12 Health management issues

CONTENTS

Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3). A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available on the CD-ROM enclosed with the Report or from the Review website at <www.pc.gov.au/gsp>.

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 breast cancer and mental health, which represent some activities of the Australian, State and Territory governments in health management.

12.1 Overview of health management

Health management is the ongoing process beginning with initial client contact and including all actions relating to the client: assessment/evaluation; education of the person, family or carer(s); diagnosis; and treatment. Problems associated with adherence to treatment and liaison with, or referral to, other agencies are also included.

This chapter examines the performance of a number of services in influencing outcomes for women with breast cancer and for people with a mental illness. Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as national health priority areas (as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions and, since 2008, obesity). The national health priority areas represented over 70 per cent of the total burden of disease and injury in Australia in 2003, and their management offers considerable scope for reducing this burden (Begg *et al.* 2007).

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow up and palliative care services (DHS 1999).

Specialised mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and 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, 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.

Both breast cancer and mental health are 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.

The following improvements have been made to the chapter this year:

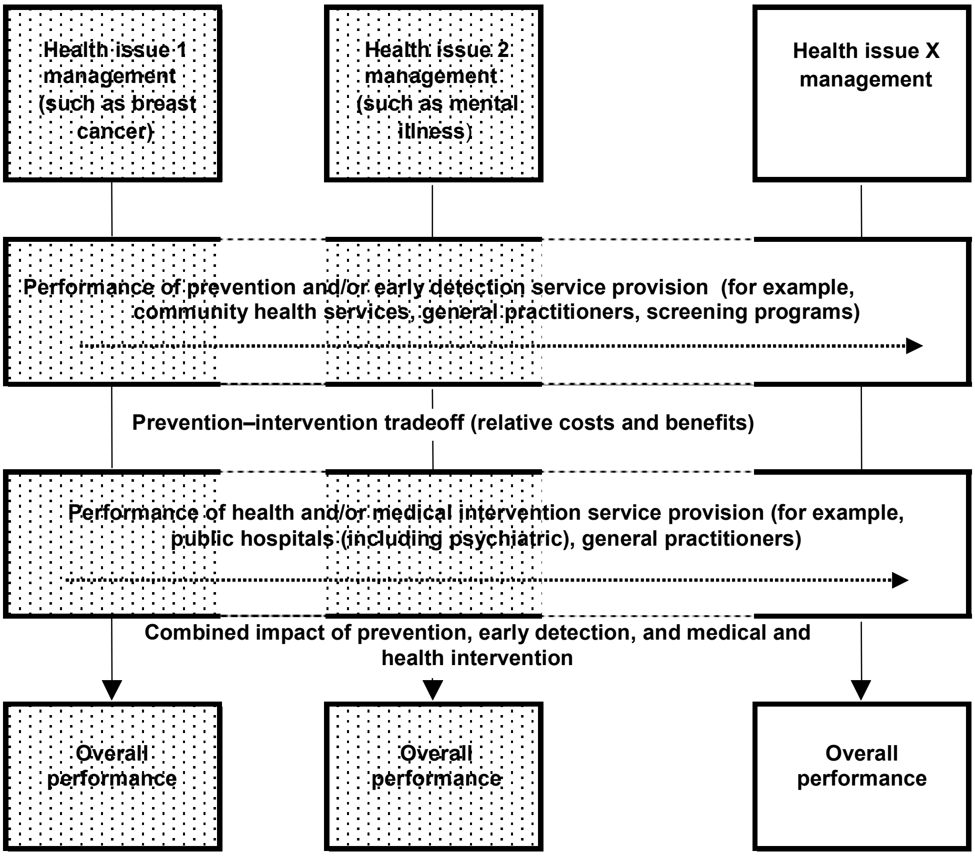
- Breast cancer detection rate data are reported as annual averages for the first time.
- Two measures replace the previously reported measure for the 'Average cost of ambulatory care' indicator (cost per treated patient in the community). Work on the new measures is ongoing; however, they are from the agreed set of *National Mental Health Key Performance Indicators* and are more comparable than the previous measure.
- Data from the *2007 National Survey of Mental Health and Wellbeing* (SMHWB) are now reported under the indicator 'prevalence of mental illness', previously these data were in the profile section.

12.2 Framework for measuring the performance of health management

Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. Measuring performance in the management of a health problem involves measuring the performance of service providers, and the overall management of a spectrum of services, including prevention, early detection and treatment programs.

The 'Health preface' of this Report outlines the complexities of reporting on the performance of the overall health system in meeting its objectives. Frameworks for public hospitals and primary and community health services report the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital-based versus community-based) are the focus of reporting in this chapter. The measurement approach is summarised in figure 12.1.

Figure 12.1 **The Australian health system — measurement approach**



The appropriate mix of services — including the prevention of illness and injury, medical treatment and the appropriate mix of service delivery mechanisms — is measured by focusing on a specific health management issue (represented by the vertical arrows). The chapter covers breast cancer detection and management, and specialised mental health services. The breast cancer management framework integrates early detection and medical intervention strategies, which should inform the decisions in the allocation of resources between these two strategies. The mental health framework provides information on the interaction and integration arrangements between community-based and hospital-based providers in meeting the needs of Australians with a mental illness.

COAG has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (see chapter 1 for more detail on reforms to federal financial relations). The *National Healthcare Agreement* (NHA) covers the areas of health and aged care services, while the *National Indigenous Reform Agreement* establishes specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the

Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC).

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements as appropriate for the 2011 Report.

12.3 Breast cancer

Profile

Breast cancer is a disease whereby abnormal cells in the ducts (that carry milk to the nipple) or lobules (where milk is produced) of the breast grow and multiply out of control (box 12.1). Breast cancer can be invasive or non-invasive. Non-invasive breast cancer remains in the ducts or lobules. Invasive breast cancer spreads beyond the ducts or lobules to invade surrounding breast tissue, and can spread to other parts of the body, or metastasize (AIHW 2009a). If left untreated, most invasive cancers (tumours) are life-threatening (AIHW 2009a). The focus of this Report is on invasive cancer, although some data are reported for non-invasive cancer. Breast cancer in males is rare, and is not examined in this Report.

Box 12.1 Some common health terms used in breast cancer detection and management

Some common breast cancer detection and management related terms are defined below.

Breast conserving surgery: an operation to remove the breast cancer but not the breast itself. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).

(Continued on next page)

Box 12.1 (Continued)

BreastScreen Australia: BreastScreen Australia is the national mammographic population screening program. It is aimed at healthy women without symptoms of breast cancer. It provides free screening mammograms at two-yearly intervals for women aged 50–69 years with the aim of reducing deaths from breast cancer in this target group through early detection of the disease. Women aged 40–49 years and 70 years or over are eligible to attend but are not actively targeted. Services provided by BreastScreen Australia include all screening and assessment services to the point of diagnosis. The program includes health promotion activities, information provision, counselling and data collection across the screening and assessment pathways. BreastScreen Australia is jointly funded by the Australian, State and Territory governments.

Ductal carcinoma in situ **(DCIS):** a non-invasive tumour of the mammary gland (breast) arising from cells lining the ducts. Also known as intraductal carcinoma.

Incidence rate: the proportion of the population newly diagnosed with a particular disorder or illness during a given period (often expressed per 100 000 people).

Invasive cancer: a cancer (tumour) whose cells invade healthy or normal tissue.

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).

Screening: the performance of tests on apparently well people to detect disease at an earlier stage than would otherwise be the case.

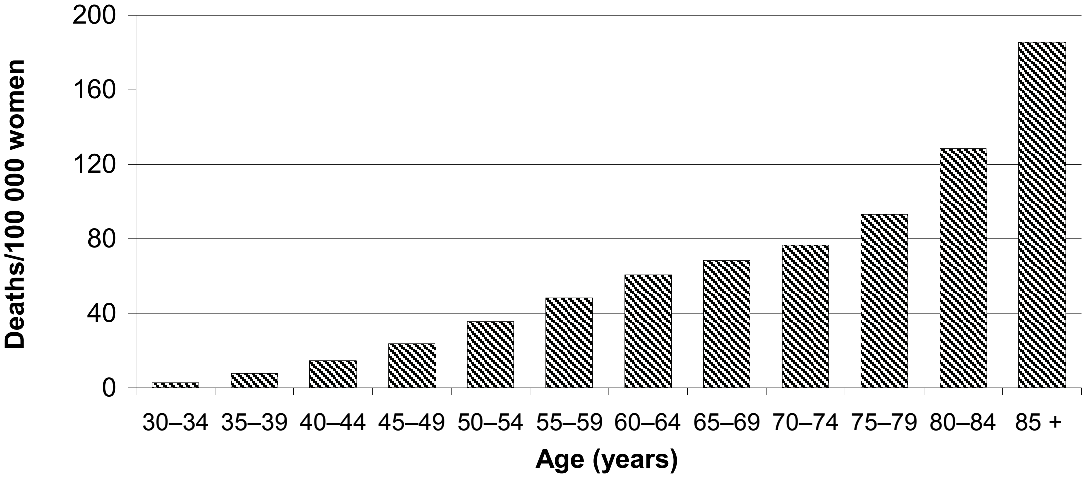
Screening round (first): a woman's first visit to a BreastScreen Australia service.

Screening round (subsequent): a woman's second or subsequent visit to a BreastScreen Australia service.

Total mastectomy: removal of the breast (also known as a simple mastectomy).

Breast cancer was the cause of 2618 female deaths in 2006, making it one of the most common causes of death from cancer for females (AIHW and NBOCC 2009). The strong relationship between age and the mortality rate from breast cancer is shown for the period 2003–2007 in figure 12.2. For women aged 40–44 years at diagnosis the annual average mortality rate over this period was 14.5 per 100 000, whereas for women aged 75–79 years at diagnosis, the annual average mortality rate was 93.2 per 100 000.

Figure 12.2 **Annual average mortality rates from breast cancer, by age group, 2003–2007**

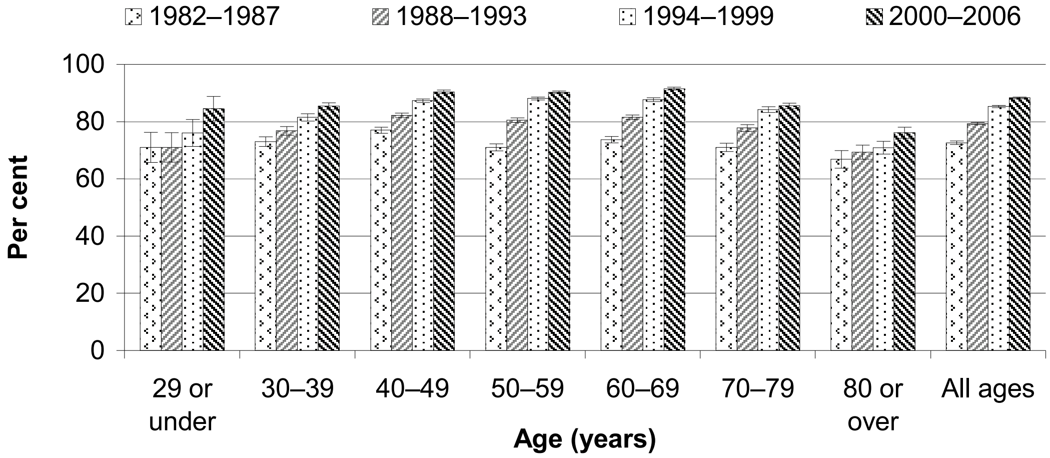


Source: Australian Bureau of Statistics (ABS) (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; table 12A.1.

Survival after diagnosis of breast cancer in females is better than for other cancers. The relative survival rate 10 years after diagnosis was 77.8 per cent for women diagnosed in 1994–1999. For women diagnosed during the period 2000–2006, the relative survival rate was 97.4 per cent one year after diagnosis and 88.3 per cent five years after diagnosis (AIHW and NBOCC 2009).

There was a significant increase in the five year relative survival rate after diagnosis of breast cancer in females between 1982–1987 and 2000–2006 (figure 12.3). Five year relative survival for breast cancer in Australia diagnosed over the period 2000–2006 increased with age at diagnosis from the age group 29 years or under (84.5 per cent) to a peak for the age group 60–69 years (91.5 per cent) and were similar for the age groups 40–49 and 50–59 years (90.4 and 90.3 per cent, respectively). The five year relative survival rate declined with age at diagnosis for women over 70 years (figure 12.3).

Figure 12.3 **Breast cancer five year relative survival at diagnosis, by age group**



Source: AIHW and NBOCC (2009) *Breast cancer in Australia: an overview, 2009*, Cancer series no. 50, Cat. no. CAN 46; table 12A.2.

Incidence and prevalence

Breast cancer is the second most common cancer affecting Australian women (AIHW 2009a). In 2005, the estimated risk of a woman in Australia developing breast cancer before the age of 75 years was one in eleven (AIHW and AACR 2008). The number of new cases of breast cancer diagnosed in Australian women increased from an annual average of 11 318 over the period 1998–2002 to an annual average of 12 185 over the period 2002–2006 (table 12.1). The number of cases detected reflects both the underlying rate of breast cancer and the early detection of cancers that previously would not have been discovered for some years, primarily through the activity of BreastScreen Australia (AIHW 2003).

Table 12.1 **Annual average new cases of breast cancer diagnosed (number)[a]**

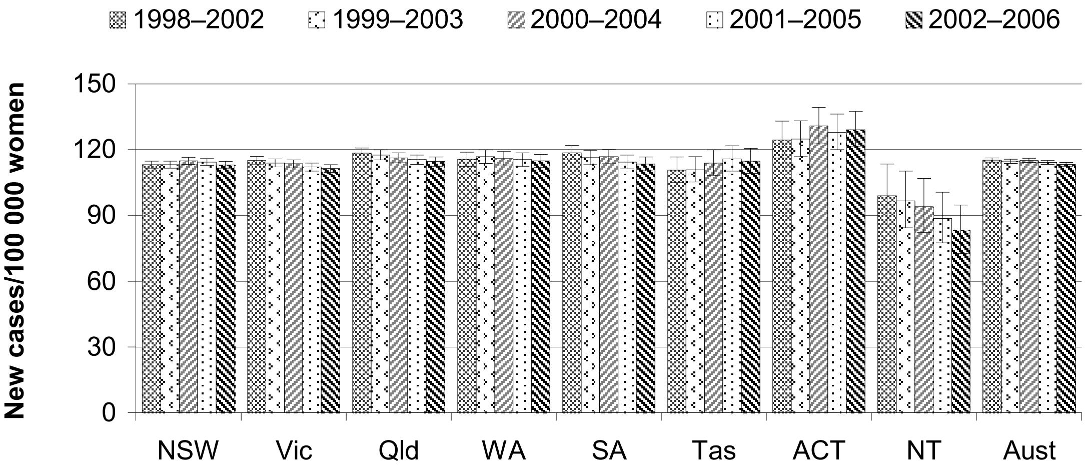
	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
1998–2002	3 819	2 864	2 083	1 046	991	282	178	55	11 318
1999–2003	3 900	2 894	2 138	1 089	989	288	184	59	11 542
2000–2004	4 033	2 943	2 188	1 114	1 010	303	198	60	11 849
2001–2005	4 084	2 967	2 247	1 142	1 010	314	198	61	12 022
2002–2006	4 101	3 009	2 304	1 168	1 022	317	204	59	12 185

[a] A new case is defined as a person who has a cancer diagnosed for the first time. One person can have more than one cancer, so can be counted twice in incidence statistics if it is decided that the two cancers are not of the same origin.

Source: AIHW (unpublished) Australian Cancer Database (formerly the National Cancer Statistics Clearing House [NCSCH]); table 12A.3.

Annual average age standardised incidence rates of breast cancer are presented in figure 12.4. Breast cancer incidence data are averaged over five year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variations in rates from year to year. Australia-wide, the annual average incidence rate from the period 1998–2002 to the period 2002–2006 fluctuated between 113.2 and 115.2 per 100 000 women.

Figure 12.4 **Annual average age standardised incidence rates of breast cancer for women of all ages**[a, b]



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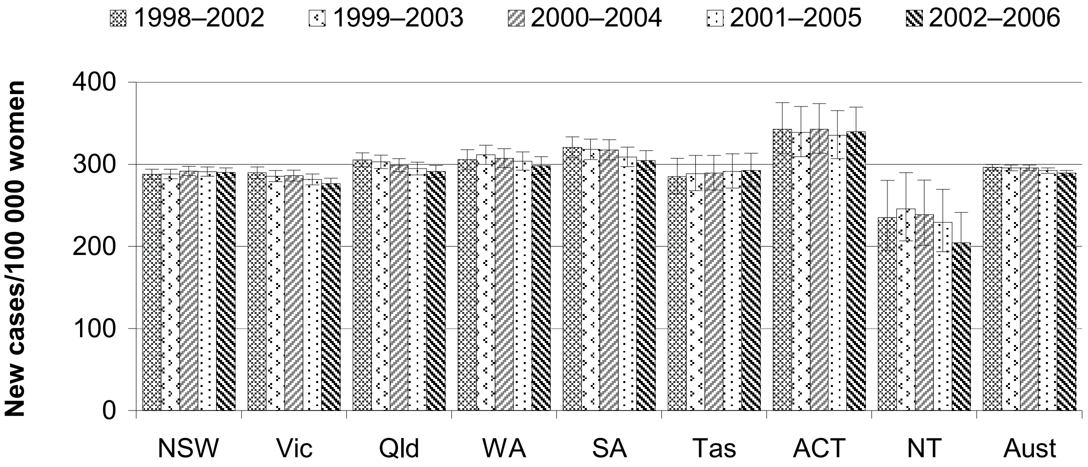
[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished) Australian Cancer Database (formerly the NCSCH); table 12A.4.

Annual average age standardised incidence rates of breast cancer for women aged 50–69 years are shown in figure 12.5.

Figure 12.5 **Annual average age standardised incidence rates of breast cancer for women aged 50–69 years**[a, b]



[a] Incidence refers to the number of new cases of breast cancer per 100 000 women. [b] Rates are age standardised to the Australian 2001 population standard.

Source: AIHW (unpublished) Australian Cancer Database (formerly the NCSCH); table 12A.4.

Size and scope of breast cancer detection and management services

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. An Australian study found that women aged 50–69 years whose cancer was diagnosed before it had spread outside the breast had a 97 per cent chance of surviving five years relative to all Australian women aged 50–69 years and for women whose cancer had spread to other parts of the body before diagnosis, relative survival was 83 per cent (AIHW and NBCC 2007). It is generally accepted that cancers detected early can be treated more conservatively and that these women have a higher likelihood of survival.

The BreastScreen Australia Program, jointly funded by the Australian, State and Territory governments, undertakes nationwide breast cancer screening. It targets women aged 50–69 years for screening once every two years, aiming for a participation rate of at least 70 per cent. Recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although the service is also available to women aged 40–49 years, and 70 years or over.

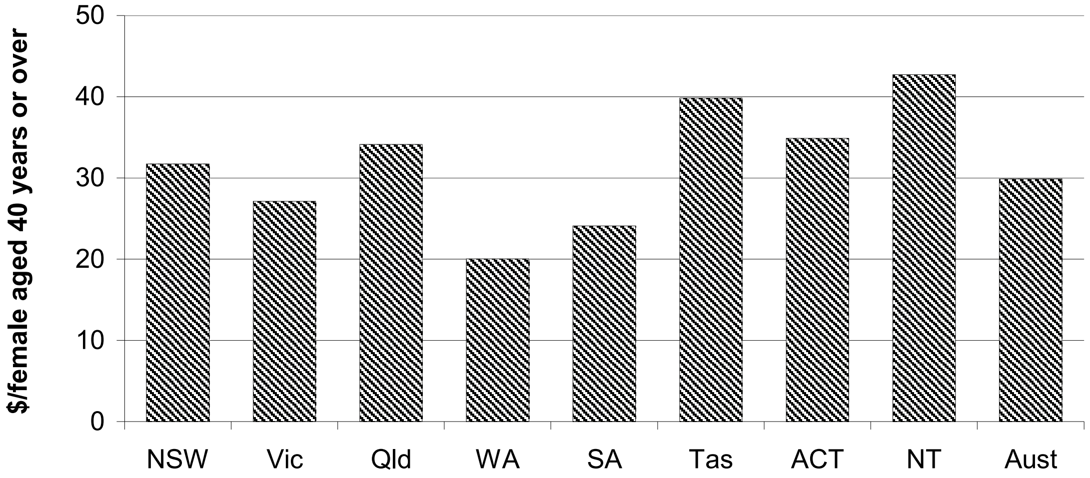
Services provided by BreastScreen Australia in each State and Territory include all screening and assessment services to the point of diagnosis. The Program includes health promotion activities, information provision, counselling, and data collection across the screening and assessment pathways. Assessment services funded under the BreastScreen Australia Program include fine needle aspiration (FNA) and core biopsies and, in some states and territories, open biopsies. Open biopsies are funded outside the Program in Queensland, SA, Tasmania and the NT (table 12A.5).

Each jurisdiction manages a central BreastScreen Australia registry to ensure women with an abnormality detected at screening are recalled for assessment and to enable women to be invited for re-screening at the appropriate interval. Data collected from the registries allow for quality assurance, monitoring and evaluation of the Program. Information on BreastScreen Australia performance is published by the Australian Institute of Health and Welfare (AIHW) in the *BreastScreen Australia monitoring* reports, the most recent of which was published in 2009 (AIHW 2009a).

A recent evaluation of the BreastScreen Australia Program found that it has been successful in reducing mortality from breast cancer in the target age group (women aged 50–69 years) by approximately 21–28 per cent since screening commenced in 1991 (DoHA 2009a). The evaluation also found that participation in the Program reduces treatment-related morbidity, associated with a relatively high proportion of cancers detected early and treated by breast conserving surgery.

Governments spent around $150 million on breast cancer screening in 2007-08 (table 12A.6). Estimates of government expenditure on breast cancer screening per woman aged 40 years or over are presented by jurisdiction in figure 12.6. These estimates include Australian, State and Territory government expenditure. Differences across jurisdictions partly reflect variation in the proportion of women in the target age group for breast cancer screening, data deficiencies and collection methods, as well as the nature of the services and their relative efficiency. Some differences can also be due to the geography of a State or Territory, and to the proportion of the target population living in rural and remote areas. The data therefore need to be interpreted with care.

Figure 12.6 **Public health expenditure on breast cancer screening, 2007-08**[a, b, c, d, e, f, g]



[a] In every jurisdiction, BreastScreen Australia is a joint initiative funded by both the State or Territory government and the Australian Government. [b] The data need to be interpreted with care because of data deficiencies, differences across jurisdictions relating to the use of cash accounting and accrual methods, the treatment of corporate and central office costs, differences in methods used to collect expenditure figures, and differences in the interpretation of public health expenditure definitions. In addition, the data do not account for variation between jurisdictions in either population age structure or the proportion of eligible women (40 years or over) outside the target population (50–69 years) who are screened. [c] The Australian total includes Australian Government direct project expenditure, database or registry and other program support, population health non-grant program costs and running costs. [d] Medicare funding for radiographic breast examinations is excluded because it is not public health expenditure. [e] Victorian data include depreciation. [f] Data for the ACT include expenditure on BreastScreen ACT and the Cancer Registry. [g] Data for the NT include public health information systems, disease surveillance and epidemiological analysis, public health communication and advocacy, public health policy, program and legislation development, and public health workforce development.

Source: AIHW (unpublished) AIHW Health Expenditure Database; ABS (unpublished) *Estimated Residential Population*, Cat. no. 3101.0; tables AA.1 and 12A.6.

The number of women aged 40 years or over screened by BreastScreen Australia indicates the size of the BreastScreen Australia Program. Over 855 000 women in this age group were screened in 2008, compared with around 846 000 in 2004 (table 12.2).

Table 12.2 **Number of women aged 40 years or over screened by BreastScreen Australia**[a]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2004	270 598	198 743	191 084	78 773	69 882	23 107	9 995	4 045	846 227
2005	235 812	197 627	199 981	81 351	70 909	25 440	11 901	4 481	827 502
2006	257 211	202 462	200 992	88 667	67 476	24 963	11 446	4 136	857 353
2007	249 193	195 288	202 372	81 629	67 508	24 041	12 277	4 635	836 943
2008	253 118	183 098	217 534	86 829	74 259	25 003	11 225	4 375	855 441

[a] First and subsequent screening rounds, for women aged 40 years or over.

Source: State and Territory governments (unpublished); table 12A.7.

Breast cancer is diagnosed outside the BreastScreen Australia Program when women access mammographic services privately, are outside the age range for the program, or have symptoms which make it inappropriate for them to attend for screening. For these women, GPs are critical as the initial point of referral to specialists for diagnosis and treatment services.

Inpatient separations in public hospitals for selected breast cancer related Australian refined diagnosis related groups (AR-DRGs) in 2007-08 are presented in table 12.3.

Table 12.3 **Separations for selected AR-DRGs related to breast cancer, public hospitals, 2007-08 (per 10 000 people)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Breast cancer related conditions									
Major procedures for malignant breast conditions	3.2	3.1	2.9	2.6	3.1	2.9	2.8	1.3	3.0
Minor procedures for malignant breast conditions	0.9	1.1	1.2	1.0	0.8	1.6	0.8	0.4	1.0
Skin, subcutaneous tissue and breast plastic operating room procedures	3.0	3.1	3.3	3.5	6.1	3.1	2.0	2.7	3.4
Other skin, subcutaneous tissue and breast procedures	12.4	22.8	18.4	19.4	21.3	16.2	8.3	11.4	17.5
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)	0.5	0.6	0.5	0.5	1.0	0.9	0.4	0.5	0.6
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)	0.2	0.8	0.4	1.6	0.5	0.6	0.1	0.3	0.6
All conditions[c]	**2 050.2**	**2 506.0**	**1 894.7**	**2 080.5**	**2 242.0**	**1 902.0**	**2 235.2**	**4 092.4**	**2 169.7**

W=with. W/O=without. CC=complications and co-morbidities. Cat or Sev=catastrophic or severe. [a] Care needs to be taken when comparing jurisdictions because admission practices vary. [b] AR-DRG version 5.1. [c] The total includes separations for which the care type was reported as acute, or newborn with qualified patient days, or was not reported. Crude rate based on the Australian population as at 31 December 2007.

Source: AIHW (2009) *Australian hospital statistics 2007–08*, Cat. no. HSE 71; table 12A.8.

Framework of performance indicators

The indicators developed to report on the performance of breast cancer detection and management are based on the shared government objectives for managing the disease (box 12.2). The Health preface explains the performance indicator framework for health services as a whole, including the health services subdimensions for quality and sustainability that have been added to the standard Report framework. The framework for breast cancer detection and management focuses on achieving a balance between early detection and treatment. It has a tripartite structure — that is, performance indicators presented relate to early detection, intervention and overall performance. Breast cancer prevention is excluded from the framework in the absence of definitive primary preventative measures, although there are known associated risk factors. There are ongoing trials examining possible preventative interventions for the small proportion of the population at high risk of breast cancer due to the presence of BRCA1 or BRCA2 genetic variations.

Box 12.2 **Objectives for breast cancer detection and management**

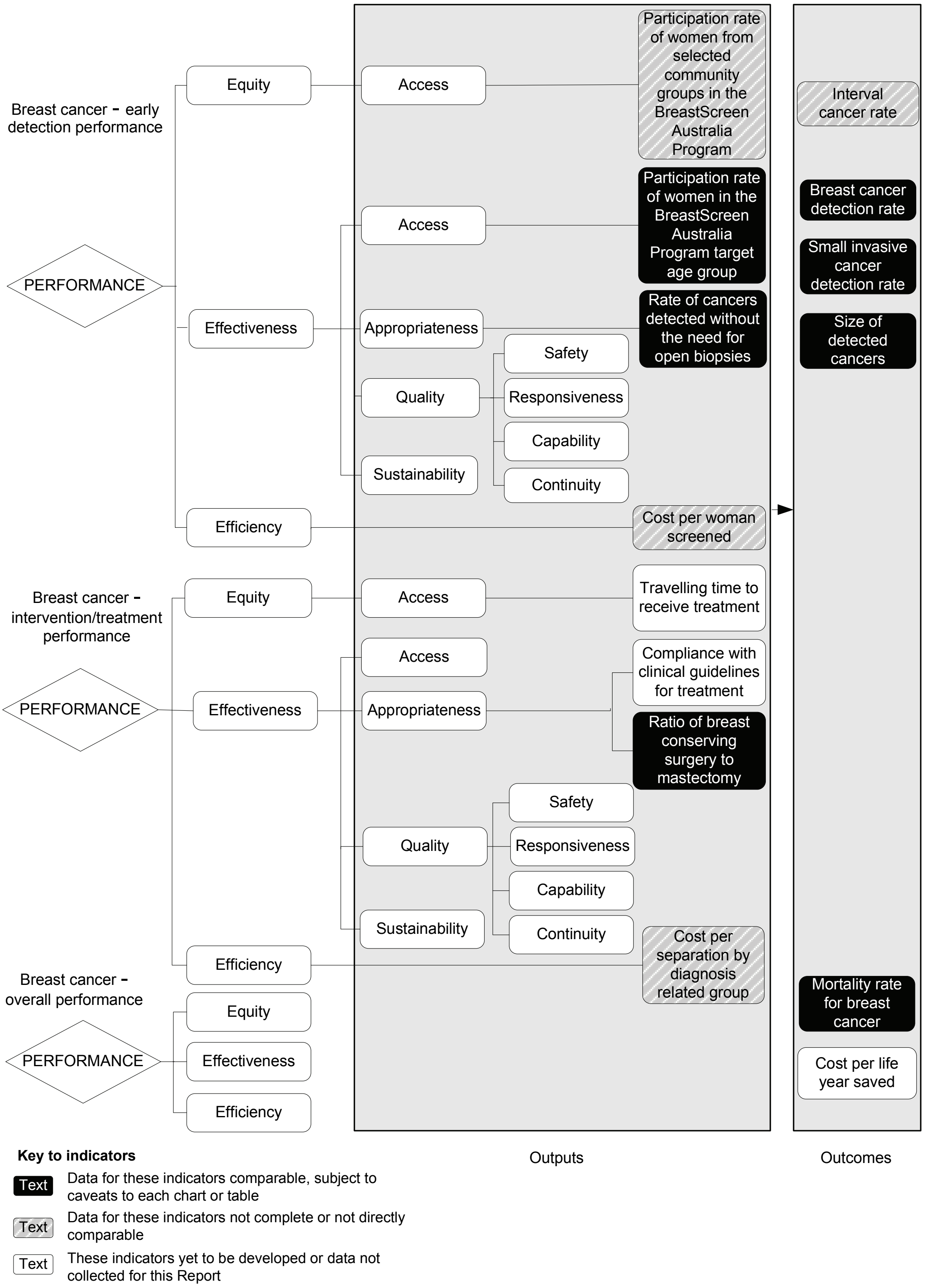
The objectives for breast cancer detection and management are:

- to reduce morbidity and mortality attributable to breast cancer
- to improve the quality and duration of life of women with breast cancer
- through delivering services in a manner that is equitable and efficient.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 12.7). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see 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 12.7 **Performance indicators for breast cancer detection and management**



Key performance indicator results

Data relating to breast cancer screening are readily available through the BreastScreen Australia Program, while data relating to the management and treatment of breast cancer are limited. Hence, most of the breast cancer detection and management data in this Report are provided by BreastScreen Australia, and screening is currently the main focus of reporting. It is a Steering Committee priority to extend reporting in the area of the management and treatment of breast cancer.

Ongoing monitoring of BreastScreen Australia involves reporting Program performance against specific indicators such as participation, detection of small invasive cancers, sensitivity, detection rate for *ductal carcinoma in situ* (DCIS), recall to assessment and rescreening rates. Data are collected at the jurisdictional level and provide an overview of the performance of the Program.

In addition, each BreastScreen Australia service is assessed against 173 National Accreditation Standards as part of their accreditation process. These Standards include a number of indicators that collectively assess the safety of the services provided by individual BreastScreen Australia services.

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Early detection — participation rate of women from selected community groups in the BreastScreen Australia Program

'Participation rate of women from selected community groups in the BreastScreen Australia Program' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies, in a manner that is equitable (box 12.3).

Box 12.3 Participation rate of women from selected community groups in the BreastScreen Australia Program

‘Participation rate of women from selected community groups in the BreastScreen Australia Program’ is defined as the proportion of the target population in each selected community group attending the screening program within a 24 month period.

Participation rates for community groups that are at, or close to, those for the total population indicate equitable access to early detection services.

Data reported for this indicator are not directly comparable.

Early detection is associated with reduced morbidity and mortality for women with breast cancer. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In the 24 month period 2007 and 2008, the national age standardised participation rate for Indigenous women aged 50–69 (35.8 per cent) was below the total participation rate in that age group (54.9 per cent), although this can be influenced by the quality of Indigenous identification in screening program records. For NESB women for the same 24 month period and age group, the national participation rate of 48.1 per cent was also lower than that of the national total female population (table 12.4). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data.

Table 12.4 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2007 and 2008 (24 month period) (per cent)[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*[c]	*ACT*	*NT*	*Aust*
Indigenous[d]	37.0	27.6	46.4	30.8	31.6	39.5	44.2	23.5	35.8
NESB[e]	53.0	34.6	66.6	62.5	55.1	22.2	17.3	38.5	48.1
All women aged 50–69 years	54.6	53.1	57.1	55.2	57.4	54.5	53.8	39.8	54.9

[a] First and subsequent rounds. [b] Rates are standardised to the 2001 Australian population standard. [c] Participation rates for NESB women may be understated due to a change in the BreastScreen Tasmania client registration form in the 2005-2006 screening period. This saw self-reporting of NESB status drop by 40 per cent between the 2004-2005 24 month reporting period and the 2006-2007 24 month reporting period. Actual NESB participation is not believed to have changed significantly compared to previous reporting periods. [d] Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent [e] NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2008*, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *2006 Census of Population and Housing*; tables 12A.9–12A.12.

Updated data for participation rates by geographic location were not available for the 2010 Report. Historical data are presented in table 12A.13.

Early detection — participation rate of women in the BreastScreen Australia Program target age group

‘Participation rate of women in the BreastScreen Australia target age group’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies (box 12.4).

Box 12.4 **Participation rate of women in the BreastScreen Australia Program target age group**

‘Participation rate of women in the BreastScreen Australia Program target age group’ is defined as the number of women aged 50–69 years attending the screening program within a 24 month period, divided by the estimated population of women aged 50–69 years.

A high or increasing screening participation rate is desirable.

Data reported for this indicator are comparable.

Early detection is associated with improved outcomes for women with breast cancer, in terms of morbidity and mortality. The aim under the National Accreditation Standards 2004, is that at least 70 per cent of women aged 50–69 years participate in screening over a 24 month period. Recruitment activities undertaken by BreastScreen Australia specifically target women in this age group (BreastScreen Australia 2004). Access to the program is also provided for women aged 40–49 years and 70 years or over.

The national participation rate of women aged 50–69 years in BreastScreen Australia screening programs was 54.8 per cent in the 24 month period 2007 and 2008. At a national level, the participation rate has been relatively steady since the 24 month period 2003 and 2004, well below the 70 per cent aim under the National Accreditation Standards (figure 12.8).

Figure 12.8 **Age standardised participation rate of women aged 50–69 years in BreastScreen Australia screening programs (24 month period)[a, b, c, d]**

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[a] The participation rate is the number of women aged 50–69 years resident in the jurisdiction who were screened during the reference period, divided by the estimated number of women aged 50–69 years resident in the jurisdiction midway through the reference period. [b] Women resident in the jurisdiction represent over 99 per cent of the women screened in each jurisdiction except the ACT (91.4 per cent) and the NT (98.6 per cent). [c] The estimated resident population (ERP) is computed as the average of the ERP in each calendar year of the reference period. [d] Rates are standardised to the 2001 Australian population standard.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2008*, Cat. no. 3201.0; tables 12A.9, 12A.10.

Early detection — rate of cancers detected without the need for open biopsies

‘Rate of cancers detected without the need for open biopsies’ is an indicator of governments’ objective to provide appropriate early detection services (box 12.5).

Box 12.5 **Rate of cancers detected without the need for open biopsies**

‘Rate of cancers detected without the need for open biopsies’ is defined as the number of cancers detected without open biopsy as a proportion of all breast cancers detected (invasive and DCIS).

A high or increasing rate of cancers detected without the need for open biopsies is desirable.

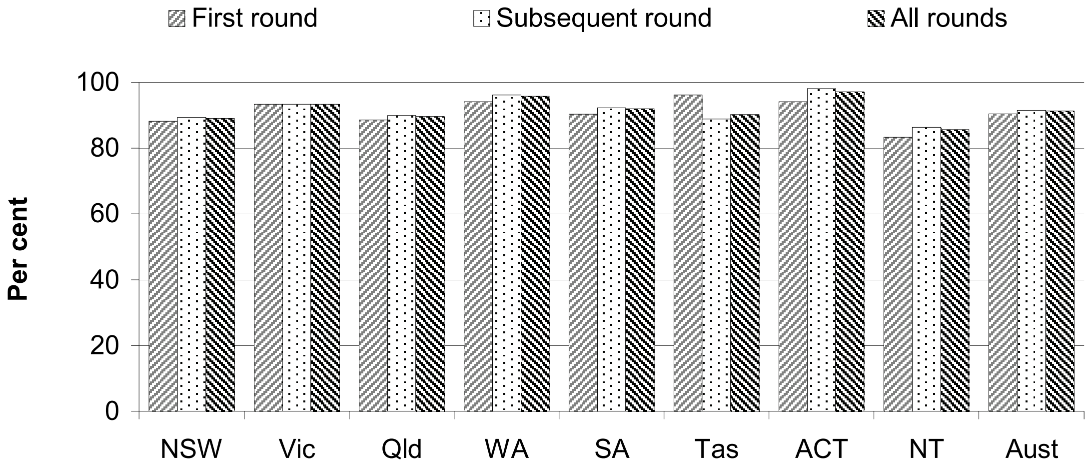
Data reported for this indicator are comparable.

Diagnosis of breast cancer involves histological examination of tissue samples collected by FNA, core biopsy or open biopsy. Open biopsy is the most invasive of these procedures.

High rates of cancers detected without the need for open biopsies indicates effectiveness in detecting malignancies while minimising the need for invasive procedures. The BreastScreen Australia National Accreditation Standards 2004 state that 75 per cent or more of invasive cancers or DCIS should be diagnosed without the need for a diagnostic open biopsy (BreastScreen Australia 2004).

In 2008, for women attending their first screening round, the rate of cancers detected without the need for open biopsies was 90.4 per cent Australia wide. For women attending a subsequent round the rate was 91.5 per cent Australia wide, well above the National Accreditation Standard of 75 per cent (figure 12.9).

Figure 12.9 **Rate of cancers detected without the need for open biopsies, all women, 2008**



Source: State and Territory governments (unpublished); table 12A.14.

Early detection — cost per woman screened

‘Cost per woman screened’ is an indicator of governments’ objective to provide early detection services in an efficient manner (box 12.6).

Box 12.6 **Cost per woman screened**

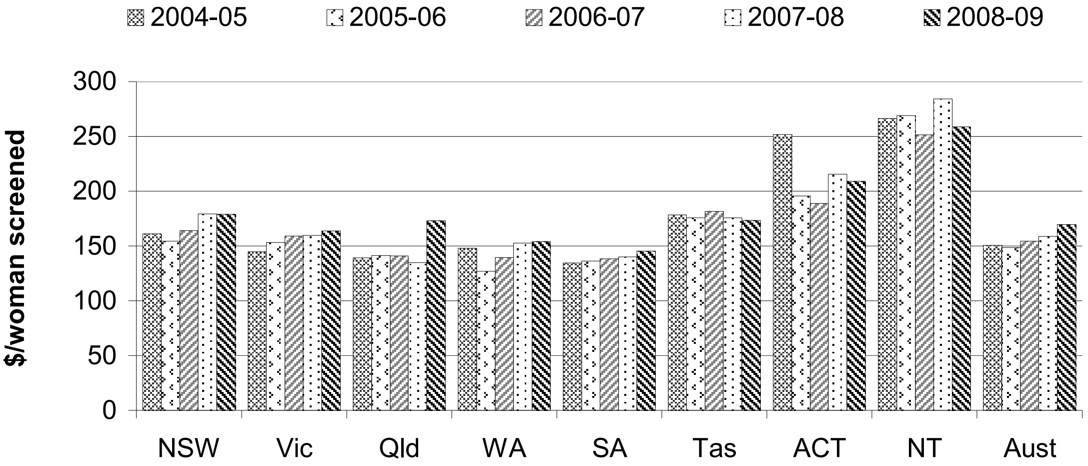
'Cost per woman screened' is defined as the total cost of providing early detection services (including screening, assessment and program management) divided by the number of women screened.

Caution should be used when interpreting this indicator. While a low or decreasing cost per woman screened can reflect high or increasing efficiency, it can also reflect low or decreasing quality of service. Cost per women screened can also be influenced by characteristics of the target population, for example, the number and type of barriers to service access.

Data reported for this indicator are not directly comparable.

Care needs to be taken when making comparisons across jurisdictions. There are potential differences in the items included in the measures of cost (particularly in the treatment of depreciation and capital asset charges, and the inclusion of subsidies). There can also be differences across jurisdictions in the scope of activities being costed. The Review is working to identify these differences across jurisdictions to improve data comparability in future (table 12A.16). Preliminary estimates of costs in each jurisdiction are presented in figure 12.10. The average cost per woman screened in Australia in 2008-09 was around $170.

Figure 12.10 **Real cost per woman screened, BreastScreen Australia services (2008-09 dollars)[a, b]**



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[a] Real expenditure based on the ABS gross domestic product price deflator (2008-09 = 100) (table AA.26). [b] Data for NSW do not include subsidies.

Source: State and Territory governments (unpublished); tables AA.26 and 12A.15.

Intervention/treatment — travelling time to receive treatment

‘Travelling time to receive treatment’ has been identified for development as an indicator of governments’ objective to provide breast cancer intervention and treatment services in an equitable manner (box 12.7).

Box 12.7 **Travelling time to receive treatment**

‘Travelling time to receive treatment’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Intervention/treatment — compliance with clinical guidelines for treatment

‘Compliance with clinical guidelines for treatment’ has been identified as an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer, and to improve the quality and duration of life of women with breast cancer, through provision of effective and appropriate intervention and treatment services (box 12.8).

Box 12.8 **Compliance with clinical guidelines for treatment**

‘Compliance with clinical guidelines for treatment’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Intervention/treatment — ratio of breast conserving surgery to mastectomy

‘Ratio of breast conserving surgery to mastectomy’ is an indicator of governments’ objective to improve the quality of life of women with breast cancer through appropriate intervention and treatment services (box 12.9).

Box 12.9 **Ratio of breast conserving surgery to mastectomy**

‘Ratio of breast conserving surgery to mastectomy’ is defined as the number of cases for which breast conserving surgery or no surgery was performed divided by the number of cases for which a mastectomy was performed.

Breast conserving surgery removes the breast cancer but not the whole breast. Caution should be used in interpreting this indicator, as clinical and familial factors are important determinants of the most appropriate treatment. For cases identified through early detection services such as BreastScreen Australia, a higher ratio can indicate more appropriate intervention and treatment services.

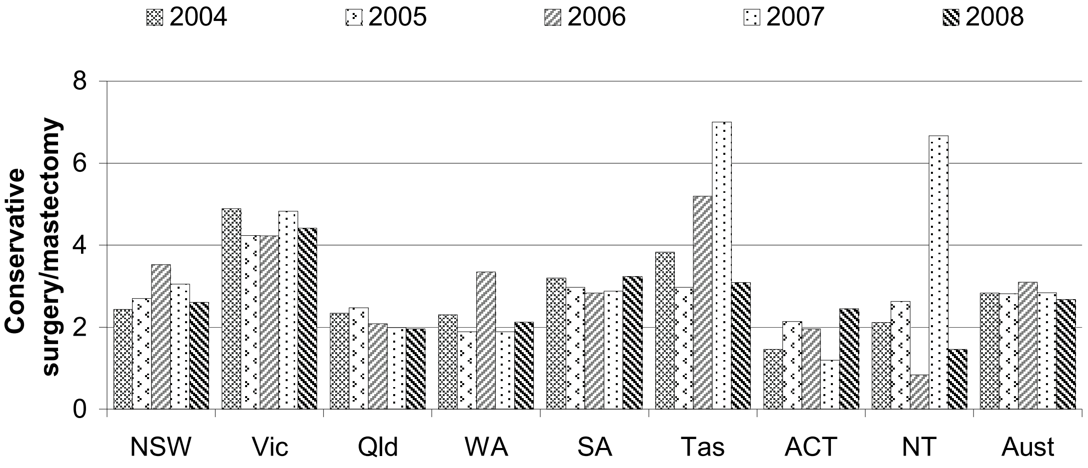
Data reported for this indicator are comparable.

Cancer size and localisation to the breast are two of the clinical determinants for appropriate treatment of breast cancer (NBOCC 2004). A recent evaluation of the BreastScreen Australia Program found that breast cancers detected through the Program are significantly more likely to be smaller than those diagnosed outside the Program, and that a higher proportion are treated with breast conserving surgery rather than mastectomy (DoHA 2009a).

Data for this indicator are for women diagnosed only within the BreastScreen Australia Program. They represent only a portion of breast cancer treatment information, and are not necessarily representative of general clinical practice.

In 2008, the ratio of conserving surgery to mastectomy averaged 2.7:1 nationally, but varied across jurisdictions (figure 12.11).

Figure 12.11 **Ratio of conserving surgery to mastectomy**[a, b]



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[a] Applies for women of all ages diagnosed by the Breastcreen Australia Program. [b] Small numbers result in fluctuations from year to year. It is advisable to view changes in the indicator over a period of several years (rather than consecutive years).

Source: State and Territory governments (unpublished); table 12A.17.

Intervention/treatment — cost per separation by diagnosis related group

'Cost per separation by diagnosis related group' is an indicator of governments' objective to provide breast cancer intervention and treatment services in an efficient manner (box 12.10).

Box 12.10 **Cost per separation by diagnosis related group**

'Cost per separation by diagnosis related group' is a proxy indicator of efficiency, defined as the cost of care per separation in public hospitals for selected breast cancer related conditions.

Caution must be used when interpreting this indicator. While a low cost per separation can indicate efficiency, no information on the quality of service is provided.

Data reported for this indicator are not directly comparable.

The National Hospital Cost Data Collection (NHCDC) is an annual collection of hospital cost and activity data. Participation in the NHCDC is voluntary, and participating hospitals are not necessarily a representative sample of the hospitals in each jurisdiction (although coverage is improving over time). An estimation process has been carried out to create representative national activity figures from the sample data. Further, the purpose of the NHCDC is to calculate DRG cost weights, not to compare the efficiency of hospitals (DoHA 2009b).

Table 12.5 summarises costs per separation for selected breast cancer AR-DRGs. The average cost of major procedures for malignant breast conditions across Australia was $6765 per separation in 2007-08 and minor procedures for malignant breast conditions cost $3318 per separation on average. Table 12A.18 summarises the average length of stay (in public hospitals) associated with each AR-DRG.

Table 12.5 **Average cost per separation, public hospitals by selected breast cancer AR-DRGs, 2007-08 (dollars)**[a, b, c, d]

AR-DRG	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Major procedures for malignant breast conditions									
	6 014	7 253	7 168	7 814	6 272	6 271	6 271	7 721	6 765
Minor procedures for malignant breast conditions									
	2 814	3 167	3 827	3 971	3 353	3 426	2 863	2 669	3 318
Malignant breast disorders (Age >69 W CC) or W (Cat or Sev CC)									
	5 371	3 932	5 632	7 152	5 872	10 982	10 499	6 096	5 538
Malignant breast disorders (Age>69 W/O CC) or W/O (Cat or Sev CC)									
	2 171	3 028	2 005	1 548	1 416	4 803	1 883	4 673	2 270

W = with. W/O = without. CC = complications and co-morbidities. Cat or Sev = catastrophic or severe. [a] Estimated population costs are obtained by weighting the sample results according to the known characteristics of the population. [b] Data are based on the AR-DRG classification version 5.1. [c] Average cost is affected by a number of factors, including admission practices, sample size, remoteness and the types of hospital contributing to the collection. Direct comparison across jurisdictions is difficult because there are differences in hospital costing systems. [d] In accordance with NHCDC method, depreciation and some capital costs are included in these figures, except for Victoria, which does not include depreciation.

Source: DoHA (2009) *National Hospital Cost Data Collection Cost Report Round 12 (2007-08), v5.1*; table 12A.18.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

Early detection — interval cancer rate

‘Interval cancer rate’ is an outcome indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer, through provision of effective early detection services (box 12.11).

Box 12.11 **Interval cancer rate**

'Interval cancer rate' is defined as the number of interval cancers per 10 000 women years at risk of interval or screen-detected breast cancer, where:

- an interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination
- women years at risk of interval or screen-detected breast cancer are all women with no personal history of breast cancer, in the period between a negative screening result and the next scheduled screening examination.

A lower interval cancer rate is desirable because it suggests that early detection of breast cancer services are effective. Caution should be applied when comparing data as differences in the interval cancer rate can also reflect different policies regarding diagnostic and administrative procedures.

This indicator should be interpreted in conjunction with the breast cancer detection indicators.

Data reported for this indicator are not directly comparable.

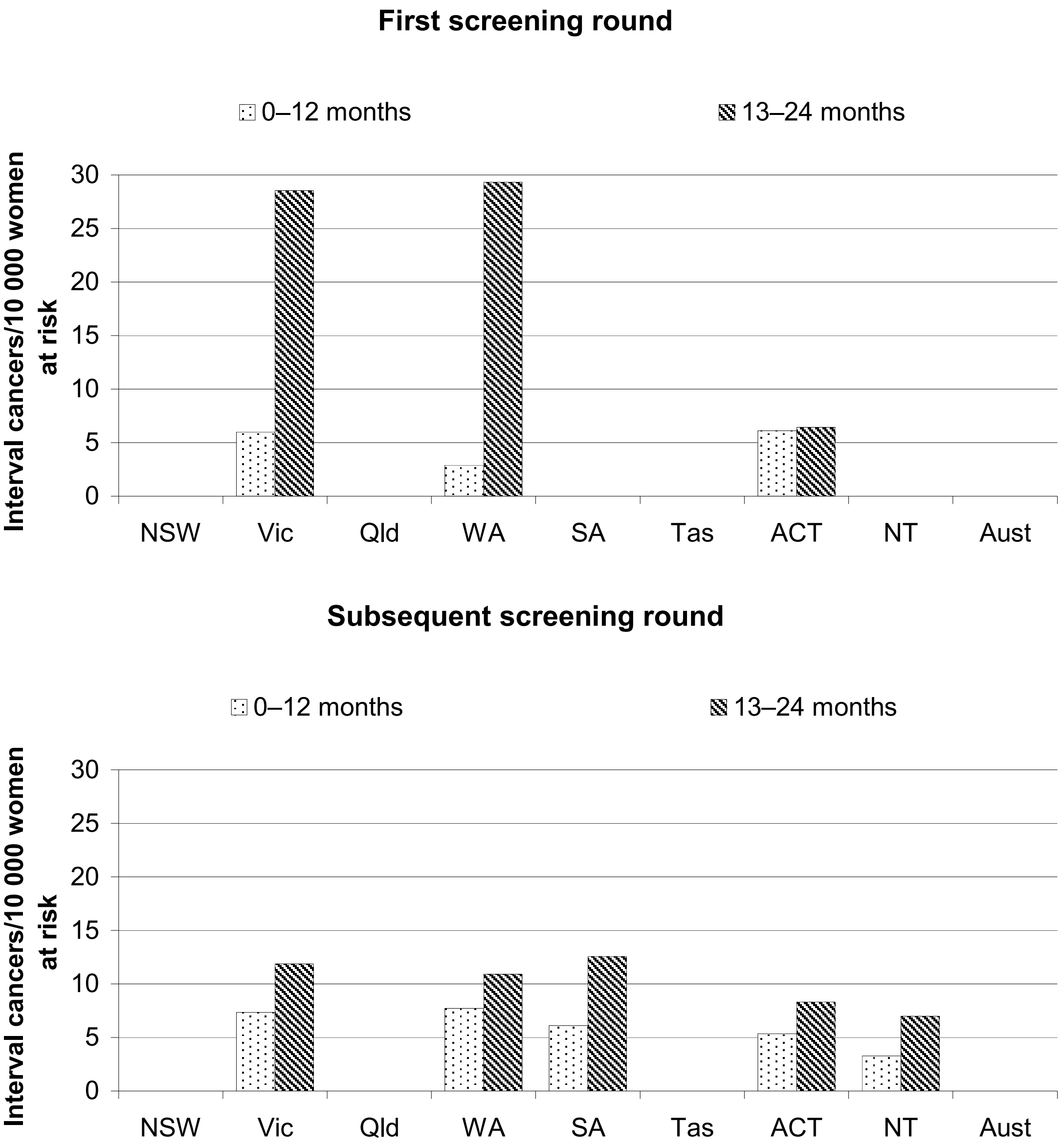
An interval cancer is an invasive breast cancer diagnosed in the interval between a negative screening result and the next scheduled screening examination, a period of 24 months in the case of routine screening (less in the case that more frequent screening is recommended) (AIHW 2009a). The cancer can have been present (but not detected) at the most recent screening episode, or may not have been present. A high rate of interval cancer can suggest that screening services are not optimally effective in the early detection of breast cancer.

There is a time lag in data availability for this indicator. Interval cancer can be detected up to 24 months following a routine negative screening episode. It can then be several months before the diagnosis of invasive cancer is recorded in the cancer registry. BreastScreen Australia programs identify interval cancers diagnosed outside the program through a process of data matching between cancer registry and BreastScreen Australia data. Thus, for women screened in any given year, the number of interval cancers cannot be determined until several years later. The most recent data available for this Report are for women screened during 2005.

Policy variation between jurisdictions can be reflected in interval cancer rates, and comparisons across jurisdictions need to be made with care. For example, policies differ in relation to women whose mammograms appear normal but who report symptoms of breast abnormalities. Some jurisdictions conduct further diagnostic procedures, which can be reflected in a higher cancer detection rate and lower interval cancer rate. Where these women are instead advised to visit their GP for referral to a diagnostic service (such as in SA and some services in NSW) cancers subsequently detected can be reflected in increased interval cancer rates.

Figure 12.12 presents the age standardised interval cancer rate by screening round and time since screened for women aged 50–69 years.

Figure 12.12 **Age standardised interval cancer rate, women aged 50–69 years, 2005**[a, b, c, d]



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[a] Rates are expressed as the number of interval cancers per 10 000 women years at risk, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998. [b] Small numbers result in fluctuations from year to year. It is advisable to view the indicator over several years rather than from one year to the next. [c] Data were not available for NSW, Queensland or Tasmania. [d] No interval cancers were reported for women aged 50–69 years in SA and the NT in the first round for 0–12 and 13–24 months.

Source: State and Territory governments (unpublished); table 12A.19.

Early detection — breast cancer detection rate

'Breast cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer, through the provision of effective early detection services (box 12.12).

Box 12.12 **Breast cancer detection rate**

'Breast cancer detection rate' is defined as the number of detected cancers per 10 000 women screened.

A higher rate of breast cancer detection is desirable in terms of the effectiveness of breast screening services (although a high incidence of breast cancer is not desirable). The breast cancer detection rate should be considered in conjunction with detection rates for invasive cancer, small invasive cancer, DCIS and interval cancer.

Data reported for this indicator are directly comparable.

Early detection of cancers that are small and localised to the breast is associated with reduced morbidity and mortality for women with breast cancer (DoHA 2009a; NBOCC 2004). Changes in breast cancer detection rates can also reflect changes in the incidence of breast cancer.

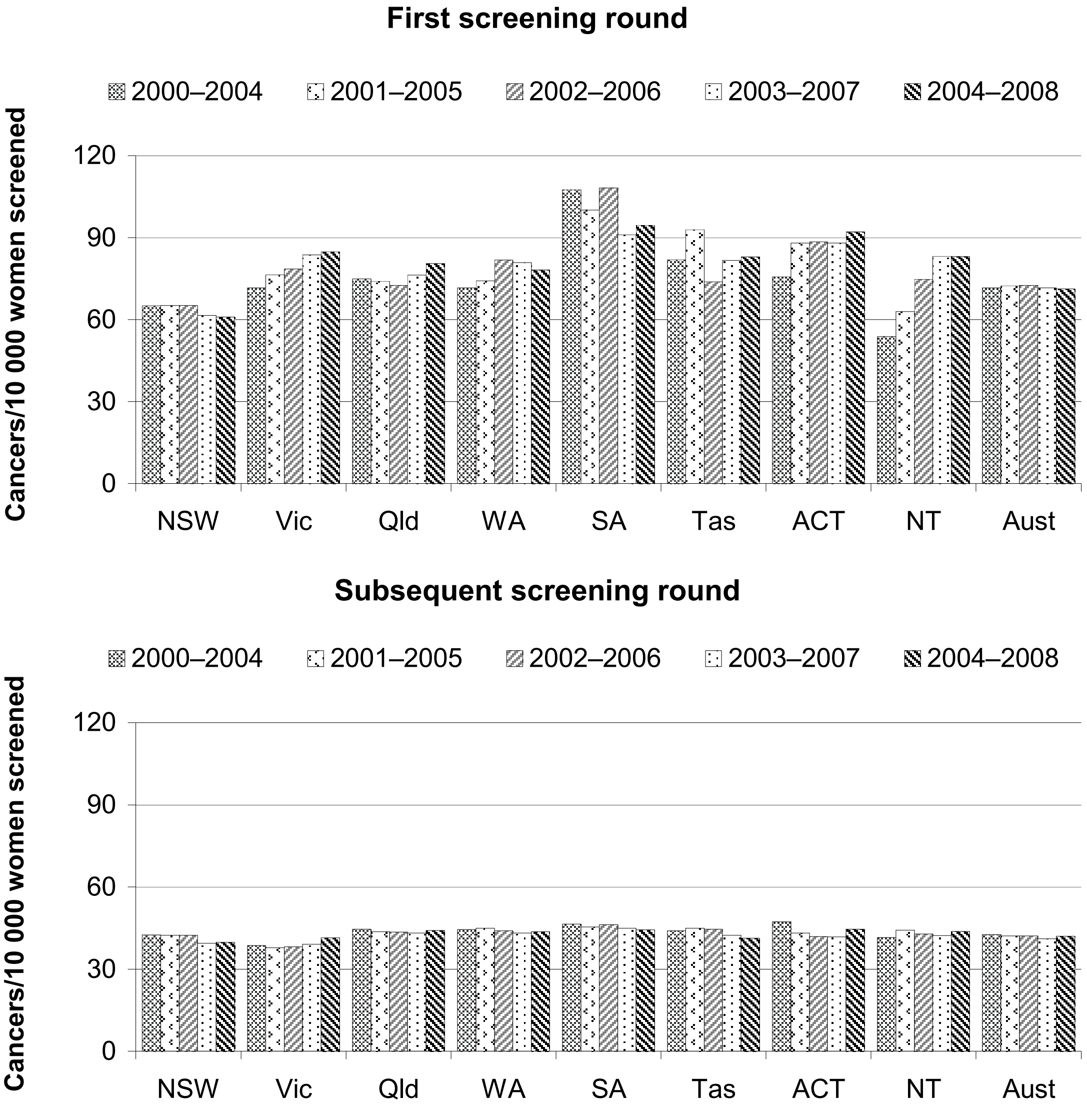
BreastScreen Australia National Accreditation Standards for detection rates are based on expected Australian rates (BreastScreen Australia 2004):

- greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with invasive breast cancer
- greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with invasive breast cancer
- greater than or equal to 12 per 10 000 women aged 50–69 years who attend for their first screen are diagnosed with DCIS
- greater than or equal to 7 per 10 000 women aged 50–69 years who attend for their second or subsequent screen are diagnosed with DCIS.

Figure 12.13 reports the annual average age standardised number of invasive cancers detected per 10 000 women screened aged 50–69 years, by screening round. These data are averaged over 5 year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year.

Nationally, in 2004–2008, the age standardised invasive breast cancer detection rate was 71.2 per 10 000 women aged 50–69 years attending their first screen. This was above the Breastscreen Australia National Accreditation Standard of greater than or equal to 50 per 10 000 women aged 50–69 years who attend for their first screen being diagnosed with invasive breast cancer. Nationally, the annual average age standardised invasive breast cancer detection rate was 41.8 per 10 000 women aged 50–69 years attending the second or subsequent screen. This was above the National Accreditation Standard of greater than or equal to 35 per 10 000 women aged 50–69 years who attend for their second or subsequent screen being diagnosed with invasive breast cancer (figure 12.13). The rate of DCIS detected per 10 000 women screened is reported in table 12A.20. (Definitions are in box 12.1 and section 12.7.)

Figure 12.13 **Annual average age standardised breast cancer detection rate for women aged 50–69 years, invasive cancers**[a]



[a] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.20.

Early detection — small invasive cancer detection rate

'Small invasive cancer detection rate' is an indicator of governments' objective to reduce morbidity and mortality attributable to breast cancer through the provision of effective early detection services (box 12.13).

Box 12.13 **Small invasive cancer detection rate**

'Small invasive cancer detection rate' is defined as the number of invasive cancers detected with a diameter of 15 millimetres or less, per 10 000 women screened.

It is desirable that a high proportion of cancers detected are small cancers. The small invasive cancer detection rate should be considered in conjunction with detection rates for invasive cancer, DCIS and interval cancer.

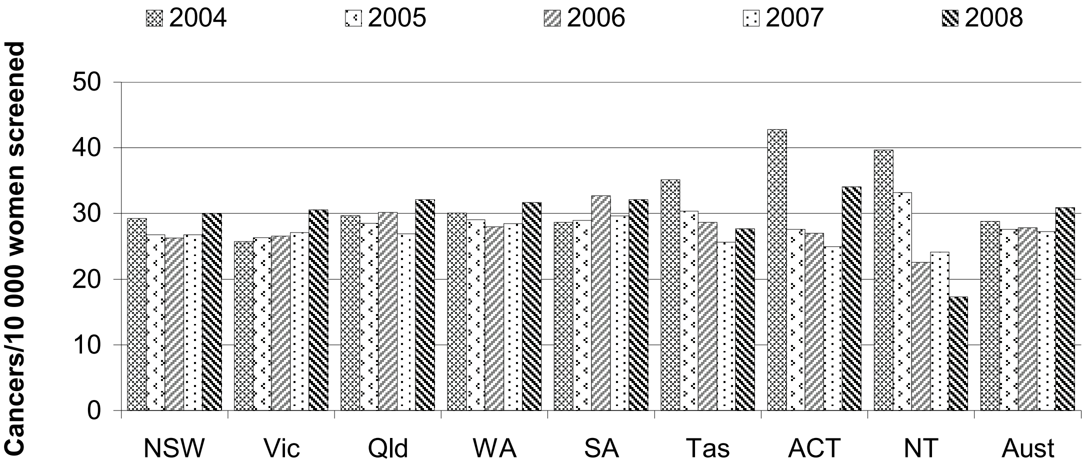
Data reported for this indicator are comparable.

Early detection of cancers that are small and localised to the breast is associated with reduced morbidity and mortality, as well as cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998; DoHA 2009a).

The BreastScreen Australia National Accreditation Standards 2004 specify that 25 or more women per 10 000 women aged 50–69 years who attend screening are expected to be diagnosed with a small (15 millimetres or less) invasive breast cancer (BreastScreen Australia 2004).

Age standardised rates for small invasive cancer detection for women aged 50–69 years screened by BreastScreen Australia in 2008 are reported in figure 12.14. The rate for Australia was 30.9 cancers per 10 000 women aged 50–69 years attending screening in 2008, above the National Accreditation Standard of 25 or more.

Figure 12.14 **Age standardised small diameter cancer detection rate for women aged 50–69 years, all rounds of screening**[a, b]



[a] Small diameter cancers are defined as invasive cancers up to and including 15 millimetre in diameter. [b] Rates are per 10 000 women screened, and age standardised to the Australian population of women attending a BreastScreen Australia service in 1998.

Source: State and Territory governments (unpublished); table 12A.21.

Early detection — size of detected cancers

'Size of detected cancers' is an indicator of governments' objective to provide effective services for the early detection of breast cancer (box 12.14).

Box 12.14 **Size of detected cancers**

'Size of detected cancers' is defined as the number of detected invasive cancers by cancer size, as a proportion of total detected invasive cancers for women aged 40 years or over.

High rates of detection of small cancers, relative to rates of detection of large cancers, are desirable.

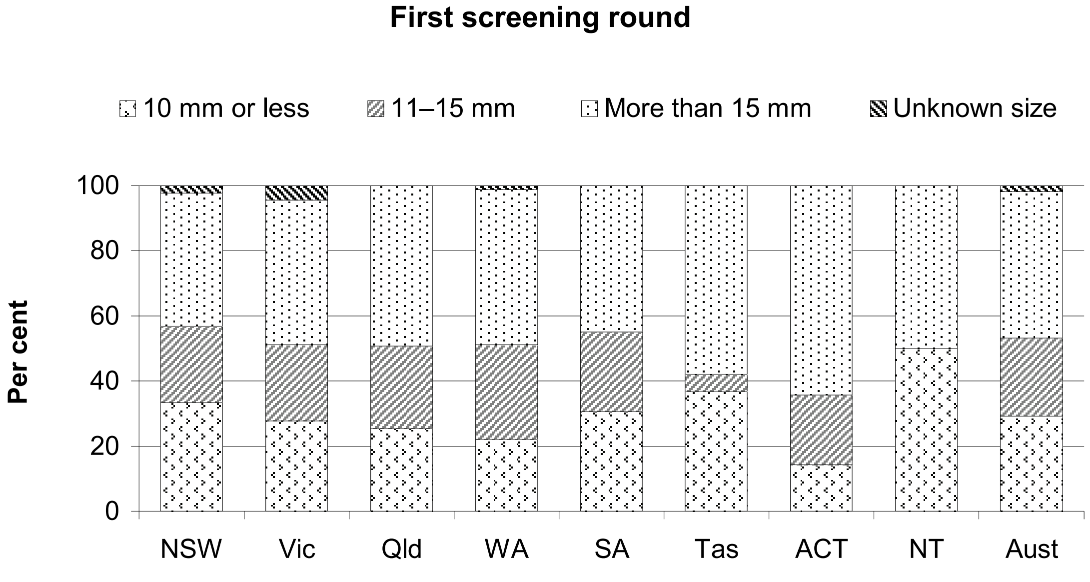
Data reported for this indicator are comparable.

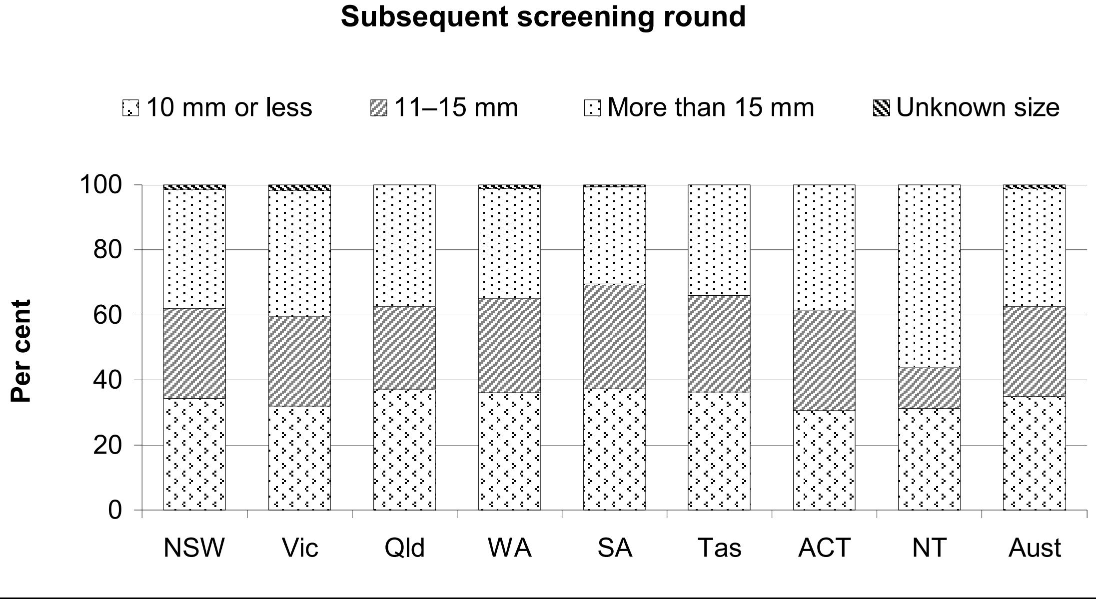
Detection of small cancers (those with a diameter of 15 millimetres or less) is generally associated with increased survival rates and reduced morbidity and mortality, as well as some cost savings to the health care system and women (AIHW, BreastScreen Australia and the NCSP 1998; DoHA 2009a).

Data are reported by round because larger cancers are expected to be found in the first round of screening. In subsequent rounds, cancers should be smaller if the program is achieving its objective (that is, early detection of small cancers through regular two yearly screening).

Figure 12.15 presents the proportion of cancers by size, by screening round, for 2008.

Figure 12.15 **Detected invasive cancers, women aged 40 years or over, by screening round and size of cancer 2008**[a, b, c]





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[a] Data are for BreastScreen Australia clients only. [b] Non-breast malignancies were not counted. [c] For small jurisdictions, fluctuations due to small numbers can make comparisons unreliable.

Source: State and Territory governments (unpublished); table 12A.22.

Overall performance — mortality rate for breast cancer

'Mortality rate for breast cancer' is an indicator of governments' objective to reduce mortality attributable to breast cancer, through the provision of effective early detection, and treatment, services (box 12.15).

Box 12.15 **Mortality rate for breast cancer**

'Mortality rate for breast cancer' is defined as the age standardised mortality from breast cancer per 100 000 women, expressed as a 5 year rolling average.

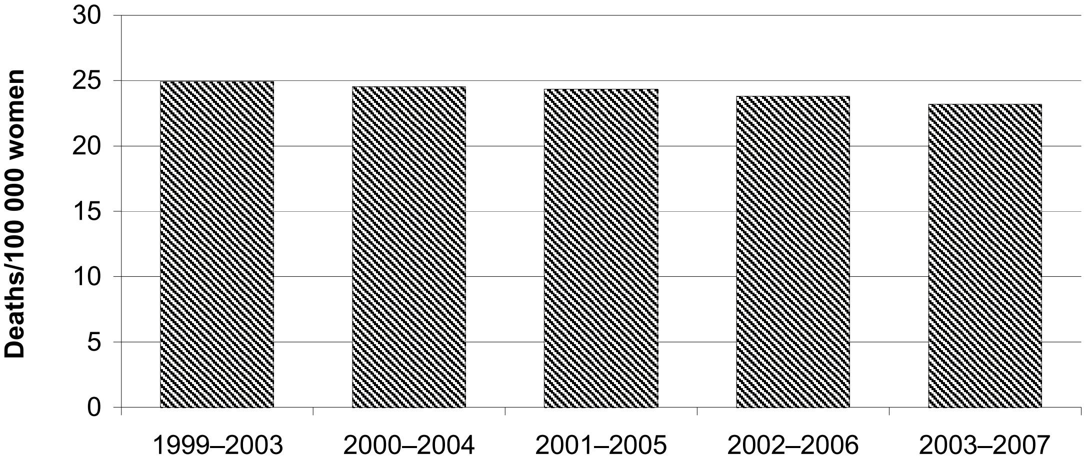
A lower mortality rate for breast cancer is desirable.

Data reported for this indicator are comparable.

Breast cancer mortality data are averaged over 5 year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions that tend to have fewer cases and relatively large variation in rates from year to year. Caution should nevertheless be used when comparing results for smaller jurisdictions (table 12A.1).

The average annual age standardised mortality rate for breast cancer declined from 24.9 per 100 000 women in the period 1999–2003 to 23.2 per 100 000 women in the period 2003–2007 (figure 12.16).

Figure 12.16 **Annual average age standardised mortality rate from breast cancer, all ages[a, b]**



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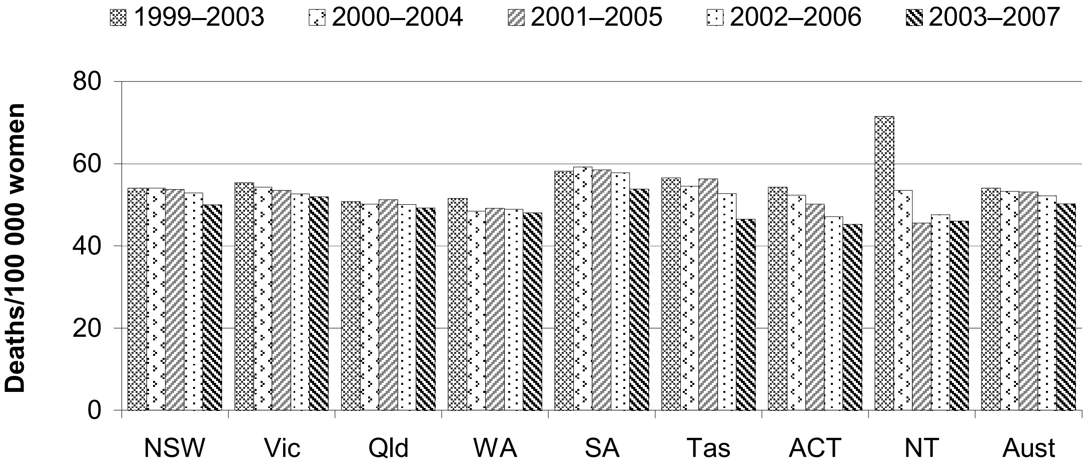
[a] Age standardised to the Australian population at 30 June 2001. [b] Data for the period 2003 to 2007 were not available from the AIHW due to delayed release of causes of death data by the ABS. Data for the period 2003 to 2007 are sourced from the ABS. Data for all other periods are sourced from the AIHW.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; AIHW (unpublished) AIHW National Mortality Database; table 12A.1.

The annual average age standardised mortality rate from breast cancer for women aged 50–69 years also declined, from 54.0 per 100 000 women over the period 1999–2003 to 50.2 per 100 000 women over the period 2003–2007 (figure 12.17).

Figure 12.17 **Annual average age standardised mortality rate from breast cancer, women aged 50–69 years**[a, b]



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[a] Age standardised to the Australian population at 30 June 2001. [b] Data for the period 2003 to 2007 were not available from the AIHW due to delayed release of causes of death data by the ABS. Data for the period 2003 to 2007 are sourced from the ABS. Data for all other periods are sourced from the AIHW.

Source: ABS (unpublished) *Causes of Death, Australia*, Cat. no. 3303.0; AIHW (unpublished) AIHW National Mortality Database; table 12A.1.

Overall performance — cost per life year saved

'Cost per life year saved' has been identified for development as an indicator of the efficiency of overall performance of services in detection and management of breast cancer (box 12.16).

Box 12.16 **Cost per life year saved**

'Cost per life year saved' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

12.4 Mental health

Profile

Mental health relates to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (DHAC and AIHW 1999). The World Health Organization (WHO) describes positive mental health as:

> ... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

There is a wide range of mental illnesses that can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in terms of its incidence across the lifespan, causal factors and treatments.

This section focuses on publicly funded specialised mental health services that treat mostly low prevalence but severe mental illnesses. The quality of data relating to these services, collected under the *Mental Health Establishments (MHE) National Minimum Data Set* (*NMDS*) or the *Community Mental Health Care* (*CMHC*) *NMDS* continues to improve. However, data are subject to ongoing historical validation. Results reported in this section might therefore differ slightly to those in the *Mental Health Services in Australia* publications and the *National Mental Health Report*.

Other health and related services are also important for people with a mental illness, including GPs and alcohol and drug treatment services (chapter 11), public hospitals (chapter 10), and aged care services (chapter 13). This Report does not include specific performance information on these services' treatment of people with a mental illness. Mental health patients often have complex needs that can also affect other government services they receive, such as those covered in chapter 4 ('School education'), chapter 8 ('Corrective services'), chapter 9 ('Emergency management') and chapter 14 ('Services for people with a disability').

Some common terms used in mental health management are outlined in box 12.17.

Box 12.17 **Some common terms relating to mental health**

Some common mental health management related terms are defined below.

Acute services: mental health services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. Acute episodes are characterised by the recent onset of severe clinical symptoms of mental illness, that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that treatment effort is focused on the short term. Acute services can focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental illness for whom there has been an acute exacerbation of symptoms.

Ambulatory care services: mental health services dedicated to the assessment, treatment, rehabilitation and/or care of non-admitted patients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.

Community residential services: mental health services that employ mental health-trained staff on-site; provide rehabilitation, treatment or extended care to residents in a domestic-like environment and that is intended to be on an overnight basis; and encourage the resident to take responsibility for their daily living activities. All these services employ on-site mental health trained staff for some part of each day. Some services employ mental health trained staff on-site for 24 hours per day. Services that are not staffed for 24-hours per day must provide mental health trained staff on-site for a minimum of 6 hours per day and at least 50 hours per week.

Early intervention: actions that are appropriate for and specifically target people displaying the early signs and symptoms of a mental health problem or mental illness and people developing or experiencing a first episode of mental illness.

Inpatient services: mental health services that provide admitted patient care. These are stand-alone psychiatric hospitals or specialised psychiatric units located within general (non-psychiatric) hospitals.

Mental illness: a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities. Sometimes described as mental disorder.

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 problem: diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental illness are met.

(Continued on next page)

Box 12.17 **(Continued)**

Mental health promotion: action taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the ‘coping’ capacity of communities, families and individuals by giving power, knowledge, skills and the necessary resources.

Mental illness prevention: interventions that occur before the initial onset of an illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and illnesses.

Non-acute services: provide rehabilitation and extended care services to patients who usually show a relatively stable pattern of clinical symptoms. Rehabilitation focuses on intervention to reduce functional impairments that limit the independence of patients and seek to promote personal recovery. They are also characterised by an expectation of substantial improvement over the short to medium term. Extended care services provide care over an indefinite period for patients who have a stable but severe level of functional impairment and inability to function independently without extensive care and support (including those with high levels of severe unremitting symptoms of mental illness). Treatment effort focuses on preventing deterioration and reducing impairment. Improvement is expected only over a long period.

Non-government organisations: private not-for-profit community managed organisations that receive State and Territory government funding specifically to provide community support services for people affected by a mental illness. Programs provided by non-government organisations 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).

Specialised care service: services whose primary function is to provide treatment, rehabilitation or community support targeted to people with mental illness. This criterion is applicable irrespective of the source of funds. Such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function.

Source: AIHW (2006); DoHA (2005).

Prevalence of mental illness

Prevalence of mental illness data are from the SMHWB. The term mental disorder is used when referring directly to SMHWB data (as it is used in that survey). Elsewhere, the term mental illness is used to describe the illness associated with mental disorders.

The SMHWB data are reported with 95 per cent confidence intervals. These intervals assist with making comparisons between jurisdictions, and between different mental disorder status groups. Confidence intervals are a standard way of expressing the degree of uncertainty associated with survey estimates. An estimate of 80 (for example, mean age 80 years) with a confidence interval of ± 4 means that if another sample had been drawn there is a 95 per cent chance that the result would lie between 76 and 84. Where ranges do not overlap, there is a statistically significant difference. A statistically significant difference means there is a high probability that there is an actual difference — it does not imply that the difference is necessarily large or important.

According to the SMHWB, in 2007, 20.0 ± 1.1 per cent of adults aged 16–85 years (or approximately 3.2 million adults) met the criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months before the survey (the SMHWB refers to this as a ‘12-month mental disorder’). A further 25.5 ± 1.4 per cent of adults aged 16–85 years had experienced a mental disorder at some point in their life, but did not have symptoms in the previous 12 months (table 12A.56). Additional data on the prevalence of selected mental illnesses are reported under the indicator ‘prevalence of mental illness’.

Impact of mental illness

Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (Begg *et al.* 2007). The total burden comprises the amount of ‘years’ lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of ‘healthy’ life lost due to disability). Mental illness is also the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg *et al.* 2007).

Mental illness can affect an individual’s functioning and quality of life. According to the SMHWB, in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who:

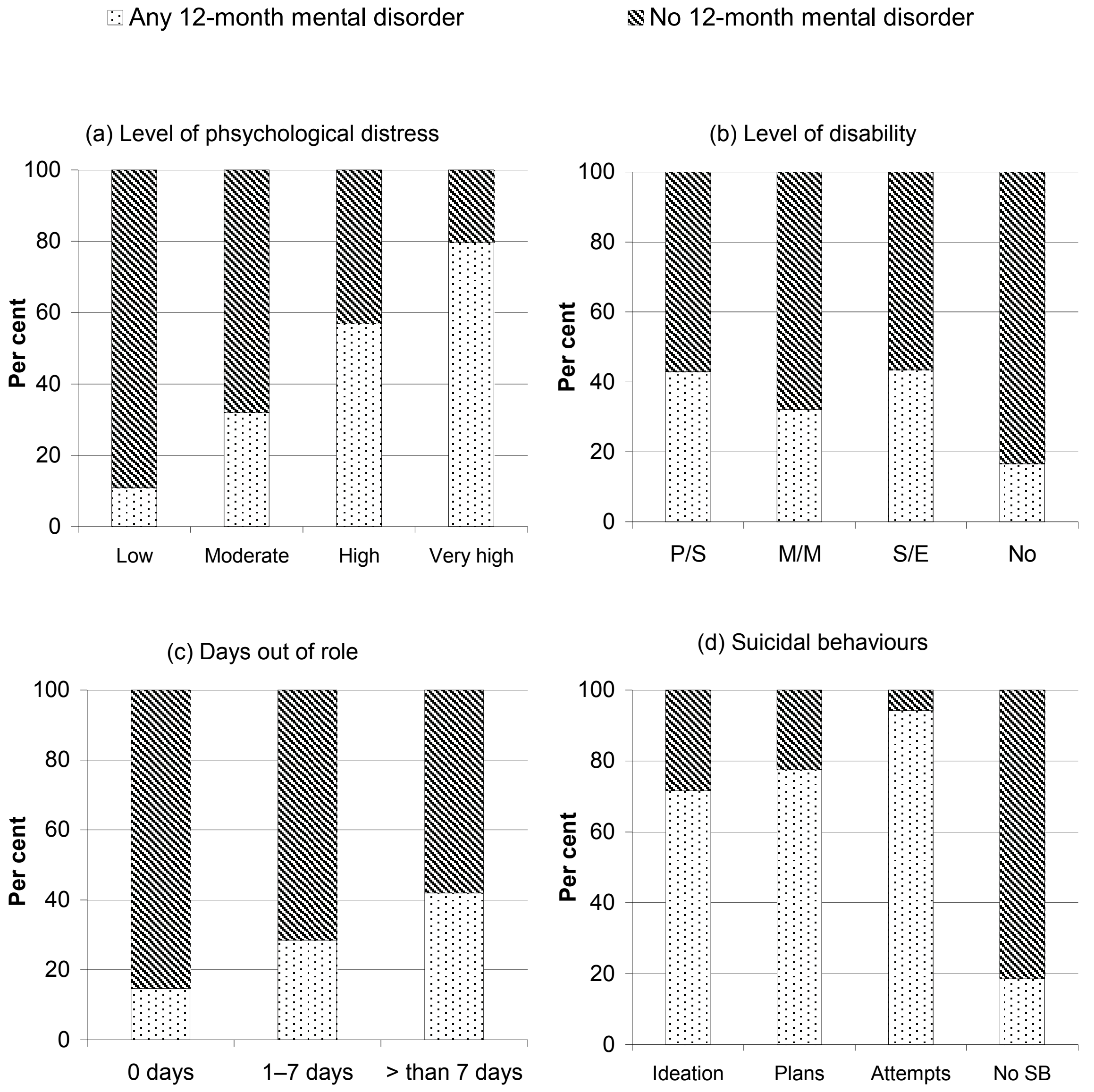
- had high to very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (figure 12.18a)
- had a profound/severe core activity limitation or a school/employment restriction — 42.9 ± 8.2 per cent and 43.4 ± 7.1 per cent of these populations respectively (figure 12.18b)
- for more than 7 in the last 30 days were unable to work or carry out normal activities or had to cut down on what they did because of their health — 42.0 ± 5.2 per cent of this population (figure 12.18c)

- exhibited suicidal behaviours — 71.7 ± 8.7 per cent of those who had suicidal ideation, 77.5 ± 12.6 per cent of those who planned suicide and 94.2 ± 9.0 per cent of those who had attempted suicide (figure 12.18d).

Information on levels of psychological distress across states and territories, by age and sex, are available from the 2007-08 National Health Survey (table 12A.24). Nationally, the proportion of people with reported high/very high levels of psychological distress was significantly higher for females than males, and higher for people aged 18–64 years of age than for people aged 65 years or over (figure 12.19).

The *National Aboriginal and Torres Strait Islander Health Survey* conducted in 2004-05 found that after adjusting for age, approximately 27 per cent of Indigenous Australians reported high levels of psychological distress (AHMAC 2008). This was more than twice the rate for non-Indigenous adults (13 per cent).

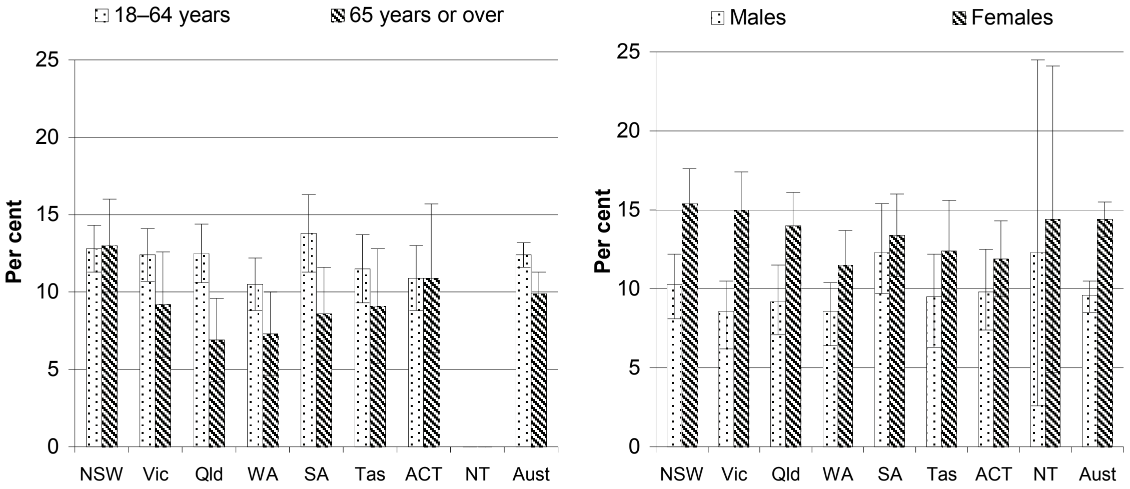
Figure 12.18 Functioning and quality of life measures, by 12-month mental disorder status, 2007[a, b, c, d]



P/S = profound or severe core activity limitation, M/M = moderate or mild core activity limitation, S/E = schooling/employment restriction only, No = No disability/No specific limitations or restrictions, No SB = no suicidal behaviours. [a] Level of psychological distress is measured by the Kessler Psychological Distress Scale (K10), from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; lower scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50. [b] Suicidal ideation refers to the presence of serious thoughts about committing suicide. [c] The estimated proportion of people who planned suicide with no 12-month mental disorder has a relative standard error (RSE) of 25 to 50 per cent and should be used with care. The estimated proportion of people who attempted suicide with no 12-month mental disorder has a RSE greater than 50 per cent and is considered too unreliable for general use. [d] Confidence intervals are not shown in the figure, but are reported in table 12A.25.

Source: ABS (2008) *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0; table 12A.23.

Figure 12.19 **K10 high/very high levels of psychological distress, people aged 18 years or over, by age and sex, 2007-08**[a, b]



[a] Level of psychological distress is measured by the K10, from which a score of 10 to 50 is produced. Higher scores indicate a higher level of distress; lower scores indicate a low level of distress. Scores are grouped as follows: Low 10–15, Moderate 16–21, High 22–29, and Very high 30–50. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate.

Source: ABS (unpublished) *National Health Survey 2007-08*, Cat. no. 4364.0; table 12A.24.

Mental illness can act as a barrier to gaining and maintaining employment (AHMC 2008). Nationally, in 2007, the labour force participation rate for people who had a 12-month mental disorder was 73.6 ± 2.7 per cent, statistically significantly below the rate of those who did not have a lifetime mental disorder (78.4 ± 1.6 per cent) (table 12A.25). Of those in the labour force, 94.5 ± 1.7 per cent of people who had a 12-month mental disorder were employed compared to the 96.8 ± 0.9 per cent of those without a lifetime mental disorder (table 12A.25).

Mental illness in early adult years can lead to disrupted education and premature exit from school or tertiary training, or disruptions in the transition from school to work (AHMC 2008). The impact of these disruptions can be long term, restricting the person's capacity to participate in a range of social and vocational roles over their lifetime (AHMC 2008). Nationally, in 2007, the proportion of people aged 16–30 years who had a 12-month mental disorder who were participating in study was 42.0 ± 4.9 per cent, statistically significantly lower than the rate for those without a lifetime mental disorder (51.6 ± 3.8 per cent) (table 12A.26). Further data on the participation of people aged 16–30 years in the labour force and study are in tables 12A.26 and 12A.27.

Roles and responsibilities

State and Territory governments are responsible for the funding, delivery and management of public specialised mental health services including admitted patient care in hospitals; ambulatory care services and community residential care (for further detail see box 12.17). As noted above, performance information in this section focuses on these specialised mental health services.

The Australian Government is responsible for the funding of the following mental health related services and programs:

- Medicare Benefits Schedule (MBS) services provided by GPs (both general and specific mental health items), private psychiatrists and allied mental health professionals (clinical psychologists, psychologists, social workers and occupational therapists)
- Pharmaceutical Benefits Scheme (PBS) funded mental health related medications
- other specific programs designed to increase the level of social support and community-based care for people with a mental illness and to prevent suicide.

In addition, the Australian Government provides funding for mental health related services through the Medicare Safety Net, the Department of Veteran's Affairs (DVA) and the Private Hospital Insurance Premium Rebates.

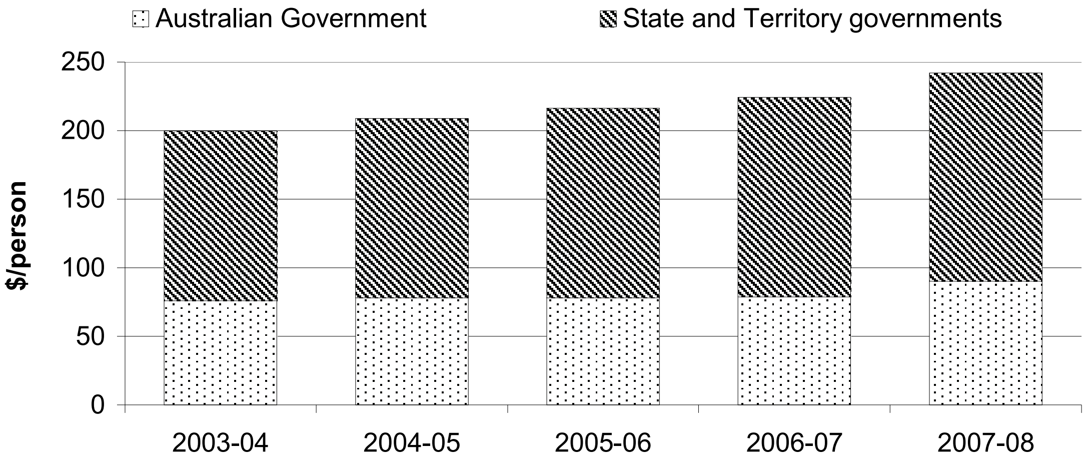
The Australian Government also provides a special purpose payment (SPP) to State and Territory governments under the new NHA, which was effective from 1 July 2009. According to the *Intergovernmental Agreement on Federal Financial Relations*, under which this SPP is provided, State and Territory governments must expend the SPP on the health sector, but they have full budget flexibility to allocate funds within that sector as they deem appropriate. Under the previous Australian Health Care Agreements (AHCA) the Australian Government provided State and Territory governments with base grants and specific funding to undertake reforms in the directions advocated by the National Mental Health Strategy (NMHS) for mental health services (DoHA 2007). Data reported in this chapter relate to services provided up to 2007-08 and were therefore provided under the previous AHCA arrangements.

The Australian, State and Territory governments also fund/provide other services that people with mental illnesses can access, such as employment, accommodation, income support, rehabilitation, residential aged care and other services for older people and people with disability (see chapters 13 and 14, respectively).

Funding

Real government recurrent expenditure of around $5.1 billion was allocated to mental health services in 2007-08 (tables 12A.28 and 12A.29). State and Territory governments made the largest contribution ($3.2 billion, or 62.8 per cent), although this included some Australian Government base grant funds under the AHCA (table 12A.29). The Australian Government spent $1.9 billion (table 12A.28). Real Australian Government expenditure per person increased from an average $76 in 2003-04 to $90 in 2007-08. National average State and Territory governments' expenditure per person in 2007-08 was $152, an increase from $124 in 2003-04 (figure 12.20).

Figure 12.20 **Real government recurrent expenditure on mental health services per person (2007-08 dollars)[a, b]**



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[a] Real expenditure for all years (2007-08 dollars), using the implicit price deflator for non-farm gross domestic product (table 12A.66) for Australian Government expenditure, and the State and Territory implicit price deflators for general government final consumption expenditure on hospital clinical services for State and Territory governments' expenditure (table 12A.65). [b] Includes expenditure sourced from patient fees and reimbursement by third party compensation insurers and 'other Australian Government funds'.

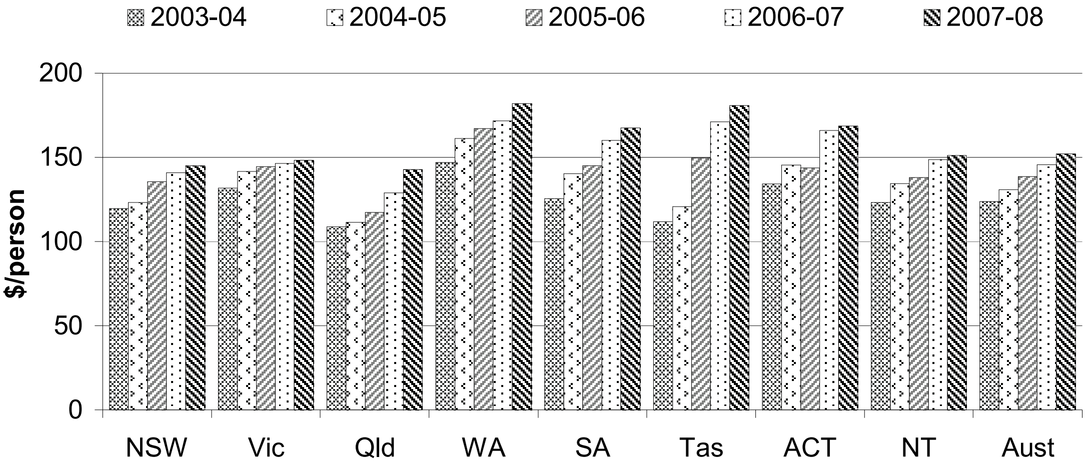
Source: Department of Health and Ageing (DoHA) (unpublished); State and Territory governments (unpublished); AIHW (unpublished) *MHE NMDS*; tables 12A.29 and 12A.30.

The largest component of Australian Government expenditure on mental health services in 2007-08 was expenditure under the PBS for psychiatric medication ($701.7 million). Expenditure on psychiatric medication decreased by an annual average rate of 0.2 per cent between 2003-04 and 2007-08 and decreased from 46.5 per cent of Australian Government expenditure on mental health services in 2003-04 to 36.8 per cent in 2007-08 (table 12A.28). The decrease in expenditure on psychiatric medication is due to a number of frequently prescribed medications coming off patent, which allowed lower cost generic medicines to be used. For most patients, these lower cost medicines are not counted in the PBS data because their costs fall below the PBS subsidy threshold.

In 2007-08, the next largest component of Australian Government expenditure for mental health services was MBS payments for consultant psychiatrists (12.6 per cent) followed by NMHS funds (9.9 per cent). The residual included expenditure on MBS payments for clinical psychologists and other allied health professionals (9.3 per cent) (2007-08 was the first full year that these items were available), DVA services (7.4 per cent), GPs (6.9 per cent) and private hospital insurance premium rebates (3.5 per cent) (table 12A.28).

Real expenditure per person at State and Territory governments discretion has increased over time (figure 12.21). Data in figure 12.21 for State and Territory governments expenditure include Australian Government base grant funds provided under the AHCA, but exclude special purpose grants provided for mental health reform (NMHS funds) and also funding provided to State and Territory governments by the DVA. Data on NMHS and DVA funding are reported in table 12A.33. The data are referred to as expenditure ‘at State and Territory governments’ discretion’. The data in figure 12.21 also exclude depreciation. Estimates of depreciation are presented in table 12A.32. State and Territory governments expenditure estimates excluding revenue from other sources and other Australian Government funds are presented in table 12A.31. The revenue categories are subject to minimal validation and might be inconsistently treated across jurisdictions. In addition, it is not possible to extract revenue from other sources and other Australian Government funds uniformly across time.

Figure 12.21 **Real recurrent expenditure at the discretion of State and Territory governments (2007-08 dollars)**[a, b, c]



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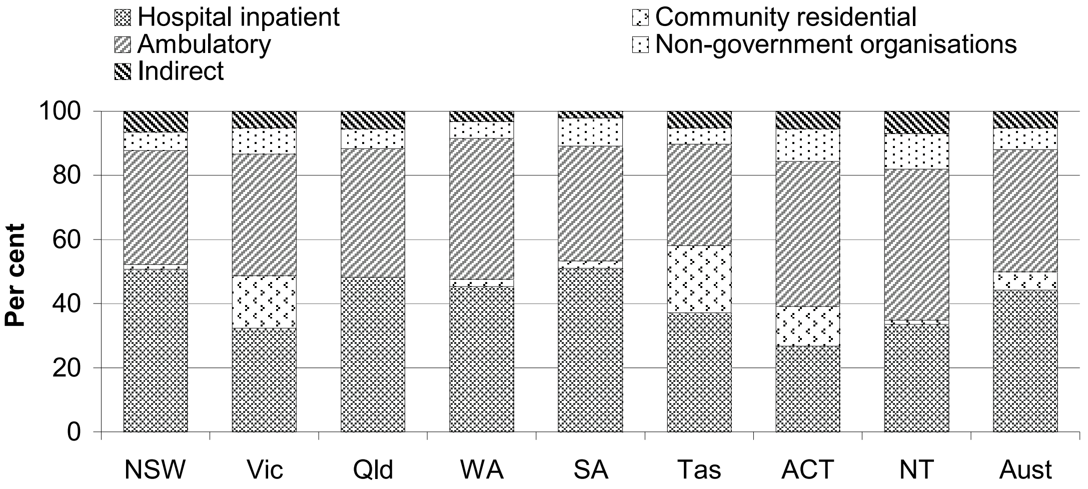
[a] Real expenditure (2007-08 dollars), using State and Territory implicit price deflators for general government final consumption on hospital clinical services (table 12A.65). [b] Estimates of State and Territory government spending include revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and 'other Australian Government funds', but exclude Australian Government funding provided under the NMHS and through the DVA. NMHS and DVA funding data are reported in table 12A.33. [c] Depreciation is excluded for all years. Depreciation estimates are reported in table 12A.32.

Source: DoHA (unpublished); State and Territory governments (unpublished); AIHW (unpublished) *MHE NMDS*; table 12A.29.

Figure 12.22 shows how expenditure at the discretion of State and Territory governments was distributed across the range of mental health services in 2007-08.

Figure 12.22 **State and Territory governments' recurrent expenditure, by service category, 2007-08**[a, b, c, d]



[a] Includes all State and Territory governments' expenditure on mental health services, regardless of source of funds. [b] Depreciation is excluded. Depreciation estimates are reported in table 12A.32. [c] The differential reporting of clinical service providers and non-government organisations artificially segregates the mental health data. Given that the role of non-government organisations varies across states and territories, the level of expenditure on non-government organisations does not necessarily reflect the level of community support services available. [d] Queensland does not fund community residential services, but it funds a number of extended treatment services (both campus-based and non-campus-based) that provide longer term inpatient treatment and rehabilitation services with full clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.36.

Size and scope

In 2007-08, 4.8 per cent and 1.5 per cent of the total population received Medicare-funded and State and Territory clinical mental health care services, respectively (figure 12.23). These data need to be interpreted carefully. Data for State/Territory mental health services are based on people who received one or more ambulatory mental health services (most people who have received a State and Territory inpatient service have also received an ambulatory mental health service). States and territories also differ in the way they count the number of people under care (AHMC 2010).

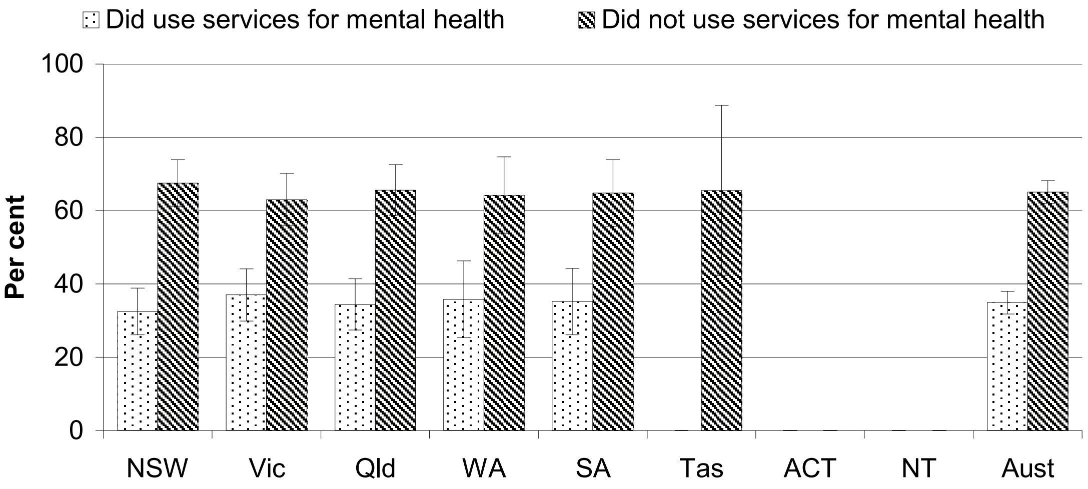
Figure 12.23 **Population receiving clinical mental health care, 2007-08**[a, b, c, d]

[a] Estimates are preliminary only and based on unique counts of individuals receiving care from the particular services within the year. An individual is only counted once, irrespective of the number of services received. An individual could have received a Medicare-funded and a State/Territory mental health service in the given year. [b] Person counts for State and Territory mental health services are confined to those receiving one or more contacts provided by ambulatory mental health services. All service contacts are counted in defining whether a person receives a service, including those delivered 'on behalf' of the consumer. [c] Jurisdictions differ in their capacity to provide accurate estimates of people receiving services due to the lack of unique patient identifiers, or data matching systems. Tasmania and SA data are derived without use of a unique patient identifier or data matching approaches. [d] All Medicare funded data are based on year of processing, as provided by the Australian Government (DoHA) and billing data maintained by Medicare Australia.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.37.

Nationally, in 2007, 34.9 ± 3.1 per cent of people with a 12-month mental disorder used a service for mental health (figure 12.24). People with a mental illness can have low rates of service use due to them choosing not to access services, unavailability of appropriate services, lack of awareness that services are available and negative experiences associated with the previous use of services (AHMC 2008). In addition, it might not be appropriate for all people with a mental illness to use a service, for example, some can seek and receive assistance from outside the health system (AHMC 2008).

Figure 12.24 **People with 12-month mental disorder, use of services for mental health, 2007**[a, b, c]



[a] Services used for mental health included hospitals, GPs, psychiatrists, psychologists, other mental health professionals and other health professionals. [b] Error bars represent the 95 per cent confidence interval associated with each point estimate. [c] Estimates with RSEs over 25 per cent are not published. This is the case for Tasmanian data for the category 'did use services for mental health', the ACT and the NT.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.35.

According to the SMHWB, service use was more common among people with more severe disorders. Almost two thirds (64.8 per cent) of people with severe mental disorders used services, compared to 40.2 per cent of those with moderate mental disorders and 17.9 per cent of people with mild mental disorders (Slade *et al.* 2009). For people who did not use services, the SMHWB examined whether there were services or types of help that they thought they needed, but had not received. For those with a 12-month mental disorder who did not use a service, 85.7 per cent reported that they had no need for any of the types of help asked about in the survey (information, medication, talking therapy, social intervention, or skills training) (Slade *et al.* 2009). Data on the proportion of people with a mental disorder with symptoms in the previous 12 months who used different types of health services are reported in table 12A.34.

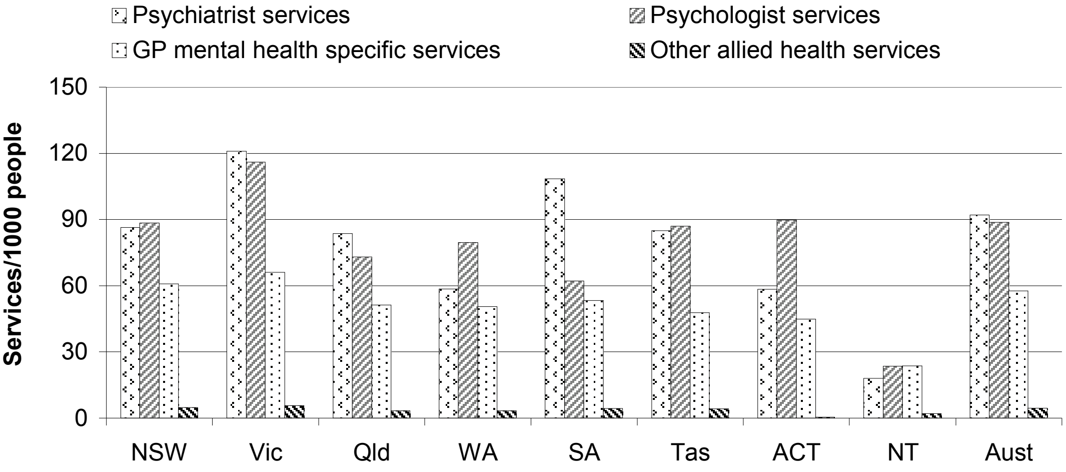
MBS-subsidised mental health services

MBS-subsidised mental health services are mental health services provided by a GP, psychiatrist or an allied health professional (psychologists, social workers and occupational therapists) on a fee-for-service basis that are partially or fully funded under Medicare. GPs provide mental health-related services under specific mental health MBS items (GP Mental Health Care Plans and Focussed Psychological

Strategies) and through other mental health-related encounters such as, through a standard surgery consultation.

In 2007-08, there were 1.2 million services provided by GPs (under specific mental health MBS items), 1.9 million services provided by psychiatrists, 1.9 million services provided by psychologists and 94 709 services provided by other allied health professionals (table 12A.38). This was equivalent to 57.6 GP services, 92.1 psychiatrist services, 88.7 psychologist services and 4.5 other allied health services per 1000 people (figure 12.25).

Figure 12.25 **MBS-subsidised mental health services, 2007-08**[a]



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[a] Crude rates based on the preliminary Australian ERP as at 31 December 2007.

Source: AIHW (2009) *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74; table 12A.38.

Information on GPs mental health-related encounters is also available from the *Bettering the Evaluation and Care of Health* (BEACH) survey data. Data for the BEACH survey are collected from a sample of 1000 GPs. Under the BEACH, a mental health-related encounter is defined as one at which a mental health-related problem is managed.

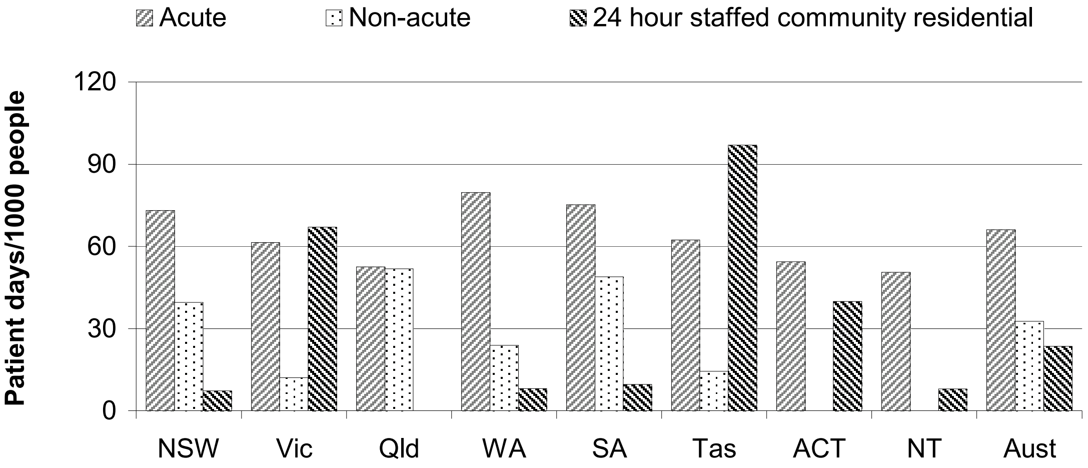
In 2007–08, 10.8 per cent of all GP encounters reported for the BEACH data were mental health-related encounters. The BEACH survey asks GPs to record an MBS item for each encounter. These encounters were most often recorded as standard surgery consultations (over 90 per cent of all encounters for which an MBS item was recorded). The GP mental health-specific MBS items (reported above), represented only 6.6 per cent of MBS items recorded for mental health-related encounters in the 2007–08 BEACH survey (AIHW 2009b).

In 2007-08, on average 11.5 psychological/mental health problems were managed by GPs in every 100 encounters (more than one problem can be managed in a single encounter). The most frequently reported mental health related problem managed was depression (4.0 per 100 GP encounters). Anxiety (1.8 per 100 GP encounters) and sleep disturbance (1.6 per 100 GP encounters) were the next most common psychological problems managed. In 2007-08, depression was the fifth most frequently managed problem by a GP (Britt *et al.* 2008). A GP may manage more than one problem at a single encounter. Problems managed reflect the GP's understanding of the health problem presented by the patient.

State and Territory publicly funded specialised mental health services — service activity

Estimating activity across the publicly funded specialised mental health services sector is problematic. Data for accrued mental health patient days are provided in figure 12.26 by acute, non-acute and 24 hour staffed community residential care (as defined in box 12.17). Hospital inpatient days and community residential accrued patient days are included in figure 12.26, but other types of community services are not covered.

Figure 12.26 **Accrued mental health patient days, 2007-08**[a, b]



[a] Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. Data from these services are included as non-acute. [b] The ACT and the NT did not provide mental health care in non-acute units.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.39.

Other measures of service activity include separations for admitted patient care, episodes for community residential care and contacts for community mental health services. In 2006-07, there were:

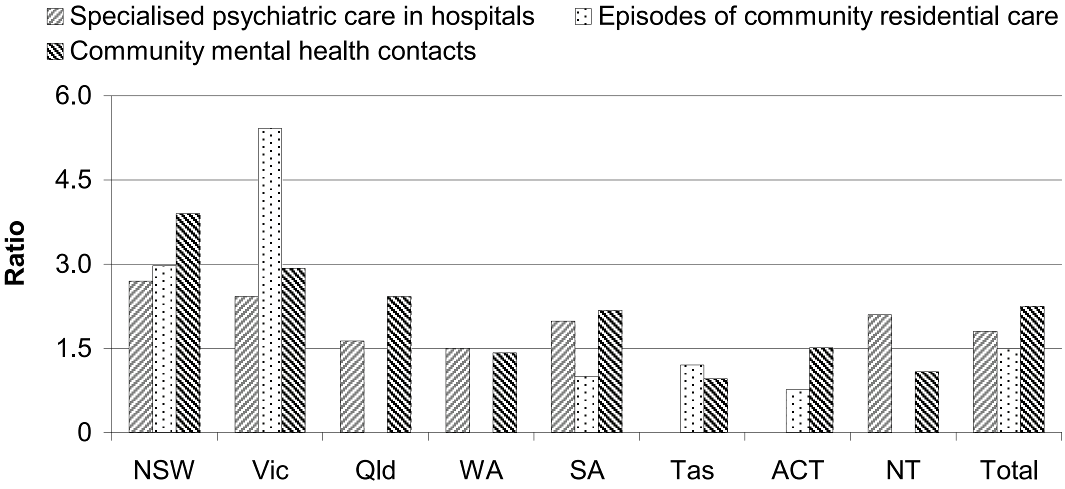
- 79 738 separations with specialised psychiatric care in public acute hospitals and 12 771 specialised psychiatric care separations in public psychiatric hospitals (table 12A.40). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (22.1 per cent in public acute hospitals and 23.6 per cent in public psychiatric hospitals) (table 12A.40). There were a further 4937 ambulatory equivalent same day separations with specialised psychiatric care in public acute hospitals and 1547 in public psychiatric hospitals (AIHW 2009b)
- 2531 episodes of community residential mental health care. Schizophrenia, schizotypal and other delusional disorders accounted for the largest proportion of these episodes with a principal diagnosis (72.2 per cent) (AIHW 2009b)
- 6.0 million community mental health care patient contacts, equivalent to 288 contacts per 1000 people (table 12A.41). Community mental health care service contacts are not restricted to face-to-face communication but can include telephone, video link or other forms of direct communication. For those contacts where a principal diagnosis were available, the largest proportion was for schizophrenia (31.8 per cent) (AIHW 2009b).

Service use by Indigenous status of patient

Data on service use by the Indigenous status of patients are available, but comparisons are difficult 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 1.8 times more likely to receive specialised psychiatric care in hospitals (both public and private hospitals), 1.5 times more likely to have an episode of community residential care and 2.2 times more likely to have a community mental health contact than non-Indigenous people (figure 12.27). Table 12A.42 contains further information on use of these services by Indigenous status.

Figure 12.27 Ratio of Indigenous to non-Indigenous specialised mental health service use, 2006-07[a, b, c, d, e, f]



[a] Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. Of the jurisdictions for which data are available, only Tasmania and the ACT considered their Indigenous data to be of acceptable quality. [b] 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 are considered of acceptable quality for 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. Data for non-Indigenous includes people whose Indigenous status was 'not stated'. [d] Data for specialised psychiatric care in hospitals includes both public and private hospitals. [e] Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. [f] Data by Indigenous status are not published for WA and the NT for episodes of community residential care and for Tasmania and the ACT for specialised psychiatric care in hospitals.

Source: AIHW (2009) *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74 (internet only tables); table 12A.42.

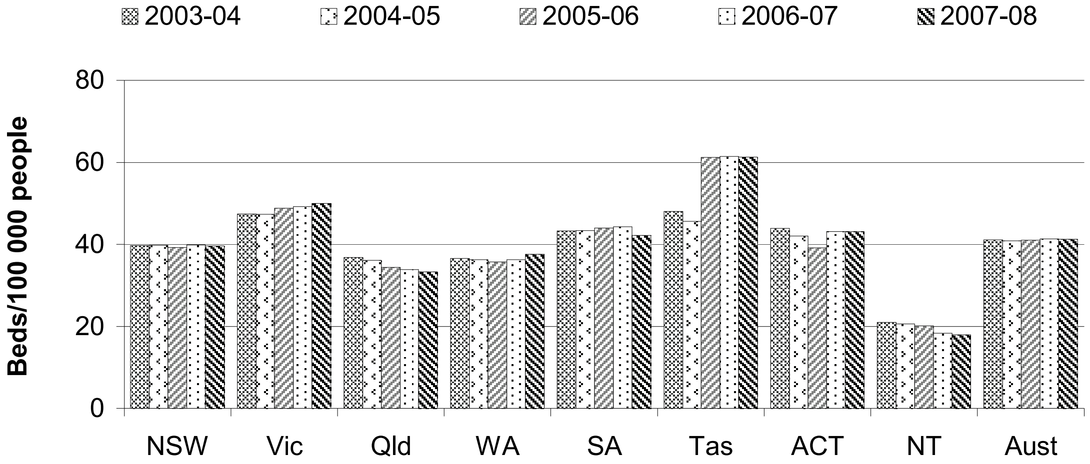
State and Territory publicly funded specialised mental health services — mental health beds

Beds are counted as those immediately available for use by admitted patients if required. They are available for use immediately — or within a reasonable period of time — if located in a suitable place for care with nursing or other auxiliary staff available.

Available beds are counted differently across years. For data from 2005-06, available beds are counted as the average of monthly available bed numbers. For previous years, available beds are counted at 30 June. In addition, for data from 2005-06, available beds counts excluded beds in wards that were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only). For previous years, available beds counts included wards that were temporarily closed for reasons such as renovation or strike, but that would normally be open.

Figure 12.28 presents the number of beds per 100 000 people for public hospitals and community residential facilities combined.

Figure 12.28 **Mental health beds in public hospitals and publicly funded community residential units**[a, b, c, d]



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[a] Includes beds in public hospitals and publicly funded community residential units. [b] In 2005-06, there was a temporary closure of acute beds in one Queensland hospital and some transitional extended treatment beds were permanently closed. In addition, Queensland did not change the method for counting beds until 2007-08. [c] Beds numbers in WA include publicly funded mental health beds in private hospitals for all years. Bed numbers in WA from 2005-06 include emergency department observation beds in one hospital. [d] In Tasmania, for 2005-06, non-government organisations' residential beds funded by government are included for the first time in the publicly funded community residential facilities category. This has led to a significant change in the bed numbers between 2004-05 and 2005-06.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.43.

Figure 12.29 presents the number of beds by service setting for 2007-08. These data show the differences in service mix across states and territories.

Figure 12.29 **Available beds, by service setting, 2007-08**[a, b]

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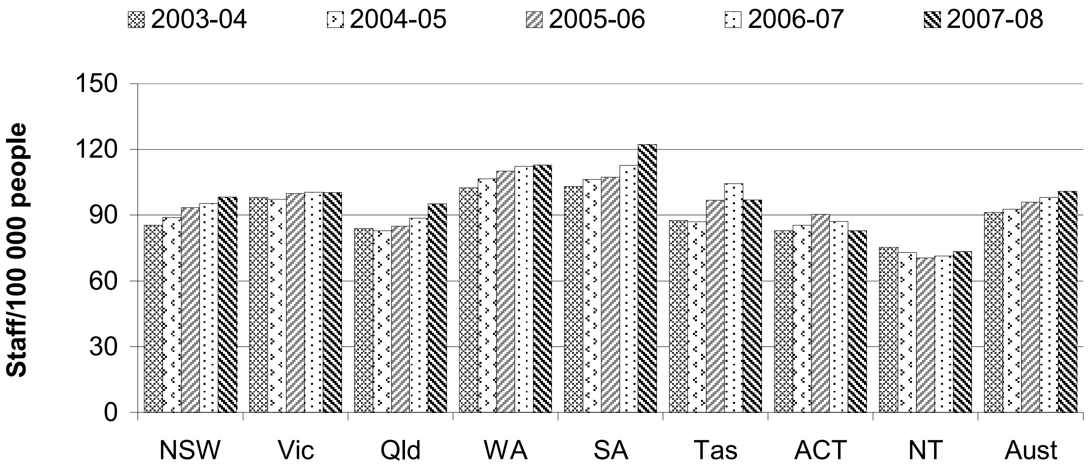
[a] Queensland does not fund community residential services, but it funds a number of campus-based and non-campus-based extended treatment services. These services are reported either as beds in public acute hospitals or beds in public psychiatric hospitals. [b] Tasmania, the ACT and the NT do not have public psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.43.

State and Territory publicly funded specialised mental health services — staff

Figure 12.30 reports full time equivalent (FTE) health professional direct care staff per 100 000 people.

Figure 12.30 **FTE health professional direct care staff**[a]



[a] Includes staff within the health professional categories of 'medical', 'nursing' and 'allied health'. 'Medical' staff consist of consultant psychiatrists, psychiatry registrars, and other medical officers who are neither registered as psychiatrists within the State or Territory, nor are formal trainees of the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program. 'Nursing' staff consist of registered and non-registered nurses. 'Allied health' staff consist of occupational therapists, social workers, psychologists and other allied health staff. 'Other personal care' direct care staff are excluded. 'Other personal care' staff include attendants, assistants, home companions, family aides, ward helpers, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents and who are not formally qualified or are still training in nursing or allied health professions. Definitions for staffing categories are provided in more detail in section 12.7.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.44.

Nursing staff comprise the largest FTE component of health care professionals employed in mental health services. Across Australia in 2007-08, 64.8 nurses per 100 000 people were working in specialised mental health services, compared with 24.1 allied health care staff and 11.9 medical staff (table 12A.44). FTE direct care staff employed in specialised mental health services, by service setting, are reported in table 12A.45.

Framework of performance indicators

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.

The framework of performance indicators for specialised 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 12.18). The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (admitted patient and community-based services) and includes outcome indicators of system wide performance. Improving the framework is a priority of the Steering Committee.

Box 12.18 **Broad objectives of National Mental Health Policy**[a]

Key broad objectives include to:

- improve the effectiveness and quality of service delivery and outcomes
- promote, where appropriate, community awareness of mental health problems
- prevent, where possible, the development of mental health problems and mental illness
- undertake, where appropriate, early intervention for mental health problems and mental illness
- promote recovery from mental health problems and mental illness
- reduce, where possible, 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 are based on the National Mental Health Policy 2008. They represent a paraphrased interpretation of aspects of the Policy.

In 1991, Australian Health Ministers signed the *Mental Health Statement of Rights and Responsibilities*. This Statement seeks to ensure that consumers, carers, advocates, service providers and the community are aware of their rights and responsibilities and can be confident in exercising them (Australian Health Ministers 1991). The Statement underpins the NMHS endorsed by Australian, State and Territory governments in 1992 (AIHW 2008).

The NMHS was established to guide the reform agenda for mental health in Australia across the whole-of-government. The NMHS consists of the National Mental Health Policy and the National Mental Health Plan.

- The National Mental Health Policy describes the broad aims and objectives of the NMHS. The revised *National Mental Health Policy 2008* includes a renewed emphasis on whole-of-government mental health reform and commits the Australian, State and Territory governments to the continual improvement of Australia's mental health system. Under the Policy, these governments will seek to ensure Australians with a mental illness have access to services that detect and intervene early in illness, promote recovery and provide effective and appropriate treatment and community supports to enable them to fully participate in the community.

- The National Mental Health Plan describes the approach to implementing the aims and objectives of the Policy. A fourth plan (2009–2014) was endorsed by all Australian Health Ministers in September 2009. This plan consolidates reforms begun under the first three plans (the first operated from 1993–1998, the second from 1998–2003 and the third from 2003–2008). The plan strengthens the accountability framework with Australian, State and Territory governments agreeing to develop targets and data sources for a set of indicators and to provide annual progress reports to COAG (AHMC 2009). These indicators will be the primary vehicle for monitoring the progress of these governments in achieving national mental health reform under the fourth plan.

In 2006, COAG agreed to the *National Action Plan on Mental Health 2006–2011* (COAG 2006). This plan involves a joint package of measures and new investments by all governments aimed at promoting improved mental health and providing additional support to people with mental illness, their families and their carers. The Action Plan is designed to further promote mental health reform and focuses on areas that have not progressed sufficiently under the NMHS. The Action Plan is directed at achieving four outcomes:

- reducing the prevalence and severity of mental illness in Australia
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery
- increasing the proportion of people with an emerging or established mental illness who are able to access appropriate health care and other relevant community services at the necessary time, with a particular focus on early intervention
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

A series of measures have been identified to monitor progress against these outcomes. Australian Health Ministers agreed to report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes.

Governments also agreed to an independent evaluation and review of the Plan after 5 years (COAG 2006).

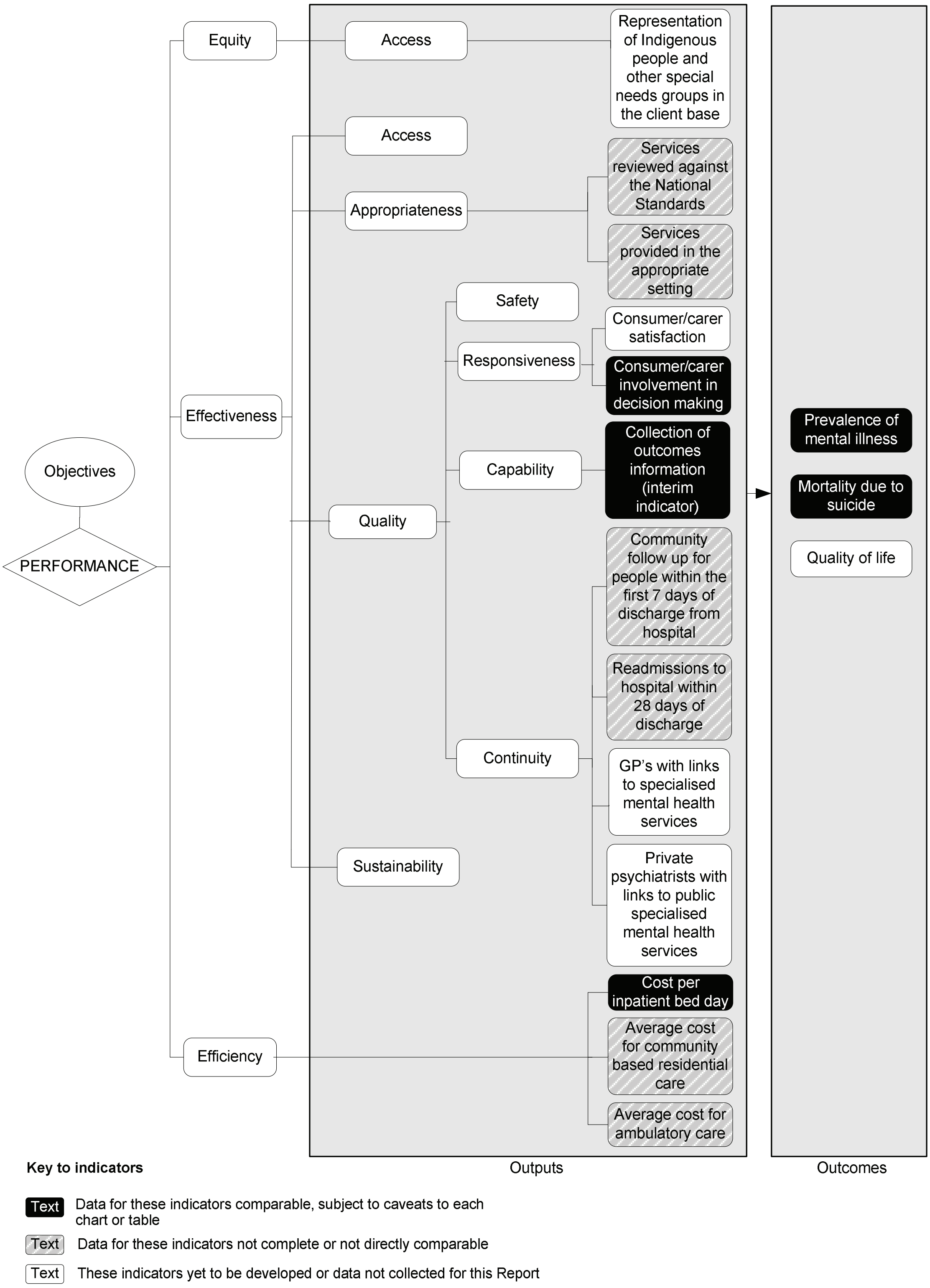
Over the period 2004–2009, the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004–2009* (the Social and Emotional Well Being Framework) provided a basis for action by all governments and communities to improve the social and emotional well being and mental health needs of Indigenous Australians. Ongoing monitoring is provided under the *Aboriginal and Torres Strait Islander Health Performance Framework*. This framework includes 71 performance indicators that measure progress against closing the gap in Indigenous health outcomes. Of these indicators, two relate specifically to social and emotional well being. The performance indicators are reported on biennially.

The performance indicator framework shows which data are comparable in the 2010 Report (figure 12.31). For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective (see section 1.6). The Health preface explains the performance indicator framework for health services as a whole, including the sub-dimensions for quality and sustainability that have been added to the standard Review framework.

Some changes have been made to the mental health framework for the 2010 Report. The measure used in previous reports for the 'Average cost of ambulatory care' indicator (cost per treated patient in the community) has been replaced by two measures from the set of National Mental Health Key Performance Indicators. This is the first time these measures have been reported and work on them is ongoing. The Steering Committee will continue to seek advice on possible modifications and improvements to their formulation for future reports.

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 12.31 **Performance indicators for mental health management**



Key to indicators

Text	Data for these indicators comparable, subject to caveats to each chart or table
Text	Data for these indicators not complete or not directly comparable
Text	These indicators yet to be developed or data not collected for this Report

Key performance indicator results

Outputs

Outputs are the actual services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1, section 1.5).

Equity — representation of Indigenous people and other special needs groups in the client base

‘Representation of Indigenous people and other special needs groups in the client base’ 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 12.19).

Box 12.19 **Representation of Indigenous people and other special needs groups in the client base**

‘Representation of Indigenous people and other special needs groups in the client base’ is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Access

The Steering Committee has identified access as an area for reporting, but no indicators have yet been developed.

Appropriateness — services reviewed against the National Standards

‘Services reviewed against the National Standards’ is an indicator of governments’ objective to provide mental health services that are appropriate (box 12.20). It is a process indicator of appropriateness, reflecting progress made in meeting the national standards for mental health care.

Box 12.20 **Services reviewed against the National Standards**

‘Services reviewed against the National Standards’ is defined as the proportion of specialist mental health services that had completed a review by an external accreditation agency against the *National Standards for Mental Health Services* (NSMHS). Services were assessed as level 1 or level 2, where these levels are defined as:

- *Services assessed at level 1* — reviewed by an external accreditation agency against the NSMHS and assessed as meeting all Standards
- *Services assessed at level 2* — reviewed by an external accreditation agency against the NSMHS and assessed as meeting some, but not all Standards.

A high or increasing proportion of specialist mental health services that had completed a review by an external accreditation agency against the NSMHS and that had been assessed as level 1 or level 2 is desirable. It suggests an improvement in the quality of services.

The indicator does not provide information on whether the standards or assessment process are appropriate. In addition, services that had not been assessed do not necessarily deliver services of lower quality. Some services that had not completed an external review included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation.

Data reported for this indicator are not directly comparable.

The NSMHS are outlined in box 12.21. A comprehensive review of these Standards was completed in May 2008. The review was conducted to align the Standards with developments in mental health reform, current legislation and to assist mental health services to provide quality care for people with a mental illness (consumers) that is evidence-based, integrated and recovery-focussed. A revised set of standards has been developed. Implementation strategies for the different service sectors are being developed to accompany the release of the revised Standards.

External accreditation agencies, such as the Australian Council on Healthcare Standards, undertake accreditation of a parent health organisation (for example, a hospital) that can cover a number of specialised services, including mental health services. Accreditation of a parent organisation does not currently require a mental health service to be separately assessed against the National Standards; rather, assessment against the National Standards must be specifically requested and involves a separate review process.

Box 12.21 **The *National Standards for Mental Health Services***

The NSMHS were developed under the *First National Mental Health Plan* for use in assessing service quality and as a guide for continuous quality improvement in all Australian mental health services. They comprise 11 major criteria:

1. Rights.
2. Safety.
3. Consumer and carer participation.
4. Promoting community acceptance.
5. Privacy and confidentiality.
6. Prevention and mental health promotion.
7. Cultural awareness.
8. Integration.
9. Service development.
10. Documentation.
11. Delivery of care.

Source: DoHA (2002).

Table 12.6 shows the percentage of specialised public mental health services that had completed an external review against the NSMHS. Services were assessed as meeting ‘all Standards’ (level 1) or as meeting ‘some but not all Standards’ (level 2).

Table 12.6 Specialised public mental health services reviewed against the NSMHS, 30 June (per cent)[a, b]

	NSW	Vic[c]	Qld	WA[d]	SA	Tas	ACT	NT
2004								
Level 1	na	100.0	74.2	na	49.5	na	81.3	50.0
Level 2	na	–	8.3	na	5.6	na	–	–
2005								
Level 1	73.4	100.0	75.0	64.5	72.7	46.9	87.5	50.0
Level 2	0.6	–	6.7	12.9	2.7	–	–	50.0
2006								
Level 1	78.0	100.0	78.5	51.6	62.9	36.4	100.0	100.0
Level 2	0.9	–	1.7	9.7	3.4	15.2	–	–
2007								
Level 1	77.5	96.0	82.8	44.1	71.8	37.9	100.0	100.0
Level 2	0.9	–	0.8	41.2	1.8	6.9	–	–
2008								
Level 1	86.0	100.0	83.1	31.4	50.9	39.4	100.0	100.0
Level 2	2.3	–	4.2	34.3	1.8	–	–	–

[a] Services that had not completed a review by an external accreditation agency included those that were undergoing a review and those that had booked for review and were engaged in self-assessment preparation. [b] NSW, Queensland, SA, Tasmania and the ACT report at the service unit level. Victoria, WA and the NT report at the organisation level. [c] In Victoria, two agencies did not report at 'Level 1' for 2007. However, both agencies were in the process of re-accreditation and therefore can be deemed as having gained accreditation. [d] WA data include public sector services only. In 2008, WA had 11 services booked for review by an external accreditation agency and were engaged in self-assessment preparation prior to the formal external review. These services are not included. **na** Not available. – Nil or rounded to zero.

Source: AIHW (unpublished) MHE NMDS; State and Territory governments (unpublished); table 12A.46.

Appropriateness — services provided in the appropriate setting

‘Services provided in the appropriate setting’ is an indicator of governments’ objective to provide mental health services in mainstream or community settings wherever possible (box 12.22).

Box 12.22 **Services provided in the appropriate setting**

'Services provided in the appropriate setting' is defined by two measures:

- recurrent expenditure on community-based services as a proportion of total expenditure on mental health services (excluding aged care community residential expenditure)
- acute mental health patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals.

A high or increasing proportion of recurrent expenditure expended on community-based services is desirable, reflecting a greater reliance on services that are based in community settings. A high or increasing proportion of acute patient days that were provided in public acute hospitals is desirable, reflecting a reduced reliance on stand-alone psychiatric hospitals and greater mainstreaming of mental health services.

Data reported for this indicator are not directly comparable.

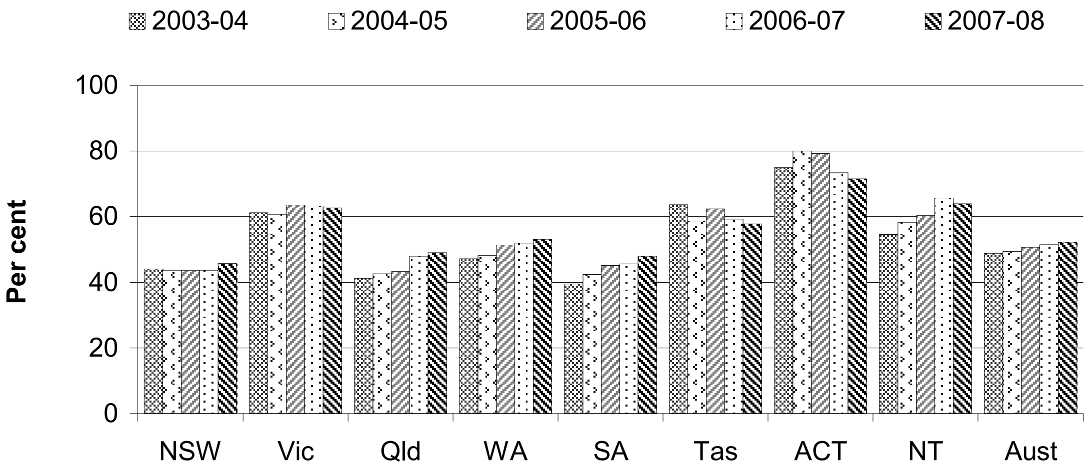
The development of local, comprehensive mental health service systems is advocated by the NMHS. Mental health services must be capable of responding to the individual needs of people with mental illnesses and of providing continuity of care to enable consumers to move between services as their needs change. The Strategy advocates:

- a reduced reliance on stand-alone psychiatric hospitals
- the expanded delivery of community-based care integrated with inpatient care
- increased mainstreaming of mental health services with other components of health care.

More appropriate treatment options can be provided by encouraging the treatment of patients in community settings and public (non-psychiatric) hospitals, rather than in stand-alone psychiatric hospitals.

Figure 12.32 shows recurrent expenditure on community-based services as a proportion of total expenditure on mental health services. Nationally, recurrent expenditure on community-based services as a proportion of total expenditure on mental health services increased over the period from 2003-04 to 2007-08.

Figure 12.32 **Recurrent expenditure on community-based services as a proportion of total expenditure on mental health services**[a, b, c]



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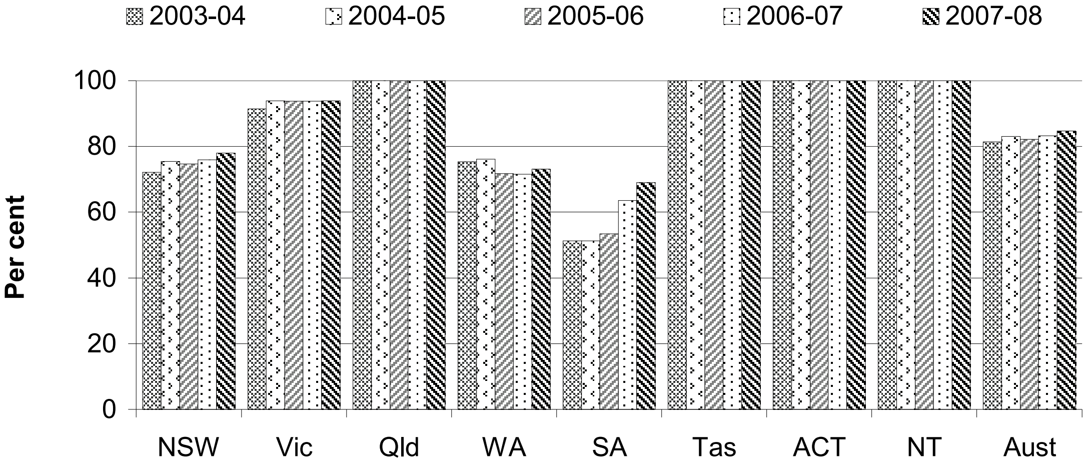
[a] Community-based expenditure includes expenditure on ambulatory, non-government and adult community residential services. Aged care community residential expenditure is excluded to improve comparability. [b] Total expenditure on mental health services excludes indirect/residual expenditure that could not be apportioned directly to services and aged care community residential expenditure. [c] Queensland does not fund community residential services, but funds a number of extended treatment (campus-based and non-campus-based) services that provide longer term inpatient treatment and rehabilitation services with clinical staffing for 24 hours a day, 7 days a week.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.47.

Figure 12.33 shows acute mental health patient days in public acute hospitals as a proportion of the total acute inpatient bed days in public acute and psychiatric hospitals. Nationally, the proportion of acute patient days in public acute hospitals as a proportion of total acute inpatient bed days (in both public acute and psychiatric hospitals) increased over the period from 2003-04 to 2007-08.

Figure 12.33 **Acute mental health patient days in public acute hospitals as a proportion of total acute inpatient bed days in public acute and psychiatric hospitals**



Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.47.

Quality — consumer and carer satisfaction

'Consumer and carer satisfaction' is an indicator of governments objective that services are responsive to the needs of consumers and their carers (box 12.23). Consumers and their carers should be satisfied with both clinicians' responses and with services provided, in all areas of mental health. Both are important aspects of the NMHS.

Box 12.23 **Consumer and carer satisfaction**

'Consumer and carer satisfaction' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — consumer and carer involvement in decision making

'Consumer and carer involvement in decision making' is an indicator of governments' objective that consumers' and carers' are involved at the service delivery level, where they have the opportunity to influence the services they receive (box 12.24). Consumer and carer involvement is an important aspect of the NMHS.

Box 12.24 **Consumer and carer involvement in decision making**

‘Consumer and carer involvement in decision making’ is defined by two measures:

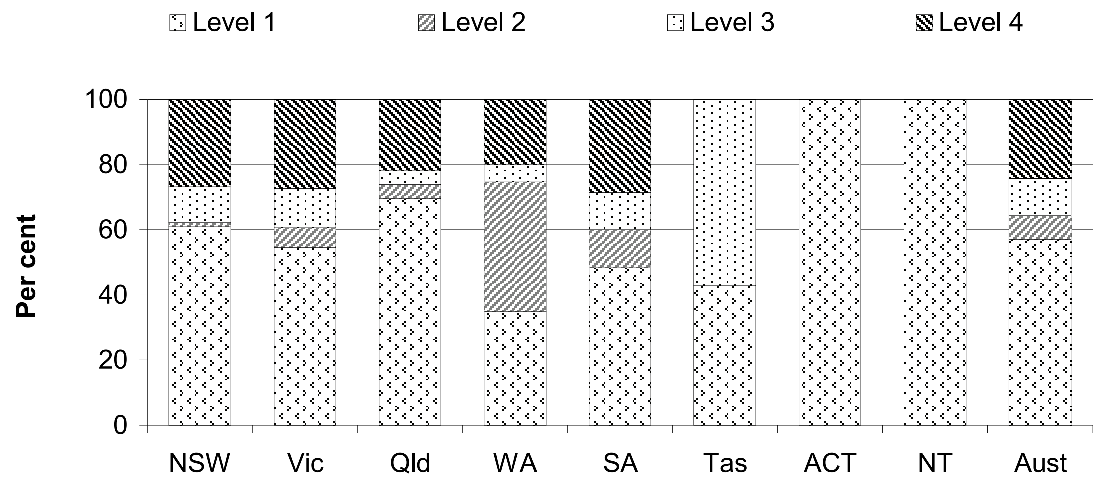
- The proportion of organisations that have in place arrangements that allow consumers to contribute to local service planning and delivery in specialised mental health services. An organisation can be classified at only one level. Arrangements are grouped into four categories:
  - level 1 — organisation has a formal position for mental health consumers on the management committee or a specific mental health consumer advisory group exists to advise on all aspects of service delivery
  - level 2 — organisation has a specific mental health consumer advisory group to advise on some but not all aspects of service delivery
  - level 3 — organisation includes mental health consumers on a broadly based advisory committee
  - level 4 — organisation has minimal/no arrangements for mental health consumer participation in planning and evaluation of services.
- The number of paid FTE consumer consultants per 10 000 clinical staff and the number of paid FTE carer consultants per 10 000 FTE clinicians.

A high or increasing proportion of organisations with level 1 arrangements is desirable, while a high or increasing proportion of organisations with level 4 arrangements is undesirable. High or increasing numbers of paid FTE consumer/carer consultants implies a greater opportunity for consumers and carers to be involved in decision making.

Data reported for this indicator are comparable.

Figure 12.34 illustrates the degree of consumer participation in decision making. Current categories do not match all State or Territory governments’ arrangements for consumer participation in decision making. The Steering Committee has identified that work to improve reporting in this area is needed.

Figure 12.34 **Organisations with consumer participation in decision making, 2007-08**[a, b]



[a] Non-government organisations are included only where they provide staffed residential services. [b] WA data are for public sector services only.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.48.

Table 12.7 illustrates the number of paid FTE consumer and carer consultants per 10 000 FTE clinicians.

Table 12.7 **Paid FTE consumer and carer consultants per 10 000 FTE clinical staff**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Paid consumer consultants per 10 000 clinicians									
2005-06	43.0	38.6	28.5	2.2	16.7	–	43.3	–	31.1
2006-07	37.9	36.6	28.1	3.4	11.8	–	–	–	27.9
2007-08	40.9	38.1	24.1	5.1	24.2	0.6	–	–	29.7
Paid carer consultants per 10 000 clinicians									
2005-06	4.3	23.0	1.2 |	–	–	–	–	–	7.5
2006-07	13.2	26.2	2.5	–	–	–	–	–	11.3
2007-08	10.2	29.5	3.7	3.2	9.5	–	–	–	12.4

– Nil or rounded to zero.

Source: AIHW (unpublished) *MHE NMDS*; State and Territory governments (unpublished); table 12A.48.

Quality — collection of outcomes information (interim indicator)

‘Collection of outcomes information’ is an indicator of governments’ objective that consumer outcomes be monitored (box 12.25). It is an interim process indicator, reflecting the capability of services in establishing systems to collect consumer outcomes information. It will be replaced by information on consumer outcomes when they become available.

Box 12.25 **Collection of outcomes information (interim indicator)**

'Collection of outcomes information (interim indicator)' is defined as the proportion of specialised mental health services that have introduced routine collection of consumer outcomes information.

A high or increasing proportion of services that are collecting consumer outcomes information is desirable.

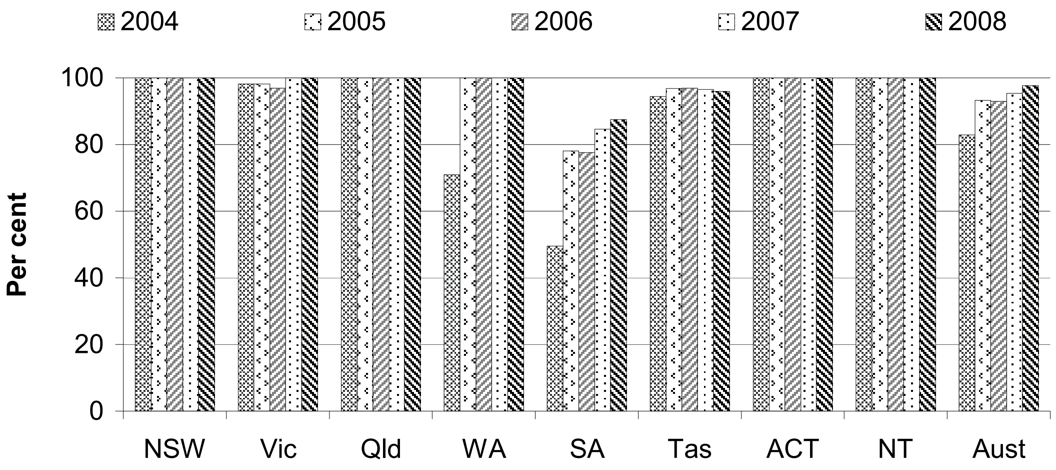
Data reported for this indicator are comparable.

Establishing a system for the routine monitoring of consumer outcomes was introduced as part of the *National Mental Health Plan 2003–2008*. State and Territory governments have taken the following approach to introduce consumer outcomes measurement as part of day-to-day service delivery:

- Introduced measures to include ratings by clinicians and self-ratings by consumers.
- Ensured that all clinical staff have undergone training in collection.
- Established processes to ensure uniformity in collection.
- Funded information systems to store, analyse and report on the data.
- Taken a national approach to data analysis, reporting and benchmarking (DoHA 2002).

The proportions of specialised mental health services that have introduced routine consumer outcomes measurement are shown in figure 12.35.

Figure 12.35 Specialised mental health services that routinely collect consumer outcomes measures, June[a]



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[a] Data are based on reports from jurisdictions. Jurisdictions report at varying levels, reflecting differences in service structure — for example, data can be reported at area health service level or at hospital level, with each level containing a number of specialised mental health services. Data are thus aggregated.

Source: State and Territory governments (unpublished); table 12A.49.

Quality — community follow up for people within the first 7 days of discharge from hospital

'Community follow up for people within the first 7 days of discharge from hospital' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services (box 12.26).

Box 12.26 Community follow up for people within the first 7 days of discharge from hospital

'Community follow up for people within the first 7 days of discharge from hospital' is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services for which a community mental health contact was recorded in the 7 days following separation.

A high or increasing rate of community follow up within the first 7 days of discharge from hospitals is desirable.

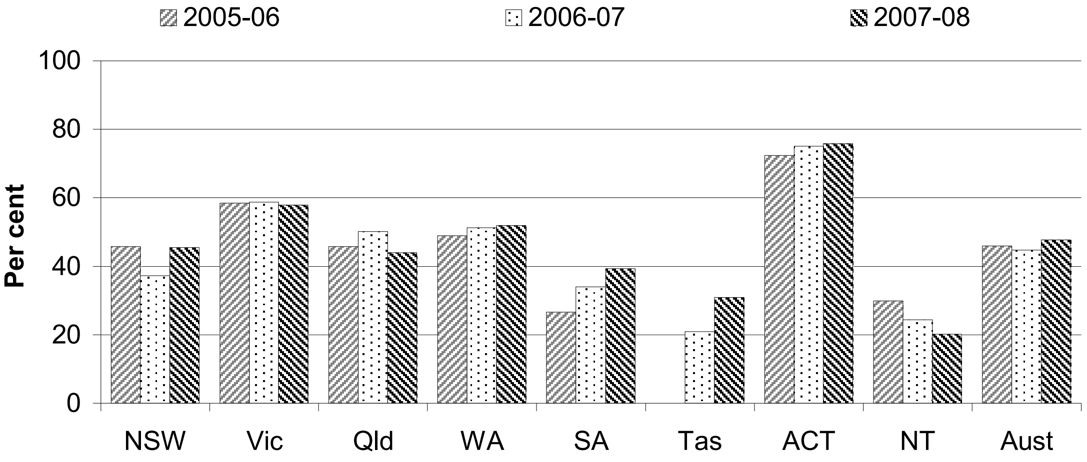
This indicator does not measure the frequency of contacts recorded in the 7 days following separation. It also does not distinguish qualitative differences between phone and face-to-face community contacts.

Data reported for this indicator are not directly comparable.

Continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital (AHMC 2008). A community support system for people who are discharged from hospital after an acute psychiatric episode is essential to maintain clinical and functional stability (NMHWG 2005). Patients leaving hospital with a discharge plan, involving linkages with community services and supports, are less likely to need early readmission.

Data on the rates of community follow up for people within the first 7 days of discharge from hospital are reported in figure 12.36.

Figure 12.36 **Community follow up for people within the first 7 days of discharge from hospital**[a, b, c, d]



[a] Data for 2005-06 and 2006-07 are for the full year, but data for 2007-08 are based on the first 9 months of the year. [b] Community mental health contacts counted for determining whether follow up occurred are restricted to those in which the consumer participated, except for the NT where the data include all contacts (the NT has advised that the impact on the indicator is marginal). Contacts made on the day of discharge are also excluded. [c] Data are not comparable across jurisdictions. SA and Tasmania are not able to accurately track post-discharge follow up between hospitals and community service organisations, due to the lack of unique patient identifiers or data matching systems. For these states, post discharge follow up is regarded to have occurred only when the community mental health contact was recorded by the discharging organisation. Results for these jurisdictions could appear ‘lower’ relative to jurisdictions that are able to track utilisation across services. [d] Tasmanian data for 2005-06 are not available.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers’ Advisory Council (forthcoming); table 12A.50.

Quality — readmissions to hospital within 28 days of discharge

‘Readmissions to hospital within 28 days of discharge’ is an indicator of the governments’ objective to provide effective care and continuity of care in the delivery of mental health services (box 12.27).

Box 12.27 **Readmissions to hospital within 28 days of discharge**

‘Readmissions to hospital within 28 days of discharge’ is defined as the proportion of admitted patient overnight separations from State and Territory psychiatric inpatient services that were followed by readmission to psychiatric inpatient services within 28 days of discharge.

A low or decreasing rate of readmissions to hospital within 28 days of discharge from hospitals is desirable. Higher rates can indicate deficiencies in hospital treatment or community follow up, or a combination of the two (NMHWG 2005).

Readmission rates are affected by factors other than deficiencies in specialised mental health services, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the mental health system (NMHWG 2005). While inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible, readmissions following a recent discharge can indicate that inpatient treatment was either incomplete or ineffective, or that follow up care was inadequate to maintain the person out of hospital (AHMC 2008).

Data reported for this indicator are not directly comparable.

Data on the rates of readmission to hospital within 28 days of discharge are reported in figure 12.37.

Figure 12.37 **Readmissions to hospital within 28 days of discharge**[a, b, c]

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[a] Data for 2005-06 and 2006-07 are for the full year, but data for 2007-08 are based on the first 9 months of the year. [b] No distinction is made between planned and unplanned readmissions because data collection systems in most Australian mental health services do not include a reliable and consistent method to distinguish a planned from an unplanned admission to hospital. [c] Data are not comparable across jurisdictions. SA and Tasmania can only track readmission back to the same hospital from which the person was discharged. For these states, readmissions are regarded to have occurred only when it is recorded by the discharging organisation. Results for these states, could appear 'lower' relative to jurisdictions that are able to track utilisation across services.

Source: AHMC (2010) *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2007-08*, Report prepared under the auspice of the Mental Health Standing Committee of the Australian Health Ministers' Advisory Council (forthcoming); table 12A.51.

Quality — GPs with links to specialised mental health services

'GPs with links to specialised public mental health services' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services. GPs can be an important first point of contact for those with a mental illness (box 12.28).

Box 12.28 **GPs with links to specialised public mental health services**

'GPs with links to specialised public mental health services' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Quality — private psychiatrists with links to public specialised mental health services

'Private psychiatrists with links to public specialised mental health services' is an indicator of governments' objective to provide continuity of care in the delivery of mental health services (box 12.29).

Box 12.29 **Private psychiatrists with links to public specialised mental health services**

'Private psychiatrists with links to public specialised mental health services' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

Sustainability

The Steering Committee has identified sustainability as an area for reporting but no indicators have yet been identified.

Efficiency

Efficiency — cost per inpatient bed day

'Cost per inpatient bed day' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.30).

Box 12.30 **Cost per inpatient bed day**

'Cost per inpatient bed day' is defined as the cost of providing inpatient services per inpatient bed day. Reported real inpatient costs per day are disaggregated by inpatient program type (general mental health services, child and adolescent mental health services, older peoples' mental health services and forensic mental health services) and hospital type (psychiatric hospitals (acute units), psychiatric hospitals (non-acute units) and general hospitals).

A low or decreasing cost per inpatient bed day can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

(Continued next page)

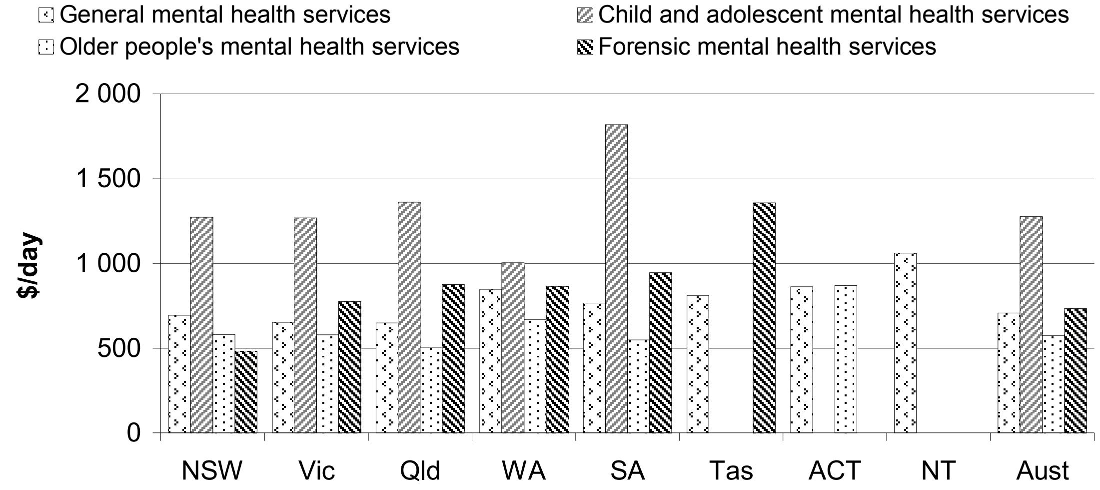
Box 12.30 **(continued)**

This indicator does not account for differences in the client mix and average length of stay. The client mix in inpatient settings can differ — for example, some jurisdictions treat a higher proportion of less complex patients in inpatient settings as distinct from treating them in the community. Longer lengths of stay can also be associated with lower average inpatient day costs because the costs of admission, discharge and more intensive treatment early in a stay are spread over more days of care. A more suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases, to develop a cost per casemix adjusted separation similar to that presented for public hospitals (chapter 10), but as casemix funding has not been applied to specialised mental health services data are not available.

Data reported for this indicator are comparable.

Inpatient costs per day are presented in figures 12.38 (by inpatient target population) and 12.39 (by hospital type). Changes over time partly reflect institutional change in accordance with the NMHS (for example, a shift to the delivery of services in mainstream settings).

Figure 12.38 **Average recurrent cost per inpatient bed day, public hospitals, by target population, 2007-08**[a, b, c, d, e]



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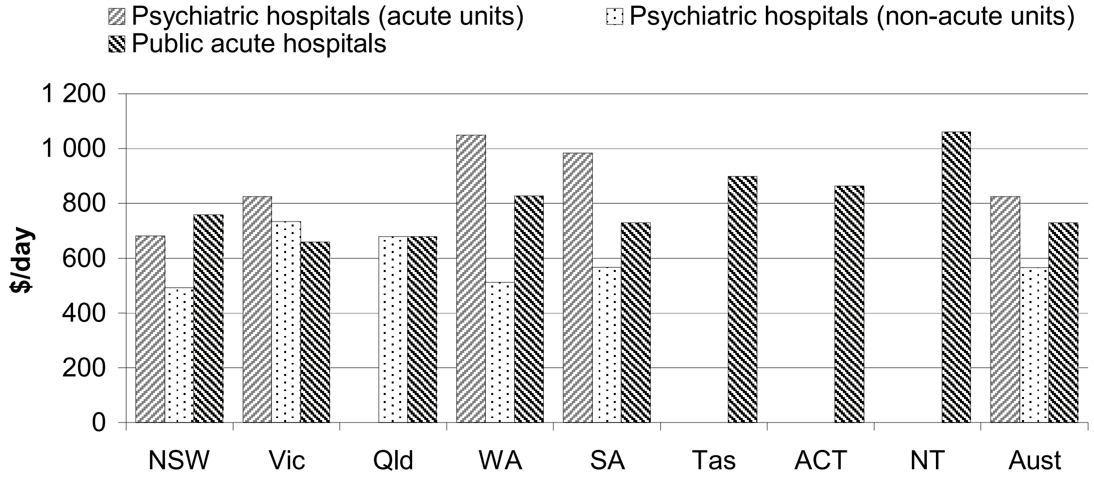
[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland provides older people's mental health services using a variety of different service models, including extended treatment services co-located with other services. These different service models are all reported as older people's mental health services, which lowers the average patient day costs, and limits comparability with the costs of jurisdictions that report these services differently. [d] Tasmania and the NT do not provide, or cannot separately identify, child and adolescent mental health services or older people's mental health services. [e] The ACT does not have separate forensic or child and adolescent mental health inpatient services.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.52.

Figure 12.39 **Average recurrent cost per inpatient bed day, public hospitals, by hospital type, 2007-08**[a, b, c, d, e]



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[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across jurisdictions and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Mainstreaming has occurred at different rates across jurisdictions. Victorian data for psychiatric hospitals comprise mainly forensic services, because nearly all general psychiatric treatment occurs in mainstreamed units in general acute hospitals. This means the client profile and service costs are very different from those of a jurisdiction in which general psychiatric treatment still occurs mostly in psychiatric hospitals. [d] Queensland data for public acute hospitals include costs associated with extended treatment services (campus-based and non-campus-based) that report through general acute hospitals. Queensland does not provide acute services in psychiatric hospitals. [e] Tasmania, the ACT and the NT do not have psychiatric hospitals.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.53.

Efficiency — average cost for community-based residential care

'Average cost for community-based residential care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.31).

Box 12.31 **Average cost for community-based residential care**

‘Average cost for community-based residential care’ is defined as the cost of providing community-based residential care per inpatient day.

A low or decreasing average cost can indicate efficiency, although efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

The indicator does not account for differences in the client mix. The client mix in community-based residential care can differ across states and territories — for example, some jurisdictions treat a higher proportion of more complex patients in community-based residential settings.

Data reported for this indicator are not directly comparable.

These data are likely to be affected by institutional changes occurring as a result of the NMHS (for example, a shift to the delivery of services in mainstream settings). Differences across jurisdictions in the types of patient admitted to community residential care affect average costs in these facilities. Average recurrent costs to government per patient day for these services are reported for both the care of adults and the care of older people. The distinction is made to reflect the differing unit costs of treating the two groups.

The average recurrent cost to government per patient day for community residential services is presented in table 12.8. For general adult units in 2007-08, the average cost to government per patient day for 24 hour staffed community-based residential services was an estimated $362 nationally. For non-24 hour staffed community residential units, the average cost to government per patient day was $123 nationally. For State or Territory governments that had community-based older people’s care units in 2007-08, the average recurrent cost to government per patient day for 24 hour staffed community residential services was $304 nationally (table 12.8).

Table 12.8 Average recurrent cost per inpatient day for community-based residential services, by target population and staffing provided, 2007-08[a, b]

	NSW	*Vic*	*Qld*[c]	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
General adult units									
24 hour staffed	207	405	..	438	357	332	529	263	362
Non-24 hour staffed	93	130	..	123	438	..	98	..	123
Older people's care units									
24 hour staffed	465	287	..	..	..	722	165	..	304
Non-24 hour staffed	154	284	..	..	..	..	..	..	198

[a] Depreciation is excluded. [b] Costs are not adjusted for differences in the complexity of cases across states and territories and can reflect differences in the rate of institutional change (that is, the mainstreaming of mental health services). [c] Queensland does not fund community residential services, although it funds a number of campus-based and non-campus-based extended treatment services. .. Not applicable.

Source: AIHW (unpublished) *MHE NMDS*; table 12A.54.

Efficiency — average cost for ambulatory care

'Average cost for ambulatory care' is an indicator of governments' objective that mental health services be delivered in an efficient manner (box 12.32).

Box 12.32 Average cost for ambulatory care

'Average cost for ambulatory care' indicator is defined by two measures:

- Average cost per episode of ambulatory care provided by community mental health services.
- Average number of community treatment days per episode of ambulatory care provided by community mental health services. This measure is provided along with average costs as frequency of servicing is the main driver of variation in community care costs. It is equivalent to the 'length of stay' efficiency measure for public hospitals.

An episode of ambulatory care is a three month period of ambulatory care for an individual registered patient where the patient was under 'active care' (one or more *treatment* days in the period). Community care periods relate to the following four fixed three monthly periods: January to March, April to June, July to September, and October to December. Treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered client during an ambulatory care episode.

(Continued next page)

Box 12.32 **(continued)**

A low or decreasing average cost or fewer community treatment days can indicate greater efficiency. However, efficiency data need to be interpreted with care as they do not provide any information on the quality of service provided.

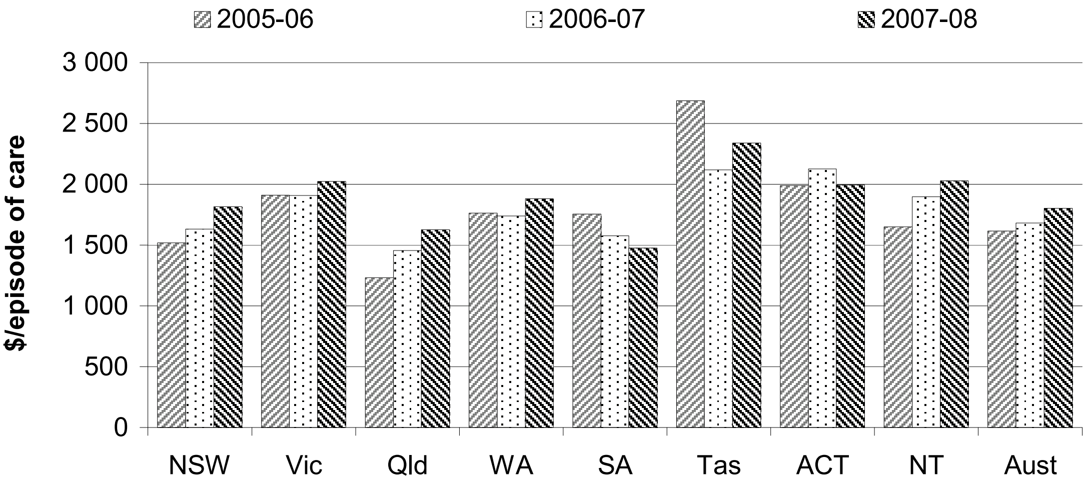
The measures do not account for differences in the client mix. The client mix in community care can differ across jurisdictions — for example, some State and Territory governments treat a higher proportion of more complex patients in community settings.

Data reported for this indicator are not directly comparable.

For this year's Report, two measures from the set of *National Mental Health Key Performance Indicators* replace the measure reported in previous reports. This is the first time these new measures have been reported and work on them is ongoing. The Steering Committee will continue to seek advice on possible modifications and improvements to their formulation for future reports.

Average recurrent cost per episode of ambulatory care data are shown in figure 12.40 and average treatment days per episode of ambulatory care are shown in figure 12.41.

Figure 12.40 **Average recurrent cost per episode of ambulatory care (2007-08 dollars)[a, b]**



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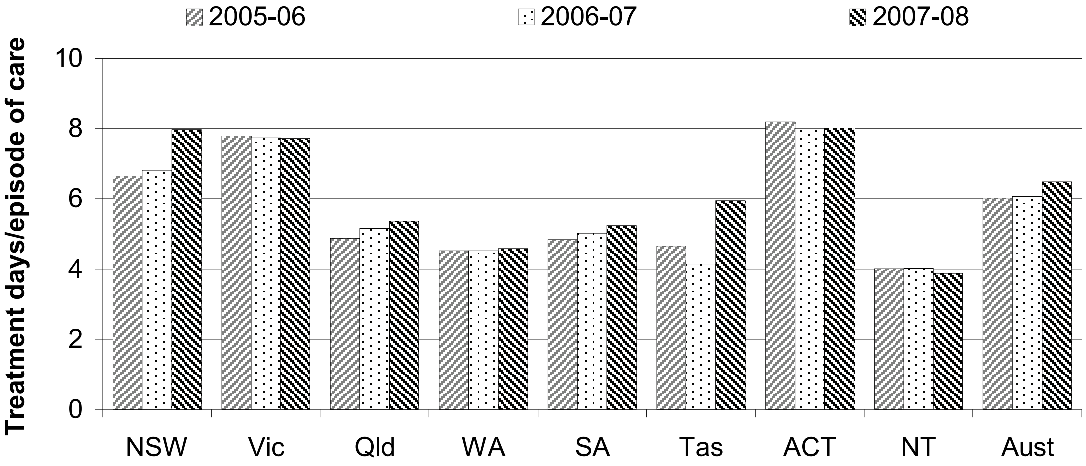
[a] Recurrent expenditure data used to derive this measure have been adjusted (that is, reduced) to account for the proportion of clients in the *CMHC NMDS* that were defined as 'unregistered (or insufficiently identified)'. Therefore, it does not match recurrent expenditure on ambulatory care reported elsewhere. [b] Unregistered (or insufficiently identified) patients have been excluded from the episodes of ambulatory care.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.55.

Figure 12.41 **Average treatment days per episode of ambulatory care**[a]



[a] Unregistered (or insufficiently identified) patients have been excluded from the episodes of ambulatory care and treatment days data.

Source: AIHW (unpublished) *CMHC NMDS*; AIHW (unpublished) *MHE NMDS*; table 12A.55.

Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the actual services delivered) (see chapter 1, section 1.5).

The output indicators reported above focus on specialised mental health services funded by State and Territory governments. The outcome indicators identified and/or reported here are not direct measures of the outcomes for people who access these services. The outcomes identified and/or reported here tend to reflect the performance of governments (including the mental health sector) against the broad objectives of the NMHS.

The whole-of-government approach within the *Fourth National Mental Health Plan 2009–2014* acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system. The fourth plan identifies that the mental health sector must form partnerships with other sectors in order to develop successful interventions (AHMC 2009).

Prevalence of mental illness

'Prevalence of mental illnesses' is an indicator of governments' objective under the NMHS to prevent the development of mental health problems and mental illness where possible (box 12.33).

Box 12.33 **Prevalence of mental illness**

'Prevalence of mental illness' is defined as the proportion of the total population who have a mental illness. Proportions are reported for all people, for males and females and for people of different ages, by disorder type.

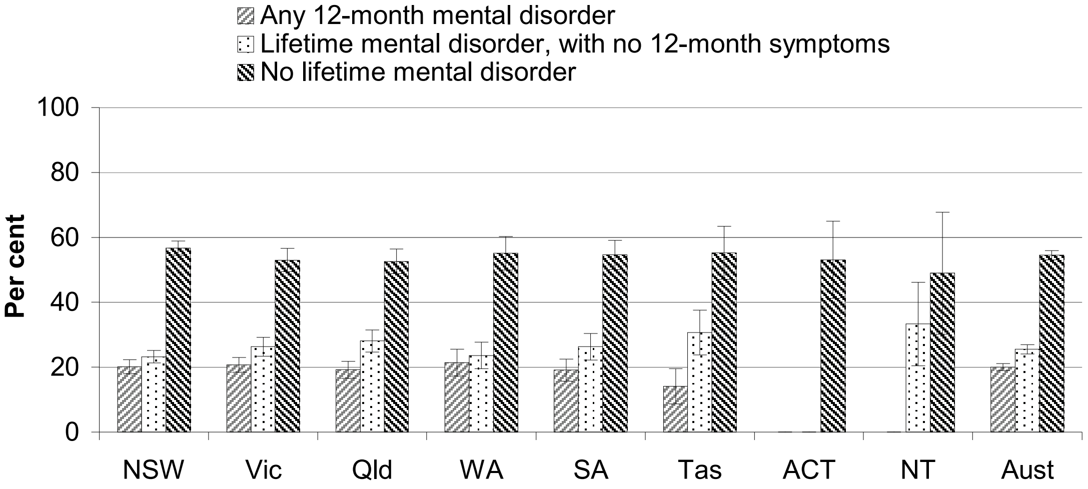
A low or decreasing prevalence of mental illness can indicate that measures to prevent mental illness have been effective.

Reduction in prevalence can be brought about by preventative efforts to stop an illness occurring, or by increasing access to effective treatments for those in whom the illness has begun (AHMC 2008). Many of the risk and protective factors that impact on the development of mental health problems and mental illness lie outside the ambit of the mental health system, in sectors that impact on the daily lives of individuals and communities. These include environmental, sociocultural and economic factors — for example, adverse childhood experiences (such as sexual abuse) and exposure to domestic violence can increase the risk of mental illness, whereas employment is recognised as important in supporting good mental health. A reduction in the prevalence of mental illness, therefore, will be a result of a coordinated response across a range of collaborating agencies including education, justice and community services. Not all mental illnesses are preventable and a reduction of the impact of symptoms and an improved quality of life will be a positive outcome for many people with a mental illness.

Data reported for this indicator are comparable.

Data on the prevalence of mental illness are available from the ABS 2007 SMHWB. The 2007 SMHWB was designed to provide reliable estimates at the national level, not at State and Territory level, however, some jurisdictional data are available and are reported in figure 12.42. The Survey was designed to provide prevalence estimates for the mental disorders that are considered to have the highest incidence rates in the population — anxiety disorders (such as social phobia), affective disorders (such as depression) and substance use disorders (such as harmful alcohol use). The Survey does not measure the prevalence of some severe mental disorders, such as schizophrenia and bipolar disorder.

Figure 12.42 **Prevalence of mental disorders, 2007**[a, b]



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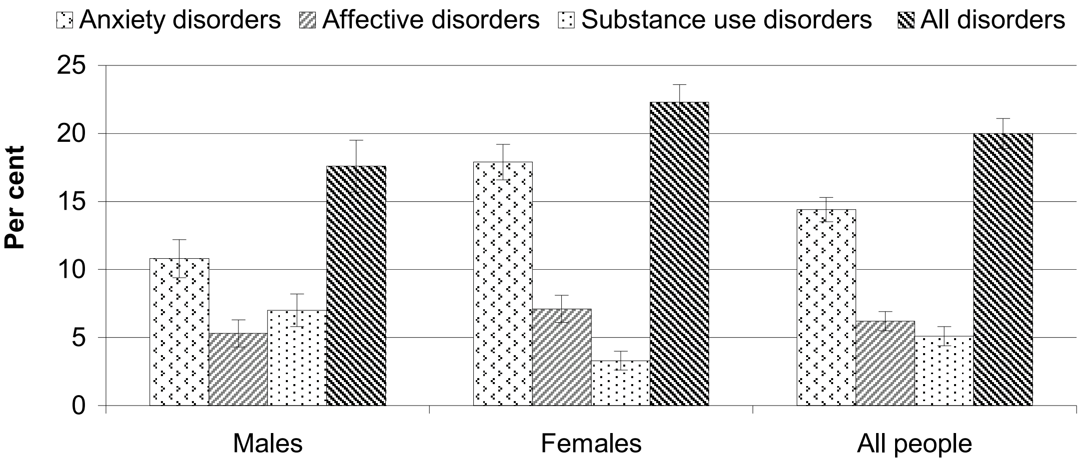
[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] Estimates with RSEs greater than 25 per cent are not published.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.56.

There were differences in the prevalence of 12-month mental disorders between males and females (figure 12.43). Females most commonly experienced anxiety disorders (17.9 ± 1.3 per cent), followed by affective disorders (7.1 ± 1.0 per cent) and substance abuse (3.3 ± 0.7 per cent). Males most commonly suffered anxiety disorders (10.8 ± 1.4 per cent), followed by substance use disorders (7.0 ± 1.2 per cent) and affective disorders (5.3 ± 1.0 per cent).

The prevalence of mental illness was higher among younger people than older people (figure 12.44). Of adults aged 16–24 years, 26.4 ± 2.7 per cent experienced a 12-month mental disorder compared with 8.6 ± 1.6 per cent of people aged 65–74 years and 5.9 ± 2.1 per cent of people aged 75–85 years.

Figure 12.43 **Prevalence of 12-month mental disorders, by sex, 2007**[a, b, c]



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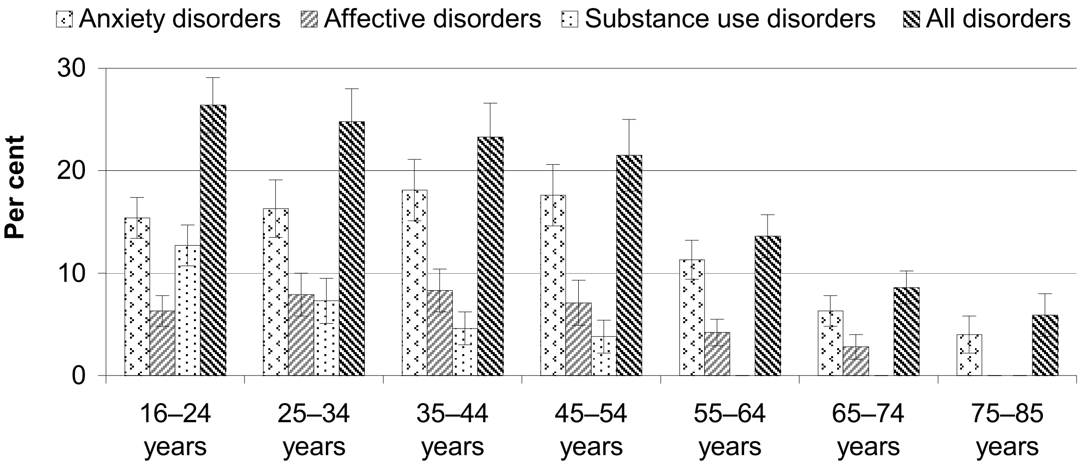
[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] A person can have more than one mental disorder. Therefore, the components might not add to the total of all disorders. [c] People who had a mental disorder with symptoms in the 12 months prior to the survey.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.57.

Figure 12.44 **Prevalence of 12-month mental disorders, by age, 2007**[a, b, c, d]



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[a] Error bars represent the 95 per cent confidence interval associated with each point estimate. [b] A person can have more than one mental disorder. Therefore, the components may not add to the total of all disorders. [c] People who had a mental disorder with symptoms in the 12 months prior to the survey. [d] Estimates with RSEs over 25 per cent are not published.

Source: ABS (unpublished) *2007 SMHWB,* Cat. no. 4326.0; table 12A.58.

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 12.34).

Box 12.34 **Mortality due to suicide**

'Mortality due to suicide' is defined as the suicide rate per 100 000 people. The suicide rate is reported for all people, for males and females, for people of different ages (including those aged 15–24 years), people living in capital cities, people living in other urban areas, people living in rural areas, 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 the intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government departments, 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 agencies.

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.

People with a mental illness are at a higher risk of suicide than are the general population. They are also at a 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 mortality data are the source of suicide statistics in this chapter (ABS 2009). Care needs to be taken in interpreting these suicide statistics as there are indications that suicide deaths in recent years could be underestimated by between 3–16 per cent (Harrison *et al.* 2009). The ABS is one of three main agencies involved in the complex process that generates these statistics. The two other main agencies involved are coroner's offices and the *National*

Coroners Information System. The processes and practices of these agencies have the potential to influence the ways a death is recorded in national mortality data, and consequently whether an 'actual' suicide is reported as a suicide in national statistics. It is also possible that some suicides are not referred to a coroner as they appear similar to death due to natural causes. Harrison J.E. *et al.* (2009) contains a comprehensive discussion of the potential sources of errors that can impact on the quality of suicide statistics.

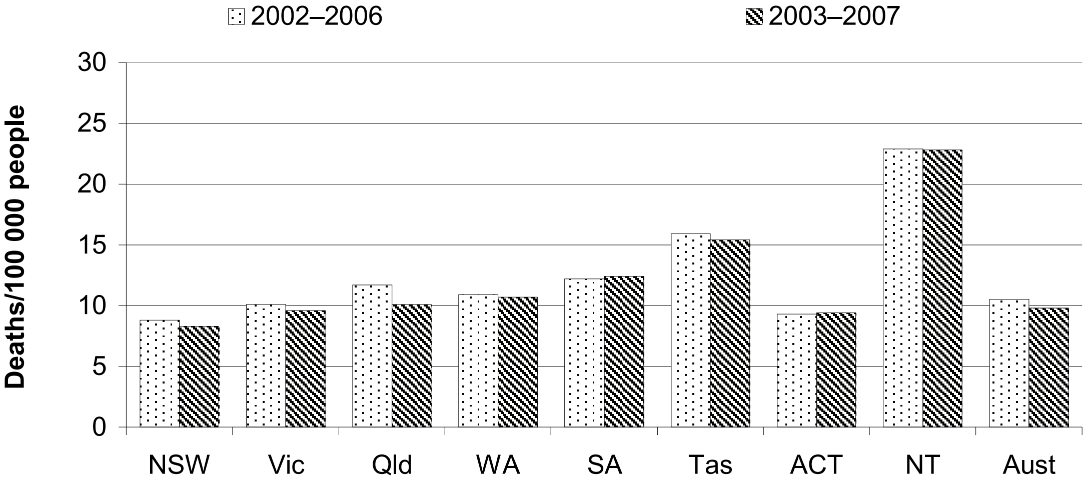
As a response to concerns regarding data quality, the ABS has undertaken a number of investigations (ABS 2007, 2008) and made the changes listed below:

- All coroner certified deaths registered after 1 January 2007 will be subject to a revision process. Previously all ABS processing of causes of death data for a particular reference period was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death (for example, a coroner certified death was yet to be finalised by the Coroner) less specific International Classification of Diseases (ICD) codes were assigned as required by the ICD coding rules. The revision process will enable the use of additional information relating to coroner certified deaths as it becomes available over time resulting in increased specificity of the assigned ICD-10 codes.
- Improved quality assurance processes particularly aimed at assessing and improving the quality of suicide coding have been implemented.
- ABS suicide coding instructions have been revised to ensure greater consistency in coding outcomes.

In the period 2003–2007, 10 094 deaths by suicide were recorded in Australia (table 12A.61) — equivalent to 9.8 deaths per 100 000 people (figure 12.45). The rate for males (15.6 per 100 000 males) was almost four times that for females (4.3 per 100 000 females) in that period — a ratio that was relatively constant over all age groups, except for those aged over 85 years where the male suicide rate was over 9 times the female rate (figure 12.46). Table 12A.62 shows suicide death rates per 100 000 people aged 15–24 years for all jurisdictions.

Nationally the suicide rate in the period 2003–2007 was higher in rural areas. There were 9.1 suicides per 100 000 people in capital cities and 9.9 suicides per 100 000 people in other urban areas, compared with 12.7 suicides per 100 000 people in rural areas in Australia (figure 12.47).

Figure 12.45 **Suicide rates, 5 year average**[a, b]



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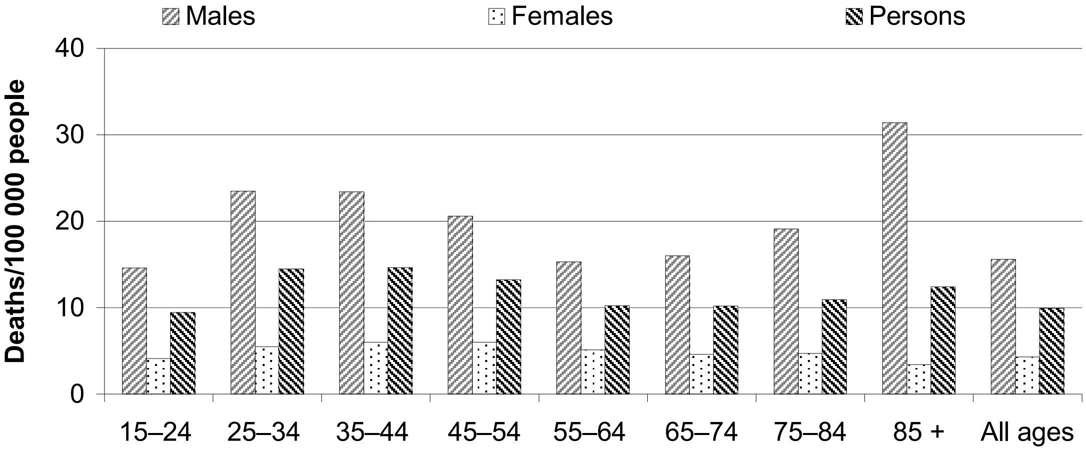
[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.61.

Figure 12.46 **Suicide rates, by age and sex, 2003–2007**[a, b, c]



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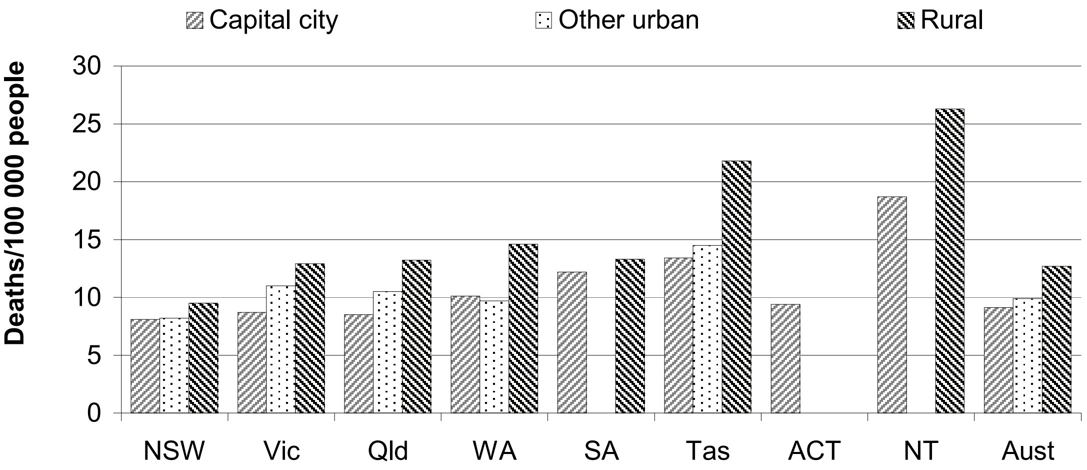
[a] By year of registration of death. Year-to-year variation can be influenced by coronial workloads. [b] The death rate is age standardised to the mid-year 2001 population. [c] Age specific death rates are calculated as the number of suicides for an age group per 100 000 population in the same age group, for the period 2003–2007.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.60.

Figure 12.47 **Suicide rates, by area, 2003–2007**[a, b, c, d]



[a] Area categories are defined as follows: 'capital cities' — comprising capital city statistical divisions; 'urban centres' — based on 'statistical districts' that are urban centres with population >25 000 people, excluding capital city statistical divisions, (three statistical districts cross state boundaries and have to be split across the relevant states/territories — Albury–Wodonga, Canberra–Queanbeyan and Gold Coast–Tweed); 'rural' — balance of State, that is all areas other than capital cities and urban centres. [b] The suicide rate is age standardised to the mid-year 2001 population. [c] Suicides are reported by year of registration of death. [d] SA, the ACT and the NT do not have any 'other urban' areas. The ACT did not have any recorded suicide deaths in 'rural' areas.

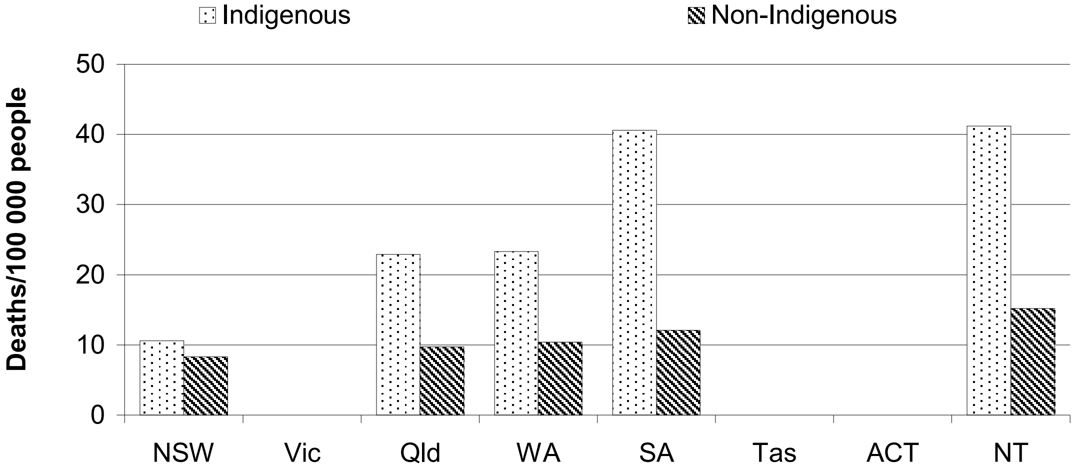
Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.63.

Tables 12A.59–63 contain single year time series suicide data.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.48). After adjusting for differences in the age structure of the two populations, the suicide rates for Indigenous people for the period 2003–2007 were higher than the corresponding rates 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. The Health preface discusses the quality of Indigenous mortality and other data.

Figure 12.48 **Suicide rates, by Indigenous status, 2003–2007**[a, b]



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[a] Indigenous population figures are based on ABS's *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (series B, 2006 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis. [b] Data for Victoria, Tasmania and the ACT are not reported due to varying coverage in the identification of Indigenous deaths in death registrations.

Source: ABS (unpublished) *Causes of Deaths, Australia;* Cat. no. 3303.0; table 12A.64.

Quality of life

'Quality of life' is an indicator of governments' objective to prevent and reduce mental health problems so as to improve the quality of life for people with a mental illness (box 12.35).

Box 12.35 **Quality of life**

'Quality of life' is yet to be defined.

Data for this indicator were not available for the 2010 Report.

12.5 Future directions in performance reporting

Breast cancer

Key challenges for improving reporting of breast cancer include:

- improving the measurement and comparability of existing indicators
- expanding reporting on intervention and treatment and overall performance
- further developing indicators of outcomes.

Existing performance data for breast cancer management place more emphasis on the performance of the BreastScreen Australia Program than on the treatment and ongoing management of breast cancer. This emphasis is largely due to the relative availability of breast cancer screening data across jurisdictions. The Steering Committee aims to expand reporting to incorporate treatment and clinical outcomes data.

Mental health

Key challenges for improving the reporting of mental health management are similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care
- revising the performance indicator framework to ensure reporting remains consistent with government policy objectives for mental health.

A set of key performance indicators for use in Australia's public sector mental health services has been developed, based on the *National Health Performance Framework* and linked to the strategic directions of the *National Mental Health Plan 2009–2014*. Further work is required to develop indicators and data collections in the areas of safety and responsiveness of services. This will then provide data covering all the domains of the *National Health Performance Framework*. Further information can be found in National Mental Health Working Group Information Strategy Committee Performance Indicator Drafting Group (2005).

COAG developments

Report on Government Services (ROGS) alignment with National Agreement reporting

It is anticipated that future editions of health chapters will align with applicable National Agreement (NA) indicators, including the *National Indigenous Reform Agreement*. Further alignment between the ROGS and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

Outcomes from review of ROGS

COAG agreed to Terms of Reference for a Heads of Treasuries/Senior Officials review of the Report in November 2008, to report to COAG by end-September 2009. The review examined the ongoing usefulness of the Report in the context of new national reporting under the Intergovernmental Agreement on Federal Financial Relations.

No significant changes from this review are reflected in the 2010 Report. Any COAG endorsed recommendations from the review are likely to be implemented for the 2011 Report.

12.6 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in this section of the Report.

Australian Government comments

“Through the Council of Australian Governments (COAG), the Australian, State and Territory governments are continuing to work together on the development of initiatives in priority health and aged care reform areas. These include driving improvements in hospitals, health workforce and infrastructure, maternity services, mental health and health services provided in rural areas.

