental health service contacts provided by public sector community mental health services, 2009-10 (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT (b)	NT	Aust	
	Age-standardised rates per 1000 population (c)									*no. of services*
Sex										
Males	372.6	329.0	217.2	284.2	354.4	419.8	665.3	183.7	323.3	3 498 939
Females	237.1	305.3	187.5	316.0	300.0	417.7	784.5	141.8	268.6	2 959 989
Indigenous status (d)										
Indigenous	1 459.1	971.2	530.2	554.4	941.3	1 211.1	1 767.0	217.4	841.8	430 894
Non-Indigneous	231.7	309.4	190.6	284.5	288.8	380.4	649.0	141.6	262.0	5 583 400
Remoteness of residence (e)										
Major cities	268.8	293.1	211.6	320.7	361.1	..	702.0	..	288.0	4 362 941
Inner regional	375.5	377.7	185.1	227.4	212.7	444.9	np	..	320.2	1 310 094
Outer regional	392.4	442.4	193.8	281.3	194.9	343.2	..	158.5	279.5	550 200
Remote	538.4	307.2	199.4	274.9	247.7	182.6	..	232.2	265.1	84 112
Very remote	np	..	177.3	195.6	237.6	67.6	..	102.3	180.5	31 931
SEIFA of residence (f)										
Quintile 1	327.9	352.7	320.9	394.3	399.3	483.9	np	121.1	348.1	1 469 346
Quintile 2	319.5	355.7	189.5	371.5	364.7	181.5	1 419.8	652.3	315.2	1 347 000
Quintile 3	342.7	320.0	164.1	283.1	287.5	565.1	1 306.6	98.7	291.1	1 280 278
Quintile 4	198.2	343.0	177.5	361.6	277.5	57.6	1 003.3	131.8	268.5	1 174 965
Quintile 5	271.2	227.3	158.2	188.8	175.7	..	540.9	101.1	238.5	1 062 940
Total (g)	**317.7**	**317.5**	**202.5**	**303.6**	**344.9**	**435.2**	**729.1**	**163.4**	**302.4**	**6 594 064**
	Number of contacts									
Total (h)	2 242 034	1 736 010	883 458	680 134	543 348	212 599	257 497	38 984	6 594 064	

(a) Cells have been suppressed to protect confidentiality where the presentation could identify a patient or service provider or where rates are likely to be highly volatile, for example, where the denominator is very small.

Table 12A.23 Community mental health service contacts provided by public sector community mental health services, 2009-10 (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT* (b)	*NT*	*Aust*

(b) The ACT rates of services should be interpreted with caution since ACT services include a relatively large number of services provided to interstate resident patients while the denominator used in deriving the rates is for ACT population only.

(c) Rates are age-standardised to the Australian population as at 30 June 2001.

(d) The Indigenous status rates should be interpreted with caution due to the varying, and in some instances unknown, quality of Indigenous identification across jurisdictions.

(e) Disaggregation by remoteness area is based on a person's usual residence, not the location of the service provider. Not all remoteness areas are represented in each State or Territory. Hence, rates represent the number of contacts for people living in each remoteness area (regardless of their jurisdiction of residence) divided by the total number of people living in each remoteness area in the reporting jurisdiction.

(f) Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. Each SEIFA quintile represents approximately 20 per cent of the national population, but does not necessarily represent 20 per cent of the population in each state or territory. Disaggregation by SEIFA is by the patient's usual residence, not the location of the service provider. Hence, rates represent the number of contacts for patients living in each SEIFA quintile (regardless of their jurisdiction of residence) divided by the total number people living in each SEIFA quintile in the reporting jurisdiction.

(g) Includes contacts where sex, Indigenous status, Statistical Local Area or postcode of residence was missing or not reported.

.. Not applicable. **np** Not published.

Source: AIHW unpublished, community mental health care data; ABS unpublished, Estimated Resident Population, 30 June 2009; ABS 2009, *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, 30 June 2009*, Series B, Cat. no. 3238.0.

