12 Mental health management

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| Attachment tables are identified in references throughout this Indigenous Compendium by an ‘12A’ prefix (for example, in this chapter, table 12A.1). As the data are directly sourced from the 2014 Report, the Compendium also notes where the original table, figure or text in the 2014 Report can be found. For example, where the Compendium refers to ‘2014 Report, p. 12.15’ this is page 15 of chapter 12 of the 2014 Report, and ‘2014 Report, table 12A.1’ is attachment table 1 of attachment 12A of the 2014 Report. A list of attachment tables referred to in the Compendium is provided at the end of this chapter, and the full attachment tables are available from the Review website at www.pc.gov.au/gsp. |
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The Mental health management chapter (chapter 12) in the *Report on Government Services 2014* (2014 Report) reports on the management of mental health in Australia. Data are reported for Indigenous Australians for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the Australian, State and Territory governments’ management of mental health and mental illnesses through a variety of service types and delivery settings.

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).

Mental illness is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual’s mental health, functioning and quality of life. Each mental illness is unique in its incidence across the lifespan, causal factors and treatments. The most common mental illnesses are anxiety, affective (mood) and substance use disorders. Mental illness also includes low prevalence conditions such as schizophrenia, bipolar disorder and other psychoses, and severe personality disorder (DoHA 2010). While of lower prevalence, these conditions can severely affect people’s ability to function in their daily lives (Morgan et al. 2011).

Specialised mental health management services offered by a range of government and non‑government service providers include promotion, prevention, treatment, management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and 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.

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

### Indigenous data in the Mental health management chapter

The Mental health management chapter or attachment in the 2014 Report contains the following data for Indigenous Australians:

* age standardised rate of adults with high/very high levels of psychological distress
* use of State and Territory specialised public mental health care reported, by service type
* proportion of the population using State and Territory specialised public mental health services
* proportion of the population using MBS-subsidised ambulatory mental health services
* rate of community follow up within first seven days of discharge from a psychiatric admission
* suicide deaths.

### Size and scope of sector

#### Prevalence and impact of mental illness

According to the National Survey of Mental Health and Wellbeing (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 (2014 Report, table 12A.56). 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 (2014 Report, table 12A.56).

A proxy measure of the overall mental health and wellbeing of the population is the Kessler 10 (K10) psychological distress scale. Data from the 2007 SMHWB show that 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 or very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (2014 Report, table 12A.7). Analysis of the 1997 SMHWB showed a strong association between a high/very high K10 score and a current diagnosis of anxiety and affective disorders (ABS 2012). According to the ABS, which uses the K10 instrument in the SMHWB and National Health Surveys (NHS), the K10:

… is a scale designed to measure non‑specific psychological distress, based on questions about negative emotional states experienced in the past 30 days. … it is not a diagnostic tool, but an indicator of current psychological distress, where very high levels of distress may signify a need for professional help. It is also useful for estimating population need for mental health services (ABS 2012).

Females had higher proportions of very high levels of psychological distress than males in 2011‑12 (2014 Report, figure 12.5). People with disability or restrictive long‑term health condition and people in low socio‑economic areas also reported higher proportions of very high levels of psychological distress than other community groups (2014 Report, table 12A.9). In 2012‑13, 29.4 ± 2.1 per cent of Indigenous Australians aged 18 years or over reported high/very high levels of psychological distress (table 12A.15). After adjusting for age, this was 2.7 times the rate for non‑Indigenous adults.

#### Admitted patient care and community-based mental health services — service use, patient days, beds and staffing

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

There were 86 669 separations with specialised psychiatric care in public acute hospitals and 9561 specialised psychiatric care separations in public psychiatric hospitals in 2010‑11 (2014 Report, table 12A.19). Schizophrenia accounted for a large proportion of separations with specialised psychiatric care in public hospitals (21.0 per cent in public acute hospitals and 22.4 per cent in public psychiatric hospitals) (2014 Report, table 12A.19). Ambulatory equivalent specialised psychiatric care is also provided in public hospitals. In 2009‑10, the latest year for which data are published, there were 5193 of these separations from public acute hospitals and 132 in public psychiatric hospitals (AIHW 2013).

There were 4234 episodes of community‑based residential care in 2010‑11   
(table 12A.21). Schizophrenia, schizotypal and delusional disorders (F20‑29) as a principal diagnosis accounted for the largest proportion of these episodes   
(61.5 per cent) (AIHW 2013). There were 7.2 million community‑based ambulatory care patient contacts, equivalent to 326.8 contacts per 1000 people, in 2010‑11 (table 12A.21). For those contacts, the largest proportion was for the principal diagnosis of schizophrenia (25.6 per cent) (AIHW 2013).

Data on service use by the Indigenous status of patients are available, but comparisons are not necessarily accurate because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous Australians, and differences in the complexity, incidence and prevalence of illnesses between Indigenous and non‑Indigenous Australians. Table 12A.21 contains information on use of these services by Indigenous status.

### Framework of performance indicators for mental health management

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

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

The framework of performance indicators for mental health services draws on governments’ broad objectives for national mental health policy, as encompassed in the *National Mental Health Policy 2008* (box 12.1). The performance indicator framework reports on the equity, effectiveness and efficiency of mental health services. It covers a number of service delivery types (MBS‑subsidised, admitted patient and community‑based services) and includes outcome indicators of   
system‑wide performance.

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| Box 12.1 Broad objectives and policy directions of National Mental Health Policy |
| The *National Mental Health Policy 2008* has an 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. The key broad objectives are to:   * promote the mental health and well‑being of the Australian community and, where possible, prevent the development of mental health problems and mental illness * reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community * promote recovery from mental health problems and mental illness * assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.   The key policy directions are summarised as follows:   * Rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected. * Mental health promotion will support destigmatisation and assist people to be emotionally resilient, cope with negative experiences and participate in the community. * The proportion of people with mental health problems, mental illness and people at risk of suicide will be reduced. * Emerging mental health problems or mental illnesses will receive early intervention to minimise the severity and duration of the condition and to reduce its broader impacts. * People will receive timely access to high quality, coordinated care appropriate to their conditions and circumstances. * People with mental health problems and mental illness will enjoy full social, political and economic participation in their communities. * The crucial role of carers will be acknowledged and respected and they will be provided with appropriate support to enable them to fulfil their role. * The mental health workforce will be appropriately trained and adequate in size and distribution to meet the need for care. * Across all sectors, mental health services should be monitored and evaluated to ensure they are of high quality and achieving positive outcomes. * Research and evaluation efforts will generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of mental health management services (figure 12.1). The performance indicator framework shows which data are complete and comparable in the 2014 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 of the 2014 Report discusses data comparability from a Report‑wide perspective (2014 Report, section 1.6).

The Report’s statistical context chapter 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) (chapter 2).

Figure 12.1 Mental health management performance indicator framework

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| Figure 12.1 Mental health management performance indicator framework.  More details can be found within the text surrounding this image. |

*Source*: 2014 Report, figure 12.9, p. 12.22.

### Equity — access — mental health service use by selected community groups

‘Mental health service use by selected community groups’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by selected community groups such as Indigenous Australians (box 12.2).

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| Box 12.2 Mental health service use by special needs groups |
| ‘Mental health service use by selected community groups’ is defined by two measures:   * proportion of the population in a selected community group using State and Territory specialised public mental health services, compared with the proportion of the population outside the selected community group using State and Territory specialised public mental health services * proportion of the population in a selected community group using MBS‑subsidised ambulatory mental health services provided by private psychiatrists, GPs and allied health providers (psychologists, social workers, occupational therapists, mental health nurses and Aboriginal health workers), compared with the proportion of the population outside the selected community group using MBS‑subsidised ambulatory mental health services.   The selected community groups reported are Indigenous Australians, people from outer regional, remote and very remote locations and people residing in low socio‑economic areas. For MBS‑subsidised ambulatory mental health services, data by socio‑economic status are reported by decile at the national level only.  This indicator is difficult to interpret. It does not measure access according to need, that is, according to the prevalence of mental illness across the selected community group. Variations in use could be due to variations in access, but could also be a result of differences in the prevalence of mental illness. It also does not provide information on whether the services are appropriate for the needs of the people receiving them, or correctly targeted to those most in need.  Data reported for the ‘proportion of the population in a selected community group using State and Territory specialised public mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011‑12 by geographic location and Socio Economic Indexes for Areas (SEIFA) are not comparable to previous years’ data * incomplete for the current reporting period (subject to caveats). All required 2011‑12 data are not available for Victoria. |
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| Box 12.2 (Continued) |
| Data reported for the ‘proportion of the population in a selected community group using MBS‑subsidised ambulatory mental health services’ measure are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data for 2011‑12 by geographic location and SEIFA are not comparable to previous years’ data * complete for the current reporting period (subject to caveats). All required 2011‑12 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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The proportions of the population using State and Territory specialised public mental health services in 2011‑12, by selected community groups are reported in   
figure 12.2. The results are not available for Victoria or at the national level.

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

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

The proportions of the population using MBS‑subsidised ambulatory mental health services, by selected community groups, are reported in figure 12.12. Data are not available at the State and Territory level for Socio Economic Indexes for Areas (SEIFA) quintiles.

Data on the use of State and Territory community‑based specialised public mental health services and MBS‑subsidised ambulatory mental health services by SEIFA deciles are in 2014 Report, table 12A.29. Data on the use of private hospital mental health services are also contained in table 12A.26 and 2014 Report,   
tables 12A.27–29.

Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group, 2011‑12**a, b, c, d, e, f, g, h**

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| **Indigenous status** |
| Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group 2011-12  a) by Indigenous status  More details can be found within the text surrounding this image. |
| **Geographic location** |
| Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group 2011-12   b) by geographic location  More details can be found within the text surrounding this image. |
| **SEIFA** |
| Figure 12.2 Population using State and Territory specialised public mental health services, by selected community group 2011-12   c) by SEIFA  More details can be found within the text surrounding this image. |

SEIFA = Socio‑Economic Indexes for Areas. a Proportions are age‑standardised to the Australian population as at 30 June 2001. b State and Territory specialised public mental health services are counts of people receiving one or more service contact provided by community‑based ambulatory services. c Data are not available for Victoria or at the national level. d SA submitted data that were not based on unique patient identifiers or data matching approaches. Therefore, caution needs to be taken when making jurisdictional comparisons. e Disaggregation by remoteness area is based on a person’s usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. f Tasmania does not have major cities. SEIFA Quintile 5 is not applicable for Tasmania. g The ACT does not have outer regional, remote or very remote locations. ACT data are not published for inner regional areas. Data for quintile 1 are not published for the ACT. h The NT does not have major cities or inner regional locations.

*Source*: State and Territory governments (unpublished) Community Mental Health Care (CMHC) data;   
table 12A.26 and 2014 Report, tables 12A.27-28; 2014 Report, figure 12.11, p. 12.27.

Figure 12.3 Population using MBS‑subsidised ambulatory mental health services, by selected community group, 2011‑12**a, b, c, d, e**

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| **Indigenous status** |
| Figure 12.3 Population using MBS- subsidised ambulatory mental health services, by selected community group 2011-12   a) by Indigenous status  More details can be found within the text surrounding this image. |
| **Geographic location** |
| Figure 12.3 Population using MBS-subsidised ambulatory mental health services, by selected community group 2011-12   b) by Geographic location  More details can be found within the text surrounding this image. |
| **SEIFA** |
| Figure 12.3 Population using MBS-subsidised ambulatory mental health services, by selected community group 2011-12  c) by SEIFA  More details can be found within the text surrounding this image. |

SEIFA = Socio‑Economic Indexes for Areas. a Proportions are age‑standardised to the Australian population as at 30 June 2001. b MBS‑subsidised services are those mental health‑specific services provided under the general MBS and by DVA. The specific Medicare items included are detailed in 2014 Report, table 12A.30.   
c Disaggregation by remoteness area is based on a person’s usual residence, not the location of the service provider. However, where a state or territory does not have a particular remoteness category a rate cannot be calculated. d Victoria does not have very remote areas. Tasmania does not have major cities. The ACT does not have outer regional, remote or very remote locations. The NT does not have major cities or inner regional locations. e Data for SEIFA quintiles are not available by state or territory.

*Source*: Department of Health (unpublished) MBS Statistics data; DVA (unpublished); table 12A.26 and   
2014 Report, tables 12A.27–28; 2014 Report, figure 12.12, p. 12.28.

### Mortality due to suicide

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

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| Box 12.3 Mortality due to suicide |
| ‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for 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 Australians.  A low or decreasing suicide rate per 100 000 people is desirable.  While mental health services contribute to reducing suicides, other government services also have a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by severe mental illness, some of whom have either attempted, or indicated an intention, to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of other government agencies, non‑government organisations and other special interest groups. Any effect on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including education, housing, justice and community services.  Many factors outside the control of mental health services can influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with an increased risk of suicidal behaviour. Other factors that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often a combination of these factors can increase the risk of suicidal behaviour.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions but a break in series means that data are not comparable across time periods for some dissagregations (see the attachment tables 12A.60–63 for details) * complete for the current reporting period (subject to caveats). All required 2011 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2014. |
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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; Lawrence et al. 2013).

All Coroner certified deaths registered after 1 January 2006 are subject to a revisions process. The revisions process enables the use of additional information relating to Coroner certified deaths either 12 or 24 months after initial processing. This increases the specificity of the assigned ICD‑10 codes over time (ABS 2010). Each year of data is now released as preliminary, revised and final. For further information on this revisions process see the DQI for this indicator.

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and   
the NT (figure 12.4). After adjusting for differences in the age structure of the two populations, the suicide rate for Indigenous Australians during the period   
2007–2011, for the reported jurisdictions, was higher than the corresponding rate for non‑Indigenous Australians.

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

Figure 12.4 Suicide rates, by Indigenous status, 2007–2011**a, b, c, d, e, f**

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| Figure 12.4 Suicide rates, by Indigenous status, 2007-2011.  More details can be found within the text surrounding this image. |

a Deaths from suicides are deaths with ICD‑10 codes X60–X84 and Y87.0. b Suicide rates are  
age‑standardised. c Data on deaths of Indigenous Australians are affected by differing levels of coverage of deaths identified as Indigenous across states and territories. Care should be exercised in analysing these data, particularly in making comparisons across states and territories and between Indigenous and non‑Indigenous data. d Deaths with a ‘not stated’ Indigenous status are included in the data for   
non‑Indigenous. e Causes of death data for 2007, 2008 and 2009 have undergone revisions and are now considered final. Causes of death data for 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revisions process. f Total data are for NSW, Queensland, WA, SA, and the NT combined, based on the state or territory of usual residence. Data for the Indigenous mortality analysis are excluded for Victoria, Tasmania and the ACT due to insufficient levels of identification or numbers of deaths.

*Source*: ABS (unpublished) *Causes of Deaths, Australia,* Cat. no. 3303.0; table 12A.64; 2014 Report,   
figure 12.29, p. 12.63.

### Future directions for reporting on mental health management

Priorities for future reporting on mental health management include improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups.

### Definitions of key terms

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| **General terms** |  |
| **General practice** | The organisational structure in which one or more GPs provide and supervise health care for a ‘population’ of patients. This definition includes medical practitioners who work solely with one specific population, such as women’s health or Indigenous health. |
| **Health management** | The ongoing process beginning with initial client contact and including all actions relating to the client. Includes assessment/evaluation, education of the person, family or carer(s), and diagnosis and treatment. Involves problems with adherence to treatment and liaison with, or referral to, other agencies. |
| **Separation** | An episode of care for an admitted patient, which can be a total hospital stay, or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care. |
| **Mental health** |  |
| **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. |
| **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. |
| **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. |
| **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. |
| **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). |
| **Psychiatrist** | A medical practitioner with specialist training in psychiatry. |
| **Public health** | The organised, social response to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. Public health is characterised by a focus on the health of the population (and particular at‑risk groups) and complements clinical provision of health care services. |
| **Schizophrenia** | A combination of signs and symptoms that can include delusions, hallucinations, disorganised speech or behaviour, a flattening in emotions, and restrictions in thought, speech and goal directed behaviour. |
| **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. |
| **Substance use disorders** | Disorders in which drugs or alcohol are used to such an extent that behaviour becomes maladaptive, social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug can be psychological (as in substance misuse) or physiological (as in substance dependence). |

### List of attachment tables

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

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| **Table 12A.15** | Age standardised rate of adults with high/ very high levels of psychological distress, by State and Territory, by Indigenous status, 2011-13 |
| **Table 12A.21** | Specialised mental health care reported, by Indigenous status |
| **Table 12A.26** | Proportion of people receiving clinical mental health services by service type and Indigenous status |
| **Table 12A.40** | Rate of community follow up within first seven days of discharge from a psychiatric admission, by State and Territory, by Indigenous status, remoteness, 2011-12 |
| **Table 12A.64** | Suicide deaths, by Indigenous status, 2007–2011 |

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