Major reform will continue through the new *National Healthcare Agreement*. This new agreement goes beyond the scope of previous agreements, setting objectives for prevention, primary and community health, hospital and related care, and aged care. The new Agreement has a stronger focus on achieving and monitoring outcomes and provides more funding for public hospitals and the training of doctors and nurses. As part of COAG’s $64 billion boost to health and hospital funding, the Agreement offers $60 billion over five years, an increase of $22 billion over previous agreements.

A Healthier Future for all Australians, the final report by the National Health and Hospitals Reform Commission tasked to provide long term, comprehensive options for health care reform, was released in July 2009. Recommendations from this report, together with the draft *National Primary Health Care Strategy* and the *National Preventative Health Strategy* are being used as the basis for direct consultation with the health sector and the Australian public. These consultations will inform a reform plan to be put to the states and territories in 2010. A public communication website, www.yourhealth.gov.au, has been launched to enable members of the public and organisations in the health sector to provide their views about options for health reform.

Australian Government funding commitments in the 2009-10 budget will contribute to further health reform with delivery of:

- $3.2 billion Health and Hospitals Fund which includes $1.3 billion investment in cancer infrastructure, $1.5 billion to upgrade hospitals and clinical training infrastructure, and $430.3 million in translational research and clinical training facilities
- $120.5 million package to improve maternity services
- $134.4 million package to further support rural and remote based doctors
- 35 per cent increase in GP training places and growing the nursing workforce.

The Government continues to work through COAG’s *Indigenous Health National Partnership* to improve access to primary health care and follow-up services, providing targeted prevention activities to reduce the burden of chronic disease on Indigenous Australia.”

New South Wales Government comments

The continued growth in demand for health services from an ageing population, the need for care of the chronically ill and the increased use of emergency department services are constant pressures on the NSW health system. The NSW Government is striving to provide the best possible care for the people of NSW and, to assist in meeting these demands and expectations, is implementing new models of care to provide greater flexibility and efficiency in the treatment of patients.

The results of these initiatives has seen a marked increase in the number of patients seen within clinical benchmark times in our emergency departments, to be one of the best performing jurisdictions, with 76 per cent of NSW emergency department patients seen within triage category timeframes compared with 69 per cent of patients seen within triage category timeframes across Australia. This high level performance has also been achieved in the reduction of patients waiting more than 365 days for elective surgery, through the strategies of the Predictable Surgery Program.

The NSW Government has been active across a number of cross-jurisdictional and interagency forums, including the Council of Australian Governments (COAG) and the Australian Health Ministers' Conference, and will continue to work with the Commonwealth through COAG to ensure the interests of the people of NSW are represented in the delivery of the reform agenda.

During 2008, a Commission of Inquiry was undertaken into the delivery of acute care services within the NSW public health system, with the development of *Caring Together: The Health Action Plan for NSW*, which includes measures that will be put in place to help improve not just clinical care, but the environment in which that care is delivered, and the compassion and sensitivity with which it is delivered. The plan also includes further work to be undertaken in partnership with the community, doctors, nurses, midwives, allied health and other health workers to develop initiatives aimed at delivering greater sustainability for the public health system. Following on from this, an intergenerational plan will be developed to build on these improvements and deliver a system better able to respond to increases in demand and one that can be passed on with pride to future generations.

The NSW Government is also working to create better experiences for those using public health services by ensuring services are of high quality, appropriate, safe, available when and where needed, and coordinated to meet individual needs. The health system will aim to provide ready access to health services while keeping patients and their carers informed and involved in decisions.

Victorian Government comments

Victorian Government health priorities are in the areas of cancer, infrastructure, providing more services for elective surgery patients and improving access to services for all Victorians. A growing population together with its relative ageing, increasing patient complexity and continued growth in emergency and inpatient activity combine to drive significant increases in demand for health services.

More Victorians are receiving elective surgery as the Victorian Government continues to focus on elective surgery activity and reducing waiting times for patients. In 2008-09, the State and Australian governments provided a combined total of $60 million one-off funding to treat additional elective surgery patients as part of the Elective Surgery Waiting List Reduction Plan.

The *Sustaining Health Service Capacity* initiative ($780.9 million over five years from 2008-09) will significantly boost the capacity for hospitals to provide treatment in the key areas of cancer treatment, acute care and sub-acute services.

In March 2009 the Victorian Government released *Because mental health matters — Victorian mental health reform strategy 2009–19*. Developed through extensive consultation with those who live with mental illness, their families, friends, carers and those who work to support them, the reform strategy represents a commitment by the Government to ensure all Victorians have the opportunities they need to maintain good mental health while also supporting those with a mental illness to access high quality, timely care and live successfully in the community. Implementation of this agenda has already begun, with initiatives announced in the 2009-10 State Budget totalling $182 million over four years.

Victoria has a well established primary health sector which provides significant access to services for the most vulnerable groups in the community, promotes good health, and seeks to intervene early to maximise health outcomes and to prevent or slow progression of ill health. Primary Care Partnerships are a core component of the primary health care sector.

There is a continued focus on working with organisations to:

- close the gap in Indigenous health outcomes by improving access to primary health care
- continue to improve primary health care in Victoria, strengthening agencies' engagement with general practice to support client care, developing and reviewing specific program guidelines to support best practice, and strengthening workforce capacity though a range of development initiatives.

With the continued hard work and dedication of Victoria's health professionals, delivering world class public hospitals and innovation in service delivery the Government is committed to invest and respond to the challenges and increasing demand for hospital services.

Queensland Government comments

Queensland's hospitals and health system have undergone significant reform since the release of the Queensland Government's five-year *Action Plan — Building a better health service for Queensland* in October 2005. The Queensland Government's *Toward Q2: Tomorrow's Queensland and Advancing Health Action* sets ambitious health targets including that Queensland will have the shortest public hospital waiting times in Australia and will cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure.

Queensland Health has implemented a range of initiatives to reduce the number of patients waiting too long for surgery, including using private sector capacity through the Surgery Connect program, as well as increasing internal public hospital capacity through the provision of additional operating theatres. Funding was committed this year to meet increasing demand and provide extra services including $80 million for extra elective surgery procedures and emergency department services.

A total of $122.5 million was invested in 2008-09 to develop clinical solutions to support direct patient care, upgrade supporting infrastructure including telecommunications and develop Queensland Health's e-Health strategy.

These initiatives contributed to the treatment of 125 412 elective surgery patients in 2008-09, a 10 per cent increase on the 114 015 patients who received elective surgery in the previous year. Additionally, the number of 'long-wait' patients on elective surgery waiting lists has fallen by 19.1 per cent from 7510 at 1 July 2008 to 6079 at 1 July 2009.

Queensland Health is committed to faster emergency care in its hospitals with funding allocated for expanded emergency departments ($125.7 million capital and $19.5 million operational over three years), expanded rehabilitation and step down facilities ($69.9 million operational and $14.7 million capital funding over four years) and more nurse practitioners ($7.9 million total operational funding over three years).

In 2008-09, Queensland public hospitals provided 547 929 new case specialist outpatient occasions of service — an increase of 1.8 per cent on the 538 438 occasions of service provided in 2007-08.

Funding of $20 million in 2008-09 has enabled the implementation of strategies to improve outpatient services, including strategies to reduce waiting times for specialist outpatient services in Queensland public hospitals and the development of innovative and complementary models of care.

Our focus on closing the gap on Indigenous health outcomes saw the development and rollout of innovative, award-winning programs such as *Deadly Ears, Deadly Kids, Deadly Communities: 2009–2013*, a commitment to better manage ear health conditions affecting Aboriginal and Torres Strait Islander children across Queensland.

In 2009-10, the Queensland Health budget will grow to $9.04 billion, an increase of 8.2 per cent on the 2008-09 budget.

Western Australian Government comments

WA Health — the Western Australian public health system — works to ensure healthier and better lives for all Western Australians and to protect the health of the WA community by providing a safe, high quality, accountable and sustainable health care system. WA Health has been implementing innovative solutions to improve access to appropriate health care within constraints resulting from global and local economic conditions, growing demand for healthcare services, a worldwide shortage of healthcare personnel, burgeoning technology costs and growth of lifestyle diseases.

Managing unplanned care — To counter the increasing number of attendances, innovative reforms are being implemented to improve emergency care and manage the demand on the emergency departments. The *Four-hour Rule* program will ensure that the majority of patients arriving at emergency departments are admitted, discharged or transferred within a four-hour timeframe, unless the patient needs to remain in the emergency department for clinical reasons. Additionally, the FINE (*Friend in Need – Emergency*) program is another innovation to aid the reduction of emergency departments' traffic by providing alternative care arrangements to hospitalisation for older and chronically ill patients. Under this program, service liaison staff in emergency departments ensure timely arrangement of service delivery in community settings.

Elective surgery — Population growth and improvements in outpatient processes have seen the demand on surgical waitlists increased. Reform over the past year has seen WA Health performing more elective surgery procedures.

Health Workforce — In addressing changing population demographics, accelerating retirement rates and workforce sustainability, WA Health has increased the number of medical interns employed and introduced initiatives to expand nurse numbers and support professional development.

Aboriginal health — WA Health has continued to work towards the improvement of Aboriginal health by developing and implementing appropriate strategies to progress initiatives under the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*. WA Health is committed to ensuring Aboriginal community involvement which is central to achieving improved health outcomes for Aboriginal individuals, families and communities.

Health Promotion, Protection and Prevention — WA Health has continued to work towards improving lifestyles, preventing ill-health and implementing long term, integrated health promotion campaigns to combat childhood obesity and prevent chronic disease. Initiatives that have been implemented to combat childhood obesity include *Unplug and Play*, the *School Breakfast Program* and *Make Tracks2 School*.

Primary Care and chronic disease management — Substantial progress has been made in primary health, care and management of long-term conditions, and the application and implementation of health and medical research.

South Australian Government comments

Following *South Australia's Health Care Plan 2007–2016*, several new action plans to enhance the health of South Australians were released including the *Chronic Disease Action Plan*, the *HIV Action Plan* and the *Hepatitis C Action Plan*. The action plans make practical recommendations to address the continued and emerging challenges of chronic disease, HIV and Hepatitis C, and ultimately decrease the burden on our health system. These plans include priorities and actions that complement existing initiatives by the South Australian and Australian governments in a partnership approach with non-government organisations, health professionals, research organisations and the community.

SA Health undertook initiatives during 2009 to make preventative health a focus and priority. A multitude of projects concentrated on achieving healthy weight for South Australians of all ages, reducing cigarette smoking and providing support for new parents and their newborn babies. The *Obesity Prevention and Lifestyle* initiative was commenced, a three way partnership between Australian, State and local governments to promote healthy eating and physical activity.

On 17 May 2009 the Australian Government announced, in response to a proposal by the South Australian Government, that a $200 million state of the art Health and Medical Research Institute would be built close to the new Royal Adelaide Hospital on North Terrace. This is an exciting development bringing significant benefits to South Australia's economy and ensuring South Australia has a leading role on the global health and medical research stage.

Planning for the most advanced hospital in Australia, the $1.7 billion new Royal Adelaide Hospital continues with the development of a *Model of Care* and the release of an Expression of Interest for services in design, construction, commissioning, finance and facilities management. The *Model of Care* strives for clinical excellence and quality of care through a patient centred approach. The site remediation plan being developed will contribute to rehabilitation of the environment, improved access to the River Torrens, and new cultural and open spaces.

During 2008-09 $78 million was invested in capital projects to redevelop metropolitan hospitals and health service infrastructure. The investment includes: continued refurbishment of the Flinders Medical Centre Coronary Care Unit and construction of a new south wing extension, completion of the research facilities and infrastructure upgrades as part of the stage 2B redevelopment of The Queen Elizabeth Hospital and continued redevelopment of the Lyell McEwen Hospital including a 30 bed adult acute mental health unit, a 20 bed aged acute mental health unit and the completion of a SA Pathology facility. An additional $17 million was invested in the purchase of major medical equipment.

The *Mental Health Act 2009* (SA) was passed by Parliament in June 2009. The new Act expands and protects the rights of people with mental illness. It recognises the needs of people from culturally and linguistically diverse backgrounds, the role of carers and the circumstances of children who are experiencing or who are affected by people with a serious mental illness.

Tasmanian Government comments

“The Tasmanian Government is focused on putting its patients and clients at the centre of all it does.

In May 2007, the Tasmanian Government released *Tasmania’s Health Plan* — the most significant health reform the State has ever undertaken. *Tasmania’s Health Plan* is based on providing services as close as possible to where people live, as long as sustainability, quality and safety standards are met in all cases.

The principles of *Tasmania’s Health Plan* have now been built into the ongoing work of the Department of Health and Human Services and are reflected in the reform agenda in *09–12 Strategic Directions*. *Tasmania’s Health Plan* is one of six key *Future Health* strategic reforms to be implemented over the next three years.

The others include: the reform of mental health services (*Bridging The Gap*); safety and quality reforms (*Keeping Our Services Safe*); Tasmania’s elective surgery improvement plan (*Improving Time to Treatment*); a strategic approach to health promotion (*Working in Health Promoting Ways*); and strategies for an adaptive health professional workforce (*Leading the Way*).

For the period 2009–12, the Agency has set the following five key strategic objectives:

- Supporting individuals, families and communities to have more control over what matters to them.
- Promoting health and wellbeing and intervening early when needed.
- Developing responsive, accessible and sustainable services.
- Creating collaborative partnerships to support the development of healthier communities.
- Shaping our workforce to be capable of meeting changing needs and future requirements.

Practically, this approach is reflected in the recent establishment of the three Area Health Services, providing local management and accountability. Health Department central administration has been reduced in size and accounts for less than 3 per cent of the health budget.

Significant funding has been provided in 2009-10 for major initiatives including: upgrades at the Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and several Community Health Centres; developments of the Clarence GP Super Clinic and Integrated Care Centre (ICC) and the Launceston ICC (in partnership with the Australian Government); improvements in health information technology; improving the alcohol and drug sector and continuing the implementation of the Better Dental Care package.”

Australian Capital Territory Government comments

“The ACT Government provides health services to local residents through two major hospitals: Canberra Hospital and Calvary Public Hospital. These public hospitals provide the full range of acute care, including inpatient, outpatient and emergency department services. Both hospitals are teaching hospitals in cooperation with the Australian National University’s Medical School and the University of Canberra. Canberra Hospital is the major trauma referral hospital for the ACT and surrounding area of NSW with a quarter of public hospital separations being for residents of NSW.

In 2007, the ACT Government published *access health*, a key health document which sets the future direction for ACT public health services until 2010. *access health* is about ensuring that people have access to the right type of health care with better collaboration with the primary health care sector to ensure the provision of health services that meet people’s needs.

The year 2007-08 demonstrated a more efficient public hospital system in the ACT with the public hospitals exceeding the Government’s objective of reducing the ACT’s average cost of hospital services to within 10 per cent of the national average ahead of the deadline of 2011-12. The ACT’s 2007-08 average cost per casemix-adjusted separation is now about 6.6 per cent above the national average. This demonstrates a major improvement from the 2002-03 figure of 30 per cent above the national average cost.

In the year 2007-08, the ACT’s bed capacity also increased by 8 per cent from 785 beds in 2006-07 to 851 beds in 2007-08.

The most exciting development for the ACT’s public health care system was the completion of the Capital and Asset Development Plan (CADP). The CADP was requested by the ACT Minister for Health as an assessment of the projected health system demands up to 2021-22. The CADP was a total assessment of capital stock, workforce and infrastructure requirements across the ACT health care system.

As a result of the CADP, the ACT Government has committed to a $1 billion plus overhaul of the health system, and appropriated $300 million as the first tranche in the 2008-09 Budget. This program will take seven to 10 years to complete, and will be one of the most significant investments in public health infrastructure across Australia.”

Northern Territory Government comments

- The Northern Territory is a culturally diverse and geographically dispersed jurisdiction where 30 per cent of the population are Aboriginal. Together with acknowledged health and wellbeing challenges a range of factors place a significant impost on service design, delivery and evaluation efforts. The Department of Health and Families is the major provider and funder for hospital and community services in the Territory and is responsible for the majority of primary care to Territorians. Aboriginal Territorians consume the majority of health and wellbeing services provided by the department.
- Local demographic, cultural and market circumstances demand innovative approaches to service design and delivery. Building an integrated health system inclusive of community controlled providers and which bridges the space between health centres and families and individuals has been critical. The introduction of transdisciplinary Aboriginal Community Workers, a Cultural Security framework and strengthened community engagement frameworks and functions have created further opportunities for gain.
- The department has an extensive collaborative relationship with many non-government organisations to ensure optimal service coverage for Territorians. The NT has well established partnerships with the Aboriginal community controlled health sector and the Australian Government through which significant levels of joint primary care planning, service development and performance monitoring occurs.
- With responsibility for the five public hospitals located in each of the major population centres, Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs, and inpatient mental health services available in Darwin and Alice Springs, the department works closely with the Darwin Private Hospital and other jurisdictions to meet acute care needs. Territorians sometimes have to travel to access medical care and this is supported by an expanding Shared Electronic Health records service and specialist health access programs for travel to hospital, between hospitals and interstate when required.
- A priority for this jurisdiction is to help and support people to better manage their health and wellbeing closer to home and where possible in a non-acute setting. The Palmerston Urgent Care After Hours Service has commenced operation to take pressure off the Emergency Department at Royal Darwin Hospital. Some remote communities now have access to relocatable self care renal dialysis facilities. Midwifery Group Practice has been developed to allow for the continuity of care through the later stage of pregnancy, labour, birth and early postnatal period for women travelling to urban centres to give birth. Substantial progress has been made on the construction of the radiation Oncology unit and accommodation. This will allow care closer to home for patients requiring this service.

12.7 Definitions of key terms and indicators

AR-DRG v5.1 (Australian refined diagnosis related group, version 5.1)	A patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG v5.1 is based on the ICD-10-AM classification.
Casemix adjustment	Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis related groups (AR-DRGs) that represent a class of patients with similar clinical conditions requiring similar hospital services.
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.
Incidence rate	Proportion of the population experiencing a disorder or illness for the first time during a given period (often expressed per 100 000 people).
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.

Breast cancer

Breast conserving surgery	An operation to remove the breast cancer but not the breast. Types of breast conserving surgery include lumpectomy (removal of the lump), quadrantectomy (removal of one quarter of the breast) and segmental mastectomy (removal of the cancer as well as some of the breast tissue around the tumour and the lining over the chest muscles below the tumour).
Cost per woman screened	The total cost of the provision of breast screening services, divided by the number of women screened. The total cost includes the cost of providing the BreastScreen Australia program in each jurisdiction, in addition to the cost of providing the program to women.
Detection rate for small cancers	The rate of small (less than or equal to 15 millimetres in diameter) invasive breast cancers detected per 10 000 women screened.
Ductal carcinoma in situ	A non-invasive tumour of the mammary gland (breast) arising from cells lining the ducts. Also known as intraductal carcinoma.
Invasive cancer	A tumour whose cells invade healthy or normal tissue.
Modified radical mastectomy	Surgery for breast cancer in which the breast, some of the lymph nodes under the arm, the lining over the chest muscles, and sometimes part of the chest wall muscles are removed.
Mortality rate from breast cancer	The age-specific and age standardised mortality rates of women who die as a result of breast cancer, expressed per 100 000 women in the population.
Participation	The number of women resident in the catchment area screened, divided by the number of women resident in the catchment area, expressed as a percentage. If a woman is screened more than once during the reference period, then only the first screen is counted.

	Catchment area is a geographic region based on service size in relation to the population, accessibility and the location of other services. It is uniquely defined for each service based on postcode or statistical local area.
Radiation therapy	The use of high energy radiation from X-rays, gamma rays, neutrons, and other sources to kill cancer cells and shrink tumours. Radiation can come from a machine outside the body (external beam radiation therapy) or from materials called radioisotopes. Radioisotopes produce radiation and can be placed in or near the tumour or in the area near cancer cells. This type of radiation treatment is called internal radiation therapy, implant radiation, interstitial radiation or brachytherapy. Systemic radiation therapy uses a radioactive substance (such as a radiolabelled monoclonal antibody) that circulates throughout the body.
Screening	The performance of tests on apparently well people to detect a medical condition at an earlier stage than otherwise would be the case.
Screening round (first)	A woman's first visit to a BreastScreen Australia mammography screening service.
Screening round (subsequent)	A woman's visit to a BreastScreen Australia mammography screening service when she has previously attended such a service.
Size of detected cancers	Invasive cancers detected, classified according to tumour size.
Total mastectomy	Removal of the breast — also known as simple mastectomy.

Mental health

Acute services	Services that primarily provide specialised psychiatric care for people with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort focuses on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short term treatment. Acute services can: • focus on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric illness for whom there has been an acute exacerbation of symptoms • target the general population or be specialised in nature, targeting specific clinical populations. The latter group include psychogeriatric, child and adolescent, and forensic mental health services.
Affective disorders	A mood disturbance, including mania, hypomania, bipolar affective disorder, depression and dysthymia.
Ambulatory care services	Mental health services dedicated to the assessment, treatment, rehabilitation or care of non-admitted inpatients, including but not confined to crisis assessment and treatment services, mobile assessment and treatment services, outpatient clinic services (whether provided from a hospital or community mental health centre), child and adolescent outpatient treatment teams, social and living skills programs (including day programs, day hospitals and living skills centres), and psychogeriatric assessment teams and day programs.
Anxiety disorders	Feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive–compulsive disorder and post-traumatic stress disorder.
Available beds	The number of immediately available beds for use by admitted

	patients if required. Beds are immediately available for use if located in a suitable place of care with nursing or other auxiliary staff available within a reasonable period. In many cases, available beds will be less than the number of approved beds, with the former controlled by utilisation factors and resourcing levels, while the latter refers to the maximum capacity allowed for the hospital, given sufficient resources and community demand.
Child and adolescent mental health services	Services principally targeted at children and young people up to the age of 18 years. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on children or adolescents. These services can include a forensic component.
Co-located services	Psychiatric inpatient services established physically and organisationally as part of a general hospital.
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.
Co-morbidity	The simultaneous occurrence of two or more illnesses such as depressive illness with anxiety disorder, or depressive disorder with anorexia.
Consumer involvement in decision making	Consumer participation arrangements in public sector mental health service organisations according to the scoring hierarchy (levels 1–4) developed for monitoring State and Territory performance under Medicare Agreements Schedule F1 indicators.
Cost per inpatient bed day	The average patient day cost according to the inpatient type.
Depression	A state of gloom, despondency or sadness lasting at least two weeks. The person usually suffers from low mood, loss of interest and enjoyment, and reduced energy. Sleep, appetite and concentration can be affected.
Forensic mental health services	Services principally providing assessment, treatment and care of mentally ill individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.
General mental health services	Services that principally target the general adult population (18–65 years old) but that can provide services to children, adolescents or older people. Includes, therefore, those services that cannot be described as specialised child and adolescent, older people's or forensic services. General mental health services include hospital units whose principal function is to provide some form of specialised service to the general adult population (for example, inpatient psychotherapy) or to focus on specific clinical disorders within the adult population (for example, post-natal depression, anxiety disorders).
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.
Mental health promotion	Actions taken to maximise mental health and wellbeing among populations and individuals. It is aimed at changing environments (social, physical, economic, educational, cultural) and enhancing the 'coping' capacity of communities, families and individuals by giving power, knowledge, skills and necessary resources.
Mental illness prevention	Interventions that occur before the initial onset of a illness to prevent its development. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental illnesses.
Mortality rate from suicide	The percentage of the population who die as a result of suicide.
Non-acute services	Non-acute services are defined by two categories: • Rehabilitation services that have a primary focus on intervention to reduce functional impairments that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery. They are characterised by an expectation of substantial improvement over the short to mid term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms. • Extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which can include high levels of severe unremitting symptoms of mental illness. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.
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.
Older people's mental health services	Services principally targeting people in the age group 65 years or over. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient service on aged people. These services can include a forensic component. Excludes general mental health services that may treat older people as part of a more general service.
Outpatient services — community-based	Services primarily provided to non-admitted patients on an appointment basis and delivered from health centres located in community settings, physically separated within hospital sites. They can include outreach or domiciliary care as an adjunct to services provided from the centre base.
Outpatient services	Services primarily provided to non-admitted patients on an appointment basis and delivered from clinics located within hospitals.

— hospital-based	They can include outreach or domiciliary care as an adjunct to services provided from the clinic base.
Patient days (occupied bed days)	All days or part days for which patient was in hospital during the reporting year (1 July to 30 June), regardless of the original date of admission or discharge. Key definitional rules include the following: • For a patient admitted and discharged on different days, only the day of admission is counted as a patient day. • Admission and discharge on the same day are equal to one patient day. • Leave days are not included when they involve an overnight absence. • A patient day is recorded on the day of return from leave.
Percentage of facilities accredited	The percentage of facilities providing mental health services that are accredited according to the National Standards for Mental Health Services.
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.
Public (non-psychiatric) hospital	A hospital that provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and around-the-clock, comprehensive, qualified nursing services, as well as other necessary professional 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.
Specialised mental health inpatient services	Services provided to admitted patients in stand-alone psychiatric hospitals or specialised psychiatric units located within general hospitals.
Specialised mental health services	Services whose primary function is specifically to provide treatment, rehabilitation or community support targeted towards people affected by a mental illness or psychiatric disability. Further, such activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health function. This criterion applies regardless of the source of funds.
Specialised residential services	Services provided in the community that are staffed by mental health professionals on a 24 hour basis.
Staffing categories (mental health)	Medical officers: all medical officers employed or engaged by the organisation on a full time or part time basis. Includes visiting medical officers who are engaged on an hourly, sessional or fee-for-service basis. Psychiatrists and consultant psychiatrists: medical officers who are registered to practice psychiatry under the relevant State or Territory medical registration board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health

Insurance Commission as a specialist in Psychiatry.

Psychiatry registrars and trainees: medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Other medical officers: medical officers employed or engaged by the organisation who are not registered as psychiatrists within the State or Territory, or as formal trainees within the Royal Australian and New Zealand College of Psychiatrists' Postgraduate Training Program.

Nursing staff: all categories of registered nurses and enrolled nurses, employed or engaged by the organisation.

Registered nurses: people with at least a three year training certificate or tertiary qualification who are certified as being a registered nurse with the State or Territory registration board. This is a comprehensive category and includes general and specialised categories of registered nurses.

Enrolled nurses: Refers to people who are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Diagnostic and health professionals: qualified staff (other than qualified medical or nursing staff) who are engaged in duties of a diagnostic, professional or technical nature. This category covers all allied health professionals, such as social workers, psychologists, occupational therapists, physiotherapists, and other diagnostic and health professionals.

Social workers: people who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Psychologists: people who are registered as psychologists with the relevant State or Territory registration board.

Occupational therapists: people who have completed a course of recognised training and who are eligible for membership of the Australian Association of Occupational Therapists.

Other personal care staff: attendants, assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants who are engaged primarily in the provision of personal care to patients or residents, and who are not formally qualified or who are undergoing training in nursing or allied health professions.

Administrative and clerical staff: staff engaged in administrative and clerical duties. Excludes medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties, who should be counted under their appropriate occupational categories. Civil engineers and computing staff are included in this category.

Domestic and other staff: staff involved in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

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).

12.8 Attachment tables

Attachment tables are identified in references throughout this chapter by a '12A' suffix (for example, table 12A.3). Attachment tables are provided on the CD-ROM enclosed with the Report and on the Review website (www.pc.gov.au/gsp). Users without access to the CD-ROM or the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

Breast cancer

Mental health

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