Table 12A.26 Rate of ambulatory mental health services provided, by sex, Indigenous status, remoteness and SEIFA quintiles, by State and Territory, 2010-11 (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	
	Age standardised rate per 1000 population (b)									*no. of services*
Sex										
Males	270.9	311.5	248.7	191.2	251.4	228.5	205.8	71.1	262.3	2 914 126
Females	431.6	537.4	414.6	356.7	404.3	420.2	347.5	133.9	440.2	4 921 422
Indigenous status (c)										
Indigenous	na	na	na	na	na	na	na	na	na	na
Non-Indigenous	na	na	na	na	na	na	na	na	na	na
Remoteness of residence (d)										
Major cities	381.3	460.7	392.6	312.3	372.9	..	276.7	..	394.4	6 080 986
Inner regional	303.7	342.8	292.3	214.5	287.2	383.6	265.1	..	309.9	1 324 642
Outer regional	189.5	210.0	196.4	185.4	153.4	223.3	..	133.1	188.3	384 812
Remote	71.3	194.5	106.3	83.1	120.4	100.3	..	58.4	91.2	29 604
Very remote	116.4	..	58.6	47.2	57.5	227.6	..	57.2	57.7	9 857
SEIFA of residence (e)										
Quintile 1 (most disadvantaged)	267.3	345.6	287.7	126.8	283.4	260.5	255.3	37.4	279.1	1 208 938
Quintile 2	323.6	349.5	286.1	249.5	328.9	242.6	319.0	115.2	314.5	1 384 923
Quintile 3	353.7	415.6	332.0	246.4	313.8	352.8	276.9	99.8	342.9	1 537 396
Quintile 4	375.6	436.3	364.3	251.4	340.5	526.7	272.1	88.1	370.7	1 671 895
Quintile 5 (least disadvantaged)	437.0	518.6	374.9	339.2	411.5	..	272.4	74.1	425.3	1 930 581

(a) Disaggregation by State and Territory, remoteness area and SEIFA is based on the patient's postcode at the date their last service was processed in the reference period. This is not necessarily the location where the service was received.

(b) Rates are age-standardised to the Australian population as at 30 June 2001.

(c) DVA data by Indigenous status are not available. DoHA Medicare Benefits Schedule (MBS) data by Indigenous status are not available for this indicator in 2010-11.

(d) Not all remoteness areas are represented in each State or Territory.

Table 12A.26 Rate of ambulatory mental health services provided, by sex, Indigenous status, remoteness and SEIFA quintiles, by State and Territory, 2010-11 (a)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*

(e) DVA data is not available by SEIFA for the Northern Territory. Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-economic Disadvantage, with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged. SEIFA quintiles represent approximately 20 per cent of the national population, but do not necessarily represent 20 per cent of the population in each State or Territory. Not all quintiles are represented in each State or Territory.

.. Not applicable. **na** Not available.

Source: DoHA unpublished, MBS Statistics; DVA unpublished data; ABS unpublished, Estimated Resident Population, 30 June 2010.

Table 12A.56 Suicide deaths, by Indigenous status, 2005–2009 (a), (b), (c), (d), (e), (f), (g), (h), (i)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number									
Indigenous	62	np	146	99	43	np	np	103	453
Non-Indigenous	2 663	np	2 145	1 100	884	np	np	101	6 893
Total	2 766	np	2 345	1 252	968	np	np	205	7 536
Suicide rate per 100 000 (f)									
Indigenous	10.1	np	24.8	33.2	36.8	np	np	37.2	23.9
Non-Indigenous	7.8	np	10.6	10.7	11.2	np	np	12.9	9.4

(a) Suicide deaths include ICD-10 codes X60-X84 and Y87.0.

(b) Data cells with small values have been randomly assigned to protect the confidentiality of individuals. As a result, some totals will not equal the sum of their components. It is important to note that cells with a zero value have not been affected by confidentialisation.

(c) Data on deaths of Aboriginal and Torres Strait Islander Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between the Indigenous and non-Indigenous data.

(d) Causes of death data for 2007 have undergone two years of revisions. Causes of death data for 2008 have been revised and are subject to further revisions. Causes of death data for 2009 are preliminary and subject to a revisions process. See ABS *Causes of Death, Australia, 2009*, Cat. no. 3303.0, Technical Note: Causes of Death Revisions.

(e) Based on State or Territory of usual residence.

(f) Indirect standardised death rate per 100,000 population.

(g) Denominators used in the calculation of rates for the Indigenous population are *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (ABS Cat. no. 3238.0, Series B, 2006 base).

(h) Non-Indigenous estimates are available for census years only. In the intervening years, Indigenous population figures are derived from assumptions about past and future levels of fertility, mortality and migration. In the absence of non-Indigenous population figures for these years, it is possible to derive denominators for calculating non-Indigenous rates by subtracting the Indigenous population from the total population. Such figures have a degree of uncertainty and should be used with caution, particularly as the time from the base year of the projection series increases.

(i) Non-Indigenous does not include deaths with a ‘not stated’ Indigenous status.

np Not published.

Source: SCRGSP 